Office of Health Insurance Programs
Division of Program Development and Management
Waiver Management Unit
Empire State Plaza, Corning Tower -OCP 1208
Albany, NY 12237

May 13, 2016

Re: Public Comments on New York State's 1115 Partnership Plan Waiver Programs

To Whom It May Concern:

God's Love We Deliver is a non-sectarian, 501(c)(3) non-profit. We are the only food and nutrition services agency that provides individually tailored, life-sustaining meals and medical nutrition therapy to individuals living with life-threatening illnesses throughout the five boroughs of New York City. In our service area, we provide 1.5 million meals annually, which contribute to the delivery of better, more cost-effective healthcare. Many of those meals are provided through contracts with managed care companies, whose services are made possible by the New York State's Medicaid Section 1115 Partnership Plan Waiver. Without the Waiver, we would not be able to cover the cost of delivering those meals, and many recipients would go without the food and nutritional supports that are critical to their health and independence.

Below, we will discuss how the model of care provided through God's Love has had substantial impacts across a wide range of managed care models.

Nutrition Plays a Vital Role in the Management of Chronic Disease
While adequate food and nutrition are essential to maintaining health for all persons, good nutrition is especially critical for the management of chronic illness. Proper nutrition is needed to increase absorption of medications, reduce side effects, and maintain healthy body weight. Good nutrition reduces the risk of, or helps manage, some of the most costly chronic diseases to treat: heart disease, diabetes, hypertension, chronic obstructive pulmonary disease (COPD), HIV/AIDS and, in most cases, cancer. Food and nutrition service providers can therefore serve a key role in supporting clients throughout the trajectory of their illness, from diagnosis through treatment and maintenance.

Malnutrition can play a particularly significant role for patients who require hospitalization. Roughly one in three people in the U.S. admitted to the hospital is malnourished.[i] Studies show that once admitted, nutritionally compromised patients have longer hospital stays,[ii] higher costs of hospitalization,[iii] and are almost twice as likely as nourished patients to be readmitted within fifteen days.[iv] In fact, for Medicare recipients suffering from common conditions such as heart failure, pneumonia, and COPD, nutrition-related diagnosis-related groups (DRGs) are among the top ten causes of readmission.[v]

Additionally, FNS facilitates engagement with medical care, especially among vulnerable populations and dramatically reduces the cost of care for the highest-risk, highest need populations.[vi] The return on

investment for medically tailored meals is clear. A recent pilot study showed a 28% drop (from $38,937 to $28,183) in average monthly health care costs for patients battling life-threatening illness who received medically tailored meals and medical nutrition therapy (MNT).[vii] When compared to similar patients who did not receive these services, study participants also experienced 50% fewer hospital admissions[viii] and were 23% more likely to be discharged to their homes rather than another facility.[ix] Investing in interventions that respond to complicated health needs, while reducing costly interventions, makes good business sense.[x]

Managed Long Term Care (MLTC) and Fully Integrated Duals Advantage
Food and nutrition services have proved to be very beneficial to the populations served by the MLTC and FIDA programs. God's Love We Deliver currently subcontracts with 34 MLTC/PACE/MAP/FIDA plans in NYC to deliver medically tailored home-delivered meals to beneficiaries with multiple co-morbidities, activities of daily living (ADL) limitations, and risk factors for possible institutionalization or re-hospitalization. Referrals are at the plans' discretion, and God's Love program staff work closely with case managers and social workers to determine who would benefit most from FNS services. These referrals have produced positive health outcomes and cost savings, by facilitating access, maintenance and adherence to care. They have also given beneficiaries the choice to remain in their homes and out of more expensive forms of care, such as hospitals or nursing homes. In the 10 years of partnership with MLTC/PACE/MAP/FIDA plans, the program has grown from 3,500 to nearly 300,000 meals each year.

Redesigning the Medicaid Managed Care Benefit Package
With the movement to care management for all, many specialized waiver populations are being moved into mainstream Medicaid managed care (MMC) along with the fee-for-service benefits that accommodate their unique needs. However, food and nutrition services (FNS) have only been carved in for certain individuals transferring out of fee-for-service, and is not yet available to the majority of those in MMC, even if they have the same medical profiles and health needs. Furthermore, over the next 2-3 years, more waiver populations that could benefit from FNS will be moved into MMC, such as the Nursing Home Transition and Diversion and the Traumatic Brain Injury waiver populations, and those with intense behavioral health needs who will be enrolled in the new Health and Recovery Plans (HARP).

God's Love has discussed with the New York State Department of Health moving food and nutrition services into the benefit packages of more managed care products. The potential cost savings and the relatively inexpensive nature of providing medically tailored meals for at-risk populations argues that it should be made available to as many populations as possible. In a managed care context these savings would mean lower medical expenditures by managed care plans, and, by extension, a reduction in capitation rates paid by the State. Currently, caring for almost 400,000 SSI members in Medicaid managed care plans costs almost $900 PMPM on average, and significantly more for the sickest members of that cohort.[xi] At a total cost of care savings of 62% (per the MANNA study), implementing FNS for all SSI members would pay for itself, and the program would yield significant cost benefits. Without New York State's Medicaid Section 1115 Partnership Plan Waiver, we will be unable to continue to pursue these expansions.

Delivery System Reform Incentive Payment Model
God's Love is heavily involved in the infrastructure building for the Delivery System Reform Incentive Payment (DSRIP) model as we play an integral role in the project goal of driving down avoidable hospitalizations by 25%. We currently partner with 12 of the Performing Provider Systems in the New York metropolitan area and are deeply invested with both staff time and resources in the success of DSRIP. New York State's Medicaid Section 1115 Waiver makes this program possible.

While we support DSRIP wholeheartedly, we would like to continue to urge the state to provide explicit guidance encouraging hospitals to fund community-based interventions that help keep beneficiaries

healthy and in their homes. At present, hospitals could choose to refer out to community-based organizations (CBOs), most of which are nonprofits, reap the benefits of their services in achieving DSRIP goals and never reimburse for those services. On top of this, 95% of the incentive payments available must go to hospitals with only 5% to CBOs. In this scenario, because the services provided by God's Love are not reimbursable under mainstream Medicaid, we could be overwhelmed by referrals that we have no resources to address. Other models, some made possible by the 1115 Waiver, have this similar problem: Health Homes, Accountable Care Organizations (ACOs), Primary Care Medical Homes (PCMHs), etc. All rightly encourage and foster partnership with CBOs, but none provide payment parameters or mechanisms for community-based services.

Value Based Payment Initiative

We applaud the move toward 80-90% value based payments for healthcare in NYS, an initiative again made possible by the 1115 Waiver. Awarding value over volume is a step in the right direction. Similar to DSRIP above, we encourage the state to provide guidance on the ways in which CBOs can be included in these new hybrid models and bundled payments, without the assumption that they have funding to provide services from other sources, as this is rarely, if ever, the case.

Conclusion

So many wonderful innovations have been made possible by the New York State's Medicaid Section 1115 Partnership Plan Waiver. Without the waiver, beneficiaries in MLTC would not get the nourishment they need and there would not be hope on the horizon for our healthcare system to become an integrated and community-based system focused on providing care in or close to the home. This admirable goal cannot be accomplished without providers who are in the community. We are grateful to be a part of the care and well-being of so many in our state and look forward to partnering further on innovation initiatives that will lead to healthy, nourished people and lower cost of care for our system.

Sincerely,

Karen Pearl, President & CEO, God's Love We Deliver

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[i] Coats KG et al.. *J Am Diet Assoc* 1993; 93: 27-33. Giner M et al. *Nutrition* 1996; 12: 23-29. Thomas DR et al. *Am J Clin Nutr* 2002; 75: 308-313.

[ii] Mark R. Corkins et al., *Malnutrition Diagnoses in Hospitalized Patients: United States, 2010*, 20 J. OF PARENTERAL AND ENTERAL NUTRITION 1, 3, 7 (2013).

[iii] *Id.*

[iv] Su Lin Lim et al., *Malnutrition and Its Impact on Cost of Hospitalization, Length of Stay, Readmission, and 3-year Mortality*, 31 CLINICAL NUTRITION 345, 348-350 (2012).

[v] Sam Beattie et al., *Reducing Readmissions with Nutrition Management: Briefing White Paper*, Mom's Meals NourishCare (2011), *available at* http://my.momsmeals.com/content/pdf/White_Paper_Reducing_Readmissions_with_Nutrition_Management.pdf.

[vi] Health Care Costs: A Primer. Kaiser Family Foundation. http://kff.org/health-costs/issue-brief/health-care-costs-a-primer/. (last visited Jan. 22, 2016).

[vii] Jill Gurvey et al., *Examining Health Care Costs Among MANNA Clients and a Comparison Group*, 4 J. OF PRIMARY CARE & CMTY. HEALTH 311, 313-15 (2013).

[viii] *Id.* at 315 (based upon mean monthly inpatient visits).

[ix] *Id.* at 315 (based upon mean percentage of individuals discharged to home).

[x] Bachrach, D. Pfister, H. Wallis, K., Lipson, M. Addressing Patient's Social Needs: The Emerging Business Case for Provider Investment. May 2014. Commonwealth Fund, Skoll Foundation, and Pershing Square Foundation.

[xi] 2013 Q3 Mainstream Medicaid Managed Care Operating Reports, data provided by NYSDOH. Custom tabulation by Manatt Health Solutions.

TESTIMONY TO NEW YORK STATE DSRIP PROJECT APPROVAL & OVERSIGHT PANEL
Meeting Date: May 4, 2016

Re: Community Based Organization Involvement & Reimbursement

BOOM!Health is a Bronx-based health and wellness organization currently participating in four Performing Provider Systems (PPS) in New York City. We are greatly concerned with the inconsistent and incongruous communication from the provider systems as well as the lack of meaningful involvement of community based organizations across the DSRIP roll out.

It has been our experience that participating in one PPS may require weekly (if not more frequent) webinars, conference calls and meetings with the PPS leadership to provide feedback and guidance concerning DSRIP implementation, while another PPS prefers community based organizations have little to no input in the process, but are reimbursed for attending a webinar. In many instances, community based organizations are "engaged" with the PPS in name only and in the case of one provider system, have been notified that their participation will not be permitted in the clinical projects. Additionally, inquiries concerning reporting modalities or compliance procedures are ignored. The lack of uniformity or consistency of implementation, even within a single PPS is alarming.

The provider systems have benefited greatly from the expertise and networks of the community based organizations involved with the projects. For more than two years, BOOM!Health has provided hundreds of hours of what amounts to free consulting services to several provider systems. BOOM!Health complied with the request of one PPS to, in good-faith, staff the project only to be told upon submission, our invoices will not be paid until the project receives final approval. This is just one example of how the community based organizations are being used to finance the PPS projects while the hospitals pay themselves and select providers first.

During a recent conference call between community based organizations and PPS leads, concerns surrounding the severe delays in reimbursement were met with stunning callousness. One PPS went so far as to suggest that their PPS has no incentive to reimburse community based organizations for services rendered because the DSRIP model is not sustainable and most community based agencies will not withstand the process.

BOOM!Health and similar organizations cannot be expected to finance the DSRIP roll out while the provider systems achieve project approval and credibility through our involvement. If the DSRIP program is to be successful, the state must develop uniform standards that hold the provider systems fiscally accountable and ensure meaningful participation from community based organizations.

Statement to New York State Department of Health
Comment on the Renewal of the 1115 Partnership Plan

Community Access
13 May, 2016

The NYS Partnership Plan is as comprehensive as any other state's authority to protect resources for the health and well-being of residents. Major changes to the way New Yorkers receive coverage for services have been initiated over the last few years through the Medicaid Redesign process, which has often reflected public input and community need.

At this point there are still unmet needs between systems of care, however, that require more distinct investments through the 1115 waiver, particularly for persons who struggle with their mental health. The greatest need facing residents of NYC and throughout the rest of the state is a crisis response system that can coordinate safe and effective treatment for persons in psychiatric distress. A comprehensive crisis response system is of paramount impact to achieving the goals of Medicaid Redesign and DSRIP. Resolving psychiatric crises—one of the most costly acute events to the Medicaid system—is necessarily central to the aims of reducing unnecessary hospitalizations, enhance the participant experience, and improving overall health.

For at least thirty years, experts have recommended that a comprehensive psychiatric crisis response system contain the elements in the chart below. These crisis components—when coordinated together—reduce hospitalizations, curtail police involvement in and the criminalization of psychiatric events, increase community tenure and options for recovery, and improve the overall health and well-being of residents and communities.

The red check marks in the chart below represent areas where investments have already been made to advance psychiatric crisis response in NYC, but investments in even these minimal components are sorely inadequate.

Crisis Service Components – New York City

- ✓ 24-Hour crisis telephone line (LIFENET)
- ✓ Warm line (only 8 hours/day)
- Walk-in services
- ✓ Mobile crisis outreach (semi-crisis)
- 23-Hour beds
- Crisis stabilization units (3 – 5 days)
- ✓ Crisis respite/residential services (14 days)
- Residential supports (low threshold)
- Transportation
- 911 diversion
- ER diversion
- Integrated health system (medical care)
- Real-time health information system
- Follow up supports

Community Access recommends that DOH take this opportunity to enhance supports for psychiatric crisis response in the 1115 waiver. In order to achieve this, we recommend the following specific actions for reform:

- Include crisis respite as a standard benefit in the 1115 waiver for any person with Medicaid eligibility. Its current placement in the HCBS benefit package does not meet the needs of residents who often experience a crisis as their first serious mental health episode;
- Include a comprehensive crisis response network, as indicated in the above chart, as a mandatory element of DSRIP program implementation. PPS leads should be required to contract with the range of services that would provide a sufficient behavioral health crisis response and lead coordination to prevent hospitalization, improve community tenure, and enhance options for rehabilitative services.

Community Access recognizes that the current 1115 negotiation process provides an important opportunity to secure resources for New Yorkers who experience psychiatric crisis. Thank you for the opportunity to offer this recommendation.

Comments Regarding New York State's Implementation of the 1115 Waiver

Thank you for the opportunity to comment on the implementation of the 1115 Waiver "Waiver"). The Coalition of Behavioral Health Agencies (The Coalition) represents nearly 140 community-based, non-profit behavioral health providers that serve over 350,000 New Yorkers of every age. Our members serve the entire continuum of behavioral health care in every neighborhood in New York City, Westchester, and beyond. Coalition members provide access to the whole range of outpatient mental health and substance abuse services, including supportive housing, crisis, peer, employment, Personalized Recovery Oriented Services (PROS), Club Houses, education and food nutritional services, as well as many other supports that promote recovery. Our members have been providing these types of services in the community since the dawn of the deinstitutionalization movement.

We support the goals of Medicaid redesign to reduce inpatient and emergency use; provide eligibility for Medicaid across a broader band of low-income New Yorkers; and implement Delivery System Reform Incentive Payment (DSRIP) funding to increase the quality of services provided across all spectrums. We applaud the use of DSRIP funding to serve larger and more complex Medicaid populations for work on specific issues identified by the Medicaid Redesign Team (MRT) to achieve the goals of its "Triple Aim":

1. Improving the quality of care by focusing on safety, effectiveness, patient-centeredness, timeliness, efficiency and equity;

2. Improving health by addressing root causes of poor health e.g., poor nutrition, physical inactivity, and substance use disorders; and

3. Reducing per capita costs.

Community-based behavioral health providers play an important role in achieving the goals of Medicaid redesign. Comprehensive behavioral health services provided in the community lead to better health outcomes that reduce the overall cost of medical care. These services promote recovery and thereby avoid hospital admissions and emergency room visits; prevent stays in homeless shelters and divert individuals from prisons and jails.

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Capacity and Infrastructure

New York State should invest in community-based organizations (CBO) that show promise with helping individuals living with severe mental illness and substance use disorders to recover and thrive in their communities. By providing consumers living with behavioral issues with access to culturally competent mental health and substance use services in the community, including housing and peer employment services, Coalition members in turn help to address social determinants of health factors like stable and affordable housing, living wage job opportunities, training, food security and access to social supports. We recommend that the State work with CBO's to:

- Develop payment methodologies that incentivize/reward providers provide services to people experiencing challenging social determinant barriers;

- Support infrastructure development, including information technology (IT) systems for billing and the ability to measure and collect data to demonstrate their value, as well as for contracted services, such as fiscal and legal expertise; and

- Create a "design and consultation team" of experts from relevant State agencies, advocacy and stakeholder groups to provide focused consultation and support for on developing value based payment systems.

Integrated Care

According to the Department of Health's Approaches to Integrated Care webpage, "[h]ealth care providers have long recognized that many patients have multiple physical and behavioral health care needs, yet services have traditionally been provided separately. The integration of primary care, mental health and/or substance use disorder services can help improve the overall quality of care for individuals with multiple health conditions by treating the whole person in a more comprehensive manner."

The Coalition wholeheartedly agrees. We believe that true integration, where people can receive their physical and behavioral health care in the same setting, is a goal that we should all work towards achieving. Although pathways to integrated licensure exist, significant barriers stand in the way, which make it extremely difficult (both structurally and fiscally) for community-based behavioral health providers to bring physical health services onsite. The most difficult issues arise in the area of physical plant requirements. The behavioral health agencies are held to the Article 28 clinic standards regardless of the kind of care that they intend to provide. The regulations to provide primary health services at behavioral health sites need to be drastically revised to encourage real integration.

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DSRIP

We agree with overall goal of DSRIP to create a more integrated and efficient service delivery system. The Coalition is concerned, however, about the implementation of DSRIP concerning the meaningful inclusion of community-based providers. Overall planning and funding flows primarily through hospital-based systems. Unfortunately, to date, very little of the DSRIP money has funneled down to the community-based behavioral health providers in Performing Provider Systems (PPSs) networks. This is relevant for both behavioral health initiatives in general, as well the IT capital and systems development necessary for program and outcomes monitoring/reporting. In addition, DSRIP projects require significant workforce development, training and hiring for which there has been little or no funding from the PPSs or public sources.

While PPSs require metrics reporting in order to make corrections in strategies and ensure success, the complexity of the proposed DSRIP reporting requirements and associated measures could hinder implementation efforts. New York's 1115 waiver requires each PPS to be accountable for between approximately 100 and 330 process and outcome metrics, depending on project selection. This creates a heavy administrative burden, taking focus and time away from project implementation.

Value Based Payments (VBP)

The Coalition supports the concept of payment methodologies to incentivize payment mechanisms for CBOs that enable individuals living with severe mental illness and substance use disorders to recover and thrive in the community. As previously mentioned, comprehensive behavioral health services provided in the community effects better health outcomes, which reduce medical expenses overall, particularly from averted hospitalizations and inpatient care admissions.

Sustaining behavioral health providers as we enter into VBP should be a priority given the historical lack of sufficient reimbursement for behavioral health services. The current reimbursement rates available for Medicaid in both fee-for-service and managed care environments are unsustainably low. If bundled or capitated rates, which will be based on these historic rates, are too low, this could lead to more and greater financial instability. The State should make additional funding available to CBOs to help prepare for participation in value based payment arrangements. A successful transition to VGP required funds being available for investment (and reinvestment) into developing innovative partnerships to achieve the MRT Triple Aim.

The Coalition urges that VBP payments to community-based providers include MCO/PPS rate guarantees that ensure that community based providers are reimbursed with actuarially sound rates. These rates must fully support the cost of efficient care that meets quality standards. We must underscore that the partnerships between large stakeholders (hospitals and MCOs) and

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CBOs necessitates creating a payment system that compensates the participants fairly for the true value of the services provided as well as the resources expended in achieving positive health outcomes.

We appreciate that the value based payment Roadmap recognized that addressing the social determinants of health is necessary to achieve high value care. However, The Coalition is concerned that all State agencies, including the Office of the Medicaid Inspector General, recognize this change in policy and hopefully, a concomitant change in New York State Social Services law.

