Good morning. Thank you all for being here.

Please let us know, make sure everyone can hear with microphones organized around the room.

So I'm Donna Frescatore, I'm state Medicaid director and executive director of New York State of Health.

I'm joined this morning by Greg Allen, who you, of course, know from the Office of Health Insurance Programs.

Dr. Doug Fitts, Peggy Chan, who, of course, you all know as well.

And Lisa Sabrana, also from the Office of Health Insurance Programs and Phil from our office is going to kick us off this morning. We're going to do our usual 1115 waiver, 101, a summary of where we are and various waiver initiatives.

Gregg is going to talk about the concept paper that was submitted for the DSRIP waiver extension. That's the document that's currently open for public comment.

And we very much the forward to your comments here today we will be in central New York, Syracuse specifically next week as well. So, again, thank you for joining us. Phil, take it away.

Sure. Thank you, Donna.

Good morning, everyone.

As Donna said, my name is Phil, and I'm going to provide you with a brief overview of the 1115 waiver and some of New York's MRT waiver programs as well.

First, I just want to mention everybody that I was told that the Wi-Fi password is working.

That's New York State DOH.

NYSDOH.

All uppercase for your information.

And I'm going to go through a few slides this morning.

The 11 15 demonstration waiver, also known as Section Eleven fifteen of the Social Security Act, the eleven fifteen gives the Secretary of Health and Human Services the authority to waive certain provisions and regulations and also allows Medicaid funds to be used in a way that are not otherwise allowed under federal rules, the 1115 demonstration waivers grant flexibility to states for innovative projects that advance the objectives of Title 19 of the Medicaid program and thus waive certain compliance requirements of federal Medicaid laws.

A waiver can be approved for up to five years and a state may request subsequent extensions.

Some general information on the 1115 waiver, as he sees outlined the basis of an agreement between the state and CMS, including waiver and expenditure authorities.

STC specified the states obligation to CMS during the life of the demonstration, including general and financial reporting requirements and a timetable of state deliverables, quarterly and annual reports are required and an independent evaluation is completed at the end of the demonstration program.

Federal Medicaid expenditures with the waiver cannot be more than federal Medicaid expenditures without the waiver, also known as budget neutrality or budget neutral.

New York State's 1115 waiver.

New York's MRT Waiver, formerly known as the Partnership Plan, has been in operation since 1997.

New York's 1115 was renewed on December 6, 2016 and is effective through March 31st 2021.

Several key goals for the waiver are to improve access to health care for the Medicaid population, improve the quality of health services delivered, and expand coverage with resources generated through Medicaid.

Excuse me, managed care efficiencies to additional low income New Yorkers.

Specifically, New York's waiver programs include Medicaid, managed care.

This comprehensive health care services, including all benefits available through the Medicaid state plan to low income uninsured individuals.

An opportunity for enrollees to select a managed care organization, also known as an MCO, with a focus on preventive health care.

Programs include mainstream Medicaid managed care, also known as MMMC.

Health and recovery plans, also known as HARPs and home and community based services, also known HCBS.

Managed long term care MLTC, and long term services and support LTSS.

Delivery system reform incentive program, which many of us know also by DSRIP.

Provides incentives for Medicaid providers to create and sustain an integrated high performance health care delivery system.

It's it's it's designed.

Excuse me. It's designed to effectively meet the needs of Medicaid beneficiaries and low income uninsured individuals in their local communities and thereby improving quality of care, improving health outcomes and reducing cost, which is also referred to as the CMS tripling.

At this time, I'd like to turn it over. Turn over the presentation to my DOH colleague, Greg Allen, director of program development, a management to talk about New York's pending amendments, DSRIP and some projects that DOH is currently working on.

Thank you very much, Phil.

Phil's one of the many sort of unsung heroes of waiver work.

You know, he and his team move mountains of important stuff so that we can enable, you know, this fine work. So really appreciate it, Phil, and also appreciate the table of distinguished colleagues, everybody who showed up here today to learn about the waiver and all of you who have been busy working on various aspects of advancing health care, behavioral health care and social care for our Medicaid enrolled populations and for vulnerable citizens across the city in New York and the state of New York. We really just appreciate your work and I appreciate you coming out today.

My name is Greg Allen.

I drug policy at the Medicaid program.

One of the things that I've had the privilege to work on is the states, the DSRIP initiative.

So it's going to spend just a second, providing you some quick results on DSRIP. We just closed our measurement year five.

Our last performance measurement year of DSRIP this summer.

That data is rolling in right now.

But we have some really promising results to share through through measurement year four and we're we're we're we're proud of what's what's been happening here.

But just the 1115, as Phil was mentioning to us, carries the structure for our managed care program.

It also carries the structure and the authorization for our delivery system reform incentive payment program. So all of the activities that have been carried out sort of to advance population health under the DSRIP moniker require this 1115 authority to carry it forward. And that's what we're really here to talk about today.

Just to review where we've been quickly and also to show us what what we've been doing in DSRIP is trying to make sure go forward or backward here.

So we'll talk about the justice of our population.

Sorry, I was hitting R, which isn't like go forward.

R is reverse.

So inside of the waiver, also, we have a couple of authorizations that we've been working on in addition to DSRIP and one of which is for justice of all populations. And so many of you have been working with us on the Criminal Justice Health Home Work Group, trying to advance care management for criminal justice populations, both those that are incarcerated or justice involved in the community.

Those who were involved in pre sentencing. And so we have put out for public comment that is closed and we are nearing completion of a final amendment to cover 30 days prerelease for prison populations and for those who are awaiting sentencing as well.

And this would provide behavioral health care, limited clinical services, important medicines, both addiction medicines, mental health medicines and management of chronic disease drugs for management of chronic disease, as well as in reach care management services, all designed to assure a smooth transition back to the community and to promote continue some of the progress that may have been achieved while folks were in prison.

Many of you know, we've been busy at work trying to advance eligibility so that there is more continuous eligibility while folks are in prison and keeping and being able to sort of reactuate that eligibility after release.

This links to this by actually providing services, prerelease that would be key for those individuals and getting importantly Medicaid coverage for those services.

This is a very interesting advance stick because going forward is at the bottom.

So I'm going to continue to have struggles, but I can. I can work my way through.

So we are continuing our work on DSRIP right through March 2020.

That's when our authorization ends.

There are some roll out activities that continue after that.

We will be working on this eleven fifteen authority and we also have some supportive housing work that we're doing that may take the form either of a waiver or even potentially a state point amendment.

So getting into DSRIP improper, which is somewhat the main event here, we have made remarkable progress thanks to the work of the 25 PPSs, as I mentioned, through measurement year 4.

You'll remember that our central theme here are our central goal was to reduce avoidable hospitalizations by 25 percent over the five running years of DSRIP.

We have reduced potentially preventable admissions.

That's the PPA, the Green Arrow by 21 percent.

So we are well on our way to reaching what many thought was an unreachable goal.

I had my own concerns about being able to reach that. We were on purpose building a stretch goal there. We've already reduced potentially preventable admissions by 21 percent.

We've reduced potentially preventable readmissions.

These are for people coming back to the hospital by 17 percent and we've reduced the per member per year cost associated with those events. So members that did not end up in the hospital either for that first preventable admission or a readmission, that cost has dropped by 14 percent.

That's over five hundred million dollars in savings just for those events alone. Never mind all the rest of the management that we've been doing on the ambulatory side.

But part of what we say in our application in that DSRIP is not a story about statewide average.

DSRIP is a story about excellence.

When we look very carefully under the hood of each PPS and see what it was that they did well.

Eleven PPS is have already exceeded the statewide goal of reducing either potentially preventable admissions or readmissions by twenty five percent now.

Four of them have reduced that preventable cost by 25 percent and three of these have reduced readmissions by over 40 percent.

That's a dramatic change you really can't hold in your hand what personally that means to people to be kept more healthy so they don't have to end up back in the hospital after an admission.

And this is not this is not progress that just happens.

This is progress that was built through purposeful workflow redesign, through careful analysis of data.

The clinical data.

Building interdisciplinary care management teams making care mobile.

Beginning to really think through from a care management perspective, what the care plan needs are of that individual prioritizing those hot spotting people with the with the greatest chronic disease. So we are very proud of the average, but we are even more impressed when you look inside some of the most promising practices.

This all happened despite the fact that the test got a lot harder.

Our attributed population grew by 8 percent from four point four million over four point eight million lives attributed to these PPSs during the period. What does that mean? It means that all the performance that they have to achieve the denominator is enumerators of, say, screening measures of those avoidable hospitalization measures.

They're getting more difficult because more patients are coming into the PPS, including more high risk patients that have to be flagged in the EMR, that have to provide more care.

So three hundred fifty six thousand Medicaid members came in, new that had to be engaged in care.

We reduced readmissions by 17 percent.

Three thousand fewer people had PPRs and measurement year for even though the population was growing at such a sizable pace, the number of people with asthma increased by seventy five hundred during those four years.

But we still drove the rate of long term Medicare, it's a very important marker of stabilization for asthma by 11 percent.

So we've got more folks coming at us. We're getting better at caring for them despite having more patients fall up after hospitalization for mental illness. Similarly, this is the 30 day measure to see connectivity in the community after hospitals for mental illness, mental illness improve by over 12 percent.

And those same three years.

Additional twenty five hundred people just in measurement year three receive more timely care for mental health follow up after after in patient hospitalization.

So lots of good stuff to say.

That's just a snapshot of it.

Twenty five PPSs of implemented over two hundred and fifty nine DSRIP projects across the state.

One hundred and thirteen of those were focused on system transformation.

We have twenty four hundred.

We already led the nation in PCMH certification when we went into DSRIP and we added another twenty four hundred recognized practices that were supported by the PPS and the performance in terms of improving behavioral health and primary care integration and getting to more advanced levels of certification.

Most of those 24 hundred were at advanced levels of PCMH or at New York state certification.

So dramatic changes in just the footprint of the delivery of primary care.

43 behavioral health substance use treatment projects, most of which are focused very directionally on integrating primary care and substance abuse and focusing on the highest risk members bipolar schizophrenia, opiate use disorder.

Fifty five clinical improvement projects, 48 prevention focused projects like reducing smoking, underage drinking, etc.

three point five million patient engagements.

And a lot of this is screening direct patient contact in in measure in DSRIP year four. We've earned eighty five percent of all of the available dollars, despite the fact that every single dollar was tied to some form of performance achievement during the DSRIP period, 5.5 billion dollars in system transformation.

And I believe that we we likely lead the nation in terms of this DSRIP percent earned award because of the performance that we're seeing there.

We've exceeded all of our value based payment roadmap goals thus far that have been set in front of us. We have 65 percent of Medicaid managed care contracts at level 1 or higher, meaning that there is quality attached to payment for all of those contracts and 35 percent of those contracts are at level 2 or higher, which means that there is some amount of downstream risk in the arrangement, meaning that providers have to produce both efficiency and quality in order to earn extra dollars.

So these are really important pieces, but it is these two things that we need to link.

We need to really do a better job of linking the value based payment to these projects.

And that's what we are telling our federal partners. We need more time to mature.

We need these a lot of these contracts are many of, you know, go out to the PCP.

They're based on total cost of care, but they're not purchasing a fully integrated network of ACO care.

And that's what we really need to do, is connect behavioral primary care, hospital care, social care in a more mature, value based payment contract.

And that could be the carrying vehicle for the social care that's required, the behavioral health care and integrating that with primary care and organizing it with acute care providers.

So that's the work that's in front of us in terms of continuing the transformation.

That's what our amendment request is. We seek a four year waiver. We're asking for eight billion dollars over this period.

Five billion would be focused on different performance.

Another billion on workforce development.

We have gone a long way and workforce. We have a lot further to go.

And many of you know, we have primary care shortage challenges, shortages in almost every aspect of the Ambulatory care service delivery.

Shortages of care managers to do this work. We need a pivot of our workforce as we pivot the fabric of our of our care delivery.

One point five billion dollars social determinant health access fund, very specifically to build regional networks, to promote social care, to promote CBO engagement with medical and behavioral.

And to really further the work of DSRIP 1.0 in some of that excellent work in integrating social with medical and behavioral.

Five hundred million dollars in interim access assurance.

Again, some of our most vulnerable safety net hospitals made more vulnerable by purposeful reductions in avoidable hospitalizations before the full pivot to ambulatory emergency capacities and other kinds of necessary organizational changes have fully occurred.

We have moved several hospitals out of the need for these kinds of funds. Some have come in.

Some existing ones that were vulnerable remain vulnerable.

We need to make sure that we we time this transition appropriately.

So that last bullet here is critical and this is really central to the whole aspect.

We know the secret source of change.

We know how it works.

We know through the first demonstration how to change population health for the better.

But it is supported right now primarily with these extra dollars that are coming through the DSRIP channel.

It is not yet fully supported, although we see some really promising starts by value based payment contracts.

We need more time for those contracts to mature and you'll see in the structure that we propose that maturation happening.

I commend to all of you on the weekend, if you happen, go out to the UHF website and read the DSRIP promising practices for meaningful change for New York Medicaid.

And these are practices that go beyond Medicaid.

But this is the secret sauce.

This is what we have found has been driving the promising change we showed you in the first few slides.

Examples include expansion of Medicaid assisted treatment for people with opiate use disorders.

But bring that out of exclusive settings into primary care in emergency departments, cross-sector collaborations, including those with with the justice system, including those with schools, including that with all of integrating behavioral health and primary care, more care coordination, more focused care coordination on high risk, high need.

Expansion of mobile everything, making health care move to patients rather than making patients move to health care.

Much of what many the PPSs found work the best is finding out who your highest risk patients are based on predictive and bringing care to them and maybe often starting the bringing that care with care management.

Transitioning IMDs into the community, focusing psych, focusing substance use disorder services, more on the community and less on back end inpatient.

Lots of our work really focused on the individuals that were at higher risk in the Medicaid program and the mentally ill and substituted disorder populations where primary and none of this works without us engaging the social determinants more effectively.

All of the blocking factors to healthcare performance improvement have social pieces behind them.

You move social care, you move medical measures, you move social care, you move behavioral health measures.

The solution to the health care dilemma is a social solution that is clear.

The most promising work, the furthest distance we've traveled in measures has been by carefully working and existing community capabilities into the care delivery fabric of Medicaid and then very important supporting ambulatory supporting primary care through a different way to pay. We can't get there if we continue to pay for quotable widgets, we have to pay for health.

And part of what the tilt the value based payment is, is purchasing health rather than purchasing health care.

In this, we need an entity to drive this forward.

And we think PPSs are very well positioned to do this.

But we are very specifically asking the MCOs to join these teams. Some of the best work that we saw was careful partnerships of the health plans, the Medicaid health plans, working with the PPSs and the providers to drive change.

We want to see more of that.

We very specifically reference a new name where we use performing provider system.

We now use value driving entities.

These value driving entities include the PPS or subset partners, important providers in the community. Community based organizations are central to this working effectively and MCOs and optimally these are all engaged in the steerage, the management, the oversight, the development that this is a four way design of the service delivery, leveraging those dish promising practices and bringing them to scale through the value driving entity.

And the exclusive work is to try to bake these capacities into value based payment contracts.

And that is why it's so critical to bring the MCOs in is we want the exit strategy is 100 percent value based payment carrying those promising practices forward.

Also, there are some pieces that we want to focus more on or bring the DSRIP lens to reducing maternal mortality is a clear and important goal of the governor.

We want to use DSRIP funds to support this comprehensive initiative to reduce racial disparities, improve health outcomes and reduce this really terrible statistic we have around maternal mortality.

It is exactly the kind of work that the PPSs have been doing that can make a serious impact on reducing disparities and improving maternal health.

Children's population health, other than asthmatic children and a few other high risk children, because DSRIP focus so heavily on avoidable hospitalizations.

Kids were really not the central focus, they need to be.

If we're gonna be successful in prevention, we need to bring kids in. Forty seven percent of the state's children are covered by Medicaid. So as Medicaid leads, other payers can certainly follow. But again, all of this promising work that we've been doing in population health should focus on children.

Long term care.

Similarly, we had some very good and successful long term care projects, but it was not a primary care primary focus.

We bring long term care more more specifically into the vision.

Workforce flexibility.

Again, we mentioned that earlier.

A key piece of moving this is having a prepared, ready, particularly ambulatory workforce to drive the change.

Lots of promising work on addressing the opiate epidemic, but we've got further to travel, more to go here.

We have challenges in almost every community with the opiate crisis.

There are some excellent strategies that have already been employed by many of the PPS that we can scale across the state and there are there are new things that we need to do that are evidence based that we want to work on as well.

We need to focus the DSRIP lense on the opiates as well.

And then I mentioned the interim access assurance fund.

And then, in order for all of this to work and most of the PPSs that were the most successful were not just focused on Medicaid patients, they were focused on changing care for every patient that crossed the threshold or every patient that was in front of their practices.

So we need to continue this multi-page context for all of this work.

Medicare is going to be an important piece of this, particularly as we're looking at long term care.

We need to make advances in marrying the Medicaid data to the to the Medicare data, which we are busy at work on, believing that this is going to be an important piece.

The social terminal health network is critical here.

So the idea that we have is each region would have its own exclusive social terminal health network with the exclusive job of marrying CBO capacities, vetting those CBO capacities and readying them for connectivity with these performance networks that are going to drive population health.

It is a critical piece.

If you look at any piece of literature, it is social care that is the blocking factor for especially less impactful chronic disease burden and community.

So we have to get after that.

We're getting after that through the network.

And then we really believe that we have some great learnings from the first phase of DSRIP on attribution, on the performance measures, on aligning those performance measures with the value based payment cuts that exist right now.

And we think we have some very good ideas to share with our federal partners for new ways to think about performance that borrows from the first. The first piece.

This is important, which is that we have put together what we believe based on all the conversations we've had with so many of you over the past months.

Is the is the right start, but we are very, very open to your thoughts, your ideas, your opinions.

Facts that you think we might have missed. Focus areas that we need to look more carefully at.

We need to make this our waiver ask.

And that's what today is about.

We know many of you are busy at work on written comments.

We are eager for those.

We are open for those.

We have no fixed thinking with regard to this.

We just know that we need more time.

We know we need this resource and we know that we have a tiger by the tail. We have a very good thing here that started and we want to keep it going.

And that need extra time is kind of critical. But your thinking will be important as we move forward.

The dates are all up here.

The public comment period ends on November 4th.

After that, we'll be busy at work packaging this for delivery to CMS by November.

Twenty seventh.

The waiver amendments up on the Web site.

There's a link to the document.

Here's some more resources that are available. The slides will, of course, be available on our website as well.

For those of you that are taking pictures to send to your children, we will eventually have this this up there and more resources here.

So I'm just gonna let my buddy Phil come back and be the traffic cop here a little bit for the day.

But thank you very much for taking time out of your busy days to join us.

And we'll look forward to hearing what you have to share.

Thank you very much.

Thank you Greg.

Just some housekeeping details before we get started with the public comment.

On your right, just outside those doors, there is a restroom for your convenience.

If you'd like to speak, please sign up at the registration table that's just outside the elevators.

Please make sure you sign up and you'll be given a number.

When your number is called, please come up to one of the microphones and present your public comment.

Comments will be timed just to manage the afternoon.

You have about five minutes to speak.

Please return your numbers.

Either you can give them to me or leave it at the registration table on your way out if you need assistance with the mic.

Just raise your hand and I'd be happy to help you with that.

As Craig said, written comments can be submitted at the registration table.

They can be emailed to eleven 1115waivers at health dot ny dot gov.

Just put in the subject line MRT Public comment. So that gives us a heads up that it is a public comment regarding this 1115 forum.

All public comments will be posted on the DOH Web site along with the slides.

And as this meeting is being webcast live and we'll be also archived on the DOH Web site for future viewing.

Any questions before we get started? I believe we have great 34 presenters.

Might be more by now.

Just checked in.

Yeah, we're about thirty four.

Okay.

So I'll be taking.

I will just be taking some notes.

So we have them while the formal notes are being made so we can do some work in the meantime.

So you'll see several of us writing or on iPads, please know, that's what, you know, what we're doing.

They've finally moved me to an iPad from paper.

OK.

Thank you.

OK, so I guess we'll start with speaker number one.

Number one, who's first? And number two, if you want to get on deck too, we can proceed that way, folks want to start self managing, it's probably more effective.

We know you slept overnight waiting for this here. So we want to keep it rolling quickly.

Good morning, everybody.

I'm Amy Dorin, president and CEO of the Coalition for Behavioral Health.

The Coalition for Behavioral Health, representing over 100 community based behavioral health providers.

Support is committed to partnering with the state as various transformations of the state Medicaid system move forward, including the behavioral health transition to managed care.

The shift to value based payment.

And efforts to integrate both physical and behavioral health services.

The coalition supports the New York State Department of Health in its effort to secure a continuation of funding for the Delivery System Reform Incentive Payment Program from the Centers for Medicaid Medicare.

The coalition and its membership are pleased to see the state emphasize the importance of behavioral health interventions in the new DSRIP Waiver Amendment.

The current waiver application needs to emphasize the central role of behavioral health providers in the health care system.

In order to ensure the future success of DSRIP, the Coalition's main recommendation on the new DSRIP waiver is that behavioral health providers should lead behavioral health focused projects and continue to be meaningful, engaged, meaningfully engage in DSRIP projects.

This not only recognizes the unique expertise of behavioral health providers, but also recognizes that true cost savings happen in the community, not in the emergency room or hospital.

People want to receive services in the community and near their home by providers such as our member agencies that they trust and can build meaningful connections with.

This is especially true for those with serious mental illness, substance use disorders, intellectual and developmental disabilities, and those with co occurring disorders.

So with the most difficult to engage and most costly to the Medicaid system.

In addition, many of our members offer social services that address the social determinants of health and have an incredible impact on health care outcomes and expenditures.

Over the past four years, approximately 80 percent of the Coalition's member agencies were members of multiple PPSs and involved in a variety of DSRIP projects in New York City, Long Island and Westchester.

Projects included integration of primary care and behavioral health, population health management, health home at risk and crisis stabilization services.

DSRIP allowed our providers to build stronger relationships with hospital systems, connect people leaving the hospital to the right care in the community, and access the tools, data and I.T.

infrastructure to analyze their programs and link.

Our providers received real time health care information on the people they served in order to coordinate care in an integrated and holistic fashion.

In addition, DSRIP provided our members with funding to take on these innovative projects.

On average, our providers reported receiving an average of five hundred thousand dollars each from each of the PPSs they worked with, in addition to training, technical assistance and I.T. infrastructure.

DSRIP enabled our providers to offer effective and cost saving services that helped individuals and communities.

For example, one of our members reported they were able to save the Medicaid system three million three hundred thousand dollars in hospital costs in one year with approximately 66 individuals due to their involvement in the Critical Time Intervention Project with the PPS.

That is the savings of fifty thousand dollars per person.

Coalition offers the following recommendations to improve the DSRIP waiver amendment.

These recommendations help ensure a long term cost savings by placing behavioral health providers at forth at the forefront of intervention so that individuals receive care in the community where costs are lower and provider expertise is substantial.

Behavioral health providers should lead behavioral health focused projects and be increasingly engaged in DSRIP projects, meaningful integration and behavioral health beyond mild to moderate depression and anxiety, allowing behavioral health providers to lead, manage integrated care interventions and provide incentives for integration of primary care services into behavioral health programs.

Regarding data transparency, data transparency on outcomes is needed. PPS networks and member participation by projects and funding allocation and PPS determination of funding per project and per member.

Outline a pathway to ensure shared savings, attribution behavioral health providers and allow providers to put shared savings into reserves.

Priority areas.

Expansion of MAT into primary care and emergency room settings.

Requiring three days in primary care providers to develop relationships with behavioral health providers to provide aftercare.

Regarding primary care and behavioral health integration.

Use DSRIP planning to expand the Certified Community Behavioral Health Clinic model.

Extend the DSRIP waiver to allow providers to offer up to 49 percent of services outside of the licensure.

Develop a long term integrated care solution such as the formally proposed article Ninety Nine License to allow for providers to offer integrated services without multiple agency oversight.

Regarding care coordination, care management and care transitions.

Establish a Health Home Care Management Training Institute to offer statewide standardized trainings on evidence based practices for care managers and supervisors.

So your five minutes is up.

We look forward to getting these and written public comment.

Okay. So thank you.

Okay.

Good morning. Thank you very much.

I'm Steve Rosenthal from the Monitor Health System.

And as you know, Monitor has been very much involved in DSRIP, both in the Bronx with the Bronx Health Network and the Hudson Valley, with the Hudson Valley Health Network.

And for the last several years, we've also been the fiduciary for the SOMOS PPS and in many ways working with such a large network of primary care physicians, stretching as many burrows as they have and as they do.

I thought it was important to reiterate and compel us to continue to view the relationship between primary care physicians and large integrated systems as a doable possibility for both integration and all of the nuances associated with some of the major elements that Greg was able to demonstrate in terms of some of the achievements over the last several years with regard to utilization, particularly around care management and the effective tools that we've been able to put in place in the emergency room and certainly working with many of the community based organizations to actually begin to integrate those opportunities.

And we agree that more time would be terrific.

And we wanted to support the DSRIP 2.0.

Obviously, you'll get our written comments around that as well.

And certainly to continue to sustain the opportunities for large systems like mine if you're to continue to work with a primary care network such as SOMOS so we can actually fulfill some of those integration opportunities.

Thank you.

Good morning, my name is Jo-Ann Yoo and I'm the executive director of the Asian American Federation.

We are a membership organization of about 70 Asian-American organizations that serve our city.

I am here to underscore the testimony of SOMOS community care and to give context to the importance of the work and to discuss the need to increase access to increased access to affordable, culturally competent, linguistically appropriate healthcare for our Asian community.

As you know, Asian-Americans are the fastest growing population in the city and state.

We are 15 percent of the city's residents and 70 percent of us are immigrants.

Asians have the highest rate of poverty in New York City with a high rate of under and uninsured at 25 percent.

Our greatest strength is our diversity, which is also at times our greatest obstacle as we have to do everything in 36 track languages, not counting dialects.

Other challenges, that we have the highest rate of English proficiency at 50 percent, which is further complicated by the fact that many in our community are not literate in their own language.

So we have done work with SOMOS community care because we get access to 35 Asian-American, 35 hundred Asian-American doctors and we are really thrilled by this partnership because it means that we have new front line allies to talk about what is happening in our community and how do we help to create preventive care to serve the most vulnerable members of our community.

And I would just say that, you know, with a looming threat of what is happening in public charge, I mentioned that because we were one of the plaintiffs who sued to block the Trump efforts to implement public charge.

And we were successful.

But we are you know, we understand that Asian-American.

And the reason why we joined as plaintiffs is because New York City HRA and the mayor's Office of Immigrant Affairs found that Asian non-citizens are decent rolling from public benefits at eight times the rate of Asian citizens, even though Asians are under enrolled in public benefits to begin with.

In the past year, our member agencies have also reported a greater number of clients asking to be dis enroll from any kind of public benefits, citing fear of the possibility of deportation and worry that they can harm their children's and grandchildren's future.

We, like many of our community members most vulnerable, are having to choose between essential needs and protecting their immigration status, which should never happen in New York State.

So now, more than ever, we need to increase access to health care services when there isn't one, where there isn't a fear of immigration consequences that can offer programs in language with cultural expertise.

Finally, SOMOS and Asian confederation. We've started this conversation around mental health and I think for the Asian-American Federation, we released a report a couple years ago and

we've been very deep into this work and we are the only Asians are the only racial group in New York City for whom suicide was one of the top ten leading causes of death from 1997 to 2015 and many poor families.

For many poor families, Medicaid supports mental health and addiction treatment services.

Now, more than ever, we need our state and city leaders to help us live beyond the sanctuary, city and state values into increased capacity to provide in language culturally competent health care in all forms because it is a moral and humane thing to do.

Thank you.

The last 30 seconds.

I just want to let you know that we appreciate the opportunity.

We believe that was delivering, as I said five years ago.

I mean, just introducing yourself.

I'm sorry.

Chairman of SOMOS community care.

I just want to say that we're still differing. Certainly we're working together. We're able to put together that amount and patients to prove that it's possible.

Do they? All the measures, the modern time, we need to complete our task.

Now, we know that when we came within the first 10 ACO in the country and that's the MS program, and because of the tools that we able to use to DSRIP, we are able to achieve these big things continue being for the last three years number one in the State of New York.

And one more time with Ephraim, by now we have able to our partners to work together.

They same way that this is asking for to do. Thank you.

Just want to make sure we're tracking the numbers or number five.

Three.

Number three.

Number three. Yes.

OK, good.

So good morning. My name is John Javis. I'm the CEO of Behavioral Health New York City IPA.

We are one of the BHCC or behavior health care collaboratives.

And we're supportive of the state's efforts toward a second generation of DSRIP.

Personal background, I actually came from a PPS.

I was formerly the director of Behavior Help for the Nassau Queen's PPS.

And while I was there, you know, many of the state's high value DSRIP metrics are behavioral health in nature.

Greg showed some of them before.

It's the EE visits for behavioral health. The seven day mental health follow up and initiation and engagement of alcohol and drug treatment and PPS that were successful went out and contracted with community providers to do that work.

