

## **Comments: NYS 1115 Waiver Public Forum**

Submitted by:

New York State Council for Community Behavioral Healthcare

Lauri Cole, Executive Director

Thank you for this opportunity to provide our comments regarding New York's MRT waiver to include the carve-in of New York's Behavioral Health population into Medicaid Managed Care (MMC), New York's Delivery System Reform Incentive Payment Program (DSRIP), and New York's Value-Based Payment Program.

### **Comments regarding Behavioral Health population carve-In into Medicaid managed care:**

- Some positive outcomes associated with implementation of New York State initiatives including DSRIP and carve-in of BH special population into MMC. New York should be praised for its' courage and willingness to take on major reform initiatives in efforts to improve New York's healthcare delivery system and outcomes for New Yorkers in need of care.
- The Behavioral Healthcare carve-in began in October 2015 and by February 2016 we saw evidence of and began collecting data around the failure of MCOs to supervise the BHOs they had hired to process claims.
- We began meeting with representatives from the Department of Health (DoH) and the Office of Health Insurance Programs (OHIP) on this matter in February 2016 at which time there was little response by the state other than to treat incidents of inappropriately denied claims as 'one-offs'.
- Over the past three and one-half years the numbers of inappropriately denied claims has exploded. We have met with DoH and OHIP officials on a very regular basis and complained frequently regarding:
  1. inappropriate denials of claims that negatively impact access to and continuity of care for BH service recipients
  2. use of prohibited clauses in some MCO contracts
  3. failure by some MCOs to adequately oversee and address BHO failure to perform

4. failure by the state to systematically address high rates of denials of claims from beginning of BH carve in until December 2018
  5. failure by DFS to respond in a timely manner to prompt pay complaints
- In December 2018, New York State enacted a Prospective Payment Program after completing a Root Cause Analysis that showed unusually high rates of claims denials for 5 commonly paid services. This led to a requirement that most MCOs and their vendors fix claims denials issues within a certain amount of time or begin paying retroactive as well as prospective payments to providers for claims denials.
  - At present many providers across the behavioral healthcare system of care are owed (collectively) tens of millions of dollars while MCOs and their BHOs continue to make excuses for failure to reconcile and pay in full. These agencies have no margin, are financially stressed and without resources to hire legal firms to address these matters. This is an unacceptable situation.
  - Providers who took advantage of Prospective Payment System are now faced with a significant and time-consuming reconciliation process.

**Recommendations:**

- State should re-consider current MMC model in which BHOs can act on behalf of MCOs to pay claims.
- State should formalize and strengthen its' 'Readiness Assessment' process of all BHOs and MCOS for implementation of a carve in of any special population.
- State agency leaders, DOB and the executive should re-assess current staffing levels at the DoH and the Department of Financial Services (DFS) to ensure adequate staffing is available to perform substantial surveillance, monitoring and enforcement activities.
- When a Health Plan breaks the law, state penalties should be swift and should impact the financial bottom line of the Plan. This is the only way to get its' attention.
- BHOs like Beacon Health Options who now have a significant history of failure to pay claims on time or in full should not be permitted to continue

to participate in current or future carve-ins of special populations in New York for a period of no less than 3 years.

- When the Attorney General's Office issues an enforcement against a BHO or MCO shortly before the carve in of a special population for which that same BHO has significant responsibilities, the BHO should not be permitted to enter into the newly carved in market for a minimum of two years.

### ***Comments regarding NY's DSRIP Program***

The New York State Council strongly supports New York's efforts to transform the healthcare delivery system through DSRIP. However, as of November 2018, mental health prevention, treatment and recovery service providers had received just 1.8% of all DSRIP funding received by PPS' around the state while substance use disorder/addictions prevention, treatment and recovery providers had received just .7% of the same. Obviously, these numbers stand in stark contrast to the very significant impacts community-based care providers have had on the success of the DSRIP Program in its' goal to reduce unnecessary hospital re-admissions and to care for New Yorkers in their local communities.

New York has a significant history of failing to adequately invest in community-based care. Sometimes this happens when community-based organizations are deemed ineligible for new funds as was the case with the HEAL-NY Program, or when there is a nonprofit conversion or healthcare merger that results in new resources coming in to New York and those resources benefitting only one area of the healthcare delivery system. I can tell you that right now the community-based sector is drowning. Workforce shortages are robbing our sector of the oxygen it needs to sustain itself while the weight of the Opioid Epidemic and ever-increasing rates of suicide are pulling us further under water with each new day. If DSRIP is about transforming our system of care shouldn't we be working from the bottom up rather than from the top down?

As New York contemplates a new DSRIP Program, we urge the state to ensure the Program includes strong rules that require PPS systems to invest a minimum of 40% of the funds received by the PPS into the programs and services that are making the DSRIP Program the success that it is. Going forward, PPS projects

should not be focused on replicating services or advancing a PPS lead's particular business strategy, but should build off existing capabilities for providing community-based primary and behavioral health care.

***Comments: New York's Value-Based Payment Initiative***

The New York State Council appreciates the opportunity to comment on the state's current model for the implementation of value-based purchasing.

Few if any of the 18 provider networks that formed across the behavioral health sector in response to the state's push for them to participate in value-based contracting are under contract to do so. This is in large part due to the specifics of New York's value based contracting model (as laid out in the state's VBP Roadmap) that do not lend themselves to meaningful participation by community-based organizations including but not limited to mental health and substance use disorder/addictions providers. These road blocks are solvable but only if the state amends the Roadmap to incorporate the following recommendations:

**Attribution**

Value-based care initiatives must be designed to be person / patient centered and informed by the clinical/medical and social determinants of health issues faced by distinct client populations. If the care recipients' needs are primarily behavioral health-focused and the primary relationship of the care recipient is with (or should be where clients are disengaged from the treatment system) a behavioral health provider, then attribution should be to the behavioral health provider where the engagement is occurring or is most likely to occur. In this attribution model, coordination of care for these individuals becomes the responsibility of the BH provider. This would include coordination of primary care as well as specialty care and social determinants of health. Behavioral health providers (individually as well as collectively as BHCCs/IPAs) are more than capable of assuming these responsibilities (many of which they perform now). *We urge NYS*

be based on their contribution to and achievement of outcomes related to these BH metrics and related medical metrics

#### Network Adequacy Standards

NYS currently has standards for health plans' network adequacy, but not for the VBP contractors that are entering into total cost of care contracts. This omission can lead to Medicaid beneficiaries experiencing barriers to accessing community-based BH care and increases in use of higher levels of care.

The NYS Council believes that Network Adequacy standards should be put in place in order to ensure a more inclusive provider network than is currently required or discussed in the state's current VBP Roadmap. A robust network adequacy program would include policy, regulatory requirements, operational management and financial transparency and reporting. At a minimum, the network should contain a sufficient number and array of behavioral health providers to meet the diverse needs and choices of adults and children and assure timely access to Medicaid managed care and HARP benefits and services.

The goal is to demonstrate access to and availability of community-based mental health and substance use programs and services without unreasonable delay and recognizing delivery of said services may be through one or more of the following programs and service models:

- independent licensed behavioral health programs
- coordinated licensed primary care and behavioral health programs
- integrated, licensed primary care and behavioral health.

#### Transparency

We urge the state to require the budgets submitted by plans to OHIP for approval be aggregated so there is transparency regarding the intended spend on the BH population that has been swept into TCOCGP arrangements. *The budget should have a target spend set by the state. Surveillance and monitoring of adherence to these commitments should be a high priority.*

**From:** [REDACTED]  
**To:** [doh.sm.1115Waivers](mailto:doh.sm.1115Waivers)  
**Subject:** 1115 Public Forum Comment  
**Date:** Thursday, June 13, 2019 5:44:18 PM

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I am a disABLED member of the VNS Choice MLTC. I was a former of the Independence Care System before it was done away with by the Dept. of Health early this year. Former members were told that our services would remain the same for one year (which ends in April, 2020). However, I have been told by former ICS members that VNS Choice is making our transition very difficult as far as receiving our supplies, and having transportation to our medical appointments.

As for my personal situation, my movement disorder requires that I be active. Thereby, I asked to join a wellness adult center which is open Sundays. I was informed by VNS that this will affect my health home care hours which I need very much. It seems that VNS Choice is forcing me to choose between remaining active and independent, AND my health needs (hours).

I attended *a Public Comment Day at the Academy of Medicine in NYC last November 29th*. I cannot attend the June meeting since it is too far, but I hope my testimony shows my interest in this matter which affects many in the disABILITY community.

Thank you for your attention.

Robert Acevedo  
DisABLED In Action of Metropolitan NY

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**From:** Juan Pinzon [REDACTED]  
**Sent:** Monday, June 24, 2019 12:11 PM  
**To:** doh.sm.1115Waivers  
**Subject:** 1115 Public Forum Comment  
**Attachments:** CSS 1115 Medicaid Waiver FINAL.docx; ATT00001.htm

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Hi,

Please find attached CSS's comments which I will deliver in person at today's forum.

All the best,

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

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

June 24, 2019

New York State Department of Health  
Medicaid Redesign Team  
[115waivers@health.ny.gov](mailto:115waivers@health.ny.gov)

Re: Comments of the Community Service  
Society of New York on the New York's  
1115 Medicaid waiver programs.

The Community Service Society of New York (CSS) would like to thank the New York State Department of Health for the opportunity to provide comments on New York's 1115 Medicaid waiver programs. For over two decades, CSS has worked in partnership with the New York State Department of Health to build capacity in nearly 100 community-based organizations (CBOs), serving every county, to ensure that consumers and small businesses are able to find and use quality healthcare.<sup>1</sup> Our role in these networks has included technical assistance, capacity building, and planning for sustainability.

Research has demonstrated that nonclinical factors such as poverty, lack of social supports, poor education, and racial discrimination and segregation significantly contribute to avoidable illness and premature death.<sup>2</sup> In fact, the traditional healthcare delivery system only accounts for 10 percent of what is necessary to make a person healthy.<sup>3</sup> The impact of these social determinants of health (SDH) helps explain why our nation's outsized spending on the healthcare delivery system has done little to improve overall health outcomes.

CSS believes that CBOs are best positioned to help the healthcare delivery system address SDH because they provide vital social support services and often reach the hardest to reach communities. To this end, CSS recently worked closely with New York's largest Performing Provider System, Health + Hospital's OneCity Health, to increase CBO engagement and readiness to

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<sup>1</sup> With generous support of the New York State Department of Health and other funders, CSS has led the following CBO-based healthcare networks: Community Health Advocates, the state's all-payor health insurance ombudsprogram; ICAN [insert description], CNN [insert description]; FE-ABD [insert description]; and the Small Business Assistance Program, which helped small businesses understand the Affordable Care Act and help its employees find and use coverage.

<sup>2</sup> S. Galea et al., "Estimated Deaths Attributable to Social Factors in the United States" *American Journal of Public Health* 101, no. 8 (August 2011):1456-1465, doi:10.2105/AJPH.2010.300086.

<sup>3</sup> S. Schroeder, "We Can Do Better — Improving the Health of the American People," *New England Journal of Medicine* 357 (Sept. 20, 2007):1221-1228, doi:10.1056/NEJMsa073350.

participate in value based purchasing arrangements. Through this partnership, we have had the opportunity to intensively assess the capacity of 52 OneCity Health CBO partners through an on-site organizational assessment followed by a learning collaborative program.

Because partnerships between healthcare entities and CBOs are such an important mechanism to address SDH and help the state achieve its healthcare system transformation goals, we urge the state to consider amending its 1115 Medicaid Waiver to continue a DSRIP program that better addresses SDH through direct funding of CBO projects and capacity building. North Carolina's 1115 Medicaid Waiver, recently approved by CMS, could serve as a model for this CBO program. As part of the North Carolina waiver, CMS approved a \$650 million Healthy Opportunities Pilot program to address SDH, \$100 million of which will be allocated for capacity building of service providers, including CBOs and social service agencies. The funding will be distributed to lead non-medical pilot entities (LPEs) that will be responsible for developing the infrastructure needed by service providers to deliver services, receive payment, and report outcomes. The LPEs also monitor the pilots and provide technical assistance to CBO service providers.<sup>4</sup>

Our work with OneCity Health leads us to believe that New York State successor DSRIP program represents an important opportunity to build capacity in well-placed, small- and mid-sized non-Medicaid billing CBOs, who are best positioned to meaningfully build trust in vulnerable populations who are most affected by SDH. Our work indicates that New York State's CBOs, like those in North Carolina, would benefit from a dedicated stream of funding to build capacity in the following three areas:

1. New York should consider creating a technical assistance program to focus on building business acumen and the capacities needed for CBOs to successfully partner with the healthcare sector in the VBP environment

Most CBOs who completed the OneCity Health assessment reported struggling in areas around market analysis that can identify clients to sell their services to (i.e. healthcare providers) versus their traditional funders. New York State's DSRIP waiver should provide financial support to establish regional peer-learning communities that would offer technical assistance and capacity-building in the areas identified in the OneCity assessment process, such as: understanding the healthcare landscape, market analysis and marketing, prospecting, building an evidence base for services, pricing and demonstrating return on investment, and communicating organizational value. This peer-learning program should focus on building business acumen and the capacities needed to partner with the healthcare sector in a VBP environment. There is substantial evidence that learning collaboratives are an effective vehicle for inducing change at the local level.<sup>5</sup> A well-curated learning

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<sup>4</sup> A First Look at North Carolina's Section 1115 Medicaid Waiver's Healthy Opportunities Pilots – Issue Brief – 9307 | The Henry J. Kaiser Foundation. <https://www.kff.org/report-section/a-first-look-at-north-carolinas-section-1115-medicaid-waivers-healthy-opportunities-pilots-issue-brief>

<sup>5</sup> M. Nix et al, "Learning Collaboratives: Insights and a New Taxonomy from AHRQ's Two Decades of Experience," *Health Affairs*, Vol. 37(2), February 2018 ("AHRQ's experience with a diverse portfolio of collaboratives over nearly two decades illustrates the potential of collaboratives to accelerate the diffusion and implementation of innovation and to advance research.")

community also can offer opportunities for CBOs to interact with possible provider and payer partners and elevate policy issues with state and local government officials.

## 2. Consider allocating capital funding and technical support for IT systems to track processes and outcome data

The OneCity Health readiness assessment process validated the belief that CBOs need additional capital and technical support to develop IT systems that track outcomes and interact with healthcare providers and payers, and possibly the state's health information networks (the RHIOs and SHIN-NY). The assessment revealed that many of the smaller, non-Medicaid-billing CBOs need help implementing basic IT and/or data entry systems to collect, share, and manage data for programmatic and reporting purposes. Most of the CBOs assessed do not have the capital to invest in new information technology systems. The new DSRIP waiver should provide dedicated capital funding for CBOs to build a uniform IT system that can monitor and track the CBO's efforts to help their healthcare partners address SDH and other health objectives.

In the past, New York State has helped improve health information technology for the healthcare system through the Health Efficiency and Affordability Law (HEAL) that authorized up to \$1 billion to help providers develop health information technology and restructure their delivery systems towards community, rather than in-patient, care. More recently, the New York State eHealth Collaborative may be working to address some of these issues and could potentially offer CBO support in this area. A continuation of DSRIP should consider providing initial capital funding and ongoing technical assistance to CBOs so that they may meet the data-driven demands of VBP contracts.

## #3. Consider encouraging and funding formal CBO partnerships

As part of a continuation of DSRIP, New York's new DSRIP waiver should follow North Carolina's lead and support formal partnerships amongst CBOs to reduce administrative burden and provide contracting support as they enter into VBP contracts with MCOs. Here in New York, many CBOs had positive experiences working in collaboration with like-minded organizations. For example, a number of the behavioral health CBOs expressed the desire for more opportunities like the New York State Office of Mental Health's Behavioral Health Value Based Payment Readiness Program or the New York City Department of Aging's CommunityCare Link program, which would help CBOs provide services on a scale that is of value for health partners. These CBOs indicate that it would be easier for contracting purposes for health partners to deal with networks of providers and it would make evaluations more likely to produce enough data to capture meaningful results. A CBO network model could provide services for the CBOs who need help negotiating agreements, collecting and aggregating data, and managing the legal and administrative burdens that participating in such VBP projects might require.

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

## doh.sm.1115Waivers

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**From:** Elizabeth Hamlin [REDACTED]  
**Sent:** Monday, June 24, 2019 4:19 PM  
**To:** doh.sm.1115Waivers  
**Subject:** 1115 Public Forum Comment  
**Attachments:** NY Medicaid Waiver Comments 6.24.19.pdf

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Please accept the attached document.

Thank you.

**Elizabeth Hamlin**

Director | Advocacy | New York, Massachusetts and Vermont

**American Lung Association**

418 Broadway | Albany, NY 12207

[REDACTED]  
Lung HelpLine: 1-800-LUNGUSA

[Lung.org](http://Lung.org) | [REDACTED]

Preferred Pronouns: She/Her/Hers





My name is Elizabeth Hamlin and I am the Director for Advocacy for the American Lung Association in New York. The American Lung Association is the oldest voluntary health organization in the United States. For more than 110 years, the Lung Association has been working to save lives by improving lung health and preventing lung disease through research, education and advocacy. The Lung Association works on behalf of the 35 million Americans living with lung diseases such as asthma, COPD and lung cancer, including more than 2.3 million New Yorkers.

The American Lung Association appreciates this opportunity to comment on New York's 1115 waiver programs, which facilitate New York's Medicaid managed care program. Ensuring access to quality and affordable healthcare coverage is a top priority for the Lung Association. Coverage through the Medicaid program is especially important for patients with asthma; nationally, nearly half of all children with asthma receive their health coverage through Medicaid or the Children's Health Insurance Program (CHIP), and adults in Medicaid are almost twice as likely to have asthma as those with private health insurance.<sup>i,ii</sup> New York State has more than 377,000 children living with asthma.

Asthma cannot be cured, but it can be managed effectively through care based on the National Heart, Lung and Blood Institute's National Asthma Education and Prevention Program (NAEPP) Guidelines. The NAEPP Guidelines provide important evidence-based recommendations on the best ways to treat asthma, including assessment and monitoring of asthma patients, asthma self-management education, access and adherence to asthma medications and control of environmental exposures that affect asthma.

Through the Asthma Care Coverage Project, the American Lung Association tracks Medicaid coverage of and barriers to guidelines-based asthma care across all 50 states. Updated coverage data was released this month and reveals gaps in coverage of important treatments and services for asthma patients who receive their healthcare coverage through Medicaid managed care organizations (MCOs) in New York.<sup>iii</sup> Improving access to guidelines-based asthma care as part of this initiative would help New York to both improve health outcomes for patients in asthma and reduce healthcare costs.

Specifically, Medicaid MCOs should cover a wide variety of quick relief and controller medications and related medical devices for asthma, while removing current barriers to coverage such as copays, prior authorizations, step therapy requirements and quantity limits that can make it difficult for patients to obtain the treatments that they need. Individual health care providers are best equipped to ensure that their patients have the appropriate treatments for their unique needs, but these barriers to care can prevent patients from accessing and adhering to recommended treatments. Additionally, as progress in science leads to new and innovative medications for asthma entering the market, Medicaid MCOs should offer open access to these treatments as well.

Additionally, all Medicaid MCOs should provide coverage for home visits for asthma patients without barriers. These visits provide an opportunity to identify environmental factors, such as pests, mold or secondhand smoke, that may trigger a patient's asthma and provide additional educational and care coordination services that can help to prevent future exacerbations. Many evaluations of home visit

Elizabeth Hamlin

Director | Advocacy | New York

American Lung Association in New York

418 Broadway | Albany, NY 12207





programs have shown improvements in health outcomes and evidence of cost effectiveness; one systematic review of home-based asthma interventions reported a return on investment (ROI) of \$5.30 to \$14 per dollar spent.<sup>iv</sup>

In conclusion, improving access to guidelines-based asthma care will improve health outcomes for individuals living with asthma in the New York. The American Lung Association recommends that New York's Medicaid program work with MCOs to cover all components of guidelines-based asthma care without any barriers. Thank you for your time and attention to this matter.

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<sup>i</sup> Kaiser Family Foundation. Kaiser Commission on Key Facts: The Role of Medicaid for People with Respiratory Disease. November 2012.

<sup>ii</sup> National Survey of Children's Health, 2011-2012: [https://www.cdc.gov/asthma/asthma\\_stats/documents/asthmastats\\_healthcare\\_coverage\\_children\\_aged\\_0-17\\_years\\_with\\_charts\\_2\\_f..508.pdf](https://www.cdc.gov/asthma/asthma_stats/documents/asthmastats_healthcare_coverage_children_aged_0-17_years_with_charts_2_f..508.pdf).

<sup>iii</sup> American Lung Association, Asthma Care Coverage Database - New York June 6, 2019. Available at: <https://www.lung.org/lung-health-and-diseases/lung-disease-lookup/asthma/asthma-education-advocacy/asthma-care-coverage/database/state.html?id=33>.

<sup>iv</sup> Nurmagambetov TA, Barnett SB, Jacob V, Chattopadhyay SK, Hopkins DP, Crocker DD, Dumitru GG, Kinyota S; Task Force on Community Preventive Services. Economic value of home-based, multi-trigger, multicomponent interventions with an environmental focus for reducing asthma morbidity a community guide systematic review. *Am J Prev Med.* 2011 Aug; 41(2 Suppl 1): S33-47. doi:10.1016/j.amepre.2011.05.011.

Elizabeth Hamlin  
Director | Advocacy | New York  
American Lung Association in New York  
418 Broadway | Albany, NY 12207



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**From:** Joanne Robinson [REDACTED]  
**Sent:** Wednesday, June 26, 2019 1:32 PM  
**To:** doh.sm.1115Waivers  
**Cc:** Rebecca Sanin; David Sinclair; Jean Kelly  
**Subject:** 1115 Public Forum Comments  
**Attachments:** INN Action Letter 1115 Waiver.pdf

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Attached please find a letter from The Interfaith Nutrition Network, Inc. containing feedback related to the 1115 Waiver Public Forum comments.

Thank you for your attention to this important topic.

**Joanne Robinson, RN, MSPH**  
*Managing Director*  
*The INN (Interfaith Nutrition Network)*  
*211 Fulton Avenue*  
*Hempstead, NY 11550*

[www.the-inn.org](http://www.the-inn.org)



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The Interfaith Nutrition Network, Inc.  
211 Fulton Avenue, Hempstead NY 11550

June 26, 2019

Dear Medicaid Redesign Team:

The INN is a 501c3 organization which has been addressing hunger and homelessness on Long Island since 1983.

When New York State invested money to develop consortia of community-based organizations across the state in preparation to engage in Value Based Payment, it recognized that CBOs play a critical role in addressing social determinants of health. Repeated data support that holistically meeting people's needs in their communities improves overall health outcomes, reduces medical costs and most importantly, provides families pathways to economic stability and improved quality of life.

For almost two years, Health Equity Alliance of Long Island, a consortium of over 80 CBOs, has been examining how to improve care and service to families through a shared technological platform that can track referrals & data, enable cross-sector collaboration and standardize screening & intake processes. As NYS moves ahead with Medicaid reform and the VBP Roadmap, we have the following recommendations:

- There should be a focus on outcomes specifically related to racial equity and social determinants of health.
- Since NYS invested money in the planning process and the creation of a strategic plan for CBOs to engage in VBP, there should be funding allocated to support the implementation of that plan.
- The majority of DSRIP funds were distributed to the hospitals and healthcare systems through the formation of PPSs. DSRIP 2.0 should be laser focused on cross-sector collaboration and dollars should be distributed equally through a third-party to all participants, particularly CBOs and local government.
- Managed Care Organizations need more direction from NYS to contract with coalitions of CBOs addressing a spectrum of SDH and not simply one CBO to metaphorically "check the box."

Long Island needs the infrastructure it so sorely lacks if it is to be successful in moving ahead with the State's vision for VBP. And if we collectively believe that SDH are critical to improving health outcomes, then there must be support to launch a scalable and sustainable model for CBOs to engage with healthcare partners on a level playing field.

Thank you for your time and attention.

Sincerely,

A handwritten signature in black ink that reads "Joanne Robinson". The signature is written in a cursive, flowing style.

Joanne Robinson  
Managing Director

## doh.sm.1115Waivers

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**From:** Lindsay Knowlton [REDACTED]  
**Sent:** Thursday, June 27, 2019 12:56 PM  
**To:** doh.sm.1115Waivers  
**Subject:** 1115 Public Forum Comment  
**Attachments:** NCI 1115 Public Comment.pdf

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Good afternoon,

Please find attached a comment from the North Country Initiative PPS regarding the MRT waiver.

Thanks,

Lindsay

**NORTHCOUNTRY**  
INITIATIVE



Lindsay Knowlton  
DSRIP Director  
120 Washington St., Suite 230  
Watertown, NY 13601  
[REDACTED]

North Country  
INITIATIVE | DSRIP  
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July 5, 2019

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

Re: 1115 Public Forum Comment

To Whom It May Concern,

North Country Initiative PPS appreciates the opportunity to provide feedback to the Department of Health regarding the Section 1115 waiver. The PPS supports the State's efforts in pursuing a DSRIP renewal to continue improving access to health services and achieving better health outcomes for Medicaid and uninsured beneficiaries. To continue these efforts, North Country Initiative recommends the following be included in the DSRIP Renewal Concept Paper:

- Maintain at least one entity structure in each region (i.e. PPS) inclusive of stakeholders from Health Homes, Behavioral Health Care Collaboratives (BHCCs), Population Health Improvement Programs (PHIPs), Coordinated Care Organizations (CCOs), CBO Consortia, health systems, hospitals, primary care providers, and other healthcare entities relevant to the selected projects.
- Require entities and MCOs to analyze regional data to define community needs and improvement opportunities. Determine common goals and collaborate to develop project initiatives based on the DSRIP Playbook. Define deliverables to collaboratively accomplish project deliverables.
- Include PPS-led Medicaid Accelerated eXchange (MAX) series as a best practice within the DSRIP Playbook. While focus has been on ED and inpatient hospitalizations, create flexibility in the MAX objectives to potentially apply Rapid Cycle Continuous Improvement (RCCI) methodology to non-hospitals (i.e. outpatient behavioral health, nursing homes).
- Include clinical standardization as a best practice within the DSRIP Playbook. Create flexibility in areas of standardization to be mutually agreed upon by PPS and MCO in alignment with regional needs and common goals (i.e. SDH screening standardization, disease state standardized protocols)
- Focus on fewer performance metrics that align with regional needs as defined collaboratively between the MCO and PPS. These measures may focus on avoidable hospitalizations in addition to metrics associated with standardized clinical care, population health, and access to care.
- Utilize MCO data to include quality reporting, transparency in expenditures, and utilization.
- Continue requirements for PCMH, primary care and behavioral health integration, and RHIO connectivity.
- Continue to remove barriers imposed by healthcare regulations that may unintentionally limit care coordination and accessibility to the right care at the right time.
- Do not set funding restrictions to non-safety net providers (i.e. community-based organizations).
- Do not silo State agency (i.e. DOH, OMH, OASAS) initiatives toward common goals.
- Do not set prescribed project tasks and reporting requirements that may not impact performance measures.
- Do not tie financial implications to entities as a result of MCOs not meeting their project deliverables.

