

## doh.sm.1115Waivers

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**From:** A Deck [REDACTED]  
**Sent:** Monday, August 14, 2017 10:07 AM  
**To:** doh.sm.1115Waivers  
**Subject:** "1115 Public Forum Comment"  
**Attachments:** The Upstate Public Comment Day will be held on August 14.pdf

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see attachment

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Amber Decker  
Email [REDACTED]

The **Upstate Public Comment Day** will be held on **August 14, 2017** in Albany at the SUNY Albany School of Public Health (1 University Pl, Rensselaer), from *1:00pm – 4:00pm*.

**For the MRT 1115 Wavier Public Comment 08/14/17**

**If Health Homes are Key Tool for PPSs to Leverage to Achieve DSRIP Goals Then Health Homes has to work. And if** Health Homes work with Plans and multi-disciplinary team of providers to provide comprehensive, integrated (physical and behavioral health, and community and social supports) person-centered **care planning and management** to eligible Medicaid members with Serious Mental Illness (SMI), HIV, or multiple chronic conditions. Then accountability is essential in order to make Health homes work

The health home model does not work now for two basic reasons:

1. There is no standardized training for all care managers.
2. There is no CAP on caseloads and “acuity based” is not clear enough to protect care managers and consumers. There are care managers that have over 80 cases! How can care coordination really ever happen?

#### **OTHER MAJOR AREAS OF CONCERN**

3. While the state has spent thousands of dollars to MTAC and CTAC none of their webinars or trainings are required. Many of the Care managers do not even know that these webinars exist!
4. There is no communication to the consumer from the Managed Care Organization in terms of what is being billed with respect to care management
5. There are no grievance policies and or procedures provided to consumers who are not being provided services via the Health Home Model.
6. The health homes themselves provide little oversight and or guidance to independent agencies that are providing care management.
7. The RPCs are not inviting consumers and or families to discuss care management and or access. There are little to no consumers at steering groups, because they do not know about the regional Planning Consortiums. Health home Care managers also do not know Regional Planning Consortiums the website does not have meeting min.
8. Little to zero consumer education materials exist, further no grievance policy or explanation for consumers.

Thank You.

Amber Decker

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**From:** James Blum [REDACTED]  
**Sent:** Monday, August 14, 2017 10:20 AM  
**To:** doh.sm.1115Waivers  
**Cc:** Zina Huxley-Reicher; Ray Cornbill; Palermo, Ann-Gel; Miguel Bustos  
**Subject:** 1115 Public Forum Comment - East Harlem Community Health Committee  
**Attachments:** PAOP Comment EHCHC 8.14.17.pdf

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Hi,

Please find attached a public forum comment on the 1115 Waiver Program from the East Harlem Community Health Committee. Please let us know if you have any questions.

Thanks,

James

**East Harlem  
Community Health  
Committee, Inc.**

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c/o Settlement Health  
212 East 106<sup>th</sup> Street  
New York, NY 10029  
(212) 360-2661  
[ehchcinc@gmail.com](mailto:ehchcinc@gmail.com)

**Committees:**

General Membership  
Health Policy & Legislation  
Older Adults  
Referral Advisory Group  
Substance Abuse & Mental Health

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*Communications Director*

Guedy Amiella  
Eric Canales  
Jose Caraballo  
Ray Cornbill  
Erika Donovan Estades  
Sandra Talavera

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**Upstate 1115 Waiver Public Comment Day**

Founded in 1976, the East Harlem Community Health Committee's mission (EHCHC) is to improve the health status of East Harlem. The EHCHC is deeply concerned by several aspects of how the Delivery System Reform Incentive Payment (DSRIP) Program is being implemented. There are documented problems with DSRIP across New York State<sup>1</sup>, and the EHCHC is particularly concerned with the Performing Provider Systems (PPSs) located in our neighborhood – the Mount Sinai PPS (MSPPS) and the One City Health PPS (OCHPPS).

Given that one of the missions of DSRIP is to promote community-level collaborations and system reform<sup>2</sup>, it is hard to understand why funding distributions statewide skew heavily toward PPS project management offices (PMO) and away from communities. For example, as of the third quarter of DSRIP Year 2, the MSPPS PMO received 66.4 percent of funds distributed by the PPS across its network and the OCHPPS PMO received 67.7 percent of distributed funds while community-based organizations only received .98 percent and .89 percent, respectively<sup>3</sup>. If DSRIP has any hope of meeting its goal of reducing unnecessary hospitalizations by 25 percent over five years, patients must receive preventative and curative care in the community, not at the PMO.

This data shows that PPSs are taking advantage of DSRIP to ask more of their community partners (CBOs, community based primary care providers, etc.) without providing fair support or reimbursement. While community partners are expected to increase caseloads, design new programs, and hire new staff, they are given little funding to accomplish these goals. For example, one individual associated with a community organization in East Harlem said that the support received “doesn't cover our true costs and the overtime.” Just as hospitals demand fair pay for their work, CBOs should also receive fair compensation for their efforts.

It is especially troubling that community organizations appear to have received so little support as DSRIP recently transitioned from paying for reporting to paying for performance. The goals of DSRIP require that hospitals and communities work together in partnership. Unfortunately, the planning phase of DSRIP appears to have only widened

the gap in resources and trust between hospitals and communities. Given these trends, it is unlikely that DSRIP will be able to accomplish its original goals, which require coordination. Individuals associated with four large, well-established organizations in East Harlem all expressed doubt that DSRIP would end up positively impacting East Harlem. Rather than setting DSRIP up for success, the planning phase has laid the groundwork for failure.

The EHCHC fears that DSRIP will end up being nothing more than an \$8 billion giveaway to hospitals and health systems while community organizations, and the communities they serve, are left in the dark. While continuing reports from New York's State Department of Health might suggest all is going well with DSRIP, those on the ground in East Harlem know this is not true. They also know that the only way for DSRIP to succeed is for funding, resources, and true partnership to be offered to communities. Moving forward, the EHCHC hopes that stronger efforts are made to ensure that positive results of DSRIP will be actually seen in the communities it purportedly helps rather than partnership just on paper.

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<sup>1</sup> Implementing New York's DSRIP Program. Implications for Medicaid Payment and Delivery System Reform. Deborah Bachrach, William Bernstein, Jared Augenstein, Mindy Lipson, and Reni Ellis. The Commonwealth Fund. April 2016.

<sup>2</sup> New York State Delivery System Reform Incentive Payment Program Project Toolkit. New York State Department of Health. October 2014.

<sup>3</sup> New York City Department of Health, Health and Hospitals PPS, LLC, Mount Sinai PPS, LLC, DSRIP Year 2, Third Quarter Reports

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**From:** Andria Berger [REDACTED]  
**Sent:** Monday, August 14, 2017 3:08 PM  
**To:** doh.sm.1115Waivers  
**Subject:** 1115 Public Forum Comment  
**Attachments:** 20170814145142353.pdf

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Thank you for the opportunity to comment. My comment pertains solely to the OPWDD state operated IRA homes, in upstate New York. My comment is no reflection of the OPWDD *certified* IRA homes or any other OPWDD program.

There is a significant lack of oversight and implementation of the promised compliance measures related to the Center for Medicaid Services 2014 final rule in the OPWDD state **operated**, IRA homes. The waiver regulations and guidelines are not implemented and instead, service participant's lives are riddled with pre-historic perceptions, reminiscent of Willowbrook only in nicer neighborhoods. Despite newer, shinier, initiatives, progress has remained stunted for years and there is no correction on the horizon.

Waiver benefits such as, employment training /opportunities, quality social experiences, utilizing community supports, person-centered/driven choices, quality outcomes- not any of which is in effect. Advocacy is missing, the distribution of benefit information is missing and the restructuring of institutional routines is unabashedly neglected. All of which is clouded, in state operated secrecy via the extreme inability to enforce regulations at the state level.

The OPWDD agency is only working tirelessly to convey revised verbiage of its transparency efforts, re-invented initiatives, transformation plan and promises of compliance. The messages of promised progress is in full recognition that over 70% of IRA residents living under the auspices of upstate, NY, OPWDD's IRA homes, cannot use traditional methods to express themselves, have no active family member involvement and are without advocacy services.

Assistive technology is rarely offered, the agency has not provided opportunities for exterior supports and based on the numerous pending and previously dismissed, retaliation based lawsuits, the agency has left no room for the Direct Support Professional (DSP) to provide advocacy efforts.

The sad fact is that retaliation complaints documented by an OPWDD, state employed, DSP "advocate" position have not been initiated **for any other reason except after speaking up about the OPWDD agency leadership and/or the state operations, unlawful effects on the individuals receiving services.** The message enforces DSP diminished advocacy efforts and secures the OPWDD upper managements convenience.

The DSP's are never informed what waiver benefits entail. Instead, DSP's are constantly shuffled to unfamiliar IRA homes devoid of person-centered training or awareness, without location specific, fire safety training and incredulously without, person-specific medication training or knowledge. The OPWDD agency is barely concerned with minimum staffing levels. DSP are not working in light of the service participant's rights to independence and choices in every aspect of their daily lives. The DSP remain under the disheartening impression that they work for OPWDD chain of command rather than working on behalf of service participants.

Hence, consumers are not provided opportunities for overnight vacations, trips to Albany, NY Disability Awareness Day and are crudely denied Americans with Disabilities Act annual celebratory events. Due to the lack of OPWDD management accountability, service participants are denied the right to individual empowerment and disability rights knowledge.

Waiver services are chosen based on the convenience of the OPWDD agency's upper management. The state is accepting billions of federal and state dollars and the OPWDD, state operated, IRA home residents are still living under state, structured routines with no ability to recognize the waivers purpose or the correlating opportunities that are constantly denied to OPWDD-IRA home residents.

Tossing a ball alone in the backyard, bringing a plate to the kitchen sink after a meal and going to the corner Stewart's store for a snack- is not what the acceptance of federally funded, waivers have

promised. Yet this is what remains year after sad year in state operated IRA homes. Service participants want choices and opportunities to live and grow. The folks receiving services are expected to have the same opportunities as all else. That is what the state promised to provide for. The private sector is keen and more inclined to compliance, based on the accountability factor that is sorely missing in the state agency.

The severity of the massive, variety of conflicting interests, interferes with true OPWDD oversight. The NYS Dept. of Health and OPWDD engage in constant NYS lateral, employment transfers that come equipped with higher salaries. The NYS Justice Center is not of the ability to hold OPWDD Management Confidential (M/C) accountable due to the AG's office legal protections and its collective ability to abuse the state's immunity status. For every compliance avenue that the OPWDD claims to have in place, i.e. Ombudsman, Advisory Board, Committee/s, Board of Visitors, Quality Assurances, Coordinated Assessment System, the Justice Center...I am ready to prove the map is funding the alleviation of accountability, and why there remains no avenue for correction in support of my peers, fellow NYS residents, friends and family member that live with disabilities under the auspices of OPWDD IRA homes.

The OPWDD Management Confidential (M/C) are state employment positions that include, Treatment Team Leaders (TTL) and the by the titles definition, are responsible to adhere to:

**“Provide administrative leadership and oversight to Core Team staff to ensure that all staff understands the Agency mission, philosophy and goals, plus their own role in the organization. Ensure appropriate utilization of allocated staff resources to maximize each consumer's valued outcomes and maintain a safe, sanitary environment while controlling personal service costs. Ensure appropriate training for all staff. Ensure appropriate and timely follow-up on problem issues identified by auditors and/or other individuals. Participate fully and constructively as a member of the DDSO and local administrative teams in planning, coordinating and developing a sound residential and habilitative program.”**

The fact is that OPWDD TTL's earn upwards of \$100 thousand dollars a year and with that, have been allowed to proceed in layers of cushioned, self-serving, conveniences that are secured in NYS public officers law 17. The unjustly, afforded privilege is an automatic legal protection courtesy of the NYS Attorney General's office. Further the oxymoron of OPWDD promising “transparency” yet the agency has not waived claim to the more valid branches of governments, sovereign immunity privileges. Sovereign immunity has no place in an agency that is charged with serving, person-chosen, person-driven choices to folks who live with varying disabilities.

Direct Support Staff (DSP) are not provided with even basic knowledge of waiver benefits. Additionally, DSP's annual Medicaid service training is completed online, simultaneously during caregiving hours and without any further knowledge provided nor an opportunity for Q&A.

The state does not require an RFP or a bid or another new “initiative” to offer Independent Living Center services (ILC). Advocates from ILC's located all around NYS would be happy to speak at state operated IRA homes regarding the ILC philosophy, available services and the Olmstead decision. Why must the state attach funding to a service that is already freely and happily offered?

ILC's want invitations to state operated IRA homes to provided outreach and service information and ILC's want state operated, IRA homes to plan trips for folks to local ILC's in an honest, integrity driven effort to finally, allow for equal opportunities, as promised.



Some of the known complaints coming from OPWDD operated-IRA homes since 2014 to current date:

A consumer forced to move out of her years long, OPWDD operated, IRA home because there was no wheelchair accessibility in that home. (OPWDD should not be organizing any homes that are not fully, ADA compliant)

A consumer that has been asking the OPWDD Treatment Team (who is supposed to be serving him) for an educational opportunity for three years, to no avail. Currently OPWDD has now even denied him computer access in his IRA home, consequently restricting him from online educational course.

A consumer whose parent was scared to ask the OPWDD TTL when her daughter would be going on an outing, due to the fear that OPWDD would make her daughter leave the IRA home. (The young girl was without an outing for months).

A consumer who died due to a TTL's negligent, work directives for the DSP's to follow. (DSP had no person-centered training to learn about the individuals, choking risk or dietary needs.)

A mother to a young, female consumer requested only female staff assist her daughter during intimate, hygiene time. OPWDD TTL asserted no provisions to honor the mothers request.

A consumer who wants to go on vacation to NYC and year after year is denied the opportunity. The arrangement for him to go on a NYC vacation must be arranged through OPWDD TTL services.

Additionally, I was invited by a gentleman that lives in an OPWDD IRA home, to visit with him. The OPWDD TTL denied me the right to visit him at his house and strongly recommended that I visit him at the OPWDD workshop instead. The reason the TTL provided- there isn't enough staff on duty during the day time nor is there any "private space" in the evening time.

Furthermore, when the Dept. of Health was contacted by an OPWDD/ DSP employee regarding Medicaid abuse within the OPWDD, the DOH "Medicaid fraud" recommended the DSP contact OPWDD "chain of command". Who does the Dept. of Health think dictates the work directives at OPWDD?

Lastly, the Governor has now approved to a labor relations, contracted agreement (CSEA Union) 2017-2022 that will allow for an additional increase of the regular, overtime pay rate, when a DSP works more than 16 consecutive hours. This decision, clearly supports negligent caregiving.

Where or who is the all waiver money going?

Who can protect the folks who are depending on us?

Who can and will provide the OPWDD service participants with equal opportunities and rights?

Thank you,

Andria Berger  
Disability Rights Advocate



A handwritten signature in black ink, appearing to be 'Andria Berger', written in a cursive style.

## doh.sm.1115Waivers

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**From:** James Edmondson [REDACTED]  
**Sent:** Friday, August 18, 2017 1:08 PM  
**To:** doh.sm.1115Waivers  
**Cc:** doh.sm.DOHWEB; [REDACTED]  
**Subject:** A Plea To Go Slowly

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

Dear OPWDD,

Regarding the OPWDD's 1115 Waiver, I wish to encourage the OPWDD to proceed slowly and carefully. OPWDD's member population is fragile and highly diverse. This is the kind of population that is least well-suited to a one-size-fits-all payment models such as capitated managed care Health Homes. To do justice to OPWDD members within a Health Home in a capitated payment environment, the HH would have to be unmanageably immense. Alternatively, the HH would have to be subsumed under an existing HH, with the very real risk of losing its identity and independence.

Existing medical HHs were built on the long-time model of health maintenance organizations such as HIP and Kaiser. Over many decades, those organizations worked out countless issues to achieve a smooth operational model for the delivery of medical care by physicians. As you know, there is no such historical basis for a capitated payment model HH for long-term services and supports (LTSS). Indeed, 94% of OPWDD provider contracts were fee-for-service on the OPWDD's recent survey.

Moreover, the electronic medical record (EMR) IT investment for the acute care sector of over \$40 billion in federal money (via the HITECH Act and Meaningful Use phases) specifically excluded the LTSS sector. Therefore, the EMR vendors (Epic, McKesson, et al) have not invested in developing LTSS EMR products, as there is no market for them. Of course, LTSS providers could not afford EMRs in the absence of federal and state grants. Cares Act funding is not yet adequate to bring LTSS agencies up to speed. CMS has an eLTSS project in the works, but it is stuck at the starting line and many years away from full implementation. New York State's MMIS/eMedNY upgrade is also going nowhere and is many years from completion.

It is plainly evident from these examples that it is unrealistic to assume that comprehensive IT for OPWDD providers will appear for many years and likely many decades. I find it therefore perplexing and disturbing that the OPWDD appears to assume that comprehensive IT for OPWDD providers will be fully deployed by next year, because that is when the State's projected timeline for managed care demands it. Common sense rather demands that you demonstrate the satisfactory utility of a novel technology *before* you require that everyone buy it and use it.

I have a bigger concern than IT, however. The largest problem facing thousands of OPWDD members is the State's failure to create adequate small community housing placements. The State's focus on managed care and IT is a distraction from the much more important problem of housing. Yet I see no mention of guaranteeing better housing availability in the 1115 Waiver application. It is as if OPWDD does not consider the housing shortage to be a problem worthy of addressing in its various payment innovations, such as the 1115 Waiver.

Community housing is a major issue for OPWDD members that has no parallel in acute care HH practices. This is a huge reason why OPWDD must remain administratively and budgetarily independent from existing HHs. Lumping OPWDD members with vast numbers of non-OPWDD Medicaid recipients in huge capitated HH

systems without any explicit requirement for HHs to address the housing shortage is frankly an alarming prospect. A requirement to invest in more community housing placements absolutely belongs in the 1115 Waiver. There must be extensive OPWDD member protections explicitly stated in the 1115 Waiver applications that guarantee an adequate and meaningful investment by HHs in adequate small community housing placement options. To omit housing from the OPWDD 1115 Waiver application is to pretend that OPWDD members do not have developmental disabilities! The 1115 Waiver application as written appears to presage the eventual elimination of OPWDD altogether.

Commissioner Delany prefaced her recent webinar with a reference to the emergence of OPWDD from the Willowbrook deinstitutionalization movement, suggesting that OPWDD will continue its enlightened “person centered” policies by being ever vigilant of the horrors of Willowbrook. I fear that such lofty rhetoric was an empty promise to OPWDD’s 130,000 members. The details of the 1115 Waiver provide no protections against a return to congregate care in large institutions, as long as those institutions accept a capitated payment contract. OPWDD members have no constitutional right to community placement. It is up to the State of New York to insure the rights of OPWDD members. An extensive Bill of Rights must be found front-and-center in the 1115 Waiver. The 1115 Waiver proposes to be the founding constitutional document for the future governance of OPWDD, so it must be complete. The 1115 Waiver is indeed about capitated managed care payment models and incentives for efficient care delivery, but it must also protect the civil rights of OPWDD members against the obvious incentive to cut services inherent in a capitated payment model.

For the reason listed above, it is my impression that OPWDD is proceeding too hastily and even recklessly towards an ill-considered managed care fiasco. I urge the OPWDD to go over its 1115 Waiver proposal carefully and slowly, playing out all worst-case scenarios, in order to add meaningful protections for the civil rights of OPWDD members. As OPWDD taught me: “Nothing about us without us.”

Yours,  
James Edmondson, M.D., Ph.D.  
Forest Hills, NY

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**From:** alexander sajdkak [REDACTED]  
**Sent:** Monday, August 14, 2017 1:54 PM  
**To:** doh.sm.1115Waivers  
**Subject:** BH funding in SNFs

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Hi  
Many SNFs have large BH populations.  
Can there be more funding to prevent Hospitalizations for these patients?  
And  
Can there be more training funds to SNFs with this population to prevent Hospitalizations?  
Lastly  
Can SNFs get regulatory relief to care for these patients?  
Thx  
Alex Sajdak

Sent from my iPhone

## doh.sm.1115Waivers

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**From:** Lauren Pollow [REDACTED]  
**Sent:** Thursday, August 24, 2017 9:10 AM  
**To:** to1115waivers@health.ny.gov; doh.sm.1115Waivers  
**Cc:** Deanna Stephenson  
**Subject:** 1115 Public Forum Comment  
**Attachments:** 1115 Waiver Auth Response- NYSHFA.PDF

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Good morning, please see NYSHFA/NYSCAL's 1115 Waiver Authority comments (attached).

Thank you,

**LAUREN POLLOW**

*Director, Government Affairs*

NYS Health Facilities Association

NYS Center for Assisted Living

33 Elk Street, Suite 300 | Albany, NY 12207

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

August 4, 2017

Jason A. Helgerson  
Deputy Commissioner, NYS Medicaid Director  
Office of Health Insurance Programs  
New York State Department of Health  
One Commerce Plaza  
Albany, New York 12210-2820

Dear Mr. Helgerson:

The New York State Health Facilities Association (NYSHFA) and the New York State Center for Assisted Living (NYSCAL) represent approximately 400 members providing essential long-term care services to over 50,000 elderly and frail individuals throughout New York State. We thank you for the opportunity to provide feedback on New York's Medicaid 1115 Waiver authority, which includes expanding access to health services, improving health outcomes and efforts to transition to a managed care system.

While long-term care providers have struggled to meaningfully engage with Performing Provider Systems (PPS) in the Delivery System Reform Incentive Payment (DSRIP) Program, they are in a strong position to influence avoidable hospitalizations. Populations served by long-term care providers are frequently transitioned between higher-cost healthcare settings. Furthermore, the staff providing critical care in long-term care settings have a wealth of clinical expertise in managing those with high acuity. Given the risks associated with transitions from acute to sub-acute settings and sub-acute to community-based settings, these providers are in a unique position to prevent avoidable hospitalizations for our most vulnerable. As such, NYSHFA/NYSCAL offers the following recommendations on the State's 1115 Waiver authority:

**Nursing Home Rate Cell** – Continued discussions from the 2017-2018 State Budget “side letter” regarding the nursing home rate cell are paramount to ensuring providers and payers are adequately compensated for the true cost of the care for residents. As the MLTC program focuses on better serving individuals in the community, nursing homes are caring for higher acuity individuals with rates that do not always reflect such care.

**Triple Aim** – We support the goals of the Medicaid Redesign Team (MRT) with respect to improving care, creating better health outcomes, and reducing cost. That being said, the MLTC rate has not kept pace with changing dynamic of the high needs population it serves. With inadequate reimbursement and sparse investment from DSRIP, it is unlikely these providers will be able to innovate in a way that significantly bends the cost curve through improved outcomes.

**Fee-For-Service (FFS)** – This is an ongoing issue in need of resolution due to plans regularly terminating contracts with long-term care facilities, thereby forcing providers back into FFS reimbursement. If a plan leaves a network area entirely, the County must resume FFS payment. Such consequences create additional barriers to participation with respect to the goals of VBP.

**Value Based Purchasing** – While the Managed Long-Term Care Clinical Advisory Group (CAG) created a strong report assessing long-term care VBP recommendations in December 2016, nursing homes and assisted living providers have not been able to meaningfully engage in VBP planning with MLTCs. Additionally, the separation of long-term care funding streams between Medicare and Medicaid creates an additional barrier to meeting these goals.

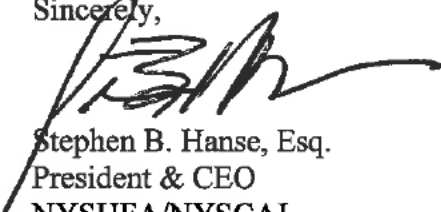
**1115 Waiver Stakeholder Group** – Given the foregoing, we would suggest the creation of a provider stakeholder group associated with the many initiatives included in the 1115 Waiver as it relates to care transitions and MLTC. This group would allow for a continuous feedback loop and contribute to the trajectory of the Waiver authority.

**State Oversight** – There needs to be continuous overall guidance with respect to the populations transitioning to MMC/MLTC. Without overall guidance and oversight, providers and plans will continue down different roads toward different goals.

**HIT Investment** – In order to advance the goals of the 1115 Waiver, investment in Electronic Health Records (EHR)/Health Information Technology (HIT) will help long-term care providers move from FFS to MLTC/VBP more effectively. While hospitals and physicians have had a litany of incentive programs to fund these investments, the same has not been offered for long-term care providers. This lack of funding has stymied necessary development of HIT and EHR adoption. Aside from the Data Exchange Incentive Program (DEIP) administered by the Regional Health Information Organizations (RHIOs), there has been a lack of investment encouraging broad participation in arrangements that will prove essential to the success of long-term care providers VBP arrangements.

**Transformation Grants** – Recent investments in healthcare infrastructure have proven to serve as a windfall for hospitals and health systems, while less than 5% of funds having been awarded to long-term care applicants. Investments in IT infrastructure, physical plant renovation, and debt retirement would enable long-term care providers to innovate and create crucial improvements as per the state’s investment plan. As you are aware, long-term care providers are in dire need of funds to upgrade aging facilities and provide new services to more medically acute residents. State financial support for such critical upgrades will enable these providers to respond to the changing needs of the populations they serve.

The New York State Health Facilities Association and New York State Center for Assisted Living appreciate the opportunity to provide input on the New York’s 1115 Waiver authority. We look forward to continuing our partnership with the Department of Health to find areas of opportunity for long-term care providers to meaningfully participate in value-based initiatives as they relate to the goals of the 1115 Waiver.

Sincerely,  
  
Stephen B. Hanse, Esq.  
President & CEO  
NYSHFA/NYSCAL

## doh.sm.1115Waivers

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**From:** KAREN MILLER [REDACTED]  
**Sent:** Saturday, August 26, 2017 8:43 AM  
**To:** doh.sm.1115Waivers  
**Subject:** Fwd: 1115 Public Forum Comment

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Sent from my iPad

Begin forwarded message:

**From:** KAREN MILLER [REDACTED]  
**Date:** August 13, 2017 at 3:30:34 PM EDT  
**To:** [to1115waivers@health.ny.gov](mailto:to1115waivers@health.ny.gov)  
**Subject:** 1115 Public Forum Comment

To: NYS Department of Health

From: Karen Miller, Kingston NY. I am very concerned about any change in the Medicaid Program DSRIP funding. This is designed to reduce hospital readmissions. So it only makes good economic, and medical sense. To keep it fully funded.

Thank you for your attention.

Sent from my iPad