

## Weber III, Joseph

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**From:** Michael Lawler [REDACTED]  
**Sent:** Thursday, December 22, 2016 11:58 AM  
**To:** DSRIP\_Midpoint  
**Subject:** DSRIP Mid-Point Assessment

I am aware that the public comment period ended on December 21<sup>st</sup>, but I wanted to echo some of the concerns that have been submitted for your review and consideration. And I hope that these brief comments can be considered despite missing the deadline by less than 24 hours.

I would like to focus on three items: First, are two of the four Organizational Recommendations found on page 15 of the DSRIP Independent Assessor Mid-Point Assessment Report, Companion Document: Partner Engagement; and Funds Flow; and finally, the use of \$1.08 billion for other Medicaid Redesign purposes.

### Partner Engagement

I agree with the Independent Assessor's finding on Partner Engagement – "Most PPS need to focus their attention and funding to engage key partners." From the outset, one of our greatest concerns was that the PPS' would not utilize the existing community-based organizations, such as Catholic Charities, and instead look to recreate hospital-focused structures to address the goals of DSRIP. That would be a poor use of limited resources and seems in direct conflict with the direction DSRIP should be headed in.

### Funds Flow

The Independent Assessor writes: "PPS will need to fund their network partners at a meaningful level going forward. For example, the PPS must execute their plans to develop and design contracts with their downstream partners to ensure that they maximize engagement across the networks as soon as possible." The flow of DSRIP funds to community-based organizations is a critical step in the success of the DSRIP initiative. CBOs are struggling to operate in today's environment, having gone lengthy periods of time without COLAs and having to address the increases in the minimum wage as well as potential changes in federal and state regulations related to overtime and exempt employees. Unless you are a Medicaid provider, there is no funding for implementing minimum wage hikes and there are no federal or state funds to comply with changes in the Fair Labor Standards Act. That is why it is so important for PPS to contract with downstream providers with reimbursement rates that will cover the cost of providing community-based services.

\$1.08 billion for Other Medicaid Redesign Purposes – these funds are set aside to "support Health Home development, and investments in long term care, workforce and enhanced behavioral health services." Catholic Charities has been a benefactor of health home development funds for its Adult Health Home in Broome County, as well as for our Encompass Family Health Home operating in 37 upstate counties. We are also in support of funding for enhanced behavioral health services where Catholic Charities provides mental health and substance use disorder services throughout New York State. We do, however, want to address the workforce issues we are facing throughout our network of providers. As is the case throughout the State, the recruitment and retention of our workforce is a critical issue. This has been exacerbated by a number of factors, including direct competition from the restaurant sector where higher wages and less stressful jobs have made it hard to compete; the pressures from the managed care sector that are able to pay a more competitive wage than most Not-for-Profits can afford; and the direct competition we are facing from PPS that are able to hire and pay workers a better wage. The funding earmarked under the DSRIP agreement provides an opportunity to address the issues facing NFP community-based organizations and we ask that the Department of Health work with the NFP community to address the workforce issues. The NFP community is a critical piece to the overall strategy to reduce hospital admissions and readmissions.

I want to thank you for the opportunity to provide brief comments on the DSRIP Mid-Point Assessment.

*Michael A. Lawler*

Michael A. Lawler  
Director of Catholic Charities  
NYS Catholic Conference



## Weber III, Joseph

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**From:** Debbie Pantin [REDACTED]  
**Sent:** Wednesday, December 21, 2016 6:15 PM  
**To:** DSRIP\_Midpoint  
**Subject:** PPS Mid-Point Assessment

Good Afternoon,

VIP Community Services is pleased to provide the following feedback related to our involvement in several NYC DSRIP PPSs. VIP community Services is a community-based organization that provides substance abuse, mental health, housing, care coordination, and primary care(FQHC) services exclusively in the Bronx, hence we are only in Bx base PPSs. This feedback is offered with respect to the DSRIP Independent Assessment Mid-point Assessment Report. Our comments are as follows:

**Bronx Health Access Bronx Lebanon:** VIP has been very active in this PPS and finds them to be open to CBO involvement and very transparent in their work. Involvement includes: Workforce, Clinical Quality Committee, PCMH Committee, Co-Lead of 3ai , Co-Lead of 4cii (which includes voting member of city-wide coalition). This PPS has a strong understanding of SUD and MH needs as well as the importance of addressing this to improve BH and medical outcomes. Funds were slow to flow but we have received 70k in performance dollars, 40k in revenue for starting a CASAC program. We have also received over 20k in "in-kind" such as PCMH certification technical assistance, training for medical assistants to become certified and we are about to partner with other CBOs to have the Language of Care class. This PPS is also working to support partners in having their Social Workers licensed (through surveying needs and then sponsoring test preparation).

**Mount Sinai:** The PPS is fairly communicative though due to size it tends to be more one-sided. We are involved in the IT committee and they are very open to feedback and trying to address the information sharing needs of the SUD treatment community. They don't have any Bronx projects so there is little availability to be involved.

**Advocate Community Partners(ACP):** We are involved in their Clinical Quality Committee and PAC. They tend to want these groups to "rubber stamp" information distributed and little provider input is incorporated. They are slow to respond to requests for involvement. They have very little understanding of SUD or BH and do not seem to be open to feedback on how to best serve this community (and how to recognize undiagnosed MH or SUD). We have collaborated on several health fairs in the NYCHA communities in the Bronx.

**HHC:** Very little involvement. Through the Bronx Leb PPS we are working on cross PPS AI Peer Certification.

**Bronx Partners for a Healthy Community/St. Barnabas-** We are a co-chair on Quality & Care Innovation Sub-committee (QCIS) committee and the Cultural committee workgroup. They first limited themselves to working with FQHCs and a limited number of MH/SUD providers. BPHC recently began engaging with a wider group of behavioral health providers, they are doing so through three behavioral health initiatives. VIP is member agency of the initiatives. No funds have followed to this group as of yet.

Regards  
Debbie Pantin

Debbie Pantin

Chief Executive Officer

**VIP Community Services**

1910 Arthur Avenue | Fifth Floor | Bronx, New York 10457

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



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## Weber III, Joseph

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**From:** Elizabeth Mauro [REDACTED]  
**Sent:** Wednesday, December 21, 2016 4:40 PM  
**To:** DSRIP\_Midpoint  
**Subject:** Comments on DSRIP mid-point

**Follow Up Flag:** Follow up  
**Flag Status:** Completed

Hello,

I am responding on behalf of Mid-Erie Mental Health Services, Inc. also dba as Endeavor. We are a safety net provider in Erie, Niagara, Orleans and Monroe counties with a variety of community based services including article 31 and 32 clinics, PROS programs, SCM, Waiver, etc. We are contracted with Millenium, Catholic Medical Partners and FLPPS.

Comments:

The engagement approach varies greatly with each of these entities.

Millenium has frequent face to face meetings and workgroups which are engaging. We have a voice in those meetings and effort is made to relationship build. They have also been generous with resources to be used in relation to projects.

For Finger Lakes there is little true engagement of community partners that I am aware of. Communication exists of mass emails, numerous software platforms that are glitchy at best and some mandatory webinars. Twice a year they have also held mandatory "partner" meetings during which they read off of PowerPoint slides to a large captive audience. There is no interactive dialogue and certainly no partnering. The project workgroup is the same. Large meetings where attendees are talked at. I have attempted several times to reach out to them regarding projects, my agency, etc and have never received a response. My Data Manager experienced the same when he reached out with questions over their recent request for data i.e. he received no response. I believe we are doing activities that could fit into some of their project categories but again they have shown little interest in working outside of their already existing hospital based system. They have built up a large new entity but what system change is going to come of it without meaningful involvement of the community is unclear. We have not received any significant resources. We have received a few thousand dollars for attending their mandatory meetings and webinars. The money is certainly not enough to do anything with other than help a bit to offset the cost of travel, lost productivity, etc.

Catholic Medical Partners which I believe is being funneled through Sisters of Charity hospital has to date not given us any resources at all. They tend to pair up with Millenium so it gets a bit confusing over which staff belong to which entity. They have held some mandatory meetings as well which have also consisted of PowerPoint slides and someone reading off of them to a captive audience. We are a part of their workgroup based on integrating behavioral health and primary care. Engagement has occurred in this venue with community partners but to date it has consisted of us giving them data, attending meetings, brainstorming ways to improve system dynamics with no return investment. According to the mid-point assessments they have invested a few million dollars into their own hospitals but nothing into community partners. A few months ago we were invited to submit projects for consideration of funding assistance with no parameters of funding

limits, categories, etc other than a budget spreadsheet developed by their long term community based partner. Mid-Erie is working on launching an integrated satellite with a primary care practice to provide behavioral health and medication assisted treatment to an underserved area. It fits perfectly with the dsrip goals of system change and service integration. We submitted our request which was met with puzzlement over being too big, numerous questions and reluctance to assist community based primary care doctors, etc. They basically said they were interested in small little projects such as a mental health clinician visiting an already established primary care practice one to two days a week. We questioned that since what we were proposing was co-locating and working toward full integration to really focus on system change not just more of what we already do. Mid-Erie has put clinicians in a variety of settings for years, including primary care. It's nice but does not create system change. We were told that our proposal was excellent and did represent the goals of dsrip and system reform but was too big for them. We are continuing to advocate over this and may still get some funding to help ramp up this initiative as they were going to kick our request up their ladder.

We will also put our request to Millenium who has been more generous with funding and open to system change projects.

Overarching concerns are provider fatigue and burnout over too many projects. Huge amounts of money are being spent to create more and more oversight, "management" bureaucracies which all want redundant attendance at meetings, webinars, data, screenings, etc. The money largely stays with these entities and little if any gets to the actual providers. What funds do get to the providers gets absorbed quickly by the additional cost to "feed" the new entity and therefore does not translate to improved care.

Conflicting messages and priorities-we try to be client focused but there are numerous imposed activities and screens that clients are not requesting. Vagueness over how much health monitoring can and should be done by behavioral health is an ongoing concern. We do not want to create a false sense of security that our screens and monitoring are an acceptable substitute for full primary care with complete, timely coordination and communication with behavioral health.

All three dsrips have some of the same goals but there is not always consensus on how to measure those goals or the definitions. This has created re-work and aggravation. It again distracts from our mission of providing services.

Lack of adequate notice or understanding of the nature of community based services. We cannot just drop everything last minute and go to meetings especially repetitive meetings where the only goal seems to be to "check off" the box that a meeting was held. Our infrastructure and staff are stretched too thin for those sorts of activities. There also seems to be quite a bit of disarray and frantic requests for surveys and/or spreadsheets to be filled out within one or two business days.

The mid-point assessments illustrate what we were already concerned with in terms of how the money was distributed. NY is a hospital based system. The hospitals have often been "bailed" out and are insular. A big part of the system change attempting to be accomplished is to keep clients out of the hospital by in part enhancing the community based services. Hospitals make money by admissions and full beds yet they were given the money and have spent the vast bulk of it on themselves not on community based organizations or even in the creation of their own community based network. Some small community projects have been funded from what I have heard but they are not of a level to create system change and keep clients out of the hospital and certainly not even close to what the hospitals have given themselves.

The amount of money that has gone into capital projects for the hospitals is stunning. No funding for community partners the first round (again hospitals were put in charge of the decisions) yet we were all told we could apply and we did which took weeks of time and effort. Second round funds were distributed to some community partners. We submitted for the first round but not the second unfortunately. We do not own buildings or have grant writing staff to keep taking weeks of time to submit applications. They did not allow a resubmission of the extensive first application but required a whole new one. Hopefully more rounds of funding come through that are more in reach of medium size providers.

A whole new wing was renovated at Erie County Medical Center with DSRIP money. It housed the DSRIP staff for less than an a year and then was moved to a community site which was then built all out beautifully with equipment and furniture and security guards, etc that any community based agency would love to have. Now we are hearing that they are going to use DSRIP money to build a new trauma center. I am not sure how that is going to create system change. Our capital request was to renovate our front end and a few offices to accommodate doing more health monitoring work and inclusion of medical staff for a safety net population at our busiest location. It was not funded as I mentioned previously.

And last but not least there are activities that are what I call “teaching to the test”. They are geared solely towards getting a particular data point but have little if anything to do with system change or quality. All the providers know this but with such big dollars at stake the conversations and goal becomes to just get the number and not about what is really going to make a difference and improve quality and create lasting change.

I think the goals of the dsrip project are commendable and that there are some very talented and dedicated people working to achieve those goals. My concern is that we are halfway through the time allotted and I am worried that we will run out of time before we are able to get meaningful change in place.

Thank you for the opportunity to comment.  
Elizabeth

*Elizabeth Mauro*  
Chief Executive Officer  
Mid-Erie Counseling and Treatment Service  
*also doing business as*  
Endeavor Health Services

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To get more information about Mid-Erie visit our website at [www.mid-erie.org](http://www.mid-erie.org)

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## Weber III, Joseph

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**From:** Marcus Harazin <statewidepatientsrights@gmail.com>  
**Sent:** Wednesday, December 21, 2016 3:53 PM  
**To:** DSRIP\_Midpoint  
**Cc:** Maria Alvarez; NY StateWide Senior Action Council; Lara Kassel  
**Subject:** Mid Point Assessment Comments from New York StateWide Senior Action Council, Inc.  
**Attachments:** Comments on Mid Point Assessment from the New York StateWide Senior Action Council final.docx

TO: DoH Mid Point Assessors:

I am submitting comments for the New York StateWide Senior Action Council on the Mid Point Assessments. The New York StateWide Senior Action Council is a consumer run organization that promotes the independence and quality of life for older persons and their care givers. StateWide has member chapters across the state including Chapters in Albany (Capital District) and Saratoga Counties.

Our comments are related primarily the PPSs in the Capital District including:

Albany Medical Center, Alliance for Better Health Care, and Adirondack Health Institute.

However, many of these comments are applicable to most PPSs.

Thank you for the opportunity to comment on the Mid Point Assessments of the PPSs. The time available to comment on this massive amount of information was limited by we tried to capture some points base on our experiences to date.

Marcus Harazin  
Coordinator Patient Advocates Program  
New York StateWide Senior Action Council

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

Patients Rights Helpline: [800-333-4374](tel:800-333-4374)



***Comments on from the New York StateWide Senior Action Council, Inc,  
on the DSRIP PPS Mid Point Assessment Related for PPSs Serving the Capital  
Region of New York These Include:***

***(Albany Medical Center, Alliance for Better Health Care, and Adirondack Health  
Institute)***

The complexity of the DSRIP implementation presents a daunting challenge for all of the PPSs. It is very complicated and hopefully this complexity will not prevent success. We recognize that the PPSs are struggling to meeting difficult deadlines and project requirements and metrics. Our comments are not meant to criticize the efforts of these PPSs to date, but rather to provide opportunities for continuous improvement. The goal is for New York State to improve health care for low income persons and avoid unnecessary hospital readmissions and we are all in this together.

**Inconsistent approaches to engaging CBOs**

The involvement and support from the states CBOs is important to assure that PPS projects address the need to address social determinants of health that may present barriers to preventing readmissions. The three PPSs were inconsistent in their approaches for outreach, education and involvement of community based organizations in the planning and delivery of PPS projects. Community based organizations have to navigate a confusing array of project implementation strategies to provide input or engage the PPSs. In the Capital District area some CBOs are dealing with all three PPSs and they are using completely different input and contracting approaches. This is a strain on CBO time and resources.

It is good to see that that these PPSs have collaborated in some of their approaches to workforce planning and public information and cultural competency and health literacy but much more could be done.

**The PPSs have lost opportunities to build support and involvement by community based organizations. Little time is available for public review and discussion resulting in lost opportunities for input and support.**

For example, while the Albany Medical Center PPS developed an excellent Community Engagement Plan, the report was developed primarily in house and while the Consumer and Community Affairs Committee was provided the report there was limited or no discussion with the report. This was a lost opportunity to engage the community in the development of the plan. The PPSs should all work to engage CBOs to obtain suggestions to broaden community support for projects and more actively engage Medicaid participants. This may have been caused by tight timeframes for approval of the plan and submission to NYS DoH. However, the process repeated itself when the plan was recently updated. The same approach occurred to some extent with the presentation of reports developed in house on health care hotspots. A suggestion is to engage CBOs and consumer further upstream in the development of such documents and in discussions about next steps. This recommendation is important for all PPSs.

### Regular Opportunities for Input

The AMC DSRIP is the only PPS that has held monthly Community Affairs and Consumer Advisory Meetings and PAC meetings that are open to the public. All PPSs should be inviting CBOs and consumers to participate in regular meetings held at least every other month or quarterly.

### Alliance for Better Health Care CBO Participation is Limited

This PPS was invited to participate in community forums held by CBOs to discuss their plans. This provided them with an opportunity to connect with the CBOs and consumer organizations. However, they did not reciprocate. Initially the Alliance engaged area CBOs to participate in health to home discussions about improving discharge planning and reducing readmissions. However, these meetings were inexplicably canceled and no follow up occurred. Instead CBOs were told they should speak to individual hospitals participating in this PPS. This was a lost opportunity for engaging and involving CBOs. While some CBOs have been invited to participate in the Alliance PAC meetings, the lack of follow up has left many CBOs on the outside of the projects and PPS discussions. Little or no follow up communication has occurred. If PPS efforts are to be transformative then more effort has to be put into engaging and following up with CBOs.

### Hotspot information is important to share with the community

All PPSs should hold meetings to discuss best ways to address problems identified with in hotspot areas. Providers, CBOs, and consumers should all be invited to participate in discussions of how to best identify these problems. Discussions should include examination of how PPS projects, both those underway or those in the planning stages, can be improved or supported to improve health care in these hotspot areas. Some such discussions may be occurring at project team levels but project teams are generally dominated by hospital and health care provider professionals.

### Information on Availability of 5% Funding is Limited

Little information has been available from all of these PPSs regarding how CBOs might be able to partner with the PPSs to use 5% funding available for non-safety net providers. This is the only flexible funding that the PPSs have to address social determinants and other community based services. However, it does not appear that there is an open process for applying for such funding. Projects funded seem to be determined in house with little community input.

### AMC PPS Consumer Listening Sessions

It is very difficult to obtain input from Medicaid recipients about community health care needs. They don't have time to attend committee meetings yet their insights are very important. The Albany Medical Center was very innovative in using listening sessions to obtain input from Medicaid participants and residents of underserved areas. They did an RFA to engage trusted CBOs to pull together consumers in various areas and have informal discussions about barriers they face that may prevent them from getting needed care or services they need to help them avoid readmissions.

Subsequently, the Alliance for Better Health Care has also recently released a RFP for listening sessions to be held in March of 2017. The process for the RFP and selection of worthy projects involved input from the Alliance's Cultural Competency/ Health Literacy Task Force which includes CBOs and consumer groups. It is certainly a good effort. However, it is disconcerting that the PPSs are having consumer listening sessions so late in the implementation of DSRIP but better late than never.

It is extremely important that the consumer voice is heard during the implementation of DSRIP projects and systems improvement initiatives. All PPSs should be encouraged to hold listening sessions and engage CBOs to implement the sessions.

#### CBOs need to be utilized for case management and patient navigation strategies

Increased availability of patient navigation is a critical component of DSRIP. Medicaid recipients most at risk of readmission can benefit from patient navigation. However, the PPSs have focused primarily on placing these navigators in the emergency rooms and hospitals. The PPSs need to find ways to contract with CBOs to provide such services out in the community. CBOs are often in the best position to meet address the problems of various special needs groups such as the elderly or limited English speaking populations. It is expensive for CBOs to hire and sustain staff for this function especially if they do not serve large numbers of Medicaid recipients at any one point in time. Therefore, the PPSs should work with CBOs to find ways to address this problem. One approach could be to help find a lead organization that can receive referrals from health care providers, link these referrals to patient navigators available from participating CBOs, serve as a conduit for funding these CBOs for their work, and maintain the need IT support for tracking and reporting. Such an approach could work for target groups for example those who are elderly and their caregivers, limited English speaking populations, those with asthma, those with mental health issues, etc..

The Albany Medical Center intends to contract the process for care coordination out to a managed care organization. Efforts should be made to use appropriate CBOs in the care coordination process as they are in a much better position to work with individuals at the neighborhood level. All of the PPSs should find ways to utilize CBOs for coordination of non medical care in the community rather than duplicating this function though a contract with a medically oriented managed care organization.

#### Albany Medical Center PPS Project 2. a.v.

This project is unique among PPSs in that it considers redeploying up to 100 nursing home beds in the five county area. In addition to surveying area nursing home bed capacity the PPS should review ways to address needs of residents sent out of the area for special needs that nursing homes in the PPS area cannot currently adequately address. No area nursing home beds should be redeployed for other community needs until consideration is given to using these beds to help bring residents who are served out of town or out of state because area nursing homes cannot meet their needs. An example would be persons who have complex conditions such as traumatic brain injury, ventilator dependency, dementia and behavioral issues who cannot find a local nursing home bed and have had to obtain care elsewhere.

The neighborhood NORC concept is considered as an approach to complement a Medical Village. This is very innovative since there are large numbers of low income older persons in the service area, especially in Albany. The AMC PPS should involve senior services network providers in developing options for development of Neighborhood NORC like services, such as the Village Model, in the PPS area as a way of helping older persons age in place.

#### Cultural Competency and Health Literacy Efforts

Each of the PPSs have made efforts to engage the community and providers in increasing the ability of the local health care systems, providers, and CBOs to assist limited English speaking and culturally diverse populations. The surveys and data collected by the PPSs should be used as a baseline for measuring progress in developing the workforce to better understand and meet the needs of these consumers over time.

#### Workforce Issues

Successful discharges from hospital to home often rely on the use of in home care provided by trained aids and other personnel provided on a short or long term basis through certified home health agencies, licensed agencies, or consumer directed mechanisms. None of the PPS's deal with the need to address workforce development and shortage issues associated with the shortage of home care workers in their service delivery area. A sound supply of home care that can address the needs of discharged patients in a timely manner is a requisite component of any successful strategy for systems transition geared to reducing readmissions by 25%. While the PPSs cannot solve this problem alone, they should be actively partnering and providing leadership with other stakeholders ( i.e. home care agencies, Offices for the Aging, Local Social Services Districts, Mental Health, substance abuse providers, and ARCs) in their community to examine the problems and explore options for solutions including training and retraining area professionals as well as strategies for ongoing recruitment and retention. Each PPS should have in place a workforce roadmap that includes strategies for addressing the home care shortage.

In addition, the PPSs need to develop and coordinated plan to increase the supply of trained patient navigators. PPSs need to work with CBOs to develop a vision for Patient Navigator resources in each service area. The PPSs should explore several transitions models not just the Coleman model which relies on nurse coaches as there are other models that CBOs in hotspot areas could utilize that have greater flexibility in terms of consumer needs, staffing or volunteer requirements, and are more financially sustainable for CBOs.

Similarly , plans should be developed with CBO input for the care coordination and case management for patients in the community. This should include coordination and case management of non-medical needs that may need to be addressed in order to avoid readmissions.

## Prevention

Good screening and prevention are critical to the identifying and preventing avoidable health problems as well as dealing with chronic health conditions. Each of the PPSs is addressing particular chronic conditions. However, it is clear that preventative health screenings and tests that are available under Medicaid and Medicare are underutilized. The PPSs should identify rates of use of preventive tests and work to assure that the rates of usage in the hotspot areas is increased at to at least the county wide or statewide averages. In addition, use of patient self management strategies should be integrated into appropriate projects (i.e. heart disease, diabetes, asthma, smoking cessation). These include programs like the Chronic Disease Self Management Program. Only the AMC PPS spoke about integrating such programs into their prevention strategy. All PPSs should work with the NY Quality and Technical Assistance Center <http://www.qtacny.org/> at the University of Albany to identify useful self management programs and obtain technical assistance as was suggested by the New York State Department of Health.

## Weber III, Joseph

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**From:** Judy Wessler [REDACTED]  
**Sent:** Wednesday, December 21, 2016 3:30 PM  
**To:** DSRIP Midpoint  
**Cc:** [REDACTED]

**Subject:** Happy Holiday -- Comments on the DSRIP mid point assessment.

Dear all,

The most important message at this time of year, my best wishes for a warm, healthy, happy, and joyous holiday season, whatever it is you may celebrate. We need to be ready for the coming year which may not bring any joy.

Now to the major purpose of this email. I had hoped to spend time writing comments about the mid-point assessment prepared by the Independent Assessor, Public Consulting Group, for the DSRIP PPS's. Even though I consider myself a dedicated and avid reader, the task of reading all of the posted materials was beyond me at this point in my life. It truly reminded me of my time on the Health Systems Agency (HSA) board and executive committee in the '70's and 80's. The HSA would put out large, large reports with little review time and hope (I think) that no one would read it. I did, wrote and circulated comments which of course endeared me greatly to the executives running the agency and the board.

Instead of a full analysis, I am submitting some comments about the information that is available, what is not available, and how all of the information could be made more accessible to anyone who is not backed up by a large staff and a great investment in what happens with the DSRIP dollars.

### The Mid-Point Assessment

You can find all of the postings on the mid point assessment at: DSRIP website  
[http://www.health.ny.gov/health\\_care/medicaid/redesign/dsrip/pps\\_map/midpoint/index.htm](http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_map/midpoint/index.htm)  
<[http://www.health.ny.gov/health\\_care/medicaid/redesign/dsrip/pps\\_map/midpoint/index.htm](http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_map/midpoint/index.htm)> .

Comments are to be submitted today, December 21st to [dsrip\\_midpoint@pcgus.com](mailto:dsrip_midpoint@pcgus.com)

As noted above, I actually did start to read the thousands of pages posted about the PPS's covering New York City. I stopped after trying to get through two of the multiple reports.

I am instead writing these comments based on:

- \* My membership as the Assembly representative on the DSRIP Project Approval and Oversight Panel (PAOP).
- \* My active involvement with community-based organizations and the coalition Communities Together for Health Equity (CTHE)
- \* My visits to six of the PPSs, five through official site visits arranged by DOH and PCG, and the sixth through a community organization.

Evaluations of the projects chosen by the PPS is an important part of the assessment. This is critically important and helpful in monitoring the progress of the PPSs. But there are other important missing pieces, some of which are available in other places on the DSRIP web site, some possibly not available publicly.

#### Critical Missing Pieces

- \* Detailed Financial Information: The PAOP required, which I played a major role in pushing, that there be a new grid for reporting of the PPS financial information with very specific details allowing for a good overview and ability to follow the money. The grid was used once for the Year 1 4th quarter report. Despite strong advocacy, it has not yet been used again, specifically for the Year 2 1st quarter report. The finances shown in the mid point assessment basically tells very little to nothing. Many CBOs are not getting funding, or very little funding, and are feeling like they are unpaid consultants even though what they are doing and have to offer is totally critical to the success of DSRIP.
- \* Primary Care Report: Based on strong recommendation from Cesar Perales, as PAOP member, the PPSs were required to submit a primary care report, all of which are posted on the DSRIP web site. It would be helpful to have at least a summary of these proposals in the mid point assessment reports. The primary DSRIP goal of reducing of unnecessary hospitalizations by 25% can not be legitimately reached if primary care services, particularly located in under-served communities, are not expanded made culturally competent and acceptable, accessible.
- \* Cultural Competence: The PAOP, or at least some of the members, stressed the need for cultural competence in evaluation of the PPSs. Once again, there is a separate report on cultural competence but there does not appear to be a discussion or summary of these issues in the mid point assessment.
- \* Workforce: There is something like \$500 million available the PPSs for workforce evaluation and training. There are workforce reports, but this information is not incorporated in the mid point assessment. What are the identified needs? What training is being done? Who is doing the training? How much is being spent on these contracts? What are the ultimate goals fo these training projects.
- \* The Governor made \$1.2 billion over five years available to some of the PPSs as a supplement to the federal DSRIP dollars. This program is being managed separately and funded through HMO's in what appears to be a very complicated scheme. Reporting on this program is not incorporated in the PPS reports even though the dollars are going to many of the same PPSs. This is even more unfortunate since there are programs, maternal and child health, that were not highlighted or an important part of the original PPS projects. Information on these projects and the funding, and outcomes, should be incorporated in all of this reporting and the mid point assessment.

I am probably missing some key issues but wanted to get something out. It would be great to hear from others with their ideas and suggestions.

Judy Wessler

## Weber III, Joseph

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**From:** Bill Belec [REDACTED]  
**Sent:** Wednesday, December 21, 2016 5:22 AM  
**To:** DSRIP\_Midpoint  
**Subject:** Response to DSRIP Mid-Point Assessment

To Whom It May Concern:

Trillium Health agrees with the Independent Assessor's review and would like to provide additional comments for consideration.

As a participating partner, Trillium Health has made various efforts to participate in projects and on committees. Trillium Health has been providing comprehensive care to the Rochester community for nearly 30 years and has a well-established model. Our organization sees the value in participating in this important initiative and collaborate with community partners. However, requests to be more involved in decision making have been met with resistance. While we expressed interest in joining workgroups and committees many times, we were often told that the committees weren't accepting new members or that the workgroup/committee wasn't meeting currently. During these times, we were continuously approached by FLPPS regarding what else we could be offering. Ultimately, we have made progress and have been able to join several workgroups and committees, but have lost the opportunity to be involved in decision making up to this point.

During initial contracting, we provided significant feedback on needed contract changes, however, our feedback was not taken into consideration. As an equal partner in this process, our feedback should have been taken into account according to our contract standards. This approach has made this endeavor one-sided, instead of collaborative – one of the many purposes of this initiative.

As an equal partner in this initiative, reimbursement is minimal compared to what the larger healthcare systems are receiving. For smaller healthcare systems, it takes more staff time and resources to participate in these projects. Reimbursement should reflect this effort. We'd also appreciate timely reimbursement of funds. To date, reimbursement is often delayed 6 months past the performance period.

Thank you for your time and consideration.

Bill

**William E. Belec**  
Chief Operating Officer  
Senior Vice President, Programs and Services  
259 Monroe Avenue  
Rochester, NY 14607-3632  
E [REDACTED]  
P [REDACTED]  
F [REDACTED]  
W [www.trilliumhealth.org](http://www.trilliumhealth.org)

*Trillium Health, a community health center located in downtown Rochester at Monroe Square offers access to affordable healthcare for all. Trillium Health affords patients evening and extended hours, on-site pharmacy & lab services, free parking and sliding fees based on income. It's the extraordinary care you deserve.*





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[REDACTED]

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**From:** Ken Sass [REDACTED]  
**Sent:** Tuesday, December 20, 2016 5:12 PM  
**To:** DSRIP\_Midpoint  
**Subject:** Comment on DSRIP experience

Our DSRIP experience has not been positive. As a community based agency, we looked for a 'way in' to this new and significant development. We wrote an extensive grant in response to an RFP from a PPS for the Maternal and Child Health area, and were approved. However, when we went into 'negotiations' (at the request of the PPS) about the project, the project we had proposed and been approved for was changed significantly. We were building on an existing program that we have a current contract with OCFS, but we believed that what the PPS wanted us to do would expose us to 'double dipping' on the funding we were already receiving. I don't think this was intentional on the part of the PPS, and we tried to negotiate this for something that could work, but found we were unable to work it out with the PPS. So, we ultimately had to reject the grant award. While it is highly unusual for a nonprofit community based agency to reject significant dollars, we couldn't work through this with the PPS.

In general, my observation is that I don't see an impact on a community level of the PPS at this time. Other community based agencies that I speak with have had the same experience of not feeling included in a meaningful way by the DSRIP. I still think most of the money is going to hospitals and to the DSRIP itself. So, it doesn't have the 'feel' of a 'bottom up' approach to rebuilding our delivery system, if that is what it was intended to be.

I remain hopeful that a meaningful contribution from Community-based organizations can be incorporated into the process in the near future, resulting in more efficiencies and improved results from the system for the people we serve.



Family & Children's Service of Niagara

**Ken Sass**  
President-CEO

Family & Children's Service of Niagara  
1522 Main Street  
Niagara Falls, NY 14305

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

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\*\_\*

[REDACTED]

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**From:** Jan Lynch [REDACTED]  
**Sent:** Tuesday, December 20, 2016 3:39 PM  
**To:** DSRIP\_Midpoint  
**Subject:** DSRIP Mid-Point Comments

I am disappointed that local DSRIP coordinators have not reached out to our Independent Living Center to ask us to be a part of the conversation and planning.

We represent the interests and needs of people with all types of disabilities – disabilities they are born with as well as disabilities acquired as the result of accident, disease or aging. We feel it is important that we are at the table to bring the disability perspective into focus where it is appropriate.

Thanks for asking for feedback.

Jan Lynch

Jan Lynch  
Executive Director  
Finger Lakes Independence Center/FLIC  
215 Fifth Street Ithaca NY 14850

[REDACTED]

[REDACTED]

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**From:** Michael Burgess [REDACTED]  
**Sent:** Tuesday, December 20, 2016 1:50 PM  
**To:** DSRIP\_Midpoint  
**Subject:** DSRIP mid point assessment

Regarding the Alliance for Better Health Care

We concur with the evaluation that the Alliance needs to develop a plan for contracting with community based organizations. We served on a hospital to home committee which no longer meets - it has not met since June 2016. Committee work with CBOs seems to have discontinued for many organizations since then with little effort to involve us. A group of organizations serving older persons submitted a proposal in early 2016 to offer our services in care coordination. Meetings were held with us but have not continued and there has been no response to follow up on our proposal.

**Michael Burgess**

Community Caregivers  
2021 Western Avenue  
Albany, NY 12203  
[REDACTED]

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

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c/o Settlement Health  
212 East 106<sup>th</sup> Street  
New York, NY 10029



Committees:

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

Board of Directors:

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*Secretary*  
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*Communications Director*

Guedy Amiclla  
Eric Canales  
Jose Caraballo  
Ray Cornhill  
Erika Donovan Estades  
Sandra Talavera

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**Comment Statement from EHCHC on the DSRIP Mid-Point Report 12/20/16:**

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

Given that one of the missions of DSRIP is to promote community-level collaborations and system reform<sup>ii</sup>, it is hard to understand why nearly 42 percent of all distributions statewide have been to the PPS project management offices (PMO). The MSPPS PMO received 78.51 percent of funds distributed by the PPS across its network and the OCHPPS PMO received 94.92 percent of distributed funds while community-based organizations only received .59 percent and .95 percent, respectively<sup>iii</sup>. If DSRIP has any hope of meeting its goal of reducing unnecessary hospitalizations by 25 percent over five years<sup>2</sup>, patients must receive preventative and curative care in the community, not the PMO.

This data shows that PPSs are taking advantage of DSRIP to ask more of their community partners (CBOs, community based primary care providers etc.) without providing fair support or reimbursement. While community partners are expected to increase caseloads, design new programs, and hire new staff, they are given little funding to accomplish these goals. For example, in an interview conducted with a community-based organization (name excluded), it was explained that the organization was expected to hire new staff but was only provided with a contract for approximately \$10,000<sup>iv</sup>. While the recommendations encourage the PPSs to quicken the contracting process, they do not address whether the scheduled funds are sufficient to actually pay for the work that is being demanded of partners.

While funding is important, true partnership demands more engagement, which is why it is disappointing that the reports did not offer concrete direction or definition for what engagement means. Up to now, much of the "engagement" that has been described in interviews with community-based organizations has consisted of little more than one-way communications and directives<sup>4</sup>. Many of the partner organizations have long histories working in their areas of expertise and their neighborhoods; yet they are not being consulted on how to deliver the care that DSRIP

aims to increase and expand. The state should encourage (and ideally, monitor) bidirectional engagement that actually involves collaboration on projects. If the PPSs are not held accountable for effective engagement, DSRIP cannot succeed.

While the EHCHC has many concerns with DSRIP, these are two of our specific objections to the Mid-Point Assessment Reports. The EHCHC fears that DSRIP will end up being nothing more than an \$8 billion giveaway to hospitals and health systems while community organizations, and the communities they serve, are left in the dark. While the reports might suggest all is going well with DSRIP, communities know the truth is otherwise. Moving forward, the EHCHC hopes that stronger efforts are made to ensure that positive results of DSRIP will be actually seen in the communities it purportedly helps rather than just on paper.

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

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

<sup>iii</sup> DSRIP Independent Assessor Mid-Point Assessment Reports. Mount Sinai PPS. One City Health PPS. New York State Department of Health. November 2016.

<sup>iv</sup> Interviews were conducted with 11 community-based organizations between June 2016 and August 2016 by the EHCHC. Interviews aimed to collect information regarding the implementation of DSRIP.

[REDACTED]

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**From:** Kathy Riddle [REDACTED]  
**Sent:** Monday, December 19, 2016 5:04 PM  
**To:** DSRIP\_Midpoint  
**Subject:** PPS Mid-Point Assessments

Good Afternoon,

Outreach Development Corporation is pleased to provide the following feedback related to our involvement in several NYC and LI region DSRIP PPS's. Outreach is a community-based organization whose chemical dependency treatment programs operate under license of the NYS Office of Alcoholism and Substance Abuse Services (OASAS). This feedback is offered in association with the **DSRIP Independent Assessor Mid-Point Assessment Report**. Our comments reflect the varying levels of participation we have had with these PPS's:

▪ **Mt. Sinai PPS, LLC**

Outreach has been a partner in the Mt. Sinai PPS since inception, has engaged in PPS town halls, project-specific webinars, completed all quarterly surveys and reporting, established a good line of communication with our DSRIP partner relations contact, and a member of our management team (the Director of Outreach's Training Institute) is a member of the PPS Workforce Committee (this same Director has been privately engaged to do Motivational Interviewing training for the Mt. Sinai DSRIP). Outreach has thus far achieved the maximum distribution of funds to which we were entitled (essentially for webinar/meeting participation and survey completion), amounting to \$1000 for DY1 (received) and DY2 (yet to be disbursed).

It is clear the PPS has an understanding of substance use disorder/mental health needs, as the Mt. Sinai health system itself encompasses large substance abuse treatment components under its umbrella, and has additionally contracted with numerous community-based health providers intensely located in NY County (Manhattan) under the PPS. The fact that Outreach's outpatient chemical dependency services are geographically situated primarily in Queens and Brooklyn may work to our disadvantage with respect to financial benefits under the Mt. Sinai DSRP, although we have close relationships with primary care/FQHC providers who are also partners in the Mt. Sinai PPS, and are moving toward full integration of primary and behavioral health care (Project 3.a.i).

For work done to date, however, Outreach believes our participation has involved significant effort with relatively little benefit. Further, we anticipate additional demands as the expectation is we will need to connect to the Healthtix RHIO to achieve further engagement, and it remains unclear whether this would achieve more beneficial outcomes. We are presently seeking counsel from our partner relations representative and will re-evaluated future participation level.

▪ **Community Care of Brooklyn (CCB)/Maimonides**

Outreach has been a partner in the Community Care of Brooklyn/Maimonides PPS since inception, attended early meetings in the PPS's formation, participated in surveys, and otherwise has been only minimally engaged, receiving newsletters and other information communicated to the PPS network. Outreach recently received \$4,000 distribution of funds for participation in the required PPS surveys. Outreach has enjoyed a more direct relationship with Maimonides Medical Center, separate and apart from the DSRIP, surrounding workforce training issues. The Director of Outreach Training Institute has provided onsite training for members of the hospital clinical staff on Health Homes. It is unclear how much more deeply we will engage and participate in the future.

▪ **Suffolk Care Collaborative (SCC)/SUNY Stony Brook Medical Center**

Outreach is very active in the Stony Brook/Suffolk Care Collaborative, which has a thorough grasp of the substance use/mental health/behavioral health needs of the Long Island region. Outreach staff were active in planning committees and SCC DSRIP information meetings since inception, but since the PPS hired a director of behavioral health

and physical health integration, communication has improved substantially and SCC has been extremely responsive to our agency. In the past year, Outreach and SCC fully executed a Participation Agreement. As a substance abuse treatment provider, Outreach participates in SCC's DSRIP Projects 2.1.i, 3.a.i, and a smoking cessation project specifically undertaken to improve community health. We are in regular contact with the PPS, our IT department has established a connection and Outreach is signing on to NY Gateway (RHIO). SCC is the best fit for Outreach, as we operate several outpatient clinics in Suffolk County. We have a clear understanding of what outcomes are expected of us (connection to the RHIO, primary care on site, etc.) and to date, Outreach has received distribution of approximately \$17,000. We anticipate a fruitful and beneficial relationship throughout future contract years.

▪ **Advocate Community Partners (ACP)**

Outreach engaged with ACP in the last calendar year and has since executed a full Participation Agreement. Outreach was randomly selected by the New York State Department of Health to complete the online 360 survey about our experience as a participant in the ACP PPS network, which was part of the overall "mid-point" assessment of NYS's DSRIP program, designed to gauge the level of engagement by ACP's physicians and partners across governance, project implementation planning and efforts, and funds flow. Though attending relatively few in-person meetings, ACP maintains regular communication and Outreach received approximately \$14,000 in distribution. We have not received information related to expectations over the remaining years of the contract, but anticipate a beneficial partnership to continue.

Regards,  
Kathy Riddle

***Kathleen A. Riddle***  
President/CEO



117-11 Myrtle Ave.  
Richmond Hill, NY 11418

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

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[REDACTED]

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**From:** Philip Edie [REDACTED]  
**Sent:** Monday, December 19, 2016 8:59 AM  
**To:** DSRIP Midpoint  
**Cc:** [REDACTED] Anne Richey  
**Subject:** PPS Comments to PCG

 This Message was Encrypted

Greetings;

Thank you for providing us with the opportunity to express our thoughts about our experience with the two PPS' in which we participate.

### **Tug Hill/Seaway Valley (NCI) PPS**

This PPS engaged our organization from the beginning. They presented information about DSRIP to our Board of Directors, and suggested ways in which we could actively support the transformation. The core groups of the PPS, which are NCI and FDRHPO, have actively led the members of the PPS to achieve the required deliverables. Their staff are in constant communication with our staff.

The FDRHPO is an excellent springboard with many years of experience in leading health care initiatives. They coach constantly, realizing that DSRIP is a monumental task and that sometimes the focus needs to be narrower for teams to succeed. They actively represent the PPS in every way possible and at all levels. Most importantly, they are an active participant in the health care community.

Committees were formed and meet regularly to conduct the business of the PPS. Feedback is actively sought from stakeholders, and decisions are made to mobilize the necessary resources with as much advanced notice as possible. In short, the NCI PPS is driving the change by hiring and tapping the expertise of very talented people to the benefit of the PPS members. Not everything must be done by consensus every time. There is no substitute for strong leadership.

Our organization was able to remove one of our St. Lawrence County sites from the AHI PPS and move it into the NCI PPS during the mid-point assessment. The NCI "boots-on-the-ground" approach supported a corporate submission for PCMH Level 3 under the 2014 standards. All three of our sites, including the one located in the AHI PPS, are now Level 3 certified as a result of the direct engagement by the NCI staff to coach and guide our team. The location in the AHI PPS received the benefit of the NCI support.

The distribution of funds by category speaks for itself when examining the effectiveness of this PPS in working with the members. The ACO is not co-mingled with PPS business at all levels for ACO convenience. We look forward to continued success as members of this PPS.

### **Adirondack Health Institute (AHI) PPS**

This PPS has struggled since inception to engage and sustain the involvement of many of the smaller members. Our organization was engaged at many levels initially, which included the steering workgroup to select the measures to pursue and work through the CRFP selections. Much of the AHI effort has gone into supporting the hospitals and a major primary care provider in the PPS.

The first funds flow effort was conducted at the last minute without prior engagement of the steering committee, and almost all of the funds went to this group. Many of the lesser, but not less important, members took this as an indication of what to expect in the future. Engagement began to lessen at this point.

PPS members were assigned to Regional Health Information Teams (RHIT) and expected to develop unique solutions that met their needs. Much of the effort was ground-up, from scratch. Templates were scarce and much energy was expended to get these team off the ground.

Many organizations ceased to participate. The time and resource requirement was great and the return seemingly insufficient or distant. The turnover at the senior staff level, and an active AHI management presence in RHITs contributed to the challenges. The lack of AHI outreach to members was another challenging factor.

It appeared that AHI, the hospitals, Hudson Headwaters Health Network, and the Adirondack ACO were the primary drivers of the PPS direction. Recent changes that include assigning executive members of the AHI organization to newly created Population Health Networks (PHN) may be the reset necessary to reenergize the members and engage them at all levels.

Regards,

Philip 'Skip' Edie, MBA  
Associate Executive Director  
CP of the North Country/CHC of the North Country  
4 Commerce Lane  
Canton, New York 13617-3739

Stay Connected with Us On:



[REDACTED]

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**From:** Young Do [REDACTED]  
**Sent:** Friday, December 16, 2016 6:43 PM  
**To:** DSRIP\_Midpoint  
**Cc:** Norwig Debye-Saxinger  
**Subject:** PPS Mid-point Assessment - Hospitality House

Dear Sir or Madam,

I would like to provide a brief narrative of our DSRIP engagement with PPS'. Hospitality House is an OASAS licensed Intensive Residential Facility located in Albany with 72 beds, serving clients from all over New York State, ex-NYC. At DSRIP year 0, we sent letters of intent to 10 PPS' whose regional areas cover our clientele. We only heard back from a handful, and today, we are actively involved with four PPS': Adirondack Health Initiative, Leatherstocking, North Country Initiative, and Refuah. Our level of engagement with each PPS has been varied, and it's clear that some PPS' have done a better job of reaching out to PPS partners and communicating project processes. Some PPS' have been very active in their engagement, while we have not heard from others in quite some time. So based on our experience, here is some feedback on certain areas of the DSRIP program:

**DSRIP Projects:** Some PPS' have been very good about eliciting our feedback on certain projects, and helping with guidance on their expectations for our involvement. Others have not been so engaged.

**PPS understanding of SUD/MH needs:** Much of the language that is used in communications with PPS' seem to be focused on hospitals and physical health care, and less with behavioral health. Some of the expectations of PPS' do not cover SUD/MH and sometimes we are in the dark about what our role is.

**Funds Flow:** The resources we have expended in-house for DSRIP-related operations far exceed what we've received in terms of funds for participation. Specifically, the areas that require more funding for adequate participation include: person-hours for data collection, costs related to staff training, costs related to developing/implementing compliance plans, policies, and procedures.


As a smaller organization, we do feel that we are being overlooked and sometimes find ourselves asking whether it is really worth it for us to continue participating in PPS projects. We've met deadlines; we've committed resources to providing necessary trainings; we've collected and submitted requested patient data; we are developing policies and procedures for care transitions and coordination; we have committed considerable resources to acquiring necessary infrastructure, including a new EHR system with RHIOs connectivity. If the state committed the funds to help organizations meet these goals, we are not seeing it.

Thank you for your time in understanding our perspective of the DSRIP program.

Best regards,  
Young

\*\*\*\*\*  
Young Do, LMSW, CASAC  
Clinical Director  
Hospitality House, T.C., Inc.  
271 Central Ave. Albany NY 12206  
[REDACTED]

Doctoral Candidate  
School of Social Welfare  
State University of New York, University at Albany



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Comments on  
DSRIP Independent Assessor Midpoint Assessment Reports  
December 21, 2016

The Community Health Care Association of New York State (CHCANYS) appreciates the opportunity to submit these comments on the Independent Assessor Midpoint Assessment Reports. CHCANYS is supportive of the overall goals of DSRIP and its recognition of the need for a transformed health care system in New York—one that sustains and enhances our primary care foundation and shifts away from the historic emphasis on inpatient care. All 65 of New York’s federally qualified health centers (FQHC) are in one or more Performing Provider System (PPS) Network, and a majority are active participants on PPS governance, including finance and clinical boards. Health centers are extremely engaged in numerous DSRIP projects and have played a central role in the development and implementation of DSRIP projects that drive transformation.

CHCANYS previously submitted comments to the Department during the development of the Midpoint Assessment process and recommended that the Independent Assessor consider how PPS leads have supported and enhanced primary care and implemented primary care-focused projects, including meaningful engagement with community based providers, completion of the Primary Care Plan, and ensuring adequate flow of funds to these providers. Additionally, CHCANYS suggested integrating a “360 evaluation” type component in the Independent Assessor’s review of DSRIP projects in which the non-lead partners are interviewed and asked about their experience with substantive participation in governance, project development, project execution, communication with and between the lead and other partners, conflict resolution, dollar flow, and general satisfaction with the lead PPS. While we are pleased to see that the Reports address some of these concerns, and did incorporate a 360 review of providers, we are dismayed that much of the information shared in the Reports is high level and does not include much detail reflecting FQHC or other community-based partners’ experience in their PPS networks.

### Need for Definition of “Partner-Type” Categories

The success of DSRIP is reliant on meaningfully integrating PPS community partners into all aspects project planning and implementation and leveraging partners’ expertise and existing capabilities. PPS projects should not be focused on replicating services or advancing a PPS lead’s particular business strategy, but should build off existing capabilities for providing community-based primary care.

Throughout the Reports, however, the IA relies on broad categories of “partner-type” categories in each of its assessment without defining what types of providers are included in this term. Of particular concern to CHCANYS the lack of nuance in the “clinic” category, which, based on a chart in a DOH presentation from 2014,<sup>1</sup> appears to include FQHCs and all other diagnostic and treatment centers and does not distinguish between hospital-based clinics or community-based clinics. A PPS lead that is partnering primarily with its own D&TC, behavioral health, long term care, and substance use disorder providers would present in these reports as engaging a variety of partner types even though the DSRIP projects and funds are actually contained within one parent institution. Without a more nuanced understanding of the specific providers in each provider type – and specifically whether or not the provider-type is an affiliate of the hospital lead, it is difficult to truly assess the extent to which PPS leads are engaging with all their network partners and whether the funds are flowing beyond the four walls of the lead institutions.

The lack of specificity on the “provider-types”, as well as a clear definition or scale measuring “partner engagement” makes it difficult to fully comprehend how the IA determined the scoring and recommendations for each PPS and obscures the importance of meaningfully engaging with a range of types of partners. For example, one PPS lead reports that they are engaged with only 1 PCP (out of 258 PCP partners to which they have committed to be engaged) and 24 clinics (more than the 8 they committed to), in project 3.a.iii. Another PPS reports that they have engaged with zero partners of any kind in project 3.a.iii. No further information is included on

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<sup>1</sup> [https://www.health.ny.gov/health\\_care/medicaid/redesign/dsrp/docs/a4p\\_pct\\_ss.pdf](https://www.health.ny.gov/health_care/medicaid/redesign/dsrp/docs/a4p_pct_ss.pdf) (page 7)

what exactly “engaged” means in this context, or whether the partners are community-based, hospital affiliated or other types of providers. Both PPS leads received a score of 2 on this project, indicating that “the project is more than likely to meet intended goals but has some challenges to overcome” (despite one PPS’s very low rate of partner engagement and the other’s non-existent engagement with partners) although the IA also recommended that both of these PPS develop an action plan to increase partner engagement across all of their projects. This scoring makes it seem as though partner engagement is not a critical component of ensuring the success of DSRIP, but rather a small issue that can be worked through. If existing community infrastructure is not leveraged, it is unlikely that DSRIP goals will be met; but it is likely that DSRIP funds will be squandered to replicate existing services under a hospital’s umbrella. Furthermore, the overall lack of descriptive details about the types of partners or type of engagement that is or is not occurring within the projects makes it extremely difficult to assess how PPS leads are working with their network partners.

CHCANYS strongly recommends that the IA further develop provider type definitions to reflect the whether the members of each type are community-based, hospital affiliated or private and include these definitions in the Reports.

#### Funds Flow

This lack of specificity about partner-types obscures information about funds flow, as well. We have heard from many of our members that they have received no or very minimal funds from their PPS lead(s.) Based on the data in the Reports, appears as though only 3.9% of DSRIP funds have been distributed to PCPs and 7.5% to clinics. Again, without further details on what types of providers are in these categories a more nuanced and data-driven analysis of how and whether PPS leads are adequately funding their community-based partners in a timely manner and in compliance with the PPS financial plan is nearly impossible. Based on anecdotal evidence, CHCANYS believes that many community based partners have expended significant resources throughout the DSRIP planning and early implementation process, yet have received only

limited funds from PPS leads in support their efforts, if any. CHCANYS remains very concerned about a lack of transparency regarding flow of funds, especially in light of the expenditures by FQHCs to meet required clinical deliverables.

In collaboration with other community-based providers, CHCANYS has developed a survey for providers to assessing the amount of funds received to date by FQHCs and other community-based providers, as well as the amount expended by the provider and anticipated from the PPS lead. We are currently surveying the field and anticipate preliminary results in early next year. We look forward to sharing our analysis and ensuring that community based providers are appropriately and fairly compensated for their participation in all aspects of DSRIP.

### 360 Review

CHCANYS is pleased that the IA conducted a 360 Evaluation Survey of network partners, which is an important component for assessing how PPS have engaged with their partners. The Survey was sent to just over 1000 network partners statewide and 52% of those responded, an average for 21 responses per PPS, which seems extremely low. However, there is no indication of how many total network partners there are statewide and thus, it is not clear what percent of total network partners were surveyed. This piece of information would seem critical to developing a more accurate analysis of the network partners' experience. Furthermore, at the state level, the IA reports that the average score for PPS statewide by all provider types in 2.90, yet provides no additional information on what this score means.

The IA did not engage the provider community in developing the questions used in the survey. The first set of questions are problematic in that they generally are framed as point in time questions – has the PPS engaged you/sought your input on governance, projects, etc.? If a PPS reached out a single time to a partner, the partner would have to honestly answer yes, even if there was no follow up from the lead. The second set of questions asking for input about whether the PPS had been effective in certain areas seems to show broad swings – partners either agreeing or strongly disagreeing. As stated above, without analysis on the breakdown of whether



the agree/strongly agree responses are truly reflective of the community or given primarily by PPS lead affiliates (and the strongly disagree are given by the community based providers), the utility of the survey is limited.

CHCANYS is aware of many health centers and other community-based providers who are extremely concerned with the lack of engagement they have experienced with their PPS leads, and we applaud the Department's commitment to continue with the 360 Survey going forward. However, we encourage the Department to retool the Survey question so that experiences of the community-based providers are captured in the survey results in an actionable way. While we appreciate the IA's effort to gather information directly from partners, CHCANYS urges the IA to conduct a more detailed analysis of partners' experience of engagement, funds flow, and governance both statewide, and in individual PPS networks. Specifically, we request that the questions of the 360 survey be refined, and reflect the input of the PPS partner community. Moreover, the definition of partner-types – and whether the partners are hospital affiliated – needs to be clear throughout the Assessment, including the 360 Survey.

CHCANYS supports New York's efforts to transform the healthcare delivery system through DSRIP and is pleased that the State has recognized the importance of expanding access to comprehensive, community based care- a model that FQHCs have relied on for over fifty years. We urge the IA to ensure that the work of FQHCs, and other community-based safety net providers, is appropriately valued throughout the DSRIP project assessment and implementation process.



## **COMMENTS ON THE DSRIP INDEPENDENT ASSESSOR MID-POINT ASSESSMENT REPORT**

The Coalition for Behavioral Health, Inc. (The Coalition) is the umbrella advocacy and training organization of New York's behavioral health community, representing over 140 non-profit community-based agencies that serve more than 450,000 consumers. Our members serve the entire continuum of behavioral health care in every neighborhood of New York City, and communities in Long Island, Westchester, Rockland, and Orange counties. Coalition members provide access to the range of outpatient mental health and substance use services, supportive housing, crisis intervention, peer support services, employment readiness, Personalized Recovery Oriented Services (PROS), Club Houses, education and nutritional services, as well as many other supports that promote recovery. The Coalition also trains on average 500 human services providers monthly on cutting edge and proven clinical and best business practices through generous support from the New York State Office of Mental Health, New York City Department of Health and Mental Hygiene, the New York City Council, and in conjunction with foundations and leaders from the behavioral health sector.

The Coalition is grateful for the opportunity to provide comments on the recently released "Mid-point Assessment Report" by the DSRIP Independent Assessor. We appreciate the transparency in the process of sharing progress data and commend the State for fostering a learning environment by making data and information available to allow for mid-course corrections and innovation opportunities in this rapidly changing environment. It is an optimistic sign that the findings of the mid-point assessment review of the 25 PPS indicate that they are on track, although importantly noting that a majority of the PPS are lagging in partner engagement. There are many commendable examples of progress and we congratulate the

PPSs for this headway. However, as an organization comprised of “partners” we have deep concerns about the lack of partner engagement which is validated in the October 7, 2016, PPS Progress Report which shows that approximately only 8% of funds have flowed to community based providers. In order to achieve the admirable goals of DSRIP it is imperative that all stakeholders rise to the challenges together and are given equal opportunity to succeed. This includes being provided with the necessary resources to adapt, evolve and innovate.

The Coalition and its members are deeply invested in the success of DSRIP because of the positive impact it can have on the lives of the individuals and communities they serve. Through participation in the initial phase of DSRIP, they had envisioned and strategized a new way forward that is creative, clinically sound and grounded in real experience—they deserve every opportunity to achieve these lofty goals. We are aware that progress is on-going and moving rapidly, and offer our comments to inform, reinforce and strengthen the Recommendations of the Independent Assessor with the perspectives of the behavioral health community.

The Coalition has actively encouraged its membership to report their progress with the implementation of DSRIP to better understand and quantify its impact. As each PPS is required to include at least one measure focused on behavioral health, we believe this input is valuable. Further, behavioral health care promotes the involvement of Home and Community Based Services (HCBS) as an essential tool in recovery. Our members have developed expertise in those services, and we offer that perspective as well. Our comments focus on barriers to Partner Engagement, the ramifications of insufficient Fund Flows and the opportunity for Financial Sustainability and transition to Value Based Payments (VBP).

### Partner Engagement

The reports from many of our providers begin with overarching comments regarding the lack of structural congruence between medical and behavioral health care as a barrier to partner engagement. DSRIP proceeds from a medical care paradigm with its inherent perspective, and the institutional bias does not easily comport with or take advantage of the on the ground, immediacy and inventiveness of community based organizations (CBOs), whether they are

providing behavioral health care or the services to address the social determinants of poor health.

For example, members have expressed their frustration with perspectives that revolve on medical solutions and fail to begin with a collaborative, problem solving approach inclusive of multiple perspectives, particularly non-medical solutions. One member describes a “tortuous” process with a PPS regarding childhood asthma mitigation. The PPS looked toward clinical solutions and failed to recognize the value of stress management by CBOs as a preventive opportunity.

Another provider noted “The projects were not designed with the input of community based organizations like ours. As a result, implementation...has been a struggle...had it been designed with the input of our agency, we would have been able to inform the process and ensure that its goals could be achieved.” Even the forms requested information that is “irrelevant to the practice of a community-based behavioral health organization.”

A similar discordancy noted is a “mismatch between community modalities and the projects selected by the PPS. There is a cultural difference in their understanding of viable solutions. It was further noted that being able to offer clinical or clinic-like services facilitated understanding between the medically based PPS and the CBO.

Another barrier to effective partner engagement, one which threatens the stability of the behavioral health infrastructure, is the disadvantage of smaller community based agencies serving fewer, but yet the most vulnerable populations effectively. These organizations, deeply rooted in the neediest communities, are most likely to understand and connect with those communities. Yet they are less able to invest the time, effort and financial resources to engage in the contracting process and are the least likely to be sought out by the PPS lead agencies. Without the PPS leads committing resources to outreach community based organizations,

develop a mutually understandable dialogue and provide the resources to “bring them up to speed,” those CBOs best positioned to engage the neediest communities will not be there.

Another factor that stymies effective partnerships is the emphasis on health care as the primary driver of the PPS. As to parity between primary and behavioral health care, our members still believe the PPS “are all essentially focused on primary care.” One agency remarked “ we chose the only project which could conceivably fall within our agency’s mission.” Another called it “ a bit of a guessing game to determine which projects would be appropriate for our agency.” The CBOs questioned the assumption of a “secondary” role, while acknowledging the concerns should medical care be provided in a behavioral health setting. There is a long history of subtle (or not so subtle) discrimination and stigma against individuals living with behavioral health conditions and their providers which several respondents perceive as a barrier to equitable partnership.

#### Fund Flows

Almost all respondents cited the lack of compensation for the hours and effort that they expend on DSRIP related activities.

CBOs are more likely to be financially challenged yet are being asked to invest deeply in DSRIP readiness. They do not, however, receive any or adequate financial support to engage with PPS, enter into contracts, or participate in various workgroups, panels, committees, program development and management, or developing pilots which, without their expertise and input, are perhaps less likely to be realized and effective. They are being taxed with time and effort that is uncompensated and unrecoverable, and have no guarantee that the programs they help to establish will be actualized, or actualized as the contracted partnership.

Other issues include contracts that were never culminated or contracts that were unclear as to the available compensation or how compensation would be dispensed. “Payment for the work

we have done is extremely slow” and often untimely. Several agencies cited that the compensation is too low to make participation economically sustainable.

#### Financial Sustainability and VBP

In some instances, organizations are ramping up staff and training them for various community based functions, in order to ensure their place and readiness for when the program goes live. Yet, for a variety of reasons, there is both an uncertainty and insecurity about the sustainability of funding. For example, one program was structured such that only the primary care provider was eligible for payment, with no mechanism for payment to trickle down to the behavioral health co-provider.

One member belongs to six PPS, but receives funds from only three. Another member cites a “main partner” and other partners with who they may cease working. Organizations will continue working with a non-paying PPS if they anticipate substantial and sustainable rewards. While many factors, including compensation, confluence with the project, and equality of partnership enter into the equation, organizations ultimately focus on the PPS they believe are sustainable, even if they have not received any payment.

There is abiding concern about outcome measures for Value Based Payments, and, how that will affect the sustainability of their funding. Respondents noted the lack of existing quality measures for non-medical services and the difference in longer term objectives for clients as opposed to clinical measures which tend to be shorter term and more concrete. The transition to VBP payments will be especially difficult; DSRIP funds were intended to enable transition to payment reform, and should be directed toward providers and organizations to ensure their participation in delivery reform.

Conclusion

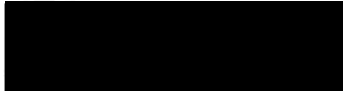
While most respondents were cautious, it is clear they believed increasing engagement with behavioral health clinics and other CBOs is necessary to meet the objectives of DSRIP. They believe cultural differences require clear dialogue and meaningful collaboration to ensure the effectiveness and efficiency of the DSRIP objectives. CBO's have stretched their resources for the sake of what they believe will be the finest opportunity to enable healthy individuals and create resilient communities. It is an opportunity that should not be missed. They deserve the confidence of their partners and the security of appropriate financing to successfully transition to delivery system and payment reforms.

Respectfully Submitted,

Christy Parque

President & CEO

The Coalition for Behavioral Health, Inc.



To: Finger Lakes Performing Provider System Board of Directors  
Cc: Carol Tegas, Executive Director, FLPPS  
December 5, 2016

We, the members of Finger Lakes and the Southern Tier (FLAST) and Finger Lakes Independent Provider Association (FLIPA) which is a collaboration of Federally Qualified Health Centers (FQHCs), Federally Qualified Health Center Look-A-Likes, Community Based Organizations (CBOs) that are providing Medicaid reimbursable services and CBOs that provide services and do not bill Medicaid. As partner organizations in the FLPPS, we urgently request revisions to funds flow to justly compensate our member organizations and those other organizations that are key to transforming the health care system.

According to the mid-point assessment, FLPPS has only distributed about 39.5% of funds received, ranking us near the bottom (19 of 25 PPS's) for funds distribution. Additionally, approximately 58.5% of funds distributed have gone to hospitals (and their provider partners as Carol Tegas noted), versus 30.4% statewide. The balance of funds was distributed among all of FLPPS non-hospital safety net participating providers and those participants that are not safety net providers. Only 1.15% of funds have been flowed to Community Based Organizations (CBOs).

We all know that 80% of health outcomes are related to health behaviors (30%), socio-economic factors (40%) and physical environment (10%), while only 20% are related to clinical care. In the US, 97% of health care spending goes to medical services and only 3% to prevention (Commissioner Zucker, 11/17/16 presentation on the Prevention Agenda)<sup>1</sup>. DSRIP is about changing this model and transforming the system, and we are not doing that, and are running out of time. Jason Helgeson, NYS Medicaid Director, has also stated this point on multiple occasions.

FLAST members, including FQHCs, FQHC look-alikes and CBOs, are the front line of preventive services for the Medicaid population. We, and other organizations that serve as our NOCN partners, are currently at risk of having to curtail our future participation in DSRIP projects due to a lack of financial support. It is our desire to fully participate in DSRIP project and we can do so with appropriate funding levels. Our Boards are seeing mounting deficits on our Profit and Loss statements. Payments in the past, and even those not yet received for services completed in March, do not match the degree of expenditures and effort we have put into working towards system transformation. Additionally, since April 1, 2016, hundreds of us have continued to do the work yet, on December 2 as we write this, we have no concrete information on how much we will be paid. Additionally FLPPS is earning capital by meeting project requirements through efforts completed by the attested partner agencies mentioned above.

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<sup>1</sup> **Source:** National health expenditure accounts: methodology paper, 2014 definitions, sources, and methods. Centers for Medicare & Medicaid Services. 2014. Available at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/dsm-14.pdf>(Accessed September 20, 2016).



With the recent Federal election and our requirement to be good stewards of public funds, we must be increasingly cautious about our business models, and undertaking work that both meets our mission, and for which we receive compensation. Otherwise we put our organizations, and our clients in jeopardy.

The funds flow distribution system based on attribution does not work. Funds flow should be adjusted to reflect contribution with respect to the above mentioned health outcomes. Recent work done by FLPPS on special contracting and payment arrangements is more in line with what needs to be in place to continue to support partner engagement and not lose partners, although some of the amounts have been too small to engage participation.

Additionally the long promised Innovation Fund needs to be put in place. There was no reason not to hit our goals with PAMs in the last period. That was money lost that should not have been lost. The organizations that are trained in PAMS could have trained and activated others if they had a small amount of money with which to pay others (Salvation Army's, food pantries, HEAP application centers, etc.) to administer PAMs. This should not happen again and unfortunately almost half of the next period is already over. Patient activation funds need to be released.

In summary, we care about the people we serve and want to continue to be able to serve them. We believe in DSRIP as a plausible method to accomplish the system transformation that needs to happen to improve health outcomes. We believe we speak for our NOCN partners when we say we cannot jeopardize the financial stability of our organizations, and need immediate relief in order to continue to participate. We respectfully request that the Board have this be an item on the agenda for the December meeting.

Sincerely,

Mary Zelazny, CEO  
Finger Lakes Community Health

Michael Leary, CEO  
Regional Primary Care Network

Martin Teller, CEO  
Finger Lakes Addictions, Counseling and Referral Agency (FLACRA)

Janice Harbin, CEO  
Anthony Jordan Health Center

Andrea Haradon, Exec. Director  
S2AY Rural Health Network

Jim Cummings, CEO  
Oak Orchard Community Health

Joyce Wheaton, CEO  
Tri-County Family Medicine



December 21, 2016

RE: DSRIP Mid-Point Assessment

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 medically tailored, life-sustaining, home-delivered meals and medical nutrition therapy to individuals with severe illnesses throughout New York City. In our service area, we cook and home-deliver more than 1.5 million meals annually, contributing to the delivery of high quality and cost-effective healthcare for NYC's high-risk populations. Many of these meals are provided to vulnerable beneficiaries through our Community Partners Program, an innovative partnership with Medicaid Managed Long Term Care and FIDA plans.

#### **DSRIP Involvement**

We have been involved with the Delivery System Reform Incentive Payment (DSRIP) from the beginning. We have become part of each Performance Provider Systems (PPS) because of our capacity to improve the health of the vulnerable beneficiaries we serve citywide and in Nassau and Westchester counties. This integration has been slow, but transformative. The DSRIP program has allowed God's Love We Deliver to engage in meaningful partnerships with all the downstate PPS, and we are deeply invested in the success of DSRIP as evidenced by the staff time and resources we have dedicated to participating in each PPS.

Because we believe our participation as a community-based organization (CBO) is vital, we have made it a priority within our organization to participate in every opportunity offered by our PPS partners. We are on Clinical Quality Committees, Project Committees, Stakeholder Engagement Committees, and Governing Committees across all the PPS in New York City. In several instances, we have been a featured partner in newsletters, highlighted at PACs, called on to educate other CBOs, been featured partners at PAOP meetings, and asked to begin pilot studies. As an allied clinical provider, we have educated PPS and other partners about the benefits of our services. And as a direct service provider, we have provided the unique perspective of the needs of the community outside the hospital. We have worked tirelessly to encourage PPS to include assessments of nutrition need and appropriate referrals to community resources in their standard assessment of beneficiaries.

PPS have come to value our services and have recently begun to reimburse us for our participation in planning projects. However, they have yet to find a mechanism to reimburse us for the nutritious and tailored meals we provide to beneficiaries who are not members of MLTC or FIDA plans. This lack of reimbursement and infrastructure funding is a significant barrier to ongoing CBO participation in DSRIP projects. CBOs are a critical part of the effort to meet DSRIP's goal of reducing hospitalization by 25%. Many hospitals have not fully utilized existing nonprofit infrastructures and the supportive services available in their community, and may be unacquainted with the struggles patients face upon discharge. CBOs fill this critical gap in our healthcare system, and are funded largely through their own fundraising efforts. Having a seat at the table through committee membership and invited presentations has given CBOs the ability to learn, grow, and teach. But, we must go one step further if we, as a State, are to achieve our ambitious DSRIP goals.

#### **Mid-Point Assessment Comments**

We are thankful for the independent mid-point assessment, but were disappointed at the lack of CBOs surveyed. Considering the immense impact CBOs have on the health of the target population, thoughts and opinions from more CBOs would have given additional beneficial feedback.

### **General Service and Infrastructure Support**

While we support DSRIP wholeheartedly, we continue to urge the state to provide explicit guidance requiring hospitals to fund community-based interventions, like God's Love, that make it possible to keep beneficiaries healthy and in their homes. Many hospitals are using DSRIP funds to strengthen and expand their infrastructures, and while this is important, we fear that if DSRIP funds are not injected into the community, the nonprofit infrastructure will be unable to absorb increased referrals. This could lead to a critical disconnect where patients are referred to a CBO by a PPS, but are unable to receive services because their referral is not accompanied by the reimbursement that gives CBOs the capacity to serve them. On top of this, 95% of the incentive payments available must go to safety net providers with only 5% to non-safety net CBOs. As a result, since the services provided by God's Love are not reimbursable under mainstream Medicaid, we could be overwhelmed by referrals and forced into a situation where we would need to conduct additional fundraising to cover unfunded care or to deny the referral for service.

### **Health Information Technology (HIT) Systems**

Health information technology is critical to the success of DSRIP. While hospitals work to share data ultimately through the RHIOs and SHIN-NY, nonprofit referrals and reporting have remained largely manual. Many PPS are in the process of setting up separate online systems in hopes of facilitating referrals from the hospital to services in the community. Unfortunately, many of these systems are little more than a phone book. Furthermore, the data and IT needs for CBOs to ramp up to the level where participation in multiple HIT systems would be meaningful is prohibitive. We ask that the state mandate that a proportion of DSRIP funds flow to infrastructure investments in technology in the community.

### **Funds Flow**

We urge the state to look into the fact that funds are not being equitably distributed to CBOs whose NPI numbers are not considered medical entities relative to similar participation by those who are categorized in this way, even though both types of entities contribute to the PPS reaching its metrics. We encourage the state to provide further guidance on the ways in which CBOs can be included in the new transition from pay for reporting to pay for performance.

### **Value Based Payment (VBP)**

We applaud the move toward 80-90% value based payments for healthcare in New York State. Rewarding value over volume is a step in the right direction. We urge the state to provide more explicit guidance on the ways in which CBOs can be included in these new hybrid models and bundled payments.

### **Conclusion**

So many wonderful innovations have been effectuated through the DSRIP program. Without innovation, there would not be hope on the horizon for our healthcare system to become an integrated, community-based system focused on providing care in or close to patients' homes, with reliance on urgent care when truly needed. 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



## **OVERVIEW**

The New York State Delivery System Reform Incentive Payment Program (DSRIP) is an important statewide effort to reform the delivery system for Medicaid beneficiaries. DSRIP rolled out rapidly over the course of several months in 2014 culminating in the submission of plans by 25 Performing Provider Systems (PPSs). Planning and implementation are fundamental to execution. This initial period was marked by frequent changes in timelines, reporting, and implementation guidance. Projected needs and plans from DSRIP's early stages have evolved.

The Healthcare Association of New York State (HANYS) facilitates an executive leadership group with representation from all 25 PPS organizations that are engaged in DSRIP. Following discussions with the New York State Department of Health (NYS DOH), our PPS Statewide Leadership Group convened a subcommittee with the goal of identifying concrete steps DOH can take, without modifying the DSRIP Standard Terms and Conditions (STCs) that would improve operations in the PPS and facilitate the achievement of the overall goals of the DSRIP program. Feedback associated with the current midpoint assessment has focused on individual PPS organizations and their corrections. This public comment recognizes that despite the largely successful early stages of implementation there are many changes that could be made structurally that will improve overall efficiency and maximize the successful transformation in the system.

The topics identified by this committee can generally be categorized into three areas. HANYS believes that general solutions in each of these categories will resolve many of the specific issues that continue to be raised at the PPS level. Not all of our identified issues required action by the state. In some cases, as particular topics have been discussed, PPSs have shared best practices and resolved issues within the current framework. We believe this is often the preferred approach and allows PPSs to build relationships and build on successes already achieved.

During the subcommittee's work, a large number of issues were identified. Once clarified the list was presented to the PPS Statewide Leadership Group, and their staff, for evaluation and ranking on a 1-5 scale with 1 being unimportant and 5 being most important. Issues with an average score of "4 and above" are addressed in this report. Issues range in urgency and priority and span reporting, provider network, and communication functions. A number of items fell outside of the purview of the DSRIP STCs, and this report does not envision changes to the STCs. Examples of underlying themes, key issues, and PPS impact are outlined below.

## **REPORTING**

The reporting requirements continue to expand. This expansion, beyond the original scope of the project, diverts significant resources away from transformation towards non value-added reporting. The current iteration of reporting requirements does not resemble the reporting that is referenced in DSRIP governing documents.

Based on our review, we recommend a significant overhaul of the reporting requirements to align with what is required by the STCs and relevant attachments (I and J). Potential revisions could include (1) the elimination of Q1 and Q3 reporting, or (2) the revision of Q1 and Q3 reporting to include the minimum necessary elements to meet the needs of the PPS, NYS DOH, and CMS instead of full MAPP updates and work stream reporting. The NYS DOH, PPS leadership, and the associations should collaborate on the revisions to ensure that reporting continues to meet the needs of the State, CMS and PPSs.

***Reporting: Scope***

PPSs are required to engage in extensive reporting efforts in order to comply with the DSRIP program and subsequently draw down DSRIP funds. The required reporting continues to grow beyond the original scope of DSRIP with new and expanding elements being added. Provider Systems are now engaged in perpetual reporting cycle activities that divert scarce resources from important transformational activities. The NYS DOH and Independent Assessor (IA) continue to issue new reporting requirements since the original DSRIP application. Updates include funds flow, workforce, primary care plans, regulatory waiver participation tracking tool, and CBO engagement reporting. Increased efforts for additional reporting level translates into less time available to focus on actual project implementation and delivery system transformation. In reviewing the STCs of the DSRIP Waiver, PPSs are required to report twice per year when requesting payment.<sup>1</sup>

HANYS recommends limiting quarterly reporting to Milestones that drive payment in the current quarter. Other reporting not specifically tied to Achievement Values (AVs) could be reclassified as annual reporting without changes to the STCs. Additionally, updates to ongoing project reporting (individual steps), where milestone timelines are not impacted, should not require additional reporting. Where appropriate methodologies can be established, we would support the awarding of partial AV's.

***Reporting: Process Updates***

We further recommend that there be no additional reporting requirements, supporting documentation, templates and validation criteria, unless explicitly required in the STCs. If additional reporting is deemed necessary, we recommend that draft versions of the new requirements be allowed a 30-day public comment period, followed by a 90-day implementation period. This would prevent PPSs from entering a quarter without a full understanding of the reporting requirements for that quarter. As an example, in DY2Q2 PPS are required to complete the "Workforce Staffing Impact/Employment Analysis" AV-driving milestone. As of September 12, no template for this reporting has been provided to the PPS.

***Reporting: Workforce AVs***

Initial workforce commitments as a percent of total PPS budget varies widely from 18.42% to 0.39%, with an average of 5.04%.<sup>2</sup> PPSs made initial workforce projections prior to knowing their total calculated AVs. Consequently, some PPSs committed to spend more than the value of their workforce AV, leaving the PPSs at a deficit for associated workforce activity.

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<sup>1</sup> See Appendix 1: Reporting Analysis of STCs

<sup>2</sup> At least one revision to the original commitment has been permitted.

Alternatively, PPSs whose initial commitments were lower than the value of the AV are required to spend much less in relation to their potential award.

HANYS recommends allowing PPSs the option of amending their workforce commitments, within certain parameters, during this mid-point assessment to accurately reflect the varying needs of their workforce. Partial AVs are part of a potential solution for the workforce work stream.

### **PROVIDER NETWORK**

Information management is fundamental to implementation. DOH and DSRIP support team sends provider data to PPSs with inconsistent identifiers, varying between NPI, MMIS numbers, and other data elements. It is recommended that all patient and provider data be released consistently using the same unique data identifier.

PPSs are required to submit provider network data for contracted PPS partners at the individual provider level, which is time intensive. DOH should explore streamlining milestone validation through the use of existing databases such as Patient-Centered Medical Home (PCMH) Certification, and RHIO/SHIN-NY connectivity. This process could be simplified with the Independent Assessor accessing these existing databases to validate completion of the milestone rather than the current plan which would require collecting thousands of individual contracts by the PPS particularly because the PPS is not always a party to these contracts.

PPSs have also identified providers in their network who are classified incorrectly and that the appeals process is not sufficiently responsive. We recommend allowing PPSs more flexibility with regard to provider classification and network modification consistent with guidance in Section X of Attachment I, as referenced in Appendix 1. The midpoint assessment should also allow for a critical re-evaluation of the project specific speed and scale commitments that were made two and a half years ago, acknowledging that better information is now available. For example, the requirements for home-based asthma inspections were not well understood or clarified when PPS made their speed and scale commitments. These have proven both difficult to achieve and are not necessarily in keeping with the larger, more significant quality improvement goals. We also recommend the development of a methodology for the awarding of partial AVs across all domains, projects & milestones.

### **COMMUNICATION**

The NYS DOH and DSRIP support team released updates and guidance regularly and as needed, usually in PDF files. These are then distributed by email, webinar, support team communication, document warehouse update, or some combination. This approach is challenging for all PPSs. It creates administrative requirements for archiving, maintaining current reference material, and amending workflows/work plans. We recommend that a single document with all requirements and guidance by project or work-stream be developed and maintained as a single source of truth. This document would be added to current document library and posted on the DSRIP website. This would serve to reduce confusion caused by varying versions of presentations and guidance that has evolved over the course of implementation. Each of these documents would include a FAQ section where all PPS questions would be curated and answered by the appropriate entity and be a consistent source of guidance state-wide.

## **CONCLUSION**

HANYS is willing to work in partnership with NYS DOH, the Independent Assessor and the DSRIP support team to identify and remediate PPSs administrative challenges. While some aspects of communication and reporting concerns can be addressed immediately, we recommend that a workgroup be established to provide a formal forum for issue resolution. The proposed workgroup will allow PPSs to share global challenges and vet ideas for complex issues (i.e., provider network considerations). It is recommended that the group meet monthly. Composition should include PPS lead entities (varying in size and geography) and other stake holders as appropriate. We welcome the opportunity to discuss this concept further, and look forward the overall success of the DSRIP program.

## APPENDIX 1

### Reporting Analysis of NYS 1115 Waiver

Below are highlights from the NYS 1115 Waiver that governs the Delivery System Reform Incentive Payment Program (DSIRP).

#### STC

##### VIII.7.a

a. Project progress milestones (Domain 1). Investments in technology, tools, and human resources that will strengthen the ability of the Performing Provider Systems to serve target populations and pursue DSRIP project goals. Performance in this domain is measured by a common set of project progress milestones, which will include milestones related to the monitoring of project spending and post-DSRIP sustainability. *This includes at least semi-annual reports on project progress specific to the performing provider system's DSRIP project and its Medicaid and uninsured patient population.*

##### Waiver VIII.12.a

a. Review of milestone achievement. At *least two times per year, Performing Provider Systems seeking payment under the DSRIP program shall submit reports to the state demonstrating progress on each of their projects as measured by project-specific milestones and metrics achieved during the reporting period.* The reports shall be submitted using the standardized reporting form approved by the state and CMS. Based on the reports, the state will calculate the incentive payments for the progress achieved according to the approved DSRIP project plan. The Performing Provider System shall have available for review by New York or CMS, upon request, all supporting data and back-up documentation. These reports will serve as the basis for authorizing incentive payments to Performing Provider Systems for achievement of DSRIP milestones.

##### Waiver VIII.12.b

b. Quarterly DSRIP Operational Protocol Report. The *state shall provide quarterly updates to CMS* and the public on the operation of the DSRIP program. The reports shall provide *sufficient information for CMS to understand implementation progress* of the demonstration and whether there has been *progress toward the goals* of the demonstration.

##### Waiver VIII.12.e

e. Additional progress milestones for at risk projects. Based on the information contained in the *Performing Provider System's semiannual report* or other monitoring and evaluation information collected, the state or CMS may identify particular projects as being "at risk" of not successfully completing its DSRIP project in a manner that will result in meaningful delivery system transformation. The state or CMS may require these projects to meet additional progress



milestones in order to receive DSRIP funding in a subsequent semi-annual reporting period. Projects that remain “at risk” are likely to be discontinued at the midpoint assessment, described in STC 11 of this section.

Waiver VIII.22.d.iv

iv. Semiannual financial and other reporting data

### ATTACHMENT I

I: b. – Preface

The state may submit modifications to this protocol for CMS review and approval in response to comments received during the post-award comment period and as necessary to implement needed changes to the program as approved by CMS.

I: 3.c.

Annual improvement targets for Performing Provider System metrics will be established using the methodology of reducing the gap to goal by 10%...

. . .The PPS will know the annual performance target to be achieved at the beginning of each DY for which performance targets are set and the method for determining the annual performance target will remain the same throughout the DSRIP years.

I: VII

3. On *a quarterly basis, the state will publish* on its website project-by-project status updates which will show available data that reflects each strategy’s progress on metrics and indicators, as relative to pre-approved targets.

5.a. Semi-annual Reporting on Project Achievement

Two times per year, Performing Provider Systems seeking payment under the DSRIP program shall submit reports to the state demonstrating progress on each of their projects as measured by the milestones and metrics described in their approved DSRIP plan.

The reports shall be submitted using the standardized reporting form approved by the state and CMS. Based on the reports, the state will calculate the incentive payments for the progress achieved in accordance with Section IX “Disbursement of DSRIP Funds”. The Performing Provider System shall have available for review by the state or CMS, upon request, all supporting data and back-up documentation. These reports will be due as indicated below after the end of each reporting

X.a

a. Modifying Existing Project Plans in Limited Circumstances

No more than once a year, *Performing Provider Systems* may submit proposed modifications to an approved DSRIP network for state and CMS review. These modifications may not decrease the scope of the project unless they also propose to decrease the project's valuation. Removal of any Performing Provider System member organization requires a proposed modification and removal of any lower performing member must follow the required governance procedures including progressive sanction requirements, as per section 4.6.10. PPS may propose changes to DSRIP project plans during the Mid-Point Assessment for state and CMS review. Modifications to any project plan may not decrease the scope of the project unless they also propose to decrease the project's valuation.

### ATTACHMENT J

#### Part II – Domain 1. Overall Project Progress Metrics

1. Semi-annual reports (pay-for-reporting) which will include:
  - a. Project narrative on status and challenges;
  - b. Information on project spending/budget and any other financial information requested by the state, including financial sustainability of system and projects;
  - c. Documentation on the number of beneficiaries served through the projects;
  - d. Update on project governance;
  - e. Update on workforce strategy implementation;
  - f. Percent of providers that are reporting relevant DSRIP project data;
  - g. Description of steps taken by the system to prepare for non-FFS reimbursement systems (including an update on any on-going negotiations with Medicaid managed care plans); and
  - h. Engagement in learning collaboratives.

## APPENDIX 2

### Summary of Issues

#### Weighted Rank Order (top 12)

| <b>DSRIP Performance Improvement Sub-Committee Issue Rank</b>   |
|---|
| 1. DOH/IA continuously releases new documents (e.g. patient engagement definitions, domain 1 milestone guidance, etc.) to be responsive to programmatic changes. This results in the PPS being required to track and maintain an up-to-date inventory of fragmented documents. The State has released "Minimum Standards," but these are often vague and follow-up clarification is not often provided. |
| 2. New milestones and reporting requirements have been added beyond the scope of the application (e.g., budget/funds flow reporting, workforce reporting, primary care plan, CBO engagement) without resources for the additional work and limited guidance.  |
| 3. Data provided by DOH does not have the same unique identifier so it is not data that can be compared from one report to the next.  |
| 4. Domain 2, 3, and 4 metrics are not often directly linked to the anticipated impacts of the projects (as defined through their domain 1 project requirements). This leaves a PPS needing to make the decision to either sacrifice the dollars associated with meeting the provider scale and speed commitments for a given project, or pursue the pay-for-performance metrics for that project.       |
| 5. DOH data specification documents are currently inadequate.   |
| 6. Lack of program flexibility does not recognize the dynamic nature of the healthcare environment. PPS provider speed and scale commitments were made 2yrs ago without knowing the requirements would be constantly changing.  |
| 7. PIT- reporting at the provider level is problematic. <sup>3</sup>  |
| 8. The NYS DOH/IA often releases new reporting requirements within the week prior to the open MAPP period or within the first two weeks of the open period.   |
| 9. The classification of providers for provider engagement speed and scale is not always straight forward and does not align with how a PPS or health system may view its providers. As an example, many resident physicians who provide the bulk of primary care in hospital-based practices are classified as "Other" rather than PCPs  |
| 10. Requiring job descriptions and Cross-walking Workforce Classifications to specific job titles for all trainings. There is a lack of standardization regionally and across the state that creates challenges at this level.  |
| 11. PPSs are currently only allowed to add providers annually and drop providers once throughout the five years, this is not consistent with the STCs.  |
| 12. PPSs are currently held to meeting their workforce strategy commitments that were made ~2 years ago with no understanding that they would be held to them in the future. This results in PPSