## doh.sm.1115Waivers

**From:** James Edmondson [redacted]
**Sent:** Wednesday, September 18, 2019 12:49 PM
**To:** doh.sm.1115Waivers
**Cc:** Dr. Edmondson, Pediatric Pulmonology; [redacted] Mary Somoza; Carolyn Wember; Carol Matthews; [redacted]; Trina Rose; Earle, Lana I (HEALTH); Frescatore, Donna J (HEALTH); Bearden, Roger A (OPWDD); marlay, katherine (OPWDD)
**Subject:** Written Comments for 1115 MRT Waiver Public Forum Information: NYC OCTOBER 25th
**Attachments:** VOR Talk 2019-06-09 + Link.pdf



Dear DOH,

My wife and I have two sons with autism who participate in Self-Direction through the OPWDD Medicaid Waiver.

We are grateful to New York State for administering the OPWDD Waiver. It gives us priceless peace of mind to know that New York State is invested in the health and well-being of our boys long after my wife and I are unable to care for them.

I will be unable to attend the 1115 MRT Waiver Public Forum Information in NYC on October 25th. Please accept these written comments.

My wife and I are doctors, and we are very familiar with managed care in the acute care sector. We are increasingly distressed at the abusive and imperious behavior of huge for-profit payer-led managed care plans in the commercial sector, the Medicare Advantage sector, and the Medicaid Managed Care sector.

I am writing to ask and beg New York State to abandon the wrong-headed Medicaid Redesign Team managed care agenda for the OPWDD. The MRT agenda is nothing less than privatization to permit certain well-connected OPWDD insiders to reap huge profits at the expense of 130,000 intellectually and developmentally disabled (I/DD) New York citizens. It is rife with conflicts-of-interest and morally indefensible. Moreover, there is no credible evidence from any US state that forcing the I/DD population into managed care saves the state any money. However, there is extensive evidence that forcing the I/DD population into managed care increases overall costs, drives long-time providers out of business, causes massive disruption in services, and increases morbidity and mortality in the I/DD population.

I urge New York State to keep Wall Street-based for-profit payer-led managed care insurance plans far away from the OPWDD. Serving and supporting and protecting the most vulnerable 2% of New York's population is the duty of the state government and must not be privatized. Advocates for the I/DD population must retain access to dedicated state-employed administrators who are directly responsible for authorizing and regulating OPWDD service providers. Inserting a profit-seeking private-sector middleman between the state fisc and the disabled population is guaranteed to do two things: (1) cost state taxpayers more money, and (2) reduce the number and quality and diversity of Medicaid-funded long-term services and supports for participants. It is not an exaggeration to say that I/DD managed care will shorten lifespans.

I am attaching slides from a talk I recently gave on managed care in the I/DD population, from the perspective of a doctor with decades of provider experience in the managed care world. A video of my talk (with sub-optimal captions) is available at https://www.youtube.com/watch?v=vror0OcFgy0&t=532s.

Yours,
James Edmondson, M.D., Ph.D.

Forest Hills, NY


*A Voice Of Reason*

*Speaking out for people with intellectual & developmental disabilities*

A Voice Of Reason

Speaking out for people with intellectual & developmental disabilities

# I/DD Managed Care

James Edmondson, M.D., Ph.D.

# James Edmondson, M.D., Ph.D.

The I/DD world is just beginning to deal with “managed care.”

The next decade will be dominated by “managed care.”

Doctors and hospitals have decades of
experience with managed care.

I am going to assume that you don’t know
much about managed care yet.

I am a third-generation physician with two boys with I/DD.

# James Edmondson, M.D., Ph.D.

I am a third-generation physician with two boys with I/DD.

My grandfather, Creighton Edmondson was a family doctor in solo practice in Madison, Wisconsin.

As often as not, he received "payment in kind."

# James Edmondson, M.D., Ph.D.

I am a third-generation physician with two boys with I/DD.

My father, Robert Edmondson, followed in his father's footsteps, specializing in hematology and oncology.

My father began his practice just as health insurance was spreading across the country.

# James Edmondson, M.D., Ph.D.

I am a third-generation physician with two boys with I/DD.

Tired of shoveling snow, my father moved to sunny rural Northern California.

He joined the Woodland Clinic Medical Group, where he biked to work and made house calls.

He was paid by fee-for-service health insurance. Life was good.

# James Edmondson, M.D., Ph.D.

I am a third-generation physician with two boys with I/DD.

But there was trouble in paradise…

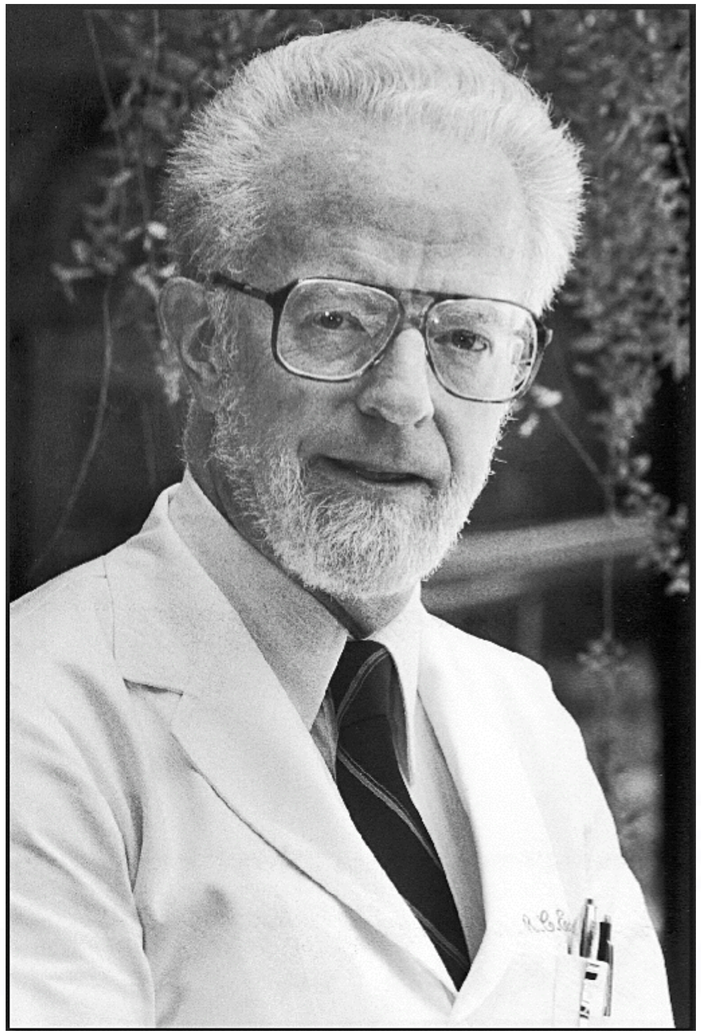
In the 1980s, a new kind of health insurance took over California:

**Managed Care**

Dad did not like it one bit.

# James Edmondson, M.D., Ph.D.

I am a third-generation physician with two boys with I/DD.



His income suffered.

His partners moved onto greener pastures.

My father chose to be a dinosaur.

He did not change his ways to adapt to managed care rules.

He retired in place, embittered.

# James Edmondson, M.D., Ph.D.

I completed my M.D. and Ph.D. at New York University.

My Ph.D. thesis was on brain development.

I became board-certified in adult and child neurology.

I had the good sense to marry my senior resident.

We have two sons on the autism spectrum.

# James Edmondson, M.D., Ph.D.

We have two sons on the autism spectrum.

I retired from clinical practice in 2008 to help our boys full-time.

# James Edmondson, M.D., Ph.D.

During all my scientific and medical training in brain development, I never learned what a Medicaid waiver was.

I diagnosed and managed the care of hundreds of people with autism, intellectual delays, epilepsy, cerebral palsy.

But it was only when I had I/DD children of my own that I began to learn about Medicaid long-term services and supports.

There is little intersection between the worlds of acute-care medicine and I/DD long-term services and supports (LTSS).

# James Edmondson, M.D., Ph.D.

There is little intersection between the worlds of acute-care medicine and I/DD long-term services and supports (LTSS).

All doctors have to know a lot about managed care.

Most doctors have grown to hate managed care.

Very few practicing doctors know about Medicaid LTSS.

Acute care medicine and I/DD LTSS are separate worlds.

**James Edmondson, M.D., Ph.D.**

Acute care medicine and I/DD LTSS are separate worlds.

In terms of dollars, acute care medicine is
almost 100 times bigger than I/DD LTSS.

These two worlds are incompatible,
and they should remain separate.

But, unfortunately, things are not always as they should be.

Forewarned is forearmed.

***Beware of Managed Care!***

# What Is Managed Care?

There are two ways to pay for services:

"Fee for service" "Managed care"

Example of a restaurant:

| "Fee-for-service" (FFS) | "Managed care" |
| --- | --- |
| Eat before paying | Pay a fixed price before eating |
| Like an a la carte menu | Like at an all-you-can-eat buffet |
| • Cannot predict total | • Can predict total |

# What Is Managed Care?

## "Fee-for-service" (FFS)

- Cannot predict total

More services

More profit

Favors seller (provider)

Promotes more utilization

## "Managed care"

- Can predict total

More services

Less profit

Favors buyer (payer)

Promotes less utilization

# 100 patients: How Managed Care Works

**Healthy** **Sick**

# 100 patients: How Managed Care Works

## General Population

Everybody pays me $100 per month = $10,000 per month.


90% of people do not seek medical care.
They paid me $9,000.
They cost me nothing.
That's $9,000 of "free money."

10% of people
They paid me $1,000
They cost me $5,000
I use $4,000 of my "free money."

## "Cost shifting"

The remaining $5,000 is overhead and profit.

# 100 patients: How Managed Care Works

## I/DD Population

Everybody pays me $100 per month = $10,000 per month.

100% of people require services each month.

They pay me $10,000.

They cost me $9,000.

No “free money.”

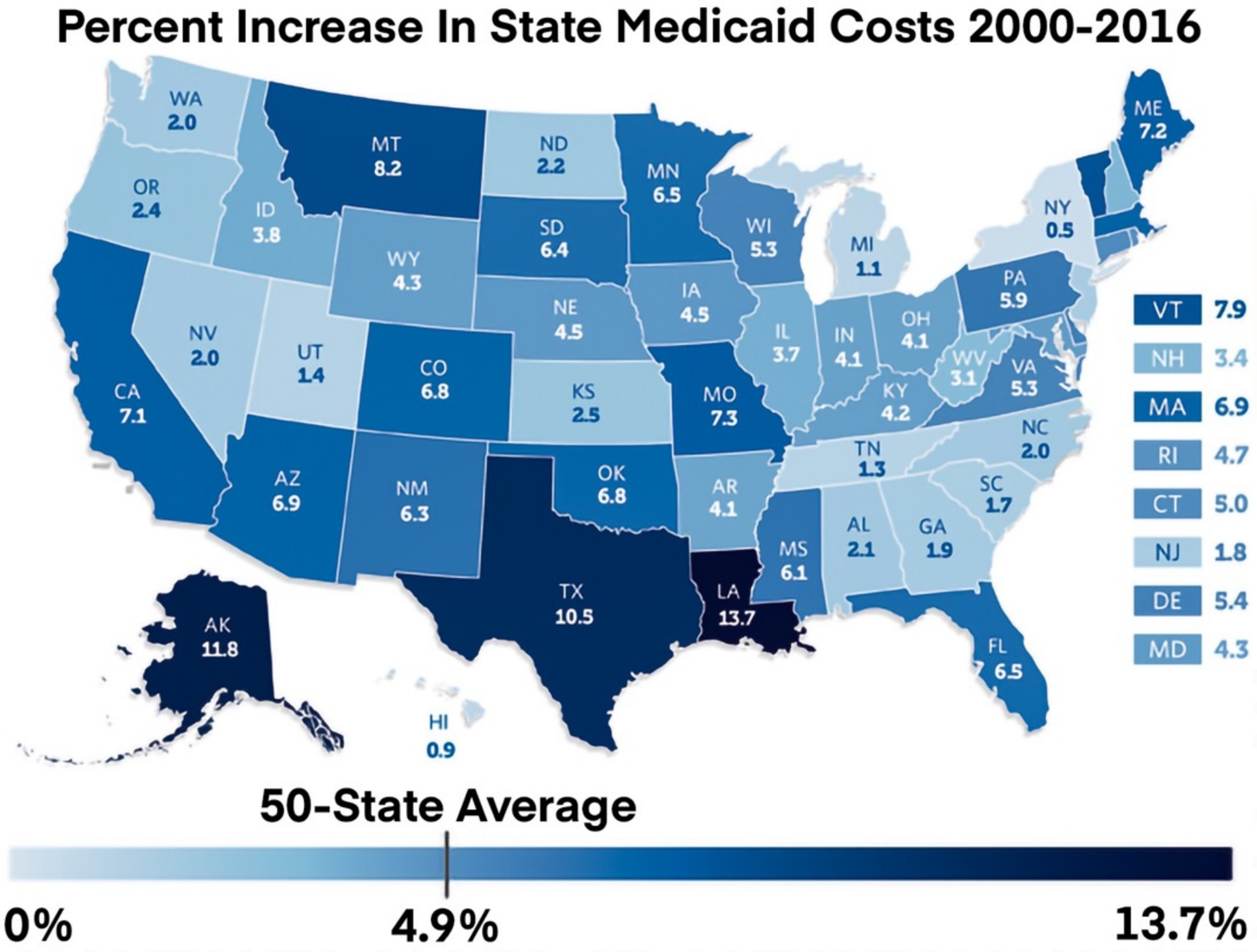
**No “cost shifting”**

The only way I can make more money is by cutting services.

# Two Kinds Of I/DD "Managed Care" Models

| *Voluntary Sector* | Payer | Provider | Participant |
|---|---|---|---|
| Fee For Service | State Medicaid Agency | Voluntary (Non-Profits) | Disabled People |
| Provider-Led Managed Care | State Medicaid Agency | Voluntary (Non-Profits) | Disabled People |
| Payer-Led Managed Care | For-Profit Corporations | Voluntary (Non-Profits) | Disabled People |

# Medicaid Inflation & State Budgets

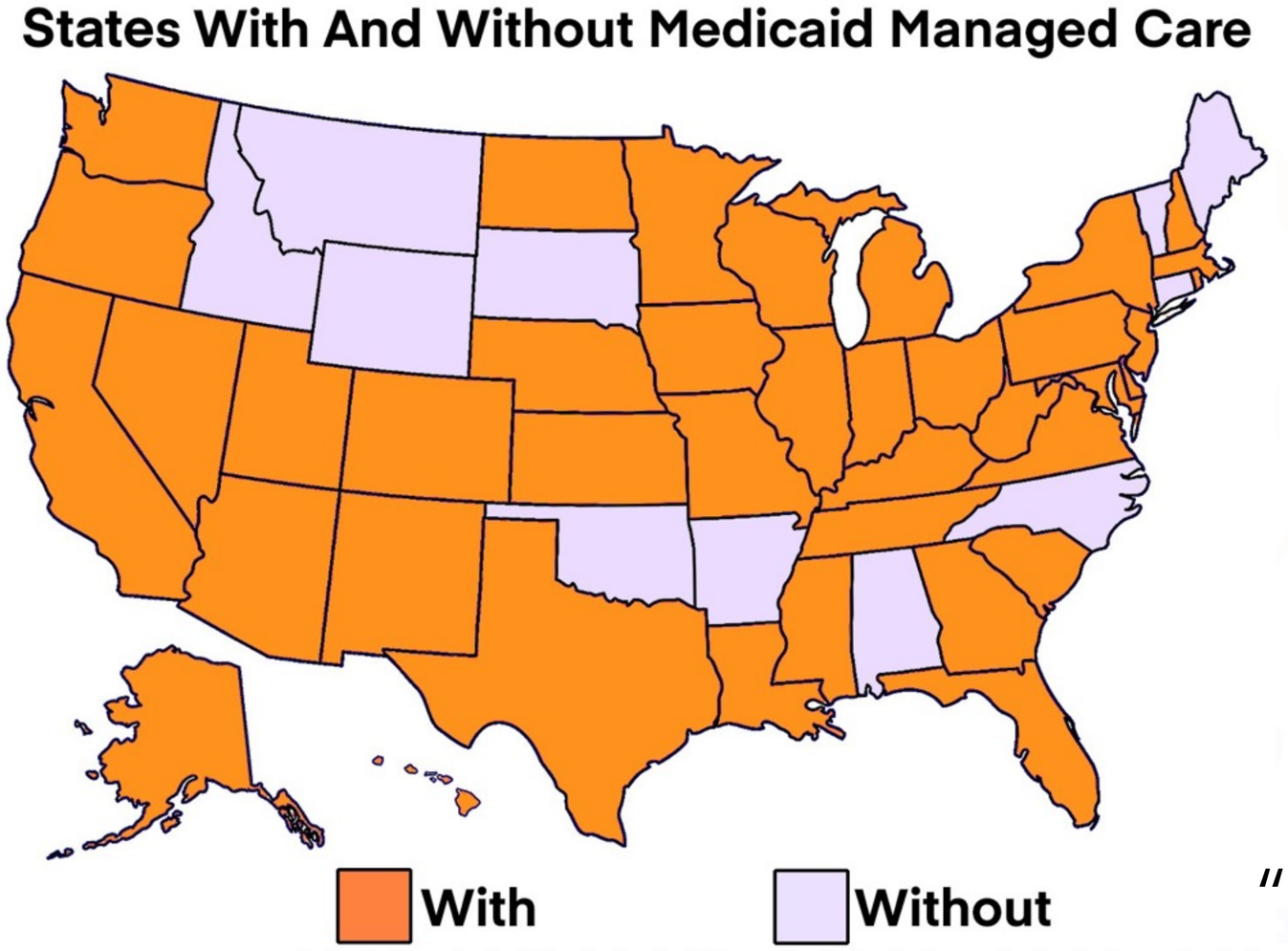



Medicaid costs are rising in every state.

State budget directors believe managed care stabilizes (cuts) costs.

39 States Have Private Corporate Medicaid Managed Care Plans.

# 39 States Have Private Corporate Medicaid Managed Care Plans



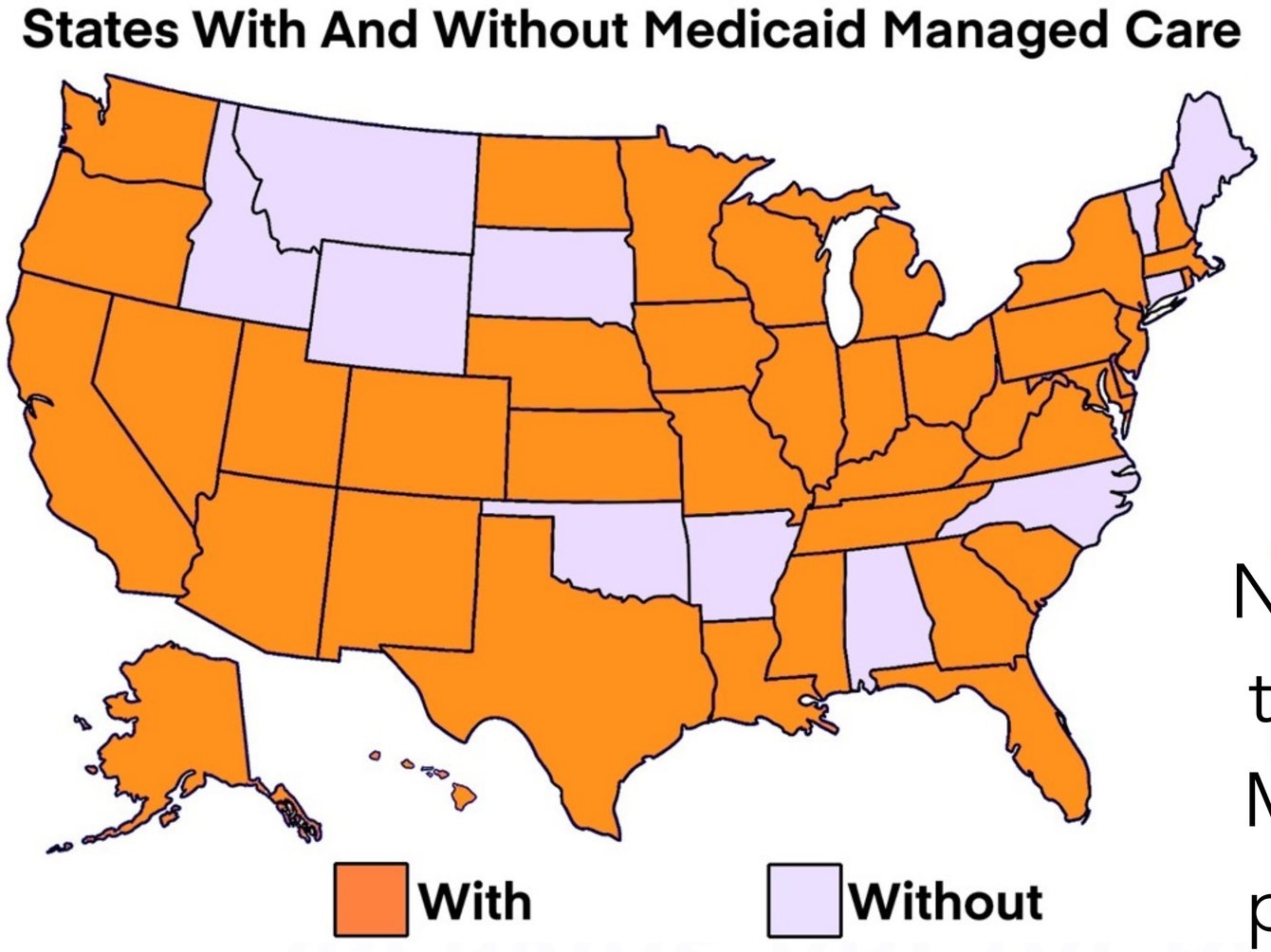

11 States have no private Medicaid Managed Care.

Policies on managed care are state-specific.

"First, you need a crisis."

"Never let a good crisis go to waste."

# The Example Of North Carolina

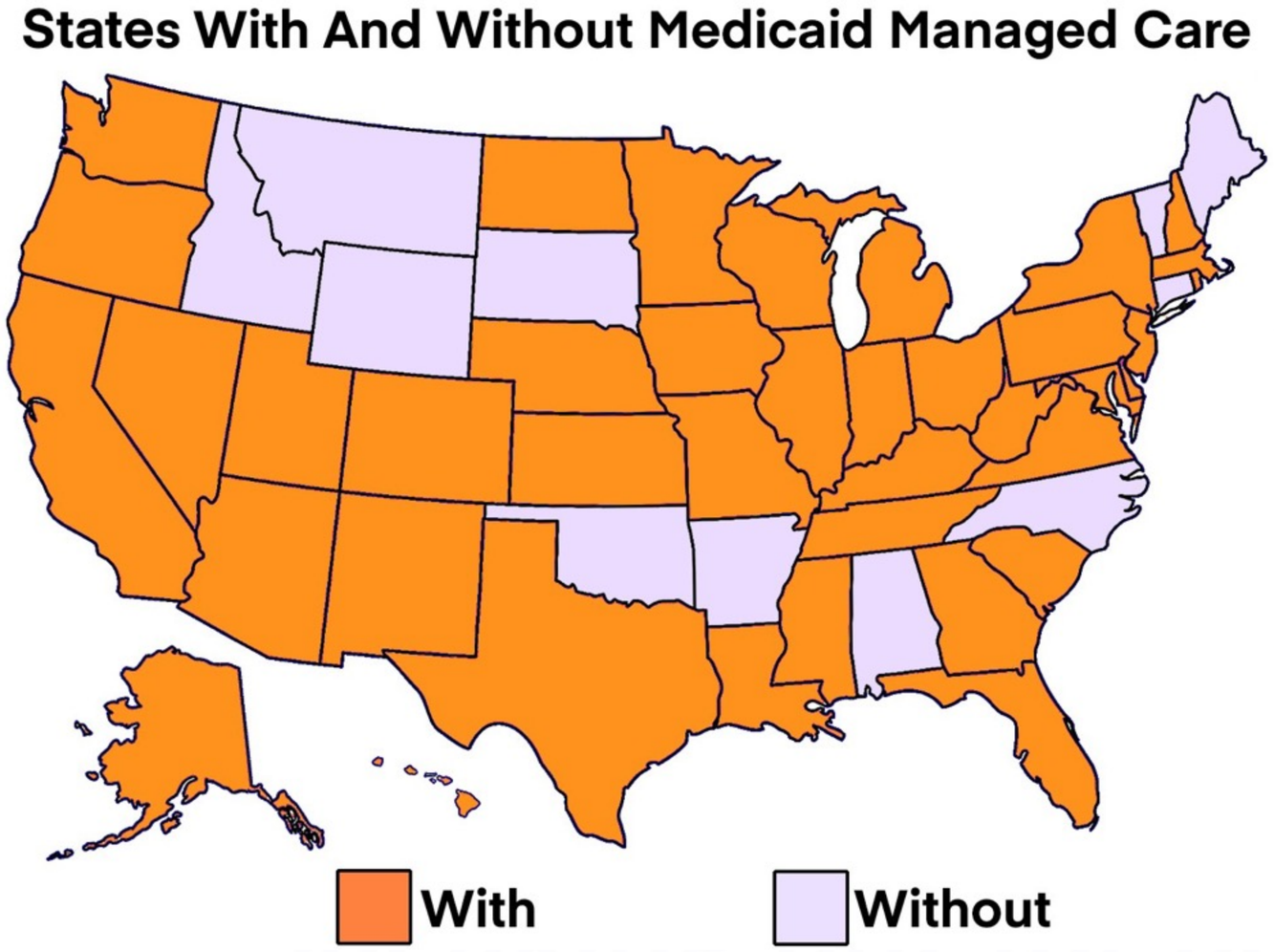



NC already has provider-led I/DD managed care plans.

North Carolina is set to be the next state to move its Medicaid population into payer-led managed care.

The transition illustrates what this will mean for the I/DD population.

# The Example Of North Carolina



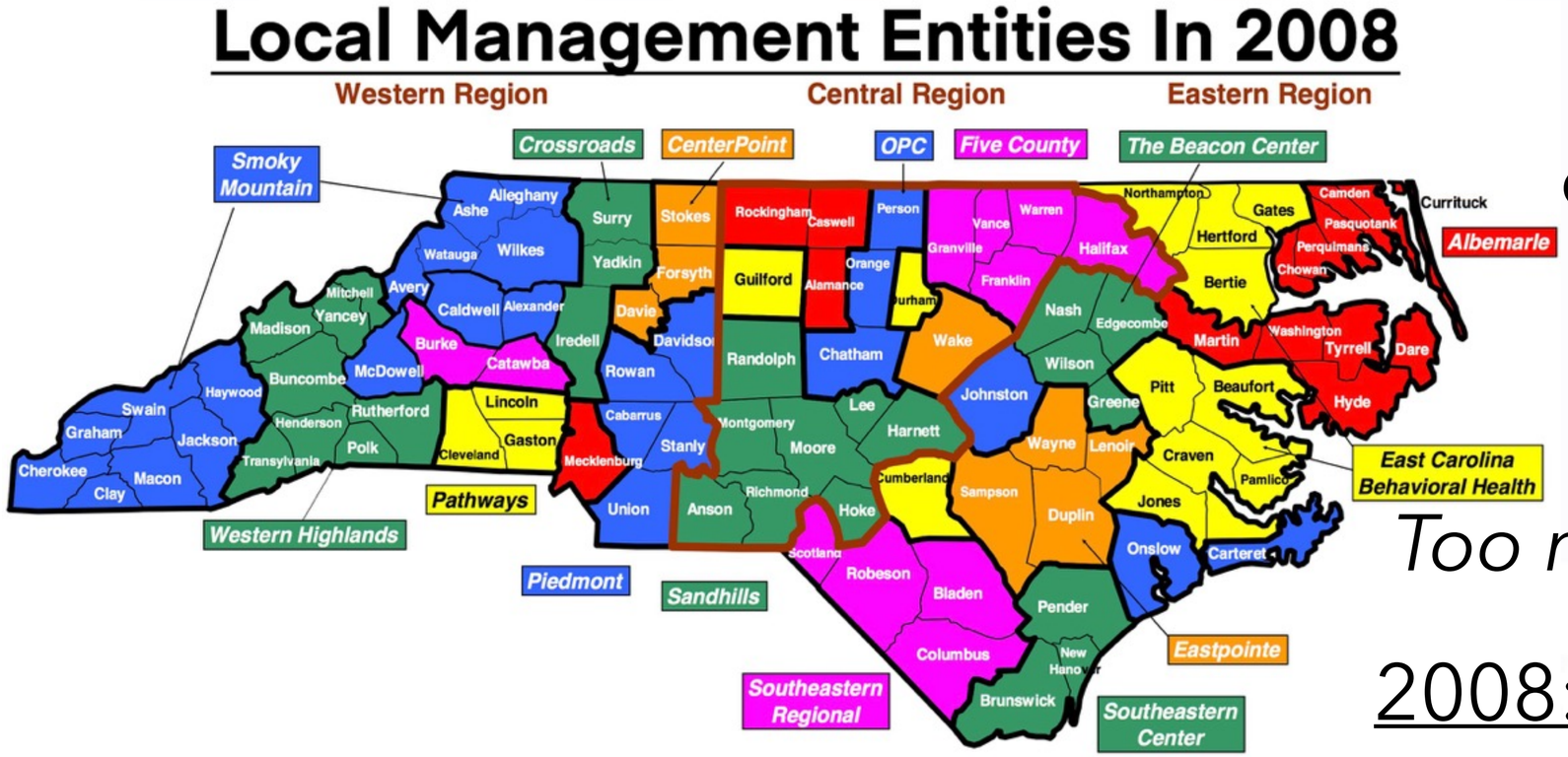


Like several states, NC's provider-led I/DD managed care system evolved locally over decades.

The non-profit, state-funded provider-led agencies cover I/DD and mental health and substance abuse.

# The Example Of North Carolina

1985: North Carolina created 40 Local Management Entities




"Mom & Pop" LMEs do person-centered planning & authorize services.

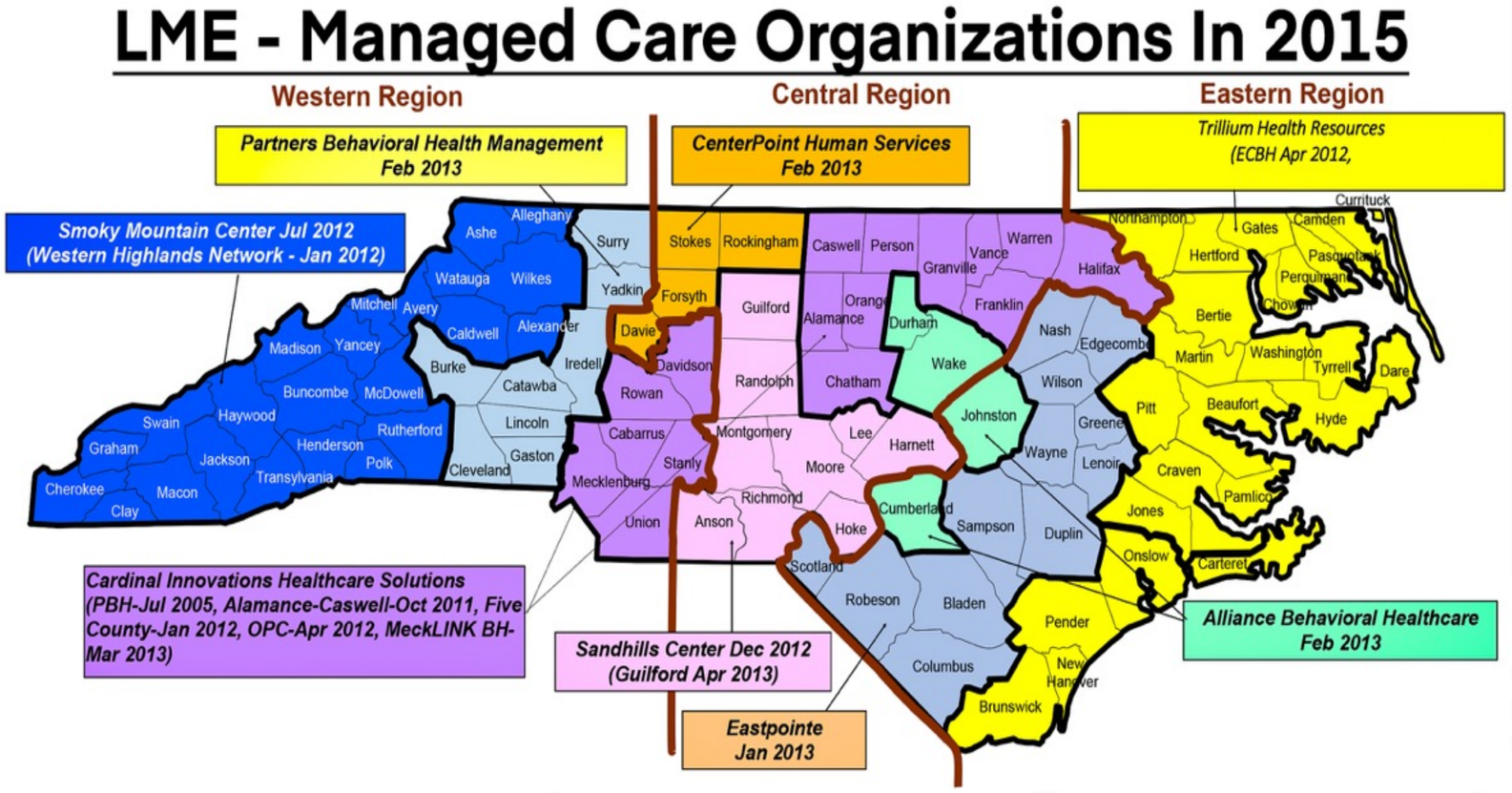
*Too much independence.*

2008: these had merged into 15 regions.

Initially fee-for-service → changed to managed care in 2012.

# The Example Of North Carolina

2015: Merged into 8 LME-Managed Care Organizations




All LME-MCOs are "provider-led" and state-funded.

North Carolina plans further changes in the next 5 years.

LME-MCOs will be absorbed by huge "payer-led" MCO plans.

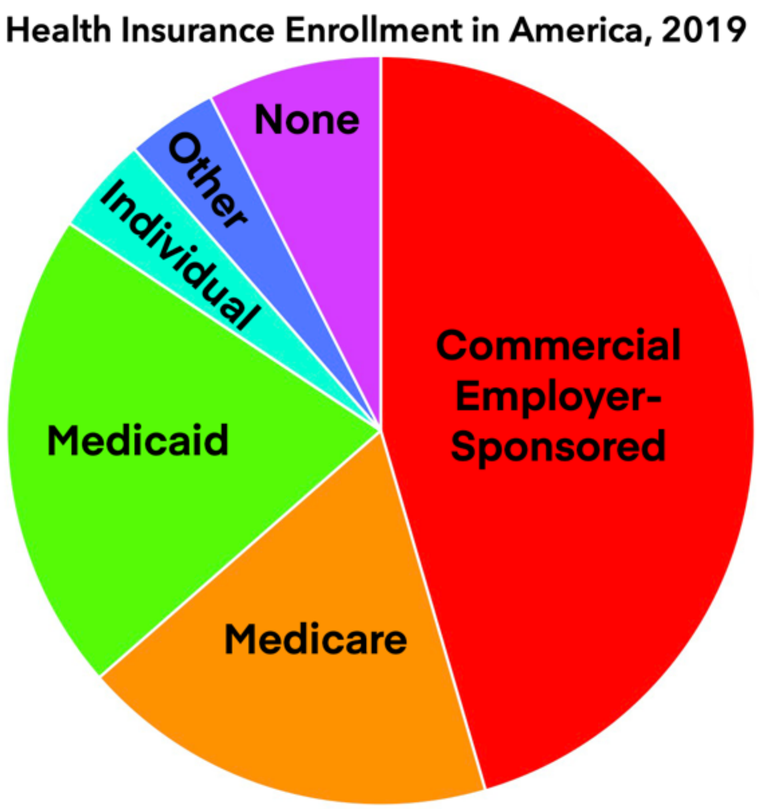
Overall trend takes away local control and gives it to Wall Street.

# **Medicaid Managed Care = Medicaid Privatization**

I am done talking about small, local, provider-led, state-funded, capitated I/DD agencies that have evolved over decades:
(i.e., Mom & Pop)
Examples: Wisconsin, Michigan, North Carolina, Arkansas, New Hampshire, Oregon, Colorado, Tennessee.

I am now going talk about huge, national, private, for-profit payer-led health insurers that originated as employer-sponsored health insurance plans.
(i.e., Wall Street)
All they care about is profit.

# Breakdown of Traditional Separation Between Public and Private Health Insurers




Fewer employers are offering health insurance as a benefit.

Commercial employer-sponsored health insurers are expanding into Medicare and Medicaid.

Commercial health insurers have consolidated from hundreds into a dozen huge corporations.

# The Major Commercial Health Insurers

# The Major Commercial Health Insurers

**$220 Billion**

**$16 Billion**

**$17 Billion**

**$42 Billion**

**$60 Billion**

**$90 Billion**

**$7 Billion**

**<u>These huge corporate insurers are coming after Medicaid.</u>**

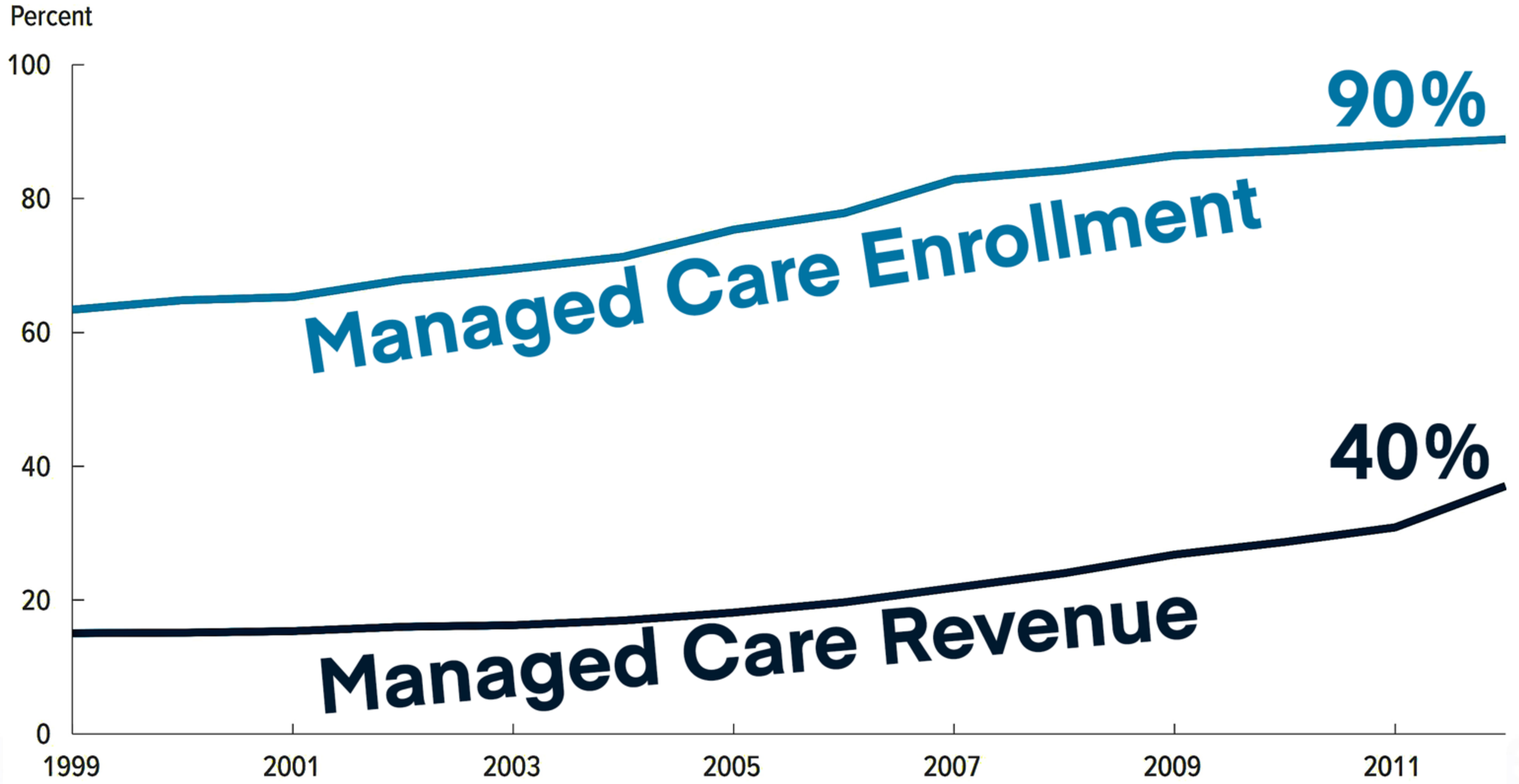
They began enrolling mainstream (non-disabled) Medicaid patients in the late 1990s.

States initially kept Medicaid waivers out of managed care.

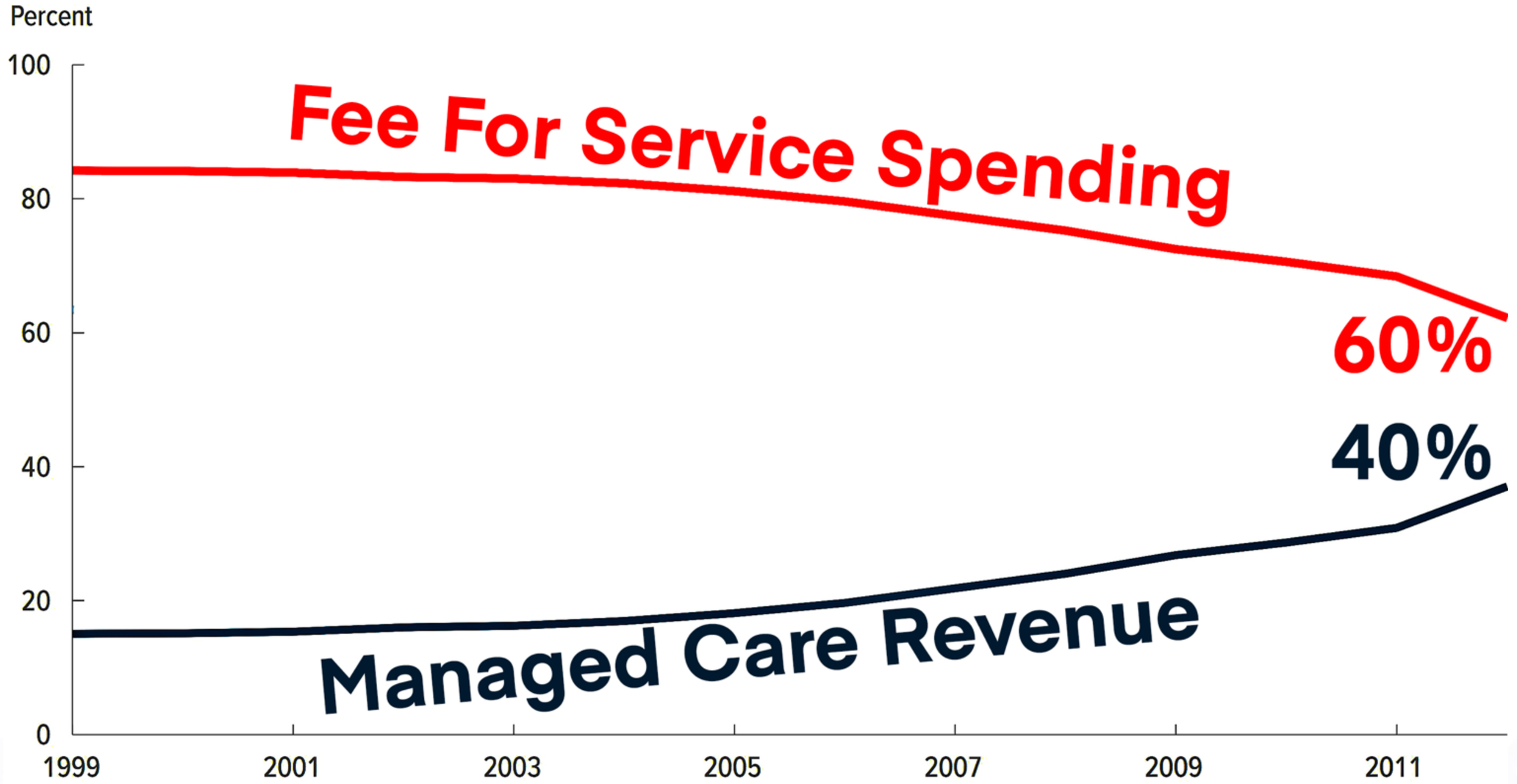
Then came the Great Recession and the “fiscal cliff” of 2011.

The American Legislative Exchange Council (ALEC) wrote a Medicaid Managed Care model bill in 2012.

# Medicaid Managed Care Plans Enrollment vs Revenue



# Medicaid Managed Care Plans Enrollment vs Revenue



# What Are The Remaining Revenue Capture Targets?


- Long-term services and supports are mostly FFS

> Institutional long-term care (ICFs, nursing homes)

> Home- & Community-Based Services (HCBS)

> Big Hurdles: **Person-Centered Planning**

**Information Technology – $$$**

**Provider & Participant Resistance**

# I/DD Managed Care Caveats

Medicaid Managed Care is part of a widespread trend in state governments of moving responsibility for social and health services into the private sector.

Medicaid Managed Care reduces the public's access to state officials and the political process.

Medicaid Managed Care hides discussions about service cuts behind a corporate veil.

Medicaid Managed Care for the I/DD population remains speculative and unproven.

# I/DD Managed Care Caveats

Managed Care does nothing to address the major problems in I/DD long-term services and supports.

- Long HCBS waiver waiting lists
- Shortage of I/DD housing
- Shortage of direct service workers
- Waste, fraud and abuse

By diverting state Medicaid funding into corporate profits, I/DD Managed Care will make all these problems worse.

# I/DD Managed Care Caveats

State budget directors want Medicaid Managed Care
for one reason: to cap Medicaid costs.

Medicaid Managed Care plans draw on huge corporate utilization management protocols to limit service authorizations.

In contrast, Medicaid Managed Care ombudsman offices
are typically small and underfunded.

Medicaid Managed Care plans demand that
states NOT scrutinize service authorizations.

# I/DD Managed Care Caveats

Medicaid Managed Care plans run expensive media and lobbying campaigns to discredit and misrepresent fee-for-service.

They contrast “costly” and “fragmented” fee-for-service with “efficient” and “coordinated” managed care.

There is no evidence that Medicaid Managed Care either saves states money or improves healthcare services vs fee-for-service.

There are numerous examples of chaos and provider bankruptcies caused by switching from fee-for-service to managed care.

# I/DD Managed Care Caveats

Detecting Medicaid fraud is more difficult in managed care than in fee-for-service.

States should intensify their surveillance of Medicaid Managed Care utilization management and fraudulent service denials.

However, to the contrary, states view Medicaid privatization as a way to reduce state Medicaid regulation and oversight.

There is a risk that states assume that “market forces” will regulate providers so the state won’t have to.

# Medicaid Managed Care Vulnerabilities

Aggressive state rate setting

Person-Centered Planning

Extensive provider & patient protections

Provider opposition and resistance

# Medicaid Managed Care Vulnerabilities

## Aggressive state rate setting

Initial capitated rate is based on previous fee-for-service costs.
If FFS was low, then managed care rates will be low.

Plans may have high start-up costs.

FFS Medicaid administrative costs are typically 3%-5%.
MCOs demand 15% overhead.

Enrollment of high-cost patients without high rates.

If Medicaid Managed Care plans cannot earn a profit,
they will simply leave the state.

# Medicaid Managed Care Vulnerabilities

## Person-Centered Planning

Medicaid Managed Care processes are optimized for authorizing medical services and paying medical claims.

"ICF/ID provides active treatment, a continuous, aggressive, and consistent implementation of a program of specialized and generic training, treatment, and health or related services, directed toward helping the enrollee function with as much self-determination and independence as possible."

"Active treatment is based on an evaluation and individualized program plan (IPP) by an interdisciplinary team."

# Medicaid Managed Care Vulnerabilities

## Person-Centered Planning

"Active treatment is based on an evaluation and individualized program plan (IPP) by an interdisciplinary team."

The I/DD community has been doing person-centered planning for 50 years.

The rest of the world is only now trying to catch up!

The last thing states should do is to replace decades of compassionate I/DD person-centered planning expertise with corporate health insurance robots and algorithms.

# Medicaid Managed Care Vulnerabilities

Extensive provider & patient protections

Strict, aggressive state regulator

High care management requirements

Transparency: Follow the Money

I/DD managed care is unproven and experimental.

I/DD provider information technology is primitive.

Taking Medicaid payments and failing to provide services is the definition of Medicaid fraud.

# Medicaid Managed Care Vulnerabilities

## Provider opposition and resistance

Rural providers may not accept low managed care rates.

Bad publicity.

Legislative investigation and scrutiny.

Litigation by providers and/or family members.

# Red Flags: Is Your State Doing These Things?

Privatization of New Capabilities

Private contracting rather than developing in-house expertise.

Out-of-state contracting to national consultants.

State agency chaos.

Involvement of any major Medicaid Managed Care Plan

Utilization management = service denials.

"Exhaustion" of internal appeals before Fair Hearing.

Pre-packaged assessment batteries instead of person-centered planning

Most are designed for nursing home populations.

Not validated or appropriate for I/DD populations.

# Red Flags: Is Your State Doing These Things?

## Moving Too Quickly

Aggressive managed care timeline dictated by budget directors.

"Start-up funds are running out" => launching before ready.

It takes months and years to change safely.

## Overselling of Information Technology

Good IT costs hundreds of millions of dollars.

Be very wary of untested IT systems.

LTSS providers have no money for new IT.

## Value-Based Payments

There is no standard definition of "value."

## Nuclear Options

Private equity

Block Grants

# Medicaid Managed Care Rate Setting

Usually very opaque, with insider & sweetheart deals.

All about monopoly negotiating power.

No input from participants.

Medicaid Managed Care plans do not competitively bid on capitated rates.

Capacity requirements may increase costs.

Switching from FFS to MC can lower or raise overall costs.

Will you get your money's worth? Depends on state oversight.

# Medicaid Managed Care Rate Setting

CMS requires “actuarially sound” capitated rates.

“Actuarially sound” is poorly defined: “income must exceed costs.”

CMS only interested in bean counting, no guarantee of quality.

Rates are calculated by accounting consultants.

Initial rates are supposed to be based on FFS experience.

Persistence of FFS rates to providers for only a year.

After that, managed care plans start screwing providers.

**After that, managed care plans start screwing providers.**

I worked for a Medicaid managed care plan for 13 years.

As an insider, I was paid very well indeed.

We offered outside providers 80% of FFS Medicaid rates.

No top-tier hospitals wanted our business.

We played two struggling hospitals against each other every few years to get lower rates.

Patients became increasingly unhappy → death spiral.

Several of our outside providers went out of business.

**<u>Several of our outside providers went out of business.</u>**

It costs providers a lot of money to survive under managed care.

The biggest cost and most essential investment is high-quality information technology.

“You can’t manage what you can’t see”

Congress gave doctors and hospitals $40 billion for IT.

Payer-led managed care plans expect good IT.

Congress gave LTSS providers $0 for IT.

Without IT, an LTSS provider has no chance under managed care.

# “Elevator Pitch” Against I/DD Managed Care

Don’t give control over I/DD funding to huge, for-profit, private corporations which have no expertise in person-centered planning and no historical connection to I/DD.

I/DD Medicaid Managed Care plans will gradually look and act like commercial managed care plans.

I/DD Medicaid Managed Care will worsen all of the major funding and capacity problems in I/DD services and supports.

I/DD managed care has already wreaked havoc in several states.

Radical change for the sake of change can be lethal.


*A Voice Of Reason*

*Speaking out for people with intellectual & developmental disabilities*

# The American Medical Association (AMA)

Founded in 1847 as a price-fixing provider cartel.

Has always lobbied for fee-for-service
and against managed care.

Major opponent of national health insurance.

Determines how much doctors are paid by Medicare.

All about doctors controlling healthcare spending.

# The American Medical Association (AMA)

All about doctors controlling healthcare spending.

AMA is controlled by surgeons and specialists.

Primary care doctors are second-class citizens.

No medical specialty is focussed on I/DD population.

AMA is deaf and blind to the LTSS needs of I/DDers.

# The American Medical Association (AMA)

AMA is deaf and blind to the LTSS needs of I/DDers.

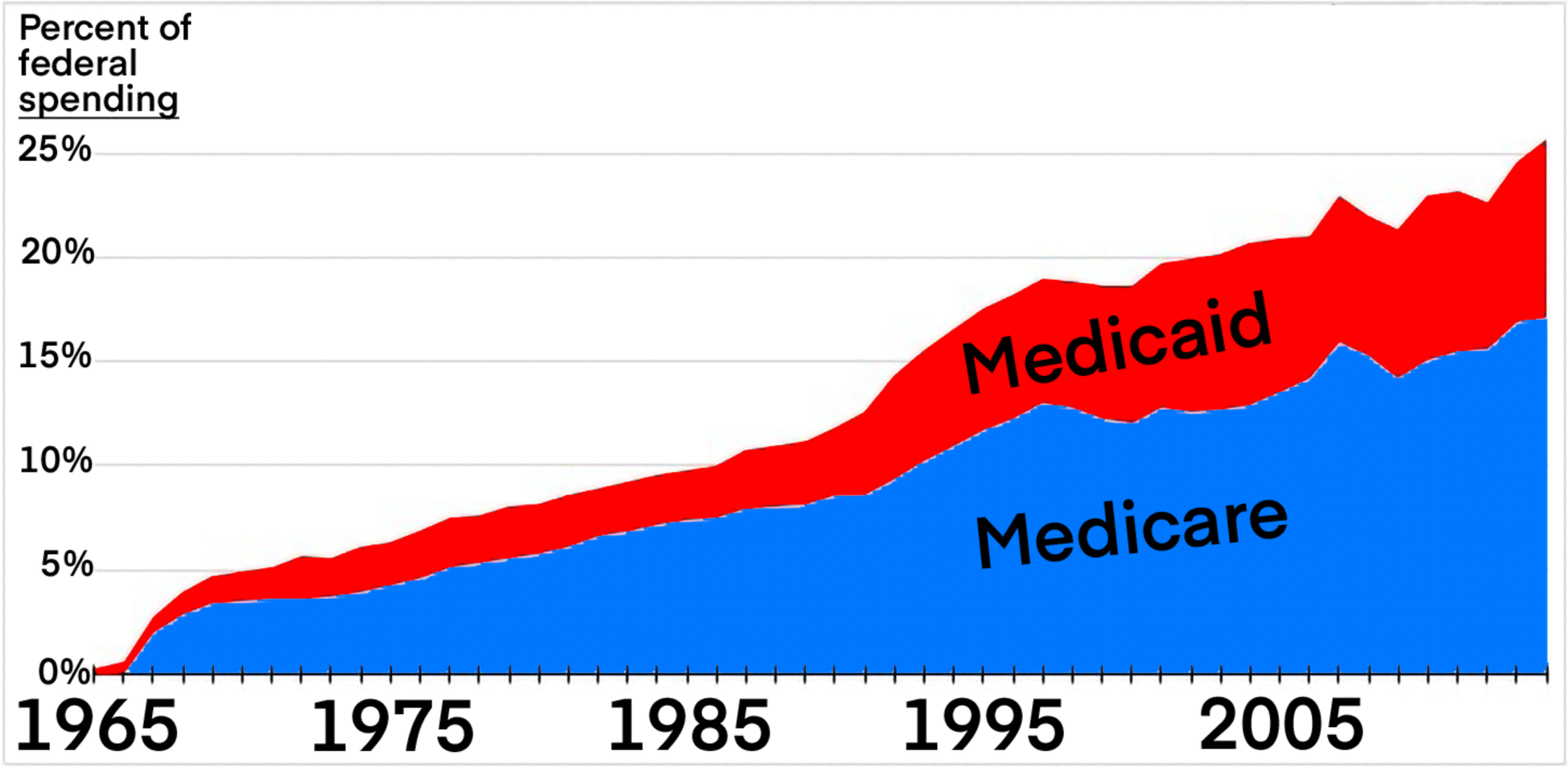
Medicaid was the first federal program to spend meaningful amounts on I/DD LTSS.
(No thanks to the AMA.)

The AMA remains a major driver of healthcare inflation.

Managed care was invented to contain the AMA's greed.

# Managed care was invented to contain the AMA's greed.

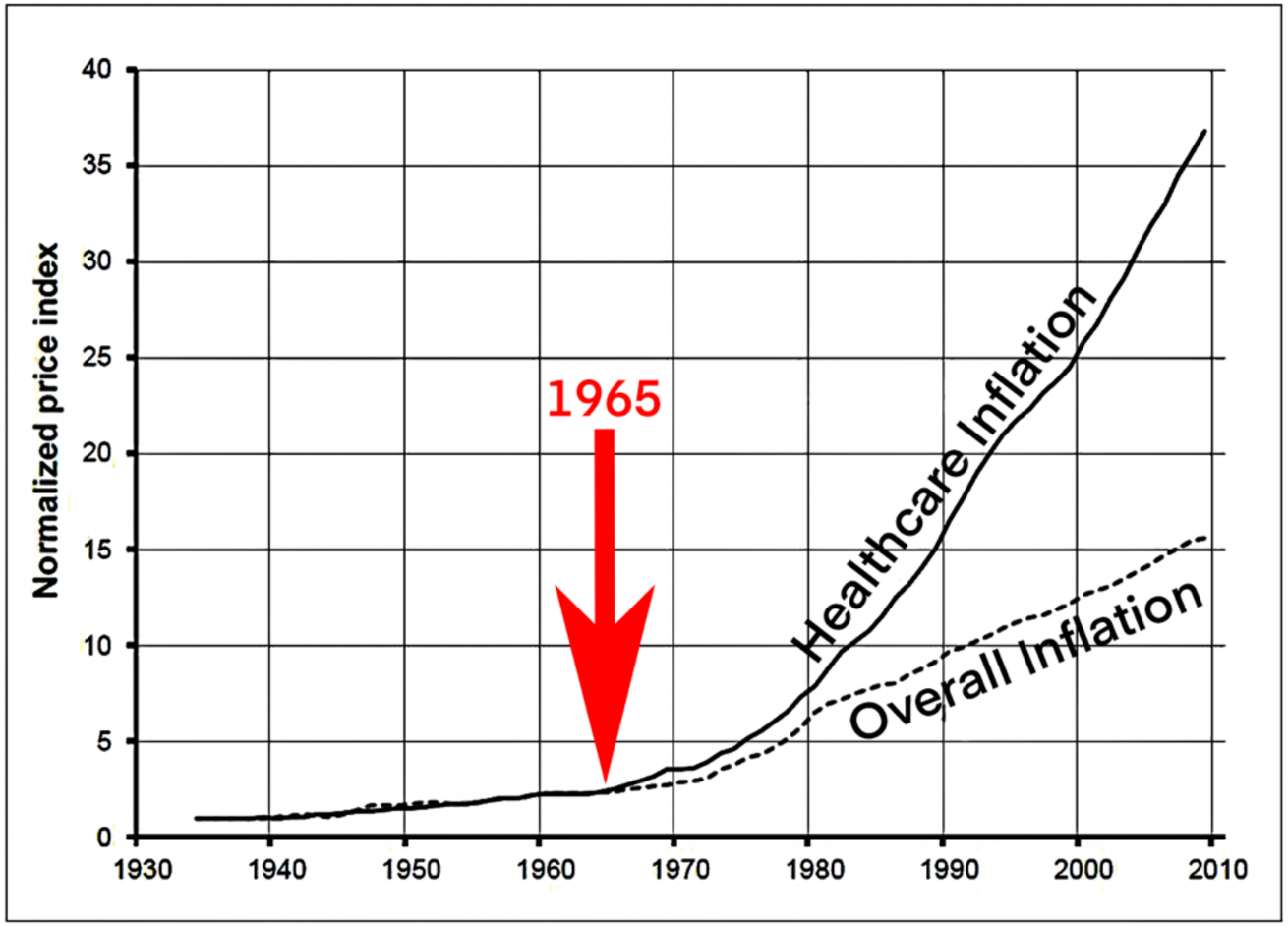
Although the AMA initially resisted Medicare and Medicaid, doctors and hospitals soon embraced federal funding.




**Source:** Congressional Budget Office

# Managed care was invented to contain the AMA's greed.

Healthcare inflation began to exceed overall inflation in 1965.




"Healthcare is too lucrative to be left to the doctors."

# **“Healthcare is too lucrative to be left to the doctors.”**

Wall Street decided that corporations should control doctors’ earnings.

Wall Street did not necessarily want to limit healthcare inflation.

Corporations simply wanted a cut of the action.

Healthcare is essentially a “protection racket.”

# Healthcare is essentially a “protection racket.”

Power over life and death.

Extreme knowledge asymmetry (1 doctor / 400 people).

Commodity guarded by a secretive guild.

Status-symbol wrapped in a religion-mystical aura.

Involves both death and taxes.

Bigger than the military-industrial complex.

Cannot be outsourced to China.

# Single-Payer National Health Insurance?

Today's political buzz about "single-payer" and "Medicare for all" is a close echo of the early 1970s.

Senator Ted Kennedy proposed a single-payer plan in 1971.

President Richard Nixon countered with privatization.

Two federal laws created today's managed care monsters:

1973 Health Maintenance Organization Act

1974 Employee Retirement Income Security Act

# 1973 Health Maintenance Organization Act

## 1971 Nixon tapes - conversation with John Ehrlichman

E: "…whether we should include these health maintenance organizations like Edgar Kaiser's Permanente thing."

N: "You know I'm not too keen on any of these damn medical programs."

E: "This is a private enterprise one."

N: "Well, that appeals to me."

# 1973 Health Maintenance Organization Act

## 1971 Nixon tapes - conversation with John Ehrlichman

E: “Edgar Kaiser is running his Permanente deal for profit. … All the incentives are toward less medical care, because the less care they give them, the more money they make."

N: “Fine.”

E: “ … the incentives run the right way.”

N: “Not bad.”

# 1973 Health Maintenance Organization Act

President Nixon understood the main selling point for managed care from the perspective of the payer: it is a private scheme for healthcare cost control.

Healthcare inflation is driven by several factors:

The American Medical Association is a price-fixing cartel.

Drug companies are an oligopoly of monopolists.

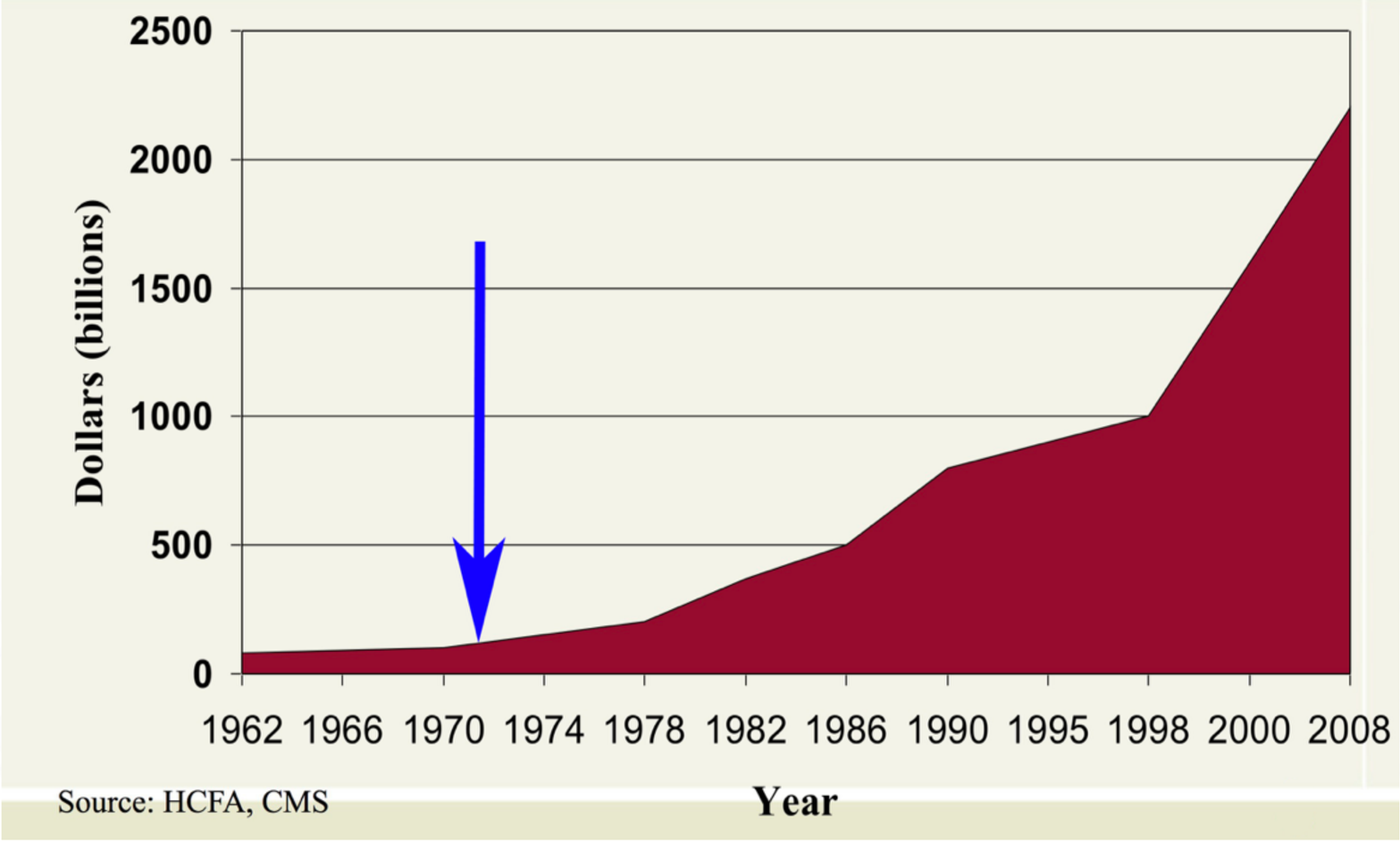
Hospital and surgical and diagnostic technology is expensive.

Healthcare is a reliably profitable Wall Street investment.

# 1973 Health Maintenance Organization Act

Sure enough, privatized healthcare costs soon exploded.

Total Cost of U.S. Healthcare Sector 1962-2008



# 1973 Health Maintenance Organization Act

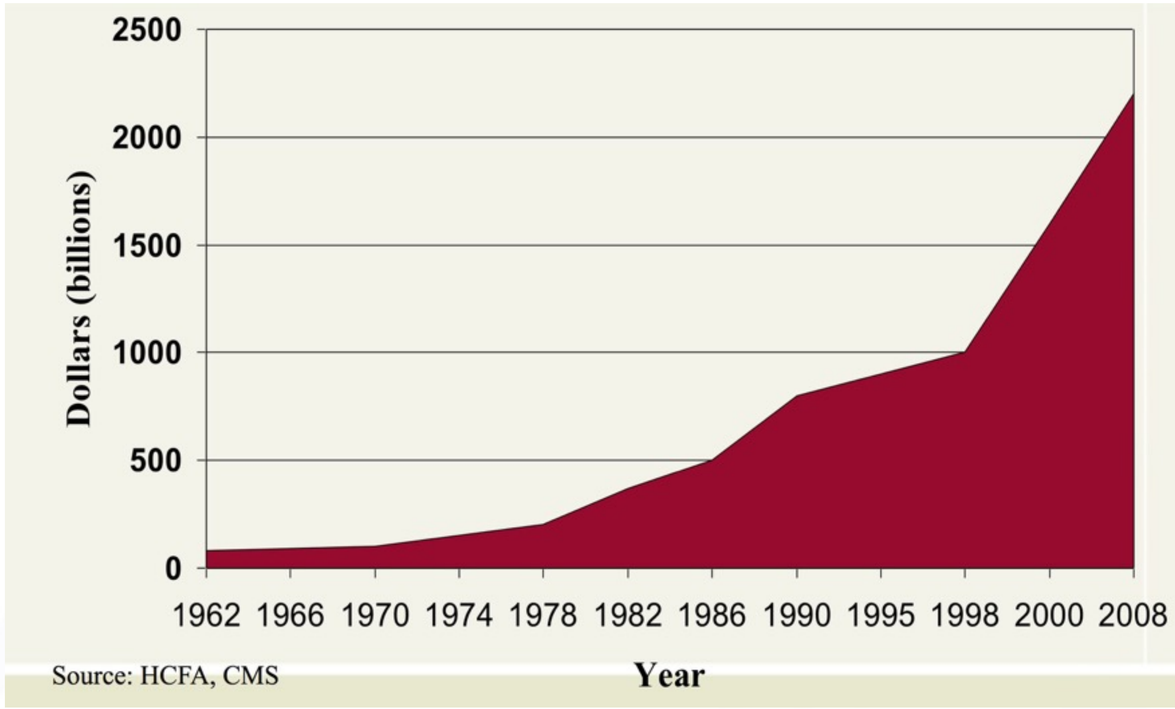
In the 1970s, managed care plans enrolled a tiny fraction of the population. Most healthcare was fee-for-service.

HMOs took several years to scale up to cover a significant percentage of the population.

Notice that well-funded, commercial managed care organizations required several years of federal grants and start-up funding to reach financial stability.

Managed care organizations are complex.

Many new managed care organizations go bankrupt.




By the 1980s, healthcare inflation was accelerating rapidly.

Employers sought ways of controlling healthcare costs.

And they had a very powerful weapon:

Employee Retirement Income Security Act of 1974 (ERISA)

# Employee Retirement Income Security Act of 1974 (ERISA)

Locked in employer-sponsored health insurance.

Congress put almost no patient protections into ERISA.

The employer-friendly Supreme Court stepped into the vacuum.

Many states have tried to add patient protections.

The Supreme Court invalidated every protection.

Managed care organizations have immunity from lawsuits.

# Employee Retirement Income Security Act of 1974 (ERISA)

SiCKO (2007) describes HMOs before Obamacare.


# Single-Payer Health Insurance

Impossible to imagine without full cooperation of the United States Supreme Court.

I am not aware of any single-payer proposals that even acknowledge the existence of LTSS.

The dream might be better than what we have now, but the ends don't justify the means.

In healthcare, radical change can be lethal.

Be careful what you wish for – you might get it.

# “Elevator Pitch” Against I/DD Managed Care

Don’t give control over I/DD funding to huge, for-profit, private corporations which have no expertise in person-centered planning and no historical connection to I/DD.

I/DD Medicaid Managed Care plans will gradually look and act like commercial managed care plans.

I/DD Medicaid Managed Care will worsen all of the major funding and capacity problems in I/DD services and supports.

I/DD managed care has already wreaked havoc in several states.

Radical change for the sake of change can be lethal.


*A Voice Of Reason*

*Speaking out for people with intellectual & developmental disabilities*

I welcome all inquiries:

[redacted]

A video of this talk is posted at

https://www.youtube.com/watch?v=vror0OcFgy0&t=532s

Click for link

## doh.sm.1115Waivers

**From:** Miriam Vincent [redacted]
**Sent:** Wednesday, September 18, 2019 2:44 PM
**To:** doh.sm.1115Waivers
**Subject:** Comment for New York's 1115 waiver program.



Dear NYS DOH and Mr. Gregory S. Allen,

This comment is made in response to the NYSDOH notice of request to CMS for a four year waiver amendment to further support the quality improvements and cost savings achieved through the DSRIP program to be in effect April 2021 through March 31, 2024.

Comment: The DSRIP Initiative, as implemented in New York State in 2015, in collaboration with OneCity Health, our PPS, presented a unique opportunity-unlike any other in my professional career. The program promoted patient-centered care and the integration and delivery of high quality primary health care and social services. DSRIP initiatives fostered the co-location of primary care and behavioral health services effectively, so needed by our patients employing an efficient and culturally acceptable approach. It was an honor to lead the DSRIP program at SUNY Downstate and remediate the triggers of asthma and preventable admissions associated with those asthma exacerbating factors in our children, preserving their precious lung function and their educational opportunities in school. Children belong in a classroom and not a hospital-our DSRIP Asthma Home Remediation Initiative helped to make this happen. Our SUNY-Downstate Transition of Care and Emergency Department Care Management Teams worked to provide transitional community care to high risk for readmission patients in need, serving to connect our patients with goods (medications, durable medical equipment, e.g.) and services (connection to primary care/preventive care, specialty care, home based care, e.g.) to allow patients to remain at home and in the community and prevent unnecessary and costly hospital readmissions. DSRIP made a difference in our Patient's lives and in New York State health outcomes, and cost savings, all in four years. The DSRIP Program was a win-win to improve healthcare in a way that made a difference.

The New York State Department of Health now requests an approval from CMS for a four year waiver amendment to further support the quality improvements and cost savings achieved through the DSRIP program to be in effect April 2021 through March 31, 2024. New York State proposes to focus high priority objectives that are aligned with federal priorities. These include Substance Use Disorder and the Opioid Crisis; Serious Mental Illness and Severe Emotional Disturbance care; Social Determinants of Health with a continued focus on Primary Care Improvement. The expected results, improving patient-centered care, and the integration of behavioral health, physical health and social service delivery proposes to build on the successful formula employed by DSRIP over these past four years. I strongly support the evolution and continuance of this effective and patient focused initiative targeting our needy and deserving New York State residents. Capital spending in physical health and integrated social services delivery to New Yorkers has proven to be a wise investment .

Thank you,
Miriam T Vincent, MD, PhD, JD

Miriam T Vincent, MD, PhD, JD
Executive Director for Healthcare Innovation and DSRIP
Medical Director of Ambulatory Care
University Hospital of Brooklyn
SUNY-Downstate Medical Center
[redacted]

## doh.sm.1115Waivers

**From:** Susan Koppenhaver [redacted]
**Sent:** Friday, October 11, 2019 12:50 PM
**To:** doh.sm.1115Waivers
**Subject:** comments on Amendment proposal



Ladies and Gentlemen:

I fell I must comment on this proposal, having firsthand experience with the community and statewide frustration on the dearth of home care aides.

The proposal, although addressing Long Term Care Services, says nothing about the lack of funding toward a more equitable wage for the direct care worker in the State. You will not be able to keep seniors at home without adequate support in the form of aides, and the reimbursement from the DOH will play an integral part of this support.

I realize DOH Medicaid reimbursement is not part of the project goals; however, your best laid plans for Long Term Care support for anyone living at home will have to include aide service for any populations you mention, including MH/BH clients, seniors, disabled living at home, etc. None of these ambitious programs will be successful without a drastic rethinking of the reimbursement methodology and outlook on the direct care work, and the career they might have given a better salary.

Thanks you for allowing comments

**Susan Koppenhaver, MPH**
**Director**
**Ulster County Office for the Aging**
**1003 Development Court**
**Kingston, New York 12401**
[redacted]

**doh.sm.1115Waivers**

**From:** Peggy Sheng [redacted]
**Sent:** Wednesday, October 16, 2019 11:58 AM
**To:** doh.sm.1115Waivers
**Subject:** Comments on DSRIP 2.0 Renewal
**Attachments:** DSRIP Renewal Public Comment - CAIPA.pdf



Dear Sir or Madam,
Please see the attached comments.
A hardcopy is en route to you as well.
Thank you very much.

Warmest Regards,

*Peggy Sheng*

202 Canal St Ste 500 | New York, NY 10013 | [redacted]

October 16, 2019

NYS Department of Health
Office of Health Insurance Programs
Waiver Management Unit
99 Washington Avenue
12th Floor, Suite 1208
Albany, NY 12210

**Re: Public Comments on Proposed MRT Waiver Amendment for DSRIP Extension/Renewal**

Thank you for the opportunity to provide comments on New York State's proposal for a renewal and extension of the DSRIP program. The Coalition of Asian-American IPAs (CAIPA) is a community-based network of health care practitioners that serves nearly 500,000 individuals in New York City. As a leader in risk-based contracting, a participant in the DSRIP process, and a partner of the Collaborative Care for Brooklyn (CCB) PPS, we have supported and continue to strongly support the State's goals for the extension and renewal of the DSRIP program. We fully agree with the DOH's aim of providing more time and resources to ensure that New York Medicaid providers and payers will put into place sustainable, value-based payment models with a focus on achieving the Triple Aim.

In the last year, CAIPA has taken many steps to help improve its own value-based contracting and population health capacities. Most prominently, we have applied for the designation of our Medicaid ACO entity, CAIPA Care, as a VBP Innovator, with the support of our MCO partner, Healthfirst. If and when approved, we intend to form one of the State's largest Level 2 contracts and one of the first structured through the Innovator program in collaboration with Healthfirst. With a well-established, integrated network of over 1,000 physicians and other health care practitioners that has successfully operated with risk-based contracts in New York's Asian-American communities for over twenty years, CAIPA possesses the experience, organizational capacity, and cultural competence needed to drive the achievement of the goals the State has established in this waiver proposal. In partnership with DOH, we are ready and eager to continue the pursuit of improved care.

<u>The State Should Require VDEs to Include Vital Community-Based Providers</u>
CAIPA is encouraged by DOH's aim to broaden the PPS concept through the establishment of new Value-Driving Entities (VDE), and its statement that VDE "governance would include additional representation from community-based providers, including primary care, behavioral health, and long-term care." For many populations, VBP contracts will not be successful if they only involve hospitals and health systems, and not the community-based providers who are members' first and ongoing contact points with the system. PPSs were intended to include a wide range of stakeholders in governance as well, but in practice, this has had varied results,

with many PPSs dominated by hospitals and health systems rather than representing the full range of care providers—in particular, independent primary care providers who were intended to be the front line of DSRIP.

We appreciate that expanded VDEs will need to be careful to maintain a sharp focus on achieving the renewed DSRIP goal—ensuring the establishment of sustainable VBP contracts that incorporate the full spectrum of providers within a local community. This is why the State stipulates that VDEs "will be required to bring MCOs in the region into the management and operational structure." To this end, we encourage the State to expand this requirement to include vital community-based primary care, behavioral health, and long-term care providers (defined as those who serve a large proportion of a VDE's attributed population) into the structure.

Attribution Must Be Based on Real Provider Relationships and Shared with VDE Partners

The PPS population attribution model was extremely complex and opaque to many DSRIP participants. Improving the attribution model will be even more crucial for the success of VDEs and ultimately impacting the ability to maintain the successes of PPSs. We presume that VDE attribution will be intended to help drive the formation of concrete, ongoing VBP service contracts, rather than primarily guiding the implementation of general network integration, clinical improvement, and population health projects as in the original DSRIP waiver. As such, VDEs must have a serious and genuine connection with the members who are attributed to them, in turn helping to build a stronger connection between the members and the providers of the VDE.

This attribution must be more flexible and adaptable than PPS attribution, so that it can match the reality of changing care patterns. In the original waiver, "attribution for valuation" never changed at all, meaning that the PPS's available funds, which were intended to reflect the ambitiousness of the PPS's goals and scope of their population, ended up being unrelated to the actual activities of the PPS. In fact, "attribution for valuation" and "attribution for performance" should not be separate concepts. More details and stakeholder involvement in this process must be a top priority of the renewed DSRIP program. At minimum, at all times, all partners meaningfully participating in the VDE's activities to support VBP contracting must be aware of the members who have been attributed to them.

Performance Measurement Should Be Simpler and More Transparent

The draft waiver application states that a list of measures agreed with CMS "will be used for performance payment under the amendment" and could be based on "improvement across the entirety of the measure set, not just on measures attached to individual projects." We agree that these would be positive changes to the DSRIP performance-based payment structure. To be effective, performance-based incentives must be clear to the participants, and they must have an actionable path towards achieving them. We urge DOH and CMS to consult widely with stakeholders before establishing a firm structure for performance-based payments which could result, as sometimes occur under the existing DSRIP program, in payments hinging on changes

in attribution (e.g., member churn), insufficiently granular measurement, or other factors that are outside the control of providers. Additionally, we encourage the State to also move towards focusing on a select number of measures that matter most, rather than the multiple varying measure sets that have inundated providers in the past, causing burden and fatigue in reporting while taking time away from direct services and care to patients.

Social Determinants of Health Interventions Could Be Funded as Services

CAIPA strongly believes in the power of primary care providers to help achieve health status improvements through prevention and wellness initiatives. We operate a Social Day Care center for senior citizens that offers food, social activities, health assessments, and culturally sensitive linkages to the community. Such initiatives are part of our commitment to addressing social determinants of health (SDH) and working with CBOs who provide services that affect SDH. Undoubtedly, many DSRIP promising practices fall into these categories, and these interventions will in the long run be the best route to improving population health and thereby reducing acute care costs.

As such, we support the draft waiver's SDHN concept and encourage the State to consider creating a structure under the waiver to make such services explicitly reimbursable with Medicaid funds. We understand the State's goal to flow funds through MCOs whenever possible, and therefore encourage the State to consider the adoption of a standardized service documentation structure that would make it possible for SDH providers to be reimbursed through MCOs for the costs of service provision. This would not need to reduce the focus on including SDH interventions and collaborations with CBOs as a common part of VBP contracts. In fact, it could help by establishing a statewide standard that would provide a starting point for discussions between MCOs, health providers, and CBOs, allowing them to tailor payment structures and delivery systems to the needs of their populations.

Thank you again for the opportunity to provide feedback on the DSRIP waiver renewal. CAIPA is ready to help support the program to the best of our ability. We welcome further engagement with the State and with other stakeholders.

Best,

Dr. George Liu, MD, PhD
President and CEO, Coalition of Asian-American IPAs

## doh.sm.1115Waivers

**From:** Jef Sneider, MD [redacted]
**Sent:** Thursday, October 17, 2019 9:58 AM
**To:** doh.sm.1115Waivers
**Cc:** [redacted]
**Subject:** 1115 Public Forum Comment



I think the goals and methods of DSRIP 1 were good. Getting medical and behavioral health providers to work together and to work with CBOs should be a benefit to the program in terms of reduced urgent visits and even hospitalizations.

One barrier to better care is the lack of access to primary care. When St. Joseph's Hospital increased the size of their emergency room a few years ago and started to treat more patients, one of their first problems was the lack of doctors who would accept referrals for post acute care. St. Joes had to hire doctors and expand their own PCP practices to accommodate the need, but still have a shortage of places to send patients after an ER visit.

My suggestion is that as part of any DSRIP 2, reimbursement to any PCP practice that accepts new DSRIP patient referrals should be increased to equal Medicare payments. Increasing the number of practices that accept Medicaid patients will decrease the need for emergency room visits and facilitate referrals from urgent care and emergency rooms to the PCP.

Thank you,

Jef Sneider, MD

**Dr. Jef Sneider, MD, FACP**
*Medical Director*
*HIE Customer Engagement Services*

HealtheConnections
Franklin Center, Suite 001
443 North Franklin Street
Syracuse, NY 13204

[redacted]

## doh.sm.1115Waivers

**From:** Paula Gorman [redacted]
**Sent:** Wednesday, October 23, 2019 10:41 AM
**To:** doh.sm.1115Waivers
**Cc:** Paula Gorman
**Subject:** 1115 Waiver DSRIP Amendment Request



Dear Colleagues:

Thank you for giving us the opportunity to provide comments to the Department of Health regarding the 1115 Waiver: Delivery System Report Incentive Payment (DSRIP) Amendment Request, dated September 17, 2019. Southgate Medical Group, LLP has been actively engaged in NYS DSRIP and a partner of Community Partners of WNY (CPWNY)/Sisters of Charity Hospital Performing Provider System (PPS) since 2015.

We have benefitted from our participation in this initiative in the following ways:

- Two main areas that our patients and practice found direct benefit of this program:
- 1) We have collaborated with Spectrum Health Services to have integrated on-site behavioral health providers.
- 2) DSRIP funding has allowed our practice to focus more intently on access and quality measure for our Medicaid population. Many in this population do not mind coming in or getting their services done, they merely need a bit of prompting or assistance which we are now able to do as I was able to assign a staff member to these functions.

CPWNY has been an effective change agent in Western New York. The work has just begun! We anticipate a favorable outcome of the 1115 Waiver DSRIP Amendment Request. We strongly endorse the work of CPWNY PPS. They are critical to the success of future DSRIP initiatives.

Sincerely,

Paula Gorman
Chief Operating Officer
Southgate Medical Group
[redacted]

## doh.sm.1115Waivers

**From:** Askew, Yvonne [redacted]
**Sent:** Wednesday, October 23, 2019 2:08 PM
**To:** doh.sm.1115Waivers
**Cc:** Askew, Yvonne
**Subject:** Amendment proposal to the Centers for Medicare and Medicaid



Dear Colleagues:

Thank you for the opportunity to provide comment to the Department of Health regarding the 1115 Waiver: Delivery System Report Incentive Payment (DSRIP) Amendment Request, dated September 17, 2019. The Faith Community Nurse Program at Catholic Health has actively partnered with Community Partners of WNY (CPWNY)/Sisters of Charity Hospital Performing Provider System (PPS) September 2017.

We have benefitted from our participation in this initiative in the following ways:

- Provided the community with the "Congregational Health Promoters" training that resulted in Eight (8) congregational members with the knowledge and skill to begin a health/visitation ministry, impacting not only their belief system but also the surrounding community.

CPWNY has been an effective change agent in Western New York. The work has just begun! We anticipate a favorable outcome of the 1115 Waiver DSRIP Amendment Request. We strongly endorse the work of CPWNY PPS. They are critical to the success of future DSRIP initiatives.

Yvonne Askew, MSN.Ed., RN-BC
Faith Community Nurse
FCN Coordinator - Mission Integration
Catholic Health Buffalo
144 Genesee Street | 5th Floor | Buffalo, New York | 14203
[redacted] Web: www.chsbuffalo.org
"Making good stewards of what God has given!" (R)

## doh.sm.1115Waivers

**From:** GEORGE WRIGHT [redacted]
**Sent:** Wednesday, October 23, 2019 5:42 PM
**To:** doh.sm.1115Waivers
**Cc:** Raul Vazquez; Jason Isbrandt
**Subject:** 1115 Public Forum Comment



Good Evening,

Please accept the following three comments / questions from Dr. Raul Vazquez, President and Chief Executive Officer of Greater Buffalo United Accountable Care Organization. If you have any questions, please feel free to contact Dr. Vazquez at the copied email.

Sincerely,
George Wright
Greater Buffalo United Accountable Care Organization

1. In Buffalo, black and Latino community members disproportionately experience chronic illness and a shortage of Medicaid-accepting primary care. This is particularly true on Buffalo's largely minority East Side. Not surprisingly, these community members are much more likely to seek medical services in a hospital emergency department. Will DSRIP 2.0 make targeted primary care investments in communities that most need this assistance? One of our two area PPS, based at a hospital, has spent significant capital building a new hospital emergency department. This seems completely contradictory to not only the purpose of DSRIP but also the dire need for primary care capacity in Buffalo's minority communities.

2. The Draft Amendment suggests the creation of CBO regional referral networks (1 per State-defined region) to coordinate and address social determinants of health interventions. What is the evidence base that such a top-down, government-inspired "Social Determinant of Health Network" would achieve the objectives explained on page 10 of the Amendment? CBOs are even less-well organized to integrate services than health care providers. Furthermore, enabling VDEs and antiquated PPS structures to assume the role of "lead entities" for CBOs' work sounds like a money-grab opportunity for, in the case of PPS, organizations that have absorbed enormous amounts of taxpayer dollars for 'administrative expenses.' The investment in SDH makes good sense. To funnel funds through hospital PPS, however, would be a slap in the face to CBOs, the Medicaid beneficiaries they assist, and the taxpayer. Instead, allow for multiple SDH networks per region and do not allow PPS or hospitals to apply for lead entities.

3. The Draft Amendment suggests that selected VDEs will exhibit likelihood of 100% sustainability from value-based agreements within three years. At present, the only entities legally eligible to pursue value-based agreements are IPAs and ACOs. Because IPAs lack certain safe harbors related to self-referral and anti-kickback statutes, is it the State's intention to emphasize ACOs as the primary mode of VDE?

## doh.sm.1115Waivers

**From:** Baroody, Patricia [redacted]
**Sent:** Thursday, October 24, 2019 10:21 AM
**To:** doh.sm.1115Waivers
**Subject:** 1115 Public Forum Comment
**Attachments:** DSRIP 2.0 Public Comment 102319.pdf



Good morning,
Please see the attached comments related to DSRIP 2.0.

Thanks for the opportunity!

*~ Patty*

***Please follow this link to provide input for the future of aging services in Steuben County. Your opinion matters. Contact us if you need assistance completing this survey!***
***https://www.surveymonkey.com/r/2019OFA-NAS***

***Patricia A. Baroody***
***Director***
***Office for the Aging***
***Steuben County Office Building***
***3 East Pulteney Sq***
***Bath NY 14810***
[redacted]

NEW YORK STATE | NY Connects
Your Link to Long Term Services and Supports
of STEUBEN COUNTY

3 East Pulteney Square
Bath, NY 14810-1510
Phone (607) 664-2298
Fax (607) 664-2371
OFAInfo@SteubenCountyNY.gov

**Steuben County**
**Office for the Aging**
Patricia Baroody, Director
*The new age of aging --*
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(800) 342-9871 607-664-2322

October 23, 2019

To Whom It May Concern:

Please accept this correspondence as written comments regarding the 1115 waiver DSRIP Proposed Amendment. I am an Area Agency on Aging Director and a board member of the Association on Aging in New York with a 20 year history working in the aging network. I applaud the intent of DSRIP to reduce avoidable hospitalizations and emergency room visits, and to better coordinate care for better outcomes and cost savings.

Under DSRIP, the aging network, as a whole, embraced and was optimistic about the potential for revolutionary change of the complex and often inefficient interface of the health care/ community based organization collaboration. Most partners are in agreement that we spend far too much for, often times, dismal outcomes in this arena. Without a well-developed CBO interface, consumers often present in acute care settings for challenges that could often be addressed or prevented through community services.

The Area Agencies on Aging (AAAs) are hoping that in DSRIP 2.0, we will be able to partner to take concrete steps to create an interface of CBO services with acute health care management and discharge planning. We would like to see DOH mandate the use of existing systems wherever possible. While our colleagues in healthcare often have a good understanding of what the aging/disabilities network offers, they lack the capacity to stay abreast of the daily changes in the community-based service delivery system, which has evolved dramatically in the past 15 years. Care management for specific populations on the community side is best handled in the very cost-effective aging network with the well-developed NYCONNECTS program as an easy portal of access to all services. It is unlikely that the hospital social worker could or should follow the discharged patient on an ongoing basis once he returns home. The AAA network has a well-established case management system that trains and certifies case managers to perform at a very high and consistent level in all areas of the state. Not only is there consistency, but our case managers have a wealth of knowledge and understanding of the complex network of services available within the communities to meet specific needs.
Beyond the short-term home health care, some individuals require ongoing custodial care or supportive services.

In the current design, a high-functioning health care system would serve the patient through the acute crisis then hand them off to the community counterpart for interventions related to the social determinants of health. In DSRIP 2.0 we need to be clear about what AAAs do and what we do not do to avoid missteps and inappropriate referrals that delay services. It is imperative that the next phase of DSRIP formally include AAAs and the aging network in the operational and process planning to ensure that the desired outcomes are achieved.

Lastly, the aging network delivers core services in every county in NYS, so we encourage a regional approach to simplify contracting and speed up implementation. There is no time to waste. Future service delivery would be improved, and our mutual consumers of services would benefit greatly, if it was mandated to include AAAs in the Social Determinant of Health Networks (page 10 under Coordinated Population Health Improvement).

Thank you for your consideration on giving a greater voice to the Aging population in New York State and the network that serves them.

Sincerely,

Patricia A Baroody

Patricia A. Baroody
Director

## doh.sm.1115Waivers

**From:** Robin Mann [redacted]
**Sent:** Thursday, October 24, 2019 12:00 PM
**To:** doh.sm.1115Waivers
**Subject:** FW: Action Requested by Mon, 11/4: DSRIP 2.0 Public Comment



Partnering with Community Partners of WNY. provided the Erie County Council for the Prevention of Alcohol and Substance Abuse, Inc. (ECCPASA)an opportunity to implement substance –use prevention programming to approximately 20000 school-aged children in schools throughout Erie County. The partnership and support afforded parenting programming for over 100 attributed families. Without the support of this partnership, many of the children and families in Erie County would not have been served. ECCPASA is grateful for the partnership support of DSRIP initiative and the Community Partners of WNY.

~Robin

Robin Mann, LMSW
Executive Director

Erie County Council for the Prevention of
Alcohol and Substance Abuse
1625 Hertel Avenue
Buffalo, NY 14216

[redacted]

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**From:** Bullis, Kyle [redacted]
**Sent:** Wednesday, October 23, 2019 12:58 PM
**To:** [redacted]
**Subject:** Action Requested by Mon, 11/4: DSRIP 2.0 Public Comment

Dear Robin:

As you may be aware, the New York State Department of Health (NYSDOH) has released **the draft of an amendment proposal** to the Centers for Medicare and Medicaid Services (CMS) for the Medicaid Redesign Team (MRT) waiver. In the proposed amendment request, NYSDOH is requesting $8 billion for a full four-year extension/renewal period to continue and refine the work of DSRIP across the State. For more information, visit the **CPWNY website**.

Community Partners of WNY is proud to have partnered with your organization to affect change and to improve care and access for Medicaid beneficiaries in Western New York. We hope to continue in the future and are asking for your support. If you feel your organization benefitted as a CPWNY partner, please consider

taking a few moments to make your voice heard. A public comment guide is included below for your convenience, or you may wish to create your own.

Written comments may be submitted by email at 1115waivers@health.ny.gov or by mail at the address below. All comments must be postmarked or emailed by **November 4, 2019.**

NYS Department of Health
Office of Health Insurance Programs
Waiver Management Unit
99 Washington Avenue
12th Floor, Suite 1208
Albany, NY 12210

If you have any questions, please contact Amy or Phyllis at the contact information listed below. Thank you for your continued partnership.

**Amy L. White-Storfer, MBA, PMP**
Director, Project Management Office
[redacted]

**Phyllis G.M. Gunning, MPH**
Director, Clinical Programs
[redacted]

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CPWNY Public Comment Guide

Dear Colleagues:

Thank you for the opportunity to provide comment to the Department of Health regarding the 1115 Waiver: Delivery System Report Incentive Payment (DSRIP) Amendment Request, dated September 17, 2019. [Name of your organization] has been actively engaged in NYS DSRIP and a partner of Community Partners of WNY (CPWNY)/Sisters of Charity Hospital Performing Provider System (PPS) since [approximate start date].

We have benefitted from our participation in this initiative in the following ways:

- [how has participation in DSRIP/CPWNY benefitted your organization; for example, expanded programs, established new collaborations, improved quality, examples of benefits to community, tell a meaningful patient story, etc.]

CPWNY has been an effective change agent in Western New York. The work has just begun! We anticipate a favorable outcome of the 1115 Waiver DSRIP Amendment Request. We strongly endorse the work of CPWNY PPS. They are critical to the success of future DSRIP initiatives.

## doh.sm.1115Waivers

**From:** Edward Cichon [redacted]
**Sent:** Friday, October 25, 2019 8:56 AM
**To:** doh.sm.1115Waivers
**Cc:** [redacted]
**Subject:** 1115 Public Forum Comment
**Attachments:** Cazenovia Recovery DSRIP Comment.pdf



Hello there!

Thank you for accepting public comments DSRIP 2.0. Attached is a signed letter from Cazenovia Recovery's CEO with some recommendations.

Thanks.


**Ed Cichon**
**Director of Marketing & Communications**
[redacted]
Administrative Office | 2671 Main St., Buffalo, NY 14214
www.cazenoviarecovery.org

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2671 Main St.
Buffalo, NY 14214
716.852.4331

Casa Di Vita
200 Albany St.
Buffalo, NY 14213
716.882.2108

Cazenovia Manor
486 N. Legion Dr.
Buffalo, NY 14210
716.822.8932

Housing Programs
1430 Main St.
Buffalo, NY 14209
716.894.7298

Madonna House
5586 Niagara St. Ext.
Lockport, NY 14094
716.438.9131

Niagara County Office
& Supportive Living
76 West Ave.
Lockport, NY 14094
716.282.8510

Somerset House
7397 Lake Rd.
Appleton, NY 14008
716.795.3719

Sundram Manor
431 Memorial Pkwy
Niagara Falls, NY 14303
716.284.6228

Supportive Living
(Erie County)
1430 Main St.
Buffalo, NY 14209
716.894.7274

Turning Point House
9136 Sandrock Rd.
Eden, NY 14057
716.992.4972

Unity House
923 Sycamore St.
Buffalo, NY 14212
716.884.4952

David Nelson,
President

Suzanne Bissonette,
CEO


October 25, 2019

New York State Department of Health
Corning Tower
Empire State Plaza,
Albany, NY 12237

RE: DSRIP 2.0 Public Comments

I commend the state's efforts to continue to evolve the DSRIP process, as it's been an essential part of effectively transitioning New York State's healthcare sector the last few years. The first round of DSRIP was critical to the survival of the state's hospitals and other large healthcare networks, and I'm excited to see it expanded.

With DSRIP 2.0, it's extremely encouraging to see a heightened focus on both the Social Determinants of Health and the important work of community-based and social care organizations. I believe that this is a fantastic development within DSRIP 2.0 and should be emphasized strongly.

I currently work for a CBO that recently went through capacity-building efforts thanks to foundations in Western New York. We've spent the last few years preparing for the upcoming transition to a new value-based system. As such, I believe that my perspective may be helpful in this public comment period. I have four primary recommendations in the paragraphs below.

First and as mentioned previously, bringing attention to the importance of the Social Determinants of Health and CBOs in general is promising. I hope that policy will be developed in a way that truly enhances the work of CBOs. We've been at the front lines of our communities saving lives for decades, and our work is understandably impactful within our neighborhoods. Please keep this focus and continue to emphasize it throughout the policy development process.

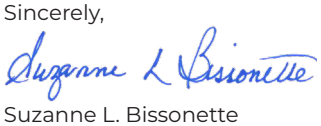
Second, as CBOs, we need to ensure that we retain our identity as truly being community-based. Encouraging further collaboration between large healthcare networks and CBOs is crucial to properly addressing the Social Determinants of Health. However, this creates the potential for CBOs and their work to be absorbed entirely by larger healthcare organizations. If this were to happen, the grassroots connection with the community could be lost, and that could have a significant impact on our ability to complete our missions. This collaboration is essential, but the goals should be mutually beneficial and not prioritize the work of one over the other. Above all else, it should prioritize a culture of embracing the "community" in community-based organizations.

Third, I agree with the goal of expanding workforce development efforts. CBOs and social care organizations across the state are currently confronting a workforce and recruitment crisis that has only exacerbated in recent years. While statewide attention and one-time injections of funding into our organizations are welcome, these two solutions will not effectively address this issue as the primary driver of the workforce crisis is low pay rates throughout the sector. Dedicated, continued, regular, and predictable funding will bring reprieve for our organizations and our staff.

Finally, I believe it is absolutely critical to continue our state's focus on addressing the opioid epidemic. The crisis is nowhere near over, and maintaining emphasis on this issue will no doubt save lives and reduce hospitalizations. I'm glad to see the opioid crisis as an area for continued investments and improvements in the current plan. However, while creating new initiatives mentioned in the plan will be helpful, CBOs focused on the crisis are struggling to staff already-existing programs. Similar to hospitals, the infrastructure within the field of substance use disorders has it start in the late 1990s. As such, programs are facing significant infrastructure deterioration. Capital dollars are needed for crumbling infrastructure that can surely be identified by the state. Increasing funding for current OASAS-licensed programs to a level that allows us to properly address the crisis should be part of the plan, as well.

Thank you for the important work you're doing and for receiving public comments. I look forward to hearing more about DSRIP 2.0.

Sincerely,



Suzanne L. Bissonette
CEO

## doh.sm.1115Waivers

**From:** Juan Pinzon [redacted]
**Sent:** Friday, October 25, 2019 12:14 PM
**To:** doh.sm.1115Waivers
**Subject:** MRT Public Comment
**Attachments:** 19_10_23 MRT Amendment Request Comments.docx; ATT00001.htm



Hi,

Please find attached the Community Service Society's comments on MRT's amendment request which I will be delivering in person today at the Public Hearing.

Best,

Juan C. Pinzon
Director of Health Services
Community Service Society

Sent from my iPad

Community Service Society | Fighting Poverty Strengthening New York

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**David R. Jones**
President & Chief Executive Officer

**Steven L. Krause**
Executive Vice President &
Chief Operating Officer

October 25, 2019

New York State Department of Health
Medicaid Redesign Team

Re: Comments of the Community Service Society of New York on the Delivery System Reform Incentive Payment (DSRIP) Amendment Request

Dear Medicaid Redesign Team,

The Community Service Society of New York (CSS) is grateful for the opportunity to provide comments on the Medicaid Redesign Team's Delivery System Reform Incentive Payment (DSRIP) Amendment Request.

CSS helps approximately 130,000 New Yorkers enroll in health coverage or otherwise access health care every year. CSS provides services through nearly 50 community-based organizations in every part of the state and provides those organizations with technical assistance, capacity-building, and planning for sustainability. CSS has worked closely with OneCityHealth, New York City's largest Performing Provider System, to increase CBO engagement and readiness to participate in value-based purchasing arrangements. For that project, CSS intensively interviewed and assessed 52 community-based organizations about their efforts to work with health care providers to improve the health of their clients.

As New York moves forward with DSRIP, CSS urges it to prioritize capacity-building beyond hospitals and large medical systems. We are pleased to see that the Medicaid Redesign Team recognizes the importance of non-clinical services and community-based organizations in the amendment request. The Social Determinants of Health Networks is a promising concept that could lead to better integration of CBOs into the health care system. CSS agrees with the Medicaid Redesign Team that a network of CBOs is the best strategy for addressing non-clinical needs like housing, nutrition, transportation, interpersonal safety, and toxic stress. However, CSS has recommendations for implementing the networks based on our direct experience administering five networks of CBOs throughout New York State, assessing CBOs about their readiness of value-based payments, and our own analysis of DSRIP 1.0.

1. **Community-based organizations should be able to form lead entities and apply for DSRIP support as Social Determinant of Health Networks.**

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One of the guiding principles of DSRIP was that positive health outcomes are driven by care provided outside of hospitals including social services. However, most DSRIP funding flowed directly through hospitals resulting in much fewer investments in non-clinical services provided by CBOs than many observers, including CSS, had hoped for.

Creating Social Determinant of Health (SDH) Networks that pool CBO expertise is an important way to introduce more balance into the relationship between CBOs and large health systems. However, if the lead entities of those networks are PPS or Value-Driven Entities, the same dynamic will reoccur. The amendment request suggests that CBOs will be part of the leadership of the new Value-Driven Entities along with PPS and managed care organizations. However in light of the lessons learned during the first five years of DSRIP, this seems unlikely – particularly as engaging CBOs in leadership is not part of the performance measures that determine payment for any entity participating in DSRIP.

New York has a robust, multi-decade tradition of directly contracting with CBOs through its facilitated enrollment, Navigator, and consumer assistance programs. The State should only permit CBOs or coalitions of CBOs to serve as lead entities of the SDH Networks. CBOs should be able to create their own networks with their own governance structure and apply for DSRIP funding to develop their network into an equal partner with health care systems. This would be a far more effective way of building a strong social services sector that can handle health care referrals than asking MCOs or provider systems to create such a network.

2. **New Yorkers need more clarity on how the Medicaid Redesign Team proposes to use the $1.5 billion it requests for Social Determinants of Health funding. CSS recommends that this money flow directly to CBOs who provide non-clinical social services as part of capacity-building project.**

The assessments conducted by CSS and OneCityHealth revealed a deep need for more capacity building and infrastructure development in the CBO community. CBOs have the skills to provide vital services to New Yorkers, services that have enormous effects on health outcomes. But they do not always have the infrastructure or skills that it takes to contract with large health systems or MCOs, or to gather data in a way that shows the value of what they do.

CSS recommends that DSRIP funds be used to create a capacity-building program to support the social services sector. The capacity-building project should:

- Create peer learning communities. CBOs interested in partnering with the health care sector would receive technical assistance, targeted training, and networking opportunities as part of the peer learning community. This would prepare CBOs with less capacity to build up their infrastructure before joining the SDH networks.

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- Issue capital and technical support grants for CBOs to build and maintain state-of-the-art IT capacity that tracks outcomes and interacts with New York's health information networks (the RHIOs and SHIN-NY) and healthcare providers and payers, similar to the New York State Department of Health HEAL grants to healthcare providers.

Thank you again for considering our comments. Should you have any questions or seek further elaboration, please do hesitate to contact me at: [redacted]

Very truly yours,

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

## doh.sm.1115Waivers

**From:** Carla Braveman [redacted]
**Sent:** Friday, October 25, 2019 12:44 PM
**To:** doh.sm.1115Waivers
**Cc:** [redacted]
**Subject:** MRT Public Comment
**Attachments:** HPCANYS Medicaid Waiver Recommendations 10 25 19 submitted.pdf



Thank you for the opportunity to provide both public and written testimony today.
We are available for any questions and look forward to fuller integration of hospice and Palliative Care into the new DSRIP models.

*Carla Braveman, BSN, RN, MEd, CHCE*
*President and CEO*
*Hospice and Palliative Care Association of New York State*
*24 Computer Drive West, Suite 104*
*Albany, NY 12205*
[redacted]

Hospice & Palliative Care Association of New York State

**Hospice & Palliative Care Association of NYS**
24 Computer Drive W., Suite 104
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Ph: 518-446-1483 ▪ Fax: 518-446-1484 www.hpcanys.org

To: 1115waivers@health.ny.gov.
Re: "1115 Public Forum Comment"
Date: 10/25/2019

The Hospice and Palliative Care Association of New York State represents the majority of hospice providers in the state providing advocacy, education and technical assistance. Thank you for allowing public comment on the 1115 Waiver.

We appreciate all of the work done by the Department of Health and all of the acute and post-acute care providers who have participated in this meaningful process. Transforming care and access to care while bending the cost curve is not an easy task. New York State's Medicaid Redesign Team called for greater access to Hospice in MRT#209 and to Palliative Care in MRT#109. We were disappointed that only two projects were picked, likely because the scoring of palliative care was low. Yet the anecdotal information from hospices involved in these programs have shown better care coordination for seriously ill individuals, increased referrals to hospice care and decreased urgent and emergent care episodes thus bending the cost curve. This conforms with national data on Medicare and Medicaid use of hospice care during the terminal phase of life.

Research shows that hospice and Palliative Care improves clinical outcomes, enjoys improved consumer satisfaction, decreases hospitalization and rehospitalizations, increases days at home where we all want to be. Hospice and Palliative Care allows for maximization of Medicare expenditure while saving money for both Medicare and Medicaid.

As we submitted public comment on 7/10/19, we again submit public comment to encourage widespread adoption of palliative care and hospice across all PPSs in DSRIP 2020 and beyond.

In order to more fully utilize and integrate palliative care and hospice into the Medicaid Redesign Process, our recommendations are as follows:

1. **Promote the increased utilization of hospice care by requiring referral relationships with Article 40 licensed hospice programs as part of the continuum of care for all applicants.** 80% of the cost of care in a person's lifetime is spent in the last 6 months of life. Since its inception, hospice has been ahead of its time, focusing on delivering high-quality, holistic care to patients and families, with features that are only recently being adopted by the rest of the healthcare system. National attention is increasingly focused on patient-centered care, social determinants of care and improved care coordination, which have always been key tenets of hospice. National and state policies now aim to reduce unplanned hospital readmissions, excessive emergency visits, and

overuse of services – all of which contribute to a sharp rise in healthcare costs and all of which have been shown to be dramatically reduced by hospice to less than 2%. Hospice utilization in NY is one of the lowest in the country.

2. **Change the scoring of palliative care and hospice projects to expand the selection of these projects within each PPS.** Currently, the scoring is low and we have been told by PPS's that it discourages picking these as projects.
3. **Although we agree with and support the use of palliative care in nursing homes, we need to see palliative care available to all Medicaid recipients facing serious illness in the community.** All PPSs need to seek out palliative care services in hospital, nursing home and community settings. Further, these palliative care programs must have a contract with and working relationships with Article 40 licensed hospice providers to be able to provide cost effective, quality end of life care.
4. **Create a concurrent care Hospice pilot for Medicaid beneficiaries over age 18**. Currently, beneficiaries under age 18 can continue to receive cure focused care as well as hospice care. The hospice staff's medical and spiritual and psychosocial services help the patient and family more fully understand the impact of the treatment decisions. They experience the supports and good pain and symptom management available to them. At the appropriate time, they can then more readily transition to decide to discontinue futile treatment options. The binary choice to stop all curative treatment in order to be on hospice, which is a difficult and painful choice for patients and families to make, now goes away. In the end, it's better care for patients and their families. This care should be available for all New Yorkers. In addition, there will be cost savings. NY state already recognizes the benefits of hospice care by providing for a 1-year prognosis rather than 6 months. Unfortunately, it is not utilized because of the need to forgo treatment for hospice care.
5. **Create a Palliative Care Benefit Pilot Under Medicaid**. New York State has received a "B" grade by the Center for the Advancement of Palliative Care for the availability of hospital based palliative care programs, but we have only 34 post-acute care palliative care programs for the entire state. Palliative care is patient centered, affordable care that has a proven track record in reducing rehospitalizations. DSRIP pilots can create palliative care demonstration models with a payment source that compensates not just for physician reimbursement, but also for the care coordination and team approach that is required for good palliative care.

We have taken the liberty to add an addendum to this document that describes hospice and the value it brings to the consumer and to the payers.

Sincerely:

Carla Braveman, RN, M.Ed., CHCE
CEO and President

**Background on Hospice Care in New York's Healthcare System – High Quality, Cost Effective Coordinated Patient Care**

Hospice and Palliative Care Association of New York State ("HPCANYS") supports New York State's efforts to ensure the healthcare industry can better serve its residents through the various policies and programs established under Medicaid Redesign. However, implementation of such policies and programs usually does not consider the benefits that hospice and palliative care programs can provide across the healthcare spectrum of services. Increasing utilization of hospice care offers a unique opportunity for New York State to provide more cost effective and coordinated care to individuals at end of life. Yet, there now exists within the current policies and practices various barriers to access and disincentives to utilize hospice services.

New York State's population is aging. 3.2 million (or 1 in 6) residents of the state are over age 65. Hospice services are also 'greying' with the majority of hospice patients aged 85 and older. As we approach the aging of the baby boomers, hospice must be a key player in caring for the dying.

High costs in long term care are highly correlated to hospital stays and rehospitalizations as well as nursing home placements. Hospice has a **1-2%** rehospitalization rate compared to the hospital 30-day unplanned all-cause readmissions of **16%** in 2017. According to a 2017 Kaiser Health News study, New York hospitals have one of the highest readmission rates in the nation with 90% of New York hospitals penalized by Medicare for their readmission rates. When you consider Medicaid only patients, and those who have both Medicare and Medicaid, the avoidable cost to the Medicaid system for care or coinsurance can be significant. Considering the low rehospitalization rate of hospice care, as this is a cornerstone of hospice care, leveraging hospice care could dramatically impact New York's high rate of admissions and readmissions.

In addition, individuals want to die at home. One survey listed 80% would prefer to die at home, yet 60% of us will die in a hospital and 20% in a nursing home. Only 20% will die at home according to national studies. In New York, only 30% of Medicare decedents are on hospice at the time of their death compared to 49.8% nationally.

Now more than ever we need an increased focus on ensuring people diagnosed with a terminal illness and/or chronic disease or condition have access to hospice and palliative care that provides for the needs of the patient and caregivers in a more cost-effective approach.

**Hospice in New York State**

- Hospice and Palliative Care offers high quality, patient centered care to patients and their families
- Hospice is one of Medicare's most cost-effective programs
- New York State's Medicaid Redesign Team called for greater access to Hospice in MRT#209 and to Palliative Care in MRT#109. And yet, in New York State, hospice utilization and length of stay are extremely low and few DSRIPS chose palliative care as a project

**Hospice: A Model for Quality Health Care**

Since its inception, hospice has been ahead of its time, focusing on delivering high-quality, holistic care to patients and families, with features that are only recently being adopted by the rest of the healthcare system. National attention is increasingly focused on patient-centered care, social determinants of care and improved care coordination, which have always been key tenets of hospice. National and state policies now aim to reduce unplanned hospital readmissions, excessive emergency visits, and overuse of services – all of which contribute to a sharp rise in healthcare costs and all of which have been shown to be dramatically reduced by hospice.

As the U.S. healthcare system continues to evolve, the understating, integration, and acceptance of hospice care is both morally and fiscally good policy. For four decades, hospice has been a model of a holistic patient and family-centered approach to caring for people at the end of-life.

**Person-Centric, Holistic Care -**A plan of care is based on the patient's needs and wishes. This plan is re-visited bi-weekly by the patient and his or her interdisciplinary hospice team. Grief support is an important aspect of the services offered by hospice. After the death, the family is offered bereavement support for at least one year. Such follow-up is not available even in trauma response facilities, where families who have experienced tragedies are sent home with little or no support toward emotional recovery.

**Comfort-Based -**Hospice puts an emphasis on managing pain and other quality of life symptoms. Quality of life is the guiding goal, and hospices address pain and discomfort on the physical, psychological, social, and spiritual levels using both medical and nonmedical interventions, often more effective and cost-efficient than traditional curative healthcare models.

**Interdisciplinary-** Hospice is required by Medicare to be delivered by an interdisciplinary team, which includes nurses, doctors, health aides, social workers trained volunteers and clergy, and may also include dieticians and occupational, speech, and physical therapists, and dieticians. The patient and family are the center of the team.

**"Home"-Based-** In the United States, hospice has evolved to a home-based model. Most hospice patients are cared for at home, where studies have shown most patient prefer to be cared for at the end-of-life. A patient's home may be wherever he or she is living - their private home, a nursing home, or an assisted living facility. When it is not possible for hospice patients to die in what is thought of as their traditional home, they can receive inpatient hospice care in special inpatient units or hospice-contracted beds in hospitals or nursing homes.

**Efficient, high-quality healthcare-** Hospice patients are supported in a way that reduces emergency room visits and unplanned hospital admissions. While pain management is not a central focus in the health care system at large, hospice clinicians have considerable expertise in managing pain. Hospice contributes to better care, as its presence in nursing homes has been shown to correlate with better performance in pain management compared with nursing homes that do not partner with hospice providers. Patients with a terminal illness who die in hospitals have been found to have a poorer quality of life compared with patients who die at home with hospice care and support for them and their loved ones.

**Ongoing involvement-** Medicare requires that bereavement support be made available to hospice family members for up to a year after a death. Some hospices go even further by offering support groups to the whole community, sponsoring grief camps, and training grief professionals.

**Cost Effective Care-** not only does hospice enjoy high levels of consumer satisfaction as measured by the publicly available CAHPS surveys on the Medicare Hospice Compare website, hospice care has been proven to bend the cost curve at end of life by the avoidance of the hospital level of care. Specifically, there was one ACO in NY state who told their local hospice program that for every hospice patient, the ACO showed an $11,000 cost savings compared to other patients with the same diagnosis who did not chose hospice care. For those who are dually eligible, hospice is a way to provide high quality care while maximizing Medicare reimbursement relieving the burden on the Medicaid system for costly and ineffective treatment coinsurance dollars. Further, hospices with residences provide a living option under Medicaid that saves the state Medicaid long term care dollars at a lesser fee than a nursing facility.

## doh.sm.1115Waivers

**From:** Andrea Smyth [redacted]
**Sent:** Friday, October 25, 2019 3:29 PM
**To:** doh.sm.1115Waivers
**Subject:** 1115 Public Forum Comments
**Attachments:** 1115 Waiver Comments Final 102519.pdf



Attached are comments on the proposed continuation and renewal of the 1115 Waiver. The Coalition plans to testify in Syracuse on Oct 30.

The NYS Coalition for Children's Behavioral Health believes the next phase of the Waiver must include a number of children's community-based behavioral health focused priority investments, including:

- Expanded pediatric integrated health-behavioral health opportunities; and
- Supported transitional care teams for children and adolescents; and
- Bundled payments for episodes of children's crisis care; and
- Enhancements for Care Coordination, including expanded use of telemedicine for care coordination, and the development of Family care coordination models; and
- Enhanced rates to deliver Evidence Based Practices to achieve improved outcomes based on social determinant of health challenges; and
- Targeted investments into the children's behavioral health workforce to stand up the most effective and carefully designed community-based mental health service expansion in the country, expand productivity through the use of Evidence Based Practices, expand productivity by promoting the use of Artificial Intelligence to support quality documentation of care by non-clinical staff upon which the re-designed services rely.

*Andrea Smyth*
***Executive Director***
***NYS Coalition for Children's Behavioral Health***
[redacted]

NEW YORK STATE COALITION FOR
CHILDREN'S BEHAVIORAL HEALTH

# DSRIP Extension Comments
# 1115 Public Forum Comments

Submitted November 4, 2019

Delivered in Syracuse, NY on October 30, 2019

Thank you for this opportunity to comment on the extension of the MRT Waiver, an agreement between the federal Centers for Medicare and Medicaid Services (CMS) and New York State. The existing agreement allows the State to use a managed care delivery system to deliver benefits to Medicaid recipients, create efficiencies in the Medicaid program, and enable the expansion of coverage and benefits to certain children who would not otherwise access them. The NYS Coalition for Children's Behavioral Health supports New York's effort to continue the existing Waiver and renew an agreement through March 2024.

The MRT waiver allowed the State to implement initiatives recommended by the Medicaid Redesign Team. The recommendations of the Children's Subcommittee of the Medicaid Redesign Team will not be fully implemented until 2021. To date, the fact that children's specialty services and exempt child populations were not enrolled in Medicaid Managed Care, limited involvement in health systems reforms and the Delivery System Reform Incentive Payment (DSRIP) program. Now, however, the "children's transition" is well underway and the time is right to put additional focus on children's system of care efforts. And, to address the alarming trends in youth suicide rates, increased demand for early childhood behavioral health services and reforms that move foster youth from congregate care into the community, the NYS Coalition for Children's Behavioral Health believes the next phase of DSRIP must include a number of children's community-based behavioral health focused priorities:

- Expanded pediatric integrated health-behavioral health opportunities; and
- Supported transitional care teams for children and adolescents; and
- Bundled payments for episodes of children's crisis care; and
- Enhancements for Care Coordination, including expanded use of telemedicine for care coordination, and the development of Family care coordination models; and
- Enhanced rates to deliver Evidence Based Practices to achieve improved outcomes based on social determinant of health challenges; and
- Targeted investments into the children's behavioral health workforce to stand up the most effective and carefully designed community-based mental health service expansion in the country, expand productivity through the use of Evidence Based Practices, expand productivity by promoting the use of Artificial Intelligence to support quality documentation of care by non-clinical staff upon which the re-designed services rely.

We have embedded our recommendations directly into the quoted children's sections of the proposal

**Children's Population Health Section Excerpts:**

"Approximately 47% of the state's children are covered by Medicaid. The next implementation phase would extend successful practices to children in the areas of chronic care management**, behavioral health integration**, pediatric-focused patient-centered medical homes, and attention to **adverse childhood experiences** and social determinants."

- "Pediatric health-behavioral health integration," The Coalition supports building upon some of the successful practices identified in the First 1,000 Days report, building upon use of the Healthy Steps approach in pediatric primary care by combining it with physicians trained through Project Teach. Project Teach, designed by the State Office of Mental health trained pediatricians and family practitioner to screen and treat children and adolescents for mild to moderate behavioral health symptoms. If we applied the successful Montefiore VBP model to the Project Teach practices, and also embedded practitioners from designed Child and Family Treatment and Support Services (CFTSS) providers, a closed loop of early periodic screening, diagnosis and treatment can be created for children eligible for Medicaid from birth to 21 years of age. The Montefiore Model featured a care integration payment for behavioral health/primary care. A total of $3 million was available to cover 90,000 youth. The payments could be used for primary care screening of emotional/behavioral needs for the whole population (above 90% screening rate for the 90,000), the application of Healthy Steps (an early childhood development and effective parenting Evidence Base Practice) and coordinated care for the pediatric services, including brief OP for low to moderate needs youth (about 13,000 of the 90,000). DSRIP funding could expand the Montefiore Model to Project Teach practices and expand the model to embed CFTS services for the youth needs beyond the low to moderate level treatment needs.
- In addition, we recommend that a combination of state, federal (e.g. Integrated Care for Kids demonstration project) funds be combined for pilots to support **enhanced rates** to support the delivery of Evidence Based Practices (EBPs) through CFTS services that are integrated to serve children and adolescents who need treatment beyond mild to moderate behavioral health services. The CFTS services have already been approved by CMS to draw down Medicaid reimbursement to providers when they deliver certain EBPs. The expanded use of evidenced-based behavioral health services through the delivery of Child and Family Treatment and Support Services, can assist the state with stabilizing families in the community by using the most effective and research tested treatment of children with high Adverse Childhood Experiences (ACEs) score, reactive attachment disorders, impulse control diagnoses and when the family dynamics require whole family treatment. The provision of Evidence Based treatments add value to care delivery by definition – the outcome data is measured as part of the delivery compliance and by incentivizing the delivery of Evidence Based treatments in integrated care models and the referral
- "Care transitions and care management for targeted groups have been very successful and would be expanded to serve the 47% of the State's child population enrolled in Medicaid (this population)", The Coalition strongly supports inclusion of this priority and has a number of recommendations that support improved productivity, workforce retention and methods of using family care coordination models to more completely address social determinants of health. We suggest investment into the Health Homes Serving Children, specifically to address workforce challenges. Between 2016-2018, recently surveyed Care Management Agencies (CMAs) reported that 55% of their care managers left community behavioral health agencies to do care coordination in other settings. Yet, of the community-based CMAs surveyed, 68% reported they need to expand services and hire more behavioral health care managers. We support the expansion of telemedicine for care coordination as a best practice and to ease the workload burdens on care managers and training initiatives that teach evidence-based practices for care managers, including Hi-Fidelity Wrap. In addition, we support the development of Family care coordination models that support social determinants of health challenges and result in better family outcomes.
- "Expanding behavioral health urgent care centers for children has decreased emergency admissions and provided further access to care." This is a critical need and high priority. There is insufficiency of appropriate Crisis Intervention options for children.* In New York City, schools are under court order to reduced emergency removals to emergency departments. We support the use of DSRIP funding to implement pilots for case rate or bundled payment models—with performance targets—for responding to children in crisis. The services that could be combine in the pilot include Mobile Crisis, the Crisis Intervention benefit as defined in the CFTS service, OMH licensed Children's Crisis Residence programs (added by amending Part 589 of Title 14 NYCRR in 2019) and other crisis services available through CFTSS in the Other Licensed Practitioner benefit. Rather than additional "brick and mortar"

investments in urgent care centers, this case rate proposal allows for the provision of consumer specific support services, allowing providers to build a continuum in a community that involves multi-level partnerships with primary care, social services, schools, probation and substance use services. These systems would be augmented with telehealth and mobile interventions to provide rapid response service delivery, family engagement and better care coordination. The pilot would build upon existing residential resources for stabilization needs and the mobile crisis response component of the Crisis Intervention benefit that mandates de-escalation, assessment and referral occurs where the child presents in crisis – home, school, community. This approach supports maximizing "care without walls" and rapid referral to crisis residences when necessary. If a short-term, out-of-home crisis service is needed, the OMH Children's Crisis Residence program has a per diem cost of less than $900.00 and length of stay restrictions and should be considered to address the call for expansion of crisis stabilization program to minimize avoidable admissions.

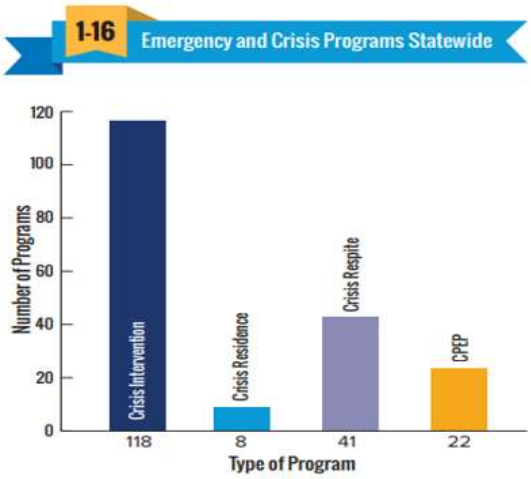
  - For children with SED, transitional care teams of clinicians and peers bridging psychiatric inpatient to community settings would be deployed. The Coalition strongly supports this priority and recommends careful and immediate consideration of a specific transitional and care management model for high needs youth populations. A high performing Evidence Based Practice (EBP) team care approach that is "shovel-ready" for Level 1 Value Based Payment agreements is the Youth Assertive Community Treatment (ACT) team. Youth ACT allows for monthly capitated payments from both Medicaid and local preventive services funding to a provider who wraps complete care around a child and family to bridge residential, juvenile justice or psychiatric discharges. The Youth ACT model has been applied in the Central New York Region by Oneida County for juvenile justice reunification and recidivism prevention and for foster care congregate care placement prevention with a 98% success rate. We believe the Youth ACT service can be applied to successfully bridging other residential and psychiatric inpatient discharge situations. This model has the potential to address some of the highest cost, complex needs, and challenging complex care discharge cases, that characterize the cross-systems, dually diagnosed, hard-to-place youth that remain in hospitals for months because of complex and intensive care needs.

- Use of telemedicine for care management of residential populations for ED triage and expansion of crisis stabilization programs would improve management of overall care and minimize avoidable admissions The expanded use of telemedicine not only supports rapid response, it is a workforce productivity tool. Between 2016-2018 recently surveyed Care Management Agencies (CMAs) reported that 55% of their care managers left community behavioral health agencies to do care coordination in other settings. Yet, of the CMAs surveyed, 68% reported they need to expand services and hire more behavioral health care managers. We support the expansion of telemedicine for care coordination as a best practice and to ease the workload burdens on care managers. We support the use of telehealth with families during residential stays for enhanced coordination and communication between family/youth and family/residential treatment teams. We strongly the support the expansion of crisis stabilization programs in the form of children's crisis residences, as avoidable admission diversion options, that bundle a case rate that includes mobile crisis, care coordination and other crisis intervention services into episodic payments.
- DSRIP Workforce Development component – It is essential that investments specific to the Children's Medicaid Transformation be prioritized both in the continuation of the current agreement and during the 3-year renewal. We believe the children's system of care workforce should be singled out for investments that support the Medicaid Redesign goals because the transition is still underway and because implementation requires training and re-training that the community based organizations that are the backbone of the children's behavioral health care systems do not have the resources to invest. The specific areas of workforce investment include: 1) re-training residential staff to enter the community-based workforce as reliance on residential is reduced; 2) investments in the start-up costs of Evidence Based Practice expansion, including fees, fidelity compliance and training time of staff with the confidence that EBPs can strengthen the work of non-clinically trained staff as valuable members of clinical team, standardize efficiency, quality and outcomes in a field that is in a chronic workforce shortage state; 3) investments in mobile workforce development, including necessary technology costs per worker (laptop, wi-fi card because of insufficient bandwidth in many rural areas, cell phones and mobile EMR modifications

to allow concurrent documentation of progress notes) and the purchase of Artificial Intelligence products that amplify the quality and value of non-clinical, direct care workers, like youth peer advocates, family peer advocates and psychosocial rehabilitation workers with tools that assist with excellence in treatment and progress note developed concurrently during treatment, but with little risk for error; 4) use funds to expand "Get on Your Feet" loan forgiveness program to allow 2 years of repayment for BA and MA level staff with qualifying loan burden that work in child-serving settings impacted by Medicaid Redesign; and 5) retention bonuses for care managers, licensed clinicians, direct care staff, mobile team staff who meet training and time of service milestones – which we believe is an economic development goal because a high percentage of the children's behavioral health care workforce is women and the economic stability that can be attained if parents do not have to work 2 jobs to support their families could be measured as a positive economic outcome of the DSRIP workforce investments.

*Crisis Service Array in OMH 5.07 Plan Update for 2018:

## Crisis and Diversion Must be a Priority




In closing, the NYS Coalition for Children's Behavioral Health supports the flexibility proposed to develop Value Driven Entities (VDEs). We believe the priority promising practices for children's behavioral health, like those we identify in our comments, would be best managed with leadership from BHCCs, IPAs formed for children's behavioral health management or an MCO with targeted interest in children's behavioral health Value Based Payment designs.

For additional information, please contact: Andrea Smyth
NYS Coalition for Children's Behavioral Health
[redacted]

## doh.sm.1115Waivers

**From:** Mason Kaufman [redacted]
**Sent:** Friday, October 25, 2019 4:07 PM
**To:** doh.sm.1115Waivers
**Subject:** 1115 Public Forum Comment
**Attachments:** Public Comments Meals on Wheels Syracuse to NYSDOH October 30, 2019.docx



Good Afternoon:

Attached is my written comment related to 1115 Public Forum for your records.

Mason

**Mason Kaufman, Executive Director**

**Meals on Wheels of Syracuse**
**300 Burt Street**
**Syracuse, NY 13202**

[redacted]

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***"SOMEONE IN OUR COMMUNITY IS WAITING FOR YOU... VOLUNTEER, DONATE,AND/OR TELL A HOMEBOUND PERSON IN NEED THAT MEALS ON WHEELS CAN HELP".***

## PUBLIC COMMENTS TO THE NYSDOH 1115 Public Forum Comment: October 30, 2019

My name is Mason Kaufman, Executive Director of Meals on Wheels of Syracuse, New York. My organization has as its mission the business of providing nutritious home delivered meals to homebound older and disabled adults who would be food insecure without some assistance for meals. We prepare, package and deliver nourishing hot and cold meals daily to those in need through a small staff and hundreds of volunteers.

A number of years ago, I was made aware of the DSRIP initiative through my local association for non-profits, the Human Service Leadership Council about joining the effort to help save healthcare dollars through the CNY Care Collaborative initiatives. I attended an IPRO Syracuse Care Transition Coalition meeting; a group of representatives from hospitals, rehab facilities, nursing homes, community healthcare services and a few community based agencies. Frankly, I thought I was part of a CNY Care Collaborative meeting at the time but later learned this Coalition meeting focused on Medicare healthcare savings. Regardless, that coalition and CNYCC combined meetings 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 healthcare savings? Then I read a report that 30-50% of U.S. seniors living in their community were entering hospitals malnourished, resulting in longer and more complicated stays and costing an additional $25 billion more in healthcare costs annually. The report also said the malnutrition was not always diagnosed in the hospital and seniors were being readmitted often as a result. The light bulb went off in my head and I saw our value in the conversation.

Meals on Wheels Programs were in the business of food security and nutrition. We could help to head off malnutrition. I alerted the IPRO/Care Collaborative group of this report and to their credit adopted a nutrition subcommittee that began monthly meetings between nutrition specialist from local healthcare institutions and CBO's. The group researched malnutrition screening protocols and put together a Nutrition Toolkit it presented as a best practice recommendation for hospitals and healthcare 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 what if all kinds of CBO's screened their clients for food insecurity and could link them to food providers? Would it lower hospitalizations and ER visits? The committee identified a research validated simple two question food insecurity screening tool.

> 1. "We worried whether our food would run out before we got money to buy more for my household in the last 12 months."
>
> 2. "The food that we bought just didn't last, and we didn't have money to get more for my household in the last 12 months."
>
> A response of "yes" to either question is an indication of food insecurity.

At that time, Innovation Grants were announced through the CNYCC and Hubs were formed to help distribute funds to CBOs interested in applying for grants. My agency joined the ARISE Hub which had dozens of CBOs who also joined. I realized this was the perfect structure to develop this food insecurity screening and linkage idea. I approached ARISE to partner as administrator and grant writer and help recruit Hub and other CBO partners. We recruited 23 other CBO screener or food provider agencies. The 12-month grant would provide agency screeners 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 screeners would then do three and six month benchmark follow up assessments to assure continuation of meals service, and assess the number of emergency room visits and hospital admits during those periods. Our outcomes would be: 1) move people from food insecurity to food security; and 2) reduce the rate of hospitalization and/or ER use among food insecure individuals in the project. I am pleased to report, the grant was accepted for funding and we are in process of getting it started very soon.

Without CNYCC building this collaborative environment between healthcare partners and CBO's; without CNYCC building this sharing and learning environment for CBO's to develop their value propositions toward impacting healthcare savings; without CNYCC providing pilot funding for innovative ideas, my idea and dozens of other promising innovative ideas would never have been born, let alone acted upon. You have seen promising results in healthcare cost savings. This approach works! Social determinants of health have been shown to be a vital piece in healthcare savings. Bringing all the parties together is essential in positive healthcare outcomes and saving dollars. Continuing to investment in this effort makes sense. I remember an old commercial about car care which said, "Pay me now or pay me more later." I encourage that we continue to invest some on the front end of solutions to saving healthcare dollars, and save big on the back end in healthcare costs. I therefore support NYSDOH's four-year waiver renewal request for DSRIP Promising Practices funding.

Mason Kaufman, Executive Director
Meals on Wheels of Syracuse, New York Inc.
300 Burt Street, Syracuse, NY 13202
[redacted]

## doh.sm.1115Waivers

**From:** Julia Tsien [redacted]
**Sent:** Friday, October 25, 2019 5:15 PM
**To:** doh.sm.1115Waivers
**Subject:** Betances Health Center Comments on DSRIP 2.0 Concept Paper
**Attachments:** Betances Comments on DSRIP 2.0 Concept Paper.pdf



Betances Health Center is submitting its comments on the DSRIP 2.0 Concept Paper.

**Julia Tsien**
*Chief Executive Officer | Betances Health Center*
[redacted]
**website:** www.betances.org
[redacted]
**address:** 280 Henry Street, New York, New York 10002

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**May 1, 2020 at Capitale, New York. For more information,**
**contact: thorton@betances.org**

**Our Mission is:** to promote quality health care as a basic right for all, regardless of the ability to pay.

BETANCES HEALTH CENTER

280 HENRY STREET, NEW YORK, NY 10002 TEL: 212-227-8401

October 25, 2019

Betances Health Center is grateful for the opportunity to provide comments on the Delivery System Reform Incentive Payment (DSRIP) Amendment Request concept paper published on September 17th. Founded in 1970 as a grassroots mobile health unit bringing urgently needed medical services to the Lower East Side's medically indigent and homeless, Betances Health Center remains committed to its mission of promoting quality health care as a basic right for all, regardless of ability to pay. For forty-nine years, Betances Health Center has been providing adult and pediatric medicine, family medicine, family planning, HIV/AIDS care, testing, and counseling, women's health, prenatal care, podiatry, behavioral health, oral health, and complementary care services to low income residents of its service area. Since 2018, Betances added 2 satellites; one in the Bushwick section of Brooklyn and another at 40 Montgomery, NYC, 10002. In 2018, Betances served close to 5,000 unique patients generating over 26,000 total visits and has a majority of minority patients with over 65% Hispanic/Latino descent. Betances commends the State's work in the first round of DSRIP to reduce costs, improve patient outcomes, and decrease unnecessary inpatient and emergency room utilization. A true transformation of the health care delivery system that sustains the gains thus far achieved through DSRIP requires a significant investment in community-based primary care. Only through this investment can the State achieve a true value-based system that improves health outcomes and reduces costs. Betances supports the renewal of the DSRIP program through March 31, 2024. Betances, a member of the Community Health Care Association of New York State (CHCANYS), supports the comments submitted by CHCANYS and has restated and revised many of their points below.

## I. Driving Promising Practices to Improve Health Outcomes and Advance VBP

By mission and in statute, Betances, a community health center (CHC) is designated as an Federally Qualified Health Center (FQHC) under the Health Resource and Services Administration (HRSA). It serves the State's most vulnerable and hard to reach populations. FQHCs are non-profit, community run centers located in medically underserved areas that provide high-quality, cost effective primary care, including behavioral and oral health services, to anyone seeking care. Our 13 member Board is governed by a 51% consumer-majority board of directors who are tasked with identifying and prioritizing the services most needed by their communities. 47% of our 4925 patients are enrolled in Medicaid or CHIP.
Our 3 sites – 2 located in Lower Eastside Manhattan, NY 10002 and 1 in Bushwick, Brooklyn, NY 11221 provide access to comprehensive primary care services, especially among populations that are most likely to present at the ED with a non-urgent or avoidable condition. In the first round of DSRIP, we participated in one Performing Provider Systems (the Mount Sinai PPS). Through the MSPPS, we engaged in collaborative initiatives and learning collaboratives which helped us achieve integration of behavioral health and primary care. The first round of DSRIP

complemented the health center model's unique and innate ability to provide comprehensive and innovative care to New York's Medicaid beneficiaries. Health centers played and continue to play a key role in advancing the promising practices within their regions and driving improved health outcomes. In the second round of DSRIP, health centers are well-prepared to take a leadership role to advance the State's vision of an expanded value-based payment (VBP) landscape driving DSRIP promising practices.

## II. Embracing the Role of VDEs

We are pleased to see that the State has acknowledged the need for additional flexibility in the next round of DSRIP and is interested in ensuring the success of Value-Driving Entities (VDEs). However, we encourage the State to provide direct investment in community-based providers. Currently, 23 of 25 of the PPS leads are hospital-based, with no specific requirements about how funds flow to partners in the PPS networks. Meaningful governance participation by community-based providers, such as community health centers and community behavioral health organizations, and downstream investments to health centers and other community-based providers varied greatly from PPS to PPS. Using publicly available data reported by the State, it is extremely difficult to determine the amount of money received by health centers in the first round of DSRIP – they are included as "clinics" with hospital ambulatory providers. However, the most up to date data reported by the State in November 2018 demonstrates that hospitals received more than 28% of total funds flow while representing only 0.2% of total engaged PPS partners.[i] It is exceedingly difficult to transform the healthcare delivery system by continuing to invest most transformation dollars into inpatient-based care models, when it is the long-standing established CHC providers and workforce that can make the biggest impact on patients' health outcomes. CHCs are especially well-posed to integrate care, make connections to address social needs, and become the more adept and agile VDEs envisioned in the State's concept paper. We support the State's charge that VDEs include providers, community-based organizations (CBOs), and managed care organizations (MCOs) to leverage VBP and advance promising practices. A collaborative partnership between community-based providers, CBOs, and MCOs is critical to implementing and supporting transformative initiatives that move away from a volume-driven care model. However, to support improved access to care in the community and reduce reliance on emergency departments and inpatient care, the State must direct additional resources to a broad range of community-based providers. **Betances Health Center requests that the State dedicate, at a minimum, 25% of DSRIP funds to the development of community-based VDEs where CHCs, in collaboration with other community-based providers, are leads.**

### a. VDE Lead Entities

The State should capitalize on existing health center Independent Practice Associations (IPAs) as a launching point for the creation of community-based VDEs. There four CHC-led IPAs currently organized across the state, Community Health IPA (CHIPA), Safety-Net IPA (SIPA), Finger Lakes IPA (FLIPA), and Upstate Community Health Collaborative IPA (UCHC), are engaged with MCOs in at least one VBP contract while working on additional agreements. We are members of Community Health IPA (CHIPA). IPAs are able to take on risk and become financially accountable for both the quality of care and the most efficient delivery of care services. We believe that IPAs are well positioned to work with other entities as a VDE in the second round of DSRIP.

While health centers like ours are already developing relationships needed to advance in VBP contracts, a second round of DSRIP is an opportunity to invest in building capacity to ensure health center and CBO IPAs have the foundation to serve as VDEs. Currently, health center-led IPAs are self-funded and have little financial capacity to support many of crucial functions that would accelerate their successful participation in VBP arrangements. **Health center-led IPAs require DSRIP investment to support the data analytic capabilities needed to effectively manage population health and drive improved outcomes.**

**b. Considerations for Engaging MCOs**

**Betances** is pleased that the State is taking steps to ensure engagement of MCOs early in the planning process for a second round of DSRIP. However, there are significant challenges that must be addressed ahead of the creation of VDEs. One of the current difficulties faced by providers as they seek to participate in VBP arrangements is a lack of comprehensive data about their attributed patients. **The State should create and enforce a uniform data sharing policy for the managed care plans to further support the transition to VBP, for example, by enforcing transparency in expenditures and utilization.**

In the first round of DSRIP, the discrepancies between MCO attribution and PPS attribution made it difficult for health centers to effectively manage patient health outcomes. PPS networks do not necessarily encompass the same providers that are contracted with a given MCO. If there are discrepancies between MCO attribution, consumer utilization, and PPS network, it becomes incredibly difficult, if not impossible, for the PPS to effectively manage health outcomes for these populations. PPS and VDEs should not be expected to manage the health care improvements of individuals who are enrolled in managed care plans that contract outside of the VDE. **Betances recommends that in the next round of DSRIP, VDE attribution should be aligned with MCO attribution to ensure seamless VBP contracting.**

Finally, we understand the State's desire to drive regional innovation – local health care needs vary based on geography, CBO and health care provider landscape, and other factors. However, we would like to raise the concern that in densely populated areas served by many MCOs with overlapping service areas (notably, New York City), defining distinct regions may prove difficult. **In New York City, Betances recommends that VDE networks should align with patient utilization patterns as much as possible.**

**III. <u>Supporting Non-Clinical Workforce to Address Social Needs</u>**

Betances echoes the State's observation that many of the successful DSRIP initiatives rely on non-traditional, non-clinical workforce that help patients navigate clinical and social services systems to address their multi-dimensional needs. In the first round of DSRIP, we embraced the flexibility to address patients' social needs. Betances assists many of its patients who struggle with social determinants of health such as food insecurities, housing, transportation, social exclusion and disability as these determinants profoundly impact the patient's health outcomes. In the first round of DSRIP, the State encouraged primary care practices to become patient-centered medical home (PCMH) recognized. Today, 97% of New York's health centers are PCMH certified. PCMH certified practices provide mental health, oral health, and health promotion/disease prevention services through comprehensive primary care. This model of patient-centered care is associated with improved health outcomes and reduced costs and should be robustly supported in the second round of DSRIP. There are numerous studies that have

analyzed the success of PCMH, including citing fewer specialty visits needed, lower per member costs, and better health outcomes amongst individuals seeing PCMH-certified providers.[ii] Betances is NCQA certified at the 2014 Level 3 and Betances operates, as an effective team based care delivery system that is patient centered and focused on improving care coordination and care management for each patient. We have population management teams comprised of a provider, medical assistant and case manager who identifies patients in high risk populations such as diabetes and hypertension. By utilizing the PCMH model of care, we have excelled in addressing some of our more challenging patients with multiple chronicities. The PCMH team based approach has allowed Betances to excel with 551+ HIV patients for example where our viral load suppression of 91% and retention rate of 89%. **The State should use a second round of DSRIP to continue investments in care management programs like PCMH and Health Homes to address patients' social and medical needs.**

## IV. Aligning Performance Measures

Betances strongly supports the State's desire to work with CMS to align performance measures across initiatives. Health centers' participation in Medicare, Medicaid, NYS PCMH, and contracts with managed care plans (among various other programs) requires a significant amount of resources invested in measure/data collection and reporting. **The State should target measures most likely to be of value for all participants in DSRIP 2.0.**

## V. Health Center Alternative Payment Methodology

FQHCs embrace the State's transition of Medicaid payment from volume to value. Betances supports this direction and is also engaged in work with CHCANYS to move away from a visit based FQHC payment to a capitated FQHC Alternative Payment Methodology (APM). Federal statute permits states to implement an APM in lieu of the legally required prospective payment system reimbursement methodology. States must ensure that reimbursement under the APM is not less than it would be under the prospective payment system rate; however, adoption of an APM is essential to move FQHCs from a visit-based payment that incentivizes volume, to a payment methodology that rewards efficiency and outcomes. A capitated FQHC APM aligns with the State's DSRIP goals of advancing VBP and provision of enhanced care coordination.
An FQHC APM supports team-based, integrated care and enables CHCs the flexibility needed to create innovative approaches to care which can include non-clinical support staff who are not billable providers under the prospective payment system rate. The creation of innovative care coordination workflows will improve care provided directly by FQHCs, therefore reducing costs across the health care system.
Betances looks forward to working closely with CHCANYS and the Office of Health Insurance Programs to establish a mutually agreeable approach that supports health centers' ability to transform their entire practice to a value-based care delivery model. Once the APM receives a federal approval, a small subset of health centers will transition from the prospective payment methodology to the APM. **To ensure the success of an APM, State investment is needed to enhance data collection capabilities and catalyze the development of new staffing roles, models for care teams, and innovative work flows.** These investments may include: enough funding to support interventions addressing patients' non-clinical social needs, support for an alternative payment learning community, clinical and cost data analyses, quality metric identification, and reporting mechanisms.

Betances has actively engaged in DSRIP implementation and contributed to many of the successes achieved. We look forward to continuing to partner with the State to achieve our shared goals of system transformation and improved patient care, better patient outcomes, and reduced care costs.

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[i] https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/paop/meetings/2018/docs/2018-11-29_updates.pdf

[ii] Kaushal R, Edwards A, Kern L. May 2015. Association Between the Patient-Centered Medical Home and Healthcare Utilization. American Journal of Managed Care. Am J Manag Care. 2015;21(5):378-386.
Raskas R, Latts L, Hummel J et al. 2012. Early Results Show WellPoint's Patient-Centered Medical Home Pilots Have Met Some Goals For Costs, Utilization, And Quality. Health Affairs. Vol. 31, No. 9: Payment Reform to Achieve Better Health care. https://doi.org/10.1377/hlthaff.2012.0364
Akuh Adaji, Gabrielle J. Melin, Ronna L. Campbell, Christine M. Lohse, Jessica J. Westphal, and David J. 2018. Katzelnick. Patient-Centered Medical Home Membership Is Associated with Decreased Hospital Admissions for Emergency Department Behavioral Health Patients. Population Health Management. Vol. 21 Issue 3. printhttp://doi.org/10.1089/pop.2016.0189

Betances Health Center

Julia Tsien, MPH, LMSW
Chief Executive Officer

## doh.sm.1115Waivers

**From:** [redacted]
**Sent:** Monday, October 28, 2019 8:24 AM
**To:** doh.sm.1115Waivers
**Subject:** Comments
**Attachments:** DOC102819-001.pdf



Good morning,

Attached are comments regarding the proposed 1115 waiver amendment. Thank you for your consideration.

Sue Carlock

Sue Carlock, Director
Livingston County Office for the Aging

LIVINGSTON COUNTY
OFFICE FOR THE AGING
3 Murray Hill Drive
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ofta@co.livingston.ny.us

Sue Carlock
Director

RE: DSRIP Amendment Request Draft Dated 9/17/2019

To Whom It May Concern:

Please accept this correspondence as written comments regarding the 1115 waiver DSRIP Amendment proposal. As an Area Agency on Aging Director and a member of the Association on Aging, I applaud the intent of DSRIP to reduce avoidable hospitalizations and emergency room visits, and to better coordinate care for better outcomes and cost savings.

I have read the DSRIP Promising Practices Report and noted the many accomplishments attained during the first five years. The area where I think significantly more progress needs to be made is addressing the Social Determinants of Health and truly moving funding upstream (achieve community collaboration and upstream investment) to address issues early and prevent negative health outcomes.

I worked in community-based nonprofits for 25 years prior to taking the position of Director of the Livingston County Office for the Aging. Since witnessing what the Area Agencies on Aging (AAAs) accomplish with limited resources, I would recommend that it be required that the AAAs have a place at the table to play a vital role in any Value-Driving Entities and Social Determinant of Health Networks established through the approved waiver amendment (Page 6, Value-Driven Entities). I would argue that if this is not implemented progress toward DSRIP goals will stagnate. We are all aware of the demographic shift that we are in the midst of and the fact that the percentage of our population comprised of older adults is growing rapidly. Older adults comprise approximately 9% of the Medicaid enrollees but account for a disproportionate 30%+ of expenditures; Medicaid funds 65% of US nursing home residents' care and 61% of all Long-Term Services and Supports (LTSS). Fifty-two percent of those 65+ will develop a disability requiring LTSS. The percentage of Medicare enrollees aged 65+ who were readmitted within 30 days of discharge in New York has not declined significantly. Many AAAs have contracted with Medicaid Managed Long Term Care programs in an effort to coordinate services and serve greater numbers of individuals. The experience has shown that there is work to be done and the system can be better. Many older adults do not understand the system and do not understand who and how to contact their plan. As a provider, we do not get authorizations in a timely manner and spend a great deal of time advocating for clients.

For decades AAAs have been providing extensive services with limited funding. Most were not to any great extent engaged in DSRIP despite our time investment and interest. If the upstream investment were to include the AAAs, the proven programs and strategies that AAAs use to serve older adults and the networks that they have developed could be leveraged in this effort to further even greater impact.

Many of the promising practices highlighted in the United Hospital Fund report involve utilizing community health workers. AAA staff are routinely performing many of the functions that are proposed for CHWs and are

trained and experienced in performing these functions. AAAs individually and through the Association on Aging are able to access training and credential programs that support professionalism, effectiveness and continual knowledge growth. The impact would be better coordinated and comprehensive services delivered within home and community settings, a reduction in potential unnecessary admissions and readmissions, better health for the aging population, and a significant cost savings.

The AAAs are working with this critical population and are performing many of the functions delineated in the promising practices document. We are routinely going to older adults' homes and performing comprehensive assessments of in-home service needs and social determinants of health. I have examined several of the tools recommended for SDH assessment and the assessment tool used by AAAs, the Compass, is much more extensive. We provide information, assistance and case management aimed at keeping individuals with activities of daily living deficits in their homes and out of higher levels of care. The EISEP program keeps individuals with chronic conditions in their homes and out of higher levels of care, resulting in tremendous financial savings. We facilitate evidence-based health promotion programs including A Matter of Balance, Tai Chi for Arthritis, and Aging Mastery that empower older adults to manage chronic disease, and improve their health status. Harvard Medical School, in their May 2009 Health Publications suggests that tai chi which is often called meditation in motion should be called medication in motion as in addition to preventing falls, it has been shown to be helpful for low bone density, Parkinson's disease, stroke, hypertension, and sleep problems. We provide many forms of care transitions and collaborate with an extensive network of aging and disability service providers. AAAs and their partners work with caregivers to reduce caregiver stress and support caregiving efforts. All of the evidence-based health promotion programs have been proven to have positive health impacts in published studies.

The AARP Foundation study concluded that the main SDH issues that older adults 50+ struggle with are food security, housing, social connectedness, finances, and transportation. AAAs address all of these issues and can be particularly effective in reducing social isolation through a variety of programs, including congregate meal programs, health promotion programs, volunteer programs, friendly visitor or caller programs, and more. The Administration for Community Living data demonstrates that congregate meal participants have fewer ED visits, fewer hospital admissions, a higher quality diet, greater food security, and increased socialization than their peers. Meals on Wheels can serve a senior for an entire year for about the same cost as just one day in a hospital or 10 days in a nursing home. Fifty-nine percent of home-delivered meal recipients live alone, and for many of them, the person delivering the meal is often the only person they will see that day. Meals on Wheels serves many of the most at-risk individuals: 75+ years of age, living alone, socioeconomic need, reporting fair or poor health, geographically isolated, etc. Seniors waiting to receive meals are more likely to report fair or poor self-rated health, not having enough money to buy food they need, recent falls or fear of falling, depression, and taking three or more medications each day. The top health care users are those with chronic conditions and functional limitations who are more likely to use emergency room and inpatient services. The top needs identified have been home delivered meals, personal care, transportation, care transitions, and evidence-based chronic disease management. These are the individuals the AAAs work with every day and the services they provide.

On a local level, the Livingston County Office for the Aging keeps individuals at home with multiple chronic diseases or functional impairments at a fraction of the cost of higher-level care through our EISEP program which combines case management with personal care and ancillary (consumer driven) services. We coordinate with EMS agencies who refer individuals who perform a geriatric screening for older adults who call for an ambulance and have identified needs. We offer multiple evidence-based health promotion programs that have proven to reduce falls and improve health. We coordinate with our local hospitals and skilled nursing facilities on care transitions.

We are just one of a network of NYS AAAs. AAAs have a keen sense of individuals' community-based needs, are aligned with DSRIP consumer health/quality of life outcome goals, have direct/personal contact with individuals, families, and caregivers, conduct assessments, monitor functional status, engage older adults in a preventive manner, and are recognized as a trusted community resource. We have an already established infrastructure and network of partners. We can help improve quality and decrease complaints and confusion. We serve clients for life, not for a care stage or episode. We are eyes and ears in the homes. We provide one door for many services to support individuals in their homes. We are mission, not insurance driven, and are data informed. Working together is to our mutual benefit as well as that of individuals and communities. We ask you to formally bring AAAs and aging services into the process for the second round of DSRIP.

Thank you in advance for your consideration.

Very truly yours,

Sue Carlock
Director, Livingston County Office for the Aging

**Livingston County EISEP & Caregiver Respite Program:**

Josephine was 81 and residing alone in her home in Green County. Client experienced fall and required multiple surgeries on her right hip and knee. Client also suffers from Parkinson's Disease making it more difficult for her to perform ADLs and IADLs independently. Client and daughter decided that Josephine should permanently move to Livingston County where her daughter would be better able to take care of client. Client has been enrolled in EISEP, EISEP Consumer Directed Program, and Caregiver Respite through OFA since 12/2014.

**Health and Safety**

- Client's health was stabilized after moving in with daughter. Client was able to receive PT, OT services after discharge from rehab. Daughter and aides continue to assist with exercises to help strengthen client's mobility with the assistance of a walker.
- Client received aide service for up to 10 hours per week to assist with bathing, dressing, cleaning, medication reminders, exercises, and laundry. This also provided assistance to daughter who was employed at that time. Aide service ensured that client had appropriate personal hygiene and assistance with IADLs.
- Client has auto alert PERS unit through Lifeline to ensure access to emergency services 24/7 four times when client must be left alone.
- Client was enrolled in caregiver respite program providing daughter with four hours of respite per week to allow daughter to complete errands and help reduce stress. Daughter attended caregiver respite meetings to learn more about caregiver stress strategies and other possible entities that may provide respite service.
- After losing aide through EISEP program, client was enrolled in the EISEP Consumer Directed Program with 10 hours of service. The Consumer Directed Program was a much better fit for the family as they were able to find aides that were able to work hours at their convenience providing ADLs and IADLs as needed.
- Client's daughter is also able to privately pay aides that she has through consumer directed program which allows for more assistance when needed.

**Improved quality of life**

- Client's quality of life has improved greatly since moving to Livingston County. Livingston County OFA provided transportation to and from respite site until client became too ill to attend. During this period client was provided with socialization and planned activities which she would not be receiving if at home while daughter was working. Now that client is homebound, she has a friendly visitor twice a week through the Alzheimer's Association for socialization as well as respite services.
- Client reports feeling safer and properly taken care of now that she has moved in with her daughter and is receiving appropriate services to assist with ADLs, IADLs, and socialization.
- Client is also able to see specialist for her Parkinson's and dementia that she would not be able to living on her own as she was not driving and did not have a support system when she resided alone. Client feels that she has a better understanding of her disease and has used information given by specialist to make adaptations to home and schedule.
- Client is grateful she is able to remain with her daughter and receive care at home even though she would qualify for nursing home placement. With just 10 hours of aid service, four hours of respite service, and a friendly visitor client has been able to remain at home where she is able to complete some tasks independently and receive services for tasks she is unable to perform. This

has also improved client's outlook on life and aided with depression by having socialization and proper assistance to help her remain in the community.

- Client was aided by case manager to apply for snap benefits which are useful to client as she has Celiac Disease and food is much more expensive.
- Client has also had home modifications completed to install grab bars and ramp through local organizations with assistance of case manager.

**EISEP/Respite/PERS Cost**

- Client has received aid service through OFA since 2014 keeping her out of the nursing home. Since moving in with daughter Josephine has not had any rehab or nursing home stays.
- **For the year of 2018 client has received auto alert Pers unit priced at $39 per month totaling $468 for the year.**
- **Average cost of Consumer Directed services for a month total approximately $667 Providing client with 10 hours per week of service. Average nursing home cost per day in Western Region-Rochester is $384 per day totaling $140,304 per year while EISEP Program is able to keep client at home for approximately $8,000 a year meaning a savings of $132,300 in Medicaid monies. Consumer Directed Program has more benefits (ability to transport client and assist with medications) and is a much cheaper rate than hiring through contracted agencies.**
- **Respite services provided total approximately $453 per month which computes to $5436 a year to provide services not only to clients but also to caregiver and helping to reduce stress.**

**Vignette 2 (Livingston County EISEP, PERS & HDM's)**

- Jean moved to Livingston County in 2007 after discussion with her children who wanted her to be closer to better assist with ADLs and IADLs. Jean was 81 at this time and living alone in a trailer in a very rural location. Client suffers from diabetes (not controlled), neuropathy, neck and back problems related to arthritis. Upon moving to Livingston County, family called OFA for services to assist with HDM's and EISEP services. Client was enrolled in EISEP, PERS, and HDM's M-F. Shortly after services began informal supports were no longer reliable and client was dependent upon EISEP and HDM services.

**Health and Safety**

- Client has had history of uncontrolled diabetes and confusion with medication leading to several hospitalizations. OFA was contacted by client's PCP stating they felt client was in need of nursing home care and should not be living alone due to inability to manage medications and diabetes. Case manager worked with client's PCP, Care Manager, and family to address problems and rectify situation. It was determined that client's daughter would manage medication and need for automatic medication dispenser to ensure client took medication at appropriate times and was unable to tamper with medications. Medication training was provided to daughter on filling medication dispenser. Client is now provided with medication dispenser through lifeline that automatically dispenses medication at programmed times and contacts emergency contacts when medication is not taken in a timely manner. Dispenser is locked and must be filled by client's daughter. Since installation of medication dispenser client has had more normal glucose levels. This has helped alleviate stress on client and family members by providing safety

measure for client. PCP felt this was an appropriate plan and feels that client is able to remain in her home with proper help from formal and informal supports.

- Client was authorized for personal care services for two hours two days a week. PCP had concerns and discussions with client as she was not bathing and had issues with incontinence; also a reason that contributed to thoughts of placement by PCP. Client now receives assistance twice a week to help with bathing and personal hygiene as well as cleaning, shopping, meal prep, and laundry. Client is now bathing at least once a week, allowing for assistance with personal hygiene, and shopping task. Case manager has seen much improvement in client's personal hygiene and compliance with expectations of EISEP program to assist in helping her remain independent in her home.
- HDM is provided M-F as client has difficulty preparing meals as she is unable to stand for long periods of time and can only cook with a microwave due to the neuropathy in her hands and feet. HDM also provides well-balanced diabetic friendly meal that has assisted in stabilizing sugar levels. Also provides main meal for client for the day as client is low income. Client was assisted in applying and approved for SNAP benefits to supplement need for food.
- Client is provided with auto alert PERS unit to help maintain safety as client has had several falls due to low sugar levels. Client recently had hospitalization due to above concern and was unable to communicate that help was needed. Pers unit enabled emergency services to be dispatched.
- Assistance with Medicaid application has been completed with client for enrollment in Consumer Directed Program to allow for more assistance, checking on client, and assistance with medications and shopping. This will ensure that client is able to remain independent in her home.
-

**Improved quality of life**

- With assistance of medication dispenser client is feeling much better and is less anxious and stressed regarding her medications. Dispenser allows for proper disbursement and reminders which have helped stabilize sugar levels.
- Home delivered meal provides main meal for client and is diabetic friendly lessening the burden on client to prepare healthy meals and family to assist.
- Aide service has become vital for client to maintain personal hygiene and serves as companionship that has lessened client's depression. Aide service has also assisted by providing the proper care that client needs as family members are unable to assist reliably.
- Case manager worked with Adult Services and family as client was being financially abused. Discussion with client and family have taken place and client understands that she does not have the funds to support her children and lead to her worrying about purchasing food and medications.
- PERS unit has helped client several times by ensuring access to emergency services in a timely manner when help is needed.

**EISEP/PERS/Medication Dispenser Cost**

- Client has received aid service through OFA since 2017 keeping her out of the nursing home.
- **For the year 2018 client has received auto alert PERS unit priced at $39 per month totaling $468 for the year.**
- **Average cost of EISEP services (2hrs 2 days a wk) for a month total approximately $484. Average nursing home cost per day in Western Region-Rochester is $384 per day totaling over$140,000 per year while EISEP Program is able to keep client at home for approximately $5800 a year yielding a savings of over $134,000 in Medicaid monies.**

## doh.sm.1115Waivers

**From:** John Javis [redacted]
**Sent:** Monday, October 28, 2019 8:24 AM
**To:** doh.sm.1115Waivers
**Subject:** 1115 Public Forum Comment
**Attachments:** DSRIP20CommentsBHNYC.doc



Please finds formal comments (attached) from Behavioral Health New York City IPA. Thank-you!

**Behavioral Health NYC, IPA, LLC**



October 25, 2019

To: New York State Department of Health
From: Behavioral Health New York City IPA
Re: Comment on DSRIP Extension Draft Proposal

The Behavioral Health New York City (BHNYC) IPA, is an Independent Practice Association comprised of 15 agencies that provide behavioral health services in the New York City area. BHNYC is one of the Behavioral Health Care Collaboratives (BHCC's) that have been funded to support the transition of behavioral health services into Value Based Payment (VBP). BHNYC is pleased to present its comments regarding the DSRIP Extension Draft Proposal.

BHNYC is supportive of New York State's efforts to extend DSRIP and to create a "second generation" of DSRIP including the development of VDE's (Value Driven Entities). BHNYC is strongly advocating that the BHCC's must be a strong partner in any VDE.

In the original DSRIP program, a majority of the "high performance" measures were behavioral health in nature. The achievement of a 10% improvement in metrics such as the 7 Day Follow-up after Hospitalization for Mental Illness and Potentially Preventable Emergency Room Visits (BH) was reliant on what occurred outside the hospital. PPS's that were successful in earning high performance dollars engaged community behavioral health providers through contracts.

Since the end of DSRIP Measurement Year 5 in June, 2019, most behavioral health related DSRIP contracts have ended, and many of the PPS's have reduced staffing levels. It should be noted that a number of former DSRIP PPS staff have been hired by BHCCs due to their knowledge of data, analytics, performance measures and the development of innovative new practices. As many PPS's have downsized operations, it would be quite duplicative for them to reconstitute behavioral health staff in the event of a DSRIP extension; a more efficient option would be for PPS's / VDE's to collaborate with BHCCs in regards to behavioral health contracting and the achievement of metrics.

Many BHCC's are organized along regional lines which should coincide with the regional approach that the VDEs are expected to take. VDE's should easily be able to contract out the achievement of behavioral health metrics to the BHCC's, who can provide a local "network" of providers. Additionally, some BHCC's (BH IPA's) have started to work with a few health plans in regards to Level 0 Behavioral Health "Quality Improvement Projects" as well as bundled payments for Medication Assisted Treatment. Given the fact that the VDE's will be tasked with working with Managed Care Organizations (MCO's) there seems to be much potential synergy between the VDE's, MCO's and BHCC's.

Additionally, due to DSRIP, behavioral health providers have made significant investments in staffing, in developing models of Integrated Care, and in efforts towards population health. The expense of these effective and innovative approaches is not adequately covered by the current Fee for Service payment models, and the inclusion of behavioral health in Value Based Payment needs more time to mature. Having behavioral health providers / BHCCs partner with the VDEs through will provide the time and financial resources to allow these efforts to take root.

BHNYC has also been involved in recent discussions with FQHCs (Federally Qualified Health Centers) around the possibility of FQHCs and BHCCs to collaborate around the coordination of care and performance outcomes and is supportive of those efforts on a wider scale.

Thank-you,

John A, Javis, CEO

## doh.sm.1115Waivers

**From:** [redacted]
**Sent:** Monday, October 28, 2019 10:07 AM
**To:** doh.sm.1115Waivers
**Subject:** 1115 Public Forum Comment
**Attachments:** Essex County Response.pdf



(See attached file: Essex County Response.pdf) Krissy Leerkes Essex County Office for the Aging P.O. Box 217 Elizabethtown, NY 12932
[redacted]

**Essex County Office for the Aging**
**P.O. Box 217**
**Elizabethtown, NY 12932-0217**

**Krissy Leerkes**
**Acting Director**

**(518) 873-3695**
**Fax: 873-3784**

Paul Francis
Deputy Secretary for Health
State Capitol
Albany, NY 12224

Donna Frescatore
Medicaid Director
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Dear Mr. Francis and Ms. Frescatore,

On behalf of Essex County Office for the Aging, I am writing to express my recommendations on the DSRIP renewal proposed by New York State Department of Health. Essex County Office for the Aging is one of 59 Area Agencies on Aging, providing services across a rural, economical depressed region. We contract with over 10 contractors to provide services and supports predicated on targeting social determinants of health. The services we provide directly impact inappropriate emergency department visits, and reduce avoidable readmissions. The NY Connects program, implemented in 2006, serves as a no wrong door for any and all services available in the region, and is a catalyst for individuals in need of assistance. The targeted goals in the proposed renewal are exactly what this network provides, and must include mandated contracting by each PPS with their local Area Agency on Aging for social determinants of health initiatives. Our office has been in existence for over 45 years, and is the trusted service provider for the fastest growing segment of the population, and the highest utilizer of health care dollars. Our services **absolutely** allow individuals to remain autonomous and remain in their own homes and communities, all while saving health care expenditures. We provide the highest level evidenced based interventions, and are experts at navigating a complex health care system, while providing person centered planning and care.

In the renewal waiver, I cannot stress highly enough that we need to harness the existing strengths of community based services, instead of recreating case management services and duplication of services. Each and every case manager in the

entire statewide aging network has received certification via Boston University School of Social Work, ensuring consistency in assessment not provided by any other system. I ask that there are mandates for each PPS to engage and contract with their local Offices for the Aging, for the services vital to keeping individuals in home and community based settings.

Thank you for your time and consideration,

Krissy Leerkes

Krissy Leerkes
Director
Essex County Office for the Aging

## doh.sm.1115Waivers

**From:** Bansal Travers, Maansi [redacted]
**Sent:** Monday, October 28, 2019 11:29 AM
**To:** doh.sm.1115Waivers
**Cc:** Bansal Travers, Maansi; White-Storfer, Amy
**Subject:** DSRIP 2.0 Public Comment



Dear Colleagues:

Thank you for the opportunity to provide comment to the Department of Health regarding the 1115 Waiver: Delivery System Report Incentive Payment (DSRIP) Amendment Request, dated September 17, 2019. Roswell Park Comprehensive Cancer Center has been actively engaged in NYS DSRIP and a partner of Community Partners of WNY (CPWNY)/Sisters of Charity Hospital Performing Provider System (PPS) since April 2015.

We have benefitted from our participation in this initiative in the following ways:

- The support of the DSRIP program has allowed the Roswell Park Comprehensive Cancer Center to expand its tobacco treatment programs and increase access to expert resources, community education, and group counseling sessions for hard-to-reach populations. It is well known that tobacco use is disproportionately greater in the low-income and underserved communities, particularly the segment of the population served by the Medicaid program. DSRIP funding has allowed our team to develop and expand partnerships with community organizations and businesses to increase the prevalence of smoke-free policies in our communities, work with municipal housing authorities to provide cessation assistance to tenants of newly smoke-free buildings, and work with faith-based organizations to educate and provide cessation assistance in an open and accessible setting. In addition, the program has given Roswell Park the opportunity to not only reach primary care and behavioral health providers, but to work with specialty providers, such as pediatricians, cardiologists, pulmonologists, respiratory therapists, and other specialists that tobacco users frequently visit. Roswell Park assists these providers in adopting best practices for assessing and treating tobacco use, facilitating systematic linkages to the NYS Smokers Quitline, and providing scholarships to providers and office staff interested in training to become a certified Tobacco Treatment Specialist. The DSRIP funding is essential for expanding our outreach into communities and settings that have been underserved by previous tobacco education and cessation efforts. The success of the DSRIP program to date in reducing hospital admissions and emergency department visits is impressive and indicative of the great work and the potential continued impact of the program on the health of our communities. Roswell Park fully supports the proposed extension and will continue to offer our support and expertise to DSRIP initiatives related to tobacco use and awareness.

CPWNY has been an effective change agent in Western New York. The work has just begun! We anticipate a favorable outcome of the 1115 Waiver DSRIP Amendment Request. We strongly endorse the work of CPWNY PPS. They are critical to the success of future DSRIP initiatives.

Thank you,
Maansi

Principal Investigator, Project 4.b.i, Community Partners of Western New York DSRIP Center

***Maansi Bansal-Travers, PhD, MS, NCTTP***
Associate Member and Associate Professor of Oncology
Department of Health Behavior
Roswell Park Comprehensive Cancer Center
Elm and Carlton Streets
Buffalo, NY 14263
[redacted]

**doh.sm.1115Waivers**

**From:** Tamie MacDonald [redacted]
**Sent:** Monday, October 28, 2019 2:06 PM
**To:** doh.sm.1115Waivers
**Subject:** 1115 Public Forum Comment
**Attachments:** Otsego County OFA DSRIP Comments 10.28.19.pdf



Please find comments attached from Otsego County Office for the Aging... thank you!

Tamie MacDonald, Director
Otsego County Office for the Aging
The Meadows Office Complex, Suite 5
140 County Highway 33 W
Cooperstown, NY 13326
[redacted]

Otsego County
OFFICE *for the* AGING

NEW YORK STATE OF OPPORTUNITY.

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Your Link to Long Term Services and Supports

140 County Hwy 33W, Meadows Complex, Suite 5, Cooperstown, NY 13326
Phone: (607) 547-4232 Fax: (607) 547-6492 Email: aginginfo@otsegocounty.com

October 28, 2019

New York State Department of Health
Office of Health Insurance Programs
One Commerce Plaza
Albany, NY 12207

To Whom It May Concern:

Otsego County Office for the Aging would like to take the opportunity to offer comments on the proposed 1115 Waiver Program (DSRIP) Amendment. First, I would like to commend you for the well thought out proposal developed and for the dedication and commitment made to improve outcomes for patients and reduce unnecessary healthcare costs.

I would specifically like to offer comment regarding one of the federal priority areas of addressing social determinants of health through community partnerships. In working with at-risk residents of all ages for nearly 20 years, I have witnessed first-hand how basic needs and what is now termed "social determinants of health" directly impact an individual's ability to function on a daily basis, and how those needs often overshadow a person's ability to properly care for themselves. Having unmet needs in any of these areas also directly affects a person's ability to access and receive proper and adequate healthcare. In order to truly improve health outcomes for our residents and to reduce health care costs overall, it is imperative that we jointly address the various social determinants of health that allow an individual to make their health a priority. In order to do this, it is essential that DOH mandate PPS' to partner and contract with their local Area Agencies on Aging as part of their efforts to address social determinants of health.

Area Agencies on Aging are a well-established network that have been providing community-based services for over 45 years that allow people to age in place safely while still retaining a high quality of life. These same services have proven to be effective in also preventing and delaying institutionalization and unnecessary admissions to the hospital. We are well connected to our community, know and understand the unique challenges faced by our local residents and work in partnership with our faith-based community, school systems, organizations, businesses and health care providers to meet the needs of our residents. Qualified Case Managers conduct comprehensive assessments with residents in their own living environment and successfully connect them to needed services and supports, helping them to navigate the complex long-term care and health care systems, while providing person-centered planning and care.

Let me share just one scenario to help bring to life the extensive support and services we are able to provide residents. To maintain confidentiality, we will call this person "Alice". Alice is an 88-year old female living in one of our rural communities with a population of less than 1,000 people.

She initially reached out to our office nearly 15 years ago with issues related to her furnace and water heater. Over the years, Alice has been helped by Otsego County Office for the Aging to apply and re-apply for HEAP benefits, SNAP and Medicaid to prevent discontinuation of services; to obtain a new furnace; repair her water heater; install new storm windows and apply for flood assistance. She has received home delivered meals, a personal emergency response system (PERS), case management, transportation and in-home services for many years as she has become frailer and less able to manage on her own. In recent years, Alice has faced increased challenges due to diagnoses of dementia, diabetes, heart disease, high blood pressure, high cholesterol, incontinence, thyroid and visual impairments.

Just in the past year, OFA staff have made phone calls, completed applications and collected necessary paperwork to help Alice apply for Enhanced STAR benefits and home repairs through Otsego Rural Housing Assistance to install a walk-in shower, toilet and new flooring in her mobile home. Alice was connected to a local non-profit agency and provided well-fitting clothes and OFA staff worked with the local Arc of Otsego to obtain adult incontinence supplies, which were desperately needed. Due to vision impairments, OFA staff connected Alice to the local Lions Club and AVRE to obtain a new magnifier to help her read, and other helpful tools to allow her to remain independent. Our transportation program not only transported Alice to 3-5 medical appointments each month, but often was required to help Alice get ready for the appointment and help her navigate the facility once she arrived. Most recently, OFA has helped her to apply for community-based long term care services through Medicaid and navigate the CFEEC process to enroll her in a Managed Long Term Care plan.

Although Alice has a son living nearby, this support was very minimal and there is no question that Alice would have been institutionalized long ago if not for the extensive services provided through the Office for the Aging over the years.

Based on this story and the many others that exist throughout our state, I strongly encourage you to take advantage of the existing network of providers that have already proven their value and worth in saving health care dollars and providing truly valuable supports to patients. Although initially created to support older adults, with the implementation of NY Connects and the No Wrong Door system, most Area Agencies on Aging have developed and established an equally strong skill-set and network to serve individuals of all ages with disabilities. Instead of duplicating and recreating services, we urge you to invest in the existing infrastructure and network of partners. We are neighbors of these residents and we are committed and passionate about supporting a healthy community for all.

Thank you for your time and attention.

Sincerely,

T MacDonald

Tamie MacDonald
Director

## doh.sm.1115Waivers

**From:** Celina Ramsey [redacted]
**Sent:** Tuesday, October 29, 2019 12:09 PM
**To:** doh.sm.1115Waivers
**Subject:** DSRIP Waiver Amendment Comments
**Attachments:** SI PPS CCHL Comments_DSRIP 2.0.pdf



Hello,

Please accept the attached document as Staten Island PPS's Cultural Competency and Health Literacy response to the proposal for DSRIP 2.0 waiver extension.

Thank you,

**Celina Ramsey, MShc**
Director of Health Literacy, Diversity & Outreach
[redacted]
Staten Island Performing Provider System
1 Edgewater Plaza, Suite 700

Staten Island
Performing Provider System

# Staten Island PPS Cultural Competency and Health Literacy Response to DSRIP 2.0 Proposal

Dear NYS DSRIP Team,

I'd like to formally share my thoughts and comments on the DSRIP Amendment Request in regard to Cultural Competency and Health Literacy:

NYS DOH was the first and only state with a DSRIP Medicaid waiver to include Cultural Competency and Health Literacy (CCHL) into the fabric of the application process and as its own 'workstream' and foundation for all initiatives and projects. NYS Department of Health set a national precedent in highlighting the importance of health communication and cultural sensitivity that had never been considered a mandatory component of successful health outcomes with performance measures and at-risk dollars associated with successful implementation of these types of trainings. In order to address the new high value practices and additional priority areas, cultural awareness and health literacy must be identified as a central component of all community education, communication and marketing, social determinant interventions and continued workforce transformation initiatives.

Cultural Awareness and/or Health Literacy should be included in the NYS DSRIP 2.0 proposal to extend the DSRIP waiver in the following two areas to ensure recognition as a statewide priority and to expand upon the excellent work completed by each PPS's CCHL Teams:

1. Continued investments in workforce transformation
2. Social Determinant of Health Networks delivering socially focused interventions related to VBP

(1) Although Workforce was a separate workstream from Cultural Competency and Health Literacy, there was a significant amount of CCHL training done in tandem with workforce transformation initiatives. For example, **nearly half** of all 70,000 workforce training hours at Staten Island PPS were Cultural Competency and Health Literacy standalone or integrated trainings.

In the proposed amendment, workforce funding will be awarded to support non-clinical workforce such as CHW's, peers and community navigators. Data suggests that at least 88% of native-born English speakers struggle to understand health information. Speakers of foreign languages are disproportionately impacted by limited health literacy. In many areas across the state, these individuals will be part of the proposed new healthcare workforce pool and will

need to be supported in their efforts to understand health information and the changing landscape of the healthcare system. They will need to be able to communicate and connect with high-risk, multi-cultural, diverse speakers of other languages with limited health literacy underscoring the need to include CCHL in this area.

We suggest that cultural competency awareness and health literacy be considered as instrumental to the success of any workforce transformation initiative. We recommend including this terminology and related objectives in the proposal for DSRIP 2.0. Require partnerships between value-driven entities and local community-based organizations who represent marginalized communities, communities of faith and the diverse communities of culture **when developing training plans and curriculum as well as sourcing potential candidates for this new non-clinical workforce**. *Nothing about us without us.*

(2) In 2018, The NYS DOH DSRIP team originally recognized Health Literacy as a Social Determinant of Health when creating the VBP Roadmap requirements and Social Determinants of Health (SDH) intervention. Health Literacy and language access were included in the SDOH Intervention Menu under 'Education' and health literacy was also listed under 'Health and Healthcare' as key determinants of health, noting that improving health literacy will:

- improve treatment adherence
- increase health stability in high risk, high chronic-illness, limited health literate populations
- reduce use of hospital emergency departments and
- increase use of primary care

In order to achieve 'wellness' the public must understand where to get and how to act on the health information they receive. Community facing health literacy initiatives were not a required component of the previous DSRIP CCHL Workstream and not every PPS adopted this type of initiative as a focus, however, we recommend this concept of community health literacy be a major focus for DSRIP 2.0.
For example, Staten Island PPS launched a successful population health literacy improvement project. We engaged over 15,000 individuals with health literacy curriculum and interventions focused on educating the public on common health disparities and empowering them to become their own health champions.

Our Social Determinants of Health project screens for and connecting patients to services addressing their social needs. Literacy and health literacy are among the top 3 social determinants of health that our patients screen positive for.

It is well documented that health miscommunication is a main contributor to adverse events including medical errors and harm. A 2005 Joint Commission review found that "communication failures were implicated at the root of over 70 percent of sentinel events" (National Patient Safety Goals, 2005.) Unfortunately, this remains true today.

NYS has an opportunity to reverse poor communication trends by continuing to support Health Literacy initiatives throughout the next 4 years of the proposed DSRIP extension plan. There is an opportunity to address Health Literacy through the proposed Social Determinant of Health

Network plan. We recommend including **education, literacy and health literacy** as one of the focus interventions:

> *New York has led the nation in requiring the use of SDH interventions by investing state Medicaid dollars in housing, by promoting SDH and community-based organizations inclusion through DSRIP and requiring managed care plans to contract for SDH interventions in risk sharing VBP contracts. Strong partnerships of CBOs and PPS have been formed under DSRIP for innovative approaches to integrate SDH services as part of treating the whole person in impacting the non-medical factors in order to improving their outcomes.*
>
> *As part of the next implementation phase, the state proposes to further advance this work through "Social Determinant of Health Networks" (SDHN) to deliver socially focused interventions linked to VBP. Lead entities will be selected through a competitive procurement with Value-Driving Entities/PPS being eligible applicants. The lead entity of the SDHN will create a network of CBOs that will collectively use evidence-based interventions to coordinate and address **housing, nutrition, transportation, interpersonal safety and toxic stress.***

Thank you for your time and consideration,

Celina Ramsey

Celina Ramsey, MShc

Director of Health Literacy, Diversity and Outreach

Staten Island Performing Provider System

## doh.sm.1115Waivers

**From:** Wilson, Danise [redacted]
**Sent:** Wednesday, October 30, 2019 12:29 PM
**To:** doh.sm.1115Waivers
**Subject:** Public Comments - Erie Niagara Area Health Education Center



Good morning,

My name is Danise Wilson, ED at Erie Niagara Area Health Education Center (AHEC) a TIER 1 health and community workforce and education organization. Erie Niagara AHEC aims to improve workforce in underserved communities by facilitating programs for community members, high school, college and graduate school students, as well as provide continued education opportunities for healthcare professionals. Since January 2017, Erie Niagara AHEC has trained over 6,000 healthcare professionals in over 114 training sessions, and over 600 community members at 30 community events. Please allow me to offer my comments.

1. Preparing to participate in DSRIP and VBP for a small Tier 1 CBO (5 or less employees) is very time and labor intensive. I suggest creating a process to provide mini-grants/funding to help support the CBO's capacity (travel, printing, personnel, IT development). This could be a very small investment of 5-6k. As an example, I could not attend this hearing in Syracuse today because I don't have a travel budget.
2. How will the VDE's be paired? Will the PPS's have to initiate partnerships with CBO's? Need regulations in place to make this process equitable.
3. How do we ensure CHW's are paid a living wage. I think NYS could lead this charge.
4. Is the NYS Doula Pilot Program involved in DSRIP 2.0? If no, they should be?
5. Will the state be developing technology to collect SDH data? Data collection should be consistent to improve tracking and reporting.
6. Also need provider training on the importance, relevance and roles of CHWs to improve patient outcomes and decrease avoidable hospitalizations. CHW's should be more respected in the healthcare world.
7. Clinical staff should be required to be trained on implicit bias and debiases techniques throughout DSRIP 2.0. Not just one and done. This should be written into the proposal. Many of our issues in BH, SUD and Maternal Health can be linked to implicit or explicit bias from the healthcare worker.

Thank you for accepting my questions/comments.

Danise

Danise C. Wilson, MPH
Executive Director
Erie Niagara Area Health Education Center
77 Goodell St.
Buffalo, NY 14203
[redacted]
www.erieniagaraahec.org

## doh.sm.1115Waivers

**From:** Joey Marie Horton [redacted]
**Sent:** Wednesday, October 30, 2019 1:02 PM
**To:** doh.sm.1115Waivers
**Subject:** Re: 1115 Public Forum Comment
**Attachments:** 19.10.30-DSRIP 2 Comments NCFHC - Updated.pdf



Please see the attached comments.

Best regards,

**Joey Marie Horton, MBA**
*Chief Executive Officer*

North Country Family Health Center, Inc
238 Arsenal Street, Watertown, New York 13601
[redacted]
***www.NoCoFamilyHealth.org.***

North Country Family Health Center, Inc.
238 Arsenal Street Watertown, NY 13601
phone: 315.782.9450 FAX: 315.782.2643
www.NoCoFamilyHealth.org

October 30, 2019

New York State Department of Health
Empire State Plaza
Albany, NY 12237

Re: 1115 Public Forum Comment

To Whom It May Concern,

As the Chief Executive Officer for the North Country Family Health Center, a Federally Qualified Health Center dedicated to providing high quality care to the uninsured and underserved in the community, I offer strong support for the DSRIP Amendment Request to CMS. The transformative work conducted under the 1115 waiver has greatly impacted our region, including a 25% reduction in avoidable admissions from MY0 – MY4 and a 27.3% reduction in readmissions from MY0 – MY4 in addition to several other performance measures that have seen significant improvement over the course of DSRIP. My belief is that one of the contributing factors for this success has come from the clinician-led North Country Initiative (NCI) PPS structure.

The NCI PPS has provided direct support to North Country Family Health Center through PPS resources and funding. Our organization is appreciative of our PPS approved funds flow logic that has been inclusive to all entity types; something that has not been experienced by all Federally Qualified Health Centers across the State. In addition, our organization was provided financial resources including the ability to recruit a dentist to the region for Medicaid beneficiaries that had not had access to dental services in five years. In addition, this funding has allowed our organization to standardize clinical protocols positively impacting quality measures and to further develop care coordination services and patient engagement. In addition, other PPS resources have been key to improving regional health and supporting regional healthcare providers include compliance and data security support, community health workers, behavioral health peer supports, Certified Diabetes Educators, and training resources.

Our PPS and North Country Family Health Center support the submission of the DSRIP Amendment Request to CMS to advance DSRIP best practices and facilitate VBP maturation. In collaboration with the North Country Initiative and the Community Healthcare Association of New York State (CHCANYS), the North Country Family Health Center strongly supports the following request components to be included in the Official Waiver Proposal to CMS:

## I. Driving Promising Practices to Improve Health Outcomes and Advance VBP

By mission and in statute, Health Centers serve the State's most vulnerable and hard to reach populations. FQHCs are non-profit, community run centers located in medically underserved areas that provide high-quality, cost effective primary care, including behavioral and oral health

services, to anyone seeking care. Each FQHC is governed by a consumer-majority board of directors who are tasked with identifying and prioritizing the services most needed by their communities. In 2019 to date we have served 11,589 unique patients with 59% being enrolled in Medicaid or CHIP.

Our 9 community-based locations in Jefferson and Lewis Counties provide access to comprehensive primary care services including oral health and behavioral health, especially among populations that are most likely to present at the ED with a non-urgent or avoidable condition.

The first round of DSRIP complemented the Health Center model's unique and innate ability to provide comprehensive and innovative care to New York's Medicaid beneficiaries. Health Centers played and continue to play a key role in advancing the promising practices within their regions and driving improved health outcomes. In the second round of DSRIP, Health Centers are well-prepared to take a leadership role to advance the State's vision of an expanded value-based payment (VBP) landscape driving DSRIP promising practices.

## II. Embracing the Role of VDEs

We are pleased to see that the State has acknowledged the need for additional flexibility in the next round of DSRIP and is interested in ensuring the success of Value-Driving Entities (VDEs). However, we encourage the State to provide direct investment in community-based providers. Currently, 23 of 25 of the PPS leads are hospital-based, with no specific requirements about how funds flow to partners in the PPS networks. Meaningful governance participation by community-based providers, such as community Health Centers and community behavioral health organizations, and downstream investments to Health Centers and other community-based providers varied greatly from PPS to PPS. Our PPS, North Country Initiative, is a successful example of how to include and invest in community-based providers including FQHCs. Our Health Center has received significantly more DSRIP funding as compared to fellow FQHC colleagues in other PPSs as North Country Initiative as valued the role we play in providing primary care services to our Medicaid patients. However, the most up to date data reported by the State in November 2018 demonstrates that hospitals received more than 28% of total funds flow while representing only 0.2% of total engaged PPS partners. It is exceedingly difficult to transform the healthcare delivery system by continuing to invest most transformation dollars into inpatient-based care models, when it is the long-standing established CHC providers and workforce that can make the biggest impact on patients' health outcomes. CHCs are especially well-posed to integrate care, make connections to address social needs, and become the more adept and agile VDEs envisioned in the State's concept paper.

We support the State's charge that VDEs include providers, community-based organizations (CBOs), and managed care organizations (MCOs) to leverage VBP and advance promising practices. A collaborative partnership between community-based providers, CBOs, and MCOs is critical to implementing and supporting transformative initiatives that move away from a

volume-driven care model. However, to support improved access to care in the community and reduce reliance on emergency departments and inpatient care, the State must direct additional resources to a broad range of community-based providers. **North Country Family Health Center requests that the State dedicate, at a minimum, 25% of DSRIP funds to the development of community-based VDEs where CHCs, in collaboration with other community-based providers, can be leads or have a governance role.**

### a. VDE Lead Entities

The State should capitalize on existing community or Health Center Independent Practice Associations (IPAs) as a launching point for the creation of community-based VDEs. There are four CHC-led IPAs currently organized across the state: Community Health IPA (CHIPA), Safety-Net IPA (SIPA), Finger Lakes IPA (FLIPA), and Upstate Community Health Collaborative IPA (UCHC). All are engaged with MCOs in at least one VBP contract while working on additional agreements. North Country Family Health Center is a member of the North Country IPA which is led by our PPS. IPAs are able to take on risk and become financially accountable for both the quality of care and the most efficient delivery of care services. We believe that IPAs are well positioned to work with other entities as a VDE in the second round of DSRIP. Healthcare Partners of the North Country led by the North Country Initiative is well equipment to move forward value-based contracting and is currently working on developing contracts.

While Health Centers like ours are already developing relationships needed to advance in VBP contracts, a second round of DSRIP is an opportunity to invest in building capacity to ensure Health Center and CBO IPAs have the foundation to serve as VDEs. Currently, Health Center-led IPAs are self-funded and have little financial capacity to support many of crucial functions that would accelerate their successful participation in VBP arrangements. **Health Center-led IPAs require DSRIP investment to support the data analytic capabilities needed to effectively manage population health and drive improved outcomes.**

### b. Considerations for Engaging MCOs

North Country Family Health Center is pleased that the State is taking steps to ensure engagement of MCOs early in the planning process for a second round of DSRIP. However, there are significant challenges that must be addressed ahead of the creation of VDEs. One of the current difficulties faced by providers as they seek to participate in VBP arrangements is a lack of comprehensive data about their attributed patients. **The State should create and enforce a uniform data sharing policy for the managed care plans to further support the transition to VBP, for example, by enforcing transparency in expenditures and utilization.**

In the first round of DSRIP, the discrepancies between MCO attribution and PPS attribution made it difficult for Health Centers to effectively manage patient health outcomes. PPS networks do not necessarily encompass the same providers that are contracted with a given MCO. If there are discrepancies between MCO attribution, consumer utilization, and PPS

network, it becomes incredibly difficult, if not impossible, for the PPS to effectively manage health outcomes for these populations. PPS and VDEs should not be expected to manage the healthcare improvements of individuals who are enrolled in managed care plans that contract outside of the VDE. **North Country Family Health Center recommends that in the next round of DSRIP, VDE attribution should be aligned with MCO attribution to ensure seamless VBP contracting.**

### III. Supporting Non-Clinical Workforce to Address Social Needs

North Country Family Health Center echoes the State's observation that many of the successful DSRIP initiatives rely on non-traditional, non-clinical workforce that help patients navigate clinical and social services systems to address their multi-dimensional needs. In the first round of DSRIP, we embraced the flexibility to address patients' social needs. For example, our PPS developed roles for Community Health Workers who worked directly in hospital emergency departments to connect at risk patients with primary care providers.

In the first round of DSRIP, the State encouraged primary care practices to become patient-centered medical home (PCMH) recognized. Today, 97% of New York's Health Centers are PCMH certified. PCMH certified practices provide mental health, oral health, and health promotion/disease prevention services through comprehensive primary care. This model of patient-centered care is associated with improved health outcomes and reduced costs and should be robustly supported in the second round of DSRIP. There are numerous studies that have analyzed the success of PCMH, including citing fewer specialty visits needed, lower per member costs, and better health outcomes amongst individuals seeing PCMH-

**The State should use a second round of DSRIP to continue investments in care management programs like PCMH and Health Homes to address patients' social and medical needs.**

### IV. Aligning Performance Measures

North Country Family Health Center strongly supports the State's desire to work with CMS to align performance measures across initiatives. Health Centers' participation in Medicare, Medicaid, NYS PCMH, and contracts with managed care plans (among various other programs) requires a significant amount of resources invested in measure/data collection and reporting. **The State should target measures most likely to be of value for all participants in DSRIP 2.0.**

### V. Health Center Alternative Payment Methodology

FQHCs embrace the State's transition of Medicaid payment from volume to value. North Country Family Health Center supports this direction and is also engaged in work with CHCANYS to move away from a visit based FQHC payment to a capitated FQHC Alternative Payment Methodology (APM). Federal statute permits states to implement an APM in lieu of the legally required prospective payment system reimbursement methodology. States must ensure that reimbursement under the APM is not less than it would be under the prospective payment

system rate; however, adoption of an APM is essential to move FQHCs from a visit-based payment that incentivizes volume, to a payment methodology that rewards efficiency and outcomes. A capitated FQHC APM aligns with the State's DSRIP goals of advancing VBP and provision of enhanced care coordination.

An FQHC APM supports team-based, integrated care and enables CHCs the flexibility needed to create innovative approaches to care which can include non-clinical support staff who are not billable providers under the prospective payment system rate. The creation of innovative care coordination workflows will improve care provided directly by FQHCs, therefore reducing costs across the healthcare system.

North Country Family Health Center looks forward to working closely with CHCANYS and the Office of Health Insurance Programs to establish a mutually agreeable approach that supports Health Centers' ability to transform their entire practice to a value-based care delivery model. Once the APM receives a federal approval, a small subset of Health Centers will transition from the prospective payment methodology to the APM. **To ensure the success of an APM, State investment is needed to enhance data collection capabilities and catalyze the development of new staffing roles, models for care teams, and innovative work flows.** These investments may include: enough funding to support interventions addressing patients' non-clinical social needs, support for an alternative payment learning community, clinical and cost data analyses, quality metric identification, and reporting mechanisms.

North Country Family Health Center has actively engaged in DSRIP implementation and contributed to many of the successes achieved. We look forward to continuing to partner with the State to achieve our shared goals of system transformation and improved patient care, better patient outcomes, and reduced care costs.

Sincerely,

Joey Marie Horton
Chief Executive Officer

## doh.sm.1115Waivers

**From:** Maryam Zoma Kiefer [redacted]
**Sent:** Wednesday, October 30, 2019 2:53 PM
**To:** doh.sm.1115Waivers
**Cc:** Amy Dorin
**Subject:** 1115 Public Forum Comment
**Attachments:** 2019_1030_DSRIPComments_CBH.pdf



Dear Medicaid Redesign Team,

The Coalition for Behavioral Health is the unified voice of New York's behavioral health community, representing over 100 community-based providers who serve approximately 400,000 individuals annually. Our training and advocacy ensure providers are equipped to advance recovery and wellness for New Yorkers in need.

The Coalition for Behavioral Health is committed to partnering with the State as various transformations to the State Medicaid system move forward, including the behavioral health transition to managed care, the shift to value-based payments (VBP) and efforts to integrate both physical and behavioral health services. The Coalition supports the New York State Department of Health in its effort to secure a continuation of funding for the Delivery System Reform Incentive Payment (DSRIP) Program from the Centers for Medicaid and Medicare.

The Coalition and its membership are pleased to see the State emphasized the importance of behavioral health interventions in the new DSRIP waiver amendment. However, the current waiver application needs to emphasize the central role of behavioral health providers in the healthcare system. In order to ensure the future success of DSRIP, **The Coalition's main recommendation on the new DSRIP waiver is that behavioral health providers should lead behavioral health-focused projects and continue to be more meaningfully engaged in DSRIP projects**. This not only recognizes the unique expertise of behavioral health providers, but also recognizes that true cost savings happen in the community, not in the emergency room or hospital. People want to receive services in the community and near their home, by providers, such as our member agencies, that they trust and can build meaningful connections with. This is especially true for those with serious mental illnesses, substance use disorders, intellectual and developmental disabilities, and those with co-occurring disorders who are the most difficult to engage and most costly to the Medicaid system. In addition, many of our members offer social services that address the social determinants of health and have an incredible impact on healthcare outcomes and expenditures.

Over the past four years, approximately 80 percent of The Coalition's agencies were members of multiple PPSs and involved in a variety of DSRIP projects in New York City, Long Island, and Westchester. Projects included integration of primary care and behavioral health, population health management, Health Home at risk, and crisis stabilization services. DSRIP allowed our providers to build stronger relationships with hospital systems, connect people leaving the hospital to the right care in the community, and access the tools, data, and IT infrastructure to analyze their programs and link to HIEs. Our providers received real-time healthcare information on the people they served in order to coordinate care in an integrated and holistic fashion. In addition, DSRIP provided our members with funding to take on these innovative projects. Our providers

reported receiving on average $500,000 from each of the PPSs they worked with (ranging from $12,000 to $1.5 million), in addition to training, technical assistance, and IT infrastructure.

DSRIP enabled our providers to offer effective and cost-saving services that helped individuals and communities. For example, one of our members reported that they were able to save the Medicaid system $3,300,000 in hospitalization costs in one year with approximately 66 individuals due to their involvement in the Critical Time Intervention project with a PPS. That is a savings of $50,000 per person.

The Coalition offers the following recommendations to improve the DSRIP waiver amendment. These recommendations help ensure long-term cost savings by placing behavioral health providers at the forefront of interventions so that individuals receive care in the community, where costs are lower and provider expertise is substantial.

- **Behavioral health providers should lead behavioral health-focused projects and continue to be more meaningfully engaged in DSRIP projects.**
- **Meaningful integration of behavioral health beyond mild to moderate depression and anxiety**:
    - **Recommendations: 1) allow behavioral health providers to lead and manage integrated care interventions; 2) provide incentives for integration of primary care services into behavioral health programs.**
    - Although part of the purpose of DSRIP was to integrate care and to remove barriers to allow for the holistic treatment of the whole person, those with acute behavioral health issues were relatively left out of integrated care efforts, even though they are some of highest utilizers of high cost services with physical health co-morbidities. The 2018 DSRIP evaluation highlights behavioral health interventions, but predominately focuses on integrating behavioral health screenings, primary care provider delivery of behavioral health services, and recognition of mental health disorders. Although this is a necessary step to address behavioral health issues in a population health approach, this does not address those with serious mental illness or substance use disorders, who cost a tremendous amount to the system but are not receiving the care they truly need. Behavioral health providers are the ones who interact the most with these individuals and have an intimate understanding of their needs and receptiveness to care.
- **Data transparency**:
    - **Recommendation: Data transparency on outcomes, PPS networks and member participation by project, and funding allocation and PPS determination of funding per project and per member.**
    - With the first round of DSRIP, there was a lack of data available to the public on PPS and organization attributed outcomes, PPS networks, and information on amount of funding to providers. It was very difficult to determine which community providers were in a PPSs network, which projects they were working on, and how much funding and support they received from the PPSs. Although there are lists available online, these lists are difficult to search. Future lists of networks should include the provider name, primary address where services are delivered, the type of provider and organization, and the specific projects the provider is involved in or contributing to. In addition, it was unclear as to how PPSs determine the amount of funding providers receive when participating in a project. If PPSs use algorithms, pay for performance, or other payment incentive models, we recommend that PPSs provide this information to providers delivering the service so they can project and understand the compensation they will receive.
- **Shared savings to behavioral health**:

- **Recommendations: 1) outline pathway to ensure shared savings attribution to behavioral health providers; 2) allow providers to put shared savings into reserves.**
- We are pleased to see the State recognizes that PCP attribution does not fully capture some of the behavioral health treatment and services that attributed to DSRIP's success, however, there is not a clear pathway outlined by the State to ensure shared savings gets attributed and provided to behavioral health organizations. The new DSRIP application mentions "more sophisticated payment models" but does not mention what these are or how successful they are in ensuring that behavioral health providers receive the resources and savings they deserve. Moreover, for behavioral health providers to be successful in future VBP-contracting arrangements, they need to have reserve funds available in order to take on risk-bearing contracts. Most behavioral health providers do not have access to reserves since State and City contracts do not allow providers to use funding to maintain reserves.

- **DSRIP 2.0 Priority areas**: The Coalition supports the emphasis on behavioral health in the promising practice categories proposed for continuation. These are all areas that directly impact behavioral health providers and clients that they serve. We offer the following suggestions for improvement:
  - **Expansion of MAT into Primary Care and ED settings**:
    - **Recommendation**: **Require EDs and primary care providers to develop relationships with behavioral health organizations to provide aftercare.**
    - Although expanding access to MAT is imperative in addressing the opioid crisis, MAT alone is not enough, and people need connections to behavioral health providers in their community to engage in aftercare and follow up.
  - **Primary care and behavioral health integration**:
    - **Recommendations: 1) use DSRIP funding to expand the Certified Community Behavioral Health Clinic (CCBHC) model; 2) extend the DSRIP waiver to allow providers to offer up to 49% of services outside of their licensure; 3) develop a long-term integrated care solution, such as the formerly proposed Article 99 license, to allow for providers to offer integrated services without multiple agency oversight.**
    - Although some of our providers participated in the 3.a.i. project in the first round of DSRIP, regulatory burdens and billing restrictions make it difficult for our providers to sustain these initiatives and successes beyond DSRIP. However, the CCBHC model has allowed three of our members to offer integrated services in the community that are financially sustainable through the prospective payment system.
  - **Care coordination, care management, and care transitions**:
    - **Recommendation: Establish a Health Home Care Management (HHCM) Training Institute (already proposed by The Coalition for Behavioral Health and the New York Health Home Coalition), to offer statewide standardized trainings on evidence-based practices for care managers and supervisors**.
    - The success of DSRIP and the Medicaid redesign initiative rests on care managers since they are the main coordinator of care for those with both high physical and behavioral health risks and needs. However, high rates of turnover and unsustainable caseloads make it difficult for care managers to effectively manage care and reduce healthcare costs. The State needs to invest in more training for frontline staff and supervisors and higher reimbursement rates in order to allow for sustainable and manageable caseloads.
  - **Focus on SMI/SED populations**:
    - **Recommendation**: **Outline how behavioral health providers will be meaningfully integrated into SMI and SED projects, what types of measurements will be used to evaluate the effectiveness of these projects, and ensure behavioral health providers will not be financially penalized when attempting to engage this population**.

- **VDEs:**
    - **Recommendations: 1) require VDEs to partner with community-based behavioral health providers; 2) require contracting with at least one community-based behavioral health provider to enter a VBP level 2 or 3 contracting arrangement OR expand and broaden the definition of tier one CBOs to include community-based behavioral health providers that bill Medicaid; 3) allow BHCCs to be lead VDEs; 4) ensure MCO accountability, standardization in processes and procedures, and price floors.**
    - The Coalition is pleased to see that the State is allowing PPSs to shift and adjust their networks to include representation from different sectors and the emphasis on governance structures that would include behavioral health providers. However, community-based behavioral health providers must be a requirement of these networks. In addition, we are pleased to see that the State has suggested that VDEs build upon existing VBP networks including BHCCs, of which 3 of our members are a lead BHCCs and 70 of our members are network or affiliate members.
- **Children's Population Health**:
    - **Recommendations: 1) fund Youth ACT teams since it is an evidenced based practice that has VBP potential and is a team approach and prevents recidivism and residential placement; 2) require behavioral health urgent care centers to partner with community-based behavioral health providers for aftercare; 3) allow behavioral health providers to lead and manage children's integrated care interventions.**
    - We are pleased to see an emphasis on high need children and children's behavioral health. We support integrated care efforts; however, children's behavioral health providers need to be involved as true partners in integrated care since children's behavioral health providers and the services they offer for the whole family greatly impacts adverse childhood experiences (ACEs). Expanding behavioral health urgent care centers provides an opportunity to address behavioral health needs, but there must be strong linkages and ties to community-based behavioral health providers for aftercare. For children with SED, connections to community-based behavioral health is imperative.
- **Long-Term Care Reform:**
    - **Recommendation: 1) integrate behavioral health services into long-term care services; 2) address the needs of older adults with SMI and SUD.**
    - We are pleased to see an emphasis in services for older adults in the new DSRIP waiver. However, as the population in New York State continues to age, connections to behavioral health services for the older adult population is imperative since lack of access to appropriate behavioral health services in the community drives up overall healthcare costs and makes it more difficult for individuals to age in place. Moreover, adults with SMI and SUD are living longer, due to access to better care. However, the workforce needs better training to assist these individuals as they age in order to differentiate between behavioral health and cognitive decline issues.

- **Workforce**:
    - **Recommendations: 1) use workforce funding for student loan forgiveness for behavioral health workers who commit to working in the community for a period of time; 2) partner with universities to explore mechanisms for tuition reimbursement and career ladders.**
    - We are pleased to see the State highlighted the importance of peers, community health workers, and other non-clinical staff and their important role around helping with care transitions, navigation, and recovery. However, there is a huge shortage of behavioral health workers across the State and high rates of turnover, approximately 40%, among behavioral

health workers. These individuals are essential to the healthcare workforce, however their limited salaries and large amounts of education required to work in clinical settings make it difficult for them to stay in the community behavioral health field.

We thank the State for the opportunity to share our feedback and recommendations to ensure the central role of behavioral health providers in the new DSRIP waiver. To achieve New York's long-term Medicaid redesign goals, it is imperative that community-based behavioral health organizations be fully integrated partners and leaders in DSRIP activities, as these organizations engage, assist, and serve the most vulnerable members of our community, many of whom continuously fall out of care and drive health care expenditures. Without full participation and engagement of the behavioral health community, the goals of DSRIP will be unattainable.

Amy Dorin, LCSW
President & CEO
The Coalition for Behavioral Health, Inc.
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New York, NY 10038
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DSRIP Waiver Comments from The Coalition for Behavioral Health

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- **Children's Population Health**:
    - **Recommendations: 1) fund Youth ACT teams since it is an evidenced based practice that has VBP potential and is a team approach and prevents recidivism and residential placement; 2) require behavioral health urgent**

**care centers to partner with community-based behavioral health providers for aftercare; 3) allow behavioral health providers to lead and manage children's integrated care interventions.**

- We are pleased to see an emphasis on high need children and children's behavioral health. We support integrated care efforts; however, children's behavioral health providers need to be involved as true partners in integrated care since children's behavioral health providers and the services they offer for the whole family greatly impacts adverse childhood experiences (ACEs). Expanding behavioral health urgent care centers provides an opportunity to address behavioral health needs, but there must be strong linkages and ties to community-based behavioral health providers for aftercare. For children with SED, connections to community-based behavioral health is imperative.

- **Long-Term Care Reform:**
  - **Recommendation: 1) integrate behavioral health services into long-term care services; 2) address the needs of older adults with SMI and SUD.**
  - We are pleased to see an emphasis in services for older adults in the new DSRIP waiver. However, as the population in New York State continues to age, connections to behavioral health services for the older adult population is imperative since lack of access to appropriate behavioral health services in the community drives up overall healthcare costs and makes it more difficult for individuals to age in place. Moreover, adults with SMI and SUD are living longer, due to access to better care. However, the workforce needs better training to assist these individuals as they age in order to differentiate between behavioral health and cognitive decline issues.

- **Workforce**:
  - **Recommendations: 1) use workforce funding for student loan forgiveness for behavioral health workers who commit to working in the community for a period of time; 2) partner with universities to explore mechanisms for tuition reimbursement and career ladders.**
  - We are pleased to see the State highlighted the importance of peers, community health workers, and other non-clinical staff and their important role around helping with care transitions, navigation, and recovery. However, there is a huge shortage of behavioral health workers across the State and high rates of turnover, approximately 40%, among behavioral health workers. These individuals are essential to the healthcare workforce, however their limited salaries and large amounts of education required to work in clinical settings make it difficult for them to stay in the community behavioral health field.

We thank the State for the opportunity to share our feedback and recommendations to ensure the central role of behavioral health providers in the new DSRIP waiver. To achieve New York's long-term Medicaid redesign goals, it is imperative that community-based behavioral health organizations be fully integrated partners and leaders in DSRIP activities, as these organizations engage, assist, and serve the most vulnerable members of our community, many of whom continuously fall out of care and drive health care expenditures. Without full participation and engagement of the behavioral health community, the goals of DSRIP will be unattainable.

Amy Dorin, LCSW
President & CEO
The Coalition for Behavioral Health, Inc.
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## doh.sm.1115Waivers

**From:** Gettman, William [redacted]
**Sent:** Wednesday, October 30, 2019 3:00 PM
**To:** doh.sm.1115Waivers
**Subject:** 1115 Waiver Comments
**Attachments:** Final Comments DSRIP October 2019.docx



Attached please find comments under the DSRIP 1115 Extension Proposal

Please contact me with any questions

BG

**William T. Gettman, Jr.**
*Chief Executive Officer*

Northern Rivers Family of Services
60 Academy Road | Albany, NY 12208

[redacted]

## Northern Rivers Family of Services Comments on DSRIP Extension Proposal

Thank you for this opportunity to comment on the extension of the MRT Waiver, an agreement between the federal Centers for Medicare and Medicaid Services (CMS) and New York State.

Below please find comments, recommendations and suggestions in regard to NYS's Delivery System Reform Incentive Payment program Proposal.

**Northern Rivers Family of Services supports New York's effort to continue the existing Waiver and renew an agreement through March 2024. We commend the State for their priority and dedicated work to design and meet the goals of the Triple Aim in terms of health services across NYS for children and adults.**

Approximately 47% of the state's children are covered by Medicaid. The next implementation phase would extend successful practices to children in the areas of chronic care management, behavioral health integration, pediatric-focused patient-centered medical homes, use of technology, workforce improvements, and attention to adverse childhood experiences and social determinants."

New York is preparing to submit a four-year waiver renewal to the Centers for Medicare and Medicaid Services that requests $8 billion to continue to improve its Medicaid program. New York is requesting $5 billion for the next phase of DSRIP, which is slated to end March 31. We support the recommended allocations:

- $1.5 billion to address the social determinants of health, such as access to food, housing and transportation;
- $1 billion for workforce development; and
- $500 million to support financially struggling hospitals.

We offer some added recommendations in regard to the priority and allocation of funds.

Our comments are directed toward the need to ensure adequate attention and funding to support children's programming. As reported by the Children's Clinical Advisory Committee and included in the First 1000 Values, the value proposition for children's health services stems from promoting optimal child health across the life course, which will lead to lower long-term health care costs and utilization (principally by preventing chronic conditions in adulthood), and producing savings and better outcomes for non-health sectors by improving child development

**Focus on Children Transformation**

The MRT waiver allowed the State to implement initiatives recommended by the Medicaid Redesign Team. The recommendations of the Children's Subcommittee of the Medicaid Redesign Team will not be fully implemented until 2021.

Now, however, the "children's transition" is well underway and the time is right to put additional focus on children's system of care efforts.

And, to address the alarming trends in youth suicide rates, increased demand for early childhood behavioral health services and reforms that move foster youth from congregate care into the community, Northern Rivers recommends that the next phase of DSRIP must include a number of children's community-based behavioral health focused priorities:

- Expanded pediatric integrated health-behavioral health opportunities;

- Supported transitional care teams for children and adolescents;

- Assess, test and pilot efforts to bundle payments for episodes of children's crisis care;

- Expand enhancements for Care Coordination, including expanded use of telemedicine for care coordination, and the development of Family care coordination models;

- Targeted investments into the children's behavioral health workforce to stand up the most effective and carefully designed community-based mental health service expansion across NYS with attention to rural and underserved areas

- "Pediatric health-behavioral health integration," Northern Rivers supports building upon some of the successful practices identified in the First 1,000 Days report, building upon use of the Healthy Steps approach in pediatric primary care by combining it with physicians trained through Project Teach. Project Teach, designed by the State Office of Mental health trained pediatricians and family practitioner to screen and treat children and adolescents for mild to moderate behavioral health symptoms.

**Focus on Evidence Based Pilots**

In addition, we recommend that a combination of state and federal funds be combined for pilots to support enhanced rates to support the delivery of Evidence Based Practices (EBPs) through CFTS services that are integrated to serve children and adolescents who need treatment beyond mild to moderate behavioral health services.

The expanded use of evidenced-based behavioral health services through the delivery of Child and Family Treatment and Support Services, can assist the state with stabilizing families in the community by using the most effective and research tested treatment of children with high

Adverse Childhood Experiences (ACEs) score, reactive attachment disorders, impulse control diagnoses and when the family dynamics require whole family treatment. The provision of Evidence Based treatments add value to care delivery by definition – the outcome data is measured as part of the delivery compliance and by incentivizing the delivery of Evidence Based treatments in integrated care models and the referral

**Focus on Workforce Development**

Northern Rivers strongly supports inclusion of this priority and has a number of recommendations that support improved productivity, workforce retention and methods of using family care coordination models to more completely address social determinants of health.

It is essential that investments specific to the Children's Medicaid Transformation be prioritized both in the continuation of the current agreement and during the renewal period. We believe the children's system of care workforce should be singled out for investments that support the Medicaid Redesign goals because the transition is still underway and because implementation requires training and re-training that the community based organizations that are the backbone of the children's behavioral health care systems do not have the resources to invest.

Between 016-2018, recently surveyed Care Management Agencies (CMAs) reported that 55% of their care managers left community behavioral health agencies to do care coordination in other settings. Yet, of the community-based CMAs surveyed, 68% reported they need to expand services and hire more behavioral health care managers.

The specific areas of workforce investment include: 1) re-training residential staff to enter the community-based workforce as reliance on residential is reduced; 2) investments in the start-up costs of Evidence Based Practice expansion, including fees, fidelity compliance and training time of staff with the confidence that EBPs can strengthen the work of non-clinically trained staff as valuable members of clinical team, standardize efficiency, quality and outcomes in a field that is in a chronic workforce shortage state; 3) investments in mobile workforce development, including necessary technology costs per worker (laptop, wi-fi card because of insufficient bandwidth in many rural areas, cell phones and mobile EMR modifications to allow concurrent documentation of progress notes) and the purchase of Artificial Intelligence products that amplify the quality and value of non-clinical, direct care workers, like youth peer advocates, family peer advocates and psychosocial rehabilitation workers with tools that assist with excellence in treatment and progress note developed concurrently during treatment, but with little risk for error; 4) use funds to expand "Get on Your Feet" loan forgiveness program to allow 2 years of repayment for BA and MA level staff with qualifying loan burden that work in child-serving settings impacted by Medicaid Redesign; and 5) retention bonuses for care managers, licensed clinicians, direct care staff, mobile team staff who meet training and time of service milestones – which we believe is an economic development goal because a high percentage of the children's behavioral health care workforce is women and the economic

stability that can be attained if parents do not have to work 2 jobs to support their families could be measured as a positive economic outcome of the DSRIP workforce investments.

**Focus on Crisis Services**

Expanding behavioral health urgent care centers for children has decreased emergency admissions and provided further access to care. This is a critical need and high priority. There is insufficiency of appropriate Crisis Intervention options for children.

In New York City, schools are under court order to reduced emergency removals to emergency departments. We support the use of DSRIP funding to implement pilots for case rate or bundled payment models—with performance targets—for responding to children in crisis.

The services that could be combine in the pilot include Mobile Crisis, the Crisis Intervention benefit as defined in the CFTS service, OMH licensed Children's Crisis Residence programs (added by amending Part 589 of Title 14 NYCRR in 2019) and other crisis services available through CFTSS in the Other Licensed Practitioner benefit.

Rather than additional "brick and mortar" investments in urgent care centers, this case rate proposal allows for the provision of consumer specific support services, allowing providers to build a continuum in a community that involves multi-level partnerships with primary care, social services, schools, probation, and substance use services. These systems would be augmented with telehealth and mobile interventions to provide rapid response service delivery, family engagement and better care coordination. The pilot would build upon existing residential resources for stabilization needs and the mobile crisis response component of the Crisis Intervention benefit that mandates de-escalation, assessment and referral occurs where the child presents in crisis – home, school, community. This approach supports maximizing "care without walls" and rapid referral to crisis residences when necessary. If a short-term, out-of-home crisis service is needed, the OMH Children's Crisis Residence program must be supported with a cost base rate and should be considered to address the call for expansion of crisis stabilization program to minimize avoidable admissions.

**Conclusion**

Thank you for this opportunity to comment on the extension of the MRT Waiver, an agreement between the federal Centers for Medicare and Medicaid Services (CMS) and New York State.

We encourage the final plan to focus on the short and long term positive impacts associated with the provision of quality and timely services to children.

For additional information, please contact [redacted]

## doh.sm.1115Waivers

**From:** Jodi Saitowitz [redacted]
**Sent:** Wednesday, October 30, 2019 4:10 PM
**To:** doh.sm.1115Waivers
**Subject:** 1115 Public Forum Comment
**Attachments:** DSRIP Comments CCF Final.docx.pdf



On behalf of The Collaborative for Children and Families, Inc. (CCF)-thank you for the opportunity to comment. Please see our comments in the attached document. If you have any questions, please feel free to reach out to me directly, my contact information can be found here below.

**Jodi A. Saitowitz, LCSW-R | Chief Executive Officer**
**Collaborative for Children and Families, Inc**.
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**CLICK HERE to make a Referral**
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# Delivery System Reform Incentive Payment (DSRIP)- Comments Submitted November 4th 2019

The Collaborative for Children & Families (CCF) is grateful for the opportunity to offer comments on the Medicaid Redesign Waiver* DSRIP Amendment request. To that end, CCF supports DOH in its request for a continuation of the existing waiver and is particularly appreciative of the Department of Health's recognition of the importance of increasing investments in initiatives that strengthen New York's children and families through March 2024.

CCF is a consortium of more than 20 voluntary foster care agencies (VFCA) and community-based organizations (CBO) whose expertise and specialty in serving children and families supports a collective vision to keep children and families in their communities and connected to services so they remain healthy and progress on their developmental trajectories. CCF is the largest Health Home Serving Children in the downstate region with over 8,000 members and is one of only three Health Homes in NYS designated to serve only children.

As DSRIP is intended to be transformational and we recognize that little funding has reached CBOs in the first years. DSRIP offers the opportunity to empower CBOs to make necessary changes at the community level. To that end, we strongly endorse a model that assures that CBOs receive direct investment – instead of directing financial resources to large hospital systems only.

The existing agreement allows the State to use a managed care delivery system to deliver benefits to Medicaid recipients, create efficiencies in the Medicaid program, and enable the expansion of coverage and benefits to children who would not otherwise have access. Due to a number of delays in the transformation, implementation of the expansion has not had sufficient time to be fully implemented and will not until 2021. Children's specialty services and exempt child populations have not fully enrolled in Managed Care. In fact, involvement in health systems reforms and the Delivery System Reform Incentive Payment (DSRIP) program have been extremely limited for children.

The "children's transition" is now underway and the time is right to place additional focus on children's system reforms. The next phase of DSRIP must retain the proposed child-focused priorities. Child-focused reforms are long overdue. It is time to address serious population health problems including youth suicide, unmet demand for early childhood behavioral health services and reforms that improve the health of children and youth in foster care.
CCF is pleased that, in section III of the proposal, *Additional High-Need Priority*

* https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/2019/docs/amendment_req.pdf

*Areas,* the state acknowledges that the next phase will "***extend successful practices to children in the areas of chronic care management, behavioral health integration, pediatric-focused patient-centered medical homes, and attention to adverse childhood experiences and social determinants. Care transitions and care management for targeted groups have been very successful and would be expanded to serve this population, in collaboration with the Health Homes Serving Children.***"

CCF has been at the forefront of ensuring the highest quality care management to assure that the needs of our children and youth are met through our Health Home program. CCF looks forward to the types of collaboration with community health workers, partnering with transitional care teams of clinicians and peers and using telemedicine in addressing the promising practices outlined in the renewal proposal. The special populations such as children with special health care needs, HIV/AIDS are groups we look forward to working with as VBP approaches are pursued.

At the same time, maintaining a sufficient and qualified workforce is critical to the success of the Health Homes Serving Children and the new Children's Behavioral Health Services to be able to meet the challenges of the new populations and new program collaborations and models. We strongly endorse the integration of telemedicine as an important component of the best practices needed to reduce the workload burdens on care managers. The strength of the workforce would also be enhanced through development of innovations that support and encourage ongoing participation of Licensed Social Workers and Behavioral Health practitioners in not- for-profit service to maintain workforce sufficiency.

In addition, drawing upon our experience in providing individual care coordination services to children and youth, CCF strongly recommends offering a similar service that has a family focused approach to care coordination. Supporting and strengthening the entire family system while providing ongoing support and ensuring that the needs of each individual within the context of families are met is a critical factor in seeing that children have every opportunity to lead healthy and productive lives. Developing a family model for care management would ensure that the needs of each family member is identified and addressed in a comprehensive approach consistent with addressing social determinants of health.

In closing, CCF applauds the State's commitment to prioritize children as part of this DSRIP waiver. We ask that the commitment invest further in assuring improved outcomes in children, youth and families. As DOH states – the success of the Health Home program are evident -- and committing further to its workforce as well as to family care models and an expansion of proven models will result in not only improved lives of children and youth on Medicaid but also a greater savings to the State over time. CCF is committed to working collaboratively with DOH to support and strengthen families as we continue in our mission to care for New York State's most vulnerable children and families.

For additional information, please contact me at [redacted]

Jodi Saitowitz, CEO
The Collaborative for Children & Families, Inc

# MEMBER ORGANIZATIONS OF THE COLLABORATIVE FOR CHILDREN AND FAMILIES

1. Abbott House
2. Andrus
3. Astor Services for Children & Families
4. Cardinal McCloskey Community Services
5. Catholic Guardian Services
6. Center for Human Development and Family Services (CHDFS)
7. Community Assistance Resources and Extended Services, (C.A.R.E.S.) Inc.
8. Forestdale
9. Good Shepherd Services
10. Hamaspik of Kings County
11. Little Flower Children and Family Services
12. Lutheran Social Services of NY
13. Martin de Porres Group Homes
14. MercyFirst
15. New Alternatives for Children
16. NY Foundling
17. Rising Ground
18. SCO Family of Services
19. Seamen's Society
20. Sheltering Arms
21. St. Christopher's Inc.
22. St. Mary's Healthcare System for Children
23. The Children's Aid Society
24. The Children's Village

## doh.sm.1115Waivers

**From:** Feruz Kidane [redacted] on behalf of Rahil Briggs [redacted]
**Sent:** Wednesday, October 30, 2019 4:56 PM
**To:** doh.sm.1115Waivers
**Cc:** Jennifer Tracey; Elizabeth Frenette
**Subject:** ZERO TO THREE - 1115 Public Forum Comment
**Attachments:** ZERO TO THREE - 1115 Public Forum Comment (002).pdf



Dear Department of Health Office of Health Insurance Programs,

Please see the attached comments from HealthySteps at ZERO TO THREE on the 1115 waiver amendment.

Best,
Rahil

**Rahil D. Briggs, PsyD**
National Director | HealthySteps
A Program of ZERO TO THREE

Clinical Associate Professor of
Pediatrics & Psychiatry,
Albert Einstein College of Medicine

[redacted]

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Washington, DC 20037

healthysteps.org

# ZERO TO THREE Comments on New York's Medicaid Redesign Team Waiver 1115 DSRIP Amendment Request

HealthySteps National Office

HealthySteps
PEDIATRIC CARE • SUPPORTING • PARENTING
A Program of ZERO TO THREE

ZERO TO THREE is pleased to have the opportunity to comment on New York's DSRIP Waiver Amendment to support additional health care system quality improvements under the Delivery System Reform Incentive Payment (DSRIP) Promising Practices. The overall aim of DSRIP 2.0 is to focus directly on community-level collaboration, in order to meet the state's first and ongoing goal of reducing avoidable admissions by 25 percent over the five-year demonstration period. We believe ZERO TO THREE's HealthySteps initiative is fully consistent with the policy directions described in the DSRIP 2.0 policy paper and should be embraced by New York State as it continues to undertake strategies to reform the primary care delivery system.

HealthySteps is an evidence-based, interdisciplinary pediatric primary care program, designed to promote nurturing parenting and healthy development for babies and toddlers. HealthySteps offers an array of services to meet families' needs through a resource-efficient, risk-stratified approach, supporting families of all income ranges, while geared specifically to lower income families. The model delivers child and adult-focused interventions that have been proven to generate short-term (annualized) cost savings to New York Medicaid. These early childhood and two-generation investments have been shown to yield even greater returns when evaluated over a longer time period, even beyond the health sector.

With the goal of behavioral health integration, a child development professional, known as a HealthySteps Specialist (HS Specialist), connects with and guides families during and between well-child visits as part of the primary care team. The HS Specialist offers support for common and complex concerns that physicians often lack time to address, including feeding, behavior, sleep, attachment, parental depression, social determinants of health (SDH), and adapting to life with a baby or young child. HS Specialists are trained to provide families with parenting guidance, support between visits, referrals, and care coordination, all specific to their needs.

HealthySteps is a population health model that includes eight core components organized into three tiers of service that are responsive to each family's needs. Universal services (Tier 1) for all children and families in the practice include: child developmental and social-emotional/behavioral screening; family needs screening; and access to a child development support line. Based on these universal screenings as well as clinical judgment and/or identified parent concerns, the practice identifies children and families in need of additional services. As needed, families receive short-term support services (Tier 2), including development and behavior consults with the HS Specialist; care coordination and systems navigation services; positive parenting guidance; and early learning resources. Children and families with the greatest needs also receive comprehensive services (Tier 3) in the form of ongoing, preventive, team-based well-child visits, during which both the HS Specialist and primary care provider meet with families.

While HS Specialists are embedded in over 45 health care practices throughout the state, there has been little success in supporting the model through direct payment or value-based payment (VBP) contracting. As the waiver amendment acknowledges, "current VBP arrangements built exclusively around primary care provider (PCP) attribution and networks do not completely embrace the kind of comprehensive integrated primary care, behavioral health, and other social care capacities that have been at the heart of most of the DSRIP success." Although HS Specialists have made demonstrable

improvements to the delivery system, those efforts have not benefited from DSRIP funding or received other support that would ensure that the model would remain sustainable across the state.

Our National Office is extremely pleased to receive resounding support for the HealthySteps model from the Preventive Pediatric Care Clinical Advisory Group. The First 1000 Days Preventive Pediatric Care Clinical Advisory Group Final Report and Recommendations called upon the state to sustain its investment in the HealthySteps model, both through the continuation of funding for the sites currently supported by the state and to allow the model to expand to more practices throughout New York. This falls within the state's 1115 waiver amendment recommended actions for securing a better future for New York's children. The HealthySteps model does just that through its commitment to promoting healthy early childhood development through a dyadic approach. These community-based provider networks cannot be sustained without investment. If the state truly expects to improve population health, then the state must provide incentives that more strongly encourage Medicaid managed care organizations (MMCOs) to partner with non-traditional yet highly effective models of care focused on prevention.

Forty-six primary care sites across the state have incorporated HealthySteps into their practices to create stronger primary care and behavioral health integration. The holistic approach of the HealthySteps model provides families with the tools and supports needed to identify and address some of the SDHs and challenges of life that directly affect the health and well-being of the family, but have not been previously addressed within the traditional scope of a primary care visit. We are encouraged that two of the federal priority areas, Social Determinants of Health and Primary Care Improvement and Alternative Payment Models, provide a stronger focus on children's health and wellness which could lead to a wider embrace of the HealthySteps Model.

Looking ahead at the unfolding of DSRIP 2.0, we applaud the state for including MMCOs and stakeholders from primary care within all Value-Driving Entities. In addition to identifying new promising practices, it is equally important to identify and discontinue supporting the practices that have not directly achieved the goals of DSRIP. Further, the state and all Value-Driving Entities should be encouraged to embrace some of the promising practices already underway in New York, whose efficacy and promise have been proven through independent randomized trials and/or documented outcomes of improved health and well-being. Indeed, it is a robust statement in support of HealthySteps that so many practices across the state have adopted the model, driven by the evidence, the return on investment, and the improved lives for their youngest patients. HealthySteps solves problems facing practices and families.

Similar to the current DSRIP program, DSRIP 2.0 intends to focus on promising practices that "will meet the needs of potentially high-cost, high-need subpopulations." The state must encourage Value-Driven Entities to support interventions that enable them to achieve these goals. HealthySteps drives short-term cost savings to the Medicaid program. The first single statewide analysis conducted by the HealthySteps National Office in 2017, in partnership with Manatt Health, demonstrated annualized savings to Medicaid of up to $1,150 per family, for an *annual* return on investment (ROI) of 83%. Recently, two additional analyses were conducted in other states. One statewide analysis, demonstrating annualized savings to Medicaid of $402 per family, for an average annual ROI of 177%

and another single site analysis, demonstrating annualized savings to Medicaid of $1,444 per family, for an average annual ROI of 383%[1].

As such, HealthySteps aligns with the direct goals of DSRIP to drive short-term cost savings as follows.

> The primary emphasis within DSRIP and VBP is achieving immediate or short-term cost savings/outcomes. Children are not, generally, high-cost users of health services today, though inattention to their developmental health could lead to future needs and costs. Regarding the SDH, evidence suggests that one of the most important things that can be done in the early years for positive health outcomes later is strengthening the stability, safety, and nurturing in the home environment. The task force should advise on how this can be accomplished in the context of VBP.
>
> > *—New York State Social Determinants of Health and Community Based Organizations Subcommittee's recommendation that "the state should form a taskforce of experts and a process specifically focused on children and adolescents in the context of VBP"*

In a recent report, the United Hospital Fund (UHF) also noted that when compared to adults, "children in Medicaid are relatively low-cost, use fewer inpatient services, and experience less chronic disease." As a result, services to children "have a distinct value proposition that warrants a distinct payment approach. That approach should encourage high-value health promotion services and reward providers for achieving longer-term health savings. In pediatric care, value primarily comes from promoting healthy child development, as well as preventing future costly health conditions, particularly adult chronic diseases, that have an enormous human toll. Payment models must be structured to motivate and support primary care providers in achieving that goal." [2] The UHF report highlights the concerning lack of focus on the needs of children within the context of payment reform.

Within the appendix of the state's 1115 waiver amendment, the state highlights current Performing Provider Systems (PPS) examples of promising practices at work. These examples, while impressive, suffer from a notable lack of focus on children. ***To ensure long-term success of the DSRIP initiative, the state must support a system that encourages payment reforms that respond to the unique and varied needs of children. This will only occur if Value-Driving Entities are strongly encouraged to partner and to invest in the interventions that address the needs of children beginning at the time of birth and onward.***

As noted by UHF, payment reform for children's health services must be uniquely flexible to support the varying services that address, "evolving patient needs through childhood." The HealthySteps model is designed to screen for those needs and to address them through the coordination of community supports and providers, many of which operate outside of the health care arena but contribute directly to the health and well-being of children.

Thank you for the opportunity to provide comments on the DSRIP Waiver Amendment and for your consideration of these comments. For more information, please contact Rahil Briggs, National Director for HealthySteps, at [redacted]

[1] ROI and cost savings are disparate across states due to cost differences.

[2] Reforming Payment for Children's Long-Term Health: Lessons from New York's Children's Value-Based Payment Effort. United Hospital Fund August 2019

## doh.sm.1115Waivers

**From:** Barry Brogan [redacted]
**Sent:** Wednesday, October 30, 2019 5:54 PM
**To:** doh.sm.1115Waivers
**Cc:** Bud Ziolkowski
**Subject:** 1115 Waiver Public Comments
**Attachments:** DSRIP 2.0 NCBHN Comments.pdf

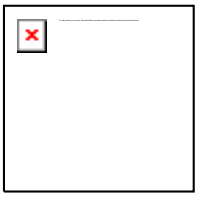
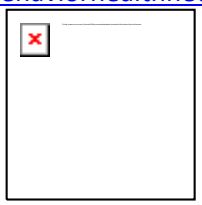


**North Country Behavioral Healthcare Network** (NCBHN) is comprised of twenty nonprofit member agencies providing mental health (MH) and substance use disorder (SUD) services in New York's seven northernmost counties as well as the Akwesasne Mohawk Reservation, collectively New York State's "North Country". NCBHN appreciates the opportunity to provide written comments on the State's proposed 1115 Waiver application for DSRIP 2.0 (D2.0).

Please find our comments attached as a PDF to this email.

Thank you for your consideration

--
Barry B. Brogan, Executive Director
North Country Behavioral Healthcare Network
[redacted]
Facebook - www.facebook.com/ncbhnandms
Website - www.behaviorhealthnet.org

# North Country Behavioral Healthcare Network

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*◆ Serving the North Country Since 1997 ◆*

October 30, 2019

NYS Department of Health
Office of Health Insurance Programs
Waiver Management Unit
99 Washington Ave
12 Floor, Suite 1208
Albany, NY 12210

**RE: DSRIP 2.0**

To Whom It May Concern

**North Country Behavioral Healthcare Network** (NCBHN) is comprised of twenty nonprofit member agencies providing mental health (MH) and substance use disorder (SUD) services in New York's seven northernmost counties as well as the Akwesasne Mohawk Reservation, collectively New York State's "North Country". NCBHN appreciates the opportunity to provide comments on the State's proposed 1115 Waiver application for DSRIP 2.0 (D2.0) and strongly supports the rationale laid out in the Amendment Request. It is imperative for the success of D2.0 that behavioral healthcare (BHC) providers are included as equal partners in models moving forward, and funded as such. The National Institutes of Health report that 80% of Medicaid super-utilizers have comorbid mental illness with 44% having serious mental illness. Meanwhile, the devastation of the opioid epidemic goes on, seemingly unchecked.

Specifically, we are in agreement with the stated strategy of aligning the rationale for the request with Federal goals and priorities through the continuation of identified promising practices. We note that eight of the nine identified promising practice categories deal directly with BHC, other community-based partners, and community partnerships to address social determinants of health (SDOH). Additionally, two of the four key Federal priorities are "continued workforce investment that includes non-traditional, non-clinical care providers such as community health workers and patient navigators" and "building on existing progress in addressing the opioid epidemic."

Further, the Amendment Request describes a new and more flexible operational structure than the initial DSRIP project, replacing Performing Provider Systems (PPS) with "'Value-Driving Entities' (VDE) which will consist of PPS (or a subset of PPS), provider, CBO and MCO teams specifically approved by the state to implement the high-priority DSRIP promising practices." We see this shift as critical to accomplishing the goals of D2.0 and note that "governance would include additional representation from community-based providers, including primary care, ***behavioral health*** (emphasis added) and long term care…" It is essential that all of these identified team members come to the table as equal partners in the governance of the VDE in order to assure that D2.0 dollars are utilized in the most effective way possible.

**Recommendation: Most NYS PPSs are governed and controlled by hospital coalitions. For D2.0 to realize its potential, the PPS must be but one voice at the VDE governance table, and not a majority one. Other stakeholders to include behavioral health (including mental health, SUD prevention, treatment and recovery service providers) and SDH providers must have equal footing. MCOs should be incentivized to participate and to contract directly with CBOs, SDHNs, and organized behavioral health providers to establish the value that these providers add to the system. Where applicable Rural Health Networks should also be represented on the governance body.**

In the current DSRIP world, the experience of BHC providers has been mixed at best, and always dependent upon the governance and cash flow provided by the (mostly) hospital-based PPS. The bulk of dollars allocated during the first two years of DSRIP went to hospitals and to the structure developed to operate the DSRIP effort. It took persistence and public attention to this issue as a problem for funding to begin to flow to community-based services and community-based organizations. The review of DSRIP performance to date contained in both the Amendment Request and the DOH-cited United Hospital Fund (UHF) report "*DSRIP Promising Practices: Strategies for Meaningful Change for New York Medicaid*" reveals a very strong reliance on behavioral healthcare and other community-based, often non-medical services and supports for success as witnessed by this excerpt from the UHF report:

"Several core practice elements have emerged, such as integrating primary care and behavioral health, ***investing in the behavioral health workforce*** (emphasis added), targeting individuals with complex behavioral health needs, reducing emergency department (ED) use through crisis stabilization, utilizing peers to support recovery, and developing new responses to the opioid epidemic."

Noting specifically the core practice element of "investing in the behavioral health workforce," the UHF report provides, as an example, the development of Mobile Crisis Assessment Teams (MCAT). While we agree that new and innovative practices can improve services and reduce costs, the BHC community-based service sector has experienced funding opportunities specific to such innovations at the same time that core substance use disorder (SUD) and mental health (MH) services have eroded and continue to erode due to a lack of adequate funding. Significant funding earmarked for BHC providers will ensure that these vital services remain available and become more robust.

The Amendment Request refers to the "best practice" of SBIRT which stands for "screening, brief intervention and referral to treatment." The "referral to treatment" portion of that best practice means referral to community-based SUD treatment, and requires further analysis. While there is a recognition of the need "to use earned dollars to support non-clinical workforce (e.g. community health workers, peers, patient /community navigators, etc.)" there is no mention of utilizing those dollars to support the credentialed SUD and licensed MH professionals who perform the core work once the referral to treatment is made.

**Recommendation: D2.0 should contain significant investment in VBP pilot projects that encourage innovative approaches to integrating community based MH, SUD and SDH services. These projects, funded through contractual arrangements with MCOs, must demonstrate a sustainable system for recruiting and retaining clinical and non-clinical staff that are reimbursed commensurate with their credential and their peers within the primary and acute care health care system.**

There has been a significant push, through DSRIP and, more broadly, in the medical community, to provide medication assisted treatment (MAT) in order to save lives that are at risk due to opioid addiction. It is, to be sure, a critical piece of addressing the epidemic. However, medication ***assisted*** treatment alone will not solve the problem. In the absence of a full range of prevention, treatment (in the traditional 'talk therapy' mode which encompasses many evidence-based best practices such as cognitive behavioral therapy) and recovery, we will continue to put out a growing number of fires without ever adequately addressing the addictive process that is causing them.

We must note as well that, while addressing the opioid addiction epidemic is critical, it is only one manifestation of the addiction crisis that we are facing. Alcohol-related deaths still outnumber opioid overdose deaths both in the State and nationwide. The latest scourge of vaping is an existential threat to our youth, returning them to high rates of nicotine use after years of prevention efforts had reduced the use rate in NY's high schools to 4%. It is now estimated by NIDA that 2 in 5 U.S. 12$^{th}$ graders are vaping, and the devastating health impacts of that practice, including addiction, are only now emerging.

The over-prescription of narcotic medication is not the only pathway to the chronic, progressive and fatal disease of addiction, and D2.0 would do well to identify and fund the full range of exit ramps from those many pathways.

**Recommendation: D2.0 should also contain long term investment in VBP pilot projects that address the causes and effects of addiction and mental illness. These pilot projects should challenge communities to develop sustainable prevention programs funded through VBP contracts that address mental illness and addiction at onset and at ALL stages through treatment and recovery. Key to demonstrating the value that these non-hospital community based services can deliver is access to population health data and costs.**

Finally, our members daily face and meet the challenges of providing services in New York State's most rural region. They have long been successfully supported by Rural Health Networks in those efforts. Now we are seeing the emergence of overlapping (and sometimes competing) entities such as the RPC, PPS, BHCC and CBO collaboratives, and now the VDE and SDHN. All the while funding to Rural Health Networks has been stagnant or diminished. It seems logical that inclusion of the Rural Health Networks as members of the VDE teams in rural regions would provide experience and expertise in meeting the unique challenges of successfully providing services in those areas.

**Recommendation: NY State's Rural Health Networks are uniquely qualified and positioned to assist in the fulfillment D2.0 objectives within rural communities. Funding to support RHNs should be made available through the D2.0 program. DOH should directly contract with RHNs that are engaged in supporting system redesign initiatives that can demonstrate increased access, improved quality and cost effectiveness. And again, a key component to demonstrating the value of RHN initiatives is access to population health data and costs.**

Thank you for the opportunity to provide comments on this important initiative. The North Country Behavioral Healthcare Network remains available to assist the DOH in any way appropriate to bring DSRIP 2.0 to New York and to New York's Rural Communities.

Thank you for your consideration.

Barry B Brogan

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

**doh.sm.1115Waivers**

**From:** Lisa Furst [redacted]
**Sent:** Wednesday, October 30, 2019 5:56 PM
**To:** doh.sm.1115Waivers
**Subject:** 1115 Public Forum Comment - Vibrant Emotional Health
**Attachments:** Comments on NYS DSRIP Amendment - Vibrant Emotional Health 10-30-19.docx



Please find attached comments regarding the DSRIP Amendment request.

**Lisa Furst, LMSW, MPH**
**Assistant Vice President**
**Center for Policy, Advocacy and Education**
**Pronouns: she/her/hers**

[redacted]

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**Comments on NYS DSRIP Amendment**

Vibrant Emotional Health appreciates the opportunity to submit comments in response to New York State's Delivery System Reform Incentive Payment (DSRIP) Amendment Request. Vibrant is pleased to note the amendment's emphasis on innovation in a few key areas, including:

- Focus on special populations, including children and those requiring long-term care services (including older adults);
- Care transitions;
- Broadening the array of community-based organizations and other non-hospital providers to address the social determinants of health;
- Support for the non-clinical workforce, including community health workers, peers, and patient navigators, among others.

**However, the amendment does not explicitly address a number of key areas that are critical to ensuring that special populations with behavioral health issues, including children, youth and older adults, receive the comprehensive and high quality care they need and deserve to recover and thrive.**

For example, suicide is the second leading cause of death for youth aged 15-19 in New York, and over half of children and youth aged 3-17 who are living with behavioral health conditions do not receive necessary treatment. Given these stark realities, **it is crucial that New York State increase its investment in children and youth, including:**

- Evidence-based programs focused on addressing the complex needs of children/youth and families;
- School-based behavioral health supports;
- Increased outpatient treatment services focused on children and youth;
- Suicide prevention programs;
- An emphasis on early identification and intervention for young children, including collaborative care models such as those included in the First 1,000 Days on Medicaid program;
- Family support services that enable families to better navigate the healthcare, behavioral health, and other service systems that influence children's recovery from serious emotional disturbance (SED).

In addition, the amendment correctly notes that New York State will experience a significant increase in its older adult population, noting that by 2040, the number of adults aged 65 and over will increase by 50%, and emphasizes the need for long-term care reform. **However, long-term care reform is framed without appropriate emphasis on the impact of behavioral health conditions among older adults. It is vital that New York State focus on the integration of behavioral health services and supports into long-term care continuum.**

Unaddressed behavioral health needs are a driver of disability among older adults, necessitating a greater reliance on long-term care services. Older adults with behavioral health conditions are more likely to be placed in institutional settings, including skilled nursing facilities and psychiatric institutions, driving up the overall cost of serving this population.

At the same time, older adults currently receiving care in institutional settings are more likely to be able to transition out of more expensive inpatient services if they are provided with appropriate clinical care, including care management, in the community. It will not be possible for older adults living with behavioral health conditions to age in place without having appropriate services and supports to address mental and substance use disorders which are so often co-morbid with physical health conditions.

**In order to help prevent or delay institutional placement, it is vital that New York State invest in strengthening the ability of the long-term care service system to identify and address behavioral health needs.** Long-term care providers, such as home health care workers, need to be trained to recognize emerging signs and symptoms of mental and substance use disorders, and long-term care provider organizations need to structure their services to be able to engage older adults with behavioral health needs to connect them to appropriate sources of care. Where possible, behavioral health treatment providers should be embedded into existing long-term care services in the community.

**New York State also needs to address the needs of adults living with serious mental illness (SMI) who are aging.** Growth is also expected in this population, and existing programs serving older adults with SMI often do not have the necessary expertise to address issues associated with aging. **Workforce investment must include the implementation of existing evidence-based programs for older adults with behavioral health needs**, including, but not limited to, Assertive Community Treatment (ACT) teams, models of community-based mental health interventions, such as the Program to Encourage Active, Rewarding Lives (PEARLS), and mobile crisis teams with specialized expertise to serve older adults, among others.

Additionally, there is a dearth of specialized community-based services for older adults with behavioral health needs; those which do exist are under-resourced**. New York State should fund opportunities for existing behavioral health providers to receive training and technical assistance to serve older adults in order to increase the number of services available. In addition, aging services providers, such as older adult case management services and geriatric care managers should be recruited into Value-Driving Entities (VDEs) in order to ensure that older adults receive needed benefits/entitlements and care coordination they need to meet their needs and age in place in the community.**

In summary, New York State's efforts to improve the delivery and quality of health care services in the public sector is laudable. However, without the specific incorporation of behavioral health services and supports in every aspect of the health care landscape, New York State will not effectively achieve its goals of improving quality, reducing unnecessary care, and lowering overall costs of service provision. For these reasons, Vibrant Emotional Health urges New York State to ensure the inclusion of behavioral health services as it builds the new health care service landscape. Behavioral health services are not auxiliary to healthcare – they are a fundamental part of it.

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**From:** Ann Battaglia [redacted]
**Sent:** Thursday, October 31, 2019 9:55 AM
**To:** doh.sm.1115Waivers
**Subject:** 1115 Public Forum Comment
**Attachments:** Rest of State CBO Consortium Comments on DSRIP 2.0_ 10.31.19.pdf



Good morning,
On behalf of the members of the CBO Consortium of Upstate New York, attached are a summary of comments and recommendations from the rest of state CBO Planning Grant membership. Thank you for the opportunity and for considering these recommendations.

***Ann Battaglia***
***Chief Executive Officer***

HEALTHY COMMUNITY ALLIANCE INCORPORATED
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Connecting for Health Equity

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**CBO Consortium of Upstate New York**
**Public Comments Submission related to DSRIP 2.0 Amendment Request**

## Introduction

CBOs are trusted members of their communities, with deep knowledge about the range of available community supports and the needs of its community members.

CBOs, both individually and collectively, have established infrastructures that support sustained and recognized service delivery to diverse, high needs communities. These infrastructures promote client navigation, education, outreach and engagement and continuity of services before, during, and after contact with the health care system.

Community agencies, over the years, have been stretched to provide their traditional services and are now being asked to accept responsibility for more people with greater health needs. This acceptance includes upfront costs and risks, such as adding additional staff, increasing information technology (IT) capacity, in some cases before any reimbursement or shared savings is received. The opportunity to change in a more holistic and systemic way can and should be incorporated in to DSRIP 2.0.

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 Planning Grant to support smaller, Tier 1, community-based organizations (CBOs) in the 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 be better positioned to engage in healthcare system transformation toward a shared goal of improving population health outcomes in their communities. The 260 member CBO Consortium of Upstate New York is the largest consortium of its kind in New York State, covering five subregions and 48 upstate counties. On behalf of its membership, the CBO Consortium of Upstate New York is respectfully submitting the following comments and recommendations for public comment related to the 1115 Waiver Delivery System Reform Incentive Payment (DSRIP) Amendment Request.

## Value Based Payment Framework

<u>Comments:</u>

1. Everything does not have to be made incredibly complex. Programs that have been developed that show good results should be given an opportunity for continuation and expanded even if they do not fit into the advanced risk sharing VBP models. It is not clear that the VBP proposed models will work in all instances. Flexibility needs to be provided to communities to allow contracts that focus on outcomes and do not shift the potential losses to small CBOs who may be critical to their success.

   Allowing focused provider/CBO/MCO teams to implement the high priority DSRIP promising practices appears to be a good idea. The CBOs should have a prominent

role in the planning, development and implementation of the proposals to assist in ensuring success.

2. Wellbeing is politically and conceptually linked with health inequality and social cohesion. Payers can demonstrate their commitment in ensuring that their policies and resource allocations embed the priorities of CBOs and our needs to ensure improved health outcomes and conditions in the lives of residents of NYS, especially the most marginalized communities.

   Payers are trying to link a whole host of factors to performance. This way of thinking will not work if CBOs and the role of community voices continues to be the last factor.

   Aligning with CBO's already serving a priority community for improving health outcomes must be part of a continuum. Not one-shot deal (s) nor as a marketing approach.

Recommendations:

- Increase CBO and social care provider inclusion in the healthcare delivery system at every level including governance, infrastructure and decision making. CBOs should be represented as an entity and not as an extension of PPSs or Value Driving Entities. The CBO Consortium is the largest collective of CBOs prepared for engagement in system reform.
- Include MCOs in planning to ensure financial incentives align to support meaningful VBP contracting with social care providers by VBP subcontractors. For example, rural CBOs need their cost of service provision to be acknowledged (travel time serving sparsely populated regions, etc.) in payment methodology. Identify a specific roadmap outlining the expectations of MCO involvement in DSRIP 2.0.
- Identification of performance measures required for this iteration of the demonstration.
- Specific roadmap outlining the expectations of CBOs, including the roles of each tier, to ensure appropriate planning, roll out and on-going implementation of the VBP framework.

**Value Driving Entities and Social Determinant of Health Networks**

Comments:

1. It's hard to comment on these new entities since not much information has been provided. This approach would give DoH the ability to push rate setting and bill paying down to fewer entities and simplify the state's administrative headaches for budgeting and reporting. However, the risk is this moves New York State's Medicaid System to a “bigger equals better model” and this may also distance health care providers and insurers even further from their communities than they already are. The proposed approach, invests more of the locus of control for program delivery, quality, and oversight to new unproven entities. The process needs to have accountability built in so that Medicaid recipients still have their due process rights

protected, so that taxpayers know where the funding is going, and so that communities have a say in developing their systems of care.

It is not clear how many of these new structures DoH would like to see in place. It is assumed it would be far less then that existing 25 PPSs. Care should be taken to not implement this in massive regional swathes that will mute specific community needs and input…. 25 may be too many but 3-5 is far too few.

2. It is a good idea to bring CBOs into the governance, as well as, into the initial planning and design process. CBOs should be represented as an entity and not as an extension of PPS'.

<u>Recommendations:</u>

- Social determinants of health networks should be led by "Social Care Provider Networks". There is a risk of exclusion of valuable community based social care providers both in rural and urban communities if the nucleus of the value driving entity (VDE) is a PPS or gargantuan hospital system. – example, the smaller CBOs both rural and urban that are now engaged under the CBO Planning Grant were, in most cases, initially excluded from PPS projects.
- Funding should be made available within DSRIP 2.0 to continue developing more building blocks to foster expanded supply and use of social determinants of health provided in the community. This should include funding for the development of IPAs for CBOs and funding for continued technical assistance through the CBO Consortiums. The CBO planning grants launched the infrastructure that provides necessary technical assistance and supports to critical, but previously excluded, CBOs. Implementation funding would leverage the $7.5 million dollar investment that DOH has already made in this infrastructure and would continue the work of increasing capacity of CBOs to engage in healthcare delivery system reform and ensure the CBO sustainability of the critical social care services they provide.
- Clarity on how lead applicants will be picked and the number of entities (minimum and maximums for demonstration, PPS, regions, etc.). Identification of basic parameters ensures fidelity of the principle and still always flexibility of the needs for each community, region, PPS.
- Identified timelines, planning and expectations of application and implementation of entities. Create mandates to ensure robust CBO inclusion in planning and roll-out. Identification should include level of involvement expectations and leadership roles specific to each CBO tier.
- Clarity on the relationship and differences between VDEs and SDOH Networks. Explanation should include reasons for two separate entities; and ability for VDEs to also be the SDOH network (why/why not).
- Consideration that SDOH networks already exist and should be contracted with instead of a creation of a new network. In other words, support a buy it vs build it model that provides investment in existing CBO networks and social care providers. This will allow for more rapid impact instead of VDE's building their own SDoH networks.
- Specific roadmap outlining the expectations of MCO involvement in both VDEs and SDOH Networks.

**Data and Analytics**

Comments:

1. Hospitals collaborating with CBO's on data collection and analysis that is needs driven can help them manage community health and wellbeing.

Recommendations:

- Define clear expectations between Hospitals, CBOs, MCOs and PPS' with regard to sharing and analyzing patient data.
- Support the development of a community information exchange platform that is a centralized source of social care data that not only provides bidirectional exchange capabilities but would provide value back to the CBOs. A closed loop referral system that stems from healthcare only provides more referrals to an already underfunded social care ecosystem. A community information exchange application originating with social care providers would process and deliver social determinant of health data across other closed loop referral systems and to multiple sectors including health care providers, PPSs, BHCCs and RHIOs. This application would provide value to DSRIP goals as it would be a central hub and repository for social care information that can be used to demonstrate health outcomes as they relate to social determinants of health. This single point of truth for social care information, coupled with claims data shared back to social care networks, would strengthen CBOs positioning in value based contracting in a manner that supports long term sustainability.

**Additional High Priority Need Areas and Performance Measurement**

Recommendations:

- An additional criterion should be added to the proposal development process for the next phase. In addition to focusing on maternal mortality, children's population health, and long-term care DoH should include revisiting the status of care in hotspot areas to see if progress has been made, identify remaining problems and require resources and projects to focus on these areas within each region.
- Identify how the uninsured populations is being addressed in this new DSRIP iteration.

**Long Term Care Reform**

Comments:

1. The recommendations from the DOH's "Long Term Care Planning Project" should be infused into the waiver request and applicants should be required to address appropriate recommendations in their applications.

2. Part of planning process should be to assess indicators selected for projects and identify any better ones especially those related to dealing with social determinants

of health. Experience in using VBP for Home Health Care is mixed, especially when providers are serving individuals with chronic conditions that may not improve and where the goal is more to maintain them in the community vs. seeing marked decreases in use of health services.

Recommendations:

- Local projects proposed should include input from the local aging network including the Area Agencies on Aging and NYConnects programs. These stakeholders should also be involved in the implementation aspects of any projects.
- More indicators are needed to address services provided to older Medicaid participants.

**Continued Workforce Flexibility and Investment**

Comments:

1. The supply of workers that provide home care also needs to be factored into the workforce development strategies. These include workers that provide home health aide, housekeeper chore, and homemaker personal care services. Innovative models for supporting workers (higher wages, use of company cars, fringe benefits, and career ladders) should be given extra points in any application process for local or regional projects.

Recommendations:

- Initial investment in workforce is needed until VBP and revenue sharing supports CHW sustainability.
- Continuing education for support workers as well as a fair/living wage. Many workforce classifications are underpaid.
- Workforce development should not only include community health care workers and patient navigators; it should also include care workers and care coordinators who are in short supply.
- Workforce investments should help offset costs for Doula training.

**Coordinated Population Health Improvement (and coordination with MEDICARE)**

Comment:

1. The continuation of requirements for PPSs and MCOs to focus on social determinants of health, will be critical to sustaining and expanding the growth of these supports in the community.

Recommendations:

- The State should also work on a parallel track to require MCOs who offer Medicare Advantage Plan products to expand the use of "Special Supplemental Benefits for Chronically Ill" beneficiaries and encourage them to coordinate such services with Medicaid funded services so that consumers have more even care in their communities and avoid perpetuation of initiatives that do not talk to or coordinate with one another.

**Cultural Competency and Diversity**

Comments:

1. The ability to create culturally responsive approaches to serving diverse communities is an expertise of the CBO's. Cultural competence means more than client satisfaction with services that only minimally meet the cultural or linguistic needs of the target community. Community-based organizations have demonstrated experience in addressing issues that are beyond the traditional reach of clinicians. Community-based organizations can identify and address risk factors, such as challenges to self-care, environmental hazards, need for social supports or protection, mental health challenges, or difficulty with medication management that can have a significant impact on health and health care spending.

2. Cultural competency is important way that payers of health care become more responsive to the needs of increase diverse communities. To do that successfully, effectively, and have a lasting impact, an equal partnership, reciprocity in decision-making, and co-design approach with community-based organizations (CBOs) or networking of CBO's is a must.

Recommendations:

- Continued requirements are needed to assure that this next phase will expand a culturally competent and diverse workforce and health care system.
- Identify ways to directly engage the Medicaid recipient and assure accountability in order to influence success of initiatives.
- Assure that patients are being assessed for SDOH and patient activation.
- Identifying the accountabilities and supports needed to engage the uninsured population.

**Care Transition, Care Management and Care Transitions**

Recommendations:

- Incentives should be provided to expand the use of these tools, along with more Patient Navigators and Community Health Workers to help DSRIP extend the health care supports out to the patient where they live, link them to the services they need in a timely manner, and support them as problems emerge. At-Risk Patients should include persons with multiple chronic conditions.

**Peer Support and Peer Mentors and Chronic Disease Management Programs**

Comments:

1. Expanding the use of these strategies is excellent. Support should also be encouraged for the use of other evidence based or informed models such as those that help prevent falls or disease or cope with chronic conditions. This would be consistent with federal and state prevention plans.

**Funds Flow and Investment**

Recommendations:

- Continue to increase CBO capacity to engage in the healthcare delivery system through implementation funding of the 3 consortia formed under the CBO Planning Grant. The three regional community planning consortiums must play a critical role in this development and operation of proposed social determinant of health networks.
- Smaller CBOs (Tier 1) should be allocated capacity dollars to allow them the ability to actively participate and position themselves in DSRIP 2.0. Dollars should be earmarked for all aspects of infrastructure including traveling costs, materials, staffing, etc.
- Provide funding to start up new IPAs for CBOs.
- Raise requirements for CBO contracting for MCOs and PPS'
- Consider more than 5% of funds flow to non-safety net providers.

We close this comment with a quote from the director of a consortium member CBO that provides critical services to new mothers living below poverty level.

She states, "Being a part of the CBO Consortium of Upstate NY 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 Social Determinants of Health that I couldn't have realized before."

Going forward, in this next phase of DSRIP, much care should be taken to not implement SDOH Networks and Value Driving Entities in massive regional swathes that will mute the community based organization addressing these specific and critical community needs. Much work has gone into helping CBOs understand and communicate their value, now we must affirm their value and ensure their sustainability.

Again, on behalf of the CBO's in the CBO Consortium of Upstate New York thank you for this opportunity.

## doh.sm.1115Waivers

**From:** Lisa Bobby [redacted]
**Sent:** Thursday, October 31, 2019 11:17 AM
**To:** doh.sm.1115Waivers
**Cc:** Chan, Peggy (HEALTH); Frescatore, Donna J (HEALTH); Fish, Douglas G (HEALTH); Gregory Allen [redacted]; Mark Ropiecki; Lenore Boris [redacted]
**Subject:** 1115 MRT Waiver Comment
**Attachments:** CCN DSRIP 2.0. Lenore Boris.10.30.2019.final.docx



Good morning,

On behalf of the Care Compass Network PPS, thank you for the opportunity to participate in the Upstate NY Public Comment day yesterday. We found the comments to be informative. We appreciate your leadership in moving this transformative work forward.

Attached are Lenore Boris's comments. We will be submitting our PPSs comments on or before November 4th.

Please let us know if there is anything we can do to further support your team.

Best,

Lisa

*Lisa Bobby*
Director of Operations

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[redacted]
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Good morning. My name is Lenore Boris, PhD, RN, and labor attorney. I am the Associate Dean for the Clinical Campus at Binghamton for SUNY Upstate Medical University and also oversee the Garabed A. Fattal Free Clinic in Binghamton New York. I have prepared some comments on behalf of the Care Compass Network PPS. Since the beginning of DSRIP 1.0, I have participated in the original application, have served as chair of the PAC Executive Council and the chair of the Workforce Committee, assist in overseeing a 1,600 on-line panel in which the PPS receives feedback from Stakeholders, of which nearly 600 are Medicaid members, and serve on many local community agency 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 communication strategies, and even prepared slates of candidates for community member seating on the CCN Board of Directors.

I want to thank the State for its leadership and approach with DSRIP. We have observed positive progress in our region which has resulted in improvements to the health and wellbeing 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 the State plans for their final submission to CMS, we strongly encourage 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 Fund's "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 their integration strategy with CBOs and/or Social Determinant of Health Networks.

We also recommend that the **requirement for 95% 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 those entities who do not meet the formal legal qualifications for safety net (e.g., Medicaid billing organizations), but functionally perform the safety net role in their delivery of services in their 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 are aiming to achieve.

With regards to the **VDE and SDH Network roles, there should be flexibility in how regions adopt the VDE concept**. In our region, we envision the evolved PPS operating as the Regional VDE *Convener*, a role which would continue and expand the region's ability to evaluate, monitor, and actively manage Performance Risk through the integration of 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 and regions**, such that will permit the true integration of community and clinical data to inform performance risk management and support VBP maturity. There is a risk that SDH Networks independent from the VDE may not effectively

integrate with the clinical impact of the social determinant work and thus not provide an effective value proposition for the sustaining VBP environment. **The SDH Network and VDE should sufficiently develop data sharing practices to support this integration.**

Lastly, what we have learned through DSRIP and the work displayed by the PPSs is that transformation is possible. Moreover, we are capable of deploying incentives at the community level to innovate and achieve results in a very short period of time. **Managed Care (MCO) engagement and partnership now needs to be more meaningfully approached** to construct VBP agreements that recognize and sustain the new, non-traditional community partnerships that have demonstrated the significant gains in performance and cost-savings. The **DOH should continue to monitor funds distributed through VBP arrangements** and also consider the development of a high level MCO engagement roadmap and **deploy an appropriate oversight group** who could provide oversight for DOH as to whether MCO engagement is on a successful path to achieve the desired outcome by March 2024.

Thank you for your time and leadership to move this very important work forward.

## doh.sm.1115Waivers

**From:** Haley Leadingham [redacted]
**Sent:** Thursday, October 31, 2019 11:36 AM
**To:** doh.sm.1115Waivers
**Cc:** [redacted]
**Subject:** 1115 Public Forum Comment
**Attachments:** Credo Community Center_1115 Comment.pdf; Children's Home of Jefferson County_1115 Comment.pdf; Jefferson County Public Health Services_1115 Comment.pdf; Lowville Medical Associates_1115 Comment.pdf; North Country Prenatal Perinatal_1115 Comment.pdf; Northern Regional Center for Independent Living_1115 Comment.pdf; Samaritan Medical Center_1115 Comment.pdf; South Jefferson Rescue Squad_1115 Comment.pdf; Watertown Urban Mission_1115 Comment.pdf; North Country Initiative_1115 Comment.pdf



Good morning,

On behalf of the Tug Hill/Seaway Valley Region, please find written public comments on the 1115 Waiver from the following entities:

Credo Community Center, Substance Abuse Treatment, John Wilson, Executive Director
Children's Home of Jefferson County, Behavioral Health Services, Karen Richmond, Executive Director
Jefferson County Public Health Services, Public Health Department, Ginger Hall, Public Health Director
Lowville Medical Associates, Primary Care Practice, Steven Lyndaker, MD, Owner/Partner
North Country Prenatal/Perinatal Council, Community-Based Organization, Tina Cobb, Executive Director
Northern Regional Center for Independent Living, Peer Run Disability Rights, Aileen Martin, Executive Director
Samaritan Medical Center, Inpatient and Outpatient Medical Center, Thomas H. Carman, Chief Operating Officer
South Jefferson Rescue Squad, EMS transport agency, Debbie Singleton, Executive Director
Watertown Urban Mission, Tier 1 Community Based Organization, Dawn Cole, Executive Director
North Country Initiative, PPS, Erika Flint, Executive Director and Collins Kellogg, MD, NCI Board Chair

Thank you,
Haley

NORTHCOUNTRY INITIATIVE
Haley Leadingham, MPH
*DSRIP Performance Coordinator*
120 Washington St., Suite 230
Watertown, NY 13601
[redacted]
http://www.northcountryinitiative.org

October 30, 2019

New York State Department of Health
Empire State Plaza
Albany, NY 12237

Re: 1115 Public Forum Comment

To Whom It May Concern,

As the Executive Director for the Credo Community Center, an organization focused on improving the lives of those impacted by substance abuse in the region, I offer strong support for the DSRIP Amendment Request to CMS. The transformative work conducted under the 1115 waiver has greatly impacted the region, including a 25% reduction in avoidable admissions from MY0 – MY4 and a 27.3% reduction in readmissions from MY0 – MY4 in addition to several other performance measures that have seen significant improvement over the course of DSRIP. Our belief is that this success has come from the clinician-led NCI PPS structure.

The NCI PPS has provided direct support to Credo Community Center through PPS resources and funding. Our organization is appreciative of the PPS approved funds flow logic that has been inclusive to all entity types and has provided agency resources including the ability to recruit providers, staffing for workflow changes, among many others. This funding has allowed our organization to provide necessary substance abuse services to the region. In addition, PPS resources have been key to improving regional health including compliance and data security support, community health workers, behavioral health peer supports, Certified Diabetes Educators, and training resources.

The PPS supports the submission of the DSRIP Amendment Request to CMS to advance DSRIP best practices and facilitate VBP maturation. In collaboration with the North Country Initiative, the Credo Community Center strongly supports the following request components to be included in the Official Waiver Proposal to CMS:

- "Value-Driving Entities" (VDE) to consist of PPS, providers, CBOs, and requiring MCOs to be active partners.
- Flexibility to implement high-priority DSRIP promising practices using provider/CBO/MCO teams
- Alignment and strategic narrowing of performance measure sets
- Continuation of primary care/behavioral health integration and primary care transformation support
- Prioritization of continued Workforce support to include a focus on non-traditional workforce and innovative strategies for training, recruitment, and retention

Additional considerations should be made to addressing the following:

- DSRIP Programmatic Breakout by Waiver Year: the current structure has 50% of the federal funding applied to year 1 of the program. Given the percentage paid for performance and the MY timeline, there might not be enough lead time to develop the VDE structure while fully implementing the promising practices that affect the performance measures within the MY.
- Alignment of the Social Determinant of Health Network (SDHN) and Value-Driving Entity regions to avoid fragmentation and to coordinate SDH as they relate to the region/market pursuing VBP arrangements.
- To build on DSRIP momentum, it is imperative that high performing PPS' infrastructure remain unchanged.

Sincerely,

John Wilson
Executive Director

CHILDREN'S HOME
OF JEFFERSON COUNTY
*A Legacy of Compassion Since 1859*
www.nnychildrenshome.com
*Greater Watertown North Country Chamber of Commerce*
*2015 Business of the Year*

October 30, 2019

Howard A. Zucker, MD, JD
Commissioner
New York State Department of Health
Empire State Plaza
Albany, New York 12237

Re: 1115 Public Forum Comment

Dear Dr. Zucker:

As the Executive Director of the Children's Home of Jefferson County (CHJC), a non-profit organization focused on improving the behavioral health and wellbeing of children and families in the North Country, I offer strong support for the DSRIP Amendment Request to CMS.

The transformative work conducted under the 1115 Waiver has greatly impacted the region, including a 25% reduction in avoidable admissions from MY0 – MY4, a 27.3% reduction in readmissions from MY0 – MY4, and several other performance measures realizing significant improvement over the course of DSRIP. I am confident this success has come from the clinician-led NCI PPS structure.

The NCI PPS has provided direct support to the Children's Home through PPS resources and funding. Our organization is appreciative of the PPS approved funds flow logic, inclusive to all entity types. It has provided Agency resources including the ability to recruit providers and staffing for workflow changes. This funding has allowed CHJC to provide necessary mental health services to the region. In addition, PPS resources have been key to improving regional health including compliance and data security support, community health workers, behavioral health peer supports, Certified Diabetes Educators, and training resources.

The PPS supports the submission of the DSRIP Amendment Request to CMS to advance DSRIP best practices and facilitate VBP maturation. In collaboration with the North Country Initiative, CHJC strongly supports the inclusion of the following request components in the Official Waiver Proposal to CMS:

- "Value-Driving Entities" (VDE) to consist of PPS, providers, CBOs, and requiring MCOs to be active partners
- Flexibility to implement high-priority DSRIP promising practices using provider/CBO/MCO teams
- Alignment and strategic narrowing of performance measure sets
- Continuation of primary care/behavioral health integration and primary care transformation support
- Prioritization of continued workforce support to include a focus on non-traditional workforce and innovative strategies for training, recruitment, and retention.

Additional considerations should be made to addressing the following:

- DSRIP Programmatic Breakout by Waiver Year: The current structure has 50% of the federal funding applied to Year One of the Program. Given the percentage paid for performance and the MY timeline, there may not be enough lead time to develop the VDE structure, while fully implementing the promising practices affecting the performance measures within the MY.
- Alignment of the Social Determinant of Health Network (SDHN) and Value-Driving Entity regions to avoid fragmentation and coordinate SDH as related to the region/market pursuing VBP arrangements.
- To build on DSRIP momentum, it is imperative high performing PPS' infrastructure remain unchanged.

I appreciate your continued and dedicated efforts at improving the health and wellbeing of citizens throughout the North Country and statewide. I would welcome an opportunity to discuss these issues with you further. Please don't hesitate to contact me.

Sincerely,

Karen Y. Richmond
Executive Director

**Jefferson County**
# PUBLIC HEALTH SERVICE

**Public Health Facility, 531 Meade Street, Watertown, New York 13601**

October 30, 2019

New York State Department of Health
Empire State Plaza
Albany, NY 12237

Re: 1115 Public Forum Comment

To Whom It May Concern,

As the Director for the Jefferson County Public Health Service, a county agency dedicated to ensuring health services and comprehensive health education to promote the well-being of county citizens and visitors, I offer strong support for the DSRIP Amendment Request to CMS. The transformative work conducted under the 1115 waiver has greatly impacted the region, including a 25% reduction in avoidable admissions from MY0 – MY4 and a 27.3% reduction in readmissions from MY0 – MY4 in addition to several other performance measures that have seen significant improvement over the course of DSRIP. Our belief is that this success has come from the clinician-led NCI PPS structure.

The NCI PPS has provided direct support to the Jefferson County Public Health Service through PPS resources and funding. Our organization is appreciative of the PPS approved funds flow logic that has been inclusive to all entity types and has provided agency resources including the ability to recruit providers, staffing for workflow changes, among many others. This funding has allowed our organization to provide necessary health promotion services in the region. In addition, PPS resources have been key to improving regional health including compliance and data security support, community health workers, behavioral health peer supports, Certified Diabetes Educators, and training resources.

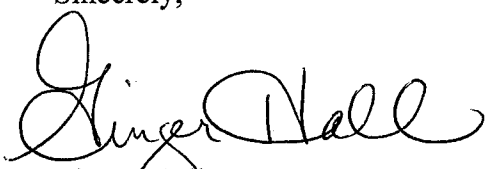
The PPS supports the submission of the DSRIP Amendment Request to CMS to advance DSRIP best practices and facilitate VBP maturation. In collaboration with the North Country Initiative, the Jefferson County Public Health Service strongly supports the following request components to be included in the Official Waiver Proposal to CMS:

- "Value-Driving Entities" (VDE) to have strategic partnerships with Regional Health Information Organization's (RHIOs), regional IPA(s), regional ACO(s), and regional BHCC(s).
- Flexibility to implement high-priority DSRIP promising practices using provider/CBO/MCO teams
- Flexibility to use earned dollars to support non-clinical (non-safety net) partners
- Prioritization of continued Workforce support to include a focus on non-traditional workforce and innovative strategies for training, recruitment, and retention

Additional considerations should be made to addressing the following:

- DSRIP Programmatic Breakout by Waiver Year: the current structure has 50% of the federal funding applied to year 1 of the program. Given the percentage paid for performance and the MY timeline, there might not be enough lead time to develop the VDE structure while fully implementing the promising practices that affect the performance measures within the MY.
- Alignment of the Social Determinant of Health Network (SDHN) and Value-Driving Entity regions to avoid fragmentation and to coordinate SDH as they relate to the region/market pursuing VBP arrangements.
- To build on DSRIP momentum, it is imperative that high performing PPS' infrastructure remain unchanged.

Sincerely,



Ginger Hall
Public Health Director

NORTHCOUNTRY INITIATIVE

October 30, 2019

New York State Department of Health
Empire State Plaza
Albany, NY 12237

Re: 1115 Public Forum Comment

To Whom It May Concern,

As the Owner/Partner of Lowville Medical Associates, a private practice offering primary care services in the region, in addition to a Medical Director for the NCI, I offer strong support for the DSRIP Amendment Request to CMS. The transformative work conducted under the 1115 waiver has greatly impacted the region, including a 25% reduction in avoidable admissions from MY0 – MY4 and a 27.3% reduction in readmissions from MY0 – MY4 in addition to several other performance measures that have seen significant improvement over the course of DSRIP. Our belief is that this success has come from the clinician-led NCI PPS structure.

The NCI PPS has provided direct support to Lowville Medical Associates through PPS resources and funding. Our organization is appreciative of the PPS approved funds flow logic that has been inclusive to all entity types and has provided agency resources including the purchase of new automated blood pressure machines in the practice, the ability to recruit providers, and staffing for workflow changes. This funding has allowed our organization to provide necessary primary care services to the region. In addition, PPS resources have been key to improving regional health including compliance and data security support, community health workers, behavioral health peer supports, Certified Diabetes Educators, and training resources.

The PPS supports the submission of the DSRIP Amendment Request to CMS to advance DSRIP best practices and facilitate VBP maturation. In collaboration with the North Country Initiative, Lowville Medical Associates strongly supports the following request components to be included in the Official Waiver Proposal to CMS:

- "Value-Driving Entities" (VDE) to consist of PPS, providers, CBOs, and requiring MCOs to be active partners.
- Flexibility to implement high-priority DSRIP promising practices using provider/CBO/MCO teams
- Alignment and strategic narrowing of performance measure sets
- Continuation of primary care/behavioral health integration and primary care transformation support
- Prioritization of continued Workforce support to include a focus on non-traditional workforce and innovative strategies for training, recruitment, and retention

Additional considerations should be made to addressing the following:

- DSRIP Programmatic Breakout by Waiver Year: the current structure has 50% of the federal funding applied to year 1 of the program. Given the percentage paid for performance and the MY timeline, there might not be enough lead time to develop the VDE structure while fully implementing the promising practices that affect the performance measures within the MY.
- Alignment of the Social Determinant of Health Network (SDHN) and Value-Driving Entity regions to avoid fragmentation and to coordinate SDH as they relate to the region/market pursuing VBP arrangements.
- To build on DSRIP momentum, it is imperative that high performing PPS' infrastructure remain unchanged.

Sincerely,

Steven Lyndaker, MD
Owner/Partner, Lowville Medical Associates

Every Woman, Every Child, Every Family
NCPPC
NORTH COUNTRY PRENATAL/PERINATAL COUNCIL, INC.

200 Washington Street, Suite 300
Watertown, NY 13601
Phone: (315) 788-8533
Fax: (315) 788-1726
Website: www.ncppc.org

October 30, 2019
New York State Department of Health
Empire State Plaza
Albany, NY 12237

Re: 1115 Public Forum Comment

To Whom It May Concern,

As the Executive Director for the North Country Prenatal/Perinatal Council (NCPPC), an organization dedicated to strengthening maternal and family health in the tri-county region, I offer strong support for the DSRIP Amendment Request to CMS. The transformative work conducted under the 1115 waiver has greatly impacted the region, including a 25% reduction in avoidable admissions from MY0 – MY4 and a 27.3% reduction in readmissions from MY0 – MY4 in addition to several other performance measures that have seen significant improvement over the course of DSRIP.

The NCI PPS has provided direct support to the NCPPC through PPS resources and funding. Our organization is appreciative of the PPS approved funds flow logic that has been inclusive to all entity types and has provided financial resources including the ability to recruit community health workers, staffing for workflow changes, among many others. This funding has allowed our organization to provide necessary community services as well as further develop patient engagement. In addition, PPS resources have been key to improving regional health including compliance and data security support, behavioral health peer supports, Certified Diabetes Educators, and training resources.

The PPS supports the submission of the DSRIP Amendment Request to CMS to advance DSRIP best practices and facilitate VBP maturation. In collaboration with the North Country Initiative, NCPPC strongly supports the following request components to be included in the Official Waiver Proposal to CMS:

- "Value-Driving Entities" (VDE) to consist of PPS, providers, CBOs, and requiring MCOs to be active partners.
- Flexibility to implement high-priority DSRIP promising practices using provider/CBO/MCO teams
- Alignment and strategic narrowing of performance measure sets
- Flexibility to use earned dollars to support non-clinical (non-safety net) partners
- Prioritization of continued Workforce support to include a focus on non-traditional workforce and innovative strategies for training, recruitment, and retention

Additional considerations should be made to addressing the following:

- DSRIP Programmatic Breakout by Waiver Year: the current structure has 50% of the federal funding applied to year 1 of the program. Given the percentage paid for performance and the MY timeline, there might not be enough lead time to develop the VDE structure while fully implementing the promising practices that affect the performance measures within the MY.
- Alignment of the Social Determinant of Health Network (SDHN) and Value-Driving Entity regions to avoid fragmentation and to coordinate SDH as they relate to the region/market pursuing VBP arrangements.
- To build on DSRIP momentum, it is imperative that high performing PPS' infrastructures remain unchanged.

Sincerely,

Tina Cobb
Executive Director

# NRCIL

**Your Disability Rights and Resource Center**

New York State Department of Health
Empire State Plaza
Albany, NY 12237

October 30, 2019

Re: 1115 Public Forum Comment

To Whom It May Concern,

As the Executive Director for the Northern Regional Center for Independent Living (NRCIL), a peer-run disability rights and resource center promoting an accessible and inclusive society, I offer strong support for the DSRIP Amendment Request to CMS. The transformative work conducted under the 1115 waiver has greatly impacted the region, including a 25% reduction in avoidable admissions from MY0 – MY4 and a 27.3% reduction in readmissions from MY0 – MY4 in addition to several other performance measures that have seen significant improvement over the course of DSRIP. Our belief is that this success has come from the clinician-led NCI PPS structure.

The NCI PPS has provided direct support to the Northern Regional Center for Independent Living through PPS resources and funding. Our organization is appreciative of the PPS approved funds flow logic that has been inclusive to all entity types and has provided agency resources including the ability to recruit behavioral health peer supports, staffing for workflow changes, among many others. This funding has allowed our organization to provide necessary advocacy and peer support services in the region. In addition, PPS resources have been key to improving regional health including compliance and data security support, community health workers, Certified Diabetes Educators, and training resources.

The PPS supports the submission of the DSRIP Amendment Request to CMS to advance DSRIP best practices and facilitate VBP maturation. In collaboration with the North Country Initiative, NRCIL strongly supports the following request components to be included in the Official Waiver Proposal to CMS:

- "Value-Driving Entities" (VDE) to consist of PPS, providers, CBOs, and requiring MCOs to be active partners.
- Flexibility to implement high-priority DSRIP promising practices using provider/CBO/MCO teams
- Alignment and strategic narrowing of performance measure sets
- Flexibility to use earned dollars to support non-clinical (non-safety net) partners
- Prioritization of continued Workforce support to include a focus on non-traditional workforce and innovative strategies for training, recruitment, and retention

Additional considerations should be made to addressing the following:

- DSRIP Programmatic Breakout by Waiver Year: the current structure has 50% of the federal funding applied to year 1 of the program. Given the percentage paid for performance and the MY timeline, there might not be enough lead time to develop the VDE structure while fully implementing the promising practices that affect the performance measures within the MY.
- Alignment of the Social Determinant of Health Network (SDHN) and Value-Driving Entity regions to avoid fragmentation and to coordinate SDH as they relate to the region/market pursuing VBP arrangements.
- To build on DSRIP momentum, it is imperative that high performing PPS' infrastructure remain unchanged.

Sincerely,

Aileen Martin

Aileen Martin, Executive Director

**www.nrcil.net**

**Watertown Office**
210 Court Street - Suite 107
Watertown, NY 13601
Phone: (315) 785-8703
TTY: (315) 785-8704
Fax: (315) 785-8612
email: nrcil@nrcil.net

**Lowville Office**
7632 North State Street
Lowville, NY 13367
Phone: (315) 836-3735
Fax: (315) 376-3404
email: karenb@nrcil.net

**Lyons Falls Office**
3979 Cherry Street
Lyons Falls, NY 13368
Phone: (315) 955-6575
Fax: (315) 513-4021
email: karenb@nrcil.net

October 30, 2019

New York State Department of Health
Empire State Plaza
Albany, NY 12237

Re: 1115 Public Forum Comment

To Whom It May Concern,

As the President and Chief Executive Officer for Samaritan Medical Center, a not-for-profit community medical center offering inpatient and outpatient services and the largest medical center within the PPS, I offer strong support for the DSRIP Amendment Request to CMS. The transformative work conducted under the 1115 waiver has greatly impacted the region, including a 25% reduction in avoidable admissions from MY0 – MY4 and a 27.3% reduction in readmissions from MY0 – MY4 in addition to several other performance measures that have seen significant improvement over the course of DSRIP. Our belief is that this success has come from the clinician-led NCI PPS structure.

The NCI PPS has provided direct support to Samaritan Medical Center through PPS resources and funding. Our organization is appreciative of the PPS approved funds flow logic that has been inclusive to all entity types and has provided financial resources that have helped with the ability to recruit providers, make workflow changes impacting quality measures, and further develop patient engagement. In addition, PPS resources have been key to improving regional health including compliance and data security support, community health workers, behavioral health peer supports, Certified Diabetes Educators, and training resources.

The PPS supports the submission of the DSRIP Amendment Request to CMS to advance DSRIP best practices and facilitate VBP maturation. In collaboration with the North Country Initiative, Samaritan Medical Center strongly supports the following request components to be included in the Official Waiver Proposal to CMS:

- "Value-Driving Entities" (VDE) to consist of PPS, providers, CBOs, and requiring MCOs to be active partners, which have strategic partnerships with Regional Health Information Organization's (RHIOs), regional IPA(s), regional ACO(s), and regional BHCC(s).
- Alignment and strategic narrowing of performance measure sets
- Continuation of primary care/behavioral health integration and primary care transformation support
- Prioritization of continued Workforce support to include a focus on non-traditional workforce and innovative strategies for training, recruitment, and retention

Additional considerations should be made to addressing the following:

- DSRIP Programmatic Breakout by Waiver Year: the current structure has 50% of the federal funding applied to year 1 of the program. Given the percentage paid for performance and the MY timeline, there might not be enough lead time to develop the VDE structure while fully implementing the promising practices that affect the performance measures within the MY.
- Alignment of the Social Determinant of Health Network (SDHN) and Value-Driving Entity regions to avoid fragmentation and to coordinate SDH as they relate to the region/market pursuing VBP arrangements.
- To build on DSRIP momentum, it is imperative that high performing PPS' infrastructure remain unchanged.

Sincerely,

Thomas H. Carman
President and Chief Executive Officer

NORTHCOUNTRY INITIATIVE

October 30, 2019

New York State Department of Health
Empire State Plaza
Albany, NY 12237

Re: 1115 Public Forum Comment

To Whom It May Concern,

As the Executive Director of South Jefferson Rescue Squad, Inc., a volunteer ambulance corps dedicated to servicing southern Jefferson County, I offer strong support for the DSRIP Amendment Request to CMS. The transformative work conducted under the 1115 waiver has greatly impacted the region, including a 25% reduction in avoidable admissions from MY0 – MY4 and a 27.3% reduction in readmissions from MY0 – MY4 in addition to several other performance measures that have seen significant improvement over the course of DSRIP. Our belief is that this success has come from the clinician-led North Country Initiative (NCI) PPS structure.

The NCI PPS has provided direct support to South Jefferson Rescue Squad, Inc. through PPS resources and funding. Our organization is appreciative of the PPS approved funds flow logic that has been inclusive to all entity types and has provided financial resources including funding for an EMS annual conference and EM Resource, a tool to better coordinate care and resource sharing between hospitals and EMS agencies. This funding has allowed our organization to provide necessary emergency medical services in the region. In addition, PPS resources have been key to improving regional health including compliance and data security support, community health workers, behavioral health peer supports, Certified Diabetes Educators, and training resources.

The PPS supports the submission of the DSRIP Amendment Request to CMS to advance DSRIP best practices and facilitate VBP maturation. In collaboration with the North Country Initiative, South Jefferson Rescue Squad, Inc. strongly supports the following request components to be included in the Official Waiver Proposal to CMS:

- "Value-Driving Entities" (VDE) to consist of PPS, providers, CBOs, and requiring MCOs to be active partners.
- Flexibility to implement high-priority DSRIP promising practices using provider/CBO/MCO teams
- Alignment and strategic narrowing of performance measure sets
- Flexibility to use earned dollars to support non-clinical (non-safety net) partners
- Prioritization of continued Workforce support to include a focus on non-traditional workforce and innovative strategies for training, recruitment, and retention

Additional considerations should be made to addressing the following:

- DSRIP Programmatic Breakout by Waiver Year: the current structure has 50% of the federal funding applied to year 1 of the program. Given the percentage paid for performance and the MY timeline, there might not be enough lead time to develop the VDE structure while fully implementing the promising practices that affect the performance measures within the MY.
- Alignment of the Social Determinant of Health Network (SDHN) and Value-Driving Entity regions to avoid fragmentation and to coordinate SDH as they relate to the region/market pursuing VBP arrangements.
- To build on DSRIP momentum, it is imperative that high performing PPS' infrastructure remain unchanged.

Sincerely,

Debbie Singleton

Debbie Singleton
Executive Director

*A Venture in Faith in the North Country*

Watertown Urban Mission

October 30, 2019

New York State Department of Health
Empire State Plaza
Albany, NY 12237

Re: 1115 Public Forum Comment

To Whom It May Concern,

As the Executive Director for the Watertown Urban Mission, a community-based organization dedicated to providing assistance to individuals experiencing difficult times, I offer strong support for the DSRIP Amendment Request to CMS. The transformative work conducted under the 1115 waiver has greatly impacted the region, including a 25% reduction in avoidable admissions from MY0 – MY4 and a 27.3% reduction in readmissions from MY0 – MY4 in addition to several other performance measures that have seen significant improvement over the course of DSRIP. Our belief is that this success has come from the clinician-led North Country Initiative (NCI) PPS structure.

The NCI PPS has provided direct support to the Watertown Urban Mission through PPS resources and funding. Our organization is appreciative of the PPS approved funds flow logic that has been inclusive to all entity types and has provided financial resources including the ability to staff workflow changes and communicate securely with other community organizations. This funding has allowed our organization to provide necessary community services as well as further develop patient engagement. In addition, PPS resources have been key to improving regional health including compliance and data security support, community health workers, behavioral health peer supports, Certified Diabetes Educators, and training resources.

The PPS supports the submission of the DSRIP Amendment Request to CMS to advance DSRIP best practices and facilitate VBP maturation. In collaboration with the North Country Initiative, the Watertown Urban Mission strongly supports the following request components to be included in the Official Waiver Proposal to CMS:

- "Value-Driving Entities" (VDE) to consist of PPS, providers, CBOs, and requiring MCOs to be active partners.
- Flexibility to implement high-priority DSRIP promising practices using provider/CBO/MCO teams
- Flexibility to use earned dollars to support non-clinical (non-safety net) partners
- Prioritization of continued Workforce support to include a focus on non-traditional workforce and innovative strategies for training, recruitment, and retention

Additional considerations should be made to addressing the following:

247 Factory Street Watertown, NY 13601 (315) 782-8440 fax: (315) 782-8441
website: www.watertownurbanmission.com

- DSRIP Programmatic Breakout by Waiver Year: the current structure has 50% of the federal funding applied to year 1 of the program. Given the percentage paid for performance and the MY timeline, there might not be enough lead time to develop the VDE structure while fully implementing the promising practices that affect the performance measures within the MY.
- Alignment of the Social Determinant of Health Network (SDHN) and Value-Driving Entity regions to avoid fragmentation and to coordinate SDH as they relate to the region/market pursuing VBP arrangements.
- To build on DSRIP momentum, it is imperative that high performing PPS' infrastructure remain unchanged.

Sincerely,

Dawn Cole

Dawn Cole
Executive Director


October 30, 2019

New York State Department of Health
Empire State Plaza
Albany, NY 12237

Re: 1115 Public Forum Comment

To Whom It May Concern,

The North Country Initiative (NCI) PPS appreciates the opportunity to provide feedback to the Department of Health regarding the Section 1115 waiver. The transformative work conducted under the 1115 waiver has greatly impacted the region, including a 25% reduction in avoidable admissions from MY0 – MY4 and a 27.3% reduction in readmissions from MY0 – MY4. In addition, there are several other performance measures that have seen significant improvement over the course of DSRIP.

Our belief is that this success has come from the clinician-led NCI PPS structure with a PPS funds flow logic inclusive of all entity types from primary care to community-based organizations to Emergency Medical Services (EMS). The collaboration of various entity types ensures that patient care is comprehensive and that community partners have relationships with other agencies with whom they can refer patients to for both social and medical needs. In addition, PPS resourced care teams have been key to improving regional health including community health workers, behavioral health peer supports, and Certified Diabetes Educators. In addition, the financial incentives have allowed PPS partner organizations to standardize clinical protocols positively impacting quality measures and to further develop care coordination services and patient engagement. Other PPS resources that have been key to improving regional health and supporting partners include compliance and data security support, training resources, and Patient-Centered Medical Home (PCMH) support.

The PPS supports the submission of the DSRIP Amendment Request to CMS to advance DSRIP best practices and facilitate VBP maturation. North Country Initiative strongly supports the following request components to be included in the Official Waiver Proposal to CMS:

- "Value-Driving Entities" (VDE) to consist of PPS, providers, CBOs, and requiring MCOs to be active partners.
- VDEs to have strategic partnerships with Regional Health Information Organization's (RHIOs), regional IPA(s), regional ACO(s), and regional BHCC(s).
- Flexibility to implement high-priority DSRIP promising practices using provider/CBO/MCO teams
- Alignment and strategic narrowing of performance measure sets
- Continuation of primary care/behavioral health integration and primary care transformation support
- Flexibility to use earned dollars to support non-clinical (non-safety net) partners
- Tracking MCO engagement for reporting purposes only
- Prioritization of continued Workforce support to include a focus on non-traditional workforce and innovative strategies for training, recruitment, and retention

Additional considerations should be made to addressing the following:

- DSRIP Programmatic Breakout by Waiver Year: the current structure has 50% of the federal funding applied to year 1 of the program. There is concern for how this would be applied given the percentage paid for performance, the Measurement Year timeline, and if there would be enough lead time to develop the VDE structure while fully implementing the promising practices that affect the performance measures within the Measurement Year.

- Role of the MCO: While the request addresses state and regional population health analytics to support the transformation, utilizing MCO data for quality measure performance, transparency in expenditures, and utilization would be required to progress towards more advanced VBP contracts. This would require the alignment of attribution assignment between the DSRIP Program and the MCOs.
- Alignment of the Social Determinant of Health Network (SDHN) and Value-Driving Entity regions to avoid fragmentation and to coordinate SDH as they relate to the region/market pursuing VBP arrangements.
- To build on DSRIP momentum, it is imperative that high performing PPS' infrastructure remain unchanged.
- Invest in care models and population health programs that address the social determinants of health: The State must maintain its investments in programs like PCMH and the Population Health Improvement Program (PHIP) to address patients' social, as well as medical, needs.

Sincerely,

Erika Flint
Director

Collins Kellogg, MD
NCI Board Chair

## doh.sm.1115Waivers

**From:** Ashley Conti [redacted]
**Sent:** Thursday, October 31, 2019 11:46 AM
**To:** doh.sm.1115Waivers
**Subject:** 1115 Public Forum Comment
**Attachments:** Healthy Community Alliance Comments on DSRIP 2.0_ 10.31.19.pdf



To Whom it May Concern,

Please find attached Healthy Community Alliance's, a rural health network, comments on DSRIP 2.0.

Thank you,

Ashley Conti
Community Engagement Specialist
Healthy Community Alliance
[redacted]

# Healthy Community Alliance Rural Health Network
# Public Comments Submission related to DSRIP 2.0 Amendment Request

## Introduction

The mission of Healthy Community Alliance Rural Health Network (HCA) is to improve quality of life in rural communities through broad-based, inclusive partnerships that support wellness and prevention. HCA is recognized throughout the region as a preeminent Rural Health Network, committed to health promotion, disease prevention, and building quality of life.
Healthy Community Alliance service area includes portions of **four** counties - southern Erie, all of Cattaraugus, northern Chautauqua and western Wyoming Counties serving some 116,000 residents including residents of two Seneca Tribal Territories in Irving and Salamanca and 1,500 Old Order Amish in Conewango Valley. There is limited or no public transportation. A substantial portion of the Alliance service area is designated as a Health Professional Shortage Area (HPSA), a Mental Health Professional Shortage Area (MHPSA), and a Dental Health Professional Shortage Area (DHPSA).

Comments and Recommendations:

Aligning with CBO's already serving a priority community for improving health outcomes must be part of a continuum. Not one-shot deal (s) nor as a marketing approach.

Social determinants of health networks should be led by "Social Care Provider Networks". There is a risk of exclusion of valuable community based social care providers both in rural and urban communities if the nucleus of the value driving entity (VDE) is a PPS or gargantuan hospital system. – example, the smaller rural CBOs that are now engaged under the CBO Planning Grant were, in most cases, initially excluded from PPS projects.

Increase CBO and social care provider inclusion in the healthcare delivery system at every level including governance, infrastructure and decision making. CBOs should be represented as an entity and not as an extension of PPSs or Value Driving Entities.

Rural communities have a high rate of older adults within the population. Local projects proposed should include input from the local aging network including the Area Agencies on Aging and NYConnects programs. These stakeholders should also be involved in the implementation aspects of any projects.

Rate setting for rural communities should account for additional costs associated with serving rural populations. Mileage adds to cost of outreach and economies of scale are difficult to achieve to due vast geographic swathes that providers cover.

It is a good idea to bring CBOs into the governance, as well as, into the initial planning and design process. CBOs should be represented as an entity and not as an extension of PPSs.

Support the development of a community information exchange platform that is a centralized source of social care data that not only provides bidirectional exchange capabilities but would provide value back to the CBOs. Rural CBOs may be attested to multiple PPSs and BHCCs

and may need to be part of multiple networks. A community information exchange application would process and deliver social determinant of health data across other closed loop referral systems and to multiple sectors including health care providers, PPSs, BHCCs and RHIOs. This application would provide value to small rural CBOS as it would be a central hub and repository for social care information that can be used to demonstrate health outcomes as they relate to social determinants of health. This single point of truth for social care information, coupled with claims data shared back to social care networks, would strengthen CBOs positioning in value based contracting in a manner that supports long term sustainability.

An additional criterion should be added to the proposal development process for the next phase. In addition to focusing on maternal mortality, children's population health, and long-term care DoH should include revisiting the status of care in hotspot areas to see if progress has been made, identify remaining problems and require resources and projects to focus on these areas within each region.

Rural communities face ongoing shortages of health care workers. The supply of workers that provide home care also needs to be factored into the workforce development strategies. These include workers that provide home health aide, housekeeper chore, and homemaker personal care services. Innovative models for supporting workers (higher wages, use of company cars, fringe benefits, and career ladders) should be given extra points in any application process for local or regional projects.

Initial investment in workforce is needed until VBP and revenue sharing supports CHW sustainability. Workforce development should not only include community health care workers and patient navigators; it should also include care workers and care coordinators who are in short supply.

Assure that patients are being assessed for SDOH and patient activation. In rural communities, community-based organizations are the trusted source and can identify and address risk factors, such as challenges to self-care, environmental hazards, need for social supports or protection, mental health challenges, or difficulty with medication management that can have a significant impact on health and health care spending.

Continue to increase CBO capacity to engage in the healthcare delivery system through implementation funding of the 3 consortia formed under the CBO Planning Grant. The three regional community planning consortiums must play a critical role in this development and operation of proposed social determinant of health networks.

Smaller CBOs (Tier 1) should be allocated capacity dollars to allow them the ability to actively participate and position themselves in DSRIP 2.0. Dollars should be earmarked for all aspects of infrastructure including traveling costs, materials, staffing, etc. Consider more than 5% of funds flow to non-safety net providers.

**Respectfully Submitted,**

**Healthy Community Alliance, a rural health network.**

## doh.sm.1115Waivers

**From:** Gloria Kim [redacted]
**Sent:** Thursday, October 31, 2019 2:02 PM
**To:** doh.sm.1115Waivers
**Subject:** 1115 Public Forum Comment
**Attachments:** DSRIP 2.0 Public Comment_HSC (1).pdf



Good afternoon,

Please see the attached comment from the Human Services Council.

Thank you,
**Gloria Kim** | *Senior Policy Analyst*

130 East 59th Street, New York, NY 10022
[redacted]

**1115 Waiver Programs for Public Comment**
**The Human Services Council**

**October 2019**

The Human Services Council (HSC) appreciates the New York State Department of Health's recognition of the import role community-based organizations (CBOs) have on the overall health and wellness of the communities they serve through a $1.5 billion investment to support the creation of Social Determinants of Health Networks (SDHNs). There is great potential in achieving the goals of DSRIP by leveraging the work and expertise of CBOs as equal partners in improving population health. By bringing healthcare services into the community, and moving away from traditional institutional care, we will be better able to meet the triple aim. Therefore, CBOs should have the opportunity to define their value and roles in the DSRIP delivery system.

Although DSRIP 2.0 has set aside support for SDHNs in an effort to support the organization of CBOs, a disproportionate amount of resources is made available for CBO needs with most of the funds focused on the needs of hospitals. New York State is dependent on CBOs to deliver human services that address social determinants of health. They care for children, the elderly, and the disabled of all socioeconomic and cultural backgrounds; provide food, housing, and transportation assistance; and deliver services and supports for immigrants, people with substance use disorders, people experiencing homelessness, individuals involved in the justice system, people with barriers to employment, and socially marginalized groups. CBOs enhance overall well-being by empowering individuals to reach their full potential and enabling communities to thrive. All of this we know impacts health outcomes.

At the same time, it is important to acknowledge that New York's vast network of CBOs is in distress. State and local governments rely heavily on these organizations to deliver services that directly contribute to health and well-being, but longstanding policies, practices, and funding patterns have undermined the fiscal health of this sector, severely reducing the operating margins necessary to take on risk. Since 2012, the State has gradually reduced the funding levels for human services contracts by **$5 billion** while the Department of Health's budget has increased by $5.6 billion from the FY2018 budget. A significant number of human services CBOs are insolvent, and many have little to no reserves. Addressing the challenges of financial uncertainty and low tolerance for risk will enable human services CBOs to perform the necessary work in communities on governments behalf and come to the table in meaningful ways to collaborate more effectively with the health care system.

Because many human services CBOs are under-resourced and lack experience partnering with the health care system, they will need an infusion of resources to develop the systems necessary to effectively engage with complex and sophisticated health care institutions. As noted in HSC's

report, Integrating Health and Human Services: A Blueprint for Partnership and Action, the State should increase support for CBO infrastructure, which would bridge the technology gap and strengthen health care information management. This can be accomplished by developing a program similar to the Nonprofit Infrastructure Capital Investment Program (NICIP), which would encompass training and technical assistance, technology upgrades, or consulting services. As CBOs look to partner with health care institutions, it is imperative that individual CBOs are enhanced with the technological capabilities to not only conduct a 360-degree view of patient interventions, but also measure the health and wellness outcomes of those they serve and determine what attributed to their improvement.

Government policies and investments are a primary driver of the State's human services sector. New York State is constitutionally obligated to provide for the public good, and State agencies have largely relied on a vast and dynamic network of nonprofit organizations to meet this obligation throughout the State's diverse communities. Unfortunately, government contracts rarely cover the full cost of human services. For the State and health care system to better leverage this sector toward improving outcomes, the financial and structural stability of these providers must be reinforced. New York State should set its nonprofit contract funding rates levels to cover the real costs of providing public services.

HSC appreciates DOH's recognition of the important role CBOs play in population health and support the investments made through DSRIP, but they are not enough to counter the damaging contracting policies and lack of investment made by the state in the work of CBOs. If we are to come to the table in a meaningful way, the State must look beyond DOH and reimagine the approach taken more broadly to supporting human service CBOs contributions to communities.

## doh.sm.1115Waivers

**From:** hanan cohen [redacted]
**Sent:** Thursday, October 31, 2019 2:15 PM
**To:** doh.sm.1115Waivers
**Subject:** 115 Public Forum Comment



I am concerned / surprised that there was no mention of community paramedicine / ambulance / paramedic / EMT / EMS in the MRT / DSRIP document.

Around NYS and the country EMS / community paramedicine is being leveraged to provide Triple-Aim centric programs greatly reducing ED utilization,
improving appropriateness of care with exceptional safety and patient outcomes / satisfaction. All of these programs have demonstrated
multi-millions of dollars in downstream savings.

Thank you,

*Hanan*

***Hanan Cohen, EMT-P, CP, CACO***
**Director of Corporate Development / MIH-CP**
**Empress EMS / Emergacare NY**
722 Nepperhan Avenue
Yonkers, NY 10703
[redacted]
www.empressems.com

## doh.sm.1115Waivers

**From:** Maria Cristalli [redacted]
**Sent:** Thursday, October 31, 2019 2:16 PM
**To:** doh.sm.1115Waivers
**Subject:** 1115 Public Forum Comment
**Attachments:** Hillside_DSRIP Comments_FINAL_10 31 19 doc.docx



I have attached Hillside Family of Agencies' comments under the DSRIP 1115 Extension proposal. Please contact me with any questions.

Thank you,

Maria

Maria Cristalli
President and CEO
Hillside Family of Agencies
[redacted]

*DSRIP Extension:*
*1115 Public Forum Comments*

*11/5/2019*

Thank you for the opportunity to comment on the extension of the MRT Waiver. For the first phase of the Delivery System Reform Incentive Payments (DSRIP) program, while tackling various projects relevant to our community writ large, fundamentally excluded children's services from the health systems reforms they addressed. In support of the children and families we serve at Hillside, we stand with the NYS Coalition for Children's Behavioral Health in support of the inclusion of children's community-based behavioral health focused priorities in the next phase of DSRIP, as outlined here:

- Expanded opportunities to integrate pediatric health and behavioral health;
- Supported transitions for children and adolescents leaving residential, juvenile justice, foster care and inpatient psychiatric settings;
- Bundled payments for episodes of children's crisis care that comprise: (i) on-site assessment, (ii) as-needed short-term admissions to children's crisis residential programs, to allow for crisis avoidance/ response and avoidance of emergency hospital admissions, and (iii) access to more appropriate levels of care;
- Expanded use of telemedicine for youth and family peer services and care coordination to maximize the productivity of our limited workforce while offering ease of access to youth and families;
- Enhanced rates to deliver Evidence Based Practices through Child and Family Treatment and Support Services; and
- Targeted investments into the children's behavioral health workforce to stand up the most effective and carefully designed community-based service array in the country.

Additionally, after careful review and consideration of the potential impact of a DSRIP Extension on the children and families we serve, we offer the following comments for your consideration:

***p7 Section III***

***Hillside Comment****: The document recognizes that "high cost and higher risk children did not benefit directly from most DSRIP initiatives unless a Medicaid-measured avoidable hospitalization could be impacted such as ER visits for childhood asthma." As a large child- and family-serving organization, Hillside appreciates this acknowledgement and strongly supports the focus on ACES and social determinants of health. Though an investment in children does not result in the same level of immediate cost savings, investment now in children's behavioral health results in future significant cost savings.*

**p. 8 Children's Population Health Section Excerpts:**

Approximately 47% of the state's children are covered by Medicaid. The next implementation phase would extend successful practices to children in the areas of chronic care management**,** behavioral health integration, pediatric-focused patient-centered medical homes, and attention to adverse childhood experiences and social determinants.

- Care transitions and care management for targeted groups have been very successful and would be expanded to serve this population,

***Hillside Comment***: *More detail regarding the expansion would be helpful – what does the expansion entail for children and families?*

- Expanding behavioral health urgent care centers for children has decreased emergency admissions and provided further access to care,

***Hillside Comment:*** *We strongly support the focus on crisis response and prevention. In addition, we know that CFTSS/HCBS services can have a strong impact on emergency room reliance. As such, we recommend that DSRIP funding also be utilized to build infrastructure to support these services, including additional staffing resources to effectively manage the requirements and rigor, technology supports, and enhanced training. We recommend expanding access to children with intellectual and development disabilities such as the OMH licensed crisis residence program and crisis intervention benefit of CFTSS.*

.

- For children with SED, transitional care teams of clinicians and peers bridging psychiatric inpatient to community settings would be deployed.

***Hillside Comment****: Youth ACT is an evidence-based practice that takes a team approach to post-discharge prevention of recidivism and residential treatment placement prevention. Hillside supports this family-focused, wraparound approach to supporting youth in their transitions from residential treatment back to their families and communities.*

- Use of telemedicine for care management of residential populations for ED triage and expansion of crisis stabilization programs would improve management of overall care and minimize avoidable admissions

***Hillside Comment****: We support the expansion of telemedicine for care coordination as a best practice and to ease the workload burdens on care managers. In addition, we strongly recommend the expansion of regulations to allow use of telemedicine for CFTSS/HCBS as well as Children's Health Home Care Management. Adding children to the list of populations for whom this would be helpful is critically important. (In chart on p. 15 add children and on p. 16 expand for more than just ED triage to include prevention of ED utilization).*

**p. 9 & 10 DSRIP Workforce Development**

***Hillside Comment**: We support the good ideas here for recruitment/retention of both clinical and non-clinical staff. We believe that the children's system of care workforce should be given specific investments to support Medicaid Redesign Goals, including: (i) retraining for residential staff to convert to a community based workforce, in light of the national move to community-based services; (ii) Funding to support the startup costs for Evidence Based Practices, recognizing the need for more of these practices and the requirements of many related transitions, including Family First Prevention Services Act; (iii) investments in mobile workforce development, including funding for technology needs such as laptops/tablets, wi-fi cards/mifi, cell phones and mobile EMR modifications to allow concurrent documentation of progress notes; (iv) expansion of loan forgiveness programs for repayments of BA and MA level staff; (v) retention bonuses for staff meeting training and time of service requirements.*

*We recommend also considering ways in which to decrease process requirements, making it more feasible and less resource-heavy for organizations to participate. Example includes the reduction or streamlining of reporting requirements to allow time to more intensively tackle project actions.*

**p.10 B Coordinated Population Health Improvement**

This integration should focus on extending promising practices upstream toward primary and secondary prevention, to increase potential for bending the longer-term utilization and cost trends.

***Hillside Comment**: We strongly support this approach and have seen firsthand, through our preventive services programming, that it is critical to intervene farther upstream in order to reduce reliance on the behavioral health system later. Additionally, the continued messaging to MCOs that upstream interventions are effective in improving measures, such as a reduction in reliance on higher levels of care and ED rooms, will help to establish a clearer attribution of children's preventive behavioral health services to the impact on population health.*

*Thank you for the opportunity to comment on the 1115 extension. For questions regarding our comments, please contact* [redacted]

## doh.sm.1115Waivers

**From:** Lori Andrade [redacted]
**Sent:** Thursday, October 31, 2019 3:49 PM
**To:** doh.sm.1115Waivers
**Cc:** Marissa Hiruma
**Subject:** 1115 Public Forum Comment
**Attachments:** HWCLI.HEALI Comments to NYS MRT Waiver FINAL.pdf



Attached please find comments written and submitted by Health and Welfare Council of Long Island on behalf of the Health Equity Alliance of Long Island (HEALI). Thank you for this opportunity to submit comments and thank you for NYS Department of Health's continued partnership in improving health outcomes for Long Islanders.

Regards,
Lori Andrade
Chief Operations Officer
Health and Welfare Council of Long Island
[redacted]



**Long Island Counts!**
***I have taken the pledge to count in the 2020 Census. Join me!***
**Click here to pledge to be counted and find out more about the 2020 Census.**

**Comments on Delivery System Reform Incentive Payment Amendment Request**
**October 2019**

For over 70 years, the Health & Welfare Council of Long Island (HWCLI) has been supporting communities through direct service and advocacy & policy work and by convening our membership of nearly 200 non-profit agencies across the region. HWCLI is submitting these comments on behalf of Health Equity Alliance of Long Island (HEALI), a coalition of over 80 health & human service agencies representing our entire region-from Montauk to Elmont - that was convened as a result of the generous funding from the NYSDOH CBO planning grant. Together, HEALI has assessed the infrastructure of the non-profit sector on Long Island and worked to develop a strategic plan to connect health & human service agencies in our region, through improved technology and shared data. In addition, we've been examining how services are delivered to clients throughout the region and where improvements can be made. HEALI has launched a discrete pilot using the technology platform, NOWPOW, to test coordinated and integrated social determinant of health service delivery and referral data sharing. As a coalition, HEALI is ready to partner with NYSDOH, managed care organizations, and health systems on providing client-centric, whole-person care through the sharing of information and through value-based payment contracts.

Thus, upon reviewing NYSDOH's DSRIP Amendment request, HEALI members are greatly encouraged by the inclusion of the following current and new priority areas:

- Partnerships with the justice systems and other cross-sector collaborations
- Addressing Social Determinant of Health through Community Partnerships
- Care Coordination, care management and care transitions
- Reducing maternal mortality, children's population health, long-term care reform and the opioid epidemic.

In order to realize these goals of the next iteration of DSRIP, there needs to be additional systems enhancement for the scaling and integration of social determinant of health services that are necessary to realize the health outcomes and cost savings desired by NYS. Without these systems enhancements, the provision of social determinants of health will fall short and will have limited impact. HEALI respectfully suggests the following social determinant of health systems enhancements to DSRIP 2.0 development and implementation:

1. Investment in coalition infrastructure. HEALI recommends a separate pool of dollars to fund the infrastructure and systems development of coalitions coordinating the provision of

social determinants of health services. The draft proposal includes a separate pool of dollars but it is unclear the role MCOs will have in distributing those funds. HEALI needs direct state funded dollars for infrastructure. HEALI is currently running a small-scale pilot with NOWPOW in the Roosevelt community for referrals of a few social determinant of health services. Optimally, HEALI would receive infrastructure resources to bring this pilot to scale and replicate it in communities across Long Island. Lessons learned as well as the process of implementing this pilot will gladly be shared state-wide with communities interested in implementing similar structures to improve local health outcomes. HEALI's ultimate goal is to build a regional data sharing system through a patchwork of community-based hubs that can localize and coordinate the system for their community that will ultimately reduce costs.

2. Increased clarity on how to contract for social determinant of health services. If we are truly to tackle poverty and support an infrastructure of health & human services on Long Island, there needs to be an investment in ALL social determinant of health services, through a holistic, person-centric system in which medical services are just one piece of the support puzzle for families and communities. HEALI is suggesting additional clarity of the role of Value Driven Entities- health systems, MCOs and CBOs. HEALI would suggest increased clarity on the funding and decision-making structure to realize an inclusive decision-making body by all of these stakeholders- not just MCOs. The draft suggests that there would be "flexibility to align funding to best future management structure for given region/market." This is unclear and leaves significant room for underinvestment in necessary services.

3. A role for county government. In all of the areas that are outlined as new high-need priority areas, county government plays a role. From the justice system to cross-sector collaborations to community partnerships to maternal mortality to the opioid epidemic- all of this work is done in collaboration with county government. If the end goal of DSRIP is to create systemic change, then the counties need to be a part of developing and implementing these systems. Otherwise, there will be two systems working at cross-purposes. To that end, HEALI would encourage a role for local government (cities or counties) on VDE's. The largest provider of social determinant of health services is local government, often through contracts with HEALI CBO's. In order to create an integrated system of care, local government is a key provider that needs to be a part of the VDEs.

HEALI applauds and is grateful to New York State for the work to date to move towards a healthcare delivery system that values improved outcomes as much as dollars saved. We look forward to our continued work together and we hope our recommendations will help develop the next phases of this work.

## doh.sm.1115Waivers

**From:** Sudha Acharya [redacted]
**Sent:** Thursday, October 31, 2019 5:37 PM
**To:** doh.sm.1115Waivers
**Subject:** Comments from SACSS
**Attachments:** Comments on DSRIP amendment.doc



Good afternoon:

Please find attached SACSS' comments on DSRIP Amendment.
Thank you.
Best,
Sudha Acharya

--
Sudha Acharya
Executive Director
**South Asian Council for Social Services (SACSS)**
**143-06 45th Avenue**
**Flushing, NY 11355**
[redacted]
**www.sacssny.org**

SACSS

South Asian Council
For Social Services

October 31, 2019

New York State Department of Health
Office of Health Insurance Programs
One Commerce Plaza
Albany, NY 12207

Re: Comments in Response to the Delivery System Reform Incentive Payment (DSRIP) Amendment Request

South Asian Council for Social Services (SACSS) is a Tier 1 New York City (NYC) community-based organizations (CBO) serving South Asian and other underserved immigrants in New York City from the past 19 years. SACSS was founded in 2000 in response to critical issues raised around the tremendous barriers to social services faced by New York City's fast-growing South Asian community.

We are a not-for-profit Community Based Organization. Our mission is to empower and integrate underserved South Asians and other immigrants into the civic and economic life of New York. SACSS' target Diaspora is comprises immigrants and their children hailing from the South Asian region which includes India, Pakistan, Bangladesh, Nepal, Sri Lanka, Afghanistan, Bhutan, and the Maldives. It also includes Indo-Caribbeans who are individuals from Caribbean nations who trace their heritage back to South Asia.

We assist individuals and families in the areas of healthcare access and awareness, connect them to various benefits, provide senior support services, promote civic engagement, and advocate for social justice. We also provide basic and advanced English and computer courses and run the first South Asian food pantry in New York. All of SACSS' programs are free and are provided by culturally competent staff members who speak 11 different South Asian languages.

SACSS fully supports the state's DSRIP Amendment Request and its emphasis on addressing SDOH as key initiatives to sustain transformation. Our organization has been an active partner and participant with One City Health. Specific mention should be made of the project, Culturally Responsive Collaborative of Queens (CRCQ) that was funded by the Innovation Fund of OCH and led by SACSS. The project brought together 4 diverse organizations located at different parts of Queens that served various underserved communities to provide assessment, case management, and connection to various benefits, healthcare access and connection to a PCP. The culturally competent staff of the organizations spoke 14 languages and surpassed the program deliverables by far.

We believe that successful implementation DSRIP will only be possible with the inclusion of CBOs from the initial stages of planning, designing, implementation and evaluation.
Thank you for the opportunity to provide comments.

Sincerely,

Sudha Acharya
Executive Director, SACSS
Chair, Queens Hub, CTHE

Address: 143-06 45th Avenue, Flushing, NY 11355 Phone: 718-321-7929 Fax: 718-321-0628
Email: sacss@sacssny.org Web Site: www.sacssny.org

**doh.sm.1115Waivers**

**From:** Jerry Cordova [redacted]
**Sent:** Thursday, October 31, 2019 5:44 PM
**To:** doh.sm.1115Waivers
**Subject:** Make Diabetes a High Need Priority



NY State **must make diabetes a High Need Priority** and concentrate on the better care and prevention that will reduce its Medicaid costs by billions and spare people terrible sickness and consequences like amputation, blindness and dialysis.

**Christian Cordova**
**Manager, Information Systems**
**Health People**
**552 Southern Boulevard**
**Bronx, NY 10455**
[redacted]
www.healthpeople.org
***Preventing and managing chronic disease through sustainable peer outreach, targeted education, and effective clinical partnerships***

HEALTH PEOPLE
Community Preventive Health Institute

## doh.sm.1115Waivers

**From:** Millie Arroyo [redacted]
**Sent:** Thursday, October 31, 2019 6:36 PM
**To:** doh.sm.1115Waivers
**Subject:** "DSRIP Comment"



HI

I am writing to you to remind you about Diabetes –and how important diabetes prevention and self-management is to our communities.
I personally have seen the effects of these programs and guess what they save the state money –which I know you guys are vying for . Diabetes cost millions if not billions and it is a debilitating disease.
NY State must make diabetes a high need Priority and make money available for these diabetes programs that save lives and money.

Thank you
Millie

**Millie Arroyo, MPA**
**Director of Programs**
**Health People Inc.**
**552 Southern Boulevard**
**Bronx, NY, 10455**
[redacted]
www.healthpeople.org
***Preventing and managing chronic disease through sustainable peer outreach, targeted education, and effective clinical partnerships***

HEALTH PEOPLE
Community Preventive Health Institute

**doh.sm.1115Waivers**

**From:** Valerie Putney [redacted]
**Sent:** Friday, November 1, 2019 8:41 AM
**To:** doh.sm.1115Waivers
**Cc:** White-Storfer, Amy [redacted] Bullis, Kyle
**Subject:** CPWNY
**Attachments:** image001.emz



WESTERN NEW YORK
WNY R-AHEC
RURAL AREA HEALTH EDUCATION CENTER

Dear Colleagues:

Thank you for the opportunity to provide comment to the Department of Health regarding the 1115 Waiver: Delivery System Report Incentive Payment (DSRIP) Amendment Request, dated September 17, 2019. WNY Rural AHEC has been actively engaged in NYS DSRIP and a partner of Community Partners of WNY (CPWNY)/Sisters of Charity Hospital Performing Provider System (PPS) since Fall 2015.

We have benefitted from our participation in this initiative as our organization was selected to act as the Workforce vendor for the CPWNY PPS. Through this contractual arrangement we completed DSRIP workforce activities in partnership with CPWNY staff. This included the current workforce assessment, the target state, completion of the gap analysis and the transition roadmap. In addition, we collected workforce spending data and required compensation and benefit information.

Through these activities we expanded our network of partners and assessed the educational/training needs of the healthcare workforce, allowing us to establish the **A**dvancement **T**raining for **H**ealthcare **O**ccupation**s** (ATHOS) program. The ATHOS program offers in-person, online and hybrid training classes targeted to meet the needs of healthcare workers. In addition, as our experience has grown, we have undertaken the task of developing a nine-module certificate program for Care Coordinators (a DSRIP emerging job title). All of these training opportunities are now directly available to the regional consortium of 170 active healthcare facility members in our Western New York Rural Broadband Health Network (WNY RBHN). These opportunities might not have been possible without the involvement and support of the CPWNY PPS.

In summary, the CPWNY has been an effective change agent in Western New York. Healthcare is changing quickly; the work has just begun. We anticipate a favorable outcome of the 1115 Waiver DSRIP Amendment Request. We strongly endorse the work of CPWNY PPS. They are critical to the success of future DSRIP initiatives.

Sincerely,

Carla P. Huff

Catherine P. Huff, CEO

## doh.sm.1115Waivers

**From:** Eric Linzer [redacted]
**Sent:** Friday, November 1, 2019 9:17 AM
**To:** doh.sm.1115Waivers
**Cc:** [redacted] Frescatore, Donna J (HEALTH); Allen, Gregory S (HEALTH); Bassiri, Amir (HEALTH)
**Subject:** 1115 Public Forum Comment
**Attachments:** HPA DSRIP Letter Final 11-01-19.pdf



Please find attached comments from the NY Health Plan Association on the proposed MRT Waiver Amendment Request for DSRIP Extension.

If you have questions or need clarification on our attached comments, please do not hesitate to contact us.

Thanks,

Eric

Eric Linzer
President & CEO
New York Health Plan Association
41 State Street, Suite 900
Albany, NY 12207
[redacted]

New York
HPA
Health Plan Association

41 State Street • Suite 900
Albany, New York 12207-2834
518.462.2293
www.nyhpa.org

November 1, 2019

Donna Frescatore, Medicaid Director
Office of Health Insurance Programs
Waiver Management Unit
99 Washington Avenue, 12th Floor, Suite 1208
Albany, New York 12210

Dear Director Frescatore:

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 4.3 million enrolled through Medicaid, we want to commend you and your team on the hard work in developing the state's proposed Delivery System Reform Incentive Payment (DSRIP) waiver amendment.

We appreciate the willingness of the New York State Department of Health to engage with stakeholders in developing the waiver amendment and the opportunity to offer comments. We share the Department's commitment to the continued transition to value-based payment (VBP) arrangements and delivery system transformation necessary to meet the needs of the state's Medicaid beneficiaries.

HPA and our member health plans have been strong supporters of the state's efforts to transition away from the fee-for-service payment system, which emphasizes volume over value, to a system that rewards high-quality and cost-effective health care through VBP arrangements. Health plans have been consistent, reliable partners in the state's health reform efforts, helping New York to achieve success in realizing the goals of its ambitious Medicaid Redesign program to date. The proposed amendment reflects the significant work health plans have undertaken in partnership with the state to reform the Medicaid program and the important role health plans will play in the state's next phase.

We share the Department's goal of constructing VBP agreements that recognize and sustain meaningful connection between value-based work and value-based payment arrangements. We agree that there needs to be additional flexibility in developing those arrangements. Specifically, there should be more flexibility to allow for 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 as there are collaborative working relationships between plans and providers. Additionally, arrangements that are value-based, demonstrate gains in performance and cost-savings, and align with state and federal priority areas should qualify as VBP arrangements that count in meeting the state's targets.

Further, the Department should take steps to ensure that all providers are moving toward VBP arrangements. One challenge health plans have faced is the unwillingness of some providers to enter into VBP arrangements. These arrangements are meant to be partnerships – with a commitment from both sides – to achieve better outcomes at a lower cost for patients. Meeting the goals of the DSRIP waiver is a shared responsibility and penalties should be applied equally to incentivize 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 the Medicaid plan rates are adequate. Given the current state budget challenges, potential Medicaid budget cuts can undercut VBP contract negotiations as reductions to plans' 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. As an example, providers may be understandably reluctant to finalize a percentage-of-premium agreement in which they would be financially responsible for medical costs when there are impending premium cuts and without predictability about finances over the term of the contract. Further, we have serious concerns with "VBP savings" that were included in plans' April 2019 mainstream Medicaid Managed Care rates. For reasons outlined above, reductions in plan reimbursement for the very success achieved through VBP will diminish future ability to invest. Additionally, plan premiums already include adjustments for efficiency. We believe that taking a separate reduction for "VBP savings" is implementing the same reduction twice.

We strongly believe that the plans' contribution to system transformation is about more than just getting to the outcome of having value-based arrangements. Plans are much 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 Value Driving Entities (VDEs) 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 successful development and launch of the NY State of Health Marketplace, and 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. As part of this effort, we would encourage that the VBP Clinical Advisory Groups build off of nationally recognized standards, such as those used by NCQA, so that there is consistency in how the state and health plans are measuring clinical performance.

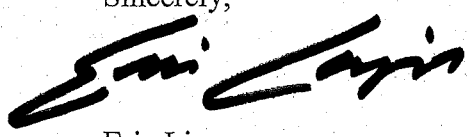
This waiver application should move beyond a program that is heavily focused on large hospital-based systems. Instead, the program will be stronger if it more successfully involves physician practices, FQHCs and other community-based providers. The current fiscal stress within the Medicaid budget may act as a deterrent to the development of additional VBP arrangements. Thus, in order for DSRIP 2.0 to succeed, the Department must give itself and health plans the leverage to encourage and achieve broader reform in the delivery system. DSRIP 2.0 should also provide flexibility to address the factors driving rising health care cost, specifically increases in hospital and prescription drug

prices and the growth in the cost of long-term care services. From the start of the state's Medicaid Redesign process, plans have proven that when given the proper tools to manage, they can reduce spending and inappropriate utilization in ways that a fee-for-service program structure never could and never will be able to achieve. DSRIP 2.0 must assure that plans are given the tools and flexibility to be successful in helping to control Medicaid spending.

With regard to long-term care, it is vital that DSRIP 2.0 encourage payment and delivery models that can effectively integrate and coordinate care and rein in costs, as well as ensure equitable payments for health plans and providers. In the evolution of the long-term care delivery system toward integrated Medicare-Medicaid structures, it will be plans that provide the infrastructure to coordinate the two programs and provide more seamless and better coordinated care to the dually eligible population. In the meantime, DSRIP 2.0 must provide existing managed 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.

Thank you again for the opportunity to offer comments on the Department's proposed waiver amendment and for your consideration of HPA's comments and suggestions. We look forward to continuing to work with you to ensure the continued success in the state's efforts to move toward value-based payments and welcome the opportunity to discuss our comments further.

Sincerely,



Eric Linzer
President & CEO

## doh.sm.1115Waivers

**From:** [redacted]
**Sent:** Friday, November 1, 2019 9:22 AM
**To:** doh.sm.1115Waivers
**Subject:** 1115 Public Forum Comment
**Attachments:** DOC110119-001.pdf



Respectfully submitted,

Sue Carlock

Sue Carlock, Director
Livingston County Office for the Aging

LIVINGSTON COUNTY
OFFICE FOR THE AGING
3 Murray Hill Drive
Mt. Morris, New York 14510

(585) 243-7520
FAX (585) 243-7516
ofta@co.livingston.ny.us

Sue Carlock
Director

November 1, 2019

Paul Francis
Deputy Secretary for Health
State Capitol
Albany, NY 12224

Donna Frescatore
Medicaid Director
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Dear Mr. Francis and Ms. Frescatore:

On behalf of the Livingston County Office for the Aging, I am writing to express my recommendations on the DSRIP renewal proposed by New York State Department of Health. The services we provide directly impact inappropriate emergency department visits, and reduce avoidable readmissions. The NY Connects program, implemented in 2006, serves as no wrong door for any and all services available in the region, and is a catalyst for individuals in need of assistance. The targeted goals in the proposed renewal are exactly what this network provides, and must include mandated contracting by each PPS with their local Area Agency on Aging for social determinants of health initiatives. Our office is the trusted service provider for the fastest growing segment of the population, and the highest utilizer of health care dollars. Our services **absolutely** allow individuals to remain in their own homes and communities, all while saving health care expenditures. We provide the highest level evidenced based interventions, and are experts at navigating a complex health care system, while providing person centered planning and care.

To demonstrate the value of the network, I would like to highlight a case that is typical to our office. Recently one of our clients testified in front of our local Board of Supervisors about the impact of our programs and services. He is seventy-two years of age and participates in our congregate meal program. He has diabetes and chronic pain. He completed our Tai Chi for Arthritis class, an evidence-based intervention, and continues to practice daily. Last year, prior to participating in Tai Chi, he fell over 10 times and was taking 60 opioid pills per month for pain. He has lost weight, reduced his A1C level, has improved energy, utilizes less insulin, and had no falls and taken no opioids in the past 3 months. He is now swimming almost daily, and is considering being trained to lead Tai Chi for Arthritis to teach others.

These evidence-based interventions are critical because falls and chronic disease are costly for individuals and for the community. The cost of one person participating in the Tai Chi and congregate meal program is approximately $2,500 annually. The conservative cost for just one ED visit for unintentional falls is over $3,000 and a hospitalization over $40,000 (CDC). Falls are the leading cause of fatal and non-fatal injuries for older Americans whose numbers we know are growing exponentially. New York State spends over 1.5 billion in direct costs for non-fatal falls and 8% of Medicaid expenses for older adults are fall-related. Tai Chi for Arthritis, just one EBI we offer, has been referred to by Harvard Medical School as "medication in motion" and has a $530 net benefit per participant for a 509% Return on Investment (NCOA).

This is one of many cases that truly displays the boots on the ground service provision in every county across the state. In the renewal waiver, I cannot stress highly enough that we need to harness the existing strengths of community-based services, instead of recreating case management services and duplication of services. Each and every case manager in the entire statewide aging network has received certification via Boston University School of Social Work, ensuring consistency in assessment not provided by any other system. I ask that there are mandates for each PPS to engage and contract with their local Offices for the Aging, for the services vital to keeping individuals in home and community-based settings.

Thank you,

Sue Carlock
Director
Livingston County Office for the Aging

## doh.sm.1115Waivers

**From:** John Milligan [redacted]
**Sent:** Friday, November 1, 2019 9:23 AM
**To:** doh.sm.1115Waivers
**Subject:** NYSDOH DSRIP Waiver Amendment Public Comment
**Attachments:** 11.1.2019 Public Comment on 1115 Public Forum Comment.pdf



To Whom It May Concern,

Thank you for the opportunity for Upstate Family Health Center to provide the attached public comment on the 1115 Medicaid Redesign (DSRIP) Waiver Amendment.

Upstate Family Health Center (UFHC) is a FQHC located in Utica and is an active member of the DSRIP program with the Central New York Care Collaborative (CNYCC). UFHC is a vital safety net facility for over 7,000 individuals in the Utica area and is recognized by the Department of Health as a safety net facility but not for DSRIP purposes. We request that the DSRIP program recognizes UFHC as a safety net provider so that the facility can take advantage of the various DSRIP opportunities that are desperately needed.

UFHC would like to encourage the New York State Department of Health and the Centers for Medicare and Medicaid Services (CMS) to continue their investment in transforming care delivery through the DSRIP program and recognize UFHC as a safety net provider for DSRIP purposes. This waiver amendment will allow our facility to build on the great work we've started to do here in Utica, New York.

Thank you,

John
**John Milligan FHFMA, FACHE, CPA**
**CEO**
Upstate Family Health Center, Inc
1001 Noyes Street
Utica NY 13502
[redacted]

Upstate Family Health Center, Inc.
Making each and every life better...
COMMUNITY HEALTH CENTER FQHC QUALITY

Upstate Family Health Center, Inc.

1001 Noyes Street, Utica NY 13502
(315) 624-9470 Phone | (315)642-9480 Fax
www.upstatefamilyhealthcenter.org

October 28, 2019

NYS Department of Health
Office of Health Insurance Programs
Waiver Management Unit
99 Washington Avenue
12th Floor, Suite 1208
Albany, NY 12210

Re: Public Comment on 1115 Public Forum Comment

To Whom It May Concern:

Upstate Family Health Center, Inc. (UFHC) is a 501(c)3, not for profit, Article 28, licensed health care center offering family health care services to individuals with a focus on the care for the under-served population and high-risk "super-utilizers" of the Mohawk Valley and its surrounding communities. The organization was formed on January 2, 2017 to address the desperate needs within the community. The experienced and dedicated staff provide the highest level of care, while ensuring that the patient's needs come first. A patient can receive a continuum of care that focuses on the patient as a whole, while addressing the patient's socio-economic needs for the individual and family.

Based on the under-served population that UFHC serves, New York State Department of Health (DOH) recognizes UFHC as a "safety net" provider and, as such, the health center will never turn away a patient based on their financial resources or socio-economic needs. Even though DOH recognizes the health center's safety net status, DSRIP's current classification does not recognize the health center as a safety net provider and therefore is not afforded the various DSRIP opportunities that other safety net providers are offered.

We request that the Medicaid Redesign Team change the DSRIP status of UFHC so that the health center is recognized as a "safety net" provider based on the population that the health center serves.

**Safety Net Definition and Acquirement**

At this point, DSRIP is not considered UFHC a safety net provider and as such the health center is not privy to the benefit of said designation. Namely, UFHC is only allowed to 5 percent of DSRIP funding while safety net providers are able to receive 95 percent of available funding. This difference has been the catalyst to our public comment.

Per the DSRIP Special Terms and Conditions, safety net providers are defined as the following:

> *A hospital must meet the following criteria to participate in a performing provider system:*
> *i. Must be either a public hospital, Critical Access Hospital or Sole Community Hospital, or*
> *ii. Must pass two tests:*
> *A. At least 35 percent of all patient volume in their outpatient lines of business must be associated with Medicaid, uninsured and Dual Eligible individuals.*
> *B. At least 30 percent of inpatient treatment must be associated with Medicaid, uninsured and Dual Eligible individuals; or*
> *iii. Must serve at least 30 percent of all Medicaid, uninsured and Dual Eligible members in the proposed county or multi-county community. The state will use Medicaid claims and encounter data as well as other sources to verify this claim. The state reserves the right to increase this percentage on a case by case basis so as to ensure that the needs of each community's Medicaid members are met.*
> *b. Non-hospital based providers, not participating as part of a state-designated health home, must have at least 35 percent of all patient volume in their primary lines of business and must be associated with Medicaid, uninsured and Dual Eligible individuals.*

As a non-hospital based provider, UFHC has well over 50 percent of all patient volume in our primary lines of business associated with Medicaid, uninsured, and Dual Eligible individuals. Per our service area, general and special populations, poverty levels, and, particularly, the aforementioned safety net definition, we formally petition to acquire the designation of safety net provider.

On behalf of Upstate Family Health Center, I thank you for the opportunity to submit this public comment. I am available to inform and answer any questions you may have.

Respectfully submitted,

John Milligan FHFMA, FACHE, CPA
CEO
Upstate Family Health Center, Inc.
1001 Noyes Street
Utica, NY 13502
[redacted]

## doh.sm.1115Waivers

**From:** Sonja Gottbrecht [redacted]
**Sent:** Friday, November 1, 2019 9:48 AM
**To:** doh.sm.1115Waivers
**Subject:** DSRIP Support Letter
**Attachments:** DSRIP Letter from CCOC.pdf



Please see attached for a letter from Catholic Charities of Onondaga County regarding our experience with DSRIP.

**Sonja Gottbrecht, LMSW**
**Chief Performance Officer**
**Catholic Charities of Onondaga County &**
**Toomey Residential and Community Services**
1654 West Onondaga St.
Syracuse, New York 13204
[redacted]
Visit our website: www.ccoc.us

Catholic Charities
DIOCESE OF SYRACUSE

Onondaga County
Michael F. Melara
Executive Director

Michael F. Melara
Executive Director
Catholic Charities of Onondaga County
1654 West Onondaga St.
Syracuse, NY 13204

Re: 1115 Medicaid Redesign (DSRIP) Waiver Amendment Proposal

To Whom It May Concern,

Thank you for the opportunity to provide public comment on the 1115 Medicaid Redesign (DSRIP) Waiver Amendment. Catholic Charities of Onondaga County is a community based organization here in central New York. In this capacity we have been able to participate in the DSRIP program with the Central New York Care Collaborative (CNYCC).

Our work with CNYCC has included two Innovation Fund projects and as part of these efforts, we've been able to insert impact of programming on services/patients. In addition, our work with CNYCC has provided us an opportunity to establish partnerships with local organizations across our community. As a lead agency on behalf of the DSRIP program, CNYCC has provided great value to our organization.

CNYCC recognizes the importance of CBOs in our community and, through the Innovation Fund, has encouraged CBOs to participate. Innovation Fund dollars have allowed us to address long-standing, unresolved needs in our Men's Shelter. The project, which started in September 2018, funds clinical services embedded in the shelter setting. In the first year, 83 men received a mental health diagnosis and became eligible for supportive housing options in the community. The Psychiatric Nurse Practitioner, a contracted partner, prescribed psychiatric medication to 45 individuals. Without the Innovation Fund, this project and its partnerships could not have been created.

In closing, we'd like to encourage the New York State Department of Health and the Centers for Medicare and Medicaid Services (CMS) to continue their investment in transforming care delivery through the DSRIP program. The waiver amendment will allow are region to build on the great work we've started to here in central New York.

On behalf of Catholic Charities of Onondaga County, I thank you for the opportunity to submit this public comment.

Respectfully submitted,

Michael F. Melara

Executive Director

## doh.sm.1115Waivers

**From:** Susan A. Brisky [redacted]
**Sent:** Friday, November 1, 2019 9:59 AM
**To:** doh.sm.1115Waivers
**Cc:** [redacted]
**Subject:** 1115 Public Forum Comment
**Attachments:** DSRIP 2.0 Letter_CCDOA_11-01-19.pdf; DSRIP 2.0 Scenarios - CCDOA_NY Connects.docx



Good morning,

Please see the attached letter and related vignettes from Cathy Mackay, director of the Cattaraugus County Department of the Aging.

Please let me know if you have any difficulty with the attachments.

Thank you.

Sue Brisky
Office Manager
Cattaraugus County Department of the Aging
[redacted]

# Cattaraugus County Department of the Aging
# Cattaraugus County NY Connects
***An Aging and Disability Resource Center***

November 1, 2019

NYS Department of Health
Office of Health Insurance Programs
Waiver Management Unit
99 Washington Avenue
12th Floor, Suite 1208
Albany, New York 12210

Re: 1115 Public Forum Comment

Dear Department of Health Representative,

On behalf of the Cattaraugus County Department of the Aging and NY Connects, I am writing to express my recommendations on the DSRIP renewal proposed by New York State Department of Health.

The services we provide directly impact inappropriate emergency department visits and reduce avoidable readmissions. The NY Connects program, implemented in 2006, serves as no wrong door for any and all services available in the region, and is a catalyst for individuals in need of assistance. The targeted goals in the proposed renewal are exactly what this network provides, and must include mandated contracting by each PPS with their local Area Agency on Aging for social determinants of health initiatives. Our office is the trusted local service provider for the fastest growing segment of the population, and the highest utilizer of health care dollars. Our services absolutely allow individuals to remain in their own homes and communities, all while saving health care expenditures. We provide the highest level evidenced based interventions and are experts at navigating a complex health care system, while providing person centered planning and care.

To demonstrate the value of the network and comprehensive case management, I have attached vignettes of recent cases that are typical of the cases handled through our office. I did not want their importance to get lost in the middle of this email message, so please refer to the attached page for real life examples of how we address complex health issues in an integrated system, collaborating with others, providing in-home oversight, and providing transitions of care throughout the entire care continuum.

# Cattaraugus County Department of the Aging
# Cattaraugus County NY Connects
***An Aging and Disability Resource Center***

We truly are the "boots on the ground" service provision in every county across the state. In the renewal waiver, I cannot stress highly enough that we need to harness the existing strengths of community based services, instead of recreating case management services and duplication of services. Each and every case manager in the entire statewide aging network has received certification via Boston University School of Social Work, ensuring consistency in assessment not provided by any other system. I ask that there are mandates for each PPS to engage and contract with their local Offices for the Aging, for the services vital to keeping individuals in home and community based settings. Thank you for your time and consideration.

Respectfully,

Cathy Mackay

Cathy Mackay
Director

CM/sab


**ADMINISTRATION**

Cathy Mackay
*Director*

Sue Brisky
*Office Manager*

Peggy Andress
*Senior Accountant*

**SERVICES**

Bonnie Saunders
*Case Supervisor/ NY Connects Administrator*

Mandi Hemphill
*Unit Supervisor*

Kim Connell
*Nutrition Program Director*

Ellen Herner
*RSVP Director*

## Scenario #1 – Cattaraugus County Department of the Aging (CCDOA) and NY Connects

Mr. M was referred by a Community Based Organization (CBO) because the worker felt he was "falling through the cracks." Mr. M is an 80-year-old divorced man living alone with complicated medical issues, a lack of informal supports, and a lack of knowledge regarding how to obtain needed services. Triggers that indicated the need for Options Counseling included depression, lack of support services, death of his dog, inability to prepare meals, need for a ramp, need for a motorized wheelchair repair, and need for furniture. Mr. M reported problems working with his Medicaid insurance company to secure a Personal Emergency Response Unit and Home Delivered Meals. Client was unsure if he had Medicaid Managed Care or Community Medicaid. Additionally, client wanted to discuss appointing a POA. We provided Mr. M with a number of options and linked him with the Department of the Aging's Robotic Pet program, where he received a dog. He truly enjoyed the dog and believes it will help with his depression and loneliness. We met with DSS and determined that Mr. M has Community Medicaid. The CCDOA worker advocated on his behalf, and he is now receiving assistance with ADLs and IADLS. The worker discussed potentially exploring Long Term Medicaid as Mr. M's needs increase. CCDOA worker continued to reach out to the Medicaid insurance company to secure PERS unit coverage through Medicaid. Mr. M was referred to CCDOA's Home Delivered Meal Program and has started to receive meals. Additionally, Mr. M is working with a CCDOA worker for assistance, advocacy and follow-up with obtaining a ramp, furniture, repairing his wheelchair, and scheduling the legal appointments for POA. Mr. M is a Medicaid recipient but reports that he was unable to connect with services and felt that he was falling through the cracks because the Medicaid services were fragmented and not properly explained. Prior to working with NY Connects and Dept. of Aging, Mr. M states it was difficult for him to get information and assistance with all of his various needs.

## Scenario #2 – Cattaraugus County Department of the Aging (CCDOA) and NY Connects

Mr. H was referred to CCDOA by Allegany County as he lives in a very rural area on the county border. Mr. H is a 57 year old disabled male who lives alone in a dilapidated mobile home. Mr. H reported that his support system is unreliable. He reports having a genetic disorder which has left him with multiple medical issues including the need for a kidney and lung transplant. He is oxygen dependent and his mobility is compromised. He does not drive and due to his medical conditions has difficulty with ADLs and IADLs. He reports his income as poverty level. On the day the NY Connects worker contacted Mr. H, he reported he had no heat and no food. He reported that he is receiving skilled nursing services through the county health department. The NY Connects worker assisted with a referral to CCDOA for assistance with emergency HEAP, SNAP, and obtaining food from a food pantry. CCDOA was able to lend him an infrared heater for that day, delivered food, and helped with a SNAP application in the home. The worker contacted Mr. H's propane distributor and was informed that he would need $384 for a propane delivery, but both his regular and emergency HEAP benefit had been used. The worker provided the options of applying for Emergency Aid through DSS and Mr. H declined, stating that he worried that DSS would attempt to become his representative payee if he applied for emergency aide. The worker contacted Catholic Charities and the Bridge, and they assisted with funding to cover the propane delivery. Mr. H's next concern was that he did not understand why his insurance changed and why he was ineligible for HDMs now, as his meals had been cancelled by his MLTC. The NY Connects Person Centered Counselor met with Mr. H and through a series of inquires found out that Mr. H's meals had been covered by his Medicaid health insurance and that per NYS the Medical insurance had been changed to another plan with the same provider, but the company erroneously stopped his meals. The worker is currently providing information and working Mr. H and Maximus to ensure Mr. H receives the benefits that are part of his plan of care. The worker also secured volunteers through both Bona Responds and Rebuilding Together to work on home repair issues with Mr. H’s mobile home this coming weekend.

**doh.sm.1115Waivers**

**From:** Cantanucci, Gina (DFA)
**Sent:** Friday, November 1, 2019 12:10 PM
**To:** doh.sm.1115Waivers
**Cc:** [redacted]
**Subject:** 1115 Public Forum Comment
**Attachments:** SKM_458e19110112100.pdf

Greetings. Please see our Public Comment attached to this e-mail. Please contact me with any questions. Thank you

*Gina Cantanucci-Mitchell*
*Director*
*Washington County Office for Aging and Disabilities Resource Center*
*Home Of NY Connects*
*383 Broadway*
*Fort Edward, NY 12828*
[redacted]

**Washington County**
**Office for Aging and Disabilities Resources**
383 Broadway
Fort Edward, New York 12828

TELEPHONE: **(518) 746-2420**
FAX: **(518) 746-2418 or 746-2571**

**Gina Cantanucci-Mitchell**
***Executive Director***

November 1, 2019

Paul Francis
Deputy Secretary for Health
State Capitol
Albany, NY 12224

Donna Frescatore
Medicaid Director
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Dear Mr. Francis and Ms. Frescatore,

On behalf of Washington County Office for Aging and Disability Resource Center, I am writing to express my recommendations on the DSRIP renewal proposed by New York State Department of Health. The services we provide directly impact inappropriate emergency department visits, and reduce avoidable readmissions. The NY Connects program, implemented in 2006, serves as no wrong door for any and all services available in the region, and is a catalyst for individuals in need of assistance. The targeted goals in the proposed renewal are exactly what this network provides, and must include mandated contracting by each PPS with their local Area Agency on Aging for social determinants of health initiatives. Our office is the trusted service provider for the fastest growing segment of the population, and the highest utilizer of health care dollars. Our services **absolutely** allow individuals to remain in their own homes and communities, all while saving health care expenditures. We provide the highest level evidenced based interventions, and are experts at navigating a complex health care system, while providing person centered planning and care.

To demonstrate the value of the network, I would like to highlight recent cases that are typical to our office.

**Sarah's Story:**
Sarah is 87 years old and lives on her own with no local supports. She weighs 89 pounds, is diagnosed as weak, frail, arthritis, back problems, thyroid issues and visual impairments. She uses a walker to ambulate. In 2016 our NY Connects team acted on a referral made to our Office. Sarah received a Comprehensive Assessment by our Certified Case Manager and a care plan was developed. Home delivered meals were immediately started, which meant immediate in-home contact by a staff member (driver). A referral was made for in-home Personal Care Services through the Aging Networks' EISEP program. On 9/20/17, Sarah started receiving Level 1 Personal Care in-home services through EISEP. Through our continuous Case Management Services, it was determined by her medical care team that she could no longer leave her home. On 3/16/2019, coordination of services was made to the Homeward Bound Program. In addition, her EISEP hours increased to encompass additional personal care needs. On 4/5/2019, Sarah's Case Manager linked her to the Cambridge Valley Mobile Crisis program for routine wellness checks performed in her home. In addition, Sarah took pride in her appearance and the Case Manager made arrangements for her hair dresser to provide services to her in her home on a monthly basis. Sarah's story shows how Sarah was able to maintain dignity and also how she can remain in her home and community.

**Irene's Story:**
Irene is 94 years old and lives on her own with no supports. She weighs 96 pounds, is diagnosed as being weak, frail, anemic, heart disease, history of stroke, and osteoporosis. She uses a walker to ambulate. In 2008, based on a referral to our NY Connects team, home delivered meals were started immediately, which meant immediate contact by our staff member (driver). While receiving Case Management services, it was determined in 2016 by her medical team that her conditions were worsening. The Case Manager started Irene on in-home Personal Care level 1 services. In 2011, Irene needed additional support and transportation services were initiated, a service that met her needs for grocery shopping and attending all her necessary medical appointments. While providing Case Management to Irene, it was determined that Irene needed to be seen by a physician. On12/19/2017, Irene's Case Manager arranged for transportation to/from her appointment and it was determined at this appointment that Irene needed emergency surgery due to her kidney's not functioning properly. Irene received the surgery and because she had EISEP supports in place to include Case Management, she was safe to return back to her home. Irene prides herself in celebrating holidays and the Case Manager arranged for her to have a Thanksgiving meal delivered to her by a local organization. Irene's case truly shows how she remained in her home with in-home services, how her Case Manager was able to act to an emergency situation, and how she avoided a higher level of care (nursing home) following her surgery.

**Bonnie's Story:**
Bonnie is 67 years old. In 2015, through a referral to our NY Connects team, Bonnie was referred to our Case Management program. Following a Comprehensive Assessment, a care plan was developed supporting her need for in-home Personal Care Services though the EISEP program. Bonnie reported mobility and health issues, which resulted in her receiving Personal Emergency Response Services (PERS) through our office. Bonnie has suffered several strokes, has chronic pain, and decreased mobility. Bonnie has lung issues, suffers incontinence, has high blood pressure, cholesterol issues, and renal disease. Bonnie relies on the use of a walker, a lift chair, grab bars, and is unable to walk very far due to pain and exhaustion. Bonnie wears compression stockings that require weekly changing. She is largely limited to her home due to her mobility challenges and has great difficulty leaving the home. Bonnie's support network is very limited, with one daughter who lives out of the area and another daughter who currently resides with her but has reportedly been unsupportive to Bonnie due to her own issues. EISEP level II in-home services remain in place currently, with Bonnie receiving 8 hours of weekly services. Bonnie has experienced housing issues, reporting back to December 2015. Her Case Manager learned that Bonnie did not follow advice given by the Temporary Assistance program in May 2017. Bonnie's Case Manager acted on this concern by making a referral to the USDA program for assistance with lapsed mortgage payments. When Bonnie's medical needs and mobility issues increased, transportation services were coordinated for her. Bonnie continues to receive Level II in-home Personal Care services and PERS, she has been assisted in obtaining her necessary compression stockings (paid for by EISEP Ancillary funds), in 2018 she received a ramp that was paid through EISEP ancillary funds and receives ongoing Case Management services to support her remaining in her home and in her community.

These are three of many cases that truly display the boots on the ground service provision in every county across the state. All three cases prove that our services are vital to supporting individuals remain in their home and avoiding the Medicaid system. In the renewal waiver, I cannot stress highly enough that we need to harness the existing strengths of community-based services, instead of recreating case management services and duplication of services. Each and every case manager in the entire statewide aging network has received certification via Boston University School of Social Work, ensuring consistency in assessment not provided by any other system. I ask that there are mandates for each PPS to engage and contract with their local Offices for the Aging, for the services vital to keeping individuals in home and community-based settings.

Thank you,

Gina Cantanucci-Mitchell
Executive Director

## doh.sm.1115Waivers

**From:** Lori Kicinski [redacted]
**Sent:** Friday, November 1, 2019 12:17 PM
**To:** doh.sm.1115Waivers
**Subject:** NYS Regional Planning Consortium (RPC) Comments in Support of DSRIP 2.0
**Attachments:** Comment on Delivery System Reform Incentive Payment Ammendment Request November 2019.docx



Medicaid Partners:

Please find the attached Statewide RPC joint comment regarding the DSRIP amendment request to CMS. As NYS county behavioral health (LGUs) and stakeholder agencies from Long Island to Western NY, the RPC community is committed to support in service as outlined in our discussion on Workforce, including peer roles, as well as all Social Determinants of Health impacting behavioral health efforts across our vast system of providers and agencies.

We respectfully request your review of our comments and look forward to future collaboration in developing framework for DSRIP 2.0. For any additional information regarding our Comment document, please feel free to contact us below.

Regards,

**Lori Kicinski, MHA**
**RPC Project Director**
41 State Street, Suite 505
Albany, NY 12207
[redacted]


The RPCs will be the central point for stakeholders to share information, collaborate and problem-solve issues surrounding the transition of the behavioral health service system from Medicaid fee-for-service to Medicaid managed care and issues that arise from other NYS behavioral health transformation initiatives which impact the transition to Medicaid managed care and the recipients of Medicaid behavioral health services. Recommendations garnered from this group will be conveyed to the NYS

Medicaid agencies (DOH, OMH, OCFS and OASAS) for follow-up action. These agencies will, in turn, use their role with Managed Care Organizations (MCOs) in their work on the behavioral health system transformation to ensure that any agreed upon recommendations are implemented to the extent practicable.

he Regional Planning Consortium (RPCs) were established to provide the forum for local input and expertise and cross-system collaboration necessary to identify concerns, issues and solutions that will naturally arise from the comprehensive transition of the service delivery system from Medicaid fee for service to Medicaid Managed Care for individuals with serious mental illness and substance use disorders. It is important to recognize the complex physical and behavioral health needs of the New Yorkers who are impacted by the transition and the comprehensive scope and scale of this project. The people served never need one service. They often have co-occurring mental health and substance use disorders and their health is impacted by social determinants including poverty, homelessness, food insecurity and unemployment. They have very high needs and are a high risk for hospitalization. Embedded in the the shift from Medicaid FFS to Medicaid Managed Care is a re-design and needed expansion of the behavioral health services and supports available to the high-need, HARP enrollees.

The RPC brings together all the stakeholder groups including consumers, MCOs, service providers, County Directors of Community Services/Mental Health Commissioners, and child serving agencies to troubleshoot and collaborate to solve regional issues that can be solved at the regional level, and feed to the state agencies, the concerns or issues that require state action. The RPC Boards, its Children and Families SubCommittees and locally-driving Ad Hoc Workgroups conduct the work of issue resolution in each of 10 Regions (all 57 counties outside of NYC). Regions include North Country, Tug Hill, Mohawk, Capital District, Central, Finger Lakes, Western, Southern Tier, Long Island, and Mid-Hudson. The RPC Boards meet quarterly and sub-committees usually more often or as needed (ad-hoc). The subcommittees focus on targeted aspects of the transition and present findings to the boards. An RPC Project Director and staff RPC Coordinators throughout the state conduct regional collaborative efforts and policy work in their regions.

The RPCs boards are comprised of a range of stakeholders impacted by and committed to the successful implementation of managed care for the behavioral health population. Stakeholders

represent the following: children/families and peers, Community Based Organizations, local mental hygiene directors, managed care organizations, hospital and Health system providers, key partners and state partners which include but are not limited to state representatives, DSRIP/PPS and other social services/law enforcement local agencies/government. In addition, these meetings are public.

Overall, the target populations are those individuals in need of quality and comprehensive behavioral health and primary care services. The move from Medicaid FFS to managed care must be carefully implemented to ensure that individuals (adults/children,and families) receive needed services in a manner that allows for improved health outcomes and greater access to all the needed services. Providers of services are also a target population as many are critical safety net services providers and must continue to operate in a fiscally stable environment.

RPCs address issues directly related to the implementation of Medicaid managed care and payment reform. The RPC staff seek clarification on state policy and guidance prior to dissemination of information in an effort to reduce confusion and misinformation at all stakeholder levels. Staff will contact identified state partners (SMEs) in a coordinated fashion by ensuring all parties have an awareness of communication and activites.

In addition, the RPCs will (a) create a process flow for data requests that include the specific data needed and the rationale for it. Data requests are made to the state following review of existing sources that may be used answer questions related to process, gaps in services and opportunities. Additional data requests (and for all those related to MCOs) will be advanced directly to the state via established protocols; (b) support operationalization of state created work flows, policies and guidance; (c) focus on components of managed care including but not limited to (i) value based payment, (ii) business case modeling and outcome measures, and (iii) adult and children managed care services and transition; (d) support state managed care initiatives in a timely manner; (e) review quarterly meeting schedule to ensure availability of state partners (as needed); and (f) Arrange quarterly and other RPC meetings and provide such notifications and materials in accordance to standards as determined by the Office of Mental Health.

## doh.sm.1115Waivers

**From:** Carol Cassell [redacted]
**Sent:** Friday, November 1, 2019 12:37 PM
**To:** doh.sm.1115Waivers
**Cc:** [redacted]; Robert Detor; Carol Cassell
**Subject:** DSRIP Amendment Request
**Attachments:** AHN RHS Final DSRIP Waiver Letter 11.01.2019.pdf



Please find attached comments from Advanced Health Network IPA (AHN) and Recovery Health Solutions IPA (RHS), both lead agencies for the NYS Behavioral Health Care Collaborative (BHCC), in support of the NYS DSRIP Waiver Amendment Request. We appreciate the opportunity to provide input and look forward to further discussion regarding the same,
Carol Cassell
Executive Director

--

**Carol Cassell**
Executive Director
[redacted]

**Recovery Health Solutions IPA LLC** | recoveryhealthsolutions.com
315 W. 36th Street
New York, NY 10018

To: 1115waivers@health.ny.gov

Date: October 31, 2019

Re: 1115 Public Forum Comment
New York State Medicaid Redesign Team (MRT) Waiver
Delivery System Reform Incentive Payment (DSRIP) Amendment request

Advanced Health Network IPA (AHN) and Recovery Health Solutions IPA (RHS) are affiliated IPA's providing comprehensive behavioral health services and leading as Behavioral Health Collaborative Care (BHCC) agencies serving the New York City and Long Island markets. We are pleased to submit the following comments regarding the above referenced DSRIP Amendment Request. We believe this request builds on the accomplishments and learning of DSRIP work recognizing individual health and healthcare needs extend beyond medical and are inclusive of behavioral and social needs across the care continuum.

DSRIP has focused more on the healthcare system having:

- Promoted a more foundational redesign of the healthcare delivery system as a platform to breakdown healthcare silos understanding and coordinating care across the continuum.
- Supported investment in data and information systems providing actionable information to better understand root cause and contributory factors of patient healthcare needs. Data is beginning to support both improvement in our healthcare system and more importantly improvement in the health of individuals and communities.
- Reinforced the understanding and learning that transformational change requires investment in culture which takes time, leadership, data and financial resources.

It is with this learning we recognize and support the following recommendations in the next phase:

- **Health and Healthcare Priority Areas of Focus** – the request references "…federal priority areas include: ***SUD Care and the Opioid Crisis; Serios Mental Illness (SMI)/Serious Emotional Disturbances (SED), social Determinants of Health***, Primary Care Improvement and Alternative Payment Models." Addressing medical conditions alone will not improve the health of individuals and our communities. It is imperative that there be integration of medical, behavioral and social services. AHN/RHS as a comprehensive behavioral health provider network is working in collaboration with healthcare systems, primary care providers, community-based organizations and corrections to improve access, care coordination and patient engagement.
- **Alternative Payments Models** – the report makes frequent reference to alternative payment models. AHN/RHS supports alternative payments models aligned to new and improved redefined care models that support value – quality outcomes and cost. AHN/RHS is currently finalizing its medication assisted treatment (MAT) bundled payment program with several health plans and working to further integrate primary care and behavioral health services.
- **Access to Population Health Analytics** – the report references "…develop APMs (Alternative Payment Models) with MCOs and CBOs the State will ***support these efforts through continued state and regional population health analytics*** and via integration of existing primary care practice transformation incentives in those emerging APMs". Data transformed into actionable information is integral to the transformation of our health and healthcare system. Access to data has become a barrier requiring leadership of all stakeholders to share and utilize data with defined purpose that best supports the health and healthcare of individuals and communities. We need to advance development and access to an all-payer data base system supported by defined business use cases.
- **Consents** – while the report itself does not specifically address patient consents, AHN/RHS request the collaboration of DOH, OMH and OASAS in support of universal consent forms that are patient informed and understandable. AHN/RHS has been working with OMH and OASAS in development of a universal consent form aligning and integrating certain existing state consents forms along with incorporation of

newly promulgated federal (CMS and SAMHSA) interpretations related to substance use. AHN/RHS request this work to continue across all NYS health agencies.

- **Alignment with Federal and State Programs** – the report references CMMI (Center for Medicare and Medicaid Innovation) and the Quality Payment Program, efforts by the Medicaid Innovation Center and reference to New York State COTI grants. AHN/RHS along with its providers support and have participated in several of these programs. We will continue to monitor, learn from and where there is opportunity participate in CCBHC, CPC+, Bundled payment programs including the CMS bundle for opioid conditions and Telehealth programs.
- **Attribution of Payments** – the report references that current attribution models "...do not completely embrace the kind of comprehensive integrated primary care, behavioral health, and other social care capacities that have been at the heart of most of the DSRIP success.' AHN/RHS supports this learning recognizing we need to meet individuals where they are at in improving their active participation and engagement in health programs. AHN/RHS is working to integrate medical, behavioral and social services at the neighborhood level with expectation alternative payment models will align with the delivery model that best supports care management, care coordination and engagement by all. AHN/RHS also recommends applying learning from the Medicare Shared Savings Program where attribution aligned with specialty physicians who became the "primary physician" based on the clinical needs of the patient.
- **Promotion of Voice at the Table – Value Driving Entity (VDE)** – the report references additional representation from community-based providers, including primary care, behavioral health, and long-term care. AHN/RHS acknowledges the importance of "voice" at the table as we work in collaboration with healthcare systems and providers today to best coordinate redesign of the system. AHN/RHS is engaged in collaborative work with health systems including Maimonides, Montefiore, Mount Sinai, New York Presbyterian, Norwell; with DSRIP PPS entities including SOMOS, Suffolk Care Collaborative; and with primary care providers.
- **Time and Trust** – the proposal references "...time for maturation at scale ..." along with "...building partnerships and trust...". AHN/RHS echoes the words time and trust. Sustainable transformation of change requires change in behaviors and habits which require investment in people, processes, technology and data. A key word is sustainable. This request will provide continued funding to support the necessary investments in health and healthcare system redesign.
- **All-payer approach** – while not specifically addressed in the waiver request, AHN/RHS recommends an all-payer approach to redesign of the delivery system and aligned alternative payment models. Redesign of the delivery system must be patient/payer focused and not payer focused. Recognizing health is a public social good, consistency of quality metrics, clinical and care delivery models and aligned alternative payment model frameworks are essential to achieve success for all.

We support the waiver request; and thank you for the opportunity to provide both feedback to and input on several additions to the DSRIP waiver amendment request. Please do not hesitate to contact us should you have questions or require clarification on the above.

Sincerely,

Advanced Health Network IPA

Karen Boorshtein, President

[redacted]

Karen Boorshtein

Robert Detor, President/CEO

[redacted]

Robert Detor

Recovery Health Solutions IPA

Roy Wallach, President

[redacted]

Roy Wallach

Carol Cassell, Executive Director

[redacted]

Carol Cassell

## doh.sm.1115Waivers

**From:** Henderson, Jared [redacted]
**Sent:** Friday, November 1, 2019 1:25 PM
**To:** doh.sm.1115Waivers
**Subject:** NYSDOH DSRIP Waiver Amendment Public Comment (CNYCC)
**Attachments:** Oneida County Department of Mental Health Public Comment - 1115 Medicaid Redesign (DSRIP) Waiver Amendment Proposal.pdf



To Whom it May Concern,

Please find attached a letter of public comment from the Oneida County Department of Mental Health on the 1115 Medicaid Redesign (DSRIP) Waiver Amendment Proposal. Please let me know if you would like any additional information.

Thank you,
Jared

*Jared Henderson*
*Program Analyst*
*Oneida County Department of Mental Health*
*120 Airline St.*
*Oriskany, NY 13424*
[redacted]

Robin E. O'Brien
Commissioner
Oneida County Department of Mental Health
120 Airline St.
Oriskany, NY 13424

Re: 1115 Medicaid Redesign (DSRIP) Waiver Amendment Proposal

To Whom It May Concern,

Thank you for the opportunity to provide public comment on the 1115 Medicaid Redesign (DSRIP) Waiver Amendment. The Oneida County Department of Mental Health provides oversight to the planning, monitoring and reviewing of services for individuals with mental illness, addiction and developmental disabilities in Oneida County (central New York). In this capacity we have been able to participate in the DSRIP program with the Central New York Care Collaborative (CNYCC).

Our work with CNYCC has provided us an opportunity to establish partnerships with local organizations across our community. We have worked collaboratively with several local community based organizations on projects aimed at increasing access to primary, specialty and behavioral healthcare, specifically for non-English speaking communities. As part of these efforts, we've been able to significantly reduce the burden/disparity that many non-English speaking people face when it comes to accessing essential healthcare services. Furthermore, our county has a very *active Coordination of Care Coalition* that meets monthly; this coalition has also produced very positive results in creating greater *access* and continuity of care for patients. The efforts of Mohawk Valley Health System (MVHS) to embed behavioral healthcare within all of its Primary Care satellite offices both materialized and succeeded, in large part, due to the work and collaboration of this coalition. As a lead agency on behalf of the DSRIP program, CNYCC has provided great value to our organization.

In closing, we'd like to encourage the New York State Department of Health and the Centers for Medicare and Medicaid Services (CMS) to continue their investment in transforming care delivery through the DSRIP program. We'd also like to encourage even greater involvement of Local Governmental Units (LGU's)—throughout our region and across the state—in the next phase of DSRIP. The waiver amendment will allow our region to build on the great work we've started to here in central New York.

On behalf of the Oneida County Department of Mental Health, I thank you for the opportunity to submit this public comment.

Respectfully submitted,

Robin E. O'Brien

Robin E. O'Brien
Commissioner

**doh.sm.1115Waivers**

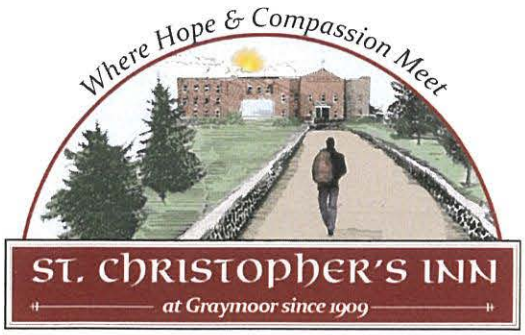
**From:** Udolf, Terri [redacted]
**Sent:** Friday, November 1, 2019 2:10 PM
**To:** doh.sm.1115Waivers
**Subject:** DSRIP 2.0 comments
**Attachments:** DSRIP 1115 Waiver comments.pdf



Thank you.

*Terri Udolf*, BSN, DSRIP Project Manager
St. Christopher's Inn
21 Franciscan Way
Garrison, NY 10524

[redacted]
www.StChristophersInn.org




21 Franciscan Way
PO Box 150
Garrison, NY 10524
Phone 845.335.1000
Fax 845.335.1017
Admissions 845.335.1020

November 1, 2019

1115Waivers@health.ny.gov
Re: DSRIP 2.0

To Whom It May Concern,

St. Christopher's Inn has participated with several PPSs since the inception of DSRIP to further New York State's efforts to improve care for its Medicaid participants.

Recognition and accolades have been given for the successes in reducing hospital utilization and improving patient care, and little of this would have been possible without the efforts of the community based agencies (CBOs). These agencies (ours included) participated on and chaired committees and workgroups, completed numerous surveys, submitted lengthy and comprehensive required documentation in support of projects undertaken, and partnered with the hospital PPSs to help construct and carry out new initiatives. In spite of these impressive efforts, the CBOs received little financial support. Sometimes, participation with a PPS was quite the opposite, and was a financial drain on agency resources due to the hours of labor, travel time and expenses incurred for their participation. The issue of funds flow was raised at every PAOP meeting for good reason, but little changed throughout the DSRIP years. While a high percentage of administrative expenses for PPSs was allowable and approved by the Department of Health, equally so was the lack of a funding stream to the CBOs for their support in the same efforts.

If DSRIP 2.0 is becomes a reality, I believe that there should be project dollars set aside by the Department of Health for participating CBOs, rather than leaving it up to the discretion of each PPS to determine whether or not to make payments, and to arbitrarily determine the value of those payments. Having worked with many PPSs, I know that there was no standard process for determining participation and project value, and payments made (if funds flowed at all) were vastly different for the same level of participation. Equally important would be to make changes in allowable Medicaid billing so that services found to be effective can continue once DSRIP funding ends, and enable the Tier 3 organizations that are not grant funded to sustain essential staff positions that led to the achievements made to date.

Also, CBOs, IPAs and other agencies that are able to negotiate risk-based contracts with MCOs for VBP contracts should not have to go through a third party to do so, but should be able to enter into agreements with MCOs directly. To date the focus of those contracts has been with large primary care providers, excluding other provider types.

Thank you for giving us the opportunity to share our thoughts.

Respectfully,

Terri Udolf, DSRIP Project Manager

## doh.sm.1115Waivers

**From:** Coveny, Irene A [redacted]
**Sent:** Friday, November 1, 2019 2:12 PM
**To:** doh.sm.1115Waivers
**Cc:** [redacted]
**Subject:** 1115 Waiver Public Comment
**Attachments:** DSRIP Public Comment Letter.pdf



Please see attached letter commenting on proposed DSRIP extension.

*Irene A. Coveny, M.P.A.*
Director, Ontario County Office for the Aging
3019 County Complex Drive
Canandaigua, NY 14424
[redacted]

[redacted]
Website: http://www.co.ontario.ny.us/aging

***Ontario County Vision Statement***
***A vibrant community where every citizen has the opportunity to be healthy, safe and successful***

*Ontario County Office for the Aging*
*Living Longer and Stronger*

**Ontario County Office for the Aging**
**3019 County Complex Dr.**
**Canandaigua, NY 14424**
**Office: (585) 396-4040 or**
**(315) 781-1321**
**Fax: (585) 396-7490**
**E-Mail: onofa@co.ontario.ny.us**
**Website: http://www.co.ontario.ny.us/aging**

November 1, 2019

NYS Department of Health
Office of Health Insurance
Waiver Management Program Unit
99 Washington Avenue
12th Floor, Suite 1208
Albany, NY 12210

To Whom It May Concern,

On behalf of Ontario County Office for the Aging, I am writing to comment on the application to extend the DSRIP waiver to March 31, 2024. The Ontario County Office for the Aging is one of 59 Area Agencies on Aging and the services we provide address the social determinants of health and often prevent higher, more costly forms of care. Our recommendation is that the second phase of DSRIP more strongly involves community-based organizations as a way of addressing the goals of DSRIP.

Our services, like those of the other Area Agencies on Aging align with the goals of the proposed DSRIP Amendment Request. We have been serving the community for about 40 years and considered trusted experts in the field of aging. Our goal is to help older adults remain independent in their own homes and delay or prevent more costly forms of care such as unnecessary hospitalizations and institutionalization. Our programs can also help older adults avoid spending down to Medicaid by providing low cost case management and home support services.

In 2010, 22% of the Ontario County population was age 60 or older and just eight years later in 2018 that has number has jumped to 27%. By 2030 that number is projected to increase to 33% of the county's population. As people live longer the problems they face are becoming larger and more complex than most people can manage themselves. Navigating the long term care system is complex, fragmented and daunting. Our NY Connects program serves as a "no wrong door" for all services available in the county. The program helps people remain independent by linking them with the right services in the right care setting.

To demonstrate the value of the Area Agencies on Aging network, I would like to highlight two recent cases that are typical to our office. We received a referral via our NY Connects program regarding an 84 year old widow, without children, who lives alone. Her only relative is her husband's niece. The amount of assistance the niece is able to provide is limited. She has severe arthritis, heart disease, breathing and vision problems. She walks with difficulty and uses a

walker to get around her apartment. She goes out only for doctor visits. As she has aged, taking care of her apartment, bathing and washing her hair, fixing meals and cleaning up the kitchen has become very difficult and exhausting. The Office for the Aging through the EISEP program provides an aide for 6.5 hours per week. Three times a week the aide helps her with a bath. The aide does the grocery shopping, the laundry, cleans the apartment, washes dishes, takes out trash, and prepares a casserole-type dish that the client can eat over the weekend. The Office for the Aging also provides Home Delivered Meals, with a volunteer bringing her a hot meal five days per week. Because she is frail, has medical problems that could result in a fall, and is alone most of the time, we provided her with a Personal Emergency Response System unit (PERS). The PERS makes it possible for her to call for help if she falls. On many days the EISEP aide and the Home Delivered Meal volunteer are the only people she sees and talks to. She looks forward to seeing them and having a little conversation. Without EISEP, HDMs and PERS she would probably not be able to stay in her own home. She cannot afford to hire outside help. Her surroundings would become dirty and neglected; she would be unwashed and social isolated. The effects of social isolation have been well documented and is linked to higher risks of a variety of physical and mental conditions: high blood pressure, heart disease, obesity, a weakened immune system, anxiety, depression, dementia and even death.

Without the help of the Office for the aging changes in her physical condition might go unnoticed. She might fall or become ill and not be able to summon help. This client would have to move to a higher and more expensive level of care. In this case we have also helped avoid emergency room visits and hospitalizations. In addition, EISEP provides her home care service at an affordable cost share and has helped her avoid spending down to Medicaid eligibility. This entire care plan was coordinated by the Office for the Aging's case manager.

In another case we helped an 81 year old woman save thousands of dollars on her prescription costs. She was on the same Medicare Part D prescription drug plan for many years and it was very affordable until the she wound up needing two different injectable insulins, one of which was not covered by her prescription plan. She continued to pay full price for this one prescription, over $600/month, for over two years, using up most of her small savings. Her annual prescription costs were totaling over $10,000 when she finally came to see a case manager at our office. We helped her to change Part D plans and apply for extra help with her prescription costs. Her annual cost for prescriptions will now only be $300. Without our assistance she told us she would have gone without her medication because she didn't want to use up her life savings. This would have led to increased medical costs due to her diabetes.

These are just two examples that display the impact the 59 Area Agencies on Aging and the power of the services they provide across the state. In the renewal waiver, I cannot stress highly enough that we need to harness the existing strengths of community- based services, instead of hospitals replicating our case management services and home support services. Each case manager in the statewide aging network has received certification by Boston University School of Social Work, ensuring consistency in assessment and care planning, not provided by any other system. I ask that there are mandates for each PPS to engage and contract with their local Offices for the Aging, for the services vital to keeping individuals in home and community based settings.

Thank You,

Irene Coveny

Irene Coveny, Director

CC: Paul Francis, Deputy Secretary for Health. Donna Frescatore, Medicaid Director, Department of Health, Assemblyman Harry B. Bronson, Chair Assembly Committee on Aging, Senator Rachel May, Chair Senate Committee on Aging

NEW YORK STATE | NY Connects
Your Link to Long Term Services and Supports
of ONTARIO COUNTY
(800) 342-9871 (585) 396-4047

## doh.sm.1115Waivers

**From:** Kelly Headrick [redacted]
**Sent:** Friday, November 1, 2019 2:15 PM
**To:** doh.sm.1115Waivers
**Subject:** 1115 Public Forum Comments from Nurse-Family Partnership
**Attachments:** Nurse-Family Partnership Comments DSRIP NY Nov 1 2019.docx

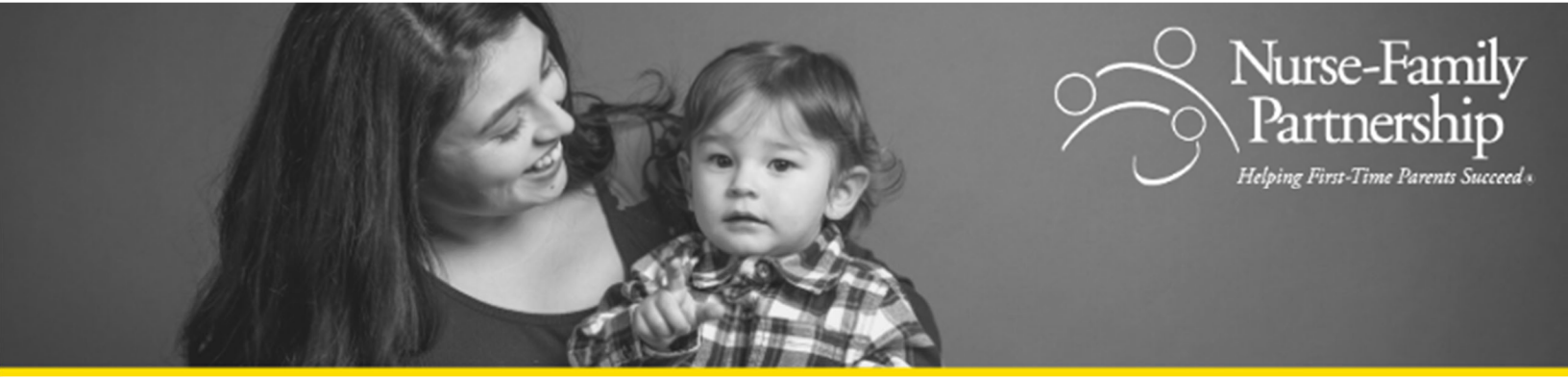


Thank you for the opportunity to provide feedback. Please see the attached public comments document, as well as our NFP New York state profile just for additional background information if helpful.

https://www.nursefamilypartnership.org/wp-content/uploads/2019/10/NY_2019-State-Profile.pdf

**KELLY HEADRICK**
National Director, Advocacy & State Government Affairs
Nurse-Family Partnership | National Service Office
1900 Grant St., 4th Floor, Denver CO 80203
[redacted]
NurseFamilyPartnership.org
Facebook | Twitter | Instagram | YouTube

*Our Vision: A future where all children are healthy, families thrive, communities prosper and the cycle of poverty is broken.*

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**NY Delivery System Reform Incentive Payment (DSRIP) 1115 Waiver 2.0 Amendment Public Comments**

**November 1, 2019**

**Submitted by:** **Kelly Headrick, National Director - Advocacy & State Government Affairs**
**Nurse-Family Partnership National Service Office**
[redacted]

Nurse-Family Partnership® (NFP) is a rigorously researched community health intervention that offers a comprehensive and holistic prevention model for first-time mothers living in poverty. Through ongoing, regular home visits conducted by registered nurses from pregnancy until the child's second birthday, nurse home visitors form a much-needed, trusting relationship with pregnant women, instilling confidence and empowering them to achieve a better life for their children and themselves. NFP has evidence of outcomes in improving health, child welfare, and family economic self-sufficiency. The NFP program is implemented by a number of local agencies in New York but is currently funded to serve only a fraction of eligible families.

NFP is pleased by the state's decision to pursue a four-year extension to the 1115 waiver to build upon the investments and successes of the initial DSRIP program. NFP appreciates the proposed investment under DSRIP 2.0 to address Social Determinants of Health that directly contribute to an individual's overall physical and mental health and wellbeing. To pursue effective delivery and payment reforms, the state must be willing to embrace nontraditional models of service delivery. Innovative efforts outside of the primary care physician's office and the clinic setting need be supported both conceptually and – more importantly – financially. Additionally, while current Value Based Payment (VBP) arrangements are built around primary care and provider attribution networks, those arrangements do not fully recognize community-based providers whose interactions with patients are far more regular. NFP appreciates that the state has acknowledged that the current networks and VBP arrangements do not embrace the comprehensive integration that will be key to the DSRIP program success.

**Section II. Changes Requested to the Demonstration**

*Aligning with Federal Goals*

In reviewing the DSRIP 2.0 amendment, the NFP model supports three of the promising practice categories that will continue to guide and inform DSRIP 2.0:

- Care coordination, care management, and care transitions – NFP nurse home visitors coordinate the care and services of NFP mothers and babies.
- Addressing Social Determinants of Health through Community Partnerships – the NFP model was developed to address the physical and mental health of expectant mothers from the onset, as well as a

comprehensive set of environmental factors that directly influence the health and wellbeing of families beginning with expectant mothers and ending with thriving families and children.

- Transforming Primary Care and Supporting Alternative Payment Models – NFP advocates for comprehensive payment of the NFP model to help ensure programs have an opportunity to receive payment for the full cost of services that NFP nurses provide, rather than partial payments that only cover a portion of a home visit. The NFP model also allows for significant flexibility within the visit schedule and among topics covered or activities performed at each individual visit, allowing nurses and mothers to tailor their interaction based on a family's needs. Accordingly, VBP structures tied to continuity of care for moms and babies and achievement of specific health outcomes and milestones are preferred over fee-for-service payments tied directly to visit frequency.

The NFP model naturally promotes coordination of care through the role of the Nurse Home Visitor, who routinely assesses the mother and child, refers both to any necessary services and follows up to see that referrals are pursued and connections are made by the mother and child to other support services within the health care system and in the community. Although some Medicaid managed care plans have taken the initiative to hire case managers who assume responsibility of managing the care of their most at-risk members, this is certainly not true for all plans. NFP is working with families in or on the brink of poverty, navigating multiples stressors and challenges related to employment, housing and financial instability. The nurse home visitors are well-equipped to conduct necessary screenings to make informed referrals for needed services and supports and following up to see that those referrals and connections were made. The NFP nurse home visitor can and does provide the care coordination that is still lacking for many Medicaid beneficiaries and could be utilized more formally by the Performing Provider Systems (PPS) to fill this need.

NFP supports the need for additional time to allow for strengthening partnerships with community-based organizations who can deliver services that address social determinants of health and we are pleased to see that those community partnerships are listed among the state's priority areas. These partnerships are particularly valuable if the state is truly looking to transform primary care. It must be acknowledged that primary care can and should extend beyond the traditional notions of a patient-physician visit. NFP nurse home visitors often serve as a second set of eyes and ears interacting with the patient outside of the physician's office and, as noted earlier, can ensure and support appropriate care coordination.

*The Second Generation – Value-Driving Entities*

Many organizations that deliver NFP services will be well-suited community-based organization partners in the proposed Value-Driving Entities (VDEs) structure.

**Section III. Additional High-Need Priority Areas**

Under the first DSRIP application, domain 3.f.i was developed to address poor pregnancy outcomes and subsequent hospitalizations. NFP was grateful for the promotion by the Department of Health as a key service model that could be employed to reverse the paradigm of poor maternal and newborn health among lower income populations. While initial investments were made to support connections with the community-based providers whose missions address the social determinants of health, state resources were limited and unfortunately could not support sustainable programming. Moving forward, DSRIP 2.0 intends to address maternal morality and child development. NFP excels at improving maternal and newborn health and wellness

through a holistic approach that addresses the myriad medical and nonmedical factors that contribute to overall wellness.

*Reducing Maternal Mortality*

NFP is designed to serve low-income women who have faced multiple adversities, and their babies; most of these families are enrolled in Medicaid. NFP applauded the governor for launching a comprehensive initiative to target maternal mortality and to reduce racial disparities in health outcomes, because NFP has been devoted to achieving the same objectives for the past 40 years and has done so with documented success. Therefore, the program is well positioned to address many of the leading concerns associated with maternal and infant mortality. NFP is also designed to encourage healthy and trusting relationships between the mother and her primary care physician. Further promotion of NFP by the state and integration of NFP in the delivery of prenatal care would support the state's goals of improved maternal health and wellness, newborn health and wellness, and promote trust and understanding among new mothers of the traditional health care delivery system.

*Children's Population Health*

NFP is grateful that the state recognizes the importance of allowing for more time for system redesign with a new focus on the integral role of community-based providers that offer non-medical support services that have direct correlation with an individual's physical and mental wellbeing. NFP is equally devoted to newborn health and early childhood development. NFP nurse home visitors are committed to the development of children and promote wellness visits, as well as conducting regular screenings to ensure child wellness and school readiness. NFP nurse home visitors work with parents to address environmental factors that could contribute to adverse childhood experiences.

**Section IV. Continued Investments/Improvements**

*C. Addressing the Opioid Epidemic*

As part of the NFP model, nurse home visitors screen parents for substance use and abuse and have served as a critical source support for parents dealing with addiction. As the state looks to increase screening for opioid use disorder (OUD), NFP encourages the state again to look beyond primary care practices. NFP nurse home visitors currently provide guidance and emotional support to expectant and new parents who are working to overcome addiction. NFP should be regarded as a critical program within a larger network of providers that can support individuals struggling to combat addiction.

**Conclusion**

NFP supports low-income women who have been affected by multiple adversities at a most opportune time – when pregnant, first-time mothers face challenges such as poverty, social isolation, abuse and other stressors. As New York continues to move in a direction where the Medicaid program seeks to pay for value, we encourage the department to take a renewed look at a program that was built upon more than 40 years of evidence, and explicitly incorporate NFP into the DSRIP 2.0 program to help address maternal mortality, improve children's population health, and address the opioid epidemic. NFP nurses empower women who are facing difficult circumstances to transform their lives and create better futures for themselves and their babies.

## doh.sm.1115Waivers

**From:** Dave Jordan [redacted]
**Sent:** Friday, November 1, 2019 2:06 PM
**To:** doh.sm.1115Waivers
**Subject:** 1115 Public Forum Comment
**Attachments:** DSRIP letter 11.19.pdf



Mr. Francis & Ms. Frescatore,

Please see attached message regarding the OFA's role in providing valuable services to older adults while saving NYS tax dollars.

*David Jordan*
Executive Director
Montgomery County Office for Aging, Inc.
135 Guy Park Ave
Amsterdam, NY 12010
[redacted]
www.officeforaging.com

# Montgomery County Office for Aging, Inc. and NY Connects

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November 1, 2019

Paul Francis
Deputy Secretary for Health
State Capitol
Albany, NY 12224

Donna Frescatore
Medicaid Director
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Dear Mr. Francis and Ms. Frescatore,

On behalf of the Montgomery County Office for Aging, Inc., I am writing to express my recommendations on the DSRIP renewal proposed by New York State Department of Health. The services we provide directly impact inappropriate emergency department visits, and reduce avoidable readmissions. The NY Connects program, implemented in 2006, serves as no wrong door for any and all services available in the region, and is a catalyst for individuals in need of assistance. The targeted goals in the proposed renewal are exactly what this network provides, and must include mandated contracting by each PPS with their local Area Agency on Aging for social determinants of health initiatives. Our office is the trusted service provider for the fastest growing segment of the population, and the highest utilizer of health care dollars. Our services **absolutely** allow individuals to remain in their own homes and communities, all while saving health care expenditures. We provide the highest level evidenced based interventions, and are experts at navigating a complex health care system, while providing person centered planning and care.

To demonstrate the value of the network, I would like to highlight a recent case that is typical to our office.

*Our agency received a referral from DSS for an 86-year old woman, living alone with diabetes and mobility issues (a recent knee replacement surgery). To enable the woman to stay in her home, she was assessed by our staff and began receiving daily, home-delivered meals and 10 hours of personal care and housekeeping services through our EISEP program. Prior to her receiving these services, she had been losing weight (20 lbs. in 6 months), her blood sugar was very unpredictable and she had frequent hospitalizations due to spikes or drops in her blood sugar levels. She was also very isolated with little, if any, contact with others since she lives in a very rural area with no family members or friends living close by. After receiving our services for 6 months, she has gained back some weight (10 lbs.) and her blood sugar levels have been more consistent and stabilized. She has had no hospitalizations since starting with our services. Also, with our home-delivered meals and EISEP programs, she has people completing wellness checks with her 5-6 days per week.*

*The total cost of services that the OFA has provided to this woman for the past 6 months is $6,350. The estimated savings compared to a nursing-home level of care (which she qualifies for) is $47,650.*

This is one of many cases that truly display the boots on the ground service provision in every county across the state. In the renewal waiver, I cannot stress highly enough that we need to harness the existing strengths of community based services, instead of recreating case management services and duplication of services. Each and every case manager in the entire statewide aging network has received certification via Boston University School of Social Work, ensuring consistency in assessment not provided by any other system. I ask that there are mandates for each PPS to engage and contract with their local Offices for the Aging, for the services vital to keeping individuals in home and community based settings.

Thank you,
David Jordan
Executive Director
Montgomery County Office for Aging, Inc.

Rotary

Fulton Montgomery
REGIONAL CHAMBER OF COMMERCE

United Way

## doh.sm.1115Waivers

**From:** Brenda Wiemann [redacted]
**Sent:** Friday, November 1, 2019 2:55 PM
**To:** doh.sm.1115Waivers
**Subject:** 1115 Public Forum Comment
**Attachments:** 1115WaiverDSRIP letter Cayuga County11-19.doc



Please include the attached letter for the 1115 Public Forum Comment. Thank you

Brenda Wiemann, LMSW
Director
Cayuga County Office for the Aging
160 Genesee St, Auburn, NY 13021
[redacted]

Cayuga County
Office for the Aging

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November 1, 2019

Paul Francis
Deputy Secretary for Health
State Capitol
Albany, NY 12224

Donna Frescatore
Medicaid Director
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Dear Mr. Francis and Ms. Frescatore,

I am writing as the Director of the Cayuga County Office for the Aging, to express my recommendations on the DSRIP renewal proposed by New York State Department of Health. The services that each county Area Agency on Aging provides directly impact inappropriate emergency department visits, and reduce avoidable readmissions. Our NY Connects program, implemented in 2006, serves as a no wrong door for any and all services available in the region, and is a catalyst for individuals in need of assistance. The targeted goals in the proposed renewal are exactly what this network provides, and must include mandated contracting by each PPS with their local Area Agency on Aging for social determinants of health initiatives. Our office is the trusted service provider for the fastest growing segment of the population, those 60 and over, who are known to be the highest utilizer of health care dollars. Our services **absolutely** allow individuals to remain in their own homes and communities, all while saving health care expenditures. We provide the highest level evidenced based interventions, and are experts at navigating a complex health care system, while providing person centered planning and care.

To demonstrate the value of the network, I would like to highlight a recent case that is typical to our office: In April of 2017, two daughters of a 94yo woman living alone in her own home came into the Cayuga County Office for the Aging (OFA)/NYConnects office because their mother was running out of funds to privately pay for around the clock care. Their mother was very frail and needed assistance with all ADLs and IADLs, indicating that she would qualify for nursing home level of care. Family was worried that going on Chronic Medicaid for nursing home placement was their only option, yet they were clear that going to a nursing home was not their wishes and would be a last resort. Our office discussed long-term care options and the family chose to pursue Medicaid Managed Long Term Care (MLTC) as the best option to keep their mother home as long as possible.

In December of 2017, the OFA assisted with the completion of the Medicaid application. The daughters were clearly overwhelmed at the start of the process, but were greatly relieved when the Community Medicaid application was approved. The OFA provided extensive assistance as the family navigated the MLTC process from the initial phone call to MAXMUS and numerous explanations of what to expect through each step.

There were several times during this process that family was leaning toward giving up and considering nursing home placement. A major frustration was when the MLTC in-home care plan was all set up, but aide services were not quite running smoothly yet. There were 3 call-ins or no-shows within 1 week period. The OFA/NYConnects staff were there for continued emotional and strategical support, as we encouraged the family to remain engaged through the transition.

We are now nearing the **two year** mark and this client is still receiving the necessary supports she needs to reside in her own home. These supports have kept her from having frequent hospital visits and have prevented more costly skilled nursing home placement during this entire time and ongoing still.

This is one of many cases that exemplifies the expert knowledge and service provided in every county across the state. In the renewal waiver, I cannot stress highly enough that we need to harness the existing strengths of community based services, instead of recreating case management services and duplication of services. Each and every case manager in the entire statewide aging network has received certification via Boston University School of Social Work, ensuring consistency in assessment not provided by any other system. I ask that there are mandates for each PPS to engage and contract with their local Offices for the Aging, for the services vital to keeping individuals in home and community based settings.

Thank you,

Brenda Wiemann, LMSW
Director
Cayuga County Office for the Aging

## doh.sm.1115Waivers

**From:** David Cohen [redacted]
**Sent:** Friday, November 1, 2019 2:56 PM
**To:** doh.sm.1115Waivers
**Subject:** 1115 Public Forum Comment [Do not encrypt]
**Attachments:** 2019.11.01_Community Care of Brooklyn DSRIP Waiver Comment Letter.pdf



To Whom It May Concern:
Attached please find comments from Community Care of Brooklyn regarding the proposed amendment to the MRT waiver.

Sincerely,
David I. Cohen, MD, MSc

Executive Vice President, Population Health and Academic Affairs
Maimonides Medical Center
4802 Tenth Avenue
Brooklyn, NY 11219
[redacted]

COMMUNITY CARE OF BROOKLYN

November 1, 2019

To Whom It May Concern:

On behalf of Community Care of Brooklyn (CCB), I want to thank you for the opportunity to provide the following comments on the proposed amendment to the MRT Waiver. As the second largest performing provider system (PPS) in New York State, with an attribution of over 630,000 Medicaid beneficiaries, CCB has been an active and effective participant in the current DSRIP program. We look forward to the next phase of our work together to improve health care in New York State.

We agree with DOH that DSRIP has had a significant positive impact and has begun the shift in New York to value-base payment (VBP). Over the DSRIP waiver period, we have built a high-functioning, collaborative network comprised of key stakeholders in Brooklyn including Community Based Organizations (CBOs), Managed Care Organizations (MCOs), hospitals, physicians, social service organizations and others to jointly develop and implement initiatives to improve health. Together, we have improved access to physical and behavioral health care; provided care management to particularly vulnerable populations, including individuals with history of incarceration; strengthened primary care; and engaged communities to address the social determinants of health across the borough. We have achieved significant outcomes including a 30 percent reduction in potentially preventable readmissions over four years. We have accomplished this through meaningful partnerships and a robust governance structure that includes individuals employed by health care institutions, social service providers, CBOs, and MCOs on our Executive and other key committees.

The proposed extension of DSRIP provides an opportunity to bring these efforts to maturity and continue to build on this strong foundation. We are particularly pleased to see the focus on reducing maternal mortality, improving children's population health, addressing the opioid epidemic, partnerships with the justice system, and the dual eligible population. We have expanded our current DSRIP initiatives to focus on these areas and look forward to continuing our partnerships to further these efforts in the future.

We support the emphasis on cross-sector collaboration as key to addressing social determinants of health to achieve system transformation. At CCB, CBOs have worked alongside healthcare providers as equal partners in leading CCB's Community Engagement Committee and Community Action and Advocacy Workgroup. These groups have directed the development and implementation of a number of successful community engagement efforts, including participatory action research projects across Brooklyn, implementation of community-driven recommendations, and cultural competency and health literacy training for PPS partners. CCB

has valued its close equitable partnerships and the inclusion of CBOs in planning and decision-making. This model will be essential to continued success of the DSRIP program in the future.

We appreciate the focus on continued flexibility and investment in developing and retaining the workforce required to successfully transform the health care and social service delivery system. We support the State's recognition of the non-traditional, non-clinical workforce, such as care managers, health coaches, and peers, who have been a major focus of our workforce development efforts to date and played a key role in our success. We also support the focus on the long-term and post-acute care workforce to address the needs of older adults.

The proposed extension also affords an opportunity to learn from our experience to refine and further promising practices. One such opportunity would come from defining a distinct, exclusive geographic region for each Value-Driving Entity (VDE) to reduce the volume of attribution churn. In Brooklyn, this has been a significant challenge; for example, only 65% of patients attributed to CCB remained attributed to us from Measurement Year 3 to Measurement Year 4. Restricting VDEs to one per geographic region will mitigate cyclical patient attribution patterns and clarify accountability for outcomes.

We also hope that there will be an opportunity to rethink the methodology for performance measurement on population health outcomes. The current approach, which rewards PPS for closing "gaps to goal," has meant that some PPS, including CCB, can make a positive and significant contribution to progress overall but miss 'gap-to-goal' targets and not achieve payments for their contributions. As you know, strong performance in one period can increase the challenge of meeting a gap-to-goal target in the following period. As noted above, as of the end of MY4, CCB achieved a 30% reduction in potentially preventable readmissions; despite this, CCB did not earn pay-for-performance achievement values for this metric.

Additionally, as you further define the specifications of VDEs we request that they not be required to be incorporated as legal entities, since this would likely delay implementation and increase costs. Many successful PPS, including CCB, did not create a new legal entity and we believe that a VDE can be equally successful without imposing this requirement.

Thank you again for the opportunity to provide feedback. We look forward to a continued successful partnership, working together with DOH and our partners to improve health care throughout Brooklyn.

David I. Cohen, MD, MSc
Chair, CCB Executive Committee

CC: Members of the CCB Executive Committee:
Linda Brady, MD, former CEO, Kingsbrook Jewish Medical Center
LaRay Brown, President & CEO, One Brooklyn Health System and CEO, Interfaith Medical Center
Donna Colonna, CEO, Services for the Underserved

Lazetta Duncan-Moore, CEO, Brooklyn Plaza Medical Center
Marilyn Fraser, MD, President, Arthur Ashe Institute for Urban Health
Kenneth Gibbs, President & CEO, Maimonides Medical Center
Jay Gormley, SVP for Strategic Planning & Policy, MJHS
Cheryl Hall, former Executive Director, Caribbean Women's Health Association
Kathryn Haslanger, CEO, JASA
Charles King, President & CEO, Housing Works
Harvey Lawrence, President & CEO, Brownsville Multi-Service Family Health Center
Coraminita Mahr, Vice President, 1199- United Healthcare Workers East SEIU
Ngozi Moses, Executive Director, Brooklyn Perinatal Network
Kevin Muir, Executive Director, EngageWell IPA
Neil Pessin, PhD, VP, Community Mental Health Services, Visiting Nurse Service of New York
Maurice Reid, Advisor, The Alliance for Healthy Communities
Ramon Rodriguez, President & CEO, Wyckoff Heights Medical Center
Ian Schaffer, MD, VP and Medical Director, Behavioral Health, Healthfirst
Steve Silber, DO, Regional Executive Medical Director of the NewYork-Presbyterian Medical Group Brooklyn
Eric Smith, Associate Director, NYSNA
Dominick Stanzione, President, Brookdale Hospital and Medical Center
Barry Stern, President & CEO, New York Community Hospital
Sandi Vito, Executive Director, 1199SEIU Training and Employment Funds
Lisa Zullig, Director of Nutrition, Gods Love We Deliver

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**From:** Jorge Petit [redacted]
**Sent:** Friday, November 1, 2019 3:07 PM
**To:** doh.sm.1115Waivers
**Cc:** Sara Sezer
**Subject:** 1115 Public Forum Comment
**Attachments:** CBC DSRIP 2.0 Written Comments FINAL 11.1.19.pdf



Good afternoon, please find attached Coordinated Behavioral Care (CBC) written public comments.
Thanks you.

**Jorge R. Petit, MD**
**President & CEO**
Coordinated Behavioral Care
55 Broadway, Suite 701
New York, NY 10006
[redacted]
TRANSFORMING COMMUNITY HEALTHCARE
www.CBCare.org
**CHECK OUT THE CBC WHITE PAPER:** Behavioral Health & Emerging Technologies

COORDINATED BEHAVIORAL CARE



November 1, 2019

To Whom It May Concern:

We are pleased that the 2nd iteration of DSRIP puts more of a focus on mental health and substance use disorders, social determinants of health, and children's population health, each of which are key priorities for Coordinated Behavioral Care (CBC).

Coordinated Behavioral Care (CBC) was developed and organized by NYC Behavioral Health not-for-profit providers. This provider-led organization includes a Health Home (HH) and an Independent Practice Association (IPA) dedicated to improving the quality of care for New Yorkers with serious mental illness and substance use disorders, minors with serious emotional disturbances, and chronic health conditions. The goal of the providers that created CBC was to improve out comes for person with serious mental illness, by integrating behavioral and medical interventions, addressing social determinants, and creating new opportunities for meaningful community experiences for the population they serve.

CBC agencies serve over 100,000 Medicaid recipients and provide over $1B in behavioral health (BH) services. Central to the vision of CBC is the evolution from a fee-for-service reimbursement system to one that rewards outcomes and allows for flexibility and innovation.

CBC is also an Innovations Hub where we incubate and disseminate new program models, such as Pathway Home™ and other care coordination/care transitions

programs, as well as promote emerging technology assisted care (TAC) solutions as strategies for improving overall wellbeing and healthcare outcomes.

CBC's providers and programs work with the high-cost/high-utilizing multi-morbid population that are the costs drivers of healthcare in NYS. CBCs network of providers have developed a number of innovative and effective programs ranging from preventive case management and community hotspotting to an ambulatory detox and withdrawal management program to Pathway Home™. These programs have had significant measurable impacts with reductions in hospital utilization, increased outpatient follow-up to both primary and specialty care, increased adherence to medications including Medication Assisted Treatment (MAT) for patients with Substance Use Disorders (SUD), decrease in gaps in care such as diabetes screening and monitoring and decrease in Emergency Department (ED) visits for those enrolled in these program.

For the most part these effective programs have been financed through state agencies, such as NYS Office of Mental Health (OMH) and Office Alcoholism and Substance Abuse Services (OASAS) or the DSRIP PPS. The only programs funded by Medicaid Managed Care Organizations (MMCO) to date are one Pathway Home™ team targeting the Medicare and dual eligible population and the newly launched ambulatory detox program. Like other behavioral IPAs, CBC has not been successful in contracting with MMCOs, in spite of the fact that the State Behavioral Health Care Collaborative (BHCC) grant anticipated such contracts between MMCOs and behavioral IPAs. For example, CBC's award-winning care transitions program, Pathway Home™ has a proven track record of improved outcomes and cost savings. In a soon to be published article we have shown a there was a significant decrease in the average number of inpatient days per person-months during enrollment and this effect was sustained after discharge, roughly a $35,000 savings per enrollee. These savings have accrued to the plans not to our providers since there are there are no meaningful MMCO contracts for these interventions. CBCs providers are concerned that the financing of these community-based care services are at risk with no sustainable model of MMCO contracting in the foreseeable future despite multiple attempts at seeking such contracting opportunities.

As a clinically integrated IPA and a BHCC award recipient, we wholeheartedly agree with the State's decision to expand the PPS concept to allow CBOs, MMCOs, IPAs, and BHCCs to form Value Driving Entities (VDEs).

As part of the proposed VDE model, we strongly urge that the State consider organizations that focus on individuals with complex behavioral health needs, such as CBC, when determining and approving VDEs. We also feel strongly believe that CBC has all the right components to be a VDE: a mature and robust quality performance and oversight division, an electronic data warehouse with business intelligence and data analytics and reporting, a strong network development and management function as well as other core functionalities such as technical assistance, learning collaborative and training, contracting and credentialing support, and other etc.

If this new initiative is to be truly person-centered and not provider centered, with more than 80% of Medicaid super-utilizers having comorbid mental illness and 44% having serious mental illness, CBC's role in transforming the healthcare system as you are proposing is not only critical but vital to the success of DSRIP 2.0. Individuals who have complex behavioral health needs benefit from the ongoing relationship with their behavioral health providers. These behavioral health providers are in the best position to manage and coordinate the necessary services and resources to meet their needs, truly a one-stop care delivery system.

CBC proposes that the State consider eliminating the attribution barriers that typically face behavioral health networks that are interested in taking on risk for the populations they serve. There is a precedence for this, the Medicare Shared Savings Plan Accountable Care Organization model of attribution is based on a preponderance of service. Thus, if the patients' needs are primarily behavioral health focused in terms of care delivery and engagement and the primary relationship of the patient is with the behavioral health provider; then attribution should be to the behavioral health provider where the engagement is occurring or most likely to occur. It will then be our role and responsibility to coordinate care for primary care, specialty care and social determinant services. The BH Attribution model should include the total cost of care for the attributed BH populations when possible but also offer ways to remediate risk or support networks of BH providers to slowly build up their tolerance for risk. These networks could start at lower levels of risk, establish guardrails to remediate significant risk or utilize models similar to HIV SNPs with specialty rates and expanded services for the BH/HARP population.

Additionally, we believe that CBC is ideally suited to serve as a regional Social Determinants of Health Network (SDHN) given the wide array of agencies, programs and services offered throughout the 5 boroughs by

the more than 50 network providers as well as our track record of providing a full range of social determinant related services in addition the care coordination, treatment, housing and other clinical services provided to high need populations.

We look forward to engaging with you on the continued system transformation that involves and includes network of providers such as the ones CBC is made of and represents.

Donna Colonna
Board Chair, CBC
Chief Executive Officer, S:US

Jorge Petit, MD
President & CEO, CBC

## doh.sm.1115Waivers

**From:** Sherman, Megan [redacted]
**Sent:** Friday, November 1, 2019 3:13 PM
**To:** doh.sm.1115Waivers
**Cc:** [redacted]
**Subject:** Planned Parenthood Empire State Acts comments on DSRIP Waiver Amendment Proposal
**Attachments:** DSRIP concept paper comments_PlannedParenthoodEmpireStateActs_vf.pdf



Good afternoon,

Attached please find the comments submitted on behalf of Planned Parenthood Empire State Acts on the Department of Health's DSRIP Waiver Amendment Proposal. Thank you for the opportunity to provide comment.

**Megan Sherman**
Associate

**Manatt, Phelps & Phillips,** LLP
136 State Street
Suite 300
Albany, NY 12207
[redacted]

manatt.com

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Planned Parenthood Empire State Acts

NYS Department of Health
Office of Health Insurance Programs
Waiver Management Unit
99 Washington Avenue
12th Floor, Suite 1208
Albany, NY 12210
1115waivers@health.ny.gov

October 25, 2019

On behalf of Planned Parenthood Empire State Acts ("PPESA"), and the nine Planned Parenthood affiliates ("affiliates") that we represent, we wanted to provide comments on the State's Delivery System Reform Incentive Payment ("DSRIP") amendment request and discuss our vision for the role of Planned Parenthood in the next stage of the State's delivery system reform efforts.

Affiliates are actively engaged in the current DSRIP program and applaud the new waiver request that allows more time to support DSRIP activities and the integration of those activities into sustainable, value-based models that are inclusive of all providers. Our affiliates have participated in the DSRIP program since its inception engaging with multiple Performing Provider Systems ("PPSs") in every region of the state and taking part in the implementation of over ten DSRIP projects, including those that:

- Integrate behavioral health services;
- Screen for substance abuse and behavioral health conditions;
- Identify and refer patients with social determinants of health needs;
- Expand access to primary care; and
- Perform care coordination for at-risk patients.

Affiliate engagement in the DSRIP program fills a critical gap for the State. Patients who seek out care from affiliates are often low income, racially and ethnically diverse and are at risk for poor health outcomes; more than half are Medicaid beneficiaries. Planned Parenthood affiliates often serve as a gateway to care and for some patients, ***Planned Parenthood providers are their only regular contact with the health care delivery system***. Patients rely on affiliates for high quality, non-judgmental sexual and reproductive health care ("SRH") services and are considered trusted advisors as they navigate sensitive health care needs.

