Good morning everybody. I'm Donna Frescatore, State Medicaid director and executive director of the New York state of health.

My folks, many of you know now let's introduce Greg Allen insurance programs and Maggie Chan & doctor Doug Bitch chief medical director and way over on the other side of ther stage Phil Amato from our office who oversees and manages waiver costs and along with his folks some oif whom are here in the audience helping you today.

So we thank you for being here.

This is really for us to hear from you as we have also been taking notes here. So, you know, all we're doing with transitions ourselves, except for pennies on paper, everything to laugh cards.

I just want you to know that we're doing that so that we haven't record of the conversation before so we can get right to it.

All right.

So with that, Phil take us away.

All right. Thank you, Donna.

Again, my name is Phil Alada.

And my my job here this morning is to kind of give you a 1115 101, a brief overview of the 1115.

And that's kind of the umbrella of over all the other 1115 programs.

And a little background on New York's MRT waiver as well.

So just bear with me.

I'm getting gonna get used to this remote here.

All right. OK, 1115 demonstration waiver, also known as a section 1115 of the Social Security Act.

The 11 15 gives the secretary of Health and Human Services the authority to waive certain provisions and regulations and also to allow Medicaid funds to be used in ways that are not otherwise allowed under federal rules.

1115 demonstration waiver 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 the state may request subsequent extensions.

Currently, New York's waiver is set to expire March 20 21.

OK, some additional information about the 1115 demonstration waiver STCs outline the basis of an agreement between the state and CMS, including waiver and expenditure authorities, and SDC specifies the state's 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 expenditures without the waiver.

And this is also known as budget neutrality or budget neutral.

This slide is focused on New York's MRT to waiver, specifically New York's marquee waiver, formerly known as the partnership plan, has been in operation since 1997.

New York's MRT waiver was renewed on Dec. 6, 2016 and is effective through March 30 first 2021, as I previously mentioned, several goals of 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 managed care efficiencies to additional low income New Yorkers.

Specifically, New York's waiver programs include Medicaid, Managed Care, a comprehensive health health care services, which includes all benefits available through the Medicaid state plan to low income uninsured individuals.

It's an opportunity for enrollees to select an MCO with a focus on preventive health care.

Programs include Mainstream Medic Make Mainstream Medicaid Managed Care, also known as M M M C Health and recovery plans.

Home and community based services manage long term care and long term services and supports.

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

It's designed to effectively meet, effectively meet the needs of Medicaid beneficiaries and low income uninsured individuals and their local communities and thereby improving quality of care.

Improving health outcomes and reducing cost, also referred to as the CMS triple aim.

DSRIP the waiver ends on March 30 1st, 2020.

I'm going to turn the present presentation over to my colleague, Greg Allen, director of program development and management, to talk about New York's pending amendments, DSRIP and some project projects. DOH is currently working on.

Thank you.

Say that to me, Phil's given me the tutelage on the flight advanced because I had one job which was to advance slides in New York City session and I blew it.

I couldn't run that. I couldn't run the remote effectively.

But my name's Greg Allen and I direct policy at state Medicaid program. Thanks, everybody, for coming today.

We really appreciate it.

And also, just a big shout out to everybody who's been busy at work helping our most vulnerable citizens get better health and health care.

And we know a lot of this work has been so important to so many of you, whether you're representing a consumer perspective, the provider perspective, or those of you who are trying to assist consumers of providers, health plans, et cetera.

Been a lot of good work happening during this waiver period that we're very proud of and we want to protect and preserve. And we'll talk about that today.

And also, just thank you for taking time out of your busy schedules to give us your ideas for the waiver, because that is very important to us.

So we have a couple of pending waiver amendments here. One is on the managed long term care partial cap plans.

There are some technical changes to the nursing home benefit.

And we are in continued discussions with CMS about modifying are the MLTC partial cap benefit to include only three calendar months of permanent nursing home placement for individuals who are permanently placed. There's been lots of community discussion about that as well.

And then consistent with what we've been doing in mainstream managed care, the amendment would allow a member to switch from one MLTC plan into another plan within a 90 day grace period falling enrollment, but then not permit switches for the remaining nine months of the year.

And again, I think this helps the plans preserve some continuity of care for that member during that time period.

They're trying to line up the way we've been doing things in the long term care benefit with what it's been operating for many years on the mainstream side.

OK.

The next piece is many of you have been following and even working with us on improving coverage for justice involved individuals. We've been working on a multiyear effort to speed up eligibility and make other technical changes to eligibility so that we can actuate coverage more quickly for individuals who become incarcerated, either on the pre sentencing side or on the on the on the sentence side.

And we are our final we've closed public comment, made some amendments and are about to submit an application for the justice involved population.

The centerpiece of that is 30 days of coverage per 30 days of coverage right before release. So the 30 days before release from incarceration, we would provide limited services, package of care management, limited clinical and pharmacy benefit.

And the goal here is to provide some pre stabilization work that would stretch into the community, because very often when in high risk individuals get released from prison and then there's this cliff on services access. And so we've been working for several years and a health home demonstration to make that better. And this this health home criminal justice work group that really has been fueling this idea.

And we will put in front of our federal partners the opportunity to cover those individuals for the 30 days prior to release.

Much of what we are going to talk about today is, is the DSRIP component of the waiver. And very specifically, we are going to be discussing what happens after our the overall waiver.

As Phil mentioned, it expires in March 2000, 21.

The DSRIP component expires in March 2020.

So we are busy at work with our federal partners discussing the ability to both extend and renew that that waiver.

And then we have another waiver that we are building and discussing with CMS for supportive housing that could either take the form of a waiver or state point a moment.

Those details are still being finalized, but the goal would be to achieve federal participation in some of the key activities that wrap individuals care in supportive housing.

OK, so we'll talk about the DSRIP waiver amendment and we'll try to go quickly here so we can get to your comments.

So we have we are.

This is working because of all of the activities that have been going on in the community.

We are seeing some very positive, measurable results.

You will remember that the central goal of the delivery system reform incentive payment program was to reduce avoidable hospitalizations by 25 percent over the five year run period of the waiver.

We just closed out measurement year 5 this summer, but based on all the close data we have in from measurement year 4, we've seen a 21 percent reduction in potentially preventable admissions. That's the Green Arrow on the left hand side.

So we are well on our way to hitting the goal that many maybe including me thought was a big stretch goal.

Reducing, reducing by a quarter are avoidable hospitalizations in the state.

We have reduced potentially preventable readmissions statewide by 17 percent and then the per member per year cost associated with those events is reduced by about 14 percent.

That's a 500 million dollar reduction in payment for care in avoidable hospital setting.

So that is a dramatic reduction both in percentage and in dollars and in accounts of events.

But what we've been saying all along as part of this waiver amendment is that this trip is not a story of averages.

Almost no demonstration or no program is just taught.

This full story is told by averages.

The actual story is told by looking under the hood, if you will, at some of the very specific PPSs the activities that they've engaged in and the results that they have shown.

We have eleven PPSs that have exceeded a 25 percent reduction in potentially preventable admissions or potentially preventable readmissions.

So eleven of the 25 PPSs have already passed the goal, if you will, at least in terms of that 25 percent reduction. Four of them took down their preventable costs by 25 percent or more as measured by those avoidable admissions and readmissions.

And three of them have reduced readmissions.

A very difficult thing to tackle, particularly because many hospitals have been working on this for a long time with community partners because of Medicare penalties and the like.

But three of them have reduced readmissions by 40 percent during this period.

So we are watching some great success statewide and we are watching some particular success when we look at the PPS specific level.

So this is despite the fact that if you think about this demonstration is a test because all of the dollars are attached to the achievement of performance awards.

The test has been getting harder during the period since we started.

Our attributed population is grown by 8 percent from four point four five three million to four point eighty 0 nine million.

So this is another three over three hundred fifty six thousand members, almost three and fifty seven thousand members from 2014 to 18 that the PPSs have had to think about relative to engage in and care to doing more screening, to doing some of this hot spotting work, to providing care management, to really trying to, you know, working with community providers and with the health plans to try to reach and engage these members in the projects and the DSRIP activities.

The readmission rate, despite all of that decrease by 17 percent, 3000 people, fewer people had potentially preventable readmissions and measurement year 4.

Very hard to hold in your hand.

What that means for those 3000 people that didn't have to go back into the hospital after an initial hospitalization and very directly related to specific work on paying more attention, particularly in the ambulatory care system, to people who had prior admissions and focusing on those, a number of people with asthma increased by seventy five hundred during this four years, and yet the rate of long term medication adherence improved by 11 percent.

So we've been have more people in front of us with chronic disease burden and we're still improving their care.

Follow up for hospitalization after mental illness.

Similarly, this is the 30 day measure approved but by over 12 percent in three years.

But an additional twenty five hundred people in just measurement year three alone received more timely ambulatory care following an inpatient admission for mental health. So and these are not things that are just happening by accident.

They're happening through the directed application of more attention, more interdisciplinary teams, more utilizing data and helping practices to extend themselves to wrap around high risk individuals.

So 25 PPSs just a snapshot of of some of the other highlights of employment, 259 DSRIP projects, 13 of those, 113 of those relate to system transformation.

We have twenty four hundred new recognized practices, most of them at advanced levels of patient centered medical home, either under the NCQA standard or in and the state APC standard.

And this is dramatic because we already led the country in terms of number and percent of practices that were at advanced levels of PCMH.

And we added another 24 hundred very specifically related to blocking and tackling by the PPSs in doing practice support to get to those levels of certification and incentivizing that in the projects.

Behavior, health and substance use treatment projects.

We had 43 of those 55 clinical improvement projects working on chronic disease, 48 prevention projects like HIV, underage drinking, smoking prevention, etc.

approximately three point five million patient engagements in DY4 so incredible amount of reach and patient touches trying to, you know, work on this population health and proudly PPSs have earned 85 percent of their available dollars.

That's 5.5 billion dollars to fuel health care system transformation and population health.

And that is despite the fact that more and more of these payments now have to be earned on objective attainment.

We also had goals relative to value based payment.

And this becomes important to our discussion today because, well, we are, you know, clearly telling the community and our federal partners is we've had some success in implementing value based payment in terms of the number of contracts and that the percent of dollars that are under contract.

We've had some really great success at improving population health of DSRIP.

The goal was to link these things so that that our value based payment would actually be the carrying vehicle for this system transformation in population health improvement.

And we've not gotten there yet.

We need to mature these value based payment contracts so they support a broader network of providers and will purchase really important things that are non quotable services in the medical service delivery system, like application of community health workers doing interdisciplinary home visiting, whether that's from home health or from clinics.

We we really need to be allowing more provider flexibility even under some pre-payment.

So we we have had success.

Over 65 percent of the dollars have been contracted at level 1 or greater and 35 percent of those at level 2 or greater, which embraces level 2, embraces some form of of downside risk.

Level one is upside only.

You are in dollars if you reach quality targets.

So we are well on our way to our goal of getting 80 percent of our of our dollars through managed care out under value based payment.

But many of those are total cost deals with primary care providers who are not yet fully connected to the behavioral health system, to the community based organizations that many of the PPSs have been working at working with. So we need a broader footprint here.

And that is what exactly our our our amendment request is focused on.

In case there's any confusion, we are seeking a four year waiver.

There are two components to that.

There's a one year extension and three years of renewal.

But we want a commitment to that full four years.

This is exactly what we did last time in terms of of a renewal and an extension.

We were in the exact same position when we got the first DSRIP waiver where we needed a conceptual agreement beyond the current period.

Five billion dollars of that is related to different performance, a billion on workforce development, a billion and a half on social determinants and 500 million on interim access assurance.

And we'll go into each of those in a minute.

And as I said, this last bullet is very important.

You know, we've really just felt that we've needed more time here to sustain and scale these the best work, you know, the DSRIP promising practices and to allow value based payment to mature enough to be the carrying vessel for those for that great work.

And speaking of that great work, if you have not gone out to the UHF website and downloaded the DSRIP promising practices for meaningful change in New York.

I suggest that you do that.

It might rain at some point and you'll be home and not knowing what to do with your day.

And you'll really want to read the dish. Promising practices.

It is. It is the centerpiece of what we're asking for here, and these are just a snapshot of what it is of this sort of secret sauce that we've been trying to, you know, spread across the state here.

But ideas like expanding Medicaid assisted treatment into other settings like primary care and E.D., partnering with justice and other cross system collaboration, driving together the primary care system in the behavioral health system, doing more care coordination, crisis management, rapping more care, particularly around iris individuals, people with multi multiple comorbid conditions, expansion of mobile crisis, crisis, respite activities that will help people stay stable in the community. There are all the way through this focusing on patient transitions from hospitals, from psych centers and other addiction treatment facilities, focusing on very specifically targeted high risk chronic populations like the seriously mentally ill, seriously emotionally disturbed.

The opiate use disorder substance abuse disorder, population building and rapping social care around individuals very purposefully in the health care and behavioral health care system and then transforming service at point of care and really trying to think about more patient focused ways of delivering care, whether that be in primary care, whether that be in the home, whether that be in other places that are members visit every day.

So inside the DSRIP promising practices are the things that have driven this performance improvement.

And we want to press copy paste on this.

We know what we need to do.

Demonstrations about learning.

We learned some things not to do.

We also learned some things to do.

And what we really want to do is to spread and replicate these promising practices, but very purposefully build them into the value based payment contracts that the health plans are working on. And speaking of health plans.

So we have, if you will, you know, rebranded the PPS into another name.

We know acronyms are very important in government. It's basically our survival tool.

So we have a new acronym.

It's called Value Driving Entities.

And we as we say in the waiver, we think of the existing PPSs are very well positioned to become a value driving entity.

But we had a lot of feedback in all of the public comment leading up to this, that even though the PPSs in many cases the success story, we hear it almost every local level.

When people are talking about success, it is it's about the partnership.

It's about leveraging existing community resources and enhancing them, connecting hospital to primary care, connecting hospital to CBO, connecting primary care to behavioral health, connecting behavioral health to social care.

It is the connectivity that is mattering. And what we are trying to do here is to create more of that.

So all the value driving entities will continue that tradition. We started in the PPS as of having a very broadly represented network, but one miss.

And again, you learn things in the demonstration is not every region that we have very strong connectivity to the managed care organization.

Most of our Medicaid members are enrolled in managed care is going to be a very important to drive together the managed care organizations with the providers and the CVOs in order to build the value driving entity so that we come out of this with functional value based payment contracts.

And that is a key feature to the value driving entity, is that we are building this team to more specifically include the MCO into the performance improvement team.

We are also expanding some additional populations.

We want to really focus the DSRIP lens on maternal mortality.

We have a lot of room to grow there that one of the common critiques and I think it was apt about DSRIP is outside of asthmatic children.

We really didn't have a heavy focus on kids as part of the reverse DSRIP round that's being corrected for. And there's a very specific focus on kids population health in the concept paper and in what we are driving toward.

The other area where we think we could expand to is long term care because there was a focus on avoidable hospitalization. There were some transition projects with nursing homes, palliative care projects, but by and large we DSRIP was not as much about long term care and we think it can and should be.

We continue the commitment on workforce.

This is key.

We need a better, more prepared, retrained workforce.

We are running into shortages in home care and care management.

All these key capacities in primary care, behavioral health, almost every social service agency is struggling with workforce these days. So we again continue to focus on on workforce.

The opiate epidemic.

We have many promising models in many upstate and downstate communities from DSRIP and outside of DSRIP on working on expanded capacities to address the opioid epidemic. Again, we point the DSRIP lazer very specifically at resolving this epidemic.

Interim Access Assurance Fund One of the things that happens when you focus on reducing avoidable hospitalisations is that that can have some consequences, particularly for more vulnerable entities, for safety net entities, those in rural areas, those that are uncomplicated markets.

We have successfully graduated many facilities out of needing this assistance.

But again, because of our success in reducing avoidable hospitalizations, there is some funding here to help those institutions through this transition to pivot more to ambulatory emergency services and urgent care focus.

Many partners should participate in this. We think we could be doing a little bit better job focusing on duals. We had some data challenges, etc. so the original intent was correct.

But this time, especially as we focus on the long term care, we need to be thinking about commercial payers, thinking about our Medicare partners and weaving that together.

Social determinants are critical to all of this. We know it.

And again, as we talk about secret sauce, a lot of that was connecting and leveraging social care.

We need to do more that we very specifically build regional networks through the waiver to advance connecting social care to behavioral health and health care that we cannot do this work effectively without having that. So we very specifically put a network together in the application to drive that work.

That network can be closely affiliated with or be the value driving entity.

But this is a key component and it should be regional.

We have many things that we have learned here and one is we need to simplify and align performance measures even more.

That was the goal of DSRIp.

It remains a goal and align them more to the value based payment contracts that are that are going to be so critical to carrying this forward.

So timeline, the public comment period is open until November 4th.

We are if you were we thought you were somewhere else.

You were in the upstate MRT public comment.

It is October 30th and we are in Syracuse, New York.

If you were doing something else, if you actually thought DSRIP the play was going to break out.

That's not what we're doing.

We are going to be hard at work during the month of November working on our application after receiving all this public comment.

And there are many resources that are available to you here that we want to make you aware of that you should be utilizing as you continue to work on your comments.

And as we make changes, these things will be available on these various Web sites.

And Phil's going to run us through the guidelines. But before that, I just want to say we are here to listen.

We did want to do that level set, but we are.

We have almost zero fixed.

That is thinking about how this next piece should go.

So we are very interested in what you have to say in your comments.

We are actively going to shape this with the New York community and with our federal partners.

What we put together here is just a beginning, not an end.

So we are very open to listening and hearing what you have to say.

You'll see us typing feverishly.

That won't be us responding to email. That will be take us taking very detailed notes which we will condense with those that we took in the downstate session and the written comments in the many meetings we've been having.

So Phil will be the drill sergeant general that will get us through the rest of this. Thank you very much, everyone.

OK.

Just some housekeeping details on the right hand side, my right hand side. There is a bathroom out on the right hand side of the lobby for those you need to access it.

Just some general guidelines on public comment this morning.

If you'd like to speak, please sign up if you haven't already done so at the table outside the doors.

You will be given a number when your number is called. Please come up to one of the microphones and your be time for five minutes for limiting comments to five minutes.

If you need assistance with a microphone, please raise your hand.

I'll be happy to help you.

Please return your number to the table on the way out.

Be very helpful and written comments can be submitted at the registration table if you brought them with you today.

Or you can e-mail comments to 1115waivers@health.NY.gov All public comments will be posted on the DOH Web site as well as the slides that were shared with you this morning.

Any questions before we get started? Video yes, this is live webcast and that will be archived on the DOH Web site as well.

I understand we have 17 speakers this morning.

And with that, I will turn it over to Peggy.

You'll be calling the numbers? Yes, I'll be the one calling the numbers as well, people.

Morning as time goes on again.

Speakers stay within the five minutes.

And if I interrupt you, I'm sorry, it's an abrupt interruption.

But again, just to keep us all on track. OK.

OK, so if we can have speaker number one and then speaker number two ready to be on deck.

And if you could introduce yourselves.

Which.

Which way should I face them? Oh, that's a good one.

It's a little awkward silence that way.

OK. And this is a song, I stay close to it.

OK.

All right.

OK. Hopefully.

Yes. I hear that now.

OK. Well, good morning.

My name's Lenore Boris.

I'm a PHD prepared registered nurse and also a labor attorney.

I'm the associate dean for the clinical campus, at Binghamton of SUNY Upstate Medical University.

And as part of my responsibilities, I oversee the Dr.