The Model Contract

We strongly urge that the process to revise the Medicaid managed care Model Contract be transparent, because so many components of the 1115 Waiver will be implemented through it. In addition, the Office of Mental Health (OMH) and Office of Alcoholism and Substance Abuse Services (OASAS), must be closely involved in the development and oversight of the Model Contract sections that deal with behavioral health care, as they are the State agencies with the subject matter expertise. Finally, The Coalition advocates strongly that the State provide an opportunity for stakeholders to comment on the Model Contract before it is finalized, as was previously the recommendation of the Regulations Committee. This public comment period will ensure the inclusion of metrics that are representative of the successful work many are already engaged in.

Consumer Access and Input

The Coalition is also concerned about the ability of clients to navigate the health care system. The recommendations of the Advocacy and Engagement Subcommittee to the MRT must be implemented, such as:

- ensuring that plans and providers communicate information to consumers that explains the incentives that different payment mechanisms generate;
- providing consumer education and promoting patient activation around what is meant by a "high value provider," as well as the right to question their providers, seek second opinions, and obtain consumer assistance services;
- assistance if a client is denied service and wants to appeal; and
- assuring that the State's Independent Consumer Advocacy Network (ICAN) and any and all consumer assistance programs are equipped to provide assistance.

It is critical that the Waiver allow robust stakeholder engagement, which includes input from consumers/clients, providers, and advocates. An advisory committee is supposed to meet to monitor and if necessary modify the Waiver, but it does not appear that such a committee has been developed. If it is the MRT committee, it has not met in a long period of time.

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Health & Recovery Plans (HARP)

- We appreciate that there will be no copayments mandated for HARP enrollees, which would be a disincentive for individuals seeking care and burdensome for providers to collect.

- We believe that the new 12-month eligibility for individuals in certain circumstances will greatly assist continuity of care for clients, especially with regard to medication access.

- We strongly agree with the New York State Department of Health's proposal to the Centers for Medicare and Medicaid to enroll individuals who are incarcerated for Medicaid within 30 days of discharge. Again, this is essential for individuals to immediately access the necessary behavioral health services and medications upon release from jail or prison, which will help to combat recidivism.

- There is concern that there will be inadequate capacity of substance use disorder services available in areas that are not geographically convenient for HARP enrollees to access.

- To date, individuals with HARP eligibility are not enrolling at the rate that was originally calculated. Without sufficient enrollment, the network, particularly for home and community based services, will not be adequate or efficient, and this entire proposal could fail. The State and provider community should review this issue to determine what can be done to increase HARP enrollment to cover all individuals eligible for and willing to enroll.

Home & Community Based Services (HCBS)

The ability for providers to offer HCBS to consumers that require them is a cornerstone of recovery and meeting the MRT's goals. Unfortunately, HCBS rates are insufficient for certain services, particularly crisis services. Furthermore, we question the appropriateness of including crisis service as part of a service plan. Crisis services should not be in HCBS, but rather have its own category. One of the primary goals of DSRIP is to reduce hospitalization and emergency room use; that goal will not be achieved absent the provision of robust crisis services.

We are also disappointed by the exclusion of people living in shelters from HCBS, since they are often in most need of these enhanced services. Additionally, the complicated and stringent rules regarding access to HCBS are a serious disincentive for providers to engage consumers/clients in these services. The process must be streamlined in order for Medicaid redesign to be successful.

Children's Medicaid Managed Care & Health Homes

Clarity is needed for providers that primarily serve children on how the new children's Health Homes will be incorporated. The timeframe for children's managed care transition is on a different trajectory than adults and we are concerned about the Medicaid "cap" with regard to

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children's services since they will be brought online subsequent to the general movement of behavioral care to Medicaid managed care. In addition, since many existing children's waiver providers, both in the OMH waiver and the Office of Children and Family Services (OCFS) waiver, will transition to the new waiver structure, there should be consistency between the two State agencies in how and when the transition will occur, with regards to the timeline for requiring new CMS requirements regarding conflict free decision-making. They should be put on the same time schedule, one that reflects the changes to come, so that providers do not have to go through two conversions within a short period of time.

Supportive Housing

The Coalition has serious concerns regarding the references to Housing and Vocational Opportunities in the VBP Roadmap. Although we absolutely agree that "[o]ffering a stable, safe, and accessible housing environment can be highly efficient and improve outcomes for vulnerable, homeless Medicaid members," it must be understood that supportive housing is considered permanent housing. If Medicaid were to pay for supportive housing, it must be structured to be permanent and flexible.

In addition, the VBP Roadmap states that "DSRIP offers the chance to introduce credentialed positions such as Community Health Care Workers and Peers, which offer a continuum of vocational opportunities to people living with chronic conditions." In order to bill for these services, many housing providers will have to implement more sophisticated billing systems, since to date, supportive housing has been funded pursuant to state contracts. In addition, the Roadmap provides that "[t]o further acknowledge that housing plays a critical role in overall health and patient behavior, the State is determined to collect standardized housing data for purposes of rate setting and appropriate intervention research and analysis." Again, in order to provide this type of information, supportive housing providers will need a funding source to build the necessary reporting systems.

Ensuring Outcomes

New York State's interest in measuring outcomes and encouraging creativity with incentive programs, specifically its plans to analyze and collected data to identify best practices, and making this information publicly available, will be a boon to all agencies to help them develop more effective programs.

However, in the State's recently released VBP Roadmap, there is little information regarding the measures that are being advanced by the Clinical Advisory Groups (CAGs). Without that information, it is difficult to determine whether those measures will be effective; are reasonable; and can be implemented on a timely basis. The Coalition strongly believes that public comment on the Model Contract could help shape the recommended measures.

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One measure that the Department of Health is using is the Healthcare Effectiveness Data and Information Set (HEDIS), which is a tool used to measure performance on important dimensions of care and service. We believe that HEDIS measures are heavily weighted toward physical health. If the transformation project is going to be successful, community-based safety net providers must thrive and we need metrics that reflect the contributions of behavioral health to outcomes. Basing the determination of incentives solely or primarily on avoiding emergency department and/or inpatient stays for medical care will not generate sufficient savings or health outcomes to justify this vast influx of Medicaid dollars.

The emphasis on metrics is critically important in efforts to address social determinants of health, but meaningful and effective support to community-based agencies has not been sufficient to provide the necessary data. In addition, the behavioral health community has not been involved in developing these metrics, although we are the experts in what is needed to develop successful population-based health strategies. Care must be given to assure that as service models and reimbursement change, there is monitoring of how this shift affects vulnerable populations and people without access to health insurance.

Finally, outcomes are also important because the Department of Health is required, "to reinvest funds allocated for behavioral health services, which are general fund savings directly related to savings realized through the transition of populations covered by this section from the applicable Medicaid fee-for-service system to a managed care model…for the purpose of increasing investment in community based behavioral health services..." (*Social Services, art. 11, § 365-m [5], as added by L 2014, ch 60*) This reinvestment of funds can be crucial for stabilizing the community-based behavioral health system and ensuring consumers/clients access to care. However, the attribution of savings must be accurately and fairly assessed, which will require the participation of OMH, OASAS, providers and other experts to develop effective measures.

We thank you again for this opportunity to comment on the State's 1115 Waiver programs. We look forward to working with you to ensure an implementation that will benefit all stakeholders.

For more information, please contact:

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HARLEM UNITED

DSRIP Public Comment
May 13, 2016

Founded in 1988, Harlem United provides full access to integrated primary health care and social services for New Yorkers experiencing multiple and complex issues, including HIV and AIDS, social stigma, mental illness, chronic substance and alcohol use, homelessness, and extreme poverty — regardless of race, ethnicity, socioeconomic status, sexual orientation, or gender identity and expression.

In 2015, Harlem United served over 16,000 clients. Over 90% were people of color and over one-third were immigrants. Most live in the poorest areas of Harlem and the South Bronx, as well as other areas of New York City served by our mobile medical, dental, and integrated harm reduction units.

Harlem United's three federally qualified health centers are the cornerstone of our commitment to community-based, comprehensive, and culturally-competent care to underserved communities. In fact, by the end of 2017 we project that we will serve a total of 3,500 patients at our clinics and provide a total of 18,986 services. At The Nest, our newest community health center, we recently opened our first pediatric care clinic, and we will also soon open our first Article 31 mental health clinic.

Harlem United has been engaged in the DSRIP process from the very beginning, and it is an active member of three PPSs, led by HHC, Presbyterian, and Mt. Sinai. Even though Harlem United is well-prepared to help meet the DSRIP goals of reducing avoidable hospital use and accessing underserved and low-income populations, we are concerned about several issues that threaten DSRIP's success specific to downstream, community-based providers.

Communication: Collecting Data over Relationship Building
Overall, the substance and effectiveness of communication from leads is inconsistent across PPSs. Harlem United fills out surveys and provides information requested, but it is unclear how or if this information will support the full potential of downstream providers to meet DSRIP goals. Some of this may be a result of the way DSRIP is structured. While survey data can help build relationships and understanding with CBOs, they can be heavy on bureaucracy and light on substance. Hospital leads need to be incentivized to more holistically learn and understand the critical role CBOs play in the community.

Hospital Leads and Cultural Change
DSRIP is also not enabling the structural and cultural change necessary for hospital leads to integrate CBOs. Data points are forcing hospitals to focus solely on CBO "value," versus the necessary cultural change that reinforces building strong, integral relationships with CBOs. For example, one hospital lead hosted a meeting of CBOs focused on providing trainings to CBO staff, including LGBTQ cultural competency training. Yet several CBOs in the room, including Callen Lorde and Harlem United, have been directly serving LGBTQ populations for decades and have themselves provided such training.

Is DSRIP incentivizing hospital leads to visit with CBOs like Harlem United so that they can truly understand what we do, who we serve, and what they can learn from us? Absent more direct relationship building, DSRIP will fail to incorporate and the social determinants of health addressed by Harlem United and other CBOs every day.

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Value Based Payment and CBOs: Information Sharing Systems and Funding
Even with the recent release of the draft Value Based Payments (VBP) roadmap, it is still very unclear to CBOs what the VBP indicators will be and how information will be shared across PPSs to fill those indicators. How will VBP indicators for chronic conditions like HIV/AIDS and Hepatitis C be created and implemented? How will electronic records data sharing systems be created, funded, and made uniform across the myriad organizations in the PPSs? Will these efforts be integrated into data sharing projects already underway through RHIOs?

During the Commonwealth Fund DSRIP webinar on May 12, 2016, a facilitator shared that far more CBOs have signed up to join PPSs than can be integrated in to the system, and Harlem United is concerned that there is misunderstanding and underestimation of the amount of funding that will eventually trickle down to downstream providers. DSRIP will fail if CBOs are left unfunded to care for more patients.

Replicating the Success of the New York-Presbyterian Hospital PPS
Amidst these significant concerns, there are opportunities to examine more successful PPS models that can be replicated. Of the three PPSs in which Harlem United is a member, New York-Presbyterian has been the most successful. For example, Presbyterian created a CBO subcommittee that hosts regular meetings at CBOs, versus forcing CBOs to come to a hospital. This facilitates more direct and complete information sharing and understanding of what CBOs do and bring to these partnerships. Presbyterian is also building a team of Community Health Workers that serve as guides to patients, helping them navigate through the providers in the PPS efficiently and effectively. Assessing and incentivizing the replication of models like this will benefit DSRIP across PPSs.

Hearing on NYS Medicaid 1115 Waiver, DSRIP and Value-based Payment Reform

Housing Works Testimony

May 4, 2016

Members of the DSRIP Project Approval and Oversight Panel and representatives of the New York State Department of Health, thank you for the opportunity to testify on behalf of Housing Works as the organization's co-founder and CEO. Housing Works is a healing community of people living with and affected by HIV/AIDS. Our mission is to end the dual crises of homelessness and AIDS through relentless advocacy, the provision of life saving services, and entrepreneurial businesses that sustain our efforts. Housing Works is also part of the Community Care of Brooklyn Performing Provider System (PPS) and the Mount Sinai PPS.

Housing Works has been an important participant in New York State's (NYS) Medicaid Waiver and health system reform process. We participated in the Medicaid Redesign Team (MRT) process by submitting over two dozen recommendations, many of which were adopted. On behalf of Housing Works, I served on several MRT work groups and currently serve on the Value-Based Payment (VBP) Work Group.

Last year the Governor's Ending the Epidemic Task Force, of which I was community co-chair, dedicated special attention to ensuring that the State's plan to end HIV/AIDS as an epidemic fully leverages and coordinates with the DSRIP program and VBP reform.

Housing Works strongly supports the State's Medicaid Waiver process and will quickly highlight the ways in which Delivery System Reform Incentive Payment (DSRIP) has already removed silos, achieved progress toward its goals, and strengthened the State's ability to end its HIV/AIDS epidemic:

1. The timing and goals of DSRIP coincide with Governor Andrew Cuomo's goal to end the State's HIV/AIDS epidemic and to decrease new HIV infections to below 750 in the year 2020. Specifically, the *Ending the Epidemic Blueprint* goals of identifying people with HIV and linking them to care, retaining HIV-positive people in care and supporting viral load suppression, and expanding access to HIV prevention tools such as nPEP and PrEP, all contribute to achieving the goals of DSRIP by improving quality care, access to primary and preventative care, and reducing costs and avoidable hospital visits for HIV-positive persons.
2. The *Ending the Epidemic Blueprint* included a recommendation to create a statewide DSRIP Learning Collaborative as a mechanism to share best practices and foster the development and implementation of innovative HIV/AIDS projects. Currently, under DSRIP, a group of Performing Provider Systems in NYC that have chosen Domain 4cii HIV projects (or in one case, New York Presbyterian, Domain 3) have taken the step of establishing a Learning Collaborative to build on their individual resources and expertise and coordinate their DSRIP response to maximize the ability to successfully increase access to and retention in HIV care, as well as viral suppression. This Learning Collaborative will also facilitate collaboration among PPSs and other community partners; provide forums for further knowledge and guidance on evidence-based interventions; establish agreed-upon definitions and metrics related to individual projects to establish commonality to support partnership and make uniform monitoring and evaluation possible; and will engage with city and state agencies to coordinate HIV activities and facilitate alignment with resources and programs.
3. Housing Works is working with Greater New York Hospital Association, Amida Care, and the NYS DOH AIDS Institute to encourage PPSs awarded 2di (Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care) to utilize these resources to identify people who are at risk for HIV to get them tested and into care, with access to antiretroviral treatment if they test HIV-positive and access to PrEP if they test negative.

4. The *Ending the Epidemic Blueprint* included a recommendation establish mechanisms for a certified HIV peer workforce to provide Medicaid-reimbursable linkage, reengagement, treatment adherence and retention in care services, while paying peers a living wage. We strongly support efforts under DSRIP to establish a self-sustaining, peer-delivered model into the health care system.

Health system reforms through DSRIP have already strengthened New York State's ability to end its HIV/AIDS epidemic. If the State implements the ETE Blueprint and achieves the goal of reducing new infections from 3,200 in 2013 to 750 in 2020, approximately 10,851 new HIV infections will be averted between now and 2020

In March 2015, Treatment Action Group and Housing Works published a joint report that shows how the State's Ending the Epidemic investments will more than pay for themselves.[i] Achieving the ETE goals has been projected to generate some $4.5 billion in total health care savings, including $3.8 billion in public sector health spending. Establishing mechanisms to measure these savings so that they can be reinvested in improving quality of care, improving population health and addressing social drivers is a crucial component of the initial implementation and long-term stability of New York's Ending the Epidemic plan.

Housing Works applauds the State's proposed VBP reform process for seeking to move the NYS Medicaid system from a fee-for-service (FFS) model to a value and outcome-based service model over the next 5 to 10 years. VBP reform will improve the State's healthcare system and allow the state to more effectively address underlying social drivers of negative health outcomes, such as homelessness, housing instability and food insecurity.

The FFS model is broken and will not lead our State to long-term, dramatic improvements in population health. For example, under the current Medicaid FFS care system, achieving positive outcomes for people with HIV and those at risk will lead to significantly less Medicaid revenue in the HIV continuum of care, thereby quickly halting or reversing any gains made in improving this population's health.

Compare this broken FFS model with the newest "Payment Reform Guiding Principle" articulated in the State's VBP Roadmap: "Financially reward, rather than penalize, providers and plans who deliver high value care through emphasizing prevention, coordination, and optimal patient outcomes, including interventions that address social determinants of health." We strongly support this guiding principle of payment reform.

Housing Works supports the State's commitment to expand and improve incentive programs and to eliminate the $125 incentive cap for incentive programs. We strongly support using patient incentives as a tool to encourage the engagement of people on Medicaid in their own health care outcomes.

We applaud DSRIP and VBP for emphasizing the need to address social determinants of health. Housing Works strongly supports housing for homeless and unstably housed people with chronic diseases as an evidence-based healthcare intervention. The inability to meet basic subsistence needs is a formidable barrier to consistent engagement in HIV care and treatment—and to treatment for other chronic illnesses. By ensuring that each eligible person with HIV is linked to critical enablers of effective HIV treatment, including a safe place to live, adequate nutrition, and the ability to travel to health care and supportive services, we can address the social drivers of the epidemic and related health disparities.

We support the State's commitment to collect standardized housing data to track homelessness and housing stability among Medicaid recipients and to address their needs and health care delivery. We believe that the State should establish a plan to ensure that all Medicaid members receive some type of Social Determinants of Health (SDH) screening. We support the VBP Roadmap's plan that Level 2 and 3 VBP contractors should be required to implement at least one intervention designed to address a social determinant of health and that managed care organizations share in the costs and responsibilities of the investment. We believe that the selection of the type of social determinant intervention to be implemented should be guided by individual

members' needs and health goals, the impact of SDH on their health outcomes, and an assessment of community needs and resources.

Since Housing Works is familiar with the pivotal role of community-based organizations (CBOs) in connecting individual Medicaid members to the larger healthcare system, we would like to use this testimony to emphasize the need for CBOs to be supported and included in health system transformation. We support the State's emphasis on including Tier 1 CBOs in VBP arrangements, and we agree that savings should be allocated appropriately among providers, and that behavioral health, long-term care and other community-based providers should not be disadvantaged. State funding and technical assistance should be made available to help CBOs prepare for participation in VBP arrangements.

Housing Works also strongly supports the concept of establishing a statewide Medicaid Accountable Care Organization (ACO) for people with HIV and those at highest risk. The State's VBP Roadmap lists HIV/AIDS as a special needs population for which total care could be conceived as a Medicaid ACO with shared savings and/or losses. Establishing a statewide ACO for people with and at high risk for HIV creates a structural model that continually improves population health outcomes and general cost savings. An ACO could be structured to include the total care of people with HIV and those at highest risk—including men who have sex with men (MSM) and transgender women, people who use injection drugs, and people in sero-discordant relationships—thereby better expanding and coordinating HIV prevention efforts as well. An ACO would improve HIV care coordination and positive HIV health outcomes, such as initiating antiretroviral treatment and staying adherent on medication and achieving viral load suppression. It would also improve screening and treatment for mental health issues or co-morbidities such as hepatitis C.

An ACO model would also allow for self-funding mechanisms to address social determinants of health, such as homelessness, housing instability, food insecurity and lack of employment opportunity, by capturing Medicaid savings to reinvest back into the health care and social services systems. It is precisely this reinvestment back into the VBP system to improve health outcomes and address the underlying social determinants of health, such as homelessness and housing instability, which will be the State's new engine for health system transformation. With a reformed and transformed health system, our great State can truly end AIDS, and this ambitious goal is only the beginning of what we can achieve.

On behalf of Housing Works, I thank you for the opportunity to testify on New York State's Medicaid Waiver process. I am available to inform and answer any questions that you may have.