Additional considerations should be made to account for the varying landscapes in rural Northern New York to include:

- Goals of value-based payment do not align with the structure of critical access hospitals.
- Workforce investments in Health Professional Shortage Areas and Medically Underserved Areas are integral to achieving performance outcomes.

Sincerely,

A handwritten signature in black ink that reads 'Erika Flint'. The signature is fluid and cursive.

Erika Flint  
Director

## doh.sm.1115Waivers

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**From:** Barbara Beatus-Vegh [REDACTED]  
**Sent:** Friday, June 28, 2019 11:13 AM  
**To:** doh.sm.1115Waivers  
**Subject:** 1115 Public Forum Comments

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To the Medicaid Redesign Team:

When New York State invested money to develop consortia of community-based organizations across the state in preparation to engage in Value Based Payment, it recognized that CBOs play a critical role in addressing social determinants of health. Repeated data support that holistically meeting people's needs in their communities improves overall health outcomes, reduces medical costs and most importantly, provides families pathways to economic stability and improved quality of life.

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Long Island needs the infrastructure it so sorely lacks if it is to be successful in moving ahead with the State's vision for VBP. And if we collectively believe that SDH are critical to improving health outcomes, then there must be support to launch a scalable and sustainable model for CBOs to engage with healthcare partners on a level playing field.

Thank you for your time and attention.

Sincerely,  
Barbara Beatus-Vegh

Best regards,

Barbara Joy Beatus-Vegh,

Associate Director

**Girls Inc. of Long Island**

819 Grand Blvd.

Deer Park, NY 11729



[www.girlsincli.org](http://www.girlsincli.org)

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**To:** [doh.sm.1115Waivers](mailto:doh.sm.1115Waivers)  
**Subject:** 1115 Public Forum Comment  
**Date:** Friday, June 28, 2019 4:18:30 PM  
**Attachments:** [1115 Pulic Forum Comment.pdf](#)

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Jeannine Rey  
Executive Director  
Rosa Lee Young Childhood Center  
180 N. Village Avenue  
Rockville Centre, NY 11570



# Rosa Lee Young

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*A child's place, a family place.*

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www.rosaleeyoungchildhoodcenter.org

Rosa Lee Young Childhood Center is committed to providing high quality education and care for children from economically, ethnically and racially diverse families in and around Rockville Centre.



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Thank you for your time and attention.

Sincerely,

Jeannine Rey

Executive Director, Member HEALI

**From:** [REDACTED]  
**To:** [doh.sm.1115Waivers](mailto:doh.sm.1115Waivers)  
**Cc:** [REDACTED]  
**Subject:** Long Island Needs  
**Date:** Monday, July 1, 2019 12:58:34 PM  
**Attachments:** [image007.png](#)  
[HWCLI- Medicaid Redesign Team 2019.7.1.pdf](#)

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July, 1, 2019

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Thank you for your time and attention.

Sincerely,

A handwritten signature in blue ink that reads "Heath I. Bloch".

Heath I. Bloch, LCSW  
Chief Operating Officer

**From:** [REDACTED]  
**To:** [doh.sm.1115Waivers](mailto:doh.sm.1115Waivers)  
**Subject:** 1115 Public Forum Comments  
**Date:** Monday, July 1, 2019 4:50:50 PM  
**Attachments:** [ActionletterMRT.pdf](#)

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Good afternoon,

Attached please find a letter from the Health & Welfare Council of Long Island containing feedback related to the 1115 Waiver Public Forum comments.

Thank you for your attention to this important topic.

Rebecca Sanin, JD, MA  
President/CEO  
Health and Welfare Council of Long Island (HWCLI)  
150 Broadhollow Road  
Suite 118  
Melville, NY 11747

[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

[www.hwcli.com](http://www.hwcli.com)

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Thank you for your time and attention.

Sincerely,

Rebecca Sanin, JD, MA

President/CEO

Health & Welfare Council of Long Island

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**From:** [REDACTED]  
**To:** [doh.sm.1115Waivers](mailto:doh.sm.1115Waivers)  
**Subject:** 1115 Public Forum Comments  
**Date:** Monday, July 1, 2019 4:59:22 PM

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To the Medicaid Redesign Team:

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Thank you for your time and attention.

Sincerely,

S. Mary Beth Moore, SC

Executive Director  
Centro Corazon de Maria  
31 Montauk Highway  
Hampton Bays, NY 11946

[REDACTED]

**From:** [REDACTED]  
**To:** [doh.sm.1115Waivers](#)  
**Subject:** 1115 Public Forum Comments  
**Date:** Tuesday, July 2, 2019 1:18:44 PM  
**Attachments:** [S.OliverActionletterMRT.ESR.docx](#)

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Hello.

Please, see attached...

Sincerely,  
Dr. Subrina D. Oliver

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July 2, 2019

To the Medicaid Redesign Team:

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**From:** [REDACTED]  
**To:** [doh.sm.1115Waivers](mailto:doh.sm.1115Waivers)  
**Subject:** 1115 Public Forum Comment  
**Date:** Tuesday, July 2, 2019 1:29:16 PM  
**Attachments:** [LIAF\\_1115 Public Forum Comment.pdf](#)

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Please see letter attached. Thank you!

**Melissa Katz, LMSW**

Director of Early Stage and In-Home Respite Programs  
Long Island Alzheimer's Foundation  
1025 Old Country Road  
Suite 115  
Westbury, NY 11590

[REDACTED]  
[REDACTED]  
[REDACTED]  
[www.liaf.org](http://www.liaf.org)





*With you every step of the way*

LONG ISLAND ALZHEIMER'S FOUNDATION

July 2, 2019

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Thank you for your time and attention.

Sincerely,

Melissa Katz, LMSW

Director of Early Stage and In-Home Respite Program

Long Island Alzheimer's Foundation

**From:** [REDACTED]  
**To:** [doh.sm.1115Waivers](mailto:doh.sm.1115Waivers)  
**Subject:** 1115 Public Forum Comment  
**Date:** Tuesday, July 2, 2019 2:03:23 PM

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To the Medicaid Redesign Team: From Ginette Rows

When New York State invested money to develop consortia of community-based organizations across the state in preparation to engage in Value Based Payment, it recognized that CBOs play a critical role in addressing social determinants of health. Repeated data support that holistically meeting people's needs in their communities improves overall health outcomes, reduces medical costs and most importantly, provides families pathways to economic stability and improved quality of life. For almost two years, Health Equity Alliance of Long Island, a consortium of over 80 CBOs, has been examining how to improve care and service to families through a shared technological platform that can track referrals & data, enable cross-sector collaboration and standardize screening & intake processes. As NYS moves ahead with Medicaid reform and the VBP Roadmap, we have the following recommendations:

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Thanks you so much for your time and attention, Ginette

***Ginette Rows***  
***Executive Director***  
***Yam Community Resource, Inc.***  
[REDACTED]

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**To:** [doh.sm.1115Waivers](mailto:doh.sm.1115Waivers)  
**Cc:** [REDACTED]  
**Subject:** 1115 Public Forum Comment  
**Date:** Tuesday, July 2, 2019 4:35:40 PM  
**Attachments:** [2019\\_0702\\_1115\\_PubCommentDay\\_CoalitionBH.pdf](#)

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Dear Medicaid Redesign Team,

The Coalition for Behavioral Health is committed to a true partnership with the State as we continue to move forward with the various transformations to the State Medicaid system, including the behavioral health transition to managed care, health care delivery system transformation, including the move to value-based payments (VBP) and efforts to integrate both physical and behavioral health services. The Coalition fully supports the State in its request to the Centers for Medicaid and Medicare to renew the 1115 waiver to continue successful and promising practices developed through the Delivery System Reform Incentive Payment (DSRIP) program. However, it is imperative that community-based behavioral health organizations be fully integrated partners in DSRIP activities, as these organizations engage, assist, and serve the most vulnerable members of our community, of whom many 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 continue to be unattainable, such as improving engagement in alcohol and other drug dependence treatment, which has, to date, demonstrated little improvement or progress across PPSs. <sup>[1]</sup> Although the first iteration of DSRIP laid the foundation for partnerships between hospital systems, primary care, behavioral health, and community-based organizations, increased collaboration between hospital systems and community-based behavioral health providers is imperative. This collaboration needs to be supported through increased funds flowing from Performing Provider Systems (PPSs) directly to behavioral health organizations engaging vulnerable patients on the ground and in the community. Moreover, the actual cost of delivering behavioral health services needs to be reflected in reimbursement rates. Current APG rates have not kept up with the true cost of services provided, making it difficult for behavioral health providers to deliver high quality, innovative care that will allow them to compete for VBP contracting arrangements. Furthermore, VBP rates must also be financially viable and no less than current APG rates to ensure

the financial stability of behavioral health organizations during the transition. Continued system transformation depends on fully utilizing the expertise and strength of behavioral health providers to implement VBP systems, employ data collection practices aligned with behavioral health outcome metrics, address the social determinants of health, integrate care and steer enrollment of behavioral Health and Recovery Plan (HARP) members into Home and Community Based Services (HCBS).

### **Enable Real Community-Based Partnerships in DSRIP**

Performing Provider Systems (PPSs) partnering with community-based providers to avoid hospitalizations is key to a successful DSRIP process. As New York State looks to renew the 1115 waiver, The Coalition recommends the renewal application require PPSs to distribute funding to community-based behavioral health provider organizations to sustain and expand promising and effective practices. Moreover, the State and PPSs must provide clear, transparent, and public data to demonstrate the total dollar amount behavioral health providers received from PPS. Funds flow data shared during the June 24 DSRIP PAOP meeting combined ambulatory and community provider data, making it difficult for the public to discern the total dollar amount received by community-based behavioral health providers. In addition, The Coalition recommends the State continue to fund CBO planning grants across the State, and unspent DSRIP funds should be allocated to an Innovation Fund available to CBOs and other community-based entities for investment in community-oriented DSRIP-related activities, particularly with relation to dollars intended for workforce sustainability.

### **Support Community-Based Provider Participation in Value-Based Payments**

The transition to VBP must maintain stability for community-based organizations with sound behavioral health performance measures and rates that truly cover the costs of helping people to transform their lives. Providers should be held accountable to metrics that reflect the outcomes the State wants to attain under DSRIP, VBP and the overall vision of the MRT. That means strengthening communities and empowering people with greater access to physical and behavioral health care where they live and work; and developing real opportunities for true integration of care. People living with severe mental illness and substance use disorders need to be able to access physical health services in the same places where they already receive behavioral health care.

To ensure community-based behavioral health providers are included in VBP arrangements at Level II or Level III, The Coalition recommends that managed care companies contract with at least one community-based behavioral health provider, like the current State requirement to contract with at least one non-Medicaid billing CBO to employ an intervention to address a social determinant of health. Community-based behavioral health providers will need support to enable and foster their participation in VBP arrangements; the State and VBP lead entities must provide funding to community-based behavioral health providers for technical assistance, contracting for outside expertise, information technology resources, and access to timely data to help us get to VBP in a deliberative way. Although the State provided some funds to behavioral health care collaboratives (BHCCs) to prepare behavioral health providers for VBP arrangements, more funding and technical support is needed for behavioral health networks to fully participate in VBP arrangements.

### **Medicaid Managed Care**

As the State continues to implement its “Care Management for All” initiative to require most Medicaid beneficiaries and services to be in mandatory managed care, it must ensure access to true, meaningful care coordination. Home and Community Based Services (HCBS) are essential in contributing to the wellbeing of people living with behavioral health issues, who are served in managed Health and Recovery Plans (HARPs). Access to HCBS must be made more expeditiously for the people who need them. To achieve this goal, The Coalition suggests that the four employment services (Pre-vocational Services, Transitional Employment, Intensive Supported Employment, and Ongoing Supported Employment) be bundled into one array of employment services to allow individuals to seamlessly transition from one service to the next as they achieve their health and recovery goals, without going through the burdensome process of updating their plan of care. Moreover, The Coalition also recommends that Education Support Services and Pre-Vocational Services be billable in 15-minute increments, rather than the current billing rate of one hour, to allow providers to offer an appropriate amount of services tailored to the individual’s recovery goals, rather than accommodating the billing increment. In addition, special attention must be paid to the transition to Medicaid managed care for children. While enhanced service rates for the transition period cover the cost of direct service provision, they will not offset the expenses incurred by delays

due to the transition and the purchase of required health information technology. Moreover, the State needs to ensure that managed care plan billing systems are up to date, include accurate rate codes, and can process clean claims to prevent any delay in reimbursements to behavioral health providers, which greatly impacts the financial stability of child serving organizations.

## **Conclusion**

To achieve New York's long-term Medicaid redesign goals, community-based behavioral health providers need to be supported with the tools necessary to make these changes, while continuing to deliver high-quality services to the individuals that need them.

Amy Dorin, LCSW  
President & CEO  
The Coalition for Behavioral Health, Inc.  
123 William Street, Suite 1901  
New York, NY 10038  
[REDACTED]  
[REDACTED]  
[www.coalitionny.org](http://www.coalitionny.org)

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-

## **About The Coalition**

The Coalition is the umbrella nonprofit, (501)(c)(3), association and public policy advocacy organization of New York's behavioral health providers, representing about 110 non-profit behavioral health agencies. Taken together, these agencies serve more than 500,000 adults and children and deliver the entire continuum of behavioral health care in every neighborhood of a diverse New York City and surrounding areas.

Founded in 1972, the mission of The Coalition is to coordinate the efforts of government and the private sector toward efficient delivery of quality behavioral health services to children, adults and families. The Coalition promotes policies and practices that support the development and provision of community-based housing, treatment, rehabilitation, and support services to all people with mental illness and addictions disorders. Our members serve a diverse group of recipients, including older adults, people who are homeless, those who living with HIV/AIDS and other co-occurring health conditions, violence and other special needs. Coalition members help people with mental health conditions and substance use disorders to recover and lead productive lives in their communities.

The Coalition provides quality learning opportunities, technical assistance and training to staff and leadership of its member agencies and to the professional community on important issues related to rehabilitation and recovery, organizational development, best practices, quality of care, billing and regulations/contract compliance, technology and finance.

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[1] According to state data shared during the June 24 DSRIP PAOP meeting.

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**From:** [REDACTED]  
**To:** [doh.sm.1115Waivers](mailto:doh.sm.1115Waivers)  
**Subject:** 1115 Public Forum Comment  
**Date:** Wednesday, July 3, 2019 4:29:42 PM

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Dear Medicaid Reform Administrators

NY State, as we know, has had a very successful waiver and made serious progress in not just reducing emergency room and hospital use, but in at least starting to move toward a system more oriented to wellness than a system which is almost entirely a sickness industry.

Given that we have seen unprecedented success, it is all the more sad and disturbing that the state has made no real effort to submit DSRIP 2 in a timely fashion that could allow uninterrupted continuance (and improvement) of projects which were so hard to implement.

Beyond that, the projects most at risk of complete collapse when DSRIP finishes are the really astonishing community projects which have basically never before existed---or existed on any scale. Health People, itself, has been able to implement a community-wide Diabetes Self-Management Program (DSMP) in the Bronx and will have engaged 2,000 Bronx Residents with Type 2 diabetes in this extremely well-evaluated six-session self-care course by the end of the year; we also are doing virtually the only regularly available foot-care education in the community to try and bring down the truly terrible diabetes-related amputation rates.

AIR NYC has its wonderful home asthma education program. With the advent of Innovation Funding in the past few years, many PPSs have only just started funding important CBO-run projects---such as Food as Medicine.

There are clearly more astonishing results to come from the many CBO efforts, but they will be just lost.

The state, if DSRIP isn't renewed, MUST have an ongoing state Innovation/Community Fund where these impressive efforts can continue. And the state needs to stop pretending that this is all going to somehow be picked up by MCOs because that just is not true.

Thank you,

**Chris Norwood**  
**Executive Director**  
**Health People**  
**552 Southern Boulevard**  
**Bronx, NY 10455**



[www.healthpeople.org](http://www.healthpeople.org)

***Preventing and managing chronic disease through sustainable peer outreach, targeted education, and effective clinical partnerships***



HEALTH PEOPLE  

---

Community Preventive Health Institute

**From:** [REDACTED]  
**To:** [doh.sm.1115Waivers](mailto:doh.sm.1115Waivers)  
**Cc:** [REDACTED]  
**Subject:** 1115 waivers  
**Date:** Wednesday, July 10, 2019 12:40:21 PM  
**Attachments:** [HPCANYS Medicaid Waiver Recommendations 2019 July 10.pdf](#)

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*ATTENTION: This email came from an external source. Do not open attachments or click on links from unknown senders or unexpected emails.*

Please accept my comments to the NY 1115 Medicaid Waiver program on behalf of the Hospice and Palliative Care Association of NY State.

*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*





## Hospice & Palliative Care Association of NYS

24 Computer Drive W., Suite 104

Albany, NY 12205

Ph: 518-446-1483 ■ Fax: 518-446-1484

[www.hpcanys.org](http://www.hpcanys.org)

To: [1115waivers@health.ny.gov](mailto:1115waivers@health.ny.gov).

Re: "1115 Public Forum Comment"

Date: 7/10/2019

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. We would like to make some comments 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.

**Delivery System Reform Incentive Payment (DSRIP) program:** Provides incentives for Medicaid providers to create and sustain an integrated, high performance health care delivery system that can effectively meet the needs of Medicaid beneficiaries and low income uninsured individuals in their local communities by improving quality of care, improving health outcomes & reducing costs (CMS Triple Aim). As we understand it, each group was able to select the most meaningful projects for their geographic area. A small number of programs chose palliative care projects for their team and 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.

Our recommendations for DSRIP beyond 2020, MLTCP, and Medicaid Redesign include the following:

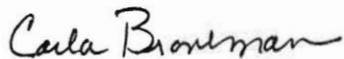
- State plan amendment to allow for a patient on hospice services who is also eligible and needing the services of a Medicaid Managed Long Term Care Plan be allowed to stay on hospice while the assessment and admission to the MLTCP occurs. Although data is unavailable on the impact to the individual during the time that they disenroll from hospice and wait to be admitted on to the MLTCP, we can make an assumption based on the needs of an individual who is enrolled in hospice. The assumption is that there is an increase in emergent and hospital levels of care although that data is not available because the emergent/ hospital care is billed to Medicare for many of these patients.
- Include hospice and palliative care professionals in Medicaid Redesign conversations and work groups. Hospice and palliative care programs improve clinical outcomes, enjoy extremely high consumer satisfaction rates, treat patients with dignity, address social determinants of care, and bends the cost curve for the most complex and seriously ill individuals. Services are offered in a variety of settings such as in an individual's home, in a nursing home, and in a hospice

residence. But access to such services in each continues to be a challenge for individuals. It is important that we address the unique challenges in each setting to ensure eligible individuals and their caregivers can benefit from these services.

- A concurrent care pilot should also be offered for Medicaid beneficiaries over age 21. Currently, beneficiaries under age 21 can continue to receive cure focused care as well as hospice care. The hospice staff's medical and spiritual and psychosocial services will help the patient and family more fully understand the impact of the treatment decisions. They will have experienced 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. 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.

The Hospice and Palliative Care Association of New York State stands ready to connect you with hospice and palliative care providers to participate in these conversations. We look forward to including the principles of hospice and palliative care in Medicaid Redesign.

Sincerely:

A handwritten signature in cursive script that reads "Carla Braveman".

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

**From:** [REDACTED]  
**To:** [doh.sm.1115Waivers](mailto:doh.sm.1115Waivers)  
**Cc:** [REDACTED]  
**Subject:** 1115 Public Forum Comment: Alliance for Better Health - Dr. Jacob Reider  
**Date:** Thursday, July 11, 2019 10:00:33 AM  
**Attachments:** [1115 Public Forum Comment Alliance for Better Health Dr. Jacob Reider.docx](#)

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*ATTENTION: This email came from an external source. Do not open attachments or click on links from unknown senders or unexpected emails.*

Hello:

- Attached (and below) please find written comment re: the 1115 MRT Waiver from Dr. Jacob Reider, CEO of Alliance for Better Health.
- 

Colleagues:

As I expressed in my public comments, we have found DSRIP to have 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 have been so successful. As I reflect on the day and the many comments shared with you as well as the presentation from United Hospital Fund on Promising Practices, I am compelled to offer additional insight that I hope will assist you in framing the policy for the next iteration of this important program. I draw your attention to the need for DOH to eliminate geographic overlap and reduce the number of PPS 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 across PPS. DSRIP is not a competitive sport, yet I find that I spend a good part of every week managing our relationship 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 is to 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 entire community. A successful PPS will, by definition, reduce fee-for-service revenue for a health system. Therefore, any PPS governed by organizations that rely on acute care fee-for-service revenue as their primary source of income will be implicitly undermined by its parent. This is an unfortunate structural flaw in the DSRIP program as currently designed. If all health systems had successfully traversed to VBP, then incentives would be aligned. The reality is that they have not, so we have a situation in which the governing boards have direct conflict of interest with the success of the PPS. A near-term solution to this problem (as we continue to evolve toward VBP) will be the requirement that each regional PPS be governed by multiple entities that represent multiple service delivery domains, as I discuss below.

### **Background**

New York State undertook a new path to achieving the triple aim via the Delivery System Reform Incentive Payment (DSRIP) Program. The goal was to improve access, improve service quality, and expand service access to New York's most vulnerable populations by shifting from a volume centered approach to a value-based approach.

“Health care” is the intersection of **medical, behavioral** (including substance use disorders) and **social** influences. Unmet needs in any one of these domains leads to less optimal outcomes in the others.

DSRIP has helped organizations collaborate on the design and implementation of initiatives that work to improve the health of all beneficiaries. This has facilitated relationships and partnerships in medical, behavioral and social services sectors. Much work remains to be done. Barriers remain to complete New York’s journey to value and realization of the benefits of a redesigned delivery system. Extension of the duration and additional funding are required. *The job is simply not finished.*

Silos remain within the Department of Health and its various agencies. Silos remain between the medical, behavioral and social safety nets. Silos remain between primary care providers, and specialty care providers and emergency care providers.

The DSRIP waiver has led to accomplishments across New York State in improving health of Medicaid recipients. The state and PPS remain committed to building on those accomplishments to advance the transformation of our communities and build a sustainable model to further improve health and health equity.

### **Desired Future State**

We need to preserve the core elements that have enabled DSRIP to succeed and have the courage to discard those that did not. The next phase could be implemented through existing entities (PPS). The following principles should guide the development of any successor program:

- Before any extension begins, existing data and reporting should be used to identify what interventions were successful.
- Focus on improving a small number of measurable *outcomes rather than pre-defined projects.*
- Clearer guidance on funding to address social determinants of health (SDoH).
- Improved integration between the medical and social care providers.
- Greater access and ability to data sharing, including Medicaid claims data, clinical data and other health information.
- Integration of behavioral health, SUD, medical providers, and SDoH, as well as agile integrated regulation among and across agencies.
- A framework to create and maintain accountability in the form of service level agreements, which include commitments on timely access to services in the most appropriate settings for individuals.

These elements are best addressed by supporting the regional PPS entities to serve the entire Medicaid population and the uninsured. Focusing on strengthening the PPS infrastructure would mean:

- Eliminating the “attribution overlap” that has created silos of engagement. Several regional

PPS would need to be consolidated.

- With regional redundancy eliminated, PPS will serve their communities in a public utility model - providing a suite of horizontal services that connect organizations and support service providers in a manner that is *agnostic to health system and MCO*. This will eliminate the silos that have hindered MCO investments in SDoH, behavioral health, care coordination, and SUD treatment.
- A process to compel payers to participate fully with the Medicaid program, through incentives rather than regulatory requirements.
- Allowing for specific population health initiatives for each region that would address regional needs and require collaboration among all stakeholders, including MCOs, health systems, primary care providers, and CBOs.
- Measuring success using appropriate outcome measures for the total population of each region.

The challenge is to develop these regional approaches while recognizing the value of competition at the MCO and health system level. Further, a sustainable model will need the close collaboration of providers, MCOs, and PPS. These entities would facilitate collaboration between payers and providers and support them in their assumption of risk. Shared savings will be the motivation for providers and payers to collaborate more effectively. The PPS may also fund specific payer or provider efforts that will generate improved access, better care and/or lower cost. Savings from prospective payments will be retained by payers and providers commensurate with risk assumed. Services needed by Medicaid recipients and the uninsured may be separated into a competitive layer and a non-competitive layer:

- MCOs would continue to compete for members and maintain primary responsibility for enrollment, access, and risk management.
- Health systems and other providers are subject to the same competitive forces to provide a suite of services and continue to evolve their contracts with MCOs toward increased VBP and accountability.
- PPS will work with all MCOs and care providers (**medical, behavioral, social**) to coordinate a wide variety of services for the Medicaid population and the uninsured, including: engaging recipients; addressing SDoH; and coordinating services among primary care, social care, and behavioral health providers, including community and government social safety net providers. The PPS will focus on specific regional problems that will be identified by each community rather than imposed or pre-selected by DOH. These regional problems may evolve over time, as communities test hypotheses and learn from experience.
- PPS will also coordinate the efforts of the high touch organizations or ideally merge with: Health Home, Behavioral Health Home, Childs Health Home, HARP, HCBW, and BHCC. Bringing all these efforts under one umbrella will deliver better coordination of services at a lower cost.

PPS would be directly funded on a risk adjusted per member per month basis. These payments would be established by the State and be calculated based on both administrative and medical component of the services provided. The PPS would be held accountable for meeting metrics appropriate to their activities, which would cause their PMPM reimbursement to rise or fall. Payers

and providers would enter into risk arrangements where they are able to share the savings generated through the collaboration.

### **Transition Period – DSRIP Waiver Extension**

-

The DSRIP waiver extension should:

- *Allow for regional consolidation among PPS where appropriate.* To the extent possible PPS would be encouraged to become independent entities with robust governance structures representative of all the key stakeholders. **Eleven** entities rather than the current twenty-five would be optimal:

1. Buffalo Region
2. Rochester Region
3. Syracuse, CNY 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 services provided by the PPS.* The framework for a core set of services provided by the PPS will be built upon the investment already made in the PPS and the lessons learned to date in DSRIP. The core set is likely to include responsibility for:
  - Data aggregation and analytics to support population health initiatives, ideally in close partnership with local QE/RHIOs. DOH/NYEC should encourage merger or QEs into PPS or PPS into QEs to align the goals of these entities, as the current measure of QE success is disconnected from improved population health. This needs to change.
  - Building and managing networks of CBOs and contracting with MCOs on behalf of CBOs.
  - Care management extending across the continuum of services required by Medicaid recipients.
- *Determine the appropriate relationship between the PPS and existing Health Homes and BHCCs, ideally merging PPS Health Homes, BHCCs, and other high touch case management services where possible to eliminate duplicative and uncoordinated models.* The goal of the PPS is to serve the entire Medicaid population rather than discrete diagnostic service categories. OPWDD's new 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.
- *Outline a process for PPS consolidation, based broadly on a set of criteria:*
  - Demonstration that the PPS are building on the DSRIP program and the investments made in population health infrastructure with a preference for existing PPS organizations that have demonstrated successful horizontal collaboration across multiple service entities and service domains rather than vertically integrated activities. We have found that the most vulnerable beneficiaries fall through the cracks created by vertical initiatives, while horizontal initiatives prevent such failures.

- A governance structure that is responsive and recognizes the diversity of stakeholders involved. This may include the creation of new independent entities.
- Demonstrated capability to coordinate/integrate with existing Health Homes, BHCCs, CCOs, and other care management and service organizations.
- Capability to contract with relevant providers, including expense projections, payment methodologies, quality oversight, and accountability standards.
- *Facilitate the development of a limited number of outcome measures for the extension period to which each PPS will be held accountable based on successes during the initial DSRIP period. The outcome measures for earning federal funds will be:*
  - Increased primary care access and use
  - Reduced acute emergency room use
  - Reduced acute hospital use
  - Increased access and use of behavioral health and SUD services
  - Expansion of SDoH services

Each PPS will identify appropriate measures. The measures selected would be level one measures that can be reported in near real time. Data from MCOs, providers, QEs or other sources should be reconciled within 30 days of the end of any payment period. The delay in reporting and lag in payment must be eliminated. Reporting on the activities should be limited to a minimum necessary standard.

PPS will be funded by the DSRIP Waiver. Over time, funding will become the responsibility of the MCOs, and the PPS will become fully operational and capable. The contracts between the MCOs and the PPS will be deemed VBP contracts and will meet all corresponding requirements for the purposes of aligning with the State's VBP Roadmap. The public hospital systems will need to play a major role in this DSRIP extension and will have to support IGT funding, ensuring them a seat at the governance table.

The DSRIP waiver extension should be at least four years long (three years funded) to allow for complete transition to the desired future state. The timeframe should be:

- PPS realignment recommendations before the end of DY5 with selection in early DY6.
- Balance of DY6 devoted to the transition of PPS with funding from DSRIP extension, while maintaining emphasis on performance (don't take foot off gas).
- Operations carry forward in DY7 with funding 1/3 through MCOs and 2/3 DSRIP extension.
- DY8 funding 2/3 through MCOs and 1/3 DSRIP extension.
- DY9 funding stream fully through the MCOs, with PMPM support from DOH.

Jacob Reider, MD, CEO  
[Alliance for Better Health](#)

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**From:** [REDACTED]  
**To:** [doh.sm.1115Waivers](#)  
**Subject:** 1115 Public Forum Comment  
**Date:** Thursday, July 11, 2019 11:32:58 AM  
**Attachments:** [Community Partners PPS \(aka Sisters of Charity Hospital\).pdf](#)

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Please find comments attached

Thank you,

Amy L. White-Storfer, MBA, PMP  
Director, Project Management Office  
Community Partners of Western New York (a DSRIP PPS)  
144 Genesee St, 5<sup>th</sup> Floor, Buffalo NY 14203  
[wnycommunitypartners.org](http://wnycommunitypartners.org)  
[REDACTED]

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## COMMUNITY PARTNERS OF WNY

*Performing Provider System*

July 9, 2019

RE: Public Comment to 1115 Waiver, New York State

To Whom It May Concern:

Community Partners of WNY (CPWNY) is strong. Simply put, our DSRIP PPS (Performing Provider System) has been successful in helping our partners and patients understand the changes happening in healthcare and how they can provide and access better care in a changing healthcare environment.

Our PPS is a collaborative group of 657 primary care providers, 1750 specialty providers and hospitalists, 63 community based organizations, 88 mental healthcare providers, and 14 hospital partners, including the PPS lead, Sisters of Charity Hospital in Buffalo NY.

Our PPS is locally-focused and locally-led, with its primary safety net hospital a proud member of the Catholic Health System. We may be among the smallest PPS teams in the state, but we make significant impacts.

Our PPS has two provider-led networks engaged with its program, the Catholic Medical Partners IPA (CMP) and Chautauqua County Health Network (CCHN). These groups support Medicaid service providers with population health tools and techniques, clinical integration strategies and patient centered medical homes, health home recruitment and data analytics strategies. Our provider network coverage area includes Erie, Niagara and Chautauqua counties.

Key successes of CPWNY are:

- Accomplished a 12.6% reduction in preventable emergency department visits (DSRIP measurement years 1-3).
- Reduced avoidable readmissions by 24% (DSRIP measurement years 0-3).
- A total of 338 providers achieved 2013 Level III Patient Centered Medical Home (PCMH) recognition from NCQA.
- Annually, the PPS delivers a provider supported clinical integration plan which supports quality improvement initiatives for the Medicaid population.
- Successfully manage a population-health focused, upside and downside risk-based contract between a local independent practice association (IPA) and Medicaid Managed Care organization.
- Provide ongoing leadership for cross-continuum collaboration between behavioral health and substance use disorder providers and primary care, including 10 integrated primary care and behavioral health sites. Several of the sites are attaining operational sustainability.

- Initiated two formal Nurse Family Partnership programs which are improving health outcomes for first-time moms and their children, including one now sustained by a local county municipal government.
- CMP and CCHN work with their primary care providers to increase access to medical services that will prevent avoidable hospital use. With the DSRIP program, there is a consistent delivery of Medicaid-focused clinical performance improvement programs, earmarking more than \$2.5 million dollars for improvements in service delivery by behavioral health providers, primary care providers and OB/GYN providers.
- Over 950 professionals have been trained and re-trained on cultural competency and health literacy.
- Community health workers are engaged in neighborhoods surrounding our Catholic Health System health centers. Community based organizations (CBOs), like the Buffalo Urban League, are leaders in our community based organization engagement.
- Expansion of palliative support and education in the Primary Care PCMH model including an at-home palliative telehealth monitoring component.
- Expansion of SBIRT (screening and brief intervention, referral to treatment) tools to support primary care providers in the identification of substance use disorders.
- Patient engagement in the hospital environment by primary care for unengaged patients and support for hospitals that continue to serve high need populations.
- Support quality improvement program and ongoing quality monitoring for Health Home care management entities.

### **Looking Ahead**

Our PPS and its network partners have a solid leadership role in population health in the Buffalo Niagara region. Teams like ours are essential to New York State's Medicaid program quality and cost management objectives, regardless of the future of the 1115 waiver program in the state. For example:

- CMP and CHS have extensive experience with managed care contracting, including managing upside and downside risk contracts.
- CHS and CMP share operational functions, with an emphasis on lean operational management and shared administrative functions.
- Our PPS has an excellent collaborative relationship with managed care, including established data sharing agreements for population health management.
- CMP has more than 20 years' experience with population health management efforts including working with hospital partners on an Accountable Care Organization (ACO).

Through these efforts, Community Partners of Western New York is committed to our network's adaptation to the value-based world. Nonetheless, the reality is that the partners with the largest cost risk, continue to face on-going challenges — balancing the fee-for-service model that does not cover the cost of service to the Medicaid population, with value programs. To do this transition work, those providers' strategic objectives must be a consideration in the process to adopt change. While collaboration is essential for healthcare change in any population, including Medicaid beneficiaries, collaboration will be jeopardized if it means exposing provider or system market advantages.

Therefore, it is essential that Community Partners of WNY PPS remain aligned with its key provider and hospital networks in the Buffalo Niagara region. This structure is especially important if those providers and networks are expected to support and manage populations with cost risk, such as those within

value-based payment arrangements. For this reason and for sustainability, two PPS groups need to remain in Western New York.

Historically, having two PPS teams, working independently and collaboratively, has been a successful model for our community. The teams determined which providers had significant engagement with each PPS entity, preventing provider confusion and duplication of efforts. For behavioral health and CBO partners, we welcomed collaborative PPS work, which resulted in great success.

As part of future planning, New York State should also work to maintain patient attribution models that support primary care as the most significant driver of the patient assignment to the PPS.

The work needed to enhance behavioral health services and substance use disorder screening and treatment is substantial. In continuing the program of the 1115 waiver, on-going support should be considered for providers who want to collaborate formally and informally between primary care and behavioral health. Providers who may want to add combined services need to be assured there is additional pathways for managing different levels of integration of service.

Our PPS recommends more flexibility in project design for future DSRIP program efforts including consideration of outcomes for performance projects which are tied to a risk-bearing contracts between providers, their networks, and managed care organizations.

Additionally, our work with CBOs needs to continue, with an emphasis on fostering a patient-centered approach. CBOs are a key link to our patients, and without that link, neighborhood buy-in and community interests are not as well represented within the direct care environment. What DSRIP has shown is that relationship building takes time. And while we have achieved much success, it feels as if our work has just begun.

We want to build on this positive momentum, without dismantling our progress. Our CBO relationships are blossoming, especially in the context of Managed Care contracting. CBOs are proving their value in a language understood by patients, providers and managed care entities alike. We know these organizations are a pipeline to services beyond the health system walls – programs targeting the social determinants of health, including financial literacy, workforce development, stable housing, education, and other wraparound services. We also know we have more work to do to help these CBOs represent their increased value to the greater healthcare system and realize their full potential to improve the overall health of our community.

Thank you for your consideration of our comments.

Regards,

A handwritten signature in black ink, appearing to read "Amy L. White-Storfer", with a long horizontal flourish extending to the right.

Amy L. White-Storfer, MBA, PMP  
Director of Project Management Office

**From:** [REDACTED]  
**To:** [doh.sm.1115Waivers](mailto:doh.sm.1115Waivers)  
**Subject:** 1115 Public Forum Comment  
**Date:** Thursday, July 11, 2019 2:56:41 PM  
**Attachments:** [2019 NYSBDC NY 1115 Waiver Renewal Comments.pdf](#)

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*ATTENTION: This email came from an external source. Do not open attachments or click on links from unknown senders or unexpected emails.*

Medicaid,

Please accept the attached written comments from the New York State Bleeding Disorders Coalition re the open public comment period for the NY DOH MRT waiver renewal application.

Thank you,  
Bob Graham

[REDACTED]

NYSBDC



**The following comments are submitted by the New York State Bleeding Disorders Coalition to the New York Department of Health regarding DOH application for a renewal of the MRT waiver.**

NYSBDC is a coalition of medical treatment centers and patient community service organizations dedicated to ensuring people with bleeding disorders in New York State have access to the quality, affordable care they need to lead a full and active life.

Bleeding disorders are complex, chronic medical conditions that can seriously impact the health of an affected person. While there are treatments for bleeding disorders, there is no cure. People with bleeding disorders require life-long access to a range of specialized care and support to manage their disorder and a range of associated physical and psycho-social complications

Many people in New York State with bleeding disorders receive health care coverage through the NY Medicaid program. Thanks to the range of treatments and care services covered by Medicaid, these people are better able to maintain their health, attend school, hold jobs, raise families, contribute to their communities, and work toward a better life for them and their families. We are profoundly grateful for the Medicaid program and the efforts of DOH staff to work with our community and others to improve the lives of patients.

We support the person centered care planning emphasized under Medicaid redesign and encourage further development of this approach. The value of providing treatment based on addressing the unique needs of individual patients has been well established as critical to optimal health outcomes. Even patients with the same diagnosis can often have very different needs; focusing treatment on the patient and creating policies to support individualized care is essential to promoting optimal health outcomes. Promoting optimal health outcomes should be the ultimate goal of any health care system and is the best means for improving health care and managing costs.

While rare medical conditions such as bleeding disorders may affect only a small percentage of people, the cost of care for people with such conditions can be disproportionately high. We recognize the need for thoughtful management of care policies which promote the best health outcomes while maximizing the investment of resources into patient care. Therefore we support further development of DOH efforts to collect data on rare disease patient care so patients, clinicians, and DOH can work together to identify best practices and explore new opportunities for improving care.

People with bleeding disorders often face the dual challenge of living with their medical condition and poverty. The problem has grown so significantly that a study by researchers at MIT indicates people living in poverty may have a decreased life expectancy of 10 years as compared with people with adequate resources. We support further development of DOH efforts to address the social determinants of health to help people address the many life challenges imposed by poverty. We also strongly support utilizing community based organizations to help address these challenges as such organizations possess a wide range of knowledge and skills vital to providing assistance tailored to the unique needs of individuals in different areas of the state. Providing the best care available won't help people who must struggle daily just to get by.

New York State has long been a leader in advancing progressive health care policies. We believe the NY Medicaid Redesign process offers great promise of continuing to promote optimal health outcomes while effectively managing care costs. Going forward, we believe by working closely with patients, clinicians, and other stakeholders to identify, develop and promote best practices and new ideas NY Medicaid can become a driver of the change our state and national health care systems need to move forward in the 21<sup>st</sup> century health care landscape.

Therefore we strongly support the DOH application for a renewal of the MRT waiver and urge it be granted without delay. Thank you for your time.

On behalf of the New York State Bleeding Disorders Coalition,



Bob Graham  
NYSBDC Public Policy Coordinator

## **New York State Bleeding Disorders Coalition:**

Albany Regional Comprehensive Center for Hemophilia & von Willebrand Disease at Albany Medical College, Albany Medical Center  
Bleeding Disorders Advocacy Network  
Bleeding Association of Northeastern New York (Albany)  
Bleeding Disorders Association of the Southern Tier (Binghamton)  
Hemophilia Association of New York (Serving the 14 counties of southeastern New York State including; New York City, Long Island, Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster and Westchester)  
Hemophilia Center of Western New York (Buffalo)  
Hemophilia Federation of America (National)  
Hemophilia Foundation of Upstate New York (Rochester)  
Mary M. Gooley Hemophilia Center (Rochester)  
National Hemophilia Foundation (National)  
New York City Hemophilia Chapter (New York City)  
Northwell Health (Formerly North Shore-LIJ Health) Hemostasis & Thrombosis Center (Long Island)  
Regional Comprehensive Hemophilia Diagnostic and Treatment Centers at Mt. Sinai Medical Center (New York City)  
SUNY Upstate Medical University-Hematology Oncology Program (Syracuse)  
The Hemophilia Treatment Center @Montefiore Medical Center (Bronx)  
UHS Blood Disorder Center (Johnson City)  
New York-Presbyterian / Weill Cornell Medical College Comprehensive Center for Hemophilia and Coagulation Disorders (New York City)

**From:** [REDACTED]  
**To:** [doh.sm.1115Waivers](mailto:doh.sm.1115Waivers)  
**Subject:** 1115 Public Forum Comment  
**Date:** Friday, July 12, 2019 1:53:12 PM  
**Attachments:** [image001.png](#)  
[MRC 1115 Waiver Renewal Comments-7-12-19.pdf](#)

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Hello,

Attached please find comments from Medicare Rights Center.

Thank you,

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Beth Shyken-Rothbart  
Senior Counsel, Client Services and New York Policy  
Medicare Rights Center  
266 West 37th Street, 3rd Floor  
New York, NY 10018

[REDACTED]  
[REDACTED]

<https://www.medicarerights.org>



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266 West 37th Street, 3rd Floor

New York, NY 10018

212-869-3850/Fax: 212-869-3532

July 12, 2019

VIA ELECTRONIC SUBMISSION

NYS Department of Health

[1115Waivers@health.ny.gov](mailto:1115Waivers@health.ny.gov)

**Re: 1115 Waiver Renewal – Nursing Home Benefit and MLTC Lock-In**

Dear DOH Administrators:

The Medicare Rights Center (Medicare Rights) is a national, nonprofit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. Medicare Rights provides services and resources to three million people with Medicare, family caregivers, and professionals each year. Medicare Rights leads the Coalition to Protect the Rights of New York’s Dually Eligible, is a coalition member of Medicaid Matters New York, and assists many of New York’s dually eligible beneficiaries.

Medicare Rights appreciates the opportunity to submit comments on the NYS 1115 waiver renewal. We recommend:

1. The elimination of the requirement that adults who are permanently placed in a nursing home for a consecutive period of three months or more are disenrolled from their Managed Long Term Care (MLTC) plan. At the very least, additional consumer protections must be implemented that will counteract the resulting incentive that will—in the State’s own words—“encourage managed care plans to pressure high-cost people served in community-based settings to enter nursing homes.”
2. The elimination of the “lock-in,” which bars MLTC members from plan-to-plan transitions after three months of enrollment.

## **1. Nursing Home Carve-Out**

When New York first amended the 1115 waiver in 2012 to include nursing home residents in the population required to enroll in MLTC plans, which was implemented in 2015, the State endorsed this change as an important step toward accomplishing the goals of the Americans with Disabilities Act:

Washington, DC Office:

202-637-0961

[www.medicarerights.org](http://www.medicarerights.org) [www.medicareinteractive.org](http://www.medicareinteractive.org)

*Building on the care management for all initiative, reforms in the 2012-2013 budget removed the financial incentives that may have encouraged nursing home placement. Previously, nursing home costs were “carved out” of managed care rates and were instead covered by the state. This policy had the potential to encourage managed care plans to pressure high-cost people served in community-based settings to enter nursing homes. Budget reforms will include the full cost of nursing home care in managed care rates, which is expected to encourage these plans to seek lower cost, community-based services.*

New York Office of the Governor, *Report and Recommendations of the Olmstead Cabinet, A Comprehensive Plan for Serving People with Disabilities in the Most Integrated Setting*, available at [https://www.ny.gov/sites/ny.gov/files/atoms/files/Olmstead\\_Final\\_Report\\_2013.pdf](https://www.ny.gov/sites/ny.gov/files/atoms/files/Olmstead_Final_Report_2013.pdf), p. 14.

Now, reversal of this policy and reinstatement of the old “carve-out” of nursing home costs from MLTC plans will move the State further away from complying with *Olmstead* because it will—in the State’s own words—“encourage managed care plans to pressure high-cost people served in community-based settings to enter nursing homes.” *Id.* Also, it could make it even harder for disabled adults to return to the community from nursing homes, since MLTC plans could resist enrolling them and providing adequate services for them to be discharged to the community.

If CMS approves the pending proposal to exclude nursing home costs from MLTC coverage after three months of permanent placement, we urge adoption of protections including, but not limited to, the following:

**a) Funding mechanisms:** Either (1) high-hour home care should also be “carved out” of MLTC after three months (generally 12 hours/day or more) or (2) a community-based rate cell, stop loss, or similar protections should be adopted to mitigate the disincentives against providing community-based care.

**b) Notice and appeal rights to contest determination of “permanent placement”:** Individuals admitted to a nursing home, or those who the MLTC plan proposes to admit to a nursing home on a permanent basis, must have a meaningful opportunity to contest a determination that they have been or will be “permanently placed,” so that they can remain in an MLTC plan to provide long-term services and supports when ready to return home. Alternatively, if they are in the community when the MLTC plan proposes placement, they must be able to contest the placement so that home care services are maintained. It is not enough for NY Medicaid Choice, the State’s enrollment broker, to provide notice of disenrollment from the plan at the *end* of the three-month period of alleged permanent placement.

Even if CMS rejects the carve-out of nursing home care, we urge these protections to encourage discharge of nursing home residents to the community:

**c) Income retention during and after temporary nursing home admission:** Nursing homes and plans must be required to ensure that members maintain SSI benefits or retain income through Medicaid “community budgeting” to maintain their home, when there is an expectation to return home. Also, the Special Income Standard for Housing Expenses approved in the 1115 Waiver should be expanded to include those who, after being discharged from a nursing home, access Medicaid personal care or consumer-directed services through the “Immediate Need” procedure, prior to being passively enrolled into an MLTC plan.

**d) Passive or direct enrollment into MLTC plans and other procedures to counter disincentives inherent in removal of nursing home care from MLTC:** In order to deter cherry-picking, people who have been determined eligible to enroll in an MLTC plan after a “Conflict Free Eligibility” assessment by Maximus, whether they are seeking MLTC enrollment while in the community or in nursing homes, should be allowed to directly enroll in an MLTC plan without the plan conducting a pre-enrollment assessment. Also, those who do not select and enroll in a plan within 75 days of the Conflict-Free assessment should be passively enrolled in an MLTC plan without a pre-enrollment assessment by the plan.

## 2. Lock-in Policy

We oppose the “lock-in” that would bar transitions from plan to plan after three months of enrollment. Dual-eligibles should have the same right to switch MLTC plans as they do Medicare Part D plans, which is once per quarter in the first three calendar quarters. Additionally, their needs are more akin to those in special needs mainstream Medicaid managed care plans, who are not locked in, than the general managed care membership. Good cause exceptions must be clearly defined and be more expansive.

Thank you for your consideration.

Sincerely,

A handwritten signature in black ink that reads "Fred Riccardi". The signature is written in a cursive style with a large initial 'F'.

Fred Riccardi  
President  
Medicare Rights Center

**From:** [REDACTED]  
**To:** [doh.sm.1115Waivers](mailto:doh.sm.1115Waivers)  
**Subject:** 1115 Public Forum Comment - NYLAG  
**Date:** Friday, July 12, 2019 2:11:40 PM  
**Attachments:** [NYLAG Comments 1115 Waiver 7-2019.pdf](#)

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Enclosed please find comments related to the 1115 Public Forum, regarding the managed long term care program.

Thank you.

Valerie J. Bogart, Director  
Evelyn Frank Legal Resources Program  
New York Legal Assistance Group  
7 Hanover Square, 18th Floor  
New York, NY 10004

[REDACTED]  
[REDACTED]  
[REDACTED]

**INTAKE CONTACTS:**

[REDACTED]

*Visit our Health Advocacy Website at <http://nyhealthaccess.org>*



July 12, 2019

NYS Department of Health  
[1115Waivers@health.ny.gov](mailto:1115Waivers@health.ny.gov)

RE: Comments re 1115 Waiver - Medicaid Redesign Team - Public Forum

Dear DOH Administrators:

The New York Legal Assistance Group<sup>1</sup> submits these comments, which are focused on the Managed Long Term Care program.

First, we recommend elimination of the requirement that if an individual is in a hospital for 45 consecutive days, the plan must initiate disenrollment. This ground for disenrollment violates federal regulations, causes disruption in services and unnecessary institutionalization. There are alternate means for the State to suspend capitation payment to a plan if a member is hospitalized for an entire calendar month.

Second, we reiterate our opposition to the State's proposal to amend the 1115 waiver to exclude from New York's MLTC program adults who are permanently placed in a nursing home for a consecutive period of three months or more. If this proposal is approved, it must be with consumer protections that counteract the resulting incentive that -- in the State's own words -- will "encourage managed care plans to pressure high-cost people served in community-based settings to enter nursing homes."

Third, we reiterate our concerns about "lock-in" MLTC members to bar plan-to-plan transitions after three months of enrollment.

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<sup>1</sup> Since its founding in 1990, the New York Legal Assistance Group (NYLAG) has used the power of the law to protect the rights of the vulnerable, strengthen communities, and fight poverty. NYLAG provides free civil legal services to over 76,000 New Yorkers each year in areas ranging from housing to government benefits and consumer protection. NYLAG reaches even the most isolated populations in 125 partner—based locations, including community centers, courts, hospitals, neighborhood organizations, and by its Mobile Legal Help Center. NYLAG's various units represent hundreds of low-income older persons and people with disabilities in accessing community-based long-term services and supports they need to live dignified, independent lives and to remain in the community. NYLAG's Evelyn Frank Legal Resources Program has been appointed by the State Department of Health to serve on various Stakeholder Workgroups regarding Managed Long Term Care (MLTC), including workgroups on the 2019 implementation of changes in the appeals process and on the State proposal to exclude permanently placed Nursing Home residents from enrollment in MLTC plans. We are active in consumer coalitions such as Medicaid Matters NY to advocate on these issues.

## SUMMARY

### I. Eliminate or Amend Involuntary Disenrollment Criterion based on 45-Days in Hospital

Presumably the reason for this ground for disenrollment is to save Medicaid dollars by avoiding payment of capitation to a plan that is not providing services because the member is hospitalized. There are other ways to claw back these payments that do not disrupt services for a member who is vulnerable following a long hospital stay and can cause unnecessary institutionalization. This provision of the model contract violates federal regulations.

### II. Nursing Home Carve-Out: Protections Needed Whether or Not Approved by CMS

When New York first amended the 1115 waiver in 2012 to include nursing home residents in the population required to enroll in MLTC plans, an expansion that was implemented in 2015, the State touted this change as an important step toward accomplishing the goals of the Americans with Disabilities Act:

Building on the care management for all initiative, reforms in the 2012-2013 budget removed the financial incentives that may have encouraged nursing home placement. Previously, nursing home costs were “carved out” of managed care rates and were instead covered by the state. This policy had the potential to encourage managed care plans to pressure high-cost people served in community-based settings to enter nursing homes. Budget reforms will include the full cost of nursing home care in managed care rates, which is expected to encourage these plans to seek lower cost, community-based services.

New York Office of the Governor, *Report and Recommendations of the Olmstead Cabinet, A Comprehensive Plan for Serving People with Disabilities in the Most Integrated Setting*, available at [https://www.ny.gov/sites/ny.gov/files/atoms/files/Olmstead\\_Final\\_Report\\_2013.pdf](https://www.ny.gov/sites/ny.gov/files/atoms/files/Olmstead_Final_Report_2013.pdf), p. 14. Now, reversal of this policy and reinstatement of the old “carve-out” of nursing home costs from MLTC plans will move the State further away from complying with *Olmstead* because it will – in the State’s own words -- “encourage managed care plans to pressure high-cost people served in community-based settings to enter nursing homes.” *Id.* Also, it will make it even harder for disabled adults to return to the community from nursing homes, since MLTC plans will resist enrolling them and providing adequate services for them to be discharged to the community.

Whether or not CMS approves the pending proposal to exclude nursing home costs from MLTC coverage after three months of permanent placement, we urge adoption of protections to incentivize plans to provide services in the community for those with high needs. These include but are not limited to the following:

- A. **Funding Mechanisms Needed To mitigate the disincentives against providing community-based care to high-need consumers** -- Either: (1) high hour home care should also be “carved out” of MLTC after three months (generally 12 hours/day or

more) or a (2) community-based rate cell, stop loss, or similar protections should be adopted to

- B. **Consumers Must Have Meaningful Right to Appeal Determination of “Permanent Placement” to Prevent Disenrollment of Those Seeking to Return Home.** Individuals admitted to a nursing home, or who the MLTC plan proposes to admit to a nursing home on a permanent basis, must have a meaningful opportunity to contest a determination that they have been or will be “permanently placed,” so that they can remain in an MLTC plan to provide LTSS when ready to return home, or if they are in the community when the MLTC plan proposes placement, so that home care services are maintained. It is not enough for NY Medicaid Choice, the State’s enrollment broker, to provide notice of disenrollment from the plan at the *end* of the three-month period of alleged permanent placement.

Even if CMS rejects the carve-out of nursing home care, we urge these protections to encourage discharge of nursing home residents to the community:

- C. **Ensure Consumer Retains Income During a Temporary Nursing Home Admission to Ensure her Ability to Maintain Her Home.** Nursing homes and plans must be required to ensure that members maintain SSI benefits or retain income through Medicaid “community budgeting” to maintain their home, when there is an expectation to return home.
- D. **The Special Income Standard for Housing Expenses should be expanded** to include those who, after being discharged from a nursing or adult home, access Medicaid personal care or consumer-directed services through the “Immediate Need” procedure, prior to being passively enrolled into an MLTC plan.
- E. **Implement Policies to Counteract Disincentives to Serving High Need Consumers, Including New Law, Once Signed by Governor, Requiring Passive Enrollment of those Approved for MLTC after a Conflict Free Assessment but Facing Delays in Enrollment.**

### **III) Lock-In Proposal - The Prohibition Against Changing Plans after 90 Days of Enrollment Should be Rejected or Modified.**

We oppose the “lock-in” that would bar transitions from plan to plan after three months of enrollment. Dual eligibles should have the same right to switch MLTC plans as they do Part D plans, which in 2019 will be once per quarter in the first three calendar quarters. Additionally, their needs are more akin to those in special needs mainstream Medicaid managed care plans, who are not locked in, than the general managed care membership. Good cause exceptions must be clearly defined and be more expansive.

## DISCUSSION

### I. Eliminate or Amend Involuntary Disenrollment Criterion based on 45-Days in Hospital

Under the model contract, the plan is required to initiate disenrollment of a member who is in a hospital for 45 consecutive days. This ground for disenrollment is nowhere in state or federal regulation, nor in the Special Terms and Conditions. This ground for disenrollment violates federal regulations requiring continuity of services, and encourages unnecessary institutionalization, violating *Olmstead*. Presumably the reason for requiring disenrollment in this instance is that the plan is not providing services to the member, since inpatient hospital care is not an MLTC benefit. Therefore, the plan is receiving its monthly capitation payment despite providing no service, costing the State money. There are other ways for the State to mitigate this cost that do not cause disruption of services for the member, preventing the member from returning home and causing unnecessary institutionalization.

The existence of this ground for disenrollment creates an incentive for a plan to delay or even refuse reinstating services for a hospitalized member so that the hospital stay lasts 45 days. The member may now require increased services as a result of the medical condition that led to the protracted hospitalization, a cost that the plan can avoid because of the 45-day rule. This enrollment ground, in effect, allows the plan to do what federal regulations specifically prohibit it from doing – requesting “...disenrollment because of an adverse change in the enrollee’s health status....” 42 C.F.R. § 438.56(b)(2). The prolonged hospital stay is in most cases an indication of an adverse change in the enrollee’s health status.

Even if it was permissible for the State to require disenrollment from MLTC plans based on a 45-day hospital stay, the State has failed to establish procedures for a member disenrolled for this reason to resume receiving community-based long term care services without delay when ready for discharge. Under the federal regulations as amended in 2016, the section titled “Continued Services to Enrollees” provides, in part:

- (a) The State agency must arrange for Medicaid services to be provided without delay ... for any Medicaid enrollee who is disenrolled from an MCO... for any reason other than ineligibility for Medicaid.
- (b) The State must have in effect a transition of care policy to ensure continued access to services during a transition from ... one MCO to another when an enrollee, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization.

42 C.F.R. § 438.62. This regulation goes on to define elements of the required transition policy, including continuity of providers and “access to services consistent with the access they

previously had...” *Id.* at 42 C.F.R. § 438.62(b)(1)i). If a member of Plan A is ready for discharge home on Day 50 of a hospital stay, under the model contract, the member is disenrolled by Maximus with no alternate services arranged. Though the member should receive notice of the right to request a hearing to contest a disenrollment based on the 45-day rule, the hearing is futile, since, under the model contract, there is no exception to the rule. When the member becomes ready for discharge or even if she has been discharged home, there is no procedure to reinstatement enrollment in the same plan or to transition to a different plan, or to halt the disenrollment if it has not yet taken place. The member is left to start all over with trying to enroll in the same or a different MLTC plan. Certainly these delays and resulting gap in services increase the risk of unnecessary institutionalization. The member is forced to obtain a new CFEEC if she has been disenrolled for 45 days. (Q&A No. 7 at [https://www.health.ny.gov/health\\_care/medicaid/redesign/2014-09-29\\_cfeec\\_faqs.htm](https://www.health.ny.gov/health_care/medicaid/redesign/2014-09-29_cfeec_faqs.htm)). This lack of any transition procedure to reinstate services for a member who has been hospitalized violates the federal regulation cited above.

If the basis for requiring disenrollment after 45 days in the hospital is an assumption that the member is no longer eligible for MLTC services, this assumption is both improper and unnecessary, as there is a separate disenrollment ground if “an Enrollee is not eligible for MLTC because he/she is assessed as no longer requiring community-based long term care services.” In *Granato v. Bane*, 74 F.3d 406 (2d Cir. 1996), the Second Circuit Court of Appeals held that a hospital stay was not a ground to terminate personal care services; instead, services are merely suspended upon admission to a hospital, and must be reinstated when ready for discharge. This court decision has long been implemented in NYS DOH policy directives, which entitle the recipient to notice of discontinuance of services with the opportunity to request reinstatement of services as “aid continuing” pending a hearing, if the agency intends to discontinue based on alleging that the recipient is no longer eligible.<sup>2</sup> The same procedure should apply here; suspending services upon admission (and capitation payment if admitted for more than a calendar month), which must be reinstated, subject to a determination with timely and adequate notice that the enrollee is no longer eligible, with the right to a hearing and aid continuing.

Moreover, a plan should not be permitted to make a unilateral determination that the individual is no longer eligible for MLTC. Upon the plan’s referral to Maximus of a proposed disenrollment on this ground, a conflict-free assessment by Maximus should be required determine eligibility, to prevent plans from alleging lack of eligibility when it suits their

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<sup>2</sup> [NYS DSS 99 OCC-LCM-2](http://www.wnylc.net/pb/docs/99OCCLCM2.pdf) (Apr. 20, 1999), available at <http://www.wnylc.net/pb/docs/99OCCLCM2.pdf>, reaffirming effectiveness of [96-MA-023 - New Notice, Aid-Continuing and Related Procedures Applicable to Hospitalized MA Recipients Who Received Personal Care Services Immediately Prior to Hospitalization \(\*Granato v. Bane; McCoy v. Schimke; Burland v. Dowling\*\)](http://www.health.state.ny.us/health_care/medicaid/publications/docs/gis/96ma023.pdf), available at [http://www.health.state.ny.us/health\\_care/medicaid/publications/docs/gis/96ma023.pdf](http://www.health.state.ny.us/health_care/medicaid/publications/docs/gis/96ma023.pdf).

interests. Given the existence of this separate ground for disenrollment, there is no need for the 45-day hospital stay ground for disenrollment. There is no intrinsic reason why a hospital stay of any length means that the member is no longer eligible for MLTC.

The State has alternatives for avoiding unnecessary payments of monthly capitation to plans whose members have been hospitalized for more than 45 days. The plan could still be required to notify Maximus if a member is hospitalized for a full calendar month. Instead of disenrolling the member, however, payment of the capitation would be suspended for any month in which the member was hospitalized for the entire month. The capitation could be clawed back through some later reconciliation process. The member would continue to be enrolled, so that when ready for discharge, the plan could reinstate services immediately, conducting a reassessment to determine if any changes in the service plan are needed. Suspension of enrollment is not desirable, since it would presumably be suspended for a full calendar month. If the member is ready for discharge on the 4<sup>th</sup> of the month of suspension, enrollment could not be reinstated until the 1<sup>st</sup> of the next month – causing unnecessary and harmful delay and potentially institutionalization.

We ask the State to amend the model contract by removing this ground for mandatory disenrollment, and instead adopting a procedure for withholding or clawing back capitation payments from the plans if a member for any full calendar month in which a member is hospitalized. If this ground for disenrollment is allowed to remain, then the State must establish a procedure to arrange reinstatement of services that meets federal regulatory requirements for continuity.

## **II. Nursing Home Carve-Out: Protections Needed Whether or Not Approved by CMS**

### **A. Funding Mechanisms are Needed to Incentivize Plans to Provide Community-Based Services to High-Need Members, such as a High Need Rate Cell**

Whether or not CMS approves the nursing home carve-out, reimbursement mechanisms are needed to incentivize plans to provide adequate care to the highest need members. If the carve-out is approved, then home care for high-need individuals should also be carved out. Whether or not the carve-out is approved, a high-need community based rate cell or stop loss mechanism must be adopted for people with the highest need for LTSS in the community. The Governor's *Olmstead* report cannot be ignored. When nursing home care was "carved in" to the MLTC package with the premise that inclusion of "the full cost of nursing home care in managed care rates . . . is expected to encourage these plans to seek lower cost, community-based services." But what of the outlier members who, because of the severity of their disabilities, need community-based services that cost as much as or more than nursing home care? Removing nursing home costs from MLTC coverage, while keeping MLTC plans

responsible for covering the cost of home care for those who need 24/7 care, creates a clear incentive to place high-need members in nursing homes. Only carving out these individuals, or utilizing a high needs community-based rate cell or stop loss, can offset this perverse incentive, which potentially violates the ADA.

In order to fairly assess budget neutrality of the State's proposal to carve out the nursing home population, the State needs to be more transparent about the extent to which MLTC members are assessed to have high needs, resulting in the need for high hours of home care, ie. 12 or more hours/day 5-7 days/week. Only with more transparency can the cost of a high need community-based rate cell or of carving out the high-need members for community-based care be fairly assessed. This data is available to the State through the Uniform Assessment System (UAS) and the quarterly Medicaid Managed Care and Operating Reports (MMCOR) filed by the plans, but is not shared with the public.<sup>3</sup> Historically, those who have such extensive need for personal care or Consumer Directed Personal Assistance Program (CDPAP) services that 24-hours 5- 7 days/week is medically necessary comprise a relatively small outlier group. Among that sector is an even smaller subgroup of outliers – those that need “continuous” care by more than one aide, sometimes called “split shift” care<sup>4</sup> The State should release data publicly about the extent to which plans as a whole authorize this level of care. At the high end, the recently closed Independence Care Systems (ICS), which specialized in the needs of younger people with severe physical disabilities such as quadriplegia, multiple sclerosis, etc., claimed that 30% of its members need and received 12 or more hours/day of home care or private duty nursing services. That cohort is much smaller in other MLTC plans, which either deter these individuals from enrolling or deny them the amount of services they need. Our proposal to

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<sup>3</sup> The MMCOR Report as of 2017, however, did not require plans to report the number of member months in which they provided Private Duty Nursing services, and at what levels of hours. This is a significant omission, as this service is needed by the most severely disabled members with need for skilled care. The same data now reported for personal care and CDPAP should also be reported for private duty nursing.

<sup>4</sup> State regulations define the functional criteria required to authorize these levels of care. "**Live-in 24-hour personal care services** means the provision of care by one personal care aide for a patient who, because of the patient's medical condition, needs assistance during a calendar day and whose need for assistance is sufficiently infrequent that a live-in 24-hour personal care aide would be likely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide's eight hour period of sleep." Title 18 New York Code of Rules & Regulations [NYCRR] 505.14(a)(4). In cases involving live-in 24-hour personal care services, the social assessment shall also evaluate whether the patient's home has sleeping accommodations for a personal care aide. 18 NYCRR 505.14(b)(4)(i)(c)(1).

**Split-shift or "Continuous personal care services means the provision of uninterrupted care**, by more than one personal care aide, for more than 16 hours in a calendar day for a patient who, because of the patient's medical condition, needs assistance during such calendar day with toileting, walking, transferring, turning or positioning, and needs assistance with such frequency that a live-in 24-hour personal care aide would be unlikely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide's eight hour period of sleep." 18 NYCRR 505.14(a)(2). Plans were directed to apply these criteria in NYS DOH [MLTC Policy 15.09: Changes to the Regulations for Personal Care Services \(PCS\) and Consumer Directed Personal Assistance \(CDPA\)](https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policies.htm), available at [https://www.health.ny.gov/health\\_care/medicaid/redesign/mrt90/mltc\\_policies.htm](https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policies.htm);

carve-out high need home care recipients or for a community-based rate cell should not be dismissed without a full public disclosure of data that identify the number of people in the high-need cohort, the percentage of the overall MLTC population that they represent, and the cost of their care relative to the entire MLTC population.

We understand that the “high need” cohort, for purposes of defining a high-need rate cell or for carving out high-need recipients of community-based care, should not be defined solely by the number of hours of home care they receive, ie 24/7 care. It is possible to identify high-need people by a combination of factors all included in the UAS -- diagnoses, degree of functional impairment in activities of daily living, living arrangement, availability of informal supports, and living conditions (ie stairs). Functional need is the basis for the State’s regulatory criteria for determining who qualifies for 24-hour care – see fn 1 – and could be used to determine who qualifies for this rate cell or to be carved out of MLTC. Diagnosis alone is not sufficient, since the degree of impairment varies and the functional need for high-hour care may result from myriad diagnoses alone or in combination. Various plans have analyzed the factors that tend to result in high-hour authorizations.<sup>5</sup>

We understand that instead of proposing a separate high needs community based rate cell, New York is instead exploring a modification of the current risk adjustment methodology. Risk adjustment does not sufficiently protect high need members from the financial disincentive to providing high-cost care. The costs of the high-need individuals are too high for the plans to willingly absorb and spread across their memberships, and plans too easily avoid these high costs by simply denying high hours of care, or by deterring enrollment of prospective members with high needs. These behaviors exist now, but will be magnified if plans are no longer responsible for the cost of nursing home care.<sup>6</sup>

To incorporate the cost of nursing home care when that service was carved in to MLTC in 2015, the State did a risk adjustment, increasing rates for plans by about 10-15 percent, reportedly

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<sup>5</sup> See, e.g. Analysis of High Cost High Need Members at VNSNY CHOICE, October 2017. DOH has also reportedly done a survey of all plans to identify factors that lead to authorization of high hours, the results of which have not been made public.

<sup>6</sup> MLTC plans are required to apply state regulatory criteria for determining whether an individual is eligible for 24-hour live-in or “split shift” personal or CDPAP care, and to consider the frequency of needs day and night, and the need for cueing as well as hands-on assistance. See NYS DOH MLTC Policy 16.07: Guidance on Task-based Assessment Tools for Personal Care Services and Consumer Directed Personal Assistance Services, available at [https://www.health.ny.gov/health\\_care/medicaid/redesign/mrt90/mltc\\_policy/16-07.htm](https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policy/16-07.htm). However, consumer advocates routinely confront refusal by plans to authorize these services, requiring advocacy and multiple levels of appeals. See., e.g., FH No. 7568162P (9/29/17); No. 7723035Z (5/23/18); No. 7748724M (9/20/18)(reversing plan’s denial of increase in hours needed for member to be discharged home from nursing home)(Decisions available at <https://otda.ny.gov/hearings/search/>). The main complaint received by our office is for people initially applying to enroll in MLTC in the community. Though the plan’s nurse doing the assessment acknowledges in the in-person meeting that the individual needs 12 or more hours of care, this amount of services is almost never authorized, deterring the high-need individual from enrolling in the plan.

resulting in rates in New York City of about \$4000 - \$5500/month. (Since rates are not made public, these are estimates). However, even with this risk adjustment, a number of MLTC plans have withdrawn from the market, claiming that the rates are not sufficient to absorb the high cost of nursing home care.<sup>7</sup> If plans cannot pay for nursing home care, for which the Medicaid rate averages \$8000/month in New York City,<sup>8</sup> then for the same reason they either cannot or will not pay for high-cost home care for those outliers who need personal care, Consumer Directed Personal Assistance Services (CDPAS), or Private Duty Nursing services in amounts that cost the same or more, such as 12-hour/day, 24-hour live-in or continuous 24-hour or “split shift” care.

Compounding the high cost of high-need care is the inability of MLTC plans to spread the risk of the cost of outliers. In regular Medicaid managed care for the general New York State population, the costs of severely ill members can be spread over the 4.36 million members distributed among 20 plans. Even there, New York like many states, utilizes a stop-loss mechanism to protect plans from extraordinary costs. MLTC plans, however, are relatively small – and their entire membership has by definition been determined to be in need of long-term care. Spreading the risk of continuous split –shift or live-in care, or the cost of Private Duty Nursing for the few who need extensive skilled care, is either not possible or not desirable for the plans.

Only a high-need rate cell or stop loss mechanism will provide the highest need members with adequate protection —both by ensuring adequate payment to the plan and by making plans accountable for demonstrating that they are using the rate cell to provide services in the community. Otherwise, people determined to need services costing the same as the average local Medicaid rate for nursing home care should be carved out. This would largely be people whose functional limitations meet the State’s regulatory criteria for 24-hour personal care or CDPAP. For private duty nursing care, since it is so expensive and needed by so few people, either a high-need rates cell or stop loss mechanism should be used, or this service should be

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<sup>7</sup> See Jonathan LaMantia, Crain’s New York Business, *Major Manhattan Nonprofit’s Insurance Arm Shutting Down Health Plan*, August 28, 2018, available at [https://www.craigslist.com/article/20180828/HEALTH\\_CARE/180829882/major-manhattan-nonprofit-s-insurance-arm-shutting-down-health-plan](https://www.craigslist.com/article/20180828/HEALTH_CARE/180829882/major-manhattan-nonprofit-s-insurance-arm-shutting-down-health-plan) (reporting planned closing of Guildnet MLTC, FIDA and Medicaid Advantage Plus plans in New York City in December 2018, following withdrawal of the same plan from other counties in 2017. Referencing the plan’s CEO, Alan Morse, the news article stated, “In January 2017 Morse told Crain’s that he thought GuildNet, which provides coverage for the chronically ill and disabled, was being under-reimbursed by the state when it covered members in high-cost nursing homes. The plan said in May 2017 that those reimbursement issues had not been resolved as it decided to pull out of Long Island and Westchester.”

<sup>8</sup> See NYS DOH Nursing Home Medicaid Rates, available at [https://www.health.ny.gov/facilities/long\\_term\\_care/reimbursement/nhr/2017/nursing\\_home\\_rates\\_july\\_2017.htm](https://www.health.ny.gov/facilities/long_term_care/reimbursement/nhr/2017/nursing_home_rates_july_2017.htm) (averaging rates in five boroughs of New York City)

carved out and available fee for service. Again, the need for this service can be determined by diagnostic and functional assessment.

The State rationalizes the proposed nursing home carve-out in part by claiming there is duplication in case management, since both nursing homes and MLTC plans arguably manage the medical care for their residents or members. In reality, however, the cost of case management is built into the capitation rate. If plans are closing because they say they are unable to pay for high-cost nursing home care even with the cost of care management built into their rate for nursing home residents, then they cannot or will not also pay for high cost home care. It does not matter whether and to what extent part of the rate is earmarked for “care management.”

### **B. Consumers Must Have Meaningful Right to Appeal Determination of “Permanent Placement” to Prevent Disenrollment of Those Seeking to Return Home**

In our comments to CMS and NYS DOH about the proposed amendments to the 1115 waiver to carve out nursing home care, we commented on the types of notices and procedures needed to implement those changes in a way that prevents undue institutionalization. We do not repeat those suggestions here, but incorporate them by reference. Instead, we focus below on changes needed whether or not CMS approves the proposed carve-out of nursing home care.

### **C. Procedures are needed to ensure Consumers Retain Their Income While in a Hospital or Nursing Home so that they can Return Home.**

i. **Medicaid “Community Budgeting.”** Federal regulations give states the option to allow single individuals or couples in a nursing home to retain an amount for maintenance of the home if “[a] physician has certified that either of the individuals is likely to return to the home within that period.” See n. 15. New York implements this option by allowing an individual to rebut the presumption that a nursing home placement is “permanent” with “adequate medical evidence” that the resident expects to return home. See n. 11. This allows for retention of income in order to pay rent or other expenses to maintain the home. This is an important right but can be confusing because this so-called “community budgeting” with rent retention is still a form of “Institutional Medicaid,” authorized only after a nursing home resident submits an Institutional Medicaid application with the 5-year lookback. Clearly, the mere filing of the institutional Medicaid application does not signify a “permanent placement” where the physician has certified she is likely to return home.

DOH should simplify the procedures for requesting this budgeting, by making it part of the Medicaid application instead of requiring separate forms, as is required in New York City (MAP-259D Discharge Alert). In fact, the presumption should be that the individual is returning home and needs the rent retention allowance budgeted.

If a separate form continues to be required, the State should require nursing homes and plans to file the requisite forms to request this budgeting. We routinely see nursing home residents unable to pay their rent because the nursing home failed to file the proper form, even when an individual has expressed a desire to return home and is actively seeking community placement as expressed, for example, through an application for the Nursing Home Transition and Diversion Waiver.

**ii. Nursing homes and managed care plans must be required to file certifications with the Social Security Administration (SSA) to ensure that individuals who depend on SSI retain their SSI benefits.**

When a Supplemental Security Income (SSI) recipient is in a hospital and/or nursing home, their SSI benefits may be continued for 90 days – which is crucial to maintain their home – but only if a physician certifies in writing that the stay is expected to be less than 90 days. The required forms must be submitted to the Social Security office before the 90<sup>th</sup> day of the institutionalization or before the discharge home, whichever is earlier. These benefits are called “Temporary Institutionalization” benefits.<sup>9</sup> We frequently see SSI recipients whose SSI check is discontinued because of a short-term SNF stay because neither the nursing home or plan filed the form.

DOH should assign responsibility for filing the requisite certifications with the SSA to either the nursing home or the plan or both. Part of plans’ care management should include obtaining and filing these forms for members who receive SSI. For people admitted to nursing homes who are not in MLTC plans, the nursing home should be responsible for filing these forms.

When the nursing home carve-in started, consumer advocates drafted and provided to DOH a model Fact Sheet with a model physician’s certification form and asked DOH to require plans, nursing homes, and hospitals to prepare and file it with the SSA (available at <http://www.wnylc.com/health/download/594/>). The fact sheet was reviewed favorably by the SSA regional office. We renew this request and ask CMS to require this procedure.

**D. The MLTC Special Income Standard for Housing Expenses Should be Available to Those who are Discharged from a Nursing or Adult Home with “Immediate Need” Home Care Services, Prior to being Passively Enrolled in an MLTC plan.**

The Special Terms & Conditions of the 1115 waiver incorporates a special incentive for people to return to the community from nursing homes and adult homes, by having extra income disregarded to pay for housing, decreasing the “spend-down” for medically needy individuals. Since the cost of housing is a barrier to discharge back to the community, this provision, authorized in New York State law, entitles Medicaid recipients who were in a nursing home or

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<sup>9</sup> See Social Security Administration, POMS Section SI 00520.140, available at <http://policy.ssa.gov/poms.nsf/lnx/0500520140>

adult home for more than 30 days, and who enrolled in or who stay enrolled in an MLTC plan upon discharge, to be budgeted with this special income disregard.<sup>10</sup> However, there are three reasons this important incentive promoting community-based services is not well used, and will be more under-used if MLTC members are disenrolled after three months of nursing home placement. The first is lack of publicity of the benefit and poor implementation by plans, nursing homes, and local Medicaid offices.<sup>11</sup>

Second, since this Special Income Standard was first approved in the Special Terms & Conditions, the State later launched a new fast-track procedure known as “Immediate need” for nursing home residents to access Medicaid personal care or CDPAP services on a temporary basis through the “fee for service” system in order to be discharged home; after 120 days of receiving the “immediate need” services, they are passively enrolled into an MLTC plan.<sup>12</sup> This procedure was developed pursuant to a state law enacted in 2015 to address severe delays for people trying to enroll in an MLTC plan -- both those trying to be discharged home from a nursing home and those trying to enroll in MLTC plans in the community. It can take less than two weeks to start personal care under the new “Immediate Need” procedure, compared to 3 - 6 months or more when enrolling directly into an MLTC plan. CMS should expand the Special Income Standard for housing to include those who are discharged from nursing homes with Immediate Need services, since they will be passively enrolled into MLTC plans after 120 days.

Third, though CMS approved an important expansion of this Special Income Standard in January 2017, NYS did not implement it until September 2018. When first implemented in 2012, the Special Income Standard was limited to those who newly enrolled into an MLTC plan to be discharged from a nursing home. See n 15. In January 2017, CMS amended the Special Terms

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<sup>10</sup> NY Social Services Law 366.14, as amended by Chapter 56 of the Laws of 2011, authorizing DOH to seek approval from CMS for this standard, which was authorized in the CMS Special Terms & Conditions, Amended August 2012, Part II, § 25, available at [https://www.health.ny.gov/health\\_care/managed\\_care/appextension/docs/special\\_terms\\_and\\_conditions.pdf](https://www.health.ny.gov/health_care/managed_care/appextension/docs/special_terms_and_conditions.pdf) at page 12. This special housing standard was implemented by DOH through NYS DOH 12- ADM-05 - Special Income Standard for Housing Expenses for Individuals Discharged from a Nursing Facility who Enroll into the Managed Long Term Care (MLTC) Program. (available at [https://www.health.ny.gov/health\\_care/medicaid/publications/](https://www.health.ny.gov/health_care/medicaid/publications/)); and MLTC Policy 13.02: MLTC Housing Disregard.

<sup>11</sup> To address the concern of lack of information about this important incentive to promote community-based services, DOH has recently issued some additional procedures that remind plans and nursing homes to assist people who are able to return to the community from a nursing home to apply for this housing disregard, and that require local districts to screen for eligibility for it. Consumer advocates thank DOH for hearing concerns raised about under-utilization of this disregard. See GIS 18 MA/012 - Special Income Standard for Housing Expenses for Certain Managed Long-Term Care Enrollees Who are Discharged from a Nursing Home, issued Sept. 28, 2018, available at [https://www.health.ny.gov/health\\_care/medicaid/publications/](https://www.health.ny.gov/health_care/medicaid/publications/), and NYS DOH September 2018 Medicaid Update article to Medicaid providers, including nursing homes, adult homes and insurance plans, available at [https://www.health.ny.gov/health\\_care/medicaid/program/update/2018/2018-09.htm#income](https://www.health.ny.gov/health_care/medicaid/program/update/2018/2018-09.htm#income).

<sup>12</sup> NY Social Services Law 366-a(12), enacted 2015; 18 NYCRR 505.14(b)(7) and (8), adopted 2016; NYS DOH 16-ADM-02 - *Immediate Need for Personal Care Services and Consumer Directed Personal Assistance Services*, available with attachments at [https://www.health.ny.gov/health\\_care/medicaid/publications/pub2016adm.htm](https://www.health.ny.gov/health_care/medicaid/publications/pub2016adm.htm).

& Conditions to expand its availability to those "who enroll into or remain enrolled in the MLTC program." (emphasis added).<sup>13</sup> This change was implemented by DOH on Sept. 28, 2018, in GIS 18 MA/012 - *Special Income Standard for Housing Expenses for Certain Managed Long-Term Care Enrollees Who are Discharged from a Nursing Home*, available at [https://www.health.ny.gov/health\\_care/medicaid/publications/](https://www.health.ny.gov/health_care/medicaid/publications/). Very few people will benefit from this expansion if the carve-out is approved, since fewer people will be discharged from nursing homes who remain enrolled in their MLTC plans. Moreover, since the GIS was issued, it has not been publicized. The State should issue a Medicaid Update to alert Nursing Homes about the change in policy, and DOH should issue an MLTC policy to plans about it as well.

Additionally, since permanent nursing home residents will no longer be passively enrolled into an MLTC plan, they cannot request their MLTC plan to authorize services to return home when ready for discharge. Now, more will face the barriers and delays for MLTC enrollment, and will utilize the fast track Immediate Need procedure as a gateway to MLTC. In order to promote Olmstead goals, this Special Income Standard should be expanded to include people discharged from nursing homes with Immediate Need services.

**E. Implement Policies to Counteract Disincentives to Serving High Need Consumers, Including New Law, Once Signed by Governor, Requiring Passive Enrollment of those Approved for MLTC after a Conflict Free Assessment but Facing Delays in Enrollment.**

The State's *Olmstead* plan cited above truthfully acknowledges the disincentives inherently created by the capitation model that deter plans from meeting the needs of those consumers with severe disabilities who need more extensive services in the community. In addition to the suggestions described throughout these comments, here are some additional ways to at least partially counter these disincentives.

- i. **Implementation of 2019 Amendments to Public Health Law § 4403-f, subd. 7(b)(iii), requiring Passive Enrollment into MLTC plans** - The legislature passed an amendment to the Public Health Law which requires passive enrollment into an MLTC plan of an individual found eligible for MLTC enrollment a Conflict-Free assessment, if that individual has not selected or enrolled in a plan prior to expiration of the CFEEC. Upon the Governor's signature, this statutory change should be rapidly implemented. This will mitigate the harm when plans deter and discourage high-need enrollees from enrolling, behavior which occurs in the community as well as nursing homes. Even if the plan does not authorize adequate hours initially, the consumer has no appeal rights until enrolled. Also this will mitigate the delays caused when a CFEEC expires because plans delay in scheduling the pre-enrollment assessments, especially when the consumer is in a nursing home.

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<sup>13</sup> Amended Special Terms & Conditions, Jan. 19, 2017, p. 26 (available at [https://www.health.ny.gov/health\\_care/managed\\_care/appextension/docs/2017-01-19\\_renewal\\_stc.pdf](https://www.health.ny.gov/health_care/managed_care/appextension/docs/2017-01-19_renewal_stc.pdf)).

- ii. **Waiver of Conflict Free Eligibility assessment ('CFEEC') and Plan Assessment within Six months of Disenrollment for Permanent Placement** - If CMS approves the nursing home carve-out, DOH has proposed that a new CFEEC would not be required, and a MLTC enrollment could be reinstated if the consumer has been in a nursing home for less than six months since being disenrolled from an MLTC plan because of "permanent placement." While this policy is helpful, additional protections are needed. The CFEEC should be waived for any nursing home resident, including those in a nursing home more than six months since being disenrolled from an MLTC plan. The continuing placement in a nursing home alone is sufficient to establish the consumer's need for long-term services and supports. Passive enrollment into an MLTC plan should be done if an MLTC plan does not enroll the individual within 30 days.
- iii. **To reduce MLTC enrollment delays, both from the community and from nursing homes, mid-month enrollment should be possible, with pro-rated capitation,** rather than limiting enrollment to only the 1<sup>st</sup> of the month. Under the systems in New York State, to secure an enrollment for the 1<sup>st</sup> of the month, the enrollment agreement must be signed and filed by the 18<sup>th</sup> of the preceding month. If it is filed on the 20<sup>th</sup>, the enrollment is delayed another 40 days until the 1<sup>st</sup> of the month after the following month. A pro-rated capitation allowing mid-month enrollment would help reduce delays at least somewhat in these cases.
- iv. **If "permanent" nursing home residents will be excluded after 3 months, clarify that a "permanently placed" consumer may still enroll into an MLTC plan in order to be discharged home, and the MLTC Plan must still be responsible for paying for nursing home care for as many days as necessary to arrange discharge.** Without this clarification, MLTC enrollment could be denied for a resident seeking to be discharged, because the consumer is "permanently placed" and arguably excluded from enrollment. Assuming a nursing home resident could enroll in an MLTC plan for purposes of being discharged home with community-based LTSS, since MLTC enrollment is effective on the 1<sup>st</sup> of the month, it is usually not possible for the plan to arrange for the consumer's discharge home to occur on the very first day of enrollment. The consumer would have to remain in the nursing home during the first week or so of enrollment in the plan in order for services to be arranged. The plan must be responsible for payment of these days of nursing home care.
- v. **Maximus must be directed to schedule and conduct the CFEEC even if housing is not yet secured.** The Open Doors Transition Center program, administered by the NY Association on Independent Living under contract with DOH, which implements the Money Follows the Person program in New York State, reports that NY Medicaid Choice frequently refuses to schedule CFEECs unless housing has already been arranged. This is a huge barrier to discharge. It is a classic "Catch-22" situation,

where the consumer cannot secure the housing, paying the security deposit, brokers fee, etc. until she knows that MLTC services will be in place upon discharge. If she has to wait to schedule the CFEEC after the apartment is secured, there can be a delay of a month or more, and it is not feasible to pay for the apartment while still in the nursing home for this delay. Even when a program like the Olmstead Housing Subsidy is available and allows for security deposit and rent to be paid for up to three months prior to discharge, the current process does not often allow for a proper service plan to be in place within 3 months without involvement of the Care Manager earlier in the process. In addition, the proposed plan can directly impact housing choices. For example, an individual who was able to secure a 1-bedroom apartment may be approved for a live-in aide requiring a 2<sup>nd</sup> bedroom. The MLTC plan care manager needs to be a part of the discharge planning process which includes securing housing.

### **3) Lock-in: The Prohibition Against Changing Plans after 90 Days of Enrollment Should be Rejected or Modified.**

We oppose the proposal to ban consumers from changing MLTC plans after 90 days of enrollment, except for good cause. While the State describes this change as aligning MLTC with other Medicaid managed care plans, MLTC members –who are dual eligibles who have been found to need long term services and supports – are as a group more vulnerable than the general membership of mainstream Medicaid managed care plans. Even within the mainstream Medicaid Managed Care program, the Department of Health has long recognized the need for additional flexibility for vulnerable populations. Mainstream beneficiaries who are eligible for Health and Recovery Plans (HARPs) because of a serious behavioral health condition and those who are eligible for Special Needs Plans (SNPs) because they are HIV+, homeless, or transgender are able to switch from a mainstream plan to a HARP or SNP at any time.<sup>14</sup> This recognition of the importance of providing individuals with special or extensive needs with flexibility to change plans to access appropriate services should be preserved in the MLTC program.

Additionally, because their primary insurance is Medicare, dual eligibles have always had additional rights. Their right to change plans should be no more restrictive than the right of a dual eligible to change Part D or Medicare Advantage plans that include prescription drugs (“MA-PD” plans). In 2019, a dual eligible has the right to change Part D or MA-PD plans once per calendar quarter for the first three calendar quarters of the year, and then effective the

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<sup>14</sup> See, e.g., N.Y. State Dep’t of Health, Medicaid Managed Care / Family Health Plus / HIV Special Needs Plan / Health and Recovery Plan Model Contract, §7.1, [https://www.health.ny.gov/health\\_care/managed\\_care/docs/mc Medicaid\\_managed\\_care\\_fhp\\_hiv-snp\\_model\\_contract.pdf](https://www.health.ny.gov/health_care/managed_care/docs/mc Medicaid_managed_care_fhp_hiv-snp_model_contract.pdf).

beginning of the following year. To avoid confusion for dual eligibles who must negotiate all of these types of plans, the rules should be the same, if not more expansive for MLTC.

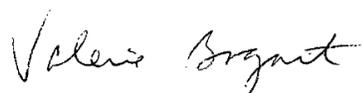
In a program that emphasizes “person-centered” care, to ban members from switching plans defeats that goal. If a member is frustrated with being unable to access services from one plan, it is an important consumer right to “vote with their feet” and change plans. The State should be monitoring plan-to-plan transfers as an indicator of quality issues if many people are leaving any one plan, rather than simply banning such transfers altogether.

We commend DOH for including as a ground for good cause the desire for continuity of a home care worker, where, for example, the worker’s home care agency may no longer contract with the MLTC plan because of the LHCSA cap. Given the importance of this caregiver relationship for people who are dependent on assistance for their most intimate needs, **DOH should also require transition rights in such situations**, ensuring the same continuity of care as applies when an MLTC plan closes.

Also, good cause should be granted where a consumer was forced to switch plans after her previous plan closed. Under NYS DOH Policy 17.02, available at [https://www.health.ny.gov/health\\_care/medicaid/redesign/mrt90/mltc\\_policies.htm](https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policies.htm), the individual will be auto-assigned to a new plan if she does not select her own plan within 60 days. The new plan must provide the same plan of care with the same providers for 120 days unless agreed to change it before. An individual in this situation will not know what the new plan’s plan of care is – and whether she must change providers -- until after the 120-day continuity of care period ends. By then, the 90-day grace period allowing plan transfers will have expired. The 90-day grace period should be extended in such cases by 120 days, to allow a meaningful opportunity for the consumer to understand the plan’s offered services.

Thank you for your consideration.

Very truly yours,



Valerie J. Bogart, Director  
Evelyn Frank Legal Resources Program  
New York Legal Assistance Group  
7 Hanover Square, 18th Floor  
New York, NY 10004



**From:** [REDACTED]  
**To:** [doh.sm.1115Waivers](https://doh.sm.1115Waivers)  
**Subject:** 1115 Public Forum Comment AIRnyc  
**Date:** Friday, July 12, 2019 2:54:56 PM  
**Attachments:** [AIRnyc 1115 comments 7.12.19.pdf](#)

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*ATTENTION: This email came from an external source. Do not open attachments or click on links from unknown senders or unexpected emails.*

Attached please find written comments from AIRnyc, a community based organization in New York City.

Rose Gasner  
Executive Vice President

[REDACTED]



# Healthy has an address

July 11, 2019

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

Re: 1115 Public Forum Comments

AIRnyc welcomes the opportunity to comment on New York's 1115 Medicaid Redesign Team (MRT) Waiver and upcoming renewal activities. Based in the South Bronx, AIRnyc is a data-driven and technology-forward community-based organization (CBO) that serves New York's most vulnerable people. Our Community Health Workers (CHWs) meet individuals and families where they live in order to assess health risks, increase health literacy, encourage healthier choices, link to social services, and inspire better self-management of one or more chronic diseases affecting an individual or family. 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.

AIRnyc has been a leader among Community Based Organizations during the implementation of the Delivery System Reform Incentive Payment (DSRIP) waiver program, as a partner to four Performing Provider Systems (Bronx Partners for Healthy Communities, Community Care of Brooklyn, Mount Sinai PPS, and OneCity Health) with whom we have contracted to provide the asthma home-based self-management program (i.e. Project 3.d.ii). The organization that is now AIRnyc began as a participatory based research initiative among Harlem Hospital Center, Columbia University's Mailman School of Public Health and the Harlem Children's Zone, and has implemented Community Health Worker-led home visiting since 2001. AIRnyc's team of culturally competent Community Health Workers and health professionals has demonstrated sustained impact based on nearly 18 years of data, including consistent reductions in avoidable emergency department visits (-70%) and hospital admissions (-75%) due to asthma, bending the cost curve.

We are now a key VBP partner to several health plans. Our asthma program supports more than 20 hospitals and other providers, helping them meet the State's VBP contracting requirements to address Social Determinants of Health (SDH) and partner with Tier 1 CBOs. We are deploying our Community Health Workers to serve Medicaid and MLTC patients. We are innovating and partnering with families to address their full range of chronic diseases and social needs, breaking down disease silos by helping people manage diabetes, hypertension and aging. We know the communities we work with and have a track record of success in promoting wellness, prevention, and management of chronic conditions while coordinating medical care.

We welcome the State's proposals for a continuation of the DSRIP program, so that we can continue the process of improving health outcomes and building evidence-based interventions that meaningfully address SDH. We encourage New York to consider the following points:

- A renewal of the DSRIP program should provide for greater involvement of CBOs in the decision-making practices at PPSs, and in the MRT process more generally.
- CBOs partnering with PPSs should have access to outcomes data, draft evaluations, and draft performance reports so that they have an opportunity to comment.
- The State should expand the scope and ambition of its requirements for VBP contracts to include (a) an allocated amount of spending and (b) collaborations with more CBOs and (c) standardization of data that captures social determinants of health.
- The State should include CBOs in interoperability initiatives and in statewide investments being made in HIT.

### **Renewal of DSRIP**

DSRIP allowed AIRnyc to create new partnerships with the health care system, helping us to expand the reach of our program and coordinate with a broader provider community. State recognition of the important role of home-based asthma services with CHWs as part of the care coordination team was an affirmation of the AIRnyc model for asthma.

However, startup times, resource allocation, data management and program models varied within and across the PPSs. With each PPS lead in almost sole control of funding and decision-making, AIRnyc and other CBOs had minimal input in how programs should be designed and implemented to best serve the patient. More time is needed to build the evidence base that will allow CBOs to prepare for the transition to VBP and make the case for investment in these collaborative initiatives that address the Social Determinants of Health. NYS should commit additional time and resources to this end.

We wholeheartedly agree that the transition to value based payments has not been as rapid as envisioned. We think that this is especially true with regard to the role of CBOs. At the June 2019 public hearing, Greg Allen acknowledged the need to more specifically engage CBOs in the process for any extension of DSRIP. We are eager and ready to participate.

### **Data Sharing & Evaluation**

DSRIP sought to fund and build a bridge to value-based contracting, and a key component of that transition is looking at which programs worked and which vendors executed successfully. In order for CBOs to fully participate in value based contracting, we need to participate in determining how our programs are evaluated and to be full partners in that work.

AIRnyc is a sophisticated data-driven organization, and we have adjusted to the data demands of our PPS partners, each of which has its own systems. We have previously commented that we welcome the State's proposed revisions in the VBP Roadmap to mitigate operational barriers for community-based organizations by establishing requirements for plans to share data with CBOs. The same data sharing should apply to PPS with any evaluations that are part of the final DSRIP reports. We are invested in the lives of the patients we serve and without the data available

to measure our work, it becomes a challenge to target our quality improvement efforts with the PPS. We believe to address this, PPSs should be mandated to share drafts of any evaluations of interventions with their community-based partners prior to final release.

As noted above, based on the data we collect, we show a 70% reduction in avoidable emergency department visits and a 75% reduction in avoidable hospital admissions. But although based on observation, we believe that our program has a positive impact on specific asthma-related quality scores—which are key performance indicators—we do not have the data to enable us do that evaluation on our own.

As the operational partners on the ground, CBOs should have the opportunity to point out program design limitations, data issues, or other concerns that could affect measured outcomes. If our PPS partners release results without consulting us, CBOs will be hard pressed to challenge negative findings which could be seen as conclusive. We also should have access to our own data, so if one vendor performed better than the average, we can learn from that information. Future partners will be able to judge for themselves based on our input, but we must have the opportunity to provide that input.

### **Future State**

New York State has strongly expressed its intent to include CBOs in its transition to value-based contracting in Medicaid. To date, this inclusion has consisted of the VBP Roadmap requirements for Level 2 and 3 risk contracts to incorporate one SDH intervention and a relationship with one CBO. We have previously commented that without clear spending directives, the Roadmap requirements are just a first step, which actually requires only that MCOs “check a box” rather than meaningfully engage CBOs. Going forward, we recommend that each VBP contract should include a minimum percentage of Medicaid spend to be allocated towards Tier 1 CBOs. We also recommend that each risk contractor be required to address multiple social determinants of health.

We also urge the State to look at the lack of interoperability within and across health organizations through the lens of CBOs, and consider statewide investment in systems that could improve the integration of CBOs into the health care system. AIRnyc is participating in Healthix, one of the three QE’s with which our PPS partners also participate as part of the Statewide Health Information Network (SHIN-NY). We are working closely with Healthix staff and the executive leadership of the SHIN-NY (Valerie Grey) in order to create ways that the system can enhance care coordination and data sharing for the patients and families we serve. However, the system and its forms were not designed for use by CBOs, provider engagement remains low, and the requisite consent process for patients is overly burdensome (for example, it is not offered in multiple languages). Our own PPS partners identify interoperability as part of the project, yet we are maneuvering among fragmented IT systems, with multiple systems that have minimal participation by providers and/or CBOs. As more providers understand the challenges of social service referrals and how to make sure that patients follow through, a statewide system for closing those loops and connecting health care to social services starts to make more and more sense. North Carolina is making that investment, and it is more efficient to do that across the Medicaid program rather than have different systems in use by different providers. We believe New York State should pursue a similar example to invest in interoperability whereas the medical and social services are no longer

siloed but are connected and working together with integration as a requirement and trusted exchange can occur for the public good.

Medicaid payment reform, although vital, is only a means to an end: it is not the priority of the people served by AIRnyc and other CBOs. Their priority is to get the support and tools they need to manage and prevent chronic diseases, access social services and navigate New York's complex health care delivery system. AIRnyc's Community Health Worker service model aligns with the goals of Medicaid payment reform, and we have the technical capacity to positively impact the health of the people we serve—IF New York State enacts real policy and regulatory pathways for the investment in the critical services we provide, then we can all deliver the Triple Aim of better care, lower cost and better quality.

AIRnyc looks forward to continuing to work with DOH. We believe our experiences could provide useful input on any DSRIP extension. Please feel free to contact us at the emails and numbers below if you have any questions or if we can be of further assistance to elaborate on our experiences working with PPSs. Thank you for your attention to this very important matter.

Sincerely,

Shoshanah Brown, Chief Executive Officer

[REDACTED]

M. Rose Gasner, Executive Vice President

[REDACTED]

**From:** [REDACTED]  
**To:** [doh.sm.1115Waivers](mailto:doh.sm.1115Waivers)  
**Cc:** [REDACTED]  
**Subject:** 1115 Public Forum Comment  
**Date:** Friday, July 12, 2019 3:05:50 PM  
**Attachments:** [CCLC 1115 Waiver Comments 07-12-19.pdf](#)

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Good afternoon: attached, please find comments submitted on behalf of Scott C. Amrhein, president of the Continuing Care Leadership Coalition. Should you have any question concerning the submission, please contact CCLC.

Gabriel S. Oberfield, J.D., M.S.J. | Vice President of Policy and Operations | CCLC | 555 West 57th Street, New York, NY 10019 | [REDACTED] | [www.cclcnyc.org](http://www.cclcnyc.org)



July 12, 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](mailto:1115waivers@health.ny.gov)*

Subject: 1115 Public Forum Comment

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, 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 recent public meeting the New York State Department of Health (DOH) convened in Albany on June 24, 2019, in order to elicit public comment on New York State's 1115 Waiver activities. This public comment period comes at an important moment for the Delivery System Reform Incentive Payment (DSRIP) program - one offering a valuable opportunity to assess what was learned during DSRIP's first chapters and to implement complementary programming to ensure that DSRIP's future more intentionally includes post-acute partners as key drivers of the change envisioned through MRT processes. In offering our comments, we will also bring context to the important proposed adjustments to managed long term care programming, also discussed on the 24<sup>th</sup>, and the potential effects of those changes on CCLC members and the individuals whom they serve.

With the above in mind, CCLC will focus its public comments on the macro environment affecting long term care services and supports in New York State, and the ways through the Waiver that efforts can strengthen the sector as well as better position it to serve the needs of vulnerable New Yorkers.

### **Overall Comments**

CCLC urges the State to develop a sustainable plan for elevating long term and post-acute care (LTPAC) as integral and central within any future DSRIP model. CCLC believes that there are significant lost opportunities that arise from only allowing LTPAC providers participate in DSRIP activities as a downstream participant. The LTPAC providers currently caring for the high-cost, medically complex populations are essential to developing value-based models offering the greatest opportunities for State savings. Therefore, we urge the State to develop DSRIP models that prioritize long term and post-acute care as the essential foundation for managing complex care populations in a value-based, and risk-based environment.

### **Funding Context - Changes That Stand to Destabilize the Sector if Left Unaddressed**

For many years CCLC members have been engaged deeply in supporting the State's Medicaid Redesign objectives, including as sponsors of an array of insurance entities, through active participation in performing provider system activities, and through dedicated efforts to align their clinical practices with MRT goals via active engagement in staff training initiatives focused on avoiding preventable hospitalizations, and, 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 the just released 2018 Nursing Home Quality Initiative data, which shows 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. In this environment, as New York State moves to implement Medicaid redesign activities facilitated under the Waiver, it is critical that it account for several complex and potentially competing factors that place simultaneous pressures on the long term care sector.

**Institutional Long Term Care.** First, it was envisioned that 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 would 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. While 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, 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 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. 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, 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 falter, and some are likely to close their doors - an outcome to be avoided at all costs at a time when the demographic demand for quality long term care services only is growing.

## Importance of Exploring Bundling and Alternate Payment Model Options Appropriate for the Long Term and Post-Acute Care Sector

CCLC members would 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. The DSRIP environment effectively can incorporate programming - particularly during its next phase - that helps to realize these goals.

We believe, in the Federal context, that the timing is right for elevating such programming within the State's Waiver extension request, particularly given that CMS has been considering an array of potential new alternate payment models, among them constructions to engage the post-acute provider community. We strongly encourage DOH to engage with CMS in exploring how models could be established that align Medicare and Medicaid in ways that capture Medicare savings deriving from care delivery changes that meaningfully reduce hospital readmissions (a key State goal), and that utilize the savings to reward, strengthen, and sustain providers, while generating savings or other financial benefits for the Federal Government and New York State.

In considering such models, we encourage the State to be mindful of the need to ensure there is enough base funding such that any bundle or alternate payment model has viability (including funding to cover data sharing, risk stratification, etc.). We also encourage conversation with CMS to consider how to engage an array of payers, including, in models for duals where there is Medicare and Medicaid involvement, by creating a way meaningfully to engage Medicare Advantage plans, given the increasing volume that such plans represent. Among other focal areas, we urge the State to consider the area of hospice and palliative care in the context of developing models that are aimed at managing care for the dually eligible population. We cannot overstate the importance of pooling Medicare and Medicaid dollars, creating greater shared savings possibilities, and finding ways to scale VBP in the long term care sector. This also could manifest through insurance products that meaningfully bridge the lessons learned during the Fully Integrated Duals Advantage demonstration, but also grow from some of its observed operational limitations.

In keeping with CCLC's recommendation to create DSRIP models that place long term and post-acute care at the center of activity for managing populations, CCLC recommends that such models account for social determinants of health. In population health management, it will be important for future DSRIP models to prioritize important factors vital to health care, including "socioeconomic status, education, neighborhood and physical environment, employment, and social support networks, as well as access to

care.”<sup>1</sup> In the long term care 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. CCLC encourages the State to consider populations’ non-medical needs in caring for complex patients to maximize improvement and success in supporting formal health care models, which explores models that provide additional payments to provide enhanced support when compared to what was previously received, among other concepts.<sup>2</sup>

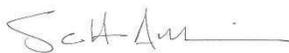
### Information Technology

The above concerns are heightened by technology deficits in the long term care sector. Through the Waiver, we view it as essential for New York State to 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 and, 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.

### Conclusion

On behalf of CCLC and its members, I appreciate the opportunity to comment on the Waiver in the context of the June 24, 2019, public meeting. 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 57<sup>th</sup> Street, Suite 1500  
New York, NY 10019

---

<sup>1</sup> 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/>

<sup>2</sup> 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>

**From:** [REDACTED]  
**To:** [doh.sm.1115Waivers](mailto:doh.sm.1115Waivers)  
**Cc:** [REDACTED]  
**Subject:** VNSNY comments on 1115 MRT Waiver  
**Date:** Friday, July 12, 2019 3:54:17 PM  
**Attachments:** [image001.png](#)  
[VNSNY Comment Letter 1115 MRT Waiver FINAL 071219.pdf](#)

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Please find attached comments from the Visiting Nurse Service of New York (VNSNY) on the New York State 1115 Medicaid Redesign Team (MRT) Waiver.

Thank you and have a good weekend,

**Dan Lowenstein, MBA**  
**Vice President of Government Affairs**  
Preferred Pronouns: He/They



Visiting Nurse Service of New York  
220 East 42<sup>nd</sup> Street, Room 6C07  
New York, NY 10017

[REDACTED]  
[www.vnsny.org](http://www.vnsny.org)

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**Visiting Nurse Service of New York**  
220 East 42<sup>nd</sup> Street  
New York, NY 10017  
www.vnsny.org

July 12, 2019

**VIA ELECTRONIC MAIL**

Office of Health Insurance Programs  
Division of Medicaid Payment Reform  
New York State Department of Health  
One Commerce Plaza  
Albany, New York 12210  
[1115waivers@health.ny.gov](mailto:1115waivers@health.ny.gov)

Re: 1115 MRT Public Comment

Dear Medicaid Redesign Team:

The Visiting Nurse Service of New York (VNSNY) appreciates the opportunity to comment on the 1115 Medicaid Redesign Team (MRT) Waiver. The largest nonprofit home and community-based healthcare organization in the U.S., VNSNY offers a wide range of services, programs, and health plans. This includes home care, hospice and palliative care, Nurse-Family Partnership (NFP), community mental health, managed long-term care (MLTC) plans, and health plans for dually eligible individuals and people living with HIV/AIDS.

VNSNY has partnered with 13 downstate Performing Provider Systems (PPSs)<sup>1</sup> on 21 distinct projects in these project categories:

- 2.a.i: Integrated Delivery System focused on Evidence-Based Medicine/ Population Health Management
- 2.a.ii: Health Home at Risk Intervention program
- 2.b.iii: Emergency Department Care Triage for At Risk Populations
- 2.b.iv: Care Transitions Intervention Model to Reduce 30-Day Readmissions
- 2.b.viii: Hospital Home Care Collaboration
- 3.a.ii: Behavioral Health Community Crisis Stabilization
- 3.f.1: Increase Support Programs for Maternal Child Health
- 3.g.ii: Integration of Palliative Care into Nursing Homes
- 4.a.iii: Mental Health and Substance Abuse Infrastructure

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<sup>1</sup> Bronx Health Access, Bronx Partners for Healthy Communities, Community Care of Brooklyn, Mount Sinai PPS, Nassau-Queens PPS, NYP (Manhattan), NYP of Queens, NYU Langone Brooklyn PPS, OneCity Health, SOMOS Community Care, Staten Island PPS, WMC Health

Our feedback on the MRT waiver is focused on the following:

1. Pending Amendments (MLTC Nursing Home Limit/Enrollment Lock-In)
2. Observations and Recommendations for Future 1115 Medicaid Waiver Design
  - a. Value-Based Payment
  - b. Integrated Care for Dually Eligible Individuals
  - c. Skilled Home Health Care
  - d. Hospice Care

### **1. Support for Pending Amendments: Partial MLTC Nursing Home Limit/Enrollment Lock-In**

To ensure effective care coordination, we strongly support the pending amendment to the 1115 Waiver that would require MLTC members to stay with their plan for one year, similar to enrollment policies in the commercial market. We also support the proposal to dis-enroll MLTC members who are in nursing homes for three months or more (Medicaid would pay nursing homes directly). Members who can return to community-based care would be able to re-enroll in an MLTC plan.

### **2. Observations and Recommendations for Future 1115 Medicaid Waiver Design**

The following comments are intended to identify opportunities for further exploration as NYS looks to renew DSRIP beyond 2020.

#### ***a. Value-Based Payment (VBP)***

VNSNY and VNSNY CHOICE Health Plans have embraced innovative delivery and payment models to improve health outcomes, improve patient experience, and reduce the cost of care – in line with the goals of DSRIP.

- CHOICE MLTC has 100% of expenditures in Level 1 VBP and 42% in Level 2 VBP.
- CHOICE FIDA and MAP plans have 37% of expenditures in Level 1 and 15% in Level 2 VBP.<sup>2</sup>
- VNSNY’s certified home health agency (CHHA) participated in CMS Bundled Payment for Care Improvement (BPCI) Models 2 and 3, and our risk-sharing, value-based post-acute “Case Rate” model enables us to manage care with greater flexibility than is possible under fee-for-service. VNSNY’s Case Rate model has demonstrated success in shortening inpatient lengths of stay, reducing avoidable hospitalizations, and increasing patient satisfaction. To date, nearly 40% of VNSNY CHHA managed care revenue is from Case Rate arrangements.

Our perspective, from both the plan and provider side, is that there remains an unwillingness or inability from some plans and providers to enter into risk-sharing contracts. Our managed care plan experience is that physician practices and health systems with which we have small panels are unwilling to take on risk, as one or two adverse health events would put them at unacceptable financial risk with a plan. Our CHHA’s experience is that managed care plans are unwilling to delegate and cover the cost of care management for post-acute care, even when that delegation involves the acceptance of significant downside risk by the provider.

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<sup>2</sup> Pending NYS Department of Health approval by the end of 2019.

**Recommendations:**

- Incentivize both plans *and* providers to enter risk-based contracts;
- Exempt plans and providers with small volume patient panels from Level 2 or 3 VBP requirements; and
- Include and emphasize CHHA-driven VBP bundles, and ensure that CHHAs providing critical care and risk management functions are compensated appropriately.

***b. Integrated Care for Dually Eligible Individuals***

One of the most vexing issues that NYS DOH must address is how to provide more cost-effective care to New York State residents who are dually eligible for both Medicaid and Medicare. Dually eligible beneficiaries are disproportionately the highest cost enrollees in both programs. Individuals who require long-term services and supports (LTSS) – both institutional and community-based – account for about 60% more in Medicare costs than those who do not use LTSS services.<sup>3</sup> Approximately 90% of CHOICE MLTC members are dually eligible – a figure that is likely consistent with the MLTC population across NYS.

Dually eligible individuals are caught up in a “wrong pocket” problem between the New York State government and the federal government. Spending on Medicaid, particularly for home-based long-term care services, saves money on costly health care interventions, particularly hospitalizations. But those savings accrue to Medicare, and aren’t currently structured to allow NYS to share in Medicare savings despite increased investments on the Medicaid side.

Except for the VBP Roadmap initiative that incentivizes the reduction of potentially avoidable hospitalizations, DSRIP did not address the needs of dually eligible individuals with long-term care needs. NYS participated in the FIDA demonstration during DSRIP, yet the two initiatives were mostly on separate tracks.

**Recommendations**

- Prioritize initiatives that explicitly improve care for dually eligible individuals;
- Align DSRIP with NYS and CMS strategies to better integrate care; and
- Develop a shared savings partnership that rewards NYS (and its Medicaid payers and providers) for Medicare savings attributed to Medicaid spending.

***c. Skilled Home Health Care***

Comprehensive care management in the home entails a level and type of expertise not usually found in hospital-led care management models, community-based clinical practices, or managed care plans. Education of patients and caregivers, environmental and home assessments, coordination and communication with primary care providers and specialists, medication management, and regular

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<sup>3</sup> 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/wp-content/uploads/2017/01/Jan18\\_MedPAC\\_MACPAC\\_DualsDataBook.pdf](https://www.macpac.gov/wp-content/uploads/2017/01/Jan18_MedPAC_MACPAC_DualsDataBook.pdf).

monitoring of health status are just some of the functions that CHHAs provide in the home that are essential to quality outcomes.

New York State ranks 44<sup>th</sup> nationally in 30-day readmission rates.<sup>4</sup> While some CHHAs (including VNSNY) have been involved in DSRIP projects, we believe the unique role CHHAs can play in care transitions and home-based care management has not been fully implemented through the 1115 Waiver. Indeed, CHHAs have been largely left out of the VBP discussion, even as two-sided post-acute care-driven risk models have proven successful in reducing readmissions and total cost of care.

For example, VNSNY's Case Rate model has demonstrated success in shortening inpatient length of stay, reducing re-hospitalizations and avoidable hospitalizations, and increasing patient satisfaction. To achieve this, VNSNY has standardized and integrated data into trend dashboards to monitor care, hospitalizations, risk/acuity levels, payment reconciliation, and utilization. Our predictive risk model provides care managers with actionable intelligence to ensure the patient's recovery stays on track, and that complications are avoided.

### **Recommendations**

- Ensure home health care providers with experience managing population health and two-sided VBP arrangements are represented on the MRT;
- Provide home and community-based healthcare providers with a more direct role and responsibility in DSRIP; and
- Ensure CHHAs can participate meaningfully in VBP arrangements (see VBP recommendation above).

#### ***d. Hospice***

The role of hospice has also 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.

Hospice has been demonstrated to save over \$9,000 per patient in end-of-life care, but New York ranks 49<sup>th</sup> in the nation in hospice utilization, with only 31.5% of Medicare decedents (nationally, more than half of all Medicare decedents utilize hospice).<sup>5</sup> NYS hospice utilization grew at only 0.4% from Q3 2017 to Q3 2018 – the fifth lowest growth rate in the U.S. By comparison, New Jersey hospice utilization grew by 5.7% - the 2<sup>nd</sup> highest in the U.S. NYS is also the fifth lowest in average hospice length of stay (ALOS) with 53 days, compared to 75 days nationally.

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<sup>4</sup> Dartmouth Atlas of Health Care, 2019.

<sup>5</sup> 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](https://www.excelhealthgroup.com/wp-content/uploads/Excel-Health-Industry-Trend-Report-Q3-2018_Final_20190411.pdf). Accessed July 10, 2019.

## Recommendations

- Ensure quality hospice providers are represented on the MRT;
- Consider having Medicaid cover concurrent care (patient can elect hospice but also receive curative care related to the terminal condition), which can increase hospice adoption rates (This includes MLTC members, who must now disenroll from MLTC to receive hospice care); and
- Develop DSRIP projects designed to increase hospice adoption and ALOS (See Medicare Shared Savings Partnership recommendation above).

Thank you for your consideration of these recommendations. We look forward to working with NYS DOH and our other partners in this important effort to improve New York State's healthcare payment and delivery system.

Sincerely,

A handwritten signature in black ink, appearing to read "Kerry M. Parker". The signature is fluid and cursive, with the first name "Kerry" being the most prominent.

Kerry M. Parker

Executive Vice President, General Counsel and Chief Risk Officer

**From:** [REDACTED]  
**To:** [doh.sm.1115Waivers](#); [doh.sm.delivery.system.reform.incentive.payment.program](#); [doh.sm.DOHWEB](#)  
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**Date:** Friday, July 12, 2019 4:07:25 PM  
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Please see attached public comment

Thank you

Amber Decker

## 1115 Public Comment

July 12, 2019

By Amber Decker Parent, Caretaker and Family Peer Advocate

To: [1115waivers@health.ny.gov](mailto:1115waivers@health.ny.gov)

### Point I

The MRT and NYS has failed to improve access to health care for the Medicaid population; including but not limited to the SMI, SUD, I/DD and other STC (Special Terms and Conditions) Population:

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 Governor who's behind the scenes colleagues have all profited from the 1115 MRT waiver. The MRT gave 98% of DSRIP funding to hospitals, to create a new bureaucracy intended to increase surveillance the Special Terms Conditions population . DSRIP has not kept anyone out of a hospital.

This is all about patronage, union votes and harassing the special terms and conditions population. DSRIP's data has not changed outcomes including Social Determinants of health. Access to health care starts with meaningful engagement of the populations being served and that has not happened

### Point II

The MRT and NYS has failed to Improve the quality of health services delivered to the Medicaid population; including but not limited to the SMI, SUD, I/DD and other STC (Special Terms and Conditions) Population: Many of the DSRIP Data available on the dashboard shows little change. See:

[https://webbi1.health.ny.gov/SASStoredProcess/guest?\\_program=/EBI/PHIG/apps/dashboard/p\\_a\\_dashboard&p=sh](https://webbi1.health.ny.gov/SASStoredProcess/guest?_program=/EBI/PHIG/apps/dashboard/p_a_dashboard&p=sh)

See Attachment

### Point III

The MRT has manipulated resources generated through managed care deficiencies to 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 and community based services. The health home program is not working and is exploiting individuals and not providing service plans to the STC population.

#### Point IV

The Process That NYS is unraveling value- Based Payments (VBP) is  
Convolutd, Formidable, and Reckless

The NYSDOH has unleashed a "Roadmap" for VBP called: [A Path toward Value Based Payment: Annual Update June 2019 : Year 5 New York State Roadmap for Medicaid Payment Reform](#) available in only one language and riddled with contradictions and fantasy. Based on the Roadmap content alone it is obvious that the DSRIP & VBP enterprise has been an ungoverned, unproductive and impractical plan; in which even those responsible cannot explain, comprehend or envision.

The NYSDOH alleges that the "Starting Point" as a Question: **"How Should an Integrated Delivery System Function from the Consumer/Member's Perspective?"** Ironically No "Consumer/Member's" perspective is inserted collected, quoted or considered. Instead the "Roadmap" goes on to claim that "The fundamental vision of NYS DSRIP is the creation of integrated delivery systems capable of meeting the diverse needs of Medicaid members." and that "Different types of members require different types of care. As foreseen in DSRIP, a high performing care delivery system encompasses three types of integrated care services, with optimal coordination between them" (page 9).

While sentiment is appreciated, it is obvious that the "Consumer/Member's Perspective" is not the starting point of NYS VBP vision, but rather a pretentious facade. One would think that VBP should start with asking medicaid members/consumers what they envision directly, which NYS has failed to do even though NYSDOH has had more than enough time to directly engage consumers/members about DSRIP since 2014<sup>1</sup> and yet nothing has been done to educate consumers/members about DSRIP or VBP. The Roadmap goes on gaslighting and declares that it "aims to act as the primary source of care for the majority of everyday care needs." (page 9).

While this pitch of a utopian fair system, there has been no real work to see what access looks like for medicaid members including those who are disabled and whose lives are already being seriously impacted by such a careless impersonal automated landscape. Providers who serve this population cannot and will not be able to keep up with such a vague and disorganized objective, This is especially true for the many underfunded, misguided CBOs & Behavioral Health Providers who refuse to provide electronic health records, and direct access to members because they themselves are not familiar with the technology and process and who simply are unable to retain the impersonal webinars and youtube video that State entities provide as "guidance and oversight.

The public and stakeholders have yet to be provided with any meaningful juncture that allows for the review information about the VBP "pilot opportunities" including those obscure pilots aimed at specific I/DD arrangements. When will these "pilot opportunities" be known or even start?

All one has to do to see the Contradictory trajectory of VBP is compare the most recent VBP Roadmaps from 2018 to 2019. For example in 2018 the Roadmap alleged that, "Due to the need for integrated Medicare and Medicaid data (planned to be operational later this calendar year), the MLTC pilots will likely not start before 2017" and " Similarly, an I/DD pilot will not start until this care has been transitioned into managed care." ([Page 65](#), but considered on Page 62 within the document). Keep in mind this is not the 2019 Roadmap.

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<sup>1</sup> [https://www.health.ny.gov/health\\_care/medicaid/redesign/dsrp/overview.htm](https://www.health.ny.gov/health_care/medicaid/redesign/dsrp/overview.htm)

The claims in the 2019 VBP Roadmap claims that "The State has also convened an I/DD advisory group which will support the VBP framework for an I/DD arrangement. Outputs from the I/DD CAG will support pilot opportunities for I/DD specific arrangements and will align with the timeline for transitioning this care." (Page 72 of the 2019 PDF, but considered Page 67 within the document).

If the "pilot arrangements" will be "aligned with the timeline for transitioning this care", does this mean that experimental VBP arrangements for the I/DD Population will begin NOW and throughout the 5-year OPWDD-"Evolution"? As we know, the 'transition' TIMELINE is already in effect, (Phase 1), yet this no one knows and no answers to basic transition questions have been forthcoming from the state. The state must be more specific about these arrangements. It has been listed as "In development" for the past several "VBP Roadmap" proposals and continues to be listed as "IN DEVELOPMENT".

Development from a consumer's perspective is dangerous, stagnant and serpentine, since it is those lives that remain in the balance. No clear picture of what kind of VBP arrangements will be implemented or when, or if they are in effect ALREADY but just not revealed to the public. Furthermore no Clinical Advisory Group (CAG) for I/DD is listed (Page 7 of this PDF, Page 2 within the document)

Again (2018) "The DOH is working together with the Office for People with Developmental Disabilities (OPWDD) to develop an I/DD arrangement. The collaboration will design the technical elements of the arrangement and identify appropriate and feasible quality measures to support the arrangement. The transition of those with intellectual and/or developmental disabilities, to managed care and VBP will be included in the next update of the VBP Roadmap". (Page 19, but considered Page 16 within the document) Thus, we've been waiting for details... BUT "2019's VBP Roadmap" just says the SAME THING. When will the VBP arrangements for the I/DD Population be available?

### **HCBS Transition plans and failure to allow public comments:**

The 1115 waiver is turning into a never ending nightmare for the STC population  
HCBS Transition plans are being published, updated repeatedly without public comments being facilitated See:

[:https://www.health.ny.gov/health\\_care/medicaid/redesign/home\\_community\\_based\\_settings.htm](https://www.health.ny.gov/health_care/medicaid/redesign/home_community_based_settings.htm)

The State did not allow or facilitate any public comments for the current

[https://www.health.ny.gov/health\\_care/medicaid/redesign/hcbs/docs/2018-11-07\\_hcbs\\_final\\_rule.pdf](https://www.health.ny.gov/health_care/medicaid/redesign/hcbs/docs/2018-11-07_hcbs_final_rule.pdf)

Thank you

Amber Decker

### **Appendix**

- 1. New York State's Statewide Transition Plan for HCBS Settings Date Unknown**
- 2. New York State HCBS Settings Transition Plan Executive Summary date 11-7-2018**
- 3. DSRIP Dash Board Sample**



NO PUBLIC COMMENT ALLOWED

[https://www.health.ny.gov/health\\_care/medicaid/redesign/docs/state\\_trans\\_plan\\_cms.pdf](https://www.health.ny.gov/health_care/medicaid/redesign/docs/state_trans_plan_cms.pdf)

[https://www.health.ny.gov/health\\_care/medicaid/redesign/state\\_trans\\_plan\\_cms.htm](https://www.health.ny.gov/health_care/medicaid/redesign/state_trans_plan_cms.htm)

# New York State's Statewide Transition Plan for HCBS Settings

A five year plan to assure that all settings in which recipients of HCB services live and/or receive these services are fully compliant with 42 CFR 441.301(c)(4) and (5); 441.710(a)(1)(2)

**NO PUBLIC COMMENT ALLOWED**

[https://www.health.ny.gov/health\\_care/medicaid/redesign/docs/state\\_trans\\_plan\\_cms.pdf](https://www.health.ny.gov/health_care/medicaid/redesign/docs/state_trans_plan_cms.pdf)

[https://www.health.ny.gov/health\\_care/medicaid/redesign/state\\_trans\\_plan\\_cms.htm](https://www.health.ny.gov/health_care/medicaid/redesign/state_trans_plan_cms.htm)

**Overview**

On January 16, 2014, the Center for Medicare and Medicaid Services (CMS) published the final rule related to Home and Community Based Settings (HCBS) for Medicaid-funded long term services and supports provided in residential and non-residential settings under the following authorities of the Social Services Act: 1915(c), 1915(i) and 1915(k). This rule implements a number of changes to home and community based waivers, finalizes regulatory changes to the 1915(i) state plan home and community based services and imposes new requirements on what is considered an appropriate home/community based residential setting for all the authorities in its scope. The crux of this final rule is to provide person-centered requirements which identify the strengths, preferences and needs (clinical and support), as well as the desired outcomes of the individual. The inclusion of defined HCBS setting requirements is one part of this strategy.

The final rule took effect March 17, 2014. States are required to submit transition plans to CMS within one year of the effective date indicating how they intend to comply with the new requirements within a reasonable time period. If states amend or renew any waivers or state plan amendments in place prior to the effective date, that action serves as a trigger for the state to submit a transition plan for all its waivers under 1915(c), as well as any state plan amendments under 1915(i) or 1915(k), within 120 days of the initial amendment/renewal submission.

The following is New York State’s statewide transition plan pursuant to this requirement.

**Background**

New York State operates 12 1915(c) waivers across the four major offices that oversee programs and services to individuals who are aged and/or physically, behaviorally, mentally, developmentally or intellectually disabled. These agencies/offices are the Department of Health (DOH), Office of Mental Health (OMH), Office for People with Developmental Disabilities (OPWDD) and Office of Children and Family Services (OCFS). In addition, the Office for Alcohol and Substance Abuse Services (OASAS) provides services to some individuals in these waivers and participated in the development of the statewide transition plan. We do not currently offer services through our state plan under a 1915(i) or 1915(k) authority, although we have applied to CMS for approval of a 1915(k) Community First Choice Option state plan amendment.

The following 1915(c) waivers are currently operating in New York State, the agency/office in parentheses operates the program under the oversight of the Department of Health, the state’s single Medicaid Agency.

- Long Term Home Health Care Program Waiver (DOH)
- Nursing Home Transition and Diversion Waiver (DOH)
- Traumatic Brain Injury Waiver (DOH)



DOH

OMH

OASAS

OCFS

OPWDD

# New York State HCBS Settings Transition Plan Executive Summary

New York State presents its Statewide Transition Plan (STP) to achieve compliance with the Home and Community-Based Services (HCBS) Final Rule. New York State operates one 1115 and twelve 1915(c) waivers across five offices that oversee programs and services to individuals with disabilities; either physical, behavioral, mental, developmental, or intellectual.

The agencies/offices which oversee New York's home and community-based service (HCBS) provision are the: Department of Health (DOH); Office for People with Developmental Disabilities (OPWDD); Office of Mental Health (OMH); Office for Alcohol and Substance Abuse Services (OASAS); and Office of Children and Family Services (OCFS). The below listed 1915(c) waivers are those currently operating in New York State. The agency/office indicated to the right of each waiver operates the waiver under the oversight of the Department of Health, the State's Medicaid Agency.

- Nursing Home Transition and Diversion Waiver (DOH)
- Traumatic Brain Injury Waiver (DOH)
- Care at Home Waivers I, II, III, IV, and VI - (I and II: DOH; III, IV, and VI: OPWDD)
- Bridges to Health (B2H) Waivers - B2H Serious Emotional Disturbances, B2H Developmental Disabilities and B2H Medically Fragile (OCFS)
- Home and Community Based Services (HCBS) Waiver (OPWDD)
- Serious Emotional Disturbances (SED) Children's Waiver (OMH)

The aforementioned agencies/offices offer home and community-based Long Term Services and Supports (LTSS) through our Medicaid program, and DOH, OMH and OASAS provide HCBS under the NY Partnership Plan 1115 Demonstration Waiver. While State Plan LTSS are not impacted by this regulation, per notification by the Centers for Medicare and Medicaid Services (CMS), New York will address the application of the HCBS Final Rule to all HCBS provided through its 1115 Demonstration in this Statewide Transition Plan.

The State's initial assessment of our HCBS delivery system indicates that the vast majority of individuals in receipt of Medicaid-funded home and community-based services are living in their own homes or the homes of family members, friends, or neighbors. In addition, many Medicaid recipients may live in group homes or other settings where they enjoy the benefits of receiving services in the community, as opposed to in an institution. However, there are individuals who



# New York State Prevention Agenda Dashboard - State Level

**State Dashboard** | County Dashboard | About This Site | Prevention Agenda 2019-2024 <sup>a</sup>

[State Dashboard Home](#) | [Data Table](#) | [Health Data NY](#)

**Filter by State Status on:** <sup>i</sup>

**PA 2018 Objective:**  Met  Not Met <sup>i</sup>

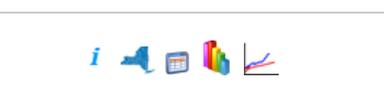
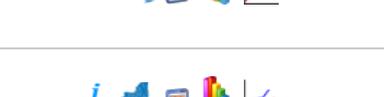
**Indicator Performance:**  Improved  No Change  Worsened <sup>i</sup>

## Improve Health Status and Reduce Health Disparities

Prevention Agenda (PA) Indicator	Data Views <sup>i</sup>	PA 2018 Objective and Most Recent Data <sup>i</sup>	Indicator Performance <sup>i</sup>
1 - Percentage of premature deaths (before age 65 years)	<sup>i</sup> <i>Socio-Economic Status</i>	NYS - 24.0 PA 2018 - 21.8	<span style="color: red;">●</span> SIGNIFICANTLY WORSENER
1.1 - Premature deaths: Ratio of Black non-Hispanics to White non-Hispanics	<sup>i</sup>	NYS - 1.93 PA 2018 - 1.87	<span style="color: yellow;">●</span> NO SIGNIFICANT CHANGE
1.2 - Premature deaths: Ratio of Hispanics to White non-Hispanics	<sup>i</sup>	NYS - 1.88 PA 2018 - 1.86	<span style="color: yellow;">●</span> NO SIGNIFICANT CHANGE
2 - Age-adjusted preventable hospitalization rate per 10,000 - Aged 18+ years <sup>b</sup>	<sup>i</sup> <i>Socio-Economic Status</i>	NYS - 119.5 PA 2018 - 122.0	<span style="color: green;">●</span> SIGNIFICANTLY IMPROVED
2.1 - Preventable hospitalizations: Ratio of Black non-Hispanics to White non-Hispanics	<sup>i</sup>	NYS - 2.17 PA 2018 - 1.85	<span style="color: yellow;">●</span> NO SIGNIFICANT CHANGE
2.2 - Preventable hospitalizations: Ratio of Hispanics to White non-Hispanics	<sup>i</sup>	NYS - 1.39 PA 2018 - 1.38	<span style="color: green;">●</span> SIGNIFICANTLY IMPROVED
3 - Percentage of adults (aged 18-64) with health insurance	<sup>i</sup> <i>Socio-Economic Status</i>	NYS - 91.4 PA 2018 - 100.0	<span style="color: green;">●</span> SIGNIFICANTLY IMPROVED
4 - Age-adjusted percentage of adults who have a regular health care provider - Aged 18+ years	<sup>i</sup> <i>Socio-Economic Status</i>	NYS - 82.6 PA 2018 - 90.8	<span style="color: yellow;">●</span> NO SIGNIFICANT CHANGE

## Promote a Healthy and Safe Environment

Prevention Agenda (PA) Indicator	Data Views <sup>i</sup>	PA 2018 Objective and Most Recent Data <sup>i</sup>	Indicator Performance <sup>i</sup>
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<p>5 - Rate of hospitalizations due to falls per 10,000 - Aged 65+ years</p>		<p>NYS - 183.6 PA 2018 - 204.6</p>	<p><b>● SIGNIFICANTLY IMPROVED</b></p>
<p>6 - Rate of emergency department visits due to falls per 10,000 - Aged 1-4 years</p>		<p>NYS - 440.1 PA 2018 - 429.1</p>	<p><b>● SIGNIFICANTLY IMPROVED</b></p>
<p>7 - Assault-related hospitalization rate per 10,000 population</p>		<p>NYS - 3.6 PA 2018 - 4.3</p>	<p><b>● SIGNIFICANTLY IMPROVED</b></p>
<p>7.1 - Assault-related hospitalization: Ratio of Black non-Hispanics to White non-Hispanics</p>		<p>NYS - 6.97 PA 2018 - 6.69</p>	<p><b>● NO SIGNIFICANT CHANGE</b></p>
<p>7.2 - Assault-related hospitalization: Ratio of Hispanics to White non-Hispanics</p>		<p>NYS - 3.21 PA 2018 - 2.75</p>	<p><b>● NO SIGNIFICANT CHANGE</b></p>
<p>7.3 - Assault-related hospitalization: Ratio of low-income ZIP codes to non-low-income ZIP codes</p>		<p>NYS - 3.34 PA 2018 - 2.92</p>	<p><b>● NO SIGNIFICANT CHANGE</b></p>
<p>8 - Rate of occupational injuries treated in ED per 10,000 adolescents - Aged 15-19 years</p>		<p>NYS - 20.6 PA 2018 - 33.0</p>	<p><b>● SIGNIFICANTLY IMPROVED</b></p>
<p>9 - Annual number of days with unhealthy levels of ozone (Air Quality Index &gt;100)</p>		<p>NYC - 10 PA 2018 - 0</p>	<p><b>● WORSENE#</b></p>
<p>10 - Annual number of days with unhealthy levels of ozone (Air Quality Index &gt;100)</p>		<p>NYS excl NYC - 21 PA 2018 - 0</p>	<p><b>● WORSENE#</b></p>
<p>11 - Annual number of days with unhealthy levels of particulate matter (Air Quality Index &gt;100)</p>		<p>NYC - 0 PA 2018 - 0</p>	<p><b>● NO CHANGE#</b></p>
<p>12 - Annual number of days with unhealthy levels of particulate matter (Air Quality Index &gt;100)</p>		<p>NYS excl NYC - 0 PA 2018 - 0</p>	<p><b>● NO CHANGE#</b></p>
<p>13 - Percentage of population that lives in a jurisdiction that adopted the Climate Smart Communities pledge</p>		<p>NYS - 35.6 PA 2018 - 32.0</p>	<p><b>● SIGNIFICANTLY IMPROVED</b></p>
<p>14 - Percentage of employed civilian workers age 16 and over who use alternate modes of transportation to work or work from home</p>		<p>NYS - 46.2 PA 2018 - 49.2</p>	<p><b>● SIGNIFICANTLY IMPROVED</b></p>
<p>15 - Percentage of population with low-income and low access to a supermarket or large grocery store</p>			<p><b>● SIGNIFICANTLY IMPROVED</b></p>

		<p>NYS - 2.25 PA 2018 - 2.24</p>	
16 - Percentage of homes in Healthy Neighborhoods Program that have fewer asthma triggers during the home revisits <sup>b</sup>		<p>NYS - 16.3 PA 2018 - 25.0</p>	● NO SIGNIFICANT CHANGE
17 - Percentage of residents served by community water systems with optimally fluoridated water		<p>NYS - 70.8 PA 2018 - 78.5</p>	● SIGNIFICANTLY WORSENE

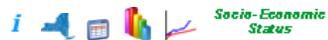
**Prevent Chronic Diseases**

Prevention Agenda (PA) Indicator	Data Views <i>i</i>	PA 2018 Objective and Most Recent Data <i>i</i>	Indicator Performance <i>i</i>
18 - Percentage of adults who are obese	Socio-Economic Status	<p>NYS - 25.5 PA 2018 - 23.2</p>	● NO SIGNIFICANT CHANGE
18.1 - Percentage of adults aged 18 years and older with an annual household income less than \$25,000 who are obese		<p>NYS - 30.5 PA 2018 - 25.4</p>	● NO SIGNIFICANT CHANGE
18.2 - Percentage of adults aged 18 years and older with disabilities who are obese		<p>NYS - 38.2 PA 2018 - 31.4</p>	● NO SIGNIFICANT CHANGE
19 - Percentage of children and adolescents who are obese		<p>NYC - 20.4 PA 2018 - 19.7</p>	● SIGNIFICANTLY IMPROVED
20 - Percentage of children and adolescents who are obese		<p>NYS excl NYC - 17.3 PA 2018 - 16.7</p>	● NO CHANGE#
21 - Percentage of children with an outpatient visit, during the measurement year, that includes an assessment for weight status - Aged 3-17 years (QARR Report)		<p>CMC - 71.5 PA 2018 - 75.0</p>	● IMPROVED#
22 - Percentage of children with an outpatient visit, during the measurement year, that includes an assessment for weight status - Aged 3-17 years (QARR Report)		<p>GSIP - 77.0 PA 2018 - 75.0</p>	● WORSENE
23 - Prevalence of any tobacco use by high school age students		<p>NYS - 25.4 PA 2018 - 15.0</p>	● NO SIGNIFICANT CHANGE
24 - Percentage of cigarette smoking among adults <sup>b</sup>	Socio-Economic Status	<p>NYS - 14.2 PA 2018 - 12.3</p>	● NO SIGNIFICANT CHANGE
24.1 - Percentage of cigarette smoking among adults with income less than \$25,000			● NO SIGNIFICANT CHANGE

			<p>NYS 19.8 PA 2018 20.0</p>	
25 - Utilization of smoking cessation benefits among smokers who are enrolled in Medicaid Managed Care			<p>MMC 24.6 PA 2018 41.0</p>	<b>● SIGNIFICANTLY IMPROVED</b>
26 - Percentage of adults who received a colorectal cancer screening based on the most recent guidelines - Aged 50-75 years <sup>b</sup>	<i>Socio-Economic Status</i>		<p>NYS 68.5 PA 2018 80.0</p>	<b>● NO SIGNIFICANT CHANGE</b>
26.1 - Percentage of adults aged 50-75 years with an income less than \$25,000 who received a colorectal cancer screening			<p>NYS 60.7 PA 2018 65.4</p>	<b>● NO SIGNIFICANT CHANGE</b>
27 - Asthma emergency department visit rate per 10,000 population	<i>Socio-Economic Status</i>		<p>NYS 86.2 PA 2018 75.1</p>	<b>● NO SIGNIFICANT CHANGE</b>
28 - Asthma emergency department visit rate per 10,000 - Aged 0-4 years	<i>Socio-Economic Status</i>		<p>NYS 205.7 PA 2018 196.5</p>	<b>● SIGNIFICANTLY IMPROVED</b>
29 - Percentage of health plan members with hypertension, who have controlled their blood pressure - Aged 18-85 years <sup>b</sup> (QARR Report)			<p>CMC 55.2 PA 2018 70.0</p>	<b>● IMPROVED#</b>
30 - Percentage of health plan members with hypertension, who have controlled their blood pressure - Aged 18-85 years <sup>b</sup> (QARR Report)			<p>MMC 61.8 PA 2018 70.0</p>	<b>● WORSENERD#</b>
30.1 - Percentage of Black health plan members with hypertension who have controlled their blood pressure - Aged 18-85 years <sup>b</sup>			<p>MMC 54.4 PA 2018 70.0</p>	<b>● WORSENERD#</b>
31 - Percentage of adult health plan members with diabetes, who have blood glucose in good control (QARR Report)			<p>CMC 59.7 PA 2018 60.5</p>	<b>● IMPROVED#</b>
32 - Percentage of adult health plan members with diabetes, who have blood glucose in good control (QARR Report)			<p>MMC 56.1 PA 2018 62.0</p>	<b>● WORSENERD#</b>
32.1 - Percentage of Black health plan members with diabetes, who have blood glucose in good control.			<p>MMC 52.6 PA 2018 58.3</p>	<b>● WORSENERD#</b>
33 - Age-adjusted heart attack hospitalization rate per 10,000 population	<i>Socio-Economic Status</i>		<p>NYS 14.0 PA 2018 14.0</p>	<b>● SIGNIFICANTLY IMPROVED</b>
34 - Rate of hospitalizations for short-term complications of diabetes per 10,000 - Aged 6-17 years	<i>Socio-Economic Status</i>			<b>● SIGNIFICANTLY IMPROVED</b>



35 - Rate of hospitalizations for short-term complications of diabetes per 10,000 - Aged 18+ years



● NO SIGNIFICANT CHANGE

**Prevent HIV/STDs, Vaccine Preventable Diseases and Healthcare-Associated Infections**

Prevention Agenda (PA) Indicator	Data Views <i>i</i>	PA 2018 Objective and Most Recent Data <i>i</i>	Indicator Performance <i>i</i>				
36 - Percentage of children with 4:3:1:3:3:1:4 immunization series - Aged 19-35 months	<i>i</i>	<table border="1"> <tr> <td>NYS</td> <td>72.3</td> </tr> <tr> <td>PA 2018</td> <td>80.0</td> </tr> </table>	NYS	72.3	PA 2018	80.0	● NO SIGNIFICANT CHANGE
NYS	72.3						
PA 2018	80.0						
37 - Percentage of adolescent females that received 3 or more doses of HPV vaccine - Aged 13-17 years	<i>i</i>	<table border="1"> <tr> <td>NYS</td> <td>50.5</td> </tr> <tr> <td>PA 2018</td> <td>50.0</td> </tr> </table>	NYS	50.5	PA 2018	50.0	● NO SIGNIFICANT CHANGE
NYS	50.5						
PA 2018	50.0						
38 - Percentage of adults with flu immunization - Aged 65+ years <sup>b</sup>	<i>i</i>	<table border="1"> <tr> <td>NYS</td> <td>59.5</td> </tr> <tr> <td>PA 2018</td> <td>70.0</td> </tr> </table>	NYS	59.5	PA 2018	70.0	● NO SIGNIFICANT CHANGE
NYS	59.5						
PA 2018	70.0						
39 - Newly diagnosed HIV case rate per 100,000 population <sup>c</sup>	<i>i</i> Socio-Economic Status	<table border="1"> <tr> <td>NYS</td> <td>14.6</td> </tr> <tr> <td>PA 2018</td> <td>16.1</td> </tr> </table>	NYS	14.6	PA 2018	16.1	● SIGNIFICANTLY IMPROVED
NYS	14.6						
PA 2018	16.1						
39.1 - Difference in rates (Black and White) of newly diagnosed HIV cases <sup>c</sup>	<i>i</i>	<table border="1"> <tr> <td>NYS</td> <td>32.7</td> </tr> <tr> <td>PA 2018</td> <td>46.8</td> </tr> </table>	NYS	32.7	PA 2018	46.8	● NO SIGNIFICANT CHANGE
NYS	32.7						
PA 2018	46.8						
39.2 - Difference in rates (Hispanic and White) of newly diagnosed HIV cases <sup>c</sup>	<i>i</i>	<table border="1"> <tr> <td>NYS</td> <td>20.9</td> </tr> <tr> <td>PA 2018</td> <td>26.6</td> </tr> </table>	NYS	20.9	PA 2018	26.6	● SIGNIFICANTLY IMPROVED
NYS	20.9						
PA 2018	26.6						
40 - Percentage of HIV-infected persons with a known diagnosis who are in care <sup>c</sup>	<i>i</i>	<table border="1"> <tr> <td>NYS</td> <td>80</td> </tr> <tr> <td>PA 2018</td> <td>90</td> </tr> </table>	NYS	80	PA 2018	90	● WORSENE#
NYS	80						
PA 2018	90						
41 - Gonorrhea case rate per 100,000 women - Aged 15-44 years	<i>i</i>	<table border="1"> <tr> <td>NYS</td> <td>206.2</td> </tr> <tr> <td>PA 2018</td> <td>183.4</td> </tr> </table>	NYS	206.2	PA 2018	183.4	● NO SIGNIFICANT CHANGE
NYS	206.2						
PA 2018	183.4						
42 - Gonorrhea case rate per 100,000 men - Aged 15-44 years	<i>i</i>	<table border="1"> <tr> <td>NYS</td> <td>452.5</td> </tr> <tr> <td>PA 2018</td> <td>199.5</td> </tr> </table>	NYS	452.5	PA 2018	199.5	● SIGNIFICANTLY WORSENE#
NYS	452.5						
PA 2018	199.5						
43 - Chlamydia case rate per 100,000 women - Aged 15-44 years	<i>i</i>	<table border="1"> <tr> <td>NYS</td> <td>1620.7</td> </tr> <tr> <td>PA 2018</td> <td>1458.0</td> </tr> </table>	NYS	1620.7	PA 2018	1458.0	● SIGNIFICANTLY WORSENE#
NYS	1620.7						
PA 2018	1458.0						
44 - Primary and secondary syphilis case rate per 100,000 men	<i>i</i>		● SIGNIFICANTLY WORSENE#				

			<p>NYS - 24.3 PA 2018 - 10.1</p>	
45 - Primary and secondary syphilis case rate per 100,000 women			<p>NYS - 1.3 PA 2018 - 0.4</p>	<b>● SIGNIFICANTLY WORSENE</b>
46 - Hospital-onset CDIs new cases per 10,000 patient days <a href="#">(Hospital Report)</a>			<p>NYS - 5.61 PA 2018 - 5.94</p>	<b>● SIGNIFICANTLY IMPROVED</b>
47 - Community-onset healthcare facility-associated CDIs new cases per 10,000 patient days			<p>NYS - 1.43 PA 2018 - 2.05</p>	<b>● SIGNIFICANTLY IMPROVED</b>

**Promote Healthy Women, Infants, and Children**

Prevention Agenda (PA) Indicator	Data Views <i>i</i>	PA 2018 Objective and Most Recent Data <i>i</i>	Indicator Performance <i>i</i>
48 - Percentage of preterm births	<i>Socio-Economic Status</i>	<p>NYS - 10.3 PA 2018 - 10.2</p>	<b>● SIGNIFICANTLY IMPROVED</b>
48.1 - Premature births: Ratio of Black non-Hispanics to White non-Hispanics		<p>NYS - 1.69 PA 2018 - 1.42</p>	<b>● NO SIGNIFICANT CHANGE</b>
48.2 - Premature births: Ratio of Hispanics to White non-Hispanics		<p>NYS - 1.33 PA 2018 - 1.12</p>	<b>● NO SIGNIFICANT CHANGE</b>
48.3 - Premature births: Ratio of Medicaid births to non-Medicaid births		<p>NYS - 1.08 PA 2018 - 1.00</p>	<b>● NO SIGNIFICANT CHANGE</b>
49 - Percentage of infants exclusively breastfed in the hospital	<i>Socio-Economic Status</i>	<p>NYS - 46.3 PA 2018 - 48.1</p>	<b>● SIGNIFICANTLY IMPROVED</b>
49.1 - Exclusively breastfed: Ratio of Black non-Hispanics to White non-Hispanics		<p>NYS - 0.61 PA 2018 - 0.57</p>	<b>● SIGNIFICANTLY IMPROVED</b>
49.2 - Exclusively breastfed: Ratio of Hispanics to White non-Hispanics		<p>NYS - 0.59 PA 2018 - 0.64</p>	<b>● SIGNIFICANTLY IMPROVED</b>
49.3 - Exclusively breastfed: Ratio of Medicaid births to non-Medicaid births		<p>NYS - 0.58 PA 2018 - 0.66</p>	<b>● NO SIGNIFICANT CHANGE</b>
50 - Maternal mortality rate per 100,000 live births			<b>● IMPROVED#</b>

			<p>NYS - 20.4 PA 2018 - 21.0</p>	
50.1 - Maternal mortality: Ratio of Black non-Hispanics to White non-Hispanics			<p>NYS - 4.68 PA 2018 - 4.76</p>	<b>IMPROVED#</b>
51 - Percentage of children who have had the recommended number of well child visits in government sponsored insurance programs			<p>GSIP - 74.0 PA 2018 - 76.9</p>	<b>SIGNIFICANTLY IMPROVED</b>
51.1 - Percentage of children aged 0-15 months who have had the recommended number of well child visits in government sponsored insurance programs (QARR Report)			<p>GSIP - 80.1 PA 2018 - 91.3</p>	<b>NO SIGNIFICANT CHANGE</b>
51.2 - Percentage of children aged 3-6 years who have had the recommended number of well child visits in government sponsored insurance programs (QARR Report)			<p>GSIP - 84.3 PA 2018 - 91.3</p>	<b>SIGNIFICANTLY IMPROVED</b>
51.3 - Percentage of children aged 12-21 years who have had the recommended number of well child visits in government sponsored insurance programs (QARR Report)			<p>GSIP - 68.1 PA 2018 - 67.1</p>	<b>SIGNIFICANTLY IMPROVED</b>
52 - Percentage of children (aged under 19 years) with health insurance			<p>NYS - 97.4 PA 2018 - 100.0</p>	<b>NO SIGNIFICANT CHANGE</b>
53 - Percentage of third-grade children with evidence of untreated tooth decay			<p>NYS excl NYC - 24.0 PA 2018 - 21.6</p>	<b>BASELINE DATA</b>
53.1 - Tooth decay: Ratio of low-income children to non-low-income children			<p>NYS excl NYC - 2.46 PA 2018 - 2.21</p>	<b>BASELINE DATA</b>
54 - Adolescent pregnancy rate per 1,000 females - Aged 15-17 years			<p>NYS - 13.3 PA 2018 - 25.6</p>	<b>SIGNIFICANTLY IMPROVED</b>
54.1 - Adolescent pregnancy: Ratio of Black non-Hispanics to White non-Hispanics			<p>NYS - 4.67 PA 2018 - 4.90</p>	<b>NO SIGNIFICANT CHANGE</b>
54.2 - Adolescent pregnancy: Ratio of Hispanics to White non-Hispanics			<p>NYS - 4.29 PA 2018 - 4.10</p>	<b>NO SIGNIFICANT CHANGE</b>
55 - Percentage of unintended pregnancy among live births	<i>Socio-Economic Status</i>		<p>NYS - 22.6 PA 2018 - 23.8</p>	<b>SIGNIFICANTLY IMPROVED</b>
55.1 - Unintended pregnancy: Ratio of Black non-Hispanic to White non-Hispanic				<b>NO SIGNIFICANT CHANGE</b>

			<p>NYS - 2.12 PA 2018 - 1.90</p>	
55.2 - Unintended pregnancy: Ratio of Hispanics to White non-Hispanics			<p>NYS - 1.68 PA 2018 - 1.43</p>	● NO SIGNIFICANT CHANGE
55.3 - Unintended pregnancy: Ratio of Medicaid births to non-Medicaid births			<p>NYS - 1.71 PA 2018 - 1.54</p>	● SIGNIFICANTLY IMPROVED
56 - Percentage of women (aged 18-64) with health insurance	Socio-Economic Status		<p>NYS - 93.1 PA 2018 - 100.0</p>	● SIGNIFICANTLY IMPROVED
57 - Percentage of live births that occur within 24 months of a previous pregnancy	Socio-Economic Status		<p>NYS - 19.8 PA 2018 - 17.0</p>	● SIGNIFICANTLY WORSENE

### + Promote Mental Health and Prevent Substance Abuse

#### Notes

<sup>a</sup>: The Prevention Agenda 2013-2017 has been extended to 2018 to align and coordinate timelines with other state and federal health care reform initiatives.

<sup>b</sup>: A new target has been set for 2018. [Click for more information.](#)

<sup>c</sup>: Indicator baseline data, trend data, and 2018 objective were revised and updated. [Click for more information.](#)

See [technical notes](#) for information about the indicators and data sources.

Questions or comments: [prevention@health.ny.gov](mailto:prevention@health.ny.gov)

Revised: September 2018

**From:** [REDACTED]  
**To:** [doh.sm.1115Waivers](mailto:doh.sm.1115Waivers)  
**Cc:** [REDACTED]  
**Subject:** 1115 Public Forum Comment  
**Date:** Friday, July 12, 2019 4:28:23 PM  
**Attachments:** [EmblemHlthCmtstoMRT7\\_12\\_19.pdf](#)

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Please see the attached comments from EmblemHealth. Thank you very much for this opportunity to provide input.

Howard Weiss  
EmblemHealth, Government Affairs & Policy  
[REDACTED]

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EmblemHealth®

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55 Water Street, New York, New York 10041-8190

July 12, 2019

Submitted via email at [1115waivers@health.ny.gov](mailto:1115waivers@health.ny.gov).

**Re: 1115 Public Forum Comment**

On behalf of EmblemHealth, we appreciate this opportunity to provide comments as New York State develops its Medicaid Redesign Team Section 1115 Waiver renewal. The issues raised by this process are of direct importance to the more than 125,000 Medicaid beneficiaries we serve, who have come to rely upon our innovative approach to providing health care services.

The state Medicaid program is now operating under a waiver from the federal Centers for Medicare & Medicaid Services (CMS) approved in December 2016 and set to expire in March 2021. That waiver incorporates concepts included in the state's 2014 waiver establishing the Delivery System Reform Incentive Program (DSRIP) to increase the use of value-based payment (VBP) arrangements in the Medicaid program. EmblemHealth is uniquely positioned to provide input.

- We have an unparalleled enterprise 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 located in low-income and ethnically diverse areas throughout New York City staffed by customer care navigators who work with local residents to help them through the health care and social service systems. Neighborhood Care navigators contribute to care management programs which are key elements of our value-based strategy. Their close working relationships with other local community organizations connect these individuals with employment and financial resources to address the full range of social factors affecting their health.
- We also recently began a partnership with Cityblock, a new Alphabet-backed firm focused on care delivery for high-needs patients, including Medicare-Medicaid dual eligible beneficiaries. On July 1, 2018, Cityblock and EmblemHealth launched local teams in Brooklyn, including behavioral health specialists, data analysts, community health partners, and primary care clinicians who work with high-needs individuals where they live to provide the care they need. Our partnership with Cityblock is crucial to bringing the lessons we have learned from value-based programs to our area's most vulnerable individuals.

These partnerships represent our enterprise's commitment to value-based care. Emblem Health's core mission is to create healthier futures for our customers and communities. Our value-based ethos is fundamental to accomplishing this goal. We incorporate value-based concepts into every contract we negotiate with physicians and hospitals and ACPNY requires individual providers to apply the population health mindset to all our patients across Medicaid, Medicare, and employer-based coverage sources including those who are not EmblemHealth members. As a health plan and a provider, we design value-based programs that understand what physicians need to make them work.

The state is rightly proud of its trailblazing role in promoting value-based care. We are in lockstep with the state in its perspective on the importance of focusing on the development of plan-provider arrangements that stress mutual accountability to improve the health and welfare of Medicaid beneficiaries. Below we provide recommendations to renew and expand upon our shared goals and help the state move forward with its VBP agenda.

## **RECOMMENDATIONS**

### **1. Continue Holding Medicaid Health Plans Accountable under the VBP Roadmap**

The state has established performance targets for Medicaid health plans which include rewards and penalties for VBP adoption. The state should continue encouraging plans to negotiate these arrangements under the Roadmap's terms with two recommended modifications.

- Medicaid Health Plan Rewards: The state's Medicaid health plan performance targets are based upon achieving goals towards VBP adoption included in the 2014 waiver and tied to the availability of additional federal funding. It is not yet clear whether the Trump Administration will continue approving additional federal investments to support DSRIP. If not, the state may need to consider alternatives to maintain the momentum towards VBP.

The state could consider creative options delinking the adoption of VBP from federal funds while continuing to create incentives for plans and providers. For example, the state recently proposed revisions to the Roadmap strongly supported by EmblemHealth that count plan investments in social determinants as a medical expense in the Medicaid medical loss ratio (MLR) formula and related caps on administrative expenses. There are other actions that could be taken that would not likely increase state or federal costs. For example, Medicaid health plans with the highest percentage of VBP arrangements could receive bonus points towards their QARR scores or additional considerations for autoenrollment. Doing so would create meaningful rewards for Medicaid health plans to continue adopting VBP.

- Physician and Hospital Incentives: Some of our provider partners continue to work off a fee-for-service framework that makes team-based care more challenging. The state should consider payment incentives for physicians and hospitals that participate in risk-

sharing VBP arrangements. Those exceeding preestablished thresholds would receive higher state payments for Medicaid beneficiaries in non-managed programs.

## **2. Create Opportunities for Health Plan Innovations That Are Accomplishing the State's Goals**

The DSRIP waiver depends upon state investments in health care systems, which to date have primarily been organized by hospitals that generally do not have the ability to establish VBP arrangements with providers. However, health plans like ours have developed partnerships with physician groups (in our case, ACPNY) and health homes (Cityblock) which follow a different roadmap yet are achieving results, especially for low-income individuals with high health care needs. These programs focus on treating the whole person, including identifying the social causes of diseases. For example, our Neighborhood Care centers and relationship with Cityblock allow us to visit with our enrollees in their communities to best determine their course of care. While neither of these organizations meet the Roadmap's definition of a Tier 1 Community-Based Organization (CBO), we have found them effective in addressing social determinants.

The state should consider permitting alternative structures in limited demonstration projects to measure results against control groups of programs following the Roadmap. We recommend the state formalize these alternatives by establishing a framework for VBP Partnerships of health plans, physicians, health homes that build upon the successes of PPSs in reducing hospitalizations and incorporate other elements that may not be permitted by the Roadmap. The state would approve these Partnerships and evaluate results to determine if and how additional successes could be more broadly disseminated. Areas where flexibility from the Roadmap's requirements would be welcome include:

- Additional opportunities to create "off-menu" arrangements. The Roadmap allows plans to develop Total Cost for the General Population (TCGP) arrangements that do not directly follow its requirements. However, plan use of off-menu flexibility is limited because of requirements that providers continue to be held at risk for specific benefits and services such as prescription drugs where they have little control of the spending. The state should allow VBP partnerships to test whether other off-menu options improve quality by focusing on benefits and services physicians and hospitals are most able to affect.
- Allow selection of a non-Tier 1 CBO to get credit for Tier 2+ VBP Arrangements. EmblemHealth strongly agrees that considering social determinants of health is crucial to addressing the needs of Medicaid beneficiaries. That is why we established our Neighborhood Care centers, which help our low-income enrollees make connections to community support services. VBP Partnerships should be granted new flexibility to work with non-Tier 1 CBOs or other entities with demonstrated effectiveness in addressing the social causes of disease and evaluated against Roadmap compliant arrangements on specific metrics measuring achievement on addressing social determinants.

- Measure performance on fewer, more focused quality metrics. Medicaid health plans are currently evaluated on as many as 30 different quality measures. The large number of measures is a barrier to more adoption of value-based care and 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 spend too much time 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 (e.g., no more than ten) 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 most 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
<ul style="list-style-type: none"><li>• Preventable Admissions</li><li>• Potentially Preventable ER Visits</li><li>• Reduced Readmissions</li><li>• Increased Delivery of Post-Acute Care</li></ul>	<ul style="list-style-type: none"><li>• Access to Healthy Foods</li><li>• Resolved Housing Issues Affecting Health</li><li>• Increased Access to Medical Services for Low-Income Enrollees</li></ul>	<ul style="list-style-type: none"><li>• Increased Use of Preventive Services</li><li>• Improved Outcomes for Chronic Diseases (e.g., Lower A1C among Diabetics; Lower Cholesterol Levels for Individuals with Heart Disease)</li></ul>

### 3. Expanding VBP to Unmanaged Populations

The state currently works through health system-based Performing-Provider Systems (PPSs) to accomplish its VBP goals. There are questions about how to continue encouraging PPSs to participate in these arrangements after the DSRIP waiver ends.

The state could consider focusing these groups on the unmanaged Medicaid FFS population to establish VBP arrangements specific to the unique needs of these individuals. For example, the state currently permits Medicaid managed long-term care plans that develop arrangements with as little as 1% downside risk to be considered Tier 2 VBP arrangements. These initiatives could be carried over to increase Medicaid FFS payment for health systems including hospitals and IPAs that require downside risk and address social determinants.

These programs could be supported by Medicaid health plans on a voluntary basis that would receive additional QARR points. Physicians and hospitals would continue to be reimbursed on a FFS basis directly by the state for services outside the VBP framework. Health plans agreeing to participate would share in savings generated through the better management and increased accountability that result from VBP.

## **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.

**From:** [REDACTED]  
**To:** [doh.sm.1115Waivers](mailto:doh.sm.1115Waivers)  
**Cc:** [REDACTED]  
**Subject:** 1115 Public Forum Comment  
**Date:** Friday, July 12, 2019 5:08:34 PM  
**Attachments:** [image001.png](#)  
[PCDC DSRIP DY4 O3 comments.pdf](#)

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**ATTENTION: This email came from an external source. Do not open attachments or click on links from unknown senders or unexpected emails.**

Good afternoon-

Attached, please find public forum comments from the Primary Care Development Corporation on the 1115 waiver.

Best-

Sasha

**Sasha G. Albohm**  
Director of Federal Affairs



Primary Care Development Corporation  
45 Broadway, Suite 530  
New York, NY 10006

[REDACTED]  
Twitter: [@primarycaredev](https://twitter.com/primarycaredev)  
[REDACTED]

*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](http://pcdc.org).*



July 12, 2019

**New York's Medicaid Redesign Team 1115 Waiver Programs Public Forum  
Comment by the Primary Care Development Corporation**

Thank you for the opportunity to comment on New York's 1115 Waiver programs and issues related to primary care included in the DSRIP Demonstration Year 4 Quarter 3 (DY4 Q3) report to the Project Approval and Oversight Panel (PAOP).

**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 Delivery System Reform Incentive Payment (DSRIP) program Performing Provider Systems (PPS) in all corners of the State. Nationally, we have improved primary care access for more than 1 million patients 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 10,000 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 over 475 primary care practices — encompassing some 2,250 providers — to achieve PCMH recognition, impacting care for more than 5 million patients nationwide.

PCDC appreciates the chance to comment on DSRIP implementation to date as well as future iterations in New York State. However, we are concerned that many of the same issues we raised in previous comments regarding primary care funds flow, access, measurement, and overall reporting persist at this late point in the demonstration. We reiterate the continued relevance of these comments and stress the importance of greater emphasis on primary care through upfront funds availability and adherence to a measurable primary care plan going forward.

Recent studies show that the need for emphasis on primary care could not be greater. A February report in the [JAMA Internal Medicine](#) showed a correlation between a lack of primary care providers and increased mortality. Greater primary care physician supply was associated with improved mortality, but per capita primary care physician supply has decreased. However, the report concluded that adding a total of 10 additional primary care physicians per 100,000 people was associated with reduced cardiovascular, cancer, and respiratory mortality by 0.9% to 1.4%.

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 2-4% of Medicare spending is on primary care. This number is neither specific nor definitive because Medicare neither defines primary care nor requires reporting on its allocation. [Other estimates](#) put the primary care spend at 5-8% of total health care spending. In [PCDC's own research](#), we have 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.

We welcome the news that funds flow has increased from PPS to providers, but we are still concerned about the minute percentage of these funds that has gone to primary care and other community-based providers. In December we looked at the [second quarter DY4 PPS update](#), and while 45% of total cumulative funds flow dollars (\$941,954,826) went to hospital systems and PPS project management offices, less than 4% of total funds on average have flowed to non-hospital primary care (\$138,266,049), mental health (\$69,559,233), and substance use treatment (\$26,452,915) providers. These figures show that the primary care system — which is already under-resourced — lacks sufficient financial support from the current PPS Funds Flow mechanism. The same report was unavailable for Q3.

However, the [DY4 Q3 presentation](#) at the PAOP (p. 35-36) includes data which seemingly indicates little correlation between funds flow to ambulatory and community providers and outcomes. But when the amount of dollars going to these providers is only 4% of the overall demonstration dollars, it is hard to show any relationship between monies distributed and results. We cannot assume that a subset of the funding as small as 4% will be able to substantially change the system unless we more adequately resource these providers. As the State moves toward a new agreement with CMS for DSRIP 2.0, we urge a serious consideration of how funds did not follow the larger primary care goals of the DSRIP program and should instead be distributed directly to providers. New York State can and should be a leader in measuring and increasing primary care spending in DSRIP and other health initiatives.