Garraed Fattal Community Free Clinic in Binghamton, New York.

I have prepared some comments on behalf of the CARE campus network PPS.

Right from the beginning of DSRIP, I've been involved with what became Care Campus Network.

I participated in the original application and as CCN evolved, I became chair of the PAC, our Stakeholders Group and its executive committee chair of the Workforce Committee.

I assist in our sixteen hundred member online panel in the PPS, which received feedback from stakeholders, including about 600 Medicaid members.

I also serve on a couple community boards.

The PAC Executive Council has a direct link to the CCN board of Directors.

Through the PAC Executive Council.

We have helped to advise CCN on program development stakeholder communications strategies and even helped prepared slates for the community board members that sit on the CCN board of directors.

I want to thank the state for the leadership and approach with DSRIP.

We have observed positive progress in our region, which has resulted in improvements to the health and well-being of the members of our community and would further suggest that these changes would not otherwise have occurred without the DSRIP waiver.

Developing DSRIP 2.0 as a path to ultimate sustainability is critical as a state plans for the final submissions to CMS We strongly encouraged that the CCN cohort management program be added as a promising practice to the extension document in Appendix B.

This program was identified by the United Hospital Funds DSRIP Promising Practices report as a promising practice for developing networks of performance.

This program has begun to display very strong results in its ability to form networks, support network operations and stimulate service alignment.

This program is highly replicable and could assist VDES in the integration strategy with CVOs and the SDH networks.

We also recommend that the requirement for 95 percent of funds be distributed to safety net providers be eliminated.

While the theory that underlies it makes some sense, the administrative burdens and the lost opportunities that have resulted are wholly disproportionate.

If the rule cannot be avoided in DSRIP 2.0, perhaps an approach would be to assign a new designation of functional safety net providers to include in the new safety net definition whose entities do not meet the formal legal qualifications for a safety net.

For example, Medicaid billing organizations.

But functionally, these organizations perform the safety net role in their delivery of service in the communities.

The current 95 5 rule simply exalts form over substance in ways that in the real world complicate and frustrate the goals that DOH and DSRIP aiming to achieve with regards to the video and SDH network rules.

There should be flexibility in how regions adopt the VDE concept in our region.

We envision the Evolve PPS operating as a regional BDC convener, a role which would continue and expand the region's ability to evaluate, monitor and actively manage performance risk through the integration of the clinical and social data in our large rural region in upstate New York.

The independent and objective third party entity is best organized to serve this role.

We also strongly recommend a very close alignment between the VDE and SDH network roles in regions such that will perform the true integration of community and clinical data to inform performance, risk and management in support of VBP maturity.

Lastly, we have learned through DSRIP.

And the work displayed by the PPSs is that transformation is possible.

Moreover, we are capable of developing incentives at the community level to innovate and achieve results in a very short period of time.

Managed care organizations, engagement and partnerships now need to be more meaningfully approached to construct VBP agreement.

We believe that what is needed is oversight to encourage the MCOs to for their participation in VDE VBP arrangements.

We're going to see if we can get someone to.

I think pretty much instruction in our offices, too.

So just ask the speakers to try to be as loud as possible.

It seems itself from the reaction of all of you, it might be a matter for you to hear the you're speaking to the wife.

So Phil is going to see if we can find something.

We think it's construction.

We know that it's potentially distracting for you.

It's not terribly loud here on the stage, but from your reaction, it looks like it's quite loud.

So no promises, but we'll see what what they say.

And if you want to move closer to.

If you want to closer look, you're close as speaker number two for.

Okay.

All right.

Now.

How's this? Good morning.

That works OK.

Good morning. My name is Alec Ellis.

I currently work as general manager for Buffalo Pharmacies, having long term care in retail pharmacies in the Buffalo and Syracuse area.

In addition, I am a serving board member for the Community Pharmacy Enhanced Services Network of New York.

And I'm here today on behalf of those organizations.

And I believe I speak for many others to advocate for an increased role for pharmacists in the DSRIP Extension.

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

The original DSRIP initiative focused on system reform through community level collaboration to reduce avoidable hospital readmissions through value based payment methodology, while not specifically included in the original DSRIP program.

Pharmacies were able to work, albeit within an extremely limited capacity, with some of the various performing provider systems.

DSRIP and Department of Health have previously recognized the role of pharmacists can play in managing poly pharmacy and promoting compliance to both reduce adverse drug reactions and control costs through medication therapy management.

But MTM is not all that pharmacists have been focusing on since the first round of DSRIP has begun.

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

Under the guidelines and requirements of Department of Health, pharmacists 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 and HIV AIDS.

Pharmacies have also worked with other stakeholders to implement transition of care plans as patients move from one level of care to another.

Pharmacist has worked with other stakeholders to share data in order to improve outcomes, whether it be through each care plans.

One of the state's regional health information organizations or any number of mechanisms that now exist, pharmacists have work to incorporate non-clinical staff, including community health workers in the implementation of patient care plans.

Pharmacists have worked with providers as Medicare explores alternative payment models such as macro and MIPS and are able to bring this experience to the DSRIP Extension.

Pharmacists have also worked with the state to expand our scope of practice through emergency orders during viral outbreaks.

In order to administer vaccines to more at risk, patient populations and pharmacists have worked with the states prescription drug, take back efforts to get unneeded medications out of homes and out of our environment.

Despite all the pharmacies have been able to accomplish, the profession remains under utilized.

It has been noted by the Department of Health the current New York law is, quote, do not provide for the full spectrum of benefits.

Patients, including Medicaid members, could realize in terms of improving their health and quality of services received in organizations such as CPS and support the recommendations of Department of Health regarding comprehensive medication management.

Bringing CMM into the community pharmacy setting will serve as one mechanism for pharmacists to help New York meet the goals of DSRIP Extension.

But it shouldn't stop there.

Allowing pharmacists to form play waived point of care testing and permanently removing the sunset on vaccination privileges of pharmacists would be examples of some others.

As such, I would encourage all deserve stakeholders and support initiatives that would allow for pharmacists to provide the care that they are training qualified to perform in order to the support the DSRIP extension and prove their value to the overall health care system by assisting in improving patient outcomes while lowering costs.

As previously mentioned, for accountable pharmacy organizations do exist and they are growing, with many more pharmacies poised to engage and offer the new value driving entities and existing workforce of highly trained, clinically oriented health care professionals with ready access to patients.

Again, 35 times a year.

It is my contention that BD should be required to contract with at least one accountable pharmacy organization that participates in the DSRIP Extension for services related to both one optimizing the digits, judicious use of medication to achieve clinical outcomes and avoid medication related adverse events, and to advance coordination of care activities and patient screening for referral to health homes, community based organizations and other entities attempting to address social determinants of health.

It is important that the Accountable Pharmacy Organization must also be able to electronically document medication optimization, care, coordination, care, planning and screening activities to share with the VDE and its related qualified entities.

The VDE must ensure that the accountable pharmacy organization is subject to value based payment opportunities that align with the VDEs meaningful measures.

High performance for outcomes focused accountable pharmacy organizations will serve as valuable partners in New York State as it attempts to meet the goals of the DSRIP Extension.

I believe that accountable pharmacy organizations and enhance pharmacy services should be formally included in the deserve extension if the state is going to sustain and expand on the promising practices already identified in the first round. Thank you for your time.

Speaking of the three.

If you can speak closer to the mike solving the construction problem.

Thank you for this opportunity to comment on the extension and renewal.

I'm Andrea Smith, the executive director of the Coalition for Children's Behavioral Health and a member of the Children's Subcommittee of the MRC Implementation of the Children's.

See you say your name.

Andrea Smith.

Thank you.

Implementation of the Children's Subcommittee recommendations just began late in 2018 and will not be fully implemented until the end of 2022 because the children's specialty services and exempt child populations weren't enrolled in Medicaid managed care until now.

They could not be a priority in the original delivery system reform incentive payment systems programs.

This is why renewal an extension of the waivers is so important to the children in New York state.

It can support the most innovative children's behavioral health reforms being undertaken in the United States today.

So the New York State Coalition for Children's Behavioral Health firmly supports the extension of renewal.

Our comments are specific to what's in the state's draft, including expanded pediatric integrated health behavior, health opportunities, expanded access to urgent and crisis care for children and adolescents, improved transitional care for youth, leaving inpatient, psychiatric, juvenile justice, residential and foster care out of settings, productivity, investments that support the children's transition to the Medicaid, Medicaid, managed care and targeted investments in the children's behavioral health workforce.

I'll begin with the DSRIP Workforce Development comments.

We recommend targeted investments that could retrain residential staff to enter community based workforce train and provide start up costs of evidence based practices which are more productive and have better outcomes.

Support the necessary mobile workforce development, including artificial intelligence that improve the documentation by peers and paraprofessionals providing in-home based support, which the entire redesign is based on, and also extending Wi-Fi in areas with insufficient bandwidth so that we can productively use offsite documentation and expand loan forgiveness programs for both our professionals and paraprofessionals, especially for the 81 percent women in our workforce who and many who are single heads of household households.

Other recommendations on pediatric health behavioral health. We support both the Thousand Days proposals and the money for your VBP pilot.

Be it, but we suggest going beyond those two recommendations and embedding the services with the new state plan, crisis counseling and supports by extending for the kids that need more extensive.

The models are really for low to moderate behavioral health and we're talking about embedding additional services to go to the kids that need additional mental health supports, expand care coordination innovations, especially the use of telehealth to improve engagement and rapid response and workforce productivity and care coordination.

And we also recommend the inclusion of therapeutic family care management models that support overhead overall child health well-being and ensure that families get treated as a unit.

We desperately need expansion of behavioral health crisis opportunities, divert, divert children from emergency departments and avoid unnecessary hospital admissions.

Crisis intervention is one of the new children's state plan services that will get added to Medicaid in January 2020.