Respectfully submitted,

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[i] Ending the Epidemic in NYS: Projected Fiscal Impact of Recommended Expansions of HIV Prevention, Antiretroviral Treatment and Housing Supports. Housing Works and Treatment Action Group. March 2015.

Engaging Community-based Organizations to Improve Health Outcomes under the New York Partnership Plan: Comments on the New York State Section 1115 Medicaid Waiver

Submitted by Tracie Robinson

May 4, 2016

Thank you for this opportunity to comment on the Social Security Act Section 1115 Waiver Number 11-W-00114/2 ("Waiver"). The Human Services Council of New York ("HSC") has been involved in developing the State's Value-based Payment ("VBP") plan through its participation in the VBP Workgroup Subcommittee on Social Determinants of Health & Community-based Organizations, and we are pleased to share the perspective of community-based organizations with respect to the Waiver.

HSC is the State's leading convener and advocate of nonprofit human services organizations. With 170 member organizations that deliver a wide range of human services to New Yorkers of all backgrounds—many of them covered by Medicaid—we are working towards a system in which nonprofits have the support they need to be effective and sustainable. We applaud the Department of Health ("DOH") and the Medicaid Redesign Team ("MRT") for recognizing the impact of social factors on health outcomes and for recognizing the role of community-based organizations ("CBOs") in addressing these factors. The State must leverage the hard-won expertise of nonprofit community-based organizations to achieve its vision under the Waiver, but to do so, it must ensure that these organizations have the supports they need to deliver high-quality services in partnership with hospitals.

Accordingly, we urge the DOH to:

- Increase the transparency and inclusiveness of the waiver process by making the waiver draft available to the public and providing a 60-day public comment period;
- Ensure that CBOs are an equal partner in the governance and implementation of reforms; and
- Provide the necessary financial and administrative support to CBOs so that they can thrive and produce positive health outcomes in the new delivery system.

The Waiver Process

At the outset, we note that the waiver process is not as transparent as it should be. The draft waiver document is not yet public, which means that comments cannot be directed at proposed changes that are currently being negotiated. The Section 1115 Waiver is an important component of health care policy that should be informed by the knowledge and experience of those who will be affected by it. In particular, the many stakeholder groups responsible for implementing or complying with the waiver should have a full opportunity to existing provisions *and to proposed changes*. Unfortunately, by withholding the waiver draft,

the MRT has substantially limited the public's ability to comment with specificity, accuracy, or nuance. The annual update process for the Value-based Payment Roadmap is a good model of transparency and inclusiveness. The first proposed update was released in March 2016, and the public were given 30 days to submit comments. HSC strongly recommends that the MRT adopt a similar process—but with a 60-day comment period—for future amendments to the Waiver.

The Delivery System Reform Incentive Payment Program

CBOs deliver supports that improve the physical, emotional, and economic health and well-being of individuals and communities by addressing social determinants of health such as access to food and housing, employment, discrimination, violence, and disasters. With a growing understanding of the social context for public health, the State has acknowledged the impact of social determinants of health (SDH) such as poverty, education, housing, and health care literacy on health outcomes. Prevention as a public health strategy has become the cornerstone of the delivery system reform, and a great deal of prevention is facilitated by CBOs. For this reason, CBOs must not only have a place at the table of Managed Care governance, but they must also be treated as truly equal partners in the delivery of health and human services. Accordingly, we recommend that the Delivery System Reform Incentive Payment Program ("DSRIP") Performing Provider Systems ("PPSs") include CBO representation in their governance structures. Furthermore, DOH should require that PPSs contract with CBOs to help them address social determinants of health and reach DSRIP goals.[1]

CBOs must also be financially healthy in order to participate effectively in the new delivery system. According to the report on New York's nonprofit human services sector released by the HSC Commission to Examine Nonprofit Human Services Organization Closures this past February, nearly one out of five nonprofit human services organizations was insolvent in 2013, and 30 percent had only two months or less of operating reserves. This precarious position is largely due to underfunding of government contracts and other detrimental procurement practices.[2] Thus, the shift to VBP "poses considerable risk for human services providers," and yet "there is no assurance that any of the substantial State investment to prepare for this new system will flow to human services organizations."

Without adequate financial support, they will be unable to meet the outcomes-based demands of DSRIP. These demands include needs assessment, goal development, rapid-cycle evaluation, compliance with numerous laws and regulations, and of course, service delivery that results in positive health outcomes.[3] Unfortunately, while hospitals have received

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[1] The draft Annual Update to the Value Based Payment Roadmap requires that all Level 2 and Level 3 VBP arrangements include at least one Tier 1 CBO in order to address social determinants of health. PPSs should work with CBOs to address these determinants as well.

[2] The report released by HSC's Commission to Examine Nonprofit Human Services Organization Closures in February 2016 explores the root causes of financial instability in the human services sector. The report, *New York Nonprofits in the Aftermath of FEGS: A Call to Action*, highlights the impact of chronic underfunding of the sector, late contract registration and payment, increasing administrative burdens and unfunded mandates, lack of cost-of-living adjustments and other workforce investments, and the absence of cost escalation causes in contracts on CBOs.

[3] We also note that under DSRIP, CBOs are subject to a financial condition review. These organizations cannot be expected to pass such a review if they enter the system underfunded and do not receive the supports necessary to function once they are in the system.

millions of dollars in funding to facilitate their transition under DSRIP, CBOs have been financially neglected.

HSC is pressing the Governor and the Legislature to allocate more funding for CBOs' participation in the new delivery system, and we urge the DOH to require that DSRIP funds that are not allocated or fully spent by PPSs go to CBOs (in addition to the funds some are getting directly from the PPSs for project implementation). We also echo the recommendation of our partner Medicaid Matters New York ("MMNY") that the flow of DSRIP funds be more transparent, with PPSs being required to provide more detailed information in their funds flow reporting.

Value-based Payment

The transition to VBP is a momentous shift for CBOs because the emphasis on "value over volume" introduces tremendous uncertainty into the payment system. In particular, adding a quantitative definition of "value" to the qualitative world of social determinants of health is uncharted territory for most CBOs. In addition, as mentioned above, the State's CBOs are on the edge of a fiscal precipice. Accordingly, CBOs must be meaningfully engaged in the development and implementation VBP mandates, and there must be safeguards to ensure that they are treated as equal partners in the delivery of services, and they must be funded appropriately. We also note that a majority of the changes to Medicaid Managed Care associated with implementing VBP will need to be incorporated into the Model Contract, and as such, the Model Contract revision process should be made more transparent to allow for meaningful public input.

HSC was pleased to participate in the development of the VBP Roadmap, and we recently submitted comments on the first annual update of this document. HSC supports the following new components of the revised Roadmap:

- The requirement that VBP contractors in Level 2 or Level 3 agreements implement at least one social determinant of health intervention and that MCOs contracting with VBP Level 2 providers/provider networks will share in the costs and responsibilities associated with the investment, development, and implementation of the intervention(s) (page 41) – Based on the overwhelming research, this is the right thing to do. Social determinants have a real impact on long-term health outcomes, and addressing these factors can reduce the cost of health care over time.
- The selection criteria for the type of social determinant intervention to be implemented (page 42) – These criteria appropriately balance individual member health needs and goals, community needs, goals, and resources, and the potential impact of the intervention on the social determinant in question. Like MMNY, however, we recommend that community needs assessments be done by neutral, independent entities that are not providing the services in question.
- The upfront financial incentives created to encourage Level 1 and Level 2 providers to address social determinants of health (page 42) – This is an important recognition that social determinant interventions take time, and it will help alleviate cash flow issues that may befall providers as they embark on service delivery.
- The requirement that, beginning in January 2018, all Level 2 and Level 3 VBP arrangements include at least one Tier 1 CBO (page 42) - This will help to ensure that

the extensive expertise of CBOs is leveraged to achieve the reform goals of better care and lower cost.

- The requirement that MCOs measure and (at least) annually report on social determinants that affect their members (page 43) –
- The requirement that VBP contractors provide "a measureable reason why the SDH was selected, and identify metrics that will be used to track its success." The emphasis on metrics is critically important in making efforts to address social determinants of health meaningful and effective. (pg. 42)

We also echo the recommendation of our partner Medicaid Matters NY ("MMNY") that efforts to revise the Medicaid Managed Care Model Contract maintain the current level of stakeholder engagement to ensure that the transition to Value-based Payment ("VBP") is transparent and evidence-based.

Given the significant risk that VBP poses, HSC believes that DOH should elaborate on or strengthen the following proposed components of the annual update:

- Community needs assessment (page 42) – As noted above, we recommend that community needs assessments be performed by neutral, independent entities that are not providing the services in question. This is important in assuring that the most appropriate intervention (not the most convenient or the cheapest) is selected, thereby increasing the chance of a successful outcome.
- Contractual safeguards around prompt payment in the VBP model (page 47) – HSC strongly recommends that such safeguards be included in the annual update, that they extend to CBOs, and that there be concrete consequences for noncompliance, including the payment of interest. Safeguards should include advance payments or the availability of loans to enable CBOs to begin service delivery on time.
- Funding to facilitate CBOs' transition to VBP (page 54) – HSC strongly supports the allocation of funding to help meet the capacity, monetary, and infrastructure needs of CBOs that choose to participate in the VBP model, and we encourage DOH to be more specific in describing the potential funding structure. As mentioned above, funding should include advance payments or a loan fund to stave off cash flow challenges.
- "VBP bootcamps" (page 58) – Training for VBP providers is essential, but the education needs of hospitals and CBOs are different. Hospitals need to learn how the CBO model works, including the many regulatory and financial constraints within which CBOs operate. CBOs need additional training to be able to assess their ability to participate in the VBP model in the first place, as well as to function under the new model. Both groups need to be trained to work with each other. As advocated by MMNY, the State and/or a third party should develop educational materials on VBP that focus on both CBOs' role in the system and guidance on the value proposition CBOs should expect to provide when contracting with providers, provider networks, and MCOs. Additionally, the State and/or a third party should provide technical assistance to providers, provider networks, and MCOs' (non-CBO) contracting entities on how to work effectively with CBOs in need of assistance.

HSC recommends that DOH add the following components to the annual update:

- A mechanism for CBOs to participate in the development of outcomes metrics – Too often, CBOs are held to standards and milestones that have no basis in research or experience. The imposition of unrealistic metrics inevitably results in "failure" of interventions. CBOs must have a role in setting establishing the metrics by which their value will be measured to ensure accuracy and fairness.
- Creation of a body charged with overseeing the relationship between MCOs and CBOs and between VBP contractors and CBOs to ensure genuine collaboration – Some CBOs have already encountered difficulty working with health care providers in VBP arrangements. There must be vigilant oversight to foster collaboration and ensure that payment rates are fair.

Medicaid Managed Care

The "Care Management for All" initiative has the potential to revolutionize care for Medicaid consumers, but only if consumers have access to meaningful care coordination. HSC agrees with MMNY's position that individual, independent consumer assistance services should be available to anyone in any managed care model, and we second their recommendation that the Independent Consumer Advocacy Network ("ICAN") be sufficiently supported and ultimately expanded to realize this goal. Finally, as MMNY pointed out, extra attention must be paid to the transition to Medicaid Managed Care for populations with special needs, including children and people with intellectual or developmental disabilities, for continuity of care is of special importance.

Conclusion

The importance of social determinants of health cannot be overstated, and the role of CBOs in addressing these factors cannot be overlooked in the process of health care reform. HSC commends DOH for recognizing that CBOs will be an indispensable partner in improving health outcomes across the State. At the same time, we stress the need for better understanding and support of these organizations going forward. They must be adequately funded and meaningfully engaged in decision-making and service delivery if they are to fulfill the promise of better health and lower costs. HSC stands ready to assist the State in making sure that they are.

Thank you.

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Thank you for the opportunity to comment on New York State's Waiver 1115 programs. The Health and Welfare Council of Long Island (HWCLI) is a non-profit member organization serving the interests of the poor and vulnerable people on Long Island and is currently involved in both the Suffolk Care Collaborative (Suffolk County) and the Nassau Queens Performing Provider System. In the decade before the enactment of the ACA, the Health & Welfare Council of Long Island (HWCLI) served as one of Long Island's two lead agencies in New York State's Children and Family Health Insurance Facilitated Enrollment Program and currently serves as a Navigator Agency to assist with enrollments through the NYSOH.

As the draft waiver document has not yet been made public, we are unable to comment on those proposed changes and will instead comment on HWCLI's concerns regarding several components of the current Waiver 1115 programs.

1. Value Based Payment and Social Determinants of Health

HWCLI supports recent changes to the Value Based Payment Roadmap that further clarify the role of the CBO in VBP arrangements by requiring the inclusion of a Tier 1 CBO in VBP arrangements. We urge the State to further define the role of CBOs in VBP arrangements as it remains unclear how CBOs might share in savings generated by these arrangements.

HWCLI recommends that the State take further measures to expand CBO engagement and capacity. CBO's throughout New York State are critical to each and every PPS. However, many health systems and health providers are unaware of the role they play in connecting with and serving the project's target consumer. HWCLI recommends that the State provide educational materials and guidance for MCOs and provider networks on the value of working with CBOs, how to work with CBOs and the value of the services CBOs provide. Materials for CBOs should focus on the role of the CBO in the VBP system and guidance on the value proposition CBOs should expect to provide when contracting with providers/provider networks. In addition, HWCLI recommends the State provide funding for CBOs to facilitate their participation in VBP arrangements. CBOs will need funding for infrastructure development, IT systems, data collection and measurement systems, and contracted services such as fiscal and legal expertise. Without additional support, many CBOs may lack expertise or capacity to enter into VBP arrangements. In addition, HWCLI recommends that the State explore mechanisms for how it could assist and support CBOs if payment or cash flow issues arise.

As a health and human service member agency that works tirelessly with its partners and the consumers they serve, HWCLI strongly suggests that that the State continues to evaluate and assess how social determinants of health impact all projects and all PPS's. The role of CBO's throughout local communities is critical to the overall success of the Statewide DSRIP program. However, infrastructure and capacity within CBO's have to be supported for them to fully execute their roles.

2. Funding for CBOs

While the PPS's have thus far been very successful in reaching established goals, the most recent Independent Assessor PPS Project scores from February 2016 indicate that the majority of PPS's have not met 100% of goals for each project. Since funding is distributed based on percentage of deliverables met, not all funding is being distributed to PPS's. HWCLI recommends the State explore using undistributed DSRIP funds for CBOs to support their involvement in partnerships with PPS's.

Although PPS's express interest in addressing social determinants of health as part of their care models, there is often a mismatch between the perceived need and the dollars available to fund these interventions. New York's waiver permits only 5 percent of PPS funds to be flowed directly to non-safety-net providers. This category includes clinical providers that do not meet the state's definition of a safety-net provider and nonclinical social support services. As a result, PPS's have had to develop workarounds to flow funds to CBOs that do not provide Medicaid-reimbursable services. CBOs are an untapped resource crucial to meeting DSRIP's goals. They are well positioned to address population health issues; have long-standing, trusted community relationships; and provide critical services to New York's most vulnerable populations. The role of CBO's throughout local communities is critical to the overall success of the Statewide DSRIP program. However, infrastructure and capacity within CBO's have to be supported for them to fully execute their roles. HWCLI recommends the State provide funding for CBOs to facilitate their participation in DSRIP projects. The State should invest in CBOs that show promise in helping to address social determinants of health.

3. Medicaid Enrollment Services

As a lead agency in New York State's Children and Family Health Insurance Facilitated Enrollment Program and now as a Navigator agency, HWCLI has many years of experience assisting low-income Long Islanders with enrolling in Medicaid. After the enactment of the ACA, the number of people eligible for coverage expanded exponentially in New York. Many individuals requested assistance with navigation services, including the Medicaid population. However, the State's navigation system did not have the capacity to meet the need. This was particularly concerning in areas like Long Island, where there is a high percentage of individuals eligible for Medicaid coverage, but a shortfall of navigation assistance. The lack of capacity combined with Long Island's geography: isolated communities and lack of public transportation, make it difficult for the most vulnerable populations (such as those eligible for Medicaid) to access navigation services.

HWCLI recommends increasing funding for enrollment services for Medicaid clients. Consumers that are unable to find an available Navigator must either complete their application online (many LMI individuals do not have access to a computer) or by calling the New York State of Health Marketplace call center, frequently facing long wait times during Open Enrollment. Long Island lacks sufficient capacity to assist those that need help enrolling in health insurance. HWCLI also recommends the State consider allowing Navigators and Certified Application Counselors to complete enrollments over the phone. Each year during Open Enrollment or

during periods of inclement weather, the State allows phone enrollments for only a limited time frame. Phone enrollments would enable Navigators to more efficiently assist more consumers with their enrollments and renewals. The limited number of Navigators currently available in Nassau and Suffolk cover over 100 miles, requiring extensive travel time for the Navigator and making it difficult for those without access to a car or with disabilities to meet with someone in person.

In closing, we are appreciative of the opportunity to provide comments and recommendations on New York State's 1115 Waiver programs.

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The New York Immigration Coalition
Testimony on Delivery System Reform Incentive Payment Program to the New York State Department of Health and DSRIP Project Approval and Oversight Panel

Claudia Calhoon, MPH

May 4, 2016

Thank you for the opportunity to present this testimony. My name is Claudia Calhoon and I am the Director of Health Advocacy at the New York Immigration Coalition (NYIC). I also serve on the Executive Committee of the OneCity Health Performing Provider System (PPS). As a representative of the NYIC, an umbrella policy and advocacy organization of nearly 200 groups working with immigrants and refugees, I have close contact with community-based organizations (CBOs) and other partners with key capacity to help New York's Medicaid and uninsured make the best use of our changing health care system. As a member of the OneCity Health Executive Committee, I have also had the opportunity to support the creation and development of that PPS, which cares for hundreds of thousands of immigrant patients across the five boroughs of New York City. Although my testimony is informed by these diverse perspectives, my comments are made in my capacity as an advocate.

DSRIP presents New York with a unique opportunity to transform its health care system. Among the most important components of the program's design is its recognition of the key role of CBOs to reorient the health care delivery system from an overreliance on episodic emergency and hospital-based care to a model that prioritizes preventive, community-oriented, coordinated, culturally competent care. While attention has been paid to the importance of CBOs in DSRIP's program design, their ability to contribute to governance, project design, and implementation has not been fully realized. Some PPSs, including OneCity Health, have made concerted efforts to engage CBOs but overall what we hear from our members is that it's a struggle to participate meaningfully in this complex enterprise. In general, the overall DSRIP approach prioritizes the needs and desires of large hospital-centered systems and strategic supports are missing to enable CBOs to participate as full partners.

At a basic level, the very definition of CBOs in the context of DSRIP remains ill-defined. Without clarity on who falls under the CBO umbrella, it is difficult to know how best to engage or issue guidance to PPS members. Communities Together for Health Equity Coalition, a group of CBOs and advocacy organizations, including the New York Immigration Coalition proposed the following definition to the Project Approval and Oversight Panel co-chairs: "Community-based organizations (CBOs) are locally-controlled and consumer- or people-oriented entities that foster independence and self-sufficiency in the overall improvement of human welfare and

NEW YORK IMMIGRATION COALITION

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well-being and reflect the values of the community in which they reside. CBOs do not generally or typically provide clinical services. However, they do provide critical programs and services that address the health care and social needs of their community." We recommend that the state consider adopting this definition, and issuing guidance to PPSs that help them assess whether their partners include sufficient numbers of CBOs.