We are also troubled that so many of the PPS are struggling to hit even their self-selected project goals. With the breadth of projects available and autonomy afforded to the PPS, we worry that in DY4 only 12-54% of to-date metrics have been met. By including so many projects, we have diluted the ability of the PPS to meet their goals. In future DSRIP iterations, we believe the State should focus on a select group of core measures that would allow for across-the-board tracking and reporting and allow meaningful change to occur within the demonstration.

Further, it seems that most PPS were unable to spend the resources or time necessary to see improved primary care access through the demonstration. Only four of the 25 PPS met their improvement targets in any of the three subsets of “Adult Access to Ambulatory or Preventive Care” categories. That only four PPS met their targets — and 17 regressed on “Pediatric Access to Primary Care - Age 7-11” — is even more troubling. This is a population with near-universal access to coverage through Medicaid, Child Health Plus, and private insurance. Future waivers should build on this knowledge and require increased access to primary care as a core measure.

The PPS and State have spent significant resources and time collecting information throughout DSRIP. But there has been a lack of consistency both in reporting across PPS and of aggregated results, making tracking progress within the system difficult and often confusing. Because the data is not readily available in a sortable or calculatable way for the public, it does not allow for meaningful stakeholder engagement and analysis. It is simply difficult to make independent conclusions and provide feedback when the information that is available is a percent change over time rather than raw data. This was true when the primary care plans were created and subsequently updated over two years ago, and it remains true when results are publicly reported each quarter.

As we negotiate DSRIP 2.0, we cannot expect to see better results unless we emphasize primary care in a way that is not purely rhetorical but allows for providers to receive funds directly and with consistency, standardized reporting on a reduced set of measures, and an increased dedication to the importance of primary care as the foundation of our health care system. At PCDC we look forward to working collaboratively with the State to make this a possibility in this and future waiver requests.

**Contact:**

**Sasha Albohm, Director of Federal Affairs**

**Patrick Kwan, Senior Director of Advocacy and Communications**

**From:** [REDACTED]  
**To:** [doh.sm.1115Waivers](mailto:doh.sm.1115Waivers)  
**Subject:** 1115 Public Forum Comment  
**Date:** Friday, July 12, 2019 5:09:34 PM  
**Attachments:** [report\\_newspaper\\_final.pdf](#)  
[Frescatore, Donna \(071219\).pdf](#)  
**Importance:** High

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Dear Ms. Frescatore,

Attached you will find a letter from SOMOS and a supporting document.

Please feel free to reach out to me if you should have any questions regarding this matter.

Sincerely yours,

**Mario J. Paredes**  
Chief Executive Officer

[REDACTED]  
w: [somoscommunitycare.org](http://somoscommunitycare.org)

**SOMOS** | COMMUNITY CARE  
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519 Eighth Avenue, 14th Floor  
New York, NY 10018  
[somoscommunitycare.org](http://somoscommunitycare.org)

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July 12, 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:

Our participation in DSRIP provided us with the opportunity to develop successful approaches to highly complex and multi-faceted healthcare system challenges. Over the past four years, SOMOS has brought excellent health outcomes to our patients and essential supports to our community-based providers to allow for continuous improvement.

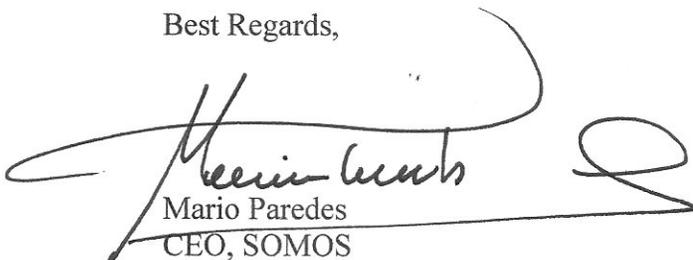
As DSRIP comes to an end, we now have unique understanding of how to address the manifold system and patient challenges. SOMOS has become a major driving force in New York's vision to move to a VBP health care delivery system. By leveraging its cultural and linguistic competency and integrated information technology infrastructure, SOMOS has been able to improve the quality of care, increase efficiency, and create cost savings as demonstrated by the reduction of avoidable hospital use.

According to the most recent full-year of programmatic data from the NYS DOH DSRIP Digital Library, through Measurement Year 3, SOMOS has successfully:

- Reduced preventable hospital readmissions by 36%
- Reduced preventable ED visits by 34%
- Reduced preventable ED visits for persons with behavioral health diagnosis by 47% among our patient pool

In the next iteration of the Medicaid Redesign Team, we encourage the State to include SOMOS in the important conversations ahead. Additionally, we believe that an extension of DSRIP is necessary to continuing the State's mission to improve health care delivery and reduce the number of emergency room visits and readmissions.

Best Regards,



Mario Paredes  
CEO, SOMOS

Report link: <http://online.fliphtml5.com/bflr/nvdd/>

# ARCHITECTURE OF INTERVENTION



### SOMOS Is Unique

SOMOS is different and our uniqueness helps us achieve transformational outcomes. Since its formation, SOMOS has stood out as different and we embrace this characterization, because how we stand out from the rest has made us distinctly capable of responding to the call for health-care reform. SOMOS Community Care PPS (SOMOS) is the only community-based, physician-led network participating in New York's DSRIP program.

### Organizational Structure

SOMOS is a network of independent physicians. These physicians are entrepreneurs, running small businesses that have come together to lead, innovate and transform healthcare in New York; at the same time significantly contributing to the neighborhood economy and tax base.

Starting out as a loosely connected group of legacy IPAs and ACOs, through DSRIP, these entities now operate as an "institution" under an organized corporate structure that is delivering results.

SOMOS is fundamentally committed to integration in the provision of health care. This means that we are providing leadership to the system by thinking differently and taking the initiative to innovate and address the complex health and social issues our patients face.

### Our Physicians

An overwhelming majority of our physicians are immigrants that have first-hand experience with the barriers immigrant patients face in obtaining quality health care. In many cases, SOMOS doctors work and live in the same neighborhoods as their patients, often sharing their linguistic and ethnic background. SOMOS has thus been able to match patients with doctors and other service providers who are living in their neighborhood; who speak their language, and who are part of their culture.

**SOMOS IS THE ONLY PHYSICIAN-LED NETWORK PARTICIPATING IN NEW YORK'S DSRIP PROGRAM**

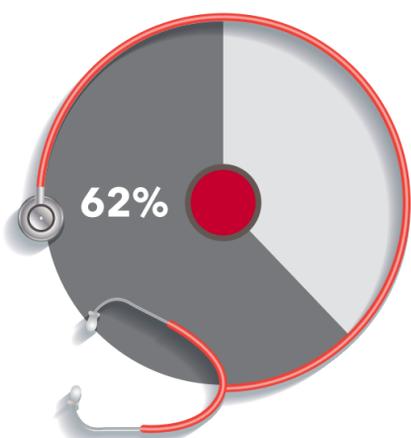
SOMOS brings to the table some of the most innovative and culturally and linguistically diverse providers in our health system. To maximize health outcomes for our pa-

tients, SOMOS is committed to serving the range of cultural and language needs. Over 20 languages other than English are spoken in our community practices.

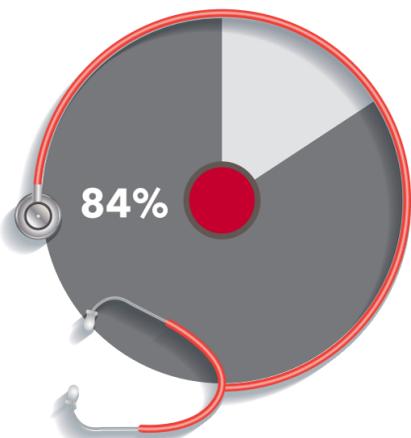
- 41% of our practices serve patients that speak Mandarin and Cantonese.
- 46% of the practices serve Spanish-speaking patients.

- The remaining 13% serve Bengali, Creole, French, Hindi, Russian and Urdu speaking patients.
- Through our network of

primary care physicians, we provide comprehensiveness, accountability, coordination and continuity of care, and community orientation.



**62%**  
OF LATINOS THINK COST IS A BARRIER TO ACCESS FOR THEMSELVES



**84%**  
OF PROVIDERS THINK COST IS A BARRIER TO ACCESS FOR LATINOS

# EXCEEDING THE DSRIP MANDATE TO REDUCE HOSPITAL USE

## SOMOS Delivers Patient-Centered, Socially-Responsible, Community-Based Care

Patient-centeredness is fundamental to our model of care. In our network of practices, we employ a highly patient-centered process for modifying patient behavior and raising health literacy. This approach holds the key to both preventive care and timely intervention, so that chronic conditions can be treated early, controlled or cured altogether. Our origins have been, and our future organizational efforts will be fundamentally centered on achieving optimal health for the most vulnerable patients. Our commitment to leading, innovating and transforming community-based care endures post-DSRIP. SOMOS is guided by social responsibility. SOMOS physicians are on the front lines of many health crises such as Hurricane Maria relief in Puerto Rico, provision of medical care to immigrants detained at the border, and addressing the ZIKA threat.

## SOMOS Is Successful

From the most recent full-year of programmatic data pulled from the NYS DSRIP Digital Library, SOMOS through measurement year 3 of DSRIP is exceeding all programmatic mandates to reduce avoidable hospital use. SOMOS has successfully reduced preventable hospital readmissions by 36% and preventable medical emergency room

visits by 34% and has reduced preventable behavioral health emergency visits by 47% among our patients from its baseline.

## Comprehensive Care And Patient Engagement

Based on the findings of its community needs assessment in the DSRIP application, SOMOS develop tailored programs that address healthcare challenges with measurable metrics. Over the course of DSRIP DY4 (April 1, 2018 – March 31, 2019) alone, based on data SOMOS submitted to the NYSDOH, SOMOS staff facilitated over 1.6 million patient engagements in the following selected clinical improvement projects:

- Behavioral Health (628,000 annual patient engagements);
- Cardiovascular Health (346,000 annual patient engagements);
- Health Home at-risk interventions (190,000 annual patient engagements);
- Diabetes care (290,000 annual patient engagements);
- Care Transitions (50,000 annual patient engagements);
- Asthma (105,000 annual patient engagements);

## The Most Expansive Chronic Illness Self-Management Program In NYS DSRIP

Through the Stanford Model Chronic Illness Self-Management program, SOMOS has engaged and educated patients who

**SOMOS has been able to implement various engagement strategies that have resulted in high levels of participation in DSRIP programs.**

struggle with diabetes, asthma, and cardiovascular diseases in self-management activities. The Self-Management Resource Center (SMRC) has completed 25 multi-phase workshops across 15 sites.

## SOMOS Investment In Practice Transformation And Physician Engagement

Since its inception, SOMOS has supported and invested in its primary care medical practices. SOMOS has been able to implement various engagement strategies that have resulted in high levels of participation in DSRIP programs and initiatives amongst the SOMOS network Primary Care Physicians.

SOMOS's Physician Engagement Specialists (PES), a dedicated team of over 20 SOMOS employees, have successfully engaged and continue to support more than 600 physician practices.

PES's are the representation of SOMOS at the practice level. They assure the providers are and remain engaged in our DSRIP

projects and follow guidelines that have been put in place to provide quality care. PES also ensure that each SOMOS provider has a direct contact/advocate to the broader SOMOS team and provides alignment with the larger community. This includes aggregating all care gap reports from the MCO, State, and EMR and bring it together in a single file for a provider. PES will work with the practice to investigate a single point as the source of truth to close gaps in care.

PES train the practices (including health-care providers and practice staff) and answer questions on SOMOS initiatives to achieve DSRIP goals in performance measures. This includes understanding and working more efficiently with their EMR (Electronic Medical Records) system.

Monthly, PES track the practice scorecards and the providers/staff workflows to prevent errors that could potentially affect the final common goal. Action plans are implemented when an issue is encoun-

tered and the PES follow-up with the practice team to ensure corrections are made and prevent future errors.

## PCMH Level III Certification

Obtaining Patient Centered Medical Home (PCMH) certification is a basic DSRIP requirement for all PCPs. PCMH certification is in fact the major tool for achieving practice transformation and readiness to participate in VBP. PCMH is a way of organizing primary care that emphasizes Team Based Care, care coordination and communication among various providers to provide optimal, timely care for patients with the most complicated and complex cases. In effect, PCMH transforms primary care by making "whole-person care" and "patient-centeredness" core principles

By March 31, 2018, over 895 SOMOS primary care providers have achieved National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home level 3 certification with the aim of improving the quality, effectiveness, and efficiency of primary care to better meet the needs of patients.



# SOMOS HAS CONNECTED NEARLY 2,000 OF ITS PROVIDERS AND CLOSE TO 600 PRACTICES TO THE BRONX RHIO



## **Health Information Technology**

A big part of DSRIP's record of success is its state-of-the-art digital architecture that allows for secure exchange of patient records; between SOMOS and practices and between SOMOS and the NYS Department of Health (DOH), which thus can measure long-term health outcomes and award patients to PPSs accordingly.

## **EMR Connectivity**

Through SOMOS's support, over 600 network practices are now integrated with an electronic medical record platform benefiting 400,000 patients.

## **RHIO Connectivity**

SOMOS has connected nearly 1,800 of its providers and over 600 practices to the Bronx RHIO. The Bronx RHIO harnesses the power of information technology to

transform the delivery of healthcare in the Bronx. Its secure, interoperable health information exchange enables providers across to access critical patient information from multiple sources as soon as it is available and deliver the ultimate benefit to their patients and the community - better, safer and more efficient healthcare. The Bronx RHIO is a critical tool in ensuring that independent SOMOS practices are able to share real-time data between providers. Furthermore, the Bronx RHIO participates in the Statewide Health Information Network for New York (the SHIN-NY) allowing SOMOS providers to access healthcare information for patients seen by RHIO-engaged providers across the entire state.

## **SOMOS Data Warehouse**

SOMOS has invested significant resources to develop data-driven insights, which are critical for identifying at-risk patient pop-

ulations through building a robust health information technology infrastructure. At the center of these investments is the development of the Claims Data Warehouse (CDW). The CDW is a longitudinal data base that will aggregate information across payers and will allow SOMOS to integrate this information with HER platform information. These analytical platforms support the development of value-based payment foundations and implementation of new data-intensive care models.

## **System Security**

Data security has always been at the forefront of the design and implementation of all SOMOS data platforms. SOMOS is NIST 800-53 Compliant and has completed all NYSDOH data security workbooks and had their data security systems verified by a third-party auditor.

**SOMOS has recruited, trained and deployed a cohort of 93 Community Health Workers (CHWs) who are culturally competent and multilingual.**

# SOMOS HAS BECOME A MAJOR DRIVING FORCE IN NEW YORK'S VISION TO MOVE TO A VBP HEALTH CARE DELIVERY SYSTEM

## **An Extensive Community Health Worker Program**

SOMOS has created the largest and most extensive Community Health Worker Program amongst the state DSRIP Performing Provider Systems given its philosophy of putting resources on the ground to close health care gaps. SOMOS aims to have these resources or providers be reflective of the communities served, especially in its community outreach and engagement initiatives.

SOMOS has recruited, trained and deployed 95 Community Health Workers (CHWs) who are culturally competent and multilingual. CHWs are trusted members of the community working with patients, medical providers, primary care teams, and community-based organizations to improve patient care and outcomes.

Not only do they work closely with network doctors to ensure that patients stick to medical protocols, but CHWs also visit patient homes as necessary, to assess living conditions, making sure medical regimens and appointments are kept, etc. Our CHWs also train doctors' practice staff in managing the digital record-keeping of Electronic Health Records (EHRs).

## **Effective Alignment Of Community-Based Resources**

To facilitate the integration of community-based organizations into the work of the PPS, SOMOS established the Community Based Organization Partnership Program (CBOPP). Through this program, we have entered into formalized partnerships with

key organizations and groups that are embedded in its targeted areas of service and thus have a deep understanding of the local population and its needs. The organizations and their staff are reflective of the ethnic and cultural backgrounds of SOMOS' patients.

There are over 80 CBOs in the partnership and 15 of these entities meet the NYSDOH definition of a Tier 1 CBO.

## **VISION FOR THE FUTURE**

### **SOMOS Is A VBP Innovator**

SOMOS has become a major driving force in New York's vision to move to a VBP health care delivery system. By leveraging its cultural and linguistic competency and integrated information technology infrastructure, SOMOS has been able to improve the quality of care, increase efficiency, and create cost savings as demonstrated by the Potentially Preventable ER Visits and Readmissions metrics.

Having accounted for half of the state's VBP Pilot program contracts, SOMOS has blazed the VBP trail to reduced medical spending while increasing the quality of care its patients receive in more efficient practice settings.

Additionally, SOMOS was designated a VBP Innovator in August 2018.

### **SOMOS Will Be A Community Builder**

Our participation in DSRIP provided us with the opportunity to develop successful approaches to highly complex and multi-faceted healthcare system challenges. We were able to strategically invest resources in creating

an organizational infrastructure through which essential technical assistance and capacity building supports were made available to our providers and network partners.

Over the past four years, SOMOS has brought excellent health outcomes to our patients and essential supports to our community-based providers to allow for continuous improvement.

As DSRIP ends, we now have greater understanding of how to address the manifold system and patient challenges along with a re-articulated vision of how we can make a transformative impact. SOMOS will build-up home grown organizations and use our local resources and relationships to meet community needs.

### **SOMOS Will Be A Nationally Recognized Leader At The Forefront Of Healthcare Transformation**

As SOMOS prepares for the final year of DSRIP, we believe our distinct history, development and core competencies put us in an unrivalled position to not only respond to the healthcare crisis in New York, but to also serve as a national leader for health system transformation.

With our innovative approaches to health care delivery combined with our ability to thrive in a VBP environment, SOMOS will be the organization that entrepreneurs, investors and other innovators will look to for innovative ideas. In doing so, SOMOS will attract private capital, which will grow our community and the local economy, while at the same time improve the health of the population we serve.

**The Self-Management Resource Center (SMRC) program is an evidence-based educational program that promotes chronic disease self-management.**

**SOMOS**

**SOMOSNYHEALTH.ORG**

**From:** [REDACTED]  
**To:** [doh.sm.1115Waivers](mailto:doh.sm.1115Waivers)  
**Subject:** 1115 Public Forum Comment  
**Date:** Friday, July 12, 2019 5:23:15 PM  
**Attachments:** [image001.png](#)  
[image002.png](#)  
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July 12, 2019

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

Re: 1115 Public Forum Comment

To Whom It May Concern,

The Adirondack Health Institute (AHI) as the lead PPS for a 9-county region in upstate New York urges the State to consider innovative new models that leverage the foundational infrastructure established through DSRIP to advance the State's goals of improving access and achieving better outcomes. The State is urged to include in future 1115 waiver submissions any flexibility needed to ensure continuation of DSRIP led payment and delivery reforms necessary to ensure optimal outcomes delivered in the most efficient and effective manner possible. Regional DSRIP partners have expressed an interest in continuation of transformational efforts. It is essential that a future 1115 waiver supports ongoing initiatives and leverages lessons learned and community engagement and participation that has been secured through AHI's role as the regional PPS.

In the North Country region (the AHI PPS region) multiple providers from disparate specialty areas (acute, primary, behavioral and community based social support organizations) have coalesced to create the North Country Innovation Pilot – an effort to engage providers, payers and residents under a single coordinated system to improve care and outcomes for all residents of the region. The North Country Innovation Pilot (NCIP), a unique provider-led care delivery model will leverage learnings, relationships and tools developed by AHI to create a regional model of care delivery and payment that seeks to ensure high quality, efficiently delivered health care and social supports for all residents of a 6-county region in the Adirondack North Country of New York State. Model participants include the Adirondack Health Institute (AHI) the region's DSRIP Performing Provider System; Northwinds' IPA (the regions BHCC); an MSSP (the Adirondacks ACO); three major acute care providers and the region's largest FQHC. Together these entities, under the rubric of NCIP are working to create

a model that is able to serve as a model for other rural regions throughout the State and Nation by testing a system of health that incorporates the full spectrum of care from acute and post-acute to primary, behavioral and long-term care, as well as services provided by community-based providers such as transportation, housing, care management, and peer outreach. More specifically NCIP is expected to achieve the following key 1115 goals:

- Increase and strengthen overall coverage of low-income individuals in the region
- Increase access to, stabilize, and strengthen providers and provider networks available to serve Medicaid and low-income populations in the region;
- Improve health outcomes for Medicaid and other low-income populations in the region; and
- Increase the efficiency and quality of care for Medicaid and other low-income populations through initiatives to transform service delivery networks.

Through a total cost of care (TCOC) payment model inclusive of global payments for hospitals, together with an aligned set of outcome-based quality metrics, the pilot aims to improve health outcomes, facilitate care integration and promote investments in primary care, public health, behavioral health and social determinants. As many as 300,000 residents of a six county area would ultimately be eligible to participate. The pilot would be developed throughout 2019 with a phased implementation in 2020. Rigorous measurement and evaluation will ensure timely reporting of results, support pilot refinements as needed and allow for replicability.

- Key concepts that will be explored through this model include:
- An all-payer total cost of care, risk-based payment model for a defined geography;
- A global budget predicated on annual pre-determined growth rates;
- Care supports and services to most efficiently meet the needs of individuals in a largely rural region;
- Value-based payment models that offer flexibility and risk-based incentives for providers without unduly burdening small and rural practices and facilities;
- Incremental adoption of risk and/or shared savings over;
- Creation of metrics and incentives that ensure predictable and stable provider funding and account for unique payment models such as Critical Access Hospital payments;
- Development of mechanisms to promote delivery of appropriate routine care within the region;
- Reduced expenses through alignment, centralized management and administrative simplification; and
- Inclusion of community-based providers inclusive of transportation, housing, education, criminal justice and municipal health services in service delivery planning and payment modeling.

Through an 1115 waiver AHI is prepared to work with NYS Medicaid to explore the following, specific to a largely rural region of New York State:

- Improve access to high-quality, person-centered services that produce positive health outcomes for individuals;
- Promote efficiencies that ensure Medicaid’s sustainability for beneficiaries over the long term;
- Support coordinated strategies to address certain health determinants that promote upward mobility, greater independence, and improved quality of life among individuals;
- Strengthen beneficiary engagement in their personal healthcare plan, including incentive structures that promote responsible decision-making;
- Enhance alignment between Medicaid policies and commercial health insurance products to facilitate smoother beneficiary transition; and
- Advance innovative delivery system and payment models to strengthen provider network capacity and drive greater value for Medicaid.

Thank you for your consideration of these comments.

Sincerely,

Eric Burton  
Chief Executive Officer  
101 Ridge Street, Glens Falls, NY 12801



*Building a healthy future* [www.ahihealth.org](http://www.ahihealth.org)



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**To:** [doh.sm.1115Waivers](mailto:doh.sm.1115Waivers)  
**Cc:** [REDACTED]  
**Subject:** Technical corrections - OneCity Health Public comments\_ 07122019.docx  
**Date:** Friday, July 12, 2019 11:13:59 PM  
**Attachments:** [OneCity Health Public comments\\_ 07122019.docx](#)

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Dear colleagues,

Please find attached technical corrections to the OneCity Health PPS public comments provided in Albany on June 24, 2019.

Regards,

Molly

Molly Chidester  
OneCity Health  
[REDACTED]

Visit [www.nychealthandhospitals.org](http://www.nychealthandhospitals.org)

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## **OneCity Health Public comments**

Hello, good afternoon and thank you for the opportunity to speak today. You get two for one here. I'll stay within our five minutes. This is Ben Goldsteen, Chief Analytics Officer from OneCity Health PPS. We'll stay within our five minutes but we wanted to speak with you jointly.

Hi Molly Chidester, Chief Strategy Officer with OneCity Health.

As a partner in establishing the first DSRIP program in New York, OneCity Health commends the State for their pursuit of mechanisms to extend the benefits of the original 1115 waiver.

We fully support these efforts and pledge to serve as your continued partners in this endeavor. As you refine elements of the extension, we are eager to share learnings from the first DSRIP program.

As the PPS for the largest public health care system, NYC Health +Hospitals, and a network of over 200 community partners, including SUNY Downstate, we believe NYSDOH should continue to invest in the health of New Yorkers by reforming the current care delivery system with an aim to increase quality and efficiency, redesign care around the whole person, and reduce health care costs.

Having just completed the community health needs assessment for New York City Health and Hospitals, we know that there is a lot of work that needs to continue to be done and can be achieved through a collective impact approach.

While many alternative payment models have historically relied exclusively on coordination within the walls of a clinic or hospital. We applaud the State for working to change that standard by establishing a new framework that integrates traditional care providers and community partners in an effort to better address a patient's need and for rethinking systems of care around the community and patient.

We are encouraged that as outlined in the VBP roadmap, the State is proposing MCOs and providers engaged in VBP arrangements work with a third party partner to identify and secure investments to address social and socio-economic risks.

In addition to new interventions that address social risk factors, we know that providing clinical care to patients begins at the frontlines and the patient's bedside. To support the integration of clinical services, non-traditional health care services and finances, partnerships should be structured across traditional health care providers, PPSs, CBOs and managed care plans.

Since the inception of the DSRIP program, we have seen a decline in avoidable hospital utilization, improvements in access to care for children and adults, and better outcomes for patients living with chronic conditions and behavioral health needs.

Significant investments have been made in the workforce, leading to higher-quality, more patient-centered care and staff with necessary skills to build the health care system of the future.

Further, providers and community-based organizations are working together in ways that are unprecedented, enabling us to address our community's holistic health needs. To ensure partnerships between CBOs, providers and MCOs are successful under value-based arrangements, we recommend additional time and investment in capacity building for CBOs.

Further, we believe more time is required to build out the underlying infrastructure that supports new models of care, including an infrastructure for the seamless and timely flow of data between partners. Progress to date has been achieved while reducing overall Medicaid spend and transitioning from a system that rewards volume to one that incentivizes high-value services.

To ensure that these beneficial gains transform into lasting change, more time is required to maximize the transition from the current DSRIP program. Without the continuation of DSRIP funding beyond 2020, these advancements in patient care are at risk of not being sustained.

Further we believe that time is required to build out the underlying infrastructure that will support new models of care including the infrastructure for the timely flow of data between partners. What we want to emphasize is that the infrastructure is not just technology but it is the people it is the processes it is the relationships and the shared goals. And these took a lot of time to build up over the past few years. And so any disruption any break in continuity would be I think very challenging to rebuild if there was any sort of break in the program. It wouldn't be starting from scratch but we would definitely lose a lot of time getting to where we are now and where we invested to get to.

And we have achieved a lot of progress to date while Medicaid spending has been reduced overall and we've been transitioning to a system that rewards volume to one that incentivizes high value services to ensure that these beneficial gains transform into lasting change. We emphasize the need for more time to maximize and solidify the transition from the current DSRIP program to this future VPB state that we've been working towards. Without the continuation of the DSRIP funding beyond 2020 and the other programs support that goes with it, these advancements in patient care are at risk of not being sustained.