We know that many of the PPS is now or currently downsizing staff as the DSRIP winds down, and that made those folks have come to work for BHCC. So including myself, three of my colleagues, are now working at another behavioral health IPA.

I think that, you know, if VDEs and PPSs were to be reconstitute, I think they'd they'd really struggle with kind of staffing up and I think be much more efficient if the BDEs and the BHCC could come together in an alignment.

You know, both of us are you know, we're organized along regional lines.

Both of us are building data, infrastructure capability, and both of us are working on metrics.

So to me, it makes sense for us to kind of come together in some way.

We know that through DSRIP, many of our providers invested a lot of time and resources into integrated care models and training staff. And as Greg said, those models need time to mature.

They're not being supported by fee for service and value based payment for behavior has been a little bit slow to to take off.

So we kind of need more time.

Additionally, there's been some recent efforts to have the federally qualified health centers, the FQACs and the BHCC has kind of come together in some way.

And could that be part of a BDE? And I think we support that.

I think those groups have an alignment in terms of philosophy coming from the community as well as kind of serving a very similar population. So I'd support those efforts as well.

And just in conclusion, again, I think it's great. So we need more time for these things to mature.

But I do think that, you know, current systems, VDEs, BHCC need to be aligned as we go forward.

Thank you.

Number four.

Hello, good morning, my name is George and I'm the present CEO of CBC. I want to thank everyone for this opportunity.

And we're very pleased that the second iteration of DSRIP puts more of a focus on mental health and substance use disorder as social determinants of health and children population health, each of which are key priority areas for coordinated behavioral care.

CBC was developed and organized by New York City Behavioral Health, not for profit providers.

This provider led organization is a health home and IPA dedicated to improving the quality of care for New Yorkers with serious mental illness and substance use disorders, miners with serious emotional disturbances and those with chronic health conditions.

CBC leverages community partnerships, bringing together over 50 community based health and human service organizations to coordinate integrated medical and behavioral health interventions, coupled with the specialized emphasis on social determinants of health to over 100000 Medicaid recipients with over a billion dollars in behavior health services in order to promote a healthier New York.

CBC providers and programs work with high cost, high utilizing multi populations under the cost drivers of health care in New York State.

CBC and its strong network of providers have developed a number of innovative and effective programs, ranging from preventive case management committee hot spotting to military detox and withdrawal management program to a pathway home. These programs have a significant, measurable impact, with reductions in hospital utilization increased outpatient follow up to both primary and specialty care, increased adherence to medications including M80 for patients with substance use disorders.

Decreases in gaps in care such as diabetes screening and monitoring.

And decreased visits for those enrolled in those programs.

For the most part, these effective programs have been financed through state agencies such as OMH, OHS and some of the PPS is the only programs funded by AMOs to date are one pathway home team.

Targeting the Medicare dual eligible population and the newly launched a military detox program.

Like other behavioral IPAs, CBC has not been successful in contracting with MCOs. In spite of the fact that the state BATC grant anticipated such contracts between MCO and behavioral IPAs.

CBC's award winning Path Care Transitions Program, Pathway Home, has a proven track record of improved outcomes and cost savings.

In a soon to be published article, we have shown that there was a significant decrease in the average number of inpatient days per person months during enrollment.

This effect was sustained after discharge with roughly a thirty five thousand dollar savings per enrollee.

These savings and cost reductions have accrued to the plans.

And since we have no meaningful MCO contracts for these programs, CBC and our network providers cannot share in those savings.

Additionally, CBC providers are extremely concerned that the financing of these innovative and effective community based care transition care coordination programs are at risk with no sustainable model of MCO financing.

As a clinically integrated IPA and a BATC award recipient, we wholeheartedly agree with the state's decision to expand the PPS concept to allow CBOs, MCOs, IPAs and BACC to form VDE.

As part of the proposed VDE model. We strongly urge the state to consider organizations that focus on individuals with complex behavioral needs such as CBC when determining and approving VDEs.

We feel that CBC has the right characteristics to be a VBD mature and robust quality performance and oversight department. Electronic Data Warehouse with business intelligence and data analytics and reporting a large network development and management function as well as other value as like technical assistance, learning collapses. Training, contracting support.

As one of the largest health homes in the state.

We also feel that health home care management has improved care outcomes and reduce costs and requires continued intervention.

But we recognize and welcome thinking about moving towards outcome based reimbursement, whether non risk or risk based.

In this new initiative is to be truly person centered and not provider sensitive.

Provider centered, sorry.

CBC role in transforming the health care system as you propose is critical.

Individuals who have complex behavioral health needs benefit from care and treatment with their behavioral health providers.

The providers with whom they have an ongoing relationship.

These behavioral health providers are in the best position to manage and coordinate the necessary services and resources to meet their needs. CBC is proposing that the State consider eliminating the attribution barriers that typically face behavioral health networks that are interested in taking on risk for the populations they serve.

There is precedence for this.

The Medicare Shared Savings Plan ACO model of attribution is based on preponderance of service.

Thus, a patient's needs are primarily behavioral health focused in terms of care delivery and engagement, and the primary relation to the patient is with the behavioral provider. The attribution should be with the behavioral health provider where the engagement is occurring.

They will then be our role and responsibly to coordinate care for primary care, specialty care and social determinants.

I also feel strongly that we are ideally suited to serve as a regional social determinants of health network, giving the wide array of social determinative health agency's programs and services offered through the five boroughs by more than 50 provider agencies within our network, with a track record of providing and coordinating care to complex and hard to reach out to engage individuals.

Thank you.

Speaker 5.

Hello, I'm Dan Lowenstein and vice president of government affairs for the Visiting Nurse Service of New York.

VNSNY is the largest and one of the oldest, not for profit home and community based health care providers in the country.

We are the largest, not for profit and hospice provider in the state.

We have a large community mental health services program that focuses a lot on the SMI population, including transitional care. Our health plans include the largest not for profit MLTC and as well as FITA and map plans for duly eligible members and an HIV special needs plan that just expanded to Nassau and Westchester counties.

We have embraced value based payment and outcomes and 31 percent of our MLTC expenditures are under a level two, the rest are on level 1.

Nearly 40 percent of our managed care payments are in a risk based arrangement tied to avoidable hospital use.

And recently we launched the Care Management Organization to manage complex care for at risk homebound populations.

We've been very active in DSRIP.

We've partnered with 12 downstate PPSs on many important initiatives and we've leveraged the MLC workforce investment program to train over 35 hundred of our home health aides, giving them enhanced skills to help them really operate in a value based long term care environment.

So DSRIP has we know, has had a number of very important successes and advances in care delivery and payment.

But we also know that there's been some missed opportunities, too.

And we think that the home based, home based care post acute long term care providers really were not provided or invested in an adequately managed care organizations, including a MLTCs and integrated plans were not included at the outset, which has made value based contracting more challenging.

And finally, dual, dual eligible population was not really a population of focus.

So our recommendations that we have some more recommendations or written comments so we're going to focus on five that are really kind of focused on the long term care spending in Medicaid, which we know is very much an issue at hand right now.

VDEs we think that entities with experience managing and delivering care in the home must be part of VDEs governance and operational structure.

And we think that long term care specialized VDEs should be authorized given the unique relationship that patients have with our long term care providers to improve care and reduce total cost.

There should be a focus on Medicare Medicaid integration in long term care. In long term care, 90 percent more than 90 percent of the population in MLTC are duly eligible in that population accounts for 60 percent more in Medicare costs than other duly eligible members.

Medicare costs.

So New York state spends billions of dollars on in Medicaid on long term care, but the savings are accruing to Medicare, but we're not seeing those savings accrue to New York State.

So we think that there should be an alignment of our own integrated care strategy with the federal initiatives around duly eligible long term services and supports.

And we should be partnering with CNS to share in the Medicare savings that result from the Medicaid investments.

Third, the incentive for home health providers to lead or fully participate in home health value based payment.

They can as we can demonstrate, they can play an important role as we have done, and they really have not been included in the VDE roadmap or in the proposal.

We think that is something that should be corrected.

Fourth, investment in the home health workforce and I.T.

infrastructure.

We're very delighted to see the investments that encourage nurses and home health aides to enter into the long term care space.

And we endorse that we think that the workforce investment program should be continued streamlined a bit, but continued.

And we think that the investment in health I.T. for home health agencies is really critical to ensure that they can connect to the home, to the health care system and play the role that we know they're capable of.

Finally, hospice and palliative care.

We rank forty ninth in the nation in hospice utilization.

Hospice can say we know over nine thousand dollars per end of life episode on average and four duly eligible members it saves Medicaid money because Medicare pays for hospice, so that takes the pressure off of long term care services.

Offer the off the co-pays and deductibles, and we think that should be included in this proposal as well. Thank you very much.

Speaker Six.

Yield my time.

Hello, my name's Elton, and I work at Help People.

I've been a Diabetes Self-management Program peer leader for over two years talking to the community about this program.

When I began as a Type 2 diabetic myself, my A1C was pretty high.

I started practicing this program and by just a couple of weeks my glucose levels started improving.

Shortly after my doctor told me that my A1 C had fallen to 7.

So my doctor took me off my diabetes medication.

Following this DSMP program carefully while running workshops for diabetics, pre diabetics and people who have loved ones with diabetes has made a huge difference in the lives of these people.

During my last workshop, a participant shared a similar experience following this program, and I can see how happy and how much better her health had become by following this program.

And I can see the what a difference this program makes.

So I felt a great sense of pride knowing this really works in helping to reverse diabetes.

But there are many people still suffering. My sister is actually an OR nurse and she tells me on a daily basis people are having amputations.

So my question is, why isn't diabetes high priority? And the answer is we must make.

We must declare diabetes a high priority plan in this plan.

Thank you.

Thank you.

Speaker Seven.

Good afternoon. Thank you for this opportunity to provide some comments today. My name is Alice Barkin.

I'm the director of policy for Child and Adolescent Health with Citizens Committee for Children, we're a multi issue children's advocacy organization committed to ensuring every New York child is healthy, housed, educated and safe.

We're also the co-lead out of the Children's Behavioral Health Campaign, which is a statewide coalition of behavioral health providers, advocates and New York, families joining together to guarantee the right of every child to receive the high quality behavioral health services they need.

We appreciate the Department of Health recognizing in its DSRIP concept paper the importance of increasing investments and initiatives that strengthen families and children.

As encouraging to hear earlier today the acknowledgement that kids have really not been the focus of DSRIP in the past.

We know that the vast majority of health and mental health resources in the state have been spent on adult care and hospital based services.

DSRIP offers an opportunity to connect children and families to community based services and to address social determinants of health, ultimately enabling children to achieve better health and mental health outcomes and allowing the state to see declines in costs associated with high hospital utilization.

The state must not overlook this opportunity to invest in child health, particularly in children's behavioral health.

Given years of underinvestment in prevention and treatment services for children and families.

The state's DSRIP program must significantly increase the funds dedicated to improving children's behavioral health.

Few areas are more important to the waiver stated goals of improving the quality of care, proving the health of populations and reducing costs.

We know there is a crisis in children's behavior health in New York. Suicide is the second leading cause of death in New York for children ages 15 to 19.

Almost 60 percent of children age through three through 17 with a mental or behavioral health condition in New York don't get the treatment they need.

We know I know many in this room know that the unmet the consequences of unmet health needs can be devastating.

Children get sicker and parents are left desperate, unable to find or afford the services they need.

Parents miss work and children miss school. And the state sees the long term costs borne out in special education, juvenile justice programs, preventable foster care placements and homeless services, and are under-resourced systems that kids become sick adults.

And the human and financial costs are felt by families, health care systems and communities more broadly. DSRIP offers one opportunity to reverse this pattern.

However, missing from DSRIP has been substantive and investment in children.

We know that.

We know the types of children's services and interventions that are needed to reduce hospitalizations and unnecessary use of psychotropic medications, as well as what intervention interventions help children become healthy, stable adults and help reduce health and other related costs.

CCC supports a number of the proposals that are put forth and the state's concept paper related to children's health and behavioral health and in our written comments will include some references to those as well.

We feel different funding needs to go further, invest in a full continuum of services for children and families from preventive and population based services to more intensive clinical services necessary for complex children and families.

The fund proposals for DSRIP funding aren't exhaustive, but they must all be supported in order to begin to address chronic underinvestment in the children's behavioral health system.

First, we strongly support increased funding for primary care and behavioral health integration, which is referenced in the concept paper.

Luckily, New York has a number of a substantial array of models to draw from, including the Healthy Steps program and proposals that came out of the first 1000 days on Medicaid initiative.

The Preventive Pediatric Care Clinical Advisory Group, one of the work groups from first 1000 days, has developed a comprehensive model of pediatric population health that integrates care for parents and other caregivers into primary care for children.

These types of models provide established and promising practices that can help meet the complex health and behavioral health needs New York's children and families.

New York is also home to an array of evidence based programs that are proven effective in addressing the impacts of adverse childhood experiences.

Addressing serious anti-social behaviors, providing family based therapeutic conventions for youth at risk of institutionalization through DSRIP New York can make real investments in programs that have been proven to improve long term outcomes for children and families.

Additionally, their high rate of adult adolescent suicide in New York points to the urgent need to invest in mental health supports.

You must identify and fund initiatives designed to reduce adolescent suicide risks.

And I know we can also look to recent reports from the state from its Suicide Prevention Task Force.

The DSRIP amendment also includes a request for behavioral health coaching and training in schools.

These we think these types of initiatives are important for early identification and intervention in schools, which really remain a critical setting for providing mental health services.

However, for many, school based clinical services have struggled with financial viability, leaving many students without access to clinical supports.

DSRIP funding should find increased school based clinical health services to address school based shortages.

And finally, CCC supports the DSRIP Amendment request to expand behavioral health urgent care centers for children.

It is essential for New York state to recognize that a much more substantive investment is needed in outpatient care to meet the needs of children. Too often, families have nowhere to go when facing a crisis.

DSRIP can help by fully investing in outpatient clinical care.

With 8 billion dollars on the line, we really feel DSRIP funding is a critical vehicle for addressing the needs and laying a foundation to improve access to care and enhance innovation in prevention and treatment. Thank you.

Thank you. Speaker Number eight.

Good morning.

Nice to see everyone and thank you for the opportunity to speak about the future.

Chris, can you introduce yourself? Yeah.

I'm Chris Norwood, executive director of Health People a peer educator based organization in the South Bronx.

We do really appreciate the work that has gone into the reapplication and of course we fully support re application.

Through DSRIP we have seen new cooperation and better outcomes, but we have also seen sadly that progress has not been equal because community based agencies have had to fight and fight to become equal partners and still are not in the last DSRIP yesr only 38 million out of the hundreds of million went to community based agencies.

Overall, though, we don't have a complete accounting.