For many CBOs the sheer complexity of the governance structure of PPSs that care for their clients serves as a barrier to getting involved. CBOs cannot fully participate in DSRIP without funding to increase their capacity to participate as full partners. The NYIC and its partners were heartened by the commitment of $2.5 million in strategic planning funding for CBOs. CBOs need to develop infrastructure to help them identify how they want to participate and up to now there has not been time/funding to do so. CBOs are diverse in size, mission, and in the types of cultural competence, health equity, and social service expertise that they bring to the DSRIP endeavor. Some will want to strengthen within a niche community or issue, while others will want to evolve into a broader range of services within or across geographies/cultures. As the state moves toward value-based payments, it is essential that CBOs have support to contribute to the success of project to redesign clinical care. We urge the state to move expeditiously to make the $2.5 million available in the near future.

Even in instances in which partnerships have been established, the lack of clarity on the timing and formulas for funds flow more generally have discouraged CBOs from partnering with PPSs. While funds flow delays affect all types of organizations participating in DSRIP, they are particularly harmful to smaller CBOs that need significant injections of funding to meaningfully fulfill their key roles as culturally competent links between the health care system and the underserved, under-resourced, and/or isolated communities they serve. Even CBOs who have been approached or engaged by PPSs in their community report that the contracting opportunities do not always remunerate them sufficiently to make their efforts worthwhile, particularly for tasks like hiring community health workers or other projects that involve supervision, fringe benefits, and overhead costs. Until CBOs have a clear mandate with corresponding funding levels, the full potential of DSRIP remains untapped.

Although the implementation of Project 11 to engage the uninsured is in its early stages, I want to highlight concerns we have about it. There's a tremendous push for Project 11-participating institutions to administer as many patient activation measure surveys (PAM) as possible. We want to highlight the equal importance of concrete planning and tracking mechanisms for linking these patients to care, and for leveraging proven methods like motivational interviewing. It's essential to ensure those data translate to patient engagement, activation and improved utilization. Just administering PAM surveys without support for the capacity to do intensive and time-consuming enrollment and navigation calls into fate of Project 11.

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A final area of concern in the overall DSRIP structure is the combining of cultural competency and health literacy into a single programmatic rubric. The conflation of two crucially important but distinct areas is troubling. Cultural competence is about the way the health care provider delivers care. Culturally competent care is a set of behaviors and practices on the part of the health care provider that reflects an understanding of a patient's background and beliefs related to their health care and larger social context. This includes the language in which they prefer to receive care, but extends into a communication of respect by the health care provider for the values and assets that the patient brings to the encounter with the health care system. Health literacy, on the other hand is "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions."[i] It is about the resources and tools with which the patient approaches their health care experience. Culturally competent care should always take into consideration an individual's level of health literacy, but to assume that the two areas have sufficient overlap to be condensed into a single strategy plan indicates a misunderstanding of them as single phenomenon, when in fact they are separate challenges reflecting in the behaviors of distinct groups of stakeholders.

The shortcomings of the program design that I have outlined here may be, in part, a symptom of the lack of community engagement and opportunity for public comment during the development of the 1115 waiver itself, of which DSRIP is such an important component. The more involved affected communities are from as the process unfolds, the more likely programs will succeed.

Despite the concerns outlined in this testimony, there is time for DSRIP to turn a corner and achieve what it was designed to do. Transformational change requires the buy-in of non-traditional partners and affected communities. I am confident that safety-net providers and community-based organizations, and the communities they serve, are prepared to undertake the challenges of system redesign provided that they are given the resources and decision-making power they need. I look forward to working with the Department of Health, the DSRIP Project Approval and Oversight Panel, and all of New York's Performing Provider Systems to ensure the success of DSRIP. Thank you for your time today.

[i] http://health.gov/communication/literacy/quickguide/factsbasic.htm

NYS Council for Community Behavioral Healthcare

May 13, 2016

NYS Council Comments on New York's 1115 Waiver Programs

The NYS Council for Community Behavioral Healthcare appreciates the opportunity to submit comments on behalf of our members on New York's 1115 Waiver Programs.

Our organization is a statewide non-profit membership association representing the interests of 100 behavioral health (mental health and substance use) prevention, treatment and recovery organizations across New York. Our members include free standing community-based agencies, general hospitals, and counties that operate direct services.

The NYS Council and its members support the State's work with the Centers for Medicaid and Medicare Services (CMS) to negotiate an updated waiver to improve and strengthen the State's health care system. The waiver is an important vehicle for the State to implement the initiatives of the Medicaid Redesign Team and subsequent health system reforms, including the Delivery System Reform Incentive Payment (DSRIP) program. We also support the concepts of the "New York Partnership Plan" which will incentivize the service delivery changes needed to increase access to community-based care and decrease avoidable hospital and inpatient admissions.

DSRIP Programs

We have concerns about the focus of the Medicaid redesign and DSRIP programs being primarily on hospitals and health plans alone. There needs to be integration with community providers to help the hospitals and health plans address social determinants of health and reach DSRIP goals. Planning and implementation needs to reflect where people want to access care in the community, at providers with long term experience and awareness for culturally sensitive services.

In addition, the flow of the DSRIP funds must be more transparent; PPSs must provide more clarity and specificity in their funds flow reporting. And, for DSRIP funds not allocated or fully spent by PPSs, these funds should go to CBOs (in addition to the funds some are getting directly from the PPSs for project implementation).

Value Based Payment (VBP)

The NYS Council supports the move to VBP; however, with this change there still must be stability for community-based organizations. VBP arrangements at Level II or Level III must be held to the requirements that they contract with at least one CBO and employ at least one intervention to address a social determinant of health. CBOs will need support to enable and foster their participation in VBP arrangements and therefore the State and VBP lead entities must provide funding to CBOs for technical assistance, contracting for outside expertise, and adequate training and information technology resources to ensure our success in the program.

We also believe that behavioral health performance measures are vital in creating the new system for value-based payments. However, the established value-based measures were designed for a physical health care system. The behavioral health piece of VBP is still emerging. Therefore, it is essential to develop outcome measures that truly reflect the work of helping people to transform their lives as well as develop opportunities for true integration of care. Providers should be held accountable to metrics that reflect these outcomes we want to attain under DSRIP, VBP and the overall vision of the MRT.

Medicaid Managed Care

A majority of the changes to Medicaid Managed Care associated with implementing VBP will need to be incorporated into the Model Contract and therefore the Model Contract revision process must be made more transparent to allow for public input.

In addition, the State's "Care Management for All" initiative, which will require most Medicaid beneficiaries and services be in mandatory managed care, must ensure access to true, meaningful care coordination.

Thank you for the opportunity to provide comments on New York's 1115 Waiver Programs. If you have any questions, please contact me at (518) 461-8200 or nyscouncil@albany.twcbc.com.

Sincerely,

Lauri Cole

Lauri Cole
Executive Director

Davis, Kathleen M. (HEALTH)

From: doh.sm.delivery.system.reform.incentive.payment.program
Sent: Thursday, May 05, 2016 9:11 AM
To: Weinstein, Brooke A (HEALTH)
Subject: FW: DSRIP Public Comment Day May 4th, 3016

From: [redacted]
Sent: Wednesday, May 04, 2016 9:43 AM
To: doh.sm.delivery.system.reform.incentive.payment.program <dsrip@health.ny.gov>
Subject: DSRIP Public Comment Day May 4th, 3016

May 4 DSRIP Hearing Remarks

Thank you for the opportunity to give our comments on the DSRIP process today.

The New York State Nurses Association is the union that represents 37,000 registered nurses in New York State. We are committed advocates for improving the quality of health care and for providing universal access to care to all residents of New York. We have been involved in eighteen Performing Provider Systems around the state, including all of the downstate PPS's.

In order for DSRIP to be successful, frontline workers like nurses must be involved. We can help shape clinical projects, as well as the broader PPS structure and implementation. However, the level of participation that we are permitted to have in the governance of the PPS's has been inconsistent. Mt. Sinai, Maimonides, and HHC have included NYSNA on their governing boards, where we are able to influence broad PPS decision-making. None of the other PPS's have allowed this level of participation. We would also like to be allowed to participate in more of the clinical committees; right now, we are only on clinical committees at HHC, Maimonides, and Staten Island. Everywhere else, we have been relegated to the workforce development committees. While it is vital that we arepart of the committees that address worker issues, especially on PPS's where there might be significant workforce displacement, we need involvement in the clinical and governance sides too.

On the committees that we have been placed on, the desire for our input has also been variable. Some PPS's see us as important parts of the decision-making process—we have been able to guide and influence decisions at HHC, for example. But thus far, others have allowed little room for meaningful participation and discussion. Some decisions are clearly made before the committees have been allowed to weigh in. For example, even though we are on the Board of the Mt. Sinai PPS, when we raise concerns about issues like community health workers doing work that a licensed medical professional should do, no changes are ever made and the issue is not brought up again. DSRIP committees are fundamental parts of the process and should not just be rubber stamps for decisions made by PPS lead entities.

In addition, Stony Brook and Advocate's workforce committees meet only quarterly (and Advocate has had only two meetings since the process began). There is little opportunity for us to give any input.

We firmly believe the process will be more successful with our meaningful participation across committees, as well as with the full participation of local communities, health care advocates, and community-based organizations. We want to emphasize that we believe that CBOs are critical partners in communities that suffer disproportionately from chronic disease and need to be fully included. We are concerned that not all of the PPS's are living up to DSRIP's democratic and inclusive goals.

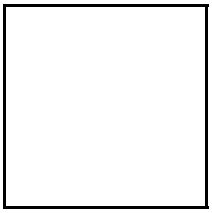
We remain troubled by the lack of transparency in the program. The quarterly reports tend to be vague. They lack description and specifics, especially in relation to plans for workforce hiring and training.

The quarterly reports also have no standardized levels of disclosure about certain items, like detailed lists of committee participants and identification of organizations that are lead participants in the PPS's. Indeed, we continue to be unsure about who is really participating in PPS's and on what level. The membership lists of PPS networks posted on the DSRIP website appear to be incredibly broad, with some organizations listed as belonging to more PPS's than seems reasonable.

We also seek clarity on certain patient care issues. Care management is expected to be an important part of DSRIP and of the restructuring of our delivery system as we move forward. But it seems that many important decisions have yet to be made about who these care managers are, what their titles and roles will be, and what kind of training, education, and certifications they will require. It is also unclear how they will interact with clinical staff at acute and sub-acute facilities.

Finally, we continue to worry that some of this work may involve RN functions, including, among others, the clinical assessment and teaching of patients. Without being able to serve on clinical committees, it is very difficult for us to assess whether the roles being assigned to care managers, or patient navigators, or community health workers, are actually appropriate.

Thank you again for allowing me to make these comments on behalf of the 37,000 members of NYSNA. We hope that we will have an opportunity to publicly comment specifically on PPS quarterly reports in the future. As we observe the effects of the DSRIP process on our patients, communities, and workforce going forward, we believe public input will be essential to a successful process.



Sent from my iPhone

To whom it may concern,

We, at the East Harlem Community Health Committee, Inc. (EHCHC), would like to first express our appreciation for the opportunity to comment on the state's implementation of the Delivery System Reform Incentive Payment (DSRIP) program. We hope that these comments are clear and can be useful in improving this program.

EHCHC has had nearly 40 years of experience working with different providers, community based organizations (CBOs), and residents in East Harlem promoting the health of our community. Over these years, we have continually been reminded of the vast disparities that exist in our health system. These are disparities that we have attempted to address on the ground, by working with the leaders of the community who are devoted to the health of our neighbors, because we believe in a vision of change that values these grassroots leaders. We recognize, however, that new policies and government programs play a key role in improving our health care landscape as well, and we hope that DSRIP will be such a program. At EHCHC, we laud the vision of creating a more coordinated, more connected health system that is at DSRIP's forefront; however, we are greatly concerned that if changes are not made to how this program is implemented, it will not succeed. In this comment, we hope to highlight these concerns, and we attempt to provide a vision for how they can be addressed moving forward.

The concerns of the EHCHC that will be focused upon in this comment revolve around two key, interconnected aspects of DSRIP: the position of CBOs within the structure of the Performing Provider Systems (PPSs), and DSRIP's attempt to address social determinants of health.

The goal of New York's DSRIP has been articulated by the Department of Health as aiming to reduce avoidable hospitalizations across the state by twenty-five percent over its five-year span. To do so, the State has recognized the need for better cooperation between providers and CBOs and has attempted to introduce such with the creation of Performing Provider Systems (PPSs). These systems aim to foster collaboration and partnership, but growing discontent about the way they were structured harrows the possibility of their success. In general, CBOs feel that their visions are not being incorporated and that their expertise is not being valued within the PPSs. This concern is ubiquitous; it is continually voiced whenever DSRIP is discussed. CBOs lament that they were not involved in the initial planning phases of DSRIP by the hospitals in charge of the PPSs, and they explain that they have yet to see any funds for the projects that will be implemented. This is not just a few, sparse CBOs who are voicing these concerns. In fact, such concerns were explained in The Commonwealth Fund's recent report titled "Implementing New York's DSRIP Program." This report[1] states that many of the stakeholders interviewed by the researchers highlighted "the dominance of hospitals in the governance and leadership of PPSs" (15) as a concern. This disconcerting power differential between hospitals and CBOs, we believe, has lead to the perception that DSRIP is—in the end—about nothing more than the hospitals, and that the inclusion of CBOs is simply an opportunity to say that communities are being engaged.

This feeling can also be supported by the apparent flow of funds from the State to the actors within DSRIP. The advocacy group Communities Together for Health Equity (a collective voice of CBOs with whom EHCHC is not officially affiliated), has been organizing as part of the Commission on the Public's Health System. This group explained to EHCHC that almost a year ago, CBOs organized and spoke to the New York Department of Health about the need for strategic planning dollars for community organizations. At this meeting, a commitment was made by the Department

of Health to distribute $2.5 million amongst CBOs for planning; however, nearly a year later now, this money has not been seen. On the other hand, this group of CBOs watched as Governor Cuomo found an additional $1 billion for the implementation of DSRIP when hospital leads found that they had underestimated the cost of implementing the program. Once again, as explained by Communities Together for Health Equity, CBOs felt that they were being left out and undervalued in the implementation of DSRIP.

We at EHCHC believe that engagement of CBOs is of paramount importance to the success of DSRIP in improving the health of our communities. Therefore, we find the overwhelming dominance of hospitals within the systems that are charged with reshaping the way health is delivered to be at odds with the goal of DSRIP. It seems that the goal to reduce avoidable hospitalizations relies on a restructuring of our health care system so that the health of the population can be addressed outside of the hospital. Yet, the experiences of the CBOs with whom we have spoken (and the experiences highlighted in The Commonwealth Fund's report) suggest that the hospitals are being put in charge of creating this new structure. In our eyes, this is incongruent. If we truly hope to improve the health of our communities and address health needs outside of hospitals, we need to allow voices outside of hospitals to be heard. We need to allow our leaders in community health—our CBOs—a more equitable position in the governance and the decision-making processes of the PPSs.

This lack of CBO involvement in PPS planning is closely linked with the second concern that we would like to highlight. DSRIP and the PPSs in charge of implementing the program have continually expressed a desire to focus on a broad vision of health, one which includes not only the biological determinants of health, but the social determinants as well. These social determinants—including access to safe housing, healthy food, quality employment opportunities, and many other factors of day-to-day life—are directly linked to the health of our communities. In fact, many of our greatest advances in public health have come from addressing social, not biological, determinants of health (i.e. access to clean water). With this new legislation, social determinants have been repeatedly touted as important—and continuously repeated as a way that DSRIP will revolutionize health care delivery—but sadly, there seems to be a lack of real commitment to this ideal in the way the program was designed. Specifically, it seems that there is a lot of talk about the importance of addressing social determinants, but that this rhetoric is not supported by the amount of money made available to specifically address them. In fact, it is written into the (1115) waiver that outlines DSRIP that only 5 percent of PPS funds can flow to "non-safety-net providers," that category that includes nonclinical social support services (i.e. services addressing social determinant of health). As explained in The Commonwealth Fund's report[1] this has led to PPSs having to search for ways to work around the system in order to fund CBOs that address social determinants of health in non-Medicaid-reimbursable manners. Once again, this seems to highlight a major inconsistency in DSRIP that we believe could pose a substantial barrier to the goals of DSRIP being met.

In order to address these concerns, changes must be made to the way DSRIP is structured and implemented. First, the commitment to addressing social determinants of health must be made in more than just rhetoric. PPSs should not be handcuffed by this 5 percent limit when the services provided by nonclinical social support groups are among the most powerful tools we have to address the care of our population in the community. Of course, if PPSs are not restructured in a way that CBOs have a real say in the decision making process, this may not matter, for hospitals should not be the sole decision-makers about what factors need to be addressed outside of the hospitals. Therefore, it is necessary that the structure of PPSs is re-negotiated as well. Here, we are

not asking the State to dismantle the PPSs that have been invested in heavily over the last years of DSRIP planning. Rather, we are asking the state to redefine the terms and conditions by which the hospital systems in charge of the PPSs partner with CBOs. These new terms and conditions, which should be planned in conjunction with CBOs, must include a requirement of community (and CBO) engagement that is clear and process-driven. They must include a clear statement about the role of CBOs as PPS partners in more than just name. And they must include requirements such as the inclusion of CBOs, or CBO consortiums, in the decision-making process before PPS plans are rolled out. In redesigning engagement terms in this manner, we believe that the State will be fostering an environment in which CBOs can engage in DSRIP knowing that their voices are valued. And we believe that such engagement will not just benefit our CBOs, but also the PPS leaders and, most importantly, our communities.

DSRIP is a sweeping reform of an already complex system. Reaching the goals of such a reform will not be done without overcoming barriers. While we think that the lack of CBO inclusion in PPS decision making and the lack of a financial commitment to addressing social determinants of health present substantial obstacles to the success of DSRIP, we do not believe them to be insurmountable. Instead, we believe that by requiring PPS leaders to commit to a process-driven engagement of CBOs and by making a real commitment to addressing social determinants of health, DSRIP will be on track to not only reduce unnecessary hospital use, but to also make a positive impact on the health of our communities, an impact that many communities—such as East Harlem—greatly need.

Thank you again for the opportunity to comment on this program.

Sincerely,

The East Harlem Community Health Committee, Inc.

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

PRIMARY CARE DEVELOPMENT CORPORATION

www.pcdc.org

Primary Care Development Corporation Comments on the New York State 1115 Waiver

May 13, 2016

Thank you for the opportunity to comment on the New York State 1115 Waiver. Our comments focus on the issues related to primary care in DSRIP, Medicaid Managed Care and the Health Homes program.

The Primary Care Development Corporation (PCDC) is a nonprofit organization dedicated to expanding access to quality primary care in underserved communities. We have helped hundreds of primary care practices strengthen their care management functions and transform into patient centered medical homes (PCMH), financed over $500 million in primary care capacity in New York State and advanced polices that support sustainable primary care, particularly as our delivery and payment system undergoes a major shift toward value.

PCDC strongly believes DSRIP must deliver on the "primary care promise," because primary care is fundamental to the improvements we are seeking in the transformation of the delivery and payment systems. The impact of DSRIP will be felt well beyond the five years of the initiative, so strong, early and sustained commitment to expanding access to quality primary care must be a central priority in DSRIP.

How is New York State faring when it comes to primary care? The good news is that primary care is emphasized in DSRIP and the Value Based Payment Roadmap. The Patient Centered Medical Home (PCMH) Medicaid Incentive Program has driven the remarkable expansion of PCMH across New York State. Currently, no fewer than three statewide "primary care transformation" initiatives are underway, which we hope will lead to further expansion of high quality primary care and help put primary care in the value based payment (VBP) driver's seat.

However, engagement of primary care providers (PCPs) and other community-based providers has varied by Performing Provider System (PPS), and DSRIP and capital funds have not yet flowed sufficiently to support DSRIP primary care goals. While there is a great deal of activity *involving* primary care, we believe that we need to increase the extent to which we are *investing in* primary care. To our knowledge, there is currently no assessment of how much New York State spends on primary care, though research suggests that it represents only 3-7 percent of national health care expenditures.[i] [ii]

DSRIP Recommendations

1. **DSRIP Primary Care Plan:** DSRIP relies heavily on primary care, and expanding quality primary care is a stated DSRIP priority. However, when the terms and conditions were finalized, DSRIP lacked a mechanism for defining the important primary care objectives and metrics necessary to measure success. We are encouraged that NYS DOH will now require all PPSs to develop and implement

Primary Care Plans and will have a dashboard to measure progress. Based largely on PCDC's "Principles for Primary Care in DSRIP," Primary Care Plans will include:

- An assessment of current primary care capacity, performance and needs, and a plan for addressing those needs;
- How primary care expansion and practice and workforce transformation will be supported with training and technical assistance;
- How primary care will play a central in an integrated delivery system;
- How the PPS will enable primary care to participate effectively in value-based payments;
- How PPS funds flow supports the PPS primary care strategies; and
- How the PPS is progressing toward integrating primary care and behavioral health

Recommendations:

- ***Primary Care Plan data should be timely, meaningful and actionable***. We recommend that NYS DOH ensure that the information that is collected, reported and disseminated is meaningful and actionable in a timely manner for all PPSs, policymakers and advocates, and work with primary care stakeholders to help develop and monitor this information.
- ***The implementation timeline should be shorter.*** We understand that the Primary Care Plan Dashboards will not be operable until late DY3 or early DY4, which will not give PPSs sufficient time to make course adjustments to their primary care plans.
- ***Primary care spending should be measured at least annually at the PPS and statewide level.*** We look forward to information on spending at the PPS and statewide level to inform the evaluation of the depth and strength of primary care transformation catalyzed by DSRIP.

2. **Expanding Primary Care Capacity:** Most DSRIP projects rely on expanded access to high quality primary care. Of the $1.5 billion in capital funds distributed this year, over 90% went to hospitals (which included some funding for hospital-owned primary care expansion and integration) and less than 10% went to community based primary care and behavioral health providers. This alone will not address the capital needs of the primary care sector to achieve DSRIP goals.

Recommendation:

- Prioritize community-based primary and behavioral health care in future capital fund distribution.

3. **PPS Engagement and Funds Flow:** According to the third quarter DY1 PPS reports, relatively little funding has been distributed to primary care to date. Early investment is critical to engaging primary care practices and ensuring they have the resources to lead or participate in DSRIP projects that rely on primary care and community based providers.

Recommendation:

- Ensure that every PPS is supporting primary care and other community based providers through timely and adequate funds flow.

4. **PCMH/APC Alignment:** New York State has three statewide primary care practice transformation initiatives that support a common goal: to enable practices to participate in new health care payment and delivery models that aim to transform New York State's primary care system. DSRIP requires all participating PCPs to become Level 3 PCMH or APC practices by 2018; The State Innovation Model expects 80% of the population to be served by APC practices by 2018, which will entail multipayer alignment on metrics and payment models; and the Transforming Clinical Practices Initiative, which supports New York State Practice Transformation Network to help 11,000 PCPs participate in new payment and delivery models.

   These initiatives, however, appear to operate separately, creating confusion and inefficiencies for practices and health plans that contract with them.

   Recommendation:

   - ***Adopt a unified approach to PCMH/APC.*** New York State should adopt a common approach to PCMH/APC, particularly with regard to metrics and payment methods. Practices that participate in PCMH/APC should have assurances that Medicaid, Medicare *and* commercial value based payment models will support and sustain their efforts in ways that do not overburden them with multiple reporting requirements and payment methods.

Medicaid Managed Care Recommendations

5. **Measuring Primary Care Spending in Medicaid:** Information about primary care spending as a share of overall health care spending is not readily available, either by Medicaid managed care plan (or any health plan) or as a share of total health care spending in New York State. As we embark on major changes in how primary care is delivered and paid for, it is important to understand the financial underpinnings of primary care. Documenting the share of overall spending, as well as what makes up that spending can serve as an important indicator of investment in primary care. Sufficient investment is essential to building strong primary care networks that have the infrastructure to improve individual and population health, gather and share data, coordinate patient care, and generate savings in overall health care costs.

   Initiatives to measure, report on and increase primary care spending are being considered and adopted in other states that are undertaking health care payment and delivery reform. Rhode Island, for instance, required all commercial plans to increase primary care spending by one percent of total spending per year over five years, which nearly doubled primary care spending as a share of total health care spending over that period.[iii] A recently-passed Oregon state law now requires that state to report on the percentage of medical spending allocated to primary care by all health plans under its authority.[iv]

   Recommendations:

   - ***Measure and publicly report primary care share of health spending.*** All Medicaid managed care plans, and New York State Medicaid as a whole, should measure and publicly report primary

care spending as a share of total health care spending, using a common definition, and provide a breakdown within primary care by types of services (e.g. clinical, care management, practice transformation support, infrastructure investment) and by types of payments (e.g. FFS, PMPM, bonus payments, shared savings) This information should be reported in a way that enables consumers, providers and policy makers to easily compare spending on primary care across health plans, and to measure primary care spending in New York State regionally and as a whole.

- ***Ensure sufficient investment in primary care as a share of overall spending.*** While there is likely spending variation between plans, all health plans must invest adequately on primary care as a share of total health care spending. The level of investment by New York State should reflect the value that primary care brings to individual and community health, the health care system and payers' networks.

Medicaid Health Home Recommendations

6. **Regularly evaluate Health Homes to drive improvements in the program:** We applaud New York State for embarking on a Health Homes program that is working to solve one of the most difficult problems in health care – providing effective care management for the population that is hardest to reach, hardest to keep in care, has the most complex health and social issues and is responsible for the highest proportion of Medicaid costs. We also recognize that there have been significant challenges to the Health Home program, including with enrollment, information exchange, administrative and payment systems, and organizational capacity.

   We are encouraged that New York State is currently evaluating the Health Home program. However the outcomes data being used (2013 and 2014) are insufficiently timely to be actionable.

   Recommendation:

   - To be most effective, Health Home providers need timely and regular utilization, clinical and cost data. This information should be made available to all Health Home leads, downstream providers, researchers, policymakers and other stakeholders. This information will enable timely, mid-course corrections as well as a comparative analysis of Health Home models and Health Home-supported interventions to determine what has the most significant and sustainable impact on outcomes, utilization and cost.

7. **Pay Health Home providers predictably and prospectively:** Retrospective payments can have a significant impact on a Health Home's ability to invest in and perform robust care management functions including non-face to face activities such as case conferencing.

   Recommendations:

   - Pay Health Homes prospectively based on patient enrollment and acuity, and require Health Homes to pay downstream providers prospectively whenever possible. Adjudication should be conducted retrospectively. This will enable better planning and investment in care management services.

- PCPs should be compensated for time spent in case conferencing at a level commensurate to an office visit.
- Health home payments should support the whole care team (including primary care and behavioral health providers as well as care managers), as their collective engagement is essential to effective care management. Appropriate payments should be be made for high-value activities such as post hospital/emergency room discharge encounters with the PCP and/or care team, case conferencing and home visits.

8. **Ensure and facilitate IT interoperability in Health Homes:** Medical care, behavioral health care and care management are often on separate IT systems that do not easily communicate with each other. This hampers the ability of providers and care managers to see and update diagnoses, medications and care plans, creating barriers to care coordination and continuity of care.

   Recommendation:

   - Provide guidance, standards, and resources for all those participating in the Health Home program to ensure that they are using systems that are fully interoperable and provide technical assistance and financial support to help providers overcome interoperability issues.

9. **Enable patient enrollment strategies that support integrated care.** Low enrollment and retention in Health Homes has been an ongoing concern. Successful enrollment programs involve the active participation of clinical providers and care team staff, and often are done more effectively from the source of care.

   Recommendations:

   - Enable Health Home providers to use real-time Medicaid claims and encounter data and coordinate with other social service agencies to find hard-to-reach patients.
   - Leverage algorithms and data analytic strategies that take clinical loyalty patterns into account to best determine to which provider/practice to assign patients, especially where there is no single provider.

10. **Reduce regulatory barriers that prevent integration of primary care and behavioral health:** Longstanding regulatory barriers impede integration of physical and behavioral health care. PPSs applied for (and often received) relief from regulations preventing primary care/behavioral health integration, but some barriers still remain.

    Recommendations:

    - Identify and address remaining regulatory barriers to integration.
    - Allow FQHCs and other providers to bill for a physical health and behavioral health visit on the same day when different providers are involved and the primary reason for the visit is distinct.
    - Support multiple models of integration.

Conclusion

The health system transformation sought by New York State through the 1115 waiver can only be accomplished with sufficient, quality primary care that is accessible to all families and communities. We are optimistic about the commitment New York State has made to primary care. We also recognize the need more investment and more effective policies to achieve the promise of primary care. We look forward to working with New York State and the many other stakeholders who share our concerns and our vision.

Contact:

Louise Cohen, CEO, Primary Care Development Corporation: 212-437-3917 / lcohen@pcdc.org

Dan Lowenstein, Senior Director of Public Affairs, Primary Care Development Corporation: 212-437-3942 / dlowenstein@pcdc.org

[i] Primary care spending is 3% of total spending for 50 million individuals under age 65 with employer-sponsored health insurance. "2014 Health Care Cost and Utilization Report" and Appendix, Table A18, pp 32-33. Health Care Cost Institute. http://www.healthcostinstitute.org/2014-health-care-cost-and-utilization-report Accessed 12/18/2015

[ii] Primary care spending is about 6-7% of Medicare spending. Phillips, R. L., and A. W. Bazemore. "Primary Care And Why It Matters For U.S. Health System Reform." Health Affairs (2010): 806-10. Print.

[iii] Primary Care Spending in Rhode Island: Commercial Health Insurer Compliance. Office of the Health Insurance Commissioner, State of Rhode Island. January 2014. http://www.ohic.ri.gov/documents/Primary-Care-Spending-generalprimary-care-Jan-2014.pdf Accessed 3/31/2016

[iv] Primary Care Spending in Oregon: A report to the Oregon State Legislature. February 2016. Primary Care Spending in Oregon A report to the Oregon State Legislature. http://www.oregon.gov/oha/pcpch/Documents/SB231_Primary-Care-Spending-in-Oregon-Report-to-the-Legislature.pdf Accessed 3/31/16

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May 12, 2016

Mr. Jason A. Helgerson
Deputy Commissioner, Office of Health Insurance Programs
Medicaid Director
New York State Department of Health
Corning Tower, Empire State Plaza
Albany, NY12237

Dear Mr. Helgerson,

This letter is being sent in response to the Department's request for comment on New York's 1115 Waiver Programs. As President of the Public Employees Federation (PEF), I am concerned about the impact that the Delivery System Reform Incentive Payments (DSRIP) program will have on the public health care providers and the critical services they provide.

PEF members proudly provide services and care for patients at public health care facilities across the state. Public health care facilities, including the state's public teaching hospitals, provide quality care to New York State's most vulnerable populations. The innovative care that the state's teaching hospitals provide is done while educating the health care professionals of the future. Maintaining the quality of care and the public status of these facilities for the patients, students and communities must be a priority for the state, regardless of the waiver agreements entered into with the federal government.

My comments on New York's Waiver Programs will be focused on concerns related to the DSRIP definition of safety net providers; the transparency and accountability of the DSRIP program; and the use of consultants for DSRIP and other Medicaid related programs.

The DSRIP definition of a safety net provider is too broad. Safety net providers are traditionally underfunded and provide health care services to a large population of Medicaid patients. Yet, New York State's DSRIP program identified 140 out of 185 facilities as safety-net providers.
Being deemed a "safety net provider" allows an organization to share in the full amount of potential performance payments of a Performing Provider System (PPS) in the DSRIP program. The state has determined, because of the definition adapted for DSRIP safety net provider, that 75 percent of participating facilities should receive a higher percentage of DSRIP funds.

Any definition of "safety net provider" that encompasses the majority of hospitals in the state is problematic. Ultimately, this will undermine the effect that "additional" funds could possibly have on the financial stability of the true safety net providers. That is the providers that consistently ensure that those who do not have access to insurance coverage are able to access the health care they need.

We recognize that New York State has many hospitals, both public and private, that serve the poor. However, past efforts (indigent care pools, for example) to subsidize the care of the medically indigent and uninsured in New York State have been undermined when payments to hospitals were largely unrelated to the number of poor they served.

In fact, hospitals providing only minimal services to the Medicaid and uninsured populations have a double advantage: they receive funds given to the state as a means of compensating for underpayment for care of the poor, and they will inevitably have better measurement of outcomes. A report by the National Quality Forum indicates that measures of quality care under federal guidelines are fundamentally flawed. These measures fail to recognize the difficulty of achieving medical success with patients who are unable to afford medication or transportation and have difficulty understanding or following written instructions for home care and the use of medications. Broadening the definition of safety net creates conditions in which funds may be unduly rewarded to participants based on flawed metrics. This would be adverse to the public interest.

Since the "savings" generated from the New York State Medicaid program are largely from the underpayment of hospitals and doctors under managed Medicaid, PEF strongly believes that the funds necessary to "reform" the system should go back to those very same safety net hospitals. These waiver "savings" should be used to repair the financial damage associated with managed Medicaid, which was done with public hospitals in California.

New Yorkers were promised that the state was going to reinvest the federal savings generated by the Medicaid Redesign Team and that this reinvestment would "lead to system transformation that will **preserve essential safety net providers** across the state…" To meet this goal the state needs to develop and commit to a more accurate definition of the DSRIP "safety net provider."

The broad definition of the DSRIP safety net provider is a concern that PEF and several other organizations have repeatedly voiced throughout this process. However, having the opportunity to comment on decisions, which have often already been made, does not make for an open/transparent or inclusive process. While we appreciate the opportunity to provide comments – to say that our concerns have been given consideration or addressed would not be accurate.

We no longer just want to be heard, we want to be part of the process. When the PPS(s) are making decisions that have a direct impact on the workforce, the representatives of the workforce must be considered decision makers at the table. For example, the hiring of a consultant to map the workforce would clearly be a time when the workforce representatives should have been part of the process in selecting the appropriate vendor. The harsh reality is that many PPS(s) make decisions and then have meetings to tell the labor representatives what will happen, who will carry it out, and when it will be done. We are concerned about the level of inclusion and transparency at the PPS-level and whether there is accountability for not including workforce representatives.

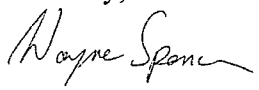
Finally, after reviewing the third quarterly DSRIP report, it is apparent that the Performing Provider Systems will spend nearly 50 percent of their waiver revenue on "Project Implementation and Administration" by the end of the DSRIP program. Unfortunately there appears to be a trend of the PPS(s) and the DOH using private firms for "Project Implementation and Administration." For example, in 2014-15 the DOH entered into a contract with KPMG for "DSRIP support team" services. In one fiscal year KPMG was paid $6.3 million in labor costs related to providing these services. KPMG provided an estimated 11 full time equivalents at an average cost of $285 an hour. The KPMG consultant employees cost the state approximately 360 percent more than the average state DOH PS&T employee.

This DSRIP support team services contract is not the only contract that the DOH has entered into to assist in "managing" Medicaid. In a recent DOH RFP, it is estimated that there are currently 130 contracted staff working across seven divisions in the Medicaid program. There is potential to expand this number to a maximum of 237 by the end of the current contract period. The RFP was actually issued to further expand the number of consultant staff providing professional assistance for New York State's Medicaid program. Projections indicate that the DOH will require 350 contracted staff to fulfill the services outlined in the RFP. PEF strongly believes that the various public programs, including the Medicaid program, that are administered through the DOH are inherently governmental work and that it is in the best interest of the state's public health service recipients and patients to have these services provided by dedicated, experienced public employees.

The bottom line is that the use of consultants appears to have become the norm for this agency. If a large share of the DSRIP funds are tied up in administrative overhead costs and wasted on the costly consultants who are awarded project implementation contracts, how much will be left to ***reinvest*** in New York State's health care infrastructure?

Thank you for your attention to these issues.

Sincerely,



President
Public Employees Federation

cc: Connolly, S.

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Planned Parenthood of New York City

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May 13, 2016

Jason Helgerson
New York State Medicaid Director and Deputy Commissioner
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New York State Department of Health
Empire State Plaza
Corning Tower (OCP-1211)
Albany, NY 11237

Comments submitted electronically to dsrip@health.ny.gov.

Comments on the Delivery System Reform Incentive Payment (DSRIP) Program, the 1115 Waiver and Medicaid Managed Care

Dear Mr. Helgerson:

Thank you for the opportunity to comment on the NYS Department of Health 1115 Waiver process.

For nearly one hundred years, Planned Parenthood of New York City (PPNYC) has offered high-quality, affordable sexual and reproductive health care services to New York City's women, men, and young people. Each year, PPNYC provides trusted sexual and reproductive health care to over 53,000 patients at our five health centers located in all five boroughs of New York City. PPNYC provides sexual and reproductive health services including birth control; emergency contraception; gynecological care (including cervical and breast cancer screenings); colposcopy; reproductive health exams for all genders; testing, counseling, and treatment for sexually transmitted infections; the HPV vaccine; HIV testing and counseling; pregnancy testing, options counseling (including adoption) and abortion, and assistance in obtaining health insurance. As one of the most trusted health care providers in New York City, we pride ourselves on the high quality, confidential care we provide to all people, no matter what.

We applaud the New York State Department of Health's commitment to providing comprehensive and coordinated health care to New Yorkers most in need of affordable and accessible services. The ability to connect more New Yorkers to services through a community based approach is central to PPNYC's mission and we are proud to see New York State's involvement in moving this effort forward. As New York State works to strengthen the provision of care through Medicaid redesign, it is important to ensure the safety and confidentiality of all New Yorkers seeking health care and uphold a continuum of care for sensitive services.

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Ensuring Comprehensive Reproductive and Sexual Health Care Services

The Delivery System Reform Incentive Payment (DSRIP) Program is predicated on the importance of building an integrated and community-based system to pro-actively meet the needs of patients. Through the triple aim of reforming the Medicaid delivery system, decreasing Medicaid costs and increasing quality, New York State aims to dramatically shift the way care is provided with a population based approach. As a leading public health provider, we understand the importance of centering patients, providing preventative care that is nonjudgmental, linguistically and culturally accessible and available to all New Yorkers. In order to fully achieve DSRIP's stated goals, it is critical that consumer and community representation be meaningfully integrated into the process via governance structures and appropriate funding measures. Community based organizations serve as a critical resource in New York City's neighborhoods, helping residents to navigate the complexities of the health care system and incorporate health information into their community's language and culture, thus reducing many of the challenges communities face in seeking out health services.

PPNYC provides on-site health insurance enrollment with our Certified Application Counselors. Many of the populations we serve continue to be ineligible for health insurance under the Affordable Care Act, or choose not to use their insurance because of confidentiality concerns. As such, PPNYC is uniquely situated to provide trusted and confidential health care for many of the hardest to reach populations in New York City. Our patients rely on us for safe, private medical care, regardless of their immigration status or ability to pay, and a percentage of our patients, as well as the larger Medicaid community, experience asthma, diabetes, obesity, hypertension, and behavioral health issues. Many of these identified DSRIP health conditions affect women and adolescents who are of reproductive age and depend on preventive reproductive and sexual health care. It is imperative that these essential healthcare services are always integrated into the DSRIP models. Experiencing an unintended pregnancy or sexually transmitted infection when one is dealing with a chronic disease can be one more stressor in a series of mounting life challenges and often exacerbates economic and health concerns associated with other health conditions.

Equally important to acknowledge is that for many young women, their entry into the health care system is often through the door of their reproductive health provider. Family planning providers not only provide essential sexual and reproductive health care services, but they also often connect patients to care for other health needs that may otherwise go undetected. Considering the disproportionately high rate of maternal and infant mortality among women of color in New York City, it is clear preventative reproductive health care cannot be separated out from other forms of care.

Safeguarding Confidentiality and Patient Privacy in Medical Records

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Confidentiality is a keystone to ensuring access and comfort for patients requiring privacy. With the advent of electronic health records, patient portals, Regional Health Information Systems (RHIOs) and the Statewide Health Information Network for New York (SHIN-NY), there are significant challenges in safeguarding sensitive services, including sexual and reproductive health care and behavioral health services. New York State has opted for a "let the data flow" model that precludes segmenting sensitive data and allows for data sharing. As one of the keystones of DSRIP is data sharing and interoperability, we remain concerned that privacy breeches will occur and result in deterring patients from accessing the services they need.

Having an opt-out clause does not guarantee that both providers and patients will understand the importance of health information and ensuring data protection. This is a complicated message and is dependent on a wide range of providers being versed in the untold effects of confidentiality breeches. As a provider of sensitive sexual health services, we can imagine an instance where a woman in an abusive relationship were to visit an orthopedist with her partner and have the doctor inadvertently disclose, "Oh I see you went to Planned Parenthood." This compromises her privacy and potentially puts her in a harmful situation. The repercussions are clear.

New York State has long recognized the crucial role that confidentiality plays in accessing sensitive and highly personal sexual and reproductive health services and provides explicit confidentiality protections under the Medicaid Family Planning Benefit Program and through The NYS Minors Consent and Confidentiality Law that permits minors to access reproductive health services without parental involvement. PPNYC urges New York State to add provisions to protect sensitive health information for sexual and reproductive health care and behavioral health services.

We strongly recommend NYS require formalized affirmative patient consent for uploading health information into the SHIN-NY, and also provide training for providers to be fully informed of the patient consent requirements.

PPNYC appreciates the opportunity to provide comments on Medicaid redesign in New York State. We look forward to working with the state to preserve the confidentiality and safety of our patients and the preventative health care services they depend on.

Sincerely,

Joan Malin

Joan Malin
President & CEO

United Neighborhood Houses
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Comments of United Neighborhood Houses
On the New York State Section 1115 Medicaid Waiver

Submitted by Nora Moran, Policy Analyst
May 2016

United Neighborhood Houses is New York City's federation of settlement houses and community centers. Rooted in the history and values of the settlement house movement begun over 100 years ago, UNH promotes and strengthens the neighborhood-based, multi-service approach to improving the lives of New Yorkers in need and the communities in which they live. UNH's membership includes 38 agencies employing 10,000 people at over 600 sites across the five boroughs to provide high quality services and activities to over 500,000 New Yorkers each year.

Several UNH member agencies provide behavioral health services through state-licensed outpatient mental health clinics (Article 31 clinics) and OASAS-licensed substance abuse programs (Part 822), have been designated as Home and Community Based Services (HCBS) providers, and are considering program opportunities under the Delivery Reform System Reform Incentive Payment (DSRIP) program.

Thank you for the opportunity to submit comments on New York State's Section 1115 Medicaid Waiver. UNH applauds New York State for recognizing the valuable role that community-based organizations (CBOs) play in creating healthy communities. Settlement houses have been at the forefront of public health solutions since their inception during the early 20th century, and continue to offer health, mental health, and wellness programming to New Yorkers within their neighborhoods.

These comments highlight the challenges faced by UNH members and CBOs in general due to Medicaid Redesign, and offer solutions to ensure equity in beneficiary and CBO participation. We must note, given that the draft waiver document is not yet public, it is difficult to comment with any specificity on changes that are currently being negotiated between New York State and the Centers for Medicare and Medicaid Services (CMS). To this end, UNH recommends that New York State adopt a process that solicits public comments after specific Waiver amendments have been proposed.

DSRIP

DSRIP presents a unique opportunity for more traditional medical institutions to partner with CBOs to achieve the Triple Aim of improving care, improving health, and reducing per capita costs. Settlement houses and CBOs regularly address the social determinants that often shape the overall health of an individual or community by offering services that provide food access, housing, employment, and education, as well as counseling supports that respond to the negative

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effects of trauma and violence. These organizations work on a daily basis with Medicaid beneficiaries, and are well positioned to connect these individuals to primary care and other wellness programs in a meaningful way, before they turn to a hospital for care. UNH applauds New York State for prioritizing collaboration under DSRIP, and has structured the program so that organizations must collaborate to achieve DSRIP goals.

However, CBOs have typically not been treated as equal partners by lead entities within the DSRIP Performing Provider Systems (PPSs), and have received little to no financial resources to prepare for participation in PPS projects, though hospitals have received significant planning grants. The flow of funding under DSRIP must be more transparent, and information about spending should be released in a timely manner in a user-friendly format that documents spending in a clear and succinct way. Furthermore, DSRIP funds that are not allocated or fully spent by PPSs should go to CBOs via a competitive bidding process. Participation in PPS meetings, completing evaluation surveys, contracting, and other activities associated with PPS participation are costly and time consuming for CBOs, who have received no start-up funds to assist in these activities. As the State looks to a value based payment model (VBP), CBOs will have to adapt to demonstrate their outcomes via goal development, data collection, evaluation, compliance with regulations, and quality assurance. Without financial support, CBOs will fall further behind in their ability to participate in DSRIP.

Collaboration under DSRIP is also compromised when Medicaid beneficiaries and CBOs do not have formal channels to provide feedback and shape DSRIP activities. The governance structures of PPSs must include beneficiaries and CBOs, so that their perspective and expertise is not lost when developing and implementing PPS projects.

Value Based Payments (VBP)

The shift to VBP represents a fundamental business shift for CBOs that will introduce tremendous uncertainty in the Medicaid reimbursement system. This transition will result in significant financial risk for CBOs. Without financial support and technical assistance from the State, CBOs will struggle to adapt to a VBP system. Funding should be allocated to CBOs to meet the capacity and infrastructure needs associated with a VBP model, and should include advance payments or revolving loan fund to avoid cash flow issues.

Furthermore, the training and educational needs of CBOs differ significantly from other health care institutions like hospitals. Recently announced “Value Based Bootcamps” from the New York State Department of Health target plans and providers to participate. Specific training for CBOs should be made available, as well as specific guides and educational materials. The State should also consider providing technical assistance, or contracting a third-party to provide such assistance. The Managed Care Technical Assistance Center (MCTAC) has been a successful model for the managed care transition, and similar assistance should be made available pertaining to VBP.

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As described in the VBP Roadmap, UNH supports the requirement that VBP arrangements at Level II or III implement at least one social determinant of health intervention, and that such arrangements include a minimum of one Tier 1 CBO. It will be crucial that New York State actively enforces this requirement in order to facilitate collaboration and partnership with CBOs. Finally, much of the changes associated with VBP will be incorporated into the managed care model contracts between plans and providers. Thus, the Model Contract revision process must be made more transparent, allowing for public input and comment.

Transition to Managed Care

In general, Medicaid Redesign has generated elevated regulatory and financial pressures on CBOs. This pressure feels particularly acute due to the transition to a managed care model. Within the UNH network, Article 31 clinics and Part 822 substance abuse facilities have experienced significant fiscal challenges. Due to the elimination of Comprehensive Outpatient Program Services (COPS), low reimbursement rates under fee-for-service Medicaid have made it difficult for clinics to continue to provide services and remain financially stable. With the loss of COPS and the growing overhead costs imposed by managed care, many providers are now operating with deficits.

Current State regulations require managed care companies to match the State reimbursement rates for outpatient visits at Article 31 clinics, but this guarantee is set to end in 2018. Smaller CBOs operating clinics question whether they will generate the volume of annual visits that will allow them to secure contracts with managed care organizations; furthermore, reimbursement rates under managed care may be even lower than the current guaranteed state rate. UNH recommends that the State continue guaranteed reimbursement rates under managed care until a VBP system is put in place. This will allow clinics time to develop the needed infrastructure to operate under managed care and prepare for the transition to a VBP system.

UNH also supports the expansion of the Independent Consumer Advocacy Network (ICAN) to support all Medicaid beneficiaries with managed care plans of any kind. Individual, independent assistance services should be available to any Medicaid beneficiary, as this is an important step to ensure consumer protections under managed care.

For questions, please contact:
Nora Moran
nmoran@unhny.org
917-484-9322

Davis, Kathleen M. (HEALTH)

From: doh.sm.delivery.system.reform.incentive.payment.program
Sent: Thursday, May 05, 2016 9:12 AM
To: Weinstein, Brooke A (HEALTH)
Subject: FW: Stop Flouridation of our water!

Brooke,
This is a fluoride public comment but mentions DSRIP funds.

From: [redacted]
Sent: Monday, May 02, 2016 3:59 PM
To: doh.sm.delivery.system.reform.incentive.payment.program <dsrip@health.ny.gov>
Subject: Stop Flouridation of our water!

To whom it may concern,
It has come to my attention that DSRIP intends to use Medicaid funds to fluoridate our water. Without going into all the other harmful effects of fluoridation, I would like you to consider that two out of three of my daughters have a **sever sensitivity to Fluoride**. I count it as a blessing that Suffolk County does NOT fluoridate the water.

Once the Fluoride is in, you cant get it out. It will be in everything my children consume. How can you have the right to force medicate the population?

I stand opposed to this proposal and will make my voice heard. Please reconsider your position on this matter.

Sincerely,
Dana Canavan

R. Warwick, AuD, B.S.
NYC Resident
Email: [redacted]
Home Address and phone number available on request

May 12th, 2016

Jason A. Helgerson
New York Department of Health,
Deputy Commissioner, Office of Health Insurance Programs,
NYS Medicaid Director
Empire State Plaza
Corning Tower Building, 14th Floor
Albany, NY 12237

Via Email: jah23@health.state.ny.us

Re: The use of New York Medicaid Funds to Support Community Water Fluoridation

Dear Deputy Commissioner Helgerson,

This submission to the DSRIP/MRT is a follow up of my presentation at the Public Comment day on Wednesday, May 4th, 2016 in NYC. As per Assembly Bill A03007, 2015-2016, a bill has been passed which

> "makes changes necessary to continue implementation of **Medicaid redesign team** recommendations ...
> "to establish a grant program to provide assistance to local governments to cover the costs of **installing**, replacing, repairing or upgrading water fluoridation equipment."

In your capacity as both the NYS Deputy Commissioner of the Department of Health and the NYS Medicaid Director, I appreciate that the mandate of cutting costs while not cutting health service must be extremely challenging to achieve and difficult choices have to be made.

Although on the face of it, adding fluoride to the drinking water may seem to be an efficient and cost saving program both common sense and recent scientific review shows that this is far from the truth.

Common sense tells us that water fluoridation is inefficient:

1. If fluoride is put into our drinking water, most of the water goes down the drain, therefore literally, most of the fluoride is *wasted*.
2. When we drink it, most of it goes down our esophagus, our digestive tract and into our stomach – very little of it is retained in our mouth (see CDC for estimated 0.016 ppm concentration in saliva).
3. Over 70 percent of US public water supplies are fluoridated, and water fluoridation has been implemented for over 70 years, therefore one would assume that tooth decay would have decreased substantially, even in poor areas with full access to fluoridated water. However, the US Surgeon General in 2000 declared dental caries as the "Silent Epidemic" and worse for children on Medicaid. If water fluoridation worked at reducing tooth decay for children of lower SES, we would not be experiencing this very serious problem 70 years later.
4. Furthermore, on inspection of the NYS DOH 2005-2012 data regarding ER visits for tooth decay, there seems to be no difference between the increase 3 and 5 year olds needing **emergency room** visits in areas with 100% water fluoridation and those with 0% fluoridation (see Exhibit D).

Common sense tells us that water fluoridation is inefficient and not working, what about the science?

In 2015 The Cochrane Review on Water Fluoridation and the prevention of dental caries published their conclusions:

> There is ***very little contemporary evidence***, meeting the review's inclusion criteria, that has evaluated the effectiveness of water fluoridation for the prevention of caries. (Emphasis added)

> The available data come predominantly from studies ***conducted prior to 1975***, and indicate that water fluoridation is effective at reducing caries levels in both deciduous and permanent dentition in children. (*However*) Our confidence in the size of the effect estimates is limited by
>
> a. the ***observational nature*** of the study designs,
> b. the ***high risk of bias*** within the studies and, importantly,
> c. the *applicability of the evidence* to current lifestyles…
>
> …There is ***insufficient evidence*** to determine whether water fluoridation results in a **change in disparities in caries levels across** Socioeconomic Status. (Emphasis added)
>
> We **did not identify *any evidence***, meeting the review's inclusion criteria, to determine the *effectiveness of water fluoridation for preventing caries in* ***adults***. (Emphasis added)
>
> There is ***insufficient information*** to determine the effect on caries levels of stopping water fluoridation programmes. (Emphasis added)
>
> There is a ***significant*** association between **dental fluorosis** (of aesthetic concern or all levels of dental fluorosis) and fluoride level. The evidence is limited due to **high risk of bias** within the studies and substantial between-study variation. (Emphasis added)
> http://www.cochrane.org/CD010856/ORAL_water-fluoridation-prevent-tooth-decay

Therefore, despite 70 years of water fluoridation, there is no substantial evidence to support that water fluoridation is effective at preventing tooth decay, especially in the poor.

In other words, millions of dollars are literally being poured down the drain to support a system that increases **dental fluorosis**, reduces decay in one surface out of four children under 10 in children based on CDC data, (clinically insignificant), and furthermore most likely does nothing to prevent tooth decay in teen and adult teeth.

This speaks to the inefficiencies of water fluoridation: what about the possible adverse effects?

As the Deputy Commissioner of the Department of Health you must be well aware of the potential hazards of adding fluoride chemicals to drinking water.

Hexafluorosilicic acid (HFSA) is not naturally occurring, as is calcium fluoride, but a hazardous waste product from the phosphate fertilizer industry with arsenic, lead and other contaminants (see Exhibit A and B).

HFSA has a probable lethal dose LD(50) of 5-50mg/kg (see exhibit B) therefore is more toxic than lead which has a LD(50) of 450 mg/kg.

Fluoride is a known developmental neurotoxicant and endocrine disruptor: these are well established facts and not in dispute within the scientific community. What is in dispute is, does the latest 0.7ppm HHS recommended level solely for tooth decay prevention, provide a sufficient safety margin for all persons at risk to exposure for the probable and possible adverse effects?

Common sense arguments against adding a known endocrine disruptor and neurotoxin to our drinking water:

1. If the government allows a lead concentration of 0.015ppm to be added to drinking water, then does not *common sense* dictate that **fluoride, which is more toxic than lead**, should have even a lower allowable level? (Fluoride maximum was recently reduced from 1.2ppm to 0.7ppm, thus in this aspect it should be less than 0.015ppm).

2. Even though there is an 'allowable' concentration of added lead and arsenic contaminants, does it make **economic** sense to add **lead** and **arsenic** to our drinking water? (see Exhibit A) This will not increase the health of anyone, particularly not those living in poverty.

Scientific Review of Adverse Side Effects

The US EPA charged the National Academies of Sciences to conduct a review on water fluoridation which was published in a 500 page document in 2006. Their conclusions (see Exhibit C) included that there is insufficient evidence (despite 70 years of water fluoridation) to rule out adverse health effects at the levels found and recommended in our drinking water. One recommendation was for the EPA to reduce its maximum contaminant level goal. (This recommendation has yet to be implemented.)

Probable and possible health effects include **reduced thyroid function**, **reduced IQ, endocrine disruption**, **arthritis**, **joint pain** and **diabetes**.

In the US, data tells us that hypothyroidism will **affect 1 in 8 women** in their lifetime, congenital hypothyroidism (causing cognitive impairment and developmental delays) has **doubled** since collecting incidence data, and 15% of children will be diagnosed with one or more neurodevelopmental disorders. That is **1 in 6** to **1 in 7 children** will have some form of disorder including Attention Deficit Disorder, Autism, reduced IQ, learning and speech delays.

As yet no studies ruling out these possible adverse effects of drinking hexafluorosilicic acid have been conducted in the US.

Are we really willing to add a further neurotoxic burden to our NYS residents, children, adults and the elderly alike? As a health professional you are fully aware that when we add a chemical to our drinking water we cannot control for dose, and our Medicaid recipients are at high risk for medical issues. Does this make **economic** sense?

Common sense dictates that water fluoridation is a waste of funds. A systematic review of the available *science* bears this out. Instead of supporting spending millions of dollars on promoting fluoridation projects, please support using these funds to promote education about dental hygiene, good nutrition and cutting down on sugar. (It is sugar that causes cavities, not lack of fluoride.) In addition, if we are really interested in serving those most in need, it is vital to provide affordable direct dental care to Medicaid patients and children.

Thank you for your time,
Yours sincerely,

Dr. Robin Warwick
Audiologist,
NYC Resident.

646R

Simplot

SIMPLOT PHOSPHATES LLC

Certificate of Analysis (COA)

SIMPLOT PHOSPHATES LLC
515 South Hwy 430
Rock Springs, WY 82901

DATE: **Friday, October 23, 2015**

TO: **Norfolk Southern TBT** **C/O BHS Marketing**

Product:	**Fluorosilicic Acid (FSA)**
Bill of Lading Number:	**036406 RS**
Rail Car Number	**GATX 4022**
Date Analyzed:	**September 23, 2015**
Other Information:	**Release # 2236266.1**

Analysis Name	Specification Max	Specification Min	Analysis
% Assay (H_2SiF_6)	25%	23%	24.41
% HF	1.0%		0.67
% P2O5			0
Specific gravity @ 60°F			1.220
Lead (Pb) ppm			0.36
Arsenic ppm			4.81
Color (APHA)	200		5
Visible Suspended Matter			0

NSF

Certified to	Max. use:
NSF/ANSI 60	6 mg/L

Meets ANSI / AWWA B703-11

Brian Thomas

Brian Thomas, Lab Supervisor

Material Safety Data Sheet

Revision Issued: 03/01/2013	Supercedes: 10/23/2009	First Issued: 1/20/1996

Section I – Product and Company Identification

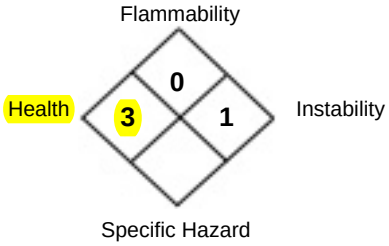
Product Name: **Hydrofluosilicic Acid**

PotashCorp MSDS No.: 52
ERG No.: 154

1101 Skokie Blvd., Northbrook, IL 60062
Phone (800) 241-6908 / (847) 849-4200

Suite 500, 122 – 1st Avenue South
Saskatoon, Saskatchewan Canada S7K7G3
Phone (800) 667-0403 from Canada
(800) 667-3930 from USA

Emergencies (800) 424-9300 (CHEMTREC)
Web Site www.potashcorp.com
Health Emergencies, Contact Your Local Poison Center



NFPA Code

Common Name: Hydrofluosilicic Acid	**Formula:** H_2SiF_6	**Synonym:** HFSA	**Uses:** Industrial

Section II – Composition / Information On Ingredients

Chemical Name	CAS No.	Exposure Limits								% by Weight
		OSHA PEL		TLV – TWA		STEL		CEIL		
		mg/m^3	ppm	mg/m^3	ppm	mg/m^3	ppm	mg/m^3	ppm	
Hydrofluosilicic Acid	16961-83-4									24
Fluoride (19%)		2.5		2.5						

* No exposure limits have been established for Hydrofluosilicic Acid, however, the OSHA Permissible Exposure Limit (PEL) and ACGIH threshold limit value (TLV) of 2.5 mg/m^3 for fluoride for the eight hour time weighted average applies.

Section III – Hazard Identification

Potential Acute Health Effects:	Hydrofluosilicic acid is extremely corrosive to the skin, eyes or mucous membrane through direct contact, inhalation or ingestion. Handle with extreme caution.		
Eyes and Skin:	May cause irritation or burns in all parts of the body. Eye contact may cause severe damage, including ulceration of the cornea and blindness if not adequately flushed.		
Inhalation:	May cause irritation or burns in all parts of the body, including nose, throat and respiratory system. Symptoms of overexposure may include ulceration of the nose and throat, coughing, salivation, headache, fatigue, dizziness, nausea, shock and pulmonary edema (fluid buildup in the lungs causing great difficulty in breathing). May lead to coma or death.		
Ingestion:	May cause tissue destruction of the digestive tract, ulceration of mucous membranes, intense thirst, abdominal pains, vomiting, shock, convulsions and death.		
Potential Chronic Health Effects:	Long-term exposure may cause chronic irritation of the nose, throat and bronchial passages. Chronic fluoride poisoning may result in bone changes (fluorosis) or calcium metabolism disorders.		
CARCINOGENICITY LISTS	**IARC Monograph:** No	**NTP:** No	**OSHA:** No

Section IV – First Aid Measures

Eyes:	Immediately flush eyes (holding eyelids apart) with plenty of water for at least 15 minutes. Get medical attention.
Skin:	Immediately flush skin with plenty of water while removing contaminated clothing. Get medical attention if irritation develops or persists.
Ingestion:	Do not induce vomiting. Drink large amounts of water (or milk if available) to dilute the acid. Prevention of absorption of the fluoride ion following ingestion can be obtained by giving milk, chewable calcium carbonate tablets or milk of magnesia to conscious victims. Get medical attention immediately.
Inhalation:	Remove to fresh air. If breathing has stopped, give artificial respiration. If breathing with difficulty, give oxygen. Observe for possible delayed reaction. Treat bronchospasm with inhaled beta 2 agonist and oral or parenteral corticosteroids.

Section V – Fire Fighting Measures			
Flash Point:	Non-flammable	**Autoignition Temperature:**	Not Applicable
Lower Explosive Limit:	Not Applicable	**Upper Explosive Limit:**	Not Applicable
Unusual Fire and Explosion Hazards:	Hydrofluosilicic Acid is not flammable however the following hazards can occur during a fire: reacts with many metals to produce flammable and explosive hydrogen gas; decomposition occurs above 227^{0}F to produce toxic, irritating and corrosive fumes including SiF_4 and HF.		
Extinguishing Media:	Use appropriate agent to extinguish surrounding material.		
Special Firefighting Procedures and Equipment:	Keep personnel removed from and upwind of fire. Wear full fire-fighting turn-out gear (full Bunker gear) and respiratory protection (SCBA). Cool containers containing hydrofluosilicic acid with water spray to prevent rupture.		

Section VI – Accidental Release Measures	
Small Spill:	Neutralize acid spill with alkali such as soda ash, sodium bicarbonate, limestone or lime. Absorb material with an inert material such as sand, vermiculite, diatomaceous earth or other absorbant material and place in chemical waste container to be disposed at an appropriate waste disposal facility according to current applicable laws and regulations and product characteristics at time of disposal. Adequate ventilation is required for soda ash due to the release of carbon dioxide gas. No smoking in spill area.
Large Spill:	Contain spill with dikes and transfer the material to appropriate containers for reclamation or disposal. Absorb remaining spill with an inert material such as sand, vermiculite or other absorbant material and place in chemical waste container to be disposed at an appropriate waste disposal facility according to current applicable laws and regulations and product characteristics at time of disposal. Neutralize residue with alkali such as soda ash, sodium bicarbonate, limestone or lime. Adequate ventilation is required for soda ash due to the release of carbon dioxide gas. No smoking in spill area.
Release Notes:	If spill could potentially enter any waterway, including intermittent dry creeks, contact the local authorities. If in the U.S., contact the US COAST GUARD NATIONAL RESPONSE CENTER toll free number 800-424-8802. In case of accident or road spill notify: CHEMTREC IN USA at 800-424-9300; CANUTEC in Canada at 613-996-6666 CHEMTREC in other countries at (International code)+1-703-527-3887.
Comments:	See Section XIII for disposal information and Section XV for regulatory requirements. Large and small spills may have a broad definition depending on the user's handling system. Therefore, the spill category must be defined at the point of release by technically qualified personnel.

Section VII – Handling and Storage	
Ventilation:	Use with adequate ventilation.
Handling:	Use appropriate personal protective equipment as specified in Section VIII. Avoid contact with skin and eyes. Avoid inhalation and ingestion.
Storage:	Store in unopened container in cool, well ventilated area, away from potential sources of heat and fire. Keep away from combustible materials, strong bases and metals. Large storage tanks should be bermed and electrically grounded. Avoid using glass, metal or stoneware containers.

Section VIII – Exposure Controls/ Personal Protection	
Engineering Controls:	Good ventilation should be sufficient to control airborne levels.
Personal Protection:	
Eye Protection:	Wear chemical splash goggles and face shield (ANSI Z87.1 or approved equivalent) when eye and face contact is possible due to splashing or spraying of material.
Protective Clothing:	Where contact is likely, wear chemical-resistant gloves, a chemical suit, rubber boots and chemical safety goggles plus a face shield.
Respiratory Protection:	Wear NIOSH approved respiratory protective equipment when vapor or mists may exceed applicable concentration limits.
Other Protective Clothing or Equipment:	Facilities storing or utilizing this material should be equipped with an eyewash facility and a safety shower.

Section IX – Physical and Chemical Properties

Appearance/Color/Odor:	Water white to straw yellow and pungent odor.	**Boiling Point:**	Decomposes at 227°F
Melting Point/Range:	-1 to -4ºF	**Boiling Point Range:**	Not Available
Solubility in Water:	Complete	**Vapor Pressure (mmHg):**	24 mm Hg @ 77ºF
Specific Gravity:	1.2 @ 75ºF	**Molecular Weight:**	144
Vapor Density:	Not Applicable	**% Volatiles:**	Not Applicable
Bulk Density:	10.3 lbs/gal	**Evaporation Rate:**	Not Applicable
pH:	1.5-2.0 in 10% solution	**Freezing Point:**	Not Applicable
Viscosity:	Not Applicable	**Density:**	Not Available

Section X – Stability and Reactivity

Stability:	This product is stable under normal conditions of storage, handling and use.
Hazardous Polymerization:	Will not occur
Conditions to Avoid:	High temperatures above 194°F. Hydrofluosilicic acid attacks glass and stoneware. Since hydrofluosilicic acid may react violently with water and generate heat, use caution if dilution is necessary. Always add acid to water, not water to acid.
Materials to Avoid (Incompatibles):	Strong alkalis, metals, glass, stoneware, strong concentrated acids such as sulfuric and perchloric acid, chlorites, combustible solids and organic peroxides. Hydrofluosilicic acid may react violently with water. It may dissociate to form extremely toxic hydrofluoric acid (HF).
Hazardous Decomposition Products:	Reacts with many metals to produce flammable and explosive hydrogen gas, decomposition occurs above 227°F to produce toxic, irritating and corrosive fumes of fluorides including SiF_4 and HF.

Section XI – Toxicological Information

Significant Routes of Exposure:	Eyes, Skin, Respiratory System, Digestive Tract	
Toxicity to Animals:	**Acute Oral Toxicity:**	LD_{50} = 200 mg/Kg (guinea pig)
	Acute Inhalation Toxicity:	LC_{50} 850 – 1070 ppm / 1 hour (Rat)
	Acute Toxicity: Other Routes:	Percutaneous: 0.5 mL. Severe erthema and edema observed (Rabbit)
	Acute Dermal Toxicity:	LD_{LO} = 140 mg/Kg (with animals)
	Repeated Dose Toxicity:	No data available.
	Eye & Skin Irritation/Corrosion:	LD_{LO} = 140 mg/Kg (with animals)
Special Remarks on Toxicity to Animals:		
	Developmental Toxicity/Teratogenicity:	No data available.
	Bacterial Genetic Toxicity In-Vitro: Gene Mutation:	No data available.
	Non-Bacterial Genetic Toxicity In-Vitro: Chromosomal Aberration:	No data available.
	Toxicity to Reproduction:	No data available.
	Carcinogenicity:	No data available.
Other Effects on Humans:		Probable oral death dose; 5-50 mg/Kg. (7 drops to one teaspoon for a 70 Kg human)
Special Remarks on Chronic Effects on Humans		Changes in bone, corrosivity of the mucous membranes, coughing, shock, pulmonary edema, fluorosis, coma and death.
Special Remarks on Other Effects on Humans:		No data available.

Section XII – Ecological Information

Ecotoxicity	**EPA Ecological Toxicity rating :**	No data available.
	Acute Toxicity to Fish:	No data available.
	Chronic Toxicity to Fish:	No data available.
	Acute Toxicity to Aquatic Invertebrates:	(Frog) Subcutaneous: LD_{LO} = 140 mg/kg.
	Chronic Toxicity to Aquatic Invertebrates:	No data available.
	Acute Toxicity to Aquatic Plants:	No data available.
	Toxicity to Soil Dwelling Organisms:	No data available.
	Toxicity to Terrestrial Plants:	No data available.
Environmental Fate:	**Stability in Water:**	Product is NSF certified to ANSI Standard 60 for the fluoridation of municipal water supplies.
	Stability in Soil:	No data available.
	Transport and Distribution:	No data available.
Toxicity:	No data available	
Degradation Products:	**Biodegradation:**	No data available.
	Photodegradation:	No data available.

Section XIII – Disposal Considerations

Product Disposal:	Dispose of waste at an appropriate waste disposal facility according to applicable laws and regulations. Neutralize with lime or other base. Collect in appropriate containers. Dispose of at an appropriate waste disposal facility in accordance with current applicable laws and regulations and product characteristics at time of disposal.
General Comments:	None

Section XIV – Transportation Information

	USDOT	**TDG - Canada**
Proper Shipping Name:	Hydrofluosilicic Acid	Hydrofluosilicic Acid
Hazard Class:	8	8
Identification Number:	UN1778	UN1778
Packing Group (Technical Name):	II	II
Labeling / Placarding:	Corrosive	Corrosive
Authorized Packaging:	Rail: DOT 111A 100 W5 Rubber lined Truck: MC307, 310, 311, 312, DOT 407, 412 Rubber Lined	
Notes:	1) Packaging must be protected with non-metallic lining impervious to the lading or have a suitable corrosion allowance. 2) Aluminum construction materials are not authorized for any part of a packaging which is normally in contact with the hazardous material.	

Section XV – Regulatory Information

UNITED STATES: SARA Hazard Category:	This product has been reviewed according to the EPA Hazard Categories promulgated under Section 311 and 312 of the Superfund Amendment and reauthorization Act of 1986 (SARA title III) and is considered, under applicable definitions, to meet the following categories:									
	Fire:	No	**Pressure Generating:**	No	**Reactivity:**	No	**Acute:**	Yes	**Chronic:**	No
	40 CFR Part 355 - Extremely Hazardous Substances:						None Applicable			
	40 CFR Part 370 - Hazardous Chemical Reporting:						Applicable			
	All intentional ingredients listed on the TSCA inventory.									

SARA Title III Information: This product contains the following substances subject to the reporting requirements of Title III (EPCRA) of the Superfund amendments and Reauthorization Act of 1986 and 40 CFR Part 372:

Chemical	CAS NO.	Percent by Weight	CERCLA RQ (lbs)	SARA (1986) Reporting		
				311	312	313
Hydrofluosilicic Acid	16961-83-4	24		Yes	Yes	No

CERCLA/Superfund, 40 CFR Parts 117, 302: If this product contains components subject to substances designated as CERCLA reportable Quantity (RQ) Substances, it will be designated in the above table with the RQ value in pounds. If there is a release of RQ Substance to the environment, notification to the National Response Center, Washington D.C. (1-800-424-8802) is required.

CANADA:	**WHMIS Hazard Symbol and Classification:**	This product is WHMIS controlled. Category E
	Ingredient Disclosure List:	This product does contain ingredient(s) on this list.
	Environmental Protection:	All intentional ingredients are listed on the DSL (Domestic Substance List).
EINECS#:	(Hydrofluosilicic Acid) 241-034-8	
California: Prop 65:	This is not a chemical known to cause cancer, nor is it listed.	

Section XVI – Other Information

NFPA Hazard Ratings:	**Health:** 3	**Flammability:** 0	**Instability:** 1	**Special Hazards:**
	0 = Insignificant	**1 = Slight**	**2 = Moderate**	**3 = High** **4 = Extreme**
COMMENTS:				
Section(s) changed since last revision:				

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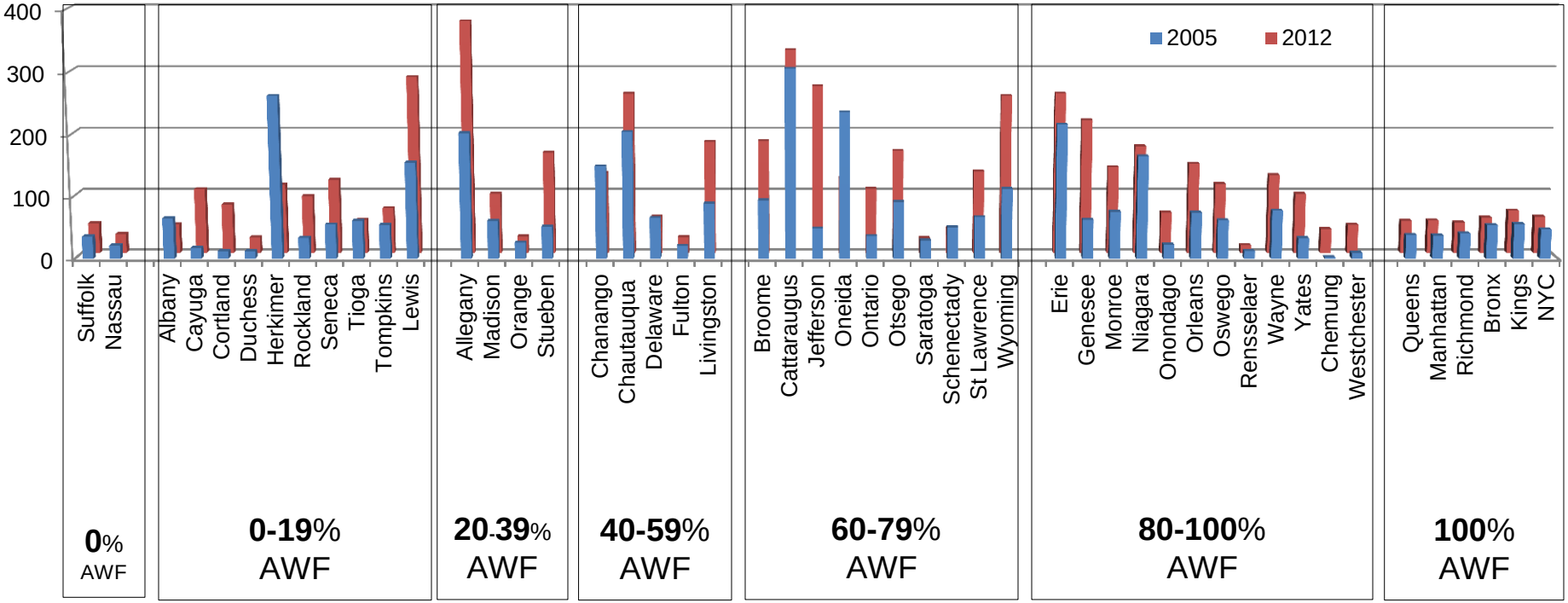
Key Messages from the National Academies of Science Report 2006: http://dels.nas.edu/Report/Fluoride-Drinking-Water-Scientific/11571?bname

Adverse Effect	Summary
Reproductive hormones Fertility Down's Syndrome	A few studies of human populations have suggested that fluoride might be associated with alterations in reproductive hormones, fertility, and Down's syndrome, but their design limitations make them of little value for risk evaluation (no studies in the US as of April 2016)
Irritation to the GI system Renal tissue and function Alter hepatic and immune system	Case reports and in vitro and animal studies indicated that exposure to fluoride at concentrations greater than 4 mg/L can be irritating to the gastrointestinal system, affect renal tissues and function, and alter hepatic and immunologic parameters. Such effects are unlikely to be a risk for the average individual exposed to fluoride at 4 mg/L in drinking water. However, a potentially susceptible subpopulation comprises individuals with renal impairments who retain more fluoride than healthy people do.
Endocrine disruptor	Fluoride is an endocrine disruptor in the broad sense of altering normal endocrine function or response, although probably not in the sense of mimicking a normal hormone. The mechanisms of action remain to be worked out and appear to include both direct and indirect mechanisms.
Lack of evidence to make accurate risk and benefit analysis.	Gaps in the information on fluoride prevented the committee from making some judgments about the safety or the risks of fluoride at concentrations of 2 to 4 mg/L.
Elderly and Chronic Kidney Disease CKD at risk for skeletal fluorosis	Groups likely to have increased bone fluoride concentrations include the elderly and people with severe renal insufficiency.
EPA's MCLG should be lowered	In light of the collective evidence on various health end points and total exposure to fluoride, the committee concludes that EPA's MCLG of 4 mg/L should be lowered.
Immune system	Little data is available on immunologic parameters in human subjects exposed to fluoride from drinking water or osteoporosis therapy, but in vitro and animal data suggest the need for more research in this area.
Neurotoxin: affects brain and body by direct and indirect means	On the basis of information largely derived from histological, chemical, and molecular studies, it is apparent that fluorides have the ability to interfere with the functions of the brain and the body by direct and indirect means.

Cannot control fluoride content/absorption into the skeleton with water fluoridating programs.	On the basis of pharmacokinetic modeling, the current best estimate for bone fluoride concentrations after 70 years of exposure to fluoride at 4 mg/L in water is 10,000 to 12,000 mg/kg in bone ash. Higher values would be predicted for people consuming large amounts of water (>2 L/day) or for those with additional sources of exposure. Less information was available for estimating bone concentrations from lifetime exposure to fluoride in water at 2 mg/L. The committee estimates average bone concentrations of 4,000 to 5,000 mg/kg ash.
Difficult to assess true toxicology across different species as rats require higher chronic exposure than humans to achieve the same plasma and bone concentrations.	Pharmacokinetics should be taken into account when comparing effects of fluoride in different species. Limited evidence suggests that rats require higher chronic exposures than humans to achieve the same plasma and bone concentrations.
Renal tissue and function Liver function Immune system with high levels of F. No good studies on lower levels of F.	Studies of the effects of fluoride on the kidney, liver, and immune system indicate that exposure to concentrations much higher than 4 mg/L can affect renal tissues and function and cause hepatic and immunologic alterations in test animals and in vitro test systems.
No good studies on GI, renal liver or immune systems with lower levels of F.	The committee did not find any human studies on drinking water containing fluoride at 4 mg/L where GI, renal, hepatic, or immune effects were carefully documented.
No appropriate studies on bone fracture.	The committee finds that the available epidemiologic data for assessing bone fracture risk in relation to fluoride exposure around 2 mg/L are inadequate for drawing firm conclusions about the risk or safety of exposures at that concentration.
2 to 4 mg/L only. Need to study benefits and risks at lower levels of concentration.	The committee's conclusions regarding the potential for adverse effects from fluoride at 2 to 4 mg/L in drinking water do not address the lower exposures commonly experienced by most U.S. citizens. The charge to the committee did not include an examination of the benefits and risks that might occur at these lower concentrations of fluoride in drinking water.
Fluorosis at “severe” level is considered to be a toxic/adverse effect.	The damage to teeth caused by severe enamel fluorosis is a toxic effect that the majority of the committee judged to be consistent with prevailing risk assessment definitions of adverse health effects.
Insufficient information to determine toxicity at moderate enamel fluorosis.	The degree to which moderate enamel fluorosis might go beyond a cosmetic effect to create an adverse psychological effect or an adverse effect on social functioning is also not known.
Fluoride exposure is mostly from water and other beverages and food, not toothpaste.	The single most important contributor to fluoride exposures (approaching 50% or more) is fluoridated water and other beverages and foods prepared or manufactured with fluoridated water.