We strongly urge that this new Medicaid benefit and the newly licensed children's crisis short term residents programs be considered as a bundled payment for an episode of crisis.

And this will allow us to develop better metrics on the utilization of crisis time.

OK.

One more comment.

And we strongly support the recommendation that transitional care teams of clinicians and peers be used to bridge not only psychiatric inpatient, but foster residential and the juvenile justice placements.

Both foster care and juvenile justice are going through major reforms where their services are being moved to the community and community based settings.

We desperately need expansion of children's behavioral health to support those those placements.

And we look forward to working with you on the renewal.

One thought that came to me during the comments that I didn't include.

We also support a children's data initiative because there aren't sufficient either payment or utilization data to do really good children's outcome measurements.

Thank you.

Yes, good morning or good afternoon to you all. My name is Bella Irizarry.

I am the coordinator of a team of community health workers at Catholic Health Systems in Buffalo, New York.

I am honored to tell you about how our collaboration with community partners of Western New York has made a difference in our lives, in the lives of the Medicare Medicaid patients.

So my staff and I are employed by the Buffalo Urban League, which is an affiliate of the National Urban League, and that has existed since 1927 to provide comprehensive array of programs and services to strengthen individuals, families and the Greater Buffalo community.

Annually, we serve about 20000 community members in myriad of areas including health, education, employment and economic development empowerment.

The Buffalo Urban League contracts with C P and W. NY to provide a community based services through hospital based setting since January of twenty seventeen.

The Buffalo Urban League has a pilot, a community health worker program which start started with one myself and has expanded to 7 C H WS in primary care and OBGYN office and one emergency room.

Department of Community Health workers are in from the community.

They are the first, foremost trusted members of the community with an exceptional understanding of resources and services within their region.

As public health influencers CHW bring strong communication, motivation, navigation, advocacy, coach and problem solving skills to each patient interaction.

The flexibility inherited in this CHW role extends to extend the reach of health care team into the community on a planned basis or in an emergency to locate, engage and activate the patient.

CHWs work as members of the health care team and provide timely and consistent feedback to providers and staff through a variety of ways, such as participation in case conferences function, appropriate access to the Electra electronic health record for information gathering, community communication and documentation and consulting with providers.

So CHWs are able to engage patients in a way that no health care system can.

We reach beyond the walls of the health care system and meet patients where they are.

We guide them along the pathway to better care.

One step at a time.

Allow this.

All this would not have been possible without DSRIP.

And our partnership with community partners of Western New York on behalf of the Buffalo Urban League and the Community Health Workers of Western New York.

We believe in the transformative work that DSRIP has brought to our community.

But it cannot that now.

And we are ready and willing and able to continue to work through the next phase of DSRIP. And in New York State.

One quick story I wanted to share with you regarding a success story.

A nurse head came to me requesting that I reach out to GYN patients who are labs had came back and there was a serious concern for the haemoglobin level was at a four point nine.

And this patient refused to answer the phone for the provider.

So the provider requested that I go out and conduct a home visit and engage the patient.

And upon going to the home, I the patient would not answer the door.

And we were kind of just lingering around to see if we would see a neighbor or family member or somebody that would eventually pop out to see who was this knocking at our door.

The husband arrives in transportation van coming back from dialysis. Unbeknownst to us.

So I introduced myself saying, I am looking for this patient.

He app. He immediately responds.

That's my wife.

He is able to bring it in.

He is able to bring the patient down. We are able to get her to talk to the nurse, and she is able to walk into the emergency room. Department received the four blood transfusions that she needed and the care, the quick hospital stay.

So overall, she is healthy and alive.

Thank you. Thank you.

Speaker 5.

Hello, I'm Amy White Stauffer.

I'm the director of Community Partners in western New York.

PPS.

We are a locally led, locally focused PPS with strong collaborative partnerships with our members.

We recently received our performance measures for Year 4 and are excited to report that of the 72 outcomes for the year 50, either improved year over year meant improvement targets or achieved high performance goals. And this is something to celebrate.

In fact, for total reduction in preventable readmissions, Community Partners has consistently beat statewide performance year after year and has achieved a 34 percent reduction in overall readmissions from year 0 to year 4.

Additionally, the PPS team is currently championing a total cost risk contract for Medicaid populations with the largest Medicaid managed care organization in New York State.

We've excelled at working together with another regional PPS while still respecting the market forces that do drive quality and patient safety.

A recent cast cap survey results were outstanding and reflect that our patients are appreciating our efforts to transform care.

We are very proud of our work.

The New York State Department of Health outline for the next phase of the Medicaid waiver gives a true vision for the future of risk bearing transformational work.

Community partners in West New York fully supports and endorses the continuance of the Medicaid waiver in our state.

I'd like to highlight several components of that concept paper for comment.

Managed care organizations or what we call em, MCOs, while central partners in transformational efforts must come prepared for transparency on the data sets and cost profiles for services that must be co managed by what are called the newly outlined value driving entities, or VDEs.

The concept paper should clearly reflect the roles and responsibilities for managed care to be at the table with the VDEs, for example, consistent data sharing and kangaroos metric and outcome goals.

The Buffalo Nag or region, has six major Medicaid and VDOs, each with different priorities.

As a result, consistent measurement and objectives are not realized across functional organizations.

This had significant cost to providers, health systems and communities through inefficiency and redundancy.

In short, managed care should be expected to and willing to make some the same amount of changes to their organization as providers have had to make changes for transformational efforts.

Managed care, our partners in defining patient attribution now and if managed care clearly identifies and assigns attributed population than risk bearing activities will be more efficiently managed and service delivery costs will be easier to understand.

The concept paper should outline that managed care come to the table with a process for dividing which primary care networks and systems they will work with and who they would like to take on risk activities.

Plus, as patient attribution is recalculated, there must be time allotted for planning this and rebase planning for this next phase of DSRIP.

Secondarily, the activities of organizations which address social determinants of health should be aligned with patient centered objectives and to be an extension of provider tools which reach out to the community.

However, these organizations could be adversely affected by aligning too closely with MCO objectives.

New York state should consider adjusting the concept paper to enable social determinant entities to work directly with networks and providers that have experienced and managed care

contracting flexibility and managed care contracting for social determinant costs and activities is essential to managing risk bearing activities.

The rigid structure outlined where all social determinants of costs flow through managed care to the entities may not allow objectives to be aligned with provider work and could an add an unnecessary cost layer.

Community Partners recognizes the state's outline of promising practices.

Allow me just one more moment to mention a few that were not in the paper but hold dramatic transformation results.

Buffaloes Do you vote college and Catholic Health are partners in workforce training and primary care, a joint project called The Hub.

The dual hub is at training the next generation of providers in care, coordination and mitigation of social determinants of health for local communities most in need.

Thank you to New York State for recognizing that workforce development is a critical component for the next waiver.

Also, our largest partner, Catholic Health System, is making commitments to digital health in western New York.

We will build upon the digital care delivery models that were piloted through current DSRIP funding and introduce more opportunities to engage patients and families through access to virtual care, both for primary and specialty services.

Thank you for your time.

Speaker 6.

Good afternoon.

Thank you for the opportunity to comment. I'm Albert Blankley, chief operating officer at Common Ground Health, formerly known as the Finger Lakes Health Systems Agency.

Presenting directly after me, we'll be Laura Gustin, director of our Community Systems Integration Project.

She'll continue our regional response discussing some of the work already occurring in our region and how that work may be incorporated into the next phase of DSRIP.

In addition to our verbal remarks today, we'll be submitting a written response detailing our feedback beyond what's possible in the limited time we have here.

Including commentary on the interim access assurance fund and performance measurement criteria.

DSRIP's implementation in our region has led to significant progress and improved outcomes through our local Finger Lakes performing provider system here today, and together with Carol Tagus, the executive director of that, as well as Anne Wilder the president of Coordinated Care Systems Inc.

Jill Eisenstein, president and CVO of the Rochester Rio.

We have coordinated a regional response to the proposal, incorporating detailed reactions to the draft proposal from over 70 organizations in the Finger Lakes.

The comments you hear today are a summary of those 70 responses.

I'm honored today to bring those thoughts to you.

Responding organizations included health care delivery organizations, managed care organizations, hospital systems, independent practices and federally qualified health centers, as well as community based organizations spanning the breadth of services, everything including behavioral health, nutrition, housing and criminal justice support, as well as a significant number of local governmental unit officials, philanthropic organizations and representatives of our education system.

All of our respondents had at least a good level of familiarity with the current DSRIP program and based on their input.

We present the following.

Overall, the proposal very much aligns with much of the collaborative work already occurring in the Finger Lakes region in terms of aligning with federal priorities.

Our partners do indicate that substance use disorder, mental health, social determinants of health, primary care improvement and advancing alternative payment models are all significant priorities for our community.

Beyond these, we recommend additional attention be paid to cultural responsiveness and dynamic stemming from structural and institutional racism.

There are also opportunities to engage the intellectual and developmental disabilities providers in a way that is not incorporated into the current waiver and is missing from the proposal.

The high need area priority areas identified, including a focus on maternal mortality, children's population, health and long term care reform, continued investment and workforce population health improvement and the epidemic are also well aligned with our regional priorities.

We do recommend moving beyond opioid use and taking a broader approach to addressing substance use and mental health, including addiction, infrastructure, recovery, housing and the integration of the BHCC s into efforts.

Secondarily, community based organization involvement is critical for all aspects of the draft proposal.

And to that end, we have the following comments.

We affirm that the CBO's inclusion in the VDOs governance structure is necessary to achieve meaningful change.

Deep connections with community partners and a broad range of community based organizations as well as health systems.

Knowledge should be critical criteria for social determinative health network. Lead consideration and CBO should be considered eligible applicants for leads.

The New York State Department of Health definitions for community based organizations deserve to be re-evaluated.

The tiered structure to accommodate for the breadth and depth of CBO providers and acknowledge organizations who would not even be considered under today's freight framework, such as faith institutions, significant technical assistance tailored to the individual needs of community based organizations will be required to assure successful integration of CBOs and the health care system.

The inclusion of managed care organizations in the VDE structure is appropriate and necessary.

However, we do as a community recognize the challenges that MCOs have faced to date with engaging in the project.

Coordinating with those managed care organizations to assure measurement and priority alignment across various managed Medicaid entities will be necessary.

This will be further complicated by the varying geographies covered by the MCOs, which will need to be accounted for.

The primary goals of the proposal will need to be explicitly stated.

The original waiver had a clear statement that the goal was to reduce unnecessary hospitalizations, but a similar goal is not apparent in the current proposal.

What do we expect will happen once the work is executed with regards to cost, experience and outcomes? Achieving the triple aim for Medicaid beneficiaries? Thanks to the DSRIP program,

as well as other collective work in our community, we have made great progress and are collaboratively moving toward many of the outcomes identified in the draft proposal.

Because of this, we have a series of requests aimed at allowing us to build upon this work.

As a leader in cross-sector integration, Laura will be presenting our community's commentary on this topic.

Thank you. Thank you.

Speaker 7.

Hello, my name is Laura Gustin and I am the director of the Monroe County Systems Integration Project.

I'm here to tell you about the groundbreaking work currently taking place him in Monroe County and build off Albert's comments by sharing more of our community's feedback on the DSRIP 2.0 proposal, particularly as it relates to our commitment to both integrate and innovate in the years to come.

Beginning in 2015, motivated by New York State's efforts to reduce poverty, improve health, enrich education and control costs.

Several local initiatives began to adopting state sponsored models of collaborative governance, data sharing and service coordination, including, but not limited to the DSRIP program.

The Empire State Poverty Reduction Initiative and implementation of the community school model within the Rochester City School district.

Unfortunately, in the quest for better integration, new silos were forming around worthy but parallel solutions.

We were in the process of redesigning our system in this in the broken image of its predecessor.

In response, over 40 local leaders from Health, Human Services and education sectors came together in the summer of 2017 to discuss the current state of disconnected services, the poor outcomes that result, and whether a single integrated solution could be both feasible and responsive to numerous sectors, initiatives and objectives.

Consequently, the Monroe County Systems Integration Project was born.

Over the last two years, we have built relationships and trust across our multi sector collaborative, which includes the Finger Lakes performing present provider system as a member and using stakeholder input.

We have solidified project design, operations, governance and funding and our currents currently embarking on implementation through this work. We have learned an important lesson the social determinants of health are the same as the social determinants of education, which are also the same as the social determinants of economic prosperity for communities who must address all three. An integrated approach is essential.

Our social service sector can be most responsive to a common set of priorities versus dozens of competing sector specific mandates and reporting requirements.

Further, person centeredness requires us to recognize our shared accountability for the holistic needs of individuals and families.

People do not live their lives in silos, and yet we serve them that way.

This is exemplified by the high risk family living in the city of Rochester, who has on average six case managers all functioning as bandaids over misaligned and dysfunctional system.

The practice of systems integration has also challenged us to be innovators.

We believe that the work of integrated service delivery and cross-sector data exchange has only just begun and its full promise is yet to be realized.

In order to produce dynamic cutting edge solutions, we practice agile project management, apply the methods of human centered design, rapidly prototype and iterate potential solutions, consistently fail, fast, learn and evolve.

While expansion of promising practices might deliver quality status quo solutions, we seek more in light of our current state and where we plan to be in the months and years ahead.

We implore you to consider the following as you develop the DSRIP 2.0 program.

First, once the goals of the waiver are set, we ask that New York State offer as much flexibility as possible to implementing organizations and regions.

Local actors with firsthand knowledge of regional variables should be empowered to establish their path to achievement without the burden of excessively restrictive guardrails.

Second, over the last four years, our community has developed a strong foundation of assets, an infrastructure that we are well positioned to meet the state goals for the next next phase of the DSRIP program.

We must be allowed to leverage and expand these resources based on well-defined program objectives and not be hindered by overly precipitous prescriptive directives on governance and operation operational infrastructure.

For example, we must be able to share best practice solutions across the region, but also have the flexibility to account for urban and rural variations in practice.

We fear new requirements that will force us to discard what is working in favor of what may not.

Finally, please recognize, celebrate and support evolving and innovative work that is underway both in Monroe County and across New York State.

We have created an alignment strategy that defines how we will achieve our community.

These vision four systems integration while concurrently meeting the goals of the current DSRIP program.

We believe this approach can be extended to DSRIP 2.0, but only through thoughtful consideration of ingenuity and improvement throughout the waiver development process.

We thank you for your time, consideration and the opportunity to speak with you today.

Thank you.

Speaker number eight.

Good morning, everyone.

I'm Val Gray.

I'm the executive director of the New York E-health Collaborative, also known as NYEHC.

NYEHC is charged with leading and managing what's called the Statewide Health Information Network of New York, known as the SHIN-NY in New York State.

The SHIN-NY is a network of connected regional health information exchanges called QE's, which together form a largely publicly funded, secure data sharing enterprise that helps improve health care and reduce costs every day by ensuring stakeholders have the clinical information they need, when they need it and where they need it.

Our government funding allows numerous services to be offered to participants free of charge.

The QEs in the SHIN-NY include the Bronx, Rio, Healthy Connections, Healthy Link, Health Checks, Hicks Ni Nice Big and the Rochester Rio.

Thank you for the opportunity to share with you some thoughts on the DSRIP 2.0 proposal.

In general, DSRIP 1.0 has win widely considered a success, especially in terms of bringing diverse stakeholders together to partner with specific invent interventions and outcome goals.

We strongly support the extension of DSRIP for four more years to ensure value based purchasing continues to expand and the broad swath of cross-sector provider types and community based organizations have the resources they need to deliver on the promising practices that work.

There's three main points I'd like to make this morning.

First, create clear adoption and usage incentives, as well as technical assistance programs for what's called non meaningful use organizations.

Those are post acute care, behavioral health CVOs and pharmacies.

I think back to years ago, the Federal High Tech Act invested significant resources in ensuring that hospitals and physicians were able to purchase the systems they need and and, you know, meaningfully use them.

There's been no such program for these sectors.

As we talk about social determinants of health, as we all know, these groups are key to making a difference. Yet they struggle sometimes with really having the most basic of systems and are not well-connected traditional health care providers.

Don't get me wrong, there are some of these organizations currently participating in the SHIN-NY. But if we really want them to flourish and make the amazing contributions we know we need, they need dedicated supports and systems.

Second, the SHIN-NY must be much more aggressively leveraged.

The QEs have been and continue to be uniquely positioned to support VDEs and the social determinants of health networks and DSRIP 1.0 QEs supported PPSs and a variety of ways comprehensive clinical information, real time patient alerts, medical record reviews that help to provide more accurate assessments, and other value added services like analytics, risk stratification and more.

In the coming months, QEs will receive Medicaid claims and they will marry the clinical data with the claims to help supercharge and target action and interventions.

We also think there may be an opportunity via an initiative by the feds with Blue Button 2.0 to also bring in Medicare claims to help with the dual eligibles.

Together we've been doing impressive work using data in the SHIN-NY for more real time quality measurement to gauge performance and official quality measurement.

Working with the NC key way in the future, we plan to add social determinants of health data to the SHIN-NY as well.

I think the bottom line is that as work gets planned, we should always ask is this something the SHIN-NY can do? If it's not, is it something it could do? And only when the answer is we don't think the SHIN-NY could do it.

Should other options be considered? The state should think about creating a strong statewide governance mechanism for I.T.

and I.T. related functions so that systems and platforms are more integrated, interoperable and not duplicative of the QEs.

Lastly, we are currently working on and we need the support to modernize our SHIN-NY policies to help facilitate and support all that DSRIP 2.0 envisions.

This work includes continuing to promote and require statewide standards, developing best practices for access for hip, a non covered, non covered entities like CVOs and pursuing an opt out consent model for general clinical information.

OK.

I would just say we need your support for recommendations you made on the opt out model and we look forward to working with you. Thank you.

OK.

Yeah, I think I need to tap it first. So Speaker number nine.

Good morning.

I'm Kaiser M. Pointer I'm privileged to serve as pastor of Agape Fellowship Baptist Church and chair of the Erie County Poverty Commission and chair of the Board of Managers of Millennium Collaborative Care PPS.

Thank you to the department for organizing a common day outside of New York City.

We appreciate not having to travel four hundred and forty miles to give comments.

We also appreciate the time and effort you have spent in writing this waiver application.

I'll share with you a conglomeration of comments that we've gathered from some of our community based organization partners.

I'm also joined here by executive director Al Hammonds, Christine Blighty and by Chris Spicer, who is an executive vice president and Planned Parenthood of central and western New York.

It should be first noted that we believe this waiver application is appropriate and necessary.

We would like you to focus on a few things that we have noted.

First and foremost, the focus of the amendment appears to align with Governor Cuomo is healthy, Healthy People 2020 initiative.

The content sounds reasonably good to us.

However, it does not describe the how of program arrangements or roll out would be implemented with community based organizations.

We are concerned that the document does not adequately distinguish between the value driven entities and value based payment initiative.

It doesn't outline the vision for how the partnership process will work for a newly formed, value driven entities.

It's conceptual in nature and does not provide enough detail on how our opportunities will be identified for potential CBO partners.

And we note that there is no way to identify gaps in services or progress initiated by PPSs in order to define future initiatives.

The state must take the lead on identifying those gaps and provide information to communities where there may be community based organizations that could have an opportunity to participate.

Further, the state needs to clear to define its role on the qualified entities that are contained within the value driven entities.

The program appears to be structured to advantage larger organizations, and there is no clear path for small CVOs to be at the table or with larger organizations and to participate meaningfully in value driving entities.

We need further definition to require that small CB always have an opportunity to be part of the governance structure of future value driven entities.

There is good recognition that the social debate, the determinants of health impact health in relation to maternal and newborn health.

We believe the key is to link community health workers with hospitals, especially with new moms and babies.

There is a need to include reimbursement guidelines to compensate CVOs fairly for the work that they do, including supplying household or non medical items such as household items.

Finally, funding guidelines should include CVO resource support for analytics and marketing programs because patients do not know that CVOs often offer these things.

We will provide additional written comments by your November 4th 2019 date. Again, thank you for listening.

We appreciate this opportunity.

Thank you.

Speaker number 10.

Hello.

My name is Erica Flynn and I'm the director of the North Country Initiative, otherwise known as NCI.

We have several partners representing independent primary care, federally qualified health centers OMH and Oasis license facilities, pharmacies, hospitals, Tier 1, community based organizations, county public health entities and EMS agencies who have contributed to this message.

And we'll be submitting more extensive separate written comments.

Therefore, on behalf of those approximate 90 partner organizations, the clinician led NCI board of directors and chaired Dr. Collins Kellogg, the NCI PPS appreciates the opportunity to provide feedback regarding the Section 11 15 waiver.

The transformative work conducted under this waiver has greatly impacted the patients of the Tug Hill Seaway Valley region, including a 25 percent reduction in avoidable admissions from NY 0 to NY 4 and at twenty seven point three percent reduction in readmissions from NY 0 to NY 4.

Our belief is that this success has come from the clinician led NCI PPS structure that has a funds flow logic inclusive of all entity types across the health care continuum.

Funds have been provided to every single partner since 2016 and have enabled them to standardize clinical protocols.

Further patient engagement and make the necessary adjustments to positively impact patient experience and quality of care.

Other PPS resources that have been key to improving regional health include compliance and data security. Support.

Workforce investments.

Patient centered medical.

Home support and PPS Resource care teams that include community health workers, peer behavioral health supports and community served by diabetes educators.

The PPS strongly supports the submission of a DSRIP amendment request to CNS and strongly supports and appreciates the following request components that have been included in your draft waiver proposal.

Those include the requirements of MCOs to be active partners within those value driving entities.

We also support the BD to have strategic partnerships with the Rio's regional IPA as the regional CVOs and the regional BHP sees.

The flexibility to implement high priority DSRIP promising practices, the alignment and strategic narrowing of performance measures sets the continuation of primary care and behavioral health integration and primary care transformation support.

The flexibility to use earned dollars to support non clinical non safety net partners.

The tracking of MCO engagement for reporting purposes only and the continuation of workforce investment.

Additional consideration should be made to address the following.

Number one, the proposed structure has 50 percent of the federal funding applied to year one of the program.

Given measurement, years have been retrospective in the current waiver.

There is concern that this would not be enough lead time to develop the VDE structure while fully implementing the promising practices that affect the performance measures within the highest funded measurement year.

Number two, while Wilder requests does address state and regional population health analytics to support the transformation.

It is imperative that we can utilize MCO data for quality measure performance, transparency and expenditures and utilization to progress towards more advanced value based payment contracts.

This would require the alignment of attribution assignment between the DSRIP program and m MCOs for socially chairman of health networks to have an impact in regional value based payment arrangements.

The networks must align within the VDE regions.

The state must maintain its investments and programs like population health improvement programs that provide the foundational data needed to guide such significant investments to ensure impactful change in appropriately prioritized quality and social determine of health indicators.

And last, it is imperative that the high performing PPF structures remain unchanged or instead of building on momentum.

We will simply be starting over.

So thank you for your time and your continued support in the health of our most vulnerable New Yorkers.

Speaker number eleven.

Good morning, good afternoon.

I'm Al Cardillo.

I am the president and CEO of the Home Care Association in New York State, and I want to thank the department for this opportunity to be able to provide some moral input today on the waiver and then move to to DSRIP round two and a broad level.

We appreciate the opportunity to participate in the planning of these major initiatives, which will have a huge impact on our system, both in quality cost effectiveness and have a major influence on really the entire shape of the system.

There are very large goals that Greg and the plan outlined earlier, but I think that one thing that will be very important will be to spend a lot of time together figuring out what are the details, what is the substance to achieving those those kinds of goals.

And while today we have we have five minutes to have the conversation, I know we'll be spending a lot of time together and appreciate that.

Looking at the goals were very much aligned with the goals that have been outlined here today.

We commend the progress and the outcomes that have been achieved in this first round of the waiver and and DSRIP, especially the work of the of the of the PPSs and the promising practices.

Many of those PPS are within the ACA membership.

We commend and support the efforts to seek continued flexibility and funding through the waiver renewal.

I'd like to commend to your attention the letter from HCA and is one of seven associations that represent the vast majority, the continuum of care that we sent to the governor's office and the department that outlined some very core principles that we view with respect to the waiver.

One of those is certainly our emphatic support for the goals of the waiver.

But but in addition to that, that letter provides input on some significant recommendations and changes that we believe the department should consider, the state should consider as you move to round two.

And as an association HCA, we'll be certainly supplementing that with further views.

So let me just review several of those areas with you right now.

One relates to the structure of program design of the system.

Probably 80 to 90, maybe 98 percent of a person's health needs are determined and interpersonal lives in their homes and communities.

Yet. Yet the structure for DSRIP is a very much a vertical top down structure, focusing most substantially at the institutional level within the walls of the hospital and then down and out to primary care and community based agencies.

We would we would assert that, in fact, that really needs to be shifted to the extent that those entities, which are the primary first layer of the system and really relate to the individual's health should be and should have a primary role in the structure and design and the rollout of programs and associated funding.

The second area really relates to the apportionment of funding under the program DSRIP.

One of the main goals was to shift individuals toward the community level. There were some very specific milestones that were discussed, but also within that is the general sense that we want to foster the right care at the right time through the optimal venue for the patient.

If you were to look at the funding structure as a pie of funding allocated within the DSRIP program, community based care and certainly home care has a slice so thin that you probably couldn't trace it with a pencil.

And I don't say that critically.

I'm just saying that as a matter of course, we would urge a consideration of how the funds are aligned to the needs that will align with the goals of the program.

The last item I want to talk about relates to leveraging new operating minute relates to leveraging new opportunities for both health improvement and cost effectiveness opportunities for the state.

One area is really thinking about moving beyond Medicaid and looking more closely at the Medicare opportunities.

One of the things that that certified home health agencies let's start with that quickly.

Certified home health agencies participate in Medicare and Medicaid.

The redesign of the waiver focuses so heavily on the Medicaid portion that I believe.

I believe the state has lost hundreds of millions of opportunities on the Medicare side.

The same would be true in terms of the utilization of hospice services, which have been very low.

I think that that's an opportunity area.

I'll just I'll just close in reference to some two other things under this. One is areas of innovation.

There are huge areas of innovation that are untapped by the waiver, but that but that offer tremendous opportunity for health improvements.

He's sorry.

Times that and and cost savings.

And I would commit those to your written comment. Yes.

And I would commit those to your attention. I think working together, there is great places we can go and we appreciate it.

Thank you very much.

Speaker 12.

Good morning.

My name is Anne Monroe.

I live in western New York and the comments I'm going to make are my personal opinions and perceptions are not related to the relationship I've had with the DSRIP program all along.

First of all, I was very happy to see long term care included in the effort for 2.0.

And then I was disappointed that an invisible population that contribute significantly to the cost of long term care was not even mentioned.

And that's the intellectual and developmental this people with intellectual and developmental disabilities.

We know from the most recent data that we've gotten and Dr. Fish had provided it that in 2015 the cost of an inpatient hospitalization for someone with IBD was fixed was twice as high as the general population, and their use of emergency rooms was 50 percent higher than people with behavioral health issues.

So the while the numbers may be small, the cost to the system is very significant.

And the lot.

The lack of attention to that population leaves an opportunity that should be very prominent on the table.

Some strategies are very simple.

Community Health Partners of Western New York and the Finger Lakes PPS supported a telehealth effort to reduce emergency use, and within six months, 35 percent of the previous emergency room visits were reduced.

So I really urge you to include that population more prominently and more visibly than it has been, particularly on the long term care side.

The second point I want to make is about the expansion of the collaboration and the leadership to include law.

Excuse me, managed care organizations and CBO knows you could not find a more different set of players, experiences, resources, etcetera between managed care organizations and small CBOs bringing them to a tent to the table is critical.

But remember from 1.0 how long it took that set of players to come together to a place where they would have trusting relationships.

And now we're adding to the mix.

As I said, two very significant populations.

You offered the MAX series, which was very successful, to help organizations address high utilizers of care, and I would urge you to look at offering, perhaps even requiring a similar sort of experience for people for VBEs to come together more rapidly, more quickly than they did the first time around.

I would observe there were some PPSs who frankly never got past the the arguments at the table.

And I don't think in this next round we can afford that.

The third thing that I would speak to is what I see as the role of the Department of Health in 2.0.

And while this might not be reflected in words in the in the application, I think it's critical that we rethink the role of the department.

I appreciate my colleagues who said we need more flexibility.

I'm very worried about so much flexibility and letting the flowers grow that they were not building on the things that we have learned, not just about promising practices, but also about structures, data collection, data analysis and.

Protocols for contract.

Things that we have learned that should not be discovered anew by the new VDE.

And the second place where I think the department has to play a very important role is with its colleagues at the state level.

We are waiting almost two years for guidelines and regulations on a limited license that would bring their basic behavioral health, substance abuse and health together in one location.

I think there needs to be much more leadership provided there and with the Department of Education, because without them, we will never address scope of practice issues and some of the barriers to workforce.

Thank you.

Speaker 13.

Good afternoon.

I am Cathy Preston.

I'm here on behalf of the New York Health Plan Association HPA, which represents 29 health plans that provide coverage to more than 8 million New Yorkers, including four point three million New Yorkers who are in the Medicaid program.

Thank you for being here today to listen to everyone's comments.

HPA and our member plans have been strong supporters of the state's efforts to transition away from the fee for service payment system to a structure that emphasizes value over volume through VBP arrangements.

With respect to the waiver amendment proposal, we share the department's goal of constructing VBP arrangements that recognize and sustain meaningful connection between value based work and value based payment.

We agree that there needs to be additional flexibility in developing these arrangements.

Specifically, there should be more flexibility to allow a broader definition of what qualifies as a value based arrangement.

For example, going forward, VBP models can be successful without full delegation of plan functions.

As long is there is as long as there are collaborative working relationships between plans and providers.

The department should take steps to ensure that all providers are moving towards VBP arrangements.

Plans have faced challenges with unwillingness of some providers to enter into VBP, which are meant to be partnerships.

Going forward, we believe penalties should be applied equally to incentivize all providers to move to VBP arrangements and align incentives across all participants.

Another critical element to encourage the move to VBP arrangements is ensuring that Medicaid plan premium rates are adequate.

Given the current state budget challenges, potential Medicaid budget cuts can undercut the VBP contract negotiations as reductions to plan premiums would have an effect on the willingness of providers to take on risk through VBP contracts and on the ability of plans to invest in the sustainability of promising practices.

Further, we have serious concerns with VBP savings that were included in plans April 20, 19, Medicaid managed care rates.

The very success achieved through VBP will be diminished if the future ability to invest in those arrangements is is taken away from plans.

We also believe that plan premiums also already include adjustments for efficiency and believe that taking a separate reduction for VBP savings is actually implementing the same cut twice.

We strongly believe that the plan's contribution to system transformation is about more than just getting to the outcome of having a VBP arrangement.

Plans are more than just payers in VBP arrangements.

Plans themselves are systems of care.

While we appreciate the recognition of health plans as critical to the collaborative work necessary for DSRIP.

We believe that plans must have an active role in the development of the value driving entities and in the determination of expectations related to governance.

Data exchange, goal selection and other operational requirements.

Active collaboration between the state and plans was instrumental to the success of the development and launch of the New York State of Health Marketplace.

We believe a similar process would bring equally successful results to delivery system reform.

We support the department's goal of aligning quality measures across initiatives, aligning state and federal priority areas, and appreciate the focus on building on existing alignment efforts.

This waiver should move beyond a program that is heavily focused on large hospital based systems.

It will be stronger.

It will be stronger if it's more successfully involves other community based providers going forward.

We are concerned that the current fiscal stress within the Medicaid budget may act as a deterrent to the development of additional VBP arrangements.

Thus, in order for DSRIP 2.0 to succeed, the state must give it oneself and health plans, the leverage to encourage and achieve broader reform in the delivery system and should provide flexibility to address factors driving rising health care costs, specifically increases in hospital and prescription drug prices, and the growth of the cost of long term care.

With regard to long term care, it's vital that DSRIP 2.0.

Encourage payment and delivery models that can effectively integrate, coordinate care and rein in costs.

In the meantime, DSRIP 2.0 must provide existing manage long term care plans with better opportunities to demonstrate the value of home based care management in improving outcomes and reducing total cost of care as we move as a system towards more integrated Medicare Medicaid care.

Thank you again for listening today.

Speaker 14.

Hello, everyone, my name is Chris Spicer. I'm the vice president of programs for Planned Parenthood of central and western New York.

I'm also a member of the Board of Managers for Safety Net IPA Independent Practice Association.

First of all, I want to just share a story about the first DSRIP years.

One of the projects that we were able to get involved with was a mobile unit project.

And what we were able to do for the first time during DSRIP years through a waiver was to actually share a mobile unit with another health care provider, a federally qualified health center.

And we were taking the mobile unit to schools where there weren't school based health services so that we could provide pediatrics and family planning and reproductive health care to students right at schools.

One of the things that we're coming up on now, we're getting a brand new unit.

And on that unit, it will be telehealth enabled.

And so when we see pediatrics patients at schools, the parents can actually telehealth into the visit so their child can actually go to school, have their pediatrics appointment, get their services and the parent can.

This can be virtually present.

So this is an innovation we were able to do and that we're coming up on and we're hoping to expand upon in coming years. So, you know, DSRIP 1.0 has gone a long way to freeing up and unfreezing the system so that we could do things like this and make real strides.

So you can think of all the social determinants of health that roll into that.

That one solution.

What I have to say, though, is that a program like that gets a lot of help, funding help.

And that would be through foundations interested wealthy people.

And, you know, the school district itself, you know, really pitching in to help.

And in terms of baking it into the system through reimbursement from health insurance and coverage, it's not sustainable at this at this time to continue that program like that past a certain point of help.

And that brings me to what we really care about, and that is population health disparities, particularly racial disparities in health outcomes.

And that is something I'm really worried about being glossed over and missed and the system being re frozen before we really do significant work there.

We have gone into negotiations with MCOs and none of them are prepared to have this discussion about health disparities on their panels.

They can't even tell if there's health disparities on their panels, some of them.

And so I think that's really a woeful place to be coming to the close of DSRIP 1.0.

So I think what I'm trying to get to is, you know, everybody says, oh, they should be required to do this.

They should be required to do that.

And, you know, like the state is the ones that have the power.

And I think that's true to a degree. But I don't think that mandating things leads us to the results that we want, because mandating things ensures minimum compliance with what the state wants.

But so what I'm suggesting here is that we should incentivize, not require MCOs to engage in a minimum number of population health disparity pilots annually.

So if you receive MCOs, you should have a minimum number of pilots going on.

Those pilots can last more than one year, but you should have a minimum number operating during any given year.

Second is there should be a minimum threshold of investment into identifying and mitigating population health disparities relating to VBP quality outcome metrics.

So it's not enough just to identify these metrics.

There are people for which the system we have created does not work. They cannot access this, access the system.

And so to really get those quality metrics, we're going to have to fundamentally change the ways that we deliver service.

And right now, that's not ready to be baked in the way we're gonna reimburse care.

So second, you know, just I think we should help the MCOs prepare for this.

Thirty seconds.

They do.

For some reason, some of them say they don't have a lot of money to invest in this stuff.

That's hard for me as a safety net provider to understand given the amount of dollars that flowed through them.

But maybe they need help from New York State.

Thank you.

My name is Mason Kaufman, executive director of Meals on Wheels of Syracuse.

My organization has as its mission in the business of providing nutritious home delivered meals to homebound older and disabled adults who would be food insecure without some assistance with meals.

We prepare our package and deliver nourishing, hot and cold meals daily to those in need.

Through a small staff and hundreds of volunteers, we are small to medium sized human service agency.

A number of years ago.

And this is before the talk about social determinants of health.

I was made aware of the DSRIP initiative through my local association of non-profits, the Human Service Leadership Council, about joining the effort to help save health care dollars through the Central New York Care Collaborative Initiative are our regional PPS.

I attended an IPO Syracuse Care Transition Coalition meeting, a group of representatives from hospitals, rehab facilities, nursing homes, community health care services and a few community based organizations like myself, like mine.

Frankly, I thought I was part of us of the CNY Care Collaborative meeting at the time, but later learned that I pro coalition meeting focused on Medicare health care savings.

Well, the Care Collaborative focused on Medicaid.

Regardless, the I Pro Coalition and the Care Collaborative combined meeting sometime afterwards.

And so I ended up in the right place.

While at these meetings I was trying to find my agency's place in the room.

What would be our value proposition to health care savings? Then I read a report that said that 30 to 50 percent of U.S. seniors living in our community were entering hospitals malnourished, resulting in longer and more complicated stays, hospital stays and costing an additional twenty five billion dollars more in health care course costs annually.

The report also said that the malnutrition was not always diagnosed in the hospital and seniors were being readmitted often as a result and the light bulb went off in my head and I saw our value to the conversation.

Meals on Wheels programs are in the business of food security and nutrition.

We could help to head off malnutrition.

I alerted the IPRO and Care Collaborative Meeting group of this report and to their credit, they formed as Nutrition Subcommittee that began monthly meetings between nutrition specialists from local health care institutions and CVOs.

The group researched malnutrition screening protocols and put together a nutrition toolkit.

It presented as best practice recommendation for local hospitals and health care facilities to consider.

During that process, we recognized that if we could screen for food insecurity at the community level, we might head off malnutrition rates.

The thought was that if if all kinds of human service CVOs screened their clients for food insecurity and can link them to food providers, we had something going there.

Would it lower hospitalizations? And ER visits? The committee identified a research validated simple to question food insecurity screening tool.

At that time, innovation grants were announced through the CARE Collaborative and they were forming hubs to help distribute funds to non safety net CVOs interested in applying for the grants.

My agency joined the Arise Hub, which had dozens of CVOs who also joined.

I realized that this was a perfect structure to develop this food insecurity, screening and linkage idea.

I approached, arise to partner to administer as administrator and grant writer and help recruit Hub and other CVO Port Partners re recruited twenty three others CVO screeners and food provider agencies.

That 12 month grant would provide agency screener payments for identifying food insecure clients, getting baseline emergency room visits and hospital admits.

For the past 12 months and linking them to food providers, the screener would then do the second three to six month benchmark follow up assessments to ensure the continuation and assess the number of emergency room visits and hospital visits.

Our outcomes would be moved people from food insecurity to food security and reduce the hospitalizations in E.R.

visits without the CNY CCC building the collaborative environment between health care partners and CVOs.

Without seeing the care collaborative building in this sharing and learning environment for the CVOs, I will submit that the rest of my statement.

Thank you.

Good afternoon.

First, I wanted to say welcome to Syracuse.

My name is Indu Gupta Commissioner of Health and an entire county.

Sorry for the issues which were happening, so I tried to address them. So I think it's quiet.

Hopefully it will stay.

So I just wanted to welcome you all.

And thank you.

Along with the Governor Cuomo for providing opportunities to the health systems throughout the New York state in addressing health care needs of the communities by implementation of DSRIP program.

As we know that the goals of the DSRIP has been to promote community level collaboration with the aim to reduce avoidable hospital use by the means of innovative projects across three domains one system transformation to clinical improvement and three, population health improvement through following New York State's prevention agenda.

I applaud the work done by various teams, including in Central New York by CNY CNY Care Collaborative, resulting in multiple projects in many communities throughout New York State with increased connectivity in collaboration.

We know that our zip code is considered a better predictor of health than our genetic code.

It is a fact that 20 percent of factors related to the access and quality of healthcare impact health of a person.

The other 80 percent are due to the factors related to social, economical, behavioral and environment environmental factors.

Why is this context matter to DSRIP? Because it matters.

You can treat a diabetic.

Fidel set off a homeless person.

Or repeated attacks of asthsma of a child reverse opiate overdose treat acute mental health so corrupt meant mental health crises are repeated. Congestive heart failure of an elderly person in a well controlled setting off a health system.

But their real life starts after they are discharged from the hospital or doctor's office after leaving four walls of health system behind.

It is evident that DSRIP implementation strategies have engaged various health systems by providing various incentives, including value based care, and are considered a good start in the long road towards changing the way many people think about health, which is not equal to health care, which is defined as a dynamic state of physical, social and emotional well-being, not just the absence of disease.

W.H. Your definition of 1948 as New York State is looking for next four years.

I would like to thank all of you to come for a listening session and provide opportunity for public comment.

As an internal medicine physician myself who took care of patient for more than 20 years of my life in an inpatient, outpatient and even in nursing home settings.

I know firsthand that medical education and health system are not prepared and equipped to address factors beyond four walls of their institution.

My primary goal was should be to provide the best care possible during most vulnerable time in patient. And it was for that I relied on the health system, not as a commissioner of how to finance our county health department, whose mission to is to protect and improve health of our county residents by working collaboratively with all their stakeholders to address those 80 percent of factors impacting health with the principle of health, equity and health across all policy.

It is logical for me to focus on the third domain of DSRIP program committed to address population health improvement based on New York State's prevention agenda.

We are already committed as a local health department.

It is a natural fit for us because our Community Health Assessment and Improvement Plan is guided by prevention agenda and addresses the very complex maze of social services of health through various partnership with the health systems, community based organization and the community itself.

We have a laser focus on improving health outcomes for all the county residents, but especially those who are considered high in high need and high risk.

I would like to provide one specific recommendation for the next cycle of DSRIP 2.0 program, which is the most important recommendation for as a commissioner.

Work related with the third domain as population health improvement in New York state, an effort to align with CMS is going to address substance use disorder, opiate crisis and addressing social drums of health. This is a true public health work and New York State Department of Health should consider working with the local county health departments in these priority areas from birth to older adults.

It is a natural fit as we have established relationship with all the stakeholders in our community.

This funded joint collaborative will avoid duplication, increase efficiency and reduce waste.

As an accredited local health department, we are the chief health strategists of our community based on our technical expertise, data, trust and commitment to constantly invest in our community to improve health of everyone.

I believe local health departments are the bridge between the community and health systems and are a leader to direct community wide changes to address 80 percent of factors responsible to impact the health outcomes.

With a strong performance management and quality improvement program, we are in a strong position for accountability, continuous improvement and long term sustainability of the work posted.

Desperate when it sunsets.

Thank you.

Thank you.

Speaker 17.

My name is Tony Sanfilippo and I'm the project manager for the CBO Consortium of upstate New York on behalf of the consortium.

I would like to thank you for the opportunity to allow us to provide comments to the DSRIP Waiver Amendment Extension request.

The CBO Consortium of Upstate New York was founded in 2018 by Healthy Community Alliance and is one of three consortia funded under the New York State Department of Health CBO plan and grant to support smaller Tier 1 community based organizations in a rapidly transforming health care and wellness delivery system.

The CBO Consortium of Upstate New York collaboratively works with CBOs to advance health equity and assist organizations to better it to be better positioned to engage in health care system transformation toward a shared goal of improving population health outcomes in their communities.

The Two Hundred and Sixty Members Members CBO Consortium of Upstate New York is the largest consortium of its kind in New York State, covering five subregions and 48 upstate counties over the past few weeks.

We have asked our CBO members to share with us their input so that we can carry their comments forward today.

The following are four common themes that we have heard across the consortium, as well as their recommendations to New York state for the final version of the extension request.

Number one, continue implementation funding for the CBO Consortium of upstate New York that is developed under the CBO plan and grant the rest of state CBO, the rest of state's consortium, along with other CBO community planning consortia.

Our business position to contribute significantly toward the success of the next phase of DSRIP the Planning Grant launch launched the infrastructure that provides the necessary technical assistance and supports to critical but previously excluded CBOs.

Implementation funding would leverage the 7 1/2 million dollar investment that the Department of Health has already made in the infrastructure and would continue the work of increasing capacity of CBOs to engage in health care delivery system reform and ensure the CBO sustainability of their critical social care services.

They provide no to any creation of social determinants of health networks designed to generate a single point of contracting for value based payment arrangements and link health care and social determinants of health interventions should be led by social care providers.

There is a risk of exclusion of valuable community based social care providers, both in rural and urban communities.

If the lead entity is not a CBO network, but instead an enormous health system, we must recognize and support already existing social care provider networks or CBO care collaborative

and require that those networks receive priority consideration in any RFA for the development of regional social determinants health networks.

Providing investment in existing networks of social care providers will allow for more rapid impact in the waiver extension period.

Number three, increased CBO and social care provider inclusion and the health care delivery system at every level, including governance, infrastructure and decision making.

CBO should be represented as an entity and not an extension of PPACA is or value driving entities.

The CBO consortium is the largest collective of CBO is prepared for engagement and system reform.

The consortium is best positioned to bring the community's voice and ensure an equal partnership in the planning and implement implementation of the next phase.

Number four support the development of the community information exchange platform that is a centralized source of social care data and not only provides bi directional exchange capabilities, but would provide value back to the CBOs a closed loop referral system that stems from health care only provides more referrals to an already underfunded social care ecosystem.

A community information exchange application originating with social care providers would would process and deliver social determinants of health data across other closed loop referral systems and enter into multiple sectors, including health care providers, PPS, PHCCs, and Rio's.

This application would provide value to DSRIP goals as it would be the central hub and repository for social care information that can be used to demonstrate health outcomes as they relate to social determinants of health.

As they relate to the social determinants of health.

The single point of truth for social care information coupled with claims data shared back to the social care networks would strengthen CBO positioning in value based contracting in a manner that supports the long term sustainability.

I will close with the comment from the director of a consortium member CBO that provides critical services to Jim new mothers living below poverty level.

She states being a part of the CBO consortium of upstate New York allows me to gain knowledge about DSRIP and value based payments, which adds value to the services we offer.

I can sit at tables with MCOs, participate in collaborative discussions and play a larger role in addressing these social determinants of health that I couldn't have realized before going forward in the next phase of DSRIP you.

Thank you. I'll submit the rest of my.

Speaker 18.

And that is the final speaker.

Thank you so much for the opportunity to provide comment.

We really admire the state for its effort to be bold in pursuing reform of the Medicaid system, and we're happy to have been a part of it.

My name is Bret Latin.

I represent 12 safety net primary care providers in western New York.

Of the eight counties there in 2019, together our member organizations served over one hundred eighty one thousand patients.

We provided over 700000 primary care, behavioral health and dental visits.

This represents approximately 13 percent of the whole western New York population.

Our member organizations serve mostly people receiving Medicaid and have a range of special populations served.

People in poverty, living in urban and rural settings, people who are homeless or in public housing, people living with HIV AIDS.

People struggling with addictions or behavioral health disorders.

People with intellectual or physical disabilities.

Last year we formed an independent practice association to help prepare our organization for value based payment reform and to help our organizations move down the road a value based payment.

So we really appreciate this opportunity and we have four recommendations we'd like the state to consider moving forward in its amendment request.

One, provide core funding support for upstate or for excuse me, primary care led independent practice association or are ACO organizations.

We are already in value based payment arrangements.

However, we lack the sort of resources to build the kind of infrastructure to better support what what we're trying to do.

We lack the ability to engage in downside risk or into risk bearing [Unrecognized] contracts or to build out the sort of technology infrastructure to the most leverage our our ability to serve patients that we serve.

Number two, we highly encourage the state to mandate a fair and representative governance model in whatever effort is coming forward.

We're looking for equal input, equal partnership at the table, regardless of the entity that we represent, where we're looking for a model that doesn't dominate by hospital representatives, that there is equal participation.

We know that we're only successful if we can do this together.

Number three, we ask the state to consider reducing the barriers that create these PPS systems that cross cross the city or in organizations so that if a patient's best hospital or their most the hospital system that they have the most experience with is right down the street.

But it's not in the PPS that we participate in.

It really makes it difficult to make an effort and effort in that. So we really encourage the state to provide an opportunity to reduce geographic and hospital barriers and that that the efforts around the VDE ease encourage collaboration among PPSs and that have equal measures and that facilitates that sort of arrangement.

Number four.

And lastly, we really need.

We think that the state is in the best position to mandate that the managed care organizations provide us the data that we need to know who our best partners are, who the behavioral health partners that we need to work with, who are the community based organizations that we need to work with.

Who are the hospital systems and the long term care facilities that we really need to engage with.

And we don't have access to that data now. So if the state were in the place to mandate that the MCOs provide us this kind of information that would really prepare us to collaborate better and to engage the right the right partners in our efforts to reform the health care system. So we thank you so much for this opportunity and good luck with the waiver.

All right. That is the.

The end of our our speaker list.

I really want to thank everyone for coming and also for those of you for staying to listen to everyone else.

So I think this is important exchange of information as well.

So with that, we look forward to written comments on November 4th.

The Web site.

Thank you and safe travels home.