Probably less than 100 million out of the eight billion with the community based agencies.

I will give one example of why this is so important.

Through one city innovation funds health people and to other tier one that is smaller CBOs Korean Community Services and the Mexican Coalition were able to implement a groundbreaking program that combined the Succession Diabetes Self-management Program with a major assessment of the social needs of Medicaid patients with type 2 diabetes.

Health People chose to entirely implement in homeless shelters.

The outcomes were outstanding.

Eighty seven percent of the 201 homeless participants completed the Diabetes Self-management Program and with peer leaders, most of whom had been homeless themselves, helping them nearly all fulfilled immediate social needs like clothing and food.

According to the New York City Department of Health, which was the evaluator, participants had a 45 percent decrease in emergency room visits and the savings were so huge.

I hardly have time to detail them here, although I know the extra costs for a person and diabetes in New York state now fifteen thousand three hundred dollars.

And I didn't tell Elton by reversing his diabetes.

He's already saved the state enough money to take everyone to lunch.

This project really showed a vital and necessary model of how smaller CBOs can work together to bring evidence based services to isolated in high need populations.

Yes, Health People achieved these outstanding results with homeless participants.

But I don't think if we went to Korean participants, the same thing would happen.

That was where Korean Community Services Justice, the Mexican coalition focused on Latinx populations.

But all of us using the same evidence based approach to engage people who shared the circumstance that while they are high need, they are often highly ignored.

Alas, the chances of anyone, including policymakers and funding learning about this breakthrough model are close to zero because it is part of the inequality of DSRIP that very few CBOs are being allowed to present their work at November's Population Health Symposium.

And of course, with a price tag of three hundred fifty dollars per person. If you're not a PPS, they're two hundred.

Almost no CBOs can attend.

The new DISRIP Application says that CBOs will be integrated.

Yet we see CBOs are still barely able to attend, much less participate in the most important learning symposium of the year.

When I see this successful small CBO model with its really unprecedented outcomes was not accepted for presentation, it makes me wonder what else is missing from CBOs that we don't know about and that we need to know about.

If the state is serious about integrating CBOs, it will integrate them now into this symposium by setting the side tables with scholarships for CBOs where they can share examples of the CBO work.

We have a petition to the state asking them to take this simple but clear step to finally end the segregation of CBOs.

And of course, everyone can sign it.

Finally, looking at the avid participation in the diabetes self-management program of these very, very different populations homeless, Korean, Mexican.

We have to ask why.

Again, the state hasn't named diabetes as a high need priority area.

It is the state's most widespread, devastating and costly disease.

And leaving it out as a priority leaves out the greatest opportunity to improve health.

Thank you.

Speaker number nine.

Hi there, my name's Carla Braverman and I'm the CEO and president of the Hospice and Palliative Care Association of New York State.

Thank you for the opportunity to share these brief comments and we will certainly send you some longer comments in written form.

Research shows that hospice and palliative care increase quality outcomes, increase consumer satisfaction, decrease hospitalization and re hospitalization, increase time at home, which is where we all want to be.

And overall decrease costs or spend both to Medicare and Medicaid.

Yet we were disturbed that we don't see a lot of hospice and palliative care used within the DSRIP programs, and we would encourage going into the future that we have more fuller integration of hospice and palliative care.

Those few programs that did hospice, did palliative care projects actually did show increased consumer satisfaction, increased quality outcomes and significant decrease costs.

Going forward, we'd like to see a requirement that there's a relationship with hospice and palliative care in each of the PPSs, that there's this change in the scoring system so that palliative care projects are actually scored higher.

We've been told that there is a discouragement in picking up the palliative care project because of the way the scoring methodology currently works.

We are delighted to see palliative care projects in nursing homes, but we'd also like to see palliative care projects in community based settings.

We know that there are only 34 community based palliative care projects or programs in New York State or service providers in New York State.

That's because the payment methodology does not allow for at home palliative care services.

You're paid for doctor visits and you need a team around you to be able to provide that care.

So we would like to see a palliative care pilot, part of PPS that would actually create a program in which the services could be reimbursed at a reasonable rate.

And we project that you will decrease costs and increase consumer outcomes and satisfaction.

And last but not least, we would like to see a concurrent care pilot project under PPS and just like modeled after the children's programs and services for under 18.

Right now there's a binary choice.

You either have full fledged care or you have comfort care.

So that focus going from cure based care to come for care is a very difficult decision for people to make. It's confusing.

They don't know about their choices. So a palliative care concurrent project would actually show or prove once and for all in the state in New York that palliative care will decrease cost.

So I will submit fuller comments, but thank you for listening to me.

Speaker 10.

Good afternoon. My name is Zach Hennessy. I'm the vice president for neighborhood health at Public Health Solutions, we're New York City's largest public health nonprofit and we support vulnerable New York City families in achieving optimal health and building pathways to reach their potential.

We provide direct services to more than one hundred and five thousand New York City families each year in neighborhoods across the five boroughs and also partner with government, philanthropy and health care, as well as more than two hundred and twenty local community based organizations on collaborative initiatives that improve public health and health equity in New York City.

So we're in the middle.

P.A.

just has developed a food and nutrition services network to connect health care patients and managed care members to the full range of food and nutrition services and resources in their local neighborhoods.

And we serve also as the hospital community bridge partner for the One City Health PPS here in New York City.

We're very excited to see a larger role for community based organizations, cross-sector collaborations and the non-clinical workforce in the proposal, which is absolutely essential if Medicaid and value based arrangements are to further contribute to improvements in the social determinants of health.

The idea of the value driven entity, a partnership of health care provider MCO and CBO is an improvement on the previous PPS concept.

The states should consider bolstering the role of CEOs in value driven entities by requiring rather than suggesting a role for them in governance of these new entities.

The state should also consider investing in infrastructure and capacity development for CBO participation and including experience capacity development organizations to help CBO is meet these needs.

The infrastructure needs that we've encountered include facilities, systems and operational upgrades for compliance, service delivery, data management systems and care coordination technologies and platforms.

Capacity development needs include informatics support, training and technical assistance to integrate new models of business service delivery and compliance requirements into the organization and workforce experience.

Capacity development CEOs can serve as trusted brokers, ensuring CEOs are able to participate in the complex regulatory environment, negotiate value based arrangements and tackle challenges such as technology integration.

The state should consider or recommend specific investments in technology to support cross-sector coordination of care and interoperability of such technologies with electronic health records and regional health information organizations.

The state should also provide more clarity about the role of the MCO in the BDC.

For example, it is unclear how problems are related to offering a special set of services for members of a particular MCO would be avoided in the BDD structure, which has been an ongoing challenge for PPS MCO partnership and DSRIP.

It was unclear if multiple CEOs were recommended to participate in each VDI construct.

While we support the proposal's emphasis of additional high need priority areas, more clear expectations for BDD are necessary to ensure they incorporate value based incentives and performance metrics for the reduction of more maternal morbidity and mortality and children's population health.

Unintended pregnancy.

Premature birth.

Low birth weights and severe maternal morbidity events are costly.

So there is significant savings potential that can be realized by ensuring access to family planning and reproductive health services, as well as evidence based maternal and child health programs.

We endorse the significant investment in the social determinants of health, as well as the approach to create one network services provider per region.

However, we suggest the regions in New York City where communities are extremely diverse.

One minute be no larger thank you than the level of county or borough.

We also recommend that the list of social determinants be brought in to be inclusive of unique regional and local needs and considerations.

Last but not least, absent from the plan is an approach to consumer engagement.

VHS believes engaging consumers and system changes and reforms are critical to success.

Additionally, consumers should understand changes that are taking place in their care.

New benefits available to them and how to provide feedback on their experience.

This was not emphasized in the last phase and we think it should be strengthened in this phase.

Thank you.

Speaker Eleven.

Good afternoon, everyone.

My name is Loretta Fleming.

I am a diabetes peer leader, educator working at health people.

I am a type 2 diabetic.

My mother is a type 2 diabetic.

My older son is a type 2 diabetic.

There was one time in my life where my diabetes was completely out of control.

I was weighing three hundred and seventy eight pounds.

My diabetes, my A1 C was thirteen point four.

I didn't know what I was going to do and I was very afraid at the time.

But by me meeting up with somebody who at the time work and help people and told me about the diabetes self-management program, I took those classes.

I was able to after six months to a year, my A1 C went from thirteen point four down to five point seven.

I also went from three hundred and seventy eight pounds down to two hundred and forty pounds.

I am now at two hundred and sixty two pounds.

I say that to say that in the South Bronx and also in the five boroughs.

Diabetes is definitely an emergency.

There are so many people who are afraid of diabetes and don't really understand that diabetes can be managed.

What we are asking for is more funding.

To have diabetes classes and diabetes self-management to go not only in the South Bronx, but to all five boroughs of New York City.

Diabetes is definitely an emergency.

There are so many people who are getting their arms and their legs amputated.

And if they had a chance to learn about diabetes and to be able to take these diabetes, self-management and diabetes prevention classes, I am sure that they would be in the same boat that I'm in now managing their diabetes and having their diabetes under control.

Educate.

Don't amputate.

Thank you.

Thank you, Loretta.

Speaker Twelve.

Hi, good afternoon.

My name is Tom D'Angelo.

I am here today in the capacity as the president elect of the Pharmacist Society of the State of New York.

On behalf of more than 21000 licensed pharmacists here in New York and the soon to be nine schools of pharmacy, I'm here to advocate for an increased role for pharmacists in the DSRIP extension.

Studies have shown that Medicaid patients present community pharmacies 35 times a year versus four times for their primary care provider, uniquely positioned pharmacists to work with New York and the Department of Health.

The original DSRIP initiative focused on system reform through community level collaborators to reduce avoidable hospital readmissions through value based payment.

While that specifically included in the original program pharmacists were able to work on, albeit in an extremely limited capacity with some of the various performing provider systems.

PPS has disappeared.

D DOH have previously recognized the role that pharmacists can play in managing poly pharmacy, promoting compliance to both reduce adverse drug reactions and control costs through medication therapy management.

But MTM is not all the pharmacists have done during the first round of DSRIP.

Pharmacists have come together to form accountable pharmacy organizations or oppose, including independent practice associations.

Under the guidelines and requirements of the Department of Health, pharmacies have worked with other stakeholders to develop and implement care plans for at risk patients in areas such as mental health and opioid abuse.

Pharmacists have worked with other stakeholders to offer disease management programs to enhance quality of life for patients with asthma, diabetes, HIV AIDS.

Pharmacists have worked with other stakeholders to implement transitions of care as patients move from one level of care to another.

Pharmacists have worked with other stakeholders to share data in order to improve outcomes, whether through care plans.

One of the state's regional health organizations radio, where any number of other mechanisms that now exist pharmacies have worked to incorporate non-clinical staff, including community health workers, in the implementation of patient care pharmacies that work with providers. As many as Medicare explores alternative payment models such as mascara and nips.

Pharmacists have worked with the state to expand our scope of practice through emergency orders during viral outbreaks in order to administer vaccines to more patients at risk in the high risk population areas, including children.

Pharmacies have worked with the states prescription drug, take back efforts to get unneeded medications out of the homes and protect our environment.

Despite all that pharmacists have been able to accomplish, the profession still remains under utilized.

It has been noted by DOH that current New York laws do not provide for the full spectrum of benefits that patients, including Medicaid members, can realize in terms of improving their health and quality of services received.

Business supports the recommendations of the Department of Health regarding comprehensive medication management.

CNN Bringing SI amendment to the community pharmacy setting will serve as one mechanism for pharmacists to help New York meet the goals of the business extension.

Allowing pharmacies to perform clear way of testing and permanently removing sunsets on vaccine privileges would be examples of some other busy others that Disney encourages DSRIP stakeholders to support.

As previously mentioned, accountable pharmacy organizations exist and offer the new value driving driving entities in existing workforce of highly trained, clinically oriented health care professionals with ready access to patients.

It is the contention of Disney that Beatty should be required to contract with at least one accountable pharmacy organization that participates in the DSRIP Extension for services related to optimizing the judicious use of medications to achieve clinical outcomes and avoid medication related adverse effects.

Advanced coordination care activities and patient screening for referral to health homes, community based organizations or other entities attempting to address social determinants of health.

The accountable pharmacy organizations must be able to electronically document medication optimization care Ford Nation Care planning and screening activities to share with the VEBA and its related qualified entities.

The video must ensure that the accountable pharmacy organization be subject to value based payment opportunities that align one that is meaningful measures.

High performing outcomes.

Focused accountability.

Accountable pharmacy organizations will serve as a valuable partner to New York State as it attempts to meet the goals of the DSRIP Extension.

Disney firmly believes that the accountable pharmacy organizations and pharmacy services must be formally included.

DSRIP extension if the state is going to sustain and expand on the promising practices identified in the first round of DSRIP.

Thank you for your time today.

We will be submitting written comments before the November 4th deadline.

Speaker Number 13.

Good afternoon.

My name is Dr. David Colley.

Moore had the pleasure and the honor of serving as the chief medical officer and senior vice president of the AKC, a network.

We're multifaceted network that provides primary care and specialty care through 8.

Article 28, facility six of which are federally qualified.

We up 108.

Bed skilled nursing facility.

One of the large.

That our debt is dedicated solely to the care of patients with HIV.

We have 32 always regulated programs, including five methadone outpatient treatment programs, two in the Bronx, one in Brooklyn, one in Albany, one in Buffalo.

We have eight residential treatment facilities.

We have daycare centers, senior centers. So we do a lot of work.

We do a lot of work.

We've been intimately involved in our DSRIP since this first iteration since 2014.

We've been members of the steering committee of the St. Barnabas led PPS, Bronx Partners for Healthy Communities.

My colleague Steve Rosenthal spoke earlier about the active involvement of community based providers within the PPS.

But if you look at the reality of the flow of funds to DSRIP through its first iteration, much of those funds, as Chris Norwood stated, did not come down to the community provider and to the community based organizations.

So in DSRIP 2.0, we are we are absolutely recommending that there be a close look at the funds flow so that community based providers, family qualified health centers, community based organizations are not receiving pennies on the dollar from that from the second iteration of this group.

I'm happy to see that MCO is a significant part of the future that the state is looking at.

They've been largely absent from DSRIP 1.0.

So we absolutely need to have greater collaboration with the payers if we're truly going to transform the health care payment and reform.

One of my colleagues, Doug Worth, is going to speak very intimately about some of the close work that we're doing with Medicare and many of the community based providers in large hospital based providers.

In addition to that and DSRIP 2.0, they absolutely need to be a greater investment in an I.T.

infrastructure for community based providers as well as CEOs.

There needs to be an emphasis on interoperability of systems with hospitals, community based partners.

Telehealth needs to be a point of emphasis as well as home based visits for for a much needed needy populations that are unable to make it out of their homes.

So, again, I'm happy to see that there is going to be an extension of this report, but we definitely need to look at the deficiencies in the areas of improvement that we can make in DSRIP 2.0.

So again, MCO involvement funds flow to community based providers, investment in I.T.

infrastructure and also in workforce development.

Thank you. And we look forward to submitting written comments.

Speaker 14.

Hi, good morning.

I'm about to tell Zach with Make the Road New York director of health programs. Thank you for giving me the opportunity to speak today.

I think the road is a be based organization or membership base with over 23000 low income members across New York City, Brooklyn, Queens, Staten Island and then also Long Island in Westchester, where dedicate to building the power of immigrant and working class communities to achieve dignity and justice through organizing policy, innovation, education and services.

We've been involved in DSRIP for the past five years, partnering with PPS as it has One City Health in Staten Island PPS through these partnerships. We've been able to run really amazing to me.

Health worker asthma projects.

We're seeing sub use committee health workers are hired by the road. But partner very closely with the clinical facilities as part of the care team.

They conduct home visits for patients with asthma or the CW ensures the family understands what they were told by their provider conducts an environmental assessment. The home ensures the client receives referrals for all necessary services, including integrated pest management services.

As New York moves forward with DSRIP, it must prioritize continuing to work and working more with committee based organizations and including this committee based organizations in all aspects of the work, including requiring CEOs be part of the governance structures of the value driving entities.

The amended request acknowledges the need to rely on nontraditional, non-clinical workforce such as health workers to achieve the goals.

We fully support this idea.

Continuing to invest in training and recruitment of the non-clinical workforce.

However, we want to make sure that funding for these training programs also includes community based training programs and not just community college trainings.

Many immigrant community members serve as excellent health workers and other non-clinical work first roles, but may not be able to access community colleges.

So, for example, Make the Road runs a C W training program.

Training immigrants to work in the health care field and then helping them find employment in hospitals, clinics or other CEOs.

These non-traditional training programs are often well suited to continue to train individuals to work in these fields.

Additionally, through DSRIP, there have been many innovative projects with community health workers like I just talked about that we really want to make sure I continue and if we move forward with DSRIP 2.0.

So through our work with the PPS is we form very strong partnerships with them and agree that the state should continue investing in social terms of health strategies.

And we fully support the idea of creating the social determinants of health networks to deliver these services.

However, we believe the state should only permit CEOs accord or coalitions of CEOs to serve as the lead entities of these networks.

Both have experience providing these services and working in collaboration with other CEOs.

Having CEOs lead these networks is one way to introduce a more back, more balance into the relationship between 20 base groups and the larger health systems.

CBO should also be able to create their own networks with their own governance structure and apply for this funding to develop these networks as an equal partner as opposed to asking the managed care organizations or provider systems to be the ones creating those networks.

Additionally, it's essential to ensure that there are resources and training for CEOs who participate in these networks moving forward.

CBS had the skills to provide these services, but they oftentimes need extra support with infrastructure and data systems to be able to really work on these relationships with the larger health systems are managed care organizations and to be able to gather the data in a way that shows the value of the work.

Additionally, CEOs are not able to take on contracts that have downside risk.

So we need to really make sure that there's reliable funding to run the programs for those and they're unable to do so if we were forced into entering contracts where there's a requirement to take on the downside risk.

Finally, when developing these systems for the networks is appointed, develop the infrastructure for bilateral referrals from CEOs back to the health systems as well as just as well as sending referrals from the health system to CEOs.

Oftentimes CEOs can receive referrals from the health system, but don't have the right systems fail to connect back to send our own clients back to the health care system and referrals only worked at the CBO have adequate, adequate resources, staffing and funding to handle new referrals.

These networks need to be paired to sustainable financing and mechanisms in place for tracking who can handle a new referral.

Thank you. Speaker number 15.

If number 16 can get on deck.

Good afternoon, my name is Michael Cunningham.

I'm the director of the Office for Senior Resources in Putnam County, and I welcome the opportunity to comment on the on DSRIP to.

You know, the agency I work with.

We target the elderly and in particular the elderly are in many of our clients are those with severe chronic health problems and and also represent a very significant portion of the medical system dollar spent.

So it's a major, major area of concern and it is certainly a good target for for the efforts of this forum today.

Our agency is one of fifty nine throughout New York State under the auspices of the New York State Office of the Aging.

Each county, for the most part, has has an organization similar to us.

And I'm proud to say and happy to say that we celebrated our fiftieth anniversary this year as an organization, which means we've been investing in infrastructure and programs and services over these past 50 years.

As I said, I'm we're one of fifty nine agencies and a number of my colleagues will also be presenting written statements, and I'm sure they're going to be much more eloquent than I will be and perhaps more detailed in some of the the various elements of the DSRIP proposal.

But I wanted to kind of I don't want to repeat what I know they're going to say. I want to focus on on three on three items.

One of the first one is destroyed, 1 0 has really been a non event for for my organization and for many of my colleagues throughout New York State.

The second is that there have been untold in this in these past years, missed opportunities for collaboration and coordination.

For every person, every elderly person who has been discharged from medical facility to collaborate with an organization like that, like mine, we fall under the rubric of the community based organization where CBO in effect.

And what we deliver are the services that we deliver, target, what's been referred to numerous times today, the social determinants of health. That's what we're good at.

That's what what we do.

That's been our business.

And the third and I want to comment a little bit about is that hip hop has been a barrier for us. And somehow we need to take a look at that.

So first, let me just talk about, you know, we look we're looking to DSRIP to to really help change the equation in the relationship.

And I see that in, you know, in the in that that for various entities that were caught, you know, with the arrows pointing to the middle.

Happy to see that CBO is is in there and that we really need to be at the table when planning for the activities and the delivery of services that are going to be in our areas.

And I have a very simple example of where, you know, that failure that we're there spin that that has been a failure of fruit.

There was a recent public affairs announcement by a local medical institution highlighting a new taichi for arthritis program and an evidence based program to help the elderly with for prevention.

And in the newspaper article, there's a picture of one instructor with four participants, which I almost had to chuckle when I saw that, because I know that in our centers, you know, we have four centers in our county.

We have the same classes and we're gonna have 15 plus people participating in the programs.

We're kind of bursting at the seams.

If we had a dialogue, we could.

You know, my concern is that the the money that's one minute spent, you know, up till now has been really bent.

It's some of it's been a reinvest, a re investing in things that are already in place, reinventing of the wheel.

And so we're hoping that, you know, as I mentioned, we had about 50 years of infrastructure building.

We really need to see that that's taken into into value.

The rubber hits the road when we talk about coordination of of transition care.

And we there's really no reason that we should not be, you know, sitting at the table with every health facility to plan for the discharge of an elderly person back into the community to see what supports we can provide.

Given all of the services that are already in the infrastructure and we know we're being pushed, we're being pushed by a sofa, you know, all the area agencies for the aging in New York state are being pushed by myself to build what we call the business acumen initiative.

I'm sure you're familiar with that and you've heard about that.

But we really need to see is a push on the other side making sure that the providers are taking advantage of our social programs. Thank you.

Thank you.

Speaker number 16.

Thank you.

My name is Dena Huxley Riker, and I'm representing a larger group of individuals who couldn't be here today. We are members of the East Harlem Community Health Committee and medical students at the Icons School of Medicine at Mount Sinai.

Briefly, the East Harlem Community Health Committee, or AIDS? The AJC is a longstanding community health coalition whose purpose is to advocate for the health of East Harlem residents and to serve as a platform to exchange information, resources and lessons learned to improve the community health among community health providers and consumers.

Since 2016, CDC has monitored the impact of DSRIP on the health of East Harlem residents through tracking and analyzing publicly available data, conducting some structured interviews with East Harlem DSRIP contracted community based organizations, participating in citywide organizing efforts aimed at lifting the voices and experience of DSRIP Contact CBO and hosting quarterly general membership meetings with the local providers participating in DSRIP in East Harlem to assess CBO engagement and the flow of funds from the state to the PPS to the CBO providers.

We offer this testimony on the DSRIP Waiver Amendment request as medical students and residents of East Harlem who work with the CDC to understand the impact of the original DSRIP waiver on our community.

Thus, we would like to offer a community perspective aligned with each. CDC is on the importance of giving CBO a seat at the table, holding institutions accountable for addressing racism and bias in health care, and preserving accountability through oversight.

The first part of our comments centers on one of the major goals of the amendment to address social determinants of health.

While we appreciate the mention of us, it is in the amendment and the commitment of one point five million toward addressing these social determinants of health.

We believe that it is critical that this work centers.

CBO is, since addressing social determinants of health and reducing avoidable hospitalisations, best happens at the community level.

In our prior experience working with CBO as in East Harlem, we saw how community organizations often were not treated as equal partners by larger institutions such as hospitals within a PPS as detailed by the report by Niamh.

This created distrust between partners and held back savings from carrying out their work to the fullest extent possible, and they received only a small portion of the funds.

We believe it is crucial that CEOs are empowered as decision makers and funding recipients in this next iteration of desperate.

And our concern that the existing draft leaves too much space for the newest iteration of PTSD or BDD to steer the bulk of funding towards large hospital based institutions and drive the decision making process.

The amendment describes how movies and PPS as could be eligible to lead social determinants of health networks.

Rather, CBO is or existing coalitions of such organizations should be the only eligible applicants since this will be well more directly empower those stakeholders.

If the state truly wants to transform transformation, then CBO must be positioned as the major drivers and directors of this funding.

They must receive direct investment and there cannot be opportunities for this funding to go directly to large hospital systems at the expense of communities and patients.

The second part of our common centers on the importance of reducing racial disparities in how care is provided to patients and eliminating systemic racism in the health care system.

This is in line with several of the draft commitments, including addressing social determinants of health and reducing maternal maternal morbidity and mortality.

One does not need to look further than East Harlem, a neighborhood that is over 80 percent black and Latino.

To see the impacts of systemic racism, the New York City Department of Health and Mental Hygiene Community Health profiles.

It is clear that East Harlem consistently faces health challenges from pediatric asthma to substance use disorders to mental health burdens to infant mortality that are significantly less common in just a few blocks to the south in the Upper East Side.

These trends are not accidental.

The communities living in East Harlem have systemic, systematically been denied the resources to adequately address their social determinants of health.

In comparison to other populations, and regardless of the intentionality was behind such decisions, the outcomes are a clear example of systemic racism at work in New York City. One minute, as medical students, we are front row witnesses to the systemic racism and bias that is built into the health care system across New York State and the United States.

In New York state, and especially New York City, many hospitals commonly separate patients insured with Medicaid from patients with private insurance or Medicare.

This segregation can take a variety of forms.

Patients seen at different sites at the same time are in the same site at different times and at the same time by different providers.

In New York State.

People of color are twice as likely to be insured by Medicaid compared to white patients.

This operation within the health system is one of the key reasons that non-white patients have less access to care and continuity in their care compared to white patients.

DSRIP is intended to be transformational for both health care system and the health outcomes of New Yorkers.

This cannot be accomplished without empowering CEOs and eliminating systemic racism in the health care system. I just replied from the level of the community with accountability to a project approval.

Thank you very much. And all that is focused on equity would be truly transformational for our neighborhood, city and state.

Thank you.

Speaker 17.

Good afternoon. My name is Randolph Brown.

I'm not a president, nor my director.

I'm a peer.

We are one of the people who actually go out in the field and talk to people for real.

Help your service, your graphics and your charts.

I enjoy what I do.

I enjoy being on the forefront.

I enjoy what is a squat people to their apartments.

We're the ones who go to shelters and soup kitchens and look at people who face the real.

To me, there's not there's nothing more rewarding than negative. I woke up when I wake up.

No, I did something myself yesterday.

That's what it feels like for me.

You know, I work to help people.

I love work. We help people help. People need help.

Help. People need help.

I work with the asthma program at a niece who passed away from asthma about six years ago.

And uncle passed with asthma last year.

I'm a direct result of asthma things. I mean, what? I took away my left lung.

I'm not dead. So I'm also trying my right now.

My feeling mean, I was walking around pretty soon with oxygen in the inner part of the Bronx, the branches around abandoned by highways.

The problem? The first Bronx to Southern Boulevard de Deegan, Hutchison.

These are some of the places that the Bronx deal with. But the Bronx, like the stepchild Volvo's in its stop ground, is always like the last one that anybody can touch, of course.

But me, like I said at the pier, we got opportunity come out to a more graphic of Mohammed written down her lap.

I walk out of here.

I actually the holy again this time of year, closing your heart to tell me how you really feel and how I feel.

And I'm proud of what I do every single day.

Why go out to the community? I go to a soup kitchen.

I go to a homeless shelter and shake these people hand and tell. We're here to help you.

And some of the people actually come up off his back and told her that guy Brown I was talking to really, really know that Dr. Martin Field.

Escorts. What we do? Escort. I feel good about escorts.

Some people are frail.

Some people don't know how to move forward with their joints and other disease.

How people doing more of this as we do ask and we do that really.

We deal with HIV and how people get the more time classic. It's an institution.

I'm proud to be a partner in a small town before we get out there. We don't have vehicles with be foot.

We'll have a 30 percent problem solved.

We'll be on foot patrol.

And I'm proud to be from the neighborhood.

You couldn't stop my son always say, well, I was normal in your neighborhood.

You step up our shop.

Yes, in a way, for I always wanted.

Thank you.

Speaker 18.

Good afternoon. My name is One Pinzon. I'm the director of health services at the Community Service Society.

CEO says helps about 100000 New Yorkers every year in Raleigh, health insurance and access care.

And we do this through 50 community based organizations all over the state.

We provide those many sessions with technical assistance, capacity building and CSA, as has worked closely with One City Health.

One of the largest PPS is in in the state to increase CPO engagement and readiness to participate in value based payment contracts.

For that project CNS interview and assess 52 community based organizations, many of which are here today in the room about their efforts to war with health care providers and improve the health of their clients.

As new Europe moves forward with this report, success urges the state to prioritize capacity building beyond hospitals and large medical systems.

We are pleased to see that the Medicaid redesign team recognizes the importance of non-clinical services and community based organizations in the amendment request.

And CSX agrees with the M.I.T.

That's a social determinants where Health Network of CBS is the best strategy for addressing non-clinical needs.

However, CSX has recommendations for implementing these networks based on our direct experience experience administering five networks of CEOs throughout the state and assessing CEOs about their readiness for value based payments.

Our first recommendation is that CBO should be able to form lead entities and apply for this report.

Social Determinants of Health Met was one of the guiding principles of this was a positive.

Health outcomes are driven by care provided outside of hospitals, including social services.

However, most this refunding flow directly through hospitals resulted in much fewer investments in non-clinical services provided by CEOs than many observers.

Observers, including CSX, had hoped for create insulted the nurse or health networks that pulled Sebelius. But this is an important way to introduce more balance into the literal relationship between CEOs and large health systems.

However, if the lead in entities of those networks outpaces or value driven entities, we are afraid that the Sandy dynamic will take place.

The amendment requests.

So does the CBO would be part of the leadership of the new blue ribbon entities along with BP, as is an managed care organization.

However, in light of the lessons learned during the first five years of this report, it seems unlikely.

New York has a robust multi decade tradition of directly contracting with Sebelius through facilitator role meant program, the navigator program, the consumer assistance programs.

The state should only permit Sebelius or coalitions of CEOs to serve as lead entities of these association. Edwards Sebelius should be able to create their own that was with their own governance structure and apply for this refunding to develop their network into an equal partner with their health care systems.

This will be a more effective way of building a strong social services sector that can handle health care referrals and asking EM CEOs or provider systems to create such a network.

Our second recommendation is that the one point five billion it requests for social determinants of health funding should flow directly to CBO.

CBO also provide non-clinical social services, a spiral for capacity building project assessment assessments conducted by CSX and One City help reveal that the need for more capacity building and infrastructure development in the CBO community CBO is have the skills to provide vital services to New York, services that have enormous effects on health outcomes.

But they don't always have the instruct infrastructure skills that it takes to contract with a large health system or MCO or to guide data in a way that shows they value what they do.

She says recommends that these these refunds be used to create a capacity building program to support the social services sector. The capacity building project should create peer lending communities where Sebelius can receive technical assistance, targeted training and networking opportunities to build up the infrastructure before joining the association Edwards.

It should also issue capacity and technical support grants for Sebelius to build and maintain.

Instead of their 80 capacity that tracks outcomes and interacts with the new New Year's health information networks and health care providers and payers.

Similar to the new state panel health heal grants to health care providers.

Thank you again for considering our comments.

Thank you.

We're so speaker number 19, if you can hold off a sec or making an accommodation for Judy Lester.

So as Wessler.

Thank you.

Thanks, everybody.

Have a little problem with my back saying that.

I appreciate the time.

My name is Kitty West.

I'm an active member of Comedians Together from Health, Equity and the Assembly. Where? Sensitive on the pay app and I never remember what that stands for, so.

So there are some really good things in the draft and I usually don't say nice things about stuff. So, you know, we got it live in the sub a little bit less so.

But.

And if they're really done the way they are kind of stated, if the implementation, commitment and oversight is real, then this can really make a difference in our community.

So and and so we have to stay on not just commenting on the graph, but really how this gets implemented.

And as I understand it, the first year is an extension rather than the full program. And that should be a time when we really have an influence on how the next three years are implemented.

And so stay tuned, everybody.

Don't go anyplace.

So.

And the other thing I want to say is and most people don't know about it, put the pay up has played an integral part in pushing for and making sure that there's some accountability and how the money is spent.

I can tell you the CEOs wouldn't have gotten money if we hadn't.

So please support it because it's not in here.

The continuation of the pay up.

The theory is a need focus on culturally competent and linguistically competent care.

And it's not a factor that has been worked on in DSRIP 1, but we have to insist there is very much a part of this. Where to? And let's see.

I submitted three pages of comments, I'm just summarizing some of the points.

The Social I.

Others have said this, but I want to reiterate the social determinants of health network.

It's good to see one point five billion going into that.

But it's got to be controlled by CEOs and communities and preferably by consortiums.

And it's been funded consortiums that some of us in the room fought for and now they're being neglected and not funded.

So they should be very much a part of how these networks are done and where that money goes.

What's been not really focused on in DSRIP 1 and needs to be in two is expanding primary care, addressing inequities in availability and delivery of services.

Focus on cultural competence and understanding the growth of community based services to address the social determinants of health and the potentials for doing that or in the graft.

But it is the potential.

And again, we've got to be very clear about staying involved and making sure that it happens the other way. That this can really make the difference is right now.

The PPS is don't have a geographic region per say.

Some of them do, but a lot of them don't.

They should have responsibility for community.

VB or whatever I got call them the three letter diseases, you know, networks, BBC instead of PPS.

So they should have responsibility for a community and they've got to be run by managed by and governance decisions made by not only health care providers.

Hospitals have been taking the money and running a little bit and we've got to stop that.

So it's got to be a real diversity of people in the governance structure, including hospitals, but also community based providers and certainly CEOs.

And now the managed care organizations are left to say, I've been fighting with my managed care organization, has a secret shopper or my own services are mad. They need help.

So.

So I had proposed and with Chris Norwood, you've heard Nancy police CEO Feliciano, who you will hear from.

We met with.

But Don and Greg and Peggy and we're happy to see that some of what we talked to there seems to be and I say seems to appears to be reflected in the graph. And that was a good thing to say.

So, again, the three regional community planning warships, CTA G is one of them in New York City must play a critical role in the development operation.

The ad draft suggests in the first year, the extent to which I've said before, this flexibility will line funding to this future management structure for a given region of market.

And the best way that that could be done is if these new entities, the new illnesses BS would take responsibility for a community rather than having attributed patients because they use that hospital.

That's not a good way to really define responsibility and almost done so.

OK, if I can get these pages 30 seconds, I will go until I'm finished.

Thanks, Peggy.

OK. So again, the role of the community based organizations is critical and they say in the draft they mentioned over and over again.

However, they have been given the recognition and the role and the what's the word I'm looking for to honor respect currently.

So that it's got to be a real better defined what role CEOs will play and what CBO is not the 10 million dollar ones, but the small community based organizations that are located in their communities and have that kind of relationship.

Again, the governance structure.

Thanks, Judy.

With decision making, authority should to focus on improving access, quality and impact on health outcomes, cultural confidence and training positions important with within our structure.

Thank you. So we look forward to continue to work on this.

Thank you.

Speaker 19.

Thank you.

Good afternoon.

My name is Ricardo Rivera and I'm the chief business development officer for So Most Community Care and a former executive director for Medicaid in Puerto Rico.

Five years ago, New York embarked on one of the most rad towns, most radical transformation of its health care system in the history of Medicaid.

So almost embrace the challenge.

We made it ours because we firmly we firmly believe that it was the right thing to do for the benefit of our more than 600000 Medicaid patients throughout New York City.

Thomas is different.

We are a network of more than 25 hundred providers, mostly independent community based primary care physicians serving the most vulnerable populations throughout New York City.

We are deeply rooted in the community and we saw this as an opportunity to improve the quality of care for those who need it the most.

We did not waste time and in their first four years of this rig.

Among other accomplishments saw almost as a chief reduction of 20 percent in avoidable admissions and close to 26 percent in avoidable readmissions.

For perspective, this is close to 300 million dollars in savings only in these two metrics.

So most did not hesitate to participate in the pilot program.

We persevere.

Obtaining six out of the 12 pilot programs in the entire state of New York at the end of the program in December 2018.

So most was able to improve quality while creating efficiencies.

It was so successful that we enhance and extended our BBB relationships with the majority of the empty aisles beyond the end of the program along this journey.

So most fostered a strong relationship with hospitals, specialists or other key providers and community based organizations.

Further strengthening their SO must link to the community with all these valuable, their needs and relationships almost prepared to face the nation program process.

We receive the innovator designation in August 2018 and again we are one of the only three innovation designations in the entire state of New York.

Honestly, he has been a tough negotiation process with the M.S.

ALS.

However, the experience gained through DSRIP and the pilot program has helped us in these odyssey.

After more than a year of negotiations, we are finally concrete dating innovator agreements with several embryos.

All that we have worked for in this time has positively impacted our performance beyond this pilot and innovator.

Just recently we were informed that are a CEO, which has been number one in New York for the past three years, now is in the top 10 percent in all of the US as well.

Nonetheless, five years is a drop in the bucket when trying to achieve sustainable transformation of the New York state healthcare system.

Many things still need to be enhanced. For example, strengthening the integration of behavioral health, improving the social determinants of health intervention programs, and the integration of CEOs, and absorbing and managing the risk of our community patients.

For these reasons, we respectfully ask you to bite the state waiver extension proposal into two parallel and independent asks one to extend this rate for a year to match the end of the waiver and the second the three year waiver extension to March 2024.

The priority should be to negotiate a one year DSRIP extension, and during these extension period the wage would concentrate on refining its 2.0 proposal with vehemence to promote sustaining successful models and reforms in the context of a transitional plan to oppose this RIP world.

Accomplishing that, this rib extension will provide continuity to all that almost has created in these five years and will solidify our foundation to keep building the future.

We need to lock in our success and create a path forward that we can count on for the longer term reward success like ours and support real reform and change.

That means starting with those successful DSRIP models like sawmills and asking how ongoing Medicaid payment and coverage systems can appropriately incentivize and reward those models while encouraging continuous improvement and innovation.

Thank you.

Speaker 20.

Good afternoon.

I am Duckworth.

The president and CEO of the Immediate Care Innovator Network known as ACE in.

Thanks for the opportunity to testify today.

We want to ensure that DSRIP 2.0 funds are made available to support our efforts to end the HIV epidemic and strengthen New York's community based primary care infrastructure.

Aizen is made up of seven F Q H C's, Mount Sinai's five designated AIDS centers, a broad network of CEOs that constitute engage well IPA and the immediate care snip.

We've applied to become a statewide innovator, a CEO focused on improving health outcomes for people living with HIV and preventing new HIV infections.

We have over 14000 attributed lives, or about 50 percent of New York City's population of HIV positive persons with Medicaid ace and will contribute to significant improvements in health outcomes and Medicaid cost savings, including averted Medicaid program costs for the lifetime HIV treatment for persons who remain HIV negative under the existing snip.

We have achieved a 70 percent decrease in hospitalizations, a 50 percent reduction in E.D.

visits since 2008 for our members, resulting in over 170 million in Medicaid savings.

I recommend eight recommendations today are focused on leveling the playing field for community based providers, especially those focused on ETP to participate in value based payment arrangements.

First, we recommend that the state allow non PPA led entities to submit visa applications.

PPACA is in DSRIP 1.0 were formed solely on a regional basis and there was great variability in the needs of those attributed to the PPS.

This PPS structure is not the best vehicle to address the needs of certain subpopulations, such as persons who are HIV positive through DSRIP 2.0. The state should consider approving the disease that focus on serving a sub population, not based on geography that can tailor promising DSRIP 1.0 best practices to the needs of their population.

A single statewide HIV population health strategy that leverages a proven model of care is needed to increase by reload suppression among those not yet suppressed or intermittently suppressed.

Advance prep access to prevent transmission.

Achieve Medicaid cost savings within a sector where current class exceed 2 billion dollars, while also preventing new lifetime costs of HIV treatment at nearly a half a million dollars per Medicaid enrollee with demonstrated results on a larger scale.

This innovator ACA poverty model could be expanded to address other populations with similar behavioral health diagnoses and needs.

We recommend that DSRIP 2.0 funds be used to support the creation of primary care led contracting entities under DSRIP 2.0.

Funding to support diabetes contracting among community based providers would be consistent with how the Behavioral Health Care Collaborate. Pro-growth program supported the formation of Behavioral Health IPA.

We recommend that DSRIP 2.0 funding be used to improve access to actionable data, while Kiwis have made great headway since the initiation of DSRIP.

Providers are still not able to obtain the data that they need to take on risk, and when they do get it, are not able to use it in meaningful ways through DSRIP 2.0.

We must also improve the community consent process.

An important component of making data available is tackling the challenges with the existing consent process.

A critical step forward in this process was the approval of community consent.

The states should use DSRIP 2.0 funds to create a centralized mechanism to educate providers about community consent and potentially bonus payments to providers, including health home providers who get community consent from their clients.

We must redesign existing care coordination programs, which are an integral part of many of the high quality initiatives developed in DSRIP 1.0, including a number of HIV viral load suppression programs.

The OS programs, some of which provide quarterly rewards for participants who may maintain an undetectable viral load employee care coordination to ensure access to medical, behavioral and other social services.

Most programs have incorporated the health home care coordination services into their mix.

However, given the complexity of managing HIV along with other co occurring conditions, participants often need more intensive care coordination support beyond what is available through the Health Home Program.

We recommend that DSRIP 2.0 funds be used to pilot new models of care coordination.

The state should also consider implementing a strategy to increase enrollment in care coordination services and work with EMS CEOs to pilot.

A new procedure is up where MCI is prospectively enrolled there and eligible members and health home services.

Thank you. Thank you.

Speaker 21.

Good afternoon.

My name is Kadish Welby and I'm here today on behalf of the New York State Nurses Association.

Nice, nice.

And as a union of 40000 frontline nurses working to deliver high quality care to patients across New York State.

We will discuss four issues in our comments today.

Social determinants of health, workforce development, the importance of CEOs and finally, issues specific to hospitals serving vulnerable populations, social determinants of health.

We are encouraged by the fact that the next phase of disrepair more aggressively address the social determinants of health as caregivers. We know that many of our patients are being discharged to unstable housing situations, particularly those who rely on Medicaid.

Our caregivers in rural areas also point out dual issues of transportation and housing for consistent access to care before and after leaving provider settings.

Many larger providers already have access to large amounts of real estate, which they prefer to develop into clinical areas.

We note that transitional housing may be a possibility in these settings, and we want to encourage the social determinants of health networks to look to look to some larger providers for solutions to housing and transportation.

We also want to encourage BD to avoid using contingent workforces to address transportation issues and define more clinically stable ways to provide better access for patients.

Workforce development according to the most recently available data, nearly fifteen hundred registered nurses have been hired across the PPS is to facilitate DSRIP schools.

This is an encouraging step in the right direction. However, we want to point out that it seems that targeted hiring for nurse practitioners has been somewhat anemic.

And we hope that in Phase 2, more hiring is done to continue to broaden access to behavioral health and primary care service.

In addition and long term care settings, additional workforce investments are needed, particularly in rural areas.

We are encouraged that the Department of Health is acknowledging that PD need to focus on developing ways to incentivize workforce participation in this area.

We request D D 0 8 from a barrier to participation, such as providing funds for child care for LP ends and AIDS and to recommend to BDD that they also explore utilizing our friends in this capacity community benefit organizations.

The DSRIP Amendment request emphasizes community community level collaboration as an integral component of the success of DSRIPs so far.

Yet CEOs are underfunded and consistently on the outskirts of the health planning process.

Terms of collaboration continue to be defined by the state.

PPS is another payers.

Despite the acknowledged role CEOs have played in supporting the reduction of avoidable howdy hospital use and achieving other high priority desperate measures.

For this reason, we recommend the state include CBO is within governance and decision making bodies. We also recommend the state leverage regional CBO networks to lead and conduct community needs assessments, design and support, evaluation of social determinants, health measures of success and play a much more active role in the second. Second generation BD hospitals serving vulnerable populations.