We believe that there is a larger role for providers of SRH in meeting the State's goals for delivery system reform and broader use of Value-Based Purchasing ("VBP") models. PPESA and Planned Parenthood affiliates are eager to further the State's goals and offer the following suggestions for further integration of SRH providers into the DSRIP waiver.

**Integration of SRH providers into Value-Driving Entities ("VDEs").** While our affiliates have been successful at engaging in select DSRIP efforts, those efforts have been painstakingly carved out as the current DSRIP waiver does not explicitly address a role for SRH providers nor include projects or performance-based measures that address women's SRH needs outside of pregnancy. To ensure that our affiliates can continue to engage and expand our presence in system transformation efforts, we request that the state require VDEs to explicitly include SRH providers as a part of the VDE governance structure. This integration supports the role of SRH providers, who are trusted patient partners, in helping to address important state priorities, such as maternal mortality (addressed below).

**Integration of SRH providers in VBP through improved attribution models and requirement to include SRH in VBP arrangements.** PPESA agrees with the State's assertion that attribution needs to become more sophisticated to drive value-based care and reward those providers outside of primary care that improve quality and outcomes. For many women, including pregnant women, their primary interaction with the health care system is through their SRH provider. Accordingly, these providers have the opportunity to achieve better outcomes for this population, particularly in the area of prevention, prenatal care and maternal mortality (addressed below). A more sophisticated system that allows attribution to providers who are primarily responsible for an individual's care regardless of designation—including SRH providers—is needed and will better promote alignment in value-based payment models between the incentives and the providers who are driving improvements in care and quality outcomes.

To further support meaningful integration of SRH providers into VBP models, we also request that the State require that VBP models demonstrate adequate participation of SRH providers and adequate access to SRH services. This can be done both through demonstration of inclusion of SRH providers, explicitly, into VBP arrangements and through the addition of the contraceptive quality measures, which are further noted below.

**Addressing the role of SRH providers in improving maternal mortality.** We applaud the State for recognizing maternal mortality as a high need priority area for the next phase of DSRIP. New York's high maternal mortality rates, particularly among women of color, requires a broad-based policy initiative in the Medicaid program, which is responsible for covering over 50% of the births that occur in the state. As safety net providers of SRH, the Planned Parenthood affiliates are a key link in addressing the maternal mortality crisis and the racial disparities in care and we are eager to partner with the State to implement solutions.

In order to make meaningful change in the health care system aimed at addressing maternal mortality, we believe the state should take the following steps:

1. *Require VDEs to implement programs focused on maternal mortality, in partnership with providers of SRH.* All VDEs should be required to implement programs that address the specific drivers of maternal mortality in their service areas and engage with providers of SRH. We stress that this requirement is key to ensuring that all VDEs engage in programs that address this high need priority area. Moreover, we believe that VDEs need to engage with providers of SRH in order to develop and implement effective strategies for addressing maternal mortality. SRH providers can—and do—address the chronic disease risk factors (including smoking, obesity, behavioral health and cardiovascular disease risk) and underlying social determinants that drive maternal health outcomes. Without the involvement of these providers, VDEs will not be able to successfully address the causes of maternal mortality.

2. *Uplift proven strategies for addressing maternal mortality.* Combatting maternal mortality requires investment not only in interventions during pregnancy and delivery, but critically those that place emphasis on overall health and wellbeing prior to and after pregnancy. The reality is an increasing number of pregnant women have chronic health conditions that could be contributing to the increase in maternal mortality.[1] As stated above, SRH providers – like Planned Parenthood - offer a range of primary and preventive health care services that have the power to identify existing or potential health considerations that could complicate future pregnancies. While the desire to prevent an unintended pregnancy may drive people to seek

[1] Building U.S. Capacity to Review and Prevent Maternal Deaths. Report from Nine Maternal Mortality Review Committees. 2018. http://reviewtoaction.org/sites/default/files/national-portal-material/Report%20from%20Nine%20MMRCs%20final_0.pdf.

care from a SRH provider, for many it is an opportunity to receive care that can facilitate healthy pregnancies in the future. Like many SRH providers, Planned Parenthood health centers are a trusted source of care – which is the foundation for the type of education, counseling and supportive care that is most needed to prevent chronic conditions. Strategies employed by the State, and implemented by the VDEs, to address maternal mortality must include a focus on programs and interventions that meaningfully engage SRH providers, to ensure a holistic focus on preventing maternal mortality.

3. *Provide adequate funding for prenatal care*. Planned Parenthood affiliates have historically played a role in expanding access to prenatal care, particularly in rural areas of the state. However, as the State transitioned to Medicaid managed care, plans failed to reimburse prenatal care provision at a sustainable rate for those providers not engaged delivery. As a result, affiliates have had to either eliminate their prenatal care program, operate those services at a deficit or have been unable to offer services despite known community need. This impact is disproportionately felt in rural areas of the state, where women face a range of barriers to care and limited access to these services in particular. We believe the State should explore sustainable models that allow for the innovative delivery of the full range of prenatal care to women living in rural areas.

**Required use of contraceptive care quality measures in VBP arrangements to gauge access to range of contraceptive needs.** The State needs to select quality measures that are inclusive of the care most needed by women of reproductive age[2] in order to hardwire these services into value-based arrangements. New York already includes the Post-Partum Women: Most- & Moderately Effective Methods (NQF #2902) contraceptive measure in its maternity bundle and reports against the measure as part of the Medicaid Core measure set. However, the inclusion of this measure, and other contraceptive measures have not yet been incorporated as required measures for approved VBP arrangements. The State and VBP contractors can use these measures to assess if beneficiaries covered by VBP arrangements are receiving access to the full range of contraception options, identify geographic areas where there may be barriers impeding access to some or all forms of contraception, and develop strategies to improve access. We request that the State require these measures as a part of current VBP efforts and those that will be emerging through the transition to VDEs.

Use of contraceptive care quality measures in VBP requires unique considerations given the preference-sensitive nature of contraceptive use, and the history of coercive practices that limited women's contraceptive choices. For example, the State should not set "targets" for contraceptive use- even targets well below 100 percent may inadvertently encourage providers, VBP contractors or MMCOs to pressure patients into contraceptive decisions. To help states appropriately incorporate these measures into VBP, Planned Parenthood Federation of America (PPFA) developed a brief on "Measuring Quality Contraceptive Care in a Value-Based Payment System"[3] which offers several strategies and guardrails.

**Improved payment models for CBOs and front-line providers in identifying and referring for social determinants of health ("SDH") items.** We applaud the State's ongoing commitment to SDH and recognition that additional infrastructure is needed to advance community based organizations (CBOs) that are delivering meaningful SDH interventions. We believe the State needs to set up more explicit

[2] In a 2017 survey, women reported that the top three types of medical care they needed in the last two years were well-woman visits or routine check-ups, Pap tests, and birth control. See Perry Undem and Planned Parenthood. Examining the Health Care Needs and Preferences of Women Ages 18 to 44. Topline Report. https://www.plannedparenthood.org/uploads/filer_public/31/28/312868ed-0dcf-48a2-b146-03087fccff02/perryundem_research_july_2017.pdf, 5.

[3] Planned Parenthood Federation of America: Measuring Quality Contraceptive Care in a Value-Based Payment System. Available at: https://www.plannedparenthood.org/uploads/filer_public/7e/90/7e90b4cb-4b3d-499f-8c6c-f31ab865b621/ppfa-manatt_measuring_quality_contraceptive_care.pdf

payment models to ensure that funds flow from the VDEs and Medicaid managed care plans to CBOs to support the delivery of SDH interventions. We further note that SRH providers serve as front-line screeners to identify patients who require SHD services. The State needs to ensure that there is a payment structure to facilitate the reimbursement for SDH that is linked to the different points and places where women access care.

We value the opportunity to share with you our thoughts on the next phase of system transformation in New York. This is truly a time of innovation – and we look forward to continuing to partner with you as we collectively envision a delivery system that breaks down systemic inequities and reflects the needs and realities of all New Yorkers.

Sincerely,

Robin Chappelle Golston
President and CEO

Cc: Greg Allen, Director, Division of Program Development and Management

## doh.sm.1115Waivers

**From:** Nancy Dingee [redacted]
**Sent:** Friday, November 1, 2019 3:39 PM
**To:** doh.sm.1115Waivers
**Cc:** [redacted]
**Subject:** 1115 Public Forum Comment
**Attachments:** 1115 Waiver Public Comment from Schoharie County Office for the Aging.docx



Dear Sir,
Please see my attached comments on the 1115 Waiver Program.
Sincerely,
Nancy Dingee

*Nancy Dingee*
Director
Schoharie County Office for the Aging
113 Park Place, Ste 3
Schoharie, NY 12157
[redacted]

**Schoharie County Office for the Aging**
113 Park Place, Suite
Schoharie, NY 12157

Telephone: (518) 295-2001
Fax: (518) 295-2015

Nancy Dingee
Director

November 1, 2019

Paul Francis
Deputy Secretary for Health
State Capitol
Albany, NY 12224

Donna Frescatore
Medicaid Director
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Dear Mr. Francis and Ms. Frescatore,

On behalf of Schoharie County Office for the Aging, I am writing to express my recommendations on the DSRIP renewal proposed by New York State Department of Health. The services we provide directly impact inappropriate emergency department visits and reduce avoidable readmissions. The NY Connects program, implemented in 2006, serves as no wrong door for any and all services available in the region, and is a catalyst for individuals in need of assistance. The targeted goals in the proposed renewal are exactly what this network provides, and must include mandated contracting by each PPS with their local Area Agency on Aging for social determinants of health initiatives. Our office is the trusted service provider for the fastest growing segment of the population, and the highest utilizer of health care dollars. Our services **absolutely** allow individuals to remain in their own homes and communities, all while saving health care expenditures. We provide the highest level evidenced based interventions, and are experts at navigating a complex health care system, while providing person centered planning and care. We coordinating existing resources in the community to provide what ever services are needed to assist individuals to stay at home safely and comfortably.

To demonstrate the value of the network, I would like to highlight one case that is typical to our office:

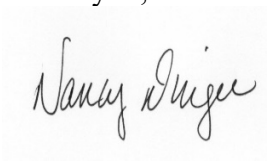
*This is a story about a gentleman that began services with OFA back in the summer of 2015 following a discharge from the hospital. He suffers COPD and CHF. There were also some vision concerns at the time regarding cataracts. Upon discharge from hospital, he began to receive Home Delivered Meals (HDM). He is typically a fairly independent man, maintaining his home and surrounding property. At that time, our client had supportive friends to assist when needed, including one that helped with common household tasks.*

*Over the years, his situation has changed, and he finds himself without informal supports. His financial, home and health situations have all taken a turn for the worse. His independence is diminished due to health issues, including vision and now finds himself in a home that he has not maintained. The home has deteriorated, and he very much wants to relocate to a healthier living environment where supports can be put in place to assist on a regular basis. He continues to be supported through services at OFA. The HDM program is still in place, with Case Management, In Home Support and he uses our Transportation Program now quite actively. Transportation is utilized for multiple appointments per month. He has also received assistive devices/products to help maintain some independence.*

*Case Management has worked diligently to find a new home where the client will feel comfortable and also be adequate for his mobility/health issues. A new apartment has been secured with a move in date in the very near future. A local charitable organization will be providing furniture as new items are needed. An HHA agency has been contacted about provision of Personal Care when client has relocated. Although change is not always easy, a supportive environment with services coordinated, has built trust and provided some comfort during this transition. Case Management will continue to spear head the coordinated services for this client in his new home.*

This is one of many cases that truly displays the boots on the ground service provision in every county across the state. In the renewal waiver, I cannot stress highly enough that we need to harness the existing strengths of community-based services, instead of recreating case management services and duplication of services. Each and every case manager in the entire statewide aging network has received certification via Boston University School of Social Work, ensuring consistency in assessment not provided by any other system. I ask that there are mandates for each PPS to engage and contract with their local Offices for the Aging, for the services vital to keeping individuals in home and community-based settings.

Thank you,



Nancy Dingee
Director
Schoharie County Office for the Aging

## doh.sm.1115Waivers

**From:** regulatory [redacted]
**Sent:** Friday, November 1, 2019 3:55 PM
**To:** doh.sm.1115Waivers
**Cc:** [redacted]
**Subject:** 1115 Public Forum Comment
**Attachments:** DSRIP Comments Fall 2019 v3.docx



Attached in Word please find NYSHFA/NYSCAL's comments to the Draft DSRIP Waiver Amendment. Thank you.

NYS Health Facilities Association
NYS Center for Assisted Living
33 Elk Street, Suite 300 | Albany, NY 12207
[redacted]
www.nyshfa.org

NYSHFA | NYSCAL

NYS HEALTH FACILITIES ASSOCIATION | NYS CENTER FOR ASSISTED LIVING

Public Comments of:

**NEW YORK STATE**
**HEALTH FACILITIES ASSOCIATION**

and the

**NEW YORK STATE**
**CENTER FOR ASSISTED LIVING**

on the

# 2019 New York State 1115 Delivery System Reform Incentive Payment (DSRIP) Waiver Amendment

NYSHFA/NYSCAL
33 Elk Street, Suite 300 | Albany, NY 12207
(518) 462-4800 | info@nyshfa.org

The New York State Health Facilities Association and the New York State Center for Assisted Living (NYSHFA/NYSCAL) appreciates the opportunity for input on the State's DSRIP Waiver Amendment Proposal, as long-term care (LTC) providers have been essentially left out of the millions of dollars invested by the Delivery System Reform Incentive Payment (DSRIP) Program to date. The State acknowledges this inconsistency its DSRIP Amendment Request Investments that "members needing long-term care did not benefit directly from most DSRIP initiatives unless a Medicaid-measured avoidable hospitalization could be impacted." However we have some concerns how "promising practices" will lay the groundwork for further VBP that is specifically designed to meet the needs of the high-cost, high-need LTC population identified in the Proposal given the historical lack of investments for this population.

NYSHFA/NYSCAL members and their 60,000 employees provide essential long-term care services to over 50,000 elderly, frail, and physically challenged women, men, and children at over 400 skilled nursing and assisted living facilities throughout New York State. Over the past twelve years, funding cuts to New York State's long-term care providers have exceeded nearly $1.9 billion. Initiatives implemented by the MRT have forced long term care providers to absorb nearly $800 million in cuts over the past five fiscal years, and the potential for additional Federal cuts to Medicare and Medicaid continues to place providers in dire straits - all during a time when providers are implementing new Federal Requirements of Participation (ROPs) and numerous quality initiatives, requirements which involve the investment of significant resources.

New York State unfortunately leads the Nation with the largest shortfall between the rate of Medicaid payment and the actual cost of providing resident care in the nursing home (approximately $55 per day). New York State's providers have continued to endure mounting budget cuts and growing operational expenses to comply with minimum wage, health insurance increases, and ever rising food and utility costs. Unlike most all other industries, skilled nursing facilities cannot pass these increased costs on to the consumer.

**Review of Factors Challenging the State's Capacity to Sustain or Improve its Quality Profile**

- No trend factor in 12 years, despite growing costs of operation.
- Rapid cycling through Medicaid reimbursement models: rebasing, to pricing, to MLTC-mediated payment.
- Growing instability and turnover within the State's provider infrastructure.
- A perfect storm of negative pressures, which in combination could cause NY's quality ranking among States to fall below current levels.
- A major shortage of health care workers across the health continuum, but especially in the long-term care (LTC) sector.
- Lack of financial support for technology for all nursing homes across all regions of NYS.
- Concerns about the consistency, timeliness and administration of the survey process, amid changing requirements of participation.

- Lack of a dedicated rate, program development, and competency-based education to meet the needs of individuals with behavioral, substance abuse and mental health needs requiring nursing home care.

On December 27, 2018, NYSHFA was part of an ad-hoc coalition of organizations representing New York's skilled nursing providers that submitted a letter outlining numerous potential solutions for developing a stronger health workforce in New York State. The recommendations set forth in our December letter are based on our collective years of experience and knowledge in developing long term care staff and bolstered by the reporting and research of the Center for Health Workforce Studies at the University of Albany's School of Public Health. The proposal addresses the assistance we need to get to the next level of solving the current and future healthcare workforce crisis. The lack of health care workforce has caused skilled nursing facilities to compete with other parts of the healthcare continuum, but not in ways that benefit health care because rates and funding for Long Term Care have simply not kept up with the costs and demand. The health care workforce continues to lose quality employees to food/retail industries, exacerbating the shortages for all health care providers. These recommendations are detailed below.

**Recommendations:**

**BUILDING A MORE EFFECTIVE, SKILLED AND FLEXIBLE LONG -TERM CARE WORKFORCE**

New York State should develop an integrated LTC workforce development strategy that focuses on the central importance of human interaction in nursing homes.

- Develop a LTC workforce development committee, inclusive of key stakeholders in the LTC field, DOH, the Department of Education and the State University System, to advise on approaches – including scope of practice issues and training and education initiatives – to improve the quality and quantity of the LTC workforce.
- Enhance the ability to create career ladders for health care workers by creating a core curriculum for entry level workers; unbundling a few Certified Nurse Aide (CNA) functions to expand levels and create a career ladder within the role; and create an advanced role of medication technicians by adding additional competencies.
- Leverage the State's training resources to drive improvement in organizational performance and workforce competence to meet the changing needs of long-term and subacute residents.
- Direct monies from current funding streams including HWRI, WIOs, the Advanced Training Initiative (ATI) and CMPs to assist with supporting initiatives for a larger number of nursing homes across NYS.
- Create a Statewide Campaign for Health Care Workers showcasing health care as a desirable profession.
- Additional support for the Designated Long Term Care Workforce Investment Organizations (WIO) which targets direct care workers, with the goals of supporting the critical long term

healthcare workforce infrastructure through retraining, redeployment, and enhancing skillsets.

- Provide dedicated funding from the proceeds of the sale of Fidelis to Centene to nursing homes throughout the state to underwrite evidence-based recruitment, onboarding, training and retention projects/initiatives.
- Provide incentives for scholarships/recruitment for regions of the state suffering from the most severe workforce shortages.
- Utilize maximum state flexibility (e.g., amount and timing of fines, etc.) in decisions about whether to institute bans on offering CNA training programs. Seeking DOH assistance for providers to retain their CNA training programs notwithstanding a minor deficiency. CNA bans also affect a facility's ability to offer administrator-in-training programs, another training initiative that should be supported.
- Support for education related to the CMS requirements if participation (ROP).
- Work with law enforcement agencies to expedite completion of criminal background checks for CNAs and avoid delays that are costly and disruptive to nursing homes.

**ALIGNING WITH FEDERAL GOALS**

It is encouraging to see that many of the federal goals align with NYSHFA/NYSCAL's priorities. Care coordination and mental health treatment are areas where the State can look to existing long-term care providers such as Assisted Living and Adult Care Facilities to provide a stable environment for New Yorkers. These facilities are a vital part of the healthcare continuum and serve to coordinate care, help transition patients from IMDs to the community, and provide much needed housing options for an increasing homeless population across the State.

**ADVANCE HEALTH INFORMATION TECHNOLOGY AND INTEROPERABILITY IN LTC SETTINGS**

New York State should more proactively work to ensure that technology and HIT interoperability are leveraged to support better care quality and care transitions in all nursing homes.

- Include LTC providers in the opportunities that arose from HIT incentive payments for hospitals and physicians, including support for technology implementation.
- Learn from the experience in the hospital and physician community to build a better LTC technology strategy that meets the providers' needs - including an intuitive and streamlined process; improves quality for patients/residents, which could result from Health Information Exchange (HIE) opportunities with hospitals, pharmacies, etc.; and creates operational efficiencies that are possible, especially in the remote care and transfer process.
- Streamline any new investment in HIT with automatic connection to State-driven HIE to gain the benefit of appropriately sharing information among providers.
- Facilitate development and expansion of LTC providers' telehealth and telecommunication capabilities to fully allow for the technology to assist patients and providers that are challenged by transportation, access to specialists and translation, coordination with transfer partner clinicians, and communication with families.

**SUSTAIN AND EXPAND FINANCIAL SUPPORT FOR LONG TERM CARE**

Years of losses from serving Medicaid beneficiaries have prevented many nursing homes from accumulating the capital needed to make transformational investments in their facilities and care delivery.

- Provide added support to the LTC community through programs such as the Vital Access Provider program, the ATI, CINERGY, the Statewide Health Care Transformation Program (SHCFTP) and any other programs offering grant funding support for capital initiatives and operating support. These programs are essential in the face of Medicaid reimbursement levels that have not been adjusted for inflation in 12 years, and that are demonstrated to fall short of actual care delivery costs by $1.6 billion annually in New York State.
- Provide support through accelerated Medicaid depreciation reimbursement and/or the SHCFTP for life safety code-related upgrades facilities need to make.
- Expand the current $50 million NHQI with funds derived from outside of the existing nursing home Medicaid funding base.
- Analyze the possibility of replacing the RUG-III classification system used for Medicaid rates with the Patient Driven Payment System Medicare is adopting for October 1, 2019 implementation.
- Provide adequate funding to address the effects of the minimum wage increase, including recognizing the effect of wage compression on other salary bands.

**PROGRAMMING AND FUNDING**

Nursing home residents are increasingly multi-morbid, frail, functionally limited and likely to be suffering from behavioral issues. Many have post-acute medical needs, and there is a need for expanded programmatic and funding support to meet these changing needs.

- Develop program regulations and enhanced Medicaid reimbursement for residents who have behavioral health, mental health and/or substance abuse issues. Existing programs and funding do not provide adequate support for addressing the needs of these populations.
- Develop program regulations and enhanced Medicaid reimbursement to support increased development of specialty units with the clinical capacity to prevent avoidable hospital and emergency room use.

**ENSURE SURVEY PROFESSIONALISM, QUALITY AND CONSISTENCY**

Assuring adequate levels of staff in the survey bureau, and adequate resources for training and oversight, is vital to assuring that the process accomplishes its goals – and that these goals are achieved professionally, timely, and with consistency in the assigned members of the survey team.

- Support DOH's efforts to seek and provide the resources to support the bureau in this regard.
- Continue efforts to address regional differences in the numbers of survey citations, and the resulting effects on facilities' Five-Star ratings.
- Reduce the frequency of annual surveys for facilities with favorable survey outcomes and increase the frequency of surveys for facilities with poor surveys.
- Revise the Informal Dispute Resolution (IDR) process to incorporate best practices such as incorporating third-party administration of the program, providing facilities with adequate time for filing requests, and providing IDR program statistics and specific feedback to facilities on the disposition of their requests.
- Adhere to federal timeframes on state surveys and to defined timeframes for completion of state investigations and "closing out" surveys to ensure timely follow up on issues and reduce operational uncertainty.

**STATE-DRIVEN PUBLIC EDUCATION**

More education and positive public relations on nursing home care would enhance worker recruitment and retention efforts; increase public support for adequate funding through Medicaid and other programs; and better align consumer expectations with provider capabilities.

- Create a Quality Campaign and showcase positive stories of quality care successes in NYS nursing homes.
- Create a Public Service Campaign to promote health care (and LTC in particular) as a valuable career choice and profession offering life-long learning and service to those most in need of care and compassion.
- Promote education to assist individuals to proactively plan for LTC before they need it or are in crisis.
- Set and manage expectations for consumers and their families about the natural decline in health that can be helped to some extent with high quality LTC services.
- Reward high performing facilities through public recognition.

**Conclusion:**

In conclusion, NYSHFA/NYSCAL is thankful for the State's time and attention on these critical issues to ensure the continued delivery of high-quality, cost effective long-term care to our most vulnerable individuals through the DSRIP Program. It is vitally important that New York State protect and enhance access to the crucial services provided by skilled nursing facilities for our rapidly aging population. Longer lifespans and better chronic disease management will contribute to the need for increased long-term care services as the baby boomer generation is aging. New York cannot continue to cut funding to essential long-term care and assisted living programs and expect to be able to adequately serve this aging population and should invest in post-acute care.

As always, NYSHFA/NYSCAL looks forward to working in partnership with the State in advancing initiatives in skilled nursing and assisted living facilities throughout New York.

## doh.sm.1115Waivers

**From:** Valerie Grey [redacted]
**Sent:** Friday, November 1, 2019 4:08 PM
**To:** doh.sm.1115Waivers
**Subject:** 1115 Waiver Public Comment
**Attachments:** DSRIP 2.0 Comment Letter to DOH 11 1 19.pdf



Dear DOH,

Thank you for the opportunity to provide feedback - Attached are NYeC's comments.

Sincerely,
Val Grey
Executive Director
New York eHealth Collaborative

NEW YORK eHEALTH COLLABORATIVE

**Valerie Grey**
**Executive Director**

November 1, 2019

Donna Frescatore, State Medicaid Director
Office of Health Insurance Programs
NYS Department of Health
Corning Tower (OCP-1211)
Albany, NY 12237

RE: New York State Medicaid Redesign Team (MRT)
1115 Research and Demonstration Waiver #11-W-00114/2
Delivery System Reform Incentive Payment (DSRIP) Amendment Request

Dear Ms. Frescatore:

The New York eHealth Collaborative (NYeC) is pleased to provide these comments in response to the Draft DSRIP Waiver Amendment. NYeC is a 501(c)(3) and New York's State Designated Entity (SDE) charged with the governance, coordination, and administration of the Statewide Health Information Network for New York (SHIN-NY). In this capacity, NYeC works as a public/private partnership with the New York State Department of Health (DOH) on the development of policies and procedures that govern how electronic health information is shared via the SHIN-NY.

The SHIN-NY is a "network of networks" consisting of Qualified Entities (QEs) or regional health information networks (HIEs) and a statewide connector that facilitates secure sharing of clinical data from participating providers' electronic health records (EHRs). Participants include hospitals, clinics, labs, radiology centers, ambulatory physicians, home care agencies, nursing homes, long-term care facilities, public health departments, health plans, behavioral health providers, DOH, Federally-Qualified Health Centers (FQHCs) and some community based organizations (CBOs). The commitment from NYS has made the SHIN-NY a national leader in HIE. Today, the SHIN-NY connects all hospitals in New York State, is used by over 100,000 healthcare and community-based professionals and serves millions of people who live in or receive care in New York.

NYeC's mission is to improve healthcare through the exchange of health information whenever and wherever needed. Numerous studies have demonstrated the value of using QE services in both better health and lower costs. With the SHIN-NY as a critical tool, we strongly believe that HIE is fundamental to the overall level of transformation aspired to in the Draft Amendment, including implementation of the high-priority DSRIP promising practices. As we move forward, the SHIN-NY needs to be more aggressively leveraged – *the QEs have been and continue to be uniquely positioned to support value driving entities (VDEs) and social determinants of health networks (SDHNs).*

We applaud DOH and the Performing Provider Systems for the tremendous success in improving Medicaid patient outcomes and reduced cost during the initial iteration of DSRIP. Thousands of healthcare providers became SHIN-NY users during this unprecedented endeavor. The impressive results are at least in part a testament to the extent by which interoperability is essential to Value-Based Care (VBC).

While the success is remarkable, a great deal of work remains to maximize the SHIN-NY as a tool to transform the NYS Medicaid as outlined by the ambitious goals set forth in the Draft Amendment as well as the Value-Based Payment (VBP) Roadmap. The SHIN-NY offers free services, called "core services," to its participants that can support VDEs and social determinants of health networks (SDHNs). These free core services include, but are not limited to, patient record look-up for comprehensive clinical information with consent, alerts when patients are admitted, discharged or transferred from the hospital, and secure messaging. The State should consider adding a strong statewide governance mechanism for spending on IT and IT-related functions so that systems and platforms are more integrated, interoperable, and not duplicative of the QEs and the SHIN-NY.

It is further worth reflecting on the history of interoperability at the state and national levels with significant investments over the last decade to build the foundation of healthcare providers, mostly based on the Meaningful Use program. The American Reinvestment & Recovery Act from 2009 included the "Health Information Technology for Economic and Clinical Health (HITECH) Act". The HITECH Act included the concept of EHRs and Meaningful Use, which was implemented by Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator for Health IT (ONC). As a leader, NYS embraced the federal initiatives and made major strides in advancing interoperability by creating a strong statewide foundation for health information technology, particularly for those healthcare providers who were eligible.

Because of that foundation, NYS is now able to shift the focus towards targeted information gaps like long term post-acute care (LTPAC), behavioral health, and social determinants of health (SDH) as well as the optimization of workflows to not only improve patient outcomes and reduce healthcare costs, but also alleviate provider burden. The "quadruple aim" is achievable and so are the ambitious statewide targets for VBC, but it is imperative that NYS keeps leading and aggressively pushing interoperability to connect the complete care continuum for Medicaid beneficiaries. *We urge DOH to dedicate resources for "left behind" sectors in interoperability (i.e. LTPAC, behavioral health, pharmacies, CBOs) that focus on financial incentives, regulatory relief, and technical assistance. We also believe that there should be similar consideration for small physician practices, especially pediatricians*, and their specific needs as it relates to the goals of the Draft Amendment.

QEs have supported PPSs in a variety of ways. One lesson learned from DSRIP should be to explore other avenues for claims data sharing. The SHIN-NY is currently seeking CMS Minimum Acceptable Risk Standards for Exchanges (MARS-E) Certification for Medicaid claims integration, as well as exploring opportunities with Medicare claims. One of those potential opportunities for collaboration could be BlueButton 2.0. Opportunities for patient access and engagement with this type of alignment could significantly streamline information and reduce burden for dual eligible beneficiaries who often have complex and co-morbid conditions to manage. *We strongly advocate for alignment and dedicated resources for clinical and claims data integration to leverage current SHIN-NY activities related to Medicaid claims and potentially patient access*.

We appreciate the reference to using SHIN-NY data in defining the population and opportunity for improvement. Over the past decade, QEs have built deep and broad clinical data and expertise and with the addition of claims data, are well positioned to do quality measurement. In particular, over the last couple years, the SHIN-NY has assisted the DSRIP medical records review process and as part of the NYS State Innovation Model (SIM), QE pilots have demonstrated a rapidly expanding capability with a focus on two use cases that directly support VDE purposes. One is providing more real-time quality performance monitoring, including gaps in care, to providers. The other is increased engagement with health plans in support of quality reporting. The engagement has led to a collaboration with the National Committee for Quality Assurance (NCQA) to explore the development of a program to validate an HIE for standard supplemental data for Healthcare Effectiveness Data and Information Set (HEDIS), which would be the first of its kind in the country. For these reasons, *the SHIN-NY role for quality measurement should be more explicit in the Draft Amendment and we strongly advocate for alignment and dedicated resources for quality measurement by the SHIN-NY.*

The increased engagement of CBOs is integral to the formation of SDHNs. In the Draft Amendment, we appreciated the emphasis on SHIN-NY as a strategic partner of Value-Driving Entities (VDEs) in sustaining and enhancing the partners' bidirectional data exchange capabilities. In addition, we strongly advocate for the same distinction with regard to the "Social Determinant of Health Networks" (SDHNs). The SHIN-NY has played a pivotal role in the advancement of this innovative work in communities across NYS. We believe that a coordinated statewide approach going forward will be instrumental to success based on SHIN-NY history. *We advocate for the SHIN-NY role with SDHNs to be made more prominent in order to leverage the existing framework for both policy and technology.* In our experience, governance and standards are paramount to the infrastructure required for the comprehensive data sharing envisioned for VDEs and SDHNs in the Draft Amendment. Furthermore, VDEs and SDHNs could benefit significantly from the sharing of SDH related state and local government data, and the SHIN-NY is a potential vehicle to assist in this area. It is also worth reiterating how dedicated resources for CBOs will also be needed for support such as technical assistance.

Successful implementation of *the Draft Amendment should include work on related policies*. The SHIN-NY is working to modernize many of our current policies that were developed a long time ago. We support an emphasis on implementing the specific recommendation of the DSRIP VBP Patient Confidentiality Subcommittee regarding an opt-out model for general clinical data sharing with a robust educational curriculum and outreach campaign. Our work also includes developing best practices for access to the SHIN-NY by HIPAA non-covered entities such as many CBOs and patients themselves.

We also support the alignment with other federal statewide quality improvement activities, such as the upcoming Clinician Quality Improvement Contractor (CQIC) Program and the previous Transforming Clinical Practice Initiative (TCPI) via the NYS Practice Transformation Network).

Thank you for the opportunity to provide comments. We are confident that we can be even stronger partners in the next phase of DSRIP and lead further improvements in the health of our communities. We look forward to our ongoing discussions.

Sincerely,

Valerie Grey
Executive Director

**New York eHealth Collaborative (NYeC)**
**Detailed Comments**

## Robust Health Information Exchange

The first iteration of DSRIP fueled an extraordinary amount of connectivity across the care continuum and it was a remarkable accomplishment. However, to extend that to the complete care continuum as the Draft Amendment stipulates and full transformation necessitates, a concerted effort and dedicated resources are needed. NYeC makes the following suggestions:

- DOH should offer financial incentives and regulatory relief to increase adoption of CEHRT (or health information technology specific to that part of the care continuum with the appropriate standards) and participation in HIEs;
- DOH should incentivize providers to collect and exchange data elements to enhance value of interoperability across the care continuum;
- DOH should offer support for technical assistance programs;

We must collectively work to engage "left behind" sectors to advance interoperability. We support incentive payments to encourage non-meaningful use providers to adopt CEHRT or health information technology specific to that part of the care continuum with the appropriate standards. While we feel incentives are necessary, many long-term and post-acute care (LTPAC) and home and community-based service providers (HCBS) avoid adoption of EHRs due to lack of IT staff and education or assistance on how to meaningfully use these products. Pharmacies have also lacked the resources and incentives to participate in HIE. The availability of funding through dedicated programs could allow for investment in advancing interoperability among these sectors and could be used for both incentives and technical assistance.

Such investments could build off previous efforts like the Regional Extension Centers (RECs) which provided on-the-ground technical assistance as well as state efforts like the New York State funded behavioral health information technology (BHIT) grant. With the support of a $10 million BHIT grant, NYeC was able to assist 114 organization across 52 counties by providing technical assistance to implement their EHR systems. Further investments in such efforts would yield greater adoption, improve usability and work toward CMS' goal of reduced provider burden.

DOH with support from CMS, established the Data Exchange Incentive Program (DEIP) to increase HIE adoption across the state for Medicaid providers. Participating organizations are incentivized to contribute a pre-defined set of data elements to the SHIN-NY through a QE. This program is designed to help defray the cost for an organization when connecting to their local QE. NYeC coordinates the rollout of the program and the incentive payments on behalf of DOH. This program was just expanded on a limited basis to pharmacies. We recommend that the design of VDEs and SDHNs encourage pharmacies to participate in the SHIN-NY to accomplish the goals for Addressing the Opioid Epidemic as outlined in the Draft Amendment.

**Community-Based Organizations & Social Determinants of Health**

NYeC applauds the recognition in the Draft Amendment of the extraordinary impact that CBOs have on improving the outcomes of Medicaid beneficiaries and would encourage supplementing these efforts with additional specificity and dedicated resources. We also want to recognize the continued leadership in the creation and work of the NYS Bureau of SDH. We believe that the alignment with federal initiatives, especially interoperability standards, will greatly assist in forming and achieving the objectives of SDHNs. Over the last couple years, and as a direct result of DSRIP, the SHIN-NY has prioritized CBO engagement and the incorporation of SDH information through a multi-sector data sharing lens.

The 2020 SHIN-NY Roadmap identifies SDH as additional data in supporting VBC and the creation of a CBO and VBC Advisory Groups to facilitate continuous statewide feedback. For the past year, the group has met quarterly to advise NYeC on the intersection of CBO services and SDH, with HIE and HIT, and the associated challenges and opportunities in to improve health outcomes in the context of VBC. This includes advocacy and awareness-raising efforts with CBOs. The advisory group is comprised of CBOs, PPSs, and healthcare leaders from across NYS.

The group has already quickly begun significantly informing SHIN-NY initiatives. For example, the SHIN-NY Policy Committee is currently exploring ways to increase CBO participation in the SHIN-NY to further integration into the care continuum for Medicaid beneficiaries, as well as improve their ability to engage with VBP. An immediate focus of the SHIN-NY Policy Committee is non-covered HIPAA entities.

The SHIN-NY currently supports communities across the state advancing innovation in this area. We believe that a robust governance structure is crucial to success and should include Medicaid beneficiaries and a mix of CBOs, including both early adopters and safety net, in order to achieve the intended improved outcomes. While governance is a prerequisite to the overall collaboration and the comprehensive data sharing contemplated in the Draft Amendment, long-term success will depend on the development and implementation of interoperability standards. Below are just a few of the many SHIN-NY examples already underway from across NYS:

- The Bronx RHIO is engaged in several initiatives to address SDH and CBOs, including obtaining SDH data elements such as homeless/housing status, employment status, and correctional health registration data. Bronx RHIO is also participating in the Bronx FUSE Initiative, which will identify homeless high utilizers in health plans and set them up with housing opportunities with coordination by the Corporation for Supportive Housing (CSH).
- Healthix, located in the New York City area, is also working on several CBO & SDH-involved initiatives, including a pilot project to standardize and incorporate SDH screenings from FQHCs.
- Hixny, in the Capital Region of NY, is working in partnership with the Alliance for Better Healthcare PPS on a Consumer Directed Exchange project aimed to assist vulnerable populations into care.

- The Rochester RHIO has begun to add other data sources into the HIE to support clinical quality care, including data from corrections and law enforcement, housing, and public health.
- HealtheConnections in the Central NY region has created the myData Platform, which is in the beginning stages of adding a SDH report that incorporates ICD-10 Z-codes. It is anticipated that the PCMH Registry and the Preventive Care Registry will incorporate the SDH table in the User Interface to assist with care management opportunities at the practice level.

The history of the SHIN-NY and interoperability standards provides lessons learned to leverage in exchanging SDH data. Cross-referencing federal standards like the Common Clinical Dataset has proven to be an effective strategy in scaling on a statewide level. We are actively engaged with national efforts to standardize SDH data and multi-sector data exchange through the Gravity Project, San Diego Community Information Exchange models, and the Robert Wood Johnson Foundation-funded All In Network/Data Across Sectors for Health. We would urge the inclusion of national standards in program implementation such the following:

- International Classification of Diseases, 10th Revision (ICD-10) Health Factors (z-codes); and
- HL7 Fast Healthcare Interoperability Resources developed by National Institutes for Health and North Carolina for an SDH Assessment.

With the existing SHIN-NY governance structure and advocacy for interoperability standards, the SHIN-NY could play a major role in supporting SDHN activities.

**Clinical and Claims Data Integration**

Bi-directional information exchange with health plans will be tantamount to the attainment of the outcomes set forth in the Draft Amendment. NYeC applauds the recognition of health plans as having a critical fundamental role in achieving the objectives outlined in the Draft Amendment. There are many statewide initiatives to increase health plan engagement in the SHIN-NY such as the creation of a health plan advisory group and a project to coordinate a statewide approach to patient care alerts for health plans. Additionally, the recently proposed CMS Interoperability and Patient Access regulation would require that certain payers participate in trusted exchange networks. Claims data integration was also identified in the SHIN-NY 2020 Roadmap as a valuable tool to support VBC and could streamline the data sharing assumed in the Draft Amendment.

We would urge that the priorities envisioned for health plans maintain their alignment with and leverage other current ongoing state and federal initiatives such as the following:

- SHIN-NY goal of CMS MARS-E Certification and Medicaid claims integration;
- CMS MyHealthEData, including Medicare BlueButton 2.0 and the Data at Point of Care Pilot; and
- the CMS Interoperability and Patient Access Proposed Rule.

QE claims integration pilots during the initial iteration of DSRIP identified a variety of important use cases and led to the prioritization of SHIN-NY Medicaid claims integration as a statewide goal. The use cases span, but are not limited to, the following:

- Quality measurement;
- Increased accuracy for gaps in care;
- Attribution;
- Data completeness and improvement;
- Enhancement of diagnosis and procedure information;
- Potentially assist in medication reconciliation with pharmacy claims; and
- Patient registries.

In this context, we also encourage the consideration of patient engagement opportunities to empower patients to control their own data and provide an asset to assist in the management of their health. We believe that these tools could be instrumental in achieving many of the aims identified in the Draft Amendment, including the Long Term Care Reform. NYS could build upon the prior work toward Medicare alignment and BlueButton 2.0- which aims to reduce patient burden, streamline information about different types of care over time, and access and monitor health information in one place.

NYeC recently released a Request for Information for Patient Access to Health Information. We have also recently funded two pilots to further explore options and ultimately inform a longer term strategy. We believe that the SHIN-NY can play a pivotal role in these important patient access and engagement activities in addition to the other important benefits from claims integration for health plans, providers and Medicaid beneficiaries.

**Quality Measurement**

Quality performance is clearly focal to both the current Waiver and this Draft Amendment, and since the last Waiver was approved, there have been major strides in both SHIN-NY data contribution as well as the capability in terms of quality measurement. VBP depends upon the contractors access to quality measurement and the SHIN-NY not only could provide a robust dataset, but also one that is more real time than claims, which enables healthcare providers and CBOs to take action.

Over the last couple years, the SHIN-NY has prioritized quality measurement and dedicated significant resources to accelerate the capability to support. Beginning in 2018, DOH and NYeC designed quality measurement pilots to support NYS Patient Centered Medical Home (PMCH) practices with the calculation of quality measures from the NYS PCMH Scorecard as part of SIM. The pilots focus is on two use cases.

The first use case is calculating quality measures for NYS PCMH to use for ongoing performance feedback on quality measurement activities to physicians. The second use case focuses on data delivery to health plans, which led to a collaboration with NCQA. NCQA is presently analyzing three QEs' current state in exploring the development of a standard that can be used nationally to validate HIE data as standard supplemental data for health plans in their HEDIS reporting. This is

the first work of its kind in the country, and we are hopeful that the SHIN-NY will the first to be validated.

The ultimate output of the pilots will be used to inform consensus building and a SHIN-NY Quality Measurement Workgroup that should be leveraged in the structure of the VDEs. For the ongoing performance feedback use case, the QEs have identified a subset of NYS PCMH Scorecard measures to focus on and begin measure specification/data contribution analysis. In addition, the QEs are working to identify target primary care practices.

Further, this past year, NYeC and QEs were involved in a collaborative effort to assist Medical Record Review (MRR) vendors with PPS performance measurement. This pilot aimed to evaluate the feasibility of the QEs in linking clinical data with Medicaid claims data and integrating this data into existing MRR workflows and providing measurement impact reports. This pilot spanned all 25 PPSs and demonstrated how the SHIN-NY was impactful for several measures. For example, one PPS measure improved 20%. This work continues through this final Measurement Year.

We strongly advocate for dedicated resources and a prominent function in the measuring quality performance for the VDEs as well as the SDHNs. We would also urge for the SHIN-NY to play a specific role in standard supplemental data for health plans in VDE support. Overall, we believe that the SHIN-NY should be an integral strategic partner in coordinated population health with vital real time information on performance.

**Alignment with Other Statewide Federal Quality Improvement Activities**

NYeC supports the aims identified in the Draft Amendment, particularly the DSRIP promising practices. Indeed, there are a variety of ways that NYS' goals are synergistic with other federal initiatives to support quality improvement and cost savings. This alignment is demonstrated by the similarities between the goals of the Draft Amendment and the following two CMS quality initiatives as examples: (1) the upcoming CMS CQIC Program, and (2) the previous TCPI via the PTN.

In the DSRIP Amendment Request, the State says it will create VDEs, across the state, to implement high-priority DSRIP promising practices. Under the CQIC Program, CMS says it will create CQIC entities across the country, that are tasked with achieving quantitative targets for maximum reach under four specific aims identified in the Program. Both programs task the VDEs and CQIC contractors respectively, to leveraging community coalitions, including community-based organizations, to drive improvement across similar areas of healthcare quality improvement. CQIC and DSRIP are similar with respect to some of its specific aims. Both the State and CMS are committed to addressing opioid misuse and overdose through a variety of initiatives. One aim of CQIC is to "Improve Behavioral Health Outcomes, including a focus on Decreased Opioid Misuse." Comparatively, the Draft Amendment states that it will address the federal priority area of Substance Use Disorder (SUD) Care and the Opioid Crisis, through two of its nine promising practices: (1) Integration and expansion of Medication-Assisted Treatment in primary care and ED settings, and (2) Partnerships with the justice system and other cross-sector collaborations.

Both CQIC and DSRIP have goals to improve care transitions in order to reduce hospital admissions. Specifically, CQIC's aim is to "Increase Quality of Care Transitions," by improving community-based care transitions to reduce Medicare hospital admissions nationally by 4.1% and Medicare hospital readmissions by 5.4%. New York State says it is well on its way to meeting its 5-year goal of reducing avoidable Medicaid hospitalizations by 25%, by posting a reduction of 21% through measurement year 4 in the first iteration of DSRIP. The Draft Amendment identifies the goal of continuing the promising practices of primary care and behavioral health integration, as well as care coordination, and care transitions, that led to meaningfully reducing avoidable Medicaid hospitalizations in the first iteration of DSRIP.

There is also an alignment between the quality improvement work proposed under the Draft Amendment and the work of New York's Practice Transformation Network (PTN) under the Transforming Clinical Practice Initiative (TCPI). This CMS initiative supported efforts to develop and implement comprehensive quality improvement strategies by aligning their practices with broad payment and practice reform in primary care and specialty care, promoting care coordination between providers of services and suppliers, establishing community-based health teams to support chronic care management, promoting improved quality and reduced cost, and developing a collaborative of institutions that support practice transformation. This type of work has been spread statewide by the PTN program and we believe this experience will strengthen VDEs going forward. We applaud the identified objectives and activities in the Draft Amendment for its alignment to federal initiatives of quality improvement.

## doh.sm.1115Waivers

**From:** Nuccilli, Janet [redacted]
**Sent:** Friday, November 1, 2019 4:18 PM
**To:** doh.sm.1115Waivers
**Cc:** [redacted]
**Subject:** 1115 Public Forum Comment
**Attachments:** DSRIP Response - Dutchess County - ltr to Paul Francis.pdf; DSRIP Response - Dutchess County - ltr to Donna Frescatore.pdf; DSRIP Response - Dutchess County - ltr to Assemblyman Bronson.pdf; DSRIP Response - Dutchess County - ltr to Senator Rachel May.pdf



**Janet Nuccilli**
**Confidential Administrative Assistant**
**Dutchess County Office for the Aging**
114 Delafield Street
Poughkeepsie, NY 12601
[redacted]

www.dutchessny.gov

MARCUS J. MOLINARO
COUNTY EXECUTIVE

TODD N. TANCREDI
DIRECTOR

COUNTY OF DUTCHESS
OFFICE FOR THE AGING

November 1, 2019

Paul Francis
Deputy Secretary for Health
State Capitol
Albany, NY 12224

Dear Mr. Francis,

On behalf of Dutchess County Office for the Aging, I am writing to express my recommendations on the DSRIP renewal proposed by New York State Department of Health. The services we provide directly impact inappropriate emergency department visits and reduce avoidable readmissions. The NY Connects program, implemented in 2006, serves as no wrong door for any and all services available in the region, and is a catalyst for individuals in need of assistance. The targeted goals in the proposed renewal are exactly what this network provides, and must include mandated contracting by each PPS with their local Area Agency on Aging for social determinants of health initiatives. Our office is the trusted service provider for the fastest growing segment of the population, and the highest utilizer of health care dollars. Our services **absolutely** allow individuals to remain in their own homes and communities, all while saving health care expenditures. We provide the highest level evidenced based interventions, and are experts at navigating a complex health care system, while providing person centered planning and care.

To demonstrate the value of the network, I would like to highlight a recent case that is typical to our office:

Mrs. B was first referred to OFA for assistance with homecare in 2012 by Adult Protective Services. At that time, a comprehensive home assessment was completed, and she was opened to Expanded In Home Services to Elderly Program (EISEP). A home care aide was set up for 2 hours weekly to assist with light housekeeping and personal care. Additionally, a Personal Emergency Response (PERS) System was approved. She had no cost for these services since the financial assessment of her income and home expenses were below 150% of the annual federal poverty levels. She was also receiving Home Delivered Meals on a weekly basis.

In March 2014, Mrs. B had several health matters that placed her in the hospital, and then in rehab at a skilled nursing facility. At that time she was 84 years old. Mrs. B received rehabilitation in the nursing home facility for 6 months. In November Mrs. B called and asked her case manager at OFA to attend her discharge plan meeting at the Nursing Facility. In attendance at the discharge meeting were the nursing facilities RN, Physical Therapist, and Social Worker. Also in attendance were Mrs.B's son and daughter in law. The recommendation from the facility was that Mrs. B remain in the facility or be required to receive 24 hour care at home.

Mrs. B who is alert and oriented, was adamant about her desire to live at home and returned to her own home.

The Case Manager from OFA completed another comprehensive assessment to determine Mrs. B's needs once she returned home. Mrs. B was again approved to receive Home Delivered Meals (7 weekly) which provide a source of nutrition and contact. She was also provided a PERS to allow her to summon help in an emergency, as she did return home to live alone. In addition to the HDM and the PERS, she was authorized and provided an aide to assist her with personal care, homemaking and shopping. OFA partnered with informal supports Mrs. B has available to assist her with daily chores and tasks. OFA provides information and assistance to both Mrs. B and her informal supports in order to ensure that she have access to all programs and benefits she is eligible. OFA Health Insurance Counseling (HIICAP) staff has also been able to assist with determining how to best meet her health insurance needs. As Mrs. B's needs have increased over the past few years with her age, hours of home care service have also increased.

Today at the age of 90, Mrs. B continues to live at home, in large part, due to Office for the Aging services such as a Home Aide, Case Management, PERS and Home Delivered Meals. The Case Management she receives from the Office for the Aging, in the form of phone calls, home visits and service coordination offer crucial emotional and social contact that help her maximize her independence in the community. Without this support from the Office for the Aging, Mrs. B would have remained in the L/T Care facility and most likely would have required additional hospitalizations.

COST CALCULATIONS:

| | | |
|---|---|---|
| **OFA** (includes Admin. Costs) | | |
| Case Mgmt. 25 hours annually provided since 2017 | | $ 3,375 |
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| 2012- | 104 hours of homecare authorized | $ 3,744 |
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| 2019 | 312 hours of homecare authorized | $ 11,232 |
| PERS | | |
| Monthly since 2012- $21/monthly | | $ 3,024 |
| Total OFA Cost | | $ 53,005/annually |
| **Nursing Home (L/T Care)** – estimate | | $100,000/annually |

This is one of many cases that truly displays the boots on the ground service provision in every county across the state. In the renewal waiver, I cannot stress highly enough that we need to harness the existing strengths of community-based services, instead of recreating case management services and duplication of services. Each and every case manager in the entire statewide aging network has received certification via Boston University School of Social Work, ensuring consistency in assessment not provided by any other system. I ask that there are mandates for each PPS to engage and contract with their local Offices for the Aging, for the services vital to keeping individuals in home and community-based settings.

Thank you,

Todd N. Tancredi
Director
Dutchess County Office for the Aging

cc: Association on Aging in New York

MARCUS J. MOLINARO
COUNTY EXECUTIVE

TODD N. TANCREDI
DIRECTOR

COUNTY OF DUTCHESS
OFFICE FOR THE AGING

November 1, 2019

Donna Frescatore
Medicaid Director
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Dear Ms. Frescatore,

On behalf of Dutchess County Office for the Aging, I am writing to express my recommendations on the DSRIP renewal proposed by New York State Department of Health. The services we provide directly impact inappropriate emergency department visits and reduce avoidable readmissions. The NY Connects program, implemented in 2006, serves as no wrong door for any and all services available in the region, and is a catalyst for individuals in need of assistance. The targeted goals in the proposed renewal are exactly what this network provides, and must include mandated contracting by each PPS with their local Area Agency on Aging for social determinants of health initiatives. Our office is the trusted service provider for the fastest growing segment of the population, and the highest utilizer of health care dollars. Our services **absolutely** allow individuals to remain in their own homes and communities, all while saving health care expenditures. We provide the highest level evidenced based interventions, and are experts at navigating a complex health care system, while providing person centered planning and care.

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Director
Dutchess County Office for the Aging

cc: Association on Aging in New York

MARCUS J. MOLINARO
COUNTY EXECUTIVE

TODD N. TANCREDI
DIRECTOR

# COUNTY OF DUTCHESS
OFFICE FOR THE AGING

November 1, 2019

The Honorable Harry B. Bronson
District 138
840 University Avenue
Rochester, NY 14607

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| 2013-2014 | 208 hours of homecare authorized | $ 7,488 |
| 2015-2018 | 260 hours of homecare authorized | $ 9,360 |
| 2019 | 312 hours of homecare authorized | $ 11,232 |
| PERS | | |
| Monthly since 2012- $21/monthly | | $ 3,024 |
| Total OFA Cost | | $ 53,005/annually |
| **Nursing Home (L/T Care)** – estimate | | $100,000/annually |

This is one of many cases that truly displays the boots on the ground service provision in every county across the state. In the renewal waiver, I cannot stress highly enough that we need to harness the existing strengths of community-based services, instead of recreating case management services and duplication of services. Each and every case manager in the entire statewide aging network has received certification via Boston University School of Social Work, ensuring consistency in assessment not provided by any other system. I ask that there are mandates for each PPS to engage and contract with their local Offices for the Aging, for the services vital to keeping individuals in home and community-based settings.

Thank you,

Todd N. Tancredi
Director
Dutchess County Office for the Aging

cc: Association on Aging in New York

MARCUS J. MOLINARO
COUNTY EXECUTIVE

TODD N. TANCREDI
DIRECTOR

# COUNTY OF DUTCHESS
OFFICE FOR THE AGING

November 1, 2019

The Honorable Rachel May
53rd Senatorial District
803 Legislative Office Building
Albany, NY 12247

Dear Senator May,

On behalf of Dutchess County Office for the Aging, I am writing to express my recommendations on the DSRIP renewal proposed by New York State Department of Health. The services we provide directly impact inappropriate emergency department visits and reduce avoidable readmissions. The NY Connects program, implemented in 2006, serves as no wrong door for any and all services available in the region, and is a catalyst for individuals in need of assistance. The targeted goals in the proposed renewal are exactly what this network provides, and must include mandated contracting by each PPS with their local Area Agency on Aging for social determinants of health initiatives. Our office is the trusted service provider for the fastest growing segment of the population, and the highest utilizer of health care dollars. Our services **absolutely** allow individuals to remain in their own homes and communities, all while saving health care expenditures. We provide the highest level evidenced based interventions, and are experts at navigating a complex health care system, while providing person centered planning and care.

To demonstrate the value of the network, I would like to highlight a recent case that is typical to our office:

Mrs. B was first referred to OFA for assistance with homecare in 2012 by Adult Protective Services. At that time, a comprehensive home assessment was completed, and she was opened to Expanded In Home Services to Elderly Program (EISEP). A home care aide was set up for 2 hours weekly to assist with light housekeeping and personal care. Additionally, a Personal Emergency Response (PERS) System was approved. She had no cost for these services since the financial assessment of her income and home expenses were below 150% of the annual federal poverty levels. She was also receiving Home Delivered Meals on a weekly basis.

In March 2014, Mrs. B had several health matters that placed her in the hospital, and then in rehab at a skilled nursing facility. At that time she was 84 years old. Mrs. B received rehabilitation in the nursing home facility for 6 months. In November Mrs. B called and asked her case manager at OFA to attend her discharge plan meeting at the Nursing Facility. In attendance at the discharge meeting were the nursing facilities RN, Physical Therapist, and Social Worker. Also in attendance were Mrs.B's son and daughter in law. The recommendation from the facility was that Mrs. B remain in the facility or be required to receive 24 hour care at home.

Mrs. B who is alert and oriented, was adamant about her desire to live at home and returned to her own home.

The Case Manager from OFA completed another comprehensive assessment to determine Mrs. B's needs once she returned home. Mrs. B was again approved to receive Home Delivered Meals (7 weekly) which provide a source of nutrition and contact. She was also provided a PERS to allow her to summon help in an emergency, as she did return home to live alone. In addition to the HDM and the PERS, she was authorized and provided an aide to assist her with personal care, homemaking and shopping. OFA partnered with informal supports Mrs. B has available to assist her with daily chores and tasks. OFA provides information and assistance to both Mrs. B and her informal supports in order to ensure that she have access to all programs and benefits she is eligible. OFA Health Insurance Counseling (HIICAP) staff has also been able to assist with determining how to best meet her health insurance needs. As Mrs. B's needs have increased over the past few years with her age, hours of home care service have also increased.

Today at the age of 90, Mrs. B continues to live at home, in large part, due to Office for the Aging services such as a Home Aide, Case Management, PERS and Home Delivered Meals. The Case Management she receives from the Office for the Aging, in the form of phone calls, home visits and service coordination offer crucial emotional and social contact that help her maximize her independence in the community. Without this support from the Office for the Aging, Mrs. B would have remained in the L/T Care facility and most likely would have required additional hospitalizations.

COST CALCULATIONS:

| | | |
|---|---|---|
| **OFA** (includes Admin. Costs) | | |
| Case Mgmt. 25 hours annually provided since 2017 | | $ 3,375 |
| HDM meals daily since 2017 | | $ 14,782 |
| HOMECARE | | |
| 2012- | 104 hours of homecare authorized | $ 3,744 |
| 2013-2014 | 208 hours of homecare authorized | $ 7,488 |
| 2015-2018 | 260 hours of homecare authorized | $ 9,360 |
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This is one of many cases that truly displays the boots on the ground service provision in every county across the state. In the renewal waiver, I cannot stress highly enough that we need to harness the existing strengths of community-based services, instead of recreating case management services and duplication of services. Each and every case manager in the entire statewide aging network has received certification via Boston University School of Social Work, ensuring consistency in assessment not provided by any other system. I ask that there are mandates for each PPS to engage and contract with their local Offices for the Aging, for the services vital to keeping individuals in home and community-based settings.

Thank you,

Todd N. Tancredi
Director
Dutchess County Office for the Aging

cc: Association on Aging in New York

## doh.sm.1115Waivers

**From:** Kevin Jobin-Davis [redacted]
**Sent:** Friday, November 1, 2019 4:24 PM
**To:** doh.sm.1115Waivers
**Subject:** 1115 Public Forum Comment



Thank you for the opportunity to submit the following comment:

Changing the economic conditions to improve health outcomes creates the opportunity to adopt or develop new service models but it doesn't necessarily bring about better outcomes. Bringing about improved health outcomes comes from selecting effective new service models and then becoming excellent at them!

One of the critical lessons from the DSRIP experiment is that health is largely determined pre and post hospital care. Therefore, the organizations that support patients in those other settings are important partners in health. In order to coordinate action among such diverse organizations, economic support is needed, but also a backbone organization to support the development of a common agenda, mutually reinforcing activities, a shared measurement system, and continuous communication. These are the conditions for collective impact. While PPSs have been assigned the backbone role in many ways, their economic role undermines the neutrality fundamental to the backbone role. There is also more than one PPS in some regions. These conditions can make it difficult for a PPS to be a successful backbone organization as they fulfill their market development, command and control functions.

Population Health Improvement Programs (PHIPs) were established by NYSDOH to support DSRIP, the Prevention Agenda and the SHIP by providing backbone support in regions throughout the state. This has resulted in PHIPs being active developers of population health data analyses, from Community Health Needs Assessments to Health Disparities and other ad hoc reports. PHIPs have also been instrumental in the development and implementation of population health strategies around New York State. Fundamental to their mission is that they are neutral conveners that support the development of common agendas within a region.

The work of PHIPs should be seriously considered as a component of DSRIP 2.0 or through separate funding. PHIPs have supported DSRIP initiatives through the development and/or provision of training and tools that support new DSRIP service delivery models, particularly those addressing social determinants of health and other clinic to community initiatives. While PPSs are necessarily focused on inter-organizational operability efficiencies and alternative models of care, PHIPs are valuable resources to accelerate the integration of community supports of health with medical supports. While the waiver proposal appears to recognize the importance of investing in these community support coordinating entities, backbone support is a collective endeavor rather than a command and control function. Funding for integrating community and medical supports should recognize the importance of both functions so that the assets and interests of the medical institutions doesn't overwhelm those of their community partners. Support of a neutral backbone organization will encourage a collective agenda with the organizational engagement and performance monitoring which reflects aligned community and medical agendas that collectively impact public health.

Kevin Jobin-Davis, Ph.D.

Executive Director
Healthy Capital District Initiative
175 Central Avenue
Albany, NY 12206
[redacted]
*www.hcdiny.org*

## doh.sm.1115Waivers

**From:** Schuhle, Lisa M. [redacted]
**Sent:** Friday, November 1, 2019 4:30 PM
**To:** doh.sm.1115Waivers
**Cc:** [redacted]
**Subject:** 1115 Public Forum comment
**Attachments:** 1115 waiver letter from Broome County 2019.docx



Please accept this letter as my public comment for the 1115 Waiver.
Thank you

**Lisa Schuhle**
Director
Broome County Office for Aging
P.O.Box 1766
Binghamton, NY 13902
[redacted]

Broome County Office for Aging

NY Connects

*You can learn more about OFA Services at [www.gobroomecounty.com/senior/](www.gobroomecounty.com/senior/)*

Find us on: facebook

State of New York
County of Broome Government Offices

**Office for Aging**
Jason T. Garnar, County Executive · Lisa M. Schuhle, Director

October 31, 2019

Subject: 1115 Public Forum Comment

Paul Francis
Deputy Secretary for Health
State Capitol
Albany, NY 12224

Donna Frescatore
Medicaid Director
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Dear Mr. Francis and Ms. Frescatore,

Please accept this letter as a written comment regarding the New York's 1115 Waiver Program (DSRIP). The intent of this letter is to highlight the value of the services provided by New York State's Area Agencies on Aging and the impact they have on social determinants of health and therefore health outcomes. Additionally, this letter details a recent client case that demonstrates the direct impact Office for Aging services have on preventing and reducing emergency room visits and hospital re-admissions.

The Broome County Office for Aging is a trusted service provider for the fastest growing segment of the population, and the highest utilizer of health care dollars. Our services absolutely allow individuals to remain in their own homes and communities, all while saving health care expenditures. We provide the highest level evidenced based interventions and the staff are experts at navigating a complex health care system, while providing person centered planning and assistance.

The Broome County Office for Aging has been assisting adults for over 40 years. We provide community-based services including case management, NY Connects, congregate and home delivered meals, transportation, personal care, shopping services, personal emergency response systems and health & wellness programs. Our NY Connects case managers trained in Options Counseling provide people with options that help them remain independent and healthy for as long as possible. In 2018 the Broome County NY Connects reported a total of 12,423 contacts with people seeking options to address their needs.

A recent client scenario demonstrates the impact our services and our staff have on those who need supports. This client scenario showcases how the efforts of our staff help clients navigate and connect to needed services ultimately prevent worsening health that leads to unnecessary medical expenses.

The Broome County Office for Aging received a referral on an 85-year-old Broome County resident (Sam) who had an outstanding balance of $12,000 with a local utility provider. A case manager visited the client to evaluate the situation in the home and determine the client's other

possible needs. Sam used to work as a crossing guard but has not been able to work due issues related to his health including COPD and 24/7 oxygen dependence. He counted on the extra income earned from his job to pay his bills. During the home visit the client's house conditions were evaluated and it was determined that the house needed many repairs. Sam had no running water due to a leak in the main water pipe and he also had no steps to the second floor. The lack of water meant that he had no access to consistent showers over the last year.

An Office for Aging case manager helped Sam apply for SNAP, HEAP, and access the Office for Aging transportation services. It was discovered the house was scheduled to be condemned within a few weeks. A referral was made to a local non-profit agency that provides funds for emergency home repairs for older adults. The outcome of this referral lead to stairs to the second floor getting replaced and water pipe repaired to restore the water to the home. It was also discovered that client owed a significant amount of money to the city for non-payment of water fees. The case manager worked with a local agency that provides emergency funds to cover what was owed to the city. Once the water was turned back on and house repairs were completed the city ceased their process of condemnation.

Without the assistance, supports and advocacy of the Office for Aging, Sam would have become homeless and his COPD related health issues would have gotten worse prompting emergency room visits and possible hospital admissions. Sam can now afford his medications and pay his other bills because of the financial assistance programs he was enrolled in with the help of the Office for Aging. We estimate a cost of $500 of a staff's time spent assisting Sam versus thousands of dollars spent in medical costs for visits to the emergency room and possible hospitalizations.

This case is one of many examples of how the Broome County Office for Aging can impact the social determinants of health and physical health of those in need. We can achieve these outcomes because of our highly trained and dedicated staff. We also utilize our community partners to find creative solutions, leverage funds and avoid duplication.

I therefore encourage the consideration of a mandate that each of the Performing Provider Systems (PPS) in the New York State Delivery System Reform Incentive Payment Program (DSRIP) contract with their local Office for Aging to avoid duplication of services and leverage already existing supports. This will benefit our communities, its residents and help save dollars.

Thank you in advance for your consideration.

Sincerely,

Lisa Schuhle
Director

CC: Harry B. Bronson, Member of the NY State Assembly, District 138
CC: Rachel May, Senator, NY State Senate, 53rd District

## doh.sm.1115Waivers

**From:** Jamilkowski, Jennifer [redacted]
**Sent:** Friday, November 1, 2019 4:38 PM
**To:** doh.sm.1115Waivers
**Cc:** Kaushansky, Kenneth
**Subject:** DSRIP amendment comments - submitted on behalf of Kenneth Kaushansky, MD, MACP, SVP Health Sciences, Dean, Renaissance School of Medicine, SBU
**Attachments:** KKaushanskyDSRIPAmendmentComments11.1.2019.pdf

**Importance:** High



Please find attached DSRIP amendment comments submitted on behalf of Kenneth Kaushansky, MD, MACP, Senior Vice President, Health Sciences, Dean, Renaissance School of Medicine at Stony Brook University. Please contact Dr. Kaushansky if you would like to discussed any of the enclosed comments, or if Stony Brook can be of additional assistance in DSRIP planning and management. He can be reached by phone at [redacted] or by email at: [redacted]

Thank you for your attention.

Sincerely,

Jennifer Jamilkowski

Jennifer Jamilkowski, MBA, MHS
Director of Planning
Stony Brook University Hospital
[redacted]

October 30, 2019

Donna Frescatore
*State Medicaid Director, Deputy Commissioner*
State of New York, Department of Health Office of Health Insurance Programs
Waiver Management Unit 99
Washington Avenue 12th Floor, Suite 1208
Albany, NY 12210

Dear Commissioner Frescatore:

Thank you for the opportunity to comment on the proposed DSRIP extension amendment. Over the last four years, DSRIP has been a valuable program for Suffolk County, bringing many successes as well as lessons learned. Stony Brook supports the State's intention to extend the program through 2024 and looks forward to continuing as a leader in the organization and delivery of DSRIP services.

In formulating this response, we consulted the Stony Brook Medicine leaders, faculty and staff who have been most closely involved in the program. In principle, there is strong agreement with the key points of the amendment including: the emphasis on behavioral health (BH) and social determinants of health (SDH); the focus on particular priority populations; the expansion of telehealth; and the need for long term care reform. We also support expanded roles for managed care organizations (MCOs) and community based organizations (CBOs) and the emphasis on achieving sustainability under Value Based Payment (VBP). We believe that the concept of Value Driving Entities (VDEs) will provide useful flexibility in adjusting the organizational structure of the PPSs during this next phase.

Despite this, we have a number of concerns and questions that we think should be explicitly addressed in planning the terms of DSRIP during the extension period (DSRIP 2). Broadly speaking, these fall into three categories: the importance of aligning DSRIP 2 with broader population health initiatives; the feasibility of implementing the proposed changes in the short timeframe; and the availability and quality of data to support patient and population health and outcomes measurement. We have outlined these concerns and questions in the remainder of this letter by functional or clinical area.

*Aligning DSRIP 2 with other population health initiatives* - Stony Brook is in the process of creating a Clinically Integrated Network (CIN) and a Medicare Accountable Care Organization (ACO) as mission critical initiatives for a sustainable future. To support this, DSRIP 2 should employ organizational structures, clinical guidelines, metrics, and technologies that will integrate seamlessly with CINs like ours and with federal VBP guidelines. Going forward, we need a viable means to work collaboratively with DOH so that we can ultimately have one system for patient care and information management.

- **It is essential that we be able to leverage the resources and the systems created under DSRIP and our CIN to support clinical integration across all payers.**

*Strategies to address BH and SDH* - While we strongly endorse an expanded focus on BH and SDH, such expansions are difficult to implement because of the shortage of providers in our region and throughout NYS. This has led to long waiting lists for patients needing BH treatment and has overburdened regional CBOs. Many of the most important SDH components (e.g. housing, economic instability, public transportation) are beyond our control even when utilizing all available CBO resources. The workforce initiatives as outlined in the draft amendment will not be able to address these shortages in the DSRIP 2 timeframe.

- **How will needed BH and SDH resources materialize in time to impact DSRIP 2 goals?**

- **Given the existing constraints, is it possible to see real transformation in quality and utilization metrics in these areas during the four-year extension period?**

*BH and other priority populations* - Within the identified BH priority populations, we recommend inclusion of developmentally disabled (OPWDD) persons. Such individuals have distinct and resource intensive needs not met by existing outpatient programs.

- **We need State support in creating urgent and emergent services, including housing, for the OPWDD population.**
- **We also note that working with the incarcerated population is particularly challenging and recommend that the State support special training for providers in this area.**

*Support for VDE formation and MCO engagement* **-** As you know, a great deal of time and effort was devoted to creating functional PPSs during the first years of DSRIP. With the shift from a PPS structure to VDEs, time will be needed to assemble the new VDEs, understand attribution, share and integrate data, and work out governance.

- **How and when will this be accommodated within the DSRIP 2 timeline?**
- **How will the State support existing PPSs and newly forming VDEs between the original DSRIP and DSRIP 2?**
- **Will bridge funds be available such that funds flow will not be disrupted?**

Furthermore, though we support the concept of a more prominent role for MCOs in DSRIP 2, we point out that MCO's didn't meaningfully participate in the original DSRIP despite the State indicating from the outset that that they expected their engagement. MCOs should be required to participate in this effort and in identifying cost and value drivers.

- **How will DSRIP 2 differ from the original DSRIP in this regard?**
- **How will the State compel and incentivize the MCOs to participate in a meaningful way so that viable VBP contracts can be put in place by the close of year three?**
- **What are the State-defined criteria designed to move VDEs toward VBP?**
- **Will providers be given the ability to analyze the total cost of care? We recommend that the State work with providers to develop a methodology to address the total cost of care across all populations.**

*Better alignment between reimbursement regulations, metrics, and clinical practices* – In some cases, state and/or federal regulations and outcome metrics (e.g. some measure in MIPS) are not aligned with best clinical practices. For example, regarding reimbursement misalignment, there are no payment provisions for many innovative and home-based eldercare programs. There are also tight restrictions on the use of certain medications in skilled nursing facility patients with dementia. Both of these situations often lead to unnecessary hospitalizations for seniors.

- **The State should continue efforts to create greater consistency between reimbursement regulations, outcome measures, and clinical best practices.**
- **The State should support pilot projects that remove perverse incentives in the delivery of patient care.**

*Improvements in data availability and utility* **–** Our concerns are perhaps the most extensive related to having adequate information for patient tracking, outcomes measurement, and population health. Within this area, we include issues regarding patient attribution—a significant problem during the original DSRIP. Our major concerns include:

*Timeliness* - Data from Salient Interactive Miner (SIM) using the MCO assigned PCP supported implementation and monitoring of program effectiveness. However, immediate evaluation of

intervention effectiveness was not possible due to the time lag in performance data. By the time the State made files available to our PPS, these data were lagging by more than a year.

- **How will this be remedied in DSRIP 2 such that PPSs can have real-time, integrated data on their patients?**

*Attribution and data sharing* – As a result of the variability in attribution, it was sometimes very difficult for the PPS to consistently follow its patients. Patients who were originally attributed to our PPS were frequently moved out of our PPS and then back in again; when they were removed from our attribution, we lost the ability to follow them. We should be given the ability to track patients over the full time period if we participate in their care. Furthermore, PPSs should not be penalized for late attribution (e.g. patients attributed in the final weeks of a reporting period) as occurred during the original DSRIP period.

- **We need more stable attribution, a consistent ability to track patients, and an effective mechanism for giving feedback on attribution**.
- **As a separate issue, we also recommend that attribution be based on the connections of patients to BH providers rather than to PCPs alone because of the primacy of the BH provider-patient relationship.**

*Integration and data organization* – Due to the technical differences between State files and our internal records, we could not comingle data or connect events to create a true longitudinal patient record. Additionally, without 3M measure calculations by hospital, our PPS was not able to utilize SIM data to track hospital performance related to potentially preventable/avoidable events. To support providers with more current data, our PPS worked with partners to access and operationalize data from MCO portals. Unfortunately, navigating the various portals was difficult for providers as they varied in content, functionality, and visualization.

- **Going forward, we need better capabilities in this regard not only for managing patient care, but also for tracking our performance on metrics with non-proprietary algorithms.**

*Separate databases* - The separation of DSRIP and non-DSRIP patients is cumbersome and inefficient for providers seeking to make treatment decisions that are payer agnostic.

- **The State should support the creation of a one-tiered system to support clinical workflow that is payer agnostic.**

*Data security* - While we fully recognize the importance of data security, the requirements in DSRIP are onerous.

- **Security requirements should be streamlined to allow easy comingling of State and internal datasets.**

*Measuring the value of prevention programs* – Despite many local and State programs aimed at preventing or reducing behavioral or physical health impacts, it is very hard to measure the value of such program (i.e. clean needles, Drug Free Communities). There are no standardized datasets that allow providers to understand what works and what doesn't work.

- **The State should consider requiring standardized data collection across the various local, regional and State programs. This would enable cost analysis related to such things as BH treatment and SDH mitigation, community services, and avoidance of higher acuity services.**

We recognize the formidable challenges that the State is confronting in guiding the evolution of DSRIP and applaud efforts thus far. We also acknowledge the complexity of the issues that we've touched upon here. The Stony Brook personnel who work most closely on DSRIP would be happy to provide the State with more detailed feedback and consultation on these and other program related matters. Please contact me if you would like me to arrange for further briefings or if Stony Brook can be of additional assistance in DSRIP planning and management. I can be reached by phone at [redacted] or by email at [redacted]

Sincerely,

Kenneth Kaushansky, MD, MACP
Senior Vice President, Health Sciences
Dean, Renaissance School of Medicine
Stony Brook University

## doh.sm.1115Waivers

**From:** Karen Lipson [redacted]
**Sent:** Friday, November 1, 2019 4:46 PM
**To:** Frescatore, Donna J (HEALTH); Ogborn, Michael (HEALTH); Allen, Gregory S (HEALTH); Chan, Peggy (HEALTH); Earle, Lana I (HEALTH); Ashe, Ryan P (HEALTH); Calicchia, Erin Kate (HEALTH); Kissinger, Mark L (HEALTH); Sheppard, Dan (HEALTH)
**Cc:** [redacted]; doh.sm.1115Waivers
**Subject:** LeadingAge New York Comments on Draft Request for DSRIP Extension and Renewal
**Attachments:** 2019 DSRIP Phase 2 Comments on Draft Application.6.pdf



Thank you for the opportunity to comment on the Department's draft application for an extension and renewal of the DSRIP program. Our comments are attached for your review. Please don't hesitate to contact us if you have any questions. We would be happy to meet with you to discuss our recommendations.
-k.

Karen Lipson
Executive Vice President for Innovation Strategies
LeadingAge New York
13 British American Blvd., Suite 2, Latham, NY 12110-1431
[redacted]

November 1, 2019

Donna Frescatore
Deputy Commissioner and Medicaid Director
Office of Health Insurance Programs
New York State Department of Health
One Commerce Plaza Albany, New York 12210

**Via E-Mail**
**Re: DSRIP Phase 2 Draft Application**

Dear Ms. Frescatore:

I am writing on behalf of LeadingAge New York to provide comments on the Department's draft application to extend and renew its Delivery System Reform Incentive Payment Program (DSRIP). As you know, LeadingAge New York is a statewide organization that represents the continuum of not-for-profit long-term/post-acute care (LTPAC) providers, senior services, and provider-sponsored managed long term care (MLTC) plans. Our members include providers of senior housing, non-medical senior services, home care agencies, adult day health care programs, assisted living facilities, hospice programs, nursing homes, and MLTC, PACE, FIDA, Medicaid Advantage Plus (MAP), and Medicare Advantage D-SNP plans.

We were pleased see long-term care recognized as an "additional high priority area" in the Department's draft DSRIP application. However, the application lacks detail on the implications of that designation and the allocation of funds to address it. If long-term care is a high priority, resources must be dedicated to support and incentivize the reforms that the Department seeks. In an environment of declining or flat reimbursement rates, rising costs, and workforce shortages, real reform cannot be achieved without upfront investment and incentives. Specifically, since approximately 40 percent of New York's Medicaid spending under the global cap is allocated to long-term care, 40 percent of DSRIP funding should similarly be dedicated to long-term care initiatives. The recommended uses and methods of allocating these funds are set forth in more detail below.

## I. Workforce: *Dedicate $1.4 Billion to LTPAC Workforce Initiatives*

Workforce recruitment and retention are the top priorities for LeadingAge New York members. The draft DSRIP application correctly highlights the major demographic shift taking place in New York State and the workforce crisis this shift has created. We applaud the Department's recognition in the application of initiatives that will support nursing students and aide trainees, such as subsidies and stipends for participating in aide certification and nursing programs and loan forgiveness programs for nursing students. We also wholeheartedly support subsidies for


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P 518.867.8383 | F 518.867.8384 | LeadingAgeNewYork.org

work barrier removal including child care and transportation for LPNs and aides. We agree that, although workforce shortages are present statewide, needs are particularly acute in rural areas.

While we commend the application's reference to these initiatives, we are concerned that the application does not appear to dedicate funding to fund them or to address directly the LTPAC workforce shortage. Instead, it implies that LTPAC workforce initiatives and funding will be funneled through the PPSs, which will be charged with identifying system reforms and workforce needs.[1] As previously noted, the PPSs are largely governed and managed by large hospital systems (plus a large physician group and a collaboration of FQHCs). Although there are isolated exceptions, such as the Staten Island PPS's long-term care apprenticeship program, PPSs have not dedicated even modest funding to LTPAC providers or LTPAC workforce to date. There is no reason to believe that they would allocate a greater proportion of PPS funding to LTPAC workforce under the second phase of DSRIP, unless the Department dedicates funding for this purpose.

Accordingly, of the $1 billion allocated for workforce development in the draft application at least 40 percent, or $400 million, should be dedicated to LTPAC workforce development. In addition, we request that an additional $1 billion drawn from the DSRIP Performance allotment be allocated to LTPAC workforce initiatives. These funds should be allocated based on regional need as grants to LTPAC providers, educational institutions, and other entities involved in workforce development, for recruitment and retention initiatives that include expansion of aide certification and nursing programs, apprenticeship programs, stipends and financial aid for aide trainees and nursing students, job-related supports (e.g., transportation, child care, peer mentoring[2]), career ladder programs, and wage subsidies.

## II. DSRIP Performance: *Require DSRIP Performance Initiatives to Incorporate LTPAC Leadership and Investment*

The draft application allocates $5 billion to "DSRIP Performance" without specifying the permitted uses of these funds. It appears that the application would link these funds to continuing with the promising practices identified in the draft application. Unfortunately, since there were only 6 long-term/post-acute care focused projects out of approximately 40 in the first phase of DSRIP, there are comparatively few DSRIP LTPAC practices to choose from in the second phase. Indeed, the body of the application contains no LTPAC promising practices. LTPAC practices are identified only in the appendix, and only two are listed – one focusing on INTERACT in nursing homes and one focusing on hospice.

### a. 40 Percent of Funds Should Be Allocated to LTPAC Models

We request that 40 percent of this $5 billion allotment -- i.e., $2 billion -- be targeted at LTPAC. As noted above, we ask that $1 billion of these funds be allocated to LTPAC workforce initiatives. The remaining $1 billion should be invested in:

[1] The application states: "Additional programs that DSRIP fueled through the PPS workforce collaborations should continue to identify the system reforms needed to support the aging population and the workforce needs that will be required."

[2] Hegeman, CR. Turnover Turnaround. Health Progress. 2005 Nov-Dec;86(6):25-30. Paraprofessional Healthcare Institute, Introducing Peer Mentoring in LTC Settings, May 2003.)

(i) Innovative care models to serve consumers with complex conditions, including:
   a. Expanded use of nurse practitioners and physician assistants in nursing homes to lead clinical interventions that promptly identify and address changes in condition and avoid negative outcomes such as hospital admissions and ED visits, including ER diversion programs and restorative care units;[3]
   b. INTERACT training and implementation support for nursing homes and home care agencies;
   c. Expansion of palliative care and hospice services through eMOLST and advance care planning education for clinicians and consumers;[4]
   d. Comprehensive post-acute care management in the home through home care agencies and in adult day health care programs, and transitional care management from post-acute care in nursing homes to home-based care, in order to reduce rehospitalization rates and optimize outcomes;[5]
   e. Inter-disciplinary, palliative care models for people with dementia, such as Comfort Matters®;[6]
   f. Telehealth interventions across the LTPAC continuum to improve outcomes and prevent avoidable hospital use, including in home care, assisted living, adult day health care and nursing home settings.[7]

(ii) EHR adoption and upgrades and health information exchange; and

(iii) Supporting and funding the use of advanced aide roles in nursing homes and home care, including medication technicians and patient care technicians in nursing homes.[8]

(iv) Funding resident assistants or service coordinators in affordable senior housing developments (described in detail on p.7-8).

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[3] NPs and PAs enable nursing home staff to respond immediately to changes in patient status and provide residents and families with additional confidence in the ability to manage their conditions outside of the hospital. This model has achieved reductions in hospitalizations in I-SNPs. See MedPac, Report to Congress, Mar. 2013. M. Perry, et al. "To hospitalize or not to hospitalize? Medical care for long-term care facility residents." Kaiser Family Foundation, Oct. 2010. Available at: http://kff.org/health-costs/report/to-hospitalize-or-not -to-hospitalize-medical/.

[4] Use of MOLST is associated with higher rates of hospice use and lower rates of in-hospital death. eMOLST enables portability of MOLST forms and access by providers across the continuum. Jennings LA. Use of Physician Orders for Life Sustaining Treatment among California Nursing Home Residents. *J Gen Intern Med.* 2016. Fromme. Association between Physician Orders for Life-Sustaining Treatment for Scope of Treatment and in-hospital death in Oregon. *J Amer Ger Soc*. Jul 2014.

[5] This could be coupled with a post-acute bundle for non-duals in mainstream managed care or duals in integrated plans.

[6] The Comfort Matters® model is supported by CaringKind, formerly the Alzheimer's Association New York City Chapter. It is a person-centered, team-based approach that was developed by the Beatitudes Campus in Arizona, which provides training and accreditation to participating facilities. Although it has been primarily implemented in nursing homes, the model can be adapted to any setting. https://caringkindnyc.org/palliativecare/

[7] Chess D. Impact of After-Hours Telemedicine on Hospitalizations in a Skilled Nursing Facility. *Am. J. Managed Care*. Aug. 2018. Grabowski. Use of Telemedicine Can Reduce Hospitalizations of Nursing Home Residents and Generate Savings for Medicare. *Health Affairs.* Feb. 2014. Rabinowitz. Benefits of a Telepsychiatry Consultation service for rural nursing home residents. *Telemed J eHealth*. Jan-Feb 2016. AHRQ. Telehealth: Mapping the Evidence for Patient Outcomes from Systematic Reviews. 2016.

[8] Paraprofessional Healthcare Institute, Raise the Floor, 2016. Walsh. Impact of Medication Aide Use on Skilled Nursing Facility Quality. *The Gerontologist*. Aug. 2013.

Like the promising practices highlighted in the draft application, these initiatives align closely with federal priorities. They are aimed at reducing avoidable emergency room use and hospital admissions, they build scale and support communication along the continuum to facilitate value-based payment arrangements, they enable efficient and effective use of a scarce workforce, and they strengthen efforts to optimize dignity and quality of life among older adults with complex medical conditions and functional limitations.

### b. Require LTPAC Focus and Leadership in Value-Driving Entities

The draft application appears to rely on the creation of value-driving entities VDEs to carry out the promising practices selected for the second phase of DSRIP, but provides little detail on the nature of such entities or their activities. They appear to be performing provider systems (PPSs) or subsets of PPSs or other entities that collaborate with managed care plans, providers and community-based organizations CBOs) to implement high-priority DSRIP promising practices. The application requires all VDEs to "bring MCOs in the region into the management and operational structure," but merely suggests that "ideally, Value-Driving Entity governance would include additional representation from community-based providers, including primary care, behavioral health and long-term care." It does not require VDEs to engage these providers in their leadership or operations.

We recommend that, if VDEs are to be the platform for DSRIP 2.0, they should be required to include LTPAC providers in their governance structure. In addition, MLTC plans (i.e., MAP, PACE and partially-capitated plans) should be included in VDE management and operations to the same extent as mainstream MCOs. VDEs should be required to participate in at least one long-term care project. We also urge the Department to authorize and fund the creation of specialized LTPAC VDEs. Notably, the State has funded the creation of network infrastructure for PPSs and behavioral health care collaboratives. It has not made similar investments in the creation of LTPAC networks.

The application establishes as the single goal of VDEs the sustainability of their DSRIP projects through VBP contracts by the close of the third year of the DSRIP extension. As described in more detail below, the LTPAC sector faces greater challenges than the acute and primary care sectors in succeeding under risk-sharing arrangements, especially in the absence of Medicare gainsharing. We urge the Department to seek an agreement with CMS to enable LTPAC-focused VDEs share in the Medicare savings they generate.

## III. Additional High Priorities: *Ensure that the High Priority Designation for Long-Term Care Drives Additional Funding and Engagement*

### a. Greater Specificity in Proposals and Dedicated Funding is Needed

We appreciate the characterization of long-term care as an "additional high priority area" in the draft application. However, the practical implications of this designation and of the proposals set forth in this section of the application are difficult to discern and require further elaboration. Moreover, the draft application does not specify the amount of funding dedicated to this high priority area.

Instead, the application implies that this high priority area will be funded through VBP arrangements led by VDEs. It provides that "[f]urther exploration of bundling and value-based payment options for this sector will be married to continued exploration of new managed care delivery models to further strengthen and integrate the broader continuum of care for patients needing longer-term services and supports." It goes on to state that "[c]ollaborations of Value-Driving Entities, MCOs, and CBOs would target a specific high-need population for activities . . . and would initially use available data (including QE data) to define the population and the opportunity(ies) for improvement.

Although the long-term care section of the application appears to rely on VDEs, the application does not require VDEs to include LTPAC providers or MLTC or PACE plans in their leadership and does not require VDEs to engage in long-term care projects. The application's emphasis on VDEs that are self-sustaining through VBP arrangements implies that the principal source of funding for this high-priority area will be shared savings. However, the application overlooks the structural, financial, programmatic challenges that LTPAC providers have faced in pursuing VBP arrangements.

**b. Success under VBP for LTPAC Providers Requires a Leadership Role and Medicaid/Medicare Integration**

Our members support value-based payment as a mechanism for improving quality and outcomes and enhancing the efficiency of the delivery system. Many have been active participants in Medicare bundled payment arrangements and in I-SNP and MLTC VBP arrangements. All are continuously working to integrate their services with acute care, other post-acute services, primary care, and physician services. However, they have faced significant challenges in succeeding financially under VBP models — not because they have failed to achieve savings or to satisfy quality metrics. On the contrary, studies of the Medicare Bundled Payents for Care Improvement Program (BPCI) have shown that the reductions in Medicare episode payments generated by these models are derived principally from reductions in post-acute care, especially in skilled nursing facility utilization and length of stay.[9]

Rather, LTPAC providers are challenged in succeeding financially under these models because of the way the models are typically structured. The bundled payment and accountable care organization models under Medicare are typically led by hospitals or large physician practices. Thus, CMS shares any savings generated (including savings generated by the post-acute sector) with the ACO or bundle leads – the hospitals or physician practices. The lead entities do not generally pass on a share of those savings to their post-acute partners.

In Medicaid's partially-capitated MLTC program, it is difficult to generate savings due to a number of factors. These include the exclusion from the MLTC benefit package of hospital services, programmatic limitations on the ability to control utilization, and mandated rate pass-throughs. As a result, VBP arrangements under Medicaid MLTC are predominantly pay-for-performance contracts, rather than shared savings or shared risk arrangements. The State has not yet provided any funding for MLTC or PACE performance incentives under VBP, although a

[9] "CMS Bundled Payments for Care Improvement Initiative Models 2-4: Year 5 Evaluation and Monitoring Report," prepared for CMS by The Lewin Group, Oct. 2018.

payment for performance on potentially avoidable hospitalizations has been promised in SFY 2020-21.

Accordingly, if the State's intention is to address the long-term care priority area through gainsharing under VBP arrangements, we are pessimistic that LTPAC providers will experience a measurable increase in resources, given current programmatic constraints.

The prospects for successful VBP arrangements for LTPAC providers are improved when Medicare and Medicaid funding streams are aligned or integrated. With integrated funding, Medicare savings achieved through the expenditure of Medicaid funds on high-quality long-term services and supports can be shared with the State and reinvested in the long-term care delivery system. Moreover, through the shared savings that can be generated in integrated models, plans and providers have greater opportunities to implement innovative care models, such as leveraging service-enriched affordable senior housing or assisted living facilities as platforms for care delivery. We believe that MAP and PACE plans sponsored by non-profit, long-term care (LTC) providers can play a key role in strengthening integration and innovative VBP arrangements with LTPAC providers. These plans offer a more person-centered approach to care management than mainstream managed care plans, have strong relationships with providers along the continuum of LTPAC, and have been committed partners in the State's long-term care policy initiatives. Further, our analysis of quality data of plans that serve the vast majority of MLTC members has shown that MLTC plans sponsored by non-profit LTC providers achieve better results on quality measures than other plans.[10]

### c. Invest in Health IT and Health Information Exchange in the LTPAC Sector

The LTPAC sector is further hindered in its ability to succeed under more sophisticated VBP arrangements by lack of public investment in IT infrastructure to engage in data collection, analytics, and health information exchange. The suggestion in the draft application that Value Driving Entities, CBOs and MCOs would initially rely on "available data (including QE data)" to define the attributed population and opportunities for improvement is well-intentioned but misguided. It overlooks the fact that LTPAC providers are under-represented among providers contributing data to QEs due to very limited public funding for EHR adoption and health information exchange among LTPAC providers.

### d. Seek Clarification of Federal Medicaid Managed Care Conflict of Interest Regulation to Allow HCBS Risk Sharing with Plans

Federal Medicaid managed care regulations and related waiver provisions governing "conflicts of interest" in care planning hinder the ability of home and community-based services (HCBS) providers to participate in VBP arrangements that involve any form of risk sharing.[11] In order

[10] LeadingAge New York analysis of NYS Department of Health, *Consumer's Guide to Managed Long-Term Care*, New York City, 2018. In the New York City region, where the vast majority of MLTC members are enrolled, the average star rating of partially-capitated plans operated by non-profit, long term care provider organizations is 3.9, compared to an average of 2.8 for other plans.
https://www.health.ny.gov/health_care/managed_care/mltc/consumer_guides/.

[11] 42 CFR 438.208(c), referencing §441.301(c)(1) and (2).

for HCBS providers to accept risk, they must be authorized to assess their attributed beneficiaries, stratify them by condition and needs, and develop service plans to manage their utilization based on their needs. Moreover, beyond managing utilization to succeed in VBP arrangements, many home care agencies or their affiliates have assumed care planning functions under delegation agreements with MLTC plans in an effort to bring care management closer to the beneficiary, his/her caregivers, and local services. If the State and federal governments truly want to align incentives and transfer increasing levels of risk from MLTC plans to providers, the Medicaid managed care conflicts of interest regulation must be interpreted or waived to permit HCBS providers to develop service plans and manage utilization.

When negotiating the next iteration of the Terms and Conditions, the State should seek clarification from CMS that, like Health Homes, HCBS providers (e.g., home care agencies) operating under managed care contracts may provide delegated care management services to the MLTC members they serve and may incorporate care management into VBP arrangements.

## IV. Interim Access Assurance Fund: *Expand Eligible Facilities to Include Nursing Homes*

Consistent with the designation of long-term care as a high priority area, we request that the Interim Access Assurance Fund be opened up to nursing homes. Like safety net hospitals, New York's nursing homes are struggling to survive in the face of rising costs and Medicaid rates that fall short of costs by an average of $64 per day, according to national study. As a direct result of serving a predominantly Medicaid population (well above the 30 percent threshold required of safety net hospitals), the average nursing home operating margin was -1.1 percent in 2017, with 41 percent of facilities incurring an operating loss. At the same time, nursing homes are struggling with reductions in nursing home utilization driven by Medicare alternative payment mechanisms, increased use of home care services, and competition from critical access hospitals that strive to improve occupancy by retaining Medicare beneficiaries in swing beds. The impact of the recent change in the Medicaid case mix index methodology has deepened nursing homes' distress, and several have indicated that they are at risk of closing.

Like safety net hospitals, many nursing homes are focusing resources on right-sizing their facilities and developing new services. They are developing services that address the needs of medically-complex residents and expanding assisted living and other forms of non-institutional care. However, revenue losses from nursing home services, without additional transition funding, may permanently destabilize some essential providers. In order to avoid closures that would force older adults to seek nursing home care far from family and friends, we urge the Department to make IAAF funding available to nursing homes.

## V. Social Determinants of Health: *Invest in Resident Assistants in Affordable Senior Housing*

We commend the State's goal of addressing the social determinants of health and integrating non-medical supports into the health care delivery system. However, the State's efforts to address social determinants of health (SDH) through managed care VBP arrangements have not been well-suited to the partially-capitated MLTC program or the needs of older adults. Several

of the SDH interventions highlighted by the Department are either targeted at younger cohorts (e.g., home-based pre-natal and peri-natal services, safe places to exercise) or are covered MLTC benefits (e.g., home-delivered meals) that are not permissible as SDH interventions. Further, the use of managed care VBP as the funding mechanism for SDH interventions assumes that significant savings will be generated to sustain them. In the context of a fully-capitated plan, such savings may be generated through reduced hospital use. However, these savings are not available in the partially-capitated program. Thus, the SDH intervention requirement is not adequately funded in the partial cap program.

One way in which the State could more effectively address social determinants of health among low-income, older adults is by supporting the use of resident assistants or service coordinators in affordable senior housing. This cost-effective model helps residents by: (1) establishing relationships with community-based services and organizations; (2) assisting residents in applying for public benefits; (3) arranging for educational, wellness, and socialization programs; (4) facilitating access to services such as housekeeping, shopping, transportation, meals-on-wheels; (5) establishing resident safety programs; and (6) advocating for residents. As noted in our earlier letter, rigorous studies have shown that these programs reduce utilization of hospital services.[12]

We recommend that the extension of the MRT Waiver include funding for resident assistants in affordable senior housing developments. A modest investment of $10 million over five years could be used by both existing and newly-created affordable housing developments, such as those created under HCR's new "Senior Housing Program," which was designed to facilitate the disbursal of the $125 million in new funding for senior housing. Pairing resident assistant services with senior housing creates an efficient and effective model for aging in place. It generates Medicaid savings to by helping low-income seniors to avoid or delay accessing more costly levels of care, such as assisted living or nursing homes.

## VI. DSRIP Data Collection and Sharing

Phase 2 of DSRIP should expand the data available concerning PPS investment in LTPAC and the beneficiaries receiving LTPAC services. The first phase of DSRIP made available an unprecedented array of data available to managed care plans, PPS staff, and providers. However, there were gaps in data collection and dissemination with respect to the LTPAC sector. For example, Medicaid data was made available to mainstream managed care plans, PPS analytics staff, and certain PPS providers through the DSRIP dashboards and MAPP tools to enable population health assessments and planning and performance improvement interventions. Unfortunately, these data were not made available to MLTC or PACE plans or LTPAC providers.

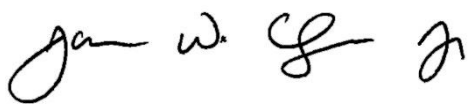
[12] Gusmano, MK. Medicare Beneficiaries Living in Housing With Supportive Services Experienced Lower Hospital Use Than Others. *Health Affairs.* Oct. 2018.

Similarly, data collected concerning the distribution of funds to PPS participating providers does not separately identify funds distributed to home care agencies. Instead, these providers appear to be included in a broader category of HCBS providers. Moreover, this category was not separately reported until the third year of DSRIP. For purposes of transparency, policy development, program design, and public input, it is important for stakeholders to understand where the DSRIP funds are budgeted and spent.

To advance the high priority goal of long-term care reform, the Department should collect more specific data from PPSs about investments and incentive payments to LTPAC providers and make available data to LTPAC providers, PACE programs, and MLTC plans to support DSRIP projects and promote population health improvement.

Thank you very much for your consideration of these comments. Please don't hesitate to contact me at [redacted] with any questions.

Sincerely yours,



James W. Clyne, Jr.
President & Chief Executive Officer

cc:
Michael Ogborn
Lana Earle
Erin Kate Calicchia
Greg Allen
Peggy Chan
Dan Sheppard
Mark Kissinger
Sean Doolan

## doh.sm.1115Waivers

**From:** Michael P O'Connor [redacted]
**Sent:** Friday, November 1, 2019 5:14 PM
**To:** doh.sm.1115Waivers
**Subject:** Re: NYU College of Dentistry Comments
**Attachments:** dsrip concept paper 11-1-19 (1).docx



To Whom It May Concern

Please find attached the NYU College of Dentistry Concept Paper and Comments With Regard to the DSRIP Program. Please let me know if you have any questions or require any additional information.

Thank You
Michael O'Connor

Michael O'Connor, EdD,MPA
Executive Vice Dean for Administration, Finance Development, Clinical, and Student Services
New York University College of Dentistry
[redacted]

On Fri, Nov 1, 2019 at 4:17 PM Michael P O'Connor [redacted] wrote:

> To Whom It May Concern
>
> Please find attached the New York University College of Dentistry Concept Paper and Comments With Regard to the Delivery System Reform Incentive Payment Program
>
> Please let me know if you have any questions or require any additional information.
> Thank You
>
> Michael O'Connor
>
> Michael O'Connor, EdD,MPA
> Executive Vice Dean for Administration, Finance Development, Clinical, and Student Services
> New York University College of Dentistry
> [redacted]

**Promoting Community-Level Collaboration and Reducing Avoidable Hospital Use: A Concept Paper Requesting DSRIP Funding on Behalf of NYU Dentistry Oral Health Center for People with Disabilities**

Research shows that people with disabilities have worse oral health than the general population and are less likely to have access to dental care services.[1] People with physical, cognitive, acquired, and/or developmental disabilities face a wide range of barriers to receiving dental care, from being unable to physically access a dentist's office because the facility cannot accommodate wheelchairs or other assistive devices, to facing major challenges getting through a checkup or cleaning because of an inability to hold their head in place or extreme environmental sensitivities.

In addition, most dentists lack confidence in their ability to meet the needs of people with disabilities, so may not be prepared or willing to welcome them. Unfortunately, the default position has been to send disabled people to hospitals for dental care, where they may wait as long as six months to get an appointment to be seen in an operating room. Such visits are one-off emergencies without follow up or continuous preventive care, which can trigger a cycle of recurring expensive dental problems. Studies have indicated that among the developmentally disabled population, reducing dental disease—which has been linked to cardiovascular disease, diabetes, and a number of other systemic conditions—will significantly decrease medical costs related to dental neglect. In fact, when dental neglect requires a patient to seek urgent/emergent dental care necessitating treatment in the hospital system, costs can become uncontrollable.

**The Challenge**

In New York State, about one in five adults (approximately 3 million people) have some form of disability.[2] For a large number of this population and for the more than 128,000 New Yorkers with developmental disabilities[3]—including intellectual disabilities, cerebral palsy, down syndrome, autism spectrum disorders, and other neurological impairments—accessing routine dental care is virtually impossible, which increases the likelihood that their conditions will worsen and they will need to seek emergency care in a hospital.

**NYU Dentistry's Response: The NYU Dentistry Oral Health Center for People with Disabilities**

With the goal of providing timely, comprehensive, cost-effective dental care for people with a full range of disabilities who experience significant barriers to accessing care, New York University College of Dentistry (NYU Dentistry) opened the NYU Dentistry Oral Health Center for People with Disabilities (OHCPD), dental.nyu.edu/ohcpd, an 8,000 square-foot, state-of-the-art Article 28 dental treatment facility in New York City, in February 2019. By providing dental care across the patient's lifespan, the center aims to be a true "dental home" for this population, thereby breaking the vicious cycle of neglect and avoidable hospital use.

In addition to offering much-needed clinical services to patients, the OHCPD provides a unique training opportunity for our students, aiming to create the next generation of dentists who will practice with competence, confidence, and compassion in treating people with disabilities. To that end, our students started full-day rotations in the center as soon as it opened.

**Progress to Date**

Since its opening, the NYU Dentistry Oral Health Center for People with Disabilities has exceeded our high expectations. The community response has been especially encouraging, including strong support within the disabilities community at the grassroots level (mainly on social media) to widespread

coverage in *The New York Times* (https://www.nytimes.com/2019/05/02/well/live/special-needs-dentist-nyu.html). Moreover, our partnerships with multiple organizations that provide services and advocacy for the disabled have facilitated a referral network that we expect to strengthen as the center continues to serve the community.[4] To further expand access to care for disabled New Yorkers, we will engage with the State's Medicaid plans to help identify high-cost dental users from various communities--possibly using Healthix-- and work collaboratively to get these patients into care at the OHCPD. We will also work with State and local hospitals to reduce unnecessary hospital admissions for disabled patients based on our ability to care for them on an outpatient basis. In addition, we are prepared to work with the State on an Alternative Payment Methodology to move away from a visit-based payment system to a value-based or capitated model for high-cost patients.

IV sedation cases began August 1, 2019, enabling adult patients to receive dental treatment without the burden of resorting to the operating room under general anesthesia for routine care. In addition, all pediatric cases requiring sedation are now treated at the center, allowing preventive, restorative, and surgical care to be delivered in the safest environment.

Currently, the OHCPD is seeing 50 patients a week, putting us on track to provide 10,000 patient visits during our first year of operation. To put this into historical context, the College's Special Care Program, which has been conducted since 1971, had been seeing approximately 2,500 patient visits annually. It is predictable that without the OHCPD, a significant number of the additional 7,500 visits would be referred to hospitals, and perhaps not treated at all. Simply put, the OHCPD has enabled a major expansion of access to care for this population. But more remains to be done.

**Our Request**

We believe that the OHCPD can be a significant asset to the State in addressing the major public health challenge of meeting the dental needs of disabled New Yorkers in a compassionate, cost-effective manner. To that end, NYU Dentistry requests that the New York State Department of Health include the NYU Dentistry Oral Health Center for People with Disabilities in DSRIP funding. Such funding will enable us to create a Center of Excellence that will expand access to dental care for thousands more disabled New Yorkers and overwhelmingly reduce costs from avoidable hospital use. The Center of Excellence will be a Value-Driving Entity (VDE) that will build a statewide network of dental providers whom we will train to provide care for this population, as well as FQHCs and managed care organizations, which will allow us to provide care coordination for high-risk individuals, including children. It will also allow us to expand the OHCPD's days and hours of operation.

We will build our provider network by offering continuing dental education (CDE) courses in caring for disabled individuals to members of the many dental associations and dental societies in New York State that sponsor continuing CDE courses--among them, the New York State Dental Association and its component dental societies and the New York Academy of Dentistry. In addition, we will provide this training for the 2,500 dentists who enroll annually in CDE courses at NYU. We will also partner with other facilities that offer some level of dental care for disabled patients in order to enhance the services they provide to their patients.

Such a public-private partnership will produce a new generation of dentists across the State with the skills and understanding needed to care for people with disabilities in their own communities, and, as a result, many fewer disabled New Yorkers will be referred to hospital ORs for care, thus significantly reducing costs to the State.

New York State has long been committed to funding projects that foster healthy communities. We have created the NYU Dentistry Oral Health Center for People with Disabilities on behalf of that goal, and we are seeking your support to create a Center of Excellence that will move all of us closer to achieving health equity for all New Yorkers.

**Endnotes**

[1] https://jada.ada.org/article/S0002-8177(14)61796-7/pdf

[2] https://www.health.ny.gov/community/disability/prevalence.htm

[3] https://www1.nyc.gov/site/mopd/resources/developmental-disability.page

[4] These include The Viscardi Center, Cerebral Palsy Associations of NYS, MyFace, the Comprehensive Epilepsy Center and Familial Dysautonomia Center at NYU Langone Health, AHRC NYC, and Metro Community Health Centers, among others.

## doh.sm.1115Waivers

**From:** Cathryn F Bern-Smith [redacted]
**Sent:** Friday, November 1, 2019 5:18 PM
**To:** doh.sm.1115Waivers
**Cc:** bronsonh; may; James Tedisco; amedoreg; SantabarbaraA; Phil Steck; Mary Beth Walsh
**Subject:** 1115 Public Forum Comment - Schenectady County
**Attachments:** Schenectady County Senior & Long Term Care Services-DSRIP Letter.pdf



Please see the attached letter I would like to submit on behalf of the Schenectady County Department of Senior and Long Term Care Services

Thank you.

Cathryn Bern-Smith
Manager
Department of Senior & Long Term Care Services
107 Nott Terrace, Suite 305
Schenectady, NY 12308-3170
[redacted]


[redacted]

# SCHENECTADY COUNTY DEPARTMENT OF SENIOR AND LONG TERM CARE SERVICES

NEW YORK STATE OF OPPORTUNITY. | NY Connect Your Link to Long Terr Services and Supports

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November 1, 2019



Mr. Paul Francis
Deputy Secretary for Health
New York State Capitol
Albany, NY 12224

Ms. Donna Frescatore
Medicaid Director
New York State Department of Health
Empire State Plaza
Corning Tower
Albany, NY 12237

Dear Mr. Francis and Ms. Frescatore:

On behalf of the Schenectady County Department of Senior and Long Term Care Services, I am writing to express my recommendations on the DSRIP renewal proposed by the New York State Department of Health. The services we provide directly impact inappropriate emergency department visits, reduce avoidable readmissions and delay or prevent nursing home admissions. The NY Connects program, implemented in 2006, serves as no wrong door for any and all services available in Schenectady County, and is a catalyst for individuals in need of assistance. The targeted goals in the proposed renewal are exactly what this network provides, and must include mandated contracting by each PPS with their local Area Agency on Aging for social determinants of health initiatives. Our office is the trusted service provider for the fastest growing segment of the population, and the highest utilizer of health care dollars. Our services **absolutely** allow individuals to remain in their own homes and communities, all while saving health care expenditures. We provide the highest level evidenced based interventions, and are experts at navigating a complex health care system, while providing options counseling, person centered planning and care. My staff are highly dedicated and skilled case managers, with decades of experience in serving a very vulnerable segment of the population.

To demonstrate the value of the network, I would like to highlight the following cases that are typical of the clients we serve.

Client #1 is a 94 year old widow who lives alone and receives EISEP Services (Personal Care Level 2) for two hours a day, two days a week, and is on our waiting list for an extra day, PERS, Case Management and Home Delivered Meals. She has been on our client caseload since June of 2012. Her health insurance is Medicare A, B and D. Her chronic illnesses include: diabetes, arthritis, CHF, recent hip fracture, hearing and sight impairments, HBP, and has suffered a stroke. The assistive devices she uses include a cane, full dentures, grab bars, glasses, hearing aid, raised toilet seat, transfer bench, tub seat and a walker (at all times). Her nutritional risk is in the moderate range. She takes 16 prescription medications, plus three OTC drugs. She has (7) IADLS and one (1) ADL. She receives Section 8 rental assistance. The cost of her services is $466.43 per month, for an annual cost of $5,597.16. She pays $170.13 per month.

Without the services provided by Schenectady County, this client would require skilled nursing care. After she spent her personal resources for skilled care, which would last slightly more than two months, she would need to apply for Medicaid. According to SeniorAdvice.com, costs of nursing home care in Schenectady generally range between $340 per day and $425 per day. The median cost is approximately $378 per day, or about $137,934 annually. The estimated average according to the NYSDOH website is slightly less at $135,360 annually. It is obvious that the services provided by Schenectady County are able to keep this client safely in her own home at significant cost savings to New York State.

Client #2 is a 77 year old woman who is wheel-chair bound, frail, sight impaired, is widowed, lives alone, and has been receiving services from Schenectady County for fourteen (14) years. She receives EISEP services (Personal Care 2, 2hrs/day, 5 days/week) and Case Management. She has Medicare A, B, and D. The total cost of her services is $737.88 per month. Her cost share is 0%. Her diagnoses include Guillain-Barre Syndrome, Arthritis, DMII and HBP. Her assistive devices include grab bars, glasses, hand held shower, raised toilet seat, transfer bench, tub seat, walker and wheelchair/transport chair. She was hospitalized for three days in May and had an ER visit in July, both for dehydration. She takes four (4) prescription medications. She needs assistance with five (5) IADLs and five (5) ADLs.

Due to her diagnoses, the fact that she is wheel-chair bound, and needs daily assistance with multiple activities such as bathing, dressing, personal hygiene, cooking, and cleaning, this client no doubt would score high on the UAS and be eligible for either MLTC or skilled care without the services she receives from Schenectady County. Her monthly resources would not cover the estimated monthly cost of skilled care. It would only be a short matter of time before she became Medicaid eligible.

These two examples show how the Personal Care and Case Management services provided by Schenectady County keep people safe and living in their own homes – where they prefer to be – and save New York State millions of dollars in Medicaid expenses.

These are two of the many cases that truly display the boots on the ground service provision in every county across New York State. In the renewal waiver, I cannot stress highly enough that we need to harness the existing strengths of community based services, instead of recreating case management services and duplication of services. Each and every case manager in the entire statewide aging network has received certification via Boston University School of Social Work, ensuring consistency in assessment not provided by any other system. I ask that there are mandates for each PPS to engage and contract with their local Offices for the Aging, for the services vital to keeping individuals in home and community based settings.

Thank you for your attention to this matter.

Sincerely,

Cathryn Bern-Smith, M.S.W.

Cathryn Bern-Smith, M.S.W.
Manager
Schenectady County Department of Senior and Long Term Care Services

*The mission of the Schenectady County Department of Senior and Long Term Care Services is to promote the long term health and well-being of Schenectady County residents and assure that they receive the necessary community-based services that they are entitled to in order to remain safely in the community. These services are provided without regard to race, color, sex, including gender identity or expression, national origin, sexual orientation, military status, age, disability, predisposing genetic characteristics, marital status or domestic violence victim status.*

## doh.sm.1115Waivers

**From:** Tom Filiak [redacted]
**Sent:** Friday, November 1, 2019 5:25 PM
**To:** doh.sm.1115Waivers
**Subject:** Public comment DSRIP Waiver Amendment proposal
**Attachments:** DSRIP Public Comment Letter.docx

**Importance:** High



Greetings ,

Please see attached DSRIP Waiver Amendment proposal comments. Best regards.

*Thomas Filiak*

Thomas Filiak, MA, BSMT (ASCP)
Auburn Community Hospital
DSRIP Projects Coordinator
[redacted]
17 Lansing Street
Auburn, NY 13021


Thomas Filiak, MA,BSMT(ASCP)
DSRIP Projects Coordinator
Auburn Community Hospital
17 Lansing Street
Auburn, NY 13021

Greetings,

Thank you for the opportunity to provide public comment on the 1115 Medicaid Redesign (DSRIP) Waiver Amendment. Auburn Community Hospital is a rural, safety net provider of Hospital, Outpatient Services including Primary and Specialty Care and Long-Term Care and Rehabilitation . In this capacity, we have been able to participate in the DSRIP program with the Central New York Care Collaborative (CNYCC).

Our work with CNYCC has included the implementation of many transformative projects that are aligned with the key objectives of the DSRIP program aimed at increasing access, increasing quality, and lowering cost. In addition, our work with CNYCC has provided us an opportunity to establish partnerships with local organizations throughout our community through providing leadership in developing Care Transitions coalitions.

As one of the NYS Performing Provider Systems(PPS's) , CNYCC has provided much value to ACH in guiding us on the path of transforming healthcare services for the benefit of our patients in our predominantly rural counties. Notably, Physician recruitment assistance, funding the start-up implementation of a Population Health Management IT system (IBM Watson and Unite US), educating us on the Social Determinants of Health, and providing resources to assist us in the transition from a Fee-for-Service environments to future Value-Based Payment contracts and initiatives.

The Leadership and the Staff of CNYCC have proven to be not only highly competent and skilled at administering the many complexities of the DSRIP

program, but have fostered relationship building and collegiality among over 120 partner organizations, many of whom are competitors.

With all of this said, the work of DSRIP is not finished. Much more needs to be done. It is our contention that with the continued leadership and programmatic excellence of CNYCC, our organization and our region will sustain the good work that has begun and further develop innovative paths to healthcare excellence for all patients in our communities.

Thank you for the opportunity to submit this public comment.

Respectfully submitted,

*Thomas Filiak*

Thomas Filiak, MA, BSMT(ASCP)
DSRIP Projects Coordinator

## doh.sm.1115Waivers

**From:** owner [redacted]
**Sent:** Sunday, November 3, 2019 1:54 PM
**To:** doh.sm.1115Waivers
**Cc:** Ann Monroe
**Subject:** Written comments on DSRIP 2.0 concept paper
**Attachments:** Monroe written comments 110419.docx



Attached is a written copy of my verbal comments from the public comment day in Syracuse. Thanks for the opportunity,

# ANN F. MONROE

## Written text of public comments 103019

**Good Morning and thank you. My name is Ann Monroe. I am here as an individual with my own perspective on this draft and not here as a member of the PAOP or the PHHPC.**

**First, I am pleased to see more emphasis on long-term care than we saw in 1.0. However, I am concerned about the total lack of attention to an invisible population that contributes significantly to the cost and quality challenges of Medicaid. That is the Intellectually and developmentally disabled population of NY State.**

**2014 data – the latest information we were able to find – showed that an inpatient stay for a person with I/DD cost more than twice the cost of the general population and almost 50% higher than a behavioral health stay. People with I/DD have almost twice as many ED visits as the general population and many of those are preventable. We saw that in WNY where People, Inc., through the support of the Community Health Partners PPS was able to utilize telemedicine to reduce avoidable ED visits. The pilot program showed a reduction of ER visits of 35% in the first six months of 2018. The total lack of attention to this population in 2.0 misses a major opportunity to improve quality, reduce costs and bring a significant range of partners and clients into a community-wide effort.**

**Second, I understand the importance of bringing some critical players into the active mix of 2.0, so I welcome the inclusion of payers and CBOs in a formal and respectful way. At the same time, I must point out the length of time – in some PPS cases measured in years – that it took for true trust to be developed among the PPS partners and real work to begin. Now two other vastly different sectors are being added to the leadership mix which is bound to create a new power dynamic. Moving through this "forming, storming, norming" process must be quickly addressed for positive movement. Just as 1.0 offered a very successful MAX series to provide tools to overcome the more difficult challenges of shifting how and where care is provided, there is a critical need for a structured professional process in which a VDE is expected to participate, with the goal of building strong collaborative relationships and trust building. I know you have heard me say before that Progress Moves at the Speed of Trust. In 2.0, it is imperative that we focus on that dimension. DOH can support that work through setting expectations and making effective organizational technical assistance available at the earliest possible time.**

**That observation leads me to the last recommendation I have. In 1.0, communities were encouraged to build their PPSs from the ground up, a strategy based on the importance of regional differences and the personality of each PPS. I encourage the DOH to be much more proscriptive this time around. Of course there should be community reflection, but that should be the icing on the cake, not the basic ingredients with which to start. Data systems, contracting templates, up-front expectations of governance, funds flow and measurement are equally important to underpin the VDEs as are the promising practices. Much more attention needs to be paid to structure and process across the VDEs so comparison can be more easily made and old lessons needn't be repeated. Please be more directive.**

**Thank you for the opportunity to add my perspective to the fine work you are doing in crafting a 2.0 that builds on the best of 1.0 and the necessary additional components to make 2.0 even more successful.**

## doh.sm.1115Waivers

**From:** Meghann Hardesty [redacted]
**Sent:** Sunday, November 3, 2019 9:31 PM
**To:** doh.sm.1115Waivers
**Cc:** Paloma Hernandez
**Subject:** 1115 Public Forum Comment
**Attachments:** DSRIP draft proposed amendment CHIPA comments.pdf



Attached please find comments from Community Health IPA on the on draft 1115 waiver request.

Community Health IPA

55 S. Broadway, Tarrytown, New York 10591
www.communityhealthipa.com
914.425.0886

October 31, 2019

Donna Frescatore
State Medicaid Director, Deputy Commissioner
State of New York, Department of Health
Empire State Plaza, Corning Tower, Room 1466
Albany, NY 12237

RE: 1115 Research and Demonstration Waiver #11-W-00114/2 Delivery System Reform Incentive Payment (DSRIP) Amendment Request

Dear Ms. Frescatore,

Community Health IPA (CHIPA) is an independent provider association comprised exclusively of Federally Qualified Health Centers in New York State. CHIPA has 14 member health centers who are the primary care provider for over 300,000 Medicaid beneficiaries. We are submitting this letter to provide our comments on the proposed amendment to the DSRIP waiver. It is our strong belief that in order to further drive cost savings and quality improvements in the Medicaid program, the DSRIP program must invest directly in community-based primary care. We understand the challenged financial environment that we collectively face. But we believe this reality creates greater urgency to ensure that targeted, appropriate resources are directed toward lower-cost community care, which has been repeatedly demonstrated to reduce the likelihood of patients seeking avoidable, higher cost healthcare in the emergency departments and hospital.

**Our comments:**

1. **Second Generation DSRIP's "Value-Driving Entities" will be led by community-based providers of care.**

First and foremost, we expect New York State to entertain applications from new networks of primary care, behavioral health, and other non-hospital-based to be Value-Driving Entities in the second generation of DSRIP.

We understand the value of continuing to invest in what was built in the first iteration of DSRIP with the establishment of PPS. However, community-based care providers must be positioned as the priority, as the front-line providers in preventing avoidable utilization rather than as subordinate or "downstream" providers of some other controlling system. Community-based providers must be driving the fiscal, organizational, and clinical decisions that in turn drive value.

Community Health IPA

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When this comment letter refers to primary care, we are describing providers delivering "comprehensive primary health care services as well as supportive services (education, translation and transportation, etc.) that promote access to health care"[1]; further, we are describing primary care providers, like federally qualified health centers (FQHCs), that are independent of larger health systems that run emergency departments and acute care facilities. There are myriad reasons for New York State to make investments in community-based primary care a cornerstone of its overarching delivery system reform strategy:

- **National evidence shows that primary care access reduces overall healthcare costs**

Regular access to a source of care ensures that people receive preventative and other chronic health treatments that prevent more emergent, costly conditions from arising.[2]

- **Independence is an important contributing factor in successful value-based care models**

Research suggests that physician leadership plays a key role in the success of ACOs. In 2015, smaller ACOs and those led by physicians performed better than ACOs led by hospitals and other large medical organizations. In addition, estimated cost savings do not appear to be linked to financial integration with a hospital.[3]

- **NY has already made initial investments in community-based primary care that can be accelerated for greater value**

If New York State continues to believe (consistent with a wide body of evidence) that primary and community-based care are key to averting costlier inpatient utilization under such arrangements, it is incumbent upon the department to ensure that primary and community-based providers have the requisite tools to both expand capacity and participate in value-based care. Adequate investment is also essential as primary care continues to be underfunded and under-resourced generally; **One recent JAMA study determined that Medicare primary care spending accounted for less than 5% of overall spending,[4] with similar dynamics in Medicaid programs across the country.**

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[1] https://www.cdc.gov/nchhstp/preventionthroughhealthcare/healthdepartments/commhealthcenters.htm
[2] http://www.nachc.org/wp-content/uploads/2015/06/ED_FS_20151.pdf
[3] *https://catalyst.nejm.org/do-independent-physician-led-acos-have-a-future/*
[4] https://revcycleintelligence.com/news/primary-care-accounts-for-less-than-5-of-medicare-spending

Community Health IPA

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New York State has already laid important groundwork in fostering a host of new IPAs, not only through the DSRIP process, but also through the Behavioral Health Care Collaborative program and other technical assistance. There are currently several primary care-led IPAs in various stages of development across the state. There is Community Health IPA (a statewide IPA with 14 FQHC members) as well as CBHCare IPA, with a footprint in the Hudson Valley and a focus on integration of primary care and behavioral health. In addition, the Finger Lakes IPA, Upstate Community Health Collaborative IPA, and the Safety Net IPA are also established and working in various upstate regions.

2. **Align DSRIP Attribution and PCP Assignment**

For very good reasons, New York adopted an attribution methodology in DSRIP's first iteration that included a unique logic for particular populations in cases where more than one PPS existed in a single region. The benefit of this approach was that it took into consideration that an individual with unique health care needs or one who might be difficult to reach may seek and receive a preponderance of their health care services outside of primary care. It recognized that those special populations might view a behavioral health care clinician, a care manager, or a specialty care provider as their primary source of care rather than a PCP.

The challenge, however, in carrying out the DSRIP objectives using this attribution methodology was that an individual who was attributed to a particular PPS using the special populations hierarchy would also have a PCP assigned to them by their managed care organization. There was no guarantee that the MCO-assigned PCP was participating in any way with the PPS to which the person was attributed under DSRIP. The PPS and the MCO-assigned PCP could be working at cross-purposes or duplicating efforts. The PPS might also "assign" such individuals to a PCP within their network and require that PCP to close gaps in care or deliver other services to them, even though that PCP would have no prior history or relationship with the individual.

There must be an alignment between DSRIP attribution and PCP assignment at the plan level. If New York State chooses to continue its special populations hierarchy, then it should also require that each individual attributed to a PPS/VDE be assigned to a PCP that actually participates in that network. If a person's PCP does not participate in the network, then the individual should have the option of either changing their PCP to one that does participate or opting out of the PPS/VDE.

3. **Add an option for a VDE that does not include an MCO as a participant and allows the VDE to contract directly with the state. Build upon the successful Medicaid Primary Care ACO model established under the Massachusetts DSRIP.**

Community Health IPA

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In Massachusetts, the Primary Care ACOs were established under the state's DSRIP and are comprised of groups of PCPs who form an ACO and receive reimbursement directly from state Medicaid. Those payments are measured against an annual cost target, and the ACOs and the state share in the savings or losses that result. These ACOs are also responsible for meeting a set of quality measures.[5]

While this approach would move New York's DSRIP in a somewhat new direction, it keeps primary care, which makes so many of the decisions and driving the changes that reduce unnecessary ED visits and hospital admissions, as the focal point and does not send dollars or control to some other intermediary entity. Additionally, PCPs (and FQHCs in particular) will be well-incented to drive savings generated back into further enhancing the primary care delivery system, more thoroughly integrating behavioral health and primary care, expanding prevention programs, and delivering social determinants of health interventions. That *is* the work of primary care and the mission of every FQHC.

4. **Expand the definition of a Community Based Organization (CBO) that may deliver a recognized Social Determinants of Health intervention to include Federally Qualified Health Centers.**

Page 10 of the amendment describes the state's proposal for creating regional SDH Networks. In New York State's Value-Based Payment Roadmap, the definition of a "CBO" that can deliver an intervention recognized by the department as impacting social determinants of health is very narrowly defined as being a "Tier 1" CBO, an entity that did not bill Medicaid. In the second generation of DSRIP, as SDH Networks are contemplated, we ask that the state expand the definition of a CBO to include Federally Qualified Health Centers.

While many health care providers often view social determinants as factors outside of their control and beyond their purview, Community Health Centers (including certain health centers that were established specifically to serve migrant communities, homeless populations, and residents of public housing), have always taken a broad view of healthcare and a whole-person approach to wellness. Impacting social determinants of health is central to the mission of every FQHC. FQHCs are, *by definition*, community-based organizations that exist to serve low-income and underserved communities. FQHCs are, *by definition*, community-driven with at least 50% of their governing boards comprised of actual health center patients. FQHCs are, *by definition*, augmenting their clinical services with non-clinical services designed to address social determinants of health. Every member of CHIPA is already providing some form of SDH intervention, including efforts to address housing insecurity, food insecurity and nutrition, transportation assistance, neighborhood safety and more.

[5] https://bluecrossmafoundation.org/sites/default/files/download/publication/ACO_Primer_July2018_Final.pdf

Community Health IPA

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Where another entity exists in the community that delivers a particular service that addresses social determinants, FQHCs have been and will continue to be enthusiastic and supportive partners. However, in instances in which FQHCs are already delivering SDH interventions and doing so in a manner that truly integrates health care and SDH approaches, such interventions should be recognized by the state as valid.

5. **Change the Methodology for Existing Primary Care participants.**

For those independent primary care providers that choose to remain in their existing PPS and join them in becoming participants in their Value-Driving Entities, we ask that the state support a different funds flow methodology that would:

- ✓ Advance an "MLR" concept for PPS budgets: limit expenses devoted to administrative costs and require administrative costs to diminish over time, readying systems for value-based contracting.
- ✓ Require Value-Driving Entities to devote a majority of funds (e.g. over 50%) to provider transformation.
- ✓ Make fund allocations more consistent with attribution for valuation, while still enabling pathway for non-attribution partners (e.g. CBOs) to derive value
- ✓ Place limit on amount of funds to same entity to both offset revenue loss and promote transformation
- ✓ Articulate statewide requirements on how dollars to offset revenue loss can be used (similar to the Interim Access Assurance Fund) and ensure non-hospital parties can access funds

6. **Support Participation of Independent Primary Care Providers in VBP Arrangements**

Outside of DSRIP, we ask that New York State take several steps that will enable independent primary care providers to effectively participate, compete, and perform under VBP arrangements. Specifically:

- ✓ Make available startup funds for primary-care led IPAs, similar to the BHCC program for specialty behavioral health provider-led IPAs
- ✓ Allow FQHCs to count as community-based organizations in VBP contracts that require a Social Determinants of Health intervention, with a written description of how an FQHC fulfills that requirement
- ✓ Enforce greater managed care transparency and standardization in data sharing
- ✓ Separate FQHC data from other primary care to better understand impacts

Community Health IPA

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Thank you for the consideration of these comments. If you have any questions, please feel free to contact CHIPA's executive director, Meghann Hardesty at [redacted]

**doh.sm.1115Waivers**

**From:** Andrea Fettinger [redacted]
**Sent:** Monday, November 4, 2019 8:07 AM
**To:** doh.sm.1115Waivers
**Subject:** 1115 waiver response from Fulton County Office for Aging
**Attachments:** 2019 dsrip response for 1115 waiver renewal.pdf



Attached please find response to the 1115 waiver from the Fulton Co. Office for Aging.

Andrea Fettinger, BA, MEd
Director
Fulton Co. Office for Aging/Youth
19 N. William St.
Johnstown, NY 12095
[redacted]
http://www.fcofa.org/
[redacted]

The Fulton County OFFICE FOR AGING
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**Youth Bureau**

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Fulton County NY POSITIVE

The Fulton County OFFICE FOR AGING
*Vital information for vital generations.*

***19 N. William St., Johnstown, NY 12095 • Andrea Fettinger, BA, MEd, Director***

November 1, 2019

Donna Frescatore, Deputy Commissioner and Medicaid Director
Office of Health Insurance Programs
New York State Department of Health
One Commerce Plaza Albany, New York 12210

**Via E-Mail**
**Re: DSRIP Phase 2 and MRT Waiver**

On behalf of Fulton County Office for Aging, I am writing to express my recommendations on the 1115 Waiver/DSRIP renewal proposed by New York State Department of Health. The Fulton County Office for Aging is one of 59 Area Agencies on Aging providing services across a mostly rural, economical challenged region. We contract with 12 local contractors to provide services and supports designed to target the social determinants of health. The services we provide directly impact inappropriate emergency department visits, and reduce avoidable readmissions. The Fulton County NYConnects program, implemented in 2006, serves as the no wrong door hub for any and all services available in the region, and it is the go-to resource for individuals in need of assistance. The identified goals in the proposed 1115 Waiver renewal truly reflect what the Aging network provides, and it is my belief that the renewal must include mandated contracting between regional PPS's and their local Area Agency on Aging for social determinants of health initiatives.

I would like to give you an example of how the Fulton Co. Office for Aging and its services fits into the Social Determinants. A case presented to the AAA and I believe it highlights the vital services provided at our office. We received a referral regarding a woman in her early 60's with complex medical needs. She and her family had just moved into the county and had initially requested assistance with housekeeping, because she recently underwent a below the knee amputation status post aneurysm. The individual was visited by a caseworker who completed a thorough assessment and it was determined that housekeeping services could be provided. Over a consistent 15 year period the following services were provided via the AAA and other community partners: Non-medical home care including housekeeping, marketing, and bathing; caregiver supports when the husband was diagnosed with cancer; caregiver supports when the daughter who was diagnosed with MS and as bi-polar; caregiver supports when the son moved out of state; bereavement support when the husband passed away; increased non-medical home care when the wife/mother found herself living alone; housing and moving assistance when the wife/mother needed to move into affordable housing; transportation to and from medical appointments and to and from visiting her daughter who had been placed in a local nursing home; ongoing case management through many HEAP applications and level of care assessments. We supported this woman and family through multiple familial issues for over 15 years and prevented premature nursing home placement and dependence on Medicaid for that same time frame.

It is estimated that the average annual cost of services for this individual was $21,000 as opposed to what it could have cost, $108,000, if she was placed in a nursing home

This is just one of many cases that truly displays the value of AAA service provision in every county across the state. I strongly encourage NYS DOH to include and acknowledge the value of the Aging Network and to

highlight the existing strengths of Aging Network community based services, instead of recreating case management services and duplication of services. I would like to see mandates for each PPS to engage and contract with their local Offices for Aging for vital services keeping vital generations at home and in community based settings meeting the tenets of the Social Determinants of Health.

Respectfully Submitted,

Andrea Fettinger, BA, MEd
Director
Fulton Co. Office for Aging & Youth

AF/

## doh.sm.1115Waivers

**From:** Kristin Wunder [redacted]
**Sent:** Monday, November 4, 2019 8:28 AM
**To:** doh.sm.1115Waivers
**Cc:** [redacted] Rob Bannon; Lyndel Urbano
**Subject:** 1115 Public Forum Comment
**Attachments:** ACIN DSRIP Waiver Amendment_Complete Letter Final.pdf; ACIN Downstate Public Comment Final.pdf



Hello:

On behalf of ACIN, I am pleased to submit our comments on the DSRIP Waiver Amendment Request Proposal released on September 17th. ACIN is made up of the Amida Care SNP, seven FQHCs, Mt. Sinai's Designated AIDS Centers, and the broad network of CBOs that constitute EngageWell IPA. We have applied to become a state-wide Innovator ACO focused on improving health outcomes for people living with HIV and preventing new HIV infections.

Attached, you will find a comprehensive letter detailing our comments along with a summary of these comments that was provided at the downstate public comment forum on October 25th. Please do not hesitate to reach out directly to Doug Wirth, President & CEO of ACIN, if you have any questions or would like to discuss our comments further. We look forward to working with the State to advance the next phase of DSRIP.

Regards,

Kristin Wunder, MPH, Chief Operating Officer
**Bannon Consulting Services, LLC**
Developing effective community-based programs

**NEW ADDRESS:**
39 W 14th St #504, NY, NY 10011
[redacted]

**ACIN**
**14 Penn Plaza, 2nd Floor**
**New York, NY 10122**

September 18, 2019

Greg Allen
Director, Division of Program Development and Management
New York State Department of Health
Empire State Plaza, Corning Tower
Albany, NY 12237

Re: Recommendations to *End the HIV Epidemic* and strengthen New York's community-based primary care infrastructure through DSRIP 2.0

Dear Greg:

I am writing on behalf of the Amida Care Innovator Network (ACIN), which as you know, has applied to become a state-wide Innovator ACO (IACO) focused on improving health outcomes for people living with HIV/AIDS (PLWH) and preventing new HIV infections. These actions will contribute to significant improvements in health outcomes and Medicaid cost savings, including averted Medicaid program costs of lifetime HIV treatment for persons who remain HIV negative.

The organizations that currently make up ACIN — Amida Care SNP, seven Federally Qualified Health Centers (FQHCs), Mt. Sinai's Designated AIDS Centers, and the broad network of community-based organizations (CBOs) that constitute EngageWell IPA — have been working with you since DSRIP was first approved. We are very proud of the achievements the State has made through DSRIP to date and are excited about the prospect of continued DSRIP funding (DSRIP 2.0) becoming available.

As such, we are writing with some initial recommendations for DSRIP 2.0 that will support efforts to *End the HIV Epidemic* (EtE) and ensure the sustainability and growth of our community-based primary care infrastructure. Many of these recommendations are aligned with those that the Community Health Care Association of New York State (CHCANYS) submitted to you in July. We echo their sentiment that *"for a real transformation of the health care delivery system to happen and to sustain the gains thus far achieved through DSRIP, there must be a significant investment in primary care. Only through this investment can the notion of a true value-based system be realized."*

Our recommendations are focused on leveling the playing field for community-based providers, especially those focused on EtE, to participate in value based payment (VBP) arrangements. We recommend that DSRIP 2.0:

- Create primary care-led contracting entities;
- Allow non-PPS led entities to become Value Driving Entities (VDEs);
- Improve access to data;
- Redesign existing care coordination programs;
- Align cost classification of consumer HIV VLS incentives as "medical costs";

- Build comprehensive Social Determinant of Health Networks; and,
- Invest in primary care and consumer workforce development.

**Create primary care-led contracting entities**

Based on a November 2018 NYSDOH survey, a total of four PPSs have or are planning to develop ACOs and 12 have or are planning to develop Independent Practice Associations (IPAs) in order to contract on behalf of their PPSs. They are putting in place plans to integrate, or align, population health management capabilities under these models. This is a critical step, since PPSs are for the most part not legal entities, and thus cannot enter into VBP contracts. Once VDEs are selected under DSRIP 2.0 and begin to develop IPAs and/or ACOs, they should be encouraged to develop governance structures that are led by community-based primary care providers. Utilizing DSRIP 2.0 funding to support VBP contracting among community-based primary care providers would be consistent with how the Behavioral Health Care Collaborative (BHCC) Program supported the formation of behavioral health IPAs.

ACIN is a model for developing future primary care-led contracting entities. Its governance structure is unique in that FQHCs and a CBO IPA sponsor (which operates in a similar manner as the proposed Social Determinant of Health Networks) will hold, in the aggregate, at least 75% of membership interests in ACIN, consistent with the regulatory requirements for NYS-certified ACOs. Amida Care, which is also provider-led, will hold up to 25% of the membership interests. These primary care providers have worked with Amida Care (some are the original sponsors of the SNP) to address the needs of vulnerable New Yorkers with HIV/AIDS by maximizing the potential of existing Medicaid programs that are available to address social determinants of health (such as Health Home and Adult Day Health Care programs) and identifying other resources to support innovation beyond the Medicaid program such as VLS initiatives and employment programs. The resulting model of care improves the health and quality of life of PLWH, decreases the costs associated with poor health outcomes, promotes HIV prevention, and, ultimately, achieves EtE goals. We have achieved a 70% decrease in hospitalizations and 50% reduction in ER/ED visits since 2008 for Amida Care members, resulting in over $150 million in Medicaid savings.

**Allow non-PPS led entities to submit VDE applications**

The DSRIP 2.0 concept paper provides for greater flexibility in the operational structure of the next DSRIP-funded entity but it is unclear if the entity must include and/or be led by an existing PPS. We believe that applications for VDEs should be considered regardless of whether they include PPSs, as long as the proposed team includes providers, CBOs, and MCOs, and establishes a meaningful connection with a Qualifying Entity (QE).

PPSs in DSRIP 1.0 were formed solely on a regional basis and there was great variability in the needs of those attributed to the PPS. This PPS structure is not the vehicle to best address the needs of sub-populations, including HIV/AIDS and Health and Recovery Plan (HARP) enrollees. Through DSRIP 2.0, NYSDOH should consider approving VDEs that focus on serving a sub-population, not based on geography, that can tailor promising DSRIP 1.0 best practices to the needs of their population.

All of the existing NYC-designated Innovators to date are PPSs (SOMOS, Montefiore, and NYU-Langone) and are expected to apply to be designated as VDEs. ACIN recently (June 2019) submitted an Innovator application. If approved, ACIN intends to apply to become a state-wide VDE for the HIV/AIDS subpopulation under DSRIP 2.0. They have all leveraged DSRIP 1.0 funding to support their development and are on course to receive additional DSRIP funds should the waiver proposal be approved. Other NYS-designated Innovators should have the opportunity to compete for these DSRIP funds.

Amida Care did originally attempt to become a PPS and submitted a DSRIP Planning Grant application, which included over 140 safety net providers that were interested in participating in its PPS. However, the state decided that MCOs were not eligible to apply and instead awarded Amida Care planning grant funds to develop recommendations for meaningful transformation of the chronic illness sector. Amida Care then advocated for PPSs to include HIV projects in their DSRIP project plans and supported the development of, and ongoing provision of technical assistance to, the NYC DSRIP HIV Coalition to support the implementation of HIV projects.

A single, statewide, HIV population health strategy that leverages a proven model of care is needed to: 1) increase viral load suppression (VLS) rates among PLWH that access healthcare through NYS Medicaid who are not yet suppressed or are intermittently suppressed; 2) advance PrEP access to prevent HIV transmission within specific populations with documented higher HIV risk; and, 3) achieve Medicaid cost savings within a sector where current costs exceed $2 billion, while also preventing new lifetime costs of HIV treatment that near a half a million dollars per Medicaid eligible person. With demonstrated results on a larger scale, this Innovator ACO/VDE model could be expanded to address other populations with similar behavioral health diagnoses and needs.

**Improve access to data**

While QEs have made great headway since the initiation of DSRIP, providers are still not able to obtain the data that they need to take on risk, and when they do get it, are not able to use in meaningful ways. ACIN has projected a 1-2% annual increase in VLS among attributed lives in its business plan. In order to be successful, we must be able to identify and support individuals who are unsuppressed or unstably suppressed. We believe that we can leverage QE data that is actionable to inform care delivery and improve patient level outcomes to achieve intended clinical and cost goals. However, this will involve considerable effort and expense. We recommend that DSRIP 2.0 funds be used to support these efforts among a range of provider types, including medical, behavioral health, and social services providers.

An important component of making data available is tackling the challenges with the existing consent process. A critical step forward in this process was the approval of the Community Consent, which was developed based on current State policies and allows access to a consented patient's data across all of the QE's participating providers.

Two key challenges to obtaining Community Consent are: 1) The process requires the patient to answer a series of questions and requires that they be provided with a complete list of QE

participants, which entails a more extensive explanation. In the case of a provider using Healthix, in order to obtain a patient's consent through the Community Consent process, they would need to provide a list of all 1,200+ participating agencies. Once signed, the Community Consent allows access to all historical patient data for all providers on the participant roster on that date. The consent does not include any agencies added to the QE's participating providers list after the date of signature. 2) Many providers do not understand the value of the Community Consent. On its face, the Community Consent only extends value to other agencies, not necessarily the individual agency where consent is being obtained. As that agency could just seek regular consent, there is no incentive to seek Community Consent. However, Community Consent is critical to building an integrated network of care—access to a patient's entire utilization record, regardless of access point, is necessary for minimizing duplicative services and identifying intervention points to reduce avoidable hospital visits and admissions.

To increase Community Consent rates, additional education must be provided to agency staff. We understand that NYSDOH and Healthix have initiated conversations to change the consent policy to allow the Community Consent to apply to any new participating providers added after the consenting date to avoid the need to reconsent, and we support this policy change. In addition, through DSRIP 2.0, the State can use funds to create a centralized mechanism to educate providers about the Community Consent and potentially provide bonus payments to providers, including Health Home providers, who get Community Consent for their clients.

Finally, we encourage the State to make real-time prescription fill data available to providers. As an IACO, ACIN will assume full risk for its attributed lives, and with our business plan predicated on a 1-2% increase in VLS annually, it is critical that we know if and when patients fill their prescriptions. While Amida Care will provide real-time data on filled prescriptions for its members, ACIN will not have timely access to this data from other plans. We encourage the State to make this data available through the QEs to ensure that entities responsible for achieving meaningful transformation of the healthcare system have all of the data and tools at their disposal to effect change.

It is important to highlight a noteworthy exception to the data gaps experienced by FQHCs contracted in VBP arrangements. Amida Care and FQHCs have co-developed a Total Cost of Care Report, which has been shared with NYSDOH and provides clinical and population health staff a detailed and comprehensive report on utilization (non-substance use disorder) and costs at the patient and PCP level. These reports are shared on a monthly basis and include details on all inpatient admissions and filled prescriptions for every patient attributed to the VBP contract with Amida Care.

**Redesign existing care coordination programs**

Care coordination is an integral part of many of the high-quality initiatives developed in the first round of DSRIP, including a number of HIV VLS programs. VLS programs, some of which provide quarterly financial rewards for participants who maintain an undetectable viral load, employ care coordination services to ensure access to medical, behavioral health, and other social services. Most programs have incorporated Health Home Care Coordination services into their service mix; however, given the complexity of managing HIV along with other co-

occurring conditions, participants often need additional, more intensive care coordination support, beyond what is available through the program. While the Health Home Plus designation provides a higher rate to support more intensive services for a subset of eligible participants (reduces caseloads to a maximum of 15), it exposes providers to financial risk as they are only paid the higher rate if they provide four core services each month, two of which must be face-to-face. If these requirements are not met, they receive less than half of the Health Home Plus rate. In addition, since reimbursement for outreach was cut from the program, providers have insufficient resources to find and engage people in services.

We recommend that DSRIP 2.0 funds be used to pilot new models of care coordination and to develop new approaches for engaging people into care coordination services. One opportunity is to develop a funding mechanism for NYSDOH AIDS Institute-certified peer workers to be incorporated into Health Home teams to conduct outreach among difficult to engage populations. Another strategy to increase enrollment in care coordination services is to work with MCOs to pilot a new procedure where they prospectively enroll their eligible members in Health Home services, with the understanding that an enrollee can later choose to "opt-out." This sound public health policy would minimize outreach expenses while maximizing the dollars on care coordination services and support.

**Align cost classification of consumer HIV VLS incentives as "medical costs"**
Patient/Consumer and provider quality incentives together support a comprehensive treatment program that contributes to patient treatment adherence and maintenance in care, both key to improved health outcomes. SNP or MCO member VLS incentive dollars, just as provider quality incentive dollars, should be reflected in a plan's Medical Costs (MLR) instead of Administrative Costs (ALR). Common classification of both patient/consumer and provider incentive components would ensure alignment of patient/consumer and provider efforts in the development of and adherence to realistic, achievable, and effective treatment programs.

**Build Comprehensive Social Determinant of Health Networks**
As the guidance for Social Determinant of Health Networks (SDHNs) takes shape, we believe there should be clarification that the list of SDH included in the concept paper (housing, nutrition, transportation, interpersonal safety, and toxic stress) are examples, but that the SDHN should address any SDH that is affecting their VDE population. In addition, there should be clarification that CBOs may include FQHCs, and that other entities that are providing services to address SDH, such as Designated AIDS Centers, could also be included in the SDHN.

**Invest in primary care and consumer workforce development**
We echo CHCANYS' recommendations to bolster the primary care workforce. As they have stated, community health centers experience significant workforce challenges, especially when competing with hospitals and larger health systems. Moreover, recent federal changes may negatively impact the ability of FQHCs in New York to receive funding for National Health Service Corps (NHSC) placements. Through DSRIP 2.0, the State can direct workforce funding to primary care training and practice sites by: 1) Developing a pipeline program where funds would be used to support providers' mentorship time; 2) Designating no less than 50% of Doctors Across New York (DANY) funds to community-based providers; and 3) Increasing

funding for the Primary Care Service Corps (PCSC) program and making it an annual grant opportunity.

Beyond these recommendations, we encourage you to allocate resources to increase the competency of the primary care workforce in behavioral health issues. Patients with serious mental illness and substance use disorder are often high utilizers of emergency departments for chronic disease and medical reasons. The relationship between mental health and chronic disease is clear, and appears to be bi-directional, with chronic conditions of one type increasing vulnerability and complicating treatment for other conditions. DSRIP 2.0 funds can be used to provide training and support to medical providers on effectively addressing behavioral health issues, including supporting an expansion of the number of providers that are approved to prescribe buprenorphine. Potentially, DSRIP funds could be used for incentives to FQHCs and/or through additional dedicated funding through MCOs (similar to what the state did with hospital monies) to expand access to MAT services.

Finally, we concur with NYSDOH's position to support a non-traditional, non-clinical workforce as detailed in the draft DSRIP Waiver Amendment Request. We specifically recommend expanding programs that provide peer delivered services, which if implemented appropriately, can lead to tremendous cost savings associated with people moving off of public assistance as well as their impact on rates of engagement and retention in care among peers' client caseloads.

DSRIP 1.0 supported a number of peer employment models which have surpassed the traditional boundaries of peer-based programs, drawing on peers lived experiences and incorporating them as part of the medical care team to provide short-term or long-term engagement with clients. Peer-delivered services have increased Health Home enrollment, supported outpatient and preventative care access and retention in care, and addressed social determinants of health. However, few of these programs have achieved the end goal to create a uniform pathway for individuals to utilize their lived experience and enter the workforce as full-time employees.

Through DSRIP 2.0, we must address the major barrier to entering the workforce as full-time employees, which is the impact of employment on public assistance. DSRIP 2.0 should support demonstration projects that allow PLWH on public assistance, like those on HASA, to be given more time to work, without being penalized for earned income. The grace period for HASA is currently 12 months and is intended to ensure that participants will not lose access to housing, medical, and other necessary public assistance that help them to remain employed. We propose extending this to five years. During the five-year grace period, benefits could be reduced based upon a sliding scale commiserate with increases in income.

As with all DSRIP projects, finding another source of funding to sustain peer delivered services is of critical importance. VDEs should work with providers to develop a mechanism to bill for these services through Medicaid MLR and ensure that adequate fee-for-service reimbursement rates are developed and cover HIV, substance use disorder, and mental health conditions.

We believe that making a significant investment in the community-based primary care infrastructure will go a long way to achieving DSRIP's goals. We are excited to work with you

and participate in the evolution of DSRIP. Please let us know if you would like to meet to discuss any of our recommendations in more detail.

Sincerely,

Doug Wirth
President/CEO
Amida Care Innovator Network

CC:
Donna Frescatore, State Medicaid Director and Executive Director, NY State of Health
Johanne Morne, Director, New York State Department of Health, AIDS Institute
Marjorie Hill, Co-Chair, ETE Subcommittee of the NYS AIDS Advisory Council
Charles King, Co-Chair, ETE Subcommittee of the NYS AIDS Advisory Council
Harrison Moss, Coordinator - Acute & Chronic HIV Care, New York State Department of Health, AIDS Institute
NYS Senate Health Committee Chair Gustavo Rivera
NYS Assembly Health Committee Chair Richard Gottfried
Acacia Network, Inc.
Apicha Community Health Center, Inc.
Community Health Project, Inc. d/b/a Callen Lorde Community Health Center
Community Healthcare Network, Inc.
EngageWell IPA, LLC
Housing Works Health Services, Inc.
Hudson River HealthCare, Inc.
Mt. Sinai Designated AIDS Center
Upper Room AIDS Ministry, Inc. (Harlem United)

Any other state legislators and key city council members… or others with whom we might want to share this idea.

Attachment:
CHCANYS July 23, 2019 letter to CMS

# ACIN
# 14 Penn Plaza, 2nd Floor
# New York, NY 10122

**DSRIP Waiver Amendment**
**Downstate Public Comment, October 25, 2019**
**Doug Wirth, President and CEO of the Amida Care Innovator Network (ACIN)**

**Introduction:**

- Good afternoon! I am Doug Wirth, President and CEO of the Amida Care Innovator Network (ACIN). Thank you for the opportunity to testify today.
- We want to ensure that DSRIP 2.0 funds are made available to support our efforts to *End the HIV Epidemic* and strengthen New York's community-based primary care infrastructure.
- ACIN is made up of the Amida Care SNP, seven FQHCs, Mt. Sinai's Designated AIDS Centers, and the broad network of CBOs that constitute EngageWell IPA. We have applied to become a state-wide Innovator ACO focused on improving health outcomes for people living with HIV and preventing new HIV infections.
- ACIN will contribute to significant improvements in health outcomes and Medicaid cost savings, including averted Medicaid program costs of lifetime HIV treatment for persons who remain HIV negative.
- Under the existing SNP we have achieved a 70% decrease in hospitalizations and 50% reduction in ER/ED visits since 2008 for Amida Care members, resulting in over $150 million in Medicaid savings.
- Our recommendations today are focused on leveling the playing field for community-based providers, especially those focused on EtE, to participate in value based payment (VBP) arrangements.

**First, we recommend that the State allow non-PPS led entities to submit VDE applications.**

- PPSs in DSRIP 1.0 were formed solely on a regional basis and there was great variability in the needs of those attributed to the PPS. This PPS structure is not the vehicle to best address the needs of sub-populations, including HIV/AIDS and HARP enrollees.
- Through DSRIP 2.0, the State should consider approving VDEs that focus on serving a sub-population, not based on geography, that can tailor promising DSRIP 1.0 best practices to the needs of their population.
- A single, statewide, HIV population health strategy that leverages a proven model of care is needed to:
    1. Increase viral load suppression (VLS) rates among PLWH that access healthcare through NYS Medicaid who are not yet suppressed or are intermittently suppressed;
    2. Advance PrEP access to prevent HIV transmission within specific populations with documented higher HIV risk; and,
    3. Achieve Medicaid cost savings within a sector where current costs exceed $2 billion, while also preventing new lifetime costs of HIV treatment that near a half a million dollars per Medicaid eligible person.
    - With demonstrated results on a larger scale, this Innovator ACO/VDE model could be expanded to address other populations with similar behavioral health diagnoses and needs.

**ACIN**
**14 Penn Plaza, 2nd Floor**
**New York, NY 10122**

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

- Based on a recent survey, a total of 4 PPSs have or are planning to develop ACOs and 12 have or are planning to develop IPAs in order to contract on behalf of their PPSs.
- Once VDEs are selected under DSRIP 2.0 and begin to develop IPAs and/or ACOs, they should be encouraged to develop governance structures that are led by community-based primary care providers.
- Utilizing DSRIP 2.0 funding to support VBP contracting among community-based primary care providers would be consistent with how the Behavioral Health Care Collaborative (BHCC) Program supported the formation of behavioral health IPAs.

**We recommend that DSRIP 2.0 funding be used to improve access to actionable data**

- While QEs have made great headway since the initiation of DSRIP, providers are still not able to obtain the data that they need to take on risk, and when they do get it, are not able to use in meaningful ways.
- ACIN has projected a 1-2% annual increase in VLS among attributed lives in its business plan. In order to be successful, we must be able to identify and support individuals who are unsuppressed or unstably suppressed.
- We believe that DSRIP 2.0 funds should be invested to improve access to QE data that is actionable to inform care delivery and improve patient level outcomes to achieve intended clinical and cost goals.

**Through DSRIP 2.0, we must improve the Community Consent process.**

- An important component of making data available is tackling the challenges with the existing consent process. A critical step forward in this process was the approval of the Community Consent, which allows access to a consented patient's data across all of the QE's participating providers.
- Community Consent is critical to building an integrated network of care, and necessary for minimizing duplicative services and identifying intervention points to reduce avoidable hospital visits and admissions.
- Through DSRIP 2.0, the State should use funds to create a centralized mechanism to educate providers about the Community Consent and potentially provide bonus payments to providers, including Health Home providers, who get Community Consent for their clients.

**We must redesign existing care coordination programs, which are an integral part of many of the high-quality initiatives developed in the first round of DSRIP, including a number of HIV VLS programs.**

- VLS programs, some of which provide quarterly financial rewards for participants who maintain an undetectable viral load, employ care coordination services to ensure access to medical, behavioral health, and other social services.
- Most programs have incorporated Health Home Care Coordination services into their service mix; however, given the complexity of managing HIV along with other co-occurring

conditions, participants often need additional, more intensive care coordination support, beyond what is available through the Health Home program.

- We recommend that DSRIP 2.0 funds be used to pilot new models of care coordination and to develop new approaches for engaging people into care coordination services.
- The State should also consider implementing a strategy to increase enrollment in care coordination services and work with MCOs to pilot a new procedure where they prospectively enroll their eligible members in Health Home services, with the understanding that an enrollee can later choose to "opt-out." This sound public health policy would minimize outreach expenses while maximizing the dollars on care coordination services and support.

**Align cost classification of consumer HIV VLS incentives as "medical costs"**

- Patient/Consumer and provider quality incentives together support a comprehensive treatment program that contributes to patient treatment adherence and maintenance in care, both key to improved health outcomes.
- SNP or MCO member VLS incentive dollars, just as provider quality incentive dollars, should be reflected in a plan's Medical Costs (MLR) instead of Administrative Costs.
- Common classification of both patient/consumer and provider incentive components would ensure alignment of patient/consumer and provider efforts in the development of and adherence to realistic, achievable, and effective treatment programs.

**Invest in primary care and consumer workforce development**

- We echo CHCANYS' recommendations to bolster the primary care workforce. Through DSRIP 2.0, the State should direct workforce funding to primary care training and practice sites by:
  1) Developing a pipeline program where funds would be used to support providers' mentorship time;
  2) Designating no less than 50% of Doctors Across New York (DANY) funds to community-based providers; and
  3) Increasing funding for the Primary Care Service Corps (PCSC) program and making it an annual grant opportunity.
- DSRIP 2.0 funds should also be used to provide training and support to medical providers on effectively addressing behavioral health issues, including supporting an expansion of the number of providers that are approved to prescribe buprenorphine. Potentially, DSRIP funds could be used for incentives to FQHCs and/or through additional dedicated funding through MCOs (similar to what the state did with hospital monies) to expand access to MAT services.
- We concur with NYSDOH's position to support a non-traditional, non-clinical workforce as detailed in the draft DSRIP Waiver Amendment Request. We specifically recommend expanding programs that provide peer delivered services, which if implemented appropriately, can lead to tremendous cost savings associated with people moving off of public assistance as well as their impact on rates of engagement and retention in care among peers' client caseloads.
- Through DSRIP 2.0, we must address the major barrier to entering the workforce as full-time employees, which is the impact of employment on public assistance.

**ACIN**
**14 Penn Plaza, 2nd Floor**
**New York, NY 10122**

**Build Comprehensive Social Determinant of Health Networks**

- As the guidance for Social Determinant of Health Networks (SDHNs) takes shape, we believe there should be clarification that the list of SDH included in the concept paper are examples, but that the SDHN should address any SDH that is affecting their VDE population.
- In addition, the State should clarify the types of CBOs included in SDHNs. We strongly encourage the State to include Tiers 1,2, and 3 CBOs, as well as other entities that are providing services to address SDH, such as Designated AIDS Centers and Independent Practice Associations (IPA) led by community-based providers.

**Make real-time prescription fill data available to support VBP efforts**

- We encourage the State to make real-time prescription fill data available to providers.
- As an IACO, ACIN will assume full risk for its attributed lives, and with our business plan predicated on a 1-2% increase in VLS annually, it is critical that we know if and when patients fill their prescriptions.
- While Amida Care will provide real-time data on filled prescriptions for its members, ACIN will not have timely access to this data from other plans.
- We encourage the State to make this data available through the QEs to ensure that entities responsible for achieving meaningful transformation of the healthcare system have all of the data and tools at their disposal to effect change.
- It is important to highlight a noteworthy exception to the data gaps experienced by FQHCs contracted in VBP arrangements.
- Amida Care and FQHCs have co-developed a Total Cost of Care Report, which has been shared with NYSDOH and provides clinical and population health staff a detailed and comprehensive report on utilization (non-substance use disorder) and costs at the patient and PCP level.
- These reports are shared on a monthly basis and include details on all inpatient admissions and filled prescriptions for every patient attributed to the VBP contract with Amida Care.

**Closing Remarks:**

- We believe that making a significant investment in the community-based primary care infrastructure will go a long way to achieving DSRIP's goals.
- We are excited to work with you and participate in the evolution of DSRIP.

**doh.sm.1115Waivers**

**From:** John Craik [redacted]
**Sent:** Monday, November 4, 2019 8:47 AM
**To:** doh.sm.1115Waivers
**Subject:** 1115 Waiver Public Comment



Dear Colleagues:

Thank you for the opportunity to provide comment to the Department of Health regarding the 1115 Waiver: Delivery System Report Incentive Payment (DSRIP) Amendment Request, dated September 17, 2019.

Population Health Collaborative (PHC) is the regional Population Health Improvement Program (PHIP) for the eight-county region of Western New York. We have been actively engaged in NYS DSRIP and a partner of our two Performing Provider Systems, Community Partners of WNY (CPWNY)/Sisters of Charity Hospital Performing Provider System (PPS) and Millennium Collaborative Care, PPS since the early days of DSRIP. Our organization, then under the name of the P2 Collaborative, conducted much of the community outreach and research that informed each of the PPS plans.

The PPSs have been active and effective institutions and they have made significant progress in the integration of mental health into healthcare services. Each PPS has been an active and visible supporter in much of our work that involves creating and aligning multi-sector stakeholders. Some other priorities and projects that the PPSs lead are just gaining traction, and it would be a lost opportunity if they did not receive funding as described in the DSRIP 2.0 draft waiver application.

We recognize that the PPSs may continue to operate as Value-Driving Entities (VDE) under the current draft of the DSRIP 2.0 draft amendment request. We believe, however, that the Social Determinant of Health Networks should be entities separate from the VDEs that can operate on a more neutral, community-based level. This assertion is particularly compelling where, as in Western New York, there is more than one PPS in the region.

In sum, CPWNY and MCC have been an effective change agent in Western New York. The work has just begun! We anticipate a favorable outcome of the 1115 Waiver DSRIP Amendment Request. We strongly endorse the work of CPWNY PPS. They are critical to the success of future DSRIP initiatives.

Again, we are grateful to have this opportunity to submit these comments.

Very truly yours,
John D. Craik

**John D. Craik, JD**
Executive Director at Population Health Collaborative

**A** 371 Delaware Avenue, Buffalo, NY 14202
[redacted] **W** www.pophealthwny.org

**doh.sm.1115Waivers**

**From:** Martha Farewell [redacted]
**Sent:** Monday, November 4, 2019 8:51 AM
**To:** doh.sm.1115Waivers
**Subject:** 1115 Public Forum Comment
**Attachments:** Aspire DSRIP 2.0 comment letter.doc



Please see attached. Thank you for your time and consideration.

*Martha J Farewell, MA,CCC-L/SLP*
Vice President of Clinical Services
Aspire of WNY Health Care Center
7 Community Drive
Cheektowaga, NY 14225
[redacted]

*Aspire of WNY's Health Center is accepting new patients!*

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Health Care Center
7 Community Drive
Cheektowaga, New York 14225
Phone: (716) 505-5630 Fax: (716) 892-1936



November 4, 2019

**Comments on NYDOH DSRIP 2.0 Amendment Request**
**October 2019**

**Aspire of WNY** is grateful for the opportunity to provide input to the laudable efforts to continue transformation of New York's Medicaid program to improve efficiency, accessibility and sustainability as outlined in the concept paper published no September 17th. **Aspire of WNY** belongs to the Safety Net Association of Primary Care Affiliated Providers - **SNAPCAP** - an organization that includes 12 primary care safety net providers – FQHCs and Article 28 licensed clinics - serving the 8 counties of Western New York. In 2019, together our member organizations served 181,000 patients. This is approximately 13% of the Western New York population. Our 12 organizations provided nearly 700,000 primary care, behavioral health and dental visits. The members our organizations serve mostly people receiving Medicaid and represent expertise in a range of special populations–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 behavioral health disorders, people struggling with addictions, and people with intellectual or physical disabilities. In 2018, we formed an Independent Practice Association, called the **Safety-Net IPA**, to help prepare our organizations for value-based payment reform and to help ourselves down the Value Based Payment Roadmap.

We recognize the many successes of the first Delivery System Reform Incentive Payment (DSRIP) program brought to our state and our organizations are happy to have been a part of them. We strongly believe that continued transformation of the health care delivery system and sustainability of the great progress made to date will require significant investment in community-based primary care. Further facilitating and enabling community-based primary care to successfully participate in Value-Based Payment reform programs will allow the State to achieve a real value-based system that improves health outcomes and reduces costs. SNAPCAP supports the renewal of the DSRIP program through March 31, 2024, but strongly urges inclusion of the following recommendations for improvement upon the original program in the proposed amendment request.

1. **<u>Provide core funding support for Safety-Net Primary Care-led IPAs</u>**

As the State has invested in core funding support for the formation of Independent Practice Associations for Hospital systems, Behavioral Health provider systems and Community Based Organizations systems, **we strongly recommend the next iteration of the DSRIP program to provide core funding support for safety-net primary care provider-lead Independent Practice Associations and/or Accountable Care Organizations**. A few have already formed – have fledgling infrastructure, and are in some degree of VBP arrangements. These organizations – ours included – have some limited grant support funding from charitable foundations, but lack capital reserves sufficient to fund necessary staffing, purchase and maintain the complex data systems to manage the care of the people we care in improved and more efficient ways and to be able to enter into risk-bearing contracts. Core funding support would allow us to focus on necessary member support efforts, rather than fundraising. Since the state has demonstrated support for the creation of such entities for Hospitals (through DRSIP), Behavioral Health providers (through the NYS Behavioral Health Value Based Payment Readiness Program) and Community Based Organizations (CBOs) (through the Grants for CBOs to facilitate their engagement in DSRIP activities), we think this is very much in line with the State's DSRIP program goals.

2. **<u>Mandate and/or incentivize a fair and representative governance model for the Value Driven Entities</u>**

In the first round of DSRIP, governance of the hospital-lead Performing Provider Systems (PPSs) is heavily dominated by hospital representation. In our experience, the solutions recommended by the PPS projects were already begun before inviting input from non-hospital stakeholders, such as primary care providers and primary care provider-lead IPAs, behavioral health organizations, etc. Non-hospital representatives were offered a seat or two on matters of governance, but clearly were out-represented by hospital representation**.** Governance and direction for transformative activities affecting primary care should have ***<u>equal</u>*** input from community-based health care organizations regardless of entity represented, whether in PPSs or Value Driving Entities (VDEs). **Therefore, we strongly recommend that the State mandate and/or incentivize *<u>equal</u>* representation of affected providers and patients on the governance of DSRIP 2.0 activities.**

3. **<u>Mandate and/or incentivize multi-party PPS participation where there are overlapping service areas</u>**

Our patients seek care from the hospital provider that is closest to their home or one they have good experience with. In our experience, this may not be the same PPS as the hospital-based PPS system that a primary care provider participates with. This leads to difficulties in current models which don't factor

in patient use of multi-hospital lead PPS where service areas overlap. Projects to receive funding and improve care offered by the PPS, are restricted to the PPS service area. The new model should create a structure that is hospital "agnostic" – facilitating transformation efforts based on the realities of an entire community, rather than one focused on particular hospital systems. **The next round of DSRIP should incentivize and/or mandate cross-PPS participation where there are overlapping service areas.**

4. **Mandate and/or incentivize Managed Care Organizations to provide upfront data about the patients served**

In our preliminary experience with Value-Based MCO contracts, data about the patients served by the MCO has been provided very late into the contract year and in formats that make it very difficult to determine where patients are actually receiving services. This makes us lack comprehensive care data about our population and prevents us from determining *where* care is actually being received and by *whom*. Without having insight into who are out best partners – whether they be behavioral health organizations, long term care entities and/or community-based organizations, we can't engage in the right partnerships for improving health outcomes when they span to areas outside of primary care, such as with behavioral health agencies, long term care or community-based organizations that address social determinants of health, especially in light of the envisioned VDE model. **We ask the State to mandate and/or incentivize Managed Care Organizations to provide upfront data about the patients served by our providers, be it individually or through IPA/ACO structures.**

**Aspire of WNY**, along with our fellow **SNAPCAP** member health centers have long recognized the complexity of need our patients have and have responded to them by building robust and comprehensive care services around our patients. We have also been actively engaged in DSRIP implementation and have contributed to many of the successes achieved to date. We look forward to continue partnering with the State to achieve our shared goals of system transformation and improved patient care, better patient outcomes and reduced care costs. DSRIP 2.0 should recognize and further fund the already great work the safety net primary care efforts to prevent an even more costly Medicaid program.

Sincerely,

Martha J Farewell, MA, CCC-L/SLP
Vice President of Clinical Services
Aspire of WNY, Inc

## doh.sm.1115Waivers

**From:** Collins, Darleen [redacted]
**Sent:** Monday, November 4, 2019 9:30 AM
**To:** doh.sm.1115Waivers
**Subject:** 1115 Public Forum Comment
**Attachments:** 1115 Waiver Clinton Response.docx



1115 Waiver comments attached.

*Darleen M. Collins*
*Director*
*Clinton County Office for the Aging*
[redacted]

**Clinton County Office for the Aging**
**135 Margaret Street, Suite 105**
**Plattsburgh, NY 12901**
**(518) 565-4620**
**Fax: (518)565-4812**

**Darleen M. Collins**
**Director**

November 4, 2019

Paul Francis
Deputy Secretary for Health
State Capitol
Albany, NY 12224

Donna Frescatore
Medicaid Director
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Dear Mr. Francis and Ms. Frescatore,

On behalf of Clinton County Office for the Aging, I am writing to express my recommendations on the DSRIP renewal proposed by New York State Department of Health. The services we provide directly impact inappropriate emergency department visits, and reduce avoidable readmissions. The NY Connects program, implemented in 2006, serves as no wrong door for any and all services available in the region, and is a catalyst for individuals in need of assistance. The targeted goals in the proposed renewal are exactly what this network provides, and must include mandated contracting by each PPS with their local Area Agency on Aging for social determinants of health initiatives. Our office is the trusted service provider for the fastest growing segment of the population, and the highest utilizer of health care dollars. Our services **absolutely** allow individuals to remain in their own homes and communities, all while saving health care expenditures. We provide the highest level evidenced based interventions, and are experts at navigating a complex health care system, while providing person centered planning and care.

An example of how the network operates, our office receives regular referrals from the local emergency room when high utilizers are in need of social supports and assistance in getting established with a primary care provider. We send a trained outreach worker into the home where they conduct a comprehensive in-home assessment. During the assessment, deficits in activities of daily living are identified; social determinants of health are assessed, including a nutrition screening. Unmet needs are addressed by linking the individual to various programs and services. By providing supports such as application assistance, home delivered meals, transportation to medical appointments, and personal care, we are able to address the social determinants of health, which can keep individuals with chronic conditions in their homes and out of nursing homes, saving thousands of dollars per year.

The local aging services networks are well established and trusted within the community. We utilize evidence-based programs to engage older adults in a preventive manner, have the ability to be the in the homes conducting assessments in the individual's living environment to more accurately identify and address needs, have eyes on the clients when drivers deliver meals five days per week, provide

personal care aides through the EISEP program that enable individuals with functional impairments and chronic conditions to remain at home, and have the ability to help clients navigate their options in rapidly changing circumstances.

In the renewal waiver, I cannot stress highly enough that we need to harness the existing strengths of community based services, instead of recreating case management services and duplication of services. Each and every case manager in the entire statewide aging network has received certification via Boston University School of Social Work, ensuring consistency in assessment not provided by any other system. I ask that there are mandates for each PPS to engage and contract with their local Offices for the Aging, for the services vital to keeping individuals in home and community based settings.

Thank you,

Darleen M. Collins
Director
Clinton County Office for the Aging

## doh.sm.1115Waivers

**From:** Lauri Cole [redacted]
**Sent:** Monday, November 4, 2019 9:32 AM
**To:** doh.sm.1115Waivers
**Subject:** Comments from New York's statewide BHCC/BH IPA Collaborative
**Attachments:** final BHCC_BH IPA DSRIP 2.0 Comments .pdf



Good morning,
Attached please find comments submitted by the members of the statewide BHCC/BH IPA Collaborative in response to the state's DSRIP 2.0 concept paper and recent request for comments.

We look forward to working with the Department as it continues to pursue an extension and amendment of the state's (current) 1115 waiver. We stand ready to assist you in every way possible.

Thank you for considering our feedback.

Respectfully submitted,
Lauri Cole on behalf of the BHCC/BH IPA Collaborative
[redacted]

--
Lauri Cole, Executive Director
*New York State Council for Community Behavioral Healthcare*
911 Central Avenue, PO Bx 152
Albany, NY 12206
[redacted]
www.nyscouncil.org

November 4, 2019

NYS Department of Health
Office of Health Insurance Programs
Waiver Management Unit
99 Washington Avenue
12th Floor, Suite 1208
Albany, NY 12210

To Whom It May Concern:

The NYS Behavioral Health Care Collaborative (*participants listed at the end of this document*), a statewide group of lead BHCC agencies and BH Independent Practice Associations (IPAs), welcomes the opportunity to submit feedback to the NYSDOH on the draft DSRIP Amendment request. We are submitting comments and feedback that reflect the experience and interests of behavioral healthcare providers who are positioning themselves for value-based contracting. With more than 80% of Medicaid super-utilizers having comorbid mental illness and 44% having serious mental illness,[1] our role in delivering on the promise of Medicaid reform efforts cannot be overstated.

The success of New York's transition to VBP relies on the strength of the partnerships between the behavioral health community, primary care providers treating the Medicaid population, and the organizations that focus directly on the provision of social determinants of health. We urge the Department to use its authority to augment its program design to increase the role and inclusion of community behavioral health providers, and their IPAs, in its waiver design. Our specific requests include:

- BH providers and BH IPAs must be included in Total Cost of Care contracts.
- Community-based BH IPAs should be integrated into the Value-Driven Entities (VDE) governance structure to ensure a role in decision making and providing critical services.
- BH IPAs that are clinically and financially integrated should be permitted to serve as lead VDEs.
- An expanded definition of what would constitute a Social Determinant of Health Network to should include BH IPAs with significant social determinant of health experience and services.
- Specific funding needs to be earmarked for behavioral health purposes.
- Specific metrics for tracking engagement with BHCCs and BH IPAs to ensure adequacy and accessibility of BH services are more meaningfully included in this next phase of DSRIP.
- Funds and leadership are needed to facilitate interoperability among ambulatory providers, inpatient providers and MCOs.
- Data from the Department showing how primary-care centered TCOC arrangements are meaningfully addressing BH needs and ensuring community-based BH care is not disrupted and appropriately expanded.
- Earmark 25% of workforce dollars for community-based providers.

As always, we look forward to collaboratively working with the State and other system stakeholders, including Performing Provider Systems (PPSs) and Medicaid Managed Care Organizations (MCOs) to

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5406260/

support the continued improvement of the Medicaid care delivery system to better meet the needs of the state's population with behavioral health conditions.

**Community Behavioral Health: Critical to Success of Value-Based Arrangements**

The highest cost Medicaid recipients have behavioral health disorders. Whether they are people with serious mental illnesses and chronic substance use disorders, or people with medical conditions whose costs of care are exacerbated by a behavioral health disorder, the greatest potential savings comes from meeting Medicaid recipients' behavioral health needs. As such, success in transforming the Medicaid service system hinges on the inclusion and integration of behavioral health providers, and the BH IPAs they have established, in Total Cost of Care (TCOC) contracts.

**Why BH IPAs versus Individual BH Providers**

The creation of BH IPAs funded through the BHCC initiative creates opportunity for BH providers but also their potential partners, including primary care providers, managed care organizations, hospitals, or government. IPAs allow BH providers to:

1. increase their capability and bring critical interventions to scale within larger TCOC contracts;
    a. provide targeted and integrated services for specialized BH populations;
2. spread risk associated with high cost, high severity populations;
3. work collectively to better harness population health data and analytic capabilities and manage their contributions within VBP contracts; and reduce administrative costs;
4. act as a bridge between social determinants of health (SDH) providers, including all levels of CBOs and community-based clinical models including primary care;
5. access referral pathways between BH clients and SDH providers, primary and specialty care; and
6. deliver large scale workforce initiatives including group education, training, technical assistance, and recruitment to address needs and shortages in underserved community.

New York State has invested in the development of BH IPAs; now they must be empowered to play the essential role for which they were created *(**see below examples from other states**)*.

**Inclusion of BH IPAs in DSRIP 2.0 Structures – Value-Driving Entities (VDEs)**

Despite the many benefits of BH Networks, to date, the inclusion of behavioral health IPAs in New York's Medicaid VBP arrangements has been elusive despite nearly two-thirds of the State's waiver priority areas being directly related to BH. There is no specific incentive for BH inclusion in emerging and existing arrangements, so existing TCOC contracts seldom include New York's behavioral health IPAs. This impedes Medicaid members' access to integrated, quality care; inhibits the savings potential of the contracts; and results in business as usual, siloed service delivery.

Currently, Value-Driving Entities (VDE) (as discussed in the DSRIP 2.0 concept paper) are not required to have BH IPAs in their governance structure. Although CBOs, which serve some – but not all – of the highest utilizers, are mandated to have a seat at the table, this does not go far enough. The mere mention of BHCCs is not enough incentive for VDEs to include such entities in their networks and the State should focus on emerging IPAs as a critical vehicle in ensuring future VBP progress. CBOs have coalesced around BH IPAs and therefore they are the logical place for their oversight, organizing and collective power.

BH IPAs that are clinically and financially integrated must be permitted to serve as lead VDEs. Several of the existing BH IPAs already provide/will soon provide network providers with quality oversight functionality

and data analytics capabilities. They will also offer training/technical assistance functions as well as other capabilities including back office supports for contracting and credentialing.

If not lead VDEs, BH IPAs must be mandated participants to ensure that CBOs have sufficient power within VDE governance not available to an individual CBO and to ensure all the benefits of the IPA described above are realized. The State must strengthen its current requirement to more explicitly integrate how community BH IPAs should be integrated in decision making and in providing critical services to all Medicaid members attributed to a VDE. The DSRIP 2.0 waiver amendment must include BH IPAs in executive steerage of VDEs.

This is especially critical for VDEs selecting promising practices impacting mental health and substance use treatment, including: expansion of Medication-Assisted Treatment into primary care and ED settings; primary care and behavioral health integration; care coordination, care management, and care transitions; expansion of Mobile Crisis Teams (MCT) and crisis respite services; focus on patients transitioning from IMDs to the community; Focus on Seriously Mentally Ill/Seriously Emotionally Disturbed populations; and addressing Social Determinants of Health (SDHs) through community partnerships. It should not be possible for VDEs to implement these practices without including the most expert and experienced community BH providers via their BH IPAs/networks.

Particularly, VDEs selecting BH focused promising practices must demonstrate their connectedness to BH IPAs, including providing governance roles, as part of their planned interventions for their attributed population. VDEs and MCOs cannot rely on general definitions of BH representation alone and instead must specifically identify how they plan to integrate with outpatient, community, and specialty BH, in addition to inpatient BH and traditional psychiatric services through their BH IPA relationships.

**DSRIP 2.0 Structures - Expanding the definition of SDHNs**

We further recommend that the state expand the definition of what would constitute a *Social Determinant of Health Network* (SDHN) to include BH IPAs with significant social determinant of health experience and services. This change would support more integration of services and reduce ongoing siloes that have emerged during DSRIP between CBOs and their BH counterparts (*sometimes being provided through the same agency*). It would allow these emerging networks to leverage existing infrastructure created by BH IPAs and avoid redundant, duplicative, and costly systems. SDH Networks, if not done correctly, may become yet another complicated and expensive infrastructure layer. We are pleased to see CBOs are included but it is equally important to include BH IPAs that also provide significant SDH interventions to enable the success of DSRIP 2.0.

BH IPAs do not solely serve people with serious behavioral health conditions; they have designed successful interventions for individuals with mild to moderate depression and anxiety, mild to moderate substance use disorders and many are positioned to be a “one stop shop” for communities seeking BH interventions to support primary care (PC) and acute care medicine in deriving value and sustaining behavior change. BH IPA members also provide social determinant of health services, including but not limited to housing, food, employment services, transportation, and peer supports, which gives them extremely broad capabilities in addressing the interdisciplinary challenges of healthcare transformation in an integrated fashion. All BHCCs/BH IPAs represent an integrated spectrum of BH services and have demonstrated progress in emergency department diversion and readmission reductions. Under this next wave of DSRIP, we must integrate and empower the behavioral health community to produce meaningful outcomes for Medicaid recipients, and significant savings for the Medicaid program.

**Funding Community Behavioral Health Networks - DSRIP 2.0**

A notable challenge in the State's design of the initial DSRIP program and now its waiver amendment draft is the *need for specific funding to be earmarked for behavioral health purposes.* In the initial DSRIP program, hospital-led PPS entities directed most funds to hospital, acute, and primary care sources minimizing the funding available to projects related to behavioral health. Without the requirement of adequate funds to support enhancements to community based mental health and substance use services, funding will be directed to care as usual in high cost settings.

To date, behavioral health providers have received a fraction of the Medicaid-reform funds for transformation efforts and we appeal to the State to address this challenge directly in its next iteration of the program. For example, under DSRIP (as of 2018), 1.8% of funds have been distributed for mental health interventions and 0.7% of funds have been invested in substance use.[2] As of 2018, VBP readiness grants awarded BHCCs just 0.7% compared to more than $9 billion total DSRIP investment.[3] And, in Phase II of the Statewide Healthcare Facility Transformation Program, there was capital funding of just 13% awarded to community BH dedicated projects; this was a slight improvement from the 6.5% awarded under the initial round of the Program.[4]

One DSRIP/PPS funded BH crisis stabilization project focused on reducing BH-related hospitalizations. The sponsoring PPS saw a *23% reduction in BH-related admissions by funding a robust crisis program linking a central point of contact, mobile crisis, and respite*. This project would not have happened without consistent participation and pressure from BH partners. Rather than this being the exception, we implore the State to align available funding for PPS Promising Practices with the sector affecting the outcomes. Promising Practices that focus on mental health, substance use disorders, or BH should include adequate funding requirements for networks of community BH providers. Community-based care is often preferred by recipients while also being less expensive, and therefore should be proportionately funded.

By globally referring to "providers" and directing funding through the existing PPS infrastructure, it is hard to see how this program design will facilitate the essential integration of behavioral healthcare, which will limit the impact of the state's transformation agenda.

Instead, we must fully fund community-based behavioral health and support additional innovation that will drive better outcomes and decreased costs for the entire system. One innovation that could move community behavioral health toward value-based payment and away from fee-for-service volume is the adoption of alternative payment models. We encourage and support the adoption and implementation of Alternative Payment Models (APM's) that support the transformation of our healthcare system along the continuum of care. APM's should be aligned to redesign of care delivery models inclusive of medical, behavioral and social needs resulting in improved access, enhanced patient engagement and measurable value – improved quality outcomes and reduced cost.

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[2] https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/paop/meetings/2018/docs/2018-11-29_updates.pdf

[3] NYS Department of Health. VBP QIP Funding and Pairing Tables, September 2018. https://www.omh.ny.gov/omhweb/bho/bh-vbp.html and https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/.

[4] https://www.governor.ny.gov/news/governor-cuomo-announces-204-million-funding-strengthen-and-preserve-access-high-quality-health

**Measures and Performance Payments: Facilitating BH in Future Value-Based Payment Models**

In addition to metrics tracking CBO, Qualified Entity, and MCO engagement, the State must include specific metrics for tracking engagement with BHCCs and BH IPAs to ensure BH services are more meaningfully included in this next phase of DSRIP. To measure BH IPA and network participation, we recommend the State track and report (1) how many BH providers and their associated IPAs have a substantial governance role in emerging networks (2) how well BH providers are moving along an on-ramp toward increased risk arrangements (*suggesting they have the capabilities and leverage they need to accomplish this, such as access to data on performance within specific contracts)* (3) what portion of shared savings under TCOC are distributed to BH partners for BH-related work and how BH networks are provided quality bonus/incentive payment opportunities.

**Information Technology**

In DSRIP 1.0, the community-level collaboration efforts to reduce Potentially Preventable Admissions and Potentially Preventable Readmissions required communication among the provider system of care. As integration increased the numbers declined. Fundamental to the integration was the enhanced interoperability the RHIOs contributed as they developed. All the Promising Practice Categories include a Behavioral Health component. Behavioral Health has not had the financial support and state-wide leadership necessary to substantially develop a level of interoperability with inpatient and other ambulatory providers critical to a successful community-level network of care.

Funds and leadership are needed to facilitate interoperability among ambulatory providers, inpatient providers and MCOs. The State must provide some guidance that drives this integration into and through the RHIOs as it improves the accessibility to and among RHIOs.

**Need for Greater Transparency and Oversight in Emerging VBP Arrangements**

New York, in its VBP Roadmap and through its implementation of the DSRIP program, has designed and relied on models that put primary and acute care service providers at the center of payment models, without the inclusion of community-based mental health and substance use disorder providers and networks. *This contrasts with other models around the country where better impact and value is being seen due to the inclusion of BH IPAs* that organize these necessary community services. Currently, in New York State it is difficult to see how total cost of care contracts include vital community BH services. We continue to request data from NYSDOH to demonstrate how networks have been formed, their impact on BH outcomes for their attributed population, and whether access to community BH services has been impacted positively or negatively. BH IPA inclusion would resolve and address this access concern and provide assurance that BH needs are met in these arrangements.

Today in New York there are more than 50 Medicaid Total Cost of Care (TCOC) arrangements between various partners and stakeholders. However, it is still unclear how and whether individuals are receiving adequate behavioral health services to address high, medium and low acuity needs under these emerging arrangements. Community-based BH services may or may not be limited under these general medical contracts. The State must address and report on how these primary-care centered TCOC arrangements are meaningfully addressing BH needs and ensuring community-based BH care is not disrupted and appropriately expanded.

**Interim Access Assurance Funds**

While we understand the need to maintain vital safety net services for individuals, what continues to be evident is the disproportionate and inequitable financing that has been spent on hospitals versus other

stakeholders in NYS. Low margins and cash flow disruptions, due to delays in payment, could put critical Medicaid community BH services at risk of not being available for individuals who rely on those services. Shifting service delivery patterns and payment transformation, makes this risk even greater for small, less well-resourced organizations.

VBP itself is not a solution for struggling providers seeking financial sustainability and yet the risk if these services were to disappear would be just as great to their patients as it would be if hospital or acute medical services were no longer available. In fact, the loss of critical BH services would drive increased hospital utilization and readmissions because the management of individuals' conditions would be inadequate if BH providers close. BH providers are seeking financial sustainability in order to ensure continued service delivery to complex clients who remain wary of physician/hospital-based providers.

To that end, we request to expand the Interim Access Assurance Fund or create alternative funding streams from waiver monies to assist community BH providers who are financially challenged. These funds should be used to invest in the needed mergers, affiliations, and partnership analyses to promote more financial security and sustainability for Medicaid-funded community BH services.

**Workforce Funds**

In addition to the funding noted above, we would recommend that a percentage of workforce dollars be earmarked for BH providers, specifically organizations that have demonstrated successful workforce projects/enhancements. We would also want to see workforce spending for projects that work to close the pay gap between hospital and community services, creating equity in hiring. A healthy workforce in community based services is critical to functioning and being able to support patients in community based levels of care.

**Value of BH IPAs in other States**

Several examples across the country, including the *Illinois Health Practice Alliance*[5] and the *Next Generation Models for Health Plan Behavioral Health Service* in Florida,[6] demonstrate how State Medicaid programs and MCOs are better leveraging Behavioral Health IPAs to advance statewide policy goals, including better management, efficiency, and cost savings for their Medicaid Program.

- In Illinois, the State-endorsed Health Practice Alliance created a BH IPA model for managing Medicaid patients with BH conditions to address inefficiencies and challenges in addressing BH conditions adequately under Primary Care models. MCO contracting was observed to be more efficient under this model, which resulted in minimal administrative overhead and enhanced enrollment opportunities. BH provider participants were rewarded with bonus or shared savings payments for enhanced quality and aligned incentives across payers and providers. The IPA is self-directed and has succeeded in creating consistent rules with MCOs for all of its BH provider members. Under the Illinois model, the data infrastructure of the IPA supports claims and performance data, care management platforms, real time updates, predictive risk stratification modeling, and BH/physical health visibility. For the most serious BH conditions in the network, the IPA supports embedded care managers, shared assessment and care plan capability, and leverages expertise from both plan and provider partners.

[5] http://cbha.net/resources/Conference/2018%20Conference/CBHA%20IHPA%20and%20MSO%20Presentation%2012-10-18.pdf

[6] https://leadership.openminds.com/wp-content/uploads/2018/09/091918OpeningKeynote.pdf

- In Florida, the State reviewed evidence that emerging VBP models were heavily Primary Care Physician based, which led to inconsistent physical/behavioral health communication, inconsistent sharing of treatment plans for common patients, and members seeing multiple behavioral health providers. The State identified program design challenges in VBP models designed around PCPs, including: the lack of a member attribution model for behavioral health, limits on what information can be shared with behavioral health providers (outside the care they provide), and minimal financial incentives for behavioral health providers. The State made modifications designed to specifically engage, integrate, and reward behavioral health providers, including VBP models that explicitly included outcome based rewards or pay for performance for BH-related HEDIS measures,[7] behavioral health homes that provide integrated BH and PC services (paid based on shared savings or capitation plus shared savings with attribution stemming from the BH IPA), and population health models, which target specialty health homes for those with SMI. As a result of these endeavors, BH IPAs in Florida have created a more predictable and reliable cash flow for BH providers, BH providers are more empowered to enter VBP and potential risks are mitigated through shared practices and learning. Florida BH providers are empowered to have more ownership and ability to influence the system of care in a more data-driven culture, and it has incented better partnership and integration between BH and PC providers.

As other states have acknowledged, BH providers need meaningful rewards for their participation in emerging VBP models. We encourage the state, via DSRIP 2.0, future evolution of NYS's VBP roadmap and in its oversight of MCOs, to incent and reward other approaches to total cost of care for the management of BH patients involved in these arrangements, including attribution of appropriate Medicaid members, direct upside risk opportunities for BH IPAs and BHCCs, pay for performance/bonus payments for such networks, and/or other innovative direct contracting approaches.

*This letter has been collectively written and is supported by the following BHCC / BH IPAs:*

Advanced Health Network IPA
Recovery Health Solutions IPA
Behavioral Health NYC IPA
EngageWell IPA
Capital Behavioral Health Network
AsOne IPA
Value Network IPA
South Central BHCC
Mohawk Valley BHCC
Central New York BHCC
Finger Lakes and Southern Tier BHCC
Lower East Side Service Center BHCC
Northwinds Integrated Health Network
Integrity Partners for Behavioral Health
Coordinated Behavioral Health Services IPA
Coordinated Behavioral Care IPA
Your Health Partners of the Finger Lakes IPA

[7] Adherence to antipsychotic medications in those with schizophrenia, Diabetes monitoring for those with diabetes and schizophrenia, Cholesterol and blood sugar testing for youth on antipsychotic medications, and Visit in 7-days post BH inpatient discharge

## doh.sm.1115Waivers

**From:** James Purcell [redacted]
**Sent:** Monday, November 4, 2019 9:46 AM
**To:** doh.sm.1115Waivers
**Subject:** DSRIP Testimony
**Attachments:** COFCCA Testimony Nov 4 DSRIP.docx

# Council of Family and Child Caring Agencies

# Comments from

# James F. Purcell, CEO

# to the

# New York State Department of Health

# November 4th, 2019

Thank you for the opportunity to submit written testimony to the Department regarding the Medicaid Redesign Waiver DSRIP Amendment request. My name is Jim Purcell and I am the CEO of the Council of Family and Child Caring Agencies (COFCCA). Our member agencies include over 100 not-for-profit organizations providing foster care, adoption, family preservation, juvenile justice, and special education services in New York State. Collectively, our member agencies employ more than 55,000 New York State residents and serve tens of thousands of children, youth and their families statewide.

COFCCA and its member agencies strongly support DOH in its request for a continuation of the existing waiver and also the renewal of the agreement with CMS through March 2024. We particularly appreciate the Department's increasing investments that strengthen families and children through community-based organizations addressing the social determinants of health. My comments will highlight 3 areas of importance to our members in the renewal:

- engagement of community-based organizations;
- emphasis on addressing the needs of children, youth and their families; and
- investment to alleviate our critical workforce shortage.

## *An Equal Seat at the Table for Community Based Organizations*

We commend the progress and the outcomes that have been achieved; and emphatically support the goals of the waiver. This is the time and the opportunity to shift the locus away from the large hospital health care delivery systems at the helm of the DSRIP initiatives to the community level where CBOs and COFCCA providers sit as the first layer of the system. Community-based care is closest to meeting the needs of the vulnerable populations we serve. While we strongly acknowledge that DSRIP to date has been transformational, little funding has reached CBOs in these first years. DSRIP 2 - as laid out in the request to CMS - offers promising opportunities through the Value Driving Entities (VDEs) in which CBOs could drive the teams that will scale and replicate DSRIP promising practices. The Department will need

to encourage, even possibly mandate, a fair and representative governance – requesting that VDEs reflect equal partnerships to achieve a model that is not dominated by hospital systems. We ask that the Department attend to this component of the implementation to assure strong collaborative partnerships with CBOs having an equal seat at the table.

## *Increasing Investments that strengthen children, youth and families*

The Department acknowledges that children have not been the focus of DSRIP to date; yet, there are few If any areas more important to the waiver's goals than investing in the comprehensive array of primary, preventive and behavioral healthcare that our children and youth so desperately need. The DSRIP request proposes that "*The next implementation phase would extend successful practices to children in the areas of chronic care management, pediatric-focused patient-centered medical homes, and attention to adverse childhood experiences and social determinants.*" New York is home to an array of evidence-based programs that have proven effective in addressing the impacts of Adverse Childhood Experiences; and, in particular our NYS voluntary foster care agencies are the providers with the most expertise and experience in trauma informed care and in addressing adverse childhood experiences. We cannot overstate the need to significantly increase investments in the evidence-based models that are known to be successful.

The use of telehealth is a particularly promising opportunity to allow birth parents/foster parents and children to share key moments, physician interactions etc. This is yet another area of promising technological advances that – utilizing such innovative models and funding from DSRIP we can jointly take steps along with MCOs to achieve new value-based outcomes for children. Our members are currently preparing to become licensed 29-I clinics through the NYS Department of Health (per statute passed in the 2017-2018 state budget); the agencies expect to be licensed by early 2020 in order to begin contracting with Managed Care Organizations (MCOs) when the foster care population enters into Medicaid Managed Care in February of 2020. As part of this transition, technology (e.g. telehealth, sharing of EHRs and instant communication when children arrive at ERs) along with a commitment and emphasis on integration of primary care and behavioral health is consistent with our member agencies' program models. Flexibility and opportunities to innovate new models for those populations of young children for whom we continue to seek promising practices is hopefully a possibility and the DOH will make it a major focus with DSRIP 2 funding. We welcome an ongoing seat at the table to scope out the promising practices and value-based outcomes pertinent to our population of children, youth and families.

## *Investment in the Workforce*

It is through the lens of our agencies' dire workforce crisis that we look at how the investment of $1 Billion in the renewal might impact our agencies' ability to meet the needs of the children, youth, and families in New York State. As stated in the renewal "many of the DSRIP initiatives that have proven results rely on non-traditional, non-clinical workforce to achieve project goals by helping members better navigate the clinical and social service systems to best meet their unique needs." The Value-Driving Entities should be investing in local workforce needs to fuel innovative approaches to achieve improvement in outcomes.

Our child welfare agencies currently experience very significant challenges in both recruitment and retention of employees for all positions, from direct care (front line) staff to clinicians to non-traditional, non -clinical workforce. Our agencies utilize a therapeutic approach, with many investing significantly in evidence-based models of care and in delivering trauma-informed treatment to the children and youth in our programs, and for family work as well. All of our programs compete with other settings to attract and to retain staff, and, especially, to attract culturally competent staff who are able to speak in languages other than English, to meet the needs of our children and families. Our agencies have a shortage of applicants from all staff—including psychologists, mental health counselors, and social workers, and at all levels of education. COFCCA has measured the turnover rates of our agencies. Our most recent workforce report, completed in August 2019, shows an average annual turnover rate statewide for Caseworkers/Case Planners of 38.3%. Staff/child relationships are the most important "ingredient" of working with a young person in foster care who has experienced trauma, and with families that are working through significant challenges in preventive services as they work to keep their children safely at home. We simply cannot afford to disrupt relationships that our children and families rely on as they work towards healing, safety, permanency, and well-being, and we believe that unless a commitment is made to address the serious workforce issues, we will be unable to continue our work and keep relationships between our staff and the children and families they work with strong and intact. It is most disheartening to see our agencies take up the new programs approved by CMS, recruit and train staff and now in some cases develop wait lists of the children and families who need the services as there is no workforce to meet the needs. Once again, we welcome the opportunity to sit together and carve out innovative approaches to addressing this most serious issue.

You have received a lot of testimony from my members as well as fellow trade associations serving children - I would like to be on the record endorsing the critical recommendations they have made about crisis diversion, the implementation of Youth Assertive Community Treatment (ACT) teams, the use of urgent care centers to decrease emergency admissions, and supporting the ongoing success and involvement of health homes serving children through which so many of my members are providing critical care management.

We appreciate the Department's efforts to renew this agreement with CMS and we respectfully request to participate in any additional stakeholder engagement opportunities the state may provide moving forward.

## doh.sm.1115Waivers

**From:** Hope Glassberg [redacted]
**Sent:** Monday, November 4, 2019 9:53 AM
**To:** doh.sm.1115Waivers
**Subject:** Hudson River Healthcare 1115 Public Forum Comment
**Attachments:** HRHCare DSRIP 2.0 comment letter.FINAL.pdf



Hello,

Attached are comments from Hudson River Healthcare.

Thank you,
Hope Glassberg

SVP, Government Affairs & Strategy
Hudson River Healthcare
[redacted]

November 4, 2019

Donna Frescatore
State Medicaid Director, Deputy Commissioner
State of New York, Department of Health
Empire State Plaza, Corning Tower, Room 1466
Albany, NY 12237

RE: 1115 Research and Demonstration Waiver #11-W-00114/2 Delivery System Reform Incentive Payment (DSRIP) Amendment Request

Dear Ms. Frescatore,

These comments are submitted on behalf of Hudson River Healthcare (HRHCare), a network of federally qualified health centers, and one of the largest community healthcare providers in the nation. The HRHCare network of 43 health centers throughout the Hudson Valley, New York City, and Long Island provides affordable, high-quality accessible care to over 225,000 patients annually. In 2018, Brightpoint Health, an FQHC network with sites in all five boroughs of New York City, joined HRHCare.

Across our network, we offer primary care, behavioral and substance use disorder treatment services, oral health care and more, alongside critical social supports related to transportation, food insecurity, child welfare and more. HRHCare has also been an early adopter of value-based models to enhance this integrated medical/social approach. HRHCare is a founding member of CBHCare, a regional IPA governed in partnership with specialty behavioral health providers. HRHCare is also a founding member of Community Health IPA (CHIPA), an independent provider association comprised exclusively of Federally Qualified Health Centers in New York. Finally, HRHCare is also a part of New York State's only CHC-led Medicare Shared Savings Program ACO.

Given these experiences, we are optimally positioned to further New York State's agenda to reduce preventable hospital admissions and readmissions. We understand that there are substantial financial challenges that the state must face. This circumstance behooves targeted investment in lower-cost community-based care more than ever as **national evidence shows that regular primary care access reduces overall healthcare costs**.[1]

[1] http://www.nachc.org/wp-content/uploads/2015/06/ED_FS_20151.pdf


To maximize state investments in healthcare transformation, **we urge New York State to make community health primary** in the DSRIP 2.0 initiative and other managed care strategies. In this spirit we offer the following comments:

1. **Prioritize community-based provider led "Value-Driving Entities"**

As we have seen, 23 of the 25 current PPS leads are hospital-based, and, accordingly, disproportionate DSRIP resources have gone toward hospital systems; data reported by the State in November 2018 demonstrates that hospitals received more than 28% of total funds flow while representing only 0.2% of total engaged PPS partners.[i] It is exceedingly difficult to transform the healthcare delivery system by continuing to invest most transformation dollars into inpatient-based care models, when it is the long-standing established CHC providers and workforce that can make the biggest impact on patients' health outcomes receive only minimal investment.

In DSRIP 2.0, we therefore expect New York State to accept applications from new networks of primary care, behavioral health, and other non-hospital based providers along the continuum of care to be Value-Driving Entities (VDEs). Potential VDEs could include CHC-led IPAs currently organized across the state such as CHIPA, Safety-Net IPA (SIPA), Finger Lakes IPA (FLIPA), and Upstate Community Health Collaborative IPA (UCHC); these IPAs are engaged with various MCOs in VBP arrangements.

We urge New York State to consider the fact that independence and physician leadership have played a key role in the success of ACO models nationally: in 2015, smaller ACOs and those led by physicians performed better than ACOs led by hospitals and other large medical organizations. In addition, estimated cost savings do not appear to be linked to financial integration with a hospital.[2] In summary, community-based care providers must be positioned as the priority in 2.0, as the front line providers in preventing avoidable utilization, rather than as subordinate or "downstream" providers of some other controlling system.

2. **Align DSRIP Attribution and PCP Assignment**

New York adopted an attribution methodology in DSRIP's first iteration that included a unique logic for particular populations in cases where more than one PPS existed in a single region. The benefit of this approach was that it took into consideration that an individual with unique health care needs or one who might be difficult to reach may seek and receive a preponderance of their health care services outside of primary care. It recognized that those special populations might view a behavioral health care clinician, a care manager, or a specialty care provider as their primary source of care rather than a PCP.

[2] *https://catalyst.nejm.org/do-independent-physician-led-acos-have-a-future/*

The challenge, however, in carrying out the DSRIP objectives using this attribution methodology was that an individual who was attributed to a particular PPS using the special populations hierarchy would also have a PCP assigned to them by their managed care organization. There was no guarantee that the MCO-assigned PCP was participating with the PPS to which the person was attributed. The PPS and the MCO-assigned PCP could be working at cross-purposes or duplicating efforts. The PPS might also "assign" such individuals to a PCP within their network and require that PCP to close gaps in care or deliver other services to them, even though that PCP would have no prior history or relationship with the individual.

There must be an alignment between DSRIP attribution and PCP assignment at the plan level. If New York State chooses to continue its special populations hierarchy, then it should also require that each individual attributed to a PPS/VDE be assigned to a PCP that actually participates in that network. If a person's PCP does not participate in the network, then the individual should have the option of either changing their PCP to one that does participate or opting out of the PPS/VDE.

3. **Add an option for a VDE that does not include an MCO as a participant and allows the VDE to contract directly with the state. Build upon the successful Medicaid Primary Care ACO model established under the Massachusetts DSRIP.**

In Massachusetts, Primary Care ACOs were established under the state's DSRIP and are comprised of groups of PCPs who form an ACO and receive reimbursement directly from state Medicaid. Those payments are measured against an annual cost target, and the ACOs and the state share in the savings or losses that result. These ACOs are also responsible for meeting a set of quality measures.[3]

While this approach would move New York's DSRIP in a somewhat new direction, it keeps primary care as the focal point and does not send dollars or control to some other intermediary entity. Additionally, PCPs (and FQHCs in particular) will be well-incented to drive savings generated back into further enhancing the primary care delivery system, more thoroughly integrating behavioral health and primary care, expanding prevention programs, and delivering social determinants of health interventions. That *is* the work of primary care and the mission of every FQHC.

4. **Expand the definition of a Community Based Organization (CBO) that may deliver a recognized Social Determinants of Health intervention to include Federally Qualified Health Centers and Medicaid Health Home leads**

Page 10 of the amendment describes the state's proposal for creating regional SDH Networks. In New York State's Value-Based Payment Roadmap, the definition of a "CBO" that can deliver an

[3] https://bluecrossmafoundation.org/sites/default/files/download/publication/ACO_Primer_July2018_Final.pdf

intervention recognized by the department as impacting social determinants of health is very narrowly defined as being a "Tier 1" CBO, an entity that did not bill Medicaid. In the second generation of DSRIP, as SDH Networks are contemplated, we ask that the state expand the definition of a CBO to include Federally Qualified Health Centers.

While many health care providers often view social determinants as factors outside of their control and beyond their purview, Community Health Centers (including certain health centers that were established specifically to serve migrant communities, homeless populations, and residents of public housing), have always taken a broad view of healthcare and a whole-person approach to wellness. Impacting social determinants of health is central to the mission of every FQHC. FQHCs in particular are, *by definition*, community-based organizations that exist to serve low-income and underserved communities. FQHCs are, *by definition*, community-driven with at least 50% of their governing boards comprised of actual health center patients. FQHCs are, *by definition*, augmenting their clinical services with non-clinical services designed to address social determinants of health.

Where another entity exists in the community that delivers a particular service that addresses social determinants, FQHCs have been and will continue to be enthusiastic and supportive partners. However, in instances in which FQHCs are already delivering SDH interventions and doing so in a manner that truly integrates health care and SDH approaches, such interventions should be recognized by the state as valid.

Finally, we would also state that Medicaid Health Home leads, which do bill the Medicaid program, have established networks of CBOs and other healthcare providers to provide social supports to high-cost/high-need Medicaid beneficiaries and should therefore also be able to become SDH Networks.

5. **Advance a New Methodology for Primary Care Participants in VDEs.**

For those independent primary care providers that choose to remain in health/hospital-system led VDEs, we ask that the state support a different funds flow methodology that would:

- Advance an "MLR" concept for PPS budgets: limit expenses devoted to administrative costs and require administrative costs to diminish over time, readying systems for value-based contracting.
- Require Value-Driving Entities to devote a majority of funds (e.g. over 50%) to provider transformation.
- Make fund allocations more consistent with attribution for valuation, while still enabling pathway for non-attribution partners (e.g. CBOs) to derive value
- Place limit on amount of funds to same entity to both offset revenue loss and promote transformation

- Articulate statewide requirements on how dollars to offset revenue loss can be used (similar to the Interim Access Assurance Fund) and ensure non-hospital parties can access funds

**6. Put Independent Primary Care Providers as a Primary Player in VBP Arrangements and Advance an FQHC Alternative Payment Model**

Outside of DSRIP, we ask that New York State take several steps that will enable independent primary care providers to effectively participate, compete, and perform under VBP arrangements. Specifically:

- Make available startup funds for primary-care led IPAs, similar to the BHCC program for specialty behavioral health provider-led IPAs
- Allow FQHCs to count as community-based organizations in VBP contracts that require a Social Determinants of Health intervention, with a written description of how an FQHC fulfills that requirement
- Enforce greater managed care transparency and standardization in data sharing
- Separate FQHC data from other primary care to better understand impacts

We also ask that the state support other work with CHCANYS to move away from a visit based FQHC payment to a capitated FQHC Alternative Payment Methodology (APM). Federal statute permits states to implement an APM in lieu of the legally required prospective payment system reimbursement methodology. States must ensure that reimbursement under the APM is not less than it would be under the prospective payment system rate; however, adoption of an APM is essential to move FQHCs from a visit-based payment that incentivizes volume, to a payment methodology that rewards efficiency and outcomes. A capitated FQHC APM aligns with the State's DSRIP goals of advancing VBP and provision of enhanced care coordination.

An FQHC APM supports team-based, integrated care and enables CHCs the flexibility needed to create innovative approaches to care which can include non-clinical support staff who are not billable providers under the prospective payment system rate. The creation of innovative care coordination workflows will improve care provided directly by FQHCs, therefore reducing costs across the health care system.

Thank you for the consideration of these comments. If you have any questions, please feel free to contact Hope Glassberg, SVP, Government Affairs and Strategy at Hudson River Healthcare [redacted]

[i] https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/paop/meetings/2018/docs/2018-11-29_updates.pdf

## doh.sm.1115Waivers

**From:** Raymond Ganoe [redacted]
**Sent:** Monday, November 4, 2019 9:56 AM
**To:** doh.sm.1115Waivers
**Subject:** 1115 Public Forum Comment
**Attachments:** 1888_001.pdf



Please see the attached comment letter regarding NYSDOH DSRIP 2.0.

Thank you!

Ray

**Raymond Ganoe**
*President/CEO*
[redacted] | https://www.evergreenhs.org
[redacted]
206 S. Elmwood Avenue, Buffalo, NY, 14201

Evergreen Health
206 S. Elmwood Ave. Buffalo, NY 14201 p. 716.847.0212 f. 716.847.0418

**Re: Comments on NYDOH DSRIP 2.0 Amendment Request**
**Date: November 2, 2019**

Evergreen Health is grateful for the opportunity to provide input to the laudable efforts to continue transformation of New York's Medicaid program to improve efficiency, accessibility and sustainability as outlined in the concept paper published no September 17th. Evergreen Health has 8 sites in Western New York, serving over 14,000 patients. Our patients are primarily the LGBTQ, drug users, safety-net and communities of color populations. We are the largest provider of HIV, PrEP and Syringe Exchange in WNY. We have an annual budget in excess of $100m / year and over 450 employees. Our organization belongs to the Safety Net Association of Primary Care Affiliated Providers - SNAPCAP - an organization that includes 12 primary care safety net providers – FQHCs and Article 28 licensed clinics - serving the 8 counties of Western New York. In 2019, together our member organizations served 181,000 patients. This is approximately 13% of the Western New York population. Our 12 organizations provided nearly 700,000 primary care, behavioral health and dental visits. The members our organizations serve mostly people receiving Medicaid and represent expertise in a range of special populations–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 behavioral health disorders, people struggling with addictions, and people with intellectual or physical disabilities. In 2018, we formed an Independent Practice Association, called the Safety-Net IPA, to help prepare our organizations for value-based payment reform and to help ourselves down the Value Based Payment Roadmap.

We recognize the many successes of the first Delivery System Reform Incentive Payment (DSRIP) program brought to our state and our organizations are happy to have been a part of them. We strongly believe that continued transformation of the health care delivery system and sustainability of the great progress made to date will require significant investment in community-based primary care. Further facilitating and enabling community-based primary care to successfully participate in Value-Based Payment reform programs will allow the State to achieve a real value-based system that improves health outcomes and reduces costs. SNAPCAP supports the renewal of the DSRIP program through March 31, 2024, but strongly urges inclusion of the following recommendations for improvement upon the original program in the proposed amendment request.

1. **Provide core funding support for Safety-Net Primary Care-led IPAs**

As the State has invested in core funding support for the formation of Independent Practice Associations for Hospital systems, Behavioral Health provider systems and Community Based Organizations systems. **We strongly recommend the next iteration of the DSRIP program to provide core funding support for safety-net primary care provider-lead Independent Practice Associations and/or Accountable Care Organizations**. A few have already formed – have fledgling infrastructure, and are in some degree of VBP

arrangements. These organizations – ours included – have some limited grant support funding from charitable foundations, but lack capital reserves sufficient to fund necessary staffing, purchase and maintain the complex data systems to manage the care of the people we care in improved and more efficient ways and to be able to enter into risk-bearing contracts. Core funding support would allow us to focus on necessary member support efforts, rather than fundraising. Since the state has demonstrated support for the creation of such entities for Hospitals (through DRSIP), Behavioral Health providers (through the NYS Behavioral Health Value Based Payment Readiness Program) and Community Based Organizations (CBOs) (through the Grants for CBOs to facilitate their engagement in DSRIP activities), we think this is very much in line with the State's DSRIP program goals.

2. **Mandate and/or incentivize a fair and representative governance model for the Value Driven Entities**

In the first round of DSRIP, governance of the hospital-lead Performing Provider Systems (PPSs) is heavily dominated by hospital representation. In our experience, the solutions recommended by the PPS projects were already begun before inviting input from non-hospital stakeholders, such as primary care providers and primary care provider-lead IPAs, behavioral health organizations, etc. Non-hospital representatives were offered a seat or two on matters of governance, but clearly were out-represented by hospital representation. Governance and direction for transformative activities affecting primary care should have *equal* input from community-based health care organizations regardless of entity represented, whether in PPSs or Value Driving Entities (VDEs). **Therefore, we strongly recommend that the State mandate and/or incentivize *equal* representation of affected providers and patients on the governance of DSRIP 2.0 activities.**

3. **Mandate and/or incentivize multi-party PPS participation where there are overlapping service areas**

Our patients seek care from the hospital provider that is closest to their home or one they have good experience with. In our experience, this may not be the same PPS as the hospital-based PPS system that a primary care provider participates with. This leads to difficulties in current models which don't factor in patient use of multi-hospital lead PPS where service areas overlap. Projects to receive funding and improve care offered by the PPS, are restricted to the PPS service area. The new model should create a structure that is hospital "agnostic" – facilitating transformation efforts based on the realities of an entire community, rather than one focused on particular hospital systems. **The next round of DSRIP should incentivize and/or mandate cross-PPS participation where there are overlapping service areas.**

4. **Mandate and/or incentivize Managed Care Organizations to provide upfront**

In our preliminary experience with Value-Based MCO contracts, data about the patients served by the MCO has been provided very late into the contract year and in formats that make it very difficult to determine where patients are actually receiving services. This makes us lack comprehensive care data

about our population and prevents us from determining *where* care is actually being received and by *whom*. Without having insight into who are out best partners – whether they be behavioral health organizations, long term care entities and/or community-based organizations, we can't engage in the right partnerships for improving health outcomes when they span to areas outside of primary care, such as with behavioral health agencies, long term care or community-based organizations that address social determinants of health, especially in light of the envisioned VDE model. **We ask the State to mandate and/or incentivize Managed Care Organizations to provide upfront data about the patients served by our providers, be it individually or through IPA/ACO structures.**

Our organization, along with our fellow SNAPCAP member health centers have long recognized the complexity of need our patients have and have responded to them by building robust and comprehensive care services around our patients. We have also been actively engaged in DSRIP implementation and have contributed to many of the successes achieved to date. We look forward to continue partnering with the State to achieve our shared goals of system transformation and improved patient care, better patient outcomes and reduced care costs. DSRIP 2.0 should recognize and further fund the already great work the safety net primary care efforts to prevent an even more costly Medicaid program.

Respectfully Submitted,

Raymond Ganoe
President / CEO

## doh.sm.1115Waivers

**From:** NYSBHA Staff [redacted]
**Sent:** Monday, November 4, 2019 10:02 AM
**To:** doh.sm.1115Waivers
**Subject:** 1115 Public Forum Comment
**Attachments:** NYSBHA DSRIP 2.0 comments .docx



Please accept attached comments - questions may be sent to Sarah Murphy at this email address, or call [redacted]

Thank you,

Sarah Murphy
executive director

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[redacted]
www.nysbha.org

NEW YORK
SCHOOL-BASED
HEALTH ALLIANCE
Healthy Children, Healthy Teens, Healthy Schools

# New York School Based Health Alliance Comments on DSRIP Extension Proposal

Thank you for this opportunity to comment on the extension of the MRT Waiver, an agreement between the federal Centers for Medicare and Medicaid Services (CMS) and New York State.

**New York School Based Health Alliance (NYSBHA) supports New York's effort to continue the existing Waiver and renew an agreement through March 2024.**

Our comments are directed toward the need to focus funding to support children by including School-Based Health Centers as a valuable provider partner with the proposed Value-Driving Entities. As reported by the Children's Clinical Advisory Committee and included in the First 1000 Days, the value proposition for children's health services stems from promoting optimal child health across the life course, which will lead to lower long-term health care costs and utilization, principally by preventing chronic conditions in adulthood.

**Integration of Primary Care and Behavioral Health and Crisis Services**

One of the priority areas identified for continuation is primary care and behavioral health integration. In New York State, 75% of school-based health centers (SBHCs) have a mental health provider. Research has found this integrated model reduces barriers experienced in traditional mental health settings are overcome in school-based settings. Mental health counseling is repeatedly identified as the leading reason for visits by students. Adolescents are 10-21 times more likely to visit the SBHC for mental health services than a community health clinic or primary care practice. Studies have also found students who reported depression and past suicide attempts were more willing to use the SBHC for services.

Expansion of crisis services is another area identified for continuation in the waiver.

Mental health providers in SBHCs provide crisis services, which has led to decreased emergency department visits. These providers help address an urgent need for the pediatric population in which there are limited crisis intervention services available.

In New York City, schools are under court order to reduce removals to emergency departments. We support the use of DSRIP funds to support SBHCs to expand mental health services to respond to children in crisis.

Overall, SBHCs improve access to primary care services, one the measures included in the first MRT waiver and reported by Performing Provider Systems.

**New York School-Based Health Alliance**
www.nysbha.org 518.694.3423 nysbha@gmail.com P.O. Box 8324 Albany NY 12208

**Alignment with First 1000 Days Recommendations**

The First 1000 Days Preventive Pediatric Care Clinical Advisory Group states "Children – as a population – have relatively few acute healthcare needs, so there is limited opportunity for short-term savings through improved health outcomes. While investment in short term savings related to health outcomes should be explored, investment in a child's optimal growth and development has the best potential to improve long-term health outcomes."

Optimal child development and wellness are not adequately captured by traditional health care measures. The Clinical Advisory Group recommends the following measures:

- Optimization of social-emotional health outcome through effective, integrated behavioral health services
- Improved High School graduation rates
- Decreased cardiovascular disease risk as youth enter adulthood
- Decreased criminal justice and child welfare involvement

SBHCs are uniquely positioned to improve these measures. Studies have found that students who utilize SBHCs decrease school absences and tardiness and have a decline in school discipline referrals.

Medical providers in SBHCs monitor students with chronic illness, the commonly asthma. SBHC staff can provide education to students on their condition and how to manage it. Students with asthma who utilize SBHCs were found to have decreased hospitalization and improvements with medication adherence.

**Conclusion**

We appreciate the opportunity to comment on the extension of the MRT waiver.

We encourage the final waiver to include School-Based Health Centers as a partner in providing valuable services to children to have a positive long-term impact.

For additional information, please contact Sarah Murphy, NYSBHA Executive Director at [redacted]

## doh.sm.1115Waivers

**From:** Lauri Cole [redacted]
**Sent:** Monday, November 4, 2019 10:02 AM
**To:** doh.sm.1115Waivers
**Subject:** Please recall prior email
**Attachments:** USE THIS NYS Council DSRIP 2.0 Comments.docx



Please omit previously submitted comments document from the NYS Council for Community Behavioral Healthcare and use the comments (attached) as our final document.

Many thanks!

Lauri Cole
NYS Council for Community Behavioral Healthcare

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Lauri Cole, Executive Director
*New York State Council for Community Behavioral Healthcare*
911 Central Avenue, PO Bx 152
Albany, NY 12206
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www.nyscouncil.org

NYS Council for Community Behavioral Healthcare

November 4, 2019

NYS Department of Health
Office of Health Insurance Programs
Waiver Management Unit
99 Washington Avenue
12th Floor, Suite 1208
Albany, NY 12210

To Whom It May Concern:

The New York State Council for Community Behavioral Healthcare (NYS Council) appreciates the opportunity to submit comments on the draft Delivery System Reform Incentive Payment (DSRIP) Amendment Request concept paper. We support the State's efforts to continue the existing waiver and to renew an amendment through March 31, 2024. This dedicated effort and priority focus has made New York a leader in achieving the goals of the Triple Aim in terms of health services across NYS for children and adults.

To continue that success, New York's transition to VBP must rely on the strength of the partnerships between the behavioral health community and primary care providers treating the Medicaid population. Expanding the DSRIP waiver to allow for more shared savings and collaborations with behavioral health providers should be a goal of the new extension. Our specific recommendations for the DSRIP Amendment include the following:

- Allocate funds specifically for behavioral health initiatives that drive savings and improve care
- Permit BHCCs, BH IPAs, and CHC IPAs to be Value-Driving Entities (VDEs)
- Incentivize PPS' to collaborate with BH community-based providers
- Provide greater transparency regarding how Total Cost of Care (TCOC) contracts include vital community BH services and address the needs of BH clients with significant co-morbid conditions.
- Address crisis level workforce shortages in BH community provider organizations that impact access to and continuity of care for children, youth and adults seeking these services
- Incentivize children's behavioral health initiatives in VBP arrangements and DSRIP 2.0

**Allocate funds specifically for behavioral health**

A notable challenge in the State's design of the initial DSRIP program and now its waiver amendment draft is the failure to identify whether *specific funding will be earmarked for behavioral health care programs and services.* In the initial DSRIP program, hospital-led PPS entities directed most funds to hospital, acute, and primary care sources minimizing the funding available to scale projects designed to improve behavioral health care to those with significant behavioral health challenges. Without the requirement of adequate funds to support enhancements to community based mental health and substance use services, funding will be directed to care as usual in high cost settings and New York will be unable to get ahead of the public health crises

(Opioid Epidemic, Increase in suicide rates) we are fighting to address.

To date, behavioral health providers have received a fraction of Medicaid-reform funds for transformation efforts and we appeal to the State to address this challenge directly in its next iteration of the program. For example, under DSRIP (as of 2018) just 1.8% of funds had been distributed for mental health interventions and 0.7% had been invested in substance use prevention, treatment, recovery community-based providers.[1] As of 2018, VBP readiness grants awarded to BHCCs a mere 0.7% compared to more than $9 billion total DSRIP investment.[2] And, in Phase II of the Statewide Healthcare Facility Transformation Program, there was capital funding of only 13% awarded to community BH dedicated projects; this was a slight improvement from the 6.5% awarded under the initial round of the Program.[3]

One DSRIP/PPS funded BH crisis stabilization project focused on reducing BH-related hospitalizations. The sponsoring PPS saw a 23% reduction in BH-related admissions by funding a robust crisis program linking a central point of contact, mobile crisis, and respite. This project would not have happened without consistent participation and pressure from BH partners. Of course, the financial impact of this accrued to MCOs, not BH providers. Rather than this being the exception, we implore the State to align available funding for PPS Promising Practices with the sector affecting the outcomes. Promising Practices that focus on mental health, substance use disorders, or BH should include adequate funding requirements for networks of community BH providers. Community-based care is often preferred by recipients while also being less expensive, and therefore should be adequately funded.

Community-based behavioral health services need to be fully-funded to support additional innovation that will drive better outcomes and decrease costs for the entire system. One innovation that could move community behavioral health toward value-based payment and away from fee-for-service volume is the adoption of alternative payment models. We encourage and support the adoption and implementation of Alternative Payment Models (APM's) that support the transformation of our healthcare system along the continuum of care. APM's should be aligned to redesign of care delivery models inclusive of medical, behavioral and social needs resulting in improved access, enhanced patient engagement and measurable value – improved quality outcomes and reduced cost.

We also request an **expansion of the Interim Access Assurance Fund,** or creation of alternative funding streams, from waiver monies, to assist financially challenged community BH providers.The state's **Vital Access Provider funds should be made available to those BH providers that are struggling to remain viable in the face of constantly increasing labor and non-personnel operating costs. Despite the increased cost of operating programs, The APG rates have remained virtually flat since inception of these rates.** Additional DSRIP funds should be used to invest in a mergers, affiliations, and partnership analyses to promote more financial sustainability for Medicaid-funded community BH services.

**Allow BHCCs, BH IPAs, and CHC IPAs to be Value-Driving Entities (VDEs)**

[1] https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/paop/meetings/2018/docs/2018-11-29_updates.pdf

[2] NYS Department of Health. VBP QIP Funding and Pairing Tables, September 2018. https://www.omh.ny.gov/omhweb/bho/bh-vbp.html and https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/

[3] https://www.governor.ny.gov/news/governor-cuomo-announces-204-million-funding-strengthen-and-preserve-access-high-quality-health

Despite the lack of State support at the level of granted to PPSs, around the state there are successful BH Independent Practice Associations (IPAs), BHCCs, and health center IPAs. By leveraging the experience and expertise of these innovative partnerships, the state can utilize these entities as leaders ofcommunity-based VDEs. These mature IPAs are already performing a variety of critical tasks including network management, contracting, quality oversight, data analytics and reporting, and training and technical assistance. Some BH IPAs also have the additional advantage of being a Health Home with a proven track record of caring for many of the most at-risk and highest cost patients.

Those BHCCs and BH IPAs that are clinically and financially prepared to do so, as well as the CHCs engaged in regional, integrated IPAs with behavioral health providers and CBOs, should be encouraged and supported to become VDEs and participate in contracting and even risk contracts.

If not lead VDEs, BH IPAs must be mandated participants to ensure that CBOs have sufficient power within VDE governance not available to an individual CBO. The State must strengthen its current requirement to more explicitly integrate how community BH IPAs should be integrated in decision making and in providing critical services to all Medicaid members attributed to a VDE. The DSRIP 2.0 waiver amendment must include BH IPAs, at a minimum, as executive partners of VDEs with authority to determine priorities for programs and funding; oversight of activities to ensure focus on improving access; quality, and impact on health outcome; cultural competence; and training for positions important within the community health structure.

This is especially critical for VDEs selecting promising practices impacting mental health and substance use treatment, including: expansion of Medication-Assisted Treatment into primary care and ED settings; primary care and behavioral health integration; care coordination, care management, and care transitions; expansion of Mobile Crisis Teams (MCT) and crisis respite services; focus on patients transitioning from IMDs to the community; focus on Seriously Mentally Ill/Seriously Emotionally Disturbed populations; and addressing Social Determinants of Health (SDHs) through community partnerships. It should not be possible for VDEs to implement these practices without including the most expert and experienced community BH providers via their BH IPAs/networks.

The New York State Council for Community Behavioral Healthcare is currently working with CHCANYS to identify opportunities for collaboration among BHCCs and health center IPAs. Our members are committed to integration of care. Acceleration and support of this work by the State can be an essential element in the State achieving its stated DSRIP goals of sustainability and improved integrated care models.

**Incentivize PPS' to collaborate with BH Providers**

New York, in its VBP Roadmap and through its implementation of the DSRIP program, has designed and relied on models that exclude community-based mental health and substance use disorder providers and networks from participating as equal partners. Some PPS initiatives have demonstrated partnerships with community providers but in most cases the incentives under the waiver and DSRIP have led to existing community resources, expertise and licensure being bypassed, and funds and authority usurped to "reinvent" rather than leverage these services.

Waiver and DSRIP 2.0 amendments should build on community-based collaboration throughout the PPS projects and align with the existing, ready and eager behavioral health community expertise. Incorporating community-based organizations reflects the population in the community and they therefore have the reach, outreach, credibility, and understanding for what's needed. The new waiver should go further to establish, as a waiver standard, the priority use of the behavioral healthcare community sectors' services, and prevent

waiver resources from duplication, exclusion and marginalization of existing services. This could be done by expanding the proposed "bonus payment system" and reward-for-high-performance provisions to explicitly include rewards for partnering with CBOs and financial penalties for failing to partner broadly or deeply enough.

If DSRIP 2.0 includes the recommended and necessary incentives for PPS collaboration then behavioral health providers across the state will be able to make a measurable impact on – and take a leadership role in – improving New Yorkers health and advancing the triple aim and desired shift from fee-for-service to value-based payment.

**Greater transparency of how Total Cost of Care (TCOC) contracts include vital community BH services**

Currently, in New York State it is difficult to determine ifTotal Cost of Care (TCOC) contracts include necessary and vital community BH services. We continue to request data from NYSDOH to demonstrate how networks have been formed, their impact on BH outcomes for their attributed population, and whether access to community BH services has been impacted positively or negatively.

Today in New York there are more than 50 Medicaid Total Cost of Care (TCOC) general population arrangements between various partners and stakeholders. However, it is still unclear how and whether individuals are receiving adequate behavioral health services to address high, medium and low acuity needs under these emerging arrangements. Community-based BH services may or may not be limited under these general medical contracts.

The State must address and report on how these primary-care centered TCOC arrangements are meaningfully addressing BH needs and ensuring community-based BH care is not disrupted and appropriately expanded.

**Address crisis level workforce shortages in BH community provider organizations**

A percentage of DSRIP workforce dollars should be earmarked for BH providers, specifically organizations that have demonstrated successful workforce projects/enhancements. The ongoing and unaddressed workforce need in the community based sectors has been a longstanding concern and has consequences related to access, cost, outcomes, and avoidable high cost system resource use. Workforce spending should be used to address shortages of critical staff position up and down the BH organizational chart.

Last year the NYS Council along with our colleagues across the mental health and substance use disorder continuum of care conducted a direct care staff turnover study that revealed turnover rates of these staff in the 35-40% / year range. These turnover rates are unsustainable and create a serious barrier to our ability to earn the trust of the individuals we serve as we continue to assist them with their recovery.

DSRIP funds should be allocated to incentivize initiatives that work to close the pay gap between hospital and community services, creating equity in hiring. A healthy workforce in community-based services is critical to sustainability and quality care – particularly in those areas of healthcare that rely heavily on continuity of staffing that can improve outcomes for care recipients as they develop a trusting relationship with their practitioner. This must include goals of adequate compensation and promotion of new worker entrants into these settings, from pipeline and professional schools. Additionally important are waiver amendments that could provide relief from undue/overbearing documentation, administration and procedures which are diverting practitioner time from direct patient care, and adversely impacting productivity, satisfaction, sustainability/turnover and cost.

**Prioritize children's community-based behavioral health**

As reported by the Children's Clinical Advisory Committee and included in the First 1000 Days Values, the value proposition for children's health services stems from promoting optimal child health across the life course, which will lead to lower long-term health care costs and utilization (principally by preventing chronic conditions in adulthood), and producing savings and better outcomes for non-health sectors by improving child development. However, to date, children's specialty services and exempt child populations have had limited involvement in health systems reforms and the DSRIP program.

With the alarming trends in youth suicide rates, increased demand for early childhood behavioral health services, and reforms that move foster youth from congregate care into the community, we believe that the next phase of DSRIP must include a number of children's community-based BH focused priorities:

- Expand pediatric integrated health-behavioral health opportunities;
- Support transitional care teams for children and adolescents leaving residential, juvenile justice, foster care and inpatient psychiatric settings;
- Assess, test and pilot efforts to bundle payments for episodes of children's crisis care to allow for comprehensive crisis avoidance and response planning, and to avoid emergency hospital admissions and provide access to a more appropriate level of care;
- Expand enhancements for Care Coordination, including expanded use of telemedicine for care coordination, and the development of family care coordination models;
- Target investments into the children's behavioral health workforce to stand up the most effective and carefully designed community-based mental health service expansion across NYS with attention to rural and underserved areas;
- Expand the number of behavioral health urgent care centers for children that will further decrease emergency admissions and provide additional access to care; and
- Use a combination of state and federal funds for pilots to provide enhanced rates to support the delivery of Evidence Based Practices (EBPs) through CFTS services that are integrated to serve children and adolescents who need treatment beyond mild to moderate BH services.

I thank you, on behalf of our entire membership, for your consideration of these comments. We look forward to collaboratively working with the State and other system stakeholders to support the continued improvement of the Medicaid delivery system to better meet the needs of the state's population with behavioral health conditions. If you have any questions, I can be reached at [redacted] or [redacted]

Sincerely,

Lauri Cole
Executive Director

## doh.sm.1115Waivers

**From:** Duffy, Christine [redacted]
**Sent:** Monday, November 4, 2019 10:35 AM
**To:** doh.sm.1115Waivers
**Subject:** 1115 Public Forum Comment
**Attachments:** St Marys 1115 Public Forum Comment (FINAL).doc



On behalf of St. Mary's Healthcare System for Children-thank you for the opportunity to comment. Please see our comments in the attached document. If you have any questions, please feel free to reach out to me directly, my contact information can be found here below.

**Christine Duffy**
Project Manager, Strategic Initiatives
St. Mary's Healthcare System for Children
5 Dakota Drive, Suite 200
New Hyde Park, NY 11042
[redacted]
www.stmaryskids.org
Get social with us!

stmaryskids
Where big hearts help little patients

November 4, 2019

Donna Frescatore
Medicaid Director
Office of Health Insurance Programs
New York State Department of Health
Corning Tower
Albany, NY 12237
Via email: 1115waivers@health.ny.gov

St. Mary's Healthcare System for Children welcomes the opportunity to offer comments on the Medicaid Redesign Waiver' DSRIP Amendment request. To that end, St. Mary's Healthcare System for Children supports the Department of Health in its request for a continuation of the existing waiver and is particularly appreciative of DOH's recognition of the importance of initiatives that place children at the forefront of this waiver extension through March 2024.

St. Mary's Healthcare System for Children (St. Mary's) is committed to improving the health and quality of life for children and families with special needs. We are New York's largest and most experienced provider of long-term care to children with medically complex conditions and New York City's only post-acute care facility for children. We provide a continuum of care to children and young adults with special needs and life-limiting conditions and pave the way in pioneering pediatric post-acute care*.

St. Mary's has been committed to the DSRIP program since its inception in 2014. We contracted early with eight (8) lead PPS organizations: One City Health, Mount Sinai, Community Care of Brooklyn, New York Presbyterian-Queens, New York Presbyterian-NYC, Nassau-Queens (NQP), Bronx Partners for Healthy Communities and the Suffolk Care Collaborative. We have engaged in and contributed to multiple DSRIP projects including: creating Integrated Delivery Systems including connecting with the Healthix RHIO, Care Transitions to prevent 30 day readmissions, Palliative Care and Health Home at Risk even though most of these projects were directed at an adult population.

Our expertise caring for the pediatric population led us to invest our resources most heavily on the only project that specifically focused on children, Project 3.d.ii Asthma Home Based Self-Management. We successfully created integrated care delivery models with One City Health, Mount Sinai and New York Presbyterian-Queens that incorporated the use of Community Health Workers, Skilled Nursing and innovative technology to conduct asthma home visits and to remotely monitor asthma patients' medication adherence.

DSRIP has provided us with the opportunity to collaborate with a new network of agencies and partners including the Asthma Coalitions in both NYC and Long Island. Our collective asthma reduction work has been featured in several media outlets, including the Home Care Association of NY newsletter, HANYs 2019 Connecting with Communities Award publication and at DSRIP Symposium poster sessions. We are proud that St. Mary's Asthma Management Program has contributed to the significant reductions in avoidable hospital use and potentially preventable ED visits achieved by the PPSs; we were one of the lead organizations to deploy CHWs as part of OneCity Health's asthma home visit program, which was cited in the DSRIP Promising Practices report issued by the United Hospital Fund.

There is still much work left to be done and thus we urge DOH to approve the next phase of DSRIP. Support for continuing existing demonstration pilots should continue, especially those focused on incorporating telemedicine and technology to help support transitions of care and remote patient monitoring. We are still enrolling asthma patients in existing technology pilots currently being conducted with both Mount Sinai and New York Presbyterian Queens for asthma medication remote monitoring. More time is required to engage a larger patient base and to acquire the claims data necessary to show significant improvement in medication adherence as well as reductions in avoidable hospitalizations, readmissions and ED visits. DSRIP extension funding would allow us to continue this valuable work and to begin to trend data for further action and adjustments.

One of DSRIPs key projects included the implementation of Care Coordination and Transitional Care Programs; however, these projects were mainly focused on transitions for an adult population. We applaud the DOH's plan to expand DSRIPs promising practices in this area to a higher-risk children's population. St. Mary's Care Coordination Program currently provides care coordination services for these higher-risk children enrolled in four Pediatric Health Homes and is ready and willing to meet the challenge of coordinating care for more patients. St. Mary's has already placed Care Coordinators onsite at Elmhurst, Bellevue and Wycoff Hospitals and with additional funding, would be able to expand these type of services to other hospital systems across the city and Long Island. St. Mary's Care Coordination Department realized the value in collecting information on patient's Social Determinant of Health (SDOH) needs and has recently begun to study trends for action; a DSRIP extension would allow the necessary time for the process to mature and to help us engage additional CBOs to resolve SDOH challenges. St. Mary's also wholeheartedly agrees with the recommendation that Managed Care Organizations be educated and equally engaged participants with shared responsibility for helping to reduce the costs associated with providing the multiple services and SDOH interventions this population requires.

Another critical area we urge DOH to fund in the transformation extension is end-of-life/palliative care for children, especially those with special health care needs. St. Mary's Hospital for Children has always provided palliative care and bereavement services to children in the inpatient setting and has depended on grant funding to offer similar services to children and young adults at home. St. Mary's Home Care was recently designated as one of only two Home and Community Based Service Providers available in the New York Metro area to provide Expressive Therapy (Art, Music, & Play) and Bereavement Services to patients and families in need. Unfortunately, the Medicaid and Managed Care reimbursement rates are not adequate enough to allow us to offer a fair wage to the skilled workforce needed to provide the services. Having DSRIP extension funding to support a community pediatric end of life and palliative care program that permits children to receive these services in their home

surrounded by family and loved ones will not only reduce unnecessary hospitalizations but provide enhanced quality of life during this most difficult time.

Lastly, we urge DOH to consider funding special projects that address children with special healthcare needs. These are children who have, or who are at increased risk of having, a chronic physical, developmental, behavioral or emotional condition and require health and related services of a type or amount beyond that usually required by children generally. Children with special healthcare needs tend to: use medical services much more frequently than the general pediatric population, require various types of healthcare services and supports such as habilitative services and home nursing services, face significant social and economic needs and tend to be enrolled in risk-based Medicaid managed care (MMC). Throughout the 5 boroughs of New York City and nationwide, children and young adults with medical fragility are a growing, high need population. Currently, an estimated 24,000 individuals with medical fragility under age 35 are enrolled in New York State's Medicaid program. This population is estimated to be growing at a rate of at least 5 percent per year.

Fifty percent of children with special healthcare needs in the US are covered by Medicaid and 19% of families with children with special healthcare needs have at least one unmet need (e.g. preventive care, specialist care.) Provider misunderstanding of Medicaid's guarantee for kids, limited or inaccessible consumer information, improper denials of care and a shortage of pediatric specialists and limited provider networks impact the provision of critical services and treatment and contribute to delays in care, which often result in potentially avoidable hospitalizations and ED visits.[1] An extension of the waiver would allow us the time and resources to implement many of the best practices and suggestions outlined in the Manatt Health report which would then result in reduced costs to the Medicaid system.

In closing, St. Mary's Healthcare System once again urges to State to move forward with the waiver extension to address all of the special areas outlined above. Without this extension, we fear that future sustainabilitly of many of the promising practices and collaborations that have been achieved and need just a few more years to gain a firm foothold will be lost.

Sincerely,

Edwin Simpser M.D.

Edwin Simpser, MD
President and CEO

[1] Mann, Cindy; Serafi, Kinda; Eder, Jen & O'Connor, Kayllee. October, 2019. *Keeping Medicaid's Promise: Strengthening Access to Services for Children with Special Healthcare Needs*. Manatt Health, Lucille Packard Foundation for Children's Health, Robert Wood Johnson. https://www.manatt.com/Health

## ***About St. Mary's Healthcare System for Children***

*St. Mary's Healthcare System for Children consists of **St. Mary's Hospital for Children**, a 124-bed post-acute skilled nursing facility, **St. Mary's Home Care**, a NYSDOH designated Special Needs Certified Home Health Agency (CHHA) able to service patients from birth up to age 44 with Skilled Nursing, PT, OT, ST, Social Work and Nutrition services, **St. Mary's Care Coordination Program**, a downstream provider of care coordination for over 500 children and young adults enrolled in Pediatric Health Homes, **St. Mary's Medical Day Care Program** for Young Adults where children receive state-of-the-art rehabilitative and medical care while participating in a variety of supervised indoor & outdoor play, sports, arts & crafts, & other fun therapeutic recreation, social & vocational activities, and **St. Mary's Community Care Professionals,** a Licensed Home Care Agency providing Private Duty Nursing.

## doh.sm.1115Waivers

**From:** Ward, Laurie [redacted]
**Sent:** Monday, November 4, 2019 10:42 AM
**To:** doh.sm.1115Waivers
**Subject:** 1115 Public Forum Comment
**Attachments:** Support Letter_Healthy Steps DSRIP funding_Wyckoff 11 4 19.pdf

Wyckoff Heights Medical Center

November 4, 2019

To Whom It May Concern:

Wyckoff Heights Medical Center (Wyckoff) is pleased to have the opportunity to comment on New York's DSRIP Waiver Amendment to support additional health care system quality improvements under the Delivery System Reform Incentive Payment (DSRIP) Promising Practices. The overall aim of DSRIP 2.0 is to focus directly on community-level collaboration, in order to meet the state's first and ongoing goal of reducing avoidable admissions by 25 percent over the five-year demonstration period. HealthySteps is fully consistent with the policy directions described in the DSRIP 2.0 policy paper and should be embraced by New York State as it continues to undertake strategies to reform the primary care delivery system.

HealthySteps is an evidence-based, interdisciplinary pediatric primary care program, designed to promote nurturing parenting and healthy development for babies and toddlers. HealthySteps offers an array of services to meet families' needs through a resource-efficient, risk-stratified approach, supporting families of all income ranges, while geared specifically to lower income families. The model delivers child and adult-focused interventions that have been proven to generate short-term (annualized) cost savings to New York Medicaid. These early childhood and two-generation investments have been shown to yield even greater returns when evaluated over a longer time period, even beyond the health sector. Our organization has successful implemented the HealthySteps model and it is making a difference for young children, their families, and our providers.

As the waiver amendment acknowledges, "current VBP arrangements built exclusively around primary care provider (PCP) attribution and networks do not completely embrace the kind of comprehensive integrated primary care, behavioral health, and other social care capacities that have been at the heart of most of the DSRIP success." Although the HealthySteps model has made demonstrable improvements to the delivery system, those efforts have not benefited from DSRIP funding or received other support that would ensure that the model would remain sustainable across the state.

The First 1000 Days Preventive Pediatric Care Clinical Advisory Group Final Report and Recommendations called upon the state to sustain its investment in the HealthySteps model, both through the continuation of funding for the sites currently supported by the state and to allow the model to expand to more practices throughout New York. This falls within the state's 1115 waiver amendment recommended actions for securing a better future for New York's children. The HealthySteps model does just that through its commitment to promoting healthy early childhood development through a dyadic approach. These community-based provider networks cannot be sustained without investment. If the state truly expects to improve population health, then the state must provide incentives that more strongly encourage Medicaid managed care

organizations (MMCOs) to partner with non-traditional yet highly effective models of care focused on prevention.

We are encouraged that two of the federal priority areas highlighted in the waiver amendment, Social Determinants of Health and Primary Care Improvement and Alternative Payment Models, provide a stronger focus on children's health and wellness which could lead to a wider embrace of the HealthySteps Model.

Within the appendix of the state's 1115 waiver amendment, the state highlights current Performing Provider Systems (PPS) examples of promising practices at work. These examples, while impressive, suffer from a notable lack of focus on children. To ensure long-term success of the DSRIP initiative, the state must support a system that encourages payment reforms that respond to the unique and varied needs of children. This will only occur if Value-Driving Entities are strongly encouraged to partner and to invest in the interventions that address the needs of children beginning at the time of birth and onward.

Thank you for the opportunity to provide comments on the DSRIP Waiver Amendment and for your consideration of these comments. For more information, please contact Dr. Laurie Ward, Director of Population Health at [redacted]

Sincerely,

Laurie Ward, MD

Laurie Ward, MD
Director, Population Health
Wyckoff Heights Medical Center

## doh.sm.1115Waivers

**From:** Kristin Miller [redacted]
**Sent:** Monday, November 4, 2019 10:44 AM
**To:** doh.sm.1115Waivers
**Subject:** 1115 Public Forum Comment
**Attachments:** CSH Comments 1115 DSRIP Waiver 11-4-19.pdf



Dear Commissioner Zucker,

Attached please find CSH's comments on New York's 1115 DRSIP waiver.

Thank you,
Kristin

Kristin Miller
Director
CSH
61 Broadway, Suite 2300
New York, NY 10006
[redacted]

**Save the Date for CSH Summit 2020: May 27-29, Philadelphia, PA**

November 4, 2019

Dr. Howard Zucker, Commissioner
New York State Department of Health
Albany, NY

Dear Commissioner Zucker:

Thank you for providing an opportunity for the Corporation for Supporting Housing (CSH) to comment on and express support for the State of New York Department of Health 1115 Delivery System Reform and Incentive Payment program (DSRIP) waiver to continue to transform NYS's Medicaid program to a program that rewards value and addresses population health.

CSH applauds the leadership in the state of New York for their previous work on the Medicaid Redesign team and for investing state savings into supportive housing. CSH appreciates NYS' efforts to engage with the supportive housing industry to ensure long-term sustainability for these valuable programs. CSH has been privileged to support the Bronx Health Access (BHA) Performing Provider System (PPS) on its BronxCare Health Systems Housing Navigator Pilot, which has developed an effective model for placing frequent hospital-utilizers experiencing street homelessness into housing, with early results showing a reduction in Inpatient and Emergency Department visits. CSH is also currently partnering with the PPS on our Bronx Frequent Users of Hospital Systems (Bronx FUSE) Initiative to match Medicaid managed care and homelessness data to identify homeless frequent utilizers of emergency medical services and offer them appropriate housing and services. We have seen firsthand how collaboration between PPSs, Health Plans, and Community Based Organizations (CBOs) such as the supportive housing providers, can help achieve the goals of the initial DSRIP waiver. NYS' leadership and requirements in years 3 and 4 ensured that funding would flow to CBOs and allowed the supportive housing and homeless services industry to truly have a seat at the table, share its expertise and resources, and contribute to the statewide 21% reduction in Potentially Preventable Admissions (PPAs).

With the Performing Provider Systems (PPS) in the previous waiver and with the Value Driving Entities (VDE), NYS can continue its leadership role in transforming health care nationwide. CSH does agrees that more time is needed for these partnerships to mature and have the bigger and broader impact on health care that we know is possible. CSH supports the new waiver request to extend and enhance these projects but strongly encourages the state to have a clearer and more directive emphasis on addressing the needs of persons experiencing homelessness and housing instability and on improving health equity for New Yorkers. CSH particularly supports the state's proposed creation of Social Determinant of Health Networks (SDHNs) with robust, sustainable funding models for networks of CBOs addressing social determinants of health. We believe the SDHNs will be stronger with state requirements to ensure funding to the CBOs earlier and at a higher rate than the previous waiver. We see the need for this requirements as a lesson learned from the previous waiver.

CSH's network and experience have seen firsthand the impact of the Social Determinants of Health (SDOH), including housing, to impact health care outcomes, costs, and individuals' experience of care. For example, a CSH-led FUSE project in Los Angeles county moved 205 high-cost Medicaid recipients experiencing homelessness into supportive housing, resulting in a 65% reduction in hospital costs after 12 months in housing and projected cost avoidance of $86,000 per patient over three years.[1] CSH has seen nationwide that supportive housing (safe, stable, affordable housing with integrated services) is essential to the health and well-being of marginalized individuals and families from all walks of life. To best serve individuals and families most in need, communities must integrate service providers alongside health care entities, a clearly articulated goal of the new waiver proposals. The state's Promising Practices highlights cross-sector collaboration between Physical and Behavioral Health, health care and justice sectors and various other community partnerships. This collaboration and specific resources targeted to the collaboration and to the non-health care sector partners will be essential to achieve the next wave of success in the NYS Medicaid program.

CSH sees real progress in the new waiver development and submission. The development of Value Driving Entities (VDEs) that include Managed Care Organizations (MCOs) as key drivers of population health moves NYS closer to a truly integrated system all focused on similar goals. Moving away from rewarding process measures is a meaningful step towards actual implementation. The continued reinvestment of resources into promising practices that build on NYS expertise and sophisticated provider networks can lead the nation in health care transformation.

CSH also values the waiver's emphasis on developing Social Determinants of Health Networks (SDHN). In the previous waiver, NYS requirements around participation of CBOs to deliver evidenced-based social services interventions made a valuable difference in the CBOs' ability to collaborate effectively, and we hope that the current climate's emphasis on flexibility will not signal a lesser role in that guidance. Our work nationally has found a disturbing trend of the health care sector's bringing services in-house, rather than relying on the existing expertise, networks, data and partners of the CBOs, in other words, "building it versus buying it." We hope that the state will continue to require that the new VDEs partner with the CBOs in an equitable manner – one that builds on their strengths and supports them through their challenges.

As the state supports the building of these networks, we want to offer some guidance informed by what we have seen nationwide in the field. While SDHs encompass a variety of issues (transportation, food insecurity, interpersonal violence, among others), we have seen that addressing housing - particularly for high-cost, high-need individuals - has the greatest impact on reducing costs, improving population health and addressing health disparities. We have also seen that given the challenges in implementing such interventions, housing is often left out of the SDOH equation as 'too hard to develop and unlikely to see results in single-year time frames.' While CSH acknowledges the reality of these challenges, we encourage the state to continue to address housing in order to achieve "coordinated population health improvement" as is its stated goal. We encourage the addition of a specific requirement for developing SDHNs to support housing activities, and have housing-related goals and metrics – including efforts to reduce/eliminate racial and ethnic disparities – included in any evaluation of the effectiveness of the SDHNs.

As the state has also prioritized long-term care reform, we believe the alignment of housing resources and housing support services is an essential part of this process. The state's efforts around care transitions for various populations to and from different settings is an essential component of these efforts. Too often, long-term care translates into needlessly long institutional stays due to a lack of affordable or supportive housing capacity in any given community. Continued strategic investment in housing will be needed for long-term care reform efforts to succeed. The State of New Jersey has set a laudable example by establishing its The Money Follows the Person Housing Partnership Program (MFPHPP), which is a

[1] https://d155kunxf1aozz.cloudfront.net/wp-content/uploads/2018/01/CSH-SIF-Evaluation-Summary-02-02-18Final.pdf.

partnership between the New Jersey Housing and Mortgage Finance Agency (NJHMFA) and the New Jersey Department of Human Services, Division of Aging Services (DoAS). The program offers a capital subsidy to developers to set aside housing units for qualified individuals transitioning from nursing facilities to community settings.[2] Investment into housing to facilitate long-term care transitions and ensure their success align well with the state's emphasis on VDEs, SDHNs and VBP models in general.

Given the shared goals of CSH's Strategic Plan and NYS' proposed waiver to serve vulnerable and marginalized populations, CSH would like to call attention to three key areas of focus we believe ought to receive special attention in the waiver amendment: racial equity, thriving, and data. Please see the CSH Strategic Plan for more information of how CSH conceives of these three drivers as key to addressing complex health and housing challenges.[3]

**A Racial Equity Framework**

The lack of Racial Equity in health care is evidenced by significant health disparities experienced by people of color, particularly Black/African American individuals. The State's *Medicaid Redesign Team Supportive Housing Evaluation: Utilization Report* released in May 2017 showed that of the early examination of the initial cohort of homeless high-need, high-cost Medicaid members (n=2,071), an astounding 42% were identified as non-Hispanic Black. Black people constitute only 15.6% of New York State's total population but account for 52% of NYC's adult homeless population. This initial utilization report demonstrates that Black individuals comprised nearly 1 in 2 of the state's high-cost Medicaid members with housing insecurity identified for the MRT Supportive Housing intervention. These glaring and costly inequities in crisis systems' overrepresentation by people of color points to a clear need for targeted health and housing interventions to systematically tackle racial health disparities. Without a focused approach on racial health inequities, the State will not meet nor sustain its intended goals outlined in the waiver amendment.

**A Focus on Thriving in the Community**

United Hospital Fund's *DSRIP Promising Practices: Strategies for Meaningful Change for New York Medicaid* report specifically identifies the health disparities suffered by many marginalized communities in NYS. The waiver has an explicit focus on building health equity in communities, and has learned the value of community engagement, as evidenced by the number of promising practices that are grounded in community engagement activities.[4] CSH views community engagement and addressing health disparities as foundational work in systems, rather than an 'add-on' to specific projects. CSH will encourage the ongoing activities to ensure that the allocation of resources, data analytics works, and building of continued success all include the voice of people with lived experience and work to ensure that these health disparities are addressed.

CSH's developing Thrive Framework highlights a multi-pronged strategy to ensuring a productive life in the community for all. The waiver draws on many Promising Practices from its previous iteration to continue to strive towards this goal, including by addressing both social needs and the necessary community partnerships and cross-sector collaborations. CSH would highlight that a small subset of persons will need more support than commonly simple care coordination provides. Persons who are experiencing homelessness, have multiple physical and behavioral health disabilities, and have multi-system involvement are commonly not able to effectively engage with the health care sector and therefore must rely too heavily on acute levels of care for assistance. Services funding to expand supportive housing and more research to better understand what populations need which supportive services to thrive would be of value to NYS and the field nationally.

[2] https://www.nj.gov/dca/hmfa/developers/needs/mfphpp/
[3] https://www.csh.org/strategicplan-2/
[4] https://uhfnyc.org/publications/publication/dsrip-promising-practices/

**Harnessing Data to Generate Results**

The waiver includes a variety of strategies and projects that harness data and improve data sharing opportunities to generate results. In the waiver, the state acknowledges the key role of the Qualified Entities, the state's health information organizations, in moving forward the goals of the VDEs. The state has the opportunity to set data standards and guide uniformity between systems, an issue that will create simpler opportunities for data matching. Bidirectional data exchange capabilities will be key to establishing effective projects that use data to target resources to individuals who need them most. It will also be essential to ensuring continuous program monitoring and success. CSH would encourage the state to prioritize resources for the CBOs, who may not have the analytics and staff capacity of their larger partners such as PPSs and MCOs, to navigate complex data sharing agreements or data analysis. Both CBOs and their healthcare partners will need this bi-directional strategic information to guide their efforts. CSH applauds the state for its Promising Practice of tracking high utilizers across multiple settings, and we might add multiple systems as well. Building on CSH's signature product, the Frequent User System Engagement model, PPSs and VDEs can track high utilizers and target resources. We would encourage new projects to include multiple systems, including criminal justice settings, the homelessness services sector and the child welfare sector.

Thank you again for the opportunity to express support for the State of New York's proposed 1115 Delivery System Reform and Incentive Payment (DSRIP) waiver. CSH will watch its continued development process with great interest. We appreciate your considering our input and look forward to continued interaction as this process unfolds.

If you have any questions or need additional input and information, please do not hesitate to contact Marcella Maguire, Director of Health Systems Integration.

Sincerely,

Kristin Miller

Director, Metro Team

CSH
61 Broadway, Suite 2300
New York, New York, 10006

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**About CSH**

CSH is a national non-profit that works with communities across the country to create supportive housing - affordable housing connected to health, human services and community supports - to help individuals and families thrive. For 25 years CSH led the national movement to end chronic homelessness through supportive housing. With this experience and expertise, CSH now leverages supportive housing as a central component to changing the way communities respond to a range of vulnerable individuals who are also *at risk* of becoming homeless, including aging seniors and people with disabilities.

**doh.sm.1115Waivers**

**From:** Darlene S. DiCarlo [redacted]
**Sent:** Monday, November 4, 2019 11:10 AM
**To:** doh.sm.1115Waivers
**Cc:** [redacted]; Robert Ortt; [redacted]
**Subject:** 1115 Public Forum Comment
**Attachments:** Letter - DSRIP Support 2019.pdf



Good morning,

Attached please find my letter in support of DSRIP renewal proposed by the NYS DOH. Here at the Office for the Aging, our services are utilized by many in the community and because of what we do.....Medicaid spending is greatly reduced as we are able to keep clients in the home with services instead of the costly skilled nursing facilities.

Thank you for your consideration.

*Darlene S. DiCarlo*
*Director*

*Niagara County Office for the Aging*
*111 Main Street, Suite 101*
*Lockport, NY 14094*
[redacted]

[redacted]

**Niagara County Office for the Aging**
111 Main Street, Suite 101
Lockport, NY 14094
Phone 438-4020
Fax 438-4029

Darlene S. DiCarlo
Director

*November 1, 2019*

*Mr. Paul Francis*
*Deputy Secretary for Health & Human Services*
*State Capitol*
*Albany, NY 12224*

*Ms. Donna Frescatore, Medicaid Director*
*NYS Department of Health*
*Department of Health*
*Corning Tower, ESP*
*Albany, NY 12237*

*Dear Mr. Francis and Ms. Frescatore,*

*On behalf of Niagara County Office for the Aging, I am writing to express my recommendations on the DSRIP renewal proposed by New York State Department of Health. The services we provide through our office have a direct impact on reducing the number of ER visits, reduce the number of hospitalizations including subsequent and costly readmissions. In addition to this, by providing in home services, NYS is saving tons of Medicaid dollars that would have been expended to put these individuals in skilled nursing facilities.*

*The NY Connects program, implemented in 2006, serves as no wrong door for any and all services available in the region, and is a catalyst for individuals in need of assistance. The targeted goals in the proposed renewal* ***are exactly what this network provides****, and must include mandated contracting by each PPS with their local Area Agency on Aging for social determinants of health initiatives.*

*Our office is the trusted service provider for the fastest growing segment of the population, and our services absolutely allow individuals to remain in their own homes and communities, all while saving valuable health care dollars. We provide the highest level evidenced based interventions, and are experts at navigating a complex health care system, while providing person centered care plans.*

*To demonstrate the value of the network, I would like to highlight a recent case that is typical to our office directly from my EISEP case worker, Jennifer.*

*I met Marilyn in July 2014 when the Home Delivered Meals program referred her to EISEP. Marilyn was handling her day-to-day pretty well but needed some housekeeping in order for her to maintain her home. I opened her case and found her an aide quite quickly, which can be difficult in a rural area. Marilyn was already linked with the OFA Transportation to get her to dialysis 2 of 3 days per week but since one of her days was on a Saturday, they were unable to get her there. Through EISEP's ancillary service, we were able to provide Marilyn with rides to and from her dialysis. Our program covered the cost of a PERS for Marilyn, which was used a handful of times through the years, especially after she developed a heart condition and needed medical assistance promptly.*

*As the years went on, and her stays at the hospital increased in frequency and duration, we were able to offer more hours with her aide as well as increasing the service to Personal Care II as she was having trouble with showering and dressing. Marilyn was fortunate to have worked with the same aide all those years. In September 2019, Marilyn was admitted to the hospital, then rehab. The decision was made to have her stay at the nursing home permanently. Marilyn and her family have expressed gratitude for all the help we were able to give for the 5 years that she was able to stay in her home. As a direct result of the services provided by the Office for the Aging, the Medicaid program saved $365,000 which is what it would have cost for skilled nursing care at the current average Medicaid SNF rate.*

*This is one of many cases that truly displays the boots on the ground service provision in every county across the state. In the renewal waiver, I cannot stress highly enough that we need to harness the existing strengths of community based services, instead of recreating case management services and duplication of services.*

*Each and every case manager in the entire statewide aging network has received certification via Boston University School of Social Work, ensuring consistency in assessment not provided by any other system. I ask that there are mandates for each PPS to engage and contract with their local Offices for the Aging, for the services vital to keeping individuals in home and community based settings.*

*Best Regards,*

Darlene S DiCarlo

*Darlene DiCarlo, Director*
*Niagara County Office for the Aging*

*Cc: Assemblymen Michael J. Norris & Harry B. Bronson*
*Senators Robert G. Ortt & Senator Rachel May*

## doh.sm.1115Waivers

**From:** Kelly Lane [redacted]
**Sent:** Monday, November 4, 2019 11:16 AM
**To:** doh.sm.1115Waivers
**Subject:** MVBHCC Response to MRT 1115 Waiver Amendment Proposal
**Attachments:** MVBHCC Response to the MRT 1115 Waiver Amendment Proposal.pdf



Good morning -

On behalf of the MVHBCC I am pleased to submit the attached feedback to the MRT 1115 Waiver Amendment Proposal.

Thank you for the opportunity to provide feedback.

Best,
Kelly

Kelly Lane
**Director, Mohawk Valley Behavioral Health Care Collaborative**

The Neighborhood Center, Inc

[redacted]
**a.** 624 Elizabeth Street Utica NY 13501 United States
[redacted]
www.neighborhoodctr.org

**MEMORANDUM**

**TO:** NYS Department of Health, Medicaid Redesign Team
Email: 1115waivers@health.ny.gov

**FROM:** Kelly Lane, Director on behalf of Network Partners
Mohawk Valley Behavioral Health Care Collaborative
Email: [redacted]

**DATE:** November 4, 2019

**SUBJECT:** Mohawk Valley Behavioral Health Care Collaborative Response to the 1115 MRT Waiver Amendment Proposal

The Mohawk Valley Behavioral Health Care Collaborative (MVBHCC) is pleased to submit this response to the 1115 Waiver Amendment proposal. The MVBHCC also supports responses submitted by the Statewide BHCC Collaborative and Mohawk Valley Regional Planning Consortium.

Overall, the BHCC was pleased to see an articulation of key priority areas (Section II) that align with efforts underway in our network. As two-thirds of the promising practices involve behavioral health, we feel strongly that gains in these areas will only be seen if behavioral health networks are resourced appropriately and have an active role in decision making. We are optimistic, with some adjustments, about the potential that VDEs have in bringing together networks in a truly integrated delivery system. Thank you for the opportunity to provide feedback.

Specifically, MVBHCC is advocating for:

- A required seat in the governance structure of the Value Driving Entities (VDEs)
- Workforce spending allocations specifically earmarked for community-based behavioral health

MVBHCC is an eight county network of mental health, substance abuse, and home and community based service providers and community based organizations that covers Chenango, Delaware, Fulton, Herkimer, Montgomery, Oneida, Otsego, and Schoharie counties. The region is largely rural and faces issues of poverty, isolation, access to broadband internet, and a lack of employment and educational opportunities. Issues related to access to transportation create barriers to individuals accessing care and have implications for maintaining a robust workforce equipped to handle the needs of our communities.

Behavioral health providers in our network, like others across the State, play a critical role in addressing the inadequately-met needs of those with complex issues and by doing so contribute to the reduction of costs in the health care system.

To prepare for contracting under Value Based Payment (VBP), our network is in the process of establishing a not-for-profit Independent Practice Association (IPA). During the course of the BHCC project, the role of behavioral health organizations in contracting has remained unclear, despite consistent recognition that individuals with complex needs, that is chronic illness and co-occurring mental health, substance use, and social determinant of health needs, cost the health system more than individuals without co-occurring issues. Managed Care Organizations are prioritizing Total Cost of Care

contracts with health systems and pushing BHCC/IPAs to subcontract with hospitals, however these organizations are still trying to assess their own participation in VBP contracts and are not prepared to engage with behavioral health.

While there were some successful efforts to close the gap between siloed health, behavioral health, and social determinant of health services in the initial round of the Delivery System Incentive Payment Reform Project (DSRIP), our region saw disparities in distribution of funds (project and infrastructure), with hospitals and health systems as primary recipients of funding. Additionally, PPSs in our region varied in their approach to collaboration with behavioral health providers. PPSs that included behavioral health and CBOs in a meaningful way saw improvements in behavioral health focused outcomes. Our concern lies in allowing VDEs to set the terms of engagement with BHCCs which we fear will result in a repeat of the first round of funding disparity and exclusion.

**Required VDE Governance Seat**

To achieve true integration, the system needs to mirror integration at all levels – at service delivery levels, organizational levels, and at the system level. Requiring a governance seat for BHCC/IPAs, will ensure network representation in mental health, substance use, and social determinant of health services. The 1115 Waiver Amendment proposal offers an opportunity to create more equity in representation in the VDE leadership structure. Across PPSs, leadership at the Executive, Board and Committee levels, was heavily represented by hospital and primary care stakeholders, organizations that in addition to outnumbering behavioral health providers, often represent large systems that "outweigh" individual providers.

It is clear that behavioral health interventions are a critical element to achieving the goals of DSRIP, as nearly 2/3 of the priority areas are linked to services represented in the BHCC networks. The State has already recognized the importance of Social Determinant of Health services, and communicated that importance via a required seat in VDE governance. We are asking for the same.

**Earmarked Behavioral Health Workforce Dollars**

A shift to community based care can only happen with an adequate workforce, capable of meeting the complex needs of high needs and high risk individuals. Earmarking workforce dollars for behavioral health providers will ensure that organizations can appropriately meet the needs of individuals transitioning from hospital based care by ensuring that organizations have an appropriate number of staff to meet demand and that staff are trained and able to respond to individuals with complex needs using evidence based treatments.

Similar to project funding, our region saw workforce dollars disproportionally directed towards hospitals and primary care organizations as compared to behavioral health organizations. In a rural environment, behavioral health providers lack resources to compete with the salaries and benefits of hospitals. Implementation and sustainability of the promising practices outlined in the 1115 Waiver Amendment Proposal hinge on the workforce employed to deliver them.

We appreciate the opportunity to provide feedback and look forward to the release of the finalized proposal.

## doh.sm.1115Waivers

**From:** Mallory Yung [redacted]
**Sent:** Monday, November 4, 2019 11:20 AM
**To:** doh.sm.1115Waivers
**Subject:** 1115 Public Forum Comment
**Attachments:** DSRIP Amendment Request Public Forum Comment.pdf



Hello,

Attached are our comments on the DSRIP Waiver Amendment Proposal. We appreciate the opportunity to provide feedback on this proposal and look forward to your response.

Best,
Mallory Yung

--
**Mallory Yung, BSc.**
*Graduate Research Assistant*
Community Health Initiative
*Master of Public Health Candidate - Health Policy*

**Dr. Howard Zucker**
Commissioner
New York State Department of Health
Attn: Delivery System Reform and Incentive Payment (DSRIP) Amendment Request - 1115 Public Forum Comment
Albany, NY 12207

**RE: Delivery System Reform and Incentive Payment (DSRIP) Amendment Request**

Dear Commissioner Zucker,

We are writing to offer comments on the New York State (NYS) Department of Health's proposed amendments to the Section 1115 DSRIP program. In this comment letter, we first clarify the definition of social determinants of health (SDOH) and then address our concerns regarding the conflation of SDOH with social needs and the effect this has on the activities proposed in NYS DSRIP Amendment Request. Based on our assessment, we recommend the following:

- Clarify the definition of SDOH and, based on this clarification, revise the current approach of the proposed NYS DSRIP SDOH strategy. The definition of SDOH that is being operationalized in DSRIP is inaccurate and equates SDOH with individual social needs. Accordingly, the current description of the proposed "Social Determinant of Health Networks" (SDHN) indicates functions of such networks that are primarily designed to address health-related social needs of Medicaid beneficiaries rather than the social determinants of health of the communities where they reside. ***We recommend that these networks be renamed "Health-Related Social Needs Networks" to more accurately reflect their role in addressing health-related social needs rather than social determinants.***

- Establish regional "Social Determinants of Health Partnerships" (SDOHP) that would focus on addressing SDOH in defined regions. Since it is desirable to address the social determinants of health impacting Medicaid beneficiaries in addition to their social needs, we propose that the DSRIP Amendment Request includes funding for multi-sector partnerships, Social Determinants of Health Partnerships, to carry out this function. The SDOHPs should focus their efforts on New York State Prevention Agenda strategies that address social determinants of health . In addition, the SDOHPs should align their efforts with those of the Health Related Social Needs Networks. Funding should be allocated to the SDOHPs and to organization(s) to provide technical assistance (TA) to support their development. ***We suggest that approximately 5% of the $1.5 billion funding currently proposed for DSRIP SDOH efforts be allocated to the proposed SDOH partnerships and their support organizations.***

**Making a Distinction between SDOH and Social Needs**

The WHO Commission on Social Determinants of Health defines social determinants of health as "the conditions in which people are born, grow, live, work, and age" that are the consequences of "structural

drivers" such as policies, programs, economic arrangements, and politics.[1] This definition implies that interventions targeting SDOH should address the underlying socioeconomic conditions that give rise to community conditions. We would like to stress the importance of the distinction between *health-related social needs* at the individual level and *social determinants of health* at the community level. This distinction has important implications for the selection of strategies with which SDOH are addressed. Social needs are typically addressed through direct services provided by community-based organizations (CBOs), social workers, or community health workers. In comparison, SDOH impact everyone within a community and require policies, organizational practices, laws, and regulations that target the root causes of community conditions. The conceptualization of SDOH in the DSRIP Amendment Request incorrectly equates individual social needs with SDOH. It is important to recognize that social needs are often the consequences of unaddressed SDOH. Thus, solely addressing individual needs is inadequate because the need for individual interventions will persist until underlying community conditions that create the need for such interventions are addressed.[2] ***We urge NYS to clarify the distinction between health-related social needs and SDOH.***

**Renaming the currently proposed "Social Determinants of Health Networks" to "Health-Related Social Needs Networks" to more accurately reflect their function**

We would like to emphasize that interventions targeting *both* social needs and SDOH will maximize efforts to improve individual and population health. We support the NYS Department of Health's efforts to integrate social and healthcare services by requiring the inclusion of social services in value-based arrangements. However, it appears that the vast majority of proposed "SDOH" interventions are, in fact, interventions that will only target *individual social needs*. Although "extending promising practices upstream towards primary prevention" is mentioned in the DSRIP proposal, there is a dearth of upstream interventions in the SDOH Intervention Menu that would actually address SDOH through primary prevention. In addition, calling these networks "Social Determinant of Health Networks" (SDHN) perpetuates this inaccurate framing as these networks will, in fact, address social needs rather than social determinants. ***We urge the NYS Department of Health to change the name of "Social Determinant of Health Networks" to "Health-Related Social Needs Networks" to more accurately reflect their focus on social needs.***

**Establishing SDOH Partnerships to identify and implement the NYS Prevention Agenda's Interventions Addressing Social Determinants of Healths**

Given the importance of addressing the SDOH as defined by WHO to improve the health of Medicaid beneficiaries, we urge the NYS Department of Health to support the development of regional SDOH Partnerships (SDOHP). These cross-sector partnerships could be new or existing partnerships that would receive DSRIP funding to implement one or more of the NYS Prevention Agenda's (2019-2024)

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[1] CDSH (2008). *Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health.*

[2] Castrucci & Auerbach. (2019). *Meeting Individual Social Needs Falls Short Of Addressing Social Determinants Of Health.*

evidence-based interventions focused on social determinants of health. For example, social determinants of children's population health is listed as a high-need priority area for the next phase of DSRIP. There are several suggested evidence-based policy and environmental changes for child obesity prevention cited in the Prevention Agenda, such as a multi-component intervention that targets physical activity and nutrition before, during, and after school. This intervention would align with other DSRIP supported interventions designed to address social needs of high risk patients such as those who are identified by screening for food insecurity in clinical settings.

Given the limited capacity among new or existing partnerships identified to address social determinants of health, we urge the NYS Department of Health to also provide funding for one or more technical assistance teams to provide cross-sector partnerships with the necessary technical assistance (i.e. needs assessments, workforce training, intervention planning, implementation coaching, and evaluation) to successfully address SDOH. As recommended by the Trust for America's Health in their 2016 Blueprint for a Healthier America, these teams would ideally be made up of practitioners and academic partners with experience in implementing and evaluating programs and policies. ***We urge the NYS Department of Health to allocate 5% of the proposed $1.5 billion SDOH investment towards establishing SDOHP and technical assistance support teams.***

We appreciate the opportunity to provide input on the proposed DSRIP Amendment Request and hope that our comments will be given consideration to improve the impact of interventions to address both health-related social needs and SDOH.

Sincerely,

Mallory Yung
MPH Candidate in Health Policy
New York University College of Global Public Health
[redacted]

Andrew Goodman, MD, MPH
Clinical Professor of Public Health Policy and Management
New York University College of Global Public Health

## doh.sm.1115Waivers

**From:** Marie Mongeon [redacted]
**Sent:** Monday, November 4, 2019 11:54 AM
**To:** doh.sm.1115Waivers
**Cc:** Lacey Clarke; [redacted]
**Subject:** 1115 Public Forum Comment
**Attachments:** CHCANYS DSRIP 2.0 Final Comments PDF.pdf



To whom it may concern:

Please find attached comments from the Community Health Care Association of New York State (CHCANYS) on the State's draft DSRIP Waiver Amendment Request.

Marie Mongeon, MPH
Policy Analyst
Community Health Care Association of New York State
90 State St., Suite 600
Albany, NY 12207
[redacted]


**Comments on the NYS Draft DSRIP Waiver Amendment Request**

**November 4, 2019**

The Community Health Care Association of New York State (CHCANYS) is grateful for the opportunity to provide comments on the Delivery System Reform Incentive Payment (DSRIP) Amendment Request concept paper published on September 17th. CHCANYS represents New York's federally-qualified health centers (FQHCs), also referred to as community health centers (CHCs), which operate over 800 sites and serve 1 in 8 New Yorkers. CHCANYS commends the State's work in the first round of DSRIP to reduce costs, improve patient outcomes, and decrease unnecessary inpatient and emergency room utilization. For New York to experience a real transformation of the health care delivery system and sustain the gains thus far achieved through DSRIP, there must be a significant investment in community-based primary care. Only through this investment can the State achieve a true value-based system that improves health outcomes and reduces costs. CHCANYS supports the renewal of the DSRIP program through March 31, 2024 but offers the following comments on the proposed amendment request.

## I. Driving Promising Practices to Improve Health Outcomes and Advance VBP

By mission and in statute, health centers serve the State's most vulnerable and hard to reach populations. FQHCs are non-profit, community run centers located in medically underserved areas that provide high-quality, cost effective primary care, including behavioral and oral health services, to anyone seeking care. Each FQHC is governed by a consumer-majority board of directors who are tasked with identifying and prioritizing the services most needed by their communities. 59% of New York State health centers' 2.4 million patients are enrolled in Medicaid or CHIP.

The more than 800 CHCs located across the State provide access to comprehensive primary care services, especially among populations that are most likely to present at the ED with a non-urgent or avoidable condition. In the first round of DSRIP, every health center participated in at least one Performing Provider System (PPS) and many health centers were members of multiple PPS. Multiple health centers expanded their capabilities to address the opioid crisis by expanding the number of physicians that are waivered to provide Medication Assisted Treatment (MAT). One PPS provided a health center with funds to create a residency program to address nursing workforce shortages. One health center used DSRIP funds to enhance their Electronic Health Record (EHR) to include Aunt Bertha, a software to identify local social services organizations. The health center also tracks referral volume and receives feedback from community partners regarding attendance and utilization. DSRIP provided health centers the flexibility to waive regulations to more effectively integrate primary care and behavioral health services – many health centers have taken up that flexibility and also have begun hot spotting high risk patients in an effort to reduce their use of emergency departments and improve their overall quality of life. These are just a handful of examples of health centers leveraging DSRIP funds to drive promising practices.

The first round of DSRIP complemented the health center model's unique and innate ability to provide comprehensive and innovative care to New York's Medicaid beneficiaries. Health centers played and

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continue to play a key role in advancing the promising practices within their regions and driving improved health outcomes. In the second round of DSRIP, health centers are well-prepared to take a leadership role to advance the State's vision of an expanded value-based payment (VBP) landscape driving DSRIP promising practices.

## II. Embracing the Role of VDEs

CHCANYS is pleased to see that the State has acknowledged the need for additional flexibility in the next round of DSRIP and is interested in ensuring the success of Value-Driving Entities (VDEs). However, we encourage the State to provide direct investment in community-based providers. Currently, 23 of 25 of the PPS leads are hospital-based, with no specific requirements about how funds flow to partners in the PPS networks. Meaningful governance participation by community-based providers, such as community health centers and community behavioral health organizations, and downstream investments to health centers and other community-based providers varied greatly from PPS to PPS. Using publicly available data reported by the State, it is extremely difficult to determine the amount of money received by health centers in the first round of DSRIP – they are included as "clinics" with hospital ambulatory providers. However, the most up to date data reported by the State in November 2018 demonstrates that hospitals received more than 28% of total funds flow while representing only 0.2% of total engaged PPS partners.[i] It is exceedingly difficult to transform the healthcare delivery system by continuing to invest most transformation dollars into inpatient-based care models, when it is the long-standing established CHC providers and workforce that can make the biggest impact on patients' health outcomes. CHCs are especially well-posed to integrate care, make connections to address social needs, and become the more adept and agile VDEs envisioned in the State's concept paper.

We support the State's charge that VDEs include providers, community-based organizations (CBOs), and managed care organizations (MCOs) to leverage VBP and advance promising practices. A collaborative partnership between community-based providers, CBOs, and MCOs is critical to implementing and supporting transformative initiatives that move away from a volume-driven care model. However, to support improved access to care in the community and reduce reliance on emergency departments and inpatient care, the State must direct additional resources to a broad range of community-based providers. **CHCANYS requests that the State dedicate, at a minimum, 25% of DSRIP funds to the development of community-based VDEs where CHCs, in collaboration with other community-based providers, are leads.**

### a. VDE Lead Entities

The State should capitalize on existing health center Independent Practice Associations (IPAs) as a launching point for the creation of community-based VDEs. There four CHC-led IPAs currently organized across the state, Community Health IPA (CHIPA), Safety-Net IPA (SIPA), Finger Lakes IPA (FLIPA), and Upstate Community Health Collaborative IPA (UCHC), are engaged with MCOs in at least one VBP contract while working on additional agreements. Also, several CHCs are engaged in regional, integrated IPAs with behavioral health providers and CBOs. These IPAs leverage the experience and expertise of

primary care and behavioral health providers to improve care coordination and care delivery for many of the most at-risk and highest cost patients. Another key feature of these IPAs is their ability to take on risk and become financially accountable for both the quality of care and the most efficient delivery of care services. CHCANYS believes that these integrated IPAs are well positioned to work with other entities as a VDE in the second round of DSRIP. Below are some examples.

Finger Lakes PPS (FLPPS) invested $275,000 into the creation of an integrated IPA, FLIPA, which includes 5 community health centers and 6 community behavioral health organizations and covers about 60,000 lives. The initial investment supported clinical and information technology population health management activities. To date, FLIPA has is engaged in two VBP contracts with regional MCOs and their work has saved FLPPS $11.5 million.

EngageWell IPA, which is supported by a grant from the State's Behavioral Health Care Collaborative (BHCC) program, is an integrated IPA serving Medicaid Managed Care enrollees. Over 20 member agencies, including health centers, provide health care, mental health and substance use treatment, harm reduction, care coordination, supportive housing and housing assistance, education, employment support, food and nutrition and benefits assistance address enrollees social needs to improve their health outcomes. EngageWell is in the process of using investments to launch quality data dashboards and a corresponding internal quality improvement program for all participating providers.

These two successful models of promising practices can be scaled and modified for replication in other areas of the State. CHCANYS is currently working with the New York State Council for Community Behavioral Healthcare to identify opportunities for collaboration among BHCCs and health center IPAs. Our members are committed to this integration of care approach piloted by FLIPA and EngageWell. Acceleration and support of this work by the State can only result in the State achieving its stated DSRIP goals of sustainability and improved integrated care models.

While health centers are already developing relationships needed to advance in VBP contracts, a second round of DSRIP is an opportunity to invest in building capacity to ensure health center and CBO IPAs have the foundation to serve as VDEs. Currently, health center-led IPAs are self-funded and have little financial capacity to support many of crucial functions that would accelerate their successful participation in VBP arrangements. **Health center-led IPAs require DSRIP investment to support the data analytic capabilities needed to effectively manage population health and drive improved outcomes.**

**b. Considerations for Engaging MCOs**

CHCANYS is pleased that the State is taking steps to ensure engagement of MCOs early in the planning process for a second round of DSRIP. However, there are significant challenges that must be addressed ahead of the creation of VDEs. One of the current difficulties faced by providers as they seek to participate in VBP arrangements is a lack of comprehensive data about their attributed patients. **The State should update the MCO Model Contract to create and enforce a uniform data sharing policy for**

**the managed care plans to further support the transition to VBP, for example, by enforcing transparency in expenditures and utilization.**

In the first round of DSRIP, the discrepancies between MCO attribution and PPS attribution made it difficult for health centers to effectively manage patient health outcomes. PPS networks do not necessarily encompass the same providers that are contracted with a given MCO. If there are discrepancies between MCO attribution, consumer utilization, and PPS network, it becomes incredibly difficult, if not impossible, for the PPS to effectively manage health outcomes for these populations. PPS and VDEs should not be expected to manage the health care improvements of individuals who are enrolled in managed care plans that contract outside of the VDE. **CHCANYS recommends that in the next round of DSRIP, VDE attribution should be aligned with MCO attribution to ensure seamless VBP contracting.**

Finally, we understand the State's desire to drive regional innovation – local health care needs vary based on geography, CBO and health care provider landscape, and other factors. However, we would like to raise the concern that in densely populated areas served by many MCOs with overlapping service areas (notably, New York City), defining distinct regions may prove difficult. **In New York City, CHCANYS recommends that VDE networks should align with patient utilization patterns as much as possible.**

## III. Relationships of PPS and VDEs

Based on the language included in the concept paper, *"The Second Generation "Value-Driving Entities" (VDEs) will consist of a Performing Provider System (or a subset of the Performing Provider System), provider, CBO and MCO teams specifically approved by the state to implement the high-priority DSRIP promising practices."* it is our understanding that the PPS will be active agents in the creation of VDEs. In addition to our recommendation that the State dedicate at least 25% of DSRIP funds to the development of community-based VDEs, two other attributes of the PPS and VDE structures must be addressed.

### a. Re-Open PPS Provider Networks

The PPS provider networks were established in 2015 when most providers were not familiar with the mechanics and relationships required for successful participation in DSRIP. Primary care providers and community behavioral health organizations made their PPS selections based on the information available at the time. The PPS selection was locked-in over the 5-year DSRIP program. Since that time, health centers have fostered new relationships with hospitals, behavioral health providers, and CBOs as new payment models have evolved - many outside of the PPS structure. To continue to foster the provider networks that have evolved over the past 4-5 years, **DSRIP 2.0 must allow for providers to re-assess and revise their PPS selection.**

### b. Approval of a Single VDE Across Multiple PPS

Many primary care providers, including FQHCs and community behavioral health organizations, work with multiple hospital systems within the communities they serve. As most PPS are hospital-led and

providers were initially able to select one PPS, this has created an operational nightmare for the primary care and behavioral health provider communities. Health centers have been required to participate in certain projects for their patients within their selected PPS, meanwhile a subset of their patients are served through hospital relationships that exist in a different PPS. Over these past 4-5 years, providers have formed relationships in preparation for VBP, both within and outside of the PPS structure. To allow for a more cohesive and seamless primary care delivery system, **the extension of the DSRIP waiver must provide for VDEs that cross PPS and are eligible to receive investments for provider networks that cut across multiple PPS.**

## IV. Supporting Non-Clinical Workforce to Address Social Needs

CHCANYS echoes the State's observation that many of the successful DSRIP initiatives rely on non-traditional, non-clinical workforce that help patients navigate clinical and social services systems to address their multi-dimensional needs. In the first round of DSRIP, health centers embraced the flexibility to address patients' social needs. Many health centers have leveraged DSRIP investments to gain contracts for WIC programs onsite, collaborate with food kitchens, local jails, transportation and employment agencies, and have hired additional non-clinical, non-reimbursable support staff, such as Community Health Workers (CHWs) and peer navigators.

In the first round of DSRIP, the State encouraged primary care practices to become patient-centered medical home (PCMH) recognized. Today, 97% of New York's health centers are PCMH certified. PCMH certified practices provide mental health, oral health, and health promotion/disease prevention services through comprehensive primary care. This model of patient-centered care is associated with improved health outcomes and reduced costs and should be robustly supported in the second round of DSRIP. There are numerous studies that have analyzed the success of PCMH, including citing fewer specialty visits needed, lower per member costs, and better health outcomes amongst individuals seeing PCMH-certified providers.[ii]

One NYS PCMH accredited FQHC reported that the PCMH program served as the impetus for their engagement in VBP contracts. Incentive payments aided in the development of comprehensive risk stratification algorithms that ultimately identified patients for intense care management. After reviewing the risk score, patient advocates, behavioral health providers, and other non-clinical staff were engaged to comprehensively address patients' needs and address gaps in care. In addition to the specific NYS PCMH qualifications, PCMH payments allow the health center to focus on quality improvement processes within the health center and improve timely, data-driven, team-based communication. **The State should use a second round of DSRIP to continue investments in care management programs like PCMH and Health Homes to address patients' social and medical needs.**

## V. Aligning Performance Measures

CHCANYS strongly supports the State's desire to work with CMS to align performance measures across initiatives. Health centers' participation in Medicare, Medicaid, NYS PCMH, and contracts with managed care plans (among various other programs) requires a significant amount of resources invested in

measure/data collection and reporting. **The State should target measures most likely to be of value for all participants in DSRIP 2.0.**

## VI. Health Center Alternative Payment Methodology

FQHCs embrace the State's transition of Medicaid payment from volume to value. CHCANYS supports this direction and is also engaged in permissible activities to move away from a visit based FQHC payment to a capitated FQHC Alternative Payment Methodology (APM). Federal statute permits states to implement an APM in lieu of the legally required prospective payment system reimbursement methodology. States must ensure that reimbursement under the APM is not less than it would be under the prospective payment system rate; however, adoption of an APM is essential to move FQHCs from a visit-based payment that incentivizes volume to a payment methodology that rewards efficiency and outcomes. A capitated FQHC APM aligns with the State's DSRIP goals of advancing VBP and provision of enhanced care coordination.

An FQHC APM supports team-based, integrated care and enables CHCs the flexibility needed to create innovative approaches to care which can include non-clinical support staff who are not billable providers under the prospective payment system rate. The creation of innovative care coordination workflows will improve care provided directly by FQHCs, therefore reducing costs across the health care system.

CHCANYS looks forward to working closely with the Office of Health Insurance Programs to establish a mutually agreeable approach that supports health centers' ability to transform their entire practice to a value-based care delivery model. Once the APM receives a federal approval, CHCANYS envisions that a small subset of health centers will transition from the prospective payment methodology to the APM. **To ensure the success of an APM, State investment is needed to enhance data collection capabilities and catalyze the development of new staffing roles, models for care teams, and innovative work flows.** These investments may include: enough funding to support interventions addressing patients' non-clinical social needs, support for an alternative payment learning community, clinical and cost data analyses, quality metric identification, and reporting mechanisms.

CHCANYS and our member community health centers have actively engaged in DSRIP implementation and contributed to many of the successes achieved. We look forward to continuing to partner with the State to achieve our shared goals of system transformation and improved patient care, better patient outcomes, and reduced care costs.

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[i] https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/paop/meetings/2018/docs/2018-11-29_updates.pdf

[ii] Kaushal R, Edwards A, Kern L. May 2015. Association Between the Patient-Centered Medical Home and Healthcare Utilization. American Journal of Managed Care. Am J Manag Care. 2015;21(5):378-386.
Raskas R, Latts L, Hummel J et al. 2012. Early Results Show WellPoint's Patient-Centered Medical Home Pilots Have Met Some Goals For Costs, Utilization, And Quality. Health Affairs. Vol. 31, No. 9: Payment Reform to Achieve Better Health care. https://doi.org/10.1377/hlthaff.2012.0364

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## doh.sm.1115Waivers

**From:** Tamre Waite [redacted]
**Sent:** Monday, November 4, 2019 11:57 AM
**To:** doh.sm.1115Waivers
**Subject:** Fw: 1115 Public Forum Comment
**Attachments:** 1115 Public Forum Comment_SchuylerCountyOFA.pdf



To Whom It May Concern;

Please accept the attachment as my comments for the 1115 Waiver for DSRIP 2.0.

Thank you for your consideration of support for the Area Agencies on Aging in this process.

Kindly,

*Tammy Waite*

Tamre (Tammy) S. Waite
Director
Schuyler County Office for the Aging
323 Owego Street, Unit 7
Montour Falls, NY 14865
[redacted]

Schuyler County
Office for the Aging
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November 4, 2019

NYS Department of Health
Office of Health Insurance Programs
Waiver Management Unit
99 Washington Avenue
12th Floor, Suite 1208
Albany, NY 12210

RE: DSRIP Amendment Request Draft Dated 9/17/2019

To Whom It May Concern;

On behalf of the Schuyler County Office for the Aging, please accept this correspondence as written comments regarding the 1115 waiver DSRIP Amendment proposal. Schuyler County Office for the Aging, one of 59 Area Agencies on Aging within New York State, provides services in a completely rural area. We are regularly contacted to help individuals who are frequenting our local emergency rooms, many times resulting in avoidable hospitalizations. With the intent of DSRIP to reduce said avoidable hospitalizations and emergency room visits, we know that the coordination of care can produce cost savings. This is a focus we have every day through the services and supports we provide both through Office for the Aging and NY Connects.

Through NY Connects, we conduct a thorough screening to fully assess the client's situation and then work with them to determine how they can best be served to insure they can improve or maintain their health through access to health and health-related services, live in a safe environment, expand their social network, and connect them to supports that can address their financial limitations.

Although there are many accomplishments noted over the past five years through DSRIP, the area of Social Determinants of Health is one where much more progress can be attained. Homing in on the physical environment, the social and economic environment and the individual characteristics and behaviors can be a pathway to address issues early on and prevent negative health outcomes. The strategies outlined in the DSRIP Promising Practices report include key points that are already addressed within the NY Connects No Wrong Door system. NY Connects is building capacity through cross-sector collaborations, providing care coordination and case management, and is working with Care Transitions. We are seeing more complex cases and issues being presented by individuals who struggle with lack of transportation, lack of access to affordable healthy food

options, lack of knowledge regarding the various health-related aspects, minimal social supports, poor housing and difficulty finding and retaining a job that can provide a livable wage. I frequently hear my staff comment that "some people just can't do life." When individuals are struggling just to get through each day, they lack the capacity to make higher level decisions that impact their health and well-being. Providing services and supports that can move people in a positive direction can steer them away from the negative health outcomes and avoid the more costly measures down the road.

As stated by one of my counterparts, the Area Agencies on Aging have been providing extensive services for years with limited funding. Ensuring that the AAAs are included in the funding going forward can guarantee an even greater impact given the success of the programs and action plans utilized to serve older adults. There are numerous stories that can be shared to demonstrate the strength of the AAA network and our ability to get the work done, from securing funding to make improvements to one's home that significantly impacted the individual's mental and physical health, to providing transportation to make sure health care was accessible, to providing healthy hot meals that improved the health of a number of older adults, to providing durable medical equipment to make it possible for one to stay home and out of the high cost facility that would be paid for through Medicaid, to connecting individuals to numerous support systems that help pay for heat, food and prescription medications. The many, many steps taken, and hours spent to keep people living successfully at a lower level of cost, is what we accomplish every day.

The Schuyler County Office for the Aging is just one small component in a much larger system, however, we are making significant contributions to lowering costs and improving the system. Together, the AAAs are a powerful force with the ability to do much more with additional funding. We are a highly trusted source of information and provider of services within our community. I respectfully ask that you give serious consideration to establishing a mandate for each PPS to engage and contract with their local Office for the Aging. Thank you for your consideration.

Most Sincerely,

Tamre S. Waite

Tamre S. Waite
Director
Schuyler County Office for the Aging

## doh.sm.1115Waivers

**From:** Matthew Lesieur [redacted]
**Sent:** Monday, November 4, 2019 12:15 PM
**To:** doh.sm.1115Waivers
**Subject:** 115 Public Forum Comment
**Attachments:** iHealth Comments on DSIP 2 Proposal.pdf



Attached please find iHealth's comments on the DSRIP Amendment Request

Matthew Lesieur
Executive Director
iHealth
307 West 38th Street, 3rd Fl
New York, NY 10018
[redacted]

iHealth Comments on
NYS Medicaid Redesign Team Waiver
Delivery System Reform Incentive Payment (DSRIP) Amendment Request
November 4, 2019

iHealth is providing comments on the NYS Department of Health's plan to submit to the U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services an application for a year four waiver amendment to continue DSRIP until March 31, 2024.

iHealth is a statewide coalition of New York Community-based providers providing care management services within the Health Home program. Our members are focused on improving the lives of persons living with chronic health care challenges. Organizations in this coalition serve some of the neediest, most complex and challenging individuals in the Medicaid program who have multiple chronic health conditions, including HIV, congestive heart failure, obesity, respiratory disease, substance abuse, serious mental illness, and more.

Created in 2012, New York State's Medicaid Health Homes program is a key component of the health care delivery system, with care coordinators in the program helping individuals with multiple health challenges to better coordinate their care and improve health care access. The Health Homes program was designed to address the social determinants of health, such as food insecurity, housing instability, addiction, mental illness, trauma, violence and health illiteracy. This program is an important ingredient for individuals with complex lives and costly health conditions.

It is with the health home program, and the role of care management agencies in the health home program, and the key role they play in care coordination across the health care delivery system that we offer our comments.

iHealth agrees wholeheartedly with Greg Allen's introductory comments at the NYC public forum on October 25th with his statement "Solution to the health care dilemma is a social solution." The next phase of DSRIP must move beyond a medical system focused approach to resolving persistent health care challenges in the Medicaid population to non-medical and non-clinical approaches that are key the social determinants of health.

iHealth supports the State of New York's proposed request to extend DSRIP another four years until 2024. While many changes have been enacted in the health care delivery system which are key to ensuring the long-term sustainability of the Medicaid program, much more is needed and added time is key to making these changes permanent. At the same time, DSRIP 2.0 could be improved by focusing less on large institution-based health systems and providing greater resources to community based providers that have a proven record of addressing the social challenges that have a dramatic impact on population health.

A strong takeaway in the United Hospital Fund's "DSRIP Promising Practices" is "For the most complex populations, substantial care management/coordination and support for care transitions appear necessary to change patients trajectories." In addition, the report also found "The involvement of CBOs (many with long histories serving people living with HIV/AIDS), community health workers and peers was vital to the outreach efforts necessary to make a population-level impact." The UHF findings of DSRIP repeatedly talk about the success of PPS' where care coordination was a center piece of the project. It is clear that for the next round of DSRIP to be successful, the healthcare system must support a robust CBO driven care coordination program.

Value Driven Entities (VDE)

The State's proposal to create Value Driven Entities holds great promise to further improve on the Performing Provider System (PPS). However, one of the great disappointments of the PPS was, because they were hospital-based networks, there was an insufficient amount of resources directed to community-based providers, many of whom were providing key care coordination services but were poorly reimbursed for their work. CBOs struggled to gain an equal footing and recognition against hospitals who controlled most of the resources. A survey of iHealth members showed that many CBOs were poorly reimbursed for the services they delivered.

The future of PPS in these new VDEs must have CBO representation that is equal in weight, authority and governance to MCOs and large health care providers. VDEs must dedicate an equal amount of resources (both monetary, technical support, IT and the like) to CBOs as they do to MCOs and other health care providers. Payments to CBOs must be greatly enhanced in VDEs.

Movement towards Value Based Payments

While the movement towards VBP offers great promise to improve the population health of those in the Medicaid program, the major changes in health care financing and operations as a result of VBP are having significant consequences for many providers.

Attribution is a major challenge for Health Homes in VBP arrangements. iHealth urges the state to consider alternative and creative additional ways to provide attribution beyond clinic-based systems. Attribution should be expanded and evolve to allow other entities beyond the

primary medical care system to assign attribution; for example a network of CBOs providing key social determinants of health to consumers should be considered a base point for attribution.

Health information data and technology is a key cornerstone of VBP. While massive amounts of resources in DSRIP were devoted to hospitals and large health care systems to upgrade their technology, CBOs struggled to identify adequate resources towards technology. In the next iteration of DSRIP, there must be dedicated resources for IT to CBOs. In addition, community based providers struggle to get access to the data they need to measure their success in VBP. DSRIP 2.0 must dedicate itself to ensure system integration including CBO access to medical records.

Interim Access Assurance Fund

$500 million for the Interim Access Assurance Fund must have dedicated resources devoted to community-based providers that are also experiencing fiscal and infrastructure challenges in the movement towards VBP and the healthcare revolution that is taking place. iHealth fails to understand why hospitals alone are reimbursed for the changes in health care that are currently taking place, yet no parallel resources are devoted to community-based providers also struggling with similar changes.

The movement to VBP will be extremely challenging for small community based providers that are key delivery vehicles to address the social determinants of health. In addition, most CBOs are not fiscally in a position to take on risk in VBP level 2 and higher arrangements, yet the state is pushing the entire delivery system towards greater risk. The Interim Access Assurance Fund should be redirected to providing CBOs with the resources, training and major assistance they will need to be ready for VBP.

Social Determinants of Health Networks (SDHN)

iHealth supports the creation of Social Determinants of Health Networks (SDHN), which are designed to deliver social focused interventions linked to VBP. The key to the success of these networks will in how they are managed - they must be wholly governed and operated by CBOs and CBO networks like iHealth, and CBOs must have full control over the allocation of the $1.5 billion dedicated to SDHNs. We urge the State to ensure that SDHN are wholly owned and controlled by community-based providers and their networks and associations.

Health Home Funding

Care managment is a key and vital component to the entire DSRIP. Yet, many care management agencies have closed their health home care management program. In many instances community-based care management providers have struggled with a declining census, lack of MCO interest in the program, and an onerous reporting system. Staff burnout in the health home program is extremely high and agencies struggle to keep talented staff in care management. This is an indication that there are significant structural challenges in the health

home program and that the current reimbursement structure does not allow CMAs to perform at their most effectiveness or maintain staff. Furthermore, starting in July 2020 the guaranteed rate structure disappears, forcing health homes to negotiate with managed care organizations for reimbursement. This has the potential to further weaken the reimbursement for the health home program and could further exacerbate challenges in health homes.

Many of the successes in DSRIP were attributed to long standing relatively smaller (compared to hospital systems) community-based care management providers who had a track record of providing services in distinct neighborhoods and populations. It does not make sense to attribute care management services as a key to the success of DSRIP, yet at the same time have a health home program which does not adequately support CBOs and causes agencies to close their care management program. iHealth must emphasize that as the State considers its options for addressing budget challenges in the Medicaid program, the value of the health home program must be preserved if DSRIP successes are to be realized even more. If the United Hospital Fund report on DSRIP demonstrated more than anything, that to effectuate change in key high cost populations, care management must be a cornerstone of the health care delivery system.

## doh.sm.1115Waivers

**From:** James Edmondson [redacted]
**Sent:** Monday, November 4, 2019 12:29 PM
**To:** doh.sm.1115Waivers
**Subject:** Comments
**Attachments:** Comments on New York's application to amend its 1115 Medicaid Waiver.pdf

Comments on New York's application to amend its 1115 Medicaid Waiver
James Edmondson, M.D., Ph.D.
Forest Hills, NY
[redacted]

I am a graduate of Stanford University, an MD-PhD graduate of New York University, a former adult and child neurologist with subject matter expertise in people with intellectual and developmental disabilities (I/DD) who cared for 60,000 Central Brooklyn patients in 13 years at HIP, and now I am retired and raising my two boys with I/DD.

I come to cast an objective eye on the malignant Medicaid Redesign Team (MRT) OPWDD managed care agenda that threatens the present and future integrity of the system of long term services and supports for New Yorkers with intellectual and developmental disabilities.

I know managed care inside out. The MRT's OPWDD managed care plan is a sick parody of true managed care. The "managed" part of managed care means using data analytics to allocate limited resources in the most cost-effective way. You cannot manage what you cannot see. The OPWDD is as blind as a bat and cannot see anything because its chosen IT system, MediSked, is very close to utterly useless. The OPWDD shows no evidence of having learned from the experience of thousands of managed care medical groups.

I am presently the self-direction parent-broker for my two sons with autism, ages 16 and 20. Like all I/DD parents, I am kept up at night worrying what will happen to our boys when my wife and I are gone. The OPWDD promises peace of mind for families like mine. Our boys will need a robust and accountable OPWDD for many decades to come. However, if the MRT's OPWDD managed care agenda proceeds on its current uncontrolled course, I foresee an uncertain and corrupt future for the OPWDD in which well-connected and highly-conflicted insiders get very rich at the expense of hundreds of thousands of I/DD participants and their loved ones. What the OPWDD is doing is not managed care but is instead looting and gutting of due process protections. The OPWDD is creating a huge mess that will be very expensive to clean up.

I am a rare OPWDD parent who has direct professional experience as a physician inside of a fully-capitated medical managed care organization. I was a neurologist at a Brooklyn HIP group for 13 years before I retired to care for our boys. When I speak about managed care, I speak from years of personal experience caring for over 50,000 Medicaid patients. I can say with full confidence that managed care is the worst possible agenda for the OPWDD. To add insult to injury, however, the OPWDD's rank incompetence and complete lack of expertise with managed care is making a tragic mockery of care management and is on track to drive many OPWDD service providers out of business with devastating consequences for New York's most vulnerable population.

Prior to the intrusion of the MRT, the most pressing chronic problems facing the OPWDD have always been the need for tens of thousands of additional residential placement slots, higher pay for direct service providers, better integration with vocational training, and more administrative transparency. Even the best managed care system that could be imposed on the OPWDD would make each of these problems worse, not better, for reasons I will explain. However, the

particular farce of a managed care system that the OPWDD has chosen for itself is so fundamentally flawed that it has no chance of long-term survival. The chaos of upending decades of established practice alone will take many years to repair.

Here are five reasons why managed care is wrong for the OPWDD:

(1) "Managed care" is a euphemism for privatization, so let's call a spade a spade. Federal "medical loss ratio" rules give a 15% cut of Medicaid managed care revenue to private managed care plans. Some of this money is spent on administrative overhead, and the rest goes into private pockets as profit. These rules siphon 15% of the OPWDD budget away from disabled participants. This effectively means up to a 15% cut in funding to OPWDD providers and participants, which would be disastrous. Alternatively, the total OPWDD budget would have to be increased by up to 15%, which would require up to $1.2 billion of additional taxpayer money. 15% off the top of the OPWDD's $8 billion budget is $1.2 billion, enough to attract all manner of unprincipled profiteers and hucksters.

Experience in other states shows that changing I/DD service payments from traditional fee for service payment models to managed care always does undesirable things: it raises costs to the state and it simultaneously cuts services to disabled people. The OPWDD has already launched Care Coordination Organizations (CCOs), which comprise Phase One of the MRT's proposed three phase replacement of fee for service with managed care. CCOs now cost the state twice as much as the Medicaid Service Coordination (MSC) system they replaced, yet CCOs are failing to serve tens of thousands of OPWDD participants once served by MSCs. I will say more about CCOs in a moment.

(2) In 2011, the MRT initially intended for New York's Mainstream Medicaid Managed Care Organizations (MMMCOs), such as UnitedHealthcare, HealthFirst, Empire, and others, to take over the OPWDD in 2014. However, those MMMCOs looked at the OPWDD's complexity, protections, and unique emphasis on person-centered planning and walked away. They explained that the start-up costs would be astronomical, that the MMMCOs have no infrastructure for person-centered planning and would have to create one from scratch, and that they calculated that they could not turn a profit for decades if ever. These plans represent the kind of managed care I practiced at HIP. Medical managed care has no understanding of person-centered planning, which is at the heart of the OPWDD's care management component. Little wonder the MMMCOs walked away from the OPWDD.

The MRT administrators, instead of then exempting the OPWDD from managed care, instead adopted an incremental approach straight out of the managed care marketing playbook. The logical conclusion of this incremental approach is to automate the OPWDD's person-centered planning, to gut participant and provider protections, and thus to fashion a crudely truncated rump OPWDD that would then be compatible with the MMMCOs existing billing infrastructure and profit schemes. There is essentially one managed care marketing playbook, and I am confident that the MRT end game for the OPWDD is privatization and corporate takeover by MMMCOs. This is a truly frightening prospect.

(3) Managed care was designed for acute care medicine with no thought given to long term services and supports for people with I/DD. Managed care absolutely requires very costly information technology – doctors and hospitals have spent hundreds of billions from government grants and from their own revenue on immense electronic health records systems (EHRs). EHRs are tightly regulated by the federal Center for Medicare and Medicaid Services. EHR systems from different vendors are mutually incompatible and non-interoperable, and many doctors dislike them. A major reason why the OPWDD cannot make managed care work is the cost of effective EHRs. The government allocated no grant money to I/DD providers to pay for I/DD-specific EHRs, and Medicaid revenue is barely enough for OPWDD providers to keep the lights on with no surplus to spend on IT, certainly nothing like the billions of dollars available to doctors and hospitals. The MRT earmarked no state funds for OPWDD IT, in violation of every tenet of managed care teaching.

As a result, the OPWDD chose a bargain basement imitation EHR called MediSked that was not certified by CMS and that had numerous HIPAA violations and that is so poorly-designed that no amount of tinkering will ever make it suitable for proper care management. The OPWDD itself disavows any responsibility for the choice of MediSked and refers all complaints to the private sector. However, all of the OPWDD's care management protocols loop through MediSked – there is no alternative. The OPWDD cannot have it both ways.

(4) The aim of the MRT OPWDD agenda was cost control at a time of great state budgetary uncertainty in the wake of the Great Recession. On the topic of cost control, the OPWDD is already on the case. The OPWDD Acting Commissioner, Dr. Ted Kastner, speaks openly and often about the need for the OPWDD to carefully and wisely ration its services equitably and in a manner consistent with it broad range of programmatic priorities. Dr. Kastner reminds people at every opportunity that the OPWDD must stay within its total budget allocation. Dr. Kastner is therefore intensely focussed on cost control. There is no logical reason to replace Dr. Kastner's expert judgment with overpaid for-hire private for-profit managed care consultants who have no prior experience with I/DD managed care. Moreover, privatization of the OPWDD would introduce an insidious corporate veil between, on the one hand, I/DD participants and loved ones and OPWDD providers and, on the other hand, profit-minded Wall Street bean counters. It would make the OPWDD effectively unaccountable to any elected officials.

(5) Finally, let's examine closely the OPWDD's rollout of Phase One, the Care Coordination Organizations. When the OPWDD put the CCO plan out for public comment in 2017, I submitted a detailed list of reasons why the CCOs would fail to fulfill the majority of the expectations laid out in the application. In its response to the public comments, the OPWDD completely ignored me and did not address even one of my concerns. I am sad to say that my assertions have been largely borne out in practice, and I am beyond frustrated at being ignored.

The 7 CCOs are consolidated from the remnants of Medicaid Service Coordination (MSC) agencies that were abruptly condemned to die on July 1, 2018. The OPWDD's then Acting Commissioner acknowledged that this shotgun wedding approach might disrupt some participants' long-time working relationships with their MSCs. But, she assured us, this was a small price to pay because those MSCs would be replaced by robots in the form of a fabulous

new IT system that would outperform even the best MSC. As I knew would happen, this proved to be a whopper of an untruth after July 1, 2018.

With a minuscule and totally inadequate IT budget, through a hidden and inscrutable procurement process, all 7 CCOs purchased a deeply flawed IT system called MediSked. MediSked performs barely 10% of what was promised and cannot be described by even the most deluded managed care fanatic as "fabulous" or even barely useful. MediSked struggles to upload files then download them at a later date. MediSked crashes often, sometimes deleting many hours of work obtained during interviews with participants. MediSked has a small fraction of the number of tech support people that we in medicine know are necessary to roll out a new EHR. Proper deployment of a new EHR IT system requires a year of incremental implementation and on-site staff teaching. In contrast, MediSked was launched pretty much overnight with no on-site tech support or teaching. Of course it's a disaster.

Thus the OPWDD traded dedicated MSCs for broken robots. In my comments, I said the CCO IT goals were "pure fantasy" and I am heartbroken to say that I was proven right. There is no shortage of good EHR consultants in New York, but the OPWDD shows no evidence of having listened to any of them.

Many but not all former MSCs continued as Care Managers in CCOs after July 1, 2018. Overall, there remains a shortage of Care Managers with high turnover rates. Care Manager caseload caps were strangly omitted from the CCO rules, except for a cap of 20 of people with the highest needs. Many experts thought a cap of 40 was pushing the limits. In practice, due to manpower shortages, some Care Managers have carried caseloads of up to 80 or more I/DD participants. Required site visits are not happening. Some families report being shuffled through several different Care Managers in the course of a few months. This serious manpower deficit has not been ameliorated even today. The exact number of Care Managers is a closely guarded secret at the OPWDD, so advocates do not know whether the number of Care Managers is growing or shrinking. For all we know, the shortages could be getting worse.

The former MSC agencies harbored vast amounts of institutional knowledge of the entire New York Medicaid system. Tragically, few former MSC supervisors moved to CCOs, resulting in the abrupt loss of millennia of valuable subject matter expertise. Many families who are assigned to a Care Manager soon discover that their Care Manager has no supervisor who knows how to get things done. None of my reporting on CCOs comes directly from the OPWDD, which appears to be sworn to silence. Rather, it comes from parent listservs and reports from advocates.

In the chaos of renegotiating hundreds of MSC contracts, some small- and medium-sized agencies report not being paid tens and hundreds of thousand of dollars, of having to sue for payment and of being countersued by CCOs. Several of the CCOs are diverting funds towards trying to create Article 44 mainstream Medicaid managed care organizations (MMMCOs) in anticipation of Phases Two and Three of the MRT OPWDD managed care agenda, which promise to be 10 times as lucrative as CCOs. This illustrates the deplorable fact that the MRT OPWDD managed care agenda has mobilized abject greed and destructive competition that directly detracts from provision of long term services and supports for New York's most vulnerable population.

The shocking contrast between the soothing and idealistic rhetoric used by the OPWDD to sell the replacement of MSCs by CCOs prior to July 1, 2018, and the institutionalized neglect and abandonment experienced by many CCO enrollees after July 1, 2018, is a very poor prognostic indicator for Phases Two and Three. At least in Phase One, the OPWDD was merely consolidating a thriving existing MSC ecosystem into 7 cookie-cutter CCOs. Some families have been fortunate to have retained their former MSC, which has mitigated the shock.

In glaring contrast, Phases Two and Three require the formation out of thin air of viable Article 44 MMMCOs, called Specialized I/DD Plans – Provider Led (SIP-PLs), which are infinitely more complex than CCOs. This is something I'm quite familiar with, having been a neurologist for 13 years at HIP, an Article 44 MMMCO in NYC. My first concern is that the track record of entirely novel managed care plans created out of thin air is not encouraging. A majority soon are bankrupt and/or are swallowed by larger managed care plans. Notable well-funded examples of failed managed care plans in New York State include Northwell Health's CareConnect and the state-run Health Republic. When those were dissolved, their contracted providers were still owed over $200M in unpaid claims. Once burned, twice shy, many providers see no reason to sign up with SIP-PL wannabees, which are poorly-funded and are run by people with no medical management experience.

In my opinion, a statewide seamless carpet of SIP-PLs will never materialize because they will be unable to recruit adequate provider panels in all medical specialties at Medicaid rates in all 58 counties. Without deep-pocketed sponsors, the SIP-PLs will never meet federal IT requirements. Therefore, present-day diversion of executive attention and funding from CCOs towards the fool's errand of forming SIP-PLs adds insult to injury from the perspective of I/DD participants who do not even know whom to call at their CCO for information.

If the DOH with all of its medical expertise cannot create a viable Article 44 MMMCO from scratch, then the likelihood of the OPWDD with almost no medical expertise succeeding in creating viable SIP-PLs is extremely low indeed. Yet, the MRT refuses to recognize this reality and continues to demand that the OPWDD waste time and resources on it futile managed care agenda. Recently, a number of senior OPWDD officers have retired and moved into the private sector, no doubt demoralized by the handwriting on the wall.

Therefore, here's where we stand at present: (1) existing MMMCOs have no interest in taking over the OPWDD, and (2) the OPWDD has a snowball's chance in Hell of launching viable home-grown MMMCOs to compete with the likes of UHC and HealthFirst and Empire. Meanwhile, the CCOs are grossly inadequate and the prognosis for their long term viability is poor even with massive infusions of bailout money. There is no visible source of the $500M or more it would take to create an effective OPWDD IT system. OPWDD officials are demoralized and participants are scared and frustrated. The best thing the MRT administrators could do would be to announce that there will be no further discussion of Phases Two and Three until all energies are devoted to repairing the damage caused in Phase One.

I ask the legislature to reclaim the oversight of the OPWDD that it ceded to the executive branch in 2011. The OPWDD must remain accountable to the public and to its elected officials. Wall

Street must be kept away. The very survival of my two boys and hundreds of thousands of people with I/DD and their loved ones depends on resisting managed care at the OPWDD.

## doh.sm.1115Waivers

**From:** Chris Norwood [redacted]
**Sent:** Monday, November 4, 2019 12:49 PM
**To:** doh.sm.1115Waivers
**Subject:** DSRIP Comment-Diabetes Priority Addresses Major CMS Concerns



Dear State Team---First thank you for your hard work. And knowing you have much to read, I will be brief.

Excess diabetes costs----that is, New York's $15,336 per diabetes patient in extra Medicaid costs (per the CDC) for the projected 1 million
Medicaid patients with diabetes ---now constitute some $15 billion out of the 74.5 billion state Medicaid budget for 2019-20.
The state, of course, pays one-third, or $5 billion of these extra costs.

It is clear that Diabetes MUST be a High Need Priority area for DSRIP. New York State cannot truly bring down Medicaid costs without a focused diabetes prevention and improved self-care program, with a real focus on evidence-based education.

**This also, very importantly, addresses major CMS concerns**. As you know, CMS has taken major steps to reduce the
costs and impact of dialysis---almost half of which is caused by diabetes.

But, of course, the precipitating kidney disease often starts while people are on Medicaid. One of the most important findings of major evaluation of the Diabetes Self-management Program (DSMP), the well-recognized 6-session patient self-management course, is that a year later **patients who take the DSMP have 90% fewer new diagnoses
of kidney disease than similar patients not in the DSMP.**

**CMS, no doubt, would be very approving a plan that included focused effort to reduce kidney disease and other expensive diabetes complications---such as blindness and amputation.**

**Also, we** urge that community groups be included on the governing bodies of VE or any new administrative and planning entities.

Thank you,

**Chris Norwood**
**Executive Director**
**Health People**
**552 Southern Boulevard**
**Bronx, NY 10455**
[redacted]
www.healthpeople.org

***Preventing and managing chronic disease through sustainable peer outreach, targeted education, and effective clinical partnerships***

HEALTH PEOPLE
Community Preventive Health Institute

## doh.sm.1115Waivers

**From:** Alice Bufkin [redacted]
**Sent:** Monday, November 4, 2019 12:59 PM
**To:** doh.sm.1115Waivers
**Subject:** 1115 Public Forum Comment - Citizens' Committee for Children
**Attachments:** CCC DSRIP Testimony_11.4.19.pdf



Good afternoon,

Please find attached comments from Citizens' Committee for Children in response to the 1115 waiver forum.

Best,

Alice

**Alice Bufkin, MPAff**
Director of Policy and Advocacy for Child and Adolescent Health
Citizens' Committee for Children of New York
[redacted]
Pronouns: She/Her

**New York State's DSRIP Waiver Request – DSRIP Extension Comments**
**New York State Department of Health, Office of Health Insurance Programs**
**November 4, 2019**

Thank you for this opportunity to provide comments on New York State's 1115 Medicaid Redesign Team (MRT) waiver and the state's application for a four-year extension of the Delivery System Reform Incentive Payment (DSRIP) Program. My name is Alice Bufkin, and I am the Director of Policy for Child and Adolescent Health at Citizens' Committee for Children of New York (CCC), a multi-issue children's advocacy organization committed to ensuring every New York child is healthy, housed, educated, and safe. We are also a co-leader of the Children's Behavioral Health Campaign, a statewide coalition of behavioral health providers, advocates, and New York families, joining together to guarantee the right of every child to receive the high-quality behavioral health services they need.

We appreciate the NYS Department of Health (DOH) recognizing in its DSRIP Waiver Amendment Request the importance of increasing investments in initiatives that strengthen children and families, including promising practices to reduce maternal mortality rates, efforts to address social determinants of health, and projects that target families with children at risk of significant and multiple adverse childhood experiences (ACES). DOH's emphasis on ACES demonstrates the state's recognition of the fundamental importance of investing in children's health and social services to prevent the need for more intensive services when children become adults.

However, we must also acknowledge that the vast majority of health and mental health resources in this state have been spent on adult care and hospital-based services. DSRIP offers an opportunity to connect children and families to community-based services and to address social determinants of health, ultimately enabling children to achieve better health and mental health outcomes and allowing the state to see declines in costs associated with high hospital utilization. DSRIP can play a critical role in these efforts, and the state must not overlook this opportunity to invest in child health, and particularly children's behavioral health. Investments in prevention and treatment for children and families are long overdue as families across the state struggle to find the care they need.

After years of under-investment in prevention and treatment services for children and families, New York must prioritize investment in and reform of the children's behavioral health system. **The state's DSRIP program must significantly increase the funds dedicated to improving children's behavioral health - few areas are more important to the waiver's stated goals of improving the quality of care, improving the health of populations, and reducing costs.**

## There is a crisis in children's behavioral health

**Suicide is the second leading cause of death for New York children age 15-19, and the third leading cause of death for children age 5-15.[1] 54.5% of children ages 3 through 17 with a mental/behavioral condition in New York don't get the treatment they need, including 55% of young people with major depression.[2]**

The consequences of unmet mental health needs can be devastating. Children get sicker and parents are left desperate and hopeless, unable to find or afford the services they need. Parents miss work and children miss school, and the state sees the long-term costs borne out in special education, juvenile justice programs, preventable foster care placements, and homeless services. Under our under-resourced system, sick kids become sick adults, and the human and financial costs are felt by families, healthcare systems, and communities more broadly. **DSRIP offers one opportunity to reverse this pattern.**

## With $8 billion on the line for DSRIP, New York *must* earmark a significant portion of DSRIP funding specifically for children and families, including for behavioral health services.

Among the stated purposes of DSRIP funding is the promotion of innovative projects that focus on system transformation, clinical improvement, and population health improvement. Missing from DSRIP has been a substantive investment in children – the bulk of DSRIP funding has instead gone to projects serving adult populations and benefiting hospitals. This is despite extensive evidence that investments in children's health and behavioral health lead to long-term benefits for children and families, as well as cost savings across systems.

We know what types of children's services and interventions are needed to reduce hospitalizations and unnecessary use of psychotropic medications, as well as what interventions are needed to help children and families thrive. These types of interventions help ensure children become healthy, stable adults and help reduce health and other related costs that compound when children's behavioral health needs go unaddressed.

However, the children's behavioral health system has been chronically under-resourced, preventing the system from meeting the needs of children, much less investing in innovative practices we know are effective and result in future savings. DSRIP can and should play a much greater role in investing in an array of community-based behavioral health priorities.

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[1] New York State Department of Health. "Leading Causes of Death, New York State, 2008-2016." https://apps.health.ny.gov/public/tabvis/PHIG_Public/lcd/reports/#state

[2] Child and Adolescent Health Measurement Initiative. 2016-2017 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health supported by Cooperative Agreement U59MC27866 from the U.S. Department of Health and Human Services, Health Resources and Services Administration's Maternal and Child Health Bureau (HRSA MCHB). Retrieved from www.childhealthdata.org. CAHMI: www.cahmi.org.; Mental Health America. "Mental Health in America – Access to Care Data: Access to Care Rankings 2020." https://www.mhanational.org/issues/mental-health-america-access-care-data

## We know what works for New York's children and families

New York's DSRIP amendment request states a commitment to children's population and behavioral health, and CCC supports a number of the proposals put forth in the state's amendment request. We see promise in the use of transitional care teams of clinicians and peers to bridge psychiatric inpatient to community settings, and the expansion of crisis stabilization programs. We also support the expanded use of telemedicine for care management of residential populations, while recognizing that telemedicine cannot by itself address the systemic shortage of children's behavioral health providers statewide.

These are all important interventions for DSRIP to pursue. **However, DSRIP funding must go further and invest in a full continuum of services for children and families, from preventive and population-based services, to more intensive clinical services necessary for complex children and families.** We know what works for children and families – the state's responsibility is to fund these programs robustly and bring them to scale so they can reach a greater number of children in need.

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

### Models of population health that integrate clinical care for parents and caregivers into primary care for children

New York State's DSRIP extension request includes repeated references to the importance of primary care and behavioral health integration, and we strongly support increased funding for such interventions. Luckily, New York has a substantial array of successful models to draw from, many of which were developed through the state's First 1,000 Days on Medicaid Initiative. The Healthy Steps program is an evidence-based, interdisciplinary pediatric primary care program that integrates child and family development professionals as part of the primary care team during pediatric well-child visits. The Preventive Pediatric Care Clinical Advisory Group, one of the workgroups within the First 1,000 Days on Medicaid Initiative, has developed a comprehensive model of pediatric population health that integrates care for parents and other caregivers into primary care for children.[3] These types of models provide established and promising practices that can help meet the complex health and behavioral health needs of New York's children and families. **New York has the opportunity to move beyond pilots and instead make substantive investments in pediatric health and behavioral health integration.**

### Evidence-based programs

New York is also home to an array of evidence-based programs that have proven effective in serving children and families with complex needs and leading to substantial long-term savings. Such programs include Youth Assertive Community Treatment (ACT) teams, Multisystemic Therapy (MST), Functional Family Therapy Behavioral Health (FFT), and many more. These and other

[3] New York State Department of Health, office of Health Insurance Programs. *Final Report of the First 1,000 Days Preventive Pediatric Care Clinical Advisory Group."* October 2019. https://health.ny.gov/health_care/medicaid/redesign/1000_days/docs/2019-10-01_final_report.pdf

evidence-based programs can play an essential role in addressing the impact of Adverse Childhood Experiences, addressing serious antisocial behaviors, and providing family-based therapeutic interventions for youth at risk of institutionalization. **Through DSRIP, New York can make real investments in programs that have been proven to improve long-term outcomes for children and families.**

**Suicide prevention programs**

The high rate of adolescent suicide in New York points to the urgent need to invest in mental health supports. Recent research has shown that suicide attempts among black teens, especially black girls, have risen at steep and alarming rates. This research indicates that the suicide attempt rate for black adolescents rose 73%, while the rate for white students fell 7.5% in the same period.[4] **New York must identify and fund initiatives designed to reduce adolescent suicide risks.** A starting point should include a review of recommendations recently released by the New York State Suicide Prevention Task Force.

**School-based clinical supports**

The DSRIP amendment request includes a request for additional investments in a program focusing on prevention and early identification of behavioral health problems among students, using coaches to train teachers and staff and deliver crisis support and behavioral health referrals to students and families. These types of initiatives are important for early identification and intervention in schools, which remain a critical setting for providing mental health services to children and adolescents. However, school training must be coupled with clinical services in order to reach the full range of students' behavioral health needs. For many years, school-based clinical services have struggled with financial viability, leaving many students without access to these crucial supports. **DSRIP funding should fund increased school-based behavioral health services to address school-based shortages.**

**Fully-funded outpatient treatment services**

The DSRIP amendment request also promotes the expansion of behavioral health urgent care centers for children to help bridge gaps in treatment and help coordinate care with schools, pediatricians, and other healthcare professionals. CCC supports additional funding for urgent care centers, but it is essential for NYS to recognize that a much more substantive investment is needed in outpatient care to meet the needs of children. **Too often, families have nowhere to go when facing a crisis; DSRIP can help by investing in outpatient clinical care.**

**For too long, New York's children and families have struggled to find the care they need. With $8 billion on the line, DSRIP funding is a critical vehicle for addressing these needs and laying a foundation to improve access to care and enhance innovation in prevention and treatment.**

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[4] Leonard Greene. "Suicide Attempts Rising Among Black Youth, Especially Girls: Study." *New York Daily News,* October 14, 2019. https://www.nydailynews.com/new-york/ny-suicide-survey-youth-attempts-20191014-dubyiaso5jcktms5budj67e6jy-story.html

## doh.sm.1115Waivers

**From:** Kathy Waring [redacted]
**Sent:** Monday, November 4, 2019 1:02 PM
**To:** doh.sm.1115Waivers
**Cc:** [redacted]
**Subject:** Comments on MRT Waiver Amendment request for DSRIP Extension
**Attachments:** image.pdf



If you can not open or read the attached letter, please call Kathy Waring at [redacted] Thank you.

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November 4, 2019

Ms. Donna Frescatore
Medicaid Director
Office of Health Insurance Programs
New York State Department of Health
Empire State Plaza, Corning Tower
Albany, New York 12237

**Via Email to 1115waivers@health.ny.gov**

Re: Comments on MRT Waiver Amendment Request for DSRIP Extension

Dear Ms. Frescatore:

We represent Excellus Health Plan, Inc. ("Excellus") in the above-referenced matter and respectfully submit these comments on their behalf. We appreciate the opportunity to provide input into this important proposal, and look forward to continued engagement with the Department during the planning and implementation phases.

As you know, Excellus is a Medicaid managed care organization serving Medicaid and HARP members in 13 counties in upstate New York. Excellus fully supports the Department's intent to seek approval to extend the Delivery System Reform Incentive Payment (DSRIP) program for an additional 4 years to continue to build on its well-documented successes. Indeed, during the initial 5 years of the DSRIP program, Excellus has established successful partnerships with a variety of providers and community based organizations to implement value-based payment arrangements that address the "triple aim".

As to the draft DSRIP extension proposal ("DSRIP 2.0"), we agree with the need for further integration of MCOs into any initiative to implement the "promising practices" and address the defined high need priority areas. That said, we believe that for DSRIP 2.0 to succeed, there needs to be more flexibility in structuring funding-eligible arrangements among MCOs, providers, PPSs, CBOs, and QEs.

Most notably, the mechanism for MCO integration, and the availability of DSRIP 2.0 funding, should not be limited to the new, second generation, value driving entities, or "VDEs". Rather, the proposal should incorporate the flexibility to implement "promising practices" and address high need priority areas via contracting arrangements among MCOs, providers, CBOs and QEs, and such "virtual VDEs" should be eligible for funding.

In particular:

- Many Performing Provider Systems ("PPSs") in the upstate region have not evolved into, and are not likely to involve into, network contracting entities (i.e., IPAs or ACOs) and, therefore, are not positioned to assume financial risk via a VBP arrangement;

- Forming VDEs as new legal entities comprised of MCOs, PPSs, providers, CBOs, QEs that meet the requisite governance and operational requirements will likely be challenging and time consuming, at best, and subject to the same integrative obstacles faced by many PPSs that resulted in their failure to evolve into risk-bearing, network contracting entities (i.e., IPAs or ACOs) during the initial 5 years of DSRIP;

- The foregoing challenges resulted in the lack of a PPS/IPA/ACO entity capable of arranging for a broad spectrum of inpatient/outpatient service providers and SDH interventions able to assume financial risk under a VBP arrangement in many upstate markets. As a result, Excellus has built "virtual ACOs" via contract arrangements to implement VBP agreements and SDH interventions in these markets, and these partnerships are now mature, fully functioning, and capable of being used as an infrastructure to implement "promising practices" and address the identified high need priority areas;

- These existing "virtual ACOs", like the proposed VDEs, are comprised of partnerships among MCOs, hospitals, primary care providers, specialists, behavioral health providers, pediatricians, IPAs, and CBOs, and serve both the Medicaid and commercial populations;

- The successful work accomplished by these existing "virtual ACOs" should be recognized and built upon in DSRIP 2.0, and not discarded in favor of a strict requirement that only VDEs are can be used to implement "promising practices" and receive funding;

- Pairing existing "virtual ACOs" with one of the new "Social Determinants of Health Networks" would be a simple contracting step that would quickly facilitate the ability to implement additional impactful SDH interventions;

- Although the role of existing PPSs as funded entities in DSRIP 2.0 is not entirely clear from the proposal, to the extent existing PPSs will continue to receive funding and continue their current initiatives as standalone entities, fully developed "virtual VDEs" and VDEs could also serve as replacements to these existing PPSs in some markets. Allowing the flexibility to do so would optimize the use of MCO-integrated entities to perform all DSRIP 2.0 initiatives; and

- Affording the flexibility to implement "promising practices" and address identified high need priority areas via existing "virtual ACOs" will result in a much faster "speed to market" for these existing entities, since the creation of new VDEs will require a substantial amount of time to negotiate, form, operationalize, establish the required

participating provider-contracted networks, and to obtain the necessary approvals to operate as either IPAs or ACOs (which will be required in order to assume financial risk under a VBP arrangement).

For all of the foregoing reasons, we strongly urge the Department to revise the MRT Waiver Amendment Request to include the flexibility to implement "Virtual VDEs" in addition to VDEs as second-generation DSRIP-funded entities.

We appreciate your consideration of our comments on this important initiative, and look forward to working with the Department and other stakeholders going forward.

Sincerely,

Sean Doolan

cc: Christopher Booth

4835-5578-7179, v. 1

## doh.sm.1115Waivers

**From:** Bill Tan [redacted]
**Sent:** Monday, November 4, 2019 1:03 PM
**To:** doh.sm.1115Waivers
**Subject:** 1115 Public Forum Comment
**Attachments:** Canopy Public Comment for DSRIP Nov-04-2019.pdf



To whom it may concern, please find our public comment attached, thank you.

Regards,
Bill

--
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Founder & Chairman
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**Let's Eliminate the Language Barrier from Healthcare. Here's a Roadmap for Getting There.**

On behalf of the many New Yorkers who are not fluent in English, we appreciate this opportunity to provide comments as New York State further develops the Delivery System Reform Incentive Payment (DSRIP) Amendment Request to the Medicaid Redesign Team Section 1115 Waiver. We applaud the gains that have been made towards equitable access to care for marginalized populations, and urge you to make the elimination of the language barrier both a component of the next phase of DSRIP and a priority in New York's public health agenda. Specifically:

- As New York's Medicaid program already partially reimburses for language services, a DSRIP project can explore a value-based approach, by adjusting the Medicaid reimbursement parameters to reward pilot facilities that can measurably improve patient outcomes, such as reduced readmissions and adverse events among non-English speaking populations.
- Removing the language barrier will accelerate the adoption of multiple Promising Practices, such as those that pertain to care coordination, care management and care transition where effective communication with patients and their caregivers is critically important.
- Furthermore, such a DSRIP project can serve as the nexus to bring together PPS and MCO partners in a Value-Driving Entity, as there is strong evidence that language assistance provided in clinical settings generate enormous downstream benefits in the form of reduced hospitalization rates and improved patient outcomes. And MCOs can complete the value-creation cycle by supporting PPS partners in their provision of language services upstream.

**If Limited English Proficiency were to be Viewed as a Chronic Condition…**

Of the 26 million people in the U.S. who are limited English proficient (LEP), 2.5 million reside in New York, accounting for 14% of the state's population. The LEP population in the U.S. that is enrolled in Medicaid, Medicare, or both is 8.7 million -- accounting for 8% of total enrollees -- with 1.2 million enrolled LEP residents living in New York.[4] The language barrier results in not only negative health consequences for LEP patients, but also significant financial impacts on the health systems that struggle to deliver equitable care. Language-minority patients have been shown to experience 20% lengthier ED visits, 4.3 days longer hospitalization, and 30% higher readmission rates compared to the general population.[1-3] The use of medical interpreters, which touches roughly only 1 in every 5 LEP patients, represents a partial solution that is already exhausting hospitals' language services budgets. A fundamentally more effective and sustainable approach is needed to overcome this communication barrier.

At 26 million, the size of the LEP population is roughly equal to the number of patients suffering from diabetes. Eliminating the language barrier would be the equivalent of eradicating a major chronic disease in terms of societal impact.

| | Population Affected in U.S. | Population Affected in NYS |
|---|---|---|
| Chronic Lung Disease | 33.2 million[10] | 2 million[10] |
| Diabetes | 30 million[8-9] | 2 million[8-9] |
| Limited English Proficiency (LEP) | 26 million[11] | 2.5 million[11] |
| Cardiovascular Disease (CVD) | 20.9 million[5] | 1.2 million[5] |
| Cancer | 1.7 million[6-7] | 0.11 million[6-7] |

**Language Access is Highly Pertinent to NYS DSRIP Priorities**

The population health burden and financial costs that stem from the language barrier also represent a vast, untapped opportunity for making measurable gains. The proposed DSRIP Amendment Request can benefit from setting a specific objective to address language access. Such a focused approach will serve to engage a significant proportion of the target populations who otherwise would be difficult to reach, and amplify the impact of the planned DSRIP initiatives. In fact, language access is inextricably linked to the High-Need Areas identified in the draft Amendment:

- ❑ Maternity Health: With maternal wellbeing as a key indicator of our nation's health, removing the language barrier presents a promising pathway to reducing complications and maternal morbidity -- a precursor to maternal mortality. Mothers who speak a non-English language face higher risk of having an obstetric trauma during a vaginal birth and higher rates of potentially high-risk and Cesarean deliveries -- among other outcomes that may lead to poor quality of life, lifetime disability, and higher hospital facility costs associated with longer length of stay periods.[12]

- ❑ Social Determinants of Health: The language barrier is essentially a type of SDoH. But unlike discrimination, economic instability and other systemic failures, the language barrier is largely an organizational and workflow deficit -- not biological, structural or macro-economic in nature -- and can be remedied with a reasonable amount of concerted effort and within a few short years.

- ❑ Workforce Development: New York has both a persistent need for a multilingual workforce and the talent pool to meet that need. Having built the most widely used Medical Spanish training platform that's been adopted throughout the U.S., we can attest to the passion and dedication that healthcare professionals bring to acquiring communicative competence in a foreign language. As part of DSRIP, we can help New York's practitioners and providers-in-training to acquire fluency in the top three or four most frequently encountered languages. Such an initiative will also serve to help providers gain insight into their true bilingual proficiency level, thus addressing the phenomenon of 'false fluency' and ensuring patient safety.

- ❑ Community Engagement: Removing the communication barrier will enable language-minority communities to provide meaningful feedback in their own voices, and access high-value healthcare services that have been undermarketed due to the language gap. Furthermore, interpreter co-op or volunteer interpreter banks can be set up to both alleviate the shortage for linguists and generate employment and economic development opportunities for community members.

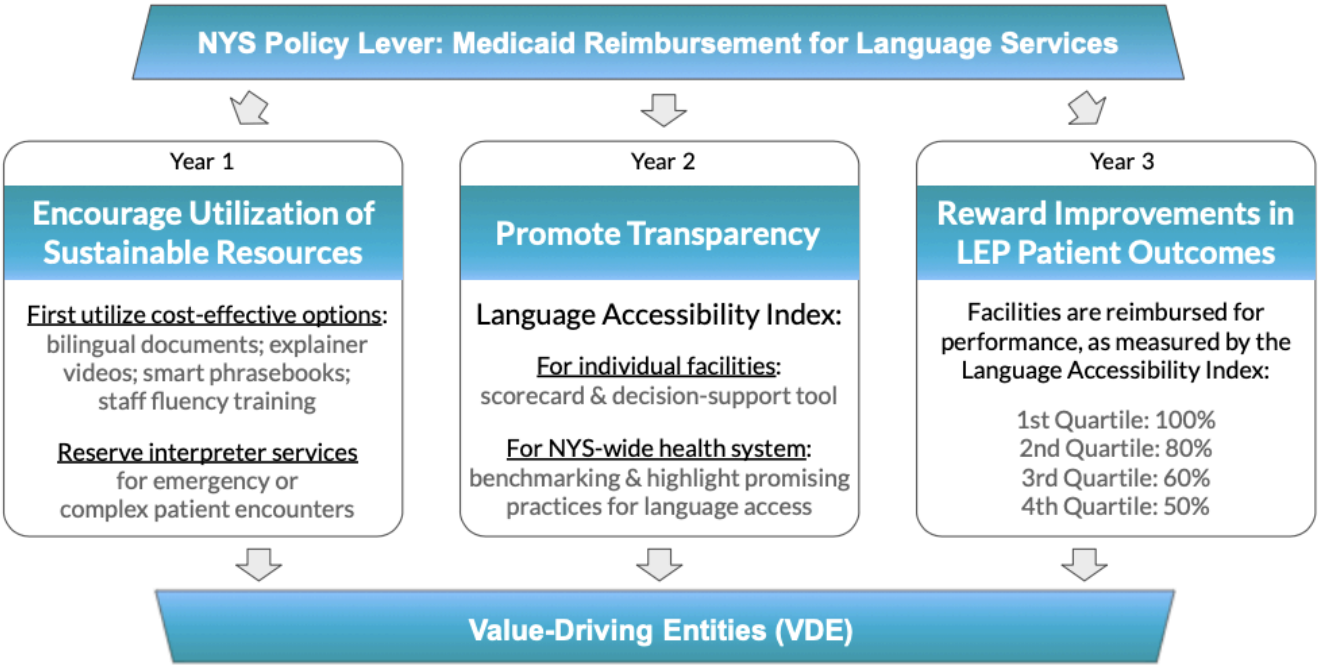
**Recommendation: a DSRIP 2.0 Project, "Value-Based Reimbursement for Language Services"**

New York is one of 15 states that currently utilize Medicaid matching funds to support language assistance services, but the actual claims rate by healthcare facilities has been low since the program began in 2012. A number of obstacles -- such as misalignment between the reimbursement parameters and frontline clinical workflow, and inadequate level of emphasis from the executive ranks -- impede the utilization of this valuable funding source. Over the past few years, our team here at Canopy Innovations has been awarded several NIH SBIR grants to develop a strategic roadmap and corresponding technology-enabled tools to reinvent language access, and to advance the vision of rendering the language barrier a relic of the past by 2030.

Building on that foundation, we ask the Department of Health to support a DSRIP project within the renewal period, for a coalition of participating PPS/VDE to substantively enhance their language service offerings through the use of a shared Language Access Platform, data-driven analysis of program performance, and accountable reporting regarding the impact on LEP patient outcomes. Through such a project, the participating facilities -- in collaboration with VDE partner MCOs -- will generate instructive case studies for their peers, and NYS can generate the evidence base to advance the following objectives:

1. Demonstrate that language services can be adequately paid for by Medicaid reimbursement; transform the perception of language access from being an underfunded cost center to that of a revenue generator, and from being viewed as an expense to that of an investment.
2. Elevate the strategic importance of language access to the C-suite and clinical leadership, by establishing its impact on clinical performance indicators, and CMS incentive programs designed to reduce avoidable readmissions and adverse events.
3. Empower NYS hospitals to become the first in the country to achieve the accessibility benchmarks set by CMS – namely, 90% of LEP patients requesting language access services receive it on the first time and are satisfied 80% of the time – and put New York on a path to fully eliminate the language barrier.

The three-year DSRIP extension period would be sufficient to yield measurable outcomes and illustrative case studies. It would also provide sufficient time for participating providers to work with partner MCOs to build the costs, savings and outcomes into sustainable value-based payment arrangements. Here's an overview of the key action steps:




- ❏ Year 1: Implement an expanded array of assistive resources that are cost-effective and reusable (such as pre-translated documents and multilingual videos for discharge instructions), and improve the workflow for accessing on-demand interpretation services for urgent and complex patient-provider interactions.

- ❏ Year 2: Equip executives with the analytics capability, including a Language Accessibility Index that tracks the performance of various language access initiatives, to continuously monitor progress, compare outcomes across facilities, and make informed decisions with regards to resource allocation, return on investment calculation, and regulatory compliance status.
- ❏ Year 3: Develop scenarios for value-based reimbursement for language access expenditure, stratified by facilities' relative performance as measured by the Language Accessibility Index (e.g. facilities performing in the first quartile get 100% of their language assistance expenses reimbursed, while those in the bottom quartile get 50%), thereby rewarding facilities whose language access programs can demonstrably improve patient outcomes and satisfaction ratings.

We commend the Department of Health for joining the rank of progressive states that reimburse for language assistance. We also wish to recognize the tireless efforts by the professionals who work in diversity and inclusion, language services, and other related departments throughout the healthcare delivery system. And, last but not least, we salute the healthcare providers who care for our most vulnerable, voiceless populations despite the less-than-ideal provisions of multilingual resources. New York has all the right ingredients and a strong foundation to build on. Together, we can develop promising practices for bridging the language gap, elevate the wellbeing of 2.5 million New Yorkers, and declare victory in this important area of health equity.

A Public Comment Submitted on November 4, 2019

To:

New York State Department of Health
Office of Health Insurance Programs
Waiver Management Unit
1115waivers@health.ny.gov

By:

Bill Z. Tan
Founder & Chairman
Canopy Innovations, Inc.
[redacted]

## References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## doh.sm.1115Waivers

**From:** Marie Andersen-Strait [redacted]
**Sent:** Monday, November 4, 2019 1:17 PM
**To:** doh.sm.1115Waivers
**Subject:** Public Comment-1115 Waiver
**Attachments:** 1115 Waiver Public Comment 11.4.19.pdf



To Whom It May Concern:

On behalf of President and CEO of Catholic Charities of Buffalo, N.Y., please see attached public comment regarding Waiver 1115: Delivery System Report Incentive Payment Amendment Request.

Regards, Marie

Marie Andersen-Strait, LMSW
Contract Manager
Pronouns: She/Her/Hers

Catholic Charities of Buffalo, N.Y.
741 Delaware Avenue
Buffalo, NY 14209
[redacted]

CATHOLIC CHARITIES
HOPE for all seasons

DENNIS C. WALCZYK
*President and Chief Executive Officer*

11/4/19

NYS Dept. of Health
Office of Health Insurance Programs
Waiver Management Unit
99 Washington Avenue
12th Floor, Suite 1208
Albany, N.Y. 12210

RE: 1115 Waiver

Dear Colleagues:

Thank you for the opportunity to provide comment to the Department of Health regarding the 1115 Waiver: Delivery System Report Incentive Payment (DSRIP) Amendment Request, dated September 17, 2019. Catholic Charities of Buffalo, N.Y., Inc. has been actively engaged in NYS DSRIP and a partner of Community Partners of WNY (CPWNY)/Sisters of Charity Hospital Performing Provider System (PPS) since April 2017.

We have benefitted from our participation in this initiative in the following ways:

- CPWNY has been influential to our learning and enhanced training opportunities to afford Catholic Charities with the knowledge to incorporate health promotion activities in areas such as health literacy and nutritional education and cooking classes. We also now have a tobacco treatment specialist to address smoking and vaping.
- We are beginning to integrate our data to improve services to clients with complex, cross-system needs. We work more collaboratively with Primary Care and have better awareness of chronic health conditions with those whom we serve with mental health conditions. We also have better tools and strategies to continue our readiness with value based propositions.
- Catholic Charities has infused its awareness of health indexes to integrate health related discussions into our SDOH related programming to improve care to clients.
- We have established new collaboration with entities such as Catholic Health, Independent Health, Western NY Integrated Care Collaborative, Coordinated Care Services Inc. and D'Youville College.
- Catholic Charities has improved quality of service delivery. We serve over 152,000 Western New Yorkers. Of those served through the Community Health Worker

program, Project HOPE, 5 MCI Mental Health Clinics and the Children's Health Home, over 90% of clients avoided use of emergency departments and in-patient services.

- We have made an impact. Through words from a client served, "I came to the Community Health Worker program because of my issues including potential homelessness. I was turned away from numerous organizations. My CHW helped me find housing. I am now linked with primary care, mental health counseling, and have peer support. I am taking my medications. I used to go to the ER weekly and now can't remember when I went last. This program has exceeded my expectations."

CPWNY has been an effective change agent in Western New York. The work has just begun! We anticipate a favorable outcome of the 1115 Waiver DSRIP Amendment Request. We strongly endorse the work of CPWNY PPS. They are critical to the success of future DSRIP initiatives.

Sincerely,

Dennis C. Walczyk
President and Chief Executive Officer

## doh.sm.1115Waivers

**From:** David Collymore [redacted]
**Sent:** Monday, November 4, 2019 1:25 PM
**To:** doh.sm.1115Waivers
**Subject:** 1115 Public Forum Comment
**Attachments:** Acacia Network - 1115 Public Forum Comment.pdf



Good Afternoon,

Attached is Acacia Network's 1115 Waiver Programs Public Forum Comment.
We look forward to engaging in active dialogue with the Department of Health.

David C. Collymore, MD, MBA| ACACIA NETWORK
Chief Medical Officer / Senior Vice President of Clinical Affairs
324 East 149th Street | Bronx, New York 10451
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November 3, 2019

Greg Allen
Director, Division of Program Development and Management
New York State Department of Health
Empire State Plaza, Corning Tower
Albany, NY 12237

RE: DSRIP 2.0

Dear Greg:

My name is David Collymore and I have the honor of serving as the Chief Medical Officer and Senior Vice President of the Acacia Network. As you may know, we are a multi-faceted network of community based organizations providing primary and specialty health care, behavioral health care (including mental health and substance use disorder), housing and economic development services throughout New York State. We operate 8 Article 28 health centers (6 of which are FQHC's), 2 Article 31 mental health centers, a skilled nursing facility dedicated to the care of patients with HIV, and 32 OASAS regulated programs (including 5 OTP Centers and 8 Residential Treatment Facilities). We are the largest provider of Transitional Homeless Housing (over 10,000 individuals) in New York City and provide over 2,000 units of Affordable and Supportive Housing. We operate Universal Pre-K and Day Care Centers and Community/Economic Development Programs. We pride ourselves on caring for complex, underserved communities. As our mission statement proclaims, our mission is "To partner with our communities, lead change, and promote healthy and prosperous individuals and families."

We have been actively engaged in New York State's first iteration of DSRIP. We have been part of the Steering Committee of the St. Barnabas Hospital lead Bronx Partners for Healthy Communities (BPHC), and active participants in 10 DSRIP projects and each subcommittee of this PPS. With our statewide reach and impact we have also participated in New York City's One City PPS, Albany's Northeast New York, Inc. PPS, and Buffalo's Millennium Collaborative Care PPS. Our size, statewide presence and active participation in DSRIP 1.0 since its inception in 2014 has provided us with valuable perspective to deliver insightful feedback and to assume a greater leadership role in DSRIP 2.0.

One glaring deficiency with DSRIP 1.0 was the absence of MCO involvement. Meaningful payment reform cannot be achieved without active involvement of the payers. Acacia stands in agreement with the state Health Department's statement in its draft proposal that, "the inclusion of the MCOs as active partners in the delivery system collaboration and in the development of more sophisticated [value-based payment] models is necessary to best support the maturing networks." The involvement of MCOs in DSRIP 2.0 must be

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Raul Russi, President & Chief Executive Officer
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Jose A. Rodriguez, Esq., Executive Vice President Chief Legal Officer
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required, and not merely an option. Their involvement must include greater data transparency – specifically regular total cost of care for each member should be shared with the member's Primary Care Provider (PCP) at least quarterly. Real-time notifications of emergency room visits and inpatient admissions must be shared with the PCPs. Acacia has had meaningful collaborative efforts with numerous Medicaid MCOs such as Healthfirst, Amidacare, Metroplus, United Healthcare and Beacon Health Options. These efforts have resulted in several Level 1 Value Based Payment contracts and numerous VBP pilot programs. Acacia is optimistically anticipating greater collaboration with our MCO partners through DSRIP 2.0.

From its inception in 2014 DSRIP was seemingly intentionally designed to be overwhelmingly dominated by large hospital systems throughout New York State. I recall being in a pre-DSRIP meeting where one FQHC CEO predicted that DSRIP would result in little more than a hospital "bed buy-back program". Five years later there appears to be some reality in this prediction. Although there have been reductions in hospitalizations and emergency department visits, the largest share of DSRIP payments seem to have done little more than funding the revenue lost by hospitals due to these service reductions. DSRIP 2.0 must be intentional about empowering, equipping and better reimbursing community based health care providers. Baseline reimbursement for non-hospital based primary care and specialty services should be increased. The primary care complexities of individuals with mental health and substance use disorder conditions must also be acknowledged through enhanced payment similar to the steps that were employed with the special needs plans that have been successful in servicing individuals living with HIV. The care of other high-need and high-cost populations such as homeless and transgender individuals also requires greater investment. The appropriate investment in non-hospital based health care providers cannot be achieved if the funds invested must flow through large hospital systems. Sustainable transformation can only be achieved if large community based providers such as Acacia serve as the fiscal intermediary.

The federal government has appropriately prioritized "substance-use disorders and the opioid crisis; care for people with serious mental illnesses; the social determinants of health; and primary care improvement and alternative payment models." Acacia has cared for these populations for over 50 years and is passionately poised to lead the expansion of services to these high-need, high-cost populations throughout New York State through DSRIP 2.0.

Information technology and the sharing of information are essential to transforming our health care system. Interoperability of the information systems of the members of each VDE must be required and funding must be allocated to meet this requirement. Information systems that communicate with each other will facilitate more efficient transitions of care, improve performance in quality measures, and improve communication between partnering organizations when patients are referred within the VDE for specialty care.

Strategic investment in clinical and non-clinical workforce is necessary to prepare a workforce that can transform our health care system. Community Health Centers must play a greater role in training and preparing the next generation of physicians and nurses. This

will require the investment of medical education funding in non-hospital based providers. In addition to physicians and nurses, the training of case management and consumer workforce (peer) staff is essential in delivering effective services to medically complex individuals.

In summary, Acacia is fully supportive of the continued investment in health care reform through DSRIP 2.0. For it to be effective DSRIP 2.0 must include significant MCO involvement and cannot be dominated by large hospital systems. Care Management, Telehealth and addressing the Social Determinants of Health are the pillars of change that must be the focus of DSRIP 2.0. If the State Health Department's intentions are genuine and DSRIP 2.0 is implemented appropriately, it will lead to meaningful sustainable change and not merely a segue to DSRIP 3.0. Acacia welcomes the opportunity to partner with the State Department of Health in the planning and implementation of DSRIP 2.0.

I am grateful for the opportunity to submit this letter and I look forward to working with you as we strive to provide high value health care in the great State of New York.

Sincerely,

David C. Collymore, MD, MBA

David C. Collymore, MD, MBA
Chief Medical Officer & Senior Vice President of Clinical Affairs
Acacia Network

## doh.sm.1115Waivers

**From:** Alexandra Khorover [redacted]
**Sent:** Monday, November 4, 2019 1:40 PM
**To:** doh.sm.1115Waivers
**Cc:** Corinna Manini; [redacted]
**Subject:** 111% Public Forum Comment



On behalf of Refuah Community Health Collaborative, please accept the following comment:

Refuah Community Health Collaborative (RCHC) is pleased to offer its support of the New York State Delivery System Reform Incentive Payment Amendment Request. As a Performing Provider System under the DSRIP program RCHC has witnessed firsthand the positive impact that DSRIP has had on improving healthcare outcomes for New York Medicaid beneficiaries. Significant achievements have been made towards the goal of reducing avoidable hospitalizations and transforming New York State's Medicaid system into a highly-functioning system that provides high-quality, efficient and cost-effective care to some of the state's most vulnerable residents. Through its participation in the DSRIP program RCHC has been able to directly impact the lives of Medicaid beneficiaries through the development of infrastructure and new workflows which have led to better care and improved access. For example, after implementation of integrative workflows and capital renovations the PPSs lead agency Refuah Health Center reduced its wait times for BH services for all ages from six months to no-wait. In cooperation with the local Department of Mental Health and community-based organizations, RCHC created a transportation program to provide access to regional intensive behavioral health day program, thereby reducing psychiatric hospitalizations.

The proposed Amendment Request is critical to allow the state's population health initiatives to continue to evolve and sustain meaningful change. RCHC supports NYSDOH's efforts to more closely integrate Medicaid payors into the existing structures and welcomes the opportunity to work with the state to create innovative payment models with the goal of providing more streamlined and value-driven care. RCHC is also pleased that the state has identified several new high-priority areas aligned with CMS priorities. In particular, RCHC believes that a focus on maternal and children's population health represent a key area that is in need of transformative measures aimed at improving access and providing more integrated and coordinated care opportunities. The interrelatedness between maternal and child health has been well-established, and represents an area that could benefit from continued DSRIP funding, with special emphasis on vaccine preventable diseases and other preventive strategies.

**Alexandra Khorover, Esq.**
General Counsel
[redacted]
**RefuahHealth | http://www.rhcnys.org**
**Refuah Community Health Collaborative | http://www.refuahchc.org**

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**From:** Jack Salo [redacted]
**Sent:** Monday, November 4, 2019 1:52 PM
**To:** doh.sm.1115Waivers
**Cc:** [redacted] Erin Summerlee; [redacted] [redacted] Pamela Guth; William Wagner; Emma Nalin
**Subject:** DSRIP 2.0 Comments: Rural Health Network of SCNY
**Attachments:** NYS - DSRIP 2.0 input.docx



Good Afternoon,

Attached, please find comments on the proposed DSRIP 2.0 from the Rural Health Network of South Central New York.

Best Regards,

Jack Salo

John C. Salo
Executive Director
Rural Health Network of SCNY
455 Court Street
Binghamton, NY 13904

[redacted]
Website: www.rhnscny.org

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# Rural Health Network of SCNY, October 29, 2019: DSRIP 2.0 Input

**I. DSRIP 2.0 Social Determinant (SD) Network Proposal:**

a. **<u>Do not</u> limit DSRIP 2.0 funding for SD interventions to SD Networks**. Encourage SD partnerships in community – clinical initiatives, innovation projects and other network formations.

b. **Recognize and build upon existing SD delivery systems not just individual CBOs** (e.g., Rural Health Networks, Maternal & Child Health Networks, Community Action Agencies, Aging Services Departments, etc.). Utilize local subject matter experts to inform planning and design. Do not be prescriptive in assigning SD Network geography or interventions. If a community organization or community organization collaboration is not the lead, establish requirements for the highest level of community organization involvement and guidance from planning and governance through service delivery.

c. **Provide sufficient financial support and incentives for small and rural community organizations to participate in SD Networks** (they may need to hire additional staff, cover travel expenses, etc. to even be at the table).

d. **Require commitments to data sharing (with guidelines) between clinical and community organizations and between community organizations.** There is a need for agreement on common date collection elements/definitions. Building on the GSI Care Management investment, continue development of integrated and holistic individual care plans that include clinical and social determinant information and data. High performance, real time care management requires a closed loop referral system to ensure action and confirmation of referrals and/or service being provided. More comprehensive data sharing will improve internal and external workflow efficiencies for case management, care coordination, data entry, care planning and integrated service delivery over time, across systems of care and during times of transitional care.

II. Current CBO Tier designations can adversely impact rural Medicaid members and rural Tier 2 organizations: **Recommend revision of the CBO designations to recognize that there are Tier 2 CBOs whose primary business is not Medicaid funded.** This is important to ensure rural CBOs that provide limited Medicaid funded services, but mostly work providing non-Medicaid social determinant services are not disadvantaged along with the rural populations they serve (Example: Tioga Opportunities, Inc.). This could be based on a percentage of total

budget formula (e.g. a Tier 2 can have a maximum Medicaid revenue of X% of total budget.

III. **Workforce: Support Community Health Worker (CHW) capacity development.** CHWs are currently recognized only as a job title by NYS Department of Labor. Workforce funding is needed to establish CHW learning standards (education & training) and recommend CHW professional competencies that lead to NYS accreditation. This will support clinical providers, reduce burnout, and better prepare the current and future non clinical workforce tasked with addressing social determinant of health support to the Medicaid population. Acknowledge CHW specialties, including CHW service to rural populations.

IV. **DSRIP 2.0 needs to be clear on how the proposed VDE-SDHN structure and DSRIP 2.0 goals fit into existing programs**, such as Health Homes, Behavioral Health Care Collaboratives, existing social determinant of health service delivery systems, etc.

V. **DSRIP 2.0 and Innovation Projects: Continue investing in promising innovation projects** with more of an emphasis on measurement, research and determination of ROI for all projects.

VI. **Increase participation and provide more opportunities for marginalized population "voice"**: rural, people of color, non-English speaking, children in need, etc.

Comments submitted by:

John (Jack) C. Salo
Executive Director
Rural Health Network of SCNY
455 Court Street
Binghamton, NY 13904

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**From:** Burton, Eric [redacted]
**Sent:** Monday, November 4, 2019 2:15 PM
**To:** doh.sm.1115Waivers
**Subject:** 1115 Public Forum Comment
**Attachments:** AHI 1115 Public Forum Comments 11.01.19.pdf



Good Afternoon,

Please see the attached comments.

Thank you.

Eric Burton
Chief Executive Officer
101 Ridge Street, Glens Falls, NY 12801
[redacted]

a·H·I

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Adirondack Health Institute
Lead Empower Innovate

November 1, 2019

NYS Department of Health
Office of Health Insurance Programs
Waiver Management Unit
99 Washington Avenue
12th Floor, Suite 1208
Albany, NY 12210

Dear NYS Department of Health:

Thank you for the opportunity to provide feedback regarding New York State's 1115 Research and Demonstration Waiver #11-W-00114/2, Delivery System Reform Incentive Payment (DSRIP) Amendment Request. As a community-based performing provider system serving a largely rural population in upstate New York we are appreciative of the opportunity to continue proven effective interventions and build on lessons learned to implement evolved models that promote optimal health and well-being for the residents of our region.

The draft proposal is well aligned with our vision for a rural-centric health delivery system that is inclusive of payers, providers and consumers as we move to align care delivery and with payment models that are premised on value. We applaud the move to further highlight the key role of community-based providers (social determinants of health networks) through unique recognition and dedicated funding. We also support enhanced inclusion of MCOs and QEs in service delivery planning and development, data capture and reporting and ongoing evaluative efforts to ensure integration and alignment in support of desired outcomes.

Our comments and suggestions are both practical and policy-oriented as we move to evolve and grow premised on lessons learned within the region, the State and the Nation.

1. Timeline: We support continuation of the current DSRIP PPS structure for an additional year prior to transitioning to VDEs and SDHNs. Careful planning for this transition is essential to ensure seamless evolution of current successful initiatives including funding to support fragile providers and to continue staffing throughout the year. We would propose that the State allow the current PPS structure to continue for the 1-year extension and allow the PPS's to use the year to evolve their governance to meet the structure and expectations of the proposed VDEs and SDHNs.

2. Region: The proposal notes that VDEs will be assigned specific regions/markets and attributed population but will be provided flexibility to accommodate additional representation for newly engage sectors (CBOs, MCOs). We would recommend that the PPS be able to define those regions during the one-year extension (or planning year) for approval by the State.

3. Funding. The proposal to expend ½ of the requested funding in year one is ambitious and assumes that entities can both accept the funding and utilize it an efficient and effective manner. Immediate planning, particularly expected goals and outcomes will facilitate the efficient use of these resources. Continuation of proven effective interventions may be the most effective way to efficiently utilize these resources as the systems and services are in place and do not have to be developed and implemented in a relatively short period of time.

   Allocation of the $4B should account for funding of CBOs that is not premised on patient attribution. Assuring enough funding to these providers, with the expectation that DSRIP 2.0 will provide further supports, will help position these often-fragile organizations to be successful in the next iteration of the DSRIP program.

4. Metrics: Population health improvements, when successful result in reduced revenues for most providers. Providers sustainability and predictability, particularly in a rural region with insufficient providers is of paramount importance and should be considered when developing metrics to define success (and payment).

5. All Payer Focus. We were heartened to see mention of all payers in the draft document ("Value-Driving Entities... should consider a multi-payer lens when implementing the promising practices to promote 360-degree population health and to further the sustainability of these reform approaches") and encourage the State to continue this focus. Inclusion of all individuals, regardless of payer, is essential to realizing desired population health improvements such as reduced rates of smoking and obesity which continue to plague the Adirondack North Country region.

6. Promising Practices: While we support alignment with federal priorities, in particular expansion of MAT, primary care / behavioral health integration, care coordination, addressing social determinants and supporting alternative payment models, we would propose allowing each VDE to focus on one or two specific areas consistent with regional need to ensure time and resources to realize effective system transformation. The promising practices highlighted in the proposal and in the UHF report while broadly applicable might be further tailored to regional need premised on the extensive work conducted over the past 5 years. We would propose the VDEs be permitted a degree of flexibility to identify specific interventions and models that are most likely to efficiently and effectively meet overarching goals. AHI has engaged in the following DSRIP supported initiatives that have proven successful and we believe should continue:

   a. Multi-Sector Performance Networks. Creation of multiple clinical and community service provider networks most relevant to serving complex patient cohorts, for the purpose of developing targeted strategies and performance goals to improve patient outcomes and prepare providers for value-based payment (VBP). The AHI PPS Population Health Network (PHN) structure created regionally-focused networks of clinical and community service providers collaborating on DSRIP & population health strategies, projects, and performance goals. AHI convened and facilitated several performance-focused workgroups throughout DSRIP, many of which were cross-sector (i.e. MAXny series, Patient Engagement/Community Navigation workgroups).

   b. Transforming Primary Care. Supporting primary care practice transformation by enabling small primary care practices to achieve patient-centered medical home recognition, training community

health workers (CHWs) to support primary care practices and fostering strong partnerships between CBOs and primary care to more effectively manage patients' social needs.

c. Connecting Clinical and Community Resources. AHI's Innovation Project grants enabled clinical organizations to partner with CBOs to implement collaborative projects intended to advance DSRIP/population health goals while strengthening the infrastructure for future cross-sector partnerships. For example, AHI implemented the ADK Wellness Connections coordinated referral network, based on the Unite Us platform, making a central IT/data platform available to all types of service providers. ADK Wellness Connections allows network partners, specifically smaller CBOs, to track the outcomes of their work in order to inform value propositions for contracting purposes.

d. Patient Activation and Engagement. AHI funded Community Navigator and Health Coach positions within 19 PPS partner organizations. Individuals in these positions were provided training on patient activation and engagement techniques, cultural competency and health literacy, Coaching for Activation, PAM survey administration, screening for SDoH, and referral & linkage processes (including connecting to Health Home & EASE).

e. Addressing Low and Non-Utilizing Medicaid Beneficiaries. AHI used data hot-spotting to determine pockets of the PPS region with high concentrations of low and non-utilizing Medicaid beneficiaries and uninsured individuals. Funding for Community Navigators and Health Coaches was premised in part on within hot spots and history of strong relationships with the targeted populations.

f. Nutrition to Improve Health and Well-Being. Food as Health programs such as "Well Fed Essex County, Wellness RX" a referral program that promotes diet modification by providing vouchers for individuals to redeem for fresh fruits and vegetables at local retailers.

g. Care Navigation. With support from AHI PPS, Nathan Littauer Hospital implemented care navigation in the ED and inpatient setting through a community based behavioral health provider, The Family Counseling Center. The care navigator is part of the care team for multi-visit patients (MVPs) alongside Nathan Littauer staff. Nathan Littauer saw a 27% reduction in PPRs over a 5-month period during a MAX initiative. Inpatient utilization for MVPs decreased from 22.3% to 17.8% between April 2018 and August 2019.

Specific additional high-need priority areas we recommend be considered include;

- Non-Medicaid population health services.
- Broadly defined long-term care inclusive of dually eligible individuals, palliative and end of life care.
- Successful models for collaborations with the K-12 school system.

7. Value Driven Entities: AHI supports reconfiguring the current PPS structure to be inclusive of health plans, community-based providers and primary care, behavioral health and long-term care to improve regional performance. In the Adirondack North Country region multiple providers, the Adirondack ACO, Integrated Delivery Systems, IPAs, NYS Behavioral Health Care Collaboratives (BHCCs) and AHI have come together to form the North Country Innovation Pilot (NCIP). This pilot is an effort to leverage lessons learned to advance an inclusive regional model of care that emphasizes whole person care and provider integration and alignment to improve care delivery and outcomes together with payment models that incent desired outcomes such as Total Cost of Care (TCOC) and global budgets. Alignment of this regional effort with

DSRIP 2.0 is potentially a very powerful tool to ensure goal attainment across the region inclusive of Medicaid-specific goals and objectives.

8. Role of MCOs: While AHI recognizes the key role and importance of MCOs as partners in health delivery there are practical considerations that must be thought through including the following;
    a. How best to balance and structure MCO participation in VDE governance.
    b. MCOs should be required to make strategic investments in population health interventions as terms of participation in the VDEs.
    c. Data transparency will be essential for the VDE to measure and evaluate impact of interventions. Participation in the VDEs by MCOs should be contingent upon willingness to share uniform, timely and transparent (including cost) data.

9. Safety Net Providers & 95/5 Requirement: AHI strongly encourages an elimination of the current 95/5 SN/NSN funds flow requirement. While the downstream concept theoretically works to meet the requirement, in practice it has not worked as a strategy to keep NSN partners engaged. Our PPS has found that SN providers are unwilling to serve as downstream agents unless it is for a specific project or initiative. As an alternative, if elimination of the 95/5 is unrealistic, we would suggest revisiting the ratio to allow a larger percentage of direct funds flow to NSN partners.

10. Workforce Investments: The earlier the PPS (VDE) is aware of state-level initiatives or focus areas the better the region can plan and ensure success. We would also encourage flexibility to define priorities that are workforce needs specific to the Adirondack North Country region.

11. Performance measurement: AHI's work to date reinforces the need for information on proposed metrics well in advance of implementation. In addition, we recommend metrics that reinforce collaboration across providers, between providers and payers and across the defined geography. Ultimately performance should be measured by population health – consistent with Prevention Agenda metrics that drive health for all.

Thank you again for the opportunity to share feedback and for your consideration of these comments.

Sincerely,

Eric Burton
Chief Executive Officer

## doh.sm.1115Waivers

**From:** Marla Tepper [redacted]
**Sent:** Monday, November 4, 2019 2:25 PM
**To:** doh.sm.1115Waivers
**Subject:** 1115 Public Forum Comments
**Attachments:** Public Health Solutions' Comments on NYS MRT Draft DSRIP Amendments 2019111.pdf



Attached please find Public Health Solutions' comments on the Draft NYS Medicaid Redesign Team DSRIP Amendment Request.
Thank you for your consideration of these comments.

Marla Tepper
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Vice President of Legal Affairs & General Counsel
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**Public Health Solutions' Comments**
**on the**
**Draft New York State Medicaid Redesign Team (MRT)**
**Delivery System Reform Incentive Payment (DSRIP) Amendment Request**

Public Health Solutions ("PHS") appreciates the opportunity to comment on the State's draft DSRIP Amendment Request and the State's commitment to improving health outcomes in New York State through DSRIP.

PHS supports vulnerable New York City ("NYC") families in achieving optimal health and building pathways to reach their potential. PHS provides direct services to more than 105,000 New Yorkers each year in neighborhoods across the five boroughs, and partners with government, philanthropy and more than 220 local healthcare and community-based organizations on collaborative initiatives that improve public health and health equity in NYC.

Recently, as recipients of an innovation award from OneCity Health for our work on food insecurity, we catalyzed a dynamic coordinated intake system for food and nutrition services, serving as a trustworthy bridge from hospitals and health plans to community-based food and nutrition providers. This coordinated system is designed to improve health outcomes and reduce potentially avoidable hospital costs by helping food insecure patients enroll in SNAP, WIC, Medically Tailored Meals, and/or congregate meals, and access to food pantries. Data from the project will be used to evaluate the innovation's potential to be scaled more broadly. We also serve as the hospital-community bridge partner for the OneCity Health Performing Provider System ("PPS"). We are keenly engaged in identifying and testing technological and operational solutions to create robust, effective and efficient closed loop referral systems to connect traditional health care partners to CBOs. This boots-on-the ground experience informs our comments.

We support continued investment in current DSRIP priority areas, as well as the proposed new priorities of reducing maternal mortality, children's population health and long term-care. We applaud the critical investment in Social Determinant of Health ("SDH") Networks to deliver interventions linked to value-based payment arrangements to address the SDH of Medicaid members.

We offer the following comments:

- **Social Determinants of Health**. We endorse the State's proposed significant investment in the SDH and its plan to create one network of service providers in each region. Dividing NYC into regions no larger than counties would facilitate SDH interventions that are responsive to NYC's diverse communities and health disparities among neighborhoods, as well as the inclusion of a

broad swath of community-based organizations ("CBOS").[1] We also recommend expanding the list of social determinants to address differing local needs and considerations.[2] Additional SDH services may include legal support, employment and job training, emergency food, and education and child care. Limiting SDH services at the onset of network development does not allow for a collaborative input process from the community. A broader list of SDH may also contribute to a more standardized social needs screener to be used throughout the VDE in the long term (and implementation could be supported by lead CBO).

- **Governance and Roles.** We are excited to see a larger role for CBOs, cross-sector collaborations and the non-clinical workforce in the proposal. CBO engagement is critical to the delivery of services to address the SDH and to realizing the goal of VBP for SDH. The concept of the value driven entity ("VDE"), a partnership of healthcare provider, MCO and CBO significantly improves on the previous PPS concept and addresses identified gaps and challenges in PPS engagement of CBOs:

  > Meaningfully engaging providers in delivery system reform within large networks formed by PPSs was challenging. Consequently, some partners play significant roles in PPS projects and governing board committees, while others have little or no involvement in PPS activities. Engaging CBOs has been particularly difficult when the lead hospitals in the PPSs did not have previous referral relationships with the organizations or the hospitals viewed the CBOs as competitors for outpatient care.[3]

  Meaningful engagement of CBOs in VDEs would be enhanced by requiring—not merely suggesting--a role for CBOs in governance of the VDEs. CBO participation in governance would likely strengthen relationships and trust among participants, reportedly deficits of the first phase of DSRIP.[4] It would also embed in the governance structure expertise of community needs and services and give CBOs a needed voice in funding decisions.

  The role and governance of the MCO requires some clarification. Ideally, the State will require multiple MCOs to participate in each VDE so that multiple SDH services will be offered through multiple CBOs. Moreover, MCOs should be governed by a set of best practices so that membership in a specific plan will not necessarily affect the type of services a consumer may receive, contributing to better and more equitable outcomes.

- **Infrastructure and Capacity Development**. The State must consider infrastructure and capacity development needs for CBO participation. Information technology is critical for effective care coordination, conducting outcome measurement and reporting and streamlining payment. As

[1] *See, e.g.,* NYC Department of Health and Mental Health, "NYC Department of Health and Mental Health Community Health Profiles", https://www1.nyc.gov/site/doh/data/data-publications/profiles.page, accessed Oct. 29, 2019 (Community level profiles emphasize that "Our health starts where we live, work and play").
[2] Emily Sokol, "How Geographic Data Can Help Address Social Determinants," Health IT Analytics, July 12, 2019, https://healthitanalytics.com/features/how-geographic-data-can-help-address-social-determinants-of-health, accessed Oct. 29, 2019 (("The distribution of social determinants of health can vary drastically even within a single zip code").
[3] Laurie Felland, Debra Lipson and Jessica Heering,"Examining New York's Delivery System Reform Incentive Payment Demonstration: Achievements at the Demonstration's Midpoint and Lessons for Other States", April 2018 at 7, https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/ny-dsrip-case-study.pdf, accessed Oct. 29, 2019, *see also* Citizens' Budget Committee, "The Challenges of Enhancing Effective Engagement of Community Based Organizations in Performing Provider Systems: A Discussion Paper", Nov.2017, accessed Oct. 29, 2019.
[4] *Ibid.*

United Health Foundation's "Promising Practices" notes, data analytics that use clinical and claims data are critical "to target and better manage the care of complex patients and populations, as well as measure performance and support continuous quality improvement."[5]

Few CBOS have the resources to purchase necessary technology or master their use. Collecting, managing and reporting data, particularly health outcomes (which CBOs may be unaccustomed to reporting) may be daunting for CBOs, as vignettes collected by the Greater NY Health Association illustrate:

> IT and data are traditionally hard for social service organizations, and so to be totally blunt about this . . . we track everything in Excel, which is hideous for us. It is hugely difficult for data we're collecting . . . it's a big burden. (CBO)
>
> We would like to know the date and time of every pediatric asthma patient that's come in over the last six months from [this zip code]. And for us, that's several keystrokes. For them, if they're not on an electronic filing system, that is a massive activity. [A] routine question . . . could potentially be a multi-week effort. But I want that right now, and they still have an organization to run that does a range of other things. (Hospital)[6]

These challenges are exacerbated by the lack of interoperability of systems, with CBOs frequently using multiple data reporting systems. One NYC settlement house, for example, reports using 26 databases to report required data.[7] Data sharing among CBOs and other providers may also be stymied because CBOs are not typically part of Regional Health Information Organizations (RHIOs) or Electronic Health Record (EHR) systems used by clinical providers.[8]

CBOs also face challenges in contracting, including complex regulatory requirements, lack of standardized terms across contracts as well as relative inexperience negotiating.[9]

To address these challenges, the State must invest in infrastructure and capacity building. The State may be guided by North Carolina's recent 1115 Medicaid waiver request, approved by CMS. As part of this waiver CMS approved a 650 million-dollar healthy opportunities pilot program to

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[5] Nathan Myers, Gregory C. Burke, Misha Sharp, Matlin Gilman, Chad Shearer, United Hospital Fund, "DSRIP Promising Practices: Strategies for Meaningful Change for New York Medicaid", July 2019, https://uhfnyc.org/media/filer_public/42/39/4239177f-a7a8-4444-885b-5116be998f33/dsrip_promisingpractices_20190716_web.pdf, accessed Oct. 30, 2019.

[6] Kerry Griffin, Carla Nelson, Lindsey Realmuto, Linda Weiss, Greater NY Hospital Association and NY Academy of Medicine, "Partnerships Between New York City Health Care Institutions and Community-Based Organizations", April 2018, https://nyam.org/media/filer_public/9f/5b/9f5b33a3-0795-4a1a-9b90-fa999e9ddf8e/hco_cbo_partnerships_digital.pdf, accessed Oct. 30, 2019.

[7] The Commission on Value-Based Care, Human Services Council, "Integrating Health and Human Services, A Blueprint for Partnership and Action", 2018, https://humanservicescouncil.org/wp-content/uploads/Initiatives/ValueBasedPayment/Value-Based-Care-Report.pdf accessed Oct. 30, 2019.

[8] *Ibid.*

[9] See, e.g., "Caveat Vendor: Lessons learned from CBO contracting with Healthcare" Presented by Sandy Atkins, Partners in Care Foundation, at Aging & Disability Business Institute Trailblazers Learning Collaborative (November 2017), https://www.picf.org/wp-content/uploads/2017/11/20171114-ADBI-Contracting-10-min.pdf, accessed Oct. 30, 2019.

address SDH, 100 million of which will be allocated for capacity building of services providers including CBOs and social service agencies.[10]

We also urge the State to consider the potential for experienced lead CBOs to support these needs by serving as backbone CBOs for capacity building. Capacity development CBOs can serve as trusted brokers, formalizing coalitions of CBOs and fostering collaboration among them, and providing network desk skills. The lead CBOs can also ensure that CBO partners are able to participate in the complex regulatory environment, negotiate value-based payments, and tackle challenges such as data analysis and technology integration, which often hinders partnerships between clinical and community.

- **New Priority Areas**. While we support the proposal's emphasis of additional high-need priority areas, clearer expectations for VDEs are necessary to ensure they incorporate value-based incentives and performance metrics for the reduction of maternal morbidity and mortality and children's population health.[11] This is particularly important where incentives among VDE partners may not be aligned and moreover, may not advance health outcomes. For example, unintended pregnancy, premature birth, low-birth weight births, and severe maternal morbidity events are costly. Significant savings potential can be realized by ensuring access to family planning and reproductive health services and evidence-based maternal and child health programs.[12] Reducing unintended pregnancies saves health plans significant amounts of money relative to the costs of effective contraception. Hospitals, however, compete for and aim to increase the number of deliveries at their facilities, so are not incentivized to make contraception more readily available; at the same time, avoiding unintended pregnancies also contributes to positive birth outcomes, which can improve a hospital's safe birth outcomes. Value-based arrangements in this have not yet been sufficiently explored, so requiring arrangements for priority areas could catalyze improvement in this area.

- **Consumer Engagement and Empowerment.** Absent from this proposal is any plan or proposed funding to effectively engage consumers to ensure that services and systems are responsive to consumer needs and support health outcomes.

  Consumers face daunting challenges understanding their health coverage. Developing and implementing robust and culturally competent consumer education, assistance and protections is critical to the success of the next phase of DSRIP, and particularly, the SDH interventions. Consumers must be empowered with information about their networks, how to access services, as well as how they can seek redress, provide feedback on services, and learn other information

[10] North Carolina Department of Health and Human Services, "North Carolina's Healthy Opportunities Pilots: A Review of Proposed Design for Interested Stakeholders", Feb. 15, 2019, https://files.nc.gov/ncdhhs/documents/Healthy-Opportunities-Pilot_Policy-Paper_2_15_19.pdf, accessed Oct. 30, 2019.

[11] *See* Arvin Garg, Charles J. Homer, Paul H. Dworkin, "Addressing Social Determinants of Health: Challenges and Opportunities in a Value-Based Model", *Pediatrics* e20182355 doi:10.1542/peds.2018-2355, March 2019, https://pediatrics.aappublications.org/content/early/2019/03/20/peds.2018-2355.full?rss=1, accessed Oct. 31, 2019.

[12] *See* Karin Stenberg, Kim Sweeny, Henrik Axelson, Marleen Temmerman, Peter Sheehan, "Returns on Investment in the Continuum of Care for Reproductive, Maternal, Newborn",2016, *Disease Control Priorities, (Volume 2, Ch. 16): Reproductive, Maternal, Newborn, and Child Health*, https://www.ncbi.nlm.nih.gov/books/NBK361897/, accessed Oct. 31. 2019.

relevant to understanding their rights.[13] Further, ensuring that consumers have access to meaningful evaluations and data (including complaint data) is essential. Information must be in plain language, in the languages spoken by New Yorkers, and in formats accessible to consumers with disabilities. CBOs, with their roots in the community, are essential partners for developing and disseminating this information and identifying the best means of consumer education. Funding should be allocated for this purpose.

Funding should also be allocated to CBOs for surveying consumers on consumer perspectives of DSRIP and engaging in advocacy on behalf of consumers. [14]

Thank you again for considering our views.

**About us:**

Founded in 1957, Public Health Solutions (PHS) is the largest public health nonprofit organization focusing on New York City. PHS is improving health and creating opportunities to help NYC's vulnerable families and neighborhoods thrive. With two million New Yorkers living at or below poverty, PHS is at the forefront of tackling crucial public health issues including food and nutrition, health insurance access, maternal and child health, reproductive health, tobacco control, and HIV/AIDS prevention. Our approach is multi-pronged, innovative, and sustainable. We work directly in the community to provide health services to underserved families. We conduct groundbreaking research that informs the public health community and policy. Through our long-standing government partnerships, we are a critical link in providing financial support and management assistance to over 200 community-based organizations across the city's five boroughs. For more information, visit healthsolutions.org.

[13] *See* Jocelyn Guyer, Naomi Shine, Robin Rudowitz and Alexandra Gates, Kaiser Family Foundation, "Key Themes From Delivery System Reform Incentive Payment (DSRIP) Waivers in 4 States", April 2015, http://files.kff.org/attachment/issue-brief-key-themes-from-delivery-system-reform-incentive-payment-dsrip-waivers-in-4-states, accessed Oct. 30, 2019.
[14] *Ibid.*

## doh.sm.1115Waivers

**From:** Frank Bercik [redacted]
**Sent:** Monday, November 4, 2019 2:31 PM
**To:** doh.sm.1115Waivers
**Subject:** DSRIP 2.0 Public Comment
**Attachments:** DSRIP 2.0 Public Comment - CADS.pdf

**Importance:** High



Hello,

See attached letter.

Sincerely,

Frank Bercik
Executive Director

**Where Every Day is a Good Day!**
"A United Way Community Partner"

**Chautauqua Adult Day Services**

November 1, 2019

Paul Francis
Deputy Secretary for Health
State Capitol
Albany, NY 12224

Donna Frescatore
Medicaid Director
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Dear Mr. Francis and Ms. Frescatore,

On behalf of Chautauqua Adult Day Services located in Chautauqua County, I am writing to express our recommendations on the DSRIP renewal proposed by New York State Department of Health.

Our agency has been in operation since 1982 and has four Adult Day Care programs that serve all of Chautauqua County located in Jamestown, Dunkirk and Westfield. One of the sites is a day program specifically for individuals with Alzheimer's Disease and Memory Loss. In addition, we provide a Latino Outreach to seniors program for Latino families and human service agencies in the community who need translation or interpretation services to older Latinos obtain senior services.

Our agency has been a partner since its inception with the Chautauqua County Office for the Aging and supports its recommendation recently submitted as well. We are directly linked with Peer Place and have worked together to help individuals remain at home. We also are linked with NY Connects and work closely with many community based organizations and agencies on an ongoing basis to provide a network of services for those in the community. We work closely with Meals on Wheels, Chautauqua Office for the Aging and Office of Mental Hygiene. The agency also works with the Veterans Administration and other providers to include the Managed Long Term Care Program and the NYS Office for People with Disabilities.

Our agency wants to be a part of the DSRIP 2.0 initiative and has the network and programs needed that will important elements of community based care, especially helping delay nursing home placement and higher levels and more costly care.

**PRESENT CENTER**
**358 East Fifth Street, Jamestown, NY 14701**
**www.seniordayprograms.com | (716) 665-4899. Option 1 | Fax (716) 665-4822**

United Way
Community Partner

**Chautauqua Adult Day Services**

The recent establishment of the Bureau of Social Determinants of Health within the Health Department is a positive step forward for New York in addressing population health and linking clinical services with community based social services. The purpose of the Bureau is to transform the New York State Healthcare delivery system by integrating health and human services and is an important step in the right direction. However, more needs to be done to make sure the playing field is level and that the integration of our network with health systems actually happens, including service resources and investments in technology that can better link the systems to improve outcomes. Addressing the Social Determinants of Health (SDOH) to improve the quality of care and health outcomes for NYS most vulnerable populations will bring about the results that this waiver intends.

**As noted, social determinants of health (individual behaviors and social and environmental factors) are responsible for 60% of all health care expenditures, yet interventions to address them comprise only 3% of national health expenditures, with 97% going to medical services.**

While health care will always be important, the heavy lift to assure that care plans and post-discharge services and supports are in place at the community level, with service organizations that work in this space daily. We are a central part of the success or failure of the health care industry. The services we provide directly impact inappropriate emergency department visits, and reduce avoidable readmissions. Our services **absolutely** allow individuals to remain in their own homes and communities, all while saving health care expenditures.

Thank you for the opportunity to provide comment on this important proposal. We feel that by implementing these recommendations the Governor will be making great strides toward making New York one of the healthiest states in the Nation.

Feel free to contact me at [redacted] or [redacted]

Sincerely,

Frank Bercik
Executive Director
Chautauqua Adult Day Services

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United Way
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## doh.sm.1115Waivers

**From:** Kate Breslin [redacted]
**Sent:** Monday, November 4, 2019 2:37 PM
**To:** doh.sm.1115Waivers
**Subject:** 1115 Public Forum Comment
**Attachments:** DSRIP2_Comments_110419_FINAL.pdf



Please see attached.

Kate Breslin
President & CEO
Schuyler Center for Analysis & Advocacy
540 Broadway
Albany, NY 12207
[redacted]
Facebook: @schuylercenter
Twitter: [redacted] / @SchuylerCenter

To: New York State Department of Health, Office of Health Insurance Programs
1115waivers@health.ny.gov
From: Please see list of signatories below
Re: 1115 Public Forum Comment - New York State's DSRIP Waiver Request
Date: November 4, 2019

Thank you for the opportunity to comment on the State's four-year amendment request, aka Delivery System Reform Incentive Payment Program (DSRIP) 2.0.

New York State Medicaid (and Child Health Plus) provide coverage for 41% of the state's children 0-18 years old, yet the first round of DSRIP provided little incentive or reward for improvement in child health outcomes. Thanks to the state's high-level cross-sector leadership, such as the robust engagement process for the First 1,000 Days on Medicaid, New York has demonstrated a deepened understanding of the great opportunity associated with improving child health outcomes and the great risk associated with inaction or failure to address needs early enough. This commitment to children from their earliest years, buoyed by great national interest and replication efforts in other states, has propelled New York as a leader in innovative new approaches to ensure children get the care they need, when they need it, even before conception. Because of this high-stakes attention, DSRIP 2.0 should commit to a strong investment in children in the second round of DSRIP, which was not the focus of the first.

Historically, the health system and Medicaid in particular, has predominantly focused on high-cost populations as targets for savings. Yet children—the largest group of Medicaid beneficiaries but at a low per capita cost-—have been significantly overlooked, allowing preventable delays or disease to escalate into costly health conditions in adulthood. The lack of focus on children has generated a system predominantly built for adults, pigeonholing children into categories of adult sickness even as their own development is dramatically different at each stage. It's time to make the system work for children, which means dedicated attention and investment in each child with the right approach – health promotion, prevention, or intervention - at the right time, from Day 1.

For DSRIP 2.0, this means New York State should put money behind its declared priorities, dedicating a significant portion of DSRIP funds to children, requiring that most or all funded projects include a child-focused component based on our recommendations below. Child development is dynamic; projects should also address issues specific to critical developmental periods, such as early childhood and adolescence.

New York has already endorsed the **recommendations from the First 1,000 Days on Medicaid** and its **Preventive Pediatric Care Clinical Advisory Group.** Building on these previous efforts, our comments below focus on several **overarching priorities**:

1. Understanding structural racism and its impact on lifelong health, and developing strategies to address it.
2. Getting farther upstream where prevention really happens.
3. Focusing on evidence-based approaches and interventions.
4. Understanding the value of and paying for two-generational approaches.
5. Coverage matters and we should ensure continuous coverage, especially for very young children (under three).
6. Reversing the State's historical under-investment in children, which has been exacerbated by value-based payment (VBP).

7. Preventing, identifying, and treating children's behavioral health needs younger, earlier, and more effectively.
8. A recognition that the long-term improvements in health outcomes that evidence-based practice promises will require a redefined value proposition—accepting modest short-term medical savings with much larger long-term and cross-sector savings.

These priorities are affirmed and echoed by the **VBP for Children CAG recommendations,** which state that New York's efforts to develop incentives and payment that generate better outcomes for children need to recognize:

- Children are not "little adults" and have a unique set of needs that will influence development and their trajectory over the next critical phases of their life.
- Healthy growth and development of children today will bring long-term value to Medicaid and other public systems, including but not limited to education, child welfare, and juvenile justice. For these reasons a longer horizon for assessing cost savings across multiple sectors must be considered.
- Access to high-quality primary care is essential, and access to specialty care—especially for maternal and child behavioral health—should be integrated into primary care settings.
- Addressing social determinants of health and preventing or mitigating the effects of adverse childhood experiences is critical.
- Strengthening systems of care, including family systems, is fundamental to improving outcomes for children.
- The health and mental health of parents/caregivers significantly influences the health and mental health of children. In particular, quality maternity care and behavioral health care for caregivers is critical for setting children on an equal footing toward lifelong health.
- Current investment in children's health may not be enough to fully meet the unique needs of children.

These priorities form the foundation for the following key recommendation areas:

**Continuous Eligibility/Coverage**

We urge the State to ensure **continuous eligibility for Medicaid from birth to age three.** Children lose access to regular, recommended care because of gaps in enrollment and re-enrollment that unnecessarily and adversely impact continuity of care, coaching, and the ability to provide evidence-based and preventive approaches.

**Upstream Health Promotion and Prevention**

The waiver amendment's proposed attention to **Children's Population Health** is a logical concept, but the language in that section is weighted only to children with chronic conditions; to be successful, the system must effectively move further **upstream. Connections between DSRIP 2.0 and the NYS DOH Prevention Agenda for children and families should be resourced, strengthened, and amplified.** The NYS DOH Prevention Agenda Dashboard provides an accessible list of specific upstream objectives at the state and county levels. Connecting DSRIP 2.0's aims directly to these metrics will yield more prevention of root causes of disease, and better tracking of what interventions are working, where, and for whom. That would lead to faster dissemination of the most effective approaches.

**Evidence-Based Approaches and Interventions**

DSRIP 2.0 should facilitate models of pediatric care that make use of **evidence-based** programs. Prioritizing evidence-based approaches promotes a critical framework for weaving and linking effective services and programs for children, youth and families across health,

education, community and social services. These types of programs, several of which are named in the Preventive Pediatric Care CAG appendix, "extend successful practices to children in the areas of behavioral health integration, pediatric-focused patient-centered medical homes, and attention to adverse childhood experiences and social determinants" (from waiver amendment section on Pediatric Population Health). **A critical evidence-based intervention that moves even further upstream in pre-conception care is evidence-based contraception that includes both education and counseling regarding improved access to Long Acting Reversible Contraception.** Including a focus in this area promotes the health and well-being of adolescents, women, and families, and yields short and long-term returns on investment via decreases in low birth weight and prematurity related to increasing rates of intended pregnancy and inter-pregnancy interval.

**Two-generation approaches yield strong outcomes and a promise of lower costs.** There are several evidence-based two-generation models; the Preventive Pediatric Care CAG report's appendix includes an illustrative, not exhaustive, list. Incentives and payment methodologies need to be built around two-generation approaches.

In children, a sizable portion of the population of high utilizers cannot be defined by ICD10 medical diagnoses alone. Family circumstances and specifics of child medical/behavioral risk must be considered.

**Cross-sector Collaboration and CBO and Consumer Empowerment**

**DSRIP 2.0 must offer financial incentives and resources to support cross-sector collaboration and CBO empowerment** as the required means of ensuring sectors work together toward better child outcomes that the health system cannot achieve in isolation. Community-based organizations and services of different types fill critical needs for children and families and should be considered essential components of a continuum of care. Examples include Early Intervention, Head Start, Help Me Grow, child care/early learning, and school. CBOs need support to improve the quality and the quantity of services that they provide for children, and for very young children specifically, as this population is least likely to be served in the community and their only point of contact may be health care. It is important to note that helping families with young children address SDH is different than school age children and adult populations. They are isolated and, unlike the situation for seniors, counties don't have departments of infants like they do Departments of Aging.

Importantly, the waiver amendment document mentions **NYeC and HIE**. Solutions that work for adults will sometimes, but not always, work for children. **System integration and connectivity for pediatrics need to be multi-directional connections to community-based non-medical resources, the education system, and inclusive/sensitive of parents** while maintaining older child confidentiality. Special attention is required for children and families in developing and implementing technological efforts to improve communication and linkages between the health sector and CBOs. Specifically, many adult efforts focus on the individual and databases are developed in that manner; for children, databases must be developed with the family as the unit of need with a child linked to parents/caregiver for all services. Therefore, specific work that addresses the needs of young children like Help Me Grow are already leveraging technology to do this. Focusing on learning from these efforts and linking systems like NYeC and HIE to them would be efficient and effective.

**Governance structures** (in the new DSRIP 2.0 entities) **should be required to have several real and empowered consumers at tables and balanced voting representation**

**from CBOs.** CBOs and consumers should represent the array of the population that Medicaid serves, not just the highest cost users. ACOs should also be integral in governance structures.

**<u>Comprehensive Approaches to Behavioral Health of Children and Families</u> (inclusive of Social-Emotional, Development, Social Determinants of Health, ACEs, and Protective Factors)**

There is an urgent and important need to address children's behavioral health beginning with **universal screening, prevention, promotion of protective factors, early intervention, and treatment**, including identifying and addressing the behavioral health needs of caregivers and families. A core principle of the discipline of pediatrics is that children's needs are dynamic—they change quickly as the child develops. A child with no needs at age six months could have many needs at age 18 months. For this reason Primary and Secondary prevention are important, and risk stratification and care coordination need to be dynamic, able to address emerging risk and documented high risk. The InCK model is needed but it is limited by only addressing well-established risk.

The model outlined in the CAG report recognizes developmental/social/emotional needs as the most important drivers of long-term health. It uses tools developed in adult advanced primary care models to impact developmental/social/emotional health. Those tools include risk stratification, care coordination, collaborative care models of integrated mental health, and strong linkages to community services, especially in the developmental support and educational sector.

For primary care practices to do this effectively, they must have access to effective screening tools, efficient practice models for screening and linkage to care management, coaching and navigation, community resources, and behavioral health models that promote an early and rapid response to emerging and moderate risk screens. Linking these efforts and systematic approaches to the work being done in community settings (e.g. childcare centers and schools) is essential to positive outcomes. **Models of integrated behavioral health are most effective where there is the opportunity to intervene early, when symptoms are emerging, before major diagnoses and dysfunction are established.** By implementing short-term brief behavioral health interventions for those with emerging and earlier risk in both primary care and community settings and facilitating coordination with existing effective behavioral supports for children and families in community settings and schools, we can begin to reduce the referral volume, improving the timeliness and success in navigation/bridging for referral to secondary and tertiary mental health care, Early Intervention, and CPSE for children at higher risk who require more intensive treatment or support. A system for facilitated referral navigation, tracking, and communication that puts children and families at the center, and includes the network of child-serving providers and agencies, is essential to true coordinated and integrated care. The capacity of primary care providers and practices to address behavioral health issues is improved through integrated behavioral health, inter-professional collaboration, and programs like Project TEACH. Trauma informed care across the health system can increase the attention, identification, and accessibility to behavioral health needs of families and should be supported in child serving institutions and practices. Additionally, increasing the capacity and quality of secondary and tertiary services, including article 31s to serve children and families particularly in the pre-school population is critical.

The population of children in special education with behavioral health needs require innovation and extension of school based mental health clinics to address their poor educational and health outcomes.

The waiver amendment recognizes the importance of social determinants of health and would create Social Determinant of Health Networks (SDHNs) to target Medicaid members with complex health and social needs and children at risk of ACEs. Most families do not have complex *health* needs yet, but many have complex *social* needs (the same social determinants that impact health and education outcomes for children and youth), that over time manifest as complex health needs (witness what we know about ACEs). There is strong evidence that it is possible to mitigate these influences—and improve outcomes—with well-placed programs focused in the pre-natal and early childhood period (witness NFP, Healthy Families America, The Perry Pre-school Project, to mention a few where good research was done to identify long-term outcomes). The model recommended by the CAG identifies families based on risks before they manifest as specific high need health conditions.

The Pediatric CAG makes specific recommendations for primary care and behavioral health integration and transforming primary care—these are called for in the DSRIP waiver amendment. **The CAG strongly advocates for alternative payment models—a pre-requisite to achieving these goals**. The CAG calls for investment in integrated mental health models that include the early childhood period—interrupting the inter-generational transmission of trauma and disadvantage. The CAG recommends fostering family resiliency, strengthening protective factors, and focusing on health promotion.

**Opioid Epidemic Affecting Children and Families**

The waiver proposal's attention on **opioids** is warranted, but needs **more focus on upstream/prevention**, including evidence-based and promising programs. In our neighboring state of Vermont, the CDC is investing heavily in preventing initiation of substance use. The project there is following the Icelandic model (Kristjansson, A. L., Mann, M. J., Sigfusson, J., Thorisdottir, I. E., Allegrante, J. P., & Sigfusdottir, I. D. (2019). Implementing the Icelandic Model for Preventing Adolescent Substance Use. Health Promotion Practice. Young, E. (2017). How Iceland got Teens to Say No to Drugs. *The Atlantic*). Medium-term progress with such efforts can be tracked with the YRBS surveys. Long-term successful prevention in this area will be an important component of comprehensive efforts to reduce the negative impacts of tobacco, alcohol, opioids and other substances.

Additionally, specific attention to the impact of opioids and maternal/child health is required. The two-generational approach to maternal health, newborn care and transition to home has promising programs that include mom/infant co-rooming, medication minimization, and linkages with home visiting and outpatient support for family (biological or foster). The co-rooming and medication minimization approaches reduce LOS and improve outcomes for babies (Matthew Grossman, Yale U.).

**The Need for Cross Sector, Short- and Long-Term Measures of Success and Alternative Payment Models**

The CAG recommends, and DSRIP should support, the development of trackable, cross-agency population health measures for optimal developmental and social-emotional outcomes that focus on long-term health, education, and wellness.

The CAG recommends developing payment models linked to the health and developmental outcomes that effectively support primary care practices to achieve this vision. **A maternal bundle that extends to 3 years of life for the child, inclusive of siblings and renewed with new births is a specific model that could support the model of care described in the CAG report.** Such a model would complement the InCK model, focusing on improving outcomes and lowering costs before children develop entrenched needs. Such a model would take advantage

of Pediatric practices' frequent contact with mothers to screen for and impact health and health risks (SDOH, Depression and other maternal mental health needs, contraception and connection to services, assisting mothers to connect to medical services in the inter-partum period when Women's Health colleagues identify a need for this). This model could provide continuous coverage during the bundle period.

A model that supports care for complex families would support both lowering short-term costs/risks and secondary prevention strategies that are inherent in a two-generation model.

**While a focus on children promises significant future returns, short-term savings are possible,** in particular with regard to teen pregnancy prevention, targeted/universal home visitation, women's health care tobacco cessation and care management during pregnancy. In each of these models, an early return on investment can be realized within one year of implementation through direct impact on medical costs related to decreased rates of low birth weight and prematurity, decreased rates of maternal depression, and decreased ED utilization in the first year of life.

For example:
**Reproductive Health Counseling and Long-Acting Reversible Contraception for Teens**
Based on figures from the CDC showing that 2,000 LARC placements equate to 250 teen births prevented and among teen births, 10% are typically low birth weight (LBW), the medical savings related to 2000 LARC insertions can be estimated:

- 2,000 new LARC insertions translates to 250 teen births prevented/year with 25 LBW births among those prevented.
- Uncomplicated term delivery ~ $10,000 (Business Insider NYS) and $3,660 for 225 NB uncomplicated births x 13,660 = $3,073,500
- 25 LBW newborns x $55,547 (cost of LBW newborn with NICU stay) = $1,388,675
- **Savings per year of $4,462,175** (conservative estimate of medical cost savings)

**Nurse Family Partnership Home Visitation**
(Pacific Institute for Research and Evaluation, Ted Miller, PhD, 2013)

- Overall savings specifically to Medicaid per NFP family - $3,650
- The break-even point for cost vs Medicaid expenses is Year 3 of the child's life
- Again, this is Medicaid savings only, **total government savings** (medical, child welfare, special education, criminal justice) **is $8,730 per family**

**Maternal Health Smoking Cessation and Care Management**
Currently, 20% of pregnant women enrolled in Medicaid smoke during pregnancy. Tobacco interventions have proven cost-effective in pregnant women because they reduce the number of low birth weight infants, preterm labor, and perinatal deaths (Lightwood, 1999). Additionally, cessation efforts in this population reduce use of newborn intensive care units, decrease hospital length of stay and reduce service intensity (Adams, 2004). **For pregnant women who quit smoking, low birth weight infants are reduced 20% and the number of preterm births are reduced by 17%** (Goldenberg, 2000; Lumley, 2000). Additional benefits of comprehensive maternal care management include reduction in maternal medical complications and improvement in maternal mental health along with counseling for and provision of LARC for inter-partum family planning (child spacing) which has a strong association with improved maternal and child outcomes. To decrease LBW rates, a focus on inter-partum/pre-conception health is critical. Two-generation models can focus on maternal inter-partum health and well-being if women's health and pediatric care is collaborative and coordinated.

**Universal Home Visitation for All Children and Families on Medicaid**
The Family Connects model from North Carolina has evidence from several trials (including two randomized controlled trails) that show a decrease in emergency room visits in the first year of life that results in **cost savings of over $3 for every $1 invested in the program**. In addition, outcomes include: greater connections to community resources for families to address social determinants of health, higher quality parenting behaviors, enhanced home environments, and improved maternal mental health.

**Additional evidence-based programs are identified in the Pediatric Primary Care CAG recommendations.**

**In Summary**
In addition to New York's robust Medicaid benefits for children and its recent First 1,000 Days on Medicaid Initiative, many innovative regional and statewide efforts serve as vital building blocks for the NYS Model of Pediatric Population Health. Key features of these efforts will need to be drawn upon as we develop and pilot this new model of primary care for children and families, with the aim of integrating New York's innovative programming under one cohesive system of primary care.

New York has boldly taken the lead in advancing children's health and the nation is watching. We urge the State to leverage this waiver amendment as an opportunity to build systems that improve long-term health outcomes.

Ben Anderson
Director of Poverty and Health Policy, **Children's Defense Fund-New York**

Bill Baccaglini and Dr. Sylvia Rowlands
President & CEO and Sr. VP, Evidence Based Community of Programs, **The New York Foundling**

Christopher Bell
Executive Director, **American Academy of Pediatrics New York Chapter 1** and
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Chair, **NYS American Academy of Pediatrics**

Laura Jean Shipley, MD
Associate Medical Director, **Accountable Health Partners** and Vice Chair for Behavioral and Population Health, Department of Pediatrics, **University of Rochester Medical Center**

Constantina (Dina) Spiropoulos, MD
Medical Specialist, **Western NY Children's Psychiatric Center**

## doh.sm.1115Waivers

**From:** O'Connor, Patricia [redacted] > on behalf of La Rue, Scott [redacted]
**Sent:** Monday, November 4, 2019 2:37 PM
**To:** doh.sm.1115Waivers
**Subject:** 1115 Public Forum Comment
**Attachments:** ArchCare MRT Extension Proposal Comment Letter.pdf



Dear MRT Waiver Management Unit,

Please find attached ArchCare's comments to the 1115 Medicaid Redesign Team Waiver Amendment Proposal. Do not hesitate to reach out with questions or clarifications.

Scott LaRue

**Patricia O'Connor**
Executive Assistant to the President and CEO
205 Lexington Avenue, 3rd Floor, New York, NY 10016
[redacted]

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November 4th, 2019

**VIA ELECTRONIC MAIL**

New York State Department of Health
Office of Health Insurance Programs
Waiver Management Unit
99 Washington Avenue
12th Floor, Suite 1208
Albany, NY 12210
1115waivers@health.ny.gov

Dear Medicaid Redesign Team:

The Continuing Care Community of the Archdiocese of New York (ArchCare) appreciates the opportunity to comment on the 1115 Medicaid Redesign Team (MRT) Waiver Amendment Proposal, hereafter referred to as "the Proposal." Sponsored by the Roman Catholic Archdiocese of New York, ArchCare provides innovative home and community-based services and manages specialty health care plans for individuals with chronic conditions and complex needs. This includes home care, long-term residential and short-term rehabilitation nursing home care, hospice and palliative care, assisted living facility arrangements, managed long-term care (MLTC) plans, Programs of All-Inclusive Care for the Elderly (PACE), and other specialized plans and services for Medicaid recipients living with Huntington's disease, HIV/AIDS, and children with severe cognitive impairments. Since its founding, ArchCare has provided high-quality, individualized care for people of all ages and faiths. We are committed to continuing innovation in how we deliver and pay for health care in New York State.

**Participation in the Current DSRIP Program and Observations to Date**

ArchCare has been actively engaged in achieving the goals of New York's current DSRIP waiver program.

- We have partnered with 9 downstate Performing Provider Systems (PPS)[1] on 8 distinct projects including project topics such as Integrated Delivery System (IDS) Services, patient discharge and transitions of care, social service referrals and coordination of home health referrals. ArchCare staff participate in the leadership of each of its PPS partners.
- ArchCare Community Life Health MLTC Plan has embraced Value-based Payment (VBP) through innovative delivery and payment models to improve health outcomes and patient experience, and reduce the cost of care:
    - ArchCare Community Life Plan has 95% of qualified expenditures (contracted CHHAs, LHCSAs, and SNFs) in Level 1 VBP arrangements.

[1]Westchester Medical Center PPS, Staten Island Performing Provider System LLC, Mount Sinai PPS, Bronx Partners for Healthy Communities PPS, Bronx Health Access, Montefiore Hudson Valley Collaborative, OneCity Health, New York-Presbyterian/Queens PPS, and NYU Langone Brooklyn PPS.

- ArchCare Community Life Plan was selected as a pass-through entity of funds for the Workforce Innovation Program, which ArchCare's LHCSA has leveraged to train our long-term care (LTC) workforce and advance MLTC VBP innovation.

We applaud New York State's current DSRIP program for making important strides in health care delivery and payment, most notably in joining participants in the State's diverse and complex health sector in a common effort to broaden access to needed health care and improved health outcomes while reducing costs. We believe DSRIP has had many positive results, but there have also been missed opportunities. These include:

- Lack of financial alignment between Medicare and Medicaid – neither the State or its LTC providers have benefitted from the Medicare savings that were realized from their efforts such as early recognition of condition complications to avoid re-hospitalizations, ensuring timely discharges to the post-acute care setting, and other projects focused in the long-term care setting and population.
- Care for dually eligible individuals, particularly those requiring LTC services, was not an area of focus, even though this population is disproportionately more complex and costlier than the Medicaid-only population.
- Additional funding allocation to the PPS infrastructure was needed as establishing IT interoperability between acute and LTC stakeholders took a great deal of time and resources.
- Despite DSRIP projects targeting advanced care planning, end of life issues remained a challenge. More education for patients and medical staff is needed.

Unfortunately, LTC organizations did not receive DSRIP funding commensurate with their contributions toward achieving the Proposal's goals. ArchCare worked with 9 major downstate PPSs that received $3.14 billion total awarded amounts through DSRIP.[2] Yet, ArchCare only received a little over $4.1 million, or 0.13% of total awarded funds to these 9 PPSs, despite being a premier LTC provider with over 1,700 nursing home beds in the downstate area. In our experiences, most of the money ArchCare did receive was offered with multiple conditions attached unrelated to the purpose of redesigning the long-term and post-acute care delivery system. ArchCare had to invest its own resources and was still able to achieve a significant decrease in length of stay across its nursing facility system. With no mechanism to recoup these savings from Medicare, ArchCare was actually adversely impacted by efforts to reduce its length of stay. Overall, we believe our experiences are representative of most LTC organizations. While the current DSRIP program drove some changes in performance, a lack of a coordinated effort and no Medicare shared savings mechanism severely limited the possible outcomes able to be achieved.

[2]DSRIP Performing Provider System Total Award Dollars. Found at: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_map/index.htm

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**Comments on the MRT Waiver DSRIP Amendment Request**

ArchCare is encouraged by several aspects of the Proposal, including the collaborative role of MCOs in Value-Driving Entities (VDEs) to ensure sustainable transformation, recognition of the need for long-term care workforce development, and mechanisms to drive the integration of programs to address the social determinants of health. We appreciate the State's recognition of the need to focus on populations with unique complex medical and social needs – chief among those: the long-term care population.

Building upon these acknowledgments, we offer the following recommendations:

- Leverage Medicare-Medicaid integration to help fund long-term care contributions to reducing the State's costs of care for its dually eligible population;
- Prioritize existing forms of fully integrated long-term care models like PACE in a renewed duals care integration strategy;
- Ensure meaningful long-term care involvement in VDEs including recognition of PACE as a population-specialized VDE, or PACE-VDE; and
- Invest in the home health workforce and promote education in end of life care planning.

***Medicare-Medicaid Alignment and Duals Care Integration***

Approximately 91% of individuals who require long-term care services in New York State are dually eligible and are disproportionately the highest cost enrollees than either Medicare-only or Medicaid-only.[3] Individuals who require LTC – both institutional and community-based – account for about 60% more in Medicare costs than those who do not require LTC services.[4] Spending on Medicaid, particularly for home-based long-term care services, saves money on costly health care interventions, particularly hospitalizations. One of the benefits of integration between Medicare and Medicaid is the possibility for the State to recover part of the Medicaid expenses that produce Medicare savings. However, the Proposal is not currently structured to allow NYS to share in Medicare savings despite increased investments on the Medicaid side. Consequently, providers and payers of Medicaid-funded services for long-term care eligible individuals do not currently share in Medicare savings and reinvestment opportunity is lost. As a result, through DSRIP Measurement Year 4 ending in June 2018, Potentially Preventable Admissions (PPAs) and Potentially Preventable Readmissions (PPRs) reductions have not reached stated goals, leaving NYS with the rank of 44th in national 30-day readmission rates.[5]

The potential role long-term care providers and the dually eligible population play in delivery system reform is clear and compelling. In the early years of the current DSRIP waiver, the Fully Integrated Duals Advantage (FIDA) Demonstration was expected to be a major feature of the State's strategy to address

[3]December 2017 data from "Providing Integrated Care for New York's Dual-Eligible Members" and New York State's Medicaid Managed Care Enrollment Report from December 2017.

[4]MedPAC and MACPAC. "Beneficiaries Dually Eligible for Medicare and Medicaid: Data Book." Exhibit 4, p. 32, and Exhibit 18, p.58. January 2018. Found here: https://www.macpac.gov/publication/data-book-beneficiaries-dually-eligible-for-medicare-and-medicaid-3/.

[5]DSRIP Project Approval Oversight Panel Meeting, June 24th, 2018.

care needs of this complex and unique population. However, FIDA failed to gain traction with the State's providers and eligible consumers and the demonstration is sunsetting at the end of this year. NYSDOH is currently exploring more cost-effective care options for dually eligible beneficiaries through its "Providing Integrated Care for New York's Dual-Eligible Members" stakeholder discussion series. Those discussions have largely focused on transitioning from the FIDA demonstration to MAP, enhancing MAP, and leveraging default enrollment for mainstream Medicaid members into either Medicaid Advantage or MAP. We fully support these efforts. However, we are concerned that they do not fully capture the opportunity to integrate care. ArchCare recommends that the State develop a new strategy to support integration and recognize the essential contribution that LTC providers make in helping to avoid hospitalizations and enable timely discharges. Providing more effective care for dually eligible individuals has been and remains a major CMS priority, so a DSRIP application that addresses this critical issue would be aligned with federal goals.[6]

***PACE***

PACE, is a proven program that incorporates the essential elements of health care funding and program reform that are sought by the Proposal. As such, it should an integral part of the Proposal. PACE has demonstrated effectiveness in improving health outcomes and reducing costs compared to other models of care.[7,8] PACE already accomplishes the Proposal's desired integration across acute and LTC stakeholders and also includes a "Medicaid offset" feature where NYS shares in savings generated to Medicare. For these reasons, ArchCare encourages NYSDOH to acknowledge PACE as an already existing form of a VDE. The Proposal states that VDEs will bring together organizations and providers with expertise in intensive care coordination, personalized care management, and home and community-based care. It goes on to suggest VDEs would implement value-based payment models designed to drive total cost of care savings by reducing potentially avoidable hospitalizations (PAH) and other avoidable interventions. As a provider staff model, PACE already accomplishes this function to a prioritized long-term care subpopulation that has the most complex needs and accounts for a disproportionate Medicaid expense and already is considered a Level 3 VBP arrangement, the highest of such arrangements in the current DSRIP program.

ArchCare recommends NYSDOH classify PACE programs as a population-specialized group of VDEs called "PACE-VDEs." A PACE program's population has far more frequent engagement with its providers than with health homes or other outside acute care providers. As such, attribution for the PACE-VDE should be based on enrollment in a PACE program at the top of the priority hierarchy. While PACE organizations receive a prepaid amount to pay for health care services, through participation as a PACE-VDE, NYSDOH

[6]"CMS Announces New Opportunities to Test Innovative Integrated Care Models for Dually Eligible Individuals." CMS, 24 Apr. 2019. Found here: https://www.cms.gov/newsroom/press-releases/cms-announces-new-opportunities-test-innovative-integrated-care-models-dually-eligible-individuals.
[7]Leavitt, M. (2009). Interim report to Congress. The quality and cost of the Program of All-Inclusive Care for the Elderly.
[8]Nadash, P. (2004). Two models of managed long-term care: Comparing PACE with a Medicaid-only plan. Gerontologist, 44 (5): 644-54.

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can ensure that funds can fuel the DSRIP-aligned goals of PACE in other ways, such as for capital expenses that PACE organizations are heavily reliant upon for program expansion.

***Other Long-Term Care Involvement in VDEs***

If NYS pursues VDEs as a new organizing entity to drive integration and VBP arrangements, there must be requirements (not just recommendations) that these entities include representation from long-term care plans and providers, both at the governance and operational level.

Comprehensive care management entails a level and type of expertise not usually found in hospital-led care management models or community-based clinical practices. Education of patients and caregivers, environmental and home assessments, coordination and communication with primary care providers and specialists, medications management, and regular monitoring of health status are just some of the functions LTC care management organizations provide. Therefore, it is important that long-term care specific MCOs are included in the general managed care involvement with VDEs. As for other providers of long-term care, investing in electronic health record (EHR) adoption and health information exchange competencies will enhance the ability of these valuable providers to contribute to VBP initiatives with acute care partnerships.

***Long-Term Care Workforce Development***

Finally, ArchCare applauds the Proposal's goal of supporting the critical LTC workforce infrastructure and we are encouraged that the Proposal would *"include subsidies and stipends for participating in aide certification and nursing programs; loan forgiveness programs for nursing graduates; and subsidies for work barrier removal including child care for LPNs and aides."* There is an enormous and growing need for a skilled and paraprofessional workforce that is willing and able to work in people's homes, and we are in agreement that efforts to bring more care delivery to the home where it is less costly and more effective will be undermined if home health agencies (LHCSAs and CHHAs) continue to struggle to attract a capable workforce.

As a recommendation, ArchCare encourages that the Proposal continue the MLTC Workforce Investment Program (WIP) as a mechanism to distribute funding for expanded education and training. Through ArchCare Community Life's function as a pass-through for Workforce Investment Organizations (WIO) and through our effort to effectively leverage WIO's to support VBP training initiatives, we have found WIP to be an effective training conduit for home health aides and nurses in providing quality care in the home. ArchCare has engaged in numerous trainings to support VBP efforts from promoting Medicare annual wellness visits and annual physical examinations, to falls prevention, recognizing urinary tract infections and sepsis, and case management training. NYSDOH should consider using workforce training funding through WIP to address other pertinent issues with the long-term care population, such as around how to have end of life care planning conversations and the importance of establishing Advanced Directives.

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**Summary of Recommendations:**

- Develop a shared savings partnership that rewards New York State for its investments in Medicaid through savings generated to Medicare;
- Create a reinvestment mechanism that allows Medicaid long-term care payers and providers to share in the savings that their efforts generate;
- Align the Proposal with a renewed strategy to better integrate care after the conclusion of FIDA;
- Recognize already established fully integrated models, such as PACE, as a viable option to achieve care integration and the MRT Extension goals;
- Consider PACE as a population-specialized VDE, or PACE-VDE;
- Ensure requirements for long-term care representation in VDE governance and operations;
- Extend the MLTC Workforce Investment Program as a mechanism for long-term care workforce training; and
- Prioritize funding for long-term care workforce training related to end of life care planning.

Thank you for your consideration of these recommendations. We look forward to working with NYSDOH and our other partners on this important effort to improve New York State's healthcare payment and delivery system.

Sincerely,

Scott LaRue
President and CEO
ArchCare

## doh.sm.1115Waivers

**From:** Eric Musser [redacted]
**Sent:** Monday, November 4, 2019 2:50 PM
**To:** doh.sm.1115Waivers
**Subject:** 1115 Public Forum Comment
**Attachments:** 11-4-19 DSRIP Amendment_NCQA Response.pdf



Hello, please find NCQA's response to NY's Draft DSRIP Waiver Amendment.

Thank you,
Eric

**Eric Musser, MPH**
Deputy Director, State Affairs
National Committee for Quality Assurance (NCQA)
1100 13th Street NW, Third Floor
Washington, DC 20005
[redacted]

November 4, 2019

New York State Department of Health
ATTN: Howard Zucker, MD, JD
Corning Tower
Empire State Plaza
Albany, NY 12237

**RE: Delivery System Reform Incentive Payment (DSRIP) Amendment Request**

Mr. Zucker:

The National Committee for Quality Assurance (NCQA) appreciates the opportunity to provide feedback on New York's Draft Delivery System Reform Incentive Payment (DSRIP) Amendment Request.

We fully support New York's request to extend the DSRIP waiver to build on the population health improvements achieved in the first five years of New York's DSRIP waiver. New York continues to be a leader in health care quality and innovation and NCQA has appreciated a strong partnership with the New York State Department of Health (NYSDOH) over the course of the waiver. We support the Medicaid Redesign Team's (MRT) proposal for a four-year waiver amendment and offer recommendations and comments to support alignment with federal priorities.

**Transforming and Integrating Behavioral Health**

NCQA has valued collaborating with NYSDOH through the development and management of NYS PCMH program. Since the program launched in April 2018, nearly 2,400 practices have committed to continuous quality improvement by participating in NYS PCMH, and over 1,300 practices have achieved NYS PCMH Recognition.

The United Hospital Fund's report "DSRIP Promising Practices: Strategies for Meaningful Change in New York Medicaid" highlighted the success of Preferred Provider Systems, and their PCMH partners, in connecting more Medicaid beneficiaries with behavioral health services throughout the course of DSRIP.

> ***"Some of the most promising practices focused on expanding access (to behavioral health) and developing new approaches to meeting patients where they are as ways to better engage them in treatment."***

Additionally, the initial evaluation completed by SUNY-Albany concluded three of four priority behavioral health measures increased throughout the initial phase of DSRIP.

> Recommendation: Given the success of PPS and PCMHs to screen and address behavioral health needs, NCQA recommends the Department formalize recognition of the PCMHs with advanced capabilities to manage behavioral health conditions by incentivizing NCQA's PCMH Distinction in Behavioral Health Integration.

NCQA's Behavioral Health Integration Distinction recognizes primary care practices that put the right resources, evidence-based protocols, standardized tools and quality measures in place to support the

broad needs of patients with behavioral health related conditions within the primary care setting. This enhances the level of care provided in a primary care practice and improves access, clinical outcomes and patient experience for patients with behavioral health conditions.

Distinction in Behavioral Health Integration is a way for practices to highlight where they excel beyond the PCMH standards. This distinction calls for a care team in primary care that can manage the broad needs of patients with behavioral health related conditions. The program requires the practice to:

- Incorporate behavioral health providers at the site, utilizes behavioral health providers outside the practice and trains the care team to address the mental health and substance use concerns of patients.
- Share patient information within and outside the practice to support an integrated/coordinated patient treatment plan.
- Use evidence-based protocols to identify and address the behavioral health needs of patients.
- Utilize quality measures to monitor the care of patients with behavioral health needs.

In 2019, Massachusetts Health Policy Commission adopted the NCQA Distinction in Behavioral Health Integration as the standard for certifying Massachusetts primary care practices as patient centered medical homes.

**Social Needs, Community Partnerships**

NCQA supports the concept of Value Driving Entities (VDE) and Social Determinants of Health Networks (SDHN) in the proposed DSRIP amendment. The proposal offers an exciting opportunity for managed care organizations (MCO) to support the state's delivery system reform efforts and address social determinants of health. Establishing entities which require collaboration between the existing Preferred Provider Systems (PPS), community-based organization (CBO), providers, MCOs and Regional Health Information Exchanges (RHIO/QEs) will help align priorities and improve coordination and integration.

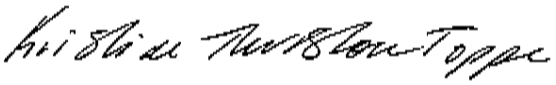
*Measures for VDE and SDHN.* As the Department considers the metrics to assess for VDE and SDHN, we recommend reviewing NCQA's rules for HEDIS Allowable Adjustments. The rules can assist the Department as it assesses how to adjust measures for the various levels of the delivery system. Recognizing that HEDIS measures have traditionally been specified for health plan reporting, and that the industry desires to apply the measures to different levels of the health care system to facilitate, for example, population health management and quality improvement, NCQA has produced a supplement to HEDIS Volume 2, the *"Rules for Allowable Adjustments of HEDIS®,"* that describes an approach and prescribes guidelines for adjusting NCQA's HEDIS measure specifications for use with other populations.

*Coding for risk.* NCQA is very interested in understanding how the Department will capture member risk factors in a standardized way across the entire population. We are involved in a coding collaborative for food insecurity, transportation insecurity and housing insecurity which will: 1) develop use cases to support documentation of specific social domains across enrollment, screening, diagnosis, treatment, and population health management activities within EHR and related systems; 2) identify common data elements and their associated value sets to support the uses cases; 3) develop a consensus-based set of recommendations on how best to capture and group these data elements for interoperable electronic exchange and aggregation; and 4) initiate creation of a HL7® Fast Health Interoperability Resource (FHIR®) Implementation Guide based on the defined use cases and associated data sets. NCQA would welcome the opportunity to explore the coding of social determinants of health with the Department.

*Validating Supplemental Data.* Additionally, NYSDOH has made significant investments in QEs to support advanced capabilities for quality measurement and reporting. NCQA is currently piloting a program with NYeC to test the capabilities of QEs as a standardized supplemental data source for HEDIS reporting. With standardized data, QEs will provide value to their VDE and SDHN partners, as the data from QEs can be used for quality improvement and value-based purchasing agreements. We appreciate this partnership with NYeC and NYSDOH to strengthen the capabilities and value of QEs.

Thank you for the opportunity to provide feedback and we welcome the opportunity to discuss these ideas in greater depth. To coordinate, I can be reached at [redacted]
We look forward to hearing from you.

Regards,



Kristine Thurston Toppe
Director, State Affairs
National Committee for Quality Assurance

Cc: Eric Musser, Deputy Director, State Affairs

## doh.sm.1115Waivers

**From:** Wessels, Brian [redacted]
**Sent:** Monday, November 4, 2019 2:53 PM
**To:** doh.sm.1115Waivers
**Subject:** 1115 Public Forum Comment
**Attachments:** ChenangoAAAdsripresponse.pdf



For your consideration. Thank you.

Brian F. Wessels
Director
Chenango County Area Agency on Aging
5 Court Street
Norwich, NY 13815
[redacted]

# Chenango County Area Agency on Aging

*Brian F. Wessels, Director*
*5 Court Street • Norwich, New York 13815*
*(607) 337-1770*


November 4, 2019

Paul Francis
Deputy Secretary for Health
State Capitol
Albany, NY 12224

Donna Frescatore
Medicaid Director
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Dear Mr. Francis and Ms. Frescatore,

On behalf of the Chenango County Area Agency on Aging, I am writing to express my recommendations on the DSRIP renewal proposed by New York State Department of Health. The services we provide directly impact inappropriate emergency department visits, and reduce avoidable readmissions. The NY Connects program, implemented in 2006, serves as no wrong door for any and all services available in the region, and is a catalyst for individuals in need of assistance. The targeted goals in the proposed renewal are exactly what this network provides, and must include mandated contracting by each PPS with their local Area Agency on Aging for social determinants of health initiatives.

Since the inception of our Agency over 45 years ago our office has become the trusted service provider for the fastest growing segment of the population, and the highest utilizer of health care dollars. Our services absolutely allow individuals to remain in their own homes and communities while achieving and maintaining their highest level of independence, all while saving health care expenditures. Our collaboration with NY Connects allows us to provide the highest level of evidence based interventions, we are experts at navigating a complex health care system, while providing person centered planning and care.

In the renewal waiver, I cannot stress highly enough that we need to harness the existing strengths of community based services, instead of recreating case management services and duplication of services. Each and every case manager in the entire statewide aging network has received certification via Boston University School of Social Work, ensuring consistency in assessment not provided by any other system. I ask that there are mandates for each PPS to engage and contract with their local Offices for the Aging, for the services vital to keeping individuals in home and community based settings.

Thank you,

Brian F. Wessels
Director

BFW/ld

## doh.sm.1115Waivers

**From:** Diana Fox [redacted]
**Sent:** Monday, November 4, 2019 2:55 PM
**To:** doh.sm.1115Waivers
**Cc:** [redacted]
**Subject:** 1115 Public forum Comment
**Attachments:** Send data from MFP07770676 11/04/2019 15:52



Please see the attached letter of support.

*Diana*

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Diana Fox, MSW
Deputy Director-Genesee County Office for the Aging
2 Bank Street
Batavia, NY 14020
[redacted]
www.co.genesee.ny.us
Click on Office for the Aging under "Departments" and NY Connects for Long Term Care
[redacted]
Leadership Genesee Class of '02

# Genesee County Office for the Aging

**RUTH SPINK**
**Director**

**2 Bank Street, Batavia, NY 14020** **OFA.Dept@co.genesee.ny.us**
**585.343.1611; 585.345.3086 (fax)** **www.co.genesee.ny.us**


November 2, 2019

Paul Francis
Deputy Secretary for Health
State Capitol
Albany, NY 12224

Donna Frescatore
Medicaid Director
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Dear Mr. Francis and Ms. Frescatore:

On behalf of Genesee County Office for the Aging, I am writing to express my recommendations on the DSRIP renewal proposed by New York State Department of Health. The services we provide directly impact inappropriate emergency department visits, and reduce avoidable readmissions.

**$170,090/year of nursing home**
**vs.**
**$30,536/year of in-home OFA assistance**

The NY Connects program, implemented in 2006, serves as no wrong door for any and all services available in the region, and is a catalyst for individuals in need of assistance. The targeted goals in the proposed renewal are exactly what this network provides, and must include mandated contracting by each PPS with their local Area Agency on Aging for social determinants of health initiatives. Our office is the trusted service provider for the fastest growing segment of the population, and the highest utilizer of health care dollars. Our services **absolutely** allow individuals to remain in their own homes and communities, all while saving health care expenditures. We provide the highest level evidenced based

interventions, and are experts at navigating a complex health care system, while providing person centered planning and care.

To demonstrate the value of the network, I would like to highlight a recent case that is typical to our office:
We received a phone call from a woman who is a caregiver for her husband, who has dementia. The woman expressed feeling overwhelmed and not sure what she can do to get any assistance for herself and her husband. She was afraid that she was going to have to place her husband in a nursing home. The woman was receptive to having a caregiver counseling referral.

As a result of that care consultation service, we provided information about long term care options and we were able to facilitate implementation of several home and community based services.

**Direct care services that our OFA office helped to put into place cost $83.66 per day. A nursing home costs $466 a day.**

Direct services costs included a homecare aide for 2 hours per day, 2 home delivered meals (one for the husband and one for his wife as caregiver, to offer her relief from the burden of caregiving), a personal emergency response system (PERS) for the husband to wear daily, and for an additional $80 (for 5 hours) the availability of a social adult daycare program for the husband that also provided much needed respite for the caregiver.

This is just one of many cases that truly displays service provision in every county across the state. In the renewal waiver, I cannot stress highly enough that we need to harness the existing strengths of community based services, instead of recreating case management services and duplication of services. Each and every case manager in the entire statewide aging network has received certification via Boston University School of Social Work, ensuring consistency in assessment not provided by any other system.
I ask that there are mandates for each PPS to engage and contract with their local Offices for the Aging, for the services vital to keeping individuals in home and community based settings.

Thank you,

Ruth Ayerst

Director
Genesee County Office for the Aging

## doh.sm.1115Waivers

**From:** Weiss, Howard [redacted]
**Sent:** Monday, November 4, 2019 2:55 PM
**To:** doh.sm.1115Waivers
**Cc:** [redacted]
**Subject:** 1115 Public Forum Comment
**Attachments:** EmblemHltmCmtstoDSRIP2_11_4.pdf



Please see the attached comments from EmblemHealth. We greatly appreciate this opportunity to submit our recommendations as the state moves forward with the DSRIP program.

Howard Weiss
EmblemHealth, Government Affairs & Policy
[redacted]

EmblemHealth®

55 Water Street, New York, New York 10041-8190

November 4, 2019

Submitted via email at 1115waivers@health.ny.gov.

**Re: 1115 Public Forum Comment**

On behalf of EmblemHealth, we appreciate this opportunity to provide comments to the New York State Department of Health's Delivery System Reform Incentive Payment (DSRIP) draft waiver amendment issued on September 17, 2019. The issues raised by this document are of direct importance to the more than 120,000 Medicaid beneficiaries we serve, who have come to rely on our innovative approach to providing health care services.

EmblemHealth strongly supports the goals of the DSRIP program. We agree that plan-provider arrangements stressing mutual accountability improve the lives of Medicaid beneficiaries. The state is rightly proud of its trailblazing role in promoting value-based care. The waiver renewal process provides an opportunity to look back on our experiences under DSRIP and consider how the program may be improved.

We have three recommendations in response to the state's draft waiver amendment request, which we further describe in the following sections.

1. **VDEs should be one lead entity -- which could be a Performing Provider System (PPS), a health plan, an Independent Practice Association (IPA), or other entity -- that is primarily responsible for organizing its activities and achieving objectives.**

2. **The Roadmap should permit new flexibility in key areas and reward entities that promote better cooperation among partners through standardized data flows and other means.**

3. **All entities receiving DSRIP funds should be required to demonstrate they are using dollars to support program goals.**

## 1. VDEs

Starting March 2021, DoH proposes to create Value-Driving Entities (VDEs) to organize projects that apply DSRIP's value-based structure to areas of need. The draft waiver amendment defines VDEs as consisting "of PPS (or a subset of PPS), provider, CBO and MCO teams specifically approved by the state to implement the high-priority DSRIP promising practices." The document then describes nine key project areas that VDEs would target using strategies

outlined in a July 2019 United Hospital Fund (UHF) report[1] to provide Medicaid beneficiaries with more coordinated, high quality care.

EmblemHealth supports the changes proposed by DoH. We are especially appreciative of the state's understanding of the importance of Medicaid health plans by requiring VDEs to include Managed Care Organizations (MCOs) in their governing structures. Many of the promising practices described by the UHF report are commonly used by health plans to improve the care of the individuals they serve. For example, EmblemHealth operates the first health plan-based Diabetes Prevention Program to be certified by the Centers for Disease Control. We also operate a care management program relying on physicians, nurses and social workers to provide field-based care, bringing care to their home, meeting our members in the hospitals, and linking acute and behavioral health care.

To take these ideas one step further, we recommend the waiver request incorporate VDEs led by health plans or other entities. Health plans have key attributes that fit into the state's framework. Population-based health is most successful when practitioners can direct individuals to the right services at the right time in the right setting. Health plans have the infrastructure to encourage wellness, manage chronic conditions, and coordinate services from the physician setting to the hospital to post-acute care. We also have experience in accepting financial risk while being held accountable for improving outcomes.

These characteristics are what the state is demanding through DSRIP. EmblemHealth has several unique attributes that make us uniquely able to address the state's objectives.

- We have a unique partnership with Advantage Care Physicians of New York (ACPNY), one of the largest medical groups in the New York City area. In effect, we are a health plan ***and*** a physician practice that is playing a leadership role in delivering population-based care.

- We have established ten Neighborhood Care centers – increasing to 12 by the end of 2019 -- located in low-income and ethnically diverse areas throughout New York City staffed by customer care navigators who help consumers through the health care and social service systems. Their close relationships with other local community organizations connect these individuals with resources to address the full range of social factors affecting their health.

- We have a full-risk partnership with Cityblock Health focused on care delivery for high-needs enrollees that uses teams of behavioral health specialists, community health partners, primary care clinicians, and data analysts, who work with high-needs individuals where they live to provide the care they need.

- We have shared savings, shared risk, and full risk arrangements with several area IPAs.

[1] United Hospital Fund, "DSRIP Promising Practices: Strategies for Meaningful Change for New York Medicaid" (July 2019)

These experiences have prepared EmblemHealth to take a leadership role in DSRIP 2.0. We look forward to working with you to consider additional opportunities to achieve our shared goals.

## 2. Roadmap Changes

The state's draft waiver amendment acknowledges "more time is needed to directly support the best DSRIP work" and proposes "additional flexibility… to align funding to the best future management structure for a given region/market". Permitting new opportunities to innovate within the Roadmap is consistent with these goals. We have the following suggestions:

- **The state should count plan-provider arrangements that meet the spirit of the Roadmap.** The Roadmap includes several specific requirements, including the scope of services that need to be covered on a two-sided or full risk basis and the levels of risk qualifying as downside under Level 2. We strongly agree with the state that value-based contracting works best when all entities within a health care system accept risk for the full range of medical and social service needs. However, as DoH acknowledges, we are not yet at a point where that goal always matches up with the maturity of the marketplace.

  The Roadmap provides opportunities for "off-menu" Total Cost for the General Population (TCGP) arrangements that must include the full scope of Medicaid benefits. However, providers may be unwilling to take downside risk for services for which they do not control the price. Prescription drugs is a notable example[2] because pricing is set by drug companies which have no accountability under these arrangements. We have therefore found our primary care partners are often unwilling to accept risk for medication costs.

  We recommend the state consider counting TCGP arrangements during the life of the waiver that exclude a limited number of Medicaid-covered services and others where the specific risk-sharing terms do not fit within the Roadmap's definitions. Providing credit for value-based contracts that meet the spirit (if not the exact letter) of the Roadmap's requirements for the next several years will promote more VBP while the market continues to mature and create the foundation for developing more comprehensive, risk-sharing arrangements.

- **The state should permit more on-menu opportunities for bundling.** The Roadmap now permits VBP contractors to develop maternity care bundles with physicians and hospitals in on-menu arrangements. The state could consider adding other bundling models. The federal Center for Medicare and Medicaid Innovation is now experimenting with bundling a variety of services including orthopedics, cardiac care, and diabetes. We have experience in our plan of doing this as well and urge the state to broaden on-menu bundling options as a way of further moving the needle towards value-based care.

[2] The Roadmap permits plans to exclude specialty drugs costing at least $670 per month from VBP arrangements. However, studies show drug cost increases are also evident in less expensive medications.

- **The Roadmap should eliminate reporting requirements on quality measures that are not outcomes-based or focused on the state's priorities.** Medicaid health plans are currently evaluated on as many as 30 different quality measures. The large number of measures significantly increases reporting burdens on physicians and hospitals. Many are process instead of outcomes based and several have complicated specifications that are constantly changing, forcing providers and plans to commit administrative time to understanding and operationalizing metrics that would be better spent addressing patient needs. To focus efforts, there needs to be a finite and manageable number of measures defining success. These measures should be meaningful for providers and payors with clear and transparent incentive structures.

  The framework below provides suggestions for a limited set of targeted metrics measuring achievement measures that are consistent with the state's goals for the DSRIP program. The state could work with health plans, physicians, health homes, and others to determine an appropriate list.

| Hospital | Health Homes | Other |
|---|---|---|
| • Preventable Admissions<br>• Potentially Preventable ER Visits<br>• Reduced Readmissions<br>• Increased Delivery of Post-Acute Care | • Access to Healthy Foods<br>• Resolved Housing Issues Affecting Health<br>• Increased Access to Medical Services for Low-Income Enrollees | • Increased Use of Preventive Services<br>• Improved Outcomes for Chronic Diseases (e.g., Lower A1C among Diabetics; Lower Cholesterol Levels for Individuals with Heart Disease) |

In addition, we recommend the following other enhancements to the Roadmap:

- **Data Flows**: We support additional accountability in the Roadmap for VDEs to ensure they are sharing actionable, usable data with their partners to improve care. ACPNY participates in four hospital-led PPSs. We have found these systems may not have developed data flows consistent with the needs of its physician group partners, meaning it is more difficult for ACPNY to take advantage of its collaboration with others in the PPS to improve care for beneficiaries. Lack of transparency around reporting and outcome metrics have made it difficult to analyze the success of interventions to improve access and quality, limiting the ability to promote greater improvement and achieve program goals. A more transparent and standardized data flow will allow partners to work together to better understand clinical outcomes and deliver evidence driven population-based care. We strongly recommend the state establish guidelines in the Roadmap to

facilitate more efficient sharing of impactful data, which could include the development of web portals accessible to all partners where this information can be accessed and used to support the program's objectives.

- **Physician and Hospital Incentives**: EmblemHealth is proud of its leadership role in adopting VBP arrangements. However, we continue to experience barriers caused by provider reluctance to adopt models requiring mutual accountability on quality and cost, even from some of our more sophisticated hospital partners. We strongly believe the state will need to create incentives for providers to adopt downside risk for meeting meaningful quality and cost benchmarks if the state's vision in DSRIP is to be realized. These incentives should include rewards for high adopters and penalties for those with a demonstrated unwillingness to participate in VBP arrangements including downside risk on terms requiring mutual accountability.

## 3. Funding Accountability

DSRIP's first four years taught us that considerable investments are necessary to create mutually beneficial partnerships between health plans, clinicians, and hospitals that support each entity's commitment to being successful and accountable. In the past, the program has been criticized for whether its funds have been used to improve care. An independent assessment published in December 2016 found "(PPS) have received over 70% of DSRIP funds to date across all PPS. PPS will need to fund their network partners at a meaningful level going forward."[3] Data recently released by the state indicate PPSs are only distributing 68% of DSRIP dollars to downstream providers.[4]

EmblemHealth strongly believes the rate should be commensurate with the Medicaid health plan requirement that at least 87% of state funds be dedicated to the direct provision of care. PPS/VDEs should be required to meet this standard.

## Conclusion

We greatly appreciate this opportunity to provide comments on the DSRIP waiver renewal and look forward to continuing to work with you to improve the quality of care for Medicaid beneficiaries. Please contact Howard Weiss at [redacted] and Cara Berkowitz at [redacted] if you have any questions.

[3] DSRIP Independent Assessor Mid-Point Assessment Report Final Report Companion Document found at https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_map/midpoint/docs/final_companion.pdf
[4] New York Department of Health, "DSRIP PAOP Meeting" (June 24, 2019). Found at https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/paop/meetings/2019/docs/2019-06-24_pm-ff.pdf

## doh.sm.1115Waivers

**From:** Helen Schaub [redacted]
**Sent:** Monday, November 4, 2019 3:03 PM
**To:** doh.sm.1115Waivers
**Subject:** 1115 Public Forum Comment
**Attachments:** 1199SEIU Comments DSRIP Amendment.pdf



Please see attached comment from 1199SEIU.

Helen Schaub
Vice President
New York State Director of Policy and Legislation
1199SEIU United Healthcare Workers East
330 West 42nd Street, 7th Floor
New York, NY 10036
[redacted]

**1199SEIU United Healthcare Workers East Comments**

**1115 Research and Demonstration Waiver**

**Delivery System Reform Incentive Payment (DSRIP) Amendment Request**

**November 4th, 2019**

Thank you for the opportunity to comment on the New York State Department of Health's Delivery System Reform Incentive Payment (DSRIP) Amendment Request proposal.

The DSRIP program has achieved impressive results over the past four years, and we strongly support the effort to extend and expand the program. Given the expiration of the overall 1115 waiver on March 31st, 2021, however, we do believe it is worth considering whether to create short-term goals for a one-year extension of the DSRIP program and then introduce large-scale program changes when a new waiver has been secured.

Given our role as the representative of hundreds of thousands of New York's healthcare workers across all settings, our comments will focus on the workforce component of the Amendment Request. We appreciate the NYSDOH's continued recognition of the ongoing workforce challenges involved in delivery system reform. We are especially glad for the emphasis on the growing gap between the needs of long-term care consumers and the availability of workers to meet those needs.

*Background*

Under the current DSRIP program, the labor-management 1199SEIU Training and Employment Funds serve as the Workforce Strategy Provider for 11 Performing Provider Systems (PPSs) and have enrolled over 25,000 healthcare workers in training activities in partnership with the PPSs. These skill enhancement trainings covered a broad array of topics, including case management, care coordination, health coaching, chronic disease managements and other programs designed to provide workers with the skills to improve health outcomes and avoid unnecessary hospitalizations and emergency room visits. We are proud of their contribution to the achievement of DSRIP goals.

The 1115 Waiver also supports the 1199SEIU Training and Employment Funds' Workforce Investment Organization "Ladders to Value WIO," where nearly 60,000 home care and nursing home workers have completed training since April 2018. In addition to skill enhancement designed to improve quality outcomes for clients and enable Managed Long-Term Care Plans and providers to establish value-based payment arrangements, Ladders to Value and other WIOs have also focused on initiatives designed to recruit and retain workers in the long-term care industry. The WIO has served as a strategic partner across the intersection of workforce, long term care providers, and managed long-term care plans.

As New York State looks to the future, it can build and expand on the success of these initiatives. The infrastructure built through these programs can enable the expansion of existing successful models while at the same time addressing additional workforce gaps.

*Needs*

Much of the DSRIP training resources were focused on short-term skill enhancement to support the implementation of PPS projects. While the training was vital to the success of the projects, few resources were available to build the workforce of the future by addressing occupational shortage areas. For example, continuing to integrate behavior health and primary care will require significant numbers of new nurse practitioners, as well as counselors, social workers and other psychiatric primary care providers. However, there has not been a structured, long-term solution for supporting the development and advancement of these primary care and behavioral health professionals.

In addition, it is clear that health system delivery change can have a significant economic impact on communities as jobs transition out of higher-paying hospitals to lower-paying community-based settings or are eliminated entirely. Given that economic well-being is a key social determinant of health, DSRIP must seek to mitigate the negative financial impacts of system transformation on individuals and communities. Providing support to retain workers in the health care system by helping them transition to needed occupations continues to be an appropriate use of DSRIP resources. However, the current definition of "at risk" workers under DSRIP is very narrowly construed, including only workers who may lose their jobs because of DSRIP projects specifically rather than because of the broader healthcare delivery transformation that DSRIP seeks to accelerate.

The much larger number of workers trained in a shorter period of time through the Workforce Investment Organizations as compared to the PPSs workforce strategy plans shows the value of industry-wide collaborations which include the managed-care organizations.

*Recommendations*

Under the new waiver, the State should create a WIO-like designation for a Healthcare Training Organization and direct MCOs to contract with them to provide services to the Value-Driving Entities. Healthcare Training Organizations that are in partnership but funded independently from the new VDEs will have a greater capacity to address the social determinants of health, industry-wide workforce challenges, and state priorities for all providers. For example, the state could designate priority areas for recruitment and retention that are health systemwide and enable the HTOs to support training and education initiatives that benefit the industry, including career pathways and recruitment into new occupations. The Department of Health would also have more latitude to direct the HTOs in priority skill building areas and to address potential downsizing directly. Job loss or lay-offs could be addressed even if the employer is not a member of the VDE but has been impacted by system transformation. Finally, industry-wide HTOs could work with providers to increase readiness for value-based payment, including by training staff on VBP principles and data collection.

Workforce Investment Organizations could continue providing training and recruitment to long term care providers and could also provide similar services to health systems for greater coordination and services and to ensure development of initiatives that work across the continuum of care.

The definition of “at risk” workers should be broadened to include those healthcare workers whose jobs are likely to be eliminated by the achievement of DSRIP goals, especially the reduction in hospital use. These include inpatient-specific occupations like housekeeping and dietary workers. These workers, who already have significant experience in healthcare settings, should be able to access career counseling and training so that they can transition into needed occupations like community health worker or patient navigator.

## doh.sm.1115Waivers

**From:** Janine Logan [redacted]
**Sent:** Monday, November 4, 2019 3:08 PM
**To:** doh.sm.1115Waivers
**Subject:** DSRIP Comments



The Long Island Health Collaborative (LIHC) is pleased to offer comments regarding the state's proposed Delivery System Reform Incentive Payment (DSRIP) program waiver seeking an extension of the current 1115 waiver for one year, ending March 31, 2021, and adding three additional years, ending March 31, 2024. The LIHC is the Population Health Improvement Program (PHIP) for the Long Island region, and it is funded by the state's PHIP grant program. The LIHC is managed by the Nassau-Suffolk Hospital Council (NSHC), the organization that represents not-for-profit and public hospitals on Long Island.

The LIHC, as the region's coordinator of population health activities, appreciates the emphasis the current DSRIP waiver has placed on the integration of the social determinants of health (SDsH) with the delivery of clinical care. As it is now widely accepted among health and social service sectors that the social determinants of health are largely responsible (70%) for health outcomes, the continued integration of SDsH along the care continuum is a foregone conclusion. Toward that goal, it is wise for the state to seek an additional mechanism and source of funding to keep the momentum of reform going, especially as the fee-for-service delivery model gives way to value-based purchasing arrangements among both public and private payers.

The application of population health principles, more specifically the emphasis on SDsH as part of the patient's care plan, is influencing value-based payment contract design. And, in fact, it would be hard to have successful value-based care unless some level of social supports are included in the contract design. This is because improvement in health outcomes, as well as the reduction of emergency department visits and inpatient hospitalizations for preventable conditions and complications, depends on meeting patients' very basic needs – access to nutritious and affordable food, safe places to exercise, dependable and affordable transportation, contaminant and allergen-free homes, etc. These non-clinical needs are present among patients whether they reside in urban, rural, or suburban areas. And further, it is often the small, hyper-focused community-based organizations that get to the heart of a population's health needs and who best deliver the specialized social supports an identified population needs to achieve health. Their interventions truly complement the clinical treatment provided by hospitals and health systems and physician practices of all sizes.

In our experience as the population health coordinator, data aggregator, and data analyzer for the Long Island region, we have helped guide the concepts of VBP and population health to create a synergy of success among a diverse group of partners. Successful regional population health requires:

- the organization of data, including the more abstract data that drives social determinant of health needs,
- the hard data about utilization and disease incidence,
- and the soft data that emerges from program/intervention evaluations relative to patients' perceptions.

The evidence offered by these data points connects the providers, patients, and payers. This reveals gaps in services and needs and, more importantly, what entity can best address them. Further, our data collection and analysis work has helped the local county health departments and the region's hospital systems uncover unmet health needs and barriers to care. That has resulted in collaborative Community Health Needs Assessments, informing not only VBP contracting, but county health department and hospital community service activities related to the state's Prevention Agenda. Some entity must continue this synergy and comprehensive data collection and analysis for the successful iteration of the next DSRIP waiver.

We offer the following specific observations regarding the state's developing DSRIP framework for addressing the social determinants of health:

- The Social Determinant of Health Networks (SDHNs) seem a natural extension of the community-building work begun by the state's Population Health Improvement Programs. These entities have established multi-sector

networks that include community-based organizations, health plans, hospitals, and physician practices, but were stopped short of engagement in social determinant of health interventions, even though they were the impetus for many VBP contracting arrangements between diverse providers. Building upon this foundation makes sense. However, the state should clarify its expectations regarding the role of Value-Driving Entities and Social Determinant of Health Networks regarding the role of socially-focused interventions as a standard part of VBP contracts.

- A formalized regional referral network operated by the SDHNs to expand the groundwork mentioned above is a good idea. This network will function best if separate from the Value-Driving Entities, to ensure participation from a diverse array of community organizations. Here again, we suggest that the state better differentiate between the roles of SDHNs and the VDEs to highlight each entity's strengths and the state's expectations for each.
- If the SDHNs are to be tasked with being the single point of contracting for VBP SDH arrangements, direct state funding for the SDHNs will be needed for several years until enough contracts are signed for these arrangements to become self-sufficient.
- We agree with the state's recommendation to have SDHNs screen beneficiaries for SDH issues and needs and make the referrals since the SDHNs are the entities with the most familiarity about the vast array of social supports/interventions offered by their network of diverse community-based organizations.

Janine Logan, MS, APR
Senior Director, Communications and Population Health
Nassau-Suffolk Hospital Council (NSHC)
Northern Metropolitan Hospital Association (NorMet)
Suburban Hospital Alliance of New York State, LLC (SHANYS)
and Director, Long Island Population Health Improvement Program and the Long Island Health Collaborative

*The combined advocacy interests of the Nassau-Suffolk Hospital Council and the Northern Metropolitan Hospital Association are represented by the Suburban Hospital Alliance of New York State, LLC.*

*The Population Health Improvement Program (PHIP) is a New York State Department of Health funded grant initiative. The Long Island Health Collaborative (LIHC) is one of the activities managed by the PHIP. LIHC is a multi-stakeholder coalition focused on the reduction of chronic diseases, especially those related to obesity.*

## doh.sm.1115Waivers

**From:** McCord, Mary [redacted]
**Sent:** Monday, November 4, 2019 3:10 PM
**To:** doh.sm.1115Waivers
**Subject:** 1115 Public Forum Comment
**Attachments:** DSRIP 2.0 PEds support for HealthySTeps comments.docx



Please see attached.

Mary McCord MD MPH
Director of Pediatrics
Gouverneur Health/Gotham Health, NYC Health and Hospitals
227 Madison St
NY NY 10002
[redacted]

November 4, 2019

We submit these comments representing the leadership of Pediatric Primary Care at NYC Health and Hospitals.

We are pleased to have the opportunity to comment on New York's DSRIP Waiver Amendment to support additional health care system quality improvements under the Delivery System Reform Incentive Payment (DSRIP) Promising Practices. We see DSRIP 2.0 as an opportunity to correct the historical under investment in Pediatric care, an under investment that we believe has directly contributed to poor outcomes and high costs of care in NY State. We have contributed separately to the NYC Health and Hospitals overall comments on the Waiver amendment and strongly endorse our health system's arguments in favor of DSRIP 2.0 prioritizing investment in children's health with the goal of achieving improvement in outcomes that will yield short term savings to our Medicaid budget and substantial long term and cross sector saving in health and well-being for the population of New York. The goal of population health interventions is investment upstream to improve health outcomes at the point where intervention is most cost effective. Intervention in childhood with the goal of improving social/emotional/developmental outcomes is a powerful upstream investment with well-documented return on investment.

The comments which follow focus specifically on support for the HealthySteps program.

HealthySteps is an evidence-based, interdisciplinary pediatric primary care program, designed to promote nurturing parenting and healthy development for babies and toddlers. HealthySteps offers an array of services to meet families' needs through a resource-efficient, risk-stratified approach, supporting families of all income ranges, while geared specifically to lower income families. The model delivers child and adult-focused interventions that have been proven to generate short-term (annualized) cost savings to New York Medicaid. These early childhood and two-generation investments have been shown to yield even greater returns when evaluated over a longer time period, even beyond the health sector. Our organization has successful implemented the HealthySteps model and it is making a difference for young children, their families, and our providers.

Healthy Steps has been named as part of the core staffing model for our Pediatric Primary Care system. It is currently implemented in 3 Health and Hospitals facilities, with a plan to add3-6 additional sites within the next 2 years. This plan is supported by well-established evidence indicating the potential for both short term and long term financial and health outcome-related return on investment. However, the sustainability of this investment within our healthcare system will depend on the incorporation of HealthySteps into NY State's future value-based payment models.

***HealthySteps is fully consistent with the policy directions described in the DSRIP 2.0 policy paper and should be embraced by New York State as it continues to undertake strategies to reform the primary care delivery system. Moreover, the First 1000 Days Preventive Pediatric Care Clinical Advisory Group Final Report and Recommendations called upon the state to sustain its investment in the HealthySteps model, both through the continuation of funding for the sites currently supported by the state and to allow the model to expand to more practices throughout New York.*** This falls within the state's 1115 waiver amendment recommended actions for investing upstream and securing a better future for New York's children. The HealthySteps model does just that through its commitment to promoting healthy early childhood development through a dyadic approach to care that is integrated into Primary Care practices. Pediatric Primary Care is the only system that universally impacts children during the first 3 years of life. Families bring their children in for care reliably and often see their child's care provider as a trusted resource. This can be leveraged to improve the health of the child and also to intervene early when risk to the health or mental health of the parent or care giver is identified.

***We are encouraged that two of the federal priority areas highlighted in the waiver amendment, Social Determinants of Health and Primary Care Improvement and Alternative Payment Models, provide a stronger focus on children's health and wellness.*** NY State must provide stronger incentives to encourage Medicaid managed care organizations to partner with Pediatric primary care providers to transform care and impact population health. The two-Generation approach exemplified by HealthySteps is a model that can effectively accomplish this.

As the waiver amendment acknowledges, "current VBP arrangements built exclusively around primary care provider (PCP) attribution and networks do not completely embrace the kind of comprehensive integrated primary care, behavioral health, and other social care capacities that have been at the heart of most of the DSRIP success." ***HealthySteps and other Early Childhood focused models have made demonstrable improvements to the delivery system, those efforts have not benefited from DSRIP funding or received other support that would ensure that the model would remain sustainable across the state. DSRIP 2.0 must address this.***

Within the appendix of the state's 1115 waiver amendment, the state highlights current Performing Provider Systems (PPS) examples of promising practices at work. These examples, while impressive, suffer from a notable lack of focus on children. ***To ensure long-term success, the state must support a system that encourages payment reforms that respond to the unique and varied needs of children***. ***This will only occur if Value-Driving Entities are strongly encouraged to partner and to invest in specific interventions that address the needs of children beginning at the time of birth and onward.***

Thank you for the opportunity to provide comments on the DSRIP Waiver Amendment and for your consideration of these comments.

For more information, please contact any one of us:


Mary McCord MD MPH [redacted]

Director of Pediatrics, Gouverneur Health/Gotham Health

Co-Chair, Pediatric Ambulatory Care Leadership Council Pediatric Workgroup

Arthur Fierman, M.D. [redacted]

Associate Director of Pediatrics, NYC H+H-Bellevue Hospital

Co-Chair, NYC H+H Pediatric Council

Marcy Stein Albert, MD [redacted]

Director of Pediatrics, NYC Health + Hospitals/Queens

Katherine Piwnica-Worms, MD, MHS [redacted]

Director, Pediatric Health Care Delivery, NYC Health + Hospitals

## doh.sm.1115Waivers

**From:** Deoul, Lise-Anne [redacted]
**Sent:** Monday, November 4, 2019 3:10 PM
**To:** doh.sm.1115Waivers
**Cc:** [redacted]
**Subject:** 1115 Public Forum Comment
**Attachments:** DSRIP letter.docx



Please see attached, thank you.

*Lise-Anne*

Lise-Anne Deoul
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**Lise-Anne Deoul**
**Director**

**Martha Scoppa,**
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**Coordinator**

**Jane Bozan,**
**Nutrition Coordinator**

**Caryn Mathews**
**Retired Senior Volunteer**
**Coordinator**

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*Mountains of Opportunities*

# Office for the Aging

**SULLIVAN COUNTY GOVERNMENT CENTER**
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**November 4, 2019**

Paul Francis
Deputy Secretary for Health
State Capitol
Albany, NY 12224

Donna Frescatore
Medicaid Director
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Dear Mr. Francis and Ms. Frescatore,

On behalf of the Sullivan County Office for the Aging, I am writing to express my recommendations on the DSRIP renewal proposed by New York State Department of Health. The services we provide directly impact inappropriate emergency department visits, and reduce avoidable readmissions. The NY Connects program, implemented in 2006, serves as no wrong door for any and all services available in the region, and is a catalyst for individuals in need of assistance. The targeted goals in the proposed renewal are exactly what this network provides, and must include mandated contracting by each PPS with their local Area Agency on Aging for social determinants of health initiatives. Our office is the trusted service provider for the fastest growing segment of the population, and the highest utilizer of health care dollars. Our services **absolutely** allow individuals to remain in their own homes and communities, all while saving health care expenditures. We provide the highest level evidenced based interventions, and are experts at navigating a complex health care system, while providing person centered planning and care.

To demonstrate the value of the network, I would like to highlight a recent case that is typical to our office.

Mr. “A” first came to our office in 2016, since then we have had MANY interactions with him, all to help him remain as independent as possible in the community. Here’s a timeline:

First contact Nov 2016
He first contacted Sullivan NY Connects when his girlfriend died in Oct 2016. Financial issues now that only 1 income.
We reviewed his budget: spends a lot of food (eating out) because he does not cook, and a lot on newspapers (3 or 4 a day)
We reviewed his bens: SNAP, MA (but does not use because cannot meet spend
down), and MSP
We discussed moving from current apartment to single room, look at classifieds, adult homes
Very anxious about housing, recertifying lease at current housing, losing security if he moves out.
NY Connects made APS referral. Nine days later, an APS worker is assigned and contacts him, says he may find an aide who can teach him to cook
Phone call from brother in NYC,with family background info
We looked into other subsidized housing
Issues with phone bill, started app for Assurance Wireless
Goes to Fed Homeless for lunches

2017
Received one-time money from mother’s estate. Weepy, afraid to report money to SNAP. Not a problem. We completed SNAP recert.
Worked with SW at VA Clinic, considering a VA pension, but not sure how added income will affect current bens.
Needs dental work. Will go to Hudson River Healthcare to inquire about MA dental
Had 74th birthday
Needs MRI for eyes, needs neurologist
Completed MA recert. Hysteria when he learns he has a new MA worker. Sure his app is lost.
Concerned about Medicare Part D plan

2018
Wants to give away some of girlfriend’s furniture – S.A.L.T., Salvation Army

Completed SNAP recert. Frantic when SNAP worker did not call at appointed time.
Did not receive MA recert paperwork at end of Nov as susual. Very worried that he will lose MA.
Signed himself up for Medicare Advantage plan. HIICAP will compare plans for him. Getting phone calls from the Advantage plan. Anxious.

2019
Worried that new Part D plan does not have his P.O. address
Completed MA recert, worried about another new MA worker
Wants MH counselor, wants specific WW at VA Clinic but he only works with combat vets. Later learned he is a combat vet.
Completed Spectrum Lifeline app for phone credit $9.25/mo
Assisted with money order
Confusion about mail order Rx and new meds.
Eye problems. VA Albany has delayed cataract surgery.
Assisted with money order 3x
At appointment very, very upset when he couldn't find papers in his tote. Hysterical. Wailed. Later we discussed MH counseling.
Convinced he is under surveillance by Police. Wants to know how to handle. OFA Legal Referral submitted.
More eye problems. Assisted with money orders 3x
Eye problem – gets 2nd opinion from non-VA doctor
Needs dental. I explain using MA with spend down. Ellen Price also explains. He will think about it.
Completed HEAP Info Request Form
Eye problem, went to new doctor at VA Albany, but very confused about what is next.
Happy about OFA lunches at housing complex
Eye problem, money order 2x, confusion with VA Albany, he wants surgery now
We created list of questions for doctor at VA Albany, very large font, so he gets answers about his "complicated case"
Always walked everywhere, but now taking taxis and using OFA med trans
Eye problem, here with mail to be read aloud, asks me to write phone numbers from his address book in large black ink
Eye problem, wants surgery now, going to second opinion doctor, afraid to walk - street traffic
Eye problem, sight is getting worse, asked about nursing home or assisted living
Worried about apartment inspection by management
Completed SNAP Change Report Form
At bank yesterday, so upset the Branch Manager drove him to eye doctor in Goshen, got him lunch, and drove him home (LAD write TY letter)
Needs help in apartment. I called DFS PCA services but not eligible because eye problems are temporary and their requirement is min 180 days.
He cannot see to walk home to apartment. Bumped into another Jeff Bank worker who drove him home.
Continues to juggle the two eye doctors – private in Goshen and VA Albany
We make arrangements with County VA Agency for him to be picked up at home for trip to VA Albany
Needs help in apartment, gave him phone number for cleaning company
Eye problem, called taxi but needed me to escort him to taxi door, wants phone # for ShopRite Shop at Home
Agonizing about cost of private doctor, then brother offered to pay for copays for both eyes, friend will drive him to surgery and next day f/u
Anxious about pre-op extra eye drops to be taken on a Sunday. I created a box with 3 compartments and he practiced
Phone call from friend who transported him to surgery and took him grocery shopping. He needs help in home. Cannot see.
At Viet Nam War Memorial Wall, Veteran's Service worker expressed great concern about him to me
He claims he has no food, HBMs – okayed for temporary through Monti congregate
Eye problems. No improvement after first eye surgery.
He needs an aide. Not eligible unless uses MA
Anxious about semi-annual apartment inspection. Must clean up by end of October and he can't see. Arranged for help.
Second eye surgery coming up. Has new eye drops for pre-op, again a Sunday. Asked me to help again with organizing the drops. Here by appointment with his box with 3 compartments and all his eye drops.
Second eye surgery went well. Can see better. Wants to continue HBMs for a while. Very anxious.
Sight – takes taxis and gets around town again
Waiting for cleaning lady to arrive. Got hysterical that he could lose his apartment, but I calmed him down.
Cleaning lady does good job and he passed inspection.
Got bill for first eye surgery, has f/u eye appointment with original eye doctor, wrote money order by himself.
Lease- must recertify by end of December
Today: received money from brother, converted to money order to pay for first surgery, worried that eye doctor would receive it, asked about Annual Election, made an appointment for Thurs Nov 7 to complete HIICAP Intake, will bring his Rx with him.

This is one of many cases that truly displays the boots on the ground service provision in every county across the state. In the renewal waiver, I cannot stress highly enough that we need to harness the existing strengths of community based services, instead of recreating case management services and duplication of services. Each and every case manager in the entire statewide aging network has received certification via Boston University School of Social Work, ensuring consistency in assessment not provided by any other system. I ask that there are mandates for each PPS to engage and contract with their local Offices for the Aging, for the services vital to keeping individuals in home and community based settings.

Thank you,

Lise-Anne Deoul
Director
Sullivan County Office for the Aging

## doh.sm.1115Waivers

**From:** Mohammad Usman [redacted]
**Sent:** Monday, November 4, 2019 3:18 PM
**To:** doh.sm.1115Waivers
**Subject:** 1115 Public Forum Comment
**Attachments:** 1115 Public Forum Comment .pdf



Dear Sir or Madam,

Please see the attached public comment.

Respectfully,

Mohammad

**Mohammad Usman, Ph.D.** | Senior Manager, Data and Applied Research
Mellon-ACLS Public Fellow
United Neighborhood Houses
45 Broadway, 22nd Floor, New York, NY 10006
[redacted]

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**Public Comment on 1115 MRT Wavier**

**4 November 2019**

United Neighborhood Houses (UNH) appreciates the opportunity to provide comment to the 1115 MRT Wavier. UNH is a policy and social change organization representing 42 neighborhood settlement houses that reach 765,000 New Yorkers from all walks of life. Settlement houses are community-based organizations (CBOs) that serve people of multiple generations with programs that provide skills, education, social services, health, arts, and connection to community. UNH leads advocacy efforts and partners with our members on a broad range of issues including civic and community engagement, neighborhood affordability, healthy aging, early childhood education, adult literacy, and youth development.

UNH is broadly encouraged by the 1115 MRT Wavier. However, there are several specific areas where there is space for improvement.

Specific feedback on the document are outlined below.

**Devise State-level System for CBO-MCO Contracting**

The present system provides no formal or official mechanism for CBOs to engage with healthcare payers. Rather, CBOs list themselves in the State's directory and create a 'value proposition' with the hopes that a healthcare partner emerges. For their part, MCOs/healthcare providers are incentivized to approach their Social Determinants of Health requirement as a check-box: partnering with any Tier 1 CBO – with no minimum funding threshold – is sufficient to meet the requirement to participate in Value Based Payment contracting.

CBOs do not have any formal process for identifying and engaging with a potential MCO or healthcare organization as partners. This arrangement is not designed to foster durable collaborations/contracts between CBOs and healthcare organizations.

The 1115 MRT Wavier must take account of the inadequacies of the present system and provide a formal system for facilitating partnerships between healthcare organizations and CBOs. This system should provide a clear pathway for qualified CBOs to enter into partnerships with healthcare organizations. The present structure places the onus on CBOs, which are already at a significant resource and informational disadvantage relative to their potential partners.

**Problematic delineations between Tier 1, 2, and 3 community-based organizations (CBOs)**

The MRT Roadmap divides community-based organizations (CBOs) into three Tiers: 1, 2, 3. In order for Managed Care Organizations (MCOs) and healthcare providers to participate in VBP, they must partner with a Tier 1 (non-Medicaid billing) CBO to address one of the five social determinants of health (SDH) areas identified by the State. The present tier-based distinction between CBOs is deeply problematic and should be revised.

The fact that one or more programs within a organization bills Medicaid should not be a basis for precluding

the entire organization from directly entering into a contract. For example, many of UNH's member settlement houses have programs that address mental health issues for which they bill Medicaid. Within these Settlement House organizations, there are numerous, completely unrelated programs such as ones focused on providing access to nutrition through a food pantry, or educational services through an adult literacy program. Due to the this tier-based structure, such a CBO would be ineligible for a direct VBP contract with an MCO or healthcare provider because some component of their organization bills Medicaid.

This present structure creates a meaningful obstacle for otherwise highly qualified CBOs, keeping them from partnering with a healthcare partner to address a SDH area where they possess strong competency, experience, and a demonstrated commitment. While we understand that it is possible for a Tier 2 or 3 CBO to enter into a VBP contract provided there is at least one Tier 1 organization participating in said contract, this is not a viable solution. Healthcare organizations seek out Tier 1 CBOs as potential VBP partners. Hence, being a Tier 2 or 3 CBO poses a severe impediment to access that is not easily overcome.

It cannot be the intention of the MRT to preclude entire CBOs that are on the forefront of addressing SDH from participating in VBP merely because some component of the CBO bills Medicaid. As such, the State should revise this tier-based system by allowing any CBO to directly partner with a healthcare organization in a VBP contract. The Medicaid billing exclusion should only apply to specific programs within the CBO, not to the entire organization.

Thank you again for the opportunity to comment on this important topic.

We can be reached for follow up by contacting Mohammad Usman at [redacted]

## doh.sm.1115Waivers

**From:** Kate Alm [redacted]
**Sent:** Monday, November 4, 2019 3:21 PM
**To:** doh.sm.1115Waivers
**Cc:** Lacey Clarke
**Subject:** DSRIP 2.0 Concept Paper Comments
**Attachments:** DSRIP Concept Paper Comments_FHN (11-4-19).docx



Please find attached comments regarding the DSRIP 2.0 Concept paper.

Thank you

Kate

*Kate Alm*
Chief Strategy Officer
Family Health Network of Central New York, Inc.
85 South West Street
Homer, NY 13077
[redacted]

Family Health Network of Central New York, Inc. is grateful for the opportunity to provide comments on the Delivery System Reform Incentive Payment (DSRIP) Amendment Request concept paper published on September 17th. Family Health Network of Central New York, Inc. is a Federally Qualified Health Center (FQHC) and a licensed Article 28 Diagnostic and Treatment Center that has been providing primary healthcare to the residents of Central New York since 1972, with a special focus on services to the vulnerable uninsured and underinsured individuals. Organizationally, FHN has (5) freestanding medical centers, one (1) of which includes dental services, plus an additional four (4) school-based health centers in Cortland, Cayuga, and Madison counties; that also service residents of the contiguous counties of Tompkins, Chenango, Broome and Tioga. FHN also provides school-based dental services to eight (8) different school systems for targeted grades. In 2018, FHN provided about 50,750 visits to over 15,200 patients. Family Health Network commends the State's work in the first round of DSRIP to reduce costs, improve patient outcomes, and decrease unnecessary inpatient and emergency room utilization. For New York to experience a real transformation of the health care delivery system and sustain the gains thus far achieved through DSRIP, there must be a significant investment in community-based primary care. Only through this investment can the State achieve a true value-based system that improves health outcomes and reduces costs. Family Health Network supports the renewal of the DSRIP program through March 31, 2024. Family Health Network, a member of the Community Health Care Association of New York State (CHCANYS), supports the comments submitted by CHCANYS and has restated and revised many of their points below.

## I. Driving Promising Practices to Improve Health Outcomes and Advance VBP

By mission and in statute, health centers serve the State's most vulnerable and hard to reach populations. FQHCs are non-profit, community run centers located in medically underserved areas that provide high-quality, cost effective primary care, including behavioral and oral health services, to anyone seeking care. Each FQHC is governed by a consumer-majority board of directors who are tasked with identifying and prioritizing the services most needed by their communities. Over 40% of our 15,000+ patients are enrolled in Medicaid or CHIP.

Our nine sites located in Cortland and Cayuga County provide access to comprehensive primary care services, especially among populations that are most likely to present at the ED with a non-urgent or avoidable condition. In the first round of DSRIP, we participated in one Performing Provider System (PPS): Care Compass Network (CCN) PPS. FHN has been extremely involved in the DSRIP process and is one of the six (6) founding Members of the CCN PPS that covers nine (9) counties. FHN has successfully been involved in 7 out of 11 possible projects and continues to be a leading partner with the implementation and outcomes of these projects. FHN has also participated in Innovation Funds Projects, Workforce Projects, the VBP Incentive Program, the Tele-Consult Program, and the Cohort Management Program.

The first round of DSRIP complemented the health center model's unique and innate ability to provide comprehensive and innovative care to New York's Medicaid beneficiaries. Health centers played and continue to play a key role in advancing the promising practices within their regions and driving improved health outcomes. In the second round of DSRIP, health centers are well-prepared to take a leadership role to advance the State's vision of an expanded value-based payment (VBP) landscape driving DSRIP promising practices.

## II. Embracing the Role of VDEs

We are pleased to see that the State has acknowledged the need for additional flexibility in the next round of DSRIP and is interested in ensuring the success of Value-Driving Entities (VDEs). However, we encourage the State to provide direct investment in community-based providers. Currently, 23 of 25 of the PPS leads are hospital-based, with no specific requirements about how funds flow to partners in the PPS networks. Meaningful governance participation by community-based providers, such as community health centers and community behavioral health organizations, and downstream investments to health centers and other community-based providers varied greatly from PPS to PPS. Using publicly available data reported by the State, it is extremely difficult to determine the amount of money received by health centers in the first round of DSRIP – they are included as "clinics" with hospital ambulatory providers. However, the most up to date data reported by the State in November 2018 demonstrates that hospitals received more than 28% of total funds flow while representing only 0.2% of total engaged PPS partners.[i] It is exceedingly difficult to transform the healthcare delivery system by continuing to invest most transformation dollars into inpatient-based care models, when it is the long-standing established CHC providers and workforce that can make the biggest impact on patients' health outcomes. CHCs are especially well-posed to integrate care, make connections to address social needs, and become the more adept and agile VDEs envisioned in the State's concept paper.

We support the State's charge that VDEs include providers, community-based organizations (CBOs), and managed care organizations (MCOs) to leverage VBP and advance promising practices. A collaborative partnership between community-based providers, CBOs, and MCOs is critical to implementing and supporting transformative initiatives that move away from a volume-driven care model. However, to support improved access to care in the community and reduce reliance on emergency departments and inpatient care, the State must direct additional resources to a broad range of community-based providers. **Family Health Network requests that the State dedicate, at a minimum, 25% of DSRIP funds to the development of community-based VDEs where CHCs, in collaboration with other community-based providers, are leads.**

### a. VDE Lead Entities

The State should capitalize on existing health center Independent Practice Associations (IPAs) as a launching point for the creation of community-based VDEs. There four CHC-led IPAs currently organized across the state, Community Health IPA (CHIPA), Safety-Net IPA (SIPA), Finger Lakes IPA (FLIPA), and Upstate Community Health Collaborative IPA (UCHC), are engaged with MCOs in at least one VBP contract while working on additional agreements. We are members of UCHC IPA. IPAs are able to take on risk and become financially accountable for both the quality of care and the most efficient delivery of care services. We believe that IPAs are well positioned to work with other entities as a VDE in the second round of DSRIP.

While health centers like ours are already developing relationships needed to advance in VBP contracts, a second round of DSRIP is an opportunity to invest in building capacity to ensure health center and CBO IPAs have the foundation to serve as VDEs. Currently, health center-led IPAs are self-funded and have little financial capacity to support many of crucial functions that would accelerate their successful participation in VBP arrangements. **Health center-led IPAs require DSRIP investment to support the data analytic capabilities needed to effectively manage population health and drive improved outcomes.**

**b. Considerations for Engaging MCOs**

Family Health Network is pleased that the State is taking steps to ensure engagement of MCOs early in the planning process for a second round of DSRIP. However, there are significant challenges that must be addressed ahead of the creation of VDEs. One of the current difficulties faced by providers as they seek to participate in VBP arrangements is a lack of comprehensive data about their attributed patients. **The State should create and enforce a uniform data sharing policy for the managed care plans to further support the transition to VBP, for example, by enforcing transparency in expenditures and utilization.**

In the first round of DSRIP, the discrepancies between MCO attribution and PPS attribution made it difficult for health centers to effectively manage patient health outcomes. PPS networks do not necessarily encompass the same providers that are contracted with a given MCO. If there are discrepancies between MCO attribution, consumer utilization, and PPS network, it becomes incredibly difficult, if not impossible, for the PPS to effectively manage health outcomes for these populations. PPS and VDEs should not be expected to manage the health care improvements of individuals who are enrolled in managed care plans that contract outside of the VDE. **Family Health Network recommends that in the next round of DSRIP, VDE attribution should be aligned with MCO attribution to ensure seamless VBP contracting.**

Finally, we understand the State's desire to drive regional innovation – local health care needs vary based on geography, CBO and health care provider landscape, and other factors. However, we would like to raise the concern that in densely populated areas served by many MCOs with overlapping service areas (notably, New York City), defining distinct regions may prove difficult. **In New York City, Family Health Network recommends that VDE networks should align with patient utilization patterns as much as possible.**

**III. <u>Supporting Non-Clinical Workforce to Address Social Needs</u>**

Family Health Network echoes the State's observation that many of the successful DSRIP initiatives rely on non-traditional, non-clinical workforce that help patients navigate clinical and social services systems to address their multi-dimensional needs. In the first round of DSRIP, we embraced the flexibility to address patients' social needs. Through the DSRIP Initiative, Family Health Network was able to expand its Care Coordination Team who act as critical members of the clinical care team and work directly with the Director of Quality Services to improve coordination of care for all FHN patients. The Care Coordinators have been crucial for advancing FHN in multiple quality initiatives, including the submission for Patient Centered Medical Home designation. The Care Coordination team has been specifically crucial in working to identify and address patient's social determinants of health internally at FHN; as well as, working to connect patients with the resources in the community that are provided to assist with the other factors that can impact an individual's health status.

In the first round of DSRIP, the State encouraged primary care practices to become patient-centered medical home (PCMH) recognized. Today, 97% of New York's health centers are PCMH certified. PCMH certified practices provide mental health, oral health, and health promotion/disease prevention services through comprehensive primary care. This model of patient-centered care is associated with improved health outcomes and reduced costs and should be robustly supported in the second round of DSRIP. There are numerous studies that have analyzed the success of PCMH, including citing fewer specialty

visits needed, lower per member costs, and better health outcomes amongst individuals seeing PCMH-certified providers.[ii]

**The State should use a second round of DSRIP to continue investments in care management programs like PCMH and Health Homes to address patients' social and medical needs.**

## IV. Aligning Performance Measures

Family Health Network strongly supports the State's desire to work with CMS to align performance measures across initiatives. Health centers' participation in Medicare, Medicaid, NYS PCMH, and contracts with managed care plans (among various other programs) requires a significant amount of resources invested in measure/data collection and reporting. **The State should target measures most likely to be of value for all participants in DSRIP 2.0.**

## V. Health Center Alternative Payment Methodology

FQHCs embrace the State's transition of Medicaid payment from volume to value. Family Health Network supports this direction and is also engaged in work with CHCANYS to move away from a visit based FQHC payment to a capitated FQHC Alternative Payment Methodology (APM). Federal statute permits states to implement an APM in lieu of the legally required prospective payment system reimbursement methodology. States must ensure that reimbursement under the APM is not less than it would be under the prospective payment system rate; however, adoption of an APM is essential to move FQHCs from a visit-based payment that incentivizes volume, to a payment methodology that rewards efficiency and outcomes. A capitated FQHC APM aligns with the State's DSRIP goals of advancing VBP and provision of enhanced care coordination.

An FQHC APM supports team-based, integrated care and enables CHCs the flexibility needed to create innovative approaches to care which can include non-clinical support staff who are not billable providers under the prospective payment system rate. The creation of innovative care coordination workflows will improve care provided directly by FQHCs, therefore reducing costs across the health care system.

Family Health Network looks forward to working closely with CHCANYS and the Office of Health Insurance Programs to establish a mutually agreeable approach that supports health centers' ability to transform their entire practice to a value-based care delivery model. Once the APM receives a federal approval, a small subset of health centers will transition from the prospective payment methodology to the APM. **To ensure the success of an APM, State investment is needed to enhance data collection capabilities and catalyze the development of new staffing roles, models for care teams, and innovative work flows.** These investments may include: enough funding to support interventions addressing patients' non-clinical social needs, support for an alternative payment learning community, clinical and cost data analyses, quality metric identification, and reporting mechanisms.

Family Health Network has actively engaged in DSRIP implementation and contributed to many of the successes achieved. We look forward to continuing to partner with the State to achieve our shared goals of system transformation and improved patient care, better patient outcomes, and reduced care costs.

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[i] https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/paop/meetings/2018/docs/2018-11-29_updates.pdf

[ii] Kaushal R, Edwards A, Kern L. May 2015. Association Between the Patient-Centered Medical Home and Healthcare Utilization. American Journal of Managed Care. Am J Manag Care. 2015;21(5):378-386.
Raskas R, Latts L, Hummel J et al. 2012. Early Results Show WellPoint's Patient-Centered Medical Home Pilots Have Met Some Goals For Costs, Utilization, And Quality. Health Affairs. Vol. 31, No. 9: Payment Reform to Achieve Better Health care. https://doi.org/10.1377/hlthaff.2012.0364
Akuh Adaji, Gabrielle J. Melin, Ronna L. Campbell, Christine M. Lohse, Jessica J. Westphal, and David J. 2018. Katzelnick. Patient-Centered Medical Home Membership Is Associated with Decreased Hospital Admissions for Emergency Department Behavioral Health Patients. Population Health Management. Vol. 21 Issue 3. printhttp://doi.org/10.1089/pop.2016.0189

## doh.sm.1115Waivers

**From:** Caroline Heindrichs [redacted]
**Sent:** Monday, November 4, 2019 3:24 PM
**To:** doh.sm.1115Waivers
**Cc:** McKenzie Pickett
**Subject:** Comments on the Draft DSRIP Waiver Amendment Proposal
**Attachments:** AsOne DSRIP 2.0 comments.pdf



Please accept the attached comments to the NYS draft waiver amendment proposal.

Thank you,
Caroline

AsOne Healthcare IPA

**Caroline Heindrichs, MA** | Executive Director
590 6th Avenue New York, NY 10011
[redacted] | myasone.org
*"Results-driven intergenerational healthcare."*

VIA EMAIL to 1115waivers@health.ny.gov

November 3rd, 2019

Re: Comments on the Draft DSRIP Waiver Amendment Proposal

To Whom It May Concern:

On behalf of AsOne Healthcare IPA, LLC (AsOne), a newly formed NYC-based healthcare Independent Practice Association (IPA) that focuses on the mental, physical, and social needs of children, adults, and families, I would like to first convey our support for New York State's effort to extend and renew this waiver. As background, AsOne was formed through a NYS VBP Readiness grant aimed at the behavioral health sector. AsOne has 15 participating provider organizations that offer a full range of mental health, substance abuse treatment, primary care, health home care management and social support services. Our mission is to focus on treating families with complex health, behavioral health and social needs. Rather than addressing only the needs of one patient individually, our IPA seeks to improve the health and lives of entire families at the same time. We believe in an intergenerational approach that improves the poor outcomes and high utilization of today while also preventing the costly health needs of the future. The AsOne member organizations were individually members of multiple DSRIP PPSs and participated in a number of projects over the last 4 years.

We are very pleased that the waiver proposal includes a focus on the pediatric population, social determinants of health, and behavioral health, all of which are key priorities for AsOne. In addition, we would like to build on that focus by recommending the inclusion of opportunities for implementing family-based approaches to improving the health of those with complex physical health, behavioral health, and social needs.

When reviewing the examples listed in the proposal Appendix B, it is clear that there have been many successful interventions that have targeted those with high and/or avoidable utilization, usually focused on a specific diagnosis or condition. However, many of the individuals and families served by AsOne members who have multiple co-morbidities, including behavioral health conditions, as well as social support needs, have not benefited from DSRIP projects as readily.

**Therefore, we recommend designing a demonstration or pilot project as part of this waiver proposal to target and treat impactable high utilization by Medicaid recipients with behavioral and medical co-morbidities and their family members.** In this approach interdisciplinary care teams would deliver interventions that include family case management and coordination as well as therapeutic family care management. Piloting this family-based approach through an extended waiver offers the opportunity to demonstrate both in-year reductions in utilization and long-lasting improved outcomes for the family over the waiver period.

According to the National Center for Complex Care, “Individuals with complex health and social needs don’t just experience multiple chronic diseases, they have many other complicating factors such as higher rates of addiction, mental illness and early-life trauma. These further exacerbate the already unstable ground of social structures such as housing instability, inefficient transportation systems, unemployment and criminal justice involvement. Given that primary care settings are not currently built to address these issues, care for these patients is extremely fragmented, resulting in high avoidable costs from things such as unnecessary emergency room visits, over-testing, hospital readmissions, and duplicative procedures.”

We would even go further to say that across multiple generations of families these complexities can have a further compounding effect. Therefore, we believe that not only stabilizing individual patients and connecting them to appropriate care is necessary for lasting improvements in overall health and well-being but also solidifying and strengthening the people in their support network and under their care is critical. Not only because these individuals can assist each other when the intervention is not present or has ended but also because poor dynamics within family unit can be the cause or contributor to illness or can be a sabotager towards better management of health, recovery and well-being. Addressing these relationships and interactions, in addition to better coordination and management of care and utilization, will ensure healthy and supportive dynamics across the family unit and lead to better and longer-lasting outcomes.

Although most high need/high utilizers are adults, a family-based approach to treatment includes serving many family members which can include children. As the DSRIP intent is to support long term reform and population health, ensuring that prevention is incorporated, especially for the pediatric population, is essential for long term cost-savings and improvement of outcomes.

There are no one size fits all approach that will be successful across all communities and populations, and there are hurdles in the current Medicaid program to serving families, but funding a demonstration program to comprehensively serve families is an important first step.

AsOne and its member agencies very much appreciate having the opportunity to share feedback on the draft DSRIP waiver amendment proposal. Please feel free to reach out to me directly with any questions about these comments.

Sincerely,

Caroline Heindrichs
Executive Director
AsOne Healthcare IPA, LLC
[redacted]

**doh.sm.1115Waivers**

**From:** Lisa Howard-Fiato [redacted]
**Sent:** Monday, November 4, 2019 3:43 PM
**To:** doh.sm.1115Waivers
**Cc:** [redacted]
**Subject:** CLMHD Comments on the NYS Medicaid Redesign Team (MRT) Waiver, Delivery System Reform Incentive Payment (DSRIP) Amendment Request
**Attachments:** Final Comments on the DSRIP 2.0 Amendment Request.pdf



Good Afternoon,

Please find (attached) the Conference of Local Mental Hygiene Directors (CLMHD) comments on the New York State Medicaid Redesign Team (MRT) Waiver, Delivery System Reform Incentive Payment (DSRIP) Amendment Request. Should you have any questions or need additional clarification please feel free to reach out to myself, Lisa Fiato – [redacted] or Courtney David at [redacted]

Thank you for the opportunity to share our thoughts and comments,
Lisa Fiato

Lisa A. Fiato, MHC
Director of Public Policy & Special Projects
NYS Conference of Local Mental Hygiene Directors
41 State Street, Suite 505
Albany, NY 12207
[redacted]
www.clmhd.org

NYS Conference of Local Mental Hygiene Directors, Inc.

41 State Street, Suite 505, Albany, NY 12207 • (518) 462-9422 • www.clmhd.org

**MEMORANDUM**

To: Donna Frescatore, Medicaid Director, NYSDOH
Gregory Allen, Director, Division of Program Development and Management, NYSDOH

From: Courtney David, Director of Governmental Relations
Lisa Fiato, Director of Public Policy and Special Projects
NYS Conference of Local Mental Hygiene Directors, CLMHD

Date: November 4, 2019

Subject: Conference of Local Mental Hygiene Directors (CLMHD) Staff Comments
NYS Medicaid Redesign Team (MRT) Draft Proposal: 1115 Waiver Delivery System Reform Incentive Payment (DSRIP) Amendment Request

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We are pleased to submit for your consideration, comments on the Department of Health's New York State Medicaid Redesign Team (MRT) Waiver, Delivery System Reform Incentive Payment (DSRIP) Amendment Request draft proposal.

Many of the considerations outlined herein, were developed to incorporate the Local Government Unit's (LGUs) legal responsibility for managing the local services system for individuals involved in any of the three populations that make up the mental hygiene system – Mental Health, Substance Use Disorder and Intellectual/Developmental Disabilities. In order to successfully fulfill the LGUs' statutory responsibility, there must be county involvement and collaboration through the local county mental health departments with the State's behavioral health delivery system of care.

**Section II. Changes Requested to the Demonstration** (Page 5)

**Aligning with Federal Goals**

- *Expansion of Medication Assisted Treatment (MAT) in Primary Care and ED Settings:*
  While we applaud the efforts of the Office of Addiction Services and Supports (OASAS) to help facilitate the expansion of MAT in ED settings through the Hospital Detox Waiver Program, there has been limited buy-in from the hospitals. The lack of access to waivered prescribers continues to be an impediment across the State, particularly in rural communities.

  CLMHD suggests that inclusion of peer engagement and community transition plans are two critical areas for successful expansion of MAT in ED settings.

  In transforming the PCP setting, the State should also take into consideration the CMS limitations in certain licensed settings that limit collaborative approaches, and as a result keep individuals receiving services in siloed approaches.

- *Partnerships with justice system and other cross-sector collaborations:*
  Consultation and collaboration with the LGUs on the development and implementation of new services will significantly strengthen the State's efforts for partnerships with the criminal justice system. Many counties have active Behavioral Health Justice Committees that have broad representation from criminal justice stakeholders (law enforcement, behavioral health providers, jails, DAs, probation, etc.) and have completed Sequential Intercept mapping. The LGUs are actively engaged in targeted solutions to address issues identified through this process. PPSs or other DSRIP involved entities should be required to coordinate any of the efforts in this area with the LGU and any BHJC that are in the area to avoid duplication and ensure appropriate use of resources.

  CLMHD also strongly supports the State's efforts seeking Federal approval to provide Medicaid coverage in jails 30 days prior to community re-entry. For the past two years, CLMHD has made it a priority to obtain State Aid funding for the development of SUD treatment and transition programs in all county correctional facilities. Including jail transition and community re-entry as a Medicaid billable service will provide much needed sustainability for these critical programs going forward, as well as, providing proper discharge planning to ensure engagement with community supports and services can start prior to returning to the community.

- *Primary care and behavioral health integration:*
  Expansion of Project TEACH, designed by Office of Mental Health, to better identify children with mild to moderate behavioral health symptoms by their pediatricians. Expansion of successful practices within the First 100 Days and Healthy Steps models. Expansion/inclusion of children and individuals with co-occurring disorders (SMI/SED, SUD and I/DD) and the removal of federal/state co-location barriers.

- *Expansion of MCTs and crisis respite services:*
  LGU involvement is critical here. The Office of Mental Health (OMH) and OASAS have worked diligently with the LGUs to expand the availability of MCT and crisis respite services in their communities resulting in a decrease in emergency admissions. Any expansion must be designed planfully to avoid duplication and unnecessary services.

  Workforce remains a challenge, however increasing Mental Health Peer Support and allowing for the ability to use them in a range of settings, including OMH Clinic settings, Emergency Departments, etc. to assist with engagement will help facilitate success. We also see the need to expand these services to co-occurring population and children.

- *Focus on patients transitioning from IMDs to the community:*
  It is critically important the State provide adequate community supports and investments to support the child/individual who is returning to a community setting for a successful transition. The counties continue to face fiscal challenges with an ever increasing need for behavioral health services (HARP, HCBS, and CFTSS). Resources must be in place in order to effectively deliver care to these high-needs populations. Increased coordination with the Adult and Children's Single Point of Access (SPOAs) would be an added benefit to assist the child/family and/or individual, as well as, the IMD facility when discharging planning back to the community. Ensuring there is appropriate supports and services in place will lead to a higher success rate with this transition back to the community.

**The Second Generation – Value-Driving Entities** (Page 6-7)

"Value-Driving Entities (VDEs) will consist of PPS (or subset), providers, Community Based Organizations (CBOs) and Managed Care Organizations (MCOs) teams specifically approved by the State to implement the high-priority DSRIP promising practices" and
"VDE governance will include additional representation from community based providers, including primary care, behavioral health and LTC to review the types of efforts and investments necessary to improve regional performance."

- The Conference believes the LGUs should serve in an advisory role or become a member of the VDE. It is critically important the LGUs continue to fulfill their statutory role by planning for service provisions for all three populations (Mental Health, Substance Use Disorder and Intellectual/Developmental Disabilities). We strongly recommend the State require the VDEs to consult with (or allow to become members of) for the accurate and appropriate development of county planning and service provision.

**Section III. Additional High-Need Priority Areas** (Pages 7-8)

**B. <u>Children's Population Health</u>**

Now that the children's transition is well underway, it is time to focus on the children's system of care. The Conference recommends that the next phase of DSRIP (2.0) include a number children's behavioral health priorities.

- There is very limited mention of the children's transition throughout DSRIP Amendment Request. We believe there should be a greater focus on the children's population.
- It will be essential to provide funding to ensure there is sufficient access to the Home and Community Based Services (HCBS) and the Children and Family Treatment and Supports Services (CFTSS), is critical for the success of the children's transition to Medicaid Managed Care (which started on 10/1/19). This will be essential for the high-need (above mild to moderate) behavioral health children.
- As mentioned above, it will be imperative for HCBS and CFTSS to be available and accessible for those children transitioning from an inpatient or residential setting back into community. They must be able to access the appropriate supports and services upon entering back into the community to ensure a successful transition.
- Also mentioned above is the importance of collaborating with the local LGUs/C-SPOAs. Collaboration and consultation with the local LGU/SPOA will provide education around what local services and supports are available to that child/family with in their community and provide assistance to health homes, MCOs, schools, pediatricians, hospitals, etc. on a child obtaining services and supports with the systems of care model.

**Section IV. Continued Investments/Improvements** (Pages 9-11)

**A. <u>Continued Workforce Flexibility and Investment</u>**

- In order for children/families to receive HCBS/CFTSS in a timely manner, workforce shortages and the lack of psychiatrists must be addressed. This area should be a priority for the DSRIP 2.0 supporting the MRT goals. Funding to support technological accommodations such as telemedicine and tele-psychiatry services, provide startup costs for Evidence Based Practices expansion, support the expansion of the OMH Project TEACH initiative, and expand options for workforce retention i.e. "get your feet wet" loan forgiveness and retention bonuses for care managers, licensed clinicians, direct care staff, etc.

- CLMHD supports efforts to expand the non-clinical workforce, however we believe that should also include clinical staff. It has been reported to the Conference that LCSWs and LCSW-Rs are leaving the Article 31 Clinics to work in the Article 28 Primary Care Practices which are funded through DSRIP. They are providing

assessments and assisting the Physicians via the Collaborative Care Model. This Collaborative Care model does not require this level of professional.

- The VDEs should consult with, or include as part of the VDE, the LGUs as they would be an essential element when assessing intervention costs and savings of workforce-related activities that would affect the future VBP model.

**B. <u>Coordinated Population Health Improvement</u>**

- CLMHD supports the promoting of Social Determinants of Health (SDH) and Community Based Organizations (CBO) inclusion through DSRIP by requiring MCOs to contract for SDH interventions in risk-sharing VBP contracts.

- Social Determinants of Health Networks (SDHN) – Again, LGU collaboration and consultation is necessary as part of their statutory authority. We also request that recommend LGUs be included as eligible applicants for procurements derived from SDHN and ask the State to allow for LGUs to directly contract with MCOs.

- The State should also look to add some additional Behavioral Health based VBP Quality Measures.

## doh.sm.1115Waivers

**From:** Glenn Liebman [redacted]
**Sent:** Monday, November 4, 2019 3:32 PM
**To:** doh.sm.1115Waivers
**Subject:** Mental Health Association in New York State (MHANYS) Comments on DSRIP 2.0
**Attachments:** MHANYS-20191104-DSRIP.pdf

The Mental Health Association in New York State, Inc. (MHANYS) is a not for profit organization comprised of 26 affiliates in 52 counties throughout New York. Our goals are to advocate for positive changes in the behavioral health system and work to end the stigma of mental illness. We are appreciative of the opportunity to comment on DSRIP 2.0

New York's ability to leverage DSRIP funding has resulted in some innovative best practices that have both reduced hospitalization and provided quality care. There are many examples of the 25 PPS's developing promising practices to align with the Triple Aim of improving patient experience, improving population health and reducing per capita costs.

Over the five years of DSRIP in New York, there are several areas that need to be addressed and we are appreciative of the opportunity to focus on several of those areas. In addition, we will provide greater focus on the key reforms that would be part of DSRIP 2.0

## 1) Community Based Organizations Engagement:

This is a prevailing theme that many have talked about in the DSRIP narrative. The reality is that there is verbiage throughout the document about the importance of Community Based Organizations as an integral part of DSRIP. Yet, unfortunately the result over the last five years have reflected a lack of engagement with CBO's.

Community based organization such as the Mental Health Associations across New York State have provided quality behavioral health care for many years. They are recognized as innovators in their communities and are a 'go to' for quality mental health programming. The same is true of many of the peer run organizations who are embedded in their communities and provide for the safety net needs of individuals with mental health related issues.

Unfortunately, throughout the process, larger entities have been the major beneficiaries of DSRIP funding and have resulted in those smaller uniquely behavioral health partners from being able to provide the services that many of our community desperately need. Hospitals and PPS lead organizations (several of whom are one and the same) should be contracting with the Community Based Providers to ensure that the unique characteristics of strong embedded community providers are a major part of achieving the outcomes of recovery and independence.

**Recommendation:**
To that end, we are joining many of our colleagues in the Not for Profit Community in calling for 30% of funds be utilized for community providers as is currently being implemented in Massachusetts.

## 2) Workforce

When DSRIP was first implemented, we had great hopes that a portion of this funding would be utilized for the not for profit workforce. Unfortunately, there are few examples of DSRIP changing practices in terms of being able to recruit and retain quality staffs in behavioral health and in other sectors.

The sad reality is that the human service workforce in New York has been undervalued for many years. Not only is this an issue of significance in insuring continuity of care for individuals but it is one of social justice as well. Over 80% of the human service workforce is comprised of women and over 40% are women of color. Salaries are not commensurate with the skills needed to work with vulnerable populations with complicated needs. While in recent years, there has been a recognition of this population, there is still a greater need for funding to insure that the quality staff is needed to help with our loved ones. A well trained and well-resourced worker is in many ways the most important ingredient in a person's move toward independence. As a family member myself, I know that so much of my loved one's recovery was based on their relationship with the staff person they work most closely with.

**Recommendation:**
We need to provide even greater flexibility and investment in the non-traditional, non-clinical workforce. While we support flexibility from the Value Driven Entities for this workforce, there has be a **resource pool** developed so that individual CBO's in the PPS network, can provide funding and tuition reimbursements to their staffs based on need. This workforce resource pool would be based on a series of criteria that could include vacancy rates, agency turnover and access to social determinants. Funding should be quickly available to CBO's. There is no more critical role for DSRIP 2.0 than insuring we have a well-resourced and well-trained workforce to work with those in greatest need.

## 3) Mental Health First Aid Training

To date, there have been over 1.5 million people in the United States trained in Mental Health First Aid. This eight-hour training provide individuals with a basic understanding of mental health and how to help someone respond to a mental health crisis.

This training should be mandatory within DSRIP. It is integral in many areas. Many of the 'hotspots' that the 25 PPS's have identified in their area including communities where there is a great deal of complex needs including poverty, health disparities and high level of substance use and mental health challenges. There are people in the workforce in those areas who do not have a full understanding of mental health. Making Mental Health First Aid training mandatory would provide them with a greater knowledge of how to deal with individuals in a crisis.

Another key reform of DSRIP has been the movement to integrate mental health and physical health through primary care initiatives. We wholeheartedly support his movement and recognize models like the Collaborative Care Model should be an ingrained part of the whole health strategy. A basic knowledge of mental health as provided in Mental Health First Aid would be essential for health care providers as we transition to the more integrated approach of DSRIP.

**Recommendation:**
Mental Health impacts all the work being done in the community through DSRIP. Mental Health First Aid would provide an essential training to all community providers and school personnel. We urge DSRIP 2.0 to include mandatory Mental Health First Aid Training.

## 4) Children's Population Health and Integration with Schools:

We are very supportive of the importance of highlighting Children's Population Health as an integral part of DSRIP 2.0. One of the area's highlighted in the report includes reference to Children with SED and utilizing care teams of clinicians to ensure that they are transitioned into community settings. This is something our organization strongly supports.

New York is the first State in the nation to make it mandatory to teach about mental health in schools. We recognize that nearly half of all High School students will have experienced a mental health disorder and that suicide completion is the second leading cause of death among adolescents. The movement within DSRIP to address these issues highlights the greater need of resourcing schools with stronger outcomes for their students.

The 47% of the state's children covered by Medicaid are in schools every day and they need to be educated about mental health like everyone else in school. The idea of mental health and wellness are integral to responding to the overall need of young people as evidenced by the Prevention Agenda.

**Recommendation:**
Use DSRIP 2.0 as an innovative resource for youth and schools. Fund innovation in the community to support children's programs dedicated to population health. These include school based mental health clinic expansion, Promise Zone Models and MHANYS School Mental Health Resource and Training Center, the only statewide program dedicated to mental health instruction in schools.

## 5) Family Engagement in DSRIP 2.0

A significant part of the success of DSRIP has been an emphasis on Whole Health. Collaborations around various partnerships throughout Health Care have helped to formulate the positive results to date.

Mental Health should not be in isolation of physical health much like individual health should not be in isolation of the family unit. A planful system of care as the goal of DSRIP 2.0 should encourage the partnership between the individual and their family. Family members are greatly impacted by the individuals in crisis. With the permission of the individual, families should play a major role in both supporting the individual and being provided with their own resources for their whole health.

Throughout the DSRIP narrative, there are examples of positive outcomes through collaboration. An approach that brings together families and individuals should be encouraged as a promising practice in DSRIP 2.0

A training program developed by MHANYS entitled MHANYS CarePath™ provides individuals and families with the tools needed for successful engagement and recovery. The flexibility of the program makes it ideal for all kinds of settings including hospitals, community based program and the prison system. To date, MHANYS has trained 100 CarePath™ Coaches across New York State assisting youth, adults and their families in person centered planning.

**Recommendation:**
Within the structure of DSRIP 2.0, there should be training available for the CarePath™. In addition, there should be greater recognition of families throughout DSRIP 2.0. Funding should be provided to make sure that families are educated about DSRIP to help their loved ones navigate the innovations of DSRIP 2.0.

## 6) HCBS and HARP:

Much has been made in the mental health community around the transition to Medicaid Managed Care. In response to this change, OMH in collaboration with DOH and OASAS, created a Health and Recovery Plan (HARP)product line that would insure that the tradition non-Medicaid services would have an ability to bill for Medicaid services instead of relying on fee for service funding.

Our organization has been supportive as we recognize that an individual's plan of care should include the traditional non Medicaid programs like peer support, supported employment, supported education and family engagement. We are also appreciative that the State was very responsive to our organization's request to include funding and innovation in community partnerships to enhance number of individuals taking advantage of HARP.

Unfortunately, the numbers, to this point, are not as high as anticipated for the population of people with mental health related challenges that would qualify.

**Recommendation:**
Create a funding pool within the mechanism of DSRIP 2.0 to fund community based HCBS designated providers directly to engage individuals eligible to HCBS that are not currently enrolled. Innovation of MHA members and other community providers directly being able to utilize a pool will dramatically help with HCBS outcomes and most importantly provide people with all the tools that will help sustain individual recovery and community integration.

## SUMMARY

While many of the achievements of DSRIP have been laudable, there is still a need for a DSRIP 2.0 that would both lend itself to the past goals but also formulate a future path to help provide the quality health care that is much needed.

We strongly recommend:

A) Greater Engagement with Community Based Organizations. Mandatory 30% contracting consistent with the legislation in Massachusetts

B) Funding Pool for Workforce that PPS programs can quickly take advantage of based on vacancy rates, turnover and links to social determinants

C) Given the importance of behavioral health to all individuals being served by DSRIP, there should be a mandatory training for all staff around Mental Health First Aid

D) Recognition of the 47% of young people on Medicaid in New York is a significant part of DSRIP 2.0. Since this population of young people are in schools, mental health education in schools should be an important part of the Prevention Agenda. Resources such as MHANYS School Mental Health Resource and Training Center should be identified and funded through DSRIP 2.0

E) Whole Health is an important part of the philosophy of the PPS's as identified by their promising practices. The role of families should be an important component of DSRIP 2.0 moving forward. The MHANYS CarePath™ program and more identified family resources and strategies should be part of the programmatic funding for DSRIP 2.0

F) Funding Pool for HCBS Designated Providers to insure that they have access to direct funding to increase the number of individuals taking taking advantage of HCBS services

## doh.sm.1115Waivers

**From:** Cadena, Marcella [redacted] on behalf of Amrhein, Scott [redacted]
**Sent:** Monday, November 4, 2019 3:32 PM
**To:** doh.sm.1115Waivers
**Subject:** CCLC Public Comments on DSRIP Extension Proposal as of 11-04-19
**Attachments:** CCLC Public Comments on DSRIP Extension Proposal as of 11-04-19.pdf



To Whom It May Concern:

With this email, CCLC submits public comments concerning New York State's proposal to extend the Delivery System Reform Incentive Payment program.

Please contact CCLC with any question concerning the attached.

Scott Amrhein | President | CCLC | 555 West 57th Street, New York, NY 10019 [redacted]
| www.cclcny.org

CONTINUING CARE LEADERSHIP COALITION CCLC

November 4, 2019

Donna Frescatore
Medicaid Director
Office of Health Insurance Programs
New York State Department of Health
Corning Tower
Albany, NY 12237
*Via email: 1115waivers@health.ny.gov*

Subject: 1115 Public Forum Comment Concerning DSRIP Waiver Extension, as Released September 17, 2019

Dear Ms. Frescatore:

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

On behalf of the long term care providers in the CCLC membership, I appreciate this opportunity to comment in connection with the New York State Department of Health (DOH) release of its proposal to extend the Delivery System Reform Incentive Payment (DSRIP) program. That proposal, as released on September 17, 2019, offers DOH's framework for the future of the DSRIP program in New York State following the conclusion of its first term, as scheduled to close on March 31, 2020. CCLC attended the public forum connected to these topics in New York City on October 25, 2019. Several CCLC members and CCLC staff also attended a briefing on similar topics provided by DOH at the offices of the Greater New York Hospital Association on November 4, 2019 (today). By way of its involvement, CCLC understands that DOH endeavors to integrate its responses to public

comments such as these into a final submission to the Federal Centers for Medicare and Medicaid Services (CMS) on or about November 27, 2019, with the further expectation that any DSRIP extension would commence during the spring of 2020. This approach would afford a continuation of DSRIP for the 1-year balance of the controlling 1115 waiver ending on March 31, 2021, and then extend programming for three further years until March 31, 2024.

### *Background on Preceding CCLC Comments*

CCLC appreciated the opportunity to comment during July 2019 on the 1115 Waiver process more generally, in prelude to the Department's publication of its September 2019 proposal. In those comments, CCLC highlighted elements it saw as critical to grow in a second phase of DSRIP, through rigorous evaluation of what New York State has learned during DSRIP's first chapter. Moreover, CCLC called for deeper implementation of complementary resourcing to ensure that DSRIP's future more intentionally includes an array of continuing care and post-acute partners as key drivers of the change envisioned through Medicaid Redesign Team (MRT) processes. The comments offered here expressly weigh in on those provisions embodied in DOH's September proposal, while drawing from the July 2019 submission where CCLC views restatement of principles as important.

### *Summary of Provisions in DOH's September 2019 Proposal*

In its September 17, 2019, submission, DOH requested $8 billion in additional funding from CMS, and, at a high level, the Department proposed that the investment would be distributed as follows:

- $5 billion for DSRIP performance;
- $1 billion for continued workforce development;
- $1.5 billion for social determinants of health; and
- $500 million for a new iteration of the Interim Access Assurance Fund (IAAF), which under DSRIP 1.0 provided financial support to financially distressed critical access and safety net providers.

The request if approved would extend DSRIP from April 1, 2020 to March 31, 2024. The work plan envisions support for "Value-Driving Entities" (VDEs) – successors to existing Performing Provider Systems (PPSs) – supporting those with strong performance to date, strong partnerships, inclusive governance structures, and potential to sustain promising practices under value-based payment (VBP) arrangements.

Within its request, the State has highlighted long term care as a "high-need priority area" in the proposed four-year program period (among other high-need areas that include maternal mortality and children's population health). Among the long term care priorities cited are the following:

- Continuing to strengthen transitions between hospital to SNF and hospital to home;
- Extending work to solidify hospital and SNF collaborations through projects on quality and clinical care protocols;
- Exploring bundling and value-based payment options more deeply that involve the long term care sector;
- Exploring new managed care delivery models to further strengthen and integrate the broader continuum of care for patients needing longer-term services and supports;
- Supporting long term care workforce investments and continuing PPS workforce collaborations, including programs providing subsidies and stipends for participating in-aide certification and nursing programs; loan forgiveness programs for nursing graduates; and subsidies for work barrier removal including childcare for LPNs and aides; and
- Encouraging collaborations of Value-Driving Entities, MCOs, and CBOs to target a specific high-need population for activities meeting a set of state-defined criteria designed to move towards VBP.

*Overall Comments*

CCLC was pleased to find a resonance in the State's September proposal with themes CCLC highlighted when it commented to the Department during July. It seems evident the State appreciates globally the need to develop a sustainable plan for elevating the broader continuing care continuum – including long term and post-acute care (LTPAC) – as integral and central within its future DSRIP modeling: the long term care priorities enunciated above hold meaningful promise and will be addressed serially, below. CCLC further is heartened by the Department's apparent appreciation that LTPAC providers currently offer differential care for high-cost, medically complex populations, and that their inclusion is essential to developing value-based models offering the greatest opportunities for State savings.

As CCLC noted in its July remarks, for many years CCLC members have been engaged deeply in supporting the State's Medicaid Redesign objectives, including a) as sponsors of an array of insurance entities, b) through active participation in performing provider system activities, c) through dedicated efforts to align their clinical practices with MRT goals via active engagement in staff training initiatives focused on avoiding preventable hospitalizations, and, d) in the case of more than 40 member organizations, by coming together collectively to form an independent practice association, the CINERGY IPA, which is actively focused on supporting the uptake of common clinical protocols explicitly intended to support value based payment objectives and MRT goals. The fruits of these efforts can be seen in 2018 Nursing Home Quality Initiative data, which show fully 93% of CCLC members scoring in the top three quintiles of overall quality, and 71% scoring in the top three quintiles on the measure of preventing avoidable hospitalizations.

*Comments on Specific DOH Program Proposals in DOH's September Release*

CCLC appreciates the attention the Department has employed in including LTPAC partners intentionally in DSRIP's next phase. Below, CCLC will offer its specific impressions of the proposals it identified in the Department's September release:

- *Continuing to strengthen transitions between hospital to SNF and hospital to home*:
    - CCLC strongly supports the intentional inclusion of post-acute partners in care transition conversations. The NHQI data cited above clearly demonstrate – through just one example – the further importance of ensuring any included partner demonstrates its commitment to quality and patient centered outcomes. There is variability in the marketplace, and DSRIP activities should orient around quality trendsetters as preferred partners;
- *Extending work to solidify hospital and SNF collaborations through projects on quality and clinical care protocols*:
    - Through its members' IPA, the CCLC community has been at the forefront of establishing meaningful and replicable clinical protocols, and we are pleased the Department affirms the value of this work;
- *Further exploring bundling and value-based payment options for the long term care sector*:
    - As CCLC commented extensively during July, CCLC members welcome structures deriving from DSRIP architecture that expressly permit post-acute providers such as CHHAs, or RHCFs (as well, CHHAs, RHCFs, and community-based human services organizations working in concert) to hold responsibility for managing the total cost of patient care during an episode of care. We note CMS has been considering an array of potential new alternate payment models – among them constructions to engage the post-acute provider community and the savings they may generate. Any such model, however, must incorporate enough base funding to ensure it has viability (including funding to cover data sharing, risk stratification, etc.);
        - The above observations relate closely to the VDE proposal within the State's September document, inasmuch as CCLC views it as critical for those in the long term care continuum to play prominent leadership roles in VDEs (including, potentially, through LTC-led VDEs that focus on the unique patient and resident population the sector serves – one that typically has fewer comparative touchpoints with health homes and primary care, by comparison) meaningfully defined to concentrate on success in serving vulnerable individuals requiring long term care services;

- As well during July, we encouraged DOH to seek with CMS an engagement of multiple partners including Medicare Advantage plans, given the increasing volume that such plans represent. Likewise, we highlighted hospice and palliative care in the context of developing models that are aimed at managing care for the dually eligible population, and reiterated the importance of pooling Medicare and Medicaid dollars to create scale and related funding streams for this work. (We recognize, of course, that the Fully Integrated Duals Advantage demonstration will sunset imminently, but lessons learned from this important State exploration should undergird these efforts.);
    - The September proposal, we are pleased to see, fundamentally tracks this approach through its call closely to involve insurer partners in the next DSRIP phase, including but not limited to further door opening to hospice and palliative care – resources that New York markedly underutilizes as per national comparison data, despite their multiplicity of known care quality and cost efficiency benefits to the health care system;
- Likewise, we reiterate the importance that such models account for social determinants of health, including "socioeconomic status, education, neighborhood and physical environment, employment, and social support networks, as well as access to care."[1] In the LTPAC context, these social determinants of health are critical to improving health delivery models and access to care, including specialty populations in need of long term care. Accordingly, CCLC encourages the State to consider populations' non-medical needs in caring for complex patients to maximize improvement and success – including additional payments to provide enhanced support,[2] and finds resonance in the State's September document concerning these principles;

- *Exploring new managed care delivery models to further strengthen and integrate the broader continuum of care for patients needing longer-term services and supports*:
    - Per the above comments, CCLC recognizes the critical opportunity to learn from experience – whether through FIDA or through other avenues and the further import of looking carefully across payor types creatively to capture and reinvest savings – if CMS were willing, one such model, could, for

[1] Artiga, S., Hinton, E., "Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity," Kaiser Family Foundation, May 2018. Accessed on 7/11/19 at https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/

[2] Schulman, M., Thomas-Henkel, C., "Opportunities for Complex Care Programs to Address the Social Determinants of Health," Center for Health Care Strategies Brief, Feb. 2019, p. 5. Accessed on 7/11/19 at https://www.chcs.org/media/TCC-SDOH-022119.pdf

instance, focus on reinvesting in New York State any shared savings derived from care focused on duals;

- *Supporting long term care workforce investments and continuing PPS workforce collaborations, including programs providing subsidies and stipends for participating in aide certification and nursing programs; loan forgiveness programs for nursing graduates; and subsidies for work barrier removal including childcare for LPNs and aides*:
    - CCLC is proud of its long commitment to workforce development and investment, including through programming it shepherded in the Health Workforce Retraining Initiative and through its longstanding labor-management partnership with 1199 SEIU Healthcare Workers East. Such work presently manifests in CCLC's important role within the Ladders to Value Workforce Investment Organization (a partnership involving branches of 1199, CCLC and the Visiting Nurse Service of New York), as complemented by other CCLC members' leadership of WIO initiatives throughout the State. Moreover, CCLC has been at the table with numerous stakeholders convened by the New York City Mayor's Office throughout 2019 to explore paradigms concerning long term care workforce growth and investment. So long as such initiatives embody a purposeful involvement of employers who meaningfully can contribute their important voices to such efforts and offer practical avenues for implementation, CCLC stands behind this positioning in the State's September proposal. Simultaneously, CCLC supports continuation of the Workforce Investment Program to solidify, if not deepen, workforce gains, to date;
- *Supporting collaborations of Value-Driving Entities, MCOs, and CBOs to target a specific high-need population for activities meeting a limited set of state-defined criteria designed to move towards VBP*:
    - CCLC members have moved into this space during DSRIP's first phase wherever possible, to encourage deeper and all-the-more meaningful opportunity for cross-continuum engagement in service of high-need populations. We wish to ensure, however, that the definition of partnership broadly includes the wide array of quality-oriented long term care providers (whether institutional, community based, or otherwise defined as a community based organization), that might have services and meaningful strategic vision to contribute.

### *The Prevailing Atmosphere in the Sector*

The timing of the State's expected submission to CMS later this fall comes in a context of short- and long-term challenges facing the not-for-profit long term care community. A more open and partner-oriented approach to DSRIP in its second phase may serve as a vehicle to alleviate some of the pressures affecting the sector – but a fundamental truth

remains: if instabilities affecting the not-for-profit community are not meaningfully addressed, the vision the state espouses of a community of quality oriented partners will not materialize. Indeed, organizations may continue to pare back their investments or cease to function entirely at a time when their services are so clearly furnishing value and demography suggests demand only to increase.

*Institutional Long Term Care.* The broader community of institutional providers faces an existential threat in the face of an estimated $300M cut the Department signaled in an October 9, 2019, Dear Administrator Letter that it will initiate during November, with retroactive effect to July 2019. This massive cut, predicated on a broad change in approach to the calculation of case mix indices, will destabilize the sector in ways that invariably will lead certain organizations to consider closing their doors. CCLC has received preliminary reports from one not-for-profit provider that operates two different facilities that, in one such facility, the provider will experience an approximately $30-per-patient-day decrement, and a $20 such decrement at the other. The funding cuts fundamentally place into question how not for profits will continue to deliver quality patient and resident care consistent with their missions in the service of others.

Another potential impediment arises as a result of language included in the enacted budget for SFY 2018-19: individuals receiving a nursing home benefit through a managed long term care (MLTC) plan were to be disenrolled three months following a determination of permanent placement. This Waiver related change, once implemented, would reduce the volume of individuals receiving long term care in residential health care facilities (RHCFs) on a plan-mediated basis. Although this proposal currently is under review before CMS, CCLC understands DOH expects the proposal is likely to be approved, very possibly during the balance of 2019. Although individuals requiring short-term care globally will remain covered by MLTC plans, the shift invariably will affect the potency of value based payment arrangements involving RHCF practitioners. If this change progresses as expected, tools and incentives to involve key long term care providers in the delivery of value based care – including but not limited to aggressive piloting activities – must be brought forward as quickly as possible.

While the MLTC RHCF "carve out" is moving toward completion, New York State also is nearing the conclusion of a series of funding distributions it has furnished to RHCFs as a "universal settlement" of various appeals and other outstanding litigation. When these important payments conclude, RHCFs will experience material, quantifiable revenue declines that, when coupled with acknowledged increased costs arising from recent collectively-bargained labor agreements and the effects of the CMI cut, will put RHCFs in an environment of diminished cash flow and elevating expense. As such, the importance of positioning RHCFs to realize revenue from successful engagement in Waiver-supported activity, including value based payment, will grow in importance. Moreover,

leveraging VBP represents a key opportunity to emphasize and reward the efforts of those providers within the long term care sector that are achieving desired superior outcomes, in ways ideally that will more deeply embed – and encourage the more widespread adoption of – cutting-edge best practices.

*Community Based Long Term Care.* CCLC is proud to represent leading organizations with deep involvement in delivering post-acute and other community based organizational services in community-based settings. These providers are vital to maximizing the extent to which individuals may receive necessary post-hospital services in the home, as well as preventative care further upstream. They also play a crucial role in facilitating care transitions involving settings such as hospitals and health systems. Among these organizations, those with Certified Home Health Agencies (CHHAs) have stressed that a panoply of pressures – including administrative challenges, relative diminishment in episodic rates, and dramatic reductions in the rates paid by managed care organizations – are forcing consideration of difficult business strategy choices. Already in 2019, we have seen CHHAs act to reduce their footprint in the area market, and others actively contemplating such change, with ripple effects impacting providers and patients.

Restoring the CHHA market to greater stability will require considerable attention and multifaceted actions to put agencies on more solid footing. Among these, activities deriving from the Waiver, including VBP structures, stand to play an important role. Absent action, organizations will pull back or falter entirely – an outcome to be avoided at all costs at a time when the demographic demand for quality long term care services only is growing.

*Changes in Medicare Reimbursement Models*

Getting DSRIP right matters even more to high-quality LTPAC providers as seismic changes arrive in their fee-for-service Medicare reimbursement affecting skilled nursing facilities (the Patient Driven Payment Model – active as of October 2019) and in home health (the Patient-Driven Groupings Model – effective January 2020). These new reimbursement paradigms – while both driven around ensuring the focus on delivery of service quality – place key pressure on providers in ways that may reduce payment. For example, CMS has folded in so-called behavioral adjustments into its PDGM modeling that reduce formula based payments by nearly 10 percent even though fraud and waste have not been documented nationally at levels CCLC views as justifying of this action. In an environment where Medicare has offered some bulwark against regular provider losses on the delivery of Medicaid services, this set of changes may deepen instability—at least in the near term.

*Information Technology*

The above concerns are heightened by technology deficits in the long term care sector, writ large. New York State must plan and fund a way for long term care providers to be connected through health information exchange, as interoperability is essential to value-based payment and the fulfillment of MRT prerogatives. To date, incentives in this space have been misaligned. Consequently, the long term care sector has been left behind – ultimately to the detriment of those in need of care at a time when the demand on continuing care only is heightening. We recognize more work needs to be done across sectors to deepen interconnectivity across the State, including through leveraging of the SHIN-NY, and we deeply support the place of long term care at this table.

*Connecting with Existing Governmental Partners Outside of the Direct Medicaid and Medicare Spheres*

CCLC has been an active participant during 2019 in a working group convened by the New York State Department of Health and the New York State Office for the Aging to map the future of long term care. This Long Term Care Planning Project – which holds important promise – is an important exemplar of the value of incorporating wide array of partners in answering questions about the future of Medicaid funded services in a VBP environment. To wit, leveraging programs such as the Expanded in-Home Services for the Elderly Program (EISEP) or otherwise working closely with regional area agencies on aging are key pathways to stretch resources further and creatively: we encourage the Department's further exploration of such avenues.

*Conclusion*

On behalf of CCLC and its members, I appreciate the opportunity to comment on the proposal to extend DSRIP programming in New York State for four years beyond its first phase. Should you need further information, or if you have questions about these comments, please contact me at CCLC.

Sincerely,

Scott Amrhein
President
Continuing Care Leadership Coalition
555 West 57th Street, Suite 1500
New York, NY 10019
[redacted]

## doh.sm.1115Waivers

**From:** Joe Gonzalez [redacted]
**Sent:** Monday, November 4, 2019 3:32 PM
**To:** doh.sm.1115Waivers
**Cc:** Judith Watson
**Subject:** DSRIP / Mount Vernon Neighborhood Health Center Network
**Attachments:** scan0038.pdf



Dear Sir / Madam,

Please find attached our comments regarding DSRIP round 2, should you have any questions please feel free to call me.

Many Thanks

Joseph Gonzalez
Chief Business Officer
Mount Vernon Neighborhood Health Center
107 West Fourth Street, 2nd Floor
Mount Vernon New York 10550
[redacted]

Mount Vernon Neighborhood Health Center, Inc.

BOARD OF DIRECTORS
Barbara Anderson
*Chairwoman*

Judith Watson, RN, BSN, MPH
*Interim Chief Executive Officer*

Monday November 4, 2019

Dear Sir / Madam,

Mount Vernon Neighborhood Health Center Network is grateful for the opportunity to provide comments on the Delivery System Reform Incentive Payment (DSRIP) Amendment Request concept paper published on September 17th. The MVNHC Network consists of three federally qualified Joint Commission accredited community health centers located in Mount Vernon, Southwest Yonkers and Greenburgh/White Plains. Health Care services are also provided at two homeless shelters in Westchester and two school-based Health Centers in Mount Vernon. The Center was one of the first community health centers to receive accreditation with commendation by the Joint Commission. The Center is accredited as a primary Care Medical Home. The Health Center was established in 1973 and provides comprehensive, patient-centered health care services to approximately 56,326 registered patients annually and 127,082 annual encounters. The ethnically diverse staff of 350, is committed to meeting the community's medical and dental needs through the provision of comprehensive, quality and affordable health care. Mount Vernon Neighborhood Health Center Network commends the State's work in the first round of DSRIP to reduce costs, improve patient outcomes, and decrease unnecessary inpatient and emergency room utilization. For New York to experience a real transformation of the health care delivery system and sustain the gains thus far achieved through DSRIP, there must be a significant investment in community-based primary care. Only through this investment can the State achieve a true value-based system that improves health outcomes and reduces costs. Mount Vernon Neighborhood Health Center Network supports the renewal of the DSRIP program through March 31, 2024. Mount Vernon Neighborhood Health Center Network, a member of the Community Health Care Association of New York State (CHCANYS), supports the comments submitted by CHCANYS and has restated and revised many of their points below.

## I. Driving Promising Practices to Improve Health Outcomes and Advance VBP

By mission and in statute, health centers serve the State's most vulnerable and hard to reach populations. FQHCs are non-profit, community run centers located in medically underserved areas that provide high-quality, cost effective primary care, including behavioral and oral health services, to anyone seeking care. Each FQHC is governed by a consumer-majority board of directors who are tasked with identifying and prioritizing the services most needed by their communities, 39% of our 56,326 patients in 2018 were enrolled in Medicaid or CHIP.

Accredited
Joint Commission
on Accreditation of Healthcare Organizations



107 West Fourth Street • Mount Vernon, New York 10550 • (914) 699-7200 • Fax (914) 699-0837

Our eight sites located in in Mount Vernon, Southwest Yonkers, Greenburgh/White Plains and Westchester area provide access to comprehensive primary care services, especially among populations that are most likely to present at the ED with a non-urgent or avoidable condition. In the first round of DSRIP, we participated in WMC Health Performing Provider Systems (PPS). In conjunction with WMC Health PPS we have integrated behavioral health into our internal medicine department, every patient is assessed for depression and the Behavioral health team is activated as needed. We have improved patient engagement in our Diabetic population through education and community outreach. We have also decreased ER visits and admissions through our transition of care coordination team which assist patients with follow up care, appointments, referrals and connecting the patient to enabling services as needed.

The first round of DSRIP complemented the health center model's unique and innate ability to provide comprehensive and innovative care to New York's Medicaid beneficiaries. Health centers played and continue to play a key role in advancing the promising practices within their regions and driving improved health outcomes. In the second round of DSRIP, health centers are well-prepared to take a leadership role to advance the State's vision of an expanded value-based payment (VBP) landscape driving DSRIP promising practices.

## II. Embracing the Role of VDEs

We are pleased to see that the State has acknowledged the need for additional flexibility in the next round of DSRIP and is interested in ensuring the success of Value-Driving Entities (VDEs). However, we encourage the State to provide direct investment in community-based providers. Currently, 23 of 25 of the PPS leads are hospital-based, with no specific requirements about how funds flow to partners in the PPS networks. Meaningful governance participation by community-based providers, such as community health centers and community behavioral health organizations, and downstream investments to health centers and other community-based providers varied greatly from PPS to PPS. Using publicly available data reported by the State, it is extremely difficult to determine the amount of money received by health centers in the first round of DSRIP – they are included as "clinics" with hospital ambulatory providers. However, the most up to date data reported by the State in November 2018 demonstrates that hospitals received more than 28% of total funds flow while representing only 0.2% of total engaged PPS partners.[i] It is exceedingly difficult to transform the healthcare delivery system by continuing to invest most transformation dollars into inpatient-based care models, when it is the long-standing established CHC providers and workforce that can make the biggest impact on patients' health outcomes. CHCs are especially well-posed to integrate care, make connections to address social needs, and become the more adept and agile VDEs envisioned in the State's concept paper.

We support the State's charge that VDEs include providers, community-based organizations (CBOs), and managed care organizations (MCOs) to leverage VBP and advance promising practices. A collaborative partnership between community-based providers, CBOs, and MCOs is critical to implementing and supporting transformative initiatives that move away from a volume-driven care model. However, to support improved access to care in the community and reduce reliance on emergency departments and inpatient care, the State must direct additional resources to a broad range of community-based providers. Mount Vernon Neighborhood Health Center Network requests **that the State dedicate, at a minimum, 25% of DSRIP funds to the development of community-based VDEs where CHCs, in collaboration with other community-based providers, are leads.**

### a. VDE Lead Entities

The State should capitalize on existing health center Independent Practice Associations (IPAs) as a launching point for the creation of community-based VDEs. There four CHC-led IPAs currently organized across the state, Community Health IPA (CHIPA), Safety-Net IPA (SIPA), Finger Lakes IPA (FLIPA), and Upstate Community Health Collaborative IPA (UCHC), are engaged with MCOs in at least one VBP contract while working on additional agreements. We are seeking to become members of the Community Health IPA (CHIPA). We believe that IPAs are well positioned to work with other entities as a VDE in the second round of DSRIP.

While health centers like ours are already developing relationships needed to advance in VBP contracts, a second round of DSRIP is an opportunity to invest in building capacity to ensure health center and CBO IPAs have the foundation to serve as VDEs. Currently, health center-led IPAs are self-funded and have little financial capacity to support many of crucial functions that would accelerate their successful participation in VBP arrangements. **Health center-led IPAs require DSRIP investment to support the data analytic capabilities needed to effectively manage population health and drive improved outcomes.**

### b. Considerations for Engaging MCOs

Mount Vernon Neighborhood Health Center Network is pleased that the State is taking steps to ensure engagement of MCOs early in the planning process for a second round of DSRIP. However, there are significant challenges that must be addressed ahead of the creation of VDEs. One of the current difficulties faced by providers as they seek to participate in VBP arrangements is a lack of comprehensive data about their attributed patients. **The State should create and enforce a uniform data sharing policy for the managed care plans to further support the transition to VBP, for example, by enforcing transparency in expenditures and utilization.**

In the first round of DSRIP, the discrepancies between MCO attribution and PPS attribution made it difficult for health centers to effectively manage patient health outcomes. PPS networks do not necessarily encompass the same providers that are contracted with a given MCO. If there are discrepancies between MCO attribution, consumer utilization, and PPS network, it becomes incredibly difficult, if not impossible, for the PPS to effectively manage health outcomes for these populations. PPS and VDEs should not be expected to manage the health care improvements of individuals who are enrolled in managed care plans that contract outside of the VDE. Mount Vernon Neighborhood Health Center Network **recommends that in the next round of DSRIP, VDE attribution should be aligned with MCO attribution to ensure seamless VBP contracting.**

Finally, we understand the State's desire to drive regional innovation – local health care needs vary based on geography, CBO and health care provider landscape, and other factors. However, we would like to raise the concern that in densely populated areas served by many MCOs with overlapping service areas (notably, New York City), defining distinct regions may prove difficult. **In New York City,** Mount Vernon Neighborhood Health Center Network **recommends that VDE networks should align with patient utilization patterns as much as possible.**

## III. Supporting Non-Clinical Workforce to Address Social Needs

Mount Vernon Neighborhood Health Center Network echoes the State's observation that many of the successful DSRIP initiatives rely on non-traditional, non-clinical workforce that help patients navigate clinical and social services systems to address their multi-dimensional needs. In the first round of DSRIP, we embraced the flexibility to address patients' social needs. At Mount Vernon Neighborhood Health Network, we screen patients for social determinants of health and address as needed in conjunction with our community partners. We have partnered with Feeding Westchester to provide healthy produce to our diabetic patients.

In the first round of DSRIP, the State encouraged primary care practices to become patient-centered medical home (PCMH) recognized. Today, 97% of New York's health centers are PCMH certified. PCMH certified practices provide mental health, oral health, and health promotion/disease prevention services through comprehensive primary care. This model of patient-centered care is associated with improved health outcomes and reduced costs and should be robustly supported in the second round of DSRIP. There are numerous studies that have analyzed the success of PCMH, including citing fewer specialty visits needed, lower per member costs, and better health outcomes amongst individuals seeing PCMH-certified providers.[ii]

As a result of our PCMH program we recognize that the adolescent population encounter stressors specific to that age group in turn leading us to change the way we assess depression in our adolescent units. Through our Diabetic programs and patient education, we have decreased our percentage of patients with A1c above 9 from 30% in 2017 to 22% in 2018. **The State should use a second round of DSRIP to continue investments in care management programs like PCMH and Health Homes to address patients' social and medical needs.**

## IV. Aligning Performance Measures

Mount Vernon Neighborhood Health Center Network strongly supports the State's desire to work with CMS to align performance measures across initiatives. Health centers' participation in Medicare, Medicaid, NYS PCMH, and contracts with managed care plans (among various other programs) requires a significant amount of resources invested in measure/data collection and reporting. **The State should target measures most likely to be of value for all participants in DSRIP 2.0.**

## V. Health Center Alternative Payment Methodology

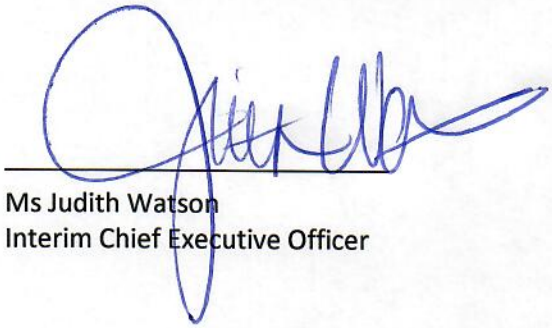
FQHCs embrace the State's transition of Medicaid payment from volume to value. Mount Vernon Neighborhood Health Center Network supports this direction and is also engaged in work with CHCANYS to move away from a visit based FQHC payment to a capitated FQHC Alternative Payment Methodology (APM). Federal statute permits states to implement an APM in lieu of the legally required prospective payment system reimbursement methodology. States must ensure that reimbursement under the APM is not less than it would be under the prospective payment system rate; however, adoption of an APM is essential to move FQHCs from a visit-based payment that incentivizes volume, to a payment methodology that rewards efficiency and outcomes. A capitated FQHC APM aligns with the State's DSRIP goals of advancing VBP and provision of enhanced care coordination.

An FQHC APM supports team-based, integrated care and enables CHCs the flexibility needed to create innovative approaches to care which can include non-clinical support staff who are not billable providers

under the prospective payment system rate. The creation of innovative care coordination workflows will improve care provided directly by FQHCs, therefore reducing costs across the health care system.

Mount Vernon Neighborhood Health Center Network looks forward to working closely with CHCANYS and the Office of Health Insurance Programs to establish a mutually agreeable approach that supports health centers' ability to transform their entire practice to a value-based care delivery model. Once the APM receives a federal approval, a small subset of health centers will transition from the prospective payment methodology to the APM. **To ensure the success of an APM, State investment is needed to enhance data collection capabilities and catalyze the development of new staffing roles, models for care teams, and innovative work flows.** These investments may include: enough funding to support interventions addressing patients' non-clinical social needs, support for an alternative payment learning community, clinical and cost data analyses, quality metric identification, and reporting mechanisms.

Mount Vernon Neighborhood Health Center Network has actively engaged in DSRIP implementation and contributed to many of the successes achieved. We look forward to continuing to partner with the State to achieve our shared goals of system transformation and improved patient care, better patient outcomes, and reduced care costs.



Ms Judith Watson
Interim Chief Executive Officer

**doh.sm.1115Waivers**

**From:** Sara Soonsik Kim [redacted]
**Sent:** Monday, November 4, 2019 3:44 PM
**To:** doh.sm.1115Waivers
**Cc:** Moonyoung Chu
**Subject:** DSRIP Comment: Korean Community and Diabetes Prevention



To whom it may concern,

Please allow me to introduce myself.
My name is Sara Kim, public health program director, representing the largest Korean non-profit organization, Korean Community Services in New York City.

As a community health worker, leading diabetes prevention program for Korean speaking immigrants. I'd hear community members' stories while I lead the Stanford University-developed 'Diabetes Self-Management Program for more than 300 residents in the past three years.

Many of the attendees regretted that they didn't realize the risks of diabetes and its complications. They all emphasized that they needed any forms of education when they were in a pre-diabetes condition, but it was not available in the past.

Much worse, their primary care doctors didn't notice any warning signs when their A1C was in the range of pre-diabetes. One of the seniors was upset one day and told me that she was told that she was a diabetic when she visited the doctor's office for her routine visit.
She said that it was all of sudden. Her doctor never mentioned any warnings that she needs to watch out her weights, diets, or exercise due to the possibility of diabetes development.

Yes, as all know, diabetes is a huge economic burden to New York and USA. Accordingly, Korean immigrant community is not an exception in terms of diabetes.

On behalf of Korean Community Services, we urge that diabetes prevention should be included in the extended DSRIP to stay New Yorkers stay from diabetes and its complications.

Thank you,

--
Sincerely,

"Sara" Soonsik Kim, MPH
Program Director
NDPP Lifestyle Coach
Public Health & Research Center

Korean Community Services of Metropolitan New York, Inc. (KCS)
Queens: 203-05 32nd Ave. Bayside, NY 11361
Manhattan: 325 West 38th St. Suite 1210, NY, NY 10018
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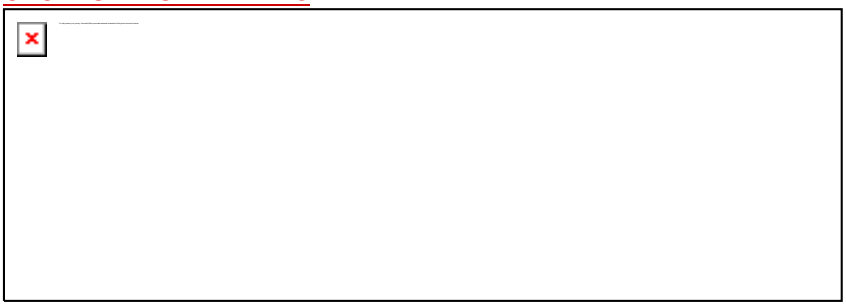
CLICK FOR MORE DETAILS



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**doh.sm.1115Waivers**

**From:** Anthony Feliciano [redacted]
**Sent:** Monday, November 4, 2019 3:43 PM
**To:** doh.sm.1115Waivers
**Subject:** 1115 Public Forum Comment
**Attachments:** CPHS DSRIP Amendment Comment 11.04.2019.pdf



Please see out comments of the State's 1115 Medicaid Waiver Amendments
--

Anthony Feliciano
Commission on the Public's Health System
Director
C/o WeWork
110 Wall Street Rm 4-006
New York, NY 10005
[redacted]

November 4, 2019

New York State Department of Health

Office of Health Insurance Programs

One Commerce Plaza

Albany, NY 12207

**Re: Comments in Response to the Delivery System Reform Incentive Payment (DSRIP) Amendment Request**

The Commission on the Public's Health System is a voice for the public health and hospital system, a voice for the allocation of public funding in the state and city budgets; a strong supporter of community organizing, and supporter of the health care safety net and access to health care services for everyone, particularly in low-income, medically underserved, immigrant and communities of color.

CPHS has a great deal of experience in working with Medicaid beneficiaries and with people who are uninsured. We know there is a myriad of barriers that are placed in the way for people who: work long hours, suffer due to dealing with bureaucracies, are immigrants in fear of the current anti-immigrant and racist climate in Washington, and speak a primary language other-than English.

We are also a Steering Committee member of a coalition of over 75 CBOs working together to ensure meaningful Involvement and engagement of communities and organizations in the state effort to reform how healthcare is reimbursed and delivered to all New Yorkers, especially people on Medicaid and uninsured. We were part of a big victory of $2.5 Million from the State DOH to develop a Strategic Plan. A plan with the aim to improve the integration of CBO's in in the State's $6.42 billion DSRIP program and our demands to support improved community-based assets to address social, economic, political conditions that impact marginalized community's health and well-being (aka Social Determinants of Health)


The state's initial investment through the regional CBO planning grants became a catalyst for the development or strengthening of networks. The grant offered opportunities for culturally and linguistically competent community-based organizations to build an infrastructure that would facilitate two important tenets. They were:

1. CBO engagement and involvement in healthcare is critical and essential component to the partnership with Hospitals and other medical entities
2. Health systems, providers, and payers recognize the significant influence that social factors have on well-being and health care spending. Therefore, community-based organizations can be best positioned and alliance between would bring best outcomes in addressing social determinants of health

DSRIP's initial proposal felt short of the commitment in the original language that envision community-based organization engagement to be valuable ingredient, and a mechanism to address SDOH. A disproportionate amount of the financial and human capital made available through DSRIP focused from the beginning to nearly the end on the institutional needs and use of hospitals. However, the proposed amendments for DSRIP 2.0 demonstrated that the voices on those concerns were heard. The State has indicated that some of the most promising aspects were the CBO collaborations with the Performing Provider Systems (PPSs). The state has mentioned that it can do more around Social Determinants of Health. We agree and believe strongly that much more can be done to add value and improvements to strengthen the state's approach.

This is best accomplished by supporting and sharing power with culturally competent community based social service and primary care service partners. There is a large and diverse body of practical work and research demonstrating that community engagement is a critical ingredient in efforts to improve the social determinants of health and the built environment. Sadly, it has not been resolved and communities that could truly benefit from lasting change are left waiting again for true community health planning process.

The following are recommendations with some additions that we support our CBO partners in Communities Together for Health Equity.

## I. Structural Change is Needed

- As the operational structure evolves, inclusion of CBOs as equitable stakeholders is essential. The proposed Second Generation Value Driving Entities (VDE) suggests a modification in the existing PPS structure to encourage representation and collaboration among PPSs, MCOs and CBOs. This requires a shift in culture and practice, and must

translate into an inclusive and equitable healthcare planning process with shared governance and decision making processes that recognizes and values the unique contributions of CBOs. The regional CBO networks are prepared and well positioned to make this happen.

**Recommendation**:

1. Language should be incorporated in the amendments to include a pre- planning process for developing guidance jointly with CBO'. The guidance would develop aims for what it would mean for the next phase of CBO engagement and partnership, especially because they would be an inclusion of the MCOs as active partners in the process.

2. If CBOs are part of this accountable communities for health, prior to any creation of VDEs, a submission to the state must include range of activities and processes used in the design of services that involve people who use or are affected by the service or program. These would be the introduction of equitable co-design.

## II. <u>Funding Distribution Reform is Needed</u>

- CBOs are mission-driven and vision- aspired organizations who primarily formed because community needs must be address collectively, particularly among low-income, immigrant, communities of color and other marginalized communities that unfortunately still contend with the structural racism, sexism and other isms in our health care system. They have a long history of addressing the unequal social and economic conditions that impact their well-being. However, are in a constant struggle to succeed because of limited capacity and resources to replicate, scale and sustain preventive initiatives and interventions.

**Recommendations:**

3. The amendments need to incorporate upfront investments from payers to ensure long-term improvements in health outcomes and dollars saved. These investments should not solely be focus on maturing VBP contracts but allowing for CBO's to contribute and mutually benefit from the better health outcomes of their communities.


4. Additionally, increased collaborations have led to and will continue to produce an influx of referrals and clients/members served. As a result, CBOs must be adequately compensated to either sustain or expand the practice. As mentioned in the DSRIP Interim Final Evaluation Report, *"If community-based organizations are relied on heavily for patient outreach and to impact the social determinants of health, their budgets may need to be increased or additional access to training or funding may be needed"*. Separate funding streams designated for CBOs addressing SDOH would ensure sustained and long-term population health improvements.

5. Payment models that share accountability must create incentives that build capacity and ability of CBO's to accomplish their mission, efforts on addressing well-being, and prevention of any shifts in how their workforce relates and engages their communities, members or clients.

## III. Making Population Health to be About Local Communities and Not Institutional Needs

- An important first step for improving population health is to understand the social and economic factors that determine a community's health and the factors that have made them historically ignored. To accomplish this, hospitals and health systems need to establish meaningful partnerships with local organizations that know how to engage the community. The inclusion of CBOs as actively engaged stakeholders in the design, planning, budgeting and implementation process ensures a comprehensive and culturally competent approach to identify priority issues that reflect on the ground community experiences, as well as defining specific regions/neighborhoods and/or attributed populations. The regional CBO networks like CTHE are prepared and well positioned to play an active role in this process and should be leveraged.

**Recommendations:**

6. Ensure there will be joint service models and not just referral models that are hand-offs of patients to one another. CBO's must be leading stakeholder in the development and evaluation efforts of screening for SDOH and the development of referral mechanisms to connect high-risk and vulnerable patients with social service providers that specialize in addressing nonclinical needs.


7. Include in the composition of VDE's, the regional CBO networks and other alliances of social/health and human services that have formed in response to ensuring DSRIP would work for their communities.

    - Allocating $1.5 billion specifically to address SDOH is a step forward to advance health and wellness, and while potential opportunities exist in the proposed Social Determinant of Health Networks, it fails to recognize and leverage the existing organized regional CBO networks.

8. There must be language in the amendments that aims that the selection, governance, decision-making, and evaluation of these Social Determinants Health Networks will be fair and equitable. One major component would be that there are based on multiple and combinations of social and health needs of those affected and not the medicalization of those conditions that make or keep communities sick or well.

Thank you for the opportunity to provide comments. We strongly urge you to take these comments and recommendations under serious consideration as you work to finalize the NYS DSRIP Amendment Request, especially if the negotiations with the Federal Center of Medicaid and Medicare Services results in less funds. We must ensure that the important steps in the proposal that focus funds for Social Determinants of Health and Community Based Organizations are not reduced.

Respectfully,
Anthony Feliciano, Director
CPHS
110 Wall Street Suite 4006
New York, NY 10005

## doh.sm.1115Waivers

**From:** Kirstin Beach [redacted]
**Sent:** Monday, November 4, 2019 3:47 PM
**To:** doh.sm.1115Waivers
**Subject:** Montefiore comments on DSRIP 2.0 Amendment Request
**Attachments:** Montefiore DSRIP 2.0 Comment Letter FINAL.pdf



Hello,

On behalf of Montefiore Health System, slease see attached.

Thank you,
Kirstin

**Kirstin Beach, MPH**
*Assistant Vice President, Regulatory and Legislative Policy*
Office of the President

**Montefiore Health System**
*The University Hospital for Albert Einstein College of Medicine*
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[redacted]
www.montefiore.org

November 4, 2019

New York State
Department of Health
Office of Health Insurance Programs
One Commerce Plaza Albany, NY 12207
1115waivers@health.ny.gov

**Re: Comments on Delivery System Reform Incentive Payment (DSRIP) Amendment Request**

***On behalf of Montefiore Health System (Montefiore), I am writing to offer comments on New York State's Delivery System Reform Incentive Payment (DSRIP) Amendment Request.*** We applaud New York State's decision to apply for an extension of the Delivery System Reform Incentive Payment (DSRIP) Program.

Montefiore currently leads the Montefiore Hudson Valley Collaborative (MHVC) and is the lead participant in the Bronx Partners for Healthy Communities (BPHC) PPS. MHVC has been a leader in innovation throughout the DSRIP program, with multiple initiatives gaining state, national and international acclaim. MHVC's work on care integration and peer supported recovery were featured in the state's "Promising Practices" report and its DSRIP 2.0 concept paper. Further, we have a long history of success in value-based arrangements (VBAs) and of spurring the integration of primary and behavioral health care. The comments that follow are based on that experience.

**The Expectations for the 1-Year Extension of DSRIP 1.0 Requires Further Clarification**

We seek to understand the expectations for performance and process activity during the 1-year no cost extension proposed by NYS. Specifically:

- ***Will the current PPS structures be measured for performance during this time? If so, will it be based on DSRIP 1.0 measures or DSRIP 2.0 measures?***
- ***Will there be any opportunity to draw down unearned funds from the DSRIP 1.0 time period, either through performance measurement or process activity in the lead-up to DSRIP 2.0?***
- ***Will PPS structure (i.e. attribution, governance, etc.) be held constant during the extension?***

**The Role and Composition of Value-Driving Entities (VDEs) Requires Further Clarification and Refinement**

While we support the progression of the PPS concept and agree that engaging the managed care plans (MCOs) into DSRIP better positions the program for long-term sustainability, we seek clarification and refinement of the VDE concept that builds on certain areas of misalignment that came to light in the DSRIP 1.0 experience.

For example, in DSRIP 1.0 providers used for attribution (such as primary care providers) were able to participate in multiple PPSs. This led to issues of split attribution. ***At a minimum, primary care providers and other drivers of attribution should not be able to participate in multiple VDEs within the same geographic area.***

Additionally, the state's concept paper addresses DSRIP 1.0 performance as a potential indicator of viability as a VDE. While we understand this logic, the reality of inaccurate and delayed data feeds (which impacted some PPS's significantly more than others) left many PPSs unable to drive performance in a coordinated fashion. ***While performance is a necessary factor and an important piece of DSRIP 2.0, it cannot be a significant driver of VDE selection.***

In addition, the role of the MCOs is unclear. Will VDEs be required to include all plans in their VDE? Like providers, MCOs have varying levels of infrastructure and readiness for VBAs. ***VDEs should not be required to include all local MCOs in the VDE.***

***The State should include Managed Long-Term Care (MLTC) as it develops the role of managed care plans in DSRIP 2.0.*** Montefiore operates a MLTC (Diamond Care) in the Bronx and Westchester. We find MLTC to be a successful strategy in simultaneously providing high quality care and achieving extraordinarily high rates of patient and family satisfaction, while achieving value.

***As is the case with health care providers and plans, CBOs have vast differences in their readiness for VBAs.*** Through MHVC, we have engaged CBOs in projects that expand CBO scope, increase their readiness to make financial and business arguments for their services, and provide paths to sustainability in a post DSRIP environment. This work has included close collaboration with food banks and those working to fight food insecurity. It has also included partnership with local public libraries to embed case workers to make libraries a part of the care continuum able to connect patrons to critical social and health services. Finally, the work has begun to strengthen CBO data exchange capability. These initiatives have all been noted by MCOs as potential points of partnership and were also included in Montefiore's, first in the state, successful Innovator application in 2018. That said, we know that CBO readiness for VBA participation is varied. The DSRIP 2.0 renewal must include programming for CBOs that help to move them towards this maturation and key next step in their evolution.

***Finally, further refinement of the intended alignment of the organizations participating in the VDE is needed.*** If the goal of the VDE is to create self-sustaining VBAs, this will require a complete overlap of the participating organizations' patient populations. For example, the participating MCO's members would need to be fully represented within the participating primary care providers' patient panels. However, we know from experience that this is never the case. Primary care providers have patients enrolled in several MCOs.

**NYS Should also Explore Solutions to Medicaid Churn and Other Eligibility Solutions that Would Enable Success**

While we recognize churn has been a part of the Medicaid program, in the scope of DSRIP and VBAs it has an outsized impact on the success of patient centered initiatives. When a program is predicated on continued and evolving contact and intervention with a defined population, losing touch with that population will have a negative effect on patient health and provider performance. ***As the PPS with one of the most significant churn rates, we view it as critical that any DSRIP 2.0 program include concerted efforts to reduce the impact of churn on PPS performance via interventions like weighting based on member-months, and also include initiatives that seek to understand the causes of churn.***

**Creating Self-Sustaining VBAs will Require Further Investment and Additional Intervention by The State**

Montefiore was the first value-based contractor in state to be approved under the Innovator Program. However, we have been unable to successfully engage in contracts through this authority due to several factors. Based on current premium levels and current administrative expense levels, the economics have not been viable. Further, not all plans have the infrastructure to engage in advanced VBAs and provide the timely and accurate data needed to enable our success.

***NYS should rethink the shared loss construct in VBAs.*** Ultimately in VBAs, the role of the value-based contractor should be to take on all risk related to costs that providers can reasonably control, while MCOs – with their larger and more diverse risk pools – should insure against factors beyond the value-based contractor's control. To date, many providers have faced shared losses based on Total Cost of Care for circumstances that did not relate to care quality and access, creating reticence to enter into standard two-sided risk contracts. This has especially been an issue for behavioral health providers, for whom many factors that influence short-term costs are outside of their purview, but who must be engaged in delivery system reform because behavioral health is such a driver of overall costs. Further, the costs for many patients who receive behavioral health services exceed the Basic Medicaid premium. In contrast, behavioral health providers may be well-positioned for total cost agreements for HARP patients, where the premium is commensurate with their morbidity.

VBAs should use measures other than Total Cost of Care in global risk contracts – and MCOs should be discouraged from tying quality incentives to performance on these metrics. For example, a VBA contract could offer enhanced incentives (and disincentives) for performance on measures that predict savings (in behavioral health, this could include Follow–Up After Hospitalization for Mental Illness, Follow–Up After Emergency Department Visit for Alcohol and Other Drug Dependence, Potentially Preventable Mental Health Related Readmission Rate 30 Days, and Adherence to Antipsychotic Medications for Individuals with Schizophrenia), rather than Total Cost of Care. In addition, since 2.0 is intended to increase focus on behavioral health, these metrics should be disproportionately weighted in order to ensure that budget is allocated accordingly.

Payment for performance on quality measures also should not be contingent on performance on the cost measures as it has been in many models, as VBP should recognize that better care is a good in-and-of itself that should be incentivized, even if costs stay the same. DSRIP 2.0 should reward projects and VBP arrangements that produce better outcomes and lower costs overall, regardless of how much risk is held. Innovation and flexibility in cost measures is especially necessary for children, who often do not cost much year-to-year and have received relatively little focus in VBP. ***Flexibility in the cost measures could spur more uptake of VBP contracts able to produce gains - especially in behavioral health - and help to determine what risk providers can bear and what plans should retain as VBP matures.***

***Further, flexibility in contracting arrangements should be given to move away from the PCP attribution model, as appropriate.*** VBAs typically follow PCP attribution, and this has limited the ability of behavioral health providers who have strengthened their focus on chronic conditions to participate in Health and Recover Plans (HARPs) and non-HARP VBAs. Therefore, we recommend the state consider contracting arrangements that allows patient attribution to BH providers preferentially for beneficiaries who meet certain criteria.

***An additional change that would improve the viability of VBAs is to require that premiums sub-capitated to the provider be based on the risk score of the provider's patient population, rather than the plan average.*** Montefiore's patient population significantly above a CRG of 1. If we only receive premium based on the plan average, this is a significant underpayment of the projected expense of this population.

***Finally, changes to underlying FFS payments should also be used to spur transformation. Specifically, NYS should address the significant underpayment of Medicaid in the outpatient setting.*** By increasing these rates, providers will have the incentive to transition care to the outpatient setting as appropriate, even in the absence of VBAs.

**Cross-Sector Collaboration Will Enable Success, Especially in Addressing the Social Determinants of Health**

Within DSRIP 2.0, NYS should fund cross-sector data integration with the justice system. This would help with care fragmentation and provide technical assistance on navigating related legal issues. Data sharing from the shelter system, foster care system, SNAP and cash assistance programs is also critical for successfully managing the care of impacted populations.

This more holistic approach to population health promotion also has the potential to achieve savings in other sectors. For example, effective management of behavioral health conditions can reduce justice system costs dramatically.

**Timely and Accurate Data is Critical to Success**

We've learned from the DSRIP experience that access to data that is timely and accurate is crucial. The ability to improve patient health and provider performance is almost entirely dependent on timely and accurate data. Within DSRIP 1.0 access to quality data was a hurdle from the beginning.

While the timeliness eventually improved, the accuracy turned out to be an even larger problem. Health Home billing changes led to unintended consequences for DSRIP attribution leaving PPSs with a blind spot as it related to some of the most vulnerable patients. Because the incorrect attribution left a subset of Health Home attributed patients invisible to the DSRIP program, it was not possible to fully and effectively implement the needed interventions.

We are encouraged to see that MCOs will be an early participant in DSRIP 2.0. With their participation comes an excellent opportunity for collaboration on timely and accurate data. Coordination between MCO and VDE attribution, and appropriate levels of data sharing, could allow both entities to achieve a great deal of success improving patient health and provider performance. ***We ask that the state's formal renewal include strong language ensuring this data sharing take place. Additionally, there is a need to ensure that funds go to support data interoperability at the network level, given that MCOs already receive direct administrative funds for that infrastructure.***

**Workforce Development is Crucial, but Reimbursement for Emerging Roles is Needed to Enable Success**

The workforce investment outlined in the DSRIP 2.0 concept paper is a critical follow up investment to the progress made over the last 4 years of DSRIP 1.0. It will be important to ensure some of the following issues/initiatives are part of a formal renewal plan:

- ***DSRIP 2.0 should make advances to expand the scope of billable services that can be generated by non-health care provider members of the care team (e.g., community health workers, peers).***
- ***DSRIP 2.0 should have a defined role for training and education entities (i.e. community colleges).***
- ***DSRIP 2.0 should utilize training infrastructure already developed by the Workforce Investment Organizations.***
- ***Workforce development investment should allow for intern and residency salaries to be covered expenses.***
- ***Further investment in emerging roles will strengthen New York's care continuum. As part of that investment, coordination and standardization of credentialing and education requirements will be key.***
- ***Emphasis on long term care and home health are also encouraging. A renewal should address the transportation issue faced by many care takers who are unable to reach the jobs for which they are badly needed.***
- ***DSRIP 1.0 required tracking of data that was not aligned across PPSs and was not accurate or actionable. DSRIP 2.0 should have the state initiate and collect data on growth in emerging roles and compensation trends to ensure accuracy.***
- ***DSRIP 1.0 highlighted the importance of health communication and cultural sensitivity through Cultural Competency and Health Literacy milestones. DRSIP 2.0 should not be silent on the impact of CCHL practices and value of workforce diversity initiatives on health outcomes.***
- ***DSRIP 2.0 should include change risk and readiness as required workforce investment.***

Further, based on our experience as an MLTC plan, we've found that the transportation needs of the long-term care workforce are significant and unmet. This is causing family members to take on caregiver roles that could have otherwise been filled by the formal workforce.

**Safety-Net Hospitals Need State investment, but VBAs May Not Be the Pathway to Sustainability**

Four safety-net hospitals within Montefiore Health System, as well as two affiliates that are part of MHVC, currently receive funding through the VBP-QIP Program. This program included value-based contracting requirements in an effort to move the safety-net hospitals toward financial sustainability. Based on the experience with that program, we believe that future safety-net hospital programs should not include requirements for VBAs. Safety-net hospitals lack the primary care footprints that are most often used to drive attribution in VBAs. Instead of VBA requirements, focus should be placed on quality improvement metrics.

**Promising Practices and Focus Areas**

We believe this list promising practices and priority areas highlights many of the key areas worth focus. ***However, we seek clarity on whether each VDE will be required to implement all of these promising practices, or whether they can choose from a menu of the projects as in DSRIP 1.0.***

In addition, we offer three specific initiatives to be included in priority areas:

- Expansion of medication-assisted treatment into primary care and ED settings – NY should consider expanding the Collaborative Care Medicaid Program (CCMP) to include high priority behavioral health conditions such as the treatment of both alcohol use and opioid use disorders, as well as ADHD for children and adolescents. As there are over 200 primary care practices around NYS that have successfully implemented collaborative care treatment of depression, anxiety, and more recently, maternal and adolescent depression, an expanded focus to these additional conditions (which is evidence based) could rapidly expand patient access to treatment using practices that are adept at integrated practice and outcomes reporting.

- Support for "reverse integration" where primary care is delivered in mental health and substance use settings.

- Support for Healthy Steps, an evidence-based, interdisciplinary pediatric primary care program, designed to promote nurturing parenting and healthy development for babies and toddlers. HealthySteps offers an array of services to meet families' needs through a resource-efficient, risk-stratified approach, supporting families of all income ranges, while geared specifically to lower income families. The model delivers child and adult-focused interventions that have been proven to generate short-term (annualized) cost savings to New York Medicaid. The first single statewide analysis conducted by the HealthySteps National Office in 2017, in partnership with Manatt Health, demonstrated annualized savings to Medicaid of up to $1,150 per family, for an annual return on investment (ROI) of 83%. These early childhood and two-generation investments have been shown to yield

even greater returns when evaluated over a longer time period, even beyond the health sector. In pediatric care, value primarily comes from promoting healthy child development, as well as preventing future costly health conditions, particularly adult chronic diseases, that have an enormous human toll. Payment models should be structured to motivate and support primary care providers in achieving that goal.

Thank you for the opportunity to provide input on this critical matter. Please contact Kirstin Beach, Assistant Vice President of Regulatory & Legislative Policy, with any questions you may have. She can be reached at [redacted]

Sincerely,

Lynn Richmond
Executive Vice President
Montefiore Medicine

## doh.sm.1115Waivers

**From:** Becca Telzak [redacted]
**Sent:** Monday, November 4, 2019 3:46 PM
**To:** doh.sm.1115Waivers
**Subject:** Make the Road New York's DSRIP 2.0 comments
**Attachments:** MRNY DSRIP 2.O comments.pdf



Attached please find Make the Road New York's DSRIP 2.0 comments. Thanks for your consideration.

Best,
Becca
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Becca Telzak

Director of Health Programs

Make the Road New York

92-10 Roosevelt Ave.

Jackson Heights, NY, 11372

[redacted]

[redacted]

*Pronouns: She, Her, Ella*

October 25, 2019

New York State Department of Health
Medicaid Redesign Team

Re: Make the Road New York (MRNY) on the Delivery System Reform Incentive Payment (DSRIP) Amendment Request

Dear Medicaid Redesign Team,

Good morning. My name is Becca Telzak and I am the Director of Health Programs at Make the Road New York (MRNY). Thank you for giving us the opportunity to provide comment on the Medicaid Redesign Team's Delivery System Reform Incentive Payment (DSRIP) Amendment Request.

Make the Road New York is a non-profit community-based membership organization with over 23,000 low-income members dedicated to building the power of immigrant and working class communities to achieve dignity and justice through organizing, policy innovation, transformative education, and survival services. We operate five community centers in Brooklyn, Queens, Staten Island, Long Island, and Westchester County.

MRNY's services teams, which includes legal, health, and adult education, serves thousands of immigrants each year to assist their ability to thrive in their communities. We provide direct legal representation, case management, and facilitated enrollment into public health insurance programs, training, and strategic support for members and organizing campaigns.

We have been involved in DSRIP projects for the past 5 years, partnering with PPS's including the One City Health PPS and the Staten Island PPS. Through these partnerships, we have run Community Health Worker (CHW) asthma projects, where CHWs are hired by MRNY but are partnered with clinical facilities and part of the care team. The CHWs conduct home visits for patients with asthma, where the CHW ensures that the family understands what they were told by their provider, conducts an environmental assessment in the home, and ensures that clients receive referrals for necessary services including referrals for integrated pest management.

As New York moves forward with DSRIP, it must prioritize working with Community Based Organizations (CBO's), and including CBO's in all aspects of the work including governance structures of the Value Driving entities. The Medicaid Redesign Team recognized the importance of non-clinical services and CBO's in the amendment request, and there are several promising concepts laid out in the amendment request, such as continued workforce investment in the non-clinical workforce, and the Social Determinants of Health Networks. However, MRNY has recommendations for how best to continue to provide trainings to non-clinical workers, and also how to implement the Social Determinants of Health Networks.

## Continued Workforce Flexibility and Investment

The amendment request acknowledges the need to rely on non-traditional, non-clinical workforce, such as Community Health Workers, to achieve project goals by helping members better navigate clinical and social service systems to best meet their unique needs. MRNY fully supports the idea of continuing to invest in training and recruitment of the non-clinical workforce, however funding for training programs should also include community based training programs, and not just community college trainings. MRNY believes that many immigrant community members serve as excellent Community Health Workers or other non-clinical workforce roles, yet may not be able to access community colleges. MRNY for example runs an intensive CHW training program, training immigrants to work in the healthcare field and then helps provide them with employment opportunities, often placing them at hospitals, clinics or other CBO's working on projects connected to DSRIP. These non-traditional training programs are often better suited to train individuals to work in these fields.

Additionally, through DSRIP, there have been many innovate CHW projects, such the asthma home visiting work where CBO's hire community health workers who partner with clinical providers to conduct home visits and connect patients to necessary services as described above. These projects should continue and expand as we hopefully move into DSRIP 2.O.

## Social Determinant of Health Networks

1. **Community-based organizations should be able to form lead entities and apply for DSRIP support as Social Determinant of Health Networks.**

MRNY has worked with several PPS's over the past 5 years and has formed strong partnerships through this work. We agree that the state should continue investing in social determinants of health strategies where the PPS's and hospitals form partnerships with CBO's. MRNY supports the idea of creating social determinants of health networks to deliver these services. However, we believe that the State should only permit CBOs or coalitions of CBOs to serve as lead entities of the SDH Networks. CBO's have experience providing these services and working in collaboration with other CBO's. Having CBO's lead these networks is one way to introduce more balance into the relationship between CBOs and larger health systems.

CBOs should be able to create their own networks with their own governance structure and apply for DSRIP funding to develop their network into an equal partner with health care systems. This would be a far more effective way of building a strong social services sector that can handle

health care referrals as opposed to asking MCOs or provider systems to create such a network.

**2. Sustained resources, training and funding for CBO's to participate in the Social Determinants of Health Networks as well as reliable financing structures.**

Additionally, it is essential to ensure that there are resources and trainings for CBOs who will participate in these networks. CBOs have the skills to provide vital services to New Yorkers, services that have enormous effects on health outcomes. But they do not always have the infrastructure or skills that it takes to contract with large health systems or MCOs, or to gather data in a way that shows the value of what they do.

Also, CBO's are not in the same financial situation as hospitals and are not able to take on contracts with downside risk. CBO's need enough reliable funding to run their programs and are unable to do so if they are entering into contracts where there is a requirement to take on downside risk.

Finally, when developing the systems for these networks, it is important to develop the infrastructure for bilateral referrals from CBOs to the health system. Often times CBO's can receive referrals from the health system but are not able to have a direct connection to make referrals back to the health system. Referrals only work if the CBOs have adequate resources, staffing, and funding to handle new referrals. These networks need to be paired with sustainable financing and also mechanisms in place for tracking who can handle a new referral.

Thank you again for considering our comments. Should you have any questions, please do hesitate to contact me at: [redacted]

Sincerely,

Becca Telzak
Director of Health Programs
Make the Road New York

**doh.sm.1115Waivers**

**From:** Marcus Harazin [redacted]
**Sent:** Monday, November 4, 2019 3:54 PM
**To:** doh.sm.1115Waivers
**Cc:** [redacted]
**Subject:** "1115 Public Forum Comment"



The New York StateWide Senior Action Council, Inc. is submitting comments on the 1115 Waiver/ DSRIP 2.0 proposal.

The New York StateWide Senior Action Council is a consumer governed non profit organization with local chapters across New York State. We provide health care and health insurance counselling, patient rights advocacy and Medicare/Medicare fraud prevention programs. Our goal is to assist older persons and their families in remaining independent and in the community.

**New York StateWide Comments on DSRIP 2.0**

**Investment in Strengthening the State's Community Based Organization and Services to Deal with Social Determinants of Health**

The Health system has finally acknowledged the importance of addressing key social barriers to attaining good health and infused the assessment of social determinants of health into the overall strategy for helping assure that patients can complete a desired course of treatment, engage in prevention and healthy lifestyles including obtaining good nutrition, adequate housing, transportation and other social services. These are no longer considered "nice things" to do or "soft services". They are now becoming regarded as critical for long term good health.

Contracting with community based organizations is critical to provide services from a community perspective - not just serving the individual who is on Medicaid. As members of communities, Medicaid recipients form parts of families, schools, groups that have common social determinants of health. By providing services to the entire community (whether all of the members are Medicaid recipients or not), we are preventing further deterioration of general health conditions in underserved areas, as well as preventing people who are on the brink of qualifying for Medicaid from winding up chronic conditions and /or visiting the emergency rooms unnecessarily and eventually winding up on Medicaid.

To grow, modernize, and sustain a good system of community based supports DOH should build upon the investment it has made in developing and supporting regional technical assistance consortiums and the hubs associated with these networks. This should include providing grants to the consortia for the duration of DSRIP 2.0 to assure continuity. These

technical assistance consortiums can continue to assess emergent needs for training and support to CBOs as New York further evolves VBP and other health care reforms. Particular support is needed to help small CBOs address challenges associated with contracting, billing, record keeping, program development, workforce development and service gap filling. Compared to the huge investments of DSRIP resources made for provider based supports that have occurred to date, this is a small request and one that is equally critical.

In addition to investing in the Regional Consortium model, the State should select representatives from each regional consortium to participated in an ongoing Medicaid reform advisory group to assure that the state is obtaining input from CBOs and a culturally diverse population.

**Value Based Payment Framework**

It is important for 2.0 to provide flexibility in contracting with CBOs as it moves to put everything into the VBP basket.

Everything is not a nail and not everything has to be made incredibly complex. Programs that have been developed that show good results should be given an opportunity for continuation and expanded even if they do not fit into the advanced risk sharing VBP models.

It is not even clear that the VBP model is going to work in all instances. Experience in using VBP for Medicare Home Health Care is mixed, especially when providers are serving individuals with chronic conditions that may not improve and where the goal is more to maintain them in the community vs. seeing marked decreases in use of health services. The VBP projects in NYS may run into similar difficulties. Only time will tell.

The current manner of contracting often demands that the community based organization assume the risk in start-up and service provision with no guarantee that the volume of referrals will realistically cover these costs. The contracting method should either: guarantee a minimum number of referrals for the contracted services OR can be an amount agreed upon by the PPS and the CBO to perform general services in the community. Start up costs and billing systems and training for the CBO should be included in the contract.

Flexibility needs to be provided to communities to allow contracts that focus on outcomes and do not shift the potential losses to small CBOs who may be critical to their success.

Allowing focused provider/CBO/MCO teams to implement the high priority DSRIP promising practices sounds like a good idea. The CBO should have a prominent role in the planning, development and implementation of the proposals.

**Value Driving Entities**

It's hard to comment on these new entities since not much information has been provided. However, this approach would give DoH the ability to push rate setting and bill paying down to fewer entities and simplify the state's administrative headaches for budgeting and reporting. However, the risk is that this moves New York State's Medicaid System to a

bigger equals better model and this may also distance health care providers and insurers even further from their communities than they already are. The proposed approach is vests more of the locus of control for program delivery, quality, and oversight to new unproven entities. The process needs to have accountability built in so that Medicaid recipients still have their due process rights protected, so that tax payers know where the funding is going, and so that communities have a say in developing their systems of care.

It is not clear how many of these new structures DoH would like to see in place. It is assumed it would be far less then that existing 25 PPSs. Care should be taken to not implement this in massive regional swathes that will mute specific community needs and input.... 25 may be too many but 3-5 is far too few.

It is critical to bring CBOs into the governance as well as into the initial planning and design process.

Funding should be made available within 2.0 to continue developing more building blocks to foster expanded supply and use of social determinants of health provided in the community . This should include funding for the development of IPAs for CBOs and funding for continued technical assistance through the CBO Consortiums.

**Additional High Priority Need Areas and Performance Measurement**

An additional criteria should be added to the proposal development process for the next phase. In addition to focusing on maternal mortality, children's population health, and long term care DoH should include revisiting the status of care in hotspot areas to see if progress has been made, identify remaining problems and require resources and projects to focus on these areas within each region.

**Long Term Care Reform**

The recommendations from the DOH's "Long Term Care Planning Project" should be infused into the waiver request and applicants should be required to address appropriate recommendations in their applications.

Part of planning process should be to assess indicators selected for projects and identify indicators that are focused on dealing with the needs of older persons and those with disabilities, especially those related to dealing with social determinants of health.

In addition, local projects proposed should include input from the local aging network including the Area Agencies on Aging and NYConnects programs. These stakeholders should also be involved in the implementation aspects of any projects.

More project indicators are needed to address services provided to older Medicaid participants.

Through MRT the state moved rate setting, bill paying, and case management over to Managed Long Term Care entities. The results are mixed* as the indirect costs associated with managed care are high, costs per individual have increased, the quality and quantity of

case management is very uneven, and nothing has been done to increase the supply and retain home care workers.

[*Managed care plans all carry the indirect costs of several layers of administrative duplication (a CEO, CFO, COO, IT Director, Marketing Director, IT System, Fraud system, etc.) none of these expenses are health care services and all are replicated by each managed care organization. It is not surprising that providing care through this system cost Medicaid (and Medicare) more per person than the fee for service system.]

The plan for 2.0 must prepare to deal with these deficits rather than just assuming the managed long term care system will work well with hospitals to coordinate and provide complimentary care so that persons a risk, including nursing home residents and home care consumers, will avoid unnecessary re-admissions or ER usage.

To accomplish this the state waiver should:

**Expand Case management services**- Under MRT local social services moved away from providing much case management for personal care or long term home health care participants, in addition very little adult preventive case management services are provided. Managed Care models are not enough to address the types of case management needed. Their is a gap from when a person on Medicaid enters and leaves a hospital and an MLTC eventually begins to provide case management. During this lag period a person can easily slip into high risk for hospitalization or deteriorate to the point where they cannot stay in a community setting. A bridge is needed to provide support between discharge and the lengthy transition process to MLTC that often takes more than 30 days to establish care.

2.0 should carve out additional resources for NY Connects and EISEP programs to expand the availability of case management services to assist individuals in need of long term care in identifying suitable options for care and linking them to that care in the community. It especially that case management assistance is available during this period to help make appointments and arrange transportation. These case managers can help work early on when the individual is still in the hospital and pending discharge to assess the need for assistance with social determinants of health and then hard link the individuals to appropriate services.

These case managers can also work with certified home health agencies to help maximize the use of available Medicare benefits to provide skilled care , home health care and physical and occupational therapy. More chronically ill elderly and disabled individuals are eligible for such care, even if their functional level is not expected to improve since the Jimmo decision. Models that help identify such individuals should be encouraged.

Even once a person is enrolled in a Managed Care Organization or MLTC there still needs to be a system that provides access to case managers or care coordinator when a patient feels their needs are not being met. The current incentive in managed care is to substitute the lowest costs services possible. This is not always in the best interest of patients. Funding

should also be expanded for the ICAN program to provide Medicaid enrollees with an independent source to follow up on complaints with an MLTC.

**Expand Care Transition Care Management Programs**

Provide funding for other initiatives that can help older or disabled persons develop a good discharge plan and work with the patient and family to link them to needed services. The state should encourage the use of and fund a variety of transitions models ( and provide many options for transitions programs as many home grown initiatives have been successful in addition to various evidence based models). Through New York's current DSRIP waiver some PPSs are already investing on such models. Communities should have the flexibility to place nurses and case managers in senior housing or in community housing where large numbers of low income seniors needing long term care live. They should also be encourage to expand the availability of resident advisors and service coordinators in these settings in order to link residents to available services, monitor their needs and assure that follow up occurs before there is a problem.

Incentives should be provided to expand the use of these tools, along with more Patient Navigators and Community Health Workers to help DSRIP extend the health care supports out to the patient where they live, link them to the services they need in a timely manner, and support them as problems emerge. At-Risk Patients should include persons with multiple chronic conditions.

ADDITIONAL COMMENTS:

**Continued Workforce Flexibility and Investment**

The supply of workers that provide home care will be pivotal in determining the success of New York in moving individuals with long term care needs out of the hospital into the community. The supply of home care workers needs to be factored into the workforce development strategies. These include workers that provide home health aide, housekeeper chore, and homemaker personal care services. Innovative models for supporting workers (higher wages, use of company cars, fringe benefits, and career ladders) should be given extra points in any application process for local or regional projects.

**Coordinated Population Health Improvement (and coordination with MEDICARE)**

The continuation of requirements for PPSs and MCOs to focus on social determinants of health will be critical to sustaining and expanding the growth of these supports in the community.

The State should also work on a parallel track to require MCOs who offer Medicare Advantage Plan products to expand the use of "Special Supplemental Benefits for Chronically Ill" beneficiaries and encourage them to coordinate such services with Medicaid funded services so that consumers have more even care in their communities and avoid perpetuation of initiatives that do not talk to or coordinate with one another.

**Cultural Competency and Diversity**

Continued requirements are needed to assure that this next phase will expand a culturally competent and diverse workforce and health care system. Priority should be given to fund community based initiatives that include providers in hot spot areas that have high densities of limited English speaking residents.

**Housing Supportive Service Initiatives**

State funded housing does not allow rental income to be used to fund service coordinators which have been exceptionally effective in HUD financed housing for seniors. 2.0 should allow state funded housing for low income seniors to pay for service coordinators through the use of DSRIP funding. These individuals can be training in how to help activate patients in the community, provide patient navigation, and link them to community services to address gaps in social determinants of health.

**Peer Support and Peer Mentors and Chronic Disease Management Programs**

The current DSRIP initiative has helped expand the use of these strategies. This is excellent but is extremely limited. Support should also be encouraged for the use of these and other evidence based or informed models such as those that help prevent falls or disease or cope with chronic conditions. Since the waiver will include a focus on long term care addition preventive programs (such as programs that help patients prevent falls, address diabetes, assist persons with low vision or hearing disabilities.) This would be consistent with federal and state prevention plans.

Thank you for the opportunity to submit these comments.

Marcus Harazin
Coordinator Patient Advocates Program
New York StateWide Senior Action Council
[redacted]
www.nysenior.org
Patients Rights Helpline: 800-333-4374

## doh.sm.1115Waivers

**From:** Wyman, Jessica [redacted]
**Sent:** Monday, November 4, 2019 3:59 PM
**To:** doh.sm.1115Waivers
**Cc:** O'Shaughnessy, Patrick M; Ziemann, Wayne D
**Subject:** Catholic Health Services of Long Island DSRIP Amendment Proposal Draft Comments
**Attachments:** CHS DSRIP 2 0 Comments 11-04-19.pdf



To Whom It May Concern:

Attached please find Catholic Health Services of Long Island's comments on the amendment proposal draft released on September 17th, 2019.

Thank you

Jessica Wyman
AVP, Operations
CHS Physician Partners
[redacted]

Catholic Health Services of Long Island
At the heart of health

November 4, 2019

NYS Department of Health
Office of Health Insurance Programs
Waiver Management Unit
99 Washington Avenue, 12th Floor, Suite 1208
Albany, New York 12210

Dear Sirs:

Catholic Health Services of Long Island (CHS) strongly supports the New York State Medicaid Redesign Team's Delivery System Reform Incentive Payment (DSRIP) Program Amendment Request. Below, please find a synopsis of how DSRIP has supported the health system's ability to improve outcomes for patients while containing costs, as well as comments and suggestions for the program moving forward.

Established by the Diocese of Rockville Centre in 1997, CHS is an integrated health care delivery system that includes six hospitals, three skilled nursing facilities, and a home nursing service, hospice, a multiservice community-based agency for persons with special needs and a network of physician practices. CHS employs more than 18,000 people and is Long Island's third largest employer, managing the health of more than 25% of the region's populace. CHS is committed to being the value-based care leader on the Island and is focused on delivering improved outcomes of care through the appropriate services deployed in the right setting at the right price point.

CHS participates in the New York State DSRIP Program through two Preferred Provider Systems (PPSs): the Nassau-Queens PPS (NQP) as a lead hub alongside Nassau University Medical Center and Northwell hubs and the Suffolk Care Collaborative (SCC) as a coalition partner, along with Northwell, under the lead entity, Stony Brook. CHS has undergone a significant population health transformation in the past five years, in large part due to the DSRIP Program. Funding from the DSRIP program and related grants, such as the Capital Restructuring Finance Program, have enabled CHS to invest heavily in population health staffing, processes and technology to support this transition and to support activity to improve patient health outcomes while reducing costs. CHS has invested in care management and analytics platforms and developed a comprehensive transition of care strategy, with a team comprising nurses, social workers, patient navigators and pharmacists. As a result of these investments, CHS has expanded access to outpatient services and improved quality, while reducing inappropriate inpatient utilization.

CHS Physician Partners (CHSPP) is a physician network consisting of more than 450 employed physicians and 1,500 voluntary providers aligned through an Independent Physician Association (IPA). CHSPP participates in the DSRIP Program, managing approximately 125,000 lives, and holds value-based agreements with five managed care organizations across Medicaid, Medicare and commercial lines, covering nearly 135,000 lives. CHSPP is one of the few non-owner Healthfirst Medicaid participants currently managing more than 10,000 lives under downside risk, with more growth to come. CHSPP has also launched Medicaid shared savings contracts with Fidelis and Empire BlueCross BlueShield HealthPlus. Additionally, CHS participates in the Pathways to Success Medicare Shared Savings Program, covering more than 35,000 lives, and is negotiating the first commercial contract with Empire BlueCross BlueShield to take on downside risk for more than 35,000 commercial lives.

Through the 15 unique DSRIP projects that CHS has participated in via its two PPSs, DSRIP has stimulated a fundamental transformation in CHS's care delivery system. Screening, Brief Intervention and Referral to Treatment (SBIRT) is now a standard screening tool across all six CHS hospitals' emergency departments and most of the inpatient units. The Transitions of Care team embeds social workers in high-need medical group primary care practices. CHSPP actively facilitates and financially supports private behavioral health organizations to embed staff in private physician practices. Patient Health Questionnaires (PHQs) have been built into the practices' electronic health record (EHR) clinical workflows. CHSPP has invested in dozens of employed and IPA primary care practices to become Patient-Centered Medical Home (PCMH)-certified. Mercy Medical Center, CHS's Nassau County safety net hospital, established a primary care practice adjacent to its Emergency Department to reduce unnecessary utilization, as well as to connect the proximate underserved population to a primary care physician, again expanding access to care.

Finally, CHS's participation in DSRIP has facilitated and strengthened numerous partnerships across the continuum of care, across numerous geographies. CHS has collaborated closely with St. John's Episcopal Hospital and its IPA in the Queens County Rockaways to implement NQP projects. The CHS hubs have formed close working relationships with numerous behavioral health organizations in Queens, Nassau and Suffolk counties, as well as nursing homes and community-based organizations that provide services aligned with social determinants and, of course, primary care providers.

Although a number of infrastructure and patient care initiatives have been launched toward supporting population health and value-based payment arrangements, population health management capabilities are not yet mature at CHS. Without continued government-sponsored investments and opportunities such as the DSRIP extension, there is a serious risk that organizations beginning the transition to value-based care without the time to mature into a financially viable model will abandon efforts to date. CHS is at such a vulnerable point in its transition and still requires incentives to operate in a value-based environment.

The recommendations below reflect CHS's perspective on components from the current DSRIP structure.

SUGGESTIONS ON COMPONENTS TO KEEP:

- The current DSRIP program incentivizes collaboration among competitors. The downstate region is dense, and many patients seek care across providers. Collaborative, global strategy, combined with local implementation, drives better experience and outcomes for patients. **CHS encourages the extension to keep incentives that align geographic coverage of services of essential DSRIP priority areas, such as one VDE per county equaling valuation for all Medicaid recipients in that county.**

- CHS would like **attribution to remain with the primary care providers in order to align with the standard value-based managed care contracting structure.** Having different attribution algorithms for the same covered population would be confusing. There are alternative gain-sharing mechanisms available to align other provider types with common goals.

SUGGESTIONS ON COMPONENTS TO DISCARD:

- In many ways, CHS has found value in the NQP and SCC Hub models and **would want to continue with this basic infrastructure. However, the organization believes it would be a detriment to offer incentives encouraging public hospitals to hold a lead position in a VDE.** In the current program, Project 11 served this function. While public hospitals are vital to the success of serving the Medicaid population and CHS is committed to working with them as partners, experience has shown that assigning lead positions to public hospitals that have not invested in the appropriate population health infrastructure severely hinders progress toward value-based care.

- As noted in the extension draft, we have worked to align quality measures across initiatives. CHS supports continuation of this work. **Additional unique, self-reported metrics, such as the Actively Engaged metrics, have proven to be extremely time-consuming and not proportionally incentivized. Placing more emphasis on fewer, widely used outcome measures will allow better focus for the providers and administrators of the program.**

QUESTIONS/SUGGESTIONS:

- The extension draft requests a start date of April 1, 2020. At that point in time, the current DSRIP PPS infrastructure will still largely be in place and more specific guidance on qualifications for participation, as well as the incentive structure details, will have only just become available, if at all**. How will the State distribute funds during the first year, while providers and partners reorganize under the VDE construct? Even a funding lag in 2020 could jeopardize the transition to value-based program participation**.

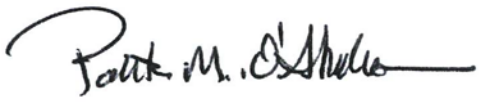
- Encouraging MCO participation in the governance of the VDEs appears to be a good way to further engage the payors in collaborating on and developing value-based contracts. **However, contracting entities typically contract with a myriad of payors. Will multiple payors be allowed or expected to participate in the governance of the VDEs? Will the payors have the bandwidth to do so?**

- Workforce is prominently featured in the amendment request draft. It is also prominently featured in the current DSRIP Program. At the onset of the program, Workforce guidance was unclear and processes were required that did not reflect anticipated analytics (for example, the IMPACT reports are based on gross FTE additions, not net changes). **CHS strongly encourages that the Workforce component of the extension amendment have clear goals and clear incentives that align with those goals, as well as specific guidance on how to obtain the incentives.**

- **If the extension is granted, CHS recommends a state-wide analytics collaboration to help the VDEs better analyze program effectiveness**. NYU has done some innovative but resource-intensive work around relating results to efforts. To identify best practices, these types of on-the-ground analyses are required.

**To reiterate, Catholic Health Services of Long Island strongly supports New York State's proposal for a four-year waiver amendment. Because of DSRIP, CHS has begun the care delivery transformation not only for the hundreds of thousands of Medicaid recipients in its service area but also for millions of Medicare and commercial patients.** We appreciate the opportunity to submit comments and suggestions highlighting successes and challenges of the past in order to strengthen the program moving forward.

Sincerely,



Alan D. Guerci, MD
President and Chief Executive Officer

Patrick M. O'Shaughnessy, DO, MBA, MS-POPH, FACEP
Executive Vice President, Chief Clinical Officer

## doh.sm.1115Waivers

**From:** Tanner, Melanie [redacted]
**Sent:** Monday, November 4, 2019 3:59 PM
**To:** doh.sm.1115Waivers [redacted]
**Cc:** [redacted]
**Subject:** 1115 Public Forum Comment
**Attachments:** DSRIP Ltr.pdf



On behalf of Director AnnMarie Maglione, Orange County Office for the Aging, attached is her letter supporting the DSRIP renewal proposed by NYS Department of Health.

Melanie Tanner
Orange County Office for the Aging
40 Matthews Street, Suite 305
Goshen, NY 10924
[redacted]

# OFFICE FOR THE AGING

Steven M. Neuhaus
*County Executive*

AnnMarie Maglione
*Director*

November 4, 2019

Paul Francis
Deputy Secretary for Health
State Capitol
Albany, NY 12224

Donna Frescatore, Medicaid Director
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Dear Mr. Francis and Ms. Frescatore,

On behalf of Orange County Office for the Aging, I am writing to express my recommendations on the DSRIP renewal proposed by New York State Department of Health. The services we provide directly impact inappropriate emergency department visits and reduce avoidable readmissions. The NY Connects program, implemented in 2006, serves as no wrong door for any and all services available in the region, and is a catalyst for individuals in need of assistance. The targeted goals in the proposed renewal are exactly what this network provides and must include mandated contracting by each PPS with their local Area Agency on Aging for social determinants of health initiatives. Our office is the trusted service provider for the fastest growing segment of the population, and the highest utilizer of health care dollars. Our services **absolutely** allow individuals to remain in their own homes and communities, all while saving health care expenditures. We provide the highest level evidenced based interventions and are experts at navigating a complex health care system, while providing person centered planning and care.

To demonstrate the value of the network, I would like to highlight a case that is typical to our office.

> AM* was referred through NY Connects from a non-profit agency in March 2009 seeking in-home assistance. Client had a history of depression and arthritis, as well as several emergency room and hospital visits. Client's spouse had died and had no

*- due to confidentially issues- client is AM

other family close by. Client was assessed and started receiving housekeeping services and case management. Over the years AM developed heart disease while the mental health issues worsened. AM remained at home with increasing hours of PCA services. PCA1 increased to PCA2 (20 hrs./week), client paid privately for weekend hours. Home Delivered Meals were started, and AM received a PERS unit. AM celebrated her 100th birthday at home, were she happily wants to be. Client also benefited from OFA's adopt a pet program, AM adopted a cat which addresses loneliness and isolation. The program pays for vet and food expenses. AM was at risk of nursing home placement. For the past 10 years, she has been able to remain living independently at home, where she wants to be. This would not be possible without the programs and services of OFA. The cost savings are great, while there is no price one can put on quality of life.

This is one of many cases that truly displays the boots on the ground service provision in every county across the state. In the renewal waiver, I cannot stress highly enough that we need to harness the existing strengths of community-based services, instead of recreating case management services and duplication of services. Each case manager in the entire statewide aging network has received certification via Boston University School of Social Work, ensuring consistency in assessment not provided by any other system. I ask that there are mandates for each PPS to engage and contract with their local Offices for the Aging, for the services vital to keeping individuals in home and community-based settings.

Thank you.

Sincerely,

AnnMarie Maglione
Director

**40 Matthew St., Goshen, New York 10924 Tel: (845) 615-3700 Fax: (845) 346-1191**

www.orangecountygov.com **E-Mail:** OFA@orangecountygov.com

## doh.sm.1115Waivers

**From:** Ashley Restaino [redacted]
**Sent:** Monday, November 4, 2019 3:59 PM
**To:** doh.sm.1115Waivers
**Subject:** Waiver Comment Submission
**Attachments:** SI PPS Waiver Comments_11-4-2019.docx



Good afternoon,

Please accept the attached written comment from the Staten Island PPS on behalf of Joseph Conte, Executive Director. Thank you.

**Ashley Restaino, MPH**
*Managing Director, Strategic Initiatives & Operations*
Staten Island Performing Provider System
1 Edgewater Plaza, Suite 700, Staten Island, NY 10305
[redacted]

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**Staten Island Performing Provider System**

**DSRIP Waiver Amendment Public Comment**

Staten Island PPS wishes to submit a comment during the public comment period for the DSRIP waiver amendment related to Medicaid member attribution for performance. The attribution methodology utilized in DSRIP 1.0 was a complete failure, it makes no sense to any clinical network providing services which is the core of population health.

The attribution methodology that was utilized during DSRIP 1.0 was abandoned reportedly due to health home billing irregularities. This as we painfully know resulted in major re-attribution and performance recalculations harming community partners and programs. It is something that must be completely changed for a 2.0. to ensure more equitable and sensible distribution and allocation of funds based on performance.

From the beginning of DSRIP many PPSs have commented on the complexity and lack of comprehension around the current attribution algorithm. An algorithm based on swim lanes, health home and care management agency billing, mutual performance networks and tie breakers make it hard for PPSs and clinical partners to understand the population of members they must manage to close gaps in care. The current logic resides in the "black box" of back end data managed by DOH and is not transparently available to each PPS to analyze and understand.

Many PPSs share communities, health systems and clinical partners which perpetuated the creation of a complex attribution algorithm. However, PPSs with mutual health systems and clinical partners in their performance networks should both earn or lose performance funds for mutual performance gains or losses. In the spirit of DSRIP, PPSs with shared populations should be collaborating on ways of improving the continuity of care across systems not in a win/lose model that the current attribution logic created and perpetuated after the old model was abandoned and a new and even more complicated approach was implemented.

Attribution in a next phase should be initiated by PPSs and providers. One such example might be for PPSs should have the ability to submit a roster of providers that wish to participate in DSRIP, with DOH requirements for including a certain percentage of different provider types only. Providers could then submit their current roster of Medicaid members to be validated and reconciled by DOH to ensure eligible and active members. With each performance cycle, DOH should base updated attribution based actual visits to a provider in an existing PPS network, not on a member's PCPs according to their MCO. A risk adjustment methodology like 3M or Milliman could be utilized to account for cherry picking or other efforts to reduce complex patients. In fact, selecting high utilizers should be rewarded in 2.0 this is where the improvement is required.

A broad representation of PPS information officers and executives should be included in the process for modifying and approving a future member attribution algorithm for performance.

**doh.sm.1115Waivers**

**From:** Barbara Crosier [redacted]
**Sent:** Monday, November 4, 2019 4:09 PM
**To:** doh.sm.1115Waivers
**Cc:** [redacted]
**Subject:** CP of NYS Comments on Proposed NYS MRT DSRIP Amendment Request
**Attachments:** CP Comments - DSRIP 2.docx



On behalf of the Cerebral Palsy Associations of New York State and our 24 Affiliates supporting people with disabilities in communities across New York State, attached are comments on the proposed New York State Medicaid Redesign Team (MRT) Delivery System Reform Incentive Payment (DSRIP) Amendment Request (9/17/19). We thank you for this opportunity to provide comments.

If you need further information, please contact Michael Alvaro or Barbara Crosier.

Thank you.

**Mike Alvaro**
**Executive Director**
**Cerebral Palsy Associations of NYS**
3 Cedar Street Extension, Suite 2
Cohoes, NY 12047
[redacted]
www.cpstate.org

*Barbara Crosier*
Vice President, Government Relations
Cerebral Palsy Associations of NYS
3 Cedar Street Extension, Suite 2
Cohoes, NY 12047
[redacted]
Please note that our emails have changed.
Please update your contact for me. Thank you!

Cerebral Palsy Associations of New York State
*Real people. Realizing potential.*

On behalf of the Cerebral Palsy Associations of New York State and our 24 Affiliates supporting people with disabilities in communities across New York State, we thank you for this opportunity to provide comments on the proposed New York State Medicaid Redesign Team (MRT) Delivery System Reform Incentive Payment (DSRIP) Amendment Request (9/17/19).

We strongly support funding and extension of DSRIP for three years as outlined: "$5 billion DSRIP performance; $1 billion Workforce Development; $1.5 billion Social Determinants of Health; and $500 million Interim Access Assurance Fund. As with the original MRT waiver, NYS seeks continuation of DSRIP for the 1-year balance of the 1115 waiver ending on March 31, 2021 and conceptual agreement to an additional 3 years from April 2021 to March 31, 2024."

However, while the funding amounts will offer significant opportunity for NYS to make headway to achieving DSRIP goals, we believe the construct of DSRIP and the plans for phase two need to go beyond the modifications suggested in the proposal. For example, incorporating managed care entities in the collaborations that will be encouraged make good sense, yet there are no explicit assurances or requirements that whole sectors of the population driving much of the areas to be addressed will be included in the collaboratives that evolve. People with developmental and other significant disabilities and the agencies that support them were not prioritized in the first round of DSRIP. Various PPS initiatives included system supports and services for people with intellectual and developmental disabilities, but the amount of Medicaid funding for this high-need, high cost population has not been proportionately reflected in DSRIP activities across the state. Incentives, preferably requirements, must be strong enough to ensure value driven entities (VDE) include I/DD providers.

**Why should I/DD be recognized?**

Within the I/DD system, there are a significant number of people who access multiple aspects of the health service system; they are high users of the system due to their medical complexity not because they are over-using services. Specialty services, mental health services, and other supports are not well integrated, leaving people with disabilities and their families struggling to efficiently access and use the systems available to them. High need demands higher costs, but doesn't necessarily warrant the



CP of NYS | 3 Cedar Street Extension, Suite 2, Cohoes, NY 12047 | (518) 436-0178 | www.cpstate.org

highest cost option for accessing the system – unfortunately the highest cost option is often the one that is left when our traditional primary care, mental health, and specialty providers are ill-prepared from a training and/or physical plant perspective to treat people with intellectual and developmental disabilities.

It should also be noted that a large part of the reason NYS can claim cost savings at the federal level is directly related to cuts in the I/DD system. The I/DD system of providers through the cuts made to the system 10 years ago, and through the lack of a trend over that same period have reduced New York State's Medicaid spend on I/DD services. In fact, if you take the original cut of $260 million annualized for 10 years ($2.6 billion) and combine it with the lack of a trend on provider payments conservatively estimated at 2% compounded over 10 years ($5.5 billion), New York State I/DD providers have already saved the federal government over $4 billion. If half that savings were to be invested in the I/DD community to achieve DSRIP goals, then justifiably $2 billion in I/DD DSRIP spending is warranted. We recommend that a significant targeted component of the State's $8 billion be invested in the sector of the Medicaid spend which generated a significant savings to help make the argument that DSRIP should be continued.

**A Value Based/Social Determinants of Health System**

DSRIP in the years 2020 – 2024 must wholly integrate people with disabilities, who, according to the Centers for Disease Control and Prevention are twice as likely not to receive medical care due to costs as the general population, as part of the State's response of health equity and system measures for all populations served. DSRIP activities must address current shortfalls in the New York State health system's ability to meet the needs of people with developmental and other significant chronic disabilities, e.g., traumatic brain injuries, who do not have access to health and social service supports needed for positive health outcomes. People across New York State and throughout the world living with disabilities are under-served: "People with disabilities have less access to health care services and therefore experience unmet health care needs." (World Health Organization, January 2018)

In addition, we looked to Healthy People 2020 who uses the "World Health Organization's (WHO) model of social determinants of health, which recognize that what defines individuals with disabilities, their abilities, and their health outcomes more often depends on their community, including social and environmental circumstances. To be healthy, all individuals with or without disabilities must have opportunities to take part in meaningful daily activities that add to their growth, development, fulfillment, and community contribution." It is significant to focus on the Healthy People 2020 report

which found that for social determinants of health, people with disabilities not only require support to attain improvements in the social determinants of health, they also are a significantly under-served sector of our community. Research shows that people with "physical disabilities or cognitive limitations had significantly higher prevalence rates for 7 chronic diseases than persons with no disabilities [and they] were also significantly less likely than the no disability group to receive 3 types of preventive care. [Moreover], adults with disabilities and chronic conditions receive significantly fewer preventive services and have poorer health status than individuals without disabilities who have the same health conditions. This indicates a need for public health interventions that address the unique characteristics of adults with disabilities, many of whom are at risk for high cost, debilitating conditions that may not have as severe an effect on other population segments."

Additional facts about people with disabilities:

- 19 percent of people with disabilities reported that they did not receive medical care needed in the previous year, compared to 6% of nondisabled persons.
- Those who did not receive treatment attributed the failure to reasons that included a lack of insurance coverage (35%), high costs (31%), problems getting to provider offices or clinics and inadequate transportation (11%), and difficulties or disagreements with doctors (8%).
- Among women with physical disabilities, nearly 1/3 report being denied services at a doctor's office solely because of their disabilities, and 56% of women with disabilities who have given birth in hospitals reported that the hospital had failed to prepare for needed disability-specific accommodations.
- Children with DD were more likely than typically developing children to have a fair or poor health status (27.7% vs. 1.1%), have two or more overnight hospitalizations (8.5% vs. 0.7%;), experience delayed treatment (10.1% vs. 2.4%;), and have one or more unmet healthcare needs (19.6% vs. 5.7%).
- The Kaiser Family Foundation reports that New York's 2017 data demonstrates that 1 in every 2 people with disabilities are covered by Medicaid; the rest are dependent on private insurance or have no coverage at all.

People with disabilities face a number of disparities and poorer outcomes compared to non-disabled peers due to an "increased risk of exposure to socio-economic disadvantage." People with disabilities are more likely to live in poverty, face social

isolation, and have trouble finding affordable accessible housing . . .[disability] also impacts people with disabilities' health and outcomes."

Within each of the key domains in the social determinants of health, compared to individuals without disabilities, individuals with disabilities are more likely to experience challenges finding a job, being included in regular educational classrooms or attending college, receiving preventive health care services, being able to visit homes in the neighborhood, using fitness facilities, using health information technology, and obtaining sufficient social-emotional support. The I/DD system is grounded in a broader health context and as such, the State's I/DD providers should have a dedicated amount of DSRIP funding set aside to enhance and ensure the social determinants of health are measured and included in the State's efforts in the next round of DSRIP.

DSRIP must address the inequities confronting the high needs group of people with disabilities. If as a system we are to move to a more integrated, community of supports for people with disabilities, the regulatory and financial infrastructure needs to support and align with those goals. Ensuring quality outcomes and incentivize performance, efficiency and innovation with greater equity of access to supports and services need to be fundamental to all aspects of the waiver program; the current construct and the waiver as proposed in this renewal has resulted in outcomes and a reality for families and service recipients that fails to meet the needs for the I/DD population to be more centrally integrated in achieving DSRIP goals.

That said, there have been some successes when PPS's have focused on the I/DD community's inclusion in their projects. For example, in the Staten Island PPS, the disability CBO component was recognized in a pilot program to reduce ER utilization through a triage program in a medically fragile residence. The two homes initially studied found a higher than 75% decrease in ER visits; when the program was expanded to more than 100 homes, that same level of decreased utilization of ER visits was maintained. The program worked and the results are replicable. The disability community is working to further expand those results, but the disability provider system has not had the investment in all parts of the state to address these and other high utilization practices.

This experience shows that when made a priority, I/DD providers can deliver in meeting NYS DSRIP goals. This is why we recommend that I/DD should be among the high priority areas for phase II and there be added aligned incentives/requirements to ensure disability providers are able to maximize the returns for the State. DSRIP performance funds need to be aligned with establishing value-based metrics for the I/DD field and

VDE's need to work with MCOs expected to support the I/DD community. Interim Access Assurance funds also should have a set-aside for disability providers who have an expertise that is not found in the general community and without those providers, only high cost, inefficient options remain. For example, when dental services are no longer accessible for the developmentally disabled population in any part of the State, we know that demand for expensive operatory time for dental procedures increases 6-9 months after because there are no other dental practices able or willing to support people with I/DD. Similarly, when providers are forced to end their services in mental health services, primary care, etc., for people with I/DD, the overall system costs increase many times. Specialty care for people with I/DD is cost effective when access points are maintained.

The I/DD funding in New York State has assisted the entire Medicaid program demonstrate to the federal government that savings had been taken from the system. As the I/DD field moves to managed care, there are less assurances that providers will be maintained in all geographic regions of the State. The DSRIP model focused on I/DD will help raise system awareness of the need to access and integration with other providers.

Thank you for the opportunity to comment on the proposed DSRIP Waiver Amendment; please let us know if you have any questions or would further clarification of our comments.

## doh.sm.1115Waivers

**From:** Kathy Febraio [redacted]
**Sent:** Monday, November 4, 2019 4:10 PM
**To:** doh.sm.1115Waivers
**Cc:** [redacted]
**Subject:** 1115 Public Forum Comment
**Attachments:** FINAL DSRIP 2.0 Comments.pdf



Please find attached HCP's comments.
Thank you.

**Kathy Febraio, CAE**
President/CEO
**New York State Association of Healthcare Providers, Inc.**
[redacted]

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**From:** Patrick Kwan [redacted]
**Sent:** Monday, November 4, 2019 4:15 PM
**To:** doh.sm.1115Waivers
**Cc:** Louise Cohen; Sasha Albohm
**Subject:** 1115 Public Forum Comment - Primary Care Development Corporation (PCDC)
**Attachments:** Primary Care Development Corporation - 1115 Waiver Amendment Request Comment.pdf



Hello,

Please find Primary Care Development Corporation (PCDC)'s comments attached in PDF. Thank you.

Warmly,

**Patrick Kwan**
**Senior Director of Advocacy and Communications**
Primary Care Development Corporation
45 Broadway, 5th Floor
New York, NY 10006
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PRIMARY CARE DEVELOPMENT CORPORATION
*Catalyzing Excellence in Primary Care*

*The Primary Care Development Corporation (PCDC) is a nationally recognized nonprofit organization and a U.S. Treasury-certified community development financial institution (CDFI) that catalyzes excellence in primary care through strategic community investment, capacity building, and policy initiatives to achieve health equity. Learn more about PCDC's programs to expand and transform the primary care sector at pcdc.org.*

**Primary Care Development Corporation (PCDC) Comment on**
**New York´s Medicaid Redesign Team 1115 Waiver Amendment Request**
**November 4, 2019**

Thank you for the opportunity to comment on New York's request approval from the Centers for Medicare and Medicaid Services (CMS) for a four (4) year Medicaid 1115 waiver amendment ("the waiver") to further support quality improvements and cost savings through the Delivery System Reform Incentive Payment (DSRIP) program.

**The Primary Care Development Corporation (PCDC) is a nonprofit organization and Community Development Financial Institution dedicated to building equity and excellence in primary care.** We provide capital financing and capacity building services throughout New York State and across the country. Our mission is to create healthier and more equitable communities by building, expanding, and strengthening the national primary care infrastructure.

Since our founding in 1993, PCDC has worked with over 600 health care sites across New York, including seven DSRIP Performing Provider Systems (PPS) in all corners of the State. Nationally, we have improved primary care access by leveraging more than $1.1 billion to finance over 130 primary care projects. Our strategic community investments have built the capacity to provide 3.8 million medical visits annually, created or preserved more than 13,000 jobs in low-income communities, and transformed 1.8 million square feet of space into fully functioning primary care practices. Through our capacity building programs, PCDC has trained and coached more than 9,000 health workers to deliver superior patient-centered care. We have also assisted nearly 550 primary care practices — encompassing some 2,250 providers — to achieve PCMH recognition, impacting care for more than 5 million patients nationwide. All told, PCDC's work has impacted 40.2 million patients in 44 states.

The purpose of a Medicaid 1115 waiver is to broadly allow state innovation within the Medicaid program. PCDC supports New York State's efforts to transform the health care system and particularly, the Medicaid program's use of the 1115 Waiver to strengthen community health, improve clinical outcomes, and reduce cost. The current waiver created a structure that was intended to improve outcomes through organization into PPS. These were meant to better manage the care of individuals through patient-centered medical homes, care coordination, and other primary care centered initiatives.

Despite the success of the last four years in reducing potentially preventable hospitalizations and readmissions, these newly designed entities were built around hospitals and for very specific programmatic initiatives, rather than building a robust primary care system. There was little incentive to direct funds to primary care or ambulatory behavioral health providers. Less than 10% overall of DSRIP funding went to primary care, behavioral health or community based social service organizations, despite the fact that these organizations provide direct services to patients and have the greatest ability to provide interventions that would reduce expensive tertiary or quaternary care.

**We strongly endorse the strategy that the next waiver amendment should be fundamentally focused on strengthening the primary care system to achieve the goals that we all share.** The evidence is clear that a focus on primary care will lead to lower costs and better outcomes. Increasing family physician comprehensiveness of care, especially as measured by claims measures, is associated with decreasing Medicare costs and

hospitalizations. And payment and practice policies that enhance primary care comprehensiveness will help "bend the cost curve." Additionally, increased primary care physician supply is associated with improved health outcomes, including all-cause, cancer, heart disease, stroke, and infant mortality; low birth weight; life expectancy; and self-rated health.

Yet, estimates are that primary care – inclusive of reimbursement and value-based payments – only receives about 5-8% of total health care spending. PCDC's research has identified significant correlations – between primary care access and overall health status; higher poverty rates and worse health outcomes; and rural counties and a lack of primary care access – based on defined measures of access and need. The State's own Medicaid data show a decreasing utilization of primary care.

Reorganizing the NYS Medicaid payment system through another 1115 waiver would allow New York to see the benefits of a system that appropriately values and reimburses for the vital services these practitioners provide. And while it is clearly necessary to invest in our primary care workforce, we have also seen that it is simply not happening. A recent RAND study indicated that only 3% of Medicare spending is on primary care. This number is neither specific nor definitive because Medicare has no definition of primary care and does not require reporting on its spending allocation. However, whether it is 3% or 5%, it is simply drastically low compared to the potential of primary care, manage the whole health of an individual and ultimately reduce cost within the system.

Under the previous waiver, PCDC advocated for the creation of primary care plans by each PPS. While these were completed by all, they were neither actionable plans nor were they standardized to allow for tracking of activity in a meaningful way. In any new waiver, requiring a community-level primary care focus, requiring all waiver-supported entities to plan, fund, and measure primary care activities from the beginning would provide valuable information as well as a measure of the effectiveness of the primary care strategy that could be used for future reforms. Requiring reporting, specifically in a standardized form that would allow for analysis by to the State as well as independent researchers on these measures, would instill accountability into the system.

In reading the waiver amendment request, we are heartened to see the continued discussion about the importance of primary care and the understanding that often, the most appropriate care is not hospital-based. The focus on inclusion of primary care, behavioral health, and community-based organizations in any newly created or existing entities is particularly important.

**PCDC urges that the New York State's proposed waiver amendment must include three key concepts in the application to create a primary care-focused Medicaid program.**

**First, funds must flow directly to primary care practices**. Trickle-down reimbursement rarely makes it to the target. If New York is serious about structuring the Medicaid program around primary care, waiver funding should go to primary care provider organizations either directly or through existing reimbursement channels, such as managed care organizations (MCO).

Additionally, the share of spending overall on primary care must substantially and meaningfully increase, which will, in turn, reduce the total cost of care as well as improve outcomes. Other states, such as Oregon, Delaware, and Rhode Island have already undergone such transformation efforts. Effective primary care payment supports more than just traditional primary care; it covers integrated behavioral and public health, care coordination, and related social determinants of health. This supports a shift towards team-based, community-oriented care.

There also must be sustained investment in existing incentive programs, such as the patient-centered medical home, to ensure that primary care providers can maintain their operational transformation, especially given the extensive New York State investment in this model of care.

Contracts, whether VBP, fee-for-service, incentive payments or a combination of all three, should cover not only the cost of providing direct care, but also care coordination and care management, data exchange, case-conferencing, and other population health activities. Research has shown that primary care spends a disproportionate amount of time on administrative tasks, including redundant or overlapping reporting requirements. Primary care physicians spend an average of 19.1 hours a week on reporting – nearly double that of their specialist colleagues – costing practices upward of $50,000 a year.

**Second, rather than just reiterating the importance of integration of primary care and behavioral health, we should find ways to appropriately attribute patients to the providers who manage their care.** This means that for many patients who have serious mental illness and primary addiction diagnoses, they should be attributed to the behavioral health organizations (BHO) where they are receiving care. These organizations would, in turn, would become responsible for connecting people to primary care and for primary care outcomes through a variety of funding mechanisms, such as Certified Community Behavioral Health Clinics, that could be funded at the State level to improve primary care access and quality for this vulnerable population. Though many of these organizations may be unable to individually take risk, it is the VDE or the MCO who should support their capacity to do so over the life of the waiver (rather than assuming this will take place at the very beginning of the process.)

While substantial reporting costs and administrative burdens have affected all practices, the problem is particularly acute for organizations providing integrated care. As part of many grant projects, demonstration studies, and insurance reimbursement structures, providers are required to document and report patient- and population-level outcomes and metrics to a multiplicity of funding agencies and organizations. In New York, a health center participating in PCMH, receiving a SAMHSA PBHCI grant, seeing Medicaid-insured patients contracted with several different MCOs as part of DSRIP PPS, and engaged in Health Homes, may be required to track and report unique metrics at different frequencies via distinct systems for each program in which they participate. In a review of the practices that PCDC supported to become PCMH-recognized, the practices had an average of **16** separate contracts.

PCDC applauds the efforts that state agencies have made in recent years to consider new regulations intended to ease reporting and operational requirements for integrated and co-located facilities, including the DSRIP integrated care license. In our recent report, *Closing the Behavioral Health Integration Gap: A New York Case Study (2019),* we still found several barriers in the state process including limited uptake of the DSRIP integrated care license, utilization thresholds that do not meet the needs of larger health centers and practices, and service/billing limitations as well as administrative requirements that are not feasible for many health centers and providers to navigate.

The new 1115 waiver must acknowledge the multiple, and at times burdensome, reporting and operational requirements that may already exist and be required by numerous funding and regulatory bodies, and work to reduce that burden by 1) aligning metrics and 2) consider a reporting system that enables NYS Medicaid practices to report one set of metrics for all NYS Medicaid programs including to any associated VDE or MCO.

**Finally, a primary-care centered Medicaid system should create and promote geographic systems of care to maximize efforts to improve population health.** Overlap of patients and provider networks does not allow for appropriate population health management. Many practices PCDC has worked with over the last four years are in multiple PPS, with additional requirements from value-based contracts with insurers and have found it difficult to effect meaningful change at the population level. The Staten Island PPS has been held up as a success case; one reason is that it is the only PPS in its geography and therefore they are able to most effectively bring together all the community stakeholders, use data at the population level to inform strategic investments, and maximize resources to support transformation goals. Other states have made this decision and funnel all Medicaid programs (reimbursement, incentive payments, health homes, etc.) into one lead provider in a region with the responsibility to contract out the funding appropriately and is accountable for population health and cost outcomes.

Besides, other challenges and opportunities remain which could also be addressed in a waiver extension. The supply of primary care providers, especially in more rural areas of the state, is a continued struggle. An 1115 extension should include strategies to ensure a sufficient pipeline of providers at all practice levels across the state. There must also be a continued focus on increasing access to capital financing for investment in facilities that appropriately support primary care and are focused on the integration of other services into the primary care setting.

Primary care is the foundation of the health care system and a cornerstone of healthy, thriving communities. Without a strengthened focus on primary care in New York's 1115 waiver amendment, we cannot make progress in managing the care, reducing cost, and improving the health of all New Yorkers.

**Contact:**

**Primary Care Development Corporation (PCDC)**
**Patrick Kwan, Senior Director of Advocacy and Communications**
[redacted]

**Sasha Albohm, Director of Federal Affairs**
[redacted]

## doh.sm.1115Waivers

**From:** Carolyn Wember [redacted]
**Sent:** Monday, November 4, 2019 4:15 PM
**To:** doh.sm.1115Waivers
**Subject:** Comment on the 1115 Waiver



My name is Carolyn Wember. I'm an attorney, as well as the parent of a severely disabled 29-year old daughter. I am a member of the Advocacy Committee of the NY Self Determination Coalition. I'm also a founding member of "SDNYC," which is an association of family members in New York City, whose children use OPWDD Self Direction.

My daughter receives HCBS waiver services from the Office for People with Developmental Disabilities (OPWDD). In particular, my daughter receives her OPWDD services through the Self Direction program. My daughter is not a suitable candidate for the more "traditional" services offered by OPWDD; but rather, has been successfully living in the community, with Self Direction services, for the past 6 or 7 years.

I am submitting this comment in support of the extensive comments submitted by Dr. James Edmondson of Queens, NY. I am in 100% agreement with Dr. Edmondson's comments. OPWDD services must remain in the fee-for-service system. OPWDD HCBS services are fundamentally incompatible with Managed Care. NYS should abandon its misguided attempt to force OPWDD services into Managed Care. As Dr. Edmondson so eloquently states, any such attempt is doomed to failure and incalculable harm to some of New York's most vulnerable citizens.

Carolyn Wember
[redacted]

**doh.sm.1115Waivers**

**From:** Johnson, Tim [redacted]
**Sent:** Monday, November 4, 2019 4:14 PM
**To:** doh.sm.1115Waivers
**Subject:** DSRIP Comment Letter
**Attachments:** GNYHA Comment Letter on DSRIP Amendment Request.pdf



Please see attached comment letter from Greater New York Hospital Association regarding New York State's Delivery System Reform Incentive Payment (DSRIP) Program Amendment Request.

Tim Johnson
Senior Vice President
Greater New York Hospital Association
[redacted]

GREATER NEW YORK HOSPITAL ASSOCIATION
555 WEST 57TH STREET, NEW YORK, NY 10019 • T (212) 246-7100 • F (212) 262-6350 • WWW.GNYHA.ORG • PRESIDENT, KENNETH E. RASKE

November
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Donna Frescatore
Medicaid Director
Office of Health Insurance Programs
New York State Department of Health

Dear Ms. Frescatore:

Greater New York Hospital Association (GNYHA) appreciates the opportunity to provide these comments regarding the New York State Department of Health's (DOH's) *Delivery System Reform Incentive Payment (DSRIP) Amendment Request* proposal.

GNYHA is supportive of the State seeking $8 billion in funding over a four-year period to continue supporting the successes of DSRIP. GNYHA is grateful for DOH's commitment to the DSRIP performing provider systems (PPS), their partners, and the communities they serve. The PPSs and their partner organizations have put a tremendous amount of effort into achieving all the successes of the current program. In addition to supporting PPSs in their efforts to manage DSRIP payments to maximize revenue and assist New York State with achieving its own statewide performance targets, GNYHA has worked with PPSs and their partners to promote best practices so these organizations can achieve long-term success. We appreciate that DOH wants to build on DSRIP's current successes for the benefit of the Medicaid population in particular. GNYHA agrees with DOH that managed care organizations (MCOs) have not been sufficiently integrated within the DSRIP structure. We also support the idea of further integrating community-based organizations (CBOs) into DSRIP activities, as they continue to play a key role in achieving DSRIP successes and providing valuable services to PPSs.

**DSRIP Extension Overall Goals**
Assuming the DSRIP extension is successfully secured, GNYHA recommends that the State work with key stakeholders in the community to develop potential options for operationalizing the program post-March 2021. We believe that the identification of these options should take into account Federal policy and program goals under different scenarios and political outcomes. GNYHA would be pleased to work with New York State officials to develop these options for Medicaid waiver funding, should this course be pursued.

GNYHA believes that such a discussion should mainly focus on the efficacy and experience associated with value-based payment (VBP) arrangements between providers and MCOs and the potential for shared savings to be derived from those arrangements to support current population health strategies (including those being implemented under DSRIP). Some GNYHA members report that VBP arrangements may need more time to mature while others question whether VBP arrangements with MCOs for the Medicaid population will ever generate savings sufficient to

sustain the investments necessary for success. We also believe that the State may want to clarify its expectation that some providers will remain largely fee-for-service. We have also heard concerns raised that the current risk-adjustment methodology is inadequate for high-cost patients and makes it particularly difficult to realize shared savings for certain populations, and that the current attribution model may not align well with VBP arrangements. Additionally, there are concerns about the number of measures, in particular when those measures are not aligned with those required as part of VBP. As we noted above, many providers also report delays in getting access to Medicaid claims data to support these activities. GNYHA is concerned that it may not be achievable for value-driving entities (VDEs) to have "the potential to sustain the selected DSRIP promising practices under VBP arrangements by the third year of the extended demonstration. We welcome the opportunity to have a robust and open conversation with State officials and other key stakeholders regarding whether the current strategy can be modified to assure that all the great work being undertaken is sustained.

**DSRIP Extension Concepts**

According to the Amendment Request, New York State is seeking "a continuation of DSRIP for the 1-year balance of 1115 waiver ending on March 31, 2021 and conceptual agreement to an additional 3 years from April 2021 to March 2024." Because of this, GNYHA believes consideration of major changes should be delayed until after March 2021 as it would be challenging for PPSs, providers, and others to undertake significant new activities without certainty regarding the potential for DSRIP or another version of Medicaid waiver funding supporting these efforts. Regardless of the future direction of the waiver, however, we do wish to comment on VDEs, the main new operational structure discussed in the Amendment Request.

According to the Amendment Request, "Value-Driving Entities (VDE) will consist of PPS (or a subset of PPS), provider, CBO, and MCO teams specifically approved by the state to implement the high-priority DSRIP promising practices." In reviewing the discussion of VDEs, we believe that should the State move forward with this concept, certain operational obstacles would need to be clarified.

In reviewing the Amendment Request, it was not immediately clear to us whether a single PPS (or provider) can lead multiple VDEs or would be expected to serve as a single VDE. GNYHA believes that the State's intent is that a PPS (or hospital or health system) would form a single VDE along with one or more MCOs and one or more CBOs and would be assigned a specific region or market and receive an attributed population. If that is the intention, GNYHA recommends that the State allow multiple VDEs to serve in an individual region or market. We believe that multiple VDEs can function in an individual region and work collaboratively for the benefit of the community in that region. To the extent that projects and the work of the VDEs would somehow tie to VBP contractual arrangements between individual providers and MCOs, we do not anticipate, nor do we believe, it would be appropriate for different MCOs to participate in those discussions.

Should the State contemplate the development of VDEs or seek to define a more integrated role for MCOs and CBOs, GNYHA would recommend that the State permit a PPS or provider to partner with an MCO and CBO in a looser affiliation (to be determined by the PPS/provider acting as the lead)where the State might define a specific set or minimum set of tasks or requirements for MCOs and CBOs to participate in the VDEs. We have already discussed above

the concept of requiring MCOs to regularly provide claims data to the PPS (or VDE). With regard to CBOs, one of the main lessons of the current DSRIP program is that although CBOs as a whole do incredible work for their communities, many of them do not have the requisite infrastructure in place to support a DSRIP-type program with a high level of reporting, data sharing, feedback, etc. GNYHA believes that if the State wants to see improved integration of CBOs into the work of PPS/VDEs, it would accomplish that, as discussed above, by dedicating some portion of funding to CBO capacity-building. GNYHA also believes there should be some flexibility regarding the structure of the VDE if a VDE demonstrates that a project could be successfully done without a CBO partner; not all projects may lend themselves to a CBO partnership.

**DSRIP Extension Year 1**

As noted in the Amendment Request, New York State is seeking an immediate one-year extension of the current DSRIP program and conceptual agreement regarding the remaining three years of the extension. Because we would expect the approval process to be different for the two timeframes, GNYHA has specific recommendations regarding what components of the overall Amendment Request should occur during the initial year of the extension.

For the period through March 31, 2021, GNYHA believes that New York State should—as much as is possible—continue the existing DSRIP program and current DSRIP activities and operational structures (including current PPS activities), and use existing or a reduced number of DSRIP measures for the PPSs to draw down funding during this associated time period. In particular, we recommend that major changes to governance structures or requirements associated with how PPSs operate that would cause a delay in PPS activities should be postponed until Year 2 of the extension, unless the Centers for Medicare & Medicaid Services (CMS) has provided strong conceptual commitment to a three-year extension for the project beyond the March 31, 2021, which may not be possible. GNYHA recognizes the State would like to create new "VDEs" and "social determinant of health networks" (SDHNs) but we believe these should not be implemented during this one-year time period, except in concept as appropriate, and not in a formal manner that would require the creation and implementation of new governance structures. While we recognize the State may want to pursue significant operational changes and "additional flexibility" for the DSRIP extension period, we expect that CMS would be unable to formally commit to any continued Medicaid waiver funding post-March 2021 except in concept. We believe that without assurance of continuation of funding under a renewal of the overall Section 1115 waiver, it would be prudent to continue the general structure of the current DSRIP program and seek flexibility to incorporate modest changes designed to address recognized challenges in the existing program. We do believe that PPSs could began planning for the transition to the new structure during Year 1 should CMS provide conceptual agreement, but that the planning activity required should be moderate.

Should the State wish to better integrate MCOs into the current DSRIP operational structure, the State could do so by requiring the plans to provide a standard set of claims data on a regular basis to the PPSs. The PPSs report that they have been hindered in progress due to not receiving timely data from the MCOs and that certain MCOs have been particularly challenging to work with. Incorporating such a requirement into the one-year extension period would connect the MCOs to the PPSs, and we believe could accelerate the positive work of the PPSs and assist with the continued adoption of VBP arrangements.

Also, should the State wish to incorporate additional high-need priority areas such as reducing maternal mortality or improving children's population health into the one-year extension, GNYHA believes that the State could develop an additional small set of short-term, high impact projects and provide the PPSs with an option for selecting from that list to draw down DSRIP funding.

For the activities to occur in Year 1 of the extension, GNYHA is supportive of the State's request for $4 billion and would recommend that the State slightly modify its request to be $3 billion for DSRIP Performance to be awarded to PPSs; $500 million for Workforce Development to be awarded to workforce investment organizations; and $500 million for the Interim Access Assurance Fund to be awarded to qualifying safety net providers. While we support the concept of funding social determinants of health activities, GNYHA believes that—for Year 1 of the extension, at least—those activities should continue to be supported through the PPSs and DSRIP performance programs. We do not believe formal approval of a single year would be appropriate for the development of a new SDHN infrastructure without clarity and assurance regarding future available funding. It would be appropriate, however, to dedicate a portion of the $500 million originally dedicated to social determinants of health to CBO capacity-building, which is generally necessary for delivery system reform and improved integration. (To that end, CBO capacity-building would be facilitated by eliminating the rule stipulating that no more than 5% of funding could be dedicated to non-safety net providers.)

**Next Steps**

We believe there are many lessons learned from the current version of DSRIP. In particular, we believe much of the complexity of the current DSRIP program, most notably in the early years of the program, should be avoided, and we look forward to working with the State at the right time to simplify the implementation of any DSRIP extension or furtherance of the current program so that New York's health care community can continue to do its great work.

Should you need to contact us, we can be reached at [redacted] and [redacted]

Sincerely,

Kathleen Shure
Senior Vice President

Tim Johnson
Senior Vice President

## doh.sm.1115Waivers

**From:** Jacob Reider [redacted]
**Sent:** Monday, November 4, 2019 4:17 PM
**To:** doh.sm.1115Waivers
**Cc:** Sarah Wong
**Subject:** Comments re: 1115 waiver extension/ renewal from Alliance for Better Health
**Attachments:** Alliance_DOH_1115_NOV_ 2019.pdf



See attached.

Thanks!

## One-page bullet-list summary of our comments

- Geographic overlap must be eliminated. Reduce from 25 PPS to 11 VDEs.
- Regardless of waiver renewal or extension, preserve incumbent PPS or successor organizations' access to data.
- Put our chips on a square that's got better odds: bring SDHN proposal of $1.4B to the top of the wavier renewal/extension request and reduce emphasis of other proposals.
- Propose $300M over four years to support VDEs that serve as regional umbrellas, converging QE, health home, BHCC and CCO activities into coordinated regional public health utilities. A pragmatic request of this magnitude this has a chance at CMS approval, and it's quite a bit more than nothing.

Therefore:

- *Create four SDHNs with $1.4B of support over four years.*

    1. Buffalo Region, Rochester Region
    2. Syracuse, Central New York Region, Capital Region, Adirondacks, Upper Hudson Valley
    3. Lower Hudson Valley, Westchester County
    4. New York City, Long Island

- *Support consolidation of PPS into VDEs, maintaining core (PMO) technical and human infrastructure with ~ $6M annual allocation for each VDE through 2024:*

    1. Buffalo Region
    2. Rochester Region
    3. Syracuse, Central New York Region
    4. Capital Region, Adirondacks, Upper Hudson Valley
    5. Lower Hudson Valley and Westchester County
    6. New York City: Manhattan
    7. New York City: Bronx
    8. New York City: Brooklyn
    9. New York City: Queens
    10. New York City: Staten Island
    11. Long Island

- Define the framework for a core set of SDHN and VDE services.
    - Data Management
    - Social Service Network creation and curation
    - Care Coordination
- Determine the appropriate relationship between the SDHNs, VDEs and existing Health Homes and BHCCs
- Create and maintain structures that ensure accountability

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DSRIP has been an extraordinary success in our community, and we implore DOH and CMS to renew the waiver and continue to support many of the initiatives that reduced total cost of care, improved health outcomes and nudged providers toward VBP. We have carefully reviewed the draft proposal from DOH and offer the following comments:

a) We reiterate our previous advice that DOH **eliminate geographic overlap** and **reduce the number of PPS (now presumably VDE) from 25 to ~ 11**. This will significantly improve both administrative efficiency for DOH and regional collaboration and will eliminate the (real or perceived) competition that exists in our communities. DSRIP is not a competitive sport, yet we spend a good part of every week managing our relationships with community partners who work with multiple PPS and frequently feel pulled between competing visions of the future. In our case, a PPS with which we share much of our geography is a subsidiary of one institution, while we are governed by five. While our shared commitment should be that we do what's right for Medicaid beneficiaries and the uninsured in our region, our sister PPS often appears to be working toward strategic dominance by their parent health system rather than what's best for the individuals we serve. A successful VDE will, by definition, reduce fee-for-service revenue for a health system. Therefore, any VDE governed by organizations that rely on acute care fee-for-service revenue as their primary source of revenue will be implicitly undermined by its parent. This is an unfortunate structural flaw in DSRIP 1.0, a flaw that was partially but insufficiently addressed in the proposal with expectation of CBO and MCO governance for VDEs. Summary: geographic overlap must be eliminated. Reduce from 25 PPS to 11 VDEs.

b) We implore DOH make plans to maintain access to claims and clinical data for attributed members during any period of transition between the existing waiver and any future waiver – even if this future remains unclear through the 2020 presidential election. We suggest that DOH execute contracts (if necessary – at minimal cost ~ $1) with existing entities or our successors so that we can maintain access to data to continue our efforts after the end of the current waiver period. Many PPS have funds remaining (and will receive funds in 2020) so will make good use of this data to sustain efforts in support of DSRIP policy goals. Summary: regardless of waiver renewal or extension, preserve incumbent PPS or successor organizations' access to data.

c) We recommend DOH take a pragmatic approach to requests of CMS under the current administration in Washington, recognizing the political challenges and the need to find shared policy goals. Therefore, we recommend that DOH enhance the relative emphasis of the waiver renewal on the Social Determinants of Health Networks (SDHNs) which mirror a similar waiver proposal, recently approved for the state of North Carolina. Secretary Azar and Administrator Verma have expressed great enthusiasm for the North Carolina model of Lead Pilot Entities (LPEs) which are similar to the SDHNs that you have proposed for New York. This model makes good business sense, solves the "free-rider problem" (Nichols and Taylor 2018) by compelling MCO engagement, and supports the migration of funding for social service providers from grants and philanthropy to VBP. This model would support a small number of SDHNs (4 – 6 statewide) and aligns well with initiatives and policy goals that CMS has publicly supported. DOH should retain a ~ $1.4B statewide allocation for SDHNs (roughly the same per-capita allocation as NC) – funded with a percentage of premium that would pass through (PMPM) from DOH to MCOs and MCOs to SDHNs. Summary: put our chips on a square that's got better odds: bring SDHN proposal of $1.4B to the top of the wavier renewal/extension request and reduce emphasis of other proposals.

d) Given a greater emphasis on SDHNs, DOH should reduce emphasis and cost of the VDE request (and the smaller, targeted programs in the proposal) for the near term, as it is unlikely that the current administration will approve of a waiver for so much money. A pragmatic approach would cause the VDE request be reduced to a scaled-back set of expectations that support the "keep

the lights on" operations of ~ 11 regional VDEs to maintain staffing and technical resources of PPS, while providing enough funds to persist community engagement and coordination of medical providers with SDHNs. Such a model would provide a framework of a public utility model - providing a suite of horizontal services (merging CCOs, health homes, QEs and BHCCs) into regional public health entities that connect organizations and support service providers in a manner that is agnostic to health system and MCO, eliminating silos and building trust. Pass-through funding for health systems would be significantly reduced or eliminated in this model – and where persisted, would be constrained to investments in facilitating aligned care coordination among primary care, behavioral health and social care providers. Therefore, we suggest that DOH request approval for a total of ~$300M over the four years from 2020 – 2024, resulting in roughly $6M annual allocation for each of eleven VDEs. This would bring the total statewide DSRIP extension/renewal request to ~ $1.7B, which we believe to be a number much more palatable to CMS, as DOH can make a good case that there will be positive return on an investment of this size. While acute care facilities do need government support (especially those who serve vulnerable populations), conduits other than DSRIP will need to be employed to provide this support. Summary: propose $300M over four years to support VDEs that serve as regional umbrellas, converging QE, health home, BHCC and CCO activities into coordinated regional public health utilities. A pragmatic request of this magnitude has a chance at CMS approval, and it's quite a bit more than nothing.

The DSRIP waiver extension should therefore:

- *Create four SDHNs with $1.4B of support over four years.*

    5. Buffalo Region, Rochester Region
    6. Syracuse, Central New York Region, Capital Region, Adirondacks, Upper Hudson Valley
    7. Lower Hudson Valley, Westchester County
    8. New York City, Long Island

- *Support consolidation of PPS into VDEs, maintaining core (PMO) technical and human infrastructure with ~ $6M annual allocation for each VDE through 2024:*

    12. Buffalo Region
    13. Rochester Region
    14. Syracuse, Central New York Region
    15. Capital Region, Adirondacks, Upper Hudson Valley
    16. Lower Hudson Valley and Westchester County
    17. New York City: Manhattan
    18. New York City: Bronx
    19. New York City: Brooklyn
    20. New York City: Queens
    21. New York City: Staten Island
    22. Long Island

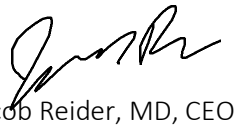
- Define the framework for a core set of SDHN and VDE services. This will be built on the investment already made in the PPS and the lessons learned to date in DSRIP. The core set should include responsibility for:

  - **Data** aggregation and analytics to support population health initiatives, ideally in partnership with local QE/RHIOs. DOH/NYeC should require the merger of, or tight affiliation of, QEs into VDEs or VDEs into QEs to align the goals of these entities, and to reduce administrative overhead. Many QEs already have the broader governance representation that DOH seeks in the VDEs.
  - Build and manage **networks** of CBOs and contracting with MCOs on behalf of CBOs.
  - Care **coordination** extending across the continuum of services required by Medicaid recipients, connecting primary care, behavioral health and social services.

- **Determine** the appropriate relationship between the SDHNs, VDEs and existing Health Homes and BHCCs, ideally merging VDEs, Health Homes, BHCCs, and other high touch case management services where possible to eliminate duplicative and uncoordinated models. The goal of the VDE is to serve the entire Medicaid population rather than discrete diagnostic service categories. OPWDD's CCO initiative has created yet another silo of services, and we encourage DOH and OPWDD to collaborate toward the elimination of this redundant network of activity and converge it with existing programs, and to eliminate the (under-funded and largely unsuccessful) BHCC model and fold it into the VDEs.

- **Accountability**. Facilitate the development of a limited number of measures for the extension period to which each region will be held accountable. The measures for earning continued federal funds should be related to increased use of primary care and prevention, coupled with reductions in preventable acute care utilization.

  Many performance measures such as HEDIS and traditional "medical model" quality measurement models would be misapplied in this context and should be abandoned, as they don't accurately reflect many of the objectives that the DSRIP program intended to address. Regional work among VDEs, SDHNs and MCOs should identify appropriate measurement activities in the domain of SDoH, working with national organizations such as NCQA and NQF. Indeed, the goal here should be that the VDEs, QEs and SDHNs perform measurement, rather than implement measures. What is measured will be dynamic and should be locally defined so that the unique needs of each community can be recognized and addressed.



Jacob Reider, MD, CEO
Alliance for Better Health

Reference:

Nichols, L. M. and L. A. Taylor (2018). "Social Determinants As Public Goods: A New Approach To Financing Key Investments In Healthy Communities." Health Aff (Millwood) **37**(8): 1223-1230.

## doh.sm.1115Waivers

**From:** Spanos, MaryAnn [redacted]
**Sent:** Monday, November 4, 2019 4:19 PM
**To:** doh.sm.1115Waivers
**Subject:** DSRIP 2.0 Comments
**Attachments:** DSRIP Response Chautauqua County.pdf



*Dr. Mary Ann Spanos , Director*
[redacted]

Chautauqua County
Office for the Aging

**George M. Borrello**
*County Executive*

**Dr. Mary Ann Spanos**
*Director*

November 1, 2019

Paul Francis
Deputy Secretary for Health
State Capitol
Albany, NY 12224

Donna Frescatore
Medicaid Director
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Dear Mr. Francis and Ms. Frescatore,

On behalf of Chautauqua County Office for the Aging, I am writing to express my support of the recommendations on the NYS DOH DSRIP 2.0 proposal submitted by the Association in Aging in NY, AARP NY, Lifespan of Greater Rochester, and LiveOn NY.

Chautauqua County Office for the Aging is one of 59 Area Agencies on Aging providing services across a rural, economically depressed region. We touch close to 7,000 older adults every year, contract with over 30 community organizations, and refer/coordinate with many more to provide services and supports targeting the social determinants of health. The services we provide directly prevent inappropriate emergency department visits and reduce avoidable hospital readmissions. Our NY Connects program serves as the "no wrong door" for all services available in the region and makes many seamless electronic referrals to ensure people in need get the help they are seeking. The targeted goals in the DSRIP 2.0 proposal are exactly what our network provides and this proposal must include a mandate that each PPS contract with their local Area Agency on Aging for social determinants of health initiatives.

Our office has been in existence for over 45 years, and is the trusted service provider for the fastest growing segment of the population, and the highest utilizers of health care dollars. Our services absolutely allow individuals to remain autonomous and remain in their own homes and communities, all while saving health care expenditures. Our nurses and social workers are all certified in case management through Boston University. We provide the highest level of evidenced-based interventions, and are experts at navigating the complex health care system, while creating a quilt of community care to wrap around and support the client with a person-centered plan. Below is an example of how we coordinate the social determinates for a client:

The client first contacted our office post hospitalization when he was 56 y.o. for home delivered meals (paid privately). He continued to contact us for information and assistance from time to time after that. He joined the congregate meal programs when he turned 60. In 2010, at the age of 64 the client was struggling with advanced Parkinson's Disease and in need of in-home care and support. He required assistance with personal care and was walking with a walker. He only left home for medical appointments. He and his wife were also in a financial crisis due to high medical bills. Since he was a veteran, we contacted his social worker at the VA to maximize that benefit and coordinate service. Since he was receiving VA healthcare but not in-home services through the VA, we contacted the county veteran's service officer to look into what benefits he was eligible and assist with eligibility

applications. In the meantime, we put in personal emergency response system (PERS), MOW, and housekeeping to assist the wife who was overwhelmed caring for her husband. We also made a legal referral to advise on bankruptcy, caregiver support program to help the wife cope better, and a health insurance counseling referral to ensure he was taking advantage of all programs they were eligible for. They were only receiving HEAP at this point in time. We helped get them enrolled with SNAP, put them in touch with the food bank, got them a Safelink phone, and access emergency benefits under HEAP as well as clean and tune. When the wife became eligible, we assisted her with Medicare and EPIC. It took almost a year but the VA finally started to provide personal care and PERs for the husband. Our local AAA continued to provide 4 hours of housekeeping to support the wife as well as the meals. Shortly after starting services, their septic system failed and sewage was backed up into their basement. We helped them complete an application for the septic repair through Chautauqua Opportunities Inc. and contacted Project Share through NYSEC who would pay a portion of the repair. The wife had her own health challenges, with poor vision and becoming blind in one eye after surgery in 2012. Family was not much help because the daughter did not drive. The client was told he may not survive long, so Hospice was discussed. As his condition continued to deteriorate he underwent a brand new procedure to have a brain stimulator implanted for his Parkinson's in mid 2012. At this point, he was confined to a wheel chair but still mentally sharp. We did several modifications to their home for better wheelchair accessibility in coordination with VA, CHRIC, COI, rural development and other community organizations. We recruited a volunteer from their church to provide in-home respite so the wife could go to church or her own doctor appointments. He continued to live at home until he passed away in January 2015. The wife continues as our client due to her own health issues which have progressed. She currently receives case management, meals, personal care services, PERS, and home repairs. The cost for OFA services he received was approx. $8,700.00/year for a total of $35,000.00 over 4 years. This client was nursing home eligible for all 4 years and would have cost the Medicaid program approximately of $65,000/year or $260,000 for the 4 years we served him. Many of the things we did can't be measured but at minimum we saved $225,000.00 in nursing home costs.

Lastly, I want to tell you that our AAA has worked closely with several primary care practices in our county for many years. Through a HRSA grant, we developed an electronic referral in the EMRs of 9 physician practices so they can generate electronic referrals for AAA services like hospital to home care transitions, meals, home repairs and more. These referrals are sent through their regional health information exchange called HealtheLink. The primary care practices I work with have requested information on the social determinants we provide to our shared clients. While I honor these requests, it is very labor intensive. With the state-wide PeerPlace system sitting on the Health Commerce System, a state-of-the-art interface could be developed with the Health Information Exchange to share information on the social determinants between all the AAA's and our subcontractors, many of whom also use the system. This is an investment that would vastly improve coordination and seamless collaboration of services both medical and non-medical and truly make New York stand out as a leader.

Sincerely,

Dr. Mary Ann Spanos

## doh.sm.1115Waivers

**From:** Nasry Michelen [redacted]
**Sent:** Monday, November 4, 2019 4:19 PM
**To:** doh.sm.1115Waivers
**Cc:** Nasry Michelen
**Subject:** 1115 Public Forum Comment
**Attachments:** DSRIP SUBMISSION v3.docx



DSRIP 2.0 Committee :
Attached please find comments/proposal from ImagineMic for consideration in the NY State DSRIP 2.0 Public forum.
We look forward to continuing participation in this process.
Sincerely,
Nasry Michelen

ImagineMIC

*Nasry Michelen*
*Chief Strategy Offier*
*2628 South Rd. Poughkeepsie, NY, 12601*
[redacted]



# DSRIP Submission

October 2019

**Anthony J. Bacchi MD**

**Founder/CEO**

ImagineMIC™

2628 South Road
Poughkeepsie, NY 12601

[redacted]

Website: www.imaginemic.com

November 1, 2019

Dear DSRIP committee:

**ImagineMIC™** is an established company based in New York's beautiful Hudson Valley, offering a comprehensive chronic care management program that utilizes cutting-edge technology that results in a significant reduction in the total cost of care for the most costly and underserved individuals residing in skilled nursing facilities and in the home setting.

We welcome this opportunity to contribute our proposal for consideration in the State's DSRIP 2.0 application. We are requesting a minimum of a $15M investment which will yield a **10:1 ROI to the State**.

ImagineMIC's™ proposal builds on the independently audited success of our TeliStat™ 3-year pilot demonstration program. The program was funded by a NYS legislative grant of $4.5M that was subsequently matched by CMS through an 1115 waiver for an additional $4.5M (NYS Senate S6407C). The purpose of the grant was to demonstrate the ability to reduce avoidable hospital readmissions while increasing the quality of care within skilled nursing facilities. The TeliStat™ model successfully reduced all-cause readmissions from the statewide average of **21+% to below 6%.**

**An independent audit commissioned by NYS conservatively estimated that if the TeliStat™ program were to be expanded to other skilled nursing facilities, it would result in a minimum savings of over $500M annually.**

Over the 3-year demonstration grant, the pilot has evolved into a more comprehensive solution which incorporates enhanced technology and continuous remote physician monitoring, 24/7/365, utilizing wireless patch technology. Recent studies have shown outcomes that demonstrate an even greater potential for savings than the original TeliStat™ program with higher rates for patient satisfaction.

ImagineMIC™ will build upon TeliStat's™ proven track record of success and maximize NYS's limited Medicaid resources demonstrating significant savings while improving the quality of care.

Respectfully submitted,

Anthony J. Bacchi, M.D.

President and CEO ImagineMIC™

**Introduction**

ImagineMIC™ respectfully submits this proposal for consideration in NY State's DSRIP2 application. We are requesting a minimum $15M investment with a projected **10:1 ROI for the State**.

ImagineMIC's™ program is a complete and comprehensive model of care that integrates cutting edge technology with critical care clinicians to improve patient outcomes and reduce total cost of care. ImagineMIC™ integrates FDA-cleared, wearable Patch technology transmitting real-time clinically actionable hemodynamic data to a Monitoring Intervention Center (MIC) staffed by ER board certified physicians, NPs, RNs and other allied health professionals. ImagineMIC™ builds upon the proven success of the TeliStat™ Restorative Care Units. Expanding on the TeliStat™ model, ImagineMIC™ addresses the following key DSRIP goals:

- **Access to Primary and Preventive Care**
- **Potentially Avoidable Services**
- **Care Coordination and Care Transitions**
- **Clinical Improvement: Cardiovascular Disease**
- **Clinical Improvement: Diabetes**

**Background**

The TeliStat™ model was developed, capitalized and introduced by Dr. Anthony Bacchi to the NYS DOH after an 18 month "proof of concept" was established in a failing upstate Skilled nursing Facility ("SNF"). By introducing first-of-its-kind enhanced telemetry and monitoring technology, along with specialty trained nurses and an interdisciplinary team of clinicians, our solution drastically reduced **all-cause** 30-day hospital readmissions from **21+% to less than 6% in grant designated SNF's.**[1] These impressive results enabled TeliStat™ to obtain a combined $9M in grants from New York State and CMS to replicate TeliStat™ Units in other skilled nursing home settings including urban, suburban, and rural areas. Independent state auditors confirmed these results on over 1000+ patients over a 3-year period, examples of which are listed below:

## Independently Audited Results

Verified Readmission Rate of **6% or Below** For All Cause Readmissions

| Top 4 Chronic Conditions Contributing to the Staggering Cost of Care | NY State / National Average | TeliStat™ | Net Reduction |
|---|---|---|---|
| **Congestive Heart Failure** (CHF) | 27.0% | **6.0%** | **78.0%** |
| **End Stage Renal Disease** (ESRD) | 50.0% | **11.1%** | **78.0%** |
| **Chronic Obstructive Pulmonary Disease** (COPD) | 20.5% | **13.1%** | **36.0%** |
| **Pneumonia** | 16.7% | **0.0%** | **100.0%** |

[1] NY State DOH Commissioned Freed/Maxick as an independent program evaluator to produce a report for the NY State Legislature.

**The independent auditor conservatively estimated that if the program were to be expanded, the TeliStat™ demonstration would result in savings of over $500M annually.**

Using the foundational history and extraordinary results of the TeliStat™ Restorative Care Unit model, **ImagineMIC™ is the new paradigm of 24-hour chronic care management**, monitoring individuals **in any setting** utilizing cutting edge technology that transmits real-time hemodynamic data to a monitoring intervention center (MIC).

ImagineMIC™ confronts serious and growing gaps in healthcare delivery, including:

- After discharge from a nursing home or a hospital to the patient's home it is difficult to monitor their health status and cumbersome for them to visit a doctor's office. This contributes to lapses in compliance with treatment regimens.
- Without technology, there is no way to monitor hemodynamic functions 24/7/365 to detect or anticipate changes in patient's condition requiring medical intervention.
- Compounding the above, is the shifting of the US geriatric population aged 65 and over, from 28 million to 79 million in the next twenty years, with a high prevalence of chronic diseases and the need for improved quality of services at affordable rates.[2]
- Currently, $26B is spent annually on hospital readmissions within 30 days, at least $17B of which is considered avoidable and unnecessary.[3] This statistic only references 30 days post-discharge, not considering admissions from the home that could have been avoided altogether. Given the shifting geriatric population into the home setting, these costs will exponentially increase.
- Shortage of critical providers in both rural and non-rural areas will drive widespread adoption of telehealth.

[2] An Aging Nation: The Older Population in the United States, May 2014
[3] How Obamacare Could Save Taxpayers $17 Billion, October 26, 2014

ImagineMIC™ has the following components:

- **MonitorMe™ App:** A downloadable, proprietary application that transforms any mobile device, laptop, tablet, or television into a functioning, cyber-secure telehealth communication tool. Features include real-time telemedicine, hemodynamic monitoring, medication management, and caregiver and patient education.
- **Patch Technology:** A small, proprietary FDA-cleared, hypoallergenic patch containing several biosensors. The patch is placed on a patient's chest and sends multiple hemodynamic signals in real time from the patient to a monitoring center. Currently, the patch transmits 2-lead ECG signals, respirations, heart rate, and skin temperature through a proprietary gateway device via cellular transmission. The patch is disposable and lasts 5 days. Additional hemodynamic information, such as oxygen level, are scheduled for release with FDA clearance in Q2 2020.

- **Gateway Device:** A proprietary device which gathers, processes and encrypts data from the patch. Additionally, through Bluetooth technology, it automatically gathers information from other electronic measuring devices in the patient's home such as glucometers, weight scales, blood pressure machines and pulse oximetry. This hemodynamic data automatically populates the Electronic Medical Record ("EMR") in the MIC.
- **Monitoring Intervention Center (MIC):** The MIC is a centralized resource for remotely monitoring an unlimited number of patients. The MIC is outfitted with proprietary MonitorMe™ software and staffed 24/7/365 with a multidisciplinary team of healthcare providers including board certified Emergency physicians, NPs, RNs and other allied health professionals.
- **Application Integration:** Through the app on their mobile device, laptop, tablet or through TV integration, the patient can interact with a member of their multidisciplinary team with any health concerns. The healthcare professional within the MIC who receives the call has immediate audio/visual communication with the patient

and, **for the first time, can simultaneously see the hemodynamic information streamed from the patient's gateway device on their screen**.

Additional Benefits: A by-product of the MIC is the creation of a data analytics repository which serves as a vehicle for development of a powerful predictive medical analytic database as well as a stratification tool to identify highest risk patients. Previously, these analyses were performed retrospectively with historically unreliable data from insurance claims. The MIC database is also an epidemiological tool to identify pockets and patterns of diseases in the earliest part of outbreaks, including flu epidemics, cancer, asthma and cardiac-related illnesses.

**DSRIP relation**:


**Potentially Avoidable services:**

- With the ability to treat in place and by avoiding unnecessary admissions and ancillary services we have demonstrated a significant reduction in the total cost of care. **The independent auditor conservatively estimated that if the program were to be expanded, the TeliStat™ demonstration would result in savings of over $500M annually.**

**Clinical improvement- Cardiovascular:**

- Preventative hypertensive screening.
- Proactive continual monitoring of a patient's hemodynamic information allows immediate intervention by clinicians, as demonstrated by the following outcomes:

## Independently Audited Results

Verified Readmission Rate of **6% or Below** For All Cause Readmissions

| **Top 4 Chronic Conditions Contributing to the Staggering Cost of Care** | NY State / National Average | **TeliStat™** | **Net Reduction** |
|---|---|---|---|
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| **Pneumonia** | 16.7% | **0.0%** | **100.0%** |

**Access to primary and preventable care**

- The ImagineMIC™ technology is available throughout the entire continuum of care allowing for both audio/visual communication and streaming of hemodynamic information from the patient to the doctor 24/7/365 in any setting whether it be rural, suburban or urban.
- Because the MIC has frequent and direct communication with patients, providers can ensure adherence to preventable metrics such as flu vaccination, pneumovax, shingles vaccine, smoking cessation, vision screening, dental screening, etc.
- Our telehealth platform allows access to quality healthcare providers in geographically underserved regions while also decreasing the impact of social determinants of health such as anxiety, isolationism, depression, etc.

**Care coordination/transition**

This technology bridges the gap in the transitions of care allowing for patients, providers and family members to participate in care planning and care transitions facilitating warm hand offs:

**Why is ImagineMIC™ a great DSRIP partner?**

- With a minimum investment of $15M, we project **10:1 ROI for the state**.
- Provides for chronic care management to the most expensive cohort of patients with over **5 or more comorbidities with the average age over 70 years old.**
- Proven cost-effective results **independently verified** over 3-years.
- **Ready "on day 1"** to be economically scalable for statewide implementation.
- State of the art technology allowing for patient monitoring **in any setting**.
- **Addresses many of the social determinants**, such as, isolation and anxiety that are main drivers of the cost of care by allowing for regular audio/visual communication.
- **Facilitates medication compliance** through patient and doctor communication.
- **Allows for a data analytics repository** which serves as a vehicle for development of a powerful predictive medical analytic database as well as a stratification tool to identify highest risk patients. The MIC database is also an epidemiological tool to identify pockets and patterns of diseases in the earliest part of outbreaks, including flu epidemics, cancer, asthma and cardiac-related illnesses.

## doh.sm.1115Waivers

**From:** Faven Araya [redacted]
**Sent:** Monday, November 4, 2019 4:23 PM
**To:** doh.sm.1115Waivers
**Subject:** 1115 Public Forum Comment
**Attachments:** CTHE DSRIP Public Comment 11.1.19.pdf



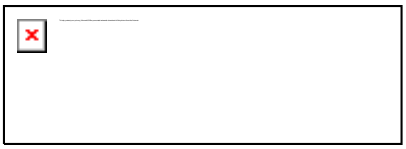
Good Morning,

On behalf of Communities Together for Health Equity (CTHE), please see the attached 1115 Public Forum Comment.

Thank you,

Faven

--
**Faven Araya, MPH**
*Community Outreach Coordinator*
*Arthur Ashe Institute for Urban Health (AAIUH)*
*450 Clarkson Ave, Box 1232*
*Brooklyn, NY 11203*
[redacted]
*Website: www.arthurasheinstitute.org*



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**Faven Araya, MPH**
*Community Outreach Coordinator*
*Arthur Ashe Institute for Urban Health (AAIUH)*
*450 Clarkson Ave, Box 1232*
*Brooklyn, NY 11203*
[redacted]
*Website: www.arthurasheinstitute.org*

November 1, 2019

New York State Department of Health

Office of Health Insurance Programs

One Commerce Plaza

Albany, NY 12207

Re: Comments in Response to the Delivery System Reform Incentive Payment (DSRIP) Amendment Request

**Communities Together for Health Equity (CTHE)** is a diverse and representative group of over 70 Tier 1 New York City (NYC) community-based organizations (CBOs) and stakeholders working to ensure comprehensive services for underserved communities. CTHE is demographically and linguistically diverse, providing social services addressing the spectrum of social determinants of health (SDOH) for over 350,000 of the most vulnerable and disenfranchised communities of NYC. We write to provide comments on the recently released NYS Medicaid Redesign Team Waiver Delivery System Reform Incentive Payment (DSRIP) Amendment Request.

Over nearly five years, DSRIP funds have invested in strategies to restructure and transform New York's healthcare system in hopes of achieving a 25% reduction in avoidable hospital use. System transformation, clinical and population health improvement were deemed focal points for transformation, and while progress has been made, additional time and support to sustain transformation is needed. Guided by the United Hospital Fund's report, *DSRIP Promising Practices*, the state's DSRIP Amendment Request leans heavily on the expansion of successful community partnerships, cross-sector collaborations and an emphasis on addressing SDOH as key initiatives to sustain transformation. While it's evident CBOs are essential stakeholders, they are persistently overlooked, excluded and lack adequate investment to meaningfully engage in the process.

The DSRIP Amendment Request emphasizes community-level collaborations as an integral component of the success of DSRIP thus far, yet it invisibilizes the contributions of CBOs. The report emphasizes the need to recognize community health and social service providers in their role supporting the reduction of avoidable hospital use and other high priority DSRIP measures, but fails to provide any analysis on the metrics associated with SDOH interventions spearheaded by CBOs.

CBOs are further undermined as terms of collaboration continue to be defined by the state, PPSs and other payers restricting the autonomy and growth of CBOs. Requests for additional flexibility to the operational structure of the next DSRIP funded entities is honored within the amendment request, but falls deaf to the requests of CBOs to operate and be funded Independent of PPSs/payers.

The state's initial investment through the regional CBO planning grants became a catalyst to develop and strengthen CBO networks. The grant offered opportunities for culturally and linguistically competent CBOs to build an infrastructure that would facilitate two important tenets:

1. CBO engagement and involvement as a critical and essential component for healthcare transformation
2. CBO capacity to partner and collaborate with providers, payers and the healthcare system to address the SDOH

Through the grant process, CBOs engaged in activities to inform and prepare themselves to establish partnerships and collaborations. Collectively, CTHE identified strategies and recommendations outlined in CTHE's Strategic Plan, *Our Collective Vision for CBO Partnership in the NYS Healthcare Delivery System*, to establish an equitable approach to ensure sustainable community engagement is integrated in NY's transformation efforts. These efforts have been met with challenges, as CBOs continue to be on the outskirts of the health planning process. Although the proposed amendment shows sign of progress, further improvements outlined below can be made to strengthen the state's approach:

I. **Structure:**
   - As the operational structure evolves, inclusion of CBOs as equitable stakeholders is essential. The proposed Second Generation Value Driving Entities (VDE) suggests a modification in the existing PPS structure to encourage representation and collaboration among PPSs, MCOs and CBOs. This requires a shift in culture and practice, and must translate into an inclusive and equitable healthcare planning process with shared governance and decision making processes that recognizes and values the unique contributions of Tier 1 CBOs.
     i. Recommendations:
        1. Inclusion of Tier 1 CBOs within the governance and decision making bodies of the Second Generation VDE's.
        2. To ensure accountability for the populations served and continuity of care, the VDE's structure and approach to healthcare delivery should be community specific. The VDE's attributed lives should be defined

by geographic territories, but responsive to the unique needs of those communities. Support from local community-centered stakeholders can help determine priority needs and intervention strategies to meet community needs

## II. Funds Flow:

- CBOs are mission-driven organizations who exist to meet community needs, particularly among vulnerable and hard-to-reach populations. They have a long history of addressing SDOH, but often have limited capacity and resources to replicate, scale and sustain interventions.
    i. Recommendations:
        1. Require upfront investments from payers to build CBO capacity to ensure CBOs are appropriately equipped to engage in VBP arrangements.
        2. Payment models that share accountability must include incentives that build CBO capacity to meet metrics while also sustaining their mission.
- Additionally, increased collaborations has led to and will continue to produce an influx of referrals and clients/members served. As a result, CBOs must be adequately compensated. As mentioned in the DSRIP Interim Final Evaluation Report, *"If community-based organizations are relied on heavily for patient outreach and to impact the social determinants of health, their budgets may need to be increased or additional access to training or funding may be needed"*.
    i. Recommendation:
        1. Create a separate sustainable funding stream designated for CBOs addressing SDOH and vulnerable populations. This would ensure sustained and long-term population health improvements.
- Low-income, uninsured, immigrant and communities of color residing in medically underserved areas of NYS should not suffer the consequences of hospital and healthcare facility closures and/or mergers.
    i. Recommendation:
        1. Prioritize funding of critical access hospitals, safety net hospitals and other hospitals that serve vulnerable populations.

## III. Coordinated Population Health Improvement

- Community wellness and population health priorities have historically been determined by clinical standards, and have lacked community perspective. The inclusion of CBOs as actively engaged stakeholders in the design, planning, budgeting and implementation process ensures a comprehensive and culturally competent approach to identify priority issues that reflect on the ground community experiences, as well as defining specific regions and/or attributed populations.
    i. Recommendation:
        1. Leverage the regional CBO networks to lead and conduct community needs assessments, identify priority areas, and design and support the evaluation of SDOH measures of success.
- Specifically allocating $1.5 billion to address SDOH is a step forward to advance health and wellness, and while potential opportunities exist in the proposed Social Determinant of Health Networks, it fails to recognize and leverage the existing organized regional CBO networks.
    i. Recommendations:
        1. Eligible applicants to serve as the lead entities of the SDOH Networks should be limited to existing CBO networks/coalitions.
        2. If the State receives approval for the DSRIP Amendment Request, but with less funding, the $1.5 billion designated to address SDOH should remain a priority, and not be reduced.

Thank you for the opportunity to provide comments. We strongly urge you to take these comments and recommendations under serious consideration as you work to finalize the NYS DSRIP Amendment Request.

Sincerely,

Marilyn Fraser, MD, CEO

Arthur Ashe Institute for Urban Health

On Behalf of Communities Together for Health Equity (CTHE)

## doh.sm.1115Waivers

**From:** Hall, Lindsay K [redacted]
**Sent:** Monday, November 4, 2019 4:24 PM
**To:** doh.sm.1115Waivers
**Cc:** Smith, Kristofer; Lamantia, Joseph
**Subject:** 1115 Public Forum Comment



*Good afternoon,*

*Please see below for Northwell Health's comments:*

Northwell Health has been an active participant and co-lead in the development of three Performing Provider Systems (PPSs) as well as implementation of their respective selected projects. Northwell has used the DSRIP waiver funding to build infrastructure to perform true population health management (analytics, care mgmt., patient and provider engagement, CBO alignment, etc.). Efforts to achieve the goals associated with DSRIP have been leveraged and organized around our hospitals, employed and non-employed physicians, our New York State (NYS) Health Home and a network of community-based organizations.

Through our partnerships and commitment from Northwell Leadership, we have advanced many of the goals of DSRIP, including:

- Expanded access to PCMH-recognized primary care practices
- Built relationships with Community Based Organizations and increased focus on addressing social determinants of health
- Co-located behavioral health providers
- Embedded both behavioral health and physical health care managers in PCP offices
- Opened new crisis stabilization clinics for children and adults
- Expanded screening and treatment options for substance abuse disorders
- Launched a CHW training program that has graduated 5 classes
- Surveyed thousands of uninsured and/or non-utilizing individuals using the PAM and provided health coaching
- Connected ambulatory, behavioral health and post-acute providers to the RHIO
- Implemented performance improvement projects across the network
- Increased the response to food insecurity through screening and a hospital-based food pantry
- Deployed a multi-site high utilizer program

Northwell is supportive of a DSRIP extension that would be focused on:

1. Value-based contracting between MCOs and healthcare organizations that delegate responsibility for managing quality and the total cost of care for an identified population that is managed across a highly aligned network of providers and community-based organizations

2. As demonstrated in the current DSRIP program, continuing to build on the essential collaboration with community-based organizations, linked through value-based care agreements, to address social determinants of health
3. Investment in population health programs broadly, but also capable of focusing on priority public health issues such as maternal mortality, opioid abuse, and childhood obesity
4. Quality strategy / set of performance metrics that is aligned with HEDIS and Health Home metrics
5. Allowing for a VDE organized and led by a large clinically integrated provider system

To take on the responsibility of coordinating the development of a high value provider network, contracting with the MCO's, and organizing a meaningful system of community-based organizations, the Value Driving Entities (VDEs) best positioned for success would be those embedded in a large provider organization or integrated delivery system. As an integrated delivery system in the downstate region, with existing relationships with MCOs and Community Based Organizations, Northwell is able to decrease the administrative expense burden to the system as well as decrease confusion to stakeholders (providers, payers, patients, etc). Northwell would have responsibility for contracting with the network and partner with the MCO's around a core set of performance based measures and targets for the management of quality and total cost of care for the attributed population. In the downstate region particularly, there are multiple MCOs and this new structure put forth by NYS must account for the practical need for VDEs to contract with more than one MCO. As a VDE, Northwell would expand upon existing programs with MCOs to serve their high risk members to achieve the goals of value-based contracts, and would hold the downside risk for such arrangements. A Northwell PPS-like entity would also allow us to harmonize our Medicaid strategy and activities with our commercial and Medicare population health obligations.

**doh.sm.1115Waivers**

**From:** Kearsing, Lori [redacted]
**Sent:** Monday, November 4, 2019 4:24 PM
**To:** doh.sm.1115Waivers
**Subject:** "1115 Public Forum Comment"
**Attachments:** DSRIP 2.0 Proposal Comments - TriaDD 11.4.19.pdf



Good afternoon. Attached please find comments from TriaDD, LLC on the Draft DSRIP Waiver Amendment Proposal.

Thank you.

**Lori Kearsing**

*Vice President of Strategic Initiatives*

**LIFEPlan CCO NY**
**939 Route 146, Building 300**
**Clifton Park, NY 12065**

**TriaDD, LLC**
**258 Genesee St., Mezzanine Level**
**Utica, NY 13502**

[redacted]

www.lifeplanccony.com

# TriaDD, LLC

258 Genesee Street, Mezzanine Level
Utica, NY 13502

VIA EMAIL to 1115waivers@health.ny.gov

November 4, 2019

To: New York State Department of Health
From: TriaDD
Re: Comments on the Draft DSRIP Waiver Amendment Proposal

TriaDD is a partnership formed by three of the largest Care Coordination Organizations / Health Homes (CCO/HHs) serving people with intellectual and developmental disabilities (I/DD) in NYS: Advance Care Alliance of NY (ACANY); LIFEPlan CCO, NY (LIFEPlan); and Person Centered Services (PCS). Together, we provide CCO/HH services to over 62,000 members (over 60% of the statewide total) in all 62 counties. In addition, all three CCO/HHs are exclusively owned and governed by over 150 not-for-profit agencies with significant experience serving individuals with I/DD.

TriaDD is very supportive of New York State's efforts to extend DSRIP and to establish Value Driven Entities (VDEs) that are more representative of the provider community. During the first phase of DSRIP, people with I/DD and I/DD service providers were largely overlooked in terms of the scope of DSRIP projects and as partners in PPSs. As part of the creation of VDEs, TriaDD is strongly advocating that CCO/HHs and I/DD service provider agencies must be partners in any VDE.

With over 100,000 Medicaid beneficiaries with I/DD enrolled in CCO/HHs throughout the state, we recognize the following about this special needs population:

- The majority of individuals with I/DD are currently not enrolled in a managed care plan for the medical portion of their Medicaid benefits (all OPWDD auspice long-term care services are carved out of the Medicaid managed care benefits package);
- They represent some of the highest cost individuals and end up in emergency rooms and even hospital inpatient beds at much higher frequencies than the rest of the Medicaid population; and
    - Recent claims data shows that 25% of individuals with I/DD in NYS have had two or more emergency department visits in the last 12 months;
- A large majority of CCO/HH enrollees are dually diagnosed with both a developmental disability and a behavioral health disorder, making them amongst the most difficult-to-manage populations from a medical perspective.

We understand the challenges the State faces in managing special needs populations and especially those with complex substantial medical, developmental, and behavioral needs. Therefore, we strongly urge that DSRIP 2.0 support provider-led efforts by CCO/HHs and I/DD provider agencies to move the I/DD population into managed care and/or alternative models that align incentives in order to improve outcomes and reduce costs consistent with the goals of the waiver amendment proposal.

With our geographic footprint throughout the entire state and long history serving this high-cost special needs population, TriaDD, its three member CCO/HHs, and its over 150 not-for-profit I/DD provider agencies are among the most uniquely positioned collaborative to address the complex health, long-term care, and social support needs of people with I/DD as part of the VDE structure.

We very much appreciate having the opportunity to share feedback on the draft DSRIP waiver amendment proposal.

Sincerely,

Walter Stockton
Board Chairman
TriaDD, LLC

Nick Cappoletti
Chief Executive Officer
TriaDD, LLC

## doh.sm.1115Waivers

**From:** Tuten, Richard [redacted]
**Sent:** Monday, November 4, 2019 4:25 PM
**To:** doh.sm.1115Waivers
**Cc:** [redacted]
**Subject:** Comments on DOH waiver Extension Request.
**Attachments:** CBHS Response to DSRIP Waiver Extension.pdf



Please see attached CBHS' comments on the above captioned document.

Thank you,

Richard M. Tuten, J.D., M.S.A.
Chief Executive Officer
CBHS IPA, LLC
70 Hatfield Lane, Suite 205
Goshen, NY 10924
[redacted]
For scheduling please contact:
Norma Byrne
[redacted]

CBHS
Independent Practice Association

To Whom It May Concern:

November 4, 2019

I am pleased to write in support of the DSRIP waiver Amendment Request. In 2012, a group of behavioral health providers in the lower Hudson Valley created Coordinated Behavioral Health Services ("CBHS"). In 2014, CBHS created CBHS IPA, LLC ("CBHS IPA") as a vehicle to explore managed care contracting opportunities.

In 2018, CBHS IPA received a Behavioral Health Care Collaboration ("BHCC") grant and merged with Coordinated Care Network of the Hudson Valley IPA, Inc. ("CCN"), another BHCC grant recipient. Prior to the merger CBHS IPA began entering into managed care agreements on behalf of its membership.

CBHS IPA consists of providers of mental health services, substance use services and services related to the social determinants of health. In addition, CBHS IPA is exploring a mechanism to collaborate with a burgeoning Social Determinants of Health Network in the Hudson Valley. We continue to work to integrate these services with the physical health providers.

Currently CBHS IPA participates in one full-risk (VBP Level 2) arrangement through a joint venture and in a Next Generation ACO with a health system partner. Another CBHS IPA contract requires CBHS IPA to handle the transitions for clients moving from inpatient facilities into an outpatient treatment environment. The United Hospital Fund has recognized this contract as a Promising Practice under the DSRIP program.

To further support the move to value based payment contracting, CBHS IPA believes that behavioral health IPAs ("BH IPA") should be able to participate in total-cost–of-care managed care contracting directly with payers. The State can accomplish this through support for a modified attribution model that would encourage the payers to attribute covered lives to the BH IPA based on the preponderance of care provided. (i.e. if a client is receiving services from their mental health provider on a weekly basis and services from the primary care provider on an

annual basis, the client will have a closer affinity to the mental health provider.) CBHS believes that this direct attribution should be included in the Extension request.

Finally, to enhance the MCO's motivation to contract with BH IPAs, the network adequacy requirements should be expanded to include detailed metrics for behavioral health, including social determinants of health.

As a current risk-bearing BH IPA, CBHS IPA supports the expansion of the DSRIP format to allow CBOs, IPAs, BHCCs, etc to participate as Value Driving Entities ("VDE"s). CBHS IPA has seasoned managed care leadership that is anxious to perform the duties of a VDE

Thank you for your consideration of these statements.

s/Liz Kadatz
Chief Operating Officer
Rehabilitation Support Services, Inc.
Co-Chair of the Board
CBHS IPA, LLC

s/Richard M. Tuten, Esq.
Chief Executive Officer
CBHS IPA, LLC

## doh.sm.1115Waivers

**From:** Brett Lawton [redacted]
**Sent:** Monday, November 4, 2019 4:28 PM
**To:** doh.sm.1115Waivers
**Subject:** 1115 Public Forum Comment
**Attachments:** SNAPCAP-SIPA comments on NYDOH DSRIP 2.0 Waiver.pdf



Please accept these comments from the Safety Net Association of Primary Care Affiliated Providers of Western New York.
Thank you, Brett

--

**Brett Lawton, MPA**
**Executive Director**
***Safety Net Association of Primary Care Affiliated Providers of WNY, Inc. &***
***Safety-Net IPA (SIPA)*** *- The Independent Practice Association of the Safety Net Association of Primary Care-Affiliated Providers (SNAPCAP) of WNY, Inc.*

3297 Bailey Ave. Buffalo, NY 14215

[redacted]

SNAPCAP
Safety Net Association of Primary Care Affiliated Providers of WNY

**Comments on NYDOH DSRIP 2.0 Amendment Request**
**October 2019**

The Safety Net Association of Primary Care Affiliated Providers of Western New York (SNAPCAP) is grateful for the opportunity to provide input to the laudable efforts to continue transformation of New York's Medicaid program to improve efficiency, accessibility and sustainability as outlined in the concept paper published no September 17th. SNAPCAP is an organization that represents 12 primary care safety net providers – FQHCs and Article 28 licensed clinics - serving the 8 counties of Western New York. In 2019, together our member organizations served 181,000 patients. This is approximately 13% of the Western New York population. Our 12 organizations provided nearly 700,000 primary care, behavioral health and dental visits. Our member organizations serve mostly people receiving Medicaid and represent expertise in a range of special populations–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 behavioral health disorders, people struggling with addictions, and people with intellectual or physical disabilities. In 2018, we formed an Independent Practice Association, called the Safety-Net IPA, to help prepare our organizations for value-based payment reform and to help ourselves down the Value Based Payment Roadmap.

SNAPCAP recognizes the many successes of the first Delivery System Reform Incentive Payment (DSRIP) program brought to our state and our organizations are happy to have been a part of them. We strongly believe that continued transformation of the health care delivery system and sustainability of the great progress made to date will require significant investment in community-based primary care. Further facilitating and enabling community-based primary care to successfully participate in Value-Based Payment reform programs will allow the State to achieve a real value-based system that improves health outcomes and reduces costs. SNAPCAP supports the renewal of the DSRIP program through March 31, 2024, but strongly urges inclusion of the following recommendations for improvement upon the original program in the proposed amendment request.

1. **Provide core funding support for Safety-Net Primary Care-led IPAs**

As the State has invested in core funding support for the formation of Independent Practice Associations for Hospital systems, Behavioral Health provider systems and Community Based Organizations systems. **We strongly recommend the next iteration of the DSRIP program to provide core funding support for safety-net primary care provider-lead Independent Practice Associations and/or Accountable Care Organizations**. A few have already formed – have fledgling infrastructure, and are in some degree of VBP arrangements. These organizations – ours included – have some limited grant support funding from charitable foundations, but lack capital reserves sufficient to fund necessary staffing, purchase and maintain the complex data systems to manage the care of the people we care in improved and more efficient ways and to be able to enter into risk-bearing contracts. Core funding support would allow us to focus on necessary member support efforts, rather than fundraising. Since the state has demonstrated support for the creation of such entities for Hospitals (through DRSIP), Behavioral Health

providers (through the NYS Behavioral Health Value Based Payment Readiness Program) and Community Based Organizations (CBOs) (through the Grants for CBOs to facilitate their engagement in DSRIP activities), we think this is very much in line with the State's DSRIP program goals.

2. **Mandate and/or incentivize a fair and representative governance model for the Value Driven Entities**

In the first round of DSRIP, governance of the hospital-lead Performing Provider Systems (PPSs) is heavily dominated by hospital representation. In our experience, the solutions recommended by the PPS projects were already begun before inviting input from non-hospital stakeholders, such as primary care providers and primary care provider-lead IPAs, behavioral health organizations, etc. Non-hospital representatives were offered a seat or two on matters of governance, but clearly were out-represented by hospital representation**.** Governance and direction for transformative activities affecting primary care should have *equal* input from community-based health care organizations regardless of entity represented, whether in PPSs or Value Driving Entities (VDEs). **Therefore, we strongly recommend that the State mandate and/or incentivize *equal* representation of affected providers and patients on the governance of DSRIP 2.0 activities.**

3. **Mandate and/or incentivize multi-party PPS participation where there are overlapping service areas**

Our patients seek care from the hospital provider that is closest to their home or one they have good experience with. In our experience, this may not be the same PPS as the hospital-based PPS system that a primary care provider participates with. This leads to difficulties in current models which don't factor in patient use of multi-hospital lead PPS where service areas overlap. Projects to receive funding and improve care offered by the PPS, are restricted to the PPS service area. The new model should create a structure that is hospital "agnostic" – facilitating transformation efforts based on the realities of an entire community, rather than one focused on particular hospital systems. **The next round of DSRIP should incentivize and/or mandate cross-PPS participation where there are overlapping service areas.**

4. **Mandate and/or incentivize Managed Care Organizations to provide data upfront on the patients served**

In our preliminary experience with Value-Based MCO contracts, data about the patients served by the MCO has been provided very late into the contract year and in formats that make it very difficult to determine where patients are actually receiving services. This makes us lack comprehensive care data about our population and prevents us from determining *where* care is actually being received and by *whom*. Without having insight into who are out best partners – whether they be behavioral health organizations, long term care entities and/or community-based organizations, we can't engage in the right partnerships for improving health outcomes when they span to areas outside of primary care, such as with behavioral health agencies, long term care or community-based organizations that address social determinants of health, especially in light of the envisioned VDE model. **We ask the State to mandate and/or incentivize Managed Care Organizations to provide upfront data about the patients served by our providers, be it individually or through IPA/ACO structures.**

SNAPCAP and our member health centers have long recognized the complexity of need our patients have and have responded to them by building robust and comprehensive care services around our patients. We have also been actively engaged in DSRIP implementation and have contributed to many of the successes achieved to date. ***The State must ensure that Primary Care is at the forefront of Medicaid payment reform efforts to support the most cost-effective delivery system of health care.*** We look forward to continue partnering with the State to achieve our shared goals of system transformation and improved patient care, better patient outcomes and reduced care costs. DSRIP 2.0 should recognize and further fund the already great work the safety net primary care efforts to prevent an even more costly Medicaid program.

## doh.sm.1115Waivers

**From:** Kevin Munjal [redacted]
**Sent:** Monday, November 4, 2019 4:27 PM
**To:** doh.sm.1115Waivers
**Subject:** 1115 Public Forum Comment
**Attachments:** NYMIHA Letter re DSRIP extension v3.pdf



To Whom It May Concern,

Please see attached Response to Request for Public Comment Re: 1115 Waiver Program (DSRIP) Amendment Draft on behalf of the New York Mobile Integrated Healthcare Association.

Thanks,

--
Kevin G. Munjal, MD, MPH
Assistant Professor, Emergency Medicine / Population Health
EMS Medical Director, Mount Sinai Hospital
Icahn School of Medicine at Mount Sinai
&
Founder, NY Mobile Integrated Healthcare Association
Medical Director, Trek Medics International
[redacted]

**Kevin Munjal, MD, MPH**
Chair, New York Mobile Integrated Healthcare Association
c/o Department of Emergency Medicine
Icahn School of Medicine at Mount Sinai
One Gustave L. Levy Place, Box 1620
New York, NY, 10029
[redacted]

Medicaid Redesign Team
New York State Department of Health
Office of Health Insurance Programs
One Commerce Plaza
Albany, NY 12207

**Response to Request for Public Comment**
**Re: Draft DSRIP Waiver Amendment**

The New York Mobile Integrated Healthcare Association (NYMIHA) strongly supports New York State's (NYS) effort to extend the 1115 Waiver Program (DSRIP) to continue to deliver benefits to Medicaid recipients, create efficiencies in the Medicaid program, and enable the extension of coverage to certain individuals who would otherwise be without health insurance. However, NYMIHA would like to **strongly recommend explicit inclusion of Emergency Medical Services (EMS) agencies and prehospital care providers like emergency medical technicians (EMTs) and paramedics** as part of the strategy to support Medicaid beneficiaries with improved access to care in their communities for both post-acute and unscheduled acute care needs.

NYMIHA is a statewide coalition seeking to promote innovative emergency medical services. We support efforts to make EMS more patient-centered, more adaptive to changes in the healthcare system, and more integrated into the continuum of healthcare delivery and the public health infrastructure. Over the past 6 years, NYMIHA and its members have helped to assemble a broad-based coalition including emergency physicians, primary care, labor unions, health information exchanges, telemedicine providers, hospital groups, as well as EMS agencies, Regional EMS Councils, EMS trade associations, and more, around the issue of mobile integrated healthcare.

Many of the state's DSRIP entities, including Mount Sinai, Montefiore, Bronx Partners, and Nassau Queens have already leveraged partnerships with EMS as part of their approach to reducing avoidable ED visits and hospitalizations with tremendous success. NYS has the opportunity to leverage the DSRIP extension process to continue to support and grow this emerging care model which is consistent with the Medicare's own recent launch of the Emergency Triage, Treat, and Transport (ET3) model which seeks to support EMS innovation in offering patients alternatives to transport to the ED.

We believe modifying the application to include EMS will improve the care provided to and overall health of the people of New York. Empowering New York's EMS providers to play a larger, more integrated role within our healthcare system will foster new collaborations and accelerate innovation for proactive out-of-hospital programs. Doing so will help to realize the Institute for Healthcare Improvement's Quadruple Aims: better quality, better patient experience, better clinician experience, at lower per-capita cost.

Sincerely,

Kevin G. Munjal, MD, MPH
Chair, NY Mobile Integrated Healthcare Association

## doh.sm.1115Waivers

**From:** Megan Landreth [redacted]
**Sent:** Monday, November 4, 2019 4:30 PM
**To:** doh.sm.1115Waivers
**Subject:** DSRIP 2.0 Comments



NYS Department of Health
Office of Health Insurance Programs Waiver Management Unit
99 Washington Avenue, 12th floor, Suite 1208
Albany, NY 12210

To Whom It May Concern:

Horizon Health Services, Inc., and Horizon Village, Inc., (Horizon Corporations), welcomes the opportunity to submit feedback to the NYSDOH on the draft DSRIP Amendment request. We are submitting comments and feedback that reflect our experience as a provider of Behavioral Health (BH) services to a large population of Medicaid recipients.

Our specific requests include:

- The Substance Use Disorder outpatient treatment system needs to serve as the hub for treatment and recovery services. Medication Assisted Treatment is a component of the treatment this system delivers, is not the sole method of treatment.
- The amendment does not mention the Mental Health outpatient system. Hospitals and inpatient care are appropriate for only a portion of the population. Without a Mental Health outpatient system, there is nowhere for patients to receive care.
- Early intervention and engagement in BH treatment prevents high health care costs later in life. Savings attributed to these early interventions should be shared with BH providers.
- Total cost of care contracts must be part of the opioid crisis response.
- Infrastructure funds are necessary to facilitate interoperability among ambulatory providers, inpatient providers and MCOs. Stand-alone EHR systems do not work.
- Workforce dollars could level the playing field between hospitals and community-based providers.

**Total Cost of Care Contracts:**
The highest cost Medicaid recipients have behavioral health disorders. Whether they are people with serious mental illnesses and chronic substance use disorders, or people with medical conditions whose costs of care are exacerbated by a behavioral health disorder, the greatest potential savings comes from meeting Medicaid recipients' behavioral health needs. Total cost of care contracts are essential for the financial viability of behavioral health providers – especially the outpatient treatment system.

**Workforce Crisis:**
The work our clinicians are doing is significantly undervalued in the health care industry. Community based BH providers routinely lose candidates and employees to more robust hospital and health care systems, while our patient demand increases. Inadequate rates do not support the work our providers are doing. Student loan debt is burying our credentialed providers and licensed counselors. BH providers need workforce dollars in order to level the playing field between hospital and the community-based safety net providers.

**Community Behavioral Health Providers need funding:**

Research and metrics demonstrate the fact that early intervention in treatment prevents future high health care costs. However, the initial DSRIP program directed most funds to hospital, acute, and primary care sources, while minimizing the savings attributable to behavioral health. Specifically, behavioral health providers have received a fraction of the Medicaid-reform funds for transformation efforts. The work done by BH providers' yields valuable savings. Savings should be shared with the responsible BH providers.

**Infrastructure:**
Funds to facilitate interoperability among ambulatory providers, inpatient providers and MCOs are essential to improved outcomes. Behavioral Health providers need financial support to develop sustainable interoperability within a community network. Integration of Electronic Health Record systems among all healthcare providers is essential to creating efficiencies within the healthcare system.

We thank you for this opportunity to share our comments about this amendment.

**Megan Landreth** | Legal Counsel & Government Relations Director | Health Management Group
55 Dodge Rd. Getzville, NY 14068 | [redacted]
Together for Recovery. Changing Lives. Saving Lives. | www.horizon-health.org

## doh.sm.1115Waivers

**From:** Sara Wall Bollinger [redacted]
**Sent:** Monday, November 4, 2019 4:33 PM
**To:** doh.sm.1115Waivers
**Cc:** [redacted]
**Subject:** NYSARH 1115 Public Forum Comment
**Attachments:** NYSARH DISRIP 2.0 Final.pdf



Hello
Please see Public Comment from the NYS Association for Rural Health, attached.
Thank you.

--
Sara Wall Bollinger
Director for Strategic Development
[redacted]

**The Mission of NYSARH is to improve the health and well-being**

**of rural New Yorkers and their communities.**

# New York State Medicaid Redesign Team 1115 Research & Demonstration Waiver Delivery System Reform Incentive Payment (DSRIP) Amendment Request

## Public Comment

The NYS Association for Rural Health (NYSARH) appreciates the opportunity to comment on the proposed Waiver Amendment.

### Introduction

The New York State Association for Rural Health suggests that the 1115 Research & Demonstration Waiver include a 'Rural Lens'. Promising Practices that work well in an urban environment may not translate to the 45 of 62 Counties (73%) that are rural. New York State defines a county as being rural if it has a population of less than 200,000. The scope of NYSARH includes the all rural counties in New York State.

- Fewer than 50,000 residents: Allegany, Cortland, Delaware, Essex, Greene, Hamilton, Lewis, Orleans, Schoharie, Schuyler, Seneca, Wyoming, Yates
- 50,000 – 100,000 residents: Cattaraugus, Cayuga, Chemung, Chenango, Clinton, Columbia, Franklin, Fulton, Genesee, Herkimer, Livingston, Madison, Montgomery, Otsego, Putnam, Steuben, Sullivan, Tioga, Warren, Washington, Wayne
- 100,000 – 200,000 residents: Chautauqua, Jefferson, Ontario, Oswego, Rensselaer, St. Lawrence, Schenectady, Tompkins, Ulster
- Portions of Dutchess and Orange Counties are federally designated as rural also.

DSRIP 2.0 will be both finite in funding and in time. With that understanding NYSARH recommends that these funds be invested in promising practices and new approaches that can build sustainable solutions for New York's rural communities that integrate primary care, behavioral health and social determinant of health solutions. The mechanism for launching new sustainable solutions should be robust investment in innovative pilot and demonstration projects that are sustainable overtime through savings realized under VBP contractual arrangements.

**Rural communities can develop rurally appropriate solutions. NYSARH recommends that a portion of the DSRIP 2.0 funds, no less than $45 million, be designated for Rural Health Pilot Projects.**

- NYSARH suggests a 36-month Pilot funding RFP specific to rural priorities. The States 30+ Rural Health Networks should be encouraged to sponsor projects.

NYSARH understands that the 1115 Waiver is for Medicaid only, but we encourage the Department of Health to develop Pilot Projects that address All Payers. New York State initiatives such as Health Across All Policies and the NYS Prevention Agenda address health disparities for ALL New Yorkers. We encourage the DOH to broaden its vision for the possible impact of DSRIP 2.0.

NYSARH supports the proposed Waiver's alignment with Federal priorities, behavioral health, prevention services, long-term care and maternal/newborn health.

NYSARH supports solution-oriented Demonstration Projects to prove improved outcomes and/or lower costs that may become sustainable via Value Based Payment arrangements with insurance companies. We note that health insurance companies need to agree to these ideas in order for DSRIP 2.0 to be successful. The State must incentivize MCOs to engage with the CBO community in pilot project development and investment.

NYSARH asks DOH to consider revising the CBO Designations to recognize that there are Tier 2 CBOs whose primary business in **not** Medicaid-funded. It is important to ensure rural CBOs that do a limited amount of Medicaid-funded work, but mostly provide non-Medicaid services, are not disadvantaged, thus disadvantaging the rural populations they serve. [examples: Tioga Opportunities, Healthcare Consortium of Columbia County]

In the DSRIP 2.0 concept paper that was distributed by DOH 9/17/19, funds flow was not articulated. NYSARH recommends that the methodology that DOH will propose needs to be more clearly articulated.

Funding should be included in DSRIP 2.0 to support the three CBO Consortiums created during the original DSRIP. NYSARH suggests $1 million each per year for four years = $12 million.

As New York State privatizes Medicaid services to Managed Care insurance companies it is important to preserve recipient Due Process rights. DSRIP 2.0 needs to include a Patient Bill of Rights that the MCOs are contractually required to uphold.

Rural communities typically experience shortages of health, behavioral health, long-term care and dental providers. Residents experience challenges with access to transportation and long distances to appropriate care providers. Rural residents experience significant health disparities compared to urban residents. On average, rural residents die two years earlier than urban residents of New York.

https://www.ruralhealthinfo.org/topics/rural-health-disparities

Please see the Rural Health Strategy recommendations links below:

https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Rural-Strategy-2018.pdf

https://www.arc.gov/assets/research_reports/BrightSpotsCaseStudiesJuly2018.pdf

https://www.rd.usda.gov/files/RuralResourceGuide.pdf

https://www.qualityforum.org/Publications/2018/08/MAP_Rural_Health_Final_Report_-_2018.aspx

**Section I: Historical Summary**

- No comment

**Section II: Changes Requested**

NYSARH supports the overarching goals of the proposed Amendment to continue the transition from fee-for-service to alternative payment mechanisms, align with federal goals and to fully develop 'promising practices' developed during the first four years of the DSRIP Waiver.

**Value-Driving Entities**

- There are 25 PPSs in the State. It is important that the state clarify the numbers of VDEs envisioned. While 25 VDEs may be too many, NYSARH is very concerned that a "mashing together" of the PPS regions could have a significant negative impact of New York's rural communities. Far too often areas in the Catskills, Finger Lakes and Southern Tier have their voices drowned out by their upstate urban neighbors.
    - Proposed regions must be open to public comment prior to implementation.
    - When considering VDE regions, please give thought to aligning the counties included in the DSRIP region/market not only with existing PPSs, but also with MCO service areas and QE service areas. Some counties are shared and split into several regions/markets.
    - Support 'additional flexibility to align the best future management structure for the given region/market'

- We are not sure how to integrate multiple competing MCOs [some for-profit, some not] in governance leadership and collaborative structure. As mentioned above, DSRIP 2.0 needs to include incentives for MCOs to engage directly with CBOs and the Behavioral Health Care Collaboratives that have established IPAs. To date many overtures from these newly engaged entities have been rebuffed by the MCOs.

- Strongly support inclusion of Qualified Entities. There was much overlap/duplication in the first roll-out of PPSs with work already done to develop the RHIOs.

- Applaud the requirement to have 'representation from community-based providers, including primary care, behavioral health and long-term care'
    - Recommend requiring the addition of health home and children's health home care coordination agencies
    - The inclusion of CBO's is referenced on page 7 'an inclusive governance structure that includes a range of providers, MCOs and CBOs in executive steerage'
        - We wish to emphasize that this makes CBO's an equal partner with the MCOs, hospitals, community-based providers, behavioral health and long-term care agencies.
    - NYSARH recommends requiring inclusion of Rural Health Networks on the VDE governance boards for those VDEs that are serving New York's rural counties.
    - Suggest that additional representation on VDE governance include pre-hospital care providers such as County 911 and regional EMS organizations.

- Support building on progress already being made by ACOs, IPAs, BHCCs etc.

**Section III: Additional Priority Areas**

- Support reducing maternal mortality and low birth weight.
    - Build on existing County-based public health initiatives
    - Build on the existing pre-natal/peri-natal coalitions that exist throughout the State
    - One project could be expanding access to doula services for women with high-risk pregnancies.
    - Bring a 'rural lens' to any proposed 'maternity bundle'. Many rural women do not have timely access to full-service obstetrical care.

- Support more effective interventions for high need children.
    - Engage with Schools, Police and Counties from the beginning – they have been working to develop mental health systems of care, foster care prevention, support for children with special needs and early intervention for decades.
    - In rural settings the Mobile Crisis Team is likely to be a more effective model than a Mental Health Urgent Care center.
    - For children with significant disabilities or illness [CP, MD, cancer, HIV etc.] utilize best practices learned from previous waivers such as the Care at Home Waiver to provide more flexible and family-oriented supports & services.

- Support training and cross-system collaboration to enhance trauma informed care and address the impacts of Adverse Childhood Experiences (ACE).
- Support Demonstration Programs that address mental health, substance use, stigma and suicide among children and teens including LGBTQ teens.
- NYSARH suggests that the DSRIP 2.0 funding may provide a unique opportunity to drive mental and behavioral health resources into rural K-12 schools for a multi-year Demonstration Project that will provide 'proof of concept' to justify long term funding. Examples include
  - The school mental health training center at MHANYS,
  - School-based clinics sponsored by community health centers,
  - System of Care programs.
- This funding might also be used to explore an expanded role for School Nurses.

- Long-Term Care Reform
  - No amount of reform will work without additional resources. Medicaid funding for all levels of long-term care needs to be <u>significantly</u> increased for the system to provide even the uneven level of quality that is currently available.
  - Systematic cost savings may be achieved by investing more in pre- and inter-institutional supports such as Telehealth, Community Paramedicine, Community Health Workers, Health Navigators, Peer Advocates, Visiting Nurses and Personal Assistance.
  - Support for Social Determinants of Health such as safe, accessible and affordable housing and nutritious, accessible and affordable food may also reduce expensive institutional placements.
  - Support INTERACT collaboration between hospitals and skilled nursing facilities.
  - Support leveraging Qualified Entities to crosswalk Medicaid and Medicare data.
  - NYSARH recommends seeking out projects that creatively and effectively address the needs of family caregivers such as information, referral, peer support, emergency and planned respite and expansion of the Consumer Directed Personal Assistance Program.
  - Include recommendations of the DOH 'Long Term Care Planning Project'.
    - Pilot Projects involving older adults should demonstrate meaningful coordination with their Area Agency on Aging and NY Connects program.
    - More indicators are needed to address services for older adults.

- Hot Spot Areas
  - DOH should use this opportunity to revisit the status of healthcare in 'hotspot' areas to learn if progress has been made and if so, spread information about best practices.

**Section IV: Continued Investment/Improvements**

- **Workforce Flexibility & Investment**
  - Support non-traditional workforce initiatives such as Community Health Workers, Health Navigators, Community Paramedicine & Peer Advocates
  - Support NYS covering the training and continuing education costs for these para-professional staff. Also providing remote, webinar and multi-site training opportunities accessible to people in rural communities.
  - Partner with the existing Area Health Education Centers, which are located in each region, to leverage existing infrastructure.
  - Engage the paraprofessional workforce in developing benchmarks and realistic outcomes for Value Based and/or Bundled Payment options.
  - Provide at least 'living wage' salaries for these types of positions. Too often, people in these positions are part-time, 'gig' contractors, volunteers or minimum wage employees.
  - Develop criteria, regulations and funding for EMS Paramedicine.
  - Innovative models are needed to support Home Health Aide, Certified Nurse Assistant, Personal Assistant and informal caregiver workforce needs.
  - Include projects that incorporate diversity and cultural sensitivity initiatives.
  - Encourage partnerships with existing workforce development programs with Department of Labor, ACCES-VR, VISTA and AmeriCorps.
  - NYSARH supports the use of peer support and peer mentors but cautions that these personnel are not a replacement for clinical services.

- **The Professional Workforce Needs Investment as well**
  - There is a significant shortage of behavioral health providers
    - NYSARH recommends funding a Pilot sustainable infrastructure Value Based Payment project that includes incentives for paid preceptorships to provide supervision time for disciplines that require a period of supervised work.
    - Another Value Based Payment Pilot project should be designed to look at behavioral health caseloads, burnout, job changing and opportunities to work at 'top of license'.
  - NYSARH recommends more funds for Rural Workforce recruitment, development, training, preceptors, residencies, internships and support.
  - NYSARH recommends some reform to immigration and licensure regulations.
    - There seems to be some need to address federal immigration policies.

        - NYS should be more flexible in allowing licensure for providers trained in other countries. Current licensure standards limit access to providers.
    - NYSARH supports adding rights for a wider variety of academically prepared mental health practitioners to bill Medicaid and be included in Medicaid VBP arrangements. These disciplines should include Licensed Certified Social Workers (LCSW) with or without the 'R' designation, Marriage and Family Therapists, Rehabilitation Counselors, Art Therapists and Music Therapists.
    - NYSARH encourages DSRIP 2.0 to fund Demonstration Projects that foster connectivity and coordination between medical universities, nursing schools and affiliated health professional training programs with rural internships and residencies, preceptors, immersion experiences and other programs to enhance the success of professional recruitment to rural areas.
        - Explore designating a portion of Doctors Across NY funding specifically for providers practicing in rural areas
    - Include projects that incorporate diversity and cultural sensitivity initiatives that address disparities in health outcomes.
        - While racial and ethnic disparities are undoubtedly important, please consider rural disparities in this part of the design.

- **Coordinated Population Health Improvement**
    - Support incorporation of Prevention Agenda Goals
    - Build on existing County-based public health initiatives
    - Build on best practices from the Population Health Improvement Program (PHIP) contracts now wrapping up
    - Support Medicaid, Medicare and a 'multi-payer lens' to promote '360° population health' [page 10]
    - The State should encourage MCOs that offer Medicare Advantage Plans to pay for evidence-based population health programs.
        - Pay for chronic disease self-management programs.
        - Support Social Determinants of Health services [transportation, nutrition, utilities etc.]
        - Expand the use of Special Supplemental Benefits for Chronically Ill to coordinate better with Medicaid-funded services.
    - Incentives should be provided for care transition, care management and care transition programs using patient navigators and community health workers to support better health outcomes for people with chronic conditions.

- **Social Determinant of Health Networks (SDHN)**
    - NYSARH recommends that the three CBO Consortia developed as part of the original DSRIP be engaged in the development of the SDHN and that they receive continued funding under DSRIP 2.0 to do this work.

The State should leverage the investment and relationships already developed through the Consortia as the foundation for the SDHN.

- We understand the SDHN to be a collaborative entity similar to an IPA or ACO for CBOs. An existing example may be the WNY Integrated Care Collaborative.
- The SDHN will require a Community Information Exchange (CIE) to effectively deliver, monitor and evaluate service delivery. What is the DOH plan for an information system (or systems) for non-clinical data sharing?
    - Please connect with the CIE Planning Project, currently in process, funded by the Health Foundation for Western & Central New York.
- Align the counties included in the SDHN region/market not only with existing PPSs, but also with MCO service areas and QE service areas.
    - Recognize and build upon existing SDH CBO delivery systems and naturally occurring networks. PLEASE do not create a new artificial construct. Let each Region select its members and leadership.
- Support extra attention for Medicaid members with complex health and social needs and children/families at risk of adverse childhood experiences.
- There is still a need for transportation solutions in rural areas that address non-medical needs such as trips to the pharmacy or grocery store. Current Medicaid transportation regulations do not permit rides for Social Determinants of Health and other needs such as employment support, probation/parole/child welfare and housing searches. We believe DSRIP 2.0 may provide an opportunity to reform Medicaid transportation regulations to permit more flexible uses of existing services, open opportunities for more public transit and support hybrid models that combine transportation methods, including volunteers.

- **Addressing the Opioid Epidemic**
    - Support for the proposed Opioid interventions
        - Expansion of Medication Assisted Recovery is positive
        - One project suggested is to explore the challenges of integrating medically assisted recovery in with the work of primary care providers with a view towards more carefully researching what the barriers are, seeking opportunities for commonalities and working toward capacity development.
    - Recommend broadening this Investment/Improvement to include a range of addiction issues that have a significant impact on rural health morbidity and mortality such as Methamphetamine, Alcohol and Tobacco.
        - Vaping (electronic cigarettes) is a relatively new area of health concern that may also need to be included.

**Section V: Performance Measurement**

- It is not clear in the Draft document (9/17/19) how people will be attributed to the VDEs. Please provide greater clarity about attribution in the next version of the Waiver application.
- The quality indicators chosen will greatly impact the financial benefits for VDEs, MCOs, SDHNs and their partners. An inclusive and broad-based input process should be developed during the next few months to pin down the quality indicators that will be used to calculate bonuses in VBP arrangements within DSRIP 2.0.
- NYSARH recommends that the revised Waiver application specify the role of the Project Approval and Oversight Panel to monitor projects selected for funding, actual funds flow, as well as project milestones and outcomes.
- NYSARH understands that documentation is essential, but our members' experience with previous initiatives has been that required documentation has been burdensome, expensive and led to some people leaving the healthcare field. We encourage a more balanced approach.

**Section VI: Interim Access Assurance Fund**

- NYSARH supports additional funding for financially distressed safety net hospitals.
- Please note that the reason many of these hospitals are financially distressed is their high percentage of patients with Medicaid insurance. While one-time funding is appreciated, the real solution is for Medicaid rates to cover the true cost of care.
- There needs to be a significant investment in subsidized Rural Residencies and Rotations to encourage new MDs, NPs, DOs and PAs to practice in rural communities.

**Section VII: Evaluation**

- NYSARH believes that the voices of people served are an essential component to an effective evaluation process. We recommend that the evaluation include an assertive in-person outreach component to a diverse range of Medicaid members who are high users of healthcare. "Nothing about us without us."

**Section VIII: Budget**

- Rural communities can develop rurally appropriate solutions. NYSARH recommends that a portion of the DSRIP 2.0 funds, no less than $45 million, be designated for Rural Health Pilot Projects.
- Funding should be included in DSRIP 2.0 to support the three CBO Consortiums created during the original DSRIP. NYSARH suggests $1 million each per year for four years = $12 million.
- As New York State privatizes Medicaid services to Managed Care insurance companies it is important to preserve recipient Due Process rights. DSRIP 2.0 needs to include a Patient Bill of Rights that the MCOs are contractually required to uphold.

- In the DSRIP 2.0 concept paper that was distributed by DOH 9/17/19, funds flow was not articulated. NYSARH recommends that the methodology that DOH will propose, needs to be clearly articulated and open to public comment.

**Section IX: Summary**

- No comment

**About NYSARH**

The Mission of NYSARH is to improve the health and well-being of rural New Yorkers and their communities. NYSARH is a not-for-profit, non-partisan, grassroots organization working to preserve and improve the health of the citizens in rural New York State. NYSARH was founded in July 2001. The organization is affiliated with the National Rural Health Association.

NYSARH is a membership organization. NYSARH membership includes representatives of all facets of the rural health care industry, as well as individuals and students. On many different levels, NYSARH serves individuals, consumers, non-profit organizations, government agencies and officials, health care facilities, emergency medical service providers, long-term care organizations, businesses, universities, foundations, associations, and other stakeholders in rural health. NYSARH members include rural hospitals and federally qualified health centers located in rural communities.

Federal approval is not guaranteed. How can NYSARH help?

*Submitted 11/4/19*

## doh.sm.1115Waivers

**From:** Bryn Coughlan [redacted]
**Sent:** Monday, November 4, 2019 4:36 PM
**To:** doh.sm.1115Waivers
**Cc:** Shang Wang; Gil Addo; Carlos Reines
**Subject:** RubiconMD eConsult Platform -
**Attachments:** RubiconMD DSRIP Comments_NOV42019.pdf



Hello,

The RubiconMD team has attached comments they would like to be considered regarding the 1115 Medicaid Waiver Programs, and have also outlined those comments below.

We very much appreciate the State's consideration of our thoughts.

---

November 4th, 2019

NYS Department of Health
Medicaid Redesign Team
1115waivers@health.ny.gov

**Re: New York's 1115 Medicaid Waiver Programs**

RubiconMD would like to thank you for the opportunity to comment on New York's 1115 Waiver Program, and for the support New York State Department of Health's Delivery System Reform Incentive Payment program has given primary care clinicians who care for Medicaid beneficiaries throughout our communities. This past year, NYS primary care clinicians have been able to leverage eConsults to improve the access and quality of care delivered to NYS' Medicaid beneficiaries. This access would not have been possible without the support of the DSRIP program. To continue to support primary care clinicians with the same day specialist insights provided by eConsults, we advocate for the state's continuation of the DSRIP program, and consideration of expanding promising practices that include telehealth, such as eConsults that support value-based care, timely access for beneficiaries and cost-savings for Medicaid.

Background on RubiconMD

RubiconMD is the leading interprofessional internet consultation (eConsult) provider in the industry, with presence in 37 states. Through our proprietary digital platform, we connect primary care clinicians with medical inquiries to specialists with the expertise to address these inquiries. To date, RubiconMD has successfully managed over **1 million eConsults**, reaching more than **4,000 clinicians** across the country.

The RubiconMD platform allows primary care clinicians to submit questions to a panel of top-tier specialists collectively representing 120 specialties and subspecialties. eConsults are addressed in a median response time in less than 3 hours. This quick response time allows primary care clinicians to incorporate top-tier

specialty insights into their patients' care plans without having to refer patients to a specialist for an in-person visit; improving access, quality and efficiency of NYS Medicaid beneficiaries' care. Alongside augmenting Medicaid beneficiaries' care plans, eConsults serve as an educational tool for primary care clinicians, empowering the providers who treat NYS Medicaid beneficiaries. Primary care clinicians can claim ½ of one Category one CME credits through the American Academy of Family Physicians (AAFP) for each eConsult they indicate was educational, enhancing the education of the workforce through upskilling to provide better care and understanding in future care plans for the clinician.

With the support of the Mount Sinai PPS, RubiconMD has been able to support NYS primary care clinicians with 1,500 eConsults submitted in the last 12 months. 75% of those eConsults were indicated to improve the patients' care plan and 35% were indicated to avoid unnecessary medical services. Thanks to the support of the DSRIP funding through the Mount Sinai PPS, we have seen a three-fold increase the volume of eConsult submissions from NYS clinicians, as we have been able to equip more clinicians with access to RubiconMD's same-day specialty insights.

Comments and suggestions and proven impact

RubiconMD supports the state's efforts to extend DSRIP funding, to allow continued funding for clinicians' access to RubiconMD. We agree that in order for better quality care to be achieved, integrated partnerships with multiple provider types, community-based organizations, payers and technological enabled companies are necessary to enhance a patient's care. We believe the state should continue to encourage public-private partnerships, specifically in technology as a necessary tool to facilitate care delivery that is convenient and targeted to the patient so they can all get the care they need at the right time, and at the right place. The impact we have seen eConsults have on NY patients have been outlined below. RubiconMD evaluates the impact of eConsults by leveraging outcomes that the submitting clinician reports after receiving insights from the specialist through the eConsult. Once clinicians have received a specialist's feedback, they can indicate that an eConsult has one or more of the following implications:

1. eConsults specialty feedback 'Avoided a referral'
2. eConsults specialty feedback 'Improved the patient care plan'
3. eConsults specialty feedback helped the submitting clinician 'Learn Something New'
4. eConsults specialty feedback had 'None of the above' impacts

The extension of DSRIP funding towards telehealth as a promising practice will allow this impactful tool to continue to be leveraged by NYS primary care clinicians to achieve the following results:

- **Improved access to specialty insights for Medicaid Beneficiaries:** NYS clinicians have submitted eConsults to 109 of 120 specialties available through the RubiconMD eConsult Platform. With 35%[1] of the eConsults having been indicated to avoid unnecessary procedures or specialty visits, we estimate that 6,513[1,2] patient wait days have been saved in the last month alone due to eConsults' readily available specialty insights.

- **Improved Care Quality:** Of the eConsults submitted by NYS clinicians since September 2018, 73%[1] of them were indicated to improve the overall quality of the patient's care plan. By improving the diagnostic workup done before a patient goes to see a specialist, primary care clinicians save the patient unnecessary follow up visits with that specialist. Quite simply, improving the quality of care delivered in the primary care setting improves the outcomes for NYS Medicaid beneficiaries.

- **Improved Physician Experience:** With each specialty response, the submitting primary care clinician has the opportunity to rate the quality of the eConsults. The rating system is composed of 5 stars, 1 star indicating the lowest possible quality rating and 5 stars indicating the highest. We saw an average star quality rating of 4.82 across all eConsults submitted by NYS clinicians in the past year[1]. We also saw a median response time of 1.90 business hours across all eConsults submitted by NYS clinicians in the last year[1]. This brief response time is particularly impressive when considering that clinicians can get insights from multiple specialties within that median response time for one patient case. Access to top tier specialty insights, from multiple specialties, within this timeframe founds a much more robust method of incorporating specialty feedback into patients' care. Finally, we saw that 204 of the eConsults submitted by NYS clinicians in this past year were used to recognize CME credit for the submitting clinician. This data indicates that eConsults are used as a high-quality tool for NYS clinicians, supporting them in their care of NYS Medicaid beneficiaries.

We commend NYSDOH for advocating for the extension of the DSRIP program. We have seen it to be a crucial conduit to improve the access to high quality care for NYS Medicaid beneficiaries, through its use to support primary care clinicians' access to eConsults.

Sincerely,

_____

Gil Addo
CEO and Co-founder
RubiconMD

--
Bryn Coughlan
[redacted]
Have a question? We're here to help

rubiconmd.com

November 4th, 2019

NYS Department of Health
Medicaid Redesign Team
1115waivers@health.ny.gov

**Re: New York's 1115 Medicaid Waiver Programs**

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[2] Merritt Hawkins Survey of Physician Appointed Wait Times

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Sincerely,

Gil Addo
CEO and Co-founder
RubiconMD

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[2] Merritt Hawkins Survey of Physician Appointed Wait Times

## doh.sm.1115Waivers

**From:** Alexandra Nudelman [redacted]
**Sent:** Monday, November 4, 2019 4:40 PM
**To:** doh.sm.1115Waivers
**Cc:** [redacted] Jennie Sutcliffe; Monika Pathak
**Subject:** Comments from NYC Health Department on NYS Delivery System Reform Incentive Payment (DSRIP) Amendment Request
**Attachments:** NYC Health Department Comments on NYS DSRIP Amendment Request.pdf



Hello:

Please see the attached for comments from the New York City Department of Health and Mental Hygiene, regarding New York State's Delivery System Reform Incentive Payment (DSRIP) Amendment Request.

**Allie Nudelman, MPA**
Senior Legislative Analyst, Intergovernmental Affairs
NYC Department of Health and Mental Hygiene
[redacted]

NEW YORK CITY DEPARTMENT OF
HEALTH AND MENTAL HYGIENE
Oxiris Barbot, MD
*Commissioner*

November 1, 2019

**Gotham Center**
**42-09 28th Street, 8th Floor**
**Queens, NY 11101-4132**

**+ 1 347 396 4100** tel

**Via electronic submission: 1115waivers@health.ny.gov**

**RE: New York State Department of Health Medicaid Redesign 1115 Waiver, Delivery System Reform Incentive Payment (DSRIP) Amendment Request**

Dear Ms. Frescatore:

The New York City (NYC) Department of Health and Mental Hygiene (Health Department) appreciates the opportunity to provide feedback on New York State's Delivery System Reform Incentive Payment (DSRIP) amendment request. We are encouraged to see the state moving forward with a continuation of the DSRIP program which has provided critical funding for, and stimulation of, innovative, collaborative and promising models to better serve vulnerable New Yorkers in the Medicaid system; and are eager to remain partners in its implementation.

We are pleased that New York State recognizes the progress made to date across the state in achieving an overall reduction in avoidable hospital use and generating a number of projects with the potential for long-term positive impact. We are also pleased the state intends to continue providing the necessary infrastructure and funding to support this work for four more years through this amendment request. We are glad to see that many of the promising practices and priority areas relate to populations and services that have not been as deeply penetrated by existing DSRIP initiatives, such as adults and children with mental health and substance use disorders, individuals within the criminal justice system, and the multitude of services that address health related social needs (HRSN). Therefore, we believe this waiver amendment represents an opportunity to more explicitly map out the path by which these populations and services can be better served by an additional four years of the DSRIP program.

Additionally, we believe the NYS Medicaid system should be deliberate in improving health and equity outcomes and preventing premature mortality while achieving long-term Medicaid cost containment. VBP incentives as currently designed only prioritize short-term cost containment because Managed Care Organizations (MCOs), providers, and Performing Provider Systems (PPS)/Value-Driving Entities (VDEs), receive payments and penalties based on annual cost and quality metric performance. This hurts Medicaid's financial viability in the long term. We offer the following recommendations which we believe would strengthen the amendment request, and the ability of the Medicaid system to incentivize payments for value that is realized in the short and the long term.

Our comments are organized in the following way:

A. Recommendations on system set up for coordinated population health improvement
B. Recommendations on DSRIP promising practices/program extension areas
C. Recommendations on the continued investments and new high need priorities

NEW YORK CITY DEPARTMENT OF
HEALTH AND MENTAL HYGIENE
Oxiris Barbot, MD
*Commissioner*

**Summary of recommendations**

**A. Recommendations on system set up for coordinated population health improvement**

1. VDEs must be accountable for all Medicaid enrollees in a geographic area and required to be collaboratively led by the primary care providers and/or behavioral health providers that cover most of the population in the awarded catchment.
    a. Set up the VDE in a way in which all relevant healthcare providers in a given geographic area must collaborate to serve their shared population.
    b. Allow a jurisdiction-wide VDE for transient population and for population with HIV.
2. Sustain the support systems for independent practices that enable them to provide behavioral health and health-related social need (HRSN) services and that achieve economies for scale for administrative and reporting functions needed in VBP.
3. Social Determinant of Health Networks (SDHNs) must be funded to deliver HRSN services and advocate for the community-level social determinants of health for all Medicaid members in a given geographic area. As such, they should be sized to achieve high penetration of Medicaid enrollees in the catchment and have specialized knowledge of most of the Community Based Organizations (CBOs) in their community.
4. Develop a competitive procurement process that favors CBOs who apply to be the lead entity of an SDHN and establish a requirement that eligible entities must be 501(c)3s.
5. Align the governance, structure and catchment areas for VDEs and SDHNs.
6. Award enhanced payments to VDEs and SDHNs whose catchments have a significantly higher concentration of individuals living in poverty, those with higher volumes of homeless populations residing in shelter or on the street, and those with high levels of the uninsured population.
7. Require SDHNs and VDEs to have specific strategies identified in supporting bi-directional information/referral exchange, both from VDE to SDHN and from SDHN to the CBO partners they contract with.
8. Support the establishment of inter-connected electronic systems across providers
9. Establish a pre-determined evaluation plan for Preventive, SDH and HRSN services.
10. Provide the data infrastructure necessary to measure impact of clinical and HRSN services on family health outcomes.

**B. Recommendations on the DSRIP promising practices/program extension areas**

***On standardized scale-up of pre-determined services that prevent premature death and that address individual and community level social determinants of health.***

11. The ultimate goal of the Medicaid system is to avoid premature death. As such, NYS DOH should determine a list of mandatory preventive services for VDEs that have the highest potential to decrease premature mortality.
12. Ensure that care coordination services, including those provided by Health Homes, are evidence-based by explicitly identifying effective models and training case management agencies on such models.
13. Establish the following three categories of Social determinant of Health services and associated funding mechanisms
    *a. Category of Services #1: Health Related Social Need identification, navigation, coordination and coaching services for all Medicaid enrollees.*
    *b. Category of Services #2: Individual HRSN services pre-approved for VBP arrangements due to NYS expectation of cost savings for the Medicaid system.*
    *c. Category #3: Community level Social Determinants of Health and Prevention services funded through pooled provider/payer funding with a geographic focus.*

***On the specific promising practices highlighted in Appendix A***

14. Encourage models that expand behavioral health urgent care services to the adult population, including integration of behavioral health clinicians in existing urgent care centers by allowing Medicaid reimbursement.
15. Incorporate changes to enhance and clarify the SMI/SED promising practices.
16. Expand and increase investment 100 Schools Project to help schools build capacity to identify and respond to student mental health needs.
17. Include family peer advocates as partners on children's mobile crisis teams alongside clinical staff and enable the Medicaid reimbursement of services provided by peers.
18. Continue the expansion of the delivery of evidenced-based food and nutrition programs, specifically medically tailored meal delivery (MTMD).
19. Encourage the inclusion of justice-involved people as a distinct high-need population.

**C. Recommendations on the continued investments and new high need priorities**

20. Perinatal health should be a mandatory component of what a VDE must address in the next wave of DSRIP funding.
21. Perinatal health projects should not be limited to expansion of DSRIP Promising Practices.
22. DSRIP renewal strategy should support recommendations for payment reform for children's long- term health and development.
23. DSRIP investments regarding the opioid epidemic should follow a series of principles and guidelines (listed in more detail below) which will enhance this project area and ensure meaningful progress with this population.
24. Establish clear guidelines on the core competencies of the non-traditional workforce including their roles and skills as well as the services to be paid for by healthcare dollars.
25. Continue investments to expand and diversify the peer and CHW workforce, particularly in the areas of maternal health and for individuals with criminal justice involvement since both populations have stark and persistent racial disparities in outcomes.
26. Equip caregivers and long-term care settings to support aging people living with chronic illnesses such as HIV, chronic hepatitis B and hepatitis C as well as with the resources and cultural competency to address issues specific to aging LGBTQ people.
27. Emphasize the Healthy People 2020 goals for adult immunization.
28. Prioritize "enhanced safety net provider" as qualifications used to target Interim Access Assurance Fund (IAAF) recipients that provide the most care to Medicaid and uninsured individuals.
29. Establish set parameters for IAAF recipients to work with partners such as health centers and community-based providers when making decisions on expanding primary care capacity to ensure that funding is shared and used across networks.

**A. Recommendations on systemic set-up for coordinated Population Health Improvement**

We welcome the State's recommendation to evolve Performing Provider Systems (PPSs) to Value Driving Entities (VDEs) and the creation of Social Determinants of Health Networks which can be the single point of contracting for Value Based Payment Arrangements, and the multi-payer lens approach. The following recommendations elaborate how the VDEs, SDHNs and supportive systems can be designed so that the State further accelerates the transition from patient to population focus, amplify investment incentives for providers to ensure long-term viability of the Medicaid system, decrease confusion among stakeholders including patient attribution, and enable conclusive evaluation on practices that work.

1. **VDEs must be accountable for all Medicaid enrollees in a geographic area and be required to be led collaboratively by the primary care providers and behavioral health providers that cover most of the population in the awarded catchment.**

   Access to high quality primary care is one of the main ways to prevent premature death, and to prevent progression of a disease to the point that it needs more expensive care such as hospital and nursing home care. Federally Qualified Health Centers (FQHCs), lookalikes, behavioral health providers, and independent primary care providers also often have strong ties to minority communities and are at the center of culturally sensitive, linguistically appropriate, and coordinated care delivery for the most vulnerable New Yorkers.

   ***a. Set up the VDE in a way that all relevant healthcare providers in a given geographic area must collaborate to serve their shared population***

   VDEs must be led collaboratively by the primary care/behavioral health providers (or their provider associations and parent health organizations) that collectively cover the vast majority of the Medicaid population in the awarded catchment, and therefore held responsible for health improvement in the catchment as a whole.

   Health Homes, hospitals, health centers, behavioral health providers including Behavioral Health Care Collaboratives (BHCCs), independent primary care practices, and Independent Practice Associations (IPAs) with significant presence in the awarded catchment area must be included in the VDE governance structure and must not be precluded from participating in multiple VDEs. However, they must have a significant portion of their membership attributed to the VDEs in which they participate. VDEs should maximize enrollment of and provide technical assistance to independent primary care and behavioral health practices in the awarded catchment.

   Specifically stating the inclusion of BHCCs and other behavioral health providers ensures more meaningful involvement and decision-making from these entities. This is especially important given their expertise in serving many of the priority populations outlined in this document, including individuals with serious mental illness, children with serious emotional disturbance, individuals with substance use disorders, and criminal justice impacted populations.

   ***b. Allow a jurisdiction-wide VDE for transient population and for population with HIV***

   We also recommend allowing the creation of a jurisdiction-wide VDE led by primary care and behavioral healthcare providers for the homeless, whose focus would be the street and sheltered homeless population, as well as a VDE for people living with or at risk of HIV. These VDEs should also be allowed to function as SDHNs.

2. **Sustain the support systems for independent practices that enable them to provide behavioral health and health-related social need (HRSN) services and achieve economies for scale for administrative and reporting functions needed in VBP.**

   Independent practices are a critical part of the healthcare delivery system as the providers of choice in some of the most underserved communities, and therefore special attention should be paid to strengthening and sustaining this infrastructure.

To strengthen the primary care infrastructure, we recommend that DSRIP allocates funding for the following activities:

- Technical assistance to primary care practices to sustain the patient-centered medical home model (PCMH)
- Technical assistance to primary care practices to deliver integrated behavioral health services
- Alignment with Qualified Entities (QEs) for better data exchange and care coordination
- Maintaining the NYS Medicaid Add on reimbursement for PCMH recognition
- Continue supporting adoption of Certified Electronic Health Record Technology (CEHRT) through technical assistance and financial incentives, such as that offered by the Enhanced Meaningful Use program
- In order to strengthen small practice capacity to offer culturally responsive and linguistically appropriate care, assistance to providers should include:
    - Trainings to increase awareness of implicit bias and to reduce stigma experienced by patients due to various components of their identity and experience, such as gender, race, country of origin, immigration status, sexual identity, HIV and hepatitis C virus (HCV) status, and history of justice involvement
    - Assistance with updating forms and EMRs to use culturally appropriate terminology (such as appropriate and inclusive race and gender categories)

3. **SDHNs must be funded to deliver HRSNs and advocate for the community-level social determinants of health for all Medicaid members in a given geographic area. As such, they should be sized to achieve high penetration of Medicaid enrollees in the catchment and to have specialized knowledge of most of the Community Based Organizations (CBOs) in their community.**
In line with our geographic-based VDE recommendation, we recommend that every geographic area should be assigned to a single SDHN, and that in counties with over 250,000 Medicaid enrollees there are at least two SDHNs with distinct catchments to meet the needs of Medicaid enrollees.

   These SDHNs should identify, enroll, and provide technical assistance to CBOs who have in-depth understanding of the community-based needs and capacity in their assigned communities. Additionally, they should be positioned to reach a large enough penetration of the Medicaid population in their catchment to deliver pre-approved HRSN services, and to proactively address community-level social determinants of health before they get to a point where they exacerbate disease and increase cost for the Medicaid system.

   Given the community health focus of FQHCs and lookalikes, they should not be precluded from participating as members in the SDHNs, and CBOs along with community health centers must not be precluded from participating in multiple SDHNS. However, they must have a significant portion of their clients residing in the relevant SDHN catchment.

4. **Develop a competitive procurement process that favors CBOs who apply to be the lead entity of an SDHN and establish a requirement that eligible entities must be 501(c)3s.**
We recommend that SDHNs are led by 501c3 organizations with a track record of success in delivering social service focused interventions; with CBOs receiving preference in the procurement process for the lead entity of an SDHN.

   SDHNs and VDEs bring distinct contributions to the transition to Value Based Payments. SDHNs are the experts in improving the social determinants of health of their communities and/or the health-related social needs of their clients, and VDEs are the experts in addressing the healthcare needs of the community. As such, the leads of VDEs and SDHNs should be organizations with first-hand experience in the work of their respective networks.

   Therefore, the procurement process for SDHNs should favor CBOs with i) demonstrated long-standing community ties, ii) demonstrated support from small CBOs in their community, iii) the capacity to provide technical assistance and infrastructure development to the smaller CBOs in their network, iv) demonstrated ability to manage multi-million dollar budgets and associated required reporting, and v) a history of blending and braiding government and philanthropic sources.

5. **Align the governance, structure and catchment areas for VDEs and SDHNs.**
   Establishing accountability for meaningful partnerships between VDEs and SDHNs by outlining specific requirements for partnership will lead to increased alignment of governance and increase the likelihood of meaningful results. While CBOs and behavioral health providers have been part of DSRIP networks in the first five years, many have reported that their participation has been limited to attending meetings, completing surveys, and other similar activities. There is a need to outline that all partners should share in planning and decision-making on behalf of the VDEs/SDHNs, and measures to hold VDEs/SDHNs accountable to these guidelines should be established.

   In order for effective collaboration between SDHNs and their CBO partners, it is critical that they currently or are in the future able to share clients, specifically Medicaid enrollees. High, easily recognizable overlap of the Medicaid enrollees that each partner is accountable for ensures that all stakeholders are invested in developing a long-term relationship, overcoming challenges, and investing in longer term strategies. Often times CBO and health care partners don't know whether they have clients they have in common, let alone the characteristics of overlapping clients, so they may engage in months longs processes to find that the overlap is minimal.

   To address this, we recommend aligning the catchment areas of VDEs, SDHNs to enable more seamless collaboration and identification of potential partners within each catchment area.

   - VDE catchment areas may be larger than SDHN catchment areas, but there should be clear correspondence between them (i.e. the entire SDHN network should correspond to a single VDE).
   - The lead entity of the SDHN must be part of the governance structure of the corresponding VDE.

6. **Award enhanced payments to VDEs and SDHNs whose catchments have a significantly higher concentration of individuals living in poverty, those with higher volumes of homeless populations residing in shelter or on the street, and those with high levels of the uninsured population.**
   Meeting the needs and providing treatment to clients with individual health related social needs is expected to be more time intensive when they reside in areas of concentrated poverty; and should be reimbursed as such.

7. **Require SDHNs and VDEs to have specific strategies identified in supporting bi-directional information/referral exchange, both from VDE to SDHN and from SDHN to the CBO partners they contract with.**
   Bi-directional information exchange is a critical component to the success of referral-based processes, such as those anticipated as VDEs engage with SDHNs to address social determinant of health (SDoH) needs for Medicaid beneficiaries. Similarly, the subsequent connection of referred patients to SDHNs to the corresponding CBOs that will address the SDoH needs also requires a strong bi-directional approach where referrals can be made that integrate well into CBO workflows, along with the provision of information back to the SDHN to ensure the referral loop has been closed. As a result, NYS should ensure that selected VDEs and SDHNs have well defined processes in place for how bi-directional information/referral exchange will be implemented and maintained. This may include use of third-party bi-directional referral services. Where feasible, these systems should also support the ability for VDEs and SDHNs to monitor and report out on key performance metrics regarding SDoH referrals.

   This system should be electronically integrated, scalable, and interoperable through the QEs or other externally-hosted platform, such that providers should be able to create and track closed-loop referrals to medical and HRSN service providers. HRSN service providers should be assisted with integration with the Qualified Entities (QEs), even if the provider does not utilize a CEHRT.

8. **Support the establishment of inter-connected electronic systems across providers.**
   Enable the connection of Local Health Department (LHD) systems to providers, such as via integration with EHRs or QE, to enable LHDs to:
   - Facilitate care coordination, such as by sending an alert when an LHD identifies and locates a patient that has fallen out of care
   - Automatically capture data from EHRs for public health surveillance and development of targeted interventions
   - Provide clinical decision-support, such as for decision-making related to emergent diseases such as Zika
   - Encourage pharmacies to interface with the QEs to integrate prescription fill data

9. **Establish a pre-determined evaluation plan for Preventive, SDH and HRSN services.**
   NYS should perform evaluation of the impact of the specific services that are pre-approved for SDHNs and VDEs to provide under DSRIP on population health and standardize the data collection that would enable aggregation across providers. Evaluation of the services provided through the SDHNs should include but not be limited to the following:
   - The impact of HRSN services on patients' health, access to healthcare, social outcomes, and patient-reported outcomes, with an understanding that it may take time for these services to be able to affect these indicators.
   - The existing gaps in funding for social services to address HRSNs of Medicaid enrollees to the extent they are not covered by Medicaid reimbursement.
   - The efficiency of SDHNs to achieve widespread penetration of HRSN services in their catchment; their efficiency in contracting, administration and training functions; and whether SDHNs can effectively leverage Tier 1 CBO infrastructure.

   We strongly encourage evaluation to be done through service delivery codes that can be tracked in the claims data, and that its seamlessly linked to the bi-directional referral system employed by the VDE and SDNHs. In order to facilitate ease of information sharing between systems there should be a standardized screening tool used to ensure consistency of eligibility between service providers.

10. **Provide the data infrastructure necessary to measure impact of clinical and HRSN services on family health outcomes.**
    - NYS should continue to invest in data improvements to link Medicaid members in the same family/household in order to more effectively measure and reward interventions whose cost-savings may accrue across members (e.g. a pediatrician connecting a family to a home visiting program may improve the health of the parent child dyad).
    - Health information exchanges should be required to be incorporated into the VDEs and encouraged to be part of the SDHNs and data linkages across families should be a required contribution of their participation so as to ensure that the impact and value of interventions are captured not just for that patient, but for the household/family.
    - NYS should also make this data available to local health departments, who can provide additional analytic capacity.

**B. Recommendations on DSRIP Promising Practices**

***Standardized scale-up of pre-determined services***

We support the state's effort to develop a list of services as outlined in Appendix A and B of the amendment. However, we encourage NYS to be more specific in the types of services to be provided by VDEs and SDHNs that should be scaled-up in a standardized way. We also encourage NYS to be more specific in the definition of "toxic stress" and the types of interventions that might be included under the category of toxic stress.

**Services that Prevent Premature Death**

11. **The ultimate goal of the Medicaid system is to avoid premature death; as such, NYS DOH should determine a list of mandatory preventive services for VDEs that have the highest potential to decrease premature mortality.**
    - Building on the DSRIP promising practices, NYS DOH should select at least three mandatory preventive services to be delivered across the board by VDEs/SDHNs in their catchment. These could include services that would increase the uptake of preventive benefits such as smoking cessation counseling, universal home visiting for pregnant people, CBO- and clinical organization-led chronic disease prevention and self-management, post-exposure prophylaxis (PEP), pre-exposure prophylaxis (PrEP), viral suppression activities to prevent morbidity and mortality related to HIV, and improvement of immunization coverage especially among older persons.
    - In addition to preventive services, VDEs should adopt a strategy to identify and provide curative treatment for hepatitis C, which is a major driver of premature mortality.
    - Local Health Departments should be given the option of being the evaluators for these services for all VDEs in their jurisdictions.

12. **Ensure that care coordination services, including those provided by Health Homes, are evidence-based by explicitly identifying effective models and training case management agencies on such models.**
    As Health Homes continue to grow and as VDEs implement care coordination services, there should be an increased emphasis on identifying and expanding the most effective care coordination models. Examples include IMPaCT or the Pathways HUB model.
    - There should be a common training for all Case Management Agencies on the effective models identified by NYS.
    - CMAs should be encouraged to employ community health workers, including peers who share lived experience with patients, on a more consistent basis, to reimburse these roles at a living wage, and to integrate the staff as essential members of care teams.

**Services that address individual and community level social determinants of health**

13. **Establish the following three categories of Social determinant of Health services and associated funding mechanisms**
    VBP arrangements typically assess value through quality metrics and cost savings within a year, but Medicaid's financial viability requires investment that yields value past that period. NYS Medicaid DSRIP 2.0 should explicitly cover the following social determinants of health-related services intended to delay onset of disease and prevent its progression, so it cuts cost and improve quality metrics for the Medicaid system 5-10 years from now.

    All the following services should be provided across SDHNs so that there is a no wrong door approach for clients and service delivery is not structured in such a way that there may be "out of network" services for clients.

    ***<u>Category of Services #1</u>: Health Related Social Need identification, navigation, coordination and coaching services for all Medicaid enrollees.***
    Early identification and management of the HRSNs of Medicaid enrollees would benefit both the individual enrollee and the Medicaid system as a whole. Services such as housing navigation, enrollment in public benefits, and allergen focused home inspections have both long- and short-term returns. In the short term these services will result in quality metric improvement, and in some cases cost savings to hospitals while in the long term these services may mitigate or reduce the development of costly diseases down the road. Making these services dependent on VBP arrangements, which share savings, disincentivizes its provision to clients who won't realize directly attributable cost savings within the measurement period.

- Medicaid (and its MCOs) should reimburse for the HRSN screening when a health worker under the supervision of a licensed provider (or the licensed provider) conduct a HRSN screening and discusses the screening results with the Medicaid enrollee.
  - NYS DOH should identify a CPT code to be used for billing of the HRSN screening, which in turn would be used to assess penetration of screening in the Medicaid population.
  - NYS DOH should gain access to the screening results through the claims data. This can be achieved by endorsing the GNYHA SDH Workgroup shortlist of ICD 10 Z codes for common HRSN needs and encouraging licensed providers to list identified HRSNs in their Medicaid claim.
- Medicaid (and its MCOs) should reimburse for the navigation, coordination, and coaching services inclusive of when these services are provided by non-clinical workers employed by the billing healthcare organization/provider, or a CBO/SDHN in contract with this healthcare organization.
  - These services should not duplicate Health Home functions and should be available to all Medicaid enrollees.

***Category of Services #2: Individual HRSN services pre-approved for VBP arrangements due to NYS expectation of cost savings for the Medicaid system.***

SDHNs are unlikely to know the medical or financial value of their interventions for the healthcare system so therefore, Medicaid should issue a pre-approved list of services to be provided by all SDHNs. This way, SDHNs can focus on identifying CBOs in their network who have the best value propositions in terms of ability to deliver the pre-approved interventions.

- NYS Medicaid should create or adopt a list of up to five mandatory core interventions per SDH domain that have been shown through evidence to affect health outcomes (housing, nutrition, transportation, interpersonal violence, and toxic stress). This list can be inspired by the DSRIP best practices, or the HRSN services approved by CMS for other states (e.g. North Carolina).
  - Examples include Medically Tailored Meal Delivery (MTMD), Medical Respite for homeless individuals, supply of Air Conditioning subsidies to individuals at high risk of Heat Related Illness, supply of services to reduce allergens in the home of children with asthma, etc.
  - Providers and CBOs should not be precluded from negotiating additional interventions beyond the core five.
- Every one of these interventions should have recommended eligibility and base cost for SDHNs to use as reference.
- Every one of these interventions should have a pre-established evaluation plan and all implementers of the intervention should supply data for evaluation via service delivery codes in the claims and/or the bi-directional referral system employed by the SDHN/VDE.
- Each service should have a standardized scope of work or standards for best practices to ensure consistency of services being provided.
- This should not be construed as a prohibition to negotiate additional services outside the pre-approved list.

***Category #3: Community level Social Determinants of Health and Prevention services funded through pooled provider/payer funding with a geographic focus.***

- A percentage of the funding flowing to VDEs, MCOs, or other VBP contractors should be set aside for community-level social determinant of health and preventive interventions included as having Strong Evidence in databases such as What Works for Health.
- This funding should be administered by the SDNHs.
- At least 85% of the funding set aside for community-level social determinant of health and preventive interventions should be deployed for community-level interventions pre-approved by the Local Health Department.

***Specific DSRIP Promising Practices as Highlighted in Appendix A***

We are encouraged to see the outline of specific DSRIP promising practices highlighted in appendix A, however, we request additional clarification about whether all projects funded through the proposed DSRIP expansion will need to specifically align with the promising practices outlined in Appendices A & B. Clarification is also needed as to whether projects that do not specify children as a target population will be applied to both children and adults. Additionally, we recommend that mechanisms are put into place to ensure adoption of projects focused on mental health and substance use issues which were not widely adopted in DSRIP to date. To support these projects, VDEs should be accountable for forming binding partnerships with community behavioral health providers (substance use, mental health, and other recovery support services) to promote community tenure and avoid behavioral health driven hospital use. This will be critical to ensure that overall health improvement and cost reduction targets are met, and that these improvements penetrate the most vulnerable populations.

**SMI/SED Demonstration**

14. **Encourage models that expand behavioral health urgent care services to the adult population, including integration of behavioral health clinicians in existing urgent care centers by allowing Medicaid reimbursement.**
    We are encouraged by the results of the Northwell project highlighted in UHF's Promising Practices document and welcome the continuation and expansion of these efforts to address urgent needs that do not require emergency department care. To maximize the potential long-term impact of this intervention at scale, coordination with community providers serving children such as schools should be demonstrated.

15. **Incorporate the following changes to enhance and clarify the SMI/SED promising practices:**
    - Transitional care teams, as well as outreach teams, should more broadly include CHWs and peers, in addition to family, youth and peer advocates
    - Include training of the workforce on trauma informed care, implicit bias, and harm reduction[1][2]
    - Include screening of this population for traumatic brain injuries or other signs of physical trauma
    - Include screening of this population for generalized anxiety, tobacco and alcohol, exposure to trauma, PTSD and partner violence
    - Clarify several of the SED promising practices noted, such as how "transitional care teams of clinicians and peers bridging psychiatric inpatient to community settings" relate to or overlap with HCBS and CFTSS Medicaid state plan services

**Children's Behavioral Health Initiatives**

We are encouraged to see the number of recommendations strengthening the children's behavioral health system including behavioral health services across the care continuum including schools and crisis response. Our work and expertise have led the identification of the following three best practices which we recommend for inclusion in DSRIP implementation.

16. **Expand and increase investment 100 Schools Project to help schools build capacity to identify and respond to student mental health needs.**
    This project has been working to demonstrate how health care funding can be used to prevent children's emergency department use during the school day.

17. **Include family peer advocates as partners on children's mobile crisis teams alongside clinical staff and enable the Medicaid reimbursement of services provided by peers.**

[1] Providing primary care to patients with a history of criminal justice system involvement. City Health Information. 2019;38(2):9-16.
[2] https://www.thenationalcouncil.org/consulting-areas-of-expertise/trauma-informed-primary-care

**Food and Nutrition**

Twenty percent of NYC's 8.4 million residents live in poverty and over 1.2 million (14.4%) are food insecure, placing them at increased risk for chronic illnesses such as diabetes and heart disease. Food insecurity disproportionately affects low-income communities and people of color, contributing to disparities in health and life expectancy. A range of initiatives can help avoid health costs caused by food insecurity, including providing medically tailored food for low-income New Yorkers at risk of or managing serious illness, including people who are food insecure, malnourished, and/or have a serious illness or disability and cannot shop or cook. Specifically, we recommend:

18. **Continue the expansion of the delivery of evidenced based food and nutrition programs, specifically medically tailored meal delivery (MTMD).**
    - Medically-tailored meal delivery (MTMD) is a particularly promising initiative for addressing food insecurity among chronically ill populations. MTMD programs provide nutrition counseling and meals designed to meet patients' medical needs.
    - Research shows that low-income patients at nutritional risk who receive MTMD have decreased healthcare costs, reduced emergency department visits and increased likelihood of being discharged from the hospital to home rather than a nursing facility.
    - There is growing momentum for cross-sector engagement to expand MTMD. Research shows MTMD programs are a promising tool for addressing poor health among HNHC patients, who account for 50% of expenditures and are disproportionality affected by food insecurity. Pilot programs have found MTMD to be a low-cost intervention with significant cost-saving potential.
    - The Center for Medicare & Medicaid Services encourages alternative payment models that incentivize investment in SDoH and allow Medicare Advantage plans to include supplemental benefits, such as MTMD.

**Justice Involved Populations**

19. **Encourage the inclusion of justice-involved people as a distinct high-need population. This would encourage the targeting of care management and navigation efforts to this population that experiences multiple intersecting health challenges.**

**C. Recommendations on Continued Investments and High Need Priorities**

***Maternal Mortality***

We strongly support prioritization of initiatives to address maternal mortality, and to reduce racial and ethnic disparities in maternal mortality and severe maternal morbidity. The United States is the only developed country where the maternal mortality rate is on the rise. Furthermore, racial inequities in maternal mortality are among the worst of any health outcome, and worse in NYC than nationally. In the US, Black women are 3-4 times more likely to die of a pregnancy-related cause than White women. In NYC, Black women are alarmingly **eight** times more likely to die of a pregnancy-related cause than White women (2011-2015), and three times more likely to experience a life-threatening complication (SMM). This is a national and statewide crisis that the DSRIP renewal can and should address and fund.

20. **Perinatal health should be a mandatory component of what a VDE must address in the next wave of DSRIP funding.**
    - In the next wave of DSRIP, the State should require that VDEs address perinatal health. California's PRIME project (part of its overall DSRIP renewal), for instance, included a mandatory requirement for participating public hospitals to implement programs to improve perinatal health as part of its DSRIP renewal. We recommend that NYS do the same.
    - Since most PPSs had hospital systems as anchor institutions and since VDEs are likely to at the very least to include hospital systems as partners, DSRIP renewal should require certain hospital QI initiatives such as those that have been successful in California's efforts to reduce maternal mortality, including instituting best practices and routine simulations (practice drills) for the leading causes of maternal mortality (obstetric hemorrhage, preeclampsia and venous thromboembolism). In addition, hospitals should be required to

implement implicit bias and trauma and resilience-informed training, and implementation of policies and practices to mitigate bias and assure respectful care to all maternity patients. Hospital adoption of such measures requires resources but is not otherwise well-supported by current incentive structures, particularly given that VBP maternity bundles have yet to see uptake.

**21. Perinatal health projects should not be limited to expansion of DSRIP Promising Practices.**

- Few PPSs selected maternal health projects during the initial DSRIP period, which naturally limited maternal-health related DSRIP Promising Practices.
- Thus, NYS should support not only DSRIP Promising Practices in this sphere such as Centering Pregnancy, but also encourage funding of interventions recommended by NYS's groundbreaking First 1,000 Days on Medicaid, including dyadic therapy and home visiting. Home visiting in particular should be prioritized and supported through Central Intake, as recommended by the 1,000 days home visiting workgroup, with a mandatory standardized prenatal risk assessment tool adopted to facilitate matching of clients to the best fitting home visiting programs.
- Initiatives specifically designed to reduce racial disparities in maternal outcomes, such as comprehensive education and training on implicit racial bias, as recommended by the Governor's Taskforce on Maternal Mortality and Disparate Racial Outcomes, should also be incentivized.

***Children's Population Health***

In its initial DSRIP efforts, the State has realized tremendous success in reducing costs and improving care, particularly for those with chronic diseases. However, long-term reform efforts of NYS Medicaid must recognize that children on Medicaid are not tiny adults. Most children on Medicaid are relatively low-cost and there are few opportunities to realize healthcare cost savings on even a 5-10 year timeframe. Savings for children may actually require an increased and sustained investment up front, in order to support the health and development of children and reduce lifelong health and other costs.

**22. DSRIP renewal strategy should support recommendations for payment reform for children's long- term health and development.**

- In order to be most effective, DSRIP renewal needs to support pediatric care payment models suggested by both the Children's Value Based Payment Effort and the First 1,000 Days on Medicaid Preventive Pediatric Care Clinical Advisory Group, including that quality measures be aligned with health and developmental outcomes, and that financial rewards acknowledge short-term cost savings of high quality care are unlikely.
  - Important strategies such as increasing developmental screenings and referral to Early Intervention programs and the creation of bidirectional communication between Early Intervention programs and children's PCPs, are unlikely to yield short-term savings for Medicaid, and may in some cases increase them. Longer term, however, these strategies are critical to child health and development and must be reimbursed accordingly under any DSRIP renewal strategies which seek to setup NYS for future VBP strategies for children.
- Strategies should also focus on health impacts to parent-child dyads, with the State supporting exploration of promising interventions through provision of claims data across entire families/households, some of which may even be multi-generational.
  - Interventions to address children's HRSNs in particular should be prioritized for data matching with family member's Medicaid claims to assess total savings to Medicaid programs.
  - In addition, the State should endeavor to match children on Medicaid receiving HRSN interventions with hospitalization/ED use of family/household members overall through HIEs, in order to capture potential savings of interventions for children on Medicaid that may also accrue to their household/family members that may be uninsured.
- When considering interventions for children's population health, strategies should be included that address the needs of vulnerable subpopulations, including LGBT youth. A 2017 literature review concluded that young people who are LGBT are disproportionately impacted by substance use, sexually transmitted infections (STIs), social isolation, anxiety, depression, and suicide.[3]

[3] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5478215/

***Opioid Epidemic***

As this program area is further developed, we urge that VDEs ensure that projects are designed to minimize stigma around, and not penalize individuals for, seeking treatment for opioid use disorders. Additionally, VDEs should be required to select measures in this area, as there has not been widespread adoption of SUD projects in the past five years.

23. **DSRIP investments regarding the opioid epidemic should follow the subsequent principles and guidelines which will enhance this project area and ensure meaningful progress with this population.**
    - Highlight the use of harm reduction approaches in the development of projects
    - Highlight new available measure indicators for SUD, including those from NYS QARR, that allow additional flexibility for providers on reporting
    - Transitional care teams should more broadly include Community Health Workers (CHWs) and peers
    - Addition of training of the workforce on trauma and resilience informed care
    - "Integration of Medication Assisted Treatment (MAT)" should explicitly reference prescribing of buprenorphine or linkage to methadone treatment to ensure that a variety of MAT options are encouraged; additionally, this category should be expanded to include naloxone access and MAT for alcohol use disorder
    - "Integration of MAT" should also consider a focus on settings beyond primary care and EDs, including substance use disorder treatment programs, mental health programs, and others.
    - Care navigation approaches should include testing for STIs, HIV, and viral hepatitis and navigation to treatment or prevention resources based on test results and risk. This recommendation is important as people with substance use disorders (SUD) may also be at increased risk for sexually transmitted infections (STIs), HIV, tuberculosis, and viral hepatitis.

***Continued Workforce Flexibility and Investment***

We strongly support the inclusion of the non-clinical workforce in the makeup of the VDEs and SDHNs. The first round of DSRIP found that the integration of peer support to be a promising practice as an intervention for a number of populations, including individuals with substance misuse disorders and/or living with mental illness and people living with HIV and hepatitis C. Community health workers (CHWs) were also incorporated into a number of DSRIP projects around chronic disease management with very positive results.

In order to build on this momentum, develop sustainable pathways for payment for the non-clinical workforce, and promote meaningful workforce development, we would recommend the state establish guidelines on the services to be delivered by non-clinical staff and the mechanism for reimbursement for those services. This could build upon existing New York State peer certification mechanisms for peers in the areas of HIV, HCV, and harm reduction through AIDS Institute, and Certified Peer Recovery Advocates through OASAS. Specifically, we recommend the state:

24. **Establish clear guidelines on the core competencies of the non-traditional workforce including their roles and skills as well as the services to be paid for by healthcare dollars.**
    Such guidelines should include the following services as services to be paid for by health care dollars: (i) care coordination, case management and health and social systems navigation, (ii) health education and coaching, and (iii) basic preventive services and screenings. Additionally, the guidelines should specify that where possible a licensed or registered health care professional can bill Medicaid for services provided by a non-clinical worker under their supervision.

25. **Continue investments to expand and diversify the peer and CHW workforce particularly in the areas of maternal health and for individuals with criminal justice involvement, both populations that have stark and persistent racial disparities in outcomes.**
    As recommended by the Taskforce on Maternal Mortality and Disparate Racial Outcomes, we support investments in tuition reimbursement and other incentives for midwifery and other maternal health educational programs which will result in a more diversified workforce that can address maternal health needs. Additionally, we specifically recommend greater investment into peer recruitment and training for specific populations including forensic peers to support criminal justice involved individuals and peers to engage and support the

aging populations in long term care settings. The use of peers in planned projects should be encouraged not just at the planning stages, but at the level of service delivery.

***Long-Term Care Reform***

26. **Equip caregivers and long-term care settings to support aging people living with chronic illnesses such as HIV and chronic hepatitis B and hepatitis C as well as with the resources and cultural competency to address issues specific to aging LGBTQ people,** including experiences of stigma, discrimination, and social isolation. In New York State in 2017, 53.6% of people living with HIV were over 50 years old.[4]

27. **Emphasize the Healthy People 2020 goals for adult immunization,** which include (i) increasing the percentage of noninstitutionalized adults ages 18+ who are vaccinated annually against seasonal influenza to 70%; (ii) increasing the percentage of noninstitutionalized adults ages 65+ who are vaccinated against pneumococcal disease to 90%; and (iii) increasing the percentage of adults ages 60+ who are vaccinated against herpes zoster to 30%.

***Interim Access Assurance Fund Comments***

28. **Prioritize "enhanced safety net provider" as qualifications used to target Interim Access Assurance Fund (IAAF) recipients that provide the most care to Medicaid and uninsured individuals.**
We strongly support the continuation of the Interim Access Assurance Fund (IAAF) to ensure support for financially distressed critical access and safety net providers. In order to ensure that hospitals serving communities that are economically depressed and experience health disparities, we encourage the state to clearly define the qualifications that Medicaid safety net providers must meet in order to receive supplemental payments through IAAF 2.0. Since the original IAAF 1.0 funds were allocated during 2014-2015, additional safety net providers have become financially distressed, particularly safety net providers that are dependent on public insurance programs such as Medicaid and disproportionately serve uninsured individuals. We support the state's consideration of the number of Medicaid beneficiaries being served and necessity of the funding to provide access to Medicaid and uninsured individuals but call for more clearly defined allocation criteria. Specifically, we recommend the state to prioritize "enhanced safety net provider" as defined under current state law as the only eligible entities for the IAAF 2.0. Under current state law, the term "enhanced safety net provider" is defined as:

    1) Any hospital that:
        - Treats not less than 50% of Medicaid or uninsured patients,
        - Not less than 40% of its inpatient discharges are covered by Medicaid;
        - 25% or less of its discharged patients are commercially insured,
        - Not less than 3% of its total number of patients are uninsured, and
        - Provides uninsured patients in its emergency room, hospital based clinics and commercially based clinics, including the provision of important community services, such as dental and prenatal care.
    2) Public hospitals operated by a county, municipality or public benefit cooperation
    3) Federally designated critical access or sole community hospital

29. **Establish set parameters for IAAF recipients to work with partners such as health centers and community-based providers when making decisions on expanding primary care capacity to ensure that funding is shared and used across networks.**
In addition to supplementing the ongoing state assistance programs and encouraging acute and ambulatory health care services, the state should continue to emphasize primary care and incentivize hospitals to work with health centers, community-based providers and independent practices, which are major primary care providers in PPS networks to fully participate in the DSRIP transformation. Health centers are already focused on providing primary care and preventive services and provide these services in community-based settings. They have referral relationships with CBOs in their community and are experienced in Medicaid billing and reporting. As a result, they are well-positioned to provide related supportive services that target Medicaid patients with complex health and social needs.

[4] https://www.health.ny.gov/diseases/aids/general/statistics/annual/2017/2017_annual_surveillance_report.pdf

NEW YORK CITY DEPARTMENT OF
HEALTH AND MENTAL HYGIENE
Oxiris Barbot, MD
*Commissioner*

Additionally, much of care is seen in independent practices - a recent study conducted by the Agency for Healthcare Research and Quality showed among adults who had four or more office visits to their usual source of provider care, 54% were seen in small or medium-sized practices. The state should require, or at a minimum, provide incentives for hospitals receiving the IAAF 2.0 funding to partner with health centers, community-based behavioral health providers and independent practices when making decisions to "make" vs. "buy" services when expanding primary care capacity. This would ensure that hospitals collaborate with and tap into the expertise of partner providers that have extensive expertise and long-standing relationships in the community and that can effectively provide these additional services. Establishing such parameters will enable recipient hospitals to work toward sustainable operations and to maintain critical health care services to their community as they work with other partner providers to participate in transformative activities to support the ultimate achievement of DSRIP goals.

Thank you for the opportunity to submit comments on this important matter.

Sincerely,

Oxiris Barbot, MD
Commissioner

## doh.sm.1115Waivers

**From:** AY- Shockley, Penny [redacted]
**Sent:** Monday, November 4, 2019 4:40 PM
**To:** doh.sm.1115Waivers
**Cc:** [redacted]
**Subject:** 1115 Public Forum Comment
**Attachments:** DSRIP2 letter-Wayne County OFA.docx PDF.pdf



Penny Shockley
Director Of Aging & Youth
Wayne County Aging and Youth
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[redacted]

**WAYNE COUNTY**
**DEPARTMENT OF AGING AND YOUTH**
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November 4, 2019

Paul Francis
Deputy Secretary for Health
State Capitol
Albany, NY 12224

Donna Frescatore
Medicaid Director
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Dear Mr. Francis and Ms. Frescatore,

On behalf of Wayne County Office for the Aging, I am writing to express my recommendations on the DSRIP renewal proposed by New York State Department of Health. The services we provide directly impact inappropriate emergency department visits, and reduce avoidable readmissions. The NY Connects program, implemented in 2006, serves as no wrong door for any and all services available in the region, and is a catalyst for individuals in need of assistance. The targeted goals in the proposed renewal are exactly what this network provides, and must include mandated contracting by each PPS with their local Area Agency on Aging for social determinants of health initiatives. Our office is the trusted service provider for the fastest growing segment of the population, and the highest utilizer of health care dollars. Our services **absolutely** allow individuals to remain in their own homes and communities, all while saving health care expenditures. We provide the highest level evidenced based interventions, and are experts at navigating a complex health care system, while providing person centered planning and care.

To demonstrate the value of the network, I would like to highlight a recent case that is typical to our office.

*We had a 71 year old veteran who had been receiving Home Delivered Meals for over a year. The HDM worker was completing a reassessment for the meals and had a lot of concerns about the client so referred the client to the EISEP program. Both of those programs are run directly out of our office so the worker was able to discuss her concerns at the weekly case management meeting to let the EISEP team know what to look for. When the EISEP case manager got involved, the client had no electricity, no transportation, and no medical insurance. The meal he received through the HDM program was likely all he had to eat. He weighed barely over 100 ponds at almost 6 foot tall. His teenage son had been put in charge of managing the checking account because they lived at the top of a steep hill and with the client's COPD, he would be unable to walk to a bank or an ATM.*

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*The EISEP caseworker (who had been cross trained with our HIICAP program which is also run out of our office), investigated his insurance issue to find out that he had been receiving care through the VA so had never signed up for Medicare Insurance. When he lost his truck he stopped receiving care because he was unaware of transportation options to get to the VA and did not have a community doctor because he did not have insurance. She was able to get financial assistance through the hospital district and make an appointment locally for one of their doctors so that he would not have any copays despite not having insurance. He was able to get seen and get prescriptions for some medications to help his breathing and some other tests the doctor wanted to see done. We did inform him of transportation options to the VA, but in his weakened condition, he would have had a lot of difficulty going any further than the 15 minutes he went to the local doctor. The VA is at least 45 minutes by car.*

*The caseworker was able to get the utility bill paid by Soldier On. It had not been paid in over 6 months. She also got a statement signed by the doctor for the utility company to put the client on the medical list so he would not be shut off in the future. She referred the client to DSS for a rep payee to assist with the bills. The rep payee worked with the client and the son to get the finances in order.*

*The caseworker also set the client up with PCA services. The caseworker tried to make a referral to the VA office for PCA services but they had a wait list. Our office recently hired some people to work in our EISEP program providing PCA services to our EISEP clients and so our staff will be working with him. At his follow up appointment, the doctor was pleased that he had gained about 5 pounds. He is receiving 2 Home Delivered Meals daily to ensure his nutritional status. He has a PERS button through our office to ensure that he is able to summon help in an emergency whether his son is home or not.*

*This veteran would likely not survived without the Office for Aging intervention. At the very least hospitalization to stabilize this gentleman with follow-up skilled nursing home care would be required to sustain him in his weakened condition. With skilled nursing home care costing an average of $140,000 annually, our intervention saved taxpayers an estimated two to three years of nursing home care up to $420,000 in Medicaide cost.*

This is one of many cases that truly displays the boots on the ground service provision in every county across the state. In the renewal waiver, I cannot stress highly enough that we need to harness the existing strengths of community based services, instead of recreating case management services and duplication of services. Each and every case manager in the entire statewide aging network has received certification via Boston University School of Social Work, ensuring consistency in assessment not provided by any other system. I ask that there are

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mandates for each PPS to engage and contract with their local Offices for the Aging, for the services vital to keeping individuals in home and community based settings.

Thank you,

Penny Shockley
Director
Wayne County Office for the Aging

## doh.sm.1115Waivers

**From:** J.R. Drexelius [redacted]
**Sent:** Monday, November 4, 2019 4:46 PM
**To:** doh.sm.1115Waivers
**Subject:** 1115 Public Forum Comment
**Attachments:** DDAWNY 2019 Comments on MRT DISRIP 2.0.pdf



To DOH Office of Health Insurance Programs, Waiver Management Unit:

Attached please find DDAWNY's , (the Developmental Disabilities Alliance of Western New York), comments in response to the proposed MRT Waiver Renewal Delivery System Reform Incentive Payment (DSRIP) Amendment request for a continuation of DSRIP for the 1-year balance of the 1115 waiver ending on March 31, 2021 and conceptual agreement to an additional 3 years from April 2021 to March 31, 2024.

**John R Drexelius, Jr.**
**Government Affairs Counsel**
**DDAWNY, the Developmental Disabilities Alliance of Western New York**

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[redacted]

DDAWNY

DEVELOPMENTAL DISABILITIES ALLIANCE OF WNY

November 4, 2019

Donna Frescatore
Director
Office of Health Insurance Programs
New York State Department of Health
Waiver Management Unit
99 Washington Avenue
12th Floor, Suite 1208
Albany, NY 12210

Via E-Mail 1115waivers@health.ny.gov

Re: NYS Medicaid Redesign Team (MRT) Waiver Renewal - DSRIP Amendment Request

Dear Ms. Frescatore:

On behalf of DDAWNY, the Developmental Disabilities Alliance of Western New York, these comments are being submitted in response to the proposed MRT Waiver Renewal Delivery System Reform Incentive Payment (DSRIP) Amendment request for a continuation of DSRIP for the 1-year balance of the 1115 waiver ending on March 31, 2021 and conceptual agreement to an additional 3 years from April 2021 to March 31, 2024.

DDAWNY is a collaborative group of member voluntary agencies providing supports and services to people with developmental disabilities. While honoring individual agency missions, it is the intent of the Alliance to assist agencies to develop relationships, promote unified strategies and share risks for the mutual aim with and for the benefit of people with disabilities.

DDAWNY member agencies employ over 22,400 individuals in the seventeen Western and Finger Lakes counties of New York State providing supports and services to over 33,000 individuals with developmental disabilities and their families and/or circle of supports. DDAWNY has also formed a Family Committee to give voice to the people served in the disability arena, but who are often unheard.

DDAWNY

DEVELOPMENTAL DISABILITIES ALLIANCE OF WNY

DDAWNY is a member of New York Disability Advocates (NYDA) (formerly the Coalition of Provider Associations -COPA), NYDA is a Statewide group of five associations - the Alliance of Long Island Agencies, Inc. (ALIA), Cerebral Palsy Associations of New York State (CP of NYS), the Developmental Disabilities Alliance of Western New York (DDAWNY), the InterAgency Council of Developmental Disabilities Agencies, Inc. (IAC), and the New York Association of Emerging and Multicultural Providers (NYAEMP).

We have unified our effort to maintain and improve services and supports for children and adults with developmental disabilities and their families through over 250 not-for-profit providers serving hundreds of thousands of New Yorkers with IDD, educating over 15,000 special education students and employing more than 120,000 dedicated professionals with combined annual operating budgets of nearly $5.2 billion.

DDAWNY has reviewed and is pleased to provide comment on the State's proposed MRT Waiver Renewal Delivery System Reform Incentive Payment (DSRIP) Amendment request. In particular, DDAWNY wishes to comment on the State's proposal to address certain high-need and high-cost populations who need long-term care and who have not benefited directly from most DSRIP initiatives. DDAWNY is concerned discussion of the Long Term Care Reform expansion being proposed is solely focused on adults age 65 and over, especially adults over 85. DDAWNY believes addressing the needs of the rapidly growing senior population and the long term care sector and workforce that will be necessary to support their future needs as proposed in the DSRIP Amendment Request, ignores the needs of a growing population of individuals with developmental disabilities (IDD) and the long term care sector and workforce who support individuals with developmental disabilities.

For Federal Fiscal Year 2016, New York State Medicaid expenditures totaled $60.4 billion. Of this spending, $26.5 billion (44% of total NYS Medicaid spending) was spend on Long Term Supports and Services (LTSS). While $17.2 billion or 65% of Long Term Care Medicaid expenditures went to Older Adults and People with Physical Disabilities, New York spent $6.8 billion on the LTSS needs of individuals with Developmental Disabilities. This represents 26% of all Long Term Care Medicaid expenditures and over 11% of total Medicaid spending in New York State in FFY16.

DDAWNY

DEVELOPMENTAL DISABILITIES ALLIANCE OF WNY

New York State is currently serving over 139,000 individuals with developmental disabilities IDD). This includes individuals living with intellectual disabilities, cerebral palsy, Down syndrome, and autism spectrum disorders. Medicaid benefits for these individuals have traditionally been delivered under a Fee-for-Service (FFS) payment system through four distinct state agencies: the Department of Health (DOH), the Office for People with Developmental Disabilities (OPWDD), the Office of Mental Health (OMH) and the Office of Alcohol and Substance Abuse Services (OASAS). At the current time, the State is seeking to transition these individuals into a capitated managed care model using newly proposed Specialized I/DD Plans - Provider Led (SIP-PL). A draft of this model was released in July of 2018, however the final SIP-PL requirements and standards model has not yet been released. While the State believes the transition to capitated managed care offers the potential for substantial cost savings through more efficient delivery of care[1], a critical question is whether the quality of and satisfaction with care will also improve.

Federal, state and local Medicaid funding totaled $49.4 billion and constituted 76% of funding for IDD services and supports in the United States in FY15 (Braddock, et al., 2017). In New York, total IDD Spending was $10.2 billion in 2015 and total federal, state and local Medicaid Spending totaled $7.4 billion, 73% of all funding for IDD services and supports in New York in FFY2015. The majority of this funding is attributed to the Home and Community Based Services (HCBS) waiver program. Nationally 53% of total IDD spending was under authority of a HCBS Waiver program. In New York 49% of total IDD spending is under the HCBS Waiver program.

The HCBS Waiver has become the primary funding source for promoting long-term services and supports for people with IDD. Nationally, the primary IDD Waiver service category funded has been residential habilitation, followed by day habilitation and companion/homemaker/chore/personal assistance/supportive living.[2]

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[1] Recent reports from Health Management Associates and the University of Texas raise serious concerns regarding the possibility of real cost savings (versus budget predictability) in a managed care environment for the IDD population. See UTHealth Final Report to the Texas Health and Human Services Commission, December 2018 accessed at: https://hhs.texas.gov/sites/default/files/documents/about-hhs/communications-events/meetings-events/idd-srac/feb-2019-idd-srac-agenda-item-3.pdf ; ANCOR and Health Management Associates, Current Landscape: Managed Long-Term Services and Supports for People with Intellectual and Developmental Disabilities June 11, 2018 accessed at: https://ancor.org/sites/default/files/ancor_mltss_report_-_final.pdf

[2] M.C. Rizzolo, et al. Home and Community Based Services (HCBS) Waivers; A Nation Wide Study of the States, Intellectiual and Developmental Disabilities 2013, Vol 51, No.1, 1-21

53% of HCBS Waiver spending in 2010 was for Residential habilitation, defined as individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living in the community. These supports include adaptive skills development, assistance with activities of daily living, community inclusion, transportation, adult educational supports, social and leisure skill development, that assist the participant to reside in the most integrated setting appropriate to his/her needs. Residential habilitation also includes personal care and protective oversight and supervision. In SFY19, New York OPWDD spending on Residential services totaled 61% of state operating funds. As of September 30, 2018, 30% of the IDD population served was authorized to receive housing supports.

The second most service funded was day habilitation (non residential) services. Nationally this constituted 19% of total HCBS Waiver spending. These supports include assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills that take place in non-residential setting, separate from the participant's private residence or other residential living arrangement. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice. In SFY19, New York OPWDD spending on day programs totaled 30% of state operating funds. As of September 30, 2018, 39% of the IDD population served was authorized to receive day habilitation service supports, 24% of the IDD population was authorized to receive Community Habilitation support, 9% of the IDD population served was authorized to receive Work-related services under the Waiver and 8% of the IDD population served was authorized to receive Supportive Employment services under the Waiver. In SFY19, DOH Medicaid Global Cap resources supported 76% of OPWDD Aid to Localities funding for individuals with IDD.

The Medicaid costs of the IDD population as compared to other populations, particularly older adults are high because of the time necessary to provide services and supports necessary to allow these individuals to live productive lives in the community. The IDD population often will require assistance for his or her entire life. Currently there are no widely used measures of quality nor accepted standards by which to measure quality for Medicaid managed LTSS (MLTSS) programs, except for those required by the National Committee for Quality Assurance (NCQA) for MCO accreditation with MLTSS distinction. DDAWNY believes the proposed MRT Waiver Renewal Delivery System Reform Incentive Payment (DSRIP) Amendment request can be used to support the development of Quality measures specific to the IDD population focused on Olmstead and ADA relevant outcomes.

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Delivery system reforms continue to play a significant role in shaping the state's Medicaid program. DDAWNY believes the proposed MRT Waiver Renewal Delivery System Reform Incentive Payment (DSRIP) Amendment request should address some of the specific challenges faced by the IDD community. This includes efforts to implement initiatives aimed at better coordinating and integrating Medicare and Medicaid services for dual eligible beneficiaries, expand HCBS programs, build incentives into the MRT Waiver to increase access to HCBS in lieu of institutional care, improve health outcomes and care quality through increased care coordination.

Similar to the Older Adult population, the IDD population requires the state to focus on system sustainability and allow the IDD population to age in place safely with quality of life while minimizing costly institutional stays. This is particularly so for the portion of the IDD population displaying challenging behaviors. A national study indicates 43% of the IDD population needs some or extensive support to manage self-injurious, disruptive, and/or destructive behavior[3]. In addition, a Workforce investment for the IDD population is as critical to the IDD community as it is for older adults. The number of working-age New Yorkers willing to serve the IDD community is beyond crisis levels. The same type of system reforms identified in the DSRIP Amendment request for aides, LPNs and nurses (subsidies and stipends for certification, loan forgiveness and child care subsidies) are required for our Direct Support Professionals (DSPs), clinicians and nurses.

The MCOs have relatively limited experience serving people with IDD and administering LTSS through capitated managed care arrangements. Service delivery concepts, such as person-centered planning, self direction, and independent living are new to health plans who are more familiar with providing acute and primary care services to parents and children who do not have a life-long diagnosis. DDAWNY believes the proposed MRT Waiver Renewal Delivery System Reform Incentive Payment (DSRIP) Amendment request can be used to support pilots in the transition of the IDD population to MTLSS, in order to build stakeholder buy-in and prove value and have ongoing, comprehensive stakeholder engagement in the transition to managed care.

DDAWNY appreciates the opportunity to comment on the proposed MRT Waiver Renewal Delivery System Reform Incentive Payment (DSRIP) Amendment request.

[3] Hiersteiner & Bradley, What Do NCI Data Reveal about Individuals With Intellectual and Developmental Disabilities Who Need Behavior Support, National Core Indicators Data Brief, May 2014


Respectfully Submitted

DDAWNY, the Developmental Disability Alliance of Western New York

John R. Drexelius, Jr.
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## doh.sm.1115Waivers

**From:** Karen Pearl [redacted]
**Sent:** Monday, November 4, 2019 4:49 PM
**To:** doh.sm.1115Waivers
**Subject:** #11-W-00114/2 - Delivery System Reform Incentive Payment (DSRIP) Amendment Request Comment from God's Love We Deliver
**Attachments:** GodsLoveWeDeliver_1115WaiverComment.pdf



Dear Director Frescatore:

Thank you for the opportunity to comment on the New York State Medicaid Redesign Team's proposed amendment request for the 1115 Research and Demonstration Waiver for the Delivery System Reform Incentive Payment (DSRIP) Program. God's Love We Deliver greatly appreciates the support of New York State Department of Health (NYSDOH) for social determinants of health providers, like us, through its healthcare innovation efforts.

Please find our comments attached.

All my best,

Karen Pearl

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**Karen Pearl**
President & CEO
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**About God's Love We Deliver**
God's Love We Deliver provides nutrition therapy, and cooks and home delivers medically tailored meals for people living with severe illness in the New York City metropolitan area. We are a non-sectarian organization. All of our services are provided free to clients and full of love.


Donna Frescatore
Medicaid Director
Office of Health Insurance Programs
Department of Health
Empire State Plaza, Corning Tower
Albany, NY 12237

November 4, 2019

RE: #11-W-00114/2 - Delivery System Reform Incentive Payment (DSRIP) Amendment Request

Dear Director Frescatore:

Thank you for the opportunity to comment on the New York State Medicaid Redesign Team's proposed amendment request for the 1115 Research and Demonstration Waiver for the Delivery System Reform Incentive Payment (DSRIP) Program. God's Love We Deliver greatly appreciates the support of New York State Department of Health (NYSDOH) for social determinants of health providers, like us, through its healthcare innovation efforts and will focus our comments on the specific areas of the proposed amendment that are concerned with these services.

**About God's Love We Deliver**
God's Love We Deliver is the New York metropolitan area's leading provider of medically tailored home-delivered meals (MTM) and medical nutrition therapy (MNT) for people living with serious illness. Medically tailored meals are delivered to individuals living with severe illness through a referral from a medical professional or healthcare plan. Meal plans are tailored to the medical needs of the recipient by a Registered Dietitian Nutritionist (RDN), and are designed to improve health outcomes, lower cost of care and increase patient satisfaction. Each year, we cook and home-deliver 1.9 million MTMs to approximately 7,600 people living with more than 200 individual diagnoses—such as heart disease, diabetes, hypertension, chronic obstructive pulmonary disease (COPD), renal failure, cancer, HIV/AIDS and many more—in all five boroughs of New York City and in Westchester, Nassau and Suffolk Counties. In new partnerships, we have been asked to expand our services to Orange, Rockland and Sullivan Counties.

As a long-time social determinant of health provider, God's Love We Deliver has made significant strides in improving the health and wellbeing of New Yorkers over the years. Beginning in 2005, through the New York State's 1115 Medicaid waiver, Medicaid Managed Long Term Care (MLTC), PACE, MAP and FIDA plans began contracting with God's Love to provide medically tailored home-delivered meals and medical nutrition therapy to their highest-risk enrollees. Since then, we have been actively involved in the State's DSRIP program; currently, we are engaged in five separate DSRIP-funded evaluation projects with various hospital partners. We have also been active on the Value-Based Payment (VBP) front, currently participating as the Tier 1 community-based organization (CBO) in several VBP contracts with both Mainstream and MLTC plans and in discussion with others for future engagements. We are a past awardee of the Balancing Incentives Program and, in September 2018, God's Love was

chosen as a winner for the NYSDOH Social Determinants of Health Innovation Award in the Community-Based Organization category. Through these and other initiatives, we have been able to bring our life-saving services to Medicaid enrollees in the communities we serve, improving their health and lowering their healthcare costs.

**Feedback on the State's Proposed Amendment to the 1115 Research and Demonstration Waiver**

**Section I. Historical Narrative Summary of the Demonstration**
As mentioned above, we were an early and ongoing participant in the State's DSRIP model, contributing in almost all the downstate PPS. We embraced the model enthusiastically, offering our expertise in healthcare contracting and delivery through trainings for other community-based organizations, often in collaboration with the New York State Department of Health, that walk attendees through the new movement towards value-based payment in Medicaid.

Because of our meaningful involvement over the last 6 years of DSRIP, we have catalogued many successes, but also some challenges. We believe this proposed amendment is a unique opportunity to surmount these challenges and build the best care system for our State.

**Section II. Changes Requested to the Demonstration**

**Aligning with Federal Goals**
We deeply appreciate the alignment with the federal goal of addressing social determinants of health (SDH) through community partnerships. Only a small proportion of health outcomes are attributable to care provided in a clinical setting: 80% of a patient's health is driven by what happens after the patient leaves the hospital or clinic.[i] As HHS Secretary Alex Azar has stated, "we believe we could spend less money on healthcare—and, most important, help Americans live healthier lives—if we did a better job of aligning federal health investments with our investments in non-healthcare needs."

The Secretary's push for healthcare institutions to have increased flexibility in how they pay for services like MTMs is a wonderful development in Medicare and Medicaid policy. Adequately addressing the root causes of illness through innovative services will advance the goal of realizing an outcomes-driven, cost-effective healthcare system.

Food insecurity and malnutrition have been strongly associated with poor health outcomes and higher healthcare costs. Summarized findings of select scientific literature on malnutrition, food insecurity, and health outcomes can be found in Appendix A. The rigorous research that demonstrates the cost-savings and improved health outcomes associated with delivery of MTMs is available in Appendix B. While there is a growing body of data, some highlights include 50% fewer hospitalizations and a 16% net cost savings for severely ill patients who receive MTM. These data suggest that incorporating access to disease-specific, nutritious food is a necessary component of improving health outcomes in Medicaid populations.

Identifying food insecurity and malnutrition in clinical settings is an urgent priority. Screening for patient food insecurity and connecting patients to food resources has been strongly supported in official statements by the Centers for Medicare and Medicaid Services, the American Academy of Pediatrics, the American Diabetes Association, the Academy of Nutrition and Dietetics and AARP. CMS has taken steps to ensure that social needs screening becomes a widespread practice within the health care system, by initiating the Accountable Health Communities model.

**However, screening alone will not be enough to yield the desired impact on health outcomes and costs, especially for individuals with complex health needs. It is critical to pair identification of nutrition risk and medical need for Medicaid beneficiaries with access to an appropriate and adequate nutrition response in a coordinated way. The next phase of DSRIP should focus on increasing access to key SDH services through coordinated referral, data and payment systems.**

**Value-Driving Entities**
This section of the proposed amendment acknowledges that current VBP arrangements are generally constructed around primary care provider (PCP) attribution, which does not completely embrace comprehensive integrated primary care, behavioral health, and other social care capacities that have been the result of much of DSRIP's success. The creation of the new, more flexible Value-Driving Entities (VDEs) approved by the State to implement identified high-priority DSRIP promising practices is an encouraging new step.

In the original implementation of DSRIP, innovation funds flowed from the hospital out to the community rather than the reverse, which resulted in delayed input on the structure of innovation by community-based organizations, who are experts in population health. Capacity building funding for the community to enable better care coordination and support unfunded services was also late to arrive and underfunded. Furthermore, the architecture of data sharing and evaluation became an addendum rather than a crucial first step in creating a coordinated referral system.

**a) Governance of VDEs**
To remedy this issue, the new VDEs must have CBOs as a core part of the governance structure with equal input, leverage and financial support as the other members of the management team. Meaningful involvement of the community in the design of future value will not be achieved without this.

**b) Funding and Service Requirement**
While we strongly support the State's delivery system reform and VBP efforts around SDH, we have highlighted, in previous input to the State, several challenges that exist for social determinants of health providers like us. As an experienced healthcare contractor, we have had some early success in securing new contracts with hospitals and health plans under DSRIP and VBP, however, these contracts often have not led to the level of service delivery that is expected under the proposal. It is important to note that while the State's current policy requires VBP arrangements to include a social determinant of health provider, it does not require that healthcare providers actually refer for the delivery of social determinants of health services, nor does it require evaluation of those services provided under the contract. Within the DSRIP amendment request, the State should go a step further to require delivery and explicit evaluation of SDH interventions delivered through the new VDEs.

The funding structure for SDH services within the new VDEs is unclear from the proposed amendment. In the current structure of VBP, funding for evidence-based SDH services that have been proven to reduce cost and improve outcomes is at the discretion of the MCOs. In the original structure of DSRIP, hospitals managed SDH funding and flow. How will funding be awarded to the VDEs and who will manage funds flow to ensure that CBOs receive the capacity building and service delivery support that will be necessary to achieve results?

### c) Care Coordination

In our experience working with vulnerable populations, quality care coordination is a crucial element to achieving overall success in care. The flexibility of the new VDEs could trend toward the creation of duplicative care coordination systems that may drain resources and cause confusion in the high-risk, high-need, high-cost population this proposal seeks to address. It would be helpful if the State could be more specific about how the care structures of the new VDEs will fit into existing care coordination structures such as: Health Homes, Managed Care and Managed Long Term Care plan staff, DSRIP-funded entities (Community Health Navigators, Transitional Care Nurses, Social Work Departments and technology platforms like NowPow and Unite Us, etc.) and more.

### d) Administrative Burden

We are also curious how the proposed VDEs will interface with current VBP arrangements and structures and whether the creation of a super structure VDE will result in additional administrative burden for all the partners within the VDE. How does the state plan to reduce the administrative burden of the project reporting structure in DSRIP?

### e) Data and Technology

We are thrilled to see the inclusion of the state's regional health information organizations (Qualified Entities, or QEs) in the structure of the VDEs, to enhance data exchange capabilities.

A key challenge with the implementation of DSRIP has been establishing a coordinated data system that accurately assesses need and eligibility for SDH interventions in clinical settings and then refers patients to appropriate providers in the community in a closed-loop fashion. To address this need, each PPS has developed their own screening and referral system, in many cases with limited input from the community. This situation has proven challenging for CBOs in terms of capacity as they endeavor to keep up with referrals from many different systems, especially without appropriate capacity funding. Furthermore, lack of clarity from the State around consent, HIPAA and other data sharing issues between clinical providers and the community has meant that the creation of an innovative, coordinated system has stagnated. Fewer patients receive the care that they need when providers are unsure of where to refer their patients, community-based organizations receive improper referrals that drain capacity, and patients are referred to services for which they are ineligible.

For this amendment proposal, we encourage the State's to describe how technology will be used to enable a more coordinated system for providers, patients and the community in order to better implement promising practices through VDEs. A system of this nature would also be required to more accurately match value to SDH services.

## Section III. Additional High-Need Priority Areas

We agree with the State that more time is needed to deliver on the promising practices that align with the federal priorities mentioned above. We also agree that certain high-need and high-cost populations, like the population needing long term care services, did not benefit directly from DSRIP initiatives unless a Medicaid-measured avoidable hospitalization was impacted.

### a) Promising Practices: Embedding Nutrition Assistance Within Health Care Settings

The report by United Hospital Fund identifies promising practices that could be expanded to increase success. Embedding nutrition assistance in healthcare settings is specifically

mentioned. Our pilot project with Nassau-Queens PPS is called out as an example of this. Through concerted involvement in a variety of PPS, God's Love has seen success with various proposals that embed nutrition in clinical care.

One such project – the Food and Nutrition Services Bundle delivered through OneCity Health PPS – offers screening and navigation to community food and nutrition resources for food insecure patients at two public hospitals in the Bronx. The project was a close partnership among Public Health Solutions, God's Love We Deliver, Lincoln Hospital, Jacobi Hospital, BronxWorks, the Food Bank for New York City, and Healthfirst. Collaborative design of the screening tool (led by God's Love) and workflows and continuous quality improvement were essential to our approach. The project used a dynamic care coordination platform, Unite Us, to manage the activities of the network, with integrated consent, assessment tools and outcome measures. PHS' Contracting and Management Services enabled the application of flexible and performance-based contracting methods for network partners, which maximized sustainable funding from a variety of sources.

The project estimated savings of more than $300,000 at the midway mark and final results will be forthcoming shortly.[ii] The structure of the pilot could serve as a model for coordinated SDH interventions, built on data and integrated funding streams.

**b) Long-Term Care Reform**

We are pleased to see a renewed focus on value-based care for the long-term care population in the proposed amendment. This high-risk, high-need, high-cost population drives much of healthcare spending. Because of this fact, many initial NYS SDH interventions have been piloted with great success in this population, including our current Community Partners Program, through which God's Love has had longstanding relationships with more than 20 Medicaid Managed Long Term Care plans and nourishes their highest risk members. Furthermore, national focus has turned to this population as the dual trends of aging and chronic illness have converged to create vulnerable patients. The State's focus is in line with national policy changes as well, such as the flexibility introduced into the Medicare Advantage program through the Special Supplemental Benefits for the Chronically Ill, which come online in 2020, and others.[iii]

**Section IV. Continued Investments/Improvements**

**A. Continued Workforce Flexibility and Investment**

The focus on building capacity in the non-traditional workforce is welcome. In addition to the care coordination workforce, we suggest a renewed focus in the workforce funding rollout on workforce capacity for CBOs themselves, as they are asked to take on more and more of the care coordination and service delivery for the larger healthcare system.

**B. Coordinated Population Health Improvement – A multi-player context for reform**

As part of the next implementation phase, the State is proposing to further advance population health work through "Social Determinant of Health Networks" (SDHN) which will deliver socially focused interventions linked to VBP. Considering the new VDEs, the creation of SDHNs raises questions about structure.

- How will the SDHNs integrate with VDEs?
- Single point of contact for contracting for VBP: Will a CBO be required to be a member of a SDHN to participate in a VDE?
- What if a CBO serves multiple regions and geographies? Are they allowed to join multiple SDHNs?

- Will the funding set aside for SDH in the proposed amendment ($1.5 billion) be awarded only through these SDHNs, or also through the VDEs?
- Will the funding for DSRIP Performance ($5 billion) flow only through the VDEs?
- If so, will VDEs have the option to invest some of this funding in SDH interventions?

We would also like to voice our overwhelming support for all Medicaid plans to be able to report expenditures on social determinants of health services as medical services. Over the years, we have heard from plans that the lack of this option has been a barrier and has hindered some innovative investments, given concerns about the impact on administrative expenses. We believe that this change will enable more health plan spending on much-needed social determinants of health services.

**Section V and VII. Performance Measurement and Evaluation**
As mentioned in Section II.e. above, a coordinated data system that includes community networks and closed-loop referrals is the only way to accurately measure performance. Furthermore, we suggest a more comprehensive set of SDH-specific VBP measures be created to fold in the meaningful involvement of the community in addressing the clinical markers we are collectively trying to improve. The creation of this set of measures could begin with the community in partnership with the Independent Evaluator (IE), but would need to be adopted by the State and become a requirement for evaluation.

**Conclusion**
We fully support the State's delivery system and payment reform goals as outlined in the proposed amendment, and we request that the State go a step further to incorporate some additional requirements related to the funding and delivery of services that address the social determinants of health. Please know that you can count on God's Love We Deliver as resource as you move forward.

We are grateful to play a role in the care and wellbeing of so many New Yorkers and we look forward to continuing our partnership with the Department of Health and other stakeholders on innovation initiatives that aim to achieve a healthier, more nourished population and lower healthcare costs.

Sincerely,

Karen Pearl
President & CEO

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**Appendix A**

- Food insecurity is associated with increased use of health services in primary care networks.[iv]
- Total healthcare costs, including inpatient care, emergency care, surgeries, and drug costs, increase as food insecurity severity increases. [v,vi]
- Hospitalizations for low-income, diabetic patients increase at the end of the month when nutrition benefits, finances, and food are in short supply, while they remain stable for middle class and upper-class households.[vii]

- Food insecurity is associated with double the odds of poor diabetes control and increased use of health services. [viii]
- Food insecurity is associated with four times the risk for osteoporosis for women in nationally representative NHANES data.[ix]
- Food insecurity is associated with nearly twice the odds of HIV treatment non-adherence,[x] and connecting HIV patients to medically tailored meals has been found to increase medication adherence by 50%.[xi]
- Malnutrition is a factor in almost two million hospital stays annually.[xii]
- Hospital stays for malnourished patients are up to three times longer than hospital stays for properly nourished patients.[xiii]
- Average inpatient hospitalization costs are 24% higher and readmission within 15 days almost twice as likely for malnourished patients as compared to properly nourished patients.[xiv]

**Appendix B - Medically Tailored Meals: The Evidence**

Recent research has demonstrated significant improvements in health outcomes and associated cost savings for Medicare and Medicaid beneficiaries. In an article published in Health Affairs in 2018, researchers used claims data and found providing MTMs for patients dually eligible for Medicaid and Medicare resulted in fewer emergency department visits, emergency transportation services, and inpatient admissions as compared to dually eligible patients not enrolled in the meal program.[xv] Specifically, as compared to matched controls, dually eligible patients receiving MTMs experienced a 70% reduction in emergency department visits, a 52% reduction in inpatient admissions, and a 72% reduction in emergency transportation events.

The MTM intervention resulted in a 16% net reduction in health care costs. The net savings after factoring in the cost of the meals was $220 per month per patient. A similar MTM program deployed in a managed care Medicaid population in Philadelphia saw 28% lower health care costs for Medicaid patients receiving MTMs as compared to a similar group of Medicaid patients.[xvi] Researchers found that individuals who received MTMs had hospital stays that were 37% shorter, visited the hospital 50% less, and were 20% more likely to be discharged to their homes. A MTM program in Denver similarly recorded a 24% decrease in health care costs for patients enrolled in their services in a retrospective cohort analysis and found a 13% decrease in all cause, 30-day readmission rate.[xvii] Finally, another study conducted in San Francisco found that for HIV patients connected to MTM, adherence to antiretroviral therapy increased from 47% to 70%, and perceived diabetes self-management significantly increased for diabetic patients.[xviii] The same study also found reduction of diabetes-related distress and recorded improved depressive symptoms and decreased binge drinking.

These studies suggest that MTMs not only improve an individual's health outcomes, but can also reduce total health care costs. As a result, private insurers across the country are looking for ways to bring these meals to their members, especially within their Medicaid and Medicare managed care plans. The time is right to examine the efficacy of administering MTMs within our public insurance programs.

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## doh.sm.1115Waivers

**From:** Diane Novy [redacted]
**Sent:** Monday, November 4, 2019 4:51 PM
**To:** doh.sm.1115Waivers
**Cc:** [redacted]
**Subject:** 1115 Public Forum Comment
**Attachments:** DSRIP 2 Comments Final.docx.doc



Good afternoon. Please accept the attached comments on behalf of The Jewish Board of Family and Children's Services. Thank you.

**Diane Novy**
**Senior Director, Managed Care**

**135 W. 50th Street, 6th Floor, New York, NY 10020**
[redacted]

**The Jewish Board**
Health and Human Services for All New Yorkers
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November 4, 2019

NYS Department of Health
Office of Health Insurance Programs
Waiver Management Unit
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To Whom it May Concern:

The Jewish Board of Family and Children's Services (Jewish Board) appreciates the opportunity to submit comments on NYS's draft Delivery System Reform Incentive Payment (DSRIP) Amendment Request concept paper.

The Jewish Board is New York City's largest human services provider, offering an unmatched continuum of behavioral health, family support, residential, early childhood, and youth programming to over 40,000 New Yorkers of all backgrounds each year, in 75 program sites across the five boroughs. For over 140 years, we have worked with children, youth, and families to support empowerment, resilience, hope, and community integration in the face of complex personal and community barriers and exposure to traumas. As such, we strongly believe that strengthening the behavioral health sector is integral to the future success of the DSRIP Amendment and the transition to Value Based Payment (VBP). Our specific comments and recommendations for the DSRIP Amendment include the following:

- Expand Certified Community Behavioral Health Clinics (CCBHC)
- Supportive Housing
- Regulatory relief to promote the integration of mental health and substance use services
- Carve out specialty populations in the VBP Roadmap
- Children's Population Health

<u>Expand Certified Community Behavioral Health Clinics</u>

Funding the transformation of the behavioral health sector addresses many of the federal priority areas such as SUD Care and the Opioid Crisis; Serious Mental Illness (SMI) / Serious Emotional Disturbance (SED), and; Social Determinants of

The Jewish Board
Health and Human Services for All New Yorkers

Health. In addition, most of the promising practice categories that are proposed for continuation in the DSRIP Amendment Request are addressed by behavioral health providers. For example, expansion of Medication-Assisted Treatment (MAT), Care coordination, care management and care transitions, expansion of Mobile Crisis Teams (MCT) and crisis respite services, focus on patients transitioning from IMDs to the community, focus on seriously mentally ill / seriously emotionally disturbed populations, addressing the social determinants of health through community partnerships and integration of primary care into behavioral health.

The expansion of CCBHCs, or the creation of a NYS CCBHC-like designation, would provide the funding behavioral health providers need to tackle these high priority areas. The additional funding would allow providers to offer competitive salaries to recruit and retain staff, and hire the additional care coordination staff, registered nurses and peers that support the new model. Commensurate with this new designation should be a reimbursement structure that supports the model and provides
sustainability for providers.

<u>Regulatory relief to promote the integration of mental health and substance use services</u>

It is estimated that there were 9.2 million people nationally with co-occurring mental illness and substance use disorders in 2018. The best treatment for dual diagnosis involves treating both conditions simultaneously. The current regulatory framework makes providing mental health and substance use services in an integrated setting prohibitive. While there has been some movement toward easing these regulations, we suggest that further steps be taken to encourage more providers to pursue providing integrated mental health and substance use services, whether within the CCBHC structure or in the current bifurcated structure. DSRIP funding should be used to support the necessary service delivery infrastructure and provide the training needed to increase the availability of integrated services.

<u>Supportive Housing</u>

Supportive housing addresses an important social determinant of health (SDOH) and has been proven to generate a positive return on investment. Moving

homeless people into supportive housing creates savings in the health care system by reducing inpatient and emergency department utilization.

We recommend that the Department of Health, Office of Mental Health and other relevant state and city agencies work together to connect and integrate supportive housing into the health care system. This could be done through the expansion of the Medicaid Managed Care benefit package to include supportive housing as a covered benefit. Also, more flexible use of supportive housing, including for crisis and respite care, and in collaboration with in-home health services, could help avert the need for emergency department and repeat hospitalizations.

Carve out specialty populations in the VBP Roadmap

Early versions of the VBP Roadmap carved out specialty populations (HARP, HIV, etc.) from the general population, however many HARP members are in total cost of care arrangements for the general population. These arrangements are not required to incorporate quality measures that are meaningful for this population, so they generally don't.

We recommend that the Roadmap be updated to carve the HARP population out, as originally intended. Since behavioral health providers are often the main connection to the health care system for this population, behavioral health providers services should be used for attribution. And, behavioral health providers, behavioral health IPAs and Behavioral Health Care Collaboratives (BHCCs) should be specifically designated as lead contractors for this population. MCOs should be required to enter into VBP arrangements with these entities. It should also be required that these arrangements incorporate more robust quality measures that are meaningful for this population.

Children's Population Health

While we are pleased to see that children's population health has been added as an additional high-need priority area in the Amendment Request, we do not agree that achieving these important outcomes can be accomplished through value-based payment arrangements. By their nature these are longer term investments which don't necessarily show short-term return-on-investment. In an environment where members can switch MCOs each year, it is unlikely that

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MCOs will enter into VBP arrangements for this population. It is our opinion that children's population health is best addressed through the continuation and future funding of successful DSRIP Domain 4 Projects.

The Jewish Board had the opportunity to participate in a cross-sector collaborative project with four PPSs, four behavioral health providers, the New York City (NYC) Departments of Education and Health and Mental Hygiene, and underserved NYC public schools to advance the 100 Schools Project. Coaches were utilized to train teachers and staff to deliver crisis support and behavioral health referrals to students and families. The program's goal was to improve students' educational outcomes, such as reductions in truancy and suspensions. Early data suggest that the participating schools have been more effective in resolving student crisis and avoiding arrest and the student needing to leave school. It has also lead to improvements in classroom learning environments and teacher morale. These types of important outcomes would not be easily captured in a value-based payment arrangement with an MCO.

We appreciate the opportunity submit these comments and thank you for your consideration. If you have any questions we can be reached at the numbers below.

Sincerely,

John Kastan

John Kastan
Chief Program Officer
[redacted]

Sincerely,

Diane Novy

Diane Novy
Sr. Director, Managed Care
[redacted]

PROUD PARTNER UJA FEDERATION

## doh.sm.1115Waivers

**From:** Bertone Dean [redacted]
**Sent:** Monday, November 4, 2019 4:53 PM
**To:** doh.sm.1115Waivers
**Cc:** [redacted]
**Subject:** DSRIP 2.0 Concept Paper FQHC Response_Comments Union Community Health Center
**Attachments:** DSRIP 2.0 Concept Paper Comments_Union Community Health Center(UNION)_final_11.4.19.pdf



New York State Department of Health 1115 Waiver Department,

Please find attached the response to DSRIP 2.0 Amendment Request Concept Paper from Union Community Health Center (UNION), a Federally Qualified Health Center located in the Bronx, New York.
Please contact [redacted] with any questions regarding the submission.
Thank you.

Dean Bertone, M.P.H.
Director of Value-Based Contracting, Value Analysis & Business Development
Union Community Health Center
260 E. 188th St.
Bronx, NY 10458
[redacted]

Union Community Health Center (UNION) is grateful for the opportunity to provide comments on the Delivery System Reform Incentive Payment (DSRIP) Amendment Request concept paper published on September 17th. UNION is a 501(c)(3) non-profit Federally Qualified Health Center (FQHC), serving over 36,000 medically underserved individuals in nine zip codes from seven locations in central Bronx, New York. UNION commends the State's work in the first round of DSRIP to reduce costs, improve patient outcomes, and decrease unnecessary inpatient and emergency room utilization. For New York to experience a real transformation of the health care delivery system and sustain the gains thus far achieved through DSRIP there must be a significant investment in community-based primary care. Only through this investment can the State achieve a true value-based system that improves health outcomes and reduces costs. UNION supports the renewal of the DSRIP program through March 31, 2024. UNION is a member of the Community Health Care Association of New York State (CHCANYS), supports the comments submitted by CHCANYS and has restated and revised many of their points below.

## I. Driving Promising Practices to Improve Health Outcomes and Advance VBP

By mission and in statute, health centers serve the State's most vulnerable and hard to reach populations. FQHCs are non-profit, community run centers located in medically underserved areas that provide high-quality, cost effective primary care, including behavioral and oral health services, to anyone seeking care. Each FQHC is governed by a consumer-majority board of directors who are tasked with identifying and prioritizing the services most needed by their communities. 75% of UNION's 36,000 patients are enrolled in Medicaid or CHIP.

UNION has seven locations, which are located at 260 E. 188th Street, 2021 Grand Concourse Ave, 2016 Bronxdale Avenue, Fordham Plaza, a Primary Care Mobile Health Unit and two sites on 3rd Avenue for dental and physical rehabilitation medicine respectively; all of which provide access to comprehensive primary care services, especially among populations that are most likely to present at the ED with a non-urgent or avoidable condition. In the first round of DSRIP, UNION participated in two Performing Provider Systems (PPS): Bronx Partners for Healthy Communities (BPHC) and One City Health PPS. As part of both BPHC and One City Health, UNION participated in ten different DSRIP programs including but not limited to: developing an Integrated Delivery System with local Bronx and NYC partner healthcare organizations, developing a Health Home At-Risk Intervention Program within UNION's care coordination department, establishing an Emergency Department and Care Transition Program with affiliated hospitals, Integrating Primary Care and Behavioral Health at UNION, and developing Disease Prevention programs around Cardiovascular and Diabetes chronic conditions such as a Drop-In

Blood Pressure clinic at both UNION's brick and mortar site and on UNION's Mobile Health Unit, a Diabetes Self-Management Education Programs and a referral management workflow to AIR NYC for asthmatic patients.

The first round of DSRIP complemented the health center model's unique and innate ability to provide comprehensive and innovative care to New York's Medicaid beneficiaries. Health centers played and continue to play a key role in advancing the promising practices within their regions and driving improved health outcomes. In the second round of DSRIP, health centers are well prepared to take a leadership role to advance the State's vision of an expanded value-based payment (VBP) landscape driving DSRIP promising practices.

## II. Embracing the Role of VDEs

We are pleased to see that the State has acknowledged the need for additional flexibility in the next round of DSRIP and is interested in ensuring the success of Value-Driving Entities (VDEs). However, we encourage the State to provide direct investment in community-based providers. Currently, 23 of 25 of the PPS leads are hospital-based, with no specific requirements about how funds flow to partners in the PPS networks. Meaningful governance participation by community-based providers, such as community health centers and community behavioral health organizations, and downstream investments to health centers and other community-based providers varied greatly from PPS to PPS. Using publicly available data reported by the State, it is extremely difficult to determine the amount of money received by health centers in the first round of DSRIP – they are included as "clinics" with hospital ambulatory providers. However, the most up to date data reported by the State in November 2018 demonstrates that hospitals received more than 28% of total funds flow while representing only 0.2% of total engaged PPS partners.[i] It is exceedingly difficult to transform the healthcare delivery system by continuing to invest most transformation dollars into inpatient-based care models, when it is the long-standing established CHC providers and workforce that can make the biggest impact on patients' health outcomes. CHCs are especially well posed to integrate care, make connections to address social needs, and become the more adept and agile VDEs envisioned in the State's concept paper.

UNION supports the State's charge that VDEs include providers, community-based organizations (CBOs), and managed care organizations (MCOs) to leverage VBP and advance promising practices. A collaborative partnership between community-based providers, CBOs, and MCOs is critical to implementing and supporting transformative initiatives that move away from a volume-driven care model. However, to support improved access to care in the community and reduce reliance on emergency departments and inpatient care, the State must direct additional resources to a broad range of community-based providers. **UNION requests that the State dedicate, at a minimum, 25% of DSRIP funds to the development of community-based VDEs where CHCs, in collaboration with other community-based providers, are leads.**

### a. VDE Lead Entities

The State should capitalize on existing health center Independent Practice Associations (IPAs) as a launching point for the creation of community-based VDEs. There four CHC-led IPAs currently organized across the state, Community Health IPA (CHIPA), Safety-Net IPA (SIPA), Finger Lakes IPA (FLIPA), and Upstate Community Health Collaborative IPA (UCHC), are engaged with MCOs in at least one VBP contract while working on additional agreements. IPAs are able to take on risk and become financially accountable for both the quality of care and the most efficient delivery of care services. We believe that IPAs are well positioned to work with other entities as a VDE in the second round of DSRIP.

While health centers like ours are already developing relationships needed to advance in VBP contracts, a second round of DSRIP is an opportunity to invest in building capacity to ensure health center and CBO IPAs have the foundation to serve as VDEs. Currently, health center-led IPAs are self-funded and have little financial capacity to support many of crucial functions that would accelerate their successful participation in VBP arrangements. **Health center-led IPAs require DSRIP investment to support the data analytic capabilities needed to effectively manage population health and drive improved outcomes.**

**b. Considerations for Engaging MCOs**

UNION is pleased that the State is taking steps to ensure engagement of MCOs early in the planning process for a second round of DSRIP. However, there are significant challenges that must be addressed ahead of the creation of VDEs. One of the current difficulties faced by providers as they seek to participate in VBP arrangements is a lack of comprehensive data about their attributed patients. **The State should create and enforce a uniform data sharing policy for the managed care plans to further support the transition to VBP, for example, by enforcing transparency in expenditures and utilization.**

In the first round of DSRIP, the discrepancies between MCO attribution and PPS attribution made it difficult for health centers to effectively manage patient health outcomes. PPS networks do not necessarily encompass the same providers that are contracted with a given MCO. If there are discrepancies between MCO attribution, consumer utilization, and PPS network, it becomes incredibly difficult, if not impossible, for the PPS to effectively manage health outcomes for these populations. PPS and VDEs should not be expected to manage the health care improvements of individuals who are enrolled in managed care plans that contract outside of the VDE. **UNION recommends that in the next round of DSRIP, VDE attribution should be aligned with MCO attribution to ensure seamless VBP contracting.**

Finally, we understand the State's desire to drive regional innovation – local health care needs vary based on geography, CBO and health care provider landscape, and other factors. However, we would like to raise the concern that in densely populated areas served by many MCOs with overlapping service areas (notably, New York City), defining distinct regions may prove difficult. **In New York City, UNION recommends that VDE networks should align with patient utilization patterns as much as possible.**

## III. Supporting Non-Clinical Workforce to Address Social Needs

UNION echoes the State's observation that many of the successful DSRIP initiatives rely on non-traditional, non-clinical workforce that help patients navigate clinical and social services systems to address their multi-dimensional needs. In the first round of DSRIP, we embraced the flexibility to address patients' social needs. UNION launched many innovative initiatives to address the social needs to its patients, for instance; building an infrastructure of a multidisciplinary care team, which involved the clinical staff, mental health specialist, and the care management department. The multidisciplinary team approaches the patients as a whole person; the EHR is utilized to identify gaps in social services for patients, namely those at high risk. A combination of these multiple approaches due to the funding from DSRIP in Phase I is what made this initiative possible.

In the first round of DSRIP, the State encouraged primary care practices to become patient-centered medical home (PCMH) recognized. Today, 97% of New York's health centers are PCMH certified. PCMH certified practices provide mental health, oral health, and health promotion/disease prevention services through comprehensive primary care. This model of patient-centered care is associated with improved health outcomes and reduced costs and should be robustly supported in the second round of DSRIP. There are numerous studies that have analyzed the success of PCMH, including citing fewer specialty visits needed, lower per member costs, and better health outcomes amongst individuals seeing PCMH-certified providers.[ii]

PCMH has allowed UNION to position resources such as the care management program to engage patients, who are at high risk of developing a chronic health condition, being a victim of social disparity, and a barrier to accessing socioeconomic resources. Patients who were engaged in care management programs demonstrated to be more in compliance with their medical appointments, followed through with other medical and non-medical visits, and accessed support services such as diabetes education, smoking cessation education, and other social services. The Health Home Program has been a pillar for many individuals served by UNION. These individuals have enrolled in social services that have made a significant impact in their lives and subsequently developed a support system with their assigned care manager, who follows up regularly with them for medical care, community resources and referrals to specialty and mental health services. Without these programs, UNION would not be able to meet the ever-pressing need of their patients. Many children, adults, and seniors would be forced to either be loss or not access their care for fear of not understanding the regulations, benefits, and resources. PCMH readiness has also prepared UNION to begin analyzing and disseminating the risk-score algorithm and stratification tools within the health center's Electronic Medical Record (EMR) System to begin aligning those risk scores with the MCO VBP arrangements UNION is securing. UNION does not have the means or current reimbursement mechanisms to support the non-clinical workforce tasked with the managing and coordination of the social services and needs of UNION's complex patient population. Therefore, without DSRIP funding to support this non-clinical workforce, UNION's patients with complex social determinants of health would

not receive the necessary resources and remain non-complaint with appointments and services to address their social and ultimately healthcare needs.

**The State should use a second round of DSRIP to continue investments in care management programs like PCMH and Health Homes to address patients' social and medical needs.**

## IV. Aligning Performance Measures

UNION strongly supports the State's desire to work with CMS to align performance measures across initiatives. Health centers' participation in Medicare, Medicaid, NYS PCMH, and contracts with managed care plans (among various other programs) requires a significant amount of resources invested in measure/data collection and reporting. **The State should target measures most likely to be of value for all participants in DSRIP 2.0.**

## V. Health Center Alternative Payment Methodology

FQHCs embrace the State's transition of Medicaid payment from volume to value. UNION supports this direction and is engaged in work with CHCANYS to move away from a visit based FQHC payment to a capitated FQHC Alternative Payment Methodology (APM). Federal statute permits states to implement an APM in lieu of the legally required prospective payment system reimbursement methodology. States must ensure that reimbursement under the APM is not less than it would be under the prospective payment system rate; however, adoption of an APM is essential to move FQHCs from a visit-based payment that incentivizes volume, to a payment methodology that rewards efficiency and outcomes. A capitated FQHC APM aligns with the State's DSRIP goals of advancing VBP and provision of enhanced care coordination.

An FQHC APM supports team-based, integrated care and enables CHCs the flexibility needed to create innovative approaches to care which can include non-clinical support staff who are not billable providers under the prospective payment system rate. The creation of innovative care coordination workflows will improve care provided directly by FQHCs, therefore reducing costs across the health care system.

UNION looks forward to working closely with CHCANYS and the Office of Health Insurance Programs to establish a mutually agreeable approach that supports health centers' ability to transform their entire practice to a value-based care delivery model. Once the APM receives a federal approval, a small subset of health centers will transition from the prospective payment methodology to the APM. **To ensure the success of an APM, State investment is needed to enhance data collection capabilities and catalyze the development of new staffing roles, models for care teams, and innovative work flows.** These investments may include: enough funding to support interventions addressing patients' non-clinical social needs, support

for an alternative payment learning community, clinical and cost data analyses, quality metric identification, and reporting mechanisms.

UNION has actively engaged in DSRIP implementation and contributed to many of the successes achieved. We look forward to continuing to partner with the State to achieve our shared goals of system transformation and improved patient care, better patient outcomes, and reduced care costs.

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Raskas R, Latts L, Hummel J et al. 2012. Early Results Show WellPoint's Patient-Centered Medical Home Pilots Have Met Some Goals For Costs, Utilization, And Quality. Health Affairs. Vol. 31, No. 9: Payment Reform to Achieve Better Health care. https://doi.org/10.1377/hlthaff.2012.0364
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## doh.sm.1115Waivers

**From:** Baroody, Patricia [redacted]
**Sent:** Monday, November 4, 2019 4:54 PM
**To:** doh.sm.1115Waivers
**Subject:** 1115 Waiver Public Comment
**Attachments:** signed letter DOH 110419.pdf



Hello,

Please accept the attached letter with comments regarding the 1115 DSRIP Waiver.

Thanks.

*~ Patty*

***Patricia A. Baroody***
***Director***
***Office for the Aging***
***Steuben County Office Building***
***3 East Pulteney Sq***
***Bath NY 14810***
[redacted]

NEW YORK STATE | NY Connects
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of STEUBEN COUNTY

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# Steuben County Office for the Aging

Patricia Baroody, Director

*The new age of aging --*
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November 4, 2019

Paul Francis
Deputy Secretary for Health
State Capitol
Albany, NY 12224

Donna Frescatore
Medicaid Director
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Dear Mr. Francis and Ms. Frescatore,

On behalf of Steuben County Office for the Aging, I am writing to express my recommendations on the DSRIP renewal proposed by New York State Department of Health. The services we provide directly impact inappropriate emergency department visits, and reduce avoidable readmissions. The NY Connects program, implemented in 2006, serves as no wrong door for any and all services available in the region, and is a catalyst for individuals in need of assistance. The targeted goals in the proposed renewal are exactly what this network provides, and must include mandated contracting by each PPS with their local Area Agency on Aging for social determinants of health initiatives. Our office is the trusted service provider for the fastest growing segment of the population, and the highest utilizer of health care dollars. Our services absolutely allow individuals to remain in their own homes and communities, all while saving health care expenditures. We provide the highest level evidenced based interventions, and are experts at navigating a complex health care system, while providing person centered planning and care.

To demonstrate the value of the network, I would like to highlight that we frequently serve families where a loved one has been discharged from a hospital or other facility, yet did not have an adequate discharge plan in place, or at least they did not understand it. We are called upon to coach them on how to get community health services in place, and to make a plan for other support services when the short term plan ends. We fill gaps around the existing system as we advocate for future enhancements to the non-medical community care network.

Our aging network provides the boots on the ground service in every county across the state, most with a 40 year proven track record! In the renewal waiver, I cannot stress enough that we need to harness the existing strengths of community based services, instead of recreating case management services and duplication of services. We are finding that emerging case management providers in our area often lack the depth of experience or that they skim only the surface of the needs of the aging population. Our case managers in the statewide aging network have received

certification via Boston University School of Social Work, ensuring consistency in assessments that is not provided by any other system. I ask that there are mandates for each PPS to engage and contract with their local Offices for the Aging for the services vital to keeping individuals in home and community based settings.

Thank you.

Sincerely,

Patricia A Baroody

Patricia A. Baroody
Director
Steuben County Office for the Aging

## doh.sm.1115Waivers

**From:** Milenka Berengolc [redacted]
**Sent:** Monday, November 4, 2019 4:57 PM
**To:** doh.sm.1115Waivers
**Subject:** 1115 Public Forum Comment
**Attachments:** Public Comment DSRIP.pdf



Attached, please find the Brooklyn Center for Independence of the Disabled's public comment.

*Milenka Berengolc*

*Director of Special Projects*

*Program Manager, Community Health Workers Program*

*Brooklyn Center for Independence of the Disabled (BCID)*

*27 Smith Street, 2nd Fl*

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BCID
Brooklyn Center for Independence of the Disabled

November 4, 2019

New York State Department of Health
Office of Health Insurance Programs
One Commerce Plaza
Albany, NY 12207

Re: Comments in Response to the Delivery System Reform Incentive Payment (DSRIP) Amendment Request

The Brooklyn Center for Independence of the Disabled (BCID) is a Tier1 community-based organization. We seek to empower people with all kinds of disabilities to live full, independent lives. We are one of hundreds of grassroots, non-residential independent living centers across the world. We exist to improve the quality of life of New York City residents with disabilities through programs that empower them to gain greater control of their lives and achieve full and equal integration into society. We accomplish this through our services, our advocacy for systems change to remove physical, attitudinal and communication barriers and through our education and awareness programs.

The disabled population is severely impacted by the social determinants of health: insecure housing, employment, transportation, education, personal safety. Our latest model, the BCID Community Health Worker Program, effectively addresses these SDOH. We hire and train people with different disabilities to offer peer support to other people with disabilities and chronic conditions, facilitating access to services while improving the quality and cultural competence of service delivery. Indeed, the positive relationship between CHWs and program members has led to closing gaps in care and more access to preventative care. Members have experienced improvements such as better management of chronic conditions (diabetes, high blood pressure), better ability to cope with challenges, healthier diets, and increased community engagement.

People with disabilities, in particular, experience significant health disparities. For example, we know that people with disabilities are more likely to go to the emergency room, a more costly approach to medical care. This results in secondary medical conditions, reduces the use of preventative health care such as cancer screenings and dental care

BCID represents the disability population as a member of the ***Communities Together for Health Equity (CTHE),*** a consortium of over 70 community-based organizations city-wide who service different underserved populations. BCID is also a member of the CTHE's ***Brooklyn Hub***, which focuses on the borough's marginalized populations and existing health disparities. CTHE has drawn up a Strategic Plan, *Our Collective Vision for CBO Partnership in the NYS Healthcare Delivery System* to establish an equitable approach to creating a sustainable community engagement in New York State's transformation efforts.

Over nearly five years, DSRIP funds have invested in strategies to restructure and transform New York's healthcare system with the hope of achieving 25% reduction in avoidable hospitalizations. While inroads in system transformation have been made, there is much left to reach this goal.

Clearly, CBOs need to be an integral part of the process. CBOs need to operate and be funded independent of PPs or value-driving entities as equitable stakeholders and essential entities. To really create change and transformation, there must be inclusion of Tier 1 CBOs within the governance and decision-making bodies of the second generation VDEs. We support the creation of a separate sustainable funding stream designated for CBOs addressing SDOH and vulnerable populations. We request the following:

- A greater state leadership to equitably integrate and engage CBOs as stakeholders in the health planning process (design, implementation, funding, and evaluation). A recent example of exclusion of CBOs is at the forthcoming NYS DOH Population Ssymposium.
- Develop an infrastructure that includes CTHE's Strategic Plan for community engagement
- Address SDOH with the appropriately engagement of the experts (CBOs)

Thank you for requesting comments as we all seek to continue to transform our healthcare system.

Very truly yours,

Milenka Berengolc

Milenka Berengolc

Community Health Worker Program Manager

Director of Special Projects

[redacted]

## doh.sm.1115Waivers

**From:** Dan Lowenstein [redacted]
**Sent:** Monday, November 4, 2019 5:00 PM
**To:** doh.sm.1115Waivers
**Cc:** Marki Flannery
**Subject:** VNSNY comments on 1115 MRT Waiver Amendment Proposal
**Attachments:** 1115 Waiver Amendment Proposal_VNSNY Comments final 110419.pdf



Attached are comments on the 1115 MRT Waiver Amendment Proposal from Visiting Nurse Service of New York (VNSNY) President and CEO Marki Flannery. Please let us know if you have any questions. We look forward to working with you on this important initiative.

Sincerely,

**Dan Lowenstein, MBA**
**Vice President of Government Affairs**
Preferred Pronouns: He/They

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November 4, 2019

**VIA ELECTRONIC MAIL**

Ms. Donna Frescatore
Deputy Commissioner and Medicaid Director
Office of Health Insurance Programs
New York State Department of Health
One Commerce Plaza
Albany, NY 12210
1115waivers@health.ny.gov

Re: 1115 Public Forum Comment

Dear Ms. Frescatore:

The Visiting Nurse Service of New York (VNSNY) appreciates the opportunity to comment on the 1115 Medicaid Redesign Team (MRT) Waiver Amendment Proposal, hereafter referred to as "the Proposal." As one of the largest not for profit home and community-based healthcare organizations in the U.S., VNSNY offers a wide range of services, programs, and health plans. This includes home care, hospice and palliative care, community behavioral health programs, managed long-term care (MLTC) plans, and other health plans for dually eligible individuals, as well as for Medicaid beneficiaries living with or at risk of HIV/AIDS. Since its founding, VNSNY has provided quality, compassionate care to vulnerable and marginalized populations in their homes and communities. Just as we brought the innovative care delivery concept of the visiting nurse to the burgeoning tenements of lower Manhattan over 125 years ago, VNSNY remains committed to innovation in how we deliver and pay for health care in New York State.

VNSNY has been actively engaged in New York's current 1115 waiver program.

- We have partnered with 12 downstate Performing Provider Systems (PPS)[1] on 21 distinct projects and participated in key governance functions with five PPSs.
- VNSNY CHOICE Health Plans and Partners in Care (LHCSA) have leveraged the Workforce Innovation Program to train our long-term care (LTC) workforce and advance MLTC VBP innovation. We have trained over 4,000 home health aides to date.

[1] Bronx Health Access, Bronx Partners for Healthy Communities, Community Care of Brooklyn, Mount Sinai PPS, Nassau-Queens PPS, NYP (Manhattan), NYP Queens, NYU Langone Brooklyn PPS, OneCity Health, SOMOS Community Care, Staten Island PPS, WMC Health.

- VNSNY has embraced Value-Based Payment (VBP) through innovative delivery and payment models to improve health outcomes, improve patient experience, and reduce the cost of care:
    - VNSNY CHOICE MLTC has 31% of qualified expenditures in Level 2 VBP, with the remainder in Level 1.
    - Our Certified Home Health Agency (CHHA) is a national leader in driving value-based, episodic managed care reimbursement models that have demonstrated success in shortening inpatient length of stays, reducing re-hospitalizations and avoidable hospitalizations. To date, nearly 40% of VNSNY CHHA managed care revenue is in two-sided risk arrangements.
    - VNSNY has been an active participant in CMS' Bundled Payment for Care Improvement (BPCI) program.
    - Leveraging expertise across the organization, VNSNY recently launched a Care Management Organization that is contracting with managed care organizations to manage the complex care needs of at-risk homebound populations.

**Observations on the Current DSRIP Program**

New York State's current DSRIP program has made important gains in health care delivery and payment, which should be built upon and extended. From our vantage point, DSRIP enabled providers like VNSNY to provide insights to PPSs on care delivery and care management in the home, allowed for the piloting of important new behavioral health projects, and brought a renewed focus to social determinants of health.

As with any large-scale initiative, it has also exposed numerous challenges and missed opportunities.

- **Home-based health care and care management** were not prioritized, even though this kind of care has been proven to reduce utilization of institutional care.
- **Managed care organizations (MCOs),** including MLTCs and Medicare/Medicaid integrated plans, were not adequately included in DSRIP planning and implementation. The lack of collaboration from the outset made VBP contracting more challenging.
- **Care for dually eligible individuals, particularly those requiring LTC services**, was not an area of focus, even though this population is disproportionately more complex and costlier than the Medicaid-only population. This is particularly critical given the growing demand for Medicaid-funded LTC services.
- While integration of palliative care was a DSRIP project, there were **no projects related to hospice adoption**, even though New York ranks 49$^{th}$ in the nation in hospice utilization.
- By and large, the process of **working with PPSs was challenging**. It was often unclear whether the effort was on behalf of the PPS or the hospital sponsor; the PPS infrastructure took a great deal of time and resources to develop; IT interoperability remained a vexing challenge; and data reporting was inconsistent as there was no uniform method across PPSs to evaluate and report.

**Comments on MRT Waiver DSRIP Amendment Request**

VNSNY is encouraged by several aspects of the Proposal, including close collaboration with MCOs to ensure sustainable transformation, a focus on LTC and recognition of the need for LTC workforce development, and mechanisms to drive the integration of programs that address the social determinants of health. We believe there are opportunities to make the next version of DSRIP more inclusive of promising practices, aligned with federal priorities, and focused on care delivery in the most appropriate and cost-effective settings.

In that spirit, we offer the following recommendations:

1. Ensure Meaningful Home and Community-Based Involvement in Value Driving Entities (VDEs) and authorize Specialized VDEs for High-Need/High Cost Subpopulations
2. Align with and Support Medicare-Medicaid Integration
3. Prioritize and Invest in Home-Based Post-Acute Care
4. Invest in the Home Health Workforce and Information Technology
5. Include Hospice and Palliative Care Utilization as a Priority
6. Address the Needs of Individuals with Serious Mental Illness (SMI)
7. Ensure Accountability and Efficiency in Addressing Social Determinants of Health (SDH)

**1. Ensure Meaningful Home and Community-Based Involvement in Value Driving Entities (VDEs) and Authorize Specialized VDEs for High-Need/High Cost Subpopulations**

If NYS pursues VDEs as new organizing entities to drive integration and VBP arrangements, there must be requirements (not just recommendations) that these entities include meaningful representation from home- and community-based healthcare providers at the governance and operational levels. Further, managed care involvement with VDEs should include MLTC plans as well as PACE and integrated plans for dually eligible members.

We appreciate the State's recognition of the need to focus on new delivery and payment models serving populations with unique and complex medical, behavioral, and social needs. Building off NYS' VBP Innovator Program for certain populations, specialized VDEs should be authorized for populations that require a unique approach to care improvement in partnership with a specialized set of health care provider, community partner, and health plan stakeholders.

***LTC-VDEs:*** We recommend that beneficiaries requiring LTC services would best be served in a specialized group of "LTC-VDEs." The LTC-VDE would bring together organizations and providers with expertise in intensive care coordination, personalized care management, and home- and community-based care. As with standard VDEs, LTC-VDEs would implement VBP models designed to drive total cost of care savings by reducing potentially avoidable hospitalizations (PAH) and other avoidable interventions. This population has far more frequent engagement with LTC providers than with health homes or primary care providers. As such, attribution for the LTC-VDE should be based on enrollment in an MLTC plan, Medicaid Advantage Plus (MAP) plan, or Program of All-inclusive Care for the Elderly (PACE).

Selection of LTC-VDEs would be based on standard VDE criteria, as well as LTC-focused criteria including:

- Prior adoption of programs that provide or manage LTC for vulnerable populations;
- Geographical/regional reach to serve targeted populations;
- Notable and demonstrated participation in VBP; and
- History of performance improvement in post-acute and long-term care such as on reducing PAH and improving on other quality measures.

***HIV-VDEs:*** While the Proposal identifies children living with HIV/AIDS as an example of a special population in need of more robust VBP approaches, this should be broadened to include all people living with or at risk of HIV/AIDS. With NYS making significant gains to End the Epidemic, a targeted effort to prevent new infections and ensure those living with HIV/AIDS have their viral load suppressed should be a key area of focus in the next iteration of DSRIP. We recommend that NYS DOH allow for specialized HIV-VDEs that would include providers, community-based organizations, and payers that have demonstrated an ability to prevent HIV transmission and suppress viral load. HIV-VDEs should serve the HIV+ population as well as individuals at an elevated risk of HIV transmission. In additional to standard VBP measures, these HIV-VDEs should be selected and evaluated based on their ability to increase HIV viral load suppression rates among HIV+ individuals and prevent infection among high-risk HIV negative individuals.

***Recommendation Summary:***

- Ensure home and community-based provider representation in VDE governance and operations; and
- Allow for specialized VDEs for high-cost, high-need subpopulations including people needing LTC services and people living with or at risk of HIV/AIDS.

**2. Align with and Support Medicare-Medicaid Integration**

The Proposal should recognize that the Medicaid population with LTC needs is primarily dually eligible and therefore should support opportunities for integration and cost savings across Medicaid *and* Medicare. Spending on Medicaid, particularly for home-based LTC services, saves money on costly health care interventions, particularly PAH. For dually eligible individuals, those savings accrue to Medicare and are not currently structured to allow NYS or entities that address LTC needs to share in Medicare savings despite increased investments on the Medicaid side.

Dually eligible enrollees have disproportionately higher costs than either Medicare-only or Medicaid-only enrollees. Dually eligible enrollees who require LTC services account for about 60% more in Medicare costs than those who do not require LTC services.[2] Approximately 90% of CHOICE MLTC members are dually eligible – a figure that is likely consistent with the MLTC population across NYS.

[2] MedPAC and MACPAC. "Beneficiaries Dually Eligible for Medicare and Medicaid: Data Book." Exhibit 4, p. 32, and Exhibit 18, p.58. January 2018. Found here: https://www.macpac.gov/publication/data-book-beneficiaries-dually-eligible-for-medicare-and-medicaid-3/

Providing more effective care for dually eligible individuals remains a major CMS priority.[3] NYSDOH is currently exploring more cost-effective care options for dually eligible beneficiaries. We appreciate that this can be undertaken outside the 1115 Waiver. However, we believe that, particularly for LTC, efforts should be made to ensure that DSRIP goals and strategies prioritize care and payment models that can effectively integrate care across these payment streams and ensure equitable payments for the State, plans and providers.

***Opportunities for non-integrated dually eligible MLTC members:*** The proposed default enrollment process in NYS focuses on the mainstream Medicaid population, leaving out the significant percentage of dually eligible beneficiaries in MLTCs. The State has an opportunity to align federal and state initiatives focusing on dually eligible MLTC members who are in non-integrated arrangements – either through fee-for-service (FFS) Medicare or in unaligned Medicare Advantage (MA) plans, including dual eligible special needs plans (D-SNPs).

***Sharing Medicare savings:*** DOH should propose to share in Medicare savings that can be attributed to Medicaid spending. In other state integrated programs, including the Program of All-Inclusive Care for the Elderly (PACE) and Financial Alignment Demonstrations (for example, in Washington State), states are accountable for improving the coordination and quality of care for dually eligible beneficiaries through integrated Medicare-Medicaid arrangements. In return, the State is eligible to receive a retrospective performance payment based on its performance on quality and savings for both Medicaid and Medicare.

***Recommendation Summary:***

- Align the Proposal with CMS strategies and national best practices to better integrate care for dually eligible individuals; and
- Develop a shared savings partnership that rewards NYS (and its Medicaid payers and providers) for Medicare savings attributed to Medicaid spending.

**3. Prioritize and Invest in Home-Based Post-Acute Care**

NYS ranks 44th nationally in 30-day readmission rates.[4] CHHAs have unique and unparalleled experience caring for individuals in the home, which is where most readmissions begin. However, their impact was not fully realized in the current DSRIP program, and the VBP Roadmap does not appear to allow for any home health-driven VBP arrangements.

Comprehensive care management in the home entails a level and type of expertise not usually found in hospital-led care management models or community-based clinical practices. Education of patients and caregivers, environmental and home assessments, coordination and communication with primary care

[3] "CMS Announces New Opportunities to Test Innovative Integrated Care Models for Dually Eligible Individuals." *CMS*, 24 Apr. 2019, https://www.cms.gov/newsroom/press-releases/cms-announces-new-opportunities-test-innovative-integrated-care-models-dually-eligible-individuals.

[4] Dartmouth Atlas of Health Care, 2019.

providers and specialists, medication management, and regular monitoring of health status are just some of the functions that CHHAs can provide in the home that are essential to quality outcomes.

The Proposal should emphasize and encourage robust post-acute value-based collaborations *in the home.* Home health post-acute providers have the potential to be **active leaders** in value-based payment for post-acute care.

While the Proposal does reference that VDEs are designed to bring MCOs and providers together for VBP contracting, home-based post-acute VBP options should be specifically encouraged amongst these. VNSNY has been successful in using predictive risk models to identify patients that are most at risk of readmission and provide care managers with actionable intelligence to ensure the patient's recovery stays on track, and that complications are avoided.

Today, VNSNY is the only home care provider managing post-acute episodic care up to 90 days post discharge through innovating models of efficient, quality care delivery and a provider-payer payment partnership with upside and downside risk with nearly 40% of VNSNY Home Care managed care members in these arrangements. VNSNY is responsible for delivering its signature services of post-acute interdisciplinary clinical care, as well as care management and utilization management for 30-, 60-, or 90-day intervals at a set payment rate. These include quality metrics, primarily focused on reducing hospitalizations, tied to incentive payments. Based on its performance against the established benchmarks, VNSNY may receive bonus payments or be subject to penalties if targets are met or missed, adding both upside and downside risk to the partnerships.

***Distinctions between LTC and PAC***

The Proposal groups Long Term Care (LTC) and Post-Acute Care (PAC) together as "LTPCA" (Long-Term and Post-Acute Care). There is growing demand for both home-based LTC and home-based PAC given the aging of the population. They can be provided concurrently and use some of the same resources to cover some of the same population. Both are also critical to reducing the need for more costly care in institutional settings. However, it is important to distinguish between these two types of care for most policy planning efforts.

**Long-Term Care** in the home usually refers to long term supports and services (LTSS) to help a person maintain the activities of daily living (ADL) and prevent costly institutional care – either in a nursing facility or a hospital. For MLTC, the individual must require these services for more than 120 days. It is assessed every six months for continued eligibility.

**Post-Acute Care** in the home is skilled care following discharge from a hospital or skilled nursing facility, or sometimes ordered by a community physician. It is provided for a finite period of time, usually in 60-day "episodes" of care. Its purpose is to help the patient recover from the surgery, illness or other underlying conditions for which they were treated.

***Recommendation Summary:***

- Prioritize initiatives that emphasize and leverage care delivery in the home; and
- Ensure that CHHAs are included in VDEs and enable capable CHHAs to drive VBP arrangements in PAC episodes tied to reductions in 30 and 60-day readmission rates.

**4. Invest in the Home Health Workforce and Information Technology**

There is an enormous and growing need for a skilled and paraprofessional workforce that is willing and able to work in people's homes. Efforts to bring more care delivery to the home where it is less costly and more effective will be undermined if home health agencies (LHCSAs and CHHAs) continue to struggle to attract a capable workforce.

VNSNY applauds the Proposal's goal of supporting the critical LTC workforce infrastructure and we are encouraged that the Proposal would *"include subsidies and stipends for participating in aide certification and nursing programs; loan forgiveness programs for nursing graduates; and subsidies for work barrier removal including child care for LPNs and aides."*

Funding should also be made available for expanded education for nursing staff who are new to the field of home care. Support is needed to provide didactic skills-based education and field preceptors to provide field-based education to help nurses transition to practice successfully. These nurses need wage support while they are shadowing other nurses in the field during case load ramp-up.

We also recommend that the Proposal continue the MLTC Workforce Investment Program (WIP) that is part of the current 1115 Waiver. Through our experience as a partner in the Ladders to Value Workforce Investment Organization (WIO) and through CHOICE MLTC's effort to effectively leverage WIO to support VBP, we have found WIP to be an effective training conduit for home health aides that supports quality care in the home. Indeed, we have trained over 4,000 home health aides to date through this important initiative.

Finally, electronic health record (EHR) adoption and health information exchange among home health providers (LTC and PAC) is very low. Major health information technology (HIT) state and federal HIT investments and initiatives have largely bypassed these entities, making care integration, data collection, analytics and health information exchange far more challenging and diminishes the ability of these valuable providers to contribute to VBP.

***Recommendation Summary:***

- Expand funding for instructors, field preceptors, and wage replacement to help new hires adapt to their roles;
- Prioritize funding for training partnerships that are committed to VBP and can demonstrate outcomes; and
- Invest in HIT for home-based providers (LTC and PAC).

**5. Include Hospice and Palliative Care Utilization as a DSRIP Priority**

New York ranks 49th in the nation in hospice utilization, with only 31.5% of NYS Medicare decedents utilizing hospice, versus more than half of all national Medicare decedents.[5] NYS is also the fifth lowest in average hospice length of stay (ALOS) with 53 days, compared to 75 days nationally.

The role of hospice has not been fully leveraged to achieve DSRIP objectives, likely because most hospice payment and utilization is through Medicare, not Medicaid. This is a missed opportunity to improve outcomes for New York State residents with terminal illness regardless of health coverage and has the potential to substantially reduce end-of-life care costs.

A major effort to increase hospice utilization will likely lead to greater cost savings in Medicare, which could be included in a Medicare shared savings program. A federal health priority, hospice has been demonstrated to save over $9,000 per patient in end-of-life care based on a 2014 JAMA-published study[6] (it is likely a greater savings today). It would also support Medicaid cost reductions: dually eligible patients who are eligible for and elect hospice have their costs associated with the terminal diagnosis (including personal care services) covered by Medicare. NYS would also not need to provide cost sharing support (co-pays, co-insurance) for those who are eligible, since in most cases Medicare enrollees who elect hospice do not have these cost burdens.

***Recommendation Summary:*** Fully incorporate and fund efforts to expand access to and adoption of hospice and palliative care, including encouraging innovative end-of-life payment and delivery models.

**6. Fund Promising Programs that Address Transitional Care for Individuals with Serious Mental Illness**

The current DSRIP program places great emphasis on behavioral health, including integration and transitional care, and we are encouraged that addressing Serious Mental Illness (SMI)/Serious Emotional Disturbance (SED) will continue to be a focus as it is at the federal level, in particular *"transitional care teams for clinicians and peers bridging psychiatric inpatient to community settings."*

VNSNY's Community Mental Health Services (CMHS), which serves over 14,000 individuals each year, was integral in piloting a number of DSRIP projects and new programs. CMHS operates several programs for the SMI/SED population that provide transitional care, case management, peer support, outreach services, behavioral health treatment, mobile response, and more through our vast network of experienced clinicians, nurses, and social workers.

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[5] Excel Health Industry Trend Report Q3 2018. *Home Health and Hospice*. 2019 https://www.excelhealthgroup.com/wp-content/uploads/Excel-Health-Industry-Trend-Report-Q3-2018_Final_20190411.pdf. Accessed July 10, 2019.

[6] Obermeyer Z, Makar M, Abujaber S, Dominici F, Block S, Cutler DM. Association Between the Medicare Hospice Benefit and Health Care Utilization and Costs for Patients With Poor-Prognosis Cancer. JAMA. 2014; 312(18):1888–1896. doi:10.1001/jama.2014.14950. http://jama.jamanetwork.com/article.aspx?articleid=1930818

VNSNY recently piloted a model, *Parachute NYC*, which serves individuals with SMI who are high utilizers of emergency departments and inpatient settings. This population is historically difficult to engage and has a history of recurrent crises. Parachute's highly-collaborative, team-based, and person-centered approach to evidence-based treatment targets key drivers of frequent re-hospitalizations and uses a multi-modal approach to treat SMI individuals transitioning from institutional settings to their homes and communities. It has been highly effective in reaching the primary goals of increasing ability to self-manage symptoms and reducing reliance on emergency department use and inpatient psychiatric hospitalizations. In a pilot program run in 2017, for example, participants showed remarkable gains over a one-year period, including a reduction of inpatient days from 45 to six days, and a reduction in readmissions from 46 to three.

***Recommendation Summary:*** Ensure that VDEs prioritize and support successful interventions like Parachute NYC for people with SMI/SED.

**7. Ensure Accountability and Efficiency in Addressing Social Determinants of Health (SDH)**

We commend the current DSRIP program for bringing the issue of SDH to light, and for including major investment for SDH in the Proposal. We believe that as SDH coordination and innovation evolves, NYS should rely less on process measures such as number of contracts with or funds allocated to community-based organizations (CBOs) and rely on more impactful measures.

We recognize that data reporting on SDH is often challenging. It can be difficult for payers and providers to track whether or not a CBO "closed the loop" on a referral. We agree that Social Determinants of Health Networks (SDHN) at the regional level will help to ensure that efforts are not duplicated and to ensure that the organizations contracted to address SDH are accountable for outcomes. We note that there are a number of vendors that will likely provide the SDHN platform to establish networks and share data. While some of these are promising, they are mostly new and untested. It will be important for these systems to also be held accountable for delivering on their promises.

We are aware that the Proposal places focus on formally organizing CBOs to implement SDH interventions and create a single point of contracting for VBP SDH arrangements. DOH should ensure that the SDH contractor selection process takes into consideration the experience that social workers, community-based care navigators, and community members have had with CBOs.

***Recommendation Summary:***

- Use outcomes measures to determine quality of SDH interventions;
- Monitor SDHN vendors and the CBOs delivering on SDHs to ensure accountability; and
- Ensure CBO selection considers the experience of those who are closest to the delivery of SDH interventions.

Thank you for your consideration of these recommendations. We look forward to working with NYS DOH and our other partners on this important effort to improve New York State's healthcare payment and delivery system.

Sincerely,

Marki Flannery
President and CEO
Visiting Nurse Service of New York

## doh.sm.1115Waivers

**From:** Kyle Plaske [redacted]
**Sent:** Monday, November 4, 2019 5:03 PM
**To:** doh.sm.1115Waivers
**Subject:** 1115 Public Forum Comment - New York Association of Addiction Services and Professionals
**Attachments:** ASAP Public Comments DSRIP 2.0.pdf



Good afternoon,

Please find our attached public comments on DSRIP 2.0. Thank you for the opportunity to provide input.

Sincerely,
Kyle Plaske
Public Policy Coordinator
[redacted]

ASAP
New York Association of Addiction Services and Professionals

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November 1, 2019

NYS Department of Health Office of Health Insurance Programs
Waiver Management Unit
99 Washington Avenue
12th Floor, Suite 1208
Albany, NY 12210

RE: DSRIP 2.0 Public Comments

The New York Association of Addiction Services and Professionals (ASAP) has worked collaboratively with stakeholders and state agency leadership from OASAS, OMH, and DOH to ensure the successful redesign of Medicaid in New York State. Serving on the Behavioral Health Subcommittee of the Medicaid Redesign Team, we advocated for a strong emphasis on the important role of substance use disorders (SUD) prevention, treatment, recovery, and harm reduction services. Based on the MRT assessment that 80% of unnecessary hospitalizations involved persons with untreated substance use disorders, we advocated that programs like DSRIP include a strong allocation of resources, and an implementation strategy, that focused on screening for substance use disorders, referral to treatment, and implementation of services for the patient and their family that included prevention, treatment, recovery, and harm reduction services.

We were pleased that the design of DSRIP included the recommendations we made. To the extent that DSRIP's Performing Provider Systems (PPS) chose to emphasize strengthening SUD services, they were successful in achieving targets to reduce unnecessary hospitalizations. To the degree that SUD services were not a primary consideration in a PPS's approach, there was less success reducing unnecessary hospitalizations.

If, when the current DSRIP waiver expires on March 31, 2021, the State is granted the extension it has requested, ASAP asserts that emphasis on collaboration with SUD services will be critical to the success of DSRIP 2.0.New York State's proposal to extend work underway to reduce unnecessary hospitalizations by creating a DSRIP 2.0 program should be given requested funding to: 1) Address workforce development needs, 2) Support financially distressed service providers via an Interim Access Assurance Fund, 3) Support local DSRIP projects so that New York can continue to reduce unnecessary hospitalizations, and 4) Support continued efforts to address social determinants of health.

ASAP is pleased that New York State's proposal for a DSRIP 2.0 includes a commitment to align with Federal priorities, especially: 1) Strengthening SUD services that address the Opioid Crisis (and, hopefully, other addiction related problems that are correlated with unnecessary hospitalizations) , 2) Expansion of Medication Assisted Treatment, 3) Better integration of SUD services with Primary

Care and Emergency Care, 4) Expansion of Mobile Crisis Teams and crisis respite services that address both SUD and MH disorders, 5) Addressing Social Determinants of Health for people at-risk of SUD, in treatment, or in recovery, 6) Strengthening partnerships with the Justice System to enhance treatment, recovery, and harm reduction services, 7) Strengthening collaboration across a variety of service delivery systems of care, 8) Improving Care Coordination and Care Management to ensure access to treatment and recovery supports, and 9) Creating alternative payment models.

ASAP strongly encourages continuation of DSRIP Promising Practices as discussed in the State's Amendment Request. We advocate that systems driving changes that reduce unnecessary hospitalizations should be compensated proportionately to the impact they have on outcomes. SUD service providers should get performance-based awards when their work is a driving force for DSRIP goal attainment.

ASAP supports creation of Value Driving Entities, where the current PPS infrastructure is not adequately balanced relative to the role that can be played by community-based SUD service providers. Where infrastructure is working, PPSs should not have to get bogged down in creation of a new governance paradigm. Where there is not balanced leadership and governance or where funds have not been allocated in a manner that benefits those driving results, creation of Value Driving Entities makes sense.

ASAP supports New York State's vision for a DSRIP 2.0. We do so with an expectation that the key role played by SUD service providers in the achievement of DSRIP goals will be amplified in DSRIP 2.0.

Sincerely,

John J. Coppola
Executive Director

## doh.sm.1115Waivers

**From:** Archer, Norman [redacted]
**Sent:** Monday, November 4, 2019 5:03 PM
**To:** doh.sm.1115Waivers
**Subject:** 1115 Public Forum Comment
**Attachments:** Housing Works DSRIP 1115 Waiver Request Comments.pdf



To Whom It May Concern,

Please see comments attached below on behalf of Housing Works.

Thank you.

Norman

---

Norman Archer | Policy & Research Associate
Advocacy | Housing Works, Inc.
[he/him/his]
[redacted]

HOUSING WORKS 81 Willoughby Street, Brooklyn, NY 11201 WWW.HOUSINGWORKS.ORG

**Housing Works Comments on NYS Medicaid Redesign Team**
**DSRIP Amendment Request**
November 4, 2019

Housing Works is grateful for the opportunity to provide comments on the Delivery System Reform Incentive Payment (DSRIP) Amendment Request concept paper published on September 17, 2019.

Housing Works is the nation's largest HIV/AIDS community-based organization, founded in New York City in 1990 with a mission to end the dual crises of AIDS and homelessness. Our organization has grown to over 900 employees providing healthcare, housing, harm reduction services, drug treatment, substance use treatment, job training and more to over 7,000 individuals every year. We operate federally qualified health centers, provide behavioral health services, and participate substantially in Health Home care coordination in four lead Health Homes (CCMP, CHN, Southwest Brooklyn/Maimonides, and Mt. Sinai). The innovative health delivery programs we operate are based on integrated care models that coordinate health care, behavioral health services, and care coordination that focuses on addressing the social and structural barriers to good health outcomes.

Housing Works commends the State's work in the first round of DSRIP to reduce costs, improve patient outcomes, and decrease unnecessary inpatient and emergency room utilization. For New York to experience a real transformation of the health care delivery system and sustain the gains thus far achieved through DSRIP, there must be a significant investment in community-based primary care and care coordination. Only through this investment can the State achieve a true value-based system that improves health outcomes and reduces costs. Housing Works supports the renewal of the DSRIP program through March 31, 2024. Housing Works is a member of the Community Health Care Association of New York State (CHCANYS) as well as iHealth NYS, supports the comments submitted by CHCANYS and iHealth, and has restated and revised many of their points below.

## I. Driving Promising Practices to Improve Health Outcomes and Advance VBP

By mission and in statute, health centers serve the State's most vulnerable and hard to reach populations. FQHCs are non-profit, community run centers located in medically underserved areas that provide high-quality, cost effective primary care, including behavioral and oral health services, to anyone seeking care. Each FQHC is governed by a consumer-majority board of directors who are tasked with identifying and prioritizing the services most needed by their communities. 79% of the 7,131 patients served by our FQHCs in 2018 were enrolled in Medicaid.

Our four FQHC sites located in Manhattan and Brooklyn provide access to comprehensive primary care services, especially among populations that are most likely to present at the ED with a non-urgent or avoidable condition. In the first round of DSRIP, we participated in two performing Provider Systems (PPS): Mount Sinai PPs and Community Care of Brooklyn (CCB) PPS, participated in eight different DSRIP projects, and provided technical assistance to CCB to

facilitate their HIV domain 4 project. One of the promising practices that our health centers engage in is the Undetectables, an innovative evidence-based HIV intervention that successfully supports HIV positive patients who face multiple barriers to medication adherence to achieve and sustain viral suppression while fostering a culture free of stigma and fear, centered on ending the AIDS epidemic.[i]

The first round of DSRIP complemented the health center model's unique and innate ability to provide comprehensive and innovative care to New York's Medicaid beneficiaries. Health centers played and continue to play a key role in advancing the promising practices within their regions and driving improved health outcomes. In the second round of DSRIP, health centers are well-prepared to take a leadership role to advance the State's vision of an expanded value-based payment (VBP) landscape driving DSRIP promising practices.

Likewise, NYS's Medicaid Health Homes program, created in 2012, has become a key component of the health care delivery system, with care coordinators in the program helping individuals with multiple health challenges to better coordinate their care and improve health care access. The Health Homes program was designed to address the social determinants of health, such as food insecurity, housing instability, substance use disorder, mental illness, trauma, violence and health illiteracy. Housing Works has found that this program is an important ingredient for individuals with complex lives and costly health conditions. We believe that the next phase of DSRIP provides a continuing opportunity to move beyond a medical system focused approach to ensure greater involvement of community-based non-medical and non-clinical approaches that are key to addressing the social determinants of persistent health care challenges in the Medicaid population.

As noted in the United Hospital Fund's report on "DSRIP Promising Practices," for complex populations, 'substantial care management/coordination and support for care transitions appear necessary to change patients' trajectories." It is clear that for the next round of DSRIP to be successful, the healthcare system must support a robust CBO driven care coordination program.

## II. Embracing the Role of VDEs

We are pleased to see that the State has acknowledged the need for additional flexibility in the next round of DSRIP and is interested in ensuring the success of Value-Driving Entities (VDEs). However, we encourage the State to provide direct investment in community-based providers. Currently, 23 of 25 of the PPS leads are hospital-based, with no specific requirements about how funds flow to partners in the PPS networks. Meaningful governance participation by community-based providers, such as community health centers and community behavioral health organizations, and downstream investments to health centers and other community-based providers varied greatly from PPS to PPS.

Using publicly available data reported by the State, it is extremely difficult to determine the amount of money received by health centers in the first round of DSRIP – they are included as "clinics" with hospital ambulatory providers. However, the most up to date data reported by the

State in November 2018 demonstrates that hospitals received more than 28% of total funds flow while representing only 0.2% of total engaged PPS partners.[ii] It is exceedingly difficult to transform the healthcare delivery system by continuing to invest most transformation dollars into inpatient-based care models, when it is the long-standing established CHC providers and workforce that can make the biggest impact on patients' health outcomes. CHCs are especially well-posed to integrate care, make connections to address social needs, and become the more adept and agile VDEs envisioned in the State's concept paper.

One disappointment of the PPS structure, because PPSs were hospital-based networks, was the insufficient amount of resources directed to community-based non-clinical providers, many of whom were providing key care coordination services but were poorly reimbursed for their work. CBOs struggled to gain an equal footing and recognition, and a survey of iHealth members showed that many CBOs were poorly reimbursed for the services they delivered.

We support the State's charge that VDEs include providers, community-based organizations (CBOs), and managed care organizations (MCOs) to leverage VBP and advance promising practices. A collaborative partnership and shared governance between community-based providers, CBOs, and MCOs is critical to implementing and supporting transformative initiatives that move away from a volume-driven care model. However, to support improved access to care in the community and reduce reliance on emergency departments and inpatient care, the State must direct additional resources to a broad range of community-based providers. **Housing Works requests that the State dedicate, at a minimum, 25% of DSRIP funds to the development of community-based VDEs where CHCs, in collaboration with other community-based providers, are leads.**

### a. VDE Lead Entities

The State should capitalize on existing health center Independent Practice Associations (IPAs) as a launching point for the creation of community-based VDEs. The four CHC-led IPAs currently organized across the state, Community Health IPA (CHIPA), Safety-Net IPA (SIPA), Finger Lakes IPA (FLIPA), and Upstate Community Health Collaborative IPA (UCHC), are engaged with MCOs in at least one VBP contract while working on additional agreements. We are members of EngageWell IPA. IPAs are able to take on risk and become financially accountable for both the quality of care and the most efficient delivery of care services. We believe that IPAs are well positioned to work with other entities as a VDE in the second round of DSRIP.

EngageWell's membership consists of approximately 20 community-based organizations that provide health care, harm reduction, OMH and OASAS licensed behavioral health care, housing, case management and vocational services to over 30,000 of NYC's most high-risk clients. EngageWell has already been funded as a Behavioral Health Care Collaborative (BHCC) and has contracts with several MCOs to deliver housing placement assistance, care coordination, and improved access to Home and Community Based Services to its members. Expanded DSRIP funding for IPAs such as EngageWell, which is fully comprised of and managed by community-

based providers, would be an ideal way to enable direct investment in CBOs and Community Based Health Centers (CBHC's).

While health centers like ours are already developing relationships needed to advance in VBP contracts, a second round of DSRIP is an opportunity to invest in building capacity to ensure health center and CBO IPAs have the foundation to serve as VDEs. Currently, health center-led IPAs are self-funded and have little financial capacity to support many of the crucial functions that would accelerate their successful participation in VBP arrangements. **Health center-led IPAs require DSRIP investment to support the data analytic capabilities needed to effectively manage population health and drive improved outcomes.**

**b. Considerations for Engaging MCOs**

Housing Works is pleased that the State is taking steps to ensure engagement of MCOs early in the planning process for a second round of DSRIP. However, there are significant challenges that must be addressed ahead of the creation of VDEs. One of the current difficulties faced by providers as they seek to participate in VBP arrangements is a lack of comprehensive data about their attributed patients. **The State should create and enforce a uniform data sharing policy for the managed care plans to further support the transition to VBP, for example, by enforcing transparency in expenditures and utilization.**

In the first round of DSRIP, the discrepancies between MCO attribution and PPS attribution made it difficult for health centers to effectively manage patient health outcomes. PPS networks do not necessarily encompass the same providers that are contracted with a given MCO. If there are discrepancies between MCO attribution, consumer utilization, and PPS network, it becomes incredibly difficult, if not impossible, for the PPS to effectively manage health outcomes for these populations. PPS and VDEs should not be expected to manage the health care improvements of individuals who are enrolled in managed care plans that contract outside of the VDE. **Housing Works recommends that in the next round of DSRIP, VDE attribution should be aligned with MCO attribution to ensure seamless VBP contracting.**

Finally, we understand the State's desire to drive regional innovation – local health care needs vary based on geography, CBO and health care provider landscape, and other factors. However, we would like to raise the concern that in densely populated areas served by many MCOs with overlapping service areas (notably, New York City), defining distinct regions may prove difficult. **In New York City, Housing Works recommends that VDE networks should align with patient utilization patterns as much as possible.**

## III. <u>Supporting Non-Clinical Workforce to Address Social Needs</u>

Housing Works echoes the State's observation that many of the successful DSRIP initiatives rely on non-traditional, non-clinical workforce that help patients navigate clinical and social services systems to address their multi-dimensional needs. In the first round of DSRIP, we embraced the flexibility to address patients' social needs. Our health centers engaged in several social need

interventions under the first round of DSRIP, including the Undetectables program, a Palliative Care program, the Impact Model of integrated medical and behavioral health care, Health Home enrollment, Health Home enrollment (hospital partnerships), Health Home care coordination), care gap activities for diabetes and hypertension, the use of health coaches, and patient-centered care planning.

It should be noted that while the movement towards VBP offers great promise to improve the population health of those in the Medicaid program, the major changes in health care financing and operations as a result of VBP are having significant consequences for many non-clinical providers. Attribution is a major challenge for Health Homes in VBP arrangements. Housing Works urges the state to consider alternative and creative additional ways to provide attribution beyond clinic-based systems. Attribution should be expanded and evolve to allow other entities beyond the primary medical care system to assign attribution; for example, a network of CBOs providing key social determinants of health to consumers should be considered a base point for attribution. Health information data and technology is another key cornerstone of VBP. While substantial DSRIP resources were devoted to hospitals and large health care systems to upgrade their technology, many CBOs struggle to identify adequate IT resources. In the next iteration of DSRIP, there must be dedicated resources for information technology to CBOs. In addition, community-based providers struggle to get access to the data they need to measure their success in VBP. DSRIP 2.0 must dedicate itself to ensure greater system integration including CBO access to medical records.

In the first round of DSRIP, the State encouraged primary care practices to become patient-centered medical home (PCMH) recognized. Today, 97% of New York's health centers are PCMH certified, including Housing Works' FQHCs. PCMH certified practices provide mental health, oral health, and health promotion/disease prevention services through comprehensive primary care. This model of patient-centered care is associated with improved health outcomes and reduced costs and should be robustly supported in the second round of DSRIP. There are numerous studies that have analyzed the success of PCMH, including citing fewer specialty visits needed, lower per member costs, and better health outcomes amongst individuals seeing PCMH-certified providers.[iii] PCMH recognition has prepared Housing Works for VBP through enhanced care coordination via daily huddles, case conferencing, care planning, and interdisciplinary teams.

As noted earlier, care management has been a vital component of DSRIP successes, including unique services provided by long standing relatively smaller (compared to hospital systems) community-based care management providers with a track record of providing services in distinct neighborhoods and populations. Yet, many care management agencies have closed their Health Home programs due to a declining census, lack of MCO interest in the program, and an onerous reporting system. Staff burnout in the health home program is extremely high and agencies struggle to keep talented staff in care management. This indicates that there are significant structural challenges in the Health Home program and that the current reimbursement structure does not allow care management agencies to operate at their most effective or to maintain staff. Furthermore, starting in July 2020 the guaranteed rate structure will disappear, forcing health homes to negotiate with managed care organizations for

reimbursement. This has the potential to further weaken the reimbursement for the Health Home program and could further exacerbate challenges. To effectuate change in key high-cost populations, it will be critical to adequately support CBO care coordination in order to preserve the value of the Health Home program as a cornerstone of the health care delivery system.

**Housing Works urges the State to use a second round of DSRIP to continue investments in care management programs like PCMH and Health Homes to address patients' social and medical needs.**

## IV. Aligning Performance Measures

Housing Works strongly supports the State's desire to work with CMS to align performance measures across initiatives. Health centers' participation in Medicare, Medicaid, NYS PCMH, and contracts with managed care plans (among various other programs) requires a significant amount of resources invested in measure/data collection and reporting. **The State should target measures most likely to be of value for all participants in DSRIP 2.0.**

## V. Health Center Alternative Payment Methodology

FQHCs embrace the State's transition of Medicaid payment from volume to value. Housing Works supports this direction and is also engaged in work with CHCANYS to move away from a visit based FQHC payment to a capitated FQHC Alternative Payment Methodology (APM). Federal statute permits states to implement an APM in lieu of the legally required prospective payment system reimbursement methodology. States must ensure that reimbursement under the APM is not less than it would be under the prospective payment system rate; however, adoption of an APM is essential to move FQHCs from a visit-based payment that incentivizes volume, to a payment methodology that rewards efficiency and outcomes. A capitated FQHC APM aligns with the State's DSRIP goals of advancing VBP and provision of enhanced care coordination.

An FQHC APM supports team-based, integrated care and enables CHCs the flexibility needed to create innovative approaches to care which can include non-clinical support staff who are not billable providers under the prospective payment system rate. The creation of innovative care coordination workflows will improve care provided directly by FQHCs, therefore reducing costs across the health care system.

Housing Works looks forward to working closely with CHCANYS and the Office of Health Insurance Programs to establish a mutually agreeable approach that supports health centers' ability to transform their entire practice to a value-based care delivery model. Once the APM receives a federal approval, a small subset of health centers will transition from the prospective payment methodology to the APM. **To ensure the success of an APM, State investment is needed to enhance data collection capabilities and catalyze the development of new staffing roles, models for care teams, and innovative work flows.** These investments may include: enough funding to support interventions addressing patients' non-clinical social needs, support

for an alternative payment learning community, clinical and cost data analyses, quality metric identification, and reporting mechanisms.

Housing Works has actively engaged in DSRIP implementation and contributed to many of the successes achieved. We look forward to continuing to partner with the State to achieve our shared goals of system transformation and improved patient care, better patient outcomes, and reduced care costs.

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[i] Ghose T, Shubert V, Poitevien V, Choudhori S, Gross R. 2019. Effectiveness of a viral load suppression intervention for highly vulnerable people living with HIV. *AIDS and Behavior,* 23(9):2443-2452.

[ii] https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/paop/meetings/2018/docs/2018-11-29_updates.pdf

[iii] Kaushal R, Edwards A, Kern L. May 2015. Association Between the Patient-Centered Medical Home and Healthcare Utilization. American Journal of Managed Care. *Am J Manag Care*, 21(5):378-386.

Raskas R, Latts L, Hummel J et al. 2012. Early Results Show WellPoint's Patient-Centered Medical Home Pilots Have Met Some Goals For Costs, Utilization, And Quality. *Health Affairs*. Vol. 31, No. 9: Payment Reform to Achieve Better Health care. https://doi.org/10.1377/hlthaff.2012.0364

Akuh Adaji, Gabrielle J. Melin, Ronna L. Campbell, Christine M. Lohse, Jessica J. Westphal, and David J. 2018. Katzelnick. Patient-Centered Medical Home Membership Is Associated with Decreased Hospital Admissions for Emergency Department Behavioral Health Patients. *Population Health Management*. Vol. 21 Issue 3. printhttp://doi.org/10.1089/pop.2016.0189

## doh.sm.1115Waivers

**From:** Ann Abdella [redacted]
**Sent:** Monday, November 4, 2019 5:04 PM
**To:** doh.sm.1115Waivers
**Subject:** Waiver Comment
**Attachments:** A2 Associates Waiver Comment Letter.pdf



To Whom It May Concern:
Please accept this comment letter on the 1115 Waiver Request.
Thank you,
Ann

Ann Morse Abdella
President
A2 Associates, LLC
276 Kiantone Road
Jamestown, NY 14701
[redacted]

A2 ASSOCIATES
Improving health in rural communities

November 1, 2019

NYS Department of Health
Office of Health Insurance Programs
Waiver Management Unit
99 Washington Avenue
12th Floor, Suite 1208
Albany, NY 12210

Dear Colleagues:

Thank you for the opportunity to provide comment to the Department of Health regarding the 1115 Waiver: Delivery System Report Incentive Payment (DSRIP) Amendment Request, dated September 17, 2019. As the former Executive Director of the Chautauqua County Health Network (CCHN) and Chautauqua Integrated Delivery System (CIDS), a rural health network and a rural physician – hospital based Independent Practice Association (IPA), the organizations have been actively engaged in NYS DSRIP and a partner of Community Partners of WNY (CPWNY)/Sisters of Charity Hospital Performing Provider System (PPS) since the spring of 2016.

In 2016, Chautauqua County ranked 7th highest in the state for percent of population living in poverty (18.88%) and the majority of Medicaid lives were, and still are, attributed to private primary care practices (PCPs). From an equity and disparities perspective, it was therefore important for as many small providers as possible to be included in DSRIP transformation efforts. The CPWNY PPS understood this aspect of Medicaid payer panel distribution in Western New York.

CPWNY and its partner organization, Catholic Medical Partners, had years of clinical integration experience, as did CCHN and CIDS. Among its various activities, CCHN has supported the integrated health care service delivery work of CIDS, focused mostly on modernization and best practice adoption in the areas of quality, patient utilization, patient satisfaction, and Community Based Organization (CBO) integration. CIDS was a 20 year old IPA that had been clinically integrating since 2009. Based on years of similar experience, CCHN was pleased to be invited to work collaboratively with CPWNY to support improved integrated health care service delivery for CIDS in partnership with the PPS network.

Overtime, CCHN and CPWNY have built a successful and meaningful partnership based on mutual trust, respect, genuiness, and commitment. It was very important to the provider community that CPWNY did not come in a try to take over; they respected local context and experience and empowered the provider community to figure out regionally how to achieve on deliverables. CCHN was privileged to have found such a partner, as many other rural communities were not able to engage well with DSRIP. The result of that partnership has certainly been positive for the network of agencies, providers, and consumers in Chautauqua County. Some highlights include:

- Acceleration of patient centered medical home adoption with improvements in performance measures, and establishment of care coordination capacity and workflows in

8 primary care practices serving an estimated 12,000 Medicaid enrollees. Earned incentive payments provided much needed bridge funding to help enable PCPs to invest in desired practice transformation they would otherwise have struggled to justify.

- The HEALTHeLINK (SHIN-NY) consent rate among attributed patients increased by more than 54% from the baseline set about 2 years ago. Chautauqua County has no tertiary care available in the county, so access to ED Visit, Admission, Discharge, and Transfer information has contributed to better tracking and transitions of care for patients who have received care outside the County.
- Considering that Chautauqua County holds HPSA designations for Primary Care, Behavioral Health, and Dental, improvements in access to care and care coordination have been demonstrated. CPWNY participating providers have built and are maintaining 95+% on their access to care measure and are seeing a steady reduction in readmission rates. The latest report on Preventable Readmissions showed these providers with an aggregate rate of 253.78/100,000 compared to the state rate of 566.06/100,000 in MY5 month 2. Care coordination efforts have also resulted in decreases in Preventable ED visits that are continuing to bring local rates (43.17/100) into closer alignment with the state (37.19).
- Regarding the integration of behavioral health into primary care, this cohort of providers has improved depression screening rates for patients 12 years and older by more than 16% since DY4 began and is working to improve SBIRT/DAST screening rates. Each practice has been identifying referral contacts and learned a great deal about the challenges related to the use of telemedicine services in private primary care offices. CCHN has facilitated several meetings between PCP's and the local Health Home to build referral and report pathways that have yielded better communication processes and greater collaboration. This has contributed to reductions in readmissions and PPV's, and improved follow-up rates for Mental Illness after Hospitalization.
- As a county with one of the worst smoking rates in NYS and as part of Chautauqua's local Million Hearts efforts, the promotion of tobacco use cessation-especially low SES and MH populations-was a priority. The main strategy was a successful partnership with Roswell Park Cancer Institute to adopt the *Opt To Quit* cessation referral policies and procedures; workflow changes resulted in an increase of 237% in referrals over 3 years.
- CPWNY has been very supportive of CBO engagement throughout the process. They provided a letter of support and helped to recruit 24 local agencies initially to the Upstate CBO Consortium. CPWNY has been very inclusive of VBP training opportunities for clinician and CBO's-to understand and build skills to effectively partner with clinicians and payers. Most notably, CPWNY has provided significant resources through their Innovations funding to enable CCHN to engage four CBO's to receive expert planning and coaching services to develop value propositions which they are just beginning to discuss with payers.
- And, the push that DSRIP gave for the MCO's to engage in contracting with IPA's and other provider networks and with encouragement from CPWNY, CIDS attracted consideration from MCOs when previously ignored. CIDS is the contracting entity for MCO value based payment and shared savings for its primary care network and currently holds contracts with both Your Care Health Plan, Inc. and Fidelis Care New York.

A2 ASSOCIATES
Improving health in rural communities

CPWNY has definitely been an effective change agent in Western New York and in Chautauqua County. CPWNY has done an outstanding job of engaging with our network of rural clinical and community based providers. The work has just begun! We anticipate a favorable outcome of the 1115 Waiver DSRIP Amendment Request. We strongly endorse the work of CPWNY PPS. They are critical to the success of future DSRIP initiatives.

Now in my current role as a contractor for rural community health development, I'd like to offer some additional thoughts regarding the waiver request.

- Rural communities can develop rurally appropriate solutions. Based on the recent National Quality Forum Rural Health Report, a NYSDOH innovation could be to designate a Rural Pilot Projects Fund to pilot projects to address specific priorities from the report.
- Articulate plan to incentivize MCOs to engage with the CBO community in pilot project development and investment.
- **Section II:** Value Driving Entities-
    - Recommend requiring inclusion of Rural Health Networks on the VDE governance boards for those VDEs that are serving New York's rural counties.
    - Has thought been given to inclusion of County 911 and/or EMS representing rural communities?
    - Support building on the progress already made by ACOs, IPAs, and BHCCs
- **Section III:** Additional Priority Areas
    - Based on current experience with Opioid Response Planning through HRSA, a Mobile Crisis Team may be an alternative model to include so communities can choose rather than strictly identifying the Mental Health Urgent Care center model.
    - Support training and cross-system collaboration to enhance trauma informed care and address the impacts of Adverse Childhood Experiences (ACE).
    - Suggest that the DSRIP 2.0 funding may provide a unique opportunity to drive mental and behavioral health resources into rural K-12 schools for a multi-year Demonstration Project that will provide 'proof of concept' to justify long term funding.
    - Based on limited access to full-service obstetrical care in some rural communities, be careful and inclusive in the design of any maternity bundle
    - Support leveraging any crosswalks with Medicaid and Medicare data; and advocate with CMS for more transparency for patient specific behavioral health cost data for networks managing total cost of care; (identify - no longer de-identify)-allow MCO's to disclose patient names to the networks with whom they contract.

- **Section IV: Continued Investment/Improvements:**
    - Workforce-
        - Recommend funding to build some infrastructure that includes incentives for paid preceptorships to provide supervision time for disciplines that require a period of supervised work such as LCSW's. There is a huge need for these professionals and no supervisors in our area to grow our workforce capacity.

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    - EMS Paramedicine is a struggle for training and retention in our region. Suggest DSRIP 2.0 might be an opportunity for developing criteria and reimbursement structures.
  - SDHN
    - Ensure alignment with existing ACOs, IPAs, BHCC
    - There is a need for a sustainable plan for non-clinical data sharing. Consider strengthening the role of SHIN-NY, 211, and NY Connects and ensure participation of rural communities in any planning
  - Opioid Epidemic: Recommend broadening this Investment/Improvement to include a range of addiction issues that have a significant impact on rural health morbidity and mortality such as Methamphetamine, Alcohol and Tobacco.

- **Section V. Performance Measurement**
  - Greater clarity could be given regarding how people will be attributed to the VDEs.
  - The quality indicators chosen will greatly impact the financial benefits for VDEs, MCOs, SDHNs and their partners. An inclusive and broad-based input process should be developed during the next few months to pin down the quality indicators that will be used to calculate bonuses in VBP arrangements within DSRIP 2.0.

Thank you again for the opportunity to comment. Please feel free to contact me if you have any questions at [redacted] Thank you for your consideration and best of luck with the waiver request.

Kind regards,

Ann Morse Abdella
President

## doh.sm.1115Waivers

**From:** Barbara Peck [redacted]
**Sent:** Monday, November 4, 2019 5:04 PM
**To:** doh.sm.1115Waivers
**Cc:** [redacted] Andrea Smyth
**Subject:** 1115 Public Forum Comment
**Attachments:** Zucker, Dr. Howard A. - DSRIP Conitnuation Support Letter - 10.31.19.pdf

**Importance:** High



Attached please find a letter of support for the 1115 Public Forum from Children's Home of Jefferson County Executive Director, Karen Y. Richmond.

Best regards,
**Barb Peck**
**Director of Administration Services**
**Children's Home of Jefferson County**
**PO Box 6550**
**1704 State Street**
**Watertown, NY 13601**
[redacted]



CHILDREN'S HOME
OF JEFFERSON COUNTY

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*A Legacy of Compassion Since 1859*
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*2015 Business of the Year*

October 31, 2019

Howard A. Zucker, M.D., J.D.
Health Commissioner
New York State Department of Health
VIA Email: 1115waivers@health.ny.gov

RE: Support for DSRIP Program Continuation – 1115 Public Forum Comment

Dear Dr. Zucker:

As the leader of the Children's Home of Jefferson County (CHJC), a non-profit agency based in Watertown, New York, I am acutely aware of the proven benefits of providing our youth in care with an integrated, comprehensive approach to their mental, physical and behavioral healthcare. As such, I am very pleased to offer my full support for the New York State Department of Health's application to the federal government for $8 billion to continue its Delivery System Reform Incentive Payment (DSRIP) program through March 2024.

The proposed extension and renewal application includes critical children's population health priorities including:

- Expanded pediatric integrated health-behavioral health opportunities
- Supported transitional care teams for children and adolescents
- Enhancements for Care Coordination including expanded use of telemedicine for Care Coordination, and the development of family Care Coordination models
- Enhanced rates to deliver Evidence based Practices to achieve improved outcomes based on social determinant of health challenges
- Targeted investments into the children's behavioral health workforce to provide the most effective and carefully designed community-based mental health service expansion in the country, expand productivity through the use of Evidence Based Practices, expand productivity by promoting the use of Artificial Intelligence to support quality documentation of care by non-clinical staff upon which the re-designed services rely, and expand loan forgiveness for employees of agencies implementing the Children's Redesign.

DSRIP's essential goals mirror CHJC's, striving to provide the highest quality service for our youth in care, their families and our community at large. I urge you to continue these significant benefits within the context of this vital and dynamic initiative.

Sincerely,

Karen Y. Richmond
Executive Director

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St. Lawrence County Foster Care
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## doh.sm.1115Waivers

**From:** Mark Ropiecki [redacted]
**Sent:** Monday, November 4, 2019 5:06 PM
**To:** doh.sm.1115Waivers
**Cc:** Leadership Team; Chan, Peggy (HEALTH)
**Subject:** Care Compass Network - 1115 Concept Paper Public Comment
**Attachments:** Care Compass Network DSRIP 2.0 Concept Feedback.docx; Care Compass Network DSRIP 2.0 Concept Feedback.pdf



Good Afternoon,

On behalf of the Care Compass Network PPS, thank you for the opportunity to both participate in the Public Comments as well as submit this written comment. We appreciate your leadership in moving this transformative work forward.

Best Regards,
-Mark

**Mark Ropiecki**
Executive Director
Care Compass Network
33 Lewis Road
Binghamton, NY 13905
[redacted]
www.carecompassnetwork.org

CARE COMPASS NETWORK

# DSRIP 2.0 PUBLIC FEEDBACK

**TO:** NYS DOH

**FROM:** THE CARE COMPASS NETWORK PPS

**DATE:** MONDAY NOVEMBER 4, 2019

***Introduction***

Care Compass Network (CCN) is one of the 25 PPSs who have implemented the DSRIP 1.0 program in New York State. To organize around nine counties in upstate NY CCN was structured as an independent new company (NewCo) PPS with agency staff deployed around four geographic performance hubs called Regional Performance Units (RPUs). CCN serves approximately 100,000 attributed Medicaid members in a region representing roughly 1/8$^{th}$ of NYS's geography. The CCN partners include 6 competing health systems, 11 hospitals, two Federally Qualified Health Centers and over 150 additional community-based organizations. Through the DSRIP program CCN implemented the maximum panel of 11 projects and deployed many other custom programs to the region.

CCN as it exists now has emerged much more from experience than from the original DSRIP design. The organization represents the aggregation of "what works" lessons from the real world which is why the model has succeeded and fits the assigned region so well. Through the course of DSRIP 1.0, CCN has made great strides in advancing the local health care environment towards a more integrated, coordinated, responsive, and value-driving system. These accomplishments are borne out of our commitment to partnership and co-design with our Partners.

Key accomplishments include:

- 100% safety net providers RHIO connected;
- 100% primary care PCMH 2014 level 3 certified;
- 64% of core DSRIP Performance Metric targets achieved in Measurement Year 4;
- PDI-90 (Pediatric Composite) improved 74% through Measurement Year 4;
- Potentially Preventable Readmissions improved by 20% through Measurement Year 4;
- 29 new EMRs purchased and implemented and 23 RHIO connections;
- 57 IT infrastructure and cybersecurity upgrades funded;
- 64 new hires that are considered a "net gain" to the PPS region;
- 3,553 individuals from 400 organizations participated in one of 213 different trainings; &
- Leveraged DSRIP dollars to secure a $14M Medicaid infrastructure grant through NYS (CRFP).

The feedback below is derived from Care Compass Network's experience as a PPS representing a large, rural region in Upstate NY with six (6) different major health care systems competing therein.

***Approach***

Care Compass Network fully supports the DSRIP 2.0 extension and plans to apply for the roles of Value Driving Entity as well as Social Determinant of Health Network. In addition to a logical and well positioned

candidate for these roles it is highly likely that much of what has been gained would be lost if CCN stepped out of its current position as the region's acknowledged leader and convener. CCN has seen the early success of VDE and SDHN concepts through its initial work with DSRIP and agrees that additional time is needed to: sustain the progress made during DSRIP 1.0, expand these best practices to additional demographics, and ultimately support the development of VBP maturity.

The vision of improved quality at a lower cost can only be achieved through cross-community collaboration. In the CCN region such collaboration has greatly increased during the latter years of the DSRIP 1.0 waiver. This region will benefit greatly from fully measuring the success of these new programs and positioning best practices for sustainability through VBP.

The feedback provided in this document is the culmination of input gathered from CCN partners through several in person work sessions, governance committees, CCN staff and leadership, and other critical community stakeholders. Among many feedback points CCN is pleased to see the addition of dual eligible individuals in the DSRIP 2.0 proposal. Dual eligible engagement is a "must have" addition in DSRIP 2.0 and one that CCN fully supports.

In addition to the feedback provided to the DSRIP 2.0 extension CCN encourages community agencies at large to see this renewal period as a call to action. From CCN's experience the Medicaid reform learning curve escalated very quickly at the onset of the DSRIP 1.0 program. Therefore, it is advantageous for VDEs to create paths to onboard new partners and for community agencies to position their organizations as "early adopters" of the DSRIP 2.0 program. VDEs should have demonstrated core competencies for rapid cycle early adoption of partners.

**Suggestions:**

1. ***Value Driving Entity Roles & Structure***

   There are two principal elements in driving value related to the achievement of improved health outcomes and cost of care:

   - Achieving large enough scale to manage insurance risk.
   - Organization of care delivery in smaller networks where performance risk can be managed.

   **Both of these elements should be addressed in the evolving delivery system at a more localized level.** What CCN has learned in DSRIP 1.0 is that the approaches taken to manage Insurance Risk are not positioned to influence or greatly inform the management of Performance Risk. Insurance Risk is typically managed through the utilization of billing data. The billing/claims data is lagged, retrospective, and provided long after the utilization of services. VBP calls for progressive performance management, using real time or predictive analytics to inform care delivery. The available billing data alone is not sufficient to manage the Performance Risk.

   Today in Upstate NY there are a number of organized networks of care which have developed and entered into entry level VBP arrangements. Building on this organic framework CCN envisions the formation of a Regional VDE Convener serving in the role of the *convener*. The Regional VDE Convener would align and integrate smaller social and clinical networks of care and assist with network operations to be able to engage competently with MCOs on advanced VBP arrangements. The VDE Convener would evaluate, monitor, and actively manage Performance Risk through the integration of

clinical and Social Determinants of Health data using regional population health management platforms. Care Compass Network suggests that the VDE Convener role is critical to ensuring that the SDHN and Clinical care networks that can effectively deliver value. The Regional VDE Convener is a shared infrastructure of the regional care delivery integrating existing value driving networks present in the community.

**Key Takeaways of the VDE Concept:**

- This design must be flexible enough to allow systems of care to form organically and evolve to meet the needs of populations being served. Living in upstate NY is much different than living in NYC and there is considerable variation in services available. The DSRIP 2.0 construct must allow for the development of supportive networks of care that work at the local and regional level. As such, funding streams and the VDE structure must be flexible to support innovation and rapid cycle and early adoption.
- VDEs must integrate the data upon which decisions are made. Performance risk should be delegated to the local care delivery system where the data resides to optimize performance and can be supplied to those managing the insurance risk.
- Metric alignment between the DSRIP 2.0 logic and VBP framework should be aligned to the fullest extent possible including consideration for localized prioritization.
- Payer engagement with the Regional VDE will be critical. The VDE should work with MCOs and medical care providers to coordinate a wide variety of services.
- VDEs must advance network formation and operations to effectively track and interpret social and clinical data to the point where they are mature enough to take and manage risk.
- VDEs must advance workforce development and transformation on behalf of the region served.

***2. 95/5 Safety Net Funds Flow***

DSRIP 1.0 required a minimum of 95% of DSRIP funds be distributed to safety net providers, permitting that non-qualified payments "totaling no more than 5 percent of a project's total valuation" (DSRIP STCs) would be permitted. The safety net provider designation is defined by NYS as being either a public hospital, critical access hospital, or sole community hospital, or an organization with approximately 30% of patient volume provided to Medicaid members. For DSRIP 1.0 purposes the safety net designation was assigned at the start of the program and not reassessed.

Despite a strong CBO funds flow model which has resulted in nearly 80% of distributed funds being provided to the "Non-Hospital" category to date (which excludes Hospital Inpatient Facilities and the PPS PMO), **Care Compass Network does not endorse continuation of the 95/5 mandate in DSRIP 2.0**. In our experience, the logistical requirement of having 95% of all DSRIP funds be distributed to safety net providers negatively impacted the PPS's ability to truly innovate and leverage the incentive dollars effectively. From a DSRIP 2.0 perspective this requirement does not align with the ultimate march toward sustainability through VBP and may serve as a distraction by placing attention on mandated compliance not otherwise required by the VBP roadmap or MCO engagement terms. By restricting the Safety Net definition to only consider Medicaid Billing requirements, critical organizations that do not bill Medicaid – but ones upon which Medicaid members rely upon heavily for services – were not eligible for direct funding in the same way that billing agencies were. Several impacts included:

- CBOs who serve critical populations but do not bill Medicaid and were therefore not eligible to earn the Safety Net designation were excluded from serving certain roles in various programs including serving the role of VBP Lead Contractor in CCN's Cohort Management Program, a program designed to serve defined populations of complex patients through high performing networks. If not for the 95/5 requirements several CBOs could have gained additional VBP preparatory experience offered through these programs. Additionally, many CBOs CCN works with provide services addressing Social Determinants of Health (SDoH). If these organizations were better positioned to demonstrate the clinical, social, and financial impact of Cohort Networks designed to address Social Determinants of Health, this would have further aligned with the intent of true system integration and transformation.
- Direct contracting with CBOs better positions them to leverage the transformative DSRIP dollars. Most CBOs operate at such tight operating margins they cannot be reasonably asked to shoulder the up-front and ongoing costs of infrastructure in support of transformation. In this work, requiring 2nd tier funds flow introduces delays in timing between service delivery and payment. Typical reimbursement steps include invoice submission, data submission by the CBO, data and invoice validation, and check approval and creation. CCN is nimble enough to do this and cut checks to partners on a weekly basis, whereas partners in 2nd tier funds flow arrangements (in order to remain compliant with 95/5) can receive payments as much as 60 days after services are performed. Direct contracting with PPS/VDEs which have developed processes and competencies for timely reimbursement and funds flow is essential.
- Administrative time and effort to monitor compliance. Care Compass Network actively monitored compliance and, in some cases, needed to slow or cease direct contracting with CBOs who were not safety net in order to maintain compliance. This resulted in CBOs contracting with safety net providers which added incremental cost. Although these CBOs ultimately engaged as downstream providers and leverage the "2nd Tier Funds Flow" concept, a more efficient model for engagement would be direct contracting of the CBO with the PPS/VDE and eliminate the additional administrative processing.
- Extensive and costly legal reviews to be in compliance with regulatory requirements.

Despite this recommendation, if DSRIP 2.0 still contains the 95/5 requirement, CCN strongly recommends that the following be considered in how to administer the 95/5 requirement:

- The Safety Net definition needs to be restructured to not solely align around Medicaid billing data elements. A new designation of "functional safety net providers" would allow entities like Tier 1 CBOs to be properly recognized for the safety net work performed albeit not billed through Medicaid.
- Dollars associated with the SDHN should be considered excluded from the 95/5 rule. With the growing emphasis on SDOH and the expectations that they are a critical component of an integrated delivery system, removal of the 95/5 rule from SDHNs is essential for the development of highly functioning SDHNs.
- NYS should redefine how the Safety Net designation is awarded to agencies. For example, this should be done annually at minimum and not just at the beginning of the DSRIP 2.0 program.

3. **Social Determinant of Health Networks / Regions**

**Care Compass Network recommends that SDHN not be allowed to operate in silo from the VDE. There should be a very close alignment between the SDHN role and VDE role that will permit the true integration of community and clinical data to inform performance risk management to support VBP maturity.** The self-evident need for tighter integration of agencies in the VDE and SDHN models will mean that gaps in the network will become more apparent and escalate the urgency by which they are addressed. In a rural setting and with CBOs of widely varying levels of capability and range, some regions may need to be able to "grow their own" capacity to meet the needs of a VDE/VBP world. The supportive and aligned workforce incentives will greatly assist this development. The close alignment between VDE and SDHN efforts will allow for a more meaningful understanding and valuation to the community-based services, which absent this integration will remain highly valued but not understood. There is a risk that SDHNs independent from the VDE may not effectively integrate with the clinical impact of the social determinant work and thus not provide an effective value proposition for the VBP environment. **SDHN and VDE should sufficiently develop data sharing practices to support this integration.**

**CCN recommends that NYS DOH permit the VDE and the SDHN to be unique roles fulfilled under the same umbrella organization.** In the CCN Cohort Management Program CCN essentially serves as a VDE, serving the role of convener supporting network formation and network operations which has shown promising results in DSRIP 1.0, especially in the integration of CBOs and SDH interventions in a wraparound care model to high need individuals. Also, under the Cohort Management Program, CCN has played the role of the SDHN, including inventorying CBO's services, capacity, service regions, and promoting VBP readiness. The Cohort Management Program rolled out in early 2019 and has resulted in successfully matching 58 CBOs with 18 safety net organization leads which are now acting as functioning networks who are contracted and case conferencing to better organize and deliver new services to a high-performance network around a population cohort. Following an outcomes measurement period, the identified high performing network activities could be sustained through a VBP arrangement. *A well-structured community engagement model underneath the VDE concept could help simplify the DSRIP 2.0 model and achieve the same desired outcome without creating additional layers.* Similar to DSRIP 1.0, the ability and flexibility for PPSs to identify regional integration models would benefit DSRIP 2.0.

4. **Attribution**

**The NYS DOH should seek to ensure that the full eligible population, as possible, is attributed to a Value Driving Entity (VDE).** In the Care Compass Network (CCN) region (a vast rural section of Upstate NY) under the DSRIP 1.0 attribution methodology, tens of thousands of individuals were not attributed in the counties that only CCN served in DSRIP 1.0. Of roughly 200K Medicaid members in the CCN region, roughly 100K were assigned to CCN for DSRIP 1.0 purposes and 67K were not attributed to any PPS. In this case, a high percentage of Medicaid member results were not attributed to the PPS nor was the supportive data for these members available to the PPS to inform program development. While it is broadly understood that attribution is not perfect and will always result in a form of overlap, CCN recommends the following in the development of DSRIP 2.0:

- Attribution for Data Sharing – There should be no unattributed individuals in DSRIP 2.0. DSRIP 2.0 should facilitate the exchange of data on the number of beneficiaries in the defined region, not solely on the basis of utilization or MCO enrollment. This should include Medicaid and dual eligible individuals and will help ensure that the VDE can properly plan for the entire region.
- This model would inherently be able to include uninsured individuals who receive enrollment at the time of care and subsequently make use of the newly found insurance. However, those who do not utilize services or do not qualify for Medicaid due to income limits may be out of reach of this model.
- Incarcerated Medicaid members should be attributed to the PPS during incarceration, and reactivation of Medicaid allowed to happen prior to re-entry into the community. Sufficient data for this new population should be included in VDE data sharing approaches.
- CCN also recommends aligning the attribution for performance model as closely as possible with the principles used in VBP arrangements with payors. These principles include a process to determine attribution for performance for a period of time (a year, for example) with no changes, as opposed to the current model of monthly updates.

5. **Promising Practices** – Appendix B Recommendations

Care Compass Network has developed a program in the latter year of DSRIP which aims to support the formation of networks which organize to impact a high need cohort of patients, and continue in the provision of network operations support. This program includes aspects of the DSRIP implementation plan for project 2ai, as well as the VBP Roadmap, and MRT Strategic Roadmap. Although this program was identified by the United Hospital Fund "DSRIP Promising Practices" report it was not included in the proposed extension in the promising practices summarized in Appendix B. The United Hospital Fund summary report on the program is included below:

> *"The Cohort Management Program of Care Compass Network (CCN) PPS is focused on better serving defined populations of complex patients. CCN created a series of networks that included clinical and community service providers it identified as most relevant to the needs of specific cohorts of complex patients. Each network established goals for performance improvement for its defined cohort. To meet these goals, networks developed strategies to improve patient outcomes by identifying required resources and deciding how funds from CCN would flow to its network partners. CCN facilitated network formation and helped partners define, assess, and risk-stratify their respective patient cohorts. CCN also supported networks in using rapid-cycle process improvement techniques to better integrate services, and it provided networks with tools to track cohort's service engagement and key quality indicators. The networks gained experience managing a continuum of services across a group of coordinating providers being held accountable for patient outcomes, a key to succeeding under future VBP arrangements."*
> *United Hospital Fund, DSRIP Promising Practices, Page 8*

**Care Compass Network recommends the inclusion of the Cohort Management Program to the promising practices section of the extension Appendix B.** This wrap around program is critical in the alignment of services that will be critical to the SDHN and VDE around the critical needs of the members served and supporting the achievement of improved health status and sustainability through system design and VBP arrangements.

***6. DSRIP 1.0 Funding Use Cases Post 2020***

Based on the December 2018 DOH survey which was shared at the January 2019 PAOP meeting, 13 of 25 (52%) PPSs self-identified a strategy to retain DSRIP 1.0 dollars post December 2020, with seven of the 13 PPSs retaining between 9 – 15% of the DSRIP award. A timeframe of when these funds would be distributed by was not included in the survey. CCN was identified as one of these PPSs with a plan to retain funds, which was a part of the original PPS approved budget in 2015, and has identified very specific use cases, summarized below based on timeline and use case. **CCN recommends the support for reasonable PPS retention of DSRIP funds, consistent with DSRIP 1.0 application purposes, in order that objectives like those outlined below can be completed in a timely manner.**

***Post 2020 Example Use Cases for DSRIP 1.0 Funds***

- Extension of promising practices through DSRIP 2.0 planning timeline. As of October 2019, DSRIP 2.0 is not yet approved and very likely to engage in an application and planning process before programs are designed, contracted, and implemented in the PPS/VDE service areas. As a result, it is highly likely that no substantial DSRIP 2.0 funds will be available to support DSRIP 1.0 promising practices until Q3/Q4 2020 at the earliest. In cases where PPSs undergo restructure exercises to be VDEs, this can potentially further impact their timely ability to release DSRIP 2.0 funds until proper infrastructure and policy is in place. It will be critical for PPSs to identify promising practices now and/or workforce impacts and leverage DSRIP 1.0 or other funding sources to sustain the progress and not lose ground until the DSRIP 2.0 dollars are available for transformative investment. *Timeline: DSRIP 1.0 funds to support DSRIP 1.0 promising programs minimally through Q4 2020.*
- Given DSRIP 2.0 is not yet finalized, PPSs do not know if local best practices will be reimbursed or otherwise supported in DSRIP 2.0. As a result, PPSs may elect to independently fund best practices to support continuity of services not reimbursed under the DSRIP 2.0 program to support the measurement and maturity path to VBP sustainability. *Timeline: DSRIP 1.0 funds to support DSRIP 1.0 programs not supported in DSRIP 2.0 through Q4 2022.*
- As the DSRIP 1.0 program has matured PPSs have created new and more complicated programs and/or adopted new partners in the latter years of DSRIP 1.0 that may not be specifically called out in the promising practices playbook. In many cases these programs or partners have not yet experienced enough time to allow data to aggregate which can help validate and properly measure program successes. In these cases, program extension should be supported by DSRIP 1.0 to ensure enough data can be used to measure success. *Timeline: DSRIP 1.0 funds to support DSRIP 1.0 latter year programs through Q4 2022.*
- Matching funds committed to the CRFP award have allowed for an additional $14.3M to be received in the Southern Tier for population health and care management solutions in support of project 2ai. This grant has incumbered DSRIP matching funds through 2023. *Timeline: CRFP related incumbered funds designated through October 2023.*
- Given DSRIP 2.0 is not yet finalized, PPSs do not know if local Workforce development and transformation best practices and pipeline development will be reimbursed or otherwise supported in DSRIP 2.0. As a result, PPSs may elect to independently fund best practices not reimbursed under the DSRIP 2.0 program to support the path to VBP sustainability. *Timeline: DSRIP 1.0 funds to support DSRIP 1.0 Workforce programs not supported in DSRIP 2.0 through Q4 2022.*

- No retained funds will be used for purposes outside the scope of the DSRIP application. All retained funds will support programs and learnings that directly impact the Medicaid members attributed to CCN as per the DSRIP 1.0 program.

**7. Regions**

There is an underlying concern regarding the work of DSRIP 1.0 and its scale in terms of attracting the attention of payers. The VDE should be established on a scale that attracts payors while respecting the existing VBP work of its partners. For this reason, a VDE that operates as a convener of these existing regions that, whether defined or not, do impact the way care is delivered today is imperative. The VDEs work should also be supportive of local government units and health system Community Health Improvement Plans and Federal and State Healthy People priorities.

**8. Legal Considerations**

Care Compass Network supports the formation of Value-Driving Entities and Social Determinant of Health Networks to advance DSRIP Promising Practices and mature networks through Value-Based Payment contracting. In order to successfully navigate the collaborative relationships integral to the DRSIP 2.0 framework, Care Compass Network asks for refreshed guidance from the DOH regarding U.S. competition laws. **Care Compass Networks encourages the DOH to engage in dialogue with the Federal government to produce updated guidelines, if any, which would continue to provide advisement on Anti-Trust compliance under DSRIP 2.0.**

To achieve DSRIP goals and improve community health outcomes, Care Compass Network partners have relied on regulatory waivers granted under DSRIP 1.0. To date, Care Compass Network partners have relied on waivers at 21 different practice sites under the auspice of DSRIP 1.0. To sustain progress and avoid program disruption **Care Compass Network recommends that the regulatory waivers granted under DSRIP 1.0 be extended through the end of DSRIP 2.0. Additionally, Care Compass Network recognizes the efforts that NYS has made to advance certain waivers into legislation and endorses the continuation of such efforts for waivers with the greatest impact on DSRIP goals.**

In response to changes to the Physician Self-Referral Laws ("Stark Law") proposed by the Department of Health and Human Services and the Office of Inspector General, Care Compass Network supports "revisions to the Safe Harbors Under the Anti-Kickback Statute and Civil Monetary Penalty Rules Regarding Beneficiary Inducement," insomuch as these exceptions are carefully designed to:

- Safeguard against overutilization and misuse.
- Promote value-based concepts to improve the quality and coordination of care.

Taking into account the above criteria, **CCN supports the proposed revisions to the Stark Laws.** Furthermore, CCN believes that the modernization of these statues will support innovations in care, foster confidence for providers to enter into VBP contracts, reduce the regulatory burden on providers, and move healthcare towards a quality over quantity service.

Regional data sharing of clinical and social information is essential to successful population health management and care coordination. Care Compass Network has performed extensive legal research into whether HIPAA and state laws and regulations allow for data sharing on this level. The NY State privacy laws and regulations are far more restrictive than HIPAA and, in some circumstances, prevent

the flow of information necessary to alert care givers of identified gaps in care without significant cross-organizational operational challenges. **CCN requests that NYS DOH review existing state-specific privacy laws and regulations to align them with recent collaborative, value-driven principles.**

**9. MCO Engagement**

The Care Compass Network community of partners has learned and demonstrated through DSRIP that transformation is possible. Moreover, the diverse regional healthcare community is capable of deploying incentives at the community level to innovate and achieve results in a very short period of time. Managed Care Organization (MCO) engagement and partnership now needs to be more meaningfully approached to construct VBP agreements that recognize and sustain the new, non-traditional community partnerships that have demonstrated the significant gains in performance and cost-savings. The DOH should continue to monitor funds distributed through VBP arrangements and also consider the development of a high level MCO engagement roadmap and deploy an appropriate oversight group who could provide oversight for DOH as to whether MCO engagement is on a successful path to achieve the desired outcome by March 2024.

- Resources to support the achievement of DSRIP goals should be provided, including cost information and data sharing between MCO and VDE.
- In the early stages of the DSRIP 2.0 timeline, MCOs should collaborate with VDEs to develop value proposition toolkits that identify how promising practices will be evaluated for continuation by the proposed year 3 deadline.
- MCO transformation to the roles and requirements outlined in the VBP roadmap and MRT Strategic Roadmap should be monitored similar to how PPS and delivery system transformation has been monitored through DSRIP 1.0. An appropriate oversight group can support an independent monitoring of MCO related transformation efforts.
- MCOs and VDEs should enter into performance engagements and work to ensure sustainability of promising practices and ensure timeliness of payments for such efforts to the network partners. Both MCO and VDE should be accountable to ensure timely distribution of funds.

**10. State Program Alignment**

Throughout the course of DSRIP 1.0, relationship building efforts with various NYS and County Offices were met with varied success at local and regional levels. Despite the attempts to align programs, there remains a separation between NY State and County Offices and the work of DSRIP 1.0, and varied levels of understanding. This separation has perpetuated the sense - whether real or perceived - that state departments are working in silos and true integration of care is a long way off. **DOH should take on the role of State agency alignment around core initiatives such as DSRIP.** Care Compass Network asks the DOH take this issue under advisement while building the framework for DSRIP 2.0. Specifically, CCN recommends that the DOH work directly with critical state departments to broker DSRIP participation at the administrative level and promote a communication approach that endorses strong participation by such agencies.

## doh.sm.1115Waivers

**From:** Sara Sunday [redacted]
**Sent:** Monday, November 4, 2019 5:09 PM
**To:** doh.sm.1115Waivers
**Subject:** 1115 Public Forum Comment
**Attachments:** DSRIP_Letter_of_Comment_OswegoCountyOFA.pdf



Please accept the attached letter comment.

Sincerely,

*Sara Sunday*

Aging Services Administrator
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Oswego NY 13126
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**County of Oswego**
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**Sara Sunday**
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**Oswego, NY 13126**

November 1, 2019

NYS Department of Health
Office of Health Insurance
Waiver Management Program Unit
99 Washington Avenue
12th Floor, Suite 1208
Albany, NY 12210

To Whom it May Concern:

On behalf of Oswego County Office for the Aging, I am writing to express my recommendations on the DSRIP renewal to March 31, 2024. The Oswego County Office for the Aging is one of 59 Area Agencies on Aging and the services we provide address the social determinants of health and often prevent higher, more costly forms of care.

The services we provide directly impact inappropriate emergency department visits and reduce avoidable readmissions. We have been serving the community for over 40 years and are considered trusted experts in te field of aging. Our goal is to help older adults remain independent in their homes and delay or prevent more costly forms of care such as unnecessary hospitalizations and institutionalization. Our programs can also help older adults avoid spending down to Medicaid by providing low cost case management and home support services.

In 2010, 18% of the Oswego Count population was aged 60 or older and just five years later in 2015 that number jumped to 21%. By 2025 that number is projected to be 27% of the County's population. As people live longer, the problems they face are becoming larger and more complex than most people can manage on their own. Navigating the long term care system is complex, fragmented and daunting. Our NY Connects program serves as a "no wrong door" for all services available in Oswego County. The program helps people remain independent by linking them with the right services, in the right care setting.

To demonstrate the value of the Area Agencies on Aging network, I would like to highlight a case that is typical to our office. A male client suffered a stroke in the Fall of 2012. He has right side residual (paralysis) and aphasia. Prior to the stroke, the Oswego County Office for the Aging had been providing Home Delivered Meals and EISEP respite with aide service had just finished. The client was assessed for EISEP homecare services in March of 2015 and approved for four hours/week. As part of the assessment, it was determined a Personal Emergency Response Systems would be beneficial and was provided. During the assessment visit the case manager determined several other programs would benefit the client and he agreed to the assistance. Programs included the Enhanced STAR, Extra Help, SNAP, HEAP and Verizon telephone discount. The Case

Manager successfully advocated with the local tax assessor for enrollment into the STAR program as the deadline had just passed.

Additionally, the Case Manager assisted the client and spouse to get a mailbox at their home, including advocating with the local USPS and utilizing ancillary funds to purchase the mailbox/post. As many programs require a street address, not just a PO Box, the addition of the mailbox assured that important recertification documents were delivered and addressed as well as the caregiver/spouse's ability to retrieve documents in a timely manner, not having to secure transportation to the post office.

The client continues with services and has had very few hospitalizations during this time. As appropriate, aide hours are added. As well, OFA assisted with the purchase of a special a special transfer bench to prevent skin breakdown. The assistance of OFA has been instrumental in keeping the client in better health and physically & emotionally safe at home. It has been extremely beneficial to his caregiver/spouse as well.

This is one of many cases that truly displays the boots on the ground service provision in every county across the state. In the renewal waiver, I cannot stress highly enough that we need to harness the existing strengths of community-based services, instead of recreating case management services and duplication of services. Each and every case manager in the entire statewide aging network has received certification via Boston University School of Social Work, ensuring consistency in assessment not provided by any other system. I ask that there are mandates for each PPS to engage and contract with their local Offices for the Aging, for the services vital to keeping individuals in home and community-based settings.

Thank you,

Sara Sunday
Director
Oswego County Office for the Aging

CC: Paul Francis, Deputy Secretary for Health
Donna Frescatore, Medicaid Director, Department of Health
Assemblyman Harry B. Bronson, Chair Assembly Committee on Aging
Senator Rachel May, Chair Senate Committee on Aging

## doh.sm.1115Waivers

**From:** Philpott-Jones, Sean PhD, MSBe [redacted]
**Sent:** Monday, November 4, 2019 5:05 PM
**To:** doh.sm.1115Waivers
**Cc:** [redacted] Bloom, Amy
**Subject:** Comments on DSRIP 2.0 Concept Paper from Hudson Headwaters Health Network
**Attachments:** DSRIP 2.0 Concept Paper Comments - Hudson Headwaters Health Network.pdf



On behalf of Hudson Headwaters Health Network, I want to thank the New York State Department of Health for inviting public input on proposed changes to New York's Delivery System Reform Incentive Payment (DSRIP) program.

As a Federally Qualified Health Center operating 19 community health centers spread across a 5,600 square mile service area in New York's Adirondack and North Country region, we consider DSRIP to be an important part of our continuing efforts to provide access to high-quality yet affordable primary care and specialty services to our 90,000+ patients.

Attached please find specific comments on the DSRIP 2.0 Concept Paper, developed in collaboration and consultation with the Community Health Center Association of New York State (CHCANYS), of which Hudson Headwaters is a proud member.

We look forward to working with the Department of Health in exploring new and innovative ways of improving access to quality health care in Northeastern New York.

--

Sean Philpott-Jones, PhD, MSBe
Director, Government Relations and Grants Management
Hudson Headwaters Health Network
9 Carey Road
Queensbury, NY 12804

Pronouns: He, him, his

[redacted]

HUDSON HEADWATERS Health Network

HUDSON HEADWATERS HEALTH NETWORK

Hudson Headwaters Health Network (hereafter referred to as Hudson Headwaters) is grateful for the opportunity to provide comments on the Delivery System Reform Incentive Payment (DSRIP) Amendment Request concept paper published on September 17th. A Federally Qualified Community Health Center (FQHC) headquartered in Queensbury, New York, Hudson Headwaters commends the State's work in the first round of DSRIP to reduce costs, improve patient outcomes, and decrease unnecessary inpatient and emergency room utilization. For New York to experience a real transformation of the health care delivery system and sustain the gains thus far achieved through DSRIP, there must be a significant investment in community-based primary care. Only through this investment can the State achieve a real value-based system that improves health outcomes and reduces costs. Hudson Headwaters supports the renewal of the DSRIP program through March 31st, 2024. Hudson Headwaters, a member of the Community Health Care Association of New York State (CHCANYS), supports the comments submitted by CHCANYS and has restated and revised many of their points below.

## I. Driving Promising Practices to Improve Health Outcomes and Advance VBP

By mission and in statute, health centers serve the State's most vulnerable and hard to reach populations. FQHCs are non-profit, community-run centers located in medically underserved areas that provide high-quality, cost-effective primary care, including behavioral and oral health services, to anyone seeking care. Each FQHC is governed by a consumer-majority board of directors tasked with identifying and prioritizing the services most needed by their communities. In 2018, 23% of our 84,347 patients were enrolled in Medicaid or CHIP.

Hudson Headwaters operates 19 health centers located across a 5,600-square mile service area stretching from Glens Falls to the Canadian border. These health centers provide patients with access to comprehensive primary care services, especially among populations that are most likely to present at the ED with a non-urgent or avoidable condition. In the first round of DSRIP, we participated in the Adirondack Health Institute PPS (Performing Provider System), a partnership of more than 120 organizations that plans for and manages DSRIP Program health care restructuring in the northern New York/Adirondack region. Over the past few years, Hudson Headwaters used DSRIP funds for a variety of projects, including integrating behavioral health and palliative services into primary care, developing patient-centered approaches to prevent and manage chronic diseases like diabetes, and creating new telehealth programs that provide mental health and vision services in remote regions of northeastern New York.

The first round of DSRIP complimented the health center model's unique and innate ability to provide comprehensive and innovative care to New York's Medicaid beneficiaries. Health centers played and continue to play a vital role in advancing the promising practices within their regions and driving improved health outcomes. In the second round of DSRIP, health centers are well-prepared to take a leadership role to advance the State's vision of an expanded value-based payment (VBP) landscape driving DSRIP promising practices.

## II. Embracing the Role of VDEs

We are pleased to see that the State has acknowledged the need for additional flexibility in the next round of DSRIP and is interested in ensuring the success of Value-Driving Entities (VDEs). However, we encourage the State to provide direct investment in community-based providers. Currently, 23 of 25 of the PPS leads are hospital-based, with no specific requirements about how funds flow to partners such as community health centers in the PPS networks. Meaningful governance participation by community-based providers, such as community health centers and community behavioral health organizations, and downstream investments to health centers and other community-based providers varied greatly from PPS to PPS. Using publicly available data reported by the State, it is challenging to determine the amount of money received by health centers in the first round of DSRIP – "clinics" are lumped together with hospital ambulatory providers in the attribution methodology. However, the most up to date data reported by the State in November 2018 demonstrates that hospitals received more than 28% of total funds flow while representing only 0.2% of total engaged PPS partners.[i] By contrast, of the nearly $187 million in DSRIP funds distributed by Adirondack Health Institute PPS over five years, only 5.4% of that money went to Hudson Headwaters. It is exceedingly difficult to transform the healthcare delivery system by continuing to invest most transformation dollars into inpatient-based care models when it is the long-standing established CHC providers and workforce that can have the most significant impact on patients' health outcomes. CHCs are especially well-posed to integrate care, make connections to address social needs, and become the more adept and agile VDEs envisioned in the State's concept paper.

We support the State's charge that VDEs include providers, community-based organizations (CBOs), and managed care organizations (MCOs) to leverage VBP and advance promising practices. A collaborative partnership between community-based providers, CBOs, and MCOs is critical to implementing and supporting transformative initiatives that move away from a volume-driven care model. However, to support improved access to care in the community and reduce reliance on emergency departments and inpatient care, the State must direct additional resources to a broad range of community-based providers. **At a minimum, Hudson Headwaters requests that the State allocate 25% of DSRIP funds to the development of community-based VDEs where CHCs, in collaboration with other community-based providers, are lead entities.**

### a. VDE Lead Entities

The State should capitalize on existing health center Independent Practice Associations (IPAs) as a launching point for the creation of community-based VDEs. The four CHC-led IPAs currently organized across the State -- Community Health IPA (CHIPA), Safety-Net IPA (SIPA), Finger Lakes IPA (FLIPA), and Upstate Community Health Collaborative IPA (UCHC) -- are engaged with MCOs in at least one VBP contract while working on additional agreements. Hudson Headwaters is not a member of an IPA, but we recognize that IPAs can take on risk and become financially accountable for both the quality of care and the most efficient delivery of care services. We believe that IPAs are well-positioned to work with other entities, including Hudson Headwaters, as a VDE in the second round of DSRIP.

While health centers like ours are already developing relationships needed to advance VBP contracts, the second round of DSRIP is an opportunity to invest in building capacity to ensure health center and CBO IPAs have the foundation to serve as VDEs. Currently, health center-led IPAs are self-funded and have little financial capacity to support many of the crucial functions that would accelerate their

participation in VBP arrangements. **Health center-led IPAs require DSRIP investment to support the data analytic capabilities needed to manage population health and drive improved outcomes.**

**b. Considerations for Engaging MCOs**

Hudson Headwaters is pleased that the State is taking steps to ensure engagement of MCOs early in the planning process for the second round of DSRIP. However, there are significant challenges to address ahead of the creation of VDEs. One of the current difficulties faced by providers as they seek to participate in VBP arrangements is a lack of comprehensive data about their attributed patients. **The State should create and enforce a consistent data sharing policy for the managed care plans to further support the transition to VBP, for example, by enforcing transparency in expenditures and utilization.**

In the first round of DSRIP, the discrepancies between MCO attribution and PPS attribution made it difficult for health centers to manage patient health outcomes effectively. PPS networks do not necessarily encompass the same providers that contract with a given MCO. If there are discrepancies between MCO attribution, consumer utilization, and PPS network, it becomes incredibly difficult, if not impossible, for the PPS to manage health outcomes for these populations. PPS and VDEs should not be expected to manage the health care improvements of individuals enrolled in managed care plans that contract outside of the VDE. **Hudson Headwaters recommends that in the next round of DSRIP, VDE attribution should be aligned with MCO attribution to ensure seamless VBP contracting.**

Finally, we understand the State's desire to drive regional innovation – local health care needs vary based on geography, CBO and health care provider landscape, and other factors. However, we would like to raise the concern that in densely populated areas served by many MCOs with overlapping service areas (notably, New York City), defining distinct regions may prove difficult. **In New York City, Hudson Headwaters recommends that VDE networks should align with patient utilization patterns as much as possible.**

## III. Supporting Non-Clinical Workforce to Address Social Needs

Hudson Headwaters echoes the State's observation that many of the successful DSRIP initiatives rely on a non-traditional, non-clinical workforce that helps patients navigate clinical and social services systems to address their multi-dimensional needs. In the first round of DSRIP, we embraced the flexibility to address patients' social needs. It is well established that addressing these so-called social determinants of health is essential for improving individual health and wellness while reducing health disparities within the community. Hudson Headwaters has used DSRIP support for projects that promote healthier lifestyles, provide referrals for mental and emotional health, and address issues of food insecurity. In collaboration with partners like the YMCA Adirondack Center, Turning Leaf Counseling, and the Town of Chester, Hudson Headwaters established a Wellness Center in the Southern Adirondacks, which provides a wide variety of prevention, intervention, treatment and recovery support services at a single centralized location. We also partnered with Comfort Food Community to create a Food Farmacy program that offers nutrition education and access to fresh produce for patients struggling to manage obesity and diabetes.

In the first round of DSRIP, the State encouraged primary care practices to become recognized as a patient-centered medical home (PCMH). Today, 97% of New York's health centers are PCMH certified. PCMH certified practices provide mental health, oral health, and health promotion/disease prevention

services through comprehensive primary care. This model of patient-centered care is associated with improved health outcomes and reduced costs and should be supported in the second round of DSRIP. Numerous studies have analyzed the success of PCMH, including citing fewer specialty visits needed, lower per member costs, and better health outcomes amongst individuals seeing PCMH-certified providers.[ii]

As an FQHC, Hudson Headwaters has always endorsed the concept of patient-centered care. In 2009, we became a certified Patient-Centered Medical Home. In 2018, Hudson Headwaters was recognized by the US Department of Health and Human Services' Health Resources and Service Administration as 10th in the nation for best overall clinical performance and 5th in New York State as a PCMH. Under the Patient Center Medical Home model, Hudson Headwaters provides access to care management services to our highest-risk patients. These services often consist of support from, at a minimum, a care manager and a community resource advocate. The resource advocate is responsible for explicitly addressing the socio-economic barriers to improved health, while the care manager manages the overall care of the patient, in collaboration with the providers. **The State should use the second round of DSRIP to continue investments in care management programs like PCMH and Health Homes to address patients' social and medical needs.**

## IV. Aligning Performance Measures

Hudson Headwaters strongly supports the State's desire to work with CMS to align performance measures across initiatives. Health centers' participation in Medicare, Medicaid, NYS PCMH, and contracts with managed care plans (among various other programs) requires a significant amount of resources invested in measure/data collection and reporting. **The State should target measures most likely to be of value for all participants in DSRIP 2.0.**

## V. Health Center Alternative Payment Methodology

FQHCs embrace the State's transition of Medicaid payment from volume to value. Hudson Headwaters supports this direction and is also engaged in work with CHCANYS to move away from a visit based FQHC payment to a capitated FQHC Alternative Payment Methodology (APM). Federal statute permits states to implement an APM in place of the legally required prospective payment system reimbursement methodology. States must ensure that reimbursement under the APM is not less than it would be under the prospective payment system rate; however, adoption of an APM is essential to move FQHCs from a visit-based payment that incentivizes volume, to a payment methodology that rewards efficiency and outcomes. A capitated FQHC APM aligns with the State's DSRIP goals of advancing VBP and the provision of enhanced care coordination.

An FQHC APM supports team-based, integrated care and enables CHCs the flexibility needed to create innovative approaches to care, which can include non-clinical support staff who are not billable providers under the prospective payment system rate. The creation of innovative care coordination workflows will improve the care provided directly by FQHCs, therefore reducing costs across the health care system.

Hudson Headwaters looks forward to working closely with CHCANYS and the Office of Health Insurance Programs to establish a mutually agreeable approach that supports health centers' ability to transform their entire practice to a value-based care delivery model. Once the APM receives federal approval, a

small subset of health centers will transition from the prospective payment methodology to the APM. **State investment is needed to enhance data collection capabilities and catalyze the development of new staffing roles, models for care teams, and innovative workflows to ensure success.** These investments may include enough funding to support interventions addressing patients' non-clinical social needs, support for an alternative payment learning community, clinical and cost data analyses, quality metric identification, and reporting mechanisms.

Hudson Headwaters has actively engaged in DSRIP implementation and contributed to many of the successes achieved. We look forward to continuing to partner with the State to achieve our shared goals of system transformation and improved patient care, better patient outcomes, and reduced care costs.

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[i] https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/paop/meetings/2018/docs/2018-11-29_updates.pdf

[ii] Kaushal R, Edwards A, Kern L. May 2015. Association Between the Patient-Centered Medical Home and Healthcare Utilization. American Journal of Managed Care. Am J Manag Care. 2015;21(5):378-386.
Raskas R, Latts L, Hummel J, et al. 2012. Early Results Show WellPoint's Patient-Centered Medical Home Pilots Have Met Some Goals For Costs, Utilization, And Quality. Health Affairs. Vol. 31, No. 9: Payment Reform to Achieve Better Health care. https://doi.org/10.1377/hlthaff.2012.0364
Akuh Adaji, Gabrielle J. Melin, Ronna L. Campbell, Christine M. Lohse, Jessica J. Westphal, and David J. 2018. Katzelnick. Patient-Centered Medical Home Membership Is Associated with Decreased Hospital Admissions for Emergency Department Behavioral Health Patients. Population Health Management. Vol. 21 Issue 3. printhttp://doi.org/10.1089/pop.2016.0189

## doh.sm.1115Waivers

**From:** Deshchenko, Olga [redacted]
**Sent:** Monday, November 4, 2019 5:26 PM
**To:** doh.sm.1115Waivers
**Cc:** Fiori, Anthony; Sherman, Megan; Lytle, James W.
**Subject:** PHP/MLTC-PACE Coalitions Comments on the NYS DSRIP Waiver Amendment Request
**Attachments:** PHP MLTC-PACE Coalitions Comments on NYS DSRIP Waiver Amendment Request.pdf



Good afternoon,

Please see attached the comments on the NYS DSRIP waiver amendment request from the PHP Coalition and the MLTC/PACE Coalition.

Please let us know if you have any questions.

Thank you.

**Olga Deshchenko**
Consultant, Manatt Health

**Manatt, Phelps & Phillips, LLP**
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November 4, 2019

**Submitted Electronically**

Donna Frescatore
Medicaid Director
Office of Health Insurance Programs
Department of Health
Empire State Plaza, Corning Tower
Albany, NY 12237

RE: Comments Regarding the New York State Delivery System Reform Incentive Payment (DSRIP) Amendment Request

Dear Donna,

Thank you for the opportunity to comment on the New York State Delivery System Reform Incentive Payment (DSRIP) amendment request. I am writing on behalf of the Coalition of NYS Public Health Plans (PHP Coalition) and the NYS Coalition of Managed Long Term Care Plans and Programs of All-Inclusive Care for the Elderly Plans (MLTC/PACE Coalition).

Established in 1995, the PHP Coalition is an important voice for New York's public program-focused health plans and their members. The PHP Coalition represents nine health plans serving more than four million individuals in New York's Medicaid Managed Care, HIV Special Needs Plan (HIV SNP), Child Health Plus, Health and Recovery Plan (HARP), Essential Plan and Qualified Health Plan programs—approximately two-thirds of all of adults and children enrolled in these programs across the State.

The MLTC/PACE Coalition represents 15 public program-focused managed long term care plans that serve elderly or disabled Medicaid beneficiaries. MLTC plans provide the full array of long term care services, ranging from personal care to nursing home care, for a fixed per-member-per-month payment through a variety of different products. These plans provide access to quality long term care at a fraction of the cost of institutional care, while also achieving high rates of patient and family satisfaction.

The foundation of plans' partnership with the State is rooted in the shared value to provide the best possible care to New Yorkers. Managed care organizations (MCOs) are active participants in the efforts to improve outcomes and drive value in the Medicaid program. Plans look forward to continuing their partnerships with the State, providers, and other stakeholders to build on the accomplishments of the initial DSRIP waiver. The comments that follow reflect plans' feedback related to the proposed design approach for the next phase of DSRIP and provide recommendations for advancing the State's vision to create an integrated healthcare system that improves the quality of care, advances population health, and reduces costs.

**Value-Driving Entities**

NYS proposes to establish Value-Driving Entities (VDEs) to lead the implementation of the high priority, DSRIP promising practices and other interventions in high priority areas identified by the State during

the DSRIP extension period. MCOs appreciate the State's recognition of their critical role as active partners in the next phase of the program and have several comments related to the structure and governance of these new entities.

First, VDEs will need ample time to establish community partnerships and programs in order to successfully launch. Performing Provider Systems (PPSs) were given time to form and work through governance issues; it's unclear if VDEs will have similar opportunities to build such capacity. The concept paper provides little detail around expectations for VDEs' contractual relationships with the State, plans, providers, community-based organizations (CBOs), and other entities. Without a clear understanding of how VDEs will differ from PPSs, plans are understandably concerned about the potential of these new entities to disrupt the existing provider and PPS relationships they've worked so hard to build.

Second, while MCOs welcome the opportunity for deeper engagement in the next phase of DSRIP, participation in the VDE governance carries plan business implications and competitive market dynamics in need of thoughtful consideration. It's unclear how the State envisions plans in the same region to collaborate through the VDE framework. Having multiple plans involved in the same governance structure could be challenging for all stakeholders. It's difficult to assess the true value of the proposed structure without a comprehensive understanding of the administrative and contractual complexities it may present in practice. Plans welcome further dialogue with the State on this requirement.

Lastly, it's important that VDE requirements and expectations are developed to promote broad participation among MCOs. NYS should be intentional about structuring the framework so that it stands to benefit and encourage participation from plans of all types and sizes throughout the State. In addition, NYS should be mindful of existing relationships between plans and providers, many of whom may participate or lead a VDE. Disrupting existing contracts, particularly those with VBP depth, for the sake of implementing a new program, should be avoided if possible.

**Social Determinant of Health Networks**

The State proposes that newly-formed Social Determinant of Health Networks (SDHNs) drive the delivery of SDH interventions. As the entities responsible for managing the outcomes, quality and costs of care for their members, plans are fully supportive of advancing such interventions. However, more detail is needed on how SDHNs would be formed and managed, how the funding would flow, and what the contractual arrangements would look like for all of the participants.

The State's proposal outlines several responsibilities for the lead SDHN applicants under the new framework, including the expectations to "formally organize CBOs to perform SDH interventions" and serve as a "single point of contracting for VBP SDH arrangements." Similar to the issues associated with the creation of VDEs, plans want to better understand how SDHNs may impact their existing relationships and VBP arrangements with SDH providers and the administrative complexities that arise with the formation of new entities.

SDHN applicants would also be responsible for coordinating regional referral networks, as well as assessing and referring Medicaid beneficiaries to needed interventions. The State should consider investing in supports to build such capacity at the plan level, as managing networks, assessing members' needs, and referring them to needed services are at the core of plans' expertise. Additionally, Medicaid beneficiaries would be best served by the member-centric entities with which they already interact with

and trust, particularly if that member has a care manager in the plan or is currently in a managed long term care product. Where possible, NYS should leverage MCO core competencies to drive efficiently toward goals on quality and outcomes, rather than increasing administrative complexity and potentially consumer confusion in the next phase of DSRIP.

**Long Term Care Reforms**

Plans fully support the State's intent to prioritize efforts that improve care for members with long term care (LTC) needs, including those individuals dually eligible for both Medicare and Medicaid. As NYS recognizes in its proposal, these populations didn't benefit directly from the initiatives of the original DSRIP waiver; thus, the next phase presents a significant opportunity to improve outcomes for these Medicaid beneficiaries by leveraging MLTC, MAP, and PACE programs across the State. Plans are interested in learning more about the State's expectations for advancing VBP arrangements in the MLTC program, given that the savings that result from reducing hospitalizations do not accrue to the plan, as well the "new managed care delivery models" for LTC referenced in the concept paper.

NYS should consider establishing dedicated LTC-VDEs for beneficiaries with LTC needs with members attributed to those providers with which they interact the most. Building off NYS' MLTC VBP program and the VBP Innovator Program for the MLTC subpopulation, the LTC-VDE would bring together organizations and providers with expertise in intensive care coordination, personalized care management, and home- and community-based care. This population has far more frequent engagement with LTC providers than with health homes or primary care providers. For example, personal care aides and other home care providers—staff on the frontlines of care for these individuals—are among the first to observe changes in condition and are key to preventing hospitalizations in this population. The home health workforce could also be instrumental in supporting the identification, documentation, and facilitation of SDH interventions. With a notable track record in managing services for these vulnerable target populations, MLTC, MAP, and PACE programs are best equipped to drive improvements in their overall care.

The State should also consider establishing VDEs that focus on dual eligibles. Given the goals to fully integrate care for this complex population on both state and federal levels, the State should utilize PACE and MAP plans to improve quality and outcomes and reduce potentially avoidable hospitalizations. While the State has struggled to engage the Centers for Medicare & Medicaid Services (CMS) in developing a value-based initiative for the duals population, these integrated plans are uniquely positioned to achieve the State's goals, as they are responsible for providing and managing all Medicare and Medicaid benefits. NYS should also explore developing shared savings partnerships or other incentives that would reward the State, its Medicaid payors, and providers for Medicare savings attributed to Medicaid spending.

**Workforce Development**

Plans appreciate the State's attention to the workforce issues in the long term care sector. MCOs support efforts to further workforce initiatives, including subsidies, stipends, loan forgiveness programs, and the continuation of the MLTC Workforce Investment Program for the critical staff that directly supports our aging population. Prioritization of funding for MLTC-provider training partnerships that can demonstrate outcomes and drive value through VBP models is also essential. As part of the funding sought by the State for these efforts, NYS should also consider making funding available for expanded didactic skills-based education for nursing staff new to the field of home care.

**Other Considerations**
Successful partnerships and coordination across the care continuum hinge on the availability of reliable data. While plans appreciate the inclusion of the State's regional health information organizations into the proposed VDE structure, other strategies should also be considered to maximize meaningful data exchange in the next phase of DSRIP. For example, sophisticated data tools used by plans today are an untapped resource that can be leveraged by providers and other partners to gain a more comprehensive picture of their attributed populations. Given their critical role in advancing DSRIP initiatives, NYS should dedicate IT infrastructure funding support specifically for behavioral health providers, care management entities, and CBOs.

The State should also consider the implications for the waiver approval in light of the recent guidance issued by CMS on budget neutrality for section 1115 waivers. Prior to this policy, states with longstanding 1115 waivers could amass sizeable savings by continuing to trend forward base data used during the initial approval, using those savings later to fund waiver pools to support delivery system reform and other investments. For states with longstanding waivers such as New York, these policies could sharply limit the amount of savings states can accrue across multiple waiver terms, restricting those states' ability to reinvest savings in their delivery systems or support other programs.

As the State acknowledges in its proposal, stakeholders have long advocated for additional flexibility to achieve meaningful and sustainable reforms in DSRIP. A less administratively prescriptive approach would allow plans and provider entities to develop strategies that make the most sense for a given region and subpopulation. With this recognition in mind, plans encourage the State to rethink its approach in measuring success in the next phase of the program and ensure that all participating stakeholders have an equal share in the accountability for achieving outcomes.

The Coalitions appreciate the opportunity to comment on the DSRIP amendment waiver proposal and look forward to continued engagement with the State, providers, and other stakeholders.

Thank you.

Sincerely,

Anthony J. Fiori

CC: PHP Coalition CEOs
MLTC/PACE Coalition CEOs
James Lytle
Megan Sherman

## doh.sm.1115Waivers

**From:** Indu Gupta [redacted]
**Sent:** Monday, November 4, 2019 5:27 PM
**To:** doh.sm.1115Waivers
**Cc:** [redacted]
**Subject:** 1115 Public Forum Comment



**To**: Ms. Donna Frescatore,
State Medicaid Director Office of Health Insurance Programs,
NYS Department of Health Corning Tower, Albany, NY 12237

**Re: Delivery System Reform Incentive Payment (DSRIP) amendment request : Public Comment**

Dear Ms Frescatore:

The goal of the DSRIP program has been to promote community–level collaboration with an aim to reduce avoidable hospital use by 25% percent over the five–year demonstration period by the means of through innovative projects across three domains:
1. System transformation,
2. Clinical improvement, and
3. Population health improvement (based on the New York State Prevention Agenda).

I applaud the work done by various Performing Provider Systems (PPS) in the New York State (NYS), including in Central New York (CNY) by the Central New York Care Collaborative (CNYCC), resulting in multiple projects in many communities throughout State which has increased connectivity and collaboration.

We know that our health is impacted by where we are born, live, go to school, play, socialize and work. Simply put – our zip code is better predictor of health than our genetic code. It is a fact that only 20% of the factors related to access to and quality of healthcare impact the health of a person. The other 80% are due to factors related to social, economical, behavioral and environmental factors – such as trauma due to violence; discrimination due to race, sex, gender, sexual orientation, language; geography; poverty; housing; nutrition; transportation; physical activity; and drug and alcohol use, just to name a few.

Why is this context important for DSRIP? You can treat a diabetic foot ulcer of a homeless person or repeated attacks of asthma of a child, reverse opioid overdose, treat an acute mental health crisis or repeated congestive heart failure (CHF) of an elderly person living alone in a well-controlled setting of a health system, but their real life starts after they are discharged from the hospital or a doctor's office, leaving the four walls of the 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 a good start in the long road towards changing the way many people think about health. Health is not equal to health care. The World Health Organization's definition of health from 1948 remains true today – the dynamic state of physical, social and emotional well-being, not merely the absence of disease.

As NYS is planning for the next 4 years, I truly appreciate the opportunity to express some thoughts regarding future work to protect and improve the health of our community one person at a time.

As an internal medicine physician who took care of patients for more than 20 years in inpatient, outpatient and even nursing homes settings, I know first-hand that medical education and health systems are not prepared and equipped to address factors beyond the four walls of their institutions. My primary goals was and should be to provide the best care possible care during the most vulnerable time in my patient's life. For that I relied on the health system. Therefore, I agree that investment in the "System Transformation and Clinical Improvement" during the current DSRIP cycle to improve health systems was a thoughtful choice.

Now as the Commissioner of Health of Onondaga County, I am representing a health department whose mission is to protect and improve health of all the county residents by working collaboratively with all stakeholders to address those 80% of factors impacting health with the principles of "Health Equity" and "Health Across All Policies."

Therefore it is logical for me to focus on the third domain of the DSRIP program committed to address population health improvement based on the New York State Prevention Agenda. This is a natural fit for a local health departments like ours. Our work with through our Community Health Assessment and Improvement Plan (CHA/CHIP) is guided by the Prevention Agenda and addresses the very complex maze of the social determinants of health (SDH) through partnerships with the health systems, community based organizations (CBOs), and the community. We have a laser focus in improving health outcomes for all county residents, but especially those who are considered high need and high risk.

Based on this brief background, I would like to provide two recommendations for the next cycle of DSRIP program, if funding becomes available:

1. Consider a focus on population health by shifting the focus from projects to policy changes that address system changes for better return on investment (ROI) and sustainability.
2. **The most important recommendation** is for the work related with the third domain of DSRIP identified as population health improvement through the prevention agenda, and NYS efforts to align with the CMS goals to address substance use disorder (SUD) and the opioid crisis; reducing ED visits, readmissions; and addressing SDH especially in reducing maternal mortality and improving children's health. This is true public health work. A funded collaborative will expand the work of LHDs. It is a natural fit as we have established relationships with all stakeholders, from the health systems, regional health information exchanges (HIE) as Qualified Entities (QEs), community based organization, other county agencies such as social services, children and family services, law enforcement, probation corrections, behavioral health and community providers, and the community itself to work in all the 5 areas of NYS Prevention Agenda 2019-2024. This joint collaborative will avoid duplication, increase efficiency and reduce waste. As an accredited local health department, we are considered "the Chief Health Strategist" of the our community based on our technical expertise, data, trust, and commitment to constantly invest in our community to improve the health of all. I believe LHDs are the bridge between the community and the health systems and are a leader to direct community wide changes to address 80 % of factors responsible for impacting health outcomes. With strong performance management (PM) and quality improvement (QI) programs, we are in a strong position for to demonstrate accountability, continuous improvement and long term sustainability of the work post DSRIP when it sunsets beyond the lifespan of DSRIP.

The next step of the DSRIP should build on the successes of past, address the identified gaps and include a pivotal role for local health department like ours.

Sincerely,
Indu Gupta

Indu Gupta MD,MPH,MA,FACP
Commissioner
Onondaga County Health Department
421 Montgomery Street, 9th Floor
Syracuse, NY 13202
[redacted]
Website: www.ongov.net/health/index.html

## doh.sm.1115Waivers

**From:** Heidi Siegfried [redacted]
**Sent:** Monday, November 4, 2019 5:35 PM
**To:** doh.sm.1115Waivers
**Subject:** 1115 Public Forum Comment"
**Attachments:** 2019-11-04.comments on 1115 waiver.doc



Please find our comments attached and below. Thank you for your attention in this matter.

Heidi Siegfried, Esq.
Project Director
New Yorkers for Accessible Health Coverage
Health Policy Director
Center for Independence of the Disabled, NY
841 Broadway, Suite 301
New York, NY 10003
[redacted]
www.cidny.org

RE: New York's Medicaid Redesign Team Waiver
1115 Research and Demonstration Waiver
#11-W-00114/2

To NYSDOH Office of Health Insurance Programs:

Thank you for the opportunity to comment on the Medicaid Redesign Team Waiver Amendment Request.

CIDNY's goal is to ensure full integration, independence and equal opportunity for all people with disabilities by removing barriers to full participation in the community. CIDNY helps consumers understand, enroll in, and use private and public health programs and access the care and long term care they need in all settings – hospitals, nursing facilities, and in their homes. We help people access home care, durable medical equipment, and home modifications so that they can maintain their independence in the community rather than being forced to get institutional care in a nursing facility. We help people in residential facilities return to the community. We also receive and address complaints about care and treatment in nursing homes, hospitals, in physician offices, and in the community.

The PowerPoint slides created for Public Comment days states that one of the goals of the waiver is to improve access to health care for the Medicaid population. The experience of the population we serve has been reduced access to care under the current 1115 waiver.

**Medicaid Global Cap**

This cap based on the 10 year rolling average of Medicaid inflation has essentially had the effect of block granting our Medicaid program, something New York would protest if imposed on us by the Federal administration, and we believe it is time to reassess its continuation.

Former Medicaid Director Jason Helgerson identified two big cost drivers for the Medicaid Program: Pharmacy and Long Term Care. As far as we have been able to see, the method of addressing Pharmacy costs of identifying high cost drugs and negotiating with the pharmaceutical companies to achieve additional savings has not reduced access to live saving drugs for the people we serve. The same cannot be said of long term care.

**Medicaid Managed Long Term Care**

The concept of achieving the triple aim (improving quality of care, improving health outcomes & reducing costs) by providing better coordinated health care services by requiring dual eligibles to select a Managed Long Term Care (MLTC) Plan has not worked out the way it could have. Managed care plans actually take public dollars out of the system through the administrative, marketing, and other expenses allowed in the Medical Loss Ratio and achieve savings by denying and reducing care – particularly in the area of home care hours. Those Plans that did not adopt this model have had to leave the market. Our years of struggles to get a high needs rate cell or some other form of risk adjustment have not succeeded. If managed care plans have slowed Medicaid inflation, it is by rationing access, cutting services, and tying up patients in endless red tape, not by effective care coordination

I was just talking last week to a consumer whose Plan wanted to reduce her from 24 hours of home care to 4 hours in the morning and 4 hours at night. This person has to be turned every two hours at night to avoid pressure sores. The Administrative Law Judge was quite impressed that she showed up on a rainy day for her hearing and she told him that this was just too important not to. The thought that NYSDOH is contemplating some form of removing this important due process protection is inconceivable. This consumer has also traveled to Albany numerous times with us to tell legislators how important her access to adequate care, physical and speech therapy, and complex rehabilitation technology are to her well-being, but now she cannot since the Plan has complied with the decision by giving her 3 eight hour shifts a day which does not allow for a day long Albany trip.

**Managed Long Term Care Partial Capitation Plans - Nursing Home Benefit**

The PowerPoint slides created for Public Comment days state that DOH is continuing to work with CMS to modify the partial capitation long term plan benefit (MLTCPC) package to include only 3 calendar months of permanent nursing home care for individuals who are permanently placed. CIDNY continues to oppose this change as it incentivizes Plans to put high needs people into nursing facilities in order to get them off their caseload. This is completely contrary to CIDNY's mission to help people maintain their independence in the community.

We also oppose the amendment would allow a member to switch from one MLTC plan to another MLTC within a 90-day grace period following enrollment, but not permit MLTC plan switches for the remaining 9 months of the year unless a good cause exception is granted. Enrollees cannot always know at the time they are making a Plan choice what network providers, durable medical equipment, or other care may be needed that they will be unable to access through their plan. The best solution when they encounter a lack of access like this could be to switch Plans and they need to have this solution available to them to access the right care.

**Supportive Housing**

The PowerPoint slides created for Public Comment days state that federal financial participation in supportive housing services is under discussion with CMS. CIDNY would like to bring to your attention that wheelchair users seeking supportive housing have had difficulty getting placed and we hope that any future contracts could rectify this.

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CIDNY's consumers were dismayed to learn of the adoption of a Medicaid Design Team proposal to place an arbitrary limit on Physical Therapy, Occupational Therapy, and Speech Therapy in Medicaid. For more than five years our consumers have traveled to Albany to tell legislators that arbitrary visit limits do not make sense and discriminate against people with disabilities. One of our consumers decided not to even begin physical therapy for a hand condition because she knew that 20 visits would not begin to treat it. Another consumer had her neck lock shortly after her PT visits were discontinued. A consumer with osteoarthritis of the spine back and knees told us that her physical therapy is often over

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Any misguided attempt to seek savings at the expense of individuals' ability to avoid pain, recover from surgery, and prevent physical decline will harm enrollees. It can result in the need for more expensive treatments like surgery and prescription medications that do not have arbitrary limits. All services for all Medicaid enrollees should be based on medical necessity so that health care consumers can participate fully in daily life, maintain their health and independence.

**DSRIP waiver renewal**

Despite our concern with how savings have been achieved in the Medicaid program to date, we do agree that investments must be made in workforce development and social determinants of health (SDH) and that a focus on Long Term Care is needed. We hope that a CBOs with the expertise needed to address these would be included to a greater degree.

Again, thank you for your attention to these comments and to those of our colleagues.

CID-NY

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**Center for Independence of the Disabled, NY**

November 4, 2019

RE: New York's Medicaid Redesign Team Waiver
1115 Research and Demonstration Waiver
#11-W-00114/2

To NYSDOH Office of Health Insurance Programs:

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Again, thank you for your attention to these comments and to those of our colleagues.

Sincerely,

Heidi Siegfried, M.S.W., J.D.
Health Policy Director

## doh.sm.1115Waivers

**From:** Judith Watson [redacted]
**Sent:** Monday, November 4, 2019 5:33 PM
**To:** doh.sm.1115Waivers
**Cc:** Kassandra Bonilla; Latisha Glover; Mirella Pachot
**Subject:** FW: DSRIP / Mount Vernon Neighborhood Health Center Network
**Attachments:** scan0038.pdf



Hello, please see the attached comments regarding DSRIP 2.0 for the Mount Vernon Neighborhood Health Center Inc. Please direct any further communications to my direct attention. Thanks much.

**Judith Watson RN, BSN , MPH**
**Chief Operating Officer/ Interim CEO**
Mount Vernon Neighborhood Health Center, Inc
107 West Fourth Street
Mount Vernon , NY 10550
[redacted]

***Mount Vernon Neighborhood Health Center***
***Greenburgh Health Center***
***Yonkers Community Health Center***
***Women's Premier Obstetrics***
***Coachman Family Center***
***Grasslands Homeless Shelter***
***School Based Health Center at Williams Elementary School***
***School Based Health Center at Mount Vernon High School***
***Mobile Express***

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**From:** Joe Gonzalez [redacted]
**Sent:** Monday, November 04, 2019 3:32 PM
**To:** 1115waivers@health.ny.gov
**Cc:** Judith Watson [redacted]
**Subject:** DSRIP / Mount Vernon Neighborhood Health Center Network

Dear Sir / Madam,

Please find attached our comments regarding DSRIP round 2, should you have any questions please feel free to call me.

Many Thanks

Joseph Gonzalez
Chief Business Officer
Mount Vernon Neighborhood Health Center
107 West Fourth Street, 2nd Floor

Mount Vernon New York 10550
[redacted]

Mount Vernon Neighborhood Health Center, Inc.

BOARD OF DIRECTORS
Barbara Anderson
*Chairwoman*

Judith Watson, RN, BSN, MPH
*Interim Chief Executive Officer*

Monday November 4, 2019

Dear Sir / Madam,

Mount Vernon Neighborhood Health Center Network is grateful for the opportunity to provide comments on the Delivery System Reform Incentive Payment (DSRIP) Amendment Request concept paper published on September 17th. The MVNHC Network consists of three federally qualified Joint Commission accredited community health centers located in Mount Vernon, Southwest Yonkers and Greenburgh/White Plains. Health Care services are also provided at two homeless shelters in Westchester and two school-based Health Centers in Mount Vernon. The Center was one of the first community health centers to receive accreditation with commendation by the Joint Commission. The Center is accredited as a primary Care Medical Home. The Health Center was established in 1973 and provides comprehensive, patient-centered health care services to approximately 56,326 registered patients annually and 127,082 annual encounters. The ethnically diverse staff of 350, is committed to meeting the community's medical and dental needs through the provision of comprehensive, quality and affordable health care. Mount Vernon Neighborhood Health Center Network commends the State's work in the first round of DSRIP to reduce costs, improve patient outcomes, and decrease unnecessary inpatient and emergency room utilization. For New York to experience a real transformation of the health care delivery system and sustain the gains thus far achieved through DSRIP, there must be a significant investment in community-based primary care. Only through this investment can the State achieve a true value-based system that improves health outcomes and reduces costs. Mount Vernon Neighborhood Health Center Network supports the renewal of the DSRIP program through March 31, 2024. Mount Vernon Neighborhood Health Center Network, a member of the Community Health Care Association of New York State (CHCANYS), supports the comments submitted by CHCANYS and has restated and revised many of their points below.

## I. Driving Promising Practices to Improve Health Outcomes and Advance VBP

By mission and in statute, health centers serve the State's most vulnerable and hard to reach populations. FQHCs are non-profit, community run centers located in medically underserved areas that provide high-quality, cost effective primary care, including behavioral and oral health services, to anyone seeking care. Each FQHC is governed by a consumer-majority board of directors who are tasked with identifying and prioritizing the services most needed by their communities, 39% of our 56,326 patients in 2018 were enrolled in Medicaid or CHIP.

Accredited
Joint Commission
on Accreditation of Healthcare Organizations



107 West Fourth Street • Mount Vernon, New York 10550 • (914) 699-7200 • Fax (914) 699-0837

Our eight sites located in in Mount Vernon, Southwest Yonkers, Greenburgh/White Plains and Westchester area provide access to comprehensive primary care services, especially among populations that are most likely to present at the ED with a non-urgent or avoidable condition. In the first round of DSRIP, we participated in WMC Health Performing Provider Systems (PPS). In conjunction with WMC Health PPS we have integrated behavioral health into our internal medicine department, every patient is assessed for depression and the Behavioral health team is activated as needed. We have improved patient engagement in our Diabetic population through education and community outreach. We have also decreased ER visits and admissions through our transition of care coordination team which assist patients with follow up care, appointments, referrals and connecting the patient to enabling services as needed.

The first round of DSRIP complemented the health center model's unique and innate ability to provide comprehensive and innovative care to New York's Medicaid beneficiaries. Health centers played and continue to play a key role in advancing the promising practices within their regions and driving improved health outcomes. In the second round of DSRIP, health centers are well-prepared to take a leadership role to advance the State's vision of an expanded value-based payment (VBP) landscape driving DSRIP promising practices.

## II. Embracing the Role of VDEs

We are pleased to see that the State has acknowledged the need for additional flexibility in the next round of DSRIP and is interested in ensuring the success of Value-Driving Entities (VDEs). However, we encourage the State to provide direct investment in community-based providers. Currently, 23 of 25 of the PPS leads are hospital-based, with no specific requirements about how funds flow to partners in the PPS networks. Meaningful governance participation by community-based providers, such as community health centers and community behavioral health organizations, and downstream investments to health centers and other community-based providers varied greatly from PPS to PPS. Using publicly available data reported by the State, it is extremely difficult to determine the amount of money received by health centers in the first round of DSRIP – they are included as "clinics" with hospital ambulatory providers. However, the most up to date data reported by the State in November 2018 demonstrates that hospitals received more than 28% of total funds flow while representing only 0.2% of total engaged PPS partners.[i] It is exceedingly difficult to transform the healthcare delivery system by continuing to invest most transformation dollars into inpatient-based care models, when it is the long-standing established CHC providers and workforce that can make the biggest impact on patients' health outcomes. CHCs are especially well-posed to integrate care, make connections to address social needs, and become the more adept and agile VDEs envisioned in the State's concept paper.

We support the State's charge that VDEs include providers, community-based organizations (CBOs), and managed care organizations (MCOs) to leverage VBP and advance promising practices. A collaborative partnership between community-based providers, CBOs, and MCOs is critical to implementing and supporting transformative initiatives that move away from a volume-driven care model. However, to support improved access to care in the community and reduce reliance on emergency departments and inpatient care, the State must direct additional resources to a broad range of community-based providers. Mount Vernon Neighborhood Health Center Network requests **that the State dedicate, at a minimum, 25% of DSRIP funds to the development of community-based VDEs where CHCs, in collaboration with other community-based providers, are leads.**

### a. VDE Lead Entities

The State should capitalize on existing health center Independent Practice Associations (IPAs) as a launching point for the creation of community-based VDEs. There four CHC-led IPAs currently organized across the state, Community Health IPA (CHIPA), Safety-Net IPA (SIPA), Finger Lakes IPA (FLIPA), and Upstate Community Health Collaborative IPA (UCHC), are engaged with MCOs in at least one VBP contract while working on additional agreements. We are seeking to become members of the Community Health IPA (CHIPA). We believe that IPAs are well positioned to work with other entities as a VDE in the second round of DSRIP.

While health centers like ours are already developing relationships needed to advance in VBP contracts, a second round of DSRIP is an opportunity to invest in building capacity to ensure health center and CBO IPAs have the foundation to serve as VDEs. Currently, health center-led IPAs are self-funded and have little financial capacity to support many of crucial functions that would accelerate their successful participation in VBP arrangements. **Health center-led IPAs require DSRIP investment to support the data analytic capabilities needed to effectively manage population health and drive improved outcomes.**

### b. Considerations for Engaging MCOs

Mount Vernon Neighborhood Health Center Network is pleased that the State is taking steps to ensure engagement of MCOs early in the planning process for a second round of DSRIP. However, there are significant challenges that must be addressed ahead of the creation of VDEs. One of the current difficulties faced by providers as they seek to participate in VBP arrangements is a lack of comprehensive data about their attributed patients. **The State should create and enforce a uniform data sharing policy for the managed care plans to further support the transition to VBP, for example, by enforcing transparency in expenditures and utilization.**

In the first round of DSRIP, the discrepancies between MCO attribution and PPS attribution made it difficult for health centers to effectively manage patient health outcomes. PPS networks do not necessarily encompass the same providers that are contracted with a given MCO. If there are discrepancies between MCO attribution, consumer utilization, and PPS network, it becomes incredibly difficult, if not impossible, for the PPS to effectively manage health outcomes for these populations. PPS and VDEs should not be expected to manage the health care improvements of individuals who are enrolled in managed care plans that contract outside of the VDE. Mount Vernon Neighborhood Health Center Network **recommends that in the next round of DSRIP, VDE attribution should be aligned with MCO attribution to ensure seamless VBP contracting.**

Finally, we understand the State's desire to drive regional innovation – local health care needs vary based on geography, CBO and health care provider landscape, and other factors. However, we would like to raise the concern that in densely populated areas served by many MCOs with overlapping service areas (notably, New York City), defining distinct regions may prove difficult. **In New York City,** Mount Vernon Neighborhood Health Center Network **recommends that VDE networks should align with patient utilization patterns as much as possible.**

## III. Supporting Non-Clinical Workforce to Address Social Needs

Mount Vernon Neighborhood Health Center Network echoes the State's observation that many of the successful DSRIP initiatives rely on non-traditional, non-clinical workforce that help patients navigate clinical and social services systems to address their multi-dimensional needs. In the first round of DSRIP, we embraced the flexibility to address patients' social needs. At Mount Vernon Neighborhood Health Network, we screen patients for social determinants of health and address as needed in conjunction with our community partners. We have partnered with Feeding Westchester to provide healthy produce to our diabetic patients.

In the first round of DSRIP, the State encouraged primary care practices to become patient-centered medical home (PCMH) recognized. Today, 97% of New York's health centers are PCMH certified. PCMH certified practices provide mental health, oral health, and health promotion/disease prevention services through comprehensive primary care. This model of patient-centered care is associated with improved health outcomes and reduced costs and should be robustly supported in the second round of DSRIP. There are numerous studies that have analyzed the success of PCMH, including citing fewer specialty visits needed, lower per member costs, and better health outcomes amongst individuals seeing PCMH-certified providers.[ii]

As a result of our PCMH program we recognize that the adolescent population encounter stressors specific to that age group in turn leading us to change the way we assess depression in our adolescent units. Through our Diabetic programs and patient education, we have decreased our percentage of patients with A1c above 9 from 30% in 2017 to 22% in 2018. **The State should use a second round of DSRIP to continue investments in care management programs like PCMH and Health Homes to address patients' social and medical needs.**

## IV. Aligning Performance Measures

Mount Vernon Neighborhood Health Center Network strongly supports the State's desire to work with CMS to align performance measures across initiatives. Health centers' participation in Medicare, Medicaid, NYS PCMH, and contracts with managed care plans (among various other programs) requires a significant amount of resources invested in measure/data collection and reporting. **The State should target measures most likely to be of value for all participants in DSRIP 2.0.**

## V. Health Center Alternative Payment Methodology

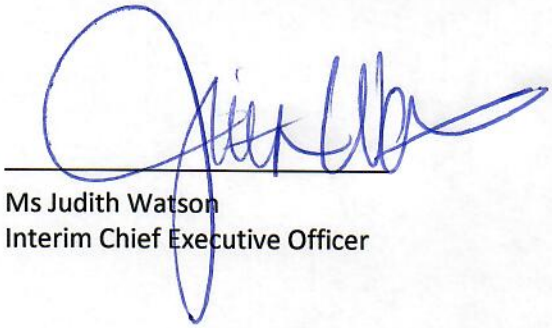
FQHCs embrace the State's transition of Medicaid payment from volume to value. Mount Vernon Neighborhood Health Center Network supports this direction and is also engaged in work with CHCANYS to move away from a visit based FQHC payment to a capitated FQHC Alternative Payment Methodology (APM). Federal statute permits states to implement an APM in lieu of the legally required prospective payment system reimbursement methodology. States must ensure that reimbursement under the APM is not less than it would be under the prospective payment system rate; however, adoption of an APM is essential to move FQHCs from a visit-based payment that incentivizes volume, to a payment methodology that rewards efficiency and outcomes. A capitated FQHC APM aligns with the State's DSRIP goals of advancing VBP and provision of enhanced care coordination.

An FQHC APM supports team-based, integrated care and enables CHCs the flexibility needed to create innovative approaches to care which can include non-clinical support staff who are not billable providers

under the prospective payment system rate. The creation of innovative care coordination workflows will improve care provided directly by FQHCs, therefore reducing costs across the health care system.

Mount Vernon Neighborhood Health Center Network looks forward to working closely with CHCANYS and the Office of Health Insurance Programs to establish a mutually agreeable approach that supports health centers' ability to transform their entire practice to a value-based care delivery model. Once the APM receives a federal approval, a small subset of health centers will transition from the prospective payment methodology to the APM. **To ensure the success of an APM, State investment is needed to enhance data collection capabilities and catalyze the development of new staffing roles, models for care teams, and innovative work flows.** These investments may include: enough funding to support interventions addressing patients' non-clinical social needs, support for an alternative payment learning community, clinical and cost data analyses, quality metric identification, and reporting mechanisms.

Mount Vernon Neighborhood Health Center Network has actively engaged in DSRIP implementation and contributed to many of the successes achieved. We look forward to continuing to partner with the State to achieve our shared goals of system transformation and improved patient care, better patient outcomes, and reduced care costs.



Ms Judith Watson
Interim Chief Executive Officer

## doh.sm.1115Waivers

**From:** Steve Moore [redacted]
**Sent:** Monday, November 4, 2019 5:46 PM
**To:** doh.sm.1115Waivers
**Cc:** [redacted]
**Subject:** 1115 Public Forum Comment - PSSNY
**Attachments:** PSSNY DSRIP Extension Written Comments - 11-04-2019.pdf



To Whom It May Concern:

Please see the attached comments from PSSNY in regards to the proposed 1115 Waiver.

Thank you!
--
Steve Moore, PharmD
PSSNY President

*If you think wellness is expensive, try illness.*

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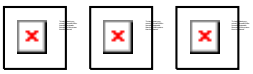
www.condopharmacy.com
[redacted]



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Pharmacists Society of the State of New York, Inc.

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November 4th, 2019

New York State Department of Health
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99 Washington Avenue
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Albany, NY 12210

Dear Department of Health:

On behalf of the more than 21,000 licensed pharmacists here in New York, and the soon to be nine schools of pharmacy, PSSNY would like to take this opportunity to advocate for an increased role for pharmacists in the proposed DSRIP extension. Studies have shown that Medicaid patients present to community pharmacies thirty-five times a year, versus four times for their primary care provider, uniquely positioning community pharmacists to work with New York and the Department of Health (DOH).[1]

In the spirit of the original DSRIP initiative, pharmacies have partnered with payers such as the DOH not only here in New York, but also throughout the country in Accountable Pharmacy Organizations (APOs) to provide value-based care in the community setting.[2] These pharmacy care management services have been proven to improve to increase adherence and compliance, optimize management of disease states, and prevent hospital readmissions.[3-5]

The original DSRIP initiative focused on system reform through community level collaborations to reduce avoidable hospital readmissions through value-based payment (VBP) methodology. While not specifically included in the original DSRIP program, pharmacists were able to work, albeit in an extremely limited capacity, with some of the various Performing Provider Systems (PPS).

DSRIP and DOH have previously recognized the role that pharmacists can play in managing polypharmacy and promoting compliance to both reduce adverse drug reactions and control costs through Medication Therapy Management (MTM). But, MTM is not all that pharmacists have done during the first round of DSRIP:

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- Pharmacists have come together to form accountable pharmacy organizations including independent practice associations (IPAs) under the guidelines and requirements of DOH.

- 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.

- Pharmacists have worked with other stake holders to implement transitions of care plans as patients move from one level of care to another.

- Pharmacists have worked with other stakeholders to share data in order to improve outcomes whether it be through eCare Plans, one of the state's Regional Health Information Organizations (RHIOs), or any number of other mechanisms that now exist.

- Pharmacists have worked to incorporate nonclinical staff including community health workers in the implementation of patient care plans.

- Pharmacists have worked with providers as Medicare explores alternative payment models (APM) such as MACRA and MIPS and are able to bring this experience to the DSRIP extension.

- Pharmacists have worked with the state to expand our scope of practice through emergency orders during viral outbreaks in order to administer vaccines to more at patients in at risk populations.

- Pharmacists have worked with state's Prescription Drug Take Back efforts to get unneeded medications out of homes and out of our environment.

Despite all that pharmacists have been able to accomplish, the profession of pharmacy remains under-utilized. It has been noted by DOH that current New York laws "… do not provide for the full spectrum of benefits that patients (including Medicaid members) could realize in terms of improving their health and quality of services received", and PSSNY supports the recommendations of DOH regarding Comprehensive Medication Management (CMM).[6]

Bringing CMM into the community pharmacy setting will serve as one mechanism for pharmacists to help New York meet the goals of the DSRIP extension. Allowing pharmacists to perform CLIA Waived, Point of Care Testing and permanently removing the sunset on the vaccination privileges of pharmacists would be examples of some others. As such, PSSNY encourages all DSRIP stakeholders to support initiatives that would allow for

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pharmacists to provide the care that we are trained and qualified to perform in order support the DSRIP extension.

As previously mentioned, accountable pharmacy organizations exist and offer the new Value Driving Entities (VDEs) an existing workforce of highly trained, clinically oriented, health care professionals with ready access to patients. It is the contention of PSSNY that the VDEs should be required to contract with at least one accountable pharmacy organization that participates in the DSRIP extension for services related to both:

1. Optimize the judicious use of medications to achieve clinical outcomes and avoid medication-related adverse events; and

2. Advance coordination of care activities and patient screening for referral to Health Homes, Community Based Organizations, or other entities attempting to address Social Determinants of Health.

Accountable pharmacy organizations must be able to electronically document medication optimization, care coordination, care planning, and screening activities to share with the VDE and its related Qualified Entities, and the VDE must ensure that the accountable pharmacy organization is subject to Value-Based Payment opportunities that align with the VDE's Meaningful Measures.

High performing, outcomes focused, accountable pharmacy organizations will serve as a valuable partner to New York State as it attempts to meet the goals of the DSRIP extension. As such, PSSNY firmly believes that accountable pharmacy organizations and pharmacy care management services must be formally included in DSRIP extension if the State is going to sustain and expand on the promising practices identified the first round of DSRIP.

Respectfully Submitted,

Steve Moore

Steve Moore, PharmD

President

PSSNY
Pharmacists Society of the State of New York, Inc.

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## doh.sm.1115Waivers

**From:** Megan Ryan [redacted]
**Sent:** Monday, November 4, 2019 5:47 PM
**To:** doh.sm.1115Waivers
**Cc:** Mariam Shafik
**Subject:** ?1115PublicForumComment?
**Attachments:** Nassau University Medical Center DSRIP 2 0 Comments_DRAFT_10 30 19_Rev 11 3 19.pdf



Good afternoon:

Please find Nassau University Medical Center's ("NUMC") public comment submission attached. NUMC is the lead entity in the NQP PPS and the only public safety net hospital in Nassau County. We are eager to maintain and improve our participation in the continuation of the DSRIP program which is vital to the community that we serve.

Please contact me if you would like to discuss further.

Regards,

**Megan C. Ryan, Esq.**
***Executive Vice President***
***Chief Compliance, Privacy and Ethics Officer***
*NuHealth*
*2201 Hempstead Turnpike*
*East Meadow, NY 11554*
[redacted]

NuHealth
Together through life.
Nassau University Medical Center
A. Holly Patterson Extended Care Facility
Family Health Centers*

**NUMC Public Comment Submission**

Nassau University Medical Center (NUMC) appreciates the opportunity to submit the following comments regarding the DSRIP 2.0 Amendment Request. As the region's premier safety net hospital, NUMC, a tertiary care and teaching hospital with a Level 1 Trauma Center distinction, has a long history of serving the region's most vulnerable and underserved communities.

As such, NUMC has been tremendously supportive of the goals and objectives of the DSRIP program and has worked with the State and the Nassau Queens Performing Provider System (NQP) to implement the program in Nassau County to ensure its success. NUMC supports the State's focus on, and success in, reducing preventable hospital use while highlighting the importance of community-based partnerships to substantially improve primary care and behavioral health outcomes.

Highlighted below are just some of the successes that NUMC, to date, has been able to achieve through DSRIP initiatives, accompanied by comments:

## Behavioral Health

As the lead hub in the Nassau Queens Performing Provider System (NQP), the NUMC hub undertook several significant Behavioral Health (BH) initiatives, including contracting with five BH Community Based Organizations (CBOs). In an effort to bolster and augment BH Community Crisis Stabilization services as well as strengthen the Mental Health and Substance Use infrastructure in Nassau County, NUMC was able to collectively award over $1.46 million in funds. Below are some of the BH initiatives that were implemented during the latter half of the DSRIP program:

- Community Crisis Stabilization Services in outpatient treatment facilities at multiple locations through three different CBOs.
- Care Transitions Intervention programs with various BH CBOs that established linkages with NUMC, and continue to focus on reducing inpatient re-admissions and ED visits.
- A Recovery Support Services Center called "Thrive Nassau," which provides SBIRT and support services for patients in the Substance Use Disorder (SUD) recovery process, along with their family members.
- A Crisis/Respite Hospital Diversion, Peer Support program, in a self-contained home environment - "Turquoise House" - that houses up to three (3) individuals at a time for up to seven (7) days at a time.

Given NUMC's position as the region's key safety net hospital that treats a preponderance of the area's residents with Substance Use Disorders and other behavioral health conditions targeted by the State, and having demonstrated the ability to successfully implement key DSRIP initiatives to address and combat these conditions, NUMC has a great interest in maintaining a leading role in the Value-Driving Entity (VDE) that will ultimately represent this region in DSRIP 2.0 so that we may continue to expand upon our successes in these critical areas.

## Community-Based Primary Care Providers

The NUMC hub successfully engaged with community-based Primary Care Providers (PCPs), the majority of whom are safety-net providers, establishing connections to NUMC and educating these critical providers about the goals and objectives of the DSRIP program, including the importance of transforming their practices to align with DSRIP objectives, and the concept of value-based reimbursement relative to patient outcomes and costs.

With technical assistance provided by the NUMC hub, these primary care practices were able to achieve PCMH Level 3 Recognition and are now in various stages of achieving NYS PCMH Recognition. Many of the practices have already made the connection to their RHIO, Healthix, while others are in different stages of connectivity; all are actively working with NUMC to ensure appropriate care transitions. NUMC is proud to have created a culture of collaboration, continuity and accountability, leading to the success of these programs.

## LIFQHC Primary Care Expansion Projects

Long Island Federally-Qualified Health Center (LIFQHC), the area's largest safety-net Primary Care Provider, has been and continues to be NUMC's principal DSRIP partner. With NUMC hub/DSRIP specific guidance, LIFQHC has continually delivered outstanding results germane to DSRIP objectives, including engaging in "Promising Practices" that drove high performance results throughout the DSRIP program.

Examples include the use of data to develop chase lists for patient outreach; mobilizing care teams around targeted disease states; integrating primary care and behavioral health through behavioral health co-location in all clinics; obtaining MAT certification for providers to administer nalaxone in addressing the opioid crisis; significant increase in Home Health enrollment; employing Community Health Workers for asthma and diabetes care management; expanding mobile crisis teams in the communities, and developing relationships with CBOs that focus on Social Determinants of Health.

LIFQHC's mission, which is "to increase access to comprehensive primary and preventive health care and to improve the health status of the community, especially for the underserved and vulnerable," aligns well with NUMC's own mission of providing "the best possible care" to the region's most vulnerable patients. Together, our missions, goals and objectives are in line with DSRIP's goal of expanding the primary care footprint in underserved areas to improve outcomes and reduce utilization of potentially avoidable healthcare services.

In this vein, NUMC has awarded approximately $10.5M to LIFQHC in four separate contracts designed to expand Primary Care services in Hempstead, Uniondale, and Roosevelt, Long Island, as well as establish School Based Health Centers (SBHC) in three separate High Schools in Freeport, Westbury, and Uniondale, all areas designated by the State as "hotspots," or high needs areas, in need of comprehensive primary care services, and having a high utilization of hospital inpatient admissions and Emergency Department visits.

These projects are well underway and are expected to be completed within another year or so and LIFQHC intends to hire qualified staff from the communities in which the facilities operate. The four primary care expansion projects are briefly summarized below:

- **Hempstead Health Center** - In addition to Hempstead Health Center's standard primary and specialty care services, with this expanded access, also in Hempstead, will employ a geriatrician to assist with managing the needs of the senior population in the community and will add additional services such as podiatry, cardiology, dental, optometry, behavioral health and other needed services. When fully operational, this center is expected to serve approximately 6,000-7,500 people providing additional 20,000-24,000 visits annually.

- **Hicksville Health Center** - The Hicksville Health Center will provide primary and specialty care services as well as dental, behavioral health, and care management services to members of the Hicksville community and will employ a staff of approximately 25-28 FTEs when operational.

- **Roosevelt Family Health Center** – The Roosevelt Family Health Center's OB/GYN and Pediatrics, services will be expanded to accommodate growth within the community and the need for these services. The center's Dental services will also be expanded to meet the community's growing demand. Additionally, LIFQHC will also work with local pharmacies to offer onsite pharmacy services to their patients in an effort to improve medication adherence and improve outcomes.

- **School-Based Health Centers (SBHC)** – The three new SBHCs will provide comprehensive primary and preventive care, as well as acute and chronic care services, including mental health services and health education for children and adolescents enrolled in the schools along with referrals as needed.

  SBHC locations were determined based on local assessment of needs and resources, with establishment geared toward schools having students with the highest prevalence of unmet medical and psychosocial needs. Services will be made available only to the students enrolled in that school and will be provided at no out of pocket costs to those students who enroll in the SBHC with parental consent. Services will be provided by a multi-disciplinary team that is inclusive of, but not limited to a Nurse Practitioner, Mental Health Professional, Physician Supervisor, and Medical Assistant.

## Skilled Nursing Facilities

The NUMC hub has assisted in significantly improving the CMS Quality Ratings scores of the Skilled Nursing Facilities allocated to and engaged with the NUMC hub, through oversight of the INTERACT initiative. The facilities' scores were raised significantly from baseline scores averaging 3.5 to current scores averaging 4.8 on the CMS scale.

## Further Considerations for NUMC

Highlighted below are additional considerations for the execution of DSRIP 2.0:

- **Assessment Reports:** In order to further achieve NUMC's goals, we are requesting a requirement of Assessment Reports of the Nassau Queens PPS' strengths, weaknesses, outcomes and performance payments relative to the three hubs.

- **Support of DSRIP 2.0:** NUMC supports the State's position of extending DSRIP through the balance of the 1115 Waiver ending on March 31, 2021 and adding an additional three years of DSRIP beginning April 1, 2021 and ending March 31, 2024. For the reasons reported above, this will give providers in the current iteration of DSRIP an opportunity to complete implementation of the projects and put what they have learned in practice.

- **Gap Analysis:** We are requesting the performance of gap analyses around VDE priorities to determine where NUMC stands relative to our strengths and identified weaknesses. This analysis will identify how we can leverage our partnerships and resources as well as the opportunities inherent in DSRIP 2.0 to better serve our community.

- **Additional Staff:** In order to continue outreach to community-based providers, additional staff is needed. This will establish critical connections, especially with Community-Based Organizations (CBOs), to ensure better patient outcomes, care coordination, and appropriate referrals that address not only medical but also Social Determinants of Health (SDH). This will serve as the basis for NUMC's Integrated Delivery Network along with the LIFQHC providers and the hospital's employed physicians.

- **Opportunity Leverage:** NUMC intends to utilize and leverage opportunities within PPS structure and governance to begin to prepare for VDE application. This will build upon the experiences gained from working within the PPS to create a professional team comprised of individuals with expertise in Managed Care, Provider Network Development, Population Health Management, Business Development, Data Analytics, and Project Management that will assume the responsibility of working diligently with DOH to ensure successful implementation of DSRIP 2.0 as well as the operation of a VDE.

- **Work Groups:** As DSRIP 2.0 is developed, NUMC would recommend the establishment of workgroups in order to prepare for VDE high priority interests. Specifically, NUMC recommends these workgroups for the programs below:
    - Behavioral Health-adults/children
    - Maternal Mortality
    - Care Coordination/Transitions
    - Long Term Care

## doh.sm.1115Waivers

**From:** Kevin Muir [redacted]
**Sent:** Monday, November 4, 2019 5:52 PM
**To:** doh.sm.1115Waivers
**Subject:** EngageWell IPA MRT (1115) Waiver Public Comment
**Attachments:** EngageWell IPA DSRIP 2.0 Comments.pdf



Thank you for accepting our comments (attached) on the upcoming MRT Waiver amendment.

**Kevin Muir, MPA**
Executive Director, EngageWell IPA
www.engagewellipa.com

[redacted]
pronouns: he/him/his

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New York, NY 10018

ENGAGEWELL IPA
COMMUNITY HEALTH SOLUTIONS
FOR NEW YORK

November 4, 2019

NYS Department of Health
Office of Health Insurance Programs
Waiver Management Unit
99 Washington Avenue
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Albany, NY 12210

Re: EngageWell IPA DSRIP 2.0 Public Comment

Dear NYS DOH OHIP:

On behalf of the entire EngageWell IPA Network, I am grateful for the opportunity to submit comments on the proposed amendment to NYS MRT Waiver. The bulk of our comments are shared with the NYS Behavioral Health Care Collaborative (BHCC) attached. We would like to offer additional detail about our IPA as an example of the valuable partnerships and collaborations that have formed among community-based behavioral health providers in response to NYS and CMS's goals to transform our Medicaid program. The EngageWell IPA is a strong example of the essential role *existing* networks of providers could play in emerging Value Driven Entities. Given our strength and focus on addressing the social/political determinants of health, EngageWell is also well positioned to become a lead Social Determinants of Health Network were the definition to be expanded to allow it.

EngageWell is a uniquely positioned network of 18 nonprofit agencies offering community-based primary and behavioral health care through FQHC/CHCs, licensed behavioral clinics, Medicaid-waiver harm reduction services, Health Home care management and social/political determinants of health services. Created in 2018 with a $2.58M NYS Behavioral Health Care Collaborative (BHCC) Value Based Payment (VBP) Readiness Program, EngageWell's strength is improving health outcomes and cost-of-care for Medicaid's most marginalized and vulnerable beneficiaries - people with HIV/AIDS, active substance users, individuals who are homeless or unstably housed, and others. The IPA serves >30,000 Medicaid members with behavioral health conditions and nearly 20% of NYC's Medicaid beneficiaries with substance use disorder.

In 2019, EngageWell was 1 of 3 networks selected in a national search to participate in Nonprofit Finance Fund's (NFF) ARCH Initiative funded by the Robert Wood Johnson Foundation. ARCH helps nonprofit CBO networks develop new contracts, payment models and partnerships with large healthcare organizations to achieve better health outcomes. NFF, EngageWell and leading Medicaid Managed Care plans, including existing partners Health First and Amida Care, are implementing existing contracts while developing several innovative VBP pilots.

Our IPA's name emphasizes our strength, which is our ability to *ENGAGE* marginalized populations into integrated service pathways that will advance the quality and reduce the overall cost of their health care. The providers in our network have a long history of supporting these populations. Early in the AIDS epidemic 30+ years' ago, our providers recognized the importance of addressing the social/political determinants of health (SDOH) and invested significant time and money into developing a robust SDOH-infrastructure. Today, EngageWell members provide food/nutrition, housing placement, job training/adult education, childcare,

free legal advice, among other life-saving services, to thousands of low-income New Yorkers. More importantly, when integrated with the other medical and behavioral health services our providers offer, these SDOH services, enable clients to live longer, healthier, and more stable lives.

EngageWell focuses SDOH evidence-based practices and has been meeting with principle investigator(s) of the *Community Health Advisory & Information Network (CHAIN)* from Columbia University's School of Public Health. CHAIN study investigators have been surveying cohorts of PWHA in NYC for decades. Analysis of their CHAIN Study shows that two key social determinants of health (SDOH) are associated with poor engagement in HIV care and failure to achieve or sustain viral suppression: food insecurity/poor nutrition and housing instability (homelessness or unstable, inadequate or unaffordable housing). EngageWell has used the CHAIN study data to design a care coordination model that prioritizes food/nutrition and housing stabilizations services as interventions for unsuppressed PWHA. We believe similar demonstration projects in the future may reflect similar results for individuals with significant behavioral health needs.

The IPA has come a long way in the last two years in developing our infrastructure, including:

- Developed an ***IT infrastructure*** that provides a forward-looking, HIPPA- compliant IT environment;
- Created ***Data Sharing/Security*** and privacy documents that outline the IPA's compliance policies and procedures and member/provider standards;
- Extensively researched ***Shared IT Platforms*** and other tech-based solutions that will ensure successful execution of and performance in VBP contracts;
- Gained access to the leading behavioral health ***Data Source***, PSYCKES, a portfolio of tools that supports our quality improvement and clinical decision-making by allowing us to review quality reports at the state, region, county, agency, site, program, and clienchain study housing
- t level; and use this data to inform treatment planning;
- Worked with Healthix to explore how this Qualified Entity (QE) in NYC can support EngageWell's IT and ***Data Analytics*** needs;
- Developed population- and patient-level ***Performance Dashboards***, which are updated quarterly, and include a summary view of high-cost, high-acuity data for target populations;
- Completed due diligence in the selection of a closed-loop ***Referral Software*** platform that will provide screening with decision support, electronic referral management, assessment and care plan management, bidirectional communication and alerts, and outcome tracking;
- Explored ***VBP-relevant Technology Platforms*** that will support our performance inside VBP arrangements;
- Developed and implemented uniform ***Quality Management & Assurance*** standards designed to improve the quality and efficacy of services delivered by providers participating in the IPA network; and
- Developed core ***Policies & Procedures***, guided by the work of EngageWell's committees that were established over the course of the last two years (Finance Committee, Program Innovation Committee, Quality Committee, and Data/IT Committee).

While the work above constitutes a significant part of achieving clinical and financial integration, EngageWell also developed a Participating Provider Agreement (PPA). The PPA provides certain procedures and standards that apply to all EngageWell members and any other Providers interested in participating within EngageWell's network for the purposes of contracting with managed care organizations (MCO), whether directly or indirectly, including through contracts with other health care

delivery organizations contracting with an MCO, such as other IPAs or accountable care organizations (ACO).

EngageWell executed three contracts with managed care plans, including one with Amida Care for waivered harm reduction services, and two for Adult Behavioral Health HCBS Infrastructure Funds (*totaling $1.6 million with Healthfirst and Empire*) for network capacity building and facilitating access to HCBS. EngageWell is also actively developing other contracts. EngageWell and Amida Care are close to contracting for care coordination and SDOH services for Amida Care's virally unsuppressed members.

EngageWell and Healthfirst are developing a pilot contract for enhanced substance use services, including members with opioid use disorder. As a sponsor of Amida Care Innovator Network (ACIN) Innovator Accountable Care Organization (IACO), EngageWell is developing a Level 1 VBP contract for substance use services, mental health treatment, care coordination, and SDOH services with an expected launch in 2020.

While we have made great progress in contracting, we continue to encounter significant barriers. An initial IPA contract takes a long time for both IPAs and MCOs to develop and execute, especially if it involves innovative service models, unique payment arrangements, and/or quality outcomes that drive payment. For example, EngageWell has been rigorously developing and negotiating with Healthfirst for its Enhanced SUD Intervention for many months, working in collaboration with Healthfirst to address foundational issues (e.g., quality metrics, the clinical model, workflows, and the reimbursement mechanisms).

Similarly, discussions with Amida Care for the HIV viral suppression pilot began in May 2019 and will likely continue through the end of 2019. The IACO Level 1 contract discussions with ACIN have also been ongoing for about a year. Some MCOs are entirely unwilling to contract with BH IPAs like EngageWell or are focused solely on TCOC VBP contracts within the primary care attribution model.

Our strongest path towards sustainability is through VBP contracting. EngageWell is working with Helgerson Solutions Group (HSG) and NFF to overcome some of the barriers listed above. They will provide a business planning and sustainability strategy, contract negotiation support, data analysis, and help with articulating the IPA's value propositions. These discussions will set the path for future IPA business opportunities.

We are confident that through engaging communities in our services, we can reduce health care disparities by eliminating barriers to accessing quality medical and behavioral care for low-income New Yorkers that are associated with race, sexual orientation, poverty, HIV/AIDS, ongoing substance use, and/or lack of stable housing.

I look forward to meeting with you in the coming months to discuss the next phase of our work and how the NYCT could provide support, leveraging the investment that you made through this grant.

Sincerely,

Kevin Muir
Executive Director
[redacted]

November 4, 2019

NYS Department of Health
Office of Health Insurance Programs
Waiver Management Unit
99 Washington Avenue
12th Floor, Suite 1208
Albany, NY 12210

To Whom It May Concern:

The NYS Behavioral Health Care Collaborative (*participants listed at the end of this document*), a statewide group of lead BHCC agencies and BH Independent Practice Associations (IPAs), welcomes the opportunity to submit feedback to the NYSDOH on the draft DSRIP Amendment request. We are submitting comments and feedback that reflect the experience and interests of behavioral healthcare providers who are positioning themselves for value-based contracting. With more than 80% of Medicaid super-utilizers having comorbid mental illness and 44% having serious mental illness,[1] our role in delivering on the promise of Medicaid reform efforts cannot be overstated.

The success of New York's transition to VBP relies on the strength of the partnerships between the behavioral health community, primary care providers treating the Medicaid population, and the organizations that focus directly on the provision of social determinants of health. We urge the Department to use its authority to augment its program design to increase the role and inclusion of community behavioral health providers, and their IPAs, in its waiver design. Our specific requests include:

- BH providers and BH IPAs must be included in Total Cost of Care contracts.
- Community-based BH IPAs should be integrated into the Value-Driven Entities (VDE) governance structure to ensure a role in decision making and providing critical services.
- BH IPAs that are clinically and financially integrated should be permitted to serve as lead VDEs.
- An expanded definition of what would constitute a Social Determinant of Health Network to should include BH IPAs with significant social determinant of health experience and services.
- Specific funding needs to be earmarked for behavioral health purposes.
- Specific metrics for tracking engagement with BHCCs and BH IPAs to ensure adequacy and accessibility of BH services are more meaningfully included in this next phase of DSRIP.
- Funds and leadership are needed to facilitate interoperability among ambulatory providers, inpatient providers and MCOs.
- Data from the Department showing how primary-care centered TCOC arrangements are meaningfully addressing BH needs and ensuring community-based BH care is not disrupted and appropriately expanded.
- Earmark 25% of workforce dollars for community-based providers.

As always, we look forward to collaboratively working with the State and other system stakeholders, including Performing Provider Systems (PPSs) and Medicaid Managed Care Organizations (MCOs) to

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5406260/

support the continued improvement of the Medicaid care delivery system to better meet the needs of the state's population with behavioral health conditions.

**Community Behavioral Health: Critical to Success of Value-Based Arrangements**

The highest cost Medicaid recipients have behavioral health disorders. Whether they are people with serious mental illnesses and chronic substance use disorders, or people with medical conditions whose costs of care are exacerbated by a behavioral health disorder, the greatest potential savings comes from meeting Medicaid recipients' behavioral health needs. As such, success in transforming the Medicaid service system hinges on the inclusion and integration of behavioral health providers, and the BH IPAs they have established, in Total Cost of Care (TCOC) contracts.

**Why BH IPAs versus Individual BH Providers**

The creation of BH IPAs funded through the BHCC initiative creates opportunity for BH providers but also their potential partners, including primary care providers, managed care organizations, hospitals, or government. IPAs allow BH providers to:

1. increase their capability and bring critical interventions to scale within larger TCOC contracts;
    a. provide targeted and integrated services for specialized BH populations;
2. spread risk associated with high cost, high severity populations;
3. work collectively to better harness population health data and analytic capabilities and manage their contributions within VBP contracts; and reduce administrative costs;
4. act as a bridge between social determinants of health (SDH) providers, including all levels of CBOs and community-based clinical models including primary care;
5. access referral pathways between BH clients and SDH providers, primary and specialty care; and
6. deliver large scale workforce initiatives including group education, training, technical assistance, and recruitment to address needs and shortages in underserved community.

New York State has invested in the development of BH IPAs; now they must be empowered to play the essential role for which they were created *(**see below examples from other states**)*.

**Inclusion of BH IPAs in DSRIP 2.0 Structures – Value-Driving Entities (VDEs)**

Despite the many benefits of BH Networks, to date, the inclusion of behavioral health IPAs in New York's Medicaid VBP arrangements has been elusive despite nearly two-thirds of the State's waiver priority areas being directly related to BH. There is no specific incentive for BH inclusion in emerging and existing arrangements, so existing TCOC contracts seldom include New York's behavioral health IPAs. This impedes Medicaid members' access to integrated, quality care; inhibits the savings potential of the contracts; and results in business as usual, siloed service delivery.

Currently, Value-Driving Entities (VDE) (as discussed in the DSRIP 2.0 concept paper) are not required to have BH IPAs in their governance structure. Although CBOs, which serve some – but not all – of the highest utilizers, are mandated to have a seat at the table, this does not go far enough. The mere mention of BHCCs is not enough incentive for VDEs to include such entities in their networks and the State should focus on emerging IPAs as a critical vehicle in ensuring future VBP progress. CBOs have coalesced around BH IPAs and therefore they are the logical place for their oversight, organizing and collective power.

BH IPAs that are clinically and financially integrated must be permitted to serve as lead VDEs. Several of the existing BH IPAs already provide/will soon provide network providers with quality oversight functionality

and data analytics capabilities. They will also offer training/technical assistance functions as well as other capabilities including back office supports for contracting and credentialing.

If not lead VDEs, BH IPAs must be mandated participants to ensure that CBOs have sufficient power within VDE governance not available to an individual CBO and to ensure all the benefits of the IPA described above are realized. The State must strengthen its current requirement to more explicitly integrate how community BH IPAs should be integrated in decision making and in providing critical services to all Medicaid members attributed to a VDE. The DSRIP 2.0 waiver amendment must include BH IPAs in executive steerage of VDEs.

This is especially critical for VDEs selecting promising practices impacting mental health and substance use treatment, including: expansion of Medication-Assisted Treatment into primary care and ED settings; primary care and behavioral health integration; care coordination, care management, and care transitions; expansion of Mobile Crisis Teams (MCT) and crisis respite services; focus on patients transitioning from IMDs to the community; Focus on Seriously Mentally Ill/Seriously Emotionally Disturbed populations; and addressing Social Determinants of Health (SDHs) through community partnerships. It should not be possible for VDEs to implement these practices without including the most expert and experienced community BH providers via their BH IPAs/networks.

Particularly, VDEs selecting BH focused promising practices must demonstrate their connectedness to BH IPAs, including providing governance roles, as part of their planned interventions for their attributed population. VDEs and MCOs cannot rely on general definitions of BH representation alone and instead must specifically identify how they plan to integrate with outpatient, community, and specialty BH, in addition to inpatient BH and traditional psychiatric services through their BH IPA relationships.

**DSRIP 2.0 Structures - Expanding the definition of SDHNs**

We further recommend that the state expand the definition of what would constitute a *Social Determinant of Health Network* (SDHN) to include BH IPAs with significant social determinant of health experience and services. This change would support more integration of services and reduce ongoing siloes that have emerged during DSRIP between CBOs and their BH counterparts (*sometimes being provided through the same agency*). It would allow these emerging networks to leverage existing infrastructure created by BH IPAs and avoid redundant, duplicative, and costly systems. SDH Networks, if not done correctly, may become yet another complicated and expensive infrastructure layer. We are pleased to see CBOs are included but it is equally important to include BH IPAs that also provide significant SDH interventions to enable the success of DSRIP 2.0.

BH IPAs do not solely serve people with serious behavioral health conditions; they have designed successful interventions for individuals with mild to moderate depression and anxiety, mild to moderate substance use disorders and many are positioned to be a “one stop shop” for communities seeking BH interventions to support primary care (PC) and acute care medicine in deriving value and sustaining behavior change. BH IPA members also provide social determinant of health services, including but not limited to housing, food, employment services, transportation, and peer supports, which gives them extremely broad capabilities in addressing the interdisciplinary challenges of healthcare transformation in an integrated fashion. All BHCCs/BH IPAs represent an integrated spectrum of BH services and have demonstrated progress in emergency department diversion and readmission reductions. Under this next wave of DSRIP, we must integrate and empower the behavioral health community to produce meaningful outcomes for Medicaid recipients, and significant savings for the Medicaid program.

**Funding Community Behavioral Health Networks - DSRIP 2.0**

A notable challenge in the State's design of the initial DSRIP program and now its waiver amendment draft is the *need for specific funding to be earmarked for behavioral health purposes.* In the initial DSRIP program, hospital-led PPS entities directed most funds to hospital, acute, and primary care sources minimizing the funding available to projects related to behavioral health. Without the requirement of adequate funds to support enhancements to community based mental health and substance use services, funding will be directed to care as usual in high cost settings.

To date, behavioral health providers have received a fraction of the Medicaid-reform funds for transformation efforts and we appeal to the State to address this challenge directly in its next iteration of the program. For example, under DSRIP (as of 2018), 1.8% of funds have been distributed for mental health interventions and 0.7% of funds have been invested in substance use.[2] As of 2018, VBP readiness grants awarded BHCCs just 0.7% compared to more than $9 billion total DSRIP investment.[3] And, in Phase II of the Statewide Healthcare Facility Transformation Program, there was capital funding of just 13% awarded to community BH dedicated projects; this was a slight improvement from the 6.5% awarded under the initial round of the Program.[4]

One DSRIP/PPS funded BH crisis stabilization project focused on reducing BH-related hospitalizations. The sponsoring PPS saw a *23% reduction in BH-related admissions by funding a robust crisis program linking a central point of contact, mobile crisis, and respite*. This project would not have happened without consistent participation and pressure from BH partners. Rather than this being the exception, we implore the State to align available funding for PPS Promising Practices with the sector affecting the outcomes. Promising Practices that focus on mental health, substance use disorders, or BH should include adequate funding requirements for networks of community BH providers. Community-based care is often preferred by recipients while also being less expensive, and therefore should be proportionately funded.

By globally referring to "providers" and directing funding through the existing PPS infrastructure, it is hard to see how this program design will facilitate the essential integration of behavioral healthcare, which will limit the impact of the state's transformation agenda.

Instead, we must fully fund community-based behavioral health and support additional innovation that will drive better outcomes and decreased costs for the entire system. One innovation that could move community behavioral health toward value-based payment and away from fee-for-service volume is the adoption of alternative payment models. We encourage and support the adoption and implementation of Alternative Payment Models (APM's) that support the transformation of our healthcare system along the continuum of care. APM's should be aligned to redesign of care delivery models inclusive of medical, behavioral and social needs resulting in improved access, enhanced patient engagement and measurable value – improved quality outcomes and reduced cost.

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[2] https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/paop/meetings/2018/docs/2018-11-29_updates.pdf

[3] NYS Department of Health. VBP QIP Funding and Pairing Tables, September 2018. https://www.omh.ny.gov/omhweb/bho/bh-vbp.html and https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/.

[4] https://www.governor.ny.gov/news/governor-cuomo-announces-204-million-funding-strengthen-and-preserve-access-high-quality-health

**Measures and Performance Payments: Facilitating BH in Future Value-Based Payment Models**

In addition to metrics tracking CBO, Qualified Entity, and MCO engagement, the State must include specific metrics for tracking engagement with BHCCs and BH IPAs to ensure BH services are more meaningfully included in this next phase of DSRIP. To measure BH IPA and network participation, we recommend the State track and report (1) how many BH providers and their associated IPAs have a substantial governance role in emerging networks (2) how well BH providers are moving along an on-ramp toward increased risk arrangements (*suggesting they have the capabilities and leverage they need to accomplish this, such as access to data on performance within specific contracts)* (3) what portion of shared savings under TCOC are distributed to BH partners for BH-related work and how BH networks are provided quality bonus/incentive payment opportunities.

**Information Technology**

In DSRIP 1.0, the community-level collaboration efforts to reduce Potentially Preventable Admissions and Potentially Preventable Readmissions required communication among the provider system of care. As integration increased the numbers declined. Fundamental to the integration was the enhanced interoperability the RHIOs contributed as they developed. All the Promising Practice Categories include a Behavioral Health component. Behavioral Health has not had the financial support and state-wide leadership necessary to substantially develop a level of interoperability with inpatient and other ambulatory providers critical to a successful community-level network of care.

Funds and leadership are needed to facilitate interoperability among ambulatory providers, inpatient providers and MCOs. The State must provide some guidance that drives this integration into and through the RHIOs as it improves the accessibility to and among RHIOs.

**Need for Greater Transparency and Oversight in Emerging VBP Arrangements**

New York, in its VBP Roadmap and through its implementation of the DSRIP program, has designed and relied on models that put primary and acute care service providers at the center of payment models, without the inclusion of community-based mental health and substance use disorder providers and networks. *This contrasts with other models around the country where better impact and value is being seen due to the inclusion of BH IPAs* that organize these necessary community services. Currently, in New York State it is difficult to see how total cost of care contracts include vital community BH services. We continue to request data from NYSDOH to demonstrate how networks have been formed, their impact on BH outcomes for their attributed population, and whether access to community BH services has been impacted positively or negatively. BH IPA inclusion would resolve and address this access concern and provide assurance that BH needs are met in these arrangements.

Today in New York there are more than 50 Medicaid Total Cost of Care (TCOC) arrangements between various partners and stakeholders. However, it is still unclear how and whether individuals are receiving adequate behavioral health services to address high, medium and low acuity needs under these emerging arrangements. Community-based BH services may or may not be limited under these general medical contracts. The State must address and report on how these primary-care centered TCOC arrangements are meaningfully addressing BH needs and ensuring community-based BH care is not disrupted and appropriately expanded.

**Interim Access Assurance Funds**

While we understand the need to maintain vital safety net services for individuals, what continues to be evident is the disproportionate and inequitable financing that has been spent on hospitals versus other

stakeholders in NYS. Low margins and cash flow disruptions, due to delays in payment, could put critical Medicaid community BH services at risk of not being available for individuals who rely on those services. Shifting service delivery patterns and payment transformation, makes this risk even greater for small, less well-resourced organizations.

VBP itself is not a solution for struggling providers seeking financial sustainability and yet the risk if these services were to disappear would be just as great to their patients as it would be if hospital or acute medical services were no longer available. In fact, the loss of critical BH services would drive increased hospital utilization and readmissions because the management of individuals' conditions would be inadequate if BH providers close. BH providers are seeking financial sustainability in order to ensure continued service delivery to complex clients who remain wary of physician/hospital-based providers.

To that end, we request to expand the Interim Access Assurance Fund or create alternative funding streams from waiver monies to assist community BH providers who are financially challenged. These funds should be used to invest in the needed mergers, affiliations, and partnership analyses to promote more financial security and sustainability for Medicaid-funded community BH services.

**Workforce Funds**

In addition to the funding noted above, we would recommend that a percentage of workforce dollars be earmarked for BH providers, specifically organizations that have demonstrated successful workforce projects/enhancements. We would also want to see workforce spending for projects that work to close the pay gap between hospital and community services, creating equity in hiring. A healthy workforce in community based services is critical to functioning and being able to support patients in community based levels of care.

**Value of BH IPAs in other States**

Several examples across the country, including the *Illinois Health Practice Alliance*[5] and the *Next Generation Models for Health Plan Behavioral Health Service* in Florida,[6] demonstrate how State Medicaid programs and MCOs are better leveraging Behavioral Health IPAs to advance statewide policy goals, including better management, efficiency, and cost savings for their Medicaid Program.

- In Illinois, the State-endorsed Health Practice Alliance created a BH IPA model for managing Medicaid patients with BH conditions to address inefficiencies and challenges in addressing BH conditions adequately under Primary Care models. MCO contracting was observed to be more efficient under this model, which resulted in minimal administrative overhead and enhanced enrollment opportunities. BH provider participants were rewarded with bonus or shared savings payments for enhanced quality and aligned incentives across payers and providers. The IPA is self-directed and has succeeded in creating consistent rules with MCOs for all of its BH provider members. Under the Illinois model, the data infrastructure of the IPA supports claims and performance data, care management platforms, real time updates, predictive risk stratification modeling, and BH/physical health visibility. For the most serious BH conditions in the network, the IPA supports embedded care managers, shared assessment and care plan capability, and leverages expertise from both plan and provider partners.

[5] http://cbha.net/resources/Conference/2018%20Conference/CBHA%20IHPA%20and%20MSO%20Presentation%2012-10-18.pdf

[6] https://leadership.openminds.com/wp-content/uploads/2018/09/091918OpeningKeynote.pdf

- In Florida, the State reviewed evidence that emerging VBP models were heavily Primary Care Physician based, which led to inconsistent physical/behavioral health communication, inconsistent sharing of treatment plans for common patients, and members seeing multiple behavioral health providers. The State identified program design challenges in VBP models designed around PCPs, including: the lack of a member attribution model for behavioral health, limits on what information can be shared with behavioral health providers (outside the care they provide), and minimal financial incentives for behavioral health providers. The State made modifications designed to specifically engage, integrate, and reward behavioral health providers, including VBP models that explicitly included outcome based rewards or pay for performance for BH-related HEDIS measures,[7] behavioral health homes that provide integrated BH and PC services (paid based on shared savings or capitation plus shared savings with attribution stemming from the BH IPA), and population health models, which target specialty health homes for those with SMI. As a result of these endeavors, BH IPAs in Florida have created a more predictable and reliable cash flow for BH providers, BH providers are more empowered to enter VBP and potential risks are mitigated through shared practices and learning. Florida BH providers are empowered to have more ownership and ability to influence the system of care in a more data-driven culture, and it has incented better partnership and integration between BH and PC providers.

As other states have acknowledged, BH providers need meaningful rewards for their participation in emerging VBP models. We encourage the state, via DSRIP 2.0, future evolution of NYS's VBP roadmap and in its oversight of MCOs, to incent and reward other approaches to total cost of care for the management of BH patients involved in these arrangements, including attribution of appropriate Medicaid members, direct upside risk opportunities for BH IPAs and BHCCs, pay for performance/bonus payments for such networks, and/or other innovative direct contracting approaches.

*This letter has been collectively written and is supported by the following BHCC / BH IPAs:*

Advanced Health Network IPA
Recovery Health Solutions IPA
Behavioral Health NYC IPA
EngageWell IPA
Capital Behavioral Health Network
AsOne IPA
Value Network IPA
South Central BHCC
Mohawk Valley BHCC
Central New York BHCC
Finger Lakes and Southern Tier BHCC
Lower East Side Service Center BHCC
Northwinds Integrated Health Network
Integrity Partners for Behavioral Health
Coordinated Behavioral Health Services IPA
Coordinated Behavioral Care IPA
Your Health Partners of the Finger Lakes IPA

[7] Adherence to antipsychotic medications in those with schizophrenia, Diabetes monitoring for those with diabetes and schizophrenia, Cholesterol and blood sugar testing for youth on antipsychotic medications, and Visit in 7-days post BH inpatient discharge

**doh.sm.1115Waivers**

**From:** DIBACCO, MICHELLE [redacted]
**Sent:** Monday, November 4, 2019 6:19 PM
**To:** doh.sm.1115Waivers
**Cc:** [redacted] Brown, Deborah
**Subject:** NYC Health + Hospitals written comments on the DSRIP Amendment Request
**Attachments:** NYC H+H comments on DSRIP 2.0 Final.pdf



Waiver Management Unit

On behalf of NYC Health + Hospitals, attached please find our written comments on the New York State Department of Health draft amendment request to Centers for Medicare and Medicaid Services for a four year waiver amendment to further support quality improvements and cost savings through the Delivery System Reform Incentive Payment (DSRIP) program.

We look forward to working with the State on the waiver amendment process. Please feel free to contact me if you should have additional questions.

Thank you for your consideration.

Michelle

Michelle DiBacco
NYC Health + Hospitals
Assistant Vice President
Government and Community Relations
[redacted]

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November 4, 2019

NYS Department of Health
Office of Health Insurance Programs
Waiver Management Unit
99 Washington Avenue
12th Floor, Suite 1208
Albany, NY 12210

Dear Waiver Management Team;

The NYC Health and Hospitals Corporation (Health + Hospitals) appreciates the opportunity to comment on the New York State Department of Health's (NYSDOH) intent to request approval from the Centers for Medicare and Medicaid Services (CMS) for a four year waiver amendment to further support quality improvements and cost savings through the Delivery System Reform Incentive Payment (DSRIP) program.

Health + Hospitals, OneCity Health, our Performing Provider System (PPS), and our subsidiary MetroPlus Health Plan are firmly committed to working to achieve the goals of the current DSRIP waiver and any subsequent extension. OneCity Health is the DSRIP program's largest PPS, comprising hundreds of healthcare providers, community-based organizations, and health systems. Health + Hospitals is OneCity's fiduciary and plays a critical role in DSRIP's overall programmatic success as the largest provider of safety net health care in New York. Over a million New Yorkers rely on our services each year, including nearly 400,000 uninsured individuals who seek care at our hospitals and other community sites. The results of Health + Hospitals and OneCity Health efforts through the existing DSRIP waiver have been an integral part in the overall statewide decreases in Potentially Preventable Admissions and Potential Preventable Readmissions. We strongly support the State's commitment to transform the health care delivery system and have worked in partnership with the State to achieve the DSRIP goals.

A significant part of that partnership has been the use of intergovernmental transfers from Health + Hospitals to finance the non-federal share of DSRIP and other MRT waiver programs. In fact, without this critical participation from Health + Hospitals and other public providers, none of the progress achieved through DSRIP would have been possible. We understand that utilization of this financing structure is proposed to continue and likely be expanded in the next iteration of the waiver program. In light of the indispensable role required of public providers to permit continuation of DSRIP, we urge the State to work closely with its public hospital partners on the waiver amendment program design and application.

**Changes Requested to the Demonstration (p. 5-7)**
The proposed DSRIP Amendment Request outlines nine promising practices proposed for continuation and identifies "Value-Driving Entities" consisting of PPSs, provider, community-based organizations (CBO) and managed care organizations (MCO) to lead the work on the promising practices**.** We are in agreement with the NYSDOH that the existing PPS is well positioned to lead the VDE.

Building upon the existing work of the PPS, namely the work identified as promising practices, is necessary as PPS' need more time and resources to see full implementation of these programs. Health + Hospitals have made significant strides in these promising practices areas which has helped achieve the state's overall success. However, much more clarity is needed on the VDE structure, and its organizational and governance requirements to fully understand the proposal.

In addition, Health + Hospitals supports the NYSDOH's proposal to enable and encourage Value-Driving Entities (VDE) to work more closely together to implement the promising practices. Health + Hospitals has demonstrated success working with MCOs through the Value Based Payments Quality Incentive Program and we regularly seek to collaborate with MCOs and community partners to address patients' social needs. This collaboration is needed since there is overwhelming evidence that unmet social needs have negative influences the health and well-being of low-income individuals and families.

**Recommendations on operational structure of the next DSRIP funded entity:**

- To support the integration of clinical services, non-traditional health care services and finances, partnerships should be structured across traditional health care providers, CBOs and MCOs.

- To be successful in these new partnerships and to ensure we are providing the best patient care, partnerships should be supported by an underlying infrastructure that allows for the seamless and timely flow of information between the partners (providers, CBOs and health plans).

- In light of the data sharing requirements that will be necessary in the next waiver, we recommend more planning with the State on transparent and accountable data. We should take this opportunity to simplify the methodologies in order to ensure continuous improvement.

- To bolster our partnerships with MCOs and expand our focus on preventative care, we encourage the State to explore how adjustments to, or waiver of, any existing managed care regulations, including but not limited to network adequacy and marketing rules, might be necessary to allow VDEs to focus on specific vulnerable populations.

- Significantly, we believe the role of the Health Homes should be formalized in the Amendment Request. Health Homes are a critical part of the care management continuum in NYS and many of these promising practices outlined rely on the care management services provided through Health Homes. Health Homes have demonstrated experience in reaching high-need, high-risk individuals to successfully engage them in care, and link them to other social and family support services to address their social determinant of health needs. Health Home care managers' provide culturally competent care and develop an individualized comprehensive plan of care for their members, and help them navigate the health care delivery system. They also provide education about managing chronic conditions and medication adherence. Since Health Homes already have relationships with MCOs and can help facilitate those linkages, they should be a vital part of the VDE infrastructure. VDEs should build on the already-existing capacity that Health Homes have developed and the care management they provide for high-need high-risk individuals.

- By following the patient across the continuum as well as throughout the health care delivery system, we can make more informed decisions and provide better care for the patient. As health care shifts to value-based payment arrangements, providers need a clear line-of-sight into the patient journey and outcomes, as well as the cost of care, to be accountable for improving quality and reducing cost.

**Health + Hospitals' efforts related to integration and expansion of Medication-Assisted Treatment (MAT) in primary care and Emergency Department (ED) settings (p. 5)**

Integrating primary care with behavioral health, and substance use treatment will increase access to treatment and enable primary care providers to better serve this patient population. Health + Hospitals

has taken many measures to transform the system by integrating behavioral health. Health + Hospitals has been an active part of a City wide comprehensive response to the opioid overdoes epidemic called HealingNYC. HealingNYC aims to reduce opioid-related overdose death citywide by 35 percent over five years. HealingNYC focuses its efforts to prevent opioid overdose deaths by distributing naloxone to communities and social networks where risk of drug overdose is highest; to prevent opioid misuse and addiction by investing in prevention and education, as well as by providing counseling and linkages to care for individuals who use opioids or who recently experienced an overdose; and increasing capacity to provide medications for addiction treatment, which are the most effective form of opioid use disorder treatments.

Each year 90,000 patients with a Substance Use Disorder (SUD) diagnosis visit Health + Hospitals. Approximately 20,000 (22%) of these patients has been diagnosed with Opioid Use Disorder (OUD). In order to better serve these patients and those who have not yet been formally diagnosed, Health + Hospitals expanded assessment, referrals, and MAT in primary care clinics, ED, and select Inpatient Medicine settings. Health + Hospitals has over 450 providers who are certified to prescribe buprenorphine across our system. We are implementing the Cascade of Care model, originally designed to ensure treatment for OUD is available system-wide, so that all 90,000 and those who are not yet identified as needing SUD services can gain access to the appropriate care anywhere in our system.

At each of our 11 hospitals and Gotham sites, our primary care clinics offer office-based opioid treatment. Opioid treatment at each clinic is led by a clinician who has undergone special training and licensing to authorize the prescription of buprenorphine. All doctors who want to prescribe buprenorphine must undergo four hours of on-line work and four hours of in-person training, followed by the licensing process, which typically takes four to six weeks. In 2019 we are building capacity to provide MAT for alcohol use disorder as well, using the same model. Health + Hospitals provides additional ongoing peer supervision for new providers so that “system champions” can share their expertise and spread best practices across the system. All providers who want to prescribe buprenorphine have access to resources including: learning more about integrating behavioral health into primary care practice; building caseloads for patients with OUD; and collaborative work with other practitioners. This 16-week enhanced training course is part of the international Project ECHO (Extension for Community Healthcare Outcomes) model. Through a video-conferencing learning collaborative, Project ECHO extends specialty education and support to primary care providers on targeted diseases or health conditions, expanding the scope of services available to patients in primary care and reducing barriers to care and treatment.

Additionally, in 2019, Health + Hospitals is conducting public trainings at each of the 11 acute care facilities. Through these trainings we have provided information to patients, family members, and community members on how to identify the symptoms of SUD, OUD in particular, how to provide life-saving emergency medication (naloxone), and where to seek help for themselves or a loved one. These trainings are open to the public, including community members, religious organizations, and local nonprofits and other community partners, including NYPD. Health + Hospitals is also training special enforcement officers, our hospital police department, to administer naloxone.

Making buprenorphine available through primary care in adult medicine clinics is part of Health + Hospitals’ system-wide strategy to deliver SUD treatment to patients wherever they feel most comfortable seeking services. SUD support and life-saving treatment is available through the emergency department, inpatient, and outpatient specialty care. Our four Opioid Treatment Programs are State-licensed to provide MAT for opioid use disorder, either methadone or buprenorphine and provide care collectively to 700 patients on average every month. In addition, all of our outpatient SUD clinics at our 11 acute care facilities around the City provide buprenorphine, and treat a broad range of SUD. These programs offer support groups and individual counseling, as well as innovative care options such as acupuncture and vocational counseling and referrals to work opportunities.

Since many patients with SUD seek care at some point for various reasons through the emergency department, Health + Hospitals is implementing a number of interventions. Health + Hospitals created Addiction Teams and a comprehensive substance use disorder response in all 11 EDs. Standardized nurse screening for SUD also assists team members in identifying patients for the teams of Peers and Counseling staff to provide assessment, intervention, naloxone distribution, and navigation to treatment post-discharge. Patients are screened for substance use in triage or the nursing assessment. The screening helps rapidly identify patients in need of intervention by one of the new Emergency Department Addiction Teams Peer advocates and licensed social workers or counselors will connect with ED patients, including those with non-fatal opioid overdose, opioid intoxication, or a history of harmful opioid use, and link them to ongoing treatment. These strategies ensure that there is no wrong door through which to enter our system, and that patients seeking care for medical needs, but who have underlying SUD symptoms can be identified and linked to treatment.

**Recommendation:**

- These examples depict work to date on these promising practices but also why the need for additional time and resources is necessary in the next waiver to complete this work integrating and expanding MAT in primary care and ED settings.

**Health + Hospitals' efforts related to partnerships with the justice system and other cross-sector collaborations (p. 5)**

NYC Health + Hospitals/Correctional Health Services (CHS) operates one of the largest correctional health care systems in the nation, with approximately 38,000 admissions per year and an average daily population of about 7,200 in 11 jails, four courthouses, and one juvenile facility across the city. CHS operates the nation's first and largest jail-based MAT program, treating patients in custody, connecting them to ongoing care upon discharge, and distributing naloxone to families and friends to help ensure that people likely to witness an overdose are equipped.

In addition to MAT, CHS provides medical and mental health care, substance use treatment, dental care, social work services, and discharge planning services to patients from pre-arraignment through reentry to the community. CHS has expanded its 24/7 Enhanced Pre-Arraignment Screening Service (EPASS) citywide, with locations in Manhattan, Brooklyn, Queens, and most recently the Bronx. EPASS helps to better identify and treat acute medical and mental health issues to avoid emergency department runs; to support diversion and alternatives to incarceration; and to identify patients with priority health issues who are admitted to jail. In our efforts to better target care to the aging justice-involved population, CHS developed a Geriatrics and Complex Care Service (GCCS), which is an interdisciplinary team of medical providers, social workers, and reentry planners who work with the oldest and most frail patients in the NYC jail system. GCCS provides clinical care, coordination of care and support to patients during their incarceration, and works with attorneys and community partners to facilitate the safest transitions for patients returning to the community. However, there continues to be a need to develop more long-term care solutions for the elderly and frail population in the community.

Recognizing the need for culturally competent and flexible care for justice-involved patients as they reenter the community, this past July, CHS launched Point of Reentry and Transition (PORT) practices, in partnership with the Office of Ambulatory Care, at Bellevue and Kings County hospitals. These new transitional primary care practices increase access to and improve continuity of care for patients recently released from custody in City jails. PORT practices are staffed by CHS primary care providers who usually work in the jails, shoulder to shoulder with primary care providers at the two hospitals. These practices are supported by CHS Community Health Workers (CHW) based at the locations, serving as bridges to help ensure successful and sustained access to community health care. Early feedback on these clinics indicate that the CHWs are a critical piece of the model and Health + Hospitals could benefit from extending this type of resource to multiple sites across its network.

Also, CHS applauds the endeavor by the NYSDOH to request approval from CMS for an amendment to its Medicaid Redesign 1115 Waiver, in order to authorize federal Medicaid matching funds for certain Medicaid-eligible services provided to sentenced and detained persons in state and local facilities. These Medicaid services would be provided in the 30-day period immediately prior to the release of individuals in custody who are eligible for and enrolled in Medicaid, and are eligible for New York's Health Home program. Further, CHS agrees with the State's proposed change to allow providers to engage detainees in jail within the first 15 days of incarceration.

**Recommendations:**

- To further efforts to reach justice involved populations, CHS asserts that the 1115 Waiver amendment extend the proposed engagement period of the first 15 days of incarceration must be in addition to the last 30 days. Early engagement upon admission and reinforcing connection just prior to discharge are both critical.

- While CHS appreciates the State's proposed inclusion of opioid use disorder as an independent Health Home criterion, we believe that all substance use disorders, and not just of opioids, should qualify as a standalone eligibility criterion for Health Homes.

- Finally, it is critical that CHS be included in the evaluation of Phase One and the planning of Phase Two of the correctional health waiver amendment, since the detained population in NYC accounts for more than one-third of the detained population in all local facilities.

**Primary care and behavioral health integration (p. 5)**
Collaborative care – embedding therapists and psychiatrists in primary care clinics – has been a ground-breaking advance that has greatly increased the uptake of mental health services across Health + Hospitals. In this collaborative and integrated model, a trusted primary care provider can walk a patient down the hall to their colleague who provides behavioral health, and the patient can feel like this is another member of the care team.

**Recommendation:**

- Unfortunately, our communities have never had enough therapists and psychiatrists to reach all the people who need their help, and thus we need to continue identifying additional funding streams to grow our Behavioral Health programs and the Amendment Request should address this issue.

**Care coordination, care management, and care transitions (p. 5)**
Case managers, also known as Accountable Care Managers within our system, provide collaborative clinical assessment, care coordination, patient education, counseling, case monitoring/clinical pathway management, discharge planning, resource management, and patient advocacy. The significant contributions of our case and care managers impact our ability to provide the best patient care possible, positively affecting the patient experience while promoting best practices and cost-effective interventions. The work they do on a daily basis plays a vital role in optimizing patient outcomes.

Addressing identified social determinant of health needs is a focal point of Health + Hospitals and of our care coordination provided by MetroPlus' care management team. When our care managers visit members recently discharged from the hospital, they complete a comprehensive assessment, which includes social determinant of health screens. In addition to coordinating meal delivery services, care managers facilitate access to services to prevent evictions, loss of benefit coverage and access to other available community resources. MetroPlus has invested time and resources addressing housing insecurity of our highest-risk members. This included the development of a Care Management Taskforce comprised of social workers and housing specialists to support members in need of permanent shelter. Strategies implemented include training of care management staff to complete housing applications and fostering partnerships with CBOs, the NYC Human Resources

Association and numerous shelters. At any given time, MetroPlus services between 8,000 – 10,000 homeless members. Led by our Care Management Taskforce, MetroPlus has successfully housed over 50 high-risk members. In addition, MetroPlus has had experience offering benefits associated with social determinants of health, including housing, meal delivery, programs for social isolation, cleaning and other support programs. Through its value-based program with Health + Hospitals, MetroPlus has incorporated a program for nutritious meal delivery services for members who have been discharged from the hospital and are hoping to see that this reduces unnecessary readmissions and eases member's transitions back to their home.

**Recommendation:**

- Health Homes also currently utilize a care management model. There needs to be better integration with Health Homes in the next waiver iteration.

**Health + Hospitals' efforts to focus on patients with Seriously Mentally Ill/Seriously Emotional Disturbed and transitioning patients to the community (p. 5)**

Many patients with behavioral health needs are high utilizers of acute care services and are often not engaged in ongoing ambulatory behavioral health care. In an effort to implement new models of care that furthers the DSRP goals of reducing avoidable hospital utilization, Health + Hospitals, in collaboration with OneCity Health, entered into a partnership with Pathway Home, a care transitions program created by Coordinated Behavioral Care, to help individuals with mental health needs transition from short-term health services to ongoing community-based care. Pathway Home aims to support adult patients with behavioral health needs navigate health care services during the transition from inpatient psychiatric care or the emergency department treatment back into the community, and connects them with the community-based services available. The Pathway Home program provides multidisciplinary care transition services to patients 18 and older transitioning from psychiatric in-patient units who have had four or more mental health inpatient visits in the past 12 months. The Pathway Home team consists of registered nurses, licensed clinicians, case managers and peers who help address clinical and social issues. Team members meet with patients at least once a week for the first one to three months, and accompany them on the day of discharge, as well as to subsequent clinical appointments. By initiating engagement before discharge from an acute care setting, this team-based model will provide high risk patient populations with support within the community to connect with outpatient clinical services as well as social services. In addition to reducing avoidable readmissions, Pathway Home aims to strengthen community-based care and improve connections to outpatient services post-discharge, shortening length of stay and increasing participation in treatment.

Health +Hospitals is one of the leaders in the state providing mental health and substance use services to those with Serious Mental Illness (SMI). Health + Hospitals has 12 Assertive Community Treatment Teams, which provide the highest level of care in the community to individuals with SMI. Individuals with SMI also make up a large majority of individuals enrolled in our outpatient continuum of care. Intermediate levels of care are important in the delivery of outpatient mental health services. Having a robust continuum allows patients to flow throughout the intermediate levels of care. We have adult Partial Hospitalization Programs (PHPs) at Kings County, Elmhurst, Jacobi and NCB. In 2017 NYS OMH released guidance of Clinic Intensive Outpatient Programs (IOPs) allowing the service to be available for the Medicaid population.

**Recommendations:**

- Integration of IOPS into existing outpatient mental health clinics would address the challenge clinics face in serving adults with higher acuity, reducing utilization of inpatient services, allowing an individual to remain in the community with support.

- Health + Hospitals recognizes the importance of bringing care to non-traditional settings, to bring care to where the need is. Flexibility and resources should be given to allow providers to open an IOP in a shelter. For example, a community-oriented rehabilitation program would

ideally be able to serve homeless adult men with SMI, with co-occurring substance abuse problems.

**Addressing Social Determinants of Health through Community Partnerships (p. 5)**
OneCity Health has successfully partnered with community providers to address social determinant of health. Through the Innovation Fund, eight community partners received $5 million, which was one of the largest allocations set aside by a PPS across the State, to support community collaborations, innovations, and best practices. The projects target DSRIP priorities and our system transformation goals, including reducing avoidable hospitalizations, improving community health outcomes, and addressing social determinants of health, such as food security and health literacy. One example of the innovative projects was from the Fortune Society, who in partnership with CHS, implemented its Connections to Care (C2C) program, using Transitional Specialists (peers), whereby individuals with opioid use disorder were screened, enrolled, and provided transitional care coordination services upon community reentry. Of the 527 expressed interest in C2C participation, a total of 93 clients enrolled and released from jail to the community between 9/1/18 – 4/30/2019, were evaluated and compared to 83 individuals who expressed interest in C2C program but were not enrolled and ultimately discharges during the same time frame. Results were promising:

- Nearly half of all C2C clients (48%) were connected to substance use treatment and primary care
- Over a quarter of C2C clients (28% were retained in substance use treatment for 90 days
- A small proportion of C2C clients and individuals interested in C2C but not enrolled experienced substance use-related potentially preventable ED visits at Health + Hospitals acute care facilities
- Rates of re-incarceration with 90 days of discharge for C2C clients (17%) and individuals who were interested in C2C but not enrolled (29%) were substantial. From this example, you can see how these community collaborations have are creating a holistic integrated delivery system.

In addition to Metroplus' use of care coordinators, and OneCity Health's community partnerships, Health + Hospitals' Office of Population Health also has a portfolio encompassing innovative care models, population health analytics, primary care transformation, chronic disease prevention and management, HIV services, implementation research, and the social determinants of health. The Office of Population Health builds upon the ongoing commitment of our facilities to address patients' unmet social needs as an essential component of health care delivery. Addressing the social determinants of health is fundamental to achieving population health. Rigorous evidence shows that factors beyond access to and quality of healthcare affect health equity and outcomes. Though health systems may not typically be a place that individuals come to for social needs, it is becoming increasingly clear that health systems can play an effective role in addressing patients' social needs as part of their commitment to improving health. The vision for addressing social determinants at Health + Hospitals is therefore to achieve systems change so that Health + Hospitals can elevate the social needs of our patients to the same level as physical health and behavioral health needs. We have a strong foundation upon which to build upon, as facility social work and other staff do assess patients' unmet social needs and endeavor to address them.

The mission of the Social Determinants Team is to add effectiveness to and scale our system's approach to addressing patients' social needs, in a way that "meets patients where they are." We define social determinants (or social needs) to be non-medical aspects of individual and family lives that, if unaddressed, can affect one's ability to maintain health and well-being. The Team focuses on four core areas: housing, food, legal services, and income support. We know housing can be a critical intervention to improve a patient's health and transform their health outcomes. We see firsthand that patients who we can help with challenges like unstable housing, food insecurity, or legal and financial concerns, are less likely to return to our emergency rooms with preventable conditions. These social

interventions can reduce unnecessary health care spending, crowding in our emergency rooms and improve patient outcomes. For instance, housing instability and homelessness can significantly affect a person's ability to manage their own chronic disease e.g. take insulin regularly or attend primary care appointments. Families experiencing food insecurity often are forced to choose between paying rent and accessing healthy foods, thus relying on processed or canned foods that are often less healthy than fresh foods and can exacerbate chronic illnesses such as diabetes[1].

As such, Health + Hospitals has undertaken a number of initiatives to invest in improving our patients' access to housing solutions. One strategy has been to use Health + Hospitals land to build affordable and supportive housing. Health + Hospitals opened Woodhull Residence to serve low-income community residents and homeless adults with special needs. The Comunilife Housing Project at NYC Health + Hospitals/Woodhull provides permanent housing to 89 mental health and low income residents of the Woodhull community.

**Recommendation:**

- Community collaborations are integral in addressing social determinants of health and there needs to be additional time and resources to sustain these partnerships.

**Health + Hospitals' investments in Community Health Workers for Chronic Disease Management for Asthma, Hypertension and Diabetes:**

We are proud the Amendment Request, Appendix B, highlights the work of OneCity Health in utilizing Community Health Workers (CHW) for chronic disease management. Health + Hospitals and OneCity Health has implemented a variety of programs to address chronic disease management, e.g. asthma, diabetes and hypertension. For example, our system implemented a population health and care management program designed to reduce avoidable hospitalizations among children who suffer from frequent or severe asthma attacks. After identifying a patient with frequent or severe asthma attacks, the primary care team develops an Asthma Action Plan and refers the patient to a community health worker. The home-based environmental management program assigns a CHW to visit homes to identify asthma triggers, reinforce strategies to help patients and their families maintain control over asthma, and supply free pillowcases, special cleaning supplies, and professional pest control services as needed. CHW ensure that patients and their families are adhering to the Asthma Action Plan on an ongoing basis, through both home visits and phone calls. The community health workers also communicate with each patient's clinical care team, using care management software to document interventions and receive alerts when patients are in the hospital. Integrated Pest Management Services are also offered to those families that met the assessment criteria. Within a six-month period, OneCity Health saw its pediatric asthma admission rates (PDI-14) decreased by 25%.

In addition to investing in asthma prevention, our system hired 29 chronic disease nurses to support intervention programs for hypertension and diabetes. Between January 2018 and June 2019, our hospital system increased the number of patients with high blood pressure under control by 3,971 more patients. During this timeframe, patients treated for hypertension who got their blood pressure under control improved from 72.6 percent to 76.4 percent. The American Heart Association and the American Medical Association recently recognized our system for its commitment to achieving better blood pressure control, with the ultimate goal of reducing the number of Americans who have heart attacks and strokes. One way in which this improvement occurred is through the "Treat-to-Target" program. In this program, nurses work closely and consistently with patients who have uncontrolled hypertension or diabetes. In this model, nurses follow up with patients every two to four weeks, in the clinic or by phone, until the blood pressure or blood glucose is controlled. Nurses assess whether the problem is due to challenges with medication adherence, a need for a change in the medication regimen, or some other social factor. The nurses work with patients and their providers as needed to adjust the care plan and assist the patient in controlling their blood pressure or blood sugar.

[1] Gucciardi, E. et al. The Intersection between Food Insecurity and Diabetes: A Review. Curr Nutr Rep. 2014; 3(4): 324-332.

To further improve the care of patients with diabetes, Health + Hospitals launched a comprehensive, primary care-centered diabetes management program, including investing in new clinical pharmacy staff, equipment, and technology to improve health outcomes and expand services through telehealth techniques. The new clinical pharmacists are integrated in primary care to help patients manage diabetes medications between primary care visits. In addition, new peer mentoring and smartphone technology services are offered to patients with diabetes to self-manage their disease. The telehealth techniques include a telephone-based mentorship so patients can speak with peer mentors who themselves have diabetes and are trained to help other patients. These peer mentors help address each patient's barriers related to the social determinants of health while inspiring healthy lifestyle behavioral changes. We are also using telehealth techniques by utilizing BlueStar, an app that provides real-time, individualized coaching, reminders and support, as well as diabetes educational tools that are actionable and personalized for each patient to monitor and manage their diabetes. The app helps to bridge the gap between patients and their providers outside of the clinic visit. Through the app, patients can track their medications, blood glucose, labs, and appointments. BlueStar provides patient feedback, guidance and education for better patient self-management and clinical decision support. The app also provides education through diabetes articles and videos, healthy recipes. Health + Hospitals has also launched teleretinal screening in primary care. Using advanced equipment makes teleretinal screening a routine part of primary care for all patients with diabetes, eliminating the need for scheduling separate screening appointments with ophthalmologists.

**Recommendations:**

- Migration toward value-based payment arrangements also necessitates addressing unmet social determinants, particularly for high-need patients, to advance health outcomes and meet financial targets.

- There are numerous opportunities to build new competencies, take advantage of emerging tools and services available, and capture social needs data with more consistency and structure to enable more timely interventions.

- These new services for people with chronic health conditions have been successful and are part of our health system's population health strategies. Through our involvement with these promising practices we recognize the need for additional time and resources to make continued improvements for these population.

**Reducing Maternal Mortality (p. 8)**

Health + Hospitals supports the inclusion in the Amendment Request of other high-need priority areas such as reducing maternal mortality, children's population health, and long-term care reform. In the area of reducing maternal mortality, Health + Hospitals has created a comprehensive maternity care program. Building upon the efforts already undertaken by the system to ensure safe maternity care, our Simulation Center is implementing simulation training in all hospital obstetric units to focus on identification and response to the three top causes of pregnancy-related deaths for women of color—postpartum hemorrhage (bleeding), severe hypertension and cardiovascular collapse. Our Simulation Center has been selected to train 24 public and private hospital obstetric healthcare teams citywide, whose patients are at highest obstetric risk. The Simulation Center is in the process of adopting a comprehensive training course created by the American College of Obstetrics and Gynecologists. To facilitate easier, year-round access to the training, Health + Hospitals will be opening mini-simulation laboratories which consist of one and two-room simulation training facilities located close to Labor and Delivery units at six public hospitals. The training delivered through these mini-labs will focus exclusively on maternal care. Further, Health + Hospitals is forming Maternal Medical homes, utilizing maternal care coordinators and social workers to enhance care by assisting women who are at higher risk of developing health problems during their pregnancy. The Maternal Medical Home will help patients navigate their appointments and receive supportive in-hospital and community services. The Interval Pregnancy Optimization program helps to improve maternal health by training providers to ask patients specifically about pregnancy intention. In this way, the health of the woman may be optimized

before she becomes pregnant. The Mother-Baby Coordinated Visit program aims to increase adherence to the postpartum visit by having the patient scheduled with her baby's visit. Further, Health + Hospitals is adopting implicit bias and anti-racism training and is focusing on a culture that emphasizes safe and respectful care.

**Recommendation:**

- As a member of the NYS Taskforce on maternal mortality and disparate racial outcomes, we would support the use of waiver dollars to address maternal mortality based on the recommendations of the Taskforce.

**Children's Population Health (p. 8)**

Health + Hospitals applauds the endeavors by NYSDOH to extend DSRIP initiatives toward value-based pediatric care transformation. This will allow increased innovation in providing behavioral health, improving care models for children in foster care, and in strengthening our focus on early childhood development. Children are an important opportunity to invest upstream and interrupting the intergeneration transmission of trauma should be a priority. There is strong evidence that evidence-based programs impacting young children can significantly improve their long-term health trajectory.

Two-generation (maternal-child) models of integrated behavioral health are an important strategy to impact social/emotional/developmental outcomes in children. Health + Hospitals has child and adolescent ambulatory behavioral health services at 9 hospitals and 3 Gotham sites; relatively robust child psychiatry and psychology staffing in hospital-based settings. Health + Hospitals has already begun investing in integrated primary care/behavioral health models in pediatrics, including Healthy Steps which is named as a core component of pediatric primary care and currently implemented in 4 Health + Hospitals sites and expanding. Additionally, Cohort 1 of '3-2-1 IMPACT' will begin in 2020, a 2-generation (maternal-child) focused, grant-funded care model with integrated behavioral health, coordinated developmental/behavioral/social determinant screenings, care coordination, and with a risk-stratified approach to family-centered/relationship-based services. Evidence-based primary and secondary prevention (in a risk tiered model) is critical to intervene before children become high needs cases. This includes screening for addressing social determinants of health (and building strong connections to community partners to address needs), screening for developmental delays (and building strong partnerships with Early Intervention to connect children to services), practice-based primary and secondary prevention programs like Reach Out and Read, Video Intervention Project and Healthy Steps (all widespread and expanding across the Health + Hospitals pediatric ambulatory care system).

**Recommendations:**

- The next DSRIP waiver should provide support for this model pre-natally and in Early Childhood, which would give us the opportunity to partner with our MCO partners and our community partners to define an alternative payment model that supports this model of care addressing the entire spectrum of needs in Early Childhood. Such models complement CMS's current InCK model, focusing on improving outcomes and lowering costs before children have developed entrenched needs. These models plan to take advantage of Pediatric practices' frequent contact with mothers to screen for and impact health and health risks (NYSDOH, Depression and other maternal mental health needs, contraception and connection to services (NYSDOH related, Nurse Family Partnership, Early Head Start)). These models also incentivize assisting mothers to connect to medical services in the inter-partum period when indicated. Current national attention on two-generation care models that focus on social/emotional/developmental outcomes will require careful thought and investment in a VBP extended maternal-child bundle to support the models of care Health + Hospitals is implementing in our 3-2-1 IMPACT model and also the model of care recommended by the First 1000 Days Pediatric Primary Care Clinical Advisory Group.

- DSRIP support is also desperately needed for models of care that addresses complex families with intensive focus on behavioral health needs and high-quality preconception care for adolescents and inter-partum mothers. Health + Hospitals is also exploring addressing other social determinants for potential intervention, such as transportation for non-emergency medical care; violence prevention (building on existing efforts at particular Health + Hospitals facilities); and access to adult education and affordable childcare resources.

- Further, as children move to managed care, there is an opportunity to work with partners on true integration. Efforts should focus on the expansion of Child/Adolescent outpatient services across the city for this underserved and vulnerable population. To that end, Health + Hospitals has begun developing its first three Foster Family Health Centers of Excellence, which will be specialized, multidisciplinary teams within Pediatric Ambulatory Care Clinics across Health + Hospitals that provide an augmented level of primary care pediatrics and care coordination to up to 8,300 children in foster care and 43,000 families in preventive services at risk for having their children removed to foster care. In February 2020 all children in foster care will move to managed care, and almost all the agencies will need more options to integrate care for this vulnerable population.

- Additionally, families at-risk for foster care in preventive services also have a very high medical and psychosocial needs, and the CBOs that provide these services are seeking partnership with health systems that can provide close coordination and information-sharing. To meet this full need of foster care and preventive services, Health + Hospitals will need to develop additional centers, and we are actively exploring avenues for increased bidirectional information-sharing between child welfare agencies to ensure we are providing timely, appropriate care to all the children and youth in his population.

- We appreciate the State considering behavioral health urgent care centers as a priority under children's population health. However, the Amendment Request should allow for behavioral health urgent care centers for both children and adults, where individuals could come to receive immediate mental health and substance use services, including 24-hour stabilization services. The current Crisis Intervention benefit is comprised of several service components that are available to children, youth, and adults. The benefit components include Mobile Crisis services as well as residential and stabilization service. The Mobile Crisis Component of the Crisis Intervention benefit includes telephonic triage and crisis response; mobile crisis response, telephonic crisis follow-up; and mobile crisis follow-up. It also outlines expected response times of 3 hours. This will be a significant shift for mobile crisis teams in NYC, where the average response time in 2018 was 19 hours. The New York City field office of NYS OMH has been operating a Crisis Response Pilot since 2017, with the goal of reducing response time to 2 hours. Health + Hospitals is involved in this pilot and has 8 Mobile Crisis Teams. With the reduced response time, Mobile Crisis Teams will be responding more rapidly to crisis**,** thus leaving a gap for individuals needing low to mid-level crisis intervention and stabilization services.

**Long-term care reform (p.8-9)**
Health + Hospitals agrees that long-term and post-acute programs are an important continuum to allow people to age in place while minimizing institutional stays and as such should be high priority program area to address in the next waiver.

**<u>Recommendation:</u>**

- Unfortunately, the Amendment Request fails to provide the necessary details and substance on how to strengthen these partnerships nor what the specific goals would be for long-term care reform. We look forward to further collaboration with the State specifically around including the dual eligible population, strengthening transitions, and other long-term care reforms.

**Continued Workforce Flexibility and Investment (p.9)**
Health + Hospitals supports the continued investment/improvements to enhance workforce flexibility, coordinated population health improvement, and addressing the opioid epidemic. Health + Hospitals is participating in the Care Restructuring Enhancement Program (CREP) pilot program to incentivize public hospital systems to retrain their workforce around managed long term care (MLTC) and behavioral health home and community-based services (HCBS). The CREPs pilots focus on Health + Hospitals ability to work with the projected MLTC and HCBS populations inside and outside of the hospital, and as they transition from the hospital to the community or lower levels of care. The intent of the pilot is to develop workforce training programs to give the nursing home and hospitals' workforce the skills needed to successfully transition to new employment roles as hospital-based care declines during and post DSRIP. The initiative has been helpful in identifying key gaps in workforce development and service implementation. The training programs have provided the initial step to upskilling our workforce to meet these challenges and to thinking as a system, how these services can be translated into practical workflows and shifts in employee roles/assignments. In addition to the CREP program, Health + Hospitals has made a significant investment in revenue cycle staff. This aligns with the system focus on improving patient services collections from insurance companies, as well as improving our ability to assist our patients with enrollment into insurance plans. Health + Hospitals began to develop and implement a comprehensive revenue cycle training program in an effort to provide our workforce the necessary information and skills to navigate the increasingly complex reimbursement requirements.

**Recommendations:**

- A key limitation of the current CREP program however, has been the absence of a viable sustainability plan that would support further implementation on the ground. With additional time and resources, Health + Hospitals would have the ability to train supervisors of frontline/patient interfacing staff to apply the skills/concepts learned in an environment of continuous assessment and learning.

- As we continue to invest in our workforce, we fully support the State's continued investment in workforce flexibility and investment in order to fully implement these programs prepare the workforce.

**Coordinated Population Health Improvement (p. 10)**
The Amendment Request seeks to leverage coordinated population health improvement by designating Social Determinant of Health Networks" (SDHN) to deliver evidence-based interventions. Health Homes share a focus on social determinants of health and have demonstrated their ability to engage the most vulnerable and hardest to reach members of the communities they serve. Health Homes have been successful in reducing avoidable hospital use, improving health outcomes for people with mental illness and/or substance use disorder, improving chronic care management, and improving connection to primary and preventive care. Health Homes should be considered a part of any integrated delivery system.

**Recommendations:**

- In furtherance of integrating Health Homes, we suggest that the State consider shifting the oversight and governance of Health Homes to PPS or the VDE governance structure promulgated by the Amendment Request. The existing NYS Medicaid Health Home program is extremely rigid in its design and overly administratively burdensome, and thus under the first DSRIP waiver, was not successfully leveraged to deliver care management services to the high-need high-risk and rising risk (Health Home At-Risk) individuals. Many PPS' ended up allocating specific resources to manage the top 5% of its highest cost and highest risk individuals in their respective attributions. Decentralizing oversight of Health Homes will

strengthen their integration with delivery systems and allow for flexibility and shared accountability and responsibility for the coordination, resourcing, management and delivery of care management services to high-risk high-need individuals, with improved precision of how, when, why, where and from whom such individuals want to receive such services.

- We believe that the best-positioned SDHN applicants will be those that have demonstrated success in fostering cross-sector partnerships during the first phase of DSRIP and have the operational and contractual infrastructure to continue to drive meaningful collaborations across a range of health-related social need services. We agree that CBOs are a critical partner in furthering work in social determinants of health, however, the SDHN must have the infrastructure to connect with VDE and MCOs as well. As such, there should be capital funds made available for SDHNs as well as VDEs to continue the modernization of these systems.

**Performance Measurement (p. 11)**
Health + Hospitals agrees that performance outcomes and measure have been an important part of the DSRIP program.

**Recommendations:**

- Our recommendation is that incentive payments in DSRIP and any supplemental programs such as the bonus payment program should have a high degree of accuracy and validity.

- As OneCity Health and our partners tackle these monumental delivery system improvements and seek to bring financial stability to our network, we rely on New York State as a partner to facilitate timely and accurate data required for the type of population health management that aligns with standards set forth in the State's VBP roadmap.

**Interim Access Assurance Fund (IAAF) 2.0 (p. 12-13)**
Health + Hospitals supports the State's general proposal to ensure that sufficient funds are available through the IAAF.

**Recommendation:**

- However, we strongly recommend that the definition of safety net provider from the current DSRIP terms and conditions be amended. The new DSRP waiver should recognize the critical role of Safety Net Hospitals in ensuring access to quality healthcare to the most vulnerable and underserved, which is the mission of Health + Hospitals. The new waiver should utilize the enhanced safety net hospital definition established by Chapter 57 of the Laws of 2018. Many of these patients served by enhanced safety net hospitals tend to be sicker and have more complex healthcare needs which require higher levels of care. Current Medicaid reimbursement rates do not account for this and do not adequately cover the costs for enhanced safety net hospitals who serve a disproportionately higher number of Medicaid and uninsured patients. Utilizing the enhanced safety net definition will ensure the funding is going to serve our most vulnerable populations. Section 2807-c of the Public Health Law defines an enhanced safety net hospital as meeting the following criteria in any of the three previous calendar year:
    - >= 50% of patients receive Medicaid or are medically uninsured;
    - >= 40% of inpatient discharges covered by Medicaid;
    - <= 25% discharged patients commercially insured;
    - >= 3% of patients served are uninsured; and
    - Provides care to uninsured patients in its ER, hospital/community-based clinics
    - Is a public hospital operated by a county, municipality, public benefit corporation or the state university of NY;
    - Is federally designated as a critical access hospital or sole community hospital

Health + Hospitals is the largest safety net provider in the state, and the nation, and funds from the IAAF would help as we move toward transform the system by investing in urgent care models, and building new ambulatory care sites. At Health + Hospitals, we have opened two ExpressCare sites and we are building three new community-based health care centers that will provide comprehensive, one-stop ambulatory care services for more than 50,000 children and adults. These new ambulatory care centers reflect our commitment to expanding access to primary care in underserved and high-need neighborhoods. IAAF payments would enable us as the largest safety net provider in the state to better serve the needs of our hospital communities. These new primary care center will give our communities more options other than the emergency room, which is consistent with the DSRIP program's goal of reducing avoidable hospital use by 25 percent.

Thank you again for the opportunity to comment on the DSRIP 2.0 concept paper. NYC Health + Hospitals, OneCity and MetroPlus remain committed to working with State to transform the delivery of the health care system in order to reduce health care disparities and improve the population health of individuals we serve. We urge the State to work with OneCity Health, MetroPlus and Health + Hospitals on finding opportunities within the existing waiver and supplemental programs, to advance the overarching goals of DSRIP.

We welcome the opportunity to discuss these comments in detail. Thank you for your consideration.

Sincerely,

Mitchell Katz, M.D.

## doh.sm.1115Waivers

**From:** Albert Blankley [redacted]
**Sent:** Monday, November 4, 2019 6:32 PM
**To:** doh.sm.1115Waivers
**Cc:** [redacted]
**Subject:** 1115 Public Forum Comment
**Attachments:** FINAL DSRIP Proposal FL Written Response 11-4-19.pdf



To Whom it may Concern:

Please find attached commentary on Draft DSRIP Waiver Amendment Proposal gathered from many stakeholders across the Finger Lakes region. Common Ground Health and the Finger Lakes Performing Provider System have worked diligently to accurately and honestly reflect the consensus of our community.

If you have any questions regarding our commentary please do not hesitate to reach out to Albert Blankley at Common Ground Health (contact information below).

Thank you,
-Albert

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**Albert Blankley**
**Chief Operating Officer**
Common Ground Health
www.commongroundhealth.org
Access a wealth of data about the health of the Finger Lakes region through our online gallery of data visualizations. All maps, graphs and charts are free to download and use.

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New York State Department of Health
1115 Waiver Program, Delivery System Reform Incentive Program
Re: 1115 Public Forum Comment

**Summary**

Together with the Finger Lakes Performing Provider System (FLPPS) and several other community partners Common Ground Health has coordinated a regional response, incorporating detailed reactions to the draft NYS MRT Waiver DSRIP Amendment Request from over 70 organizations in the Finger Lakes. This letter represents a summary of those responses.

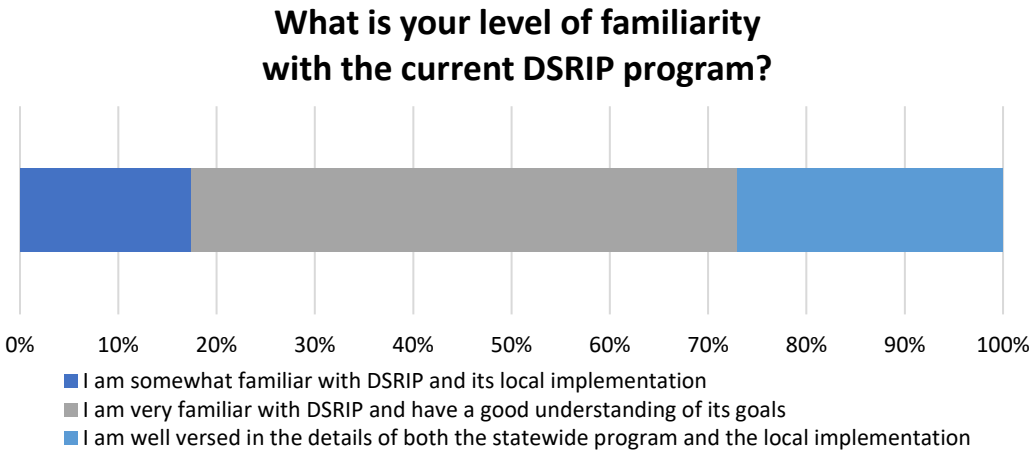
As written, the proposal creates the opportunity to build on much of the good work that has been done in our region over the past five years. Our community has been doing unique and innovative work that aligns with the intent of the draft waiver proposal and does have recommendations that would allow for a next iteration of DSRIP to flourish and drive real improvement in the outcomes of our residents.

In short, the region supports the new focus on Community Based Organizations (CBOs) and asks that their position be strengthened in this proposal. We acknowledge the positive role that hospital systems have had on the lives of Medicaid recipients in their implementation of DSRIP and how the health of those recipients can further improve with the inclusion of CBOs and renewed attention on prevention and social determinants of health. The inclusion of Managed Care Organizations (MCO) is appropriate but will require additional efforts to ensure alignment with measurements and across geographic areas. We also seek clarity on the overarching goals of the next iteration of DSRIP.

Most importantly, we ask that the program be developed with a recognition for work already occurring within our region and across the state and that new mechanisms not be developed that supersede innovation that is driving change in our communities. Deep partnerships have already been developed between our PPS, health systems and CBOs that are reducing costs and improving outcomes. We need to be able to build upon these relationships.

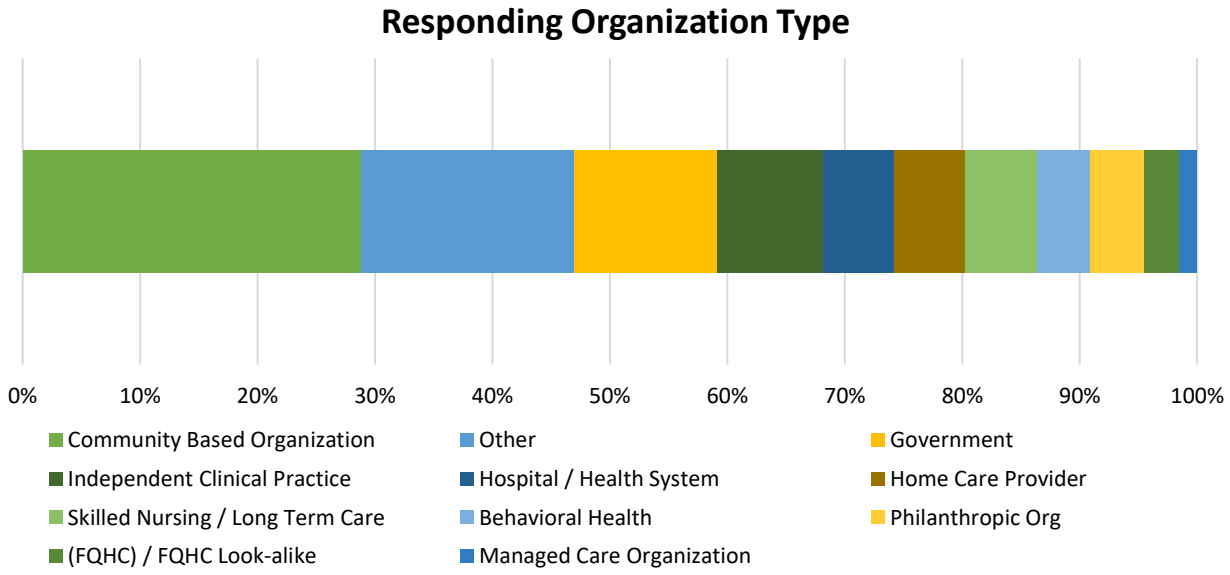
**Survey Respondent Description**

To gather as much input as possible, we conducted a survey asking over 170 individuals and organizations to review the draft waiver amendment proposal and received over 70 responses. Nearly all respondents indicated some familiarity with the DSRIP program.



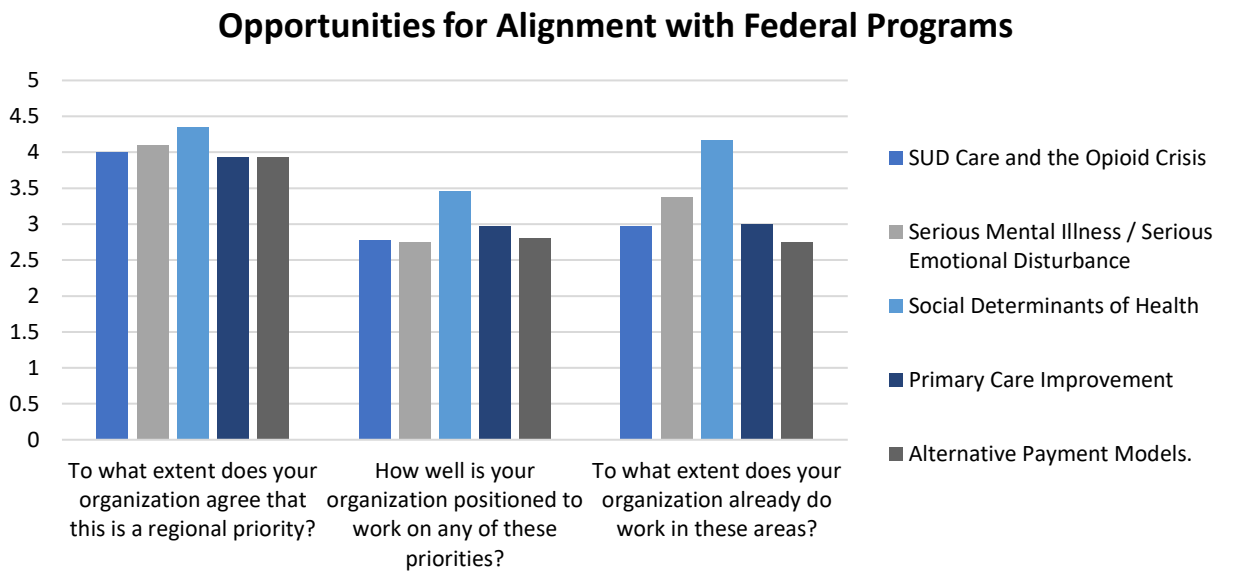

Those responding organizations include:

- Healthcare delivery organizations: Managed Care organizations, hospital and healthcare systems, independent practices, and Federally Qualified Health Centers
- Community-based organizations: behavioral health, care coordination, nutrition and food insecurity, housing, criminal justice support
- Others: Health Information Exchange, Philanthropic Organizations, Local Governmental Units (public health and mental hygiene)



**Alignment with Local Efforts**

The draft proposal outlines several opportunities for alignment with federal programs. Our partners indicate that the proposed areas of alignment are all in concert with regional priorities and organizational position. When asked to score these priorities on a 5-point Likert scale, all received average scores greater than 3.9 as a priority, 2.7 for organizational readiness, and 2.9 for already working in these areas. The highest rated response across all questions were the SDOH.




With regards to the identified promising practices, there was consensus that those listed in the draft proposal were appropriate. There were several requests for additional focus on promising practices in four areas:

| **Behavioral Health** | **Culturally Responsive Approaches** |
|---|---|
| ○ Focus to include moderate mental illness<br>○ Integration b/t medication and counseling<br>○ Telehealth<br>○ Recovery housing<br>○ Peer services / workforce | ○ Structural and Institutional Racism<br>○ Cultural Competency in service delivery<br>○ Workforce shortages in interpreting services<br>○ Family-centered care |
| **Rural Health Services** | **Focus on Children** |
| ○ Need flexibility to tailor for rural needs<br>○ Addressing uniquely rural access issues<br>○ Use of Telemedicine | ○ Inclusion of I/DD providers<br>○ Emergency child-care<br>○ Family crisis services |

The newly identified high-need priority areas, including a focus on maternal mortality, children's population health and long-term care reform and continued investment in workforce, population health improvement and the opioid epidemic are all reflective of our regional priorities.

In addition to these our region recommends three additional areas for investment:

- Technical assistance for CBO providers, including education on value-based payment, supporting IT infrastructure development and data utilization and security training.
- Moving beyond opioid use and taking a broader approach to substance use and mental health, including addiction infrastructure, recovery housing and the integration of BHCC's into efforts.
- Including pervasive and concentrated poverty as an issue and focusing beyond sector specific work to tackle underlying determinants including poverty and homelessness.

*"I think the above sections capture the pressing priorities for our community, acknowledging that high rates of poverty in many areas within our region (both urban and rural), disparities in outcomes, and challenges associated with systemic/structural racism are integrally linked to this work."*

**Performance Measurement**

Our community's response to the performance measurement focused on simplifying meaningful measures, focusing on data infrastructure support, and moving measurement upstream.

As performance measures are developed, we expect that current measurement frameworks will be heavily utilized where possible to simplify reporting. Many of the organizations in our community are already overburdened with reporting requirements and ask that recognition of the demands of reporting be integrated into the resources made available for the program. Utilizing partners such as Qualified Entities (QE) that that aggregate data can alleviate some of this burden. Organizations will also need technical support to develop systems and methodologies which produce meaningful data that support process and outcome measurement.

While using existing measures where possible is necessary, there is also a need to move measurement upstream and cross-sector. To truly understand the impacts of SDOH on outcomes these measures will need to be novel. It is likely that several iterations of measures will be needed to establish appropriate linkages to outcomes. Time and resources will be needed to develop these before using them to gauge performance.

*"They seem disconnected to social determinants of health impact. I feel like we are often reaching for reduced ED admissions or reduced hospital readmissions. Would be helpful to have true preventative measure indicators in their as well."*

**Emergency Funds**

Continued inclusion of the interim access assurance fund is critical to bridging the gap between current and future state of the reimbursement system and our partners are heartened to see it included in the proposal. There is a request for additional flexibility in the funding source to allow for investments tailored to local priorities would be valuable (i.e. workforce investment).

**Value Driving Entities (VDE) and Social Determinant of Health Networks (SDHN)**

We also solicited direct feedback on the proposed structure of the VDE and SDHN establishment and governance. For VDE, there were four areas of commentary:

- MCO Engagement in governance is necessary to expand and grow the work of DSRIP. However, there are concerns about integrating MCO's into the work of DSRIP in terms of the geographic range of some of the organizations as well as ensuring that measurement protocols are aligned to limit duplicative or conflicting reporting efforts.
- VDE applicants must be required to equitably represent all stakeholders and distribute resources across clinical and non-clinical partners based on contributions these partners make to programs and initiatives that the VDE deems critical for the further redesign of the Medicaid program
- Several respondents were concerned with the addition of a new entity into a space with multiple organizations that have, at times, conflicting incentives. The region requests the flexibility in the final proposal to implement a VDE within its current infrastructure.
- Incorporating CBO's in a meaningful way into the governance structure of the VDE is absolutely critical and mandating that as a requirement is appropriate.
- The inclusion of QE's as collaborative partners is appropriate and will build on engagements already occurring in our region
- We recommend creating a pathway for the voice of lived experience in the governance structure of the VDE, potentially including requiring representation of that perspective in a governance model.

*"The concept creates an important opportunity to take a step back and define how best to create a structure that fully leverages the existing structures / capacity / expertise within our region."*

Reactions to the SDHN model were broad ranging but focused mostly on CBO engagement.

- The lead entity of the SDHN needs to have a deep connection to the CBO community and be able to close the gaps between community and the healthcare system. Lead entities that are CBO's deserve additional consideration. Regardless of the lead entity there is a need to build capacity across the entirety of the SDHN and allow for individual organizations to seek the assistance that would be most beneficial to their ability to engage.
- As we look to engage CBO's more directly in this work, it is worth considering re-evaluating how they are defined within the framework of DSRIP. The current tiered model creates some artificial barriers and does not account for certain organizations at all, such as faith organizations.
- SDHN infrastructure needs to account for connecting sectors together. The CBO space accounts for a wide range of organizations, in terms of mission, history, and size. Being able to connect those organizations to each other and the healthcare system, particularly primary care should be a key-criteria for selection.
- There are issues unique to rural environments that need to be considered as part of a SDHN development strategy and the ability to address those should be a consideration for SDHN lead applicants.

*"In concept it seems strong; concerned about the state deciding the fate of CBOs without knowing the work. Too many of our strongest CBOs doing the most/best work don't have capacity to step forward in a formalized way."*

**Allowing for Flexibility in Implementation**

A significant number of organizations also had commentary that went beyond the details of the draft proposal to ask for the ability to set our own course as a region. We have numerous collaborative partnerships underway, already moving us toward better outcomes and lower cost that could use additional resources to grow but would be burdened by undue restrictions or imposed governance Just one of example of this is a partnership that two of our hospital systems have both contracted with a local CBO to provide general social work support and working with individuals to get access to permanent housing.

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 first-hand knowledge of regional variables, should be empowered to establish their path to achievement, without the burden of overly restrictive guardrails. Too-narrow lanes have the potential to produce too-narrow results.

Over the last four years, our community has developed a strong foundation of assets and infrastructure that are well positioned to meet the state's goals for the next iteration of DSRIP. We must be allowed to leverage and expand these resources, based on well-defined program objectives, and not be hindered by overly prescriptive directives on governance and operational infrastructure. We are leery of requirements that would 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 already underway, both in Monroe County and across New York State. We have created an alignment strategy that defines mechanisms for achieving Systems Integration, while concurrently meeting the goals of the DSRIP program. We believe that this approach can be extended, but only through thoughtful consideration of ingenuity and improvement throughout the waiver development process.

We, the undersigned respectfully submit these comments on behalf of our region. Thank you for the opportunity to include our voice in the development of this critical next step in delivery system reform.

**David Calhoun, Executive Director**
**Arc of Wayne County**

**Charlotte Crawford, Chief Executive Officer**
**Lake Plains Community Care Network**

**Marlene Bessette, Chief Executive Officer**
**Catholic Family Center**

**Andrea Haradon, Chief Executive Officer**
**Human Services Development**

**Ann Battaglia, Chief Executive Officer**
**CBO Consortium of Upstate NY**

**Ann Marie Cook, President & Chief Executive Officer**
**Lifespan**

**Wade Norwood, Chief Executive Officer**
**Common Ground Health**

**Laura Gustin, Director**
**Monroe County Systems Integration Project**

**Anne Wilder, Chief Executive Officer**
**Coordinated Care Services, Inc.**

**Bridgette Wiefling, Chief Innovation Officer**
**Rochester Regional Health**

**Pauline Clark, Director**
**Finger Lakes Independent Practice Association (FLIPA)**

**Jill Eisenstein, President and Chief Executive Officer**
**Rochester RHIO**

**Mary Zelazny, Chief Executive Officer**
**Finger Lakes Community Health**

**Nicholas H. Apostoleris, Chief Executive Officer**
**Tri-County Family Medicine**

**Carol Tegas, Executive Director**
**Finger Lakes Performing Provider System**

**Kathleen Parrinello, Chief Operating Officer**
**Strong Memorial Hospital, UR Medicine**

**Deborah Salgueiro, Chief Executive Officer**
**Health Homes of Upstate NY**

## doh.sm.1115Waivers

**From:** Amber Decker [redacted]
**Sent:** Monday, November 4, 2019 6:35 PM
**To:** doh.sm.1115Waivers
**Subject:** November 4, 2019 Public Comments
**Attachments:** 1115 Public Comment November 4, 2019 (2).pdf

1115 Public Comment
November 4, 2019

To: 1115waivers@health.ny.gov

The New York State's Medicaid Redesign Team is a catastrophe, now nonexistent, too privileged and far removed from the public and those they allege and claim to represent.
The MRT has failed to improve access to health care for the Medicaid population; including but not limited to those you consider an issue the SMI, SUD, I/DD and other STC (Special Terms and Conditions) Populations.
We know that access to health care, including behavioral health care, long-term care and home and community based services has not improved since the MRT waiver was imposed.

## The New York State's Medicaid Redesign Team was created through an executive order and has destroyed medicaid, an endless migraine.

It has failed to Improve the quality of services delivered to the medicaid population; including but not limited to the SMI, SUD, I/DD, Medically Fragile Children and other STC (Special Terms and Conditions) Population: Many of the DSRIP Data available on the dashboard shows little Change. Speaking of Dashboards so very many are used as counterfeit tools through which entities are forced to enter data that has no way of being verified.

New York State's Medicaid Redesign Team vision has manipulated resources generated through managed care deficiencies that actively exploit low-income and disabled New Yorkers. LDSS, OTDA, OPWDD, OASAS, OMH, OCFS, DOH are not complying with Olmstead, ADA or person centered service planning. Managed care plans are committing fraud and failing to provide medical, behavioral health and home and community based services all the while collecting Per Member Per Month Payments.

The Health Home program is not working, is exploiting individuals and not providing service plans to these individuals, so much blame is placed on those that they serve for being transient, homeless and not available, yet no direct information has been collected from Health Home recipients or their families.

Families and Individuals have no one, no outside impartial oversight to help them because no one can keep up with the **Mountain of Bull Crap**, that has been created. They have nowhere to turn when medicaid managed care plans deny and fail to pay for services including even basic mental health and medical treatment. Ombudsman programs cannot and do not provide oversight, access or consumer training actively.

Medicaid managed care plans issued under the 1115 waiver have continued to make new demands on providers and clients. In order to access services, you need to be able to climb a huge wall of chaos, claw through a rats nest, eat pounds of baloney and trust no one at their word in order to keep up with new demands and procedures all of which change every month. Basic screenings like an x ray now need prior approvals some of which can take weeks to get approved.

The roll out of medicaid managed care under the 1115 for this population has done nothing but make things worse. There is no publicly-available data breaking down each Medicaid Managed Care Plan's delineation of care manager responsibilities or any responsibility for that matter.

You have failed the disabled, the homeless, the sick, the weak, and the poor.
non-for-profits have become for-profits, endless conflicts of interest ( i.e. https://www.helgersonsolutions.com/blog/2019/9/18/building-off-success-looking-ahead-to-new-yorks-dsrip-20) that no one seems to mention or consider.

Seems like there are more letters than actual words! IPA, VBP, PPS, VDEs, SDHN Social Determinants of Health Networks ugh.."VDE" and "SDHN" this does not even roll off the tongue well.

## When and where do the secret MRT Meetings Happen? Who Attends?

All of this has made it clear that we cannot trust The New York State's Medicaid Redesign Team leadership as it shows all the signs of terrible leadership. The exploitation of the STC populations are boundless and subjected to constant assessments that are not clinically proven to add value to anyone's life!

## doh.sm.1115Waivers

**From:** Denise West [redacted]
**Sent:** Monday, November 4, 2019 7:01 PM
**To:** doh.sm.1115Waivers
**Cc:** Ngozi Moses; West, Denise
**Subject:** 1115 Public Forum Comment
**Attachments:** BPN DSRIP 2_0 1115 Public forum Comments Nov4_19 f.pdf; AMCHP Best Practice Designation for Certified Pathway Community HUBs Ver (2) 8-5-19 (3) (3) 0ne pager.docx

**Importance:** High



Good Day:
Please see attached public forum comment for DSRIP 2.0.

*Denise West*

**Denise West**
Deputy Executive Director
Brooklyn Perinatal Network, Inc. (BPN)
259 Bristol Street, 2nd floor Suite 242
Brooklyn, NY 11212
[redacted]
**website:** www.bpnetwork.org

**Connect with us on social media:**
Like us on Facebook : **Facebook.com/weareBPNetwork**
Follow us on Twitter : **Twitter.com/weareBPNetwork**

***Service is the rent you pay for room on this earth. – Shirley Chisholm***

Celebrating Over 30 Years of Excellence

Executive Director: Ngozi Moses, M.Sc.
Chairperson: Bettie Mays

November 4, 2019

New York State Department of Health
Office of Health Insurance Program
One Commerce Plaza
Albany, New York 12207

Re: Public Comments on the NYS DOH DSRIP 2.0 from Brooklyn Perinatal Network Inc. (BPN) on Behalf of the Coalition Leadership Team (CLT) for Brooklyn Coalition for Health Equity for Women and Families

To Whom It May Concern:

I am responding, on behalf of the Community Leadership Team (CLT ) of the 18+ year old Brooklyn Coalition for Health Equity for Women and Families, to the welcomed invitation to offer comments to inform the proposed MRT Waiver for the DSRIP 2.0 . We have **4** key recommendations to add as noted later in this document.

BPN and our CLT are members of the NYC Communities Working Together for Health Equity (CTHE) consortium and add our comments supporting theirs. BPN led the convening of the Brooklyn CBO Hub component of the CTHE. The CTHE was funded by NYSDOH for the current DSRIP with a requirement to identify strategies to plan to organize traditional small CBOs with budgets under $5M that are also anchored in the delivery of social health services in neighborhoods experiencing racial disparities in health outcomes. The CTHE membership is demographically and linguistically diverse and represents delivery of critical services to over 350,000 of the city's most vulnerable and disenfranchised populations. Brooklyn has more than 20% of its share of the borough being the most condensed with among the highest levels of poverty and social determinant that underlie the poor health outcomes.

BPN along with many partners of the CTHE and others have, for over 30 years, made addressing maternal and child health (MCH) an area of priority in the city's CBO service landscape, due to persistent grave disparities in health and birth outcomes for the populations of color and particularly Blacks. Currently, a major crisis exists in parts of NYC with black maternal deaths and severe morbidity and mortality (SMM) at a rate more than 12 times the acceptable, capturing national media attention. Yet, BPN and its coalition partners have continually experienced low levels of funding with <u>none</u> from the current DSRIP to address this community health concern. The major reason is that the current DSRIP does not sufficiently incentivize PPS's for maternal child health (MCH) service delivery and thus none chose this as a domain for PPS work. Hence, our first recommendation relates to this.

**Recommendation # 1**

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Executive Director: Ngozi Moses, M.Sc.
Chairperson: Bettie Mays

DSRIP 2.0 should give the domain maternal and child health (MCH) equal compensation priority to sufficiently incentivize PPS's to engage in funding such projects.

**Recommendation # 2**
Allocate the SDOH financial resources proposed with stipulations that only the traditional (non-commercial) community- engaged (versus only located) social service organizations can qualify to receive the funding.

As commercial social service organizations are arising quickly across the national service landscape, backed by venture capitalist funding , and NYC is no exception, a major threat has emerged and is looming large threatening the survivability of the traditional CBOs, and that will eventually marginalize those that survive as funding challenges increase for these small CBOs (of the kind the CTHE organizes) being unable to compete with the commercial giants. While DSRIP health reform was meant to assure that the clinical health care service system do more to effectively engage these traditional trusted community-based service entities, the opposite could be the reality as they rush to engage the commercial CBOs with massive capacity ignoring the smaller traditional CBOs for the usual and expected service contracts.

**Recommendation # 3**
Stipulate that capacity building for the traditional CBOs is essential, required and is encouraged to effectively engage them as a part of the service delivery structure and that formal service networks are encouraged to participate more effectively in the DSRIP economy and beyond for service delivery sustainability.

The Pathways HUB (PHUB) program model, acclaimed and promoted by the AHRQ and AMCHIP, with strong evidence-based support, has the tested structure to organize small CBOs to sustainably deliver social health services with guaranteed high quality, utilizes outcome-tracking health information technology; coordinates health and social services providers to integrate social determinants and utilizing a blended financial multi-source funding strategy. The CLT is proposing that this PHUB program model be explored and funded by the DSRIP and to be able to specifically qualify for DSRIP capacity building funds for CBOs addressing social determinants of health. The PHUB model will complement existing and emerging Medicaid funding initiatives such as health homes and the First 1000 Days On Medicaid Initiative. A major challenge is identifying the funding to develop the required administrative HUB infrastructure which is the key and core structural component of the service delivery system. Making DSRIP 2.0 funding available will alleviate this hurdle.

The Pathways Community HUB (PCH) Model has been granted "Best Practice" evidence-based designation by the Association of Maternal and Child Health Programs (AMCHP). http://www.amchp.org/programsandtopics/BestPractices/InnovationStation/ISDocs/Pathways%20Community%20HUB.pdf.

Celebrating Over 30 Years of Excellence

Executive Director: Ngozi Moses, M.Sc.
Chairperson: Bettie Mays

This designation recognized by U.S. DHHS, HRSA Bureau of Maternal and Child Health and many others brings needed evidence focused endorsement to the fidelity of the national PCH model. The designation may be important to policy makers, funders and especially Pathways Community HUB (PCH) programs. PCHs and their research and evaluation partners have worked together to demonstrate the outcome improvement and cost savings for Certified PCHs especially focusing on birth outcomes and reduced cost. The work has now extended to evaluations in chronic disease and social service-related risk reduction outcomes.

In support of this recommendation, the CLT urges the DOH to accept and implement the recently released Findings of the Congressional Briefing on Social Determinants of Health, offering **4** recommendations as noted below:

Congressional Briefing

- The first recommendation is to align policies, funding and reimbursement for addressing social determinants across private and public payers, community-based organizations and social services agencies, as well as health care systems and providers.

- The second recommendation is to develop key sets of measures to incorporate social determinants across the health ecosystem, including those to prioritize population subgroups based on most significant needs and health disparities.

- The third recommendation includes identifying locally actionable data, forming partnerships across community and clinical settings, and monitoring progress on social determinants data integration using a standardized set of community and clinical outcome measures.

- The fourth recommendation is to provide funding to test, collect data, assess and measure efforts to address social determinants.

- The fifth recommendation is to incentivize and reward health care organizations at multiple levels.

**Recommendation # 4**

We urge that this become a key concern for DOH to assure that CBOs can measurably engage in the DSRIP 2.0. The potential marginalization of the small traditional CBOs that are trusted organizations addressing social determinants with our most hard to reach /don't want to be readily reached citizens, with high risk of poor health outcomes and assisting them to more easily access social services in their respective communities, must become a concern for the DOH. This is a very pertinent local issue for NYC.

Celebrating Over 30 Years of Excellence

Executive Director: Ngozi Moses, M.Sc.
Chairperson: Bettie Mays

For your interest the AMCHIP one pager is attached.

Sincerely,

Ngozi Moses, Executive Director
Brooklyn Perinatal Network, Inc.
On behalf of the CLT

# Certified Pathway Community HUBs Designated as an AMCHP Best Practice

The Pathways Community HUB (PCH) Model has been granted "Best Practice" evidence-based designation by the Association of Maternal and Child Health Programs (AMCHP).
http://www.amchp.org/programsandtopics/BestPractices/InnovationStation/ISDocs/Pathways%20Community%20HUB.pdf.

This designation recognized by U.S. DHHS, HRSA Bureau of Maternal and Child Health and many others brings needed evidence focused endorsement to the fidelity of the national PCH model. The designation may be important to policy makers, funders and especially Pathways Community HUB (PCH) programs. PCHs and their research and evaluation partners have worked together to demonstrate the outcome improvement and cost savings for Certified PCHs especially focusing on birth outcomes and reduced cost. The work has now extended to evaluations in chronic disease and social service-related risk reduction outcomes.

The PCH model has three components that researchers at Akron Children's Hospital, Kent State University and the Georgia Health Policy Center have recognized as critical.

1. **Individually modifiable risks** spanning medical, social and behavioral health, represent critical opportunities to identify and address to improve both health and social outcomes. An expectant mother may have risk factors that span access to medical care, housing, and depression. If only one of those risks are addressed, in our currently fragmented system of care, our research shows she may not achieve the healthy birth and other related positive outcomes. The Community Health Workers deployed within the HUB model informed the model early on that a whole person approach was needed. Not only expectant mothers but also adults with chronic disease, children struggling in school, and those unable to achieve employment require an assessment of all of the factors that may be impacting their future success and assistance and support in addressing them. Helping the expectant mother with housing, depression treatment and access to prenatal care may not only achieve a healthy birth outcome, but she is also more likely to complete adult education, employment and other key health and social outcome achievements.
2. **Pay for Outcomes –** Pay for value has been a major emphasis in health care yet limited in identified successful approaches. One of the most successful approaches has been models that pay for specific client/patient level outcomes, including those that are meaningful to the client. Much of the research with this has focused on knee surgery and other medical outcome events. The PCH model extends this same accountability to other interlinking and critical outcomes such as achieving housing for a homeless individual, food, clothing, employment, adult education and many others. In each of the Pathways completed within a Certified PCH there is a confirmed risk mitigation outcome meaningful to the individual served. Fifty percent of all dollars must be tied to confirmed outcomes for nationally Certified PCHs
3. **Relationships –** Relationships are critical to achieving health. In our research examining individually modifiable risk factors we have identified that between 1/3-1/2 of the critical risks that must be addressed are learning and behavior change related. A mother of a new baby may get a handout for safe sleep at the primary care visit but does she really accomplish learning and behavior change resulting in placing the baby on its back to sleep? In collaboration and partnership with primary care and through the repeated extended home visits of the Community Health Workers (CHWs) develops a critical and supportive relationship with at-risk individuals often in crisis. The relationship is amplified through the culturally connected and community imbedded CHW who can take the time needed to make sure that the learning is accomplished across safe sleep, nutrition, compliance with medical visits, home safety, going back to school, employment and many others. CHWs can help assure connection to services and can help empower critical behavior change to improve outcomes.

The Pathways Community HUB Institute and nationally Certified PCHs across the country appreciate this evidence-based "Best Practice" designation. We also realize we have much to learn and many additional improvements we could achieve. We will work with AMCHIP to continue to critically evaluate the results and scientific evaluation to work towards the greatest improvements possible for those at risk in health and social outcomes spanning MCH populations and adult populations. For more information pchi-hub.com

PCHI – 8-5-19

## doh.sm.1115Waivers

**From:** James introne [redacted]
**Sent:** Monday, November 4, 2019 7:03 PM
**To:** doh.sm.1115Waivers
**Subject:** PACE Alliance MRT Extension Proposal Comment Letter.pdf
**Attachments:** PACE Alliance MRT Extension Proposal Comment Letter.pdf



Subject Line: **1115 Public Forum Comment**

Dear MRT Waiver Management Unit,

Please find attached New York PACE Alliance's comments to the 1115 Medicaid Redesign Team Waiver Amendment Proposal. Do not hesitate to reach out with questions or clarifications.

Jim Introne

Sent from my iPad

**The New York PACE Alliance**
205 Lexington Avenue, 3rd Floor
New York, NY 10016

November 4th, 2019

**VIA ELECTRONIC MAIL**

New York State Department of Health
Office of Health Insurance Programs
Waiver Management Unit
1115waivers@health.ny.gov

Dear Medicaid Redesign Team:

The New York PACE Alliance ("PACE Alliance") appreciates the opportunity to comment on the 1115 Medicaid Redesign Team (MRT) Waiver Amendment Proposal, hereafter referred to as "the Proposal." The PACE Alliance represents ten current and prospective PACE Programs that offer a wide range of services to over 5,000 frail, elderly, and disabled New Yorkers across the state, most of whom are dually eligible for Medicare and Medicaid. PACE covered services include Medicaid long-term care services such as home care, adult day care, specialty health, and other support services as well as Medicare services such as doctor's office visits, emergency and hospital care, Medicare Part D drug benefits and more. Through an interdisciplinary care team (IDT) model, the PACE team of doctors, nurses, social workers, nutritionists, physical and occupational therapists and others develop an individualized care plan that ensures participants receive all of the health care services they need. PACE Alliance member organizations have a track-record of delivering high quality care and are committed to helping elderly New Yorkers live safely in their own home for as long as possible.

The PACE Alliance is encouraged by the State's recognition of the need for long-term care workforce development, major involvement of social determinants of health, and the expanded role managed care organizations (MCOs) in Value-Driving Entities (VDEs) in the Proposal. In the latter, NYS proposes to establish VDEs with general MCO participation to lead the implementation of DSRIP promising practices in the next phase of the program. However, the PACE Alliance has some concerns on how PACE and treatment of specialized populations, such as long-term care eligible individuals, will fit into the generality of the VDE construct. The comments that follow reflect PACE Programs feedback related to the proposed design approach for the next phase of DSRIP and provide recommendations for advancing the State's vision to create an integrated healthcare system that improves the quality of care and reduces costs.

***Medicaid-Medicare Integration and a Renewed Duals Integration Strategy***

Approximately 91% of individuals who require long-term care services in New York State are dually eligible and are disproportionately the highest cost enrollees than either Medicare-only or Medicaid-only.[1] Individuals who

[1] December 2017 data from "Providing Integrated Care for New York's Dual-Eligible Members" and New York States Medicaid Managed Care Enrollment Report from December 2017.

require LTSS – both institutional and community-based – account for about 60% more in Medicare costs than those who do not use LTSS services.[2] Spending on Medicaid, particularly for home-based long-term care services, saves money on costly health care interventions, particularly hospitalizations. For these reasons, the need for the Proposal to focus on the potential role of care management in the long-term care dual eligible population is clear and compelling.

In the early years of the current DSRIP waiver, the Fully Integrated Duals Advantage (FIDA) Demonstration was expected to be a major feature of the State's strategy to address care needs of this complex and unique population. However, FIDA failed to gain traction with the State's providers and eligible consumers and the demonstration is sunsetting at the end of this year. NYSDOH is currently exploring more cost-effective care options for dually eligible beneficiaries through its "Providing Integrated Care for New York's Dual-Eligible Members" stakeholder discussion series. Those discussions have largely focused on transitioning from the FIDA demonstration to MAP, enhancing MAP, and leveraging default enrollment for mainstream Medicaid members into either Medicaid Advantage or MAP. We fully support these efforts. However, we are concerned that they do not fully capture the opportunity to integrate care, particularly for individuals requiring LTSS services. One of the benefits of integrating Medicare and Medicaid is the possibility for the State to recover part of the Medicaid expenses that produce Medicare savings. However, the Proposal is not currently structured to allow NYS or LTSS providers to share in Medicare savings despite the increased Medicaid covered services needed to achieve these savings. The next DSRIP demonstration must prioritize care and payment models that can effectively integrate care across these payment streams and ensure equitable payments for the State, plans and providers. Providing more effective care for dually eligible individuals has been and remains a major CMS priority, so a DSRIP application that addresses this critical issue would be aligned with federal goals.[3]

***Recognition of PACE as a Population-Specialized VDE***

PACE, is a proven program that incorporates the essential elements of health care funding and program reform that are sought by the Proposal. As such, it should be an integral part of the Proposal. PACE has demonstrated effectiveness in improving health outcomes and reducing costs compared to other models of care. A U.S. Department of Health and Human Services study found higher quality of care and better outcomes among PACE participants compared to home and community-based service (HCBS) waiver patients.[4] A New York City-specific study compared hospital and skilled nursing facility utilization between a PACE program and a Medicaid-sponsored, managed long-term care plan and found that PACE participants had fewer hospitalizations than the Medicaid plan enrollees. Medicaid plan members were more likely to be admitted to a hospital and experienced longer stays.[5] Finally, PACE program services are paid for through a single funding stream that recognizes the contribution of Medicaid spending to Medicare savings.

Because PACE already accomplishes the Proposal's desired financial and clinical integration across acute and LTC stakeholders, the PACE Alliance encourages NYSDOH to recognize PACE as a model that can reinforce the

[2] MedPAC and MACPAC. "Beneficiaries Dually Eligible for Medicare and Medicaid: Data Book." Exhibit 4, p. 32, and Exhibit 18, p.58. January 2018. Found here: https://www.macpac.gov/publication/data-book-beneficiaries-dually-eligible-for-medicare-and-medicaid-3/.

[3] "CMS Announces New Opportunities to Test Innovative Integrated Care Models for Dually Eligible Individuals." *CMS*, 24 Apr. 2019, https://www.cms.gov/newsroom/press-releases/cms-announces-new-opportunities-test-innovative-integrated-care-models-dually-eligible-individuals.

[4] Leavitt, M. (2009). Interim report to Congress. The quality and cost of the Program of All-Inclusive Care for the Elderly.

[5] Nadash, P. (2004). Two models of managed long-term care: Comparing PACE with a Medicaid-only plan. Gerontologist, 44 (5): 644-54.

Proposal's desired integration across acute and LTC stakeholders. One plausible option would be for NYSDOH to acknowledge PACE as a "PACE-VDE", or an already existing form of a VDE for a specialized subpopulation. The Proposal states that VDEs will bring together organizations and providers with expertise in intensive care coordination, personalized care management, and home and community-based care. It goes on to suggest VDEs would implement value-based payment models designed to drive total cost of care savings by reducing potentially avoidable hospitalizations (PAH) and other avoidable interventions. As a provider staff model, PACE already accomplishes this function to a prioritized long-term care subpopulation that has the most complex needs and accounts for a disproportionate Medicaid expense and already is considered a Level 3 VBP arrangement, the highest of such arrangements in the current DSRIP program. A PACE program's population has far more frequent engagement with its consumer than health homes or other outside acute care providers. As such, attribution for the PACE-VDE should be based on enrollment in a PACE program at the top of the priority hierarchy.

While PACE organizations receive a prepaid amount to pay for health care services, through participation as a PACE-VDE, NYSDOH can ensure funds can fuel the DSRIP-aligned goals of PACE in other ways, such as for capital expenses that PACE organizations are heavily reliant upon for program expansion. In addition to PACE-VDE recognition, NYSDOH can continue to support PACE enrollment growth and recognize the unique benefits of the PACE model from the other models in the State's managed long-term care construct.

Taking into account these considerations, the PACE Alliance recommends the new MRT Extension accomplish the following:

- Develop a shared savings partnership that rewards NYS (and its Medicaid payers and providers) for Medicare savings attributed to Medicaid spending;
- Recognize PACE as a viable integrated long-term care model in New York State that already accomplishes the goals of the Proposal;
- Consider PACE and its population as a population specialized PACE-VDE; and
- Do not further regulate PACE through the Proposal as PACE is already highly regulated by both NYS and the federal government.

Thank you for your consideration of these recommendations. We look forward to working with NYSDOH and our other partners on this important effort to improve New York State's healthcare payment and delivery system.

Thank you for your attention.
Sincerely,

Jim Introne
CC: Members, New York PACE Alliance

## doh.sm.1115Waivers

**From:** Cruz, Erica [redacted]
**Sent:** Monday, November 4, 2019 7:12 PM
**To:** doh.sm.1115Waivers
**Cc:** Lewis, Michelle; Juste, Nadine; Lacey Clarke
**Subject:** DSRIP Concept Paper Comment (NYC H+H/Gotham Health)
**Attachments:** DSRIP Concept Paper Comments (NYC H+H-Gotham).pdf



Hello, the attached is being submitted on behalf of NYC Health + Hospitals/Gotham Health.

**Erica Cruz**
HRSA Program Director
100 N. Portland Avenue
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[redacted]

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**To:** New York State Department of Health
**From:** Michelle Lewis, Chief Executive Officer, NYC Health + Hospitals/Gotham Health
**Date:** November 4, 2019
**Re:** Public Comments on DSRIP 2.0

NYC H+H/Gotham Health (Gotham Health) is grateful for the opportunity to provide comments on the Delivery System Reform Incentive Payment (DSRIP) Amendment Request concept paper published on September 17th. Gotham Health provides a full range of culturally and linguistically competent health care and supportive services to low income, underserved populations throughout New York City with staff reflective of our service area. Our mission has and always will be to extend equally to all individuals, regardless of their ability to pay or immigration status, comprehensive health services of the highest quality to enable all individuals to live their healthiest life. Gotham Health is NYS PCMH recognized and has received Quality Improvement Awards from HRSA for being a National Quality Leader and Health Center Quality Leader. And though we have made significant progress in addressing numerous health issues in our service area, there is still significant unmet need.

Gotham Health commends the State's work in the first round of DSRIP to reduce costs, improve patient outcomes, and decrease unnecessary inpatient and emergency room utilization. For New York to experience a real transformation of the health care delivery system and sustain the gains thus far achieved through DSRIP, there must be a significant investment in community-based primary care. Only through this investment can the State achieve a true value-based system that improves health outcomes and reduces costs. Gotham Health supports the renewal of the DSRIP program through March 31, 2024. Gotham Health, a member of the Community Health Care Association of New York State (CHCANYS), supports the comments submitted by CHCANYS and has restated and revised many of their points below.

## I. Driving Promising Practices to Improve Health Outcomes and Advance VBP

By mission and in statute, health centers serve the State's most vulnerable and hard to reach populations. FQHCs are non-profit, community run centers located in medically underserved areas that provide high-quality, cost effective primary care, including behavioral and oral health services, to anyone seeking care. Each FQHC is governed by a consumer-majority board of directors who are tasked with identifying and prioritizing the services most needed by their communities. Of the 156,102 patients served in 2018, 53% were enrolled in Medicaid or CHIP.

Our 57 sites located in Gotham Health's extensive service area encompasses 87 densely populated zip codes across all boroughs of New York City. In the first round of DSRIP, we participated 11 projects, through our PPS, OneCity Health:

| PPS Name | Project Name |
|---|---|
| 2.a.i Create an Integrated Delivery System focused on Evidence-Based Medicine and Population Health Management | *Integrated Delivery System* |

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| | |
|---|---|
| 2.a.iii Health Home At-Risk Intervention Program: Proactive Management of Higher Risk Patients Not Currently Eligible for Health Homes through Access to High Quality Primary Care and Support Services | *Health Home At-Risk Intervention Program* |
| 2.b.iii ED Care Triage for At-Risk Populations | *Emergency Department (ED) Care Triage* |
| 2.b.iv Care Transitions Intervention Model to Reduce 30-day Readmissions for Chronic Health Conditions | *Care Transitions Model* |
| 2.d.i Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care | *Patient Activation* |
| 3.a.i Integration of Primary Care and Behavioral Health Services | *Integration of Primary Care and Behavioral Health Services* |
| 3.b.i Evidence-Based Strategies for Disease Management in High Risk/Affected Populations (Adults Only) | *Cardiovascular Disease Management* |
| 3.d.ii Expansion of Asthma Home-Based Self-Management Program | *Asthma Home-Based Self-Management Program* |
| 3.g.i Integration of Palliative Care into the PCMH Model | *Palliative Care* |
| 4.a.iii Strengthen Mental Health and Substance Abuse Infrastructure across Systems | *Mental Health and Substance Use Infrastructure* |
| 4.c.ii Increase early access to, and retention in, HIV care | *HIV Care* |

Some of our promising practices included:

- In this past year, the public health system hired 29 chronic disease nurses with $3.5M in DSRIP funding to support intervention programs for chronic diseases, such as high blood pressure. The American Heart Association and the American Medical Association recently recognized the City's public health system for its commitment to achieving better blood pressure control.
- The launch of Pathway Home, an innovative care transition program created by Coordinated Behavioral Care (CBC), to help individuals with mental health needs transition from short-term health services to ongoing community-based care. The Pathway Home program will provide multidisciplinary care transition services to patients 18 and older transitioning from psychiatric inpatient units who have had four or more mental health inpatient visits in the past 12 months. Pathway Home teams will actively participate in aftercare planning and perform a transition needs assessment, accompany patients' home and arranging for any immediate needs, such as food and filling prescriptions, accompanying them to primary care visits, and meeting with them regularly for six to nine months post-discharge. In addition to reducing avoidable readmissions, Pathway Home aims to strengthen community-based care and improve connections to outpatient services post-discharge, shortening length of stay and increasing participation in treatment.

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- The 100 Schools Project, coordinated by the Jewish Board under the leadership of OneCity Health and its partners, brings together schools and community health resources to improve students' access to mental health services, creating a more productive learning environment for both students and teachers. Participating schools also learn how to connect students who have emotional, behavioral, or substance-use challenges with top-tier local mental health providers while enabling the students to remain in school. Following the recent death of a student at a high school in Brooklyn, four behavioral health coaches and their supervisor from the 100 Schools Project were immediately on hand to provide group and individual counseling, as well as information about supportive resources available to the community.

The first round of DSRIP complemented the health center model's unique and innate ability to provide comprehensive and innovative care to New York's Medicaid beneficiaries. Health centers played and continue to play a key role in advancing the promising practices within their regions and driving improved health outcomes. In the second round of DSRIP, health centers are well-prepared to take a leadership role to advance the State's vision of an expanded value-based payment (VBP) landscape driving DSRIP promising practices.

## II. Embracing the Role of VDEs

We are pleased to see that the State has acknowledged the need for additional flexibility in the next round of DSRIP and is interested in ensuring the success of Value-Driving Entities (VDEs). However, we encourage the State to provide direct investment in community-based providers. Currently, 23 of 25 of the PPS leads are hospital-based, with no specific requirements about how funds flow to partners in the PPS networks. Meaningful governance participation by community-based providers, such as community health centers and community behavioral health organizations, and downstream investments to health centers and other community-based providers varied greatly from PPS to PPS. Using publicly available data reported by the State, it is extremely difficult to determine the amount of money received by health centers in the first round of DSRIP – they are included as "clinics" with hospital ambulatory providers. However, the most up to date data reported by the State in November 2018 demonstrates that hospitals received more than 28% of total funds flow while representing only 0.2% of total engaged PPS partners.[i] It is exceedingly difficult to transform the healthcare delivery system by continuing to invest most transformation dollars into inpatient-based care models, when it is the long-standing established CHC providers and workforce that can make the biggest impact on patients' health outcomes. CHCs are especially well-posed to integrate care, make connections to address social needs, and become the more adept and agile VDEs envisioned in the State's concept paper.

We support the State's charge that VDEs include providers, community-based organizations (CBOs), and managed care organizations (MCOs) to leverage VBP and advance promising practices. A collaborative partnership between community-based providers, CBOs, and MCOs is critical to implementing and supporting transformative initiatives that move away from a volume-driven care model. However, to support improved access to care in the community and reduce reliance on emergency departments and inpatient care, the State must direct additional resources to a broad range of community-based providers. **Gotham Health requests that the State dedicate, at a minimum, 25% of DSRIP funds to the development of community-based VDEs where CHCs, in collaboration with other community-based providers, are leads.**

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**a. VDE Lead Entities**

The State should capitalize on existing health center Independent Practice Associations (IPAs) as a launching point for the creation of community-based VDEs. There four CHC-led IPAs currently organized across the state, Community Health IPA (CHIPA), Safety-Net IPA (SIPA), Finger Lakes IPA (FLIPA), and Upstate Community Health Collaborative IPA (UCHC), are engaged with MCOs in at least one VBP contract while working on additional agreements. We are members of OneCity Health, NYC's largest PPS, sponsored by Gotham's public entity: NYC Health + Hospitals. IPAs are able to take on risk and become financially accountable for both the quality of care and the most efficient delivery of care services. We believe that IPAs are well positioned to work with other entities as a VDE in the second round of DSRIP.

OneCity Health is well-equipped, prepared and committed to becoming a VDEs in its approach to addressing primary and behavioral health care services across the boroughs. To ensure appropriate care for all NYC residents – with a focus on preventive, primary and behavioral care – the OneCity Health partnership includes hundreds of community-based healthcare providers, services, and organizations, as well as NYC Health + Hospitals' network of acute care hospitals, nursing homes, community clinics, home-care service, and MetroPlus, NYC Health + Hospitals' health insurance plan.

While health centers like ours are already developing relationships needed to advance in VBP contracts, a second round of DSRIP is an opportunity to invest in building capacity to ensure health center and CBO IPAs have the foundation to serve as VDEs. Currently, health center-led IPAs are self-funded and have little financial capacity to support many of crucial functions that would accelerate their successful participation in VBP arrangements. **Health center-led IPAs require DSRIP investment to support the data analytic capabilities needed to effectively manage population health and drive improved outcomes.**

**b. Considerations for Engaging MCOs**

Gotham Health is pleased that the State is taking steps to ensure engagement of MCOs early in the planning process for a second round of DSRIP. However, there are significant challenges that must be addressed ahead of the creation of VDEs. One of the current difficulties faced by providers as they seek to participate in VBP arrangements is a lack of comprehensive data about their attributed patients. **The State should create and enforce a uniform data sharing policy for the managed care plans to further support the transition to VBP, for example, by enforcing transparency in expenditures and utilization.** In the first round of DSRIP, the discrepancies between MCO attribution and PPS attribution made it difficult for health centers to effectively manage patient health outcomes. PPS networks do not necessarily encompass the same providers that are contracted with a given MCO. If there are discrepancies between MCO attribution, consumer utilization, and PPS network, it becomes incredibly difficult, if not impossible, for the PPS to effectively manage health outcomes for these populations. PPS and VDEs should not be expected to manage the health care improvements of individuals who are enrolled in managed care plans that contract outside of the VDE. **Gotham Health recommends that in the next round of DSRIP, VDE attribution should be aligned with MCO attribution to ensure seamless VBP contracting.**

Finally, we understand the State's desire to drive regional innovation – local health care needs vary based on geography, CBO and health care provider landscape, and other factors. However, we would

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like to raise the concern that in densely populated areas served by many MCOs with overlapping service areas (notably, New York City), defining distinct regions may prove difficult. **In New York City, Gotham Health recommends that VDE networks should align with patient utilization patterns as much as possible.**

### III. Supporting Non-Clinical Workforce to Address Social Needs

Gotham Health echoes the State's observation that many of the successful DSRIP initiatives rely on non-traditional, non-clinical workforce that help patients navigate clinical and social services systems to address their multi-dimensional needs. In the first round of DSRIP, we embraced the flexibility to address patients' social needs. Recognizing the need of resource base to capture the information on the resources available to OneCity Health's partners, Now Pow was created. NowPow is a web-based social services directory and referral software available to OneCity Health partners. It enables providers to identify community resources, make referrals for patients and clients, and track patient engagement. NowPow offers multiple "products" with specific features; we made one of the products, NowRx, available during the first phase of our rollout. NowRx offers a comprehensive, accurate and searchable resource directory of New York City organizations that allows staff to find social services that meet an individual's needs and priorities. Once organization(s) are identified (using any number of filters that include geography, languages spoken, targeted conditions, etc.), staff can send patients and client referrals via email, text or printed copy.

In the first round of DSRIP, the State encouraged primary care practices to become patient-centered medical home (PCMH) recognized. Today, 97% of New York's health centers are PCMH certified. PCMH certified practices provide mental health, oral health, and health promotion/disease prevention services through comprehensive primary care. This model of patient-centered care is associated with improved health outcomes and reduced costs and should be robustly supported in the second round of DSRIP. There are numerous studies that have analyzed the success of PCMH, including citing fewer specialty visits needed, lower per member costs, and better health outcomes amongst individuals seeing PCMH-certified providers.[ii]

**The State should use a second round of DSRIP to continue investments in care management programs like PCMH and Health Homes to address patients' social and medical needs.**

### IV. Aligning Performance Measures

**Gotham Health** strongly supports the State's desire to work with CMS to align performance measures across initiatives. Health centers' participation in Medicare, Medicaid, NYS PCMH, and contracts with managed care plans (among various other programs) requires a significant amount of resources invested in measure/data collection and reporting. **The State should target measures most likely to be of value for all participants in DSRIP 2.0.**

### V. Health Center Alternative Payment Methodology

FQHCs embrace the State's transition of Medicaid payment from volume to value. Gotham Health supports this direction and is also engaged in work with CHCANYS to move away from a visit based FQHC payment to a capitated FQHC Alternative Payment Methodology (APM). Federal statute permits states to implement an APM in lieu of the legally required prospective payment system reimbursement

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methodology. States must ensure that reimbursement under the APM is not less than it would be under the prospective payment system rate; however, adoption of an APM is essential to move FQHCs from a visit-based payment that incentivizes volume, to a payment methodology that rewards efficiency and outcomes. A capitated FQHC APM aligns with the State's DSRIP goals of advancing VBP and provision of enhanced care coordination.

An FQHC APM supports team-based, integrated care and enables CHCs the flexibility needed to create innovative approaches to care which can include non-clinical support staff who are not billable providers under the prospective payment system rate. The creation of innovative care coordination workflows will improve care provided directly by FQHCs, therefore reducing costs across the health care system. Gotham Health looks forward to working closely with CHCANYS and the Office of Health Insurance Programs to establish a mutually agreeable approach that supports health centers' ability to transform their entire practice to a value-based care delivery model. Once the APM receives a federal approval, a small subset of health centers will transition from the prospective payment methodology to the APM. **To ensure the success of an APM, State investment is needed to enhance data collection capabilities and catalyze the development of new staffing roles, models for care teams, and innovative work flows.** These investments may include: enough funding to support interventions addressing patients' non-clinical social needs, support for an alternative payment learning community, clinical and cost data analyses, quality metric identification, and reporting mechanisms.

Gotham Health has actively engaged in DSRIP implementation and contributed to many of the successes achieved. We look forward to continuing to partner with the State to achieve our shared goals of system transformation and improved patient care, better patient outcomes, and reduced care costs.

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[i] https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/paop/meetings/2018/docs/2018-11-29_updates.pdf

[ii] Kaushal R, Edwards A, Kern L. May 2015. Association Between the Patient-Centered Medical Home and Healthcare Utilization. American Journal of Managed Care. Am J Manag Care. 2015;21(5):378-386.

Raskas R, Latts L, Hummel J et al. 2012. Early Results Show WellPoint's Patient-Centered Medical Home Pilots Have Met Some Goals For Costs, Utilization, And Quality. Health Affairs. Vol. 31, No. 9: Payment Reform to Achieve Better Health care. https://doi.org/10.1377/hlthaff.2012.0364

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## doh.sm.1115Waivers

**From:** Gianelli, Arthur [redacted]
**Sent:** Monday, November 4, 2019 7:38 PM
**To:** doh.sm.1115Waivers
**Subject:** Letter to NYSDOH from the Mount Sinai Health System Regarding the DSRIP Waiver Amendment Request
**Attachments:** Letter to NYSDOH from MSHS Re DSRIP Waiver Amendment Request.pdf



Please see attached.

Mount Sinai St. Luke's

**Arthur A. Gianelli**
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November 4, 2019

New York State Department of Health
Office of Health Insurance Programs
One Commerce Plaza
Albany, NY 12207

**Re: Comments Submitted by the Mount Sinai Health System to the New York State Department of Health Regarding the Delivery System Reform Incentive Payment Amendment Request**

To Whom It May Concern:

On behalf of the Mount Sinai Health System ("MSHS"), I offer the following comments to the New York State Department of Health ("NYSDOH") regarding the Amendment Request to the Section 1115 Medicaid Redesign Team Waiver ("Waiver") to extend for an additional four years the Delivery System Reform Incentive Payment Program ("DSRIP").

1. **The MSHS recommends against proposing the creation of Value-Driving Entities ("VDEs").** VDEs are proposed in the Amendment Request as a means of expanding upon Performing Provider Systems ("PPS") to be broadly inclusive of community, insurance, and data-sharing partners while emphasizing and accelerating the transition from fee-for-service to value-based payment arrangements, particularly those with attendant downside risk. It is the view of the MSHS that the creation of additional organizations to distribute funds and coordinate care for Medicaid patients segments the organization of the delivery system and unnecessarily segregates Medicaid patients from other patient populations. Instead, the MSHS proposes that the Amendment Request leverage two already-existing risk-bearing entities: Clinically Integrated Independent Physician Associations ("IPAs") or Medicaid Accountable Care Organizations ("ACOs"). Either of these risk-bearing entities can be expanded to include as members a broad array of partners, and both are the organization types that

encourage collaboration and integration amongst providers to lower costs and improve quality and outcomes. VDEs, in the view of the MSHS, are redundant, add unnecessarily to the complexity of the delivery system, and serve only to further isolate Medicaid patients from other patient classes.

2. **The MSHS recommends that NYSDOH address substantive flaws in its risk-adjustment model in order to create greater incentive for providers to assume downside risk on Medicaid patients.** The MSHS takes full capitated risk on well over 100,000 Medicaid patient lives. In managing these patients, the MSHS has been impacted both by the inadequacy of the State's risk adjustment methodology for high cost patients and by insufficient stop-loss protections against jumps in pharmaceutical costs due to public policy changes or new market entrants. With Medicaid reimbursement already lower than reimbursements for patients insured through Medicare, self-funded organizations, or by commercial carriers, exposures generated by high-cost patients and high-cost pharmaceuticals – in the absence of any broad remedial steps – have made the MSHS wary of assuming even more downside risk associated with Medicaid patients.

3. **The MSHS recommends that NYSDOH broaden the approach emphasized in the Amendment Request to include emerging mechanisms of data sharing.** As in the initial Waiver, the Amendment Request emphasizes the utilization of Qualified Entities ("QEs") to facilitate the protected exchange of patient information among organizations that do not operate under a common corporate umbrella. There are a number of challenges with this approach, including the identification of long-term funding to support the operation of QEs as well as the degree of capacity building still required to connect Community Based Organizations ("CBOs") to the QEs. Since the finalization of the initial Waiver, alternative approaches to protected data sharing have emerged, such as Care Quality, which facilitates the exchange of patient information between health data networks, including different electronic medical record systems. The Amendment Request should take note of these developments and include these alternatives as mechanisms the development and scaling of which Waiver funds can support.

4. **The MSHS recommends that NYSDOH specifically focus funds from this Waiver on building the capacity and the linkages between Community Based Organizations ("CBOs") and current and emerging mechanisms for data-sharing.** During the initial Waiver period, not enough was done to ensure that CBOs had the baseline capacities needed to connect with and exchange information through either QEs or other mechanisms of data sharing. The Amendment Request should direct funds for this purpose so that the care of Medicaid patients can be better coordinated and so the social impediments to care can be optimally addressed.

5. **The MSHS recommends against the use of the current DSRIP patient attribution methodology.** The patient attribution methodology employed in the initial Waiver created scenarios where patients on whom certain providers were taking risk were assigned to PPSs that did not include these providers. The attribution methodology also reset the assignment of Medicaid patients such that different patients were assigned to the PPS at different times, which undermined the objective of building longitudinal care relationships between providers and their patients. The MSHS, instead, recommends the use of the attribution methodologies utilized by the individual Managed Care Organizations ("MCOs").

6. **The MSHS recommends against the Amendment Request being overly prescriptive regarding the clinical and social interventions required to achieve DSRIP goals.** The Amendment Request emphasizes the broad adoption of DSRIP Promising Practices, which are interventions that demonstrated the potential to improve outcomes and lower costs in the care of patients or patient populations insured through the Medicaid program. Though the DSRIP Promising Practices should inform the development of clinical and social interventions, the MSHS believes that the Amendment Request should seek to create incentives for performance, not prescriptions for actions on the part of providers and CBOs.

7. **The MSHS recommends that the Amendment Request include specific incentives for providers, CBOs, and MCOs to rationalize the coordination of care for Medicaid patients.** Medicaid patients can have their care simultaneously coordinated by their providers, by CBOs with which they interact, and by MCOs. This creates confusion for patients; it also represents a well-intentioned but wasteful use of scarce resources. The MSHS believes that the Amendment Request should direct funds to create incentives for

these organizations to work together to rationalize and optimize the coordination of care of patients enrolled in the Medicaid program.

The MSHS participated actively and successfully in the initial Waiver, leading a well-regarded, innovative, and impactful PPS. We look forward to participating in the amended Waiver, and we appreciate very much the opportunity to share our thoughts to help shape the ultimate submission by the NYSDOH to the federal government.

Sincerely,

Arthur A. Gianelli
Chief Transformation Officer – Mount Sinai Health System
President – Mount Sinai St. Luke's Hospital

**doh.sm.1115Waivers**

**From:** Harvey Rosenthal [redacted]
**Sent:** Monday, November 4, 2019 8:47 PM
**To:** doh.sm.1115Waivers
**Cc:** [redacted]
**Subject:** 1115 Public Forum Comment
**Attachments:** NYAPRS DSRIP 2.0 Commentsa.docx



Attached please find our comments and reactions to the state's DSRIP Draft Waiver Amendment Proposal.
Thank you,
Harvey Rosenthal
CEO, New York Association of Psychiatric Rehabilitation Services (NYAPRS)

New York Association of Psychiatric Rehabilitation Services, Inc.

**Harvey Rosenthal**
*Chief Executive Officer*
harveyr@nyaprs.org

**NYAPRS Comments on New York's DSRIP 2.0 Amendment Request**
November 4, 2019

On behalf of the New York Association of Psychiatric Rehabilitation Services (NYAPRS), I would like to express our great appreciation for this opportunity to offer comments on New York's draft Delivery System Reform Incentive Payment Program (DSRIP) amendment.

## Background

Since 1981, NYAPRS has forged a unique coalition comprised of thousands of New Yorkers with major behavioral health conditions and staff from upwards of 100 recovery-focused community agencies who have jointly advocated for and long supported the recovery, rehabilitation, rights and full community integration of our community members, going back to times when none of these were considered possible by our field and our society.

We have implemented this great mission through a combination of grassroots advocacy, provider and consumer training and technical assistance and through the creation of nationally acclaimed peer support service models.

At the same time, NYAPRS' work is personal for us since so many of NYAPRS' and our member agencies' staff are people in mental health recovery, like me.

In that spirit, we have sought to represent the consumer perspective on the Medicaid Redesign Team, the Behavioral Health and Value Based Payment Work Groups and the Behavioral Health Clinical Advisory Group since their outset.

NYAPRS has also worked arduously to promote and provide both consumer and provider education in support of a number of MRT programs, most notably the HARP, Health Home and Home and Community Based Services (HCBS) initiatives, as we view bringing Medicaid reimbursement for recovery focused services to be a landmark achievement for New York State.

We write today in very strong support of New York's application for a DSRIP Amendment that would allow additional time and funding support that would permit successful initiatives to fully mature while the state transitions to a value-based payment system that is based on high quality individual and system outcomes.

Yet, so much more is needed. Following are a number of recommendations we believe will strengthen DSRIP 2.0's enormous potential to meet state and national goals of promoting healthy lives while reducing avoidable costs.

## Recommendations

### A 30% Set Aside for Community Based Organizations

Recognizing the high percentage of DSRIP eligible members who live with major mental health challenges, we expected that community recovery providers who have had decades of expertise in effectively engaging and supporting members of our community would be at the forefront of driving the new systems of care developed via DSRIP 1.0.

Yet, for most of that period, the vast majority of DSRIP funds were used to stabilize or support primarily institutional organizations, many of which have chosen to 'build rather than buy' those community behavioral health services.

For example, by November 2018, mental health prevention, treatment and recovery service providers had received just 1.8% of all DSRIP funding received by Performing Provider Systems around the state while community agencies struggled to sustain themselves and their workforce due to inadequate funding and run away staff vacancy and turnover rates.

NYS government must be just as concerned about strengthening community behavioral health and related agencies to play a pivotal role in achieving DSRIP's inspiring goals, as it has been about stabilizing our local hospitals and nursing homes.

Just as the DSRIP 2.0 proposal includes $500 million to aid distressed hospitals, we look forward to seeing that hard-pressed community behavioral healthcare agencies are afforded a meaningful portion of the $5 billion DSRIP performance and $1.5 billion social determinants of health (SDH) related funding so that they are best positioned to properly support our most vulnerable New Yorkers.

It's not enough to simply keep people out of the emergency room and hospital…it's imperative that we offer the right kinds of support and opportunities to allow our most vulnerable New Yorkers to manage their health and succeed in their home communities.

- New York should live up to our well-deserved reputation as a national leader in innovative Medicaid reform by meeting, if not surpassing, the approach adopted by our neighbors in Massachusetts, who are devoting 30% or their DSRIP funds to community based providers ($547 million of a $1.8 billion. For more details, see https://www.mass.gov/info-details/massachusetts-delivery-system-reform-incentive-payment-program#community-partners-(cps)-and-community-service-agencies-(csas)-

### Raising Requirements to Contract with Community Providers

While our amendment rightly points out that New York was first in the nation to require that value-based initiatives must include contracting with a minimum of one community-based organization (CBO), one CBO arrangement is simply no longer acceptable.

- We must take the next step forward in DSRIP 2.0 by substantially raising the number of required CBO contracts in each health plan risk-based arrangement.

**Raising Requirements to Address the Social Determinants of Health in Value Based Payment Contracting**

There is significant and powerful evidence that addressing the social determinants of health is critical to helping people to improve their health while reducing avoidable healthcare, social and criminal justice system costs.

Most notably, these have led to outcomes like improved income and employment status, greater access to housing and social support, greater community inclusion and reduced involvement with the criminal justice system.

New York currently requires managed care plans to contract for at least one SDH intervention in risk-sharing VBP contracts but, once again, that is no longer acceptable.

- DSRIP 2.0 provides us with the opportunity and $1.5 billion in funding to substantially raise the number of required SDH arrangements in the VBP environment.

Further, we are greatly encouraged by the state's intention to invest Medicaid dollars in housing and look forward to getting more details.

**Social Determinant and Recovery Related Outcome Measures**

In a pay for performance value-based payment environment, plans and providers focus on meeting specified outcome measures that are identified by the state.

Currently, New York's accepted behavioral health measures solely include medically based outcomes like follow up with mental health clinicians within 7 days of discharge from a psychiatric hospitalization, adherence with antipsychotic medication and potentially preventable mental health related readmission rates.

At the same time, state Quality Measurement experts have considered but not endorsed the addition of critically important social determinant and recovery related measures that include maintaining/improving employment or higher education status, the maintenance of stable or improved housing status and no or reduced criminal justice involvement.

While some people may need or want medication and clinical care, all people need a house, a meal and a few dollars to meet their most basic needs and that allow them to avoid crises that too often lead to costly and preventable relapses and hospital admissions or readmissions.

- State officials must greatly accelerate the process to validate, use and financially incentive personal outcomes like these and move us beyond sole reliance on medically based process measures.

In that vein, we should give equal importance to consideration of the use of Patient Reported Outcomes, per a recommendation of the VBP Advocacy and Engagement Group (https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/2015-12-04_advocacy_engagement-meeting4.pdf, slides 11-14).

**Attribution**
New York currently employs a VBP attribution model that assigns responsibility for the coordination and outcomes of care for Medicaid members, as well as the distribution of savings, to primary care providers and networks.

But many members are both unaware of this assignment and/or are not actively engaged with a medical provider.

In many instances, Medicaid members are solely engaged with behavioral health care providers who have more familiarity and experience in addressing their unique needs and who have a proven record of success at forming meaningful relationships and alliances that foster improved health and community inclusion and reduced use of hospital and emergency services.

- The state should extend attribution to behavioral health providers when they represent the primary health care relationship in a member's life and implement this practice in DSRIP 2.0, which will represent a huge win for the members, their providers and the state.

**Ensure Widespread Access to Fidelity Level Peer Support**
We now have significant and powerful evidence of the great effectiveness of peer supporters (people who use their lived experience of recovery from a broad variety of behavioral and physical healthcare conditions) in engaging, earning trust, fostering hope and supporting people with the most challenging conditions and circumstances to improve their health and advance their lives.

Peer delivered services are unique in the way they are conceived and delivered. In that spirit, they must not be seen as a replacement for case management or transportation services or as staffers who primarily connect people with clinical and medical care.

Ultimately, they are about relationships that matter, especially during the hardest times. They are especially effective because they begin where the person is, both in terms of what they identify as their primary needs and goals and as to where and how they live.

- Accordingly, new Value-Driving Entities must be afforded the flexibility to use earned dollars to hire, deploy and support peer professionals.

At the same time, organizational culture determines whether peer and other recovery services are successful. NYAPRS and many of our colleagues have seen the extraordinary, transformational impact of training and change management approaches that assist community and institutional providers alike to move from a more traditional illness, symptom management and maintenance-based set of beliefs and practices to ones that focus on wellness, recovery, personal choice, strengths and dignity.

**Further, we know that peer and recovery services are only truly effective when they are delivered by agencies that undergo a necessary process of culture change that supports them to properly understand, embrace and actualize recovery beliefs and values and to properly deploy peer supporters.**

- Hence, the state must make a serious commitment to funding efforts to promote fundamental culture change across PPS administrators, provider leads, middle management and direct care workers. Training and technical assistance of this kind will more than pay for itself going forward as recovery focused designs and trained and energized peer and non-peer staff lead to improved engagement, outcomes and savings.

Finally, we have long advocated for the use of 'peer health home bridgers' to sensitively and effectively engage individuals and to personally 'walk them' through the complex process of enrollments into Health and Recovery Plans, Health Homes and Home and Community Based Services.

- We must find a way to use waiver dollars to pay for highly engaging and effective peer services **before** involvement in the HCBS. This will allow peers to support someone through the entire process of community outreach and engagement, connection with the health home care manager, completion of the assessment and plan of care and a firm engagement with HCBS initiatives.

- We also urge the state to use a portion of DSRIP 2.0 Workforce funds to, where appropriate, keep allow successful engagement and support initiatives that were created from the OMH funded Adult BH HCBS Quality/Infrastructure Programs to go forward once those funds have been exhausted.

**Staff Recruitment and Retention**

A recently compiled survey pointedly demonstrated the magnitude of New York's human services workforce crisis, showing 35% statewide turnover rates and 14% vacancy rates for the behavioral health workforce alone.

In New York City, the turnover rate was over 45%. Underfunding human services is also an equity and racial disparity issue: the nonprofit human services workforce is 81% female and 46% women of color.

The average pay for our dedicated workforce is so low that 60% of those working in our human services sector were utilizing or had a family member utilizing some form of public assistance benefit such as Medicaid or food stamps.

DSRIP promising practices have relied on non-traditional, non-clinical workforce to achieve project goals and ongoing flexibility for VDEs to invest earned dollars to support this workforce as MCOs and CBOs design VBP approaches to sustain these models in the long term.

- A portion of the $1 billion DSRIP 2.0 Workforce development funds should be used to allow community agencies to attract and/or retain a talented workforce and sustain critically important consumer-staff relationships as agency efforts mature to secure sustainable funding from MCOs and other payers.

## A Consumer-Centered System of Care

### Patient Choice and Privacy Protections

While NYAPRS has long supported the use of electronic healthcare systems, Regional Health Information Organizations and the Statewide Health Information Network of New York (SHIN-NY), we strongly value the role of informed consent in the sharing of patient information.

- That's why we have urged the state, in both the Privacy and Confidentiality and overall Value Based Payment work groups, to continue with a Opt-In program that is tied to a strong patient education function. The studies are clear than enrollment rates into RHIOs tend towards the mid 90% range when a strong Education and Opt-In program is deployed. NYAPRS and many disability rights groups do not support approaches that permit full information sharing UNLESS patients see, understand and approve that option.

### Culturally Competent Patient Incentives

- In keeping with the recommendations of the Advocacy and Engagement subcommittee, we also urge the state to accelerate its work with health plans to offer financial and other incentives for patients who take appropriate steps to improve their own health.
- We want to ensure the use of culturally and linguistically competent incentives as identified by a recommended 'Expert Group for Achieving Cultural Competence in Incentive Programs', page 9: (https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/2015-12-04_advocacy_engagement-meeting4.pdf

### Consumer Input and Oversight

- The state should ensure that consumers and other advocates play prominent roles on the boards and advisory bodies of the new VDEs. We must also ensure a strong continued role for the vitally important Project Approval and Oversight Panel (PAOP).

Thank you again for this opportunity to offer comments on New York's proposed DSRIP amendment and value-based payment initiative.

Harvey Rosenthal, CEO
New York Association of Psychiatric Rehabilitation Services

## doh.sm.1115Waivers

**From:** Park, Dee [redacted]
**Sent:** Monday, November 4, 2019 8:48 PM
**To:** doh.sm.1115Waivers
**Subject:** 1115 Public Forum Comment
**Attachments:** DSRIP Letter.docx



Please find attached comments from the Warren/Hamilton Counties Office for the Aging regarding the DSRIP renewal proposed by the New York State Department of Health. Thank your for allowing us the opportunity to voice our recommendations.

Thank You,

Deanna Park
Director - Warren/Hamilton Counties Office for the Aging
1340 State Route 9
Lake George, NY 12845
[redacted]

WARREN/HAMILTON COUNTIES OFFICE FOR THE AGING
1340 State Route 9  Lake George, NY 12845
PH#(518)761-6347  FAX#(518)761-6344
Deanna Park  Director

November 1, 2019

To Whom It May Concern,

I am writing on behalf of the Warren/Hamilton Counties Office for the Aging, to express my recommendations on the DSRIP renewal proposed by the New York State Department of Health. The services provided by the 52 County Offices for the Aging have been demonstrated to directly reduce inappropriate emergency department visits and avoidable readmissions throughout New York State, as well as premature admissions to long term care facilities.

In conjuction with the NY Connects program,which was implemented in 2006, Office's for the Aging serve as a "no wrong door" for any and all services available in New York State, not only to seniors, but individuals of all ages and financial status. Our employees don't just assist indivdiuals with navigating our complex health care system, but also facilitate communication with providers, application assistance, arrange for services, and provide regular follow up.

The targeted goals of the proposed renewal are exactly the same as ours. Instead of reinventing the wheel and wasting tax payer dollars, we encourage you to include mandated contracting by each PPS with their local Area Agency on Aging for social determinants of health initiatives.

I would like to provide a brief example of one of the many cases that we handle on a regular basis at our office. We received a call from a loved one who was concerned about her sister, Mrs. Smith. Mrs. Smith was living alone in a tiny trailor in Lake George, NY, and was having a difficult time taking care of herself and exhibiting some memory loss/confusion. After conducting a home visit, it was determined that Mrs. Smith did not have any means of getting to and from appointments, the grocery store, to get her medications, etc. Due to this, she was not getting the proper nutrition, was not taking her medications regularly, calling 911 with any medical concern, and making frequent trips to the emergency room. The floor in her home was in very bad shape, to the point where she would fall through if she didn't walk on the edges close to the wall.

Through the efforts of our staff, we were able to set Mrs. Smith up with home delivered meals, ensuring she had at least one nutritious meal a day; arrange for transportation to medical appointments through Medicaid or an employee, reducing unneccessary emergency room visits; help her complete an application for HEAP, Food Stamps and the Medicare Savings Program, allowing her to have extra money each month to pay for food and medications; assist with transportation to the grocery store and pharmacy through our contract with her town, resulting in the ability to get her medications and food; navigate the nursing home waiver program, allowing her to get in-home care, preventing pre-mature admission to a nursing home; investigate home repair options, and when that was not an option due to the condition of the home, coordinate her moving to a rental home right next door; moving her to the new home; and providing weekly follow-ups, reducing anxiety through telephone reassurance, monitoring for changes in mental status, and then reaching out to her physician as needed, versus her calling 911.

It is hard to put a monetary amount on this, but we were able to reduce her emergency room visits to one in the course of the past year, versus at least one a month. If we had not assisted Mrs. Smith, she most likely would have been placed in a nursing home, as this was her sister's next step had we not been able to help. The average nursing home stay in our area is $518/day or $15,540 a month. In the course of a month, transportation to her primacy care physician was about $25/month; meals were $60/month; weekly transportation to the grocery store and/or pharmacy was around $30/trip; aid services $400/month; staff time $250/month, for a total of $855. This is a savings of approximately $14,685/month.

This is just one of many cases we see on a regular basis in our office. Through the "boots on the ground" services that you see in every county across the state through the Office's of the Aging, we are assisting our community members with the least amount of money. In the renewal waiver, I cannot stress highly enough that we need to harness the existing strengths of community based services, instead of recreating case management services and duplication of services. Each and every case manager in the entire statewide aging network has received certification via Boston University School of Social Work, ensuring consistency in assessment which is not provided by any other system. Again, we strongly recommend that there are mandates for each PPS to engage and contract with their local Offices for the Aging, for the services vital to keeping individuals in home and community based settings.

Thank you,

Deanna Park
Director
Warren/Hamilton Counties Office for the Aging

## doh.sm.1115Waivers

**From:** Zina Huxley-Reicher [redacted]
**Sent:** Monday, November 4, 2019 9:22 PM
**To:** doh.sm.1115Waivers
**Subject:** 1115 Public Forum Comment
**Attachments:** DSRIP Public Comment_EHCHC.pdf



Please see the attached written comment.

Regards,

Zina Huxley-Reicher
MD candidate 2020
East Harlem Community Health Committee

**East Harlem Community Health Committee, Inc.**

Attn: Mali Trilla, EHCHC Co-Chair
c/o Settlement Health Center
212 East 106 Street
New York, NY 10029
Tel: 212-360-2661
Fax: 212-360-2618
Email: ehchcinc@gmail.com



November 4, 2019

Zina Huxley-Reicher, MD 2020
Conner Fox, MD 2020
Alec Feuerbach, MD 2020
James Blum, MD MPP 2021

Members of the New York State Department of Health:

We are members of the East Harlem Community Health Committee (EHCHC), Inc. and medical students at the Icahn School of Medicine at Mount Sinai.

Briefly, the East Harlem Community Health Committee is a longstanding community health coalition whose purpose is to advocate for the health of East Harlem residents and to serve as a platform to exchange information, resources, and lessons learned to improve the community health among community health providers and consumers. Since 2017, the EHCHC has monitored the impact of the DSRIP program on the health of East Harlem residents through tracking and analyzing publicly available data, conducting semi-structured interviews with East Harlem DSRIP contracted community-based provider organizations (CBOs), participating in city-wide organizing efforts aimed at lifting the voices and experiences of DSRIP contracted CBOs, and hosting quarterly general membership meetings with the local providers participating in DSRIP in East Harlem to assess CBO engagement and the flow of funds from the State to the PPS to the CBO providers.

We offer this testimony on New York State's Draft DSRIP Waiver Amendment Request as medical students and residents of East Harlem who worked with the EHCHC to understand the impact of the original DSRIP waiver on our community. Thus, we would like to offer a community perspective, which is aligned with the EHCHC's, on the importance of giving CBOs a seat at the table, holding institutions accountable for addressing racism and bias in healthcare, and preserving accountability through oversight.

The first part of our comment centers on one of the major goals of the amendment to "address social determinants of health through community partnerships". While we appreciate the mention of social determinants of health in the amendment and the commitment of $1.5 billion toward addressing social determinants of health, we believe it is critical that this work centers CBOs since addressing social determinants of health and reducing avoidable hospitalizations best happens at the community level. In our prior experience working with CBOs in East Harlem, we saw how community organizations often were not treated as equal partners by larger institutions, such as hospitals, within a Performing Provider System (PPS). As detailed in

a report by the New York Academy of Medicine, this created distrust between ostensible partners and held back CBOs from carrying out their work to the fullest extent possible since they received only a small portion of funds.

We believe it is crucial that CBOs are empowered as decision makers and funding recipients in this next iteration of DSRIP and are concerned that the existing draft leaves too much space for the newest iteration of PPSs, Value-Driving Entities (VDEs), to steer the bulk of funding toward large hospital-based institutions and drive the decision-making process. For example, Section IV.B, "Coordinated Population Health Improvement – A multi-player context for reform", describes how VDEs and PPSs could be eligible lead applicants for "Social Determinant of Health Networks". Rather, CBOs or existing coalitions of such organizations should be the only eligible applicants since this will more directly empower these stakeholders. If the State truly wants transformation then CBOs must be positioned as the major drivers and directors of this funding. They must receive direct investment and there cannot be opportunities for this funding to go directly to large hospital systems at the expense of communities and patients.

The second part of our comment centers on the importance of reducing racial disparities in how care is provided to patients and eliminating systemic racism in the healthcare system. This is in line with several of the draft's commitments, including addressing social determinants of health and reducing maternal morbidity and mortality. One does not need to look further than East Harlem, a neighborhood that is over 80 percent Black and Latino, to see the impacts of systemic racism. In the 2018 New York City Department of Health and Mental Hygiene's Community Health Profiles, East Harlem consistently faces health challenges – from pediatric asthma to substance use disorders to mental health burdens to infant mortality – that are significantly less common just a few blocks to the south in the Upper East Side. These trends are not accidental. The communities living in East Harlem have systematically been denied the resources to adequately address their social determinants of health in comparison to other populations. And, regardless of the intentionality behind such decisions, the outcomes are a clear example of systemic racism at work in New York City.

Indeed, as medical students, we are front-row witnesses to the systemic racism and bias that is built into the healthcare system across New York State and the United States. For example, in New York State, and especially in New York City, many hospitals commonly separate patients insured with Medicaid from patients with private insurance or Medicare, a practice we will refer to as "segregated care." This segregation can take a variety of forms -- patients can be seen in separate sites, in the same site at different times, and at the same time but by different providers. Most commonly, patients with Medicaid are seen by a rotating roster of residents in one clinic while privately insured patients are seen by dedicated attending physicians in another. As described by one student who participated in a survey seeking to better understand the extent of segregated care at our own institution, *"It truly feels like every single aspect of patient care – from the way physicians and ancillary staff speak about patients, speak to patients, formulate treatment plans for patients, teach medical students to treat patients and so on – is different based on patient insurance status."* Crucially, this practice of separating patients based on insurance yields de-facto racial segregation because, according to the Kaiser Family Foundation, in New York State, people of color are twice as likely to be insured by Medicaid compared to white patients. This separation within the health system is one of the key reasons that non-white patients have less access to care

and continuity in their care compared to white patients. Given that 80 percent of individuals in East Harlem are Black or Latino, this status quo is unacceptable for community members and CBOs represented by the EHCHC.

That is why it is crucial that this iteration of DSRIP make the elimination of systemic racism and bias a priority. As it is currently written, racial disparities are only mentioned in Section III.A, "Reducing Maternal Mortality". However, given that individuals who would be impacted by DSRIP are disproportionately black and brown, DSRIP and Medicaid must be part of the solution in eliminating systemic racism. Therefore, we propose that "Eliminating Systemic Racism" be included as another "Additional High-Need Priority Area" in Section III. This is needed because none of the other issues highlighted in the amendment waiver can be addressed without thinking about systemic racism. Specifically, the waiver should be used to hold healthcare providers accountable to addressing structural racism within their own systems by providing them with funding and incentives to build an equitable, integrated healthcare delivery system. For example, hospitals will commonly cite the costs associated with making clinical spaces Article 28 compliant as a barrier to providing integrated care so DSRIP could help provide funds to convert these spaces for the purpose of integration. While health care systems may ultimately determine clinic staffing, city and state policies can play a significant role in determining what type of patients are seen where and by whom. Indeed, it was through Medicare that hospitals were initially integrated so we know the power of federal and state programs to promote equity in healthcare.

Finally, we wish to briefly focus on the importance of oversight in the next iteration of DSRIP. The initial waiver included a Project Approval and Oversight Panel (PAOP), which played a crucial role in holding stakeholders accountable and ensuring that DSRIP was able to move toward it goals. It's crucial that the new waiver also create a new version of the PAOP so that the program is held accountable and stakeholders are transparent. This oversight is particularly important around issues of community engagement and racial disparities.

DSRIP is intended to be transformational for both the healthcare system and the health outcomes of New Yorkers. This cannot be accomplished without empowering CBOs and eliminating systemic racism in the healthcare system. A DSRIP led from the level of the community, with accountability to a PAOP, that is focused on equity would be truly transformational for our neighborhoods, city, and state.

## doh.sm.1115Waivers

**From:** Lara Kassel [redacted]
**Sent:** Monday, November 4, 2019 9:59 PM
**To:** doh.sm.1115Waivers
**Subject:** 1115 Waiver comments from Medicaid Matters New York
**Attachments:** 1115 waiver comments MMNY 11-4-19.pdf



Attached please find comments on NYS' 1115 Waiver, including an extension of the DSRIP program, from Medicaid Matters New York.

Thank you.

***Lara Kassel***
***Coalition Coordinator***
***Medicaid Matters New York***
***540 Broadway***
***Albany, NY 12207***
[redacted]
***www.medicaidmattersny.org***
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Medicaid Matters New York

# Comments on New York State's 1115 Waiver Amendment Application
# November 2019

Medicaid Matters New York is the statewide coalition representing the interests of New Yorkers who are served by the Medicaid program. On behalf of the over 100 individuals and organizations that make up our coalition membership, thank you for the opportunity to submit the following comments regarding New York's 1115 Waiver amendment submission:

## Extension of the Delivery System Reform Incentive Payment (DSRIP) program

The concept paper describing the State's submission of an application to extend the DSRIP program provides extensive information about DSRIP successes and outcomes towards the overall goals of the program. While a major focus of the DSRIP program was the inclusion of community-based organizations (CBOs) in the administration of DSRIP projects, the experience of CBOs has been a mixed bag. Some report having had strong working relationships with the Performing Provider Systems (PPS), that funds flowed to them appropriately, and that they were included in governance and decision making. Many more, however, report the opposite. From the perspective of Medicaid Matters and many of our members, DSRIP has been a frustrating endeavor with much time and many resources spent on trying to figure out how to be involved in a meaningful way with little return. There is broad understanding DSRIP was never intended to be a grant program for CBOs or some new opportunity for balancing CBOs' books. However, CBOs have much to contribute to reaching DSRIP goals, and many were left out because they were not asked to lend their expertise to the projects, take part in leadership roles, or adequately supported for what they could or did provide. From the community perspective, New York's DSRIP program has been hospital-centric, representing a lost opportunity to tap community resources for their expertise, cultural competency and more.

Medicaid Matters provides the following recommendations for an extension of the DSRIP program:

- Engagement of consumers and community representatives must be required in the DSRIP program extension. Consumer and community perspective should be incorporated into DSRIP by including people and representatives impacted by DSRIP in governance and oversight structures, by completing community needs assessments – done by agencies with proven experience working within communities in culturally competent ways – to ensure goals are appropriately identified, and by fostering consumer and community involvement through public forums and culturally-competent communications.
- The concept paper is silent on independent oversight. It is critically important there be an independent body that receives periodic updates, reviews the activities of the Value-Driving Entities (VDE), examines funds flow, and more. This oversight function may be fulfilled by the existing Project Approval and Oversight Panel or some other independent body, and must include consumers and community representatives. Meetings of such a body should take place in public with opportunities for public comment.

- There must be a concerted effort to address health disparities. People of color, people residing in underserved communities, and people with disabilities have poorer health outcomes than others. The DSRIP program must focus on reaching better outcomes and achieving wellness for people who have historically experienced poor health due to their race, ethnicity, disability status, neighborhood, and other circumstances. While the current DSRIP program has made some strides in addressing health issues common in communities of color (such as asthma and diabetes, for instance), there has not been a dedicated focus on reaching health equity. Existing PPS should be asked to report how they addressed the disparities identified in the community needs assessments they were required to do at the beginning of the DSRIP program, and only those PPS that can demonstrate they were successful in addressing the needs of their communities should be eligible to apply to be a VDE for the purposes of a DSRIP extension.
- The concept paper envisions managed care organizations (MCO) will have a formal role in a DSRIP extension. It is expected they will be part of VDE networks alongside health care providers and CBOs. To contribute to the overall DSRIP goals, there must be an expectation of transparency when it comes to MCO participation. MCOs must be expected to share data across all entities involved in a VDE network to help facilitate meaningful engagement and coordination.
- For people with multiple needs or who use services across multiple systems, there is still much confusion about care coordination and who to go to within which system to get their needs met. One person may have multiple care managers or care coordinators that serve different functions, and they often operate in silos. The next DSRIP program should address this by streamlining care coordination across silos to eliminate confusion and minimize the need to go to different people across different systems.
- The newly-created Social Determinants of Health Networks should be led by CBOs. CBOs of all types bring deep knowledge and rich histories of success in meeting people where they are to address social needs.
- Attention must be paid to ensuring meaningful, efficient participation of all entities within a VDE network. This is necessarily to support data collection and reporting, as well as cross-system referrals for a variety of services. IT and data systems will need to accommodate all VDE entities, and technical assistance and support must be provided to CBOs in particular to allow them to operate in the same way as health care providers and MCOs. The regional CBO consortia have shown some success in this area, and funding should be provided to them to ensure the continuity of effective consortia-related activities.
- Long term care reform is listed in the concept paper as a new high-need priority area, which is overdue and applauded. However, people with intellectual and developmental disabilities (I/DD) and the services on which they rely are still not mentioned as a focus for reform. Work has been done to incorporate people with I/DD and their service system into the State's work toward Value Based Payment (VBP) by engaging a clinical advisory group to develop appropriate metrics for this population, and by formally adding this area of interest to the State's VBP Roadmap, which is reviewed by the federal Centers for Medicare and Medicaid Services (CMS) annually. In addition, the state Office for People with Developmental Disabilities (OPWDD), in conjunction with the state Department of Health (DOH), is working on a plan to transition this population to Medicaid Managed Care. The DSRIP extension should attempt to address the needs of people with I/DD in the health care delivery system by building on work that is already underway in the area of VBP and managed care. This should result in better health, reduced cost, and reduced hospitalizations.

- Medicaid Matters also applauds the focus on children's population health as a high-priority area. Much work has been done over the past few years to draw attention to the needs and opportunities specific to children's health. This includes extensive discussion by the Children's Subcommittee of the Medicaid Redesign Team, implementation of the children's behavioral health transition to managed care, and implementation of the First 1000 Days on Medicaid initiatives (which includes the identification of metrics by the Preventive Pediatric Care clinical advisory group of the VBP Workgroup). The DSRIP extension should build on this work and careful attention should be paid to avoid duplication of efforts.

## Expansion of Medicaid Managed Care

One of the major initiatives that came from the deliberations of the Medicaid Redesign Team in 2011 was a significant expansion of Medicaid Managed Care. Referred to as "Care Management for All," this initiative sought to move people and services previously exempt or excluded from managed care into some model of care management. Medicaid Matters has engaged in extensive advocacy related to these changes and continues to urge the State to take great care to ensure Medicaid consumers are protected in the context of managed care, during transition, through to a managed care model and beyond.

Medicaid Matters provides the following comments related to Medicaid Managed Care:

- DOH and the State Office for Mental Health (OMH) have been implementing a transition to managed care for children's behavioral health services. This includes a distinct set of home- and community-based services for children with significant needs and their families. Advocates recently learned the readiness reviews conducted with the managed care plans over the summer of 2019 demonstrated that none of the plans were adequately prepared for this transition. The State agencies report that remediation efforts have or will address the issues found by the readiness review, but this is still very concerning. The adult behavioral health transition has not gone smoothly; data shows people are not accessing the home- and community-based services that were the promise of enrollment in Health and Recovery Plans (HARP). Advocates fear the adult transition is a bellwether for what we may see as the children's transition takes shape. Special attention must be paid to making sure children and their families are able to access the services they need.
- The next big transition associated with "Care Management for All" is the move to managed care for people with intellectual and developmental disabilities. OPWDD has indicated the 1115 Waiver will not be the mechanism for implementing this transition. However, the 1115 Waiver may present opportunities to address some of the needs of individuals and their families as this transition takes shape. To that end, Medicaid Matters offers the following considerations:
    - The seven regional Care Coordination Organizations (CCO) established in 2018 are the precursor to managed care for the I/DD population. They have replaced what used to be the services provided through the Medicaid Service Coordination (MSC) program. They are currently responsible for assessments, development and maintenance of a person's Life Plan, and coordination of any and all needed services. It is unclear whether the current CCO activities will continue to be the responsibility of the CCO, the MCO, or some combination of both. The implementation of managed care for people with I/DD must include clear

delineation of roles so individuals and their advocates have precise information about who is responsible for what functions.

- Assessment for services must be evidence-based and person-centered. Individuals and their advocates report this is not always the case, resulting in service authorization that does not adequately or accurately reflect a person's needs.
- Due process protections must be in place for this population. Individuals and their advocates must understand enrollees have rights in the context of managed care and how to exercise them.
- Independent ombuds services must be available to this population.
- Communications and notices from state agencies and MCOs must be clear, accessible, and understandable. Notices, letters, website posts, etc. should be run by a number of people with I/DD.
- Stakeholder engagement is critical to ensure person-centeredness. Individuals and their families must be part of the implementation process by being offered opportunities to provide feedback and input. People with I/DD and their families and advocates should be asked to serve on state agency and MCO advisory bodies, and their participation must be supported and fostered.

## doh.sm.1115Waivers

**From:** BJ Adigun [redacted]
**Sent:** Monday, November 4, 2019 10:38 PM
**To:** doh.sm.1115Waivers
**Cc:** Cathy Homkey
**Subject:** Re: CNYCC DSRIP Waiver Amendment Request --- Public Comment
**Attachments:** CNYCC_Public Comment_11_4_19.pdf



To whom it may concern,

On behalf of CNYCC please find attached to this e-mail a copy of the public comment on the DSRIP Waiver Amendment Request.

Please let me know if you have any questions?

Sincerely

Bj

**Bj Adigun**
*Director of Communications and Stakeholder Engagement*
**Central New York Care Collaborative, Inc.** | **CNY Cares™**
109 Otisco Street, 2nd Floor | Syracuse, NY 13204
cnycares.org | [redacted]

CNY CARE COLLABORATIVE

November 4, 2019

NYS Department of Health
Office of Health Insurance Programs
Waiver Management Unit
99 Washington Avenue
12th Floor, Suite 1208
Albany, NY 12210

RE: DSRIP Waiver Amendment Request – Public Comment

The Central New York Care Collaborative (CNYCC) would like to thank you for the opportunity to provide public comment on the DSRIP Waiver Amendment Extension Request. CNYCC is one of the 25 Performing Provider Systems (PPS) in the current DSRIP program. As the lead PPS agency in central New York, our reach extends across 6 upstate counties (Cayuga Lewis Madison Oneida Onondaga Oswego) and includes over 2,000 healthcare and community-based providers. CNYCC has over 200,000 attributed Medicaid member and over 150 partner organizations that have participated in DSRIP related activities.

**We've built a foundation!**

Since the beginning of the DSRIP program, CNYCC has supported the work of partner organizations as they developed programs and projects to address the needs of the community. In many ways, these efforts have transformed care delivery and provided the catalyst to build partnerships across services. Since the beginning of the DSRIP program, CNYCC has developed programming in several key focus areas including:

- Network Development & Management
- Practice Transformation
- Care Transition Coalitions
- Primary Care/Behavioral Health Integration
- Care Management/Coordination
- Workforce Planning & Development
- Process Improvement Resources
- Training Resources
- Innovation/IDS Improvement Fund

In addition to these key focus areas, CNYCC has worked closely with network partners to implement strategies that have had a profound impact on the community. Since the beginning of the DSRIP program, our six-county region has experienced significant reductions in Potentially Preventable Readmissions (21%) and Potentially Preventable ER Visits (13%).

Network partners have also made significant strides in addressing behavioral health needs through several initiatives including: adoption of Primary Care/Behavioral Health integration across the network; increased access to behavioral health services such as mobile crisis response and crisis respite treatment; and adoption of best practice models of care such as peer counseling. These efforts have resulted in a 23% reduction in Potentially Preventable ER Visits by Patients with Behavioral Health Diagnosis. This reduction ranks CNYCC 2$^{nd}$ among all PPS' statewide in this measure.

**Can't afford to lose this momentum**

As we look back at the last four years, the Central New York region has experienced a tremendous amount of progress in building and facilitating the development of our PPS network. While this progress has not occurred without its fair share of challenges along the way, we have seen some amazing changes that have greatly impacted our community and provide a potential blue-print for the future. Network partnerships that have been established since the beginning of the DSRIP program show great promise as we look to DRSRIP 2.0. In fact, many of the examples outlined in the *DSRIP Promise Practices: Strategies for Meaningful Change for New York Medicaid* are taking place here in Central New York.

Over the past few weeks we have asked our network members to provide feedback on their experiences with CNYCC and offer input on focus areas they'd like to see continued as part of the Amendment Request:

- **Policy Changes to Further Support Meeting Community Needs:** This includes greater emphasis on regulatory waivers that will permit improved coordination of services across agencies regardless of the types of services they provide. This also includes re-evaluating the current Safety-Net designations across the network. We have several partner organizations that provide care for a significant volume of Medicaid patients, but are not classified under the Safety-Net classification. Providing a review and exception for organizations that would clearly benefit from the Safety-Net status designation would help meet both the letter and spirit of the classification.

- **Improved Ways to Enable Better Data Sharing (request of state to improve data sharing)**: One of the key focus areas in the development of our network has been data access and utilization. As we continue to offer services across the network, partners have expressed the value they see in accessing state data to help manage the populations they serve. CNYCC is in the midst of developing a comprehensive set of data technology solutions to support network partners including:
    - Population Health Analytics Programs & Services (in partnership with Nascate)
    - CNYCares Population Health Management System (in partnership with IBM Watson Health)
    - CNYCares SDOH Referral Network (in partnership with Unite Us)

- **Social Needs, Community Partnerships, and Cross-Sector Collaborations:** CNYCC has been able to facilitate extensive partnerships between clinical, behavioral, social and community-based providers since the start of the DSRIP program. These partnerships have occurred as a natural progression of project implementation efforts, but have also been enhanced through: regular facilitation through Care Transition Coalitions in each of our six counties; development of an Innovation Fund that provides grant awards for creative approaches to address community needs through partnerships across service agencies; and most recently the development of the CNYCares SDOH Referral Network in partnership with Unite Us.

- **Supporting partner's efforts in the transition to Value Based Payment**: CNYCC has enacted several initiatives to support network partners as they attempt to transition to VBP. Among these initiatives, CNYCC has:

    - Provided funding for clinical partners to build the necessary infrastructure needed to participate in a value-based arrangement
    - Offered non-clinical partners funding resources to develop strategic planning efforts that would allow them to provide services in a VBP arrangement
    - Organized a VBP 7-part training series for Community Based Organizations
    - Offered resources and technical assistance to network partners

**Let's build on the public investment**

Since the beginning of the DSRIP program, CNYCC has made great strides in laying the foundation for the changes that have occurred across the PPS network. We see the Amendment Request as an opportunity to build on what's been successfully established by CNYCC locally. The DSRIP program has provided the framework to overcome challenges and develop the necessary infrastructure and partnerships that are critical transforming care delivery. As we look to the future and the continued development of our network, it is important that we capitalize on what has been established through the DSRIP program and ensure that our successes are sustainable. Through this Amendment request, we have a great opportunity to leverage the public investments that we've made in Central New York over the past 4 years. CNYCC is well-positioned to lead the efforts outlined in the Amendment Request across Central New York and continue the journey towards a fully integrated delivery system.

Thank you once again for the opportunity to provide public comment on the DSRIP Waiver Amendment Extension Request.

Sincerely,

CNYCC

## doh.sm.1115Waivers

**From:** Sarah Wolf [redacted]
**Sent:** Monday, November 4, 2019 10:44 PM
**To:** doh.sm.1115Waivers
**Cc:** junior duplessis
**Subject:** 1115 Public Forum Comment
**Attachments:** BedStuy Restoration DSRIP Phase 2 Comments.pdf



Hello,
Please find attached comments on behalf of Bedford Stuyvesant Restoration Corporation for Phase 2 DSRIP.
Thank you for the opportunity.

Sarah
--

Sarah A Wolf, MPH, RD

Director, Center for Healthy Neighborhoods

Restoration (Bedford Stuyvesant Restoration Corporation)

www.restorationplaza.org

[redacted]

[redacted]

RESTORATION

**Restoration Public Comment for DSRIP Phase 2**

Bedford Stuyvesant Restoration Corporation (Restoration) appreciates the opportunity to submit these comments to the Medicaid Redesign Team on NYS DSRIP Phase 2. Restoration is the nation's first community development corporation, established by bi-partisan Senators Jacob Javits and Robert F. Kennedy. Restoration partners with residents and business to improve the quality of life of Central Brooklyn by fostering economic self-sufficiency, enhancing family stability and growth, promoting the arts and culture and transforming the neighborhood into a safe, vibrant place to live, work and visit. Since 1967, Restoration has constructed or renovated 2,200 units of affordable housing; provided $60 million in mortgage financing to nearly 1500 homeowners; attracted more than $500 million in investments to Central Brooklyn; placed over 20,000 youth and adults in jobs; and catalyzed physical and economic improvements.

Through its Center for Healthy Neighborhoods (CHN), and with support from national and regional private and public funders, Restoration is leading efforts to transform the Central Brooklyn food system, connecting low-income residents to local, farm fresh foods, and creating local economic business and career opportunities all along the food supply chain.

We commend the continuation and expansion of support for efforts to address individual **health-related social needs,** or midstream health determinants, for example, by proposing funding for referrals to much needed services for individuals experiencing hardships. However, we recommend that a greater portion of DSRIP Phase 2 funding be allocated to specifically address the broader underlying **social, or upstream, determinants of health** created by systemic conditions, such as housing[1] that result in health disparities among communities.[2] With behavioral health and serious emotional disturbances among children being a priority in DSRIP Phase 2, we recommend the expansion of investment in quality housing for Medicaid patients beyond the current Supportive Housing program, including expanding eligibility requirements. Research confirms that people living in poor housing conditions are known to experience levels of

[1] Healthy People 2020 Social Determinants of Health: Housing Quality. (Accessed November, 2019). https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/quality-of-housing

[2] Auerbach, J. & Castrucci, B. (January, 2019). " Meeting Individual Social Needs Falls Short Of Addressing Social Determinants Of Health". https://www.healthaffairs.org/do/10.1377/hblog20190115.234942/full/

stress and anxiety that is greater to that of the general population.[3] Investing in housing for vulnerable populations is a model that health systems nationwide are beginning to explore to ensure the long term well-being of communities.[4]

-

[3] Pevalin DJ, Reeves A, Baker E, Bentley R. The impact of persistent poor housing conditions on mental health: A longitudinal population-based study. Prev Med. 2017;105:304-310.
[4] Yen I, Neufeld S, Dubbin L. The Neighborhood As Patient: 1 Hospital's Approach to Neighborhood Effects. Pediatrics. 2018;142(3)

## doh.sm.1115Waivers

**From:** Yuridia Pena [redacted]
**Sent:** Monday, November 4, 2019 11:00 PM
**To:** doh.sm.1115Waivers
**Subject:** 1115 Public Forum Comment
**Attachments:** 11 4 19 SOMOS MRT comment letter and recommendations.pdf; 11 4 19 SOMOS MRT Comment brochure.pdf



Good evening,

Please find attached the 1115 Public Forum Comment from SOMOS Community Care.

Thank you.

Best,

**Yuridia Peña**
Vice President of Communications
[redacted]

November 4, 2019

Office of Health Insurance Programs
Attn: Donna Frescatore, Medicaid Director
Empire State Plaza
Corning Tower, Room 1466
Albany, New York 12237

Dear Ms. Frescatore:

On behalf of SOMOS Community Care, our vast network of Primary Care Physicians and the hundreds of thousands of New Yorkers we serve, we submit these observations about our experience within the program and it's continuing impact upon the future of healthcare in New York.

Since 2015, SOMOS has participated in the Delivery System Reform Incentive Program (DSRIP), helping to reform a complex healthcare system in New York. Our participation in the program has allowed providers in our network to increase quality in primary care and efficiency. As a result, SOMOS has brought excellent health outcomes to our patients and essential supports to our community-based providers to allow for continuous improvement.

We have never seen DSRIP as a permanent solution to the rising cost and complexities of providing quality care to our communities, but as a platform for addressing the immediate change necessary to reform the way health care is provided. Through our own experiences navigating the state's healthcare system, we've realized that creating real reform takes time; which is why New York needs to continue the DSRIP mission.

As a network of minority doctors, Latino and Asians, organizing themselves into a substantial institution large enough; operating at a grassroots level; but with a governance model to transact change at scale is in contemporary healthcare, an anomaly. While we have faced the difficulties of being different and attempting to "fit into" a bureacratic model set-up for pre-existing institutions, the healthy cultural conversations between us have moved the model forward, as the metrics of our impact speak for themselves. Lesson number two of the DSRIP, the relationship between the family doctor and the patient is the strongest infrastructural tool in achieving the primary goal of the DSRIP program, to reduce the cost and frequency of hospitalizations.

SOMOS was designated an Innovator in 2018 under Medicaid's Value-Based Payment (VBP) Roadmap, a key component to the DSRIP Program, making them the first physician-led group in the state to reach VBP Innovator status. The designation allows SOMOS to aggressively pursue innovative methods to address persistent health challenges experienced by the most vulnerable.

According to the most recent data, SOMOS has successfully:

- Reduced potentially preventable admission by 20%
- Reduced potentially preventable readmission by 25%
- Persevered obtaining 6 out of 12 VBP pilot contracts

Our network of doctors, after an initial period of organization marked by the same type of issues associated with the implementation of any start up institution, embraced the tenets of sustainable change espoused by the Department of Health. We implemented a strategy in line with the roadmap, began training our doctors and healthcare professionals around a new construct of value-based services and payments, and we moved quickly into six of the 12 pilot programs instituted by the state. SOMOS has led the way in redesigning the system away from fee-for-services and towards lasting reform at the provider level, with preventative and culturally competent care at the core of our efforts.

SOMOS is committed to this work and the benefits of our redesign has set a national model for minority participation in VBP strategies. We have quickly become thought leaders on VBP implementation with proven results. DSRIP laid the foundation for measurable achievements such as our IPA being number one in the state of New York, and number 11 in the United States, saving millions of dollars on behalf of the taxpayers of New York. Additionally, in spite of our early adoption of your road map and the training of our doctors, less than 50 percent of our network is ready for level three risk. Simply stated, we need more time.

We believe that an extension of DSRIP is a necessary component of continuing the State's mission to improve health care delivery and reduce the number of emergency room visits and readmissions. SOMOS has demonstrated that healthcare reform cannot succeed without primary care physicians in the front lines because family doctors are the pillars of their communities improving the quality of life for generations of families.

Best Regards,

Ramon Tallaj, MD
SOMOS Chairman

Henry Chen, MD
SOMOS President

**To:** Donna Frescatore, Medicaid Director
**RE:** DSRIP 2.0 Recommendations
**Date:** November 4, 2019

**Overview:**

Although New York State has made significant strides in accomplishing transformation in health care delivery, five years is not enough to make real substantial change statewide with long-term results. True infrastructure and payment reform takes time and the following document lays out a series of recommendations for the NYSDOH to consider.

**Recommendations:**

Reform Takes Time
New York State should request to extend DSRIP for a year to match the end of the waiver; and apply for a three-year waiver renewal of the waiver. We recommend that the State consider submitting the extension for CMS approval separate from the renewal, so that DSRIP can seamlessly continue its mission.

Primary Care is the Answer
New York State should continue to provide support to family physicians, who serve as a lifeline for so many Medicaid participants across the state. Through The State of Latino Health (https://stateoflatinohealth.com/) and the forthcoming State of Chinese Health, SOMOS has undertaken the important task of studying the health of the communities we serve. Understanding the barriers to receiving necessary and essential health care is what makes primary care a priority.

Continue Success and Innovation
High performing PPS organizations and health systems designated as VBP Innovators should automatically be included in the DSRIP 2.0 extension in order for them to continue their progressive work in providing high level value-based care. High performing PPS organizations and VBP Innovators are the leaders in New York health care transformation and should be able to continue to guide the evolution and systematic transformation of the communities they serve.

## doh.sm.1115Waivers

**From:** Robert Wingate [redacted]
**Sent:** Monday, November 4, 2019 11:19 PM
**To:** doh.sm.1115Waivers
**Cc:** Robert Wingate; [redacted]
**Subject:** 1115 Public Forum Comment
**Attachments:** Catskill Hudson AHEC - Comments on 1115 DSRIP Waiver.pdf



Sir or Madam,

Please see my remarks attached, on this document. Thank you for your time and consideration.

Best regards,

Robert H. Wingate, Executive Director
Catskill Hudson Area Health Education Center
598 State Route 299
Highland, NY 12528
[redacted]
www.chahec.org

CATSKILL HUDSON
AREA HEALTH EDUCATION CENTER

November 4, 2019

New York State Department of Health
Office of Health Insurance Programs
One Commerce Plaza
Albany, NY 12207

Dear Friends:

Thank you for this opportunity to offer comment on the draft of the New York State Medicaid Redesign Team 1115 Research and Demonstration Waiver DSRIP Amendment Request.

Catskill Hudson Area Health Education Center is a 501-c-3 nonprofit organization that is one of nine Area Health Education Centers in New York State that operates under a subcontracted cooperative funding agreement between the U.S. Health Resources and Services Administration (HRSA) and the New York State Department of Health, charged with increasing numerical and qualitative capacities of the health workforce in downstate New York in order to increase access to care for underserved patient populations and communities; and to increase the diversity and distribution of the health workforce in order to do so.

We as an "AHEC" seek to increase the interest of students in seeking health careers both by creating and delivering experiential opportunities as well as in-school vocational orientation programs; and we offer continuing education programs to current health professionals in order to educate them about the needs of underserved populations and emerging strategies for responding to them.

We receive annual recurring funds that are provided in federal and state budgets and obtain significant local sources of program, contract and grant revenue. We have an active board of directors with 23 slots representing leaders drawn from health systems, educational, public health, workforce and community agencies and foundations. They comprise a vast resource of expertise and experience in many of the domains that are integral parts of the DSRIP enterprise, and many of their home agencies are directly engaged with DSRIP projects on an independent basis.

Our center has been fortunate in recent years to have been able to contribute to positive outcomes of the DSRIP project through numerous regional DSRIP alliances across a wide range of workforce initiatives. In our center's 11 HRSA-defined counties of service, and in tandem with our counterpart centers in nearby jurisdictions, in coordination with five PPS units, these activities have included, among other activities:

- Direct service on the workforce coordinating councils of two PPS.
- Participation in funded joint initiatives with two PPS that enabled the introduction of secondary-level health career programs into public school systems and BOCES units.
- Participation in funded joint initiatives with one PPS that enabled large conferences to be held on topics of how the nursing profession can learn about, and support, health care

system transformation; how health providers can better learn to meet the needs of LGBTQ+ patient populations; how providers can identify and build systems and use evidence-based techniques to respond to the presentation of adverse childhood experiences by both pediatric and adult primary care patients; and how EMS organizations can improve sustainability at a time of systems strain and rapid change in volunteerism and financial models.

- Joint participation with CBO consortiums and the Hudson Valley Population Health Improvement Program, aimed at helping area providers and health system planners to more effectively learn about ways to address social determinants of health and challenges of patient poverty and systemic racism, and to consider the establishment of more robust local patient referral structures to improve care coordination.
- Promoting PPS-affiliated long-term care/workforce investment organization systems in underserved communities with major workforce gaps in the home health and related sectors.
- Identifying new partner organizations for possible participation in PPS roles and projects, and consulting into program model development that PPS may be considering.
- Working both formally and informally to engage educational institutions at all levels in partnering or providing resources to advance the work of PPS.
- Conducting data analysis on gap and target workforce state goals and status reviews.

Of note, our AHEC has sponsored the work of an advisory Nursing Workforce Development Workgroup for more than a decade, and which informs much of our clinical training capacities and initiatives. It was initially formed to advance the recommendations of the Institute of Medicine Report on the Future of Nursing. We partner with about 50 external agencies, schools, institutions of higher education, community-based organizations, foundations, hospitals, federally qualified health centers, health technology leaders, organizations that serve population-specific groups, health professions associations and many other entities. We are a neutral convener of programs that rely on evidence-based information to promote access and quality of care.

In this and other contexts, and because of our close relationship with state and federal agencies at many levels and most notably your Department of Health, we assess that we would remiss if we did not offer to share some of the insights we have learned in the course of the past four years of our deep engagement with the DSRIP effort, as your department plans and submits this amendment request. We assess that our capacity to offer these insights are unique and will prove to be of value to you, as AHEC holds a unique role in the health systems and workforce planning and capacity development "universe" within our state's public health fabric.

In reviewing the amendment request draft, and for future reference in related endeavors that may emanate from it, we would like to make the following observations and suggestions.

First, we are very appreciative that this document aims to more formally address gaps in the long-term care workforce, which a small concept-mapping strategic planning survey that we conducted, among the membership of our large board of directors in 2016, identified as being the highest-priority area of workforce vulnerability concern in the Hudson Valley and Catskills region among our accomplished board leaders. We agree that there is a critical need for greater investment in workforce training, recruitment, compensation subsidy, and career development support in this sector.

Second, we would encourage an emphasis on similarly distressing sustainability and workforce gaps that are rapidly emerging within the EMS workforce. We would be glad to supply data on this topic. We have hosted 15 "Emergency Responder Leadership Academies" over the years that have aimed to advance the cause of quality EMS response capacities and the field lies at a pivotal juncture as to whether its current volunteer and staff models will be able to persist, without greater connectivity and resourcing in community engagement and health systems transformation. EMS sector leaders at the statewide level are applying great energies to ensure that consistent pre-hospital acute care will be available when it is needed, and so that changes to that system can be managed efficiently and integrated into the evolving service delivery structures that the waiver amendment request envisions.

An example of a possible structure that could be conceptualized around these dynamics is the prospect of reviewing or implementing "community paramedicine" programs that bring together EMS, long-term care and other health leaders to take better advantage of both the systems capacities that EMS can offer, and with gaps in the long-term care system in mind. PPS have already supported some such models in the recent iteration of DSRIP. We believe that a well-supported EMS structure can fulfill important terms of the Triple Aim.

For both the long-term care and EMS workforces, given their low standards of compensation, again, we would see an advanced and deepening need for funding to underwrite costs of continuing education and transportation, as well as for recruitment and investigation of career ladder development options and multi-tiered vocational opportunity development.

Third, we appreciate the effort to tie the workings of the process envisioned, with the content of the 2020-2024 New York State Prevention Agenda. In the past two years in particular, our Catskill Hudson AHEC has moved rapidly to expand continuing education programs into the arena of youth and adolescent health in such a way that our clinical leaders can more frequently teach providers about emerging strategies to promote behavioral health among youth, to reduce substance abuse, to address adverse childhood experiences and to promote trauma-informed care, and to advance the health-related interests of LGBTQ+ adolescents. We are pleased at the attention that both of these documents applies to these needs. We note that you observe that 47 percent of the state's children make use of the Medicaid system.

In many areas your draft proposal cites the needs to engage community health workers more energetically and systematically in providing wraparound and in-home services to benefit this, and other, populations with related needs. May we observe that, as an agency that sponsors a robust network of nurse educators, whose efforts are dramatically growing in scope and in partnership in order to advance youth behavioral health interests, that we would recommend that your proposed intervention and mitigation strategies in these areas might beneficially also be extended to highlight the role of public health nursing professionals and that of local departments of health who have resources to provide nursing services into homes of at-risk youth, and in coordination with the other professions you have similarly referenced.

On an overall basis we might observe that faculty of institutions of higher education, many of whom have been able to play a major role in assisting with the modeling and launch of individual PPS projects, are however not universally well-versed into the process or the intended outcomes that has undergirded the current DSRIP scope.

For value-based payment structures and related healthcare system transformations to succeed, we would therefore submit that health professions training programs – such as are located at universities, boards of cooperative educational services (BOCES), in private training settings, at medical colleges, in vocational and disability and multi-lingual training environments, in rural New York State, and in other places – could benefit from a more comprehensive set of partnership opportunities with the DSRIP process, so that ultimately their students can enter the state's healthcare workforce better prepared to serve in a transformed environment.

Curriculum development and updating takes time. We would suggest consideration be given, in workforce, to identify, quantify and attend to this emerging need and which will affect a large number of educators and their students. We know that many faculty members who have been able to directly engage in the support of PPS programs have also been able to start envisioning changes to their "home institution curriculums" as a result of DSRIP, but our assessment would be that the extent of such capacities are rather limited at current.

We believe that this will unavoidably have to start changing. Those changes can be incentivized and facilitated by a more direct and formalized tie to the DSRIP system itself, if planned wisely. This in turn can more formally help lead to the enlistment of talented faculty members, researchers, teachers, academic health professionals and university administrators to inform and advance key DSRIP goals on an operational level. This is already happening in some places.

Fourth, in the area of advancing medically-assisted treatment capacities (in an area that some are alternately starting to call "medically-assisted recovery," so as to reflect more of a consumer empowerment standpoint) we are cognizant that there are difficulties in helping clinicians to learn about treatment strategies and to complete waiver training and then fully go on to adapt in their practice environments so as to serve more patients suffering from substance use disorders.

Our entire New York State AHEC System, which is based at the Department of Family Medicine at the University at Buffalo, is committed to the support and expansion of MAT strategies. We might therefore recommend that consideration be given to applying resources to more deeply research and perhaps even create DSRIP "staff" roles that could work toward identifying the scope and root causes of some of these systems-transition barriers, so that the expansion of MAT/MAR programs may proceed more expeditiously and program recruitment barriers be addressed with an eye toward innovative solutions.

Fifth, our AHEC would be in support of any resources that could be added or extended to CBO consortiums and we are surely pleased that for projects relating to social determinants of health and so many key portions of this document, CBO engagement and contracting is viewed as being central to outcomes. May we additionally note that for those aspects that relate to youth health, we are in strong support of entities like the mental health training center at the Mental Health Association of New York State and to the extent that our AHEC can play a direct role in some of these areas, we would seek extended opportunities to engage with these systems in such a way that they connect into Department of Education structures that support students. We would see connectivity between grantees of multiple state agencies as being important here. Some other examples of cross-sector entities where we see major value in joining together with, to extend these types of programs, are the New York State Center for School Health, the New York State Association of School Nurses, and other health profession associations that are specific to K-12 schools and BOCES units.

Sixth, it cannot go unmentioned that we are extremely heartened to see the emphasis on maternal and infant/perinatal health regarded in this appropriately urgent manner, as you have done.

At AHEC we look forward with anticipation to opportunities to serve at many levels in support of workforce development systems and priorities that may emerge from this new effort and we are deeply appreciative of the support and interest we receive from the Department of Health on a standing basis, and are glad to have had so many chances in recent years to learn from the DSRIP project, to be able to innovate in our programming because of its presence, and to now be able to look to its future together with you. I hope and trust that this information will prove beneficial and that you will not hesitate to let me know of any questions.

Best regards,

Robert H. Wingate, Executive Director

598 State Route 299
Highland, New York 12528
Tel (845) 883-7260 * Fax (845) 883-7837
www.chahec.org

## doh.sm.1115Waivers

**From:** Grace Tate [redacted]
**Sent:** Monday, November 4, 2019 11:28 PM
**To:** doh.sm.1115Waivers
**Subject:** In support of DSRIP continuance
**Attachments:** DSRIP.pdf



Please accept the attached letter in support of the continuance of the DSRIP initiative. Thank you for your consideration.

Grace Tate
Executive Vice President
Buffalo Urban League
15 Genesee Street
Buffalo, New York 14203-1405
[redacted]
***www.buffalourbanleague.org***

Buffalo Urban League
EMPOWERING COMMUNITIES. CHANGING LIVES.

***The Buffalo Urban League has been dedicated to servicing the Buffalo Niagara region for 91 years! Our community is growing, both in opportunity and in population. Now, more than ever, we must work together to ensure every member of the community is able to take advantage of this great potential. Please join us as we continue to empower communities and change lives by becoming a member of the League today. For more information, please visit BuffaloUrbanLeague.org, or call us at (716) 250-2400.***

Buffalo Urban League
EMPOWERING COMMUNITIES. CHANGING LIVES.

15 Genesee Street
Buffalo, New York 14203-1483
(716) 250-2400
FAX (716) 854-8960
http://BuffaloUrbanLeague.org



November 1, 2019

NYS Department of Health
Office of Health Insurance Programs
Waiver Management Unit
99 Washington Avenue
12th Floor, Suite 1208
Albany, NY 12210

Dear Colleagues:

Thank you for the opportunity to provide comment to the Department of Health regarding the 1115 Waiver: Delivery System Report Incentive Payment (DSRIP) Amendment Request, dated September 17, 2019.
The Buffalo Urban League has been actively engaged in NYS DSRIP and a partner of Community Partners of WNY (CPWNY)/Sisters of Charity Hospital Performing Provider System (PPS) since December 2014.

We have benefitted from our participation in this initiative in the following ways:

- Implemented community health worker programs in clinics and emergency rooms that have proven outcome improvements in care coordination and addressing social determinants of health
- Increased collaborations with community based organizations and other healthcare providers to support improved access to quality healthcare in communities with limited support
- Provided individualized care to individuals and families in order to assist in setting personal goals, referrals for services within the social support network, food security, housing safety, education and employment.

Through the Buffalo Urban League's Community Health Workers (CHW), actions are taken that result in patients receiving care that may ultimately improve their health outcomes and their life expectancy. As an example:

*At Sister's Hospital, a woman came for an appointment with symptoms of an ectopic pregnancy. This was confirmed by tests after she had left the hospital. The office staff had difficulty tracking her down via telephone so referred the case to the CHW. The CHW went out to her house and overcame numerous objections, convincing her to come back to the hospital right away. If she had been much later in reaching her, there would likely have been a burst – which would have resulted in the need for a higher level of medical attention and potentially internal infection.*

CPWNY has been an effective change agent in Western New York. The work has just begun! We anticipate a favorable outcome of the 1115 Waiver DSRIP Amendment Request. We strongly endorse the work of CPWNY PPS. They are critical to the success of future DSRIP initiatives.

Yours truly,

Grace D. Tate

Grace Tate
Executive Vice President

## doh.sm.1115Waivers

**From:** YEN, WILBUR [redacted]
**Sent:** Monday, November 4, 2019 11:59 PM
**To:** doh.sm.1115Waivers
**Cc:** [redacted]
**Subject:** Re: 1115 Public Forum Comment - OneCity Health
**Attachments:** 20191104 OCH Comments on DOH DSRIP waiver extension DRAFT vf.pdf



Good evening,

Attached, please find written public comment to the New York State Medicaid Redesign Team's recent DSRIP Amendment Request submitted by OneCity Health.

We thank you for this opportunity to provide written comments and look forward to working more closely with the State on the proposal in the coming months.

**Wilbur Yen, MSW/MPH**
Senior Director

[redacted]

**OneCity Health Services | NYC Health + Hospitals**
50 Water Street, 9th Floor, New York, NY 10004

**Onecityhealth.org**

**Israel Rocha, Jr.**
**CEO, OneCity Health**
**Vice President,**
**NYC Health + Hospitals**

7 Hanover Square, 9th Floor
New York, NY 10038
718-334-1638
rochai1@nychhc.org

**November 4, 2019**
**Via electronic submission: 1115waivers@health.ny.gov**
**RE: New York State Department of Health Medicaid Redesign 1115 Waiver, Delivery System Reform Incentive Payment (DSRIP) Amendment Request**

Dear Ms. Frescatore,

OneCity Health (OneCity) Performing Provider System (PPS) appreciates the opportunity to comment on the New York State Department of Health's (DOH) Delivery System Reform Incentive Payment (DSRIP) amendment request. As your partners in establishing the first DSRIP program in New York, which has achieved improved health outcomes for hundreds of thousands of New Yorkers as well as cost savings in Medicaid spending, we fully support the State's proposal to extend the current DSRIP program for another four years. This letter outlines our comments on the details presented in the September 17, 2019 Draft DSRIP Waiver Amendment by DOH. As you refine the request for an extension, we welcome the opportunity to work with the State more closely on the final details of the proposal.

OneCity is the largest PPS in New York State, comprised of hundreds of health care providers, community-based organizations, and health systems. Since the inception of DSRIP, OneCity has achieved a significant reduction in avoidable hospital admissions and avoidable visits to the ED for our population of over 700,000 lives as a result of new programs implemented across our partner network. Our collective efforts have played an integral part in the State's overall decreases in Potentially Preventable Admissions and Potential Preventable Readmissions under the DSRIP program.

Moreover, we have seen significant improvements in access to care for children and adults, and better outcomes for patients living with chronic conditions and behavioral health needs. Indeed, two of our programs were identified as promising practices for Medicaid by the United Hospital Fund in their report *DSRIP Promising Practices: Strategies for Meaningful Change for New York Medicaid*. The DSRIP Home-Based Environmental Asthma Program achieved a 25% reduction in asthma admission rates in a six-month period. The 100 Schools Project, a collaboration with other PPSs and community-based partners to help schools build capacity to address mental health, saw 49% of behavioral health crises mitigated without an arrest or the student leaving school, compared to the city average of only 26% in 2018. These results were achieved through the integration of strong partnerships clinical care, workforce training and ongoing evaluation and monitoring of performance.

For our hospital partners, these results mean critical clinical resources can be better allocated to patients whose need for emergent and acute care were necessary. For patients, addressing health needs in the community means more time spent at home with family, or at work or school, rather than in hospital or other health care facilities unnecessarily. Without the continuation of DSRIP funding beyond 2020, these advancements in patient care are at risk of not being sustained.

To be sure, the improved performance in health outcomes, quality, patient experience and cost-savings demonstrated by OneCity would not have been possible without the various points of integration,

collaboration and infrastructure required under the framework of the DSRIP program. In a relatively brief period of time, we have proven our ability to convene a diverse set of stakeholders across New York City, create common agendas, design and implement programs, and address complex problems. By investing in partners through training and funding, we have increased their capacity and that of the workforce to successfully implement programs that result in meaningful change. As a result, providers, payors and community-based organizations are working together in ways that are unprecedented, enabling us to address our community's and an individual's holistic health needs. We strongly believe that our work reflects the type of value-oriented collaborations DOH envisions in this waiver amendment request.

Like all new collaborations, it takes time to learn how to work together, along with the right infrastructure and resources. And while our success to date has been substantial, more time is necessary to expand the reach of the progress we have made together and build lasting change. More time and resources are required to accurately evaluate and assess the impact of the current programs, and to sustain these efforts through mechanisms including value-based payments (VBP). More time and resources are required to build on the technology infrastructure that is only now able to deliver on its true potential. Further, more time and flexibility in design and experimentation is required to encourage true innovation that can accelerate progress on challenges that are historically structural and complex.

We commend the State because we believe the current proposal will accommodate for this by building on and enhancing the success of the first DSRIP program. We are just now at the precipice of what the future could look like across patients, providers and payors. To help achieve better patient outcomes, advance our systems of care and increase patient access, we submit the following comments and suggestions for your consideration:

**Continuing the Transformation**

OneCity is encouraged by the State's bold proposal to seek an additional four year waiver renewal to further advance the transformation of health care delivery and payment reform in New York State. We strongly support the investment areas outlined in the proposal related to DSRIP performance, workforce development and the Interim Access Assurance Fund. While we support the use of waiver funds to coordinate and address housing, nutrition, transportation, interpersonal safety and toxic stress, we look forward to closer collaboration with DOH review and plan the extent to which these funds could be allocated to address the areas described as Social Determinants of Health.

OneCity supports the State's request for a continuation of DSRIP for the one-year balance of the 1115 waiver ending on March 31, 2021 to ensure the continuation of programs, flow of funds and sharing of data. Additional detail is needed to understand PPS expectations in the near term while a longer extension with DOH is negotiated.

**Aligning with Federal Goals**

OneCity supports the continuation of promising practices and strategies in the areas identified by DOH that align with State and Federal goals. By aligning payment incentives and reporting structures across shared federal, state and local priorities, we can make significant progress in these areas while reducing the burden of measurement and evaluation for all stakeholders across countless metrics.

Building on the foundational infrastructure and partnerships established in the first DSRIP, we strongly recommend an increase in flexibility in the design and implementation of these strategies locally to create an environment for true innovation in how improved outcomes can be achieved.

**The DSRIP Promising Practices**

More specifically, OneCitystrongly supports continued investment in the promising practices identified by the United Hospital Fund report[1]. With the support and commitment of our partners, we have achieved demonstrable progress to date in the areas of pediatric asthma and addressing mental health in schools. The DSRIP Home-Based Environmental Asthma program is now expanding to address asthma and COPD in adults and the 100 Schools Project has already expanded into community colleges. We commend the State on their proposal to further analyze these programs for future VBP arrangements as a part of the extension as more time is required to further develop, scale and sustain these models for the long-term.

**The Second Generation – Value-Driving Entities**

We commend the State on the development of new initiatives and programs in the DSRIP amendment proposal. It is our hope that creative elements such as Value-Driving Entities (VDEs) will provide the increased flexibility in operational structure that stakeholders requested in previous comment periods. Particularly, we agree that our CBO and MCO stakeholders must be increasingly active partners in our integrated networks, and that Qualified Entities should be strategic partners to ensure that bidirectional data exchange is fully achieved.

To ensure the continued success of DSRIP and its promising practices, at pace and at scale, OneCity strongly recommends that VDE structures build upon the foundation and partnerships established under the PPSs. In particular, PPSs with strong hospital-community partnerships have the existing infrastructure of primary, pre-acute, post-acute, in-home, behavioral health, and long-term care collaborations that can be leveraged for a VDE. These and formalized partnerships with MCOs and other non-traditional health care providers have enabled us to create integrated care models that have extended beyond traditional care services and finances. We are at a critical moment in DSRIP following the design, implementation and evaluation of programs, to now sustain proven practices for the long-term through value-based payments and alternative payment models. This requires the continuation of existing partnerships and infrastructure to coordinate these arrangements.

We agree with DOH that the future management structure of DSRIP should be tailored to the given region or market. For a variety of reasons, including the ways in which patients seek and receive care in New York City, geographic boundaries should not necessarily form the basis for establishing a VDE.

**Additional High-Need Priority Areas**

OneCity applauds the State's inclusion of other high-need priority areas related to populations and opportunities that have not been the primary focus of DSRIP initiatives to date. We fully support the focus on reducing maternal mortality rates, addressing the full continuum of care of children by extending successful practices to youth and adolescents, and reforming long-term care for older adults. Our network's community-based partners, neighborhood health centers, hospitals and skilled nursing facility locations and services are well-positioned to help community members manage and improve health outcomes across all life stages.

<u>Reducing Maternal Mortality</u>

We strongly support the focus on reducing maternal mortality rates and low birthweight deliveries through the DSRIP waiver. We must continue to emphasize high-quality maternal care, well baby care and neonatal care. We support the proposal for a bundled payment for maternity care to align incentives around better outcomes for both the mother and baby. How the maternity bundle is defined will be important and we welcome the opportunity to provide feedback on these details.

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[1] *DSRIP Promising Practices: Strategies for Meaningful Change for New York Medicaid.*

To ensure the safest possible care for our mothers and babies, it is critical to examine the scope of services an expecting mother should receive based on health status, age and risk, including cardiology, neurology, endocrinology and pulmonology services and clearances. Additionally, the development of integrated Triage Units with Emergency Medicine programs could help further address complex medical issues of a mother in the later part of her pregnancy when presenting to a Triage Unit. This would require some innovation to our present payment models and clinical protocols.

Maintaining a focus on maternal fetal medicine and ensuring that sub-specialty care remains equally available to all patients is critical to the health of the mother and baby. To this end, we recommend the inclusion of key performance metrics that monitor the availability and quality of care that influences the long-term health of a child, such as those cited by the Vermont Oxford Network[2]

Children's Population Health

Recognizing the critical role of the quality of preventative health care for children, and the potential long-term benefits, we support the State's recommendation to address the unique needs of children within this proposal and the recently updated New York State VBP Roadmap. Findings of the Adverse Childhood Events (ACE) score reinforce the need to focus on the health of children early in life to realize long-term positive health outcomes. We fully support arrangements that consider the full continuum of care for children, starting with prevention and spanning to care management and that recognize the intergenerational cycle of health disparities.

In general, we support the implementation of programs that make it easier and more convenient for children to receive care in their home or school (e.g., telehealth, community-health worker home visits) when it is medically appropriate. We also support programs that provide patients and families with the tools they need to get and stay healthy and better self-manage conditions (e.g., asthma action plans). Schools can have a meaningful role to play in addressing the health of children, and OneCity encourages continued investment in programs that include schools as partners in improving health outcomes for children.

We also believe that there is flexibility within the proposal to do more for sub-populations, including City-wide partnerships for the children and families involved in our foster care system.

While we support programs like the expansion of behavioral health urgent care for children we would note that these types of programs often require additional capital investments.

Long-Term Care Reform

We are encouraged by the DOH's recognition and response to the rapidly changing demographics that will see increased numbers of adults over the age of 65, and an exacerbating workforce crisis. We support the State's ongoing work with CMS to align shared savings possibilities with Medicaid and Medicare for the dual eligible population and support these changes recognizing that approximately 25% of the medical spend in this cohort is during the last year of life. To achieve optimal benefits for patients, we strongly support the exploration of mechanisms that allow patients to seamlessly engage in both Medicaid and Medicare.

We would emphasize the urgency to collaborate on innovative approaches to addressing patients with severe medical conditions who could benefit from palliative care, as well as incentivizing training in providing palliative care services to shore up our workforce. Palliative care in particular faces a gap in having an adequate workforce to meet the current demand for palliative care, let alone prepare for the future. In addition, we would support efforts to increase awareness and remove misconceptions about palliative care for both the provider workforce and our patients.

[2] The Vermont Oxford Network. https://public.vtoxford.org/

**Development of Pilot Programs**

In keeping with the critical DSRIP goals of reducing avoidable hospitalizations and preventable emergency room visits, it is critical to evaluate how we may further advance coverage for necessary services that assist individuals with serious mental illness, substance abuse disorders, or both. This needed flexibility requires the exploration of pilot programs under the 1115(a) demonstration framework.

For example, in March 2019, the Centers for Medicare and Medicaid Services (CMS) approved a Florida Section 1115 pilot program that provides behavioral health services and housing to adult Medicaid beneficiaries with serious mental illness, substance abuse disorders, or both. The Behavioral Health and Supportive Housing Assistance Pilot will provide transitional housing, tenancy support services, mobile crisis management and self- and peer-support, along with home and community-based services to people who are homeless or at risk of homelessness because of their disability.[3,4]

Housing instability is a key driver of preventable hospitalizations for patients with mental health or substance use disorders. The lack of consistent housing complicates plans of care, limits access to care, reduces patient compliance and leads to health care complications. The exploration of housing as a medical benefit under the pilot program framework could lead to substantial progress for individuals who suffer from these health challenges.

"In its consideration of Florida's MMA (Managed Medical Assistance amendment), CMS examined whether the demonstration was likely to assist in improving health outcomes, whether it would address health determinants that influence health outcomes, and whether it would incentivize beneficiaries to engage in their own healthcare and achieve better health outcomes," said Chris Traylor, CMS's Deputy Administrator and Director, in a letter this week to Beth Kidder, Florida's deputy director of Medicaid.[5]

"CMS has determined the Florida MMA Demonstration is likely to promote Medicaid objectives, and the waiver and expenditure authorities sought are necessary and appropriate to carry out the demonstration," he said. "By paying these costs, the Medicaid program helps vulnerable populations afford the medical care and services they need to attain and maintain health and well-being," Traylor said.[6]

We would encourage DOH to explore similar pilot programs for individuals with serious mental illness, substance abuse disorders, or both. These populations often include individuals who are street homeless and pregnant or incarcerated individuals who are re-entering the community.

**Continued Investments/Improvements**

<u>Continued Workforce Flexibility and Investment</u>

OneCity has expanded the use of the non-traditional, non-clinical workforce to achieve DSRIP goals and provide a more personal, culturally competent and seamless experience for patients. Peers and Community Health Workers support patient navigation and act as extensions of the interdisciplinary teams and offer advocacy and health coaching to the many communities they serve. We support the DOH's recommendation that VDEs should be positioned to continually assess the needs of both the non-clinical and clinical workforce, and possess the levers to build and optimize workforce capacity.

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[3] Letter from Angela D. Garner, Centers for Medicare and Medicaid Services, July 02, 2019 to Beth Kidder, Deputy Secretary for Medicaid, Florida Agency for Health Care Administration on Florida's Section 1l l5(a) demonstration, titled "Managed Medical Assistance" (MMA) (Project Number 11-W00206/4). https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/fl/fl-mma-ca.pdf

[4] Commins, John. "*CMS Oks Florida Medicaid Behavioral Health Housing Pilot*," Health Leaders Media, March 28, 2019. https://www.healthleadersmedia.com/strategy/cms-oks-florida-medicaid-behavioral-health-housing-pilot

[5] Ibid

[6] Ibid

Additionally, investments should continue to be made in the existing workforce to better prepare them to support the delivery system and patients of the future.

Coordinated Population Health Improvement – A multi-player context for reform

OneCity applauds the State's commitment to continue to invest in addressing social risk factors and link interventions to financing mechanisms like value-based payment. From its inception, OneCity has relied heavily on our diverse network of CBO partners and included them as strategic members at all levels of our governance structure. CBOs are valued partners whose trusted relationships with community residents can be leveraged to help achieve health equity; however, to be successful in partnering with health care payors and providers, additional infrastructure and capacity is required.

Early on, OneCity recognized that the success of the DOH's achievements in helping primary care practices receive Patient Centered Medical Home (PCMH) certification could be a best-practice model leveraged to provide similar capacity building to our CBO partners. Building on the success of the PCMH certification, OneCity partnered with Community Service Society and Collaborative Consulting, to conduct an assessment of 52 direct social service providers and their readiness for creating a health care value-proposition within a VBP environment. The assessment provided valuable feedback to OneCity on the current capacities and gaps within our CBO networks and where to direct further technical assistance. For example, the ability to have a digital mechanism to communicate about interactions between patients/clients and their providers is a key requirement for an integrated delivery system, but often a challenge for our CBO partners who are lacking the necessary IT infrastructure. Thus, a core component of SDHNs should reflect the DOH's commitment to build the infrastructure needed to track and communicate to health care and MCO partners.

Additionally, our $5M Innovation Fund represented one of the largest investments in CBOs across the State, and led to a number of innovative projects and partnerships that advanced the goals of DSRIP. These efforts highlight OneCity's recognition that the integration of social services and clinical care are critical in identifying interventions that can improve health outcomes and can be sustained through measurement and evaluation under VBP contracts.

Indeed, there have been many lessons learned through our engagement with CBO partners throughout DSRIP and we offer the following recommendations to the DOH:

- Progress moves at the speed of trust. To realize the goals of a DSRIP extension, OneCity recommends that we build on the shoulders of our success with existing infrastructure rather than start anew. SDHN collaboratives should work with MCOs to contract with a lead organization, reduce administrative burdens and meet compliance requirements.
- Along with leveraging existing infrastructure, SDHNs should heavily feature health care entities to ensure clinical integration and address social and economic factors. Clinical assessment is crucial to these efforts and provides the needed baseline if long-term gains are to be won.
- We encourage the State to consider the recommendations of the National Quality Forum's *A Framework for Medicaid Programs to Address Social Determinates of Health* findings[7] and create a framework for DSRIP 2.0 that can help overcome barriers by strengthening linkages between the community and healthcare systems, facilitating the exchange of information, and leveraging payment methods and incentivizing the discovery of new ways to deliver care and the adoption of best practices. The *hub and spoke concept*[8] presented in the Quality Forum's framework highlights the need for integration and coordination over silos. As we advance our

[7] National Health Quality Forum, "A Framework for Medicaid Programs to Address Social Determinants of Health: Food Insecurity and Housing Instability," December 2017. https://www.qualityforum.org/Publications/2017/12/Food_Insecurity_and_Housing_Instability_Final_Report.aspx

[8] Ibid, (Page 6).

ability to address SDOHs, we encourage the state to create systems that preserve and enhance collaboration and partnerships between clinical providers, governmental organizations and community based organizations.

- We ask the DOH to require alternative payment models (clinical episode/bundled payments, shared savings/risk, capitation/global payments) and evaluative infrastructure to ensure the long-term sustainability of the innovative models promulgated under the SDHNs.

Addressing the Opioid Epidemic

OneCity supports the DOH's efforts to sustain the significant gains achieved in lowering potentially preventable ED visits in the behavioral health population. We work closely with NYC Health + Hospitals, the single largest provider of behavioral health services in New York City to support and promote integrated care to meet the mental and physical health needs of our patients and improve their overall health. We are committed to bringing many of our clinics under an Integrated Outpatient Services (IOS) license to open access to whole-person care and recovery services and would like to work with our State partners more closely on addressing regulatory barriers to promote these models.

Additional gains in potentially preventable ED visits have been attributed to working with our Managed Care and CBO partners. Success on key metrics including follow-up after hospitalization for mental illness, as a part of the DSRIP and Value Based Quality Improvement Program (VBP-QIP), is evidence that collaborations between OneCity, our safety-net hospitals, and multiple payors can move the needle on key quality indicators. OneCity's partnership with the CBC-IPA through the Pathway Home Program, a State-recognized Behavioral Health Home and Community Based Service, has also shown our commitment to leverage the strengths of local partners in ensuring seamless transitions of care into the community. This new effort acknowledges that while significant gains have been made, ongoing investment and improvement is necessary to sustain momentum and improve patient experience.

With respect to the current opioid epidemic, OneCity has supported various substance use disorder (SUD) initiatives and services aimed at decreasing opioid overdose death, including the placement of peers in the Consult for Addition Treatment and Care in Hospitals (CATCH) teams at acute facilities with high rates of utilization. All of OneCity's public hospital facilities are certified Opioid Overdose Prevention Programs and prescribe naloxone and overdose prevention training to both patients and community members. These initiatives, along with City-sponsored programs such as HealingNYC (judicious opioid prescription program, increased access to Medicated Assisted Treatment, and standardizing ED responses and screening for risky opioid use), highlight the high-degree of commitment and response in the face of the epidemic within our community. We believe that the next phase of the response will focus on work with our community providers to meet and engage people where they are.

**Performance Measurement**

We support the DOH's efforts to strategically narrow measure sets and align with existing measures that have the most likelihood of driving future value. Metrics are critical to evaluating success, but only if they drive focus. To this end, we applaud the DOH's flexibility outlined in the VBP Roadmap for MCO and VBP Contractors to select measures that are appropriate for the population they serve. We would note this will require a data-driven understanding of the specific needs of the attributed population.

A simplified attribution methodology should be developed enabling data sharing that is both appropriate and rapid while also aligned with the approach of MCO and upcoming VBP initiatives. With these capabilities in place, a VDE can lead efforts to rapidly but safely share data needed to drive better patient care across all its partners.

Patient-level data must be shared in a way that is timely and flexible while performance data must follow that is accurate, transparent, and timely. To truly drive change for patients we believe that the analysis and sharing of disparate data spanning the care continuum as well as the health care delivery system is required and must be built on technology and infrastructure that will be sustainable into the future. As health care shifts from fee-for-service to VBP arrangements, providers need a clear line-of-sight into the patient journey and outcomes, as well as the cost of care, to be accountable for improving quality and reducing cost. To do so, access to MCO and CBO data is needed to ensure transparency into performance at a VDE and individual provider level.

**Interim Access Assurance Fund 2.0**

We fully support the DOH's efforts to provide additional resources and funding to facilities within OneCity's network that meet the enhanced safety net hospital definition. Many of our facilities operate in neighborhoods of the city with the highest levels of health disparities and are often the only option of care. Transitional funding allows for further transformation of systems to align with new models, such as urgent care services and other ambulatory and community-based sites. Assistance programs like VBP-QIP and the Care Restructuring Enhancement Pilot (CREP) program have provided crucial support for the DSRIP program and should be continued.

In closing, OneCity is committed to continuing the ongoing transformation of the health care delivery and payment system in New York State to benefit the patients we serve. It has taken substantial time, energy and resources to bring together, at one table, the diverse group of stakeholders that are necessary to improve the health of our communities. Addressing care for the whole-person has required us to remove traditional boundaries and accept new roles in how we partner to serve our patients. The DSRIP program created an environment for new partnerships and ways of working together; further, it planted the seeds of capital and program development to stand up new models of care for patients.

We believe DSRIP 2.0 has the potential to be the final catalyst to create new value for our patients, providers, payors and partners. We encourage the State to stay the course and prioritize continued innovation in care delivery and payment, over creating new forms of program management and structures. Let us continue to test the limits of what we can achieve together, building on what we've already learned.

We are committed at OneCity to working closely with DOH on transforming the health care delivery system to benefit the individuals and communities we serve. We would ask the State to consider the successes of OneCity and its partners in the next iteration of DSRIP. We hope that these additional comments will be considered in the final proposal for CMS.

Sincerely,

Israel Rocha
Chief Executive Officer, OneCity Health
Vice President, NYC Health + Hospitals

## doh.sm.1115Waivers

**From:** Dan Kline [redacted]
**Sent:** Tuesday, November 5, 2019 7:25 AM
**To:** doh.sm.1115Waivers
**Cc:** Daniel Keating; Dan Kline
**Subject:** 1115 Public Forum Comment
**Attachments:** NYSPMA NY 1115 Waiver Letter of Support 11042019.docx

**Importance:** High



**To:** New York State Department of Health
**Re:** 1115 Public Forum Comment

The New York State Podiatric Medical Association (NYSPMA) is in full support of current and future Delivery System Reform Incentive Payment (DSRIP) funding through the Section 1115 Waiver Renewal proposed by the Medicaid Redesign Team (MRT). We represent roughly half of New York podiatrists. We stand ready to help the Department of Health achieve its waiver goals.

We have recently been working with hospitals and other providers across the State to explore and develop clinical and alternative payment models designed to:

Reduce potentially preventable, fall-related inpatient admissions and readmissions
Reduce opioid use through appropriate treatment of lower-extremity pain
Help individuals more effectively manage their diabetes

In 2018, we met with the Centers for Medicare & Medicaid Services (CMS) to discuss our role in the development of alternative payment models and they were in full support. We have prepared several whitepapers that quantify the opportunity we have as active participants in population health management. We can provide immense value to our Medicaid beneficiaries through DSRIP and other population-wide interventions.

We fully support DSRIP 2.0 and the Waiver Renewal. We ask MRT and CMS to include podiatrists in the continuum of care when developing the Standard Terms and Conditions and DSRIP Protocols in the next phase of CMS negotiations. We see ourselves as active, participating providers within future DSRIP projects and request flexibility to fully engage in the statewide transformation and development of alternative payment models. Our role as providers can improve outcomes for several areas of DSRIP Promising Practices and DSRIP 2.0 objectives, including:

- Care coordination, care management, and care transitions
- Transforming primary care and alternative payment models
- Long-term care reform
- Addressing the opioid epidemic
- Workforce flexibility and investment

Many of our podiatrists work within hospitals and health systems that are engaged in DSRIP projects. DSRIP has been a welcome injection into New York's provider system. It has incentivized outcome-based care and innovation. Our Executive Director, Dan Kline, sits on New York's Prevention Agenda Update Task Force and we welcome additional ways to collaborate with MRT to incorporate our work into MRT's goals. We look forward to partnering with MRT, Performing Provider Systems, and Value Based Entities in the coming years to improve access to health services and improve health outcomes for New Yorkers. Please contact Dan Kline, [redacted] with any questions or to see copies of our whitepapers.

**Daniel B. Keating, DPM**
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NEW YORK STATE PODIATRIC MEDICAL ASSOCIATION
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## doh.sm.1115Waivers

**From:** Katie Weldon [redacted]
**Sent:** Tuesday, November 5, 2019 8:40 AM
**To:** doh.sm.1115Waivers
**Subject:** CNY BHCC comments for draft DSRIP amendment request
**Attachments:** NYS DOH draft DSRIP amendment request comments- CNYBHCC.pdf



The Central NY BHCC has prepared additional comments for the draft DSRIP amendment request. Please find comments attached.
Thank you

**Katie Weldon, LMSW**
***CNY BHCC Director***

**CNY Behavioral Health Care Collaborative**
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CNY BHCC
*All in for better health*

November 4, 2019

NYS Department of Health
Office of Health Insurance Programs
Waiver Management Unit
99 Washington Avenue
12th Floor, Suite 1208
Albany, NY 12210

To Whom It May Concern:

The Central New York Behavioral Health Care Collaborative (CNY BHCC) fully supports the New York State Behavioral Health Care Collaborative's feedback to the NYS Department of Health (NYS DOH) on the draft DSRIP amendment request.

CNY BHCC would like to expand on some of the feedback related to attribution. We believe that changes to current models of attribution will support behavioral health networks moving forward with more sustainable value-based contracts. Attribution has been a key challenge since the implementation of DSRIP 1.0 and with the implementation of BHCCs across New York State. As we progress through year three of the BHCC and year five for DSRIP and considering revisions that have been made to the New York State Road Map for Medicaid Payment Reform, attribution continues to remain with the MCO assigned primary care physician, with few exceptions.

The CNY BHCC supports attribution models that would assign attribution to behavioral health providers, enabling those providers to enter into contracts as the VBP Contractor, and allowing us to have a meaningful role in the Total Cost of Care relationship. As the Statewide BHCC group noted, more than 80% of Medicaid super-utilizers have comorbid mental illness and 44% have serious mental illness. Behavioral health providers play a vital role in ensuring quality outcomes and that the right services at the right time are provided in an effort to prevent unnecessary hospitalizations or utilization at inappropriate levels of care.

Encouraging MCOs to attribute high need populations with significant behavioral health challenges would create an environment where the behavioral health needs of the population are met and the sustainability needs of those organizations and networks are also addressed.

The NYS Roadmap identifies HARP recipients as being attributed to Health Homes. To date, despite the three years since the initial Roadmap was published, no movement to attribute HARP recipients to health homes has occurred. Health Homes lack the infrastructure, interest, or capability to accept this attribution. BHCCs, on the other hand, and the BH IPAs that have grown out of BHCCs, are developing just the needed infrastructure and are preparing to take on risk for these populations. As the primary providers of care to HARP recipients, BHCCs are in the best position to impact spending and outcomes for this population.

That being said, the definition of HARP poses challenges. It can be the case that individuals with severe mental illness as well as other challenges, do not meet the criteria for eligibility for HARP. Furthermore, HARP eligible individuals often are not enrolled in HARP as they choose other plans. These individuals still have intensive needs and are still being served by behavioral health organizations in their community that can effect change and ensure quality outcomes.

Attribution to Primary Care Providers (PCPs) for people with serious and persistent mental illness is problematic. The PCP is often ill-equipped to manage the behavioral health needs or to drive savings. Healthcare spending for this population is driven largely by their behavioral health diagnosis. Behavioral health networks are working to increase access, increase quality, adopt new performance metrics and change their overall workflows, in order to be in a position to provide more comprehensive care and assist MCOs in addressing the overall care of the population. If attribution remains exclusively with PCPs, behavioral health providers/networks who play a crucial role in creating the cost savings are still not able to benefit from those savings. The savings behavioral health providers/networks generate, flow to other entities because current attribution models.

As a result, it is unclear how behavioral health networks can sustain changes to infrastructure and their care delivery models if they are not included in the upside of Total Cost of Care (TCoC) contracts. Plans for expanding community based behavioral health care need to be sustainable for TCoC contracting to be successful. Behavioral health providers not only address the mental health and substance use disorders of individuals they serve, but they also assist in addressing social drivers of health, care management and care transitions. Without this full spectrum of community-based care, it is likely that we will see a return to higher, more intensive levels of intervention.

The CNY BHCC would recommend that the state reconsider attribution, especially as it pertains to people with severe mental illness and super-utilizers of behavioral health services. Models that can determine and allow for providers with the majority of visits for individuals served, should be considered. Behavioral health providers must have a more meaningful role in TCoC relationships or the highest need individuals we serve will be negatively impacted. There is something fundamentally wrong with a model that does not allow for proportional economic opportunity for the programs and services responsible for creating that opportunity.

The CNY BHCC would like to express our appreciation for the opportunity to submit comments and feedback on the draft DSRIP amendment request. We continue to strive for meaningful collaborations to address the behavioral, social and physical health of our individuals

Central New York Behavioral Health Care Collaborative
555 E. Genesee Street
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## doh.sm.1115Waivers

**From:** Aaron Felder [redacted]
**Sent:** Tuesday, November 5, 2019 8:45 AM
**To:** doh.sm.1115Waivers
**Subject:** Comments on DSRIP 2.0 concept paper
**Attachments:** DSRIP Concept Paper Comments - VIP Community Services.pdf



Attached please find comments from Vocational Instruction Project, Inc. on the above referenced paper.

Thank you,

Aaron

Aaron L. Felder
Chief Operations Officer
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VIP Community Services, Inc. (VIP) is grateful for the opportunity to provide comments on the Delivery System Reform Incentive Payment (DSRIP) Amendment Request concept paper published on September 17th. VIP is a 501(c) 3 not-for-profit organization licensed in the state of New York as a NYS Department of Health Article 28 Diagnostic & Treatment Center, a NYS Office of Mental Health Article 31 outpatient clinic and a NYS Office of Alcoholism & Substance Abuse Services Article 32 chemical dependency program. VIP operates a Federally Qualified Health Center (FQHC), residential substance abuse services, supportive housing and a shelter. VIP's comprehensive range of services was developed in response to the needs of the residents of its Central Bronx (NY) service area.

VIP commends the State's work in the first round of DSRIP to reduce costs, improve patient outcomes, and decrease unnecessary inpatient and emergency room utilization. For New York to experience a real transformation of the health care delivery system and sustain the gains thus far achieved through DSRIP, there must be a significant investment in community-based primary care. Only through this investment can the State achieve a true value-based system that improves health outcomes and reduces costs. VIP supports the renewal of the DSRIP program through March 31, 2024. VIP, a member of the Community Health Care Association of New York State (CHCANYS), supports the comments submitted by CHCANYS and has restated and revised many of their points below.

## I. Driving Promising Practices to Improve Health Outcomes and Advance VBP

By mission and in statute, health centers serve the State's most vulnerable and hard to reach populations. FQHCs are non-profit, community run centers located in medically underserved areas that provide high-quality, cost effective primary care, including **behavioral** and oral health services, to anyone seeking care. Each FQHC is governed by a consumer-majority board of directors who are tasked with identifying and prioritizing the services most needed by their communities. 48% of our 5,000 patients are enrolled in Medicaid.

Our 7 sites located in central Bronx provide access to comprehensive primary care services, especially among populations that are most likely to present at the ED with a non-urgent or avoidable condition. In the first round of DSRIP, we participated in 2 Performing Provider Systems (PPS): BPHC and Bronx Care.

The first round of DSRIP complemented the health center model's unique and innate ability to provide comprehensive and innovative care to New York's Medicaid beneficiaries. Health centers played and continue to play a key role in advancing the promising practices within their regions and driving improved health outcomes. In the second round of DSRIP, health centers are well-prepared to take a leadership role to advance the State's vision of an expanded value-based payment (VBP) landscape driving DSRIP promising practices.

## II. Embracing the Role of VDEs

We are pleased to see that the State has acknowledged the need for additional flexibility in the next round of DSRIP and is interested in ensuring the success of Value-Driving Entities (VDEs). However, we encourage the State to provide direct investment in community-based providers. Currently, 23 of 25 of the PPS leads are hospital-based, with no specific requirements about how funds flow to partners in the PPS networks. Meaningful governance participation by community-based providers, such as community health centers and community behavioral health organizations, and downstream investments to health centers and other community-based providers varied greatly from PPS to PPS. Using publicly available data reported by the State, it is extremely difficult to determine the amount of money received by

health centers in the first round of DSRIP – they are included as "clinics" with hospital ambulatory providers. However, the most up to date data reported by the State in November 2018 demonstrates that hospitals received more than 28% of total funds flow while representing only 0.2% of total engaged PPS partners.[i] It is exceedingly difficult to transform the healthcare delivery system by continuing to invest most transformation dollars into inpatient-based care models, when it is the long-standing established CHC providers and workforce that can make the biggest impact on patients' health outcomes. CHCs are especially well-posed to integrate care, make connections to address social needs, and become the more adept and agile VDEs envisioned in the State's concept paper.

We support the State's charge that VDEs include providers, community-based organizations (CBOs), and managed care organizations (MCOs) to leverage VBP and advance promising practices. A collaborative partnership between community-based providers, CBOs, and MCOs is critical to implementing and supporting transformative initiatives that move away from a volume-driven care model. However, to support improved access to care in the community and reduce reliance on emergency departments and inpatient care, the State must direct additional resources to a broad range of community-based providers. **VIP requests that the State dedicate, at a minimum, 25% of DSRIP funds to the development of community-based VDEs where CHCs, in collaboration with other community-based providers, are leads.**

### a. VDE Lead Entities

The State should capitalize on existing health center Independent Practice Associations (IPAs) as a launching point for the creation of community-based VDEs. There four CHC-led IPAs currently organized across the state, Community Health IPA (CHIPA), Safety-Net IPA (SIPA), Finger Lakes IPA (FLIPA), and Upstate Community Health Collaborative IPA (UCHC), are engaged with MCOs in at least one VBP contract while working on additional agreements. IPAs are able to take on risk and become financially accountable for both the quality of care and the most efficient delivery of care services. We believe that IPAs are well positioned to work with other entities as a VDE in the second round of DSRIP.

While health centers like ours are already developing relationships needed to advance in VBP contracts, a second round of DSRIP is an opportunity to invest in building capacity to ensure health center and CBO IPAs have the foundation to serve as VDEs. Currently, health center-led IPAs are self-funded and have little financial capacity to support many of crucial functions that would accelerate their successful participation in VBP arrangements. **Health center-led IPAs require DSRIP investment to support the data analytic capabilities needed to effectively manage population health and drive improved outcomes.**

### b. Considerations for Engaging MCOs

VIP is pleased that the State is taking steps to ensure engagement of MCOs early in the planning process for a second round of DSRIP. However, there are significant challenges that must be addressed ahead of the creation of VDEs. One of the current difficulties faced by providers as they seek to participate in VBP arrangements is a lack of comprehensive data about their attributed patients. **The State should create and enforce a uniform data sharing policy for the managed care plans to further support the transition to VBP, for example, by enforcing transparency in expenditures and utilization.**

In the first round of DSRIP, the discrepancies between MCO attribution and PPS attribution made it difficult for health centers to effectively manage patient health outcomes. PPS networks do not necessarily encompass the same providers that are contracted with a given MCO. If there are discrepancies between MCO attribution, consumer utilization, and PPS network, it becomes incredibly difficult, if not impossible, for the PPS to effectively manage health outcomes for these populations. PPS and VDEs should not be expected to manage the health care improvements of individuals who are enrolled in managed care plans that contract outside of the VDE. **VIP recommends that in the next round of DSRIP, VDE attribution should be aligned with MCO attribution to ensure seamless VBP contracting.**

Finally, we understand the State's desire to drive regional innovation – local health care needs vary based on geography, CBO and health care provider landscape, and other factors. However, we would like to raise the concern that in densely populated areas served by many MCOs with overlapping service areas (notably, New York City), defining distinct regions may prove difficult. **In New York City, VIP recommends that VDE networks should align with patient utilization patterns as much as possible.**

## III. Supporting Non-Clinical Workforce to Address Social Needs

VIP echoes the State's observation that many of the successful DSRIP initiatives rely on non-traditional, non-clinical workforce that help patients navigate clinical and social services systems to address their multi-dimensional needs. In the first round of DSRIP, we embraced the flexibility to address patients' social needs.

In the first round of DSRIP, the State encouraged primary care practices to become patient-centered medical home (PCMH) recognized. Today, 97% of New York's health centers are PCMH certified. PCMH certified practices provide mental health, oral health, and health promotion/disease prevention services through comprehensive primary care. This model of patient-centered care is associated with improved health outcomes and reduced costs and should be robustly supported in the second round of DSRIP. There are numerous studies that have analyzed the success of PCMH, including citing fewer specialty visits needed, lower per member costs, and better health outcomes amongst individuals seeing PCMH-certified providers.[ii]

**The State should use a second round of DSRIP to continue investments in care management programs like PCMH and Health Homes to address patients' social and medical needs.**

## IV. Aligning Performance Measures

VIP strongly supports the State's desire to work with CMS to align performance measures across initiatives. Health centers' participation in Medicare, Medicaid, NYS PCMH, and contracts with managed care plans (among various other programs) requires a significant amount of resources invested in measure/data collection and reporting. **The State should target measures most likely to be of value for all participants in DSRIP 2.0.**

## V. Health Center Alternative Payment Methodology

FQHCs embrace the State's transition of Medicaid payment from volume to value. VIP supports this direction and is also engaged in work with CHCANYS to move away from a visit based FQHC payment to a capitated FQHC Alternative Payment Methodology (APM). Federal statute permits states to

implement an APM in lieu of the legally required prospective payment system reimbursement methodology. States must ensure that reimbursement under the APM is not less than it would be under the prospective payment system rate; however, adoption of an APM is essential to move FQHCs from a visit-based payment that incentivizes volume, to a payment methodology that rewards efficiency and outcomes. A capitated FQHC APM aligns with the State's DSRIP goals of advancing VBP and provision of enhanced care coordination.

An FQHC APM supports team-based, integrated care and enables CHCs the flexibility needed to create innovative approaches to care which can include non-clinical support staff who are not billable providers under the prospective payment system rate. The creation of innovative care coordination workflows will improve care provided directly by FQHCs, therefore reducing costs across the health care system.

VIP looks forward to working closely with CHCANYS and the Office of Health Insurance Programs to establish a mutually agreeable approach that supports health centers' ability to transform their entire practice to a value-based care delivery model. Once the APM receives a federal approval, a small subset of health centers will transition from the prospective payment methodology to the APM. **To ensure the success of an APM, State investment is needed to enhance data collection capabilities and catalyze the development of new staffing roles, models for care teams, and innovative work flows.** These investments may include: enough funding to support interventions addressing patients' non-clinical social needs, support for an alternative payment learning community, clinical and cost data analyses, quality metric identification, and reporting mechanisms.

VIP has actively engaged in DSRIP implementation and contributed to many of the successes achieved. We look forward to continuing to partner with the State to achieve our shared goals of system transformation and improved patient care, better patient outcomes, and reduced care costs.

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[i] https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/paop/meetings/2018/docs/2018-11-29_updates.pdf

[ii] Kaushal R, Edwards A, Kern L. May 2015. Association Between the Patient-Centered Medical Home and Healthcare Utilization. American Journal of Managed Care. Am J Manag Care. 2015;21(5):378-386.
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Akuh Adaji, Gabrielle J. Melin, Ronna L. Campbell, Christine M. Lohse, Jessica J. Westphal, and David J. 2018. Katzelnick. Patient-Centered Medical Home Membership Is Associated with Decreased Hospital Admissions for Emergency Department Behavioral Health Patients. Population Health Management. Vol. 21 Issue 3. printhttp://doi.org/10.1089/pop.2016.0189

## doh.sm.1115Waivers

**From:** Rose Gasner [redacted]
**Sent:** Tuesday, November 5, 2019 2:31 PM
**To:** doh.sm.1115Waivers
**Subject:** 1115 Public Forum Comment
**Attachments:** Public Comment_DSRIP_10-25_AIRnyc (1) (1).pdf



Attached are the written comments from AIRnyc, a NYC based community based organization. These comments supplement our public testimony delivered on October 25, 2019.

**Rose Gasner, JD**
**Executive Vice President | AIRnyc**
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[redacted]
air-nyc.org

AIR nyc

Healthy has an address

October 25, 2019

Public Hearing
Proposed DSRIP Extension
New York State Department of Health

I would like to thank the New York State Department of Health for this opportunity to comment publicly on the proposed DSRIP extension. I am Rose Gasner, Executive Vice President of AIRnyc, a community based organization ("CBO") delivering home based services throughout New York City since 2001. Based in the South Bronx, AIRnyc is a data-driven and technology-forward organization that serves New York's most vulnerable people. AIRnyc's Community Health Workers meet people where they live to improve health, connect families to social care and build health equity at the community level. We collaborate with stakeholders across the spectrum and within the community, including health plans, hospital systems, provider groups, government agencies, and other CBOs, to carry out our mission.

As a CBO partner to four Performing Provider Systems: Bronx Partners for Healthy Communities, Community Care of Brooklyn, Mount Sinai PPS, and OneCity Health, AIRnyc has contracted to provide the asthma home-based self-management program (i.e. Project 3.d.ii) across NYC. Through these partnerships:

- We were recognized as one of the DSRIP "promising practices and successes" in the DSRIP extension concept paper. We were delighted to receive this recognition and we agree: our organizational model does work!
- We are proud to be one of the organizations that helped achieve the 25% reduction in asthma admissions attributed to the One City Health asthma program in the United Hospital Fund's DSRIP report.
- Bronx Partners for Healthy Communities recently reported to us that our work reduced ED utilization by 21%, admissions by 51%, length of inpatient stays by 46%, and overall utilization (length of stay plus ED) by 40%.

DSRIP and value based contracting requirements have helped AIRnyc expand its services and engage new partners. In the Managed Long Term Care program, we are now working with plans to address social isolation in their members, as well as members at risk of homelessness.

However, our work extends beyond these limited contracts and digs deeper into rooted issues and causes. We are in the business of enhancing a whole person's care. For instance, our Community Health Workers provide compassionate care as we meet members in their homes to help to care manage a patient or even a household. Often, when we visit a child with asthma, we also find a parent with diabetes. If we link a family with a food pantry or fix a persistent rodent problem through an asthma visit, the entire family benefits.

We strongly support the extension of the DSRIP program. While AIRnyc has been successful in negotiating direct contracts with several health plans, the current VBP contracting requirements are not enough to move community based organizations into true partnerships with the health care system and allow the groups closest to the patients to address the social determinants of health. Contracting is an important first step; activating contracts so they become substantive opportunities for CBOs to operate services that address the social determinants of health sustainably at scale, over time, is critical.

We reiterate that the State Department of Health should mandate a level of spending on community based social determinant interventions. The current requirements are too vague, and have not resulted in significant investments in social determinant of health interventions. We also urge that data on social determinant health spending be made public, to hold managed care organizations accountable. We understand that such data needs standardization, and we welcome the opportunity to help develop appropriate measures that deliver on patient outcomes.

With regard to the DSRIP extension, the concept paper is a step in the right direction and builds on the successes. We appreciate the recognition of our asthma program, and we hope that our Medicaid managed care partners note our reduction in hospitalizations (25% or 51%), as well as our improvements in the Asthma Medication Ratio HEDIS quality measure. We satisfy the SDOH requirements and save money! We welcome the specific training programs and certification for community health workers. This emerging workforce can play a role in the full range of chronic diseases, and government support for training will pay off in both economic and quality terms.

We applaud the new focus on social determinants of health, over siloed chronic conditions, in the proposed redesign. But the issue of most concern to us in our CBO role is understanding more clearly how the Social Determinants of Health Networks (SDHNs) will work. Any such network should be led by a community based organization. Moreover, many different types of networks of community based organizations have already begun to form. Some are based geographically, around a hospital system; others are being convened through a technology platform. Another model is the creation or extension of an IPA to include CBOs . We understand that working with community based organizations is new to some managed care organizations, and the range of organizations is daunting from a contracting perspective. We urge that whatever role the State Department of Health wants to take in this community based ecosystem, it should do so with the input and advice of the community based organizations

themselves. It is crucial that the State align with work already being done, and not create a structure that might be at odds.

Lastly, there are some ideas set forth that we believe need more development. Such as how are managed care companies going to play a larger role this time? How will a VDE differ from a PPS? We were happy to see that CBO engagement would be part of VDEs, but want to see them part of the governance of VDEs. The State can mandate that. We also urge that the DSRIP Project Approval and Oversight Panel be maintained, so that a representative group can continue to guide the DSRIP process. We reiterate the need to include CBOs in data sharing, which must be more timely and integrated to optimize meaningful interventions because we all know the importance of being able to measure and track our work.

Community based organizations can play a larger role in improving the health of New Yorkers, and our community health workers are well positioned to help patients in their own homes improve their health. New York State's efforts to use DSRIP waiver money to facilitate this transformation are welcomed and supported. We look forward to helping make this work and being a part of the conversation and thank you for the opportunity to publicly comment.

For further information, contact: Rose Gasner, Executive Vice President, AIRnyc, [redacted]

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NYS Department of Health Office of Health Insurance Programs
Waiver Management Unit
99 Washington Avenue
12th Floor, Suite 1208
Albany, NY 12210

October 22, 2019

**Re:** Public Comment on DSRIP 2.0 concept paper and 1115 Waiver/MRT/DSRIP amendment

**WHO WE ARE**

CN Guidance & Counseling Services is a behavioral health service provider in Nassau County serving 7,000 Long Island residents with licensed mental health and substance use disorder treatment along with housing/residential, Health Home, and other Social Determinants of Health (SDH) services (including peer and other non-clinical support). We serve as a community-based organization (CBO), a Certified Community Behavioral Health Clinic (CCBHC), a Center for Treatment Innovations (COTI) mobile service provider, and a member organization of both a Behavioral Health Care Collaborative (BHCC) and an Independent Practice Association (IPA). We are owners in the RHS IPA (a lead BHCC agency). We have served the community for 47 years.

Our region, under the Nassau Queens Performing Provider System (PPS), ranked next-to-last (24th) among the 25 statewide PPS's in the *360 Survey Results by Organizational Area* rankings included in the DSRIP Independent Assessor's Mid-Point Assessment Report. These metrics relate to governance, I.T., performance management, and contracts/funds flow.

As a small-to-medium organization with a $27 million budget and 360+ qualified employees, including many clinical behavioral health specialists (covering a wide variety of mental health and substance use conditions) who remain poised to help our local PPS achieve its VBP goals, we have been almost entirely left out of the DSRIP 1.0 experiment. This has occurred even though our agency: (1) is the L.I, region's only CCBHC; (2) has demonstrated strong measurable health-outcome results (shared shortly); (3) has earned high trust from federal, state, county, and local governments; (4) maintains strong relationships with leaders of the three Nassau Queens PPS "hubs" (Northwell, NUMC, and Catholic Charities); and (5) delivers both clinical and non-clinical services, including Social Determinants of Health support via partnership with United Healthcare.

**WHAT HAPPENED DURING DSRIP 1.0**

The NY State Department of Health shared statewide findings early in DSRIP 1.0 indicating that people with *behavioral health* issues were requiring and utilizing a disproportionate share of Medicaid resources—including for Emergency Department (ED) visits and unnecessary readmissions and hospitalizations. For example, per Division Director Gregory Allen's "Measuring Physical and Behavioral Health Integration in the Context of Value-Based Purchasing" December 2016 presentation, Medicaid members diagnosed with Behavioral Health conditions had

accounted for 45.1% of all ED visits and 82% of all hospital re-admission-related Medicaid dollars spent. Furthermore, as of DSRIP 1.0 Measurement Year 1, almost every PPS in NY State was performing substantially below standards regarding: (1) Follow-up After Hospitalization for Mental Illness - within 7 days; (2) Potentially Preventable Readmissions; (3) Behavioral Health (BH) Follow-up After Hospitalization for Mental Illness - within 30 days; (4) BH Potentially Preventable Emergency Department Visits (for persons with BH diagnosis); and (5) Potentially Preventable Emergency Room Visits.

At this time, there was a clearly demonstrated need for licensed providers and CBOs with strong histories of effectively delivering clinical behavioral health services and related non-clinical supports (addressing social determinants of health) to be incorporated as planned into DSRIP implementation. As such a provider in Nassau County, we were equipped to fill this need.

In our region of NY State, over the span of DSRIP 1.0's first four years, CN Guidance & Counseling Services submitted (to those governing Nassau Queens PPS decisions) numerous detailed proposals regarding ways that our behavioral health services will address DSRIP's enumerated requirements. In great detail, we recommended itemized services that CN Guidance & Counseling Services could provide as a community-attuned CBO, CCBHC, COTI mobile service provider, and member of both a BHCC and an IPA. Multiple times, we were ready and eager to deliver more than $2.8 million in requested contracts to cover specialized behavioral health and related integration services, but none of our offers went beyond the "interested discussion" stage—largely because DSRIP 1.0 included no substantial mechanism to *incentivize* or *mandate* PPS collaboration with CBOs/behavioral health providers.

Unlike in some other NY regions where partnerships with CBOs have occurred organically and voluntarily, the DSRIP Independent Assessor's Mid-Point Assessment Report[1] for Nassau Queens PPS indicated the following:

- Nassau-Queens PPS ranked next-to-last (24th) among all 25 PPS across NY State. in aggregate 360-degree Survey Results by Organizational Area (report page 5)
- The Independent Assessor (IA) found that although the Nassau Queens PPS submitted an "extensive list of engaged CBOs", it had "commenced contracting efforts with only two CBOs and only intended to compensate the same two." (p9)
- The report showed $0 had been distributed toward substance use treatment (p12)
- The report showed $0 had been distributed toward CBOs (p12)
- The report showed an overall *commitment* across DSRIP projects to 336 mental health partners but *engagement* of only 5 (p18)
- The report showed an overall *commitment* across DSRIP projects to 44 substance use partners but *engagement* of only 1 (p18)
- A recommendations-table directed to the 25 statewide PPS's includes nine rows of findings for Nassau-Queens PPS (rows 101 to 109). (Per this link; please scroll down.)

[1] Note, a Final Summative Report has not yet been completed and released, and the Final Interim Evaluation Report (Aug. 2019) by University at Albany (SUNY), does not include analyses/PPS-level detail in these same categories. While that report suggests some statewide improvement in behavioral health utilization due to DSRIP, Nassau Queens PPS is not among the leaders.

The first of these rows indicates: "The IA recommends the PPS develop a strategy to **increase partner engagement** to support the successful implementation of this project and in meeting the PPS' DSRIP goals." (bold added)

- The report included a statement of concern that expressly identifies inadequate engagement of mental health partners with regard to one of the PPS' key proposed DSRIP focus areas. It stated, "This lack of partner engagement across projects presents a significant risk to the PPS' successful implementation of the DSRIP projects."

By contrast (to Nassau-Queens PPS performance), CN Guidance & Counseling Services—our community-based organization specializing in behavioral health treatment and services (housing, Health Homes, employment readiness, economic literacy, peer support, and other non-clinical programs) related to Social Determinants of Health—has been accountably delivering substantial, quantifiable results in our area of expertise, most of which can benefit our region if **DSRIP 2.0** is appropriately modified to *incentivize* and *require* the Value-Driving Entities (VDEs[2]) to contract with organizations like ours.

Just a few examples of CBO CN Guidance & Counseling Services' impact/success:

- The CN Guidance & Counseling Services *Certified Community Behavioral Health Clinic* (CCBHC) program (one of only 18 in NYS) is performing at #1 in the state, with 96.6% of new clients coming into our clinic seen for their initial evaluation within 10 days of their first *contact* with us.
- CN Guidance's person-centered approach has been attracting and engaging people in need of treatment, including opioid users, with efficacy-levels above statewide averages:
    - Our CBO/CCBHC is exceptionally efficient at ushering struggling NYers into treatment—maintaining an average 3.5 days from a client's first contact to intake—while, by comparison, 65% of L.I. agencies experience lags of 1 week to months
    - 30 days after intake, 80% of CN Guidance's clients who were enrolled in treatment after a HOSPITAL crisis remain *engaged* in services, vs. 56% engaged across NY state.
    - 87% of clients surveyed recommend CN Guidance.
- CN Guidance's Project CONNECT partnership works in collaboration with Northwell Health to engage individuals who have overdosed and who are treated in the Emergency Departments of Southside and Huntington hospitals on Long Island, developing an action-plan for treatment and providing necessary referrals and appointments for the patient. Since its April 2018 launch, this Project Connect partnership has seen a very successful 53% engagement rate–compared to the national average of 10% in analogous programs.

**STRENGTHS OF DSRIP 2.0 AS PROPOSED—WE STRONGLY SUPPORT**

We find the DSRIP 2.0 Concept Paper and proposed 1115 Waiver/MRT/DSRIP amendment, overall, to be very strong and supportive of positive change. We especially endorse its focus on promoting community-level collaboration, engaging CBOs, integrating peer support and other non-clinical workforce services that address the Social Determinants of Health (SDH), and treating the whole person in impacting non-medical factors to improve health outcomes. We also

[2] We use "VDEs" to also include related emerging legal entities such as Accountable Care Organizations (ACO's), IPA's, etc.

strongly support DSRIP 2.0's emphases on SUD Care and the Opioid Crisis, Serious Mental Illness, Primary Care Improvement, and Alternative Payment models.

**HOW DSRIP 2.0 CAN BE MADE EVEN STRONGER**

To ensure *consistent* development, use, and endurance of partnerships that *include CBOs*, we recommend that DSRIP 2.0's mentioned "bonus payment program" and reward-for-high-performance provisions (e.g., on pp11-12) be expanded to explicitly include rewards for partnering with CBOs, and financial penalties for failing to partner broadly or deeply enough. The DSRIP 2.0 statement that currently indicates, "Additional process measures will be **considered for reporting purposes** only, especially to track MCO, **CBO**, and QE **engagement**" (bold added) would be stronger if modified. Such engagement itself should be tied to financial rewards rather than considered merely a "process measure" that is "for reporting purposes only."

**We also recommend** the addition of the following **needed provisions** in the proposed extended and amended DSRIP waiver (DSRIP 2.0), toward improving triple-aim *impact* and inclusiveness:

- **Suggested Enhancement 1**: Large hospital systems (or designated Value-Driving Entities) must be required to contract with numerous community-based organizations (**CBOs**) in order to qualify to receive DSRIP funds;

  Reason 1: hospitals cannot deliver the needed behavioral health and SDH services *alone*
  Reason 2: behavioral health and SDH services are *needed* to achieve triple-aim/VBP goals
  Reason 3: CBOs need DSRIP funding to *sustain* their capacity to deliver needed services and move closer to achieving Value-Based Care/Payment models
  Reason 4: under DSRIP 1.0, the Nassau-Queens PPS did not prioritize CBO participation, even given 4 years of CBOs' proactive attempts at value-based collaboration
  Reason 5: some hospitals / large systems demonstrate they will not take this step voluntarily

- **Suggested Enhancement 2**: If large hospital systems (or designated Value-Driving Entities) fail to *allocate* and disperse at least 25% of all DSRIP funds to CBOs, they must face substantial / financial consequences, including forfeiting up to 50% or more of DSRIP funds they'd otherwise be eligible to receive if they *did* contract with CBOs as DSRIP clearly intends;

  Reason 1: DSRIP 1.0 lacked a direct financial mechanism to enforce cooperation with CBOs
  Reason 2: Creating a requirement without financial consequence sometimes does not work
  Reason 3: Requiring a specified % strengthens clarity, commitment, and compliance

- **Suggested Enhancement 3**: Large hospital systems/VDEs in regions that have a Certified Community Behavioral Health Clinic (**CCBHC**) must be required to contract with such CCBHC(s).

  Reason 1: CCBHCs have experience moving from fee-for-service toward VBP
  Reason 2: CCBHCs' experience with VBP will help *lead* the PPS' efforts toward VBP
  Reason 3: CCBHCs share a focus on quality, health outcomes, and cost
  Reason 4: DSRIP and CCBHC operate in silos, with no structured coordination, creating inefficiency and missed opportunities for propelling Value Based Payment

Reason 5: For CCBHCs to be most effective and change health outcomes, they need strong partnerships with large hospital systems

- **Suggested Enhancement 4**: As each Value-Driving Entity (VDE) *selects* a Social Determinants of Health Network (SDHN) and "a lead SDHN entity" for each region, as per the concept paper/draft amendment, VDEs must be incentivized to contract with Behavioral Health Care Collaboratives (BHCCs) as a priority, as a way to leverage efficiencies, momentum, quality already built.

  Reason 1: BHCCs have a head-start in *integrating* primary and behavioral health
  Reason 2: BHCCs are functional networks with *existing* strengths and experience
  Reason 3: BHCCS have leadership momentum in propelling VBP arrangements
  Reason 4: BHCCs are networked with other specialized types of CBOs needed for SDHNs
  Reason 5: BHCCs are recognized/supported by OMH and OASAS
  Reason 6: BHCCs enhance quality care through clinical and financial integration and the use of community-based recovery support services.

- **Suggested Enhancement 5**: VDE's must be required to contract with Centers for Treatment Innovation (COTIs).

  Reason 1: These mobile services are especially critical to addressing the opioid epidemic.
  Reason 2: COTIs, as OASAS-certified providers, bring treatment staff into un/underserved areas, expand tele-medicine sites, and deliver enhanced peer outreach and engagement within the community. They advance Value-Based Payments (VBPs) and the triple aim.

**CONCLUSION**

CN Guidance & Counseling Services, in sharing these comments and recommendations, reflects directly experienced limitations of DSRIP 1.0 in the Nassau County region and among some organizations/communities in other parts of New York State (especially under-performing PPS/regions). We speak for residents of such communities and for those CBOs, CCBHCs, COTIs, and other mental health and substance use service providers like ours that have a large number of relevant licensed services and non-clinical supports to offer, but that have remained unfortunately disconnected under the language and provisions of DSRIP 1.0. Our recommendations, in summary, involve adjusting the language in DSRIP 2.0 to financially incentivize and/or *require* (rather than just encourage or support) the engagement of community-based social-determinants-of-health (SDH) organizations and behavioral health organizations (e.g., specialized CBOs, CCBHCs), along with COTIs, BHCCs, and IPAs.

We propose that if DSRIP 2.0 includes the recommended and necessary mandates and incentives, CN Guidance & Counseling Services, along with other CBOs, CCBHC, COTIs, and other behavioral health providers like ours across the State of New York will be able to make a measurable impact on—and help take a needed co-leadership role in—improving New Yorkers' health and advancing the triple-aim and desired shift from fee-for-service to Value-Based Payment.

Respectfully Submitted,

Jeffrey Friedman
CEO

**From:** Judy Wessler [redacted]
**To:** ladyhealth [redacted]
**Subject:** The DSRIP Amendment Request -- A Review and Recommendations
**Date:** Sun, Oct 6, 2019 6:00 pm

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Hoping that this information is helpful and that people can use it to prepare for testimony at New York City public hearing on October 25th, or at a minimum will submit comments on the state's draft DSRIP amendment. Getting approval from the federal government, and using this funding wisely could mean important benefits for our communities. TO COMMENT: The public comment day will be held on **October 25, 2019** at Baruch College, 55 Lexington Ave (Corner of 24th Street & Lexington Ave), Room 14-220 (14th Floor), New York, NY 10010. Attendees are required to check in with the security desk whereupon they will be provided direction to the appropriate room. MRT Public Comment will commence from 11am-2pm. Any written public comment may be submitted to 1115waivers@health.ny.gov through November 4, 2019. Please include "1115 Public Forum Comment" in the subject line.

## The DSRIP Amendment Request -- A Review and Recommendations

The draft amendment request has some good and important points. However, it is in the implementation, commitment, and oversight which will really make the difference. A concern could be the emphasis on flexibility, which is somewhat of an issue in the current waiver. As a member of the state Project Approval and Oversight Panel (PAOP), representing the Assembly, I am very aware that this body operating in public pushed the envelope on ensuring accountability of reporting by the PPSs. It is critical, although nowhere evident in the state's draft proposal, that the PAOP be an integral part of a continuing waiver. Reporting on PPS spending had been much less evident until some members of the PAOP pushed the issue. This was particularly true for dollar flow to community-based providers and community-based organizations.

There was only one mention, that I could find, referencing the need to "reduce racial disparities in health outcome" and that appears only in reference to maternal mortality, which is important, but not the only necessary focus. It is unfortunate that throughout DSRIP, and now in this draft, the quality of culturally competent care is not a factor to be worked on. A September 18, 2019 hearing by the New York City Council Committee on Hospitals, "The Delivery of Culturally Competent and Equitable Health Care Services in New York City Hospitals," elicited some very relevant testimony. For example, major medical centers in the city have separate services, often in separate locations, for Medicaid patients. In testimony from medical students, the institutional racism they are exposed to in their training is very troubling. https://legistar.council.nyc.gov/LegislationDetail.aspx?ID=4086467&GUID=A913A19F-B185-4662-8D25-38E3DDC61295&Options=&Search=

MAJOR POINTS IN THE DRAFT AMENDMENT

- The amendment requests four more years of funding with a price tag of $8 billion;
- The allocation of these funds: $5 billion for DSRIP performance; $1 billion for Workforce; $1.5 billion for Social Determinants of Health; and $500,000 for safety net providers (Interim Access Assurance Fund);
- The waiver calls for addressing social determinants of health through community partnerships -- a welcome point but always dependent on how this is done and who or what controls the decisions and the money flow;

- The Social Determinants of Health Network would be chosen as the lead entity through a competitive process, but the new structure, the VDE, would be eligible. The entity would create a network of CBOs to use evidence based interventions. If done well (my comment not in draft) and really under CBO control, this could be the key to success.
- A new structure would be formed with three new letters -- VDE or Value Driving Entities. There is important language that the next VDE/PPS subset would have providers, **community-based organizations,** and management teams which would be approved by the state.
- The VDE could be assigned specific regions/markets and attributed populations, modifying the existing and more representation from **CBOs,** MCOs, QEs, with more representation from community-based providers. An inclusive governance structure.
- Additional high need priority areas are added including: two mostly overlooked in the first waiver, reducing maternal mortality and children's population health. Also long term care would be a focus.
- A major focus will be on continuing promising practices that are working in the current waiver.
- The first year of the four years is an extension with the next three years as a new waiver.

**MY MAJOR PROPOSALS -- and how they fared in this draft**

I submitted a draft alternative proposal to the state for a new vision for a new DSRIP waiver. Three of us -- Chris Norwood, Anthony Feliciano, and I -- met with the principals in the state health department to present these ideas.

To transform the health care system there is a need to focus on:

- expanding primary care;
- addressing inequities in availability and delivery of services;
- focus on cultural competence;
- and unstunting the growth of community-based services to address the social determinants of health

I proposed a separate pool of dollars to fund communities providing social determinants of health services. The draft proposal includes a separate pool of dollars which is a plus. It will only work well, however, if the new network structure is of and from the community. The three regional community planning consortiums must play a critical role in this development and operation.

I proposed that the funding and decision-making structure must evolve into an inclusive body and could have a different territory for which it is responsible. The draft actually suggests that in the first year, in the extension, there would be "flexibility to align funding to best future management structure for given region/market."

I proposed that the PPS, now to be the VDE, would have a defined region based on geography, and be responsible for the Medicaid and uninsured in that region. There is a very slight possibility in the draft that this could happen.

I proposed major ways of including and incorporating community-based organizations that are of and from, reflect the population in the community so that they have the reach, outreach, credibility, and understanding for what's needed. The state draft mentions community and CBOs frequently. If truly implemented this could make a real difference. Unfortunately state practices often portray CBOs as extensions of PPSs, not of value on their own, e.g., not accepting CBO proposals for, or allowing CBOs not involved with a PPS to participate in the annual conference.

I proposed that "the governing structure, with decision-making authority, will include current PPS (or some portion thereof); ability to determine priorities for programs and funding; oversight of activities to ensure focus on improving access; quality, and impact on health outcome; cultural competence; and training for positions important within the community health structure.

Judy Wessler
October 2, 2019

cc: DEA - please enter into InterTRAC


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NEW YORK STATE OF OPPORTUNITY. | NY Connects Your Link to Long Term Services and Supports



Paul Francis
Deputy Secretary for Health
State Capitol
Albany, NY 12224

Donna Frescatore
Medicaid Director
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Dear Mr. Francis and Ms. Frescatore,

On behalf of Franklin County Office for the Aging, I am writing to express my recommendations on the DSRIP renewal proposed by New York State Department of Health. Franklin County Office for the Aging is one of 59 Area Agencies on Aging, providing services across a rural, economical depressed region. We contract with over 19 contractors to provide services and supports predicated on targeting social determinants of health. The services we provide directly impact inappropriate emergency department visits, and reduce avoidable readmissions. The NY Connects program, implemented in 2006, serves as no wrong door for any and all services available in the region, and is a catalyst for individuals in need of assistance. The targeted goals in the proposed renewal are exactly what this network provides, and must include mandated contracting by each PPS with their local Area Agency on Aging for social determinants of health initiatives. Our office has been in existence for over 40 years, and is the trusted service provider for the fastest growing segment of the population, and the highest utilizer of health care dollars. Our services **absolutely** allow individuals to remain autonomous and remain in their own homes and communities, all while saving health care expenditures. We provide the highest level evidenced based interventions, and are experts at navigating a complex health care system, while providing person centered planning and care.

To demonstrate the value of the network, I would like to highlight a recent case that is typical to our office. We received a referral via the NY Connects department regarding a gentleman in his early 60's, with complex medical needs. He was enrolled in a managed long term care Medicaid program, and due to peripheral vascular disease that had not been managed appropriately, underwent a double below the knee amputation. After a short time in rehab, the gentleman was discharged back to the community with a referral for public health nursing services. However, he lives in a very remote area, has no running water or electricity, and no means of transportation. He additionally self-reported dependency on alcohol and recreational drugs. My office immediately conducted a home visit, and determined that he was not capable of maintaining his home any longer due to his extensive mobility issues. Public health was not able to open a case for him, as it was deemed to be an unsafe living arrangement.

During the home visit by NY Connects staff, it was determined that alternate living arrangements and home care services were necessary on his behalf. Additionally, the client was in need of durable medical equipment, including a wheelchair and commode, as his outhouse was some distance from his cabin. He also had a wound on one of his amputations, and he indicated that there had been a change in the color, and discharge from the wound. As the client did not have a primary care physician in the community, staff immediately contacted the local federally qualified health care center and arranged and appointment for the client to be seen. Transportation to the appointment was also completed via a volunteer transportation program. Home delivered meals were authorized, as he was unable to prepare his own meals. Staff also brought the client a wheelchair and commode via our durable medical equipment loan program, as he was waiting for his insurance to issue he prescribed durable medical equipment. Over the course of the following week, staff continued to visit the client, he received meals, and attending his medical appointment. It was determined that the client necessitated an evaluation at the emergency department, as he spiked a temperature and became disoriented.

Staff presented to the emergency department with the client to provide information regarding his living situation. During his evaluation, the client was extremely tearful and expressed thoughts of suicide. Working in conjunction with the attending physician, NY Connects staff assisted with obtaining an inpatient bed at the crisis center adjacent to the hospital, as they were equipped to treat his depression and substance use disorder. During his stay at the crisis center, NY Connects staff were able to complete a disability application with the client, apply for subsidized housing, and complete an application for SNAP benefits. An apartment was secured, and NY Connects staff worked in conjunction with the faith based community to obtain furniture, bedding, and household items on his behalf. Staff delivered these items to the apartment, and provided transportation from the crisis center to the apartment. Staff also obtained personal care assistance orders on his behalf, and resumed home delivered meals.

Since his relocation he has been able to receive public health nursing services, and case management via Office for the Aging. Additionally, his disability application was approved, he is receiving SNAP benefits, and he is attending physician appointments with the primary care physician secured by NY Connects staff. He is a clear example of an individual that had no advocate or knowledge on how to navigate the health care system. Without the interventions provided by our office, he would have eventually necessitated nursing home placement as he was unable to care for himself. Also, even though he was enrolled in a Medicaid plan, his service coordination was in an office over 200 miles away and he had no telephone in his home to communicate with them. His entire service plan was coordinated via our office, and the outcome for him and the health care system could not have been better.

This is one of many cases that truly display the boots on the ground service provision in every county across the state. In the renewal waiver, I cannot stress highly enough that we need to harness the existing strengths of community based services, instead of recreating case management services and duplication of services. Each and every case manager in the entire statewide aging network has received certification via Boston University School of Social Work, ensuring consistency in assessment not provided by any other system. I ask that there are mandates for each PPS to engage and contract with their local Offices for the Aging, for the services vital to keeping individuals in home and community based settings.

Thank you,

Becky Rreve
Director
Franklin County Office for the Aging