ER Outpatient Visits per 10,000 for Tooth Decay per County: Aged 3-5 years, In Order of Fluoridated Water Supplies, 0 to 100%, in 2009 and 2012, Showing No Correlation with Artificial Water Fluoridation (AWF).



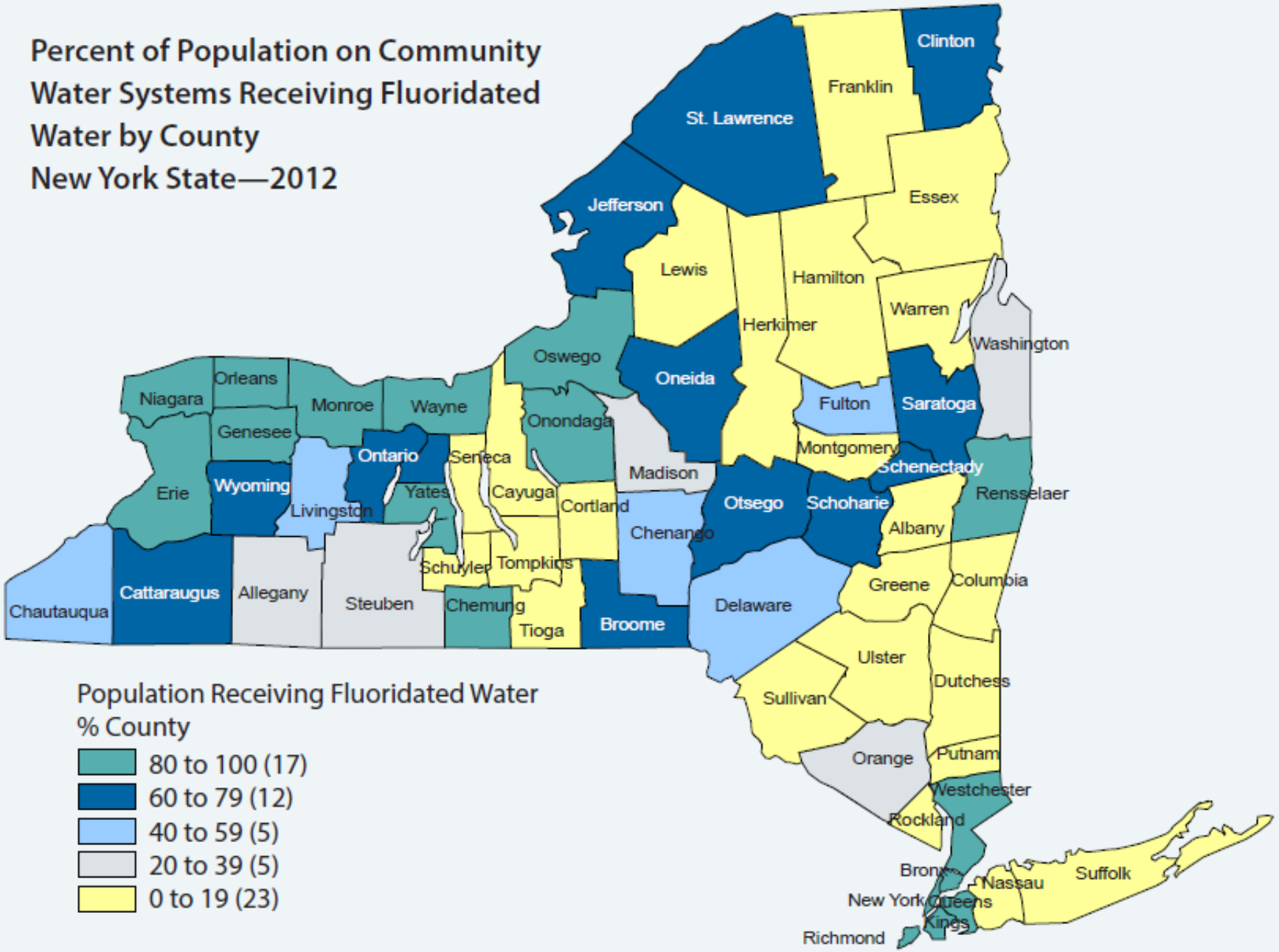
No correlation between increased levels of fluoridated water supplies and decrease in ER visits for tooth decay.

In nearly every county caries rate **increased** from 2005 to 2012, fluoridated or non-fluoridated.
In all NYC counties caries rates increased from 2005 to 2012 despite 100% access to fluoridated water

*This data is not controlled for social economic status, or blood- and/or urine-fluoride content.

Chart Data Compiled using **Schuyler Center's water fluoridation by county at http://www.scaany.org/policy-areas/health/oral-health/ and NYS DOH http://www.health.ny.gov/statistics/chac/ed/e1.htm Accessed 10/9/2015.

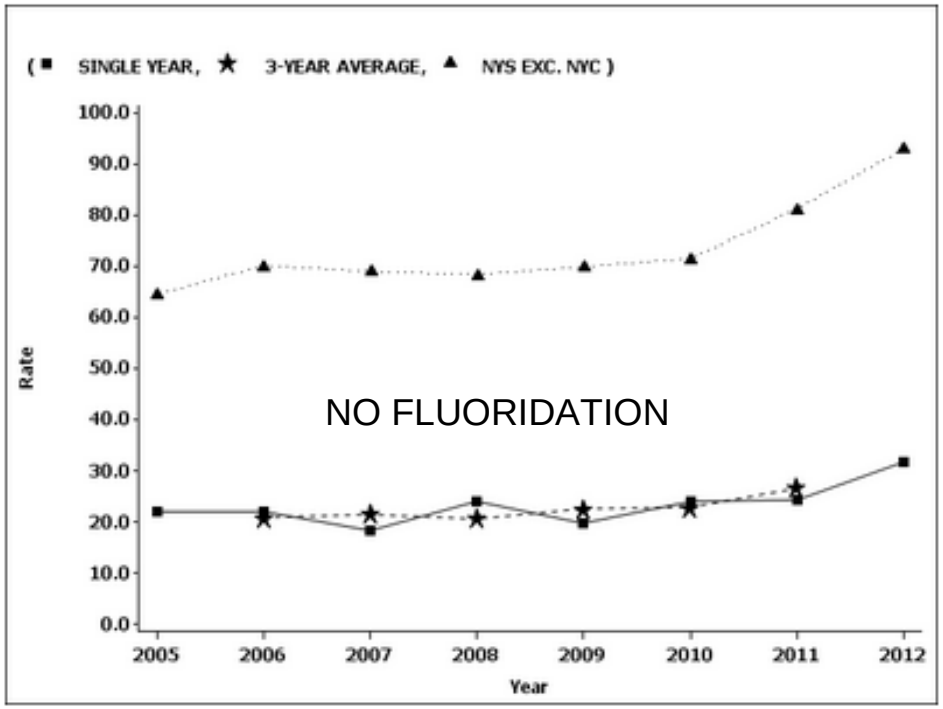
Percent of Population on Community Water Systems Receiving Fluoridated Water by County New York State—2012



Population Receiving Fluoridated Water
% County

- 80 to 100 (17)
- 60 to 79 (12)
- 40 to 59 (5)
- 20 to 39 (5)
- 0 to 19 (23)

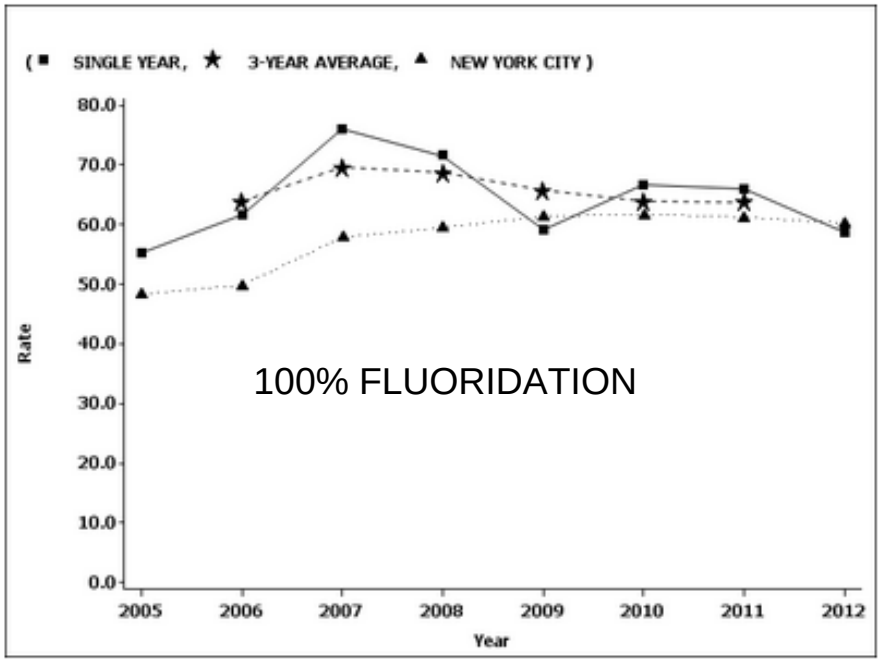
Nassau County Caries outpatient visit rate per 10,000 - Aged 3-5 years



Caries outpatient visit rate per 10,000 - Aged 3-5 years

	Crude Rate		
Year	Single Year	3-Year Average	NYS exc. NYC
2005	22.0		64.5
2006	22.1	20.9	70.1
2007	18.4	21.5	69.0
2008	24.0	20.7	68.4
2009	19.8	22.6	69.9
2010	24.1	22.8	71.5
2011	24.4	26.7	81.2
2012	31.7		92.9

Bronx County Caries outpatient visit rate per 10,000 - Age



Caries outpatient visit rate per 10,000 - Aged 3-5 years

	Crude Rate		
Year	Single Year	3-Year Average	New York City
2005	55.2		48.4
2006	61.5	63.9	49.8
2007	76.1	69.6	57.9
2008	71.6	68.7	59.5
2009	59.1	65.7	61.4
2010	66.7	63.8	61.8
2011	66.0	63.8	61.2
2012	58.7		60.3

Comments for meeting on use of Medicaid funds for water fluoridation in NY state

Simeon Hein, Ph.D.,
Institute for Resonance 501(c)3,
42 W. 24th St., NY NY 10010
InstituteforResonance.org simeon@instituteforresonance.org 415-413-8052

NYU Kimmel Center (60 Washington Square Park South), May 4th, 2016

In the early 1940's NYC was the center of a top-secret, special-access program, the Manhattan Project led by the Army's 509th Composite Group to develop atomic weapons which were used against Japan. After the war ended, the U.S. government wanted to create a better image for it's nuclear program as a whole. The idea of "dual-use technologies," those that had both military and civilian applications, was created for this purpose. The first effort was to develop peaceful uses of atomic materials in the form of medical radioisotopes[1]. These were used in ecological and "human tracer experiments" some of which remained classified until President Clinton ordered them declassified in 1998. The second was to create a better image for fluoride, which was needed in large quantities to produce atomic weapons[2]. The U.S. military was afraid of a fluoride shortage and this was another reason to improve fluoride's public image.

Both the radioisotope and fluoride programs originated at the University of Rochester and some of the same individuals worked in both. Worker and farmers near metal smelting plants had suffered physical health effects from exposure to fluoride, the most reactive chemical known, as were scientists at Columbia University working for the Manhattan Project. The idea was hatched to use it as a tooth hardener after it was observed by Trendley Dean, working for the U.S. Public Health Service, that communities with high levels of natural fluoride in their water had both higher levels of disfigured and mottled enamel from dental fluorosis and also lower incidence of cavities. But Dean was against adding fluoride to drinking water, as was first done in Grand Rapids, MI in 1945, because he observed that too much ingested fluoride caused a dental disfiguration condition known as fluorosis.

Recent research shows that we have underestimated the risks of dental fluorosis and just this week HHS suggested lowering the amounts of fluoride in drinking water from 1.2 to .7 ppm. New research links fluoride to lower IQ, thyroid issues, and ADHD: just last year the British medical journal *The Lancet* classified fluoride as one of the top-ten neurotoxins on the planet. Last year, the country of Israel banned drinking water fluoridation, leaving only a handful of countries that still do so.

The evidence that fluoride is beneficial for dental health is at best marginal and quite old at this point, while new studies suggest that caution is warranted. We no longer put lead in gasoline, use DDT, asbestos, or fluorocarbons in spray cans or refrigerators, or give pregnant women Thalidomide or unnecessary amounts of mammograms after the harms were deemed to outweigh the benefits.

Proponents of fluoridation often tout the claims that for every $1 invested in community water fluoridation it saves $35 in dental costs. However, this misleading claim was recently shown to be false by Ko and Thiessen (2015)[3]. In fact they show a NEGATIVE cost-benefit after the costs of replacing corroded municipal fluoride equipment and severe dental fluorosis are taken into account.

Comments for meeting on use of Medicaid funds for water fluoridation in NY state

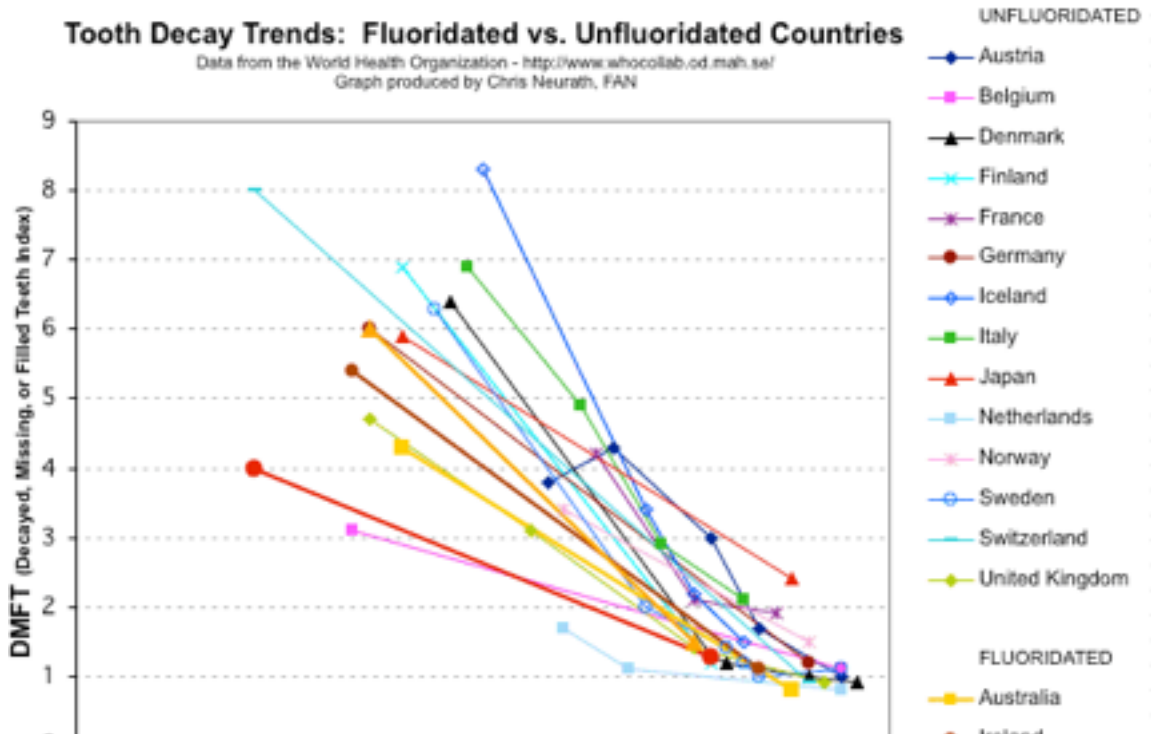
In 1998, because of its health risks, over 1500 union scientists at the EPA signed a petition against community water fluoridation due to its health risks.

In 2006, the National Research Council, part of the National Academy of Sciences concluded that benefits of fluoride are mainly topical rather than systemic: that is, applied to teeth directly in the form of toothpaste and gels used by dentists echoing a position taken by the CDC in 1999[4].

Recent research shows that the fluoride product used by many communities comes from China and as contains heavy metals like lead and cadmium, as well as uranium and arsenic all of which are toxic, some even in minute quantities.

A look at the data from many Western countries from the 1960's to 2005 show that countries that don't fluoridate their water have improved their dental health even faster than those who do[5].

In 2012, I wrote to *Science* magazine, published by the American Association for the Advancement of Science, for clarification on this issue based on a previous article that claimed that improvements in dental health in the U.S and Europe were due to fluoridated water. (See the chart below.) They responded[6]: "The article implied that both European countries and the United States added fluoride to their drinking water in the 1970s. In fact, **water in most European nations was not fluoridated**. However, **European improvements in public dental health from the 1970s to the present have matched or even exceeded those of the United States. Reasons include fluoridated toothpastes, which became widely available in the 1970s, and changing criteria for diagnosing caries.** See T. M. Marthaler, *Caries Res*. 38, 173 (2004).



CORRECTIONS AND CLARIFICATIONS

Letters: "Friends in fungi" by G. D. A. Werner and E. T. Kiers (21 September, p. 1452). The image of the rare ericoid mycorrhizal fungus was misleading. The Letter's discussion applies more closely to arbuscular mycorrhizal fungi. The image has been replaced in the HTML and PDF versions online. The caption has been changed to "Arbuscular mycorrhizal fungi" and the credit has been changed to Jan Jansa.

This Week in Science: "Modulating the clock" (31 August, p. 1017). The image with this

drinking water in the 1970s. In fact, water in most European nations was not fluoridated. However, European improvements in public dental health from the 1970s to the present have matched or even exceeded those of the United States. Reasons include fluoridated toothpastes, which became widely available in the 1970s, and changing criteria for diagnosing caries. See T. M. Marthaler, *Caries Res.* **38**, 173 (2004).

TECHNICAL COMMENT ABSTRACTS

Comments for meeting on use of Medicaid funds for water fluoridation in NY state

In short, fluoridated water is an atomic-era, Cold War idea who relatives, like widespread use of medicinal radioisotopes and intentionally exposing the general population to radioactivity are no longer tolerated. We should adopt precautionary principle with regard to a substance that has potential harm and instead go by the best science which shows that fluoride is extremely effective in preventing decay when applied by individuals and dentists directly to teeth rather than diluted in drinking water which has little benefit. Fluoridated drinking water contains known and unknown risks, especially for low-income communities, the elderly, and infants: groups which are more susceptible to the negative effects of chemical added to drinking water.

Sources:

1. Creager, Angela N. H., 2013. *Life Atomic: A History of Radioisotopes in Science and Medicine* University of Chicago Press, Ltd.

2. Bryson, Christopher. 2004. *The Fluoride Deception*. Seven Stories Press.

3. Ko, Lee and Kathleen M. Thiessen 2015. “A critique of recent economic evaluations of water fluoridation”. International Journal of Occupational and Environmental Health Vol. 21(2)

4. Centers for Disease Control, 1999 and 2001.

5. World Health Organization. Chart of “Decayed Missing and Filled Teeth by country, 1965-2005”.

6. *Science* Magazine, 2012, Nov 2. “Correction and Clarifications”, p. 604 Vol 338.