Nice now works closely in coalition with our community partners and elected officials to address serious disparities in funding for our critical access hospitals across the state.

For example, with the implantation of NYC cares in New York City, our safety net facilities that are part of the New York health and hospitals will be an essential component to a success.

Our public sector and rural hospitals upstate also continue to be an important provider for Medicaid and the dual eligible population.

These facilities need continued support with a new video paradigm.

In addition, while we share DSRIP goal of reducing avoidable hospitalizations, reduction of inpatient services without subsequent development of replacement services is problematic.

As an example, we don't.

Montefiore Health System Montefiore Health Systems decision to remove all inpatient capacity from its Mount Vernon campus and replace it with outpatient services and an off campus emergency department.

We are concerned this will lead to worse health outcomes for the community and place an undue burden on neighboring acute care facilities and community based organizations.

We urge DOH to look at these types of closures and service realignments that the stated goals of the next phase of DSRIP and provide additional oversight and scrutiny to providers that are acting unilaterally without major input from community stakeholders and CEOs.

Thank you for the opportunity to share our feedback.

Thank you. Speaker 22.

Hi, I'm Louise Cohen.

I'm the CEO of the Primary Care Development Corporation.

So I'll be talking about primary care as you could expect.

I think that we've been active in a wide variety of peoples across the state.

We're working in collaboration with the same the same grant to promote patient centered medical home recognition.

And we applaud and support your efforts to get more money into New York State to develop the transform the system.

But as you think about this new proposal, we really urge you to revamp the Medicaid waiver to focus on strengthening the primary care system.

And we think there are essentially a couple principles.

So not so much particular programs, but principles that we think would help you do this.

So the first thing is let me say that the evidence is really clear that a focus on an increase in primary care and primary care providers leads to lower cost and better outcomes across a whole variety of issues, such as all cause mortality, cancer, heart disease, diabetes, stroke in mortality and low birth weight, life expectancy and so forth.

And we're glad to share with you our extensive literature review.

If you want to see that.

But we know that the currently the health care system spends about five to seven cents on every health care dollar on primary care in New York State. We actually don't know the exact number because we don't measure it, but we actually know that the DSRIP funds flow was really quite minimal to primary care providers, even though there was money going to other organizations that were acting on the primary care providers.

And we think that with such a small investment, you can imagine that there may not have been such a strong impact as we think you could have if you really transform the investment to focus on primary care.

So we think that the waiver funding should go directly to primary care organizations through existing channels such as the managed care organizations.

Not sure about the value of creating yet another system that has to build up data systems and so forth, and that the share of the dollars should go much more predominantly to primary care.

We think the contracts, whether are value based payment contracts, fee for service in incentive payments or a combination should cover not only cost of providing direct care, but really all those things that we know matter care, coordination, care management, data exchange, case conferencing and population health activities.

And in general, I would say that upfront payment is really quite necessary for primary care providers who really don't have the balance sheets to manage sort of an after the fact payment for their work.

And we think existing payments, particularly for things like patient centered medical home, need to continue. We know that those payments have been quite important.

And I'm a little surprised that no one here today has mentioned what we know is a pretty big looming deficit in the Medicaid program. But if we think that all the investment made to date and things like patient centered medical home is actually critical, we have to make sure that those payments continue. And it's time we know that those things patients had her medical home and other activities take time to ramp up and that you really see the fruits of those those efforts. You know, two or three, four years down the line.

And so we have to continue that trajectory.

Secondly, I think that we must attribute the patients to the providers that manage their care.

And in particular, I think that we should ensure that primary that excuse me, behavioral health providers for whom who are getting the predominant for whom their patients are getting a predominant source of care in the behavioral health sector should be attributed to the behavioral health sector.

I would argue, as Doug just did, that that may be true for people with a primary HIV dose diagnosis as well, and that those organizations are ready to take on responsibility for helping those people get their care in the primary care system. And we know that because they've told us that in work that we've done with them, not everybody is prepared to take downside risk at this point.

And so we really think that you have to figure out those upfront payments and titrate in this this risk issue over some period of time.

You could certainly do value based payment. And another way, think about incentive payments and per member per month payments such as the CBC UHC program.

And finally, I think that wherever possible, we should promote geographic systems of care and everyone in it.

And in a lot of meetings around DSRIP, we hear that the Staten Island PPS has done a great job and I think they have one of the reasons for this. Certainly not the only one, but one of them is that they have a geographic location, that there is no other PPS.

We did a survey among our patient centered medical home recognition, private practice practices, large and small.

They have an average of of 16, an average of 16 insurance contracts.

And then on top of that, many of the PPS is the overlap is two.

Three for PPS is this actually doesn't work for a primary care provider who needs to be able to focus in on the work that they're doing and not have that many that many contract.

So, again, creating a new entity seems to us to ness to not necessarily support a robust primary care system.

And finally, and very importantly, I think the data that's that's provided needs to be much more transparent.

The data does show that primary care utilization in the Medicaid program has. Decreased over the past six years across all age groups and diagnoses.

It would be very important to understand this and understand how any additional waiver programs and in fact the fundamental Medicaid reimbursement can can change its trajectory since we know that primary care has a great deal to do with both outcomes and reducing cost.

Thanks.

Speaker Twenty three.

Speaker Twenty three.

OK. We heard from Speaker 24.

Speaker Twenty five.

Speaker 26.

I'm sorry. So which number are you? Twenty seven.

Twenty seven. All right, thanks.

Good afternoon. My name is Arima Jacobs. I'm the director of Medicaid Strategy and Community Engagement at Emblem Health.

Emblem Health is a non-profit plan that's a services over a one hundred and twenty thousand Medicaid members.

We're proud of our more than 80 year history servicing New York and we'll help strongly supports the goals of the DSRIP program.

And we agree that plan provider arrangements that stress mutual accountability improves the lives of Medicaid beneficiaries.

The state is rightly proud of its trailblazing role in promoting value based care.

The waiver renewal process allows us to look back at our past experiences and consider how the program may be improved in the future.

We have three main recommendations in response to the state's draft waiver amendment request value drip driving entities or VDE should include one lead entity, which could also be a health plan that is primarily responsible for organizing its activities and achieving its objectives and will help greatly appreciates the state's understanding of the importance of Medicaid health plans and requiring new value driving entities to include MCOs in their governing structures.

We support expanding that concept to permit Medicaid health plans to operate to VDEs alongside PPS led entities.

Population based health is most successful when clinicians direct patients to the right services at the right time in the right setting and health plans have the infrastructure to perform these tasks and experience and accepting and shouldering financial risk while being held accountable for improving outcomes.

These characteristics are what the state is demanding through DSRIP.

Emblem Health has several unique attributes that fit with the state's objectives.

We have an unparalleled partnership with Advantage Care Positions of New York ACPNY, one of the largest medical groups in New York City.

We've established 10 neighborhood care centers located in low income and ethnically diverse areas throughout New York City.

These centers are staffed by customer care navigators who help consumers through the health care system and the social services system.

We recently began a full partnership with City BLOCK focused on high needs enrollees that uses multiple disciplinary teams to work with individuals where they live to provide the care that they need.

We also have multiple shared savings, shared risk and full risk arrangements with several independent practice associations.

These experiences have prepared Emblem Health to take a leadership role in this next iteration of threat.

We're very excited and looking forward to working with you to consider additional opportunities to achieve these shared goals.

Our second recommendation is that the road map should permit new flexibility in key areas.

The state's draft DSRIP waiver amendment acknowledges that more time is needed to directly support the best DSRIP work.

Permitting new opportunities to innovate within the road map is consistent with these goals.

The road maps, definitions and requirements often do not reflect marketplace dynamics.

Our comments will include more specific recommendations for tweaks to the road map that promote value based care as the market continues to mature.

And third.

All entities receiving DSRIP funds should be required to demonstrate that they are using those dollars to support the program goals.

DSRIP's first four or five years taught us that considerable investments are necessary to create these partnerships between health plans, clinicians and hospitals that support each entity's commitment to both successful at being both successful and accountable.

The state has every right to insist that the investments are directed toward these activities and on behalf of them will help.

I appreciate the opportunity to provide our views on the state's waiver renewal proposal.

We look forward to continuing to work with you to best serve the low income residents of New York.

Thank you. Speaker 28.

My name's Janet Steig and I am the director of Medical Record Collection and review for Med Review.

I work for all of downstate and all 15 of the PPSs.

I've been with this project since the inception and I've seen lots of changes.

And when I first started this project, I remember I I trained physicians, I trained CPSs a metrics and best data practices.

And I walked into a group of physicians.

They were obstetricians and one was a medical director.

And we were talking to screening for clinical depression.

And he said, why do we need to do that? And I sort of step back and I said, Really? Said, why do obstetricians, why do specialists, why does anybody have to do that? And I said, remember the lady in Texas with the four children and she drowned them.

Postpartum.

Postpartum depression, then we sort of moved on.

Now, when I go in and talk to people and I meet with the providers and just met with Bronx, Lebanon, the other day, nobody looks at me like I'm stupid.

Everybody understands it now.

It took us a long time to get the providers up to that point, but nobody wanted to do it.

And it's not just a piece.

It is a specialist who touches that patient should be doing that.

And I've had social workers tell me that, you know, very they've given me presentations of lives that were saved because the PCP ask if the patient was depressed.

They did appear to Q2, then they expanded it. And then the woman felt comfortable saying, I'm going to kill myself.

And so they really felt like they saved her lives.

So it's.

My job is great because I get to go around, meet all the groups and PPSs which I love you all and some more than others.

But I also get to touch base with all of the providers in the facilities.

And there's other things going on in DSRIP that you cannot measure.

And one is we've got major health care networks that worked together that before, if we started in year one and said big hospital over here, work with big hospital over here and help us figure out to get this data into how do you get this data integrated? It would never have happened.

Today, I have big hospital over here working with big hospital over here.

They are now helping each other integrate data.

What's your best practice? Here's how we do it.

Can you train our people? Can you show us how to do it? That would never have happened at the beginning of this project.

So it's you know, we've also got we're saving you.

Just so you know, when we started this project, we had certainly budgets and we were collecting data.

A lot of the old fashioned.

And I started working with Rios when we first started working with Rios.

We all knew we could get data in there, but the quality metrics, we couldn't get them out.

So and now we're in the third year of working with them.

And we have a large participation downstate.

And it's amazing the data that we're getting out of it.

It has taken us a long time to do it. But now this particular initiative is not going to just help DSRIP.

It's going to help heat us or this quality issue or that quality issue.

So DSRIP isn't just the changes that you're making and the positive initiatives that are going on are just for the moment.

I hope they keep going because there's still a lot of work that we need to do with data integration with, you know, hospitals working together.

I've got PPSs now that they submit whole files of supplemental data that wouldn't have happened before.

And people are here now.

They hear the word DSRIP and they're excited to work for us.

It's a it has a positive connotation.

People are excited about it.

It took me about three years to I still have to explain it to some people. But.

Now, people are proud of this project, it's not like I'm walking in saying, which I used to do that and people wanted to kick me out the door.

But I walk in and say, I'm with DSRIP.

Can we get you coffee? Can we help you? People love this program.

So anything that I can do or any other information that I can give you to keep this project moving on.

I'm happy to do it. And I've been really pleased to be a part of the program. Thank you.

Speaker 29.

Speaker 30.

Molly Chittister, chief strategy officer with One City Health on behalf of the entire team at One City Health. Thank you for the opportunity to comment today.

One city health fully supports the proposal to continue to build on the success of the DSRIP program, which has already seen demonstrable success.

Since the inception of DSRIP, One City has seen a significant reduction in avoidable hospital admissions and avoidable visits to the E.R..

For our hospital partners, this means critical clinical resources can be better allocated to patients whose need for emergent and acute care were necessary.

For patients, this means they can spend more time at home with their family and community or at work rather than spending time in the hospital.

A patient in Corona, Queens, named Mercy, has seen her life and her family.

Her family's life changed as a result of the asthma home based environmental program.

After leaving her job because her son's asthma was so severe that she needed to stay home with him.

Her son, who is 6 years old at the time, was enrolled in the asthma program through DSRIP.

Mercy recently told us "I have more confidence taking him to school and I'm ready to go back to work because I see that my son is OK.

His nightly asthma attacks have subsided and they're able to manage his condition at home instead of regular trips to the E.R.." This result would not have been possible without the strong partnership of our diverse network of community based organizations who are able to address the needs of these patients and families in their home and the community.

As you've heard from many of them today.

The asthma program, along with 100 Schools project, which helps schools develop the capacity and skills to address mental health, were identified by the United Hospital Fund as promising practices for Medicaid.

Over the course of the DSRIP program, we've learned many lessons on the type of integration and collaboration that is required for success.

Like all new collaborations, it takes time to learn how to work together along with the right infrastructure and resources.

We are just now at the precipice of what the future could look like across our patients, providers and payers with regard to the proposal.

We applaud the state for recognizing the importance of addressing social risk factors, especially for populations that are facing unique health equity challenges.

We would highlight the work that has already been achieved due to our CBOs our critical partners in the journey to enhanced health.

You've seen examples of today.

The results of extended beyond quality of life alone and improved health outcomes that have included financial savings.

And we are encouraged about the commitment to continue to bring together the power of providers, MCOs and CBOs, recognizing the need of facilitation of the work between these organizations and the integration of payment so that the work can be sustained in the future.

Because this is a performance driven program.

We encourage the state to reach out to partners and DSRIP to enhance the process of Medicaid attribution around stronger systems with greater transparency on improvement of care for individual lives.

We look forward to working with the state on the details of what this innovation and collaboration could look like.

Our success today has been substantial, but more time is necessary to expand the reach of the progress we've made together and to build change that can last.

More time and resources are required to accurately evaluate and assess the impact of the current programs and to sustain these efforts through mechanisms including value based payments.

More time and resources are required to build on the technology and infrastructure that is only just now able to deliver on its true potential.

More time is required to have more stories like Mercy's and to assure families like nurses that these services will continue.

So we commend the state because we believe the proposal will accommodate for this.

And we welcome the opportunity to work with the state more closely on the final details of the proposal.

Speaker 31.

Thirty two.

Hello.

My name is Rose Gaster and I'm the executive vice president of Air NYC and it makes perfect sense to follow one city health because we are one of the contracted CBOs that help achieve some of those outcomes.

We are CBO that's been delivering community health worker home based services in New York City since 2001.

We're data driven, we're technology forward.

And I think that we've been very successful in the DSRIP space.

We were a CBO partner to four PPS systems.

Bronx Partners, Community Care of Brooklyn, Mount Sinai and one city, all of which we were operating in the asthma intervention.

I echo one city's happiness at being described as a DSRIP a promising practice that shows that our organizational model and intervention works.

For one city, we helped achieve the 25 percent reduction in asthma admissions, and we were recently told by Bronx partners that our work reduced utilization by 21 percent and admissions by 51 percent.

So this is all great DSRIP and value based contracting, which I think is a separate structure but also very important to CBOs has helped air NYC, expand its services and engaged new partners.

In manage long term care we're using our community health worker interventions to help plans address social isolation and their members as well as homelessness.

So I'm skipping over a lot of my written testimony since it's getting late, but we strongly support the extension of this program.

A few key policy points I'd like to make is even with VDP contracting.

The contracts are not enough.

People are checking the box and the real work is in implementing the contracts.

And for that reason, we recommend requiring some level of spend on social determinants interventions, not just requiring a contract.

If we're not going to get that, we also recommend making public data about how much MCOs are spending on social determinants interventions.

Holding them accountable, having that seen.

And frankly also understand that the data on how on that spend probably needs some sort of standardization.

It might be hard to to do that, but but we'd be happy to help you figure that out.

We also, in terms of what you have in the concept paper specific training programs for community health workers is very much welcomed.

Really, people trying to hide.

Hire additional community health workers.

So having standard programs and investing in that workforce is very much welcome.

Then lastly, the other point I want to make is about the we appreciate the attention to the social determinants in this version.

It's really a great advance from sort of focusing on the chronic conditions that was sort of DSRIP 1.0.

In our CBO role.

We just want you to be very mindful of the SDHNs, this idea of creating networks.

There is a lot of work going on in the community is now creating networks.

Some of them are happening through the technology platforms that probably lots of you know about now.

Power. Unite us.

That's one way of creating networks.

Some of them are coalescing around hospitals and health care systems very geographically based.

Some of their IPAs are starting to include CEOs in their network.

So there's a lot of ways that this is happening already.

And I just would urge if the state wants to get involved in the CBO ecosystem, do it with the advice of all the CBOs who are more than happy to talk to you about it.

It's been said numerous times that community based organizations want to be at the table helping to guide this process of including social care into the Medicaid program, which is necessary has to be done.

And we thank you for paying attention.

Speaker 33.

Good afternoon.

My name is Anthony Feliciano.

I'm the director of the Commission on the Public Health System.

I just want to say that the amendments we appreciate that it reflect a lot of the conversation that many CBOs have had with the State Department, and others.

I think it also probably reflects what has come out of DSRIP.

But I think there's things that still needs to be be done.

I mean, first, assess rests heavily on the partnership's ability to engage the community, develop interventions and then of community focus and led.

And that's important.

And to particularly as it disseminates information to create will to build will to do this. I think the video structures and approach must be grounded with local stakeholders from multiple sectors to determine priorities for and implement regional health efforts.

And what I mean by regionaly, I go back to support the idea of the city looking at the boroughs and into the county, but going even deeper that because there are neighborhoods within those boroughs and there's nuances between all that. So not to just think about it just as borough but borbough is the standing point when everything else moving forward. Specific needs within communities, leveraging those organization neighborhood connections to increase committee engagement and how similar initiatives must be done systematically and consistently.

Many times it's been sporadically and it hasn't always gelled together. So they've been concerned about how are the structures now and what we can do to strengthen us so we can ensure an issue of equity in the partnership, particularly on governance structure and decision making.

So I I support what was speaking up and when it came to that.

But also, I think we have an opportunity to think to also to think consider that already more funds to support small committee based organization that worked in the most vulnerable communities.

I don't know.

I think that the number shows that there is a commitment today into the one point five billion, but I don't know yet if that's going to be enough. So is there a way of valuing or phasing how that could be increased and looked at over time.

The negotiation with the federal government we know, is going to be tricky.

And so I think there's a need to be understanding if you don't get all the money that you're requesting, that there should be prioritization around CBOs, in terms of the dollars that you're ready committed to.

It would be a shame to have that cut.

And that's just a reality given the sort of administration.

Part of it is also to prioritize the funding to go to the hospital.

They provide critical access to get to the most vulnerable we our safety nets and figuring that out, because there's always been an inequity also in their distribution of those dollars when it comes to who's really serving people on Medicaid and the uninsured.

And I will just say that there is an opportunity to incentivize CBOs and to come closer together and strengthen the networks in the work we do in communities.

And also to think about the workforce aspect of this proposed amendments, what it means to have the hospital workforce and community based workforce working together.

It is not just a hierarchy of leadership deciding what things are happening.

We have to have sustainment.

And so a lot of this stuff is about sustaining things moving forward.

And you can sustain it without a community based organization, without the CBOs.

Those that are right on the ground.

So I think we need to think about what that partnership looks like.

And I think we have already established that two consortiums have come together about what it means to partner to work together. So this thing's already in place that's been discussed.

There are strategies that are being discussed within communities.

There are communities that for many years understand what needs to be done with committee based organizations coming together.

So I think that reinventing the wheel is strengthening that, providing the infrastructure.

And as the point is needed for the kinship based organizations to move forward, particularly with consortiums like ours came together, really people working so hard to get that she'd be able to continue to be supported moving forward.

And I think as well as looking at in terms of the health networks as really thinking, too, about sort of how they integrate together.

If we decide to do networks that are in silos, maternal and all that, we really understand what creates those conditions together and what causes people to get well or to be sick.

We're going to keep losing out and not use the funds effectively the way we should have.

Thank you.

Speaker 34.

Good afternoon. My name is Faban Araya and I'm on.

I'm here on behalf of the Arthur Ashe Institute for Urban Health and also as a member of Communities Together for Health Equity, similar to many Tier 1 community based organizations, that institute serves as a trusted, dependable and culturally competent broker between the community and the health system.

Over the course of twenty five plus years, we've developed trusted relationships with schools, faith based organizations, barbershops and salons that have allowed us to foster real relationships with the community.

These relationships extend far beyond any project and initiative as the reality of their conditions are complex and rooted in hundreds of years of structural racism, social and economic inequities and have shaped the quality and trajectory of their lives.

This is ever more present as the basic human rights of millions of immigrants are being challenged.

The terror and instability these actions caused cannot be captured by metrics in real time, but have a profound and life altering impact.

So while DSRIP metrics highlight the success of reduced avoidable hospital use and readmission rates, it does not reflect nor have the capacity to respond in real time without CBOs.

Leveraging the existing CBO networks and the state that the state invested in can help facilitate this process.

Transformation is ambitious, but will require a shift in culture and practice to really transform the lives of those most affected.

It can occur when CBOs are equitably represented in governance structures where decision making occurs, have the support and resources to build the infrastructure and capacity to have sustained engagement in the health care delivery system.

And want a shared agenda for health equity is practiced and implemented.

While both DSRIP promising practices and the amendment requests leans heavily on the expansion of successful community partnerships, cross-sector collaborations and an emphasis on addressing the social determinants of health as key initiatives to sustain transformation is not reflected in the policies and practices that make that a reality.

The request is simple.

Let's work together.

Let's be open and receptive to the challenges that we face.

And let's practice equity and inclusion to ensure we're accountable for our communities.

Thank you.

Speaker 35.

Good afternoon.

I'm from part of CTHE and I'm part of Arthur Ashe Institute.

I don't want to repeat, I think if we were to summarize, we hear that CBOs and any organization that are out of the hospital system is asking for inclusion, is saying you're missing some fundamental because we're a bridge over troubled water.

You're not taking care of the bridge and identifying those bridges.

And we have done everything possible and attempted to get the Department of Health to listen, to pay attention.

And some of us feel frustrated.

We feel that we're failing.

We've been in these climates.

We said the same thing.

We give data and we still have not achieved some fundamental.

One, a structure in the governance where CBO was included in the continual plan in designing and making decisions about quality of life for the community that they represent.

They're not just a CBO.

They represent those populations that you talk about, but the invisiblelize in the way you design things.

The same racialized immigrants, people with chronic disease that does it. You don't feel it when you use your data.

And these communities are the one relate on a daily basis.

Sleep with them.

Talk to them.

Walk with them.

I don't think that I don't feel that The Department of Health is addressing the most fundamental pathology that we have, which is power.

Who decide and are those people impacted by this? Participate in the process.

We invent new terms every time we look at these proposal.

Value driven entities.

CBOs are mentioned, but we're not valued.

We're not equal state holders.

We talk of a promise in practice in all the analysis and we for this earlier.

There is no serious analysis of the collaboration of CBOs and how they add value to meet those successful metrics that we're talking about.

We still have no data of CBO as engagement in those social determinants made a difference in reaching those 21 percent.

We give it to PPSs and we invisible eyes.

Everybody else has mentioned just a slogans or concept, but we're not you're not putting your capacity to also assess the value of CBOs.

We always have to have justification looking for data ourselves.

The same way you analyze it BPSs you must provide some support to analyze the impact of CBO.

I also want to I think today most of the group, most of the people itemize the stuff. There are concerns is a repetition of the same thing.

We will put it in writing.

We think we need to move from just having these therapy sessions.

And when we leave, we get the same outcome not in change.

So we are asking to pay not only lesson, but to apply to use what we tell you to redesign, change the dynamic of relationship.

Cynthia, she presented the strategy, a strategic plan.

Request shown or practice what we did.

70 ad organization.

Multiple population.

We have a word of what that strategic plan represent.

In this process or will be included.

So we need a governance structure that just not call us when we have nothing else to do but include as a systemic part of it.

I also and saying that again, we assess and bring us in the design to get over what our experience saw when we started this process.

We had to fight very hard to be listened to and there was a member of the promise.

That said, it depends on what DSRIP mean.

We're talking to previous incarcerated population about DSRIP and and we're hoping that this means something.

I hope what this person said doesn't become the end of what DSRIP is.

I want to keep hopeful that DSRIP doesn't mean deliver a system.

Rest in peace.

I hope it means delivery system that's going to transform.

Delivery system that would integrate systems that help people live a better life and quality of life.

So that's the challenge for us.

And if you do it without CBOs, without the community, there's no way to meet those metrics.

And those are public dollars that we again use for just one sector and that include all the sectors and engage.

Thank you very much.

I believe this is the final number 36 is the final speaker.

Hi, good afternoon. My name's Rob Bannon and my consulting company has been working with CBOs and FQHCs and health plans with the city and the state government agencies to advance mostly HIV projects through DSRIP.

So we've made a lot of achievements through DSRIP 1.0 to end the epidemic.

We have a great opportunity potentially to build on all of those.

Many of the achievements that have been made are outlined in the United Hospital Fund document, which is great.

Some really amazing work, but obviously not all of them could be captured in that document. And I think we just want to make sure that VDAs will have the opportunity to define and to document what promising practices they may want to advance.

You know, there's been a lot of amazing work through DSRIP1.0 that isn't in that document.

So I want to talk about a couple of the initiatives that HIV specific projects that have that have been accomplished.

The two that I want to focus on are the peer delivered services and the viral load suppression programs.

And both of those programs rely very heavily on social determinants of health services.

They bring in a large network of providers.

I know that DSRIP 2.0's focus is on sustaining a lot of these services. I think the viral load suppression programs. Doug before talked about care management making the care management, the the Medicaid funded care management programs, making them work better to support viral load suppression programs.

So I think that's really important.

And then I think so a lot of the DLS programs, people aren't familiar with them. They include incentive payments.

And so you.

So these quarterly financial rewards for participants help them to encourage them to remain undetectable.

So to sustain these programs, we need to classify those incentives as medical costs, which they're not currently patient consumer and provider quality incentives together support a comprehensive treatment program that contributes to patient treatment, adherence and maintenance and care of both key to improve health outcomes.

SNIP and MCO Member VLS incentive dollars just as provider quality incentive dollars should be reflected in the plans medical costs instead of administrative costs. Common classification of both patient, consumer and provider incentive components would ensure alignment of patient, consumer and provider efforts in the development of an adherence to realistic, achievable and effective treatment programs.

Through DSRIP, we've also done a lot of work with peer delivered services, the AIDS Institute.

Over the last five years has created the AIDS Institute certified peer.

We have OASIS has changed the regulations to support a really meaningful reimbursement rate for peer delivered services.

We actually just did an application for a new treatment program and OASIS wrote back and said, you don't have any SRPAs, you have any sort of recovery peer advocates in your application.

You've got to add them into your budget before you can approve it.

So I feel like peer delivered services, there's a lot going on and it's really exciting.

So we recommend expanding these programs through DSRIP 2.0.

We know that you actually that's one of your main components of the waiver.

The draft application is the non-clinical workforce.

So I know a lot of people close to these program were really excited to read that you're supporting nontraditional non clinical workforce.

We specifically recommend expanding these programs.

Peer delivered services which if implemented appropriately, can lead to tremendous cost savings associated with people moving off of public assistance, as well as our impact on rates of engagement, retention and care among peers client case lists.

There are a lot of barriers.

One of the biggest ones is that when you give somebody a salary, then their benefits go down through DSRIP 2.0.

We have to address this barrier to entering the workforce is for full time employees and work towards addressing the impact that that has on public assistance.

Finally, I'll just leave on the note about social determinants of health networks.

I know a lot of people have talked about that.

You know it's really exciting to see one point five billion dollars being invested across the state and social and human health networks think some of the things that I think I echo a lot of what's been said today, you know. But I think that we need to.

I believe there should be clarification that the list of social detriment of health services that are in the concept paper, that's not that that it's not limited to those I think was like work for us. I don't know exactly what that was.

But, you know, for DSRIP 1.0, we did needs assessments.

And you basically decided in my community, these are the issues that we have to address.

So I assumed it would be the same thing with social determines of health where you'd say these are the biggest social mental health issues.

The other thing is just to clarify, you know, it wasn't completely clear what CBOs, you know, exactly who is included in that definition of CBOs. But, you know, there are FQHC's or community based providers that are providing social determinants of health services and it feels like they would be included in the network.

You know, it's not.

I know some people are thinking that it's just the Tier 1 CBO's that would be in the social networks, but we would expect that it would be, you know, it could be tier 1, 2 or 3, that it could be a Medicaid billing agency.

You could be a CBO that has, you know, an 80 or 100 million dollar a year budget.

But through those really robust networks that you can make a big difference.

So I guess that's pretty much that's pretty much what I wanted to say.

So thank you for the chance to comment.

Well, thank you very much, everybody, for your comments.

We took very detailed notes, and I know many of you are submitting written comments as well. Please know that today was very appreciated.

All the comments that we received both in the upstate forum, written comments, discussions that we've been having.

They're all important to us in terms of building the final application.

So thanks again for your time and attention and we'll keep moving forward.

And for those of you who stayed through the whole thing, we have a special survivor's award on the way out the door.

But thank you again and a special thanks to some of the speakers here who shared personal experience with us or moving moments. They're appreciated, so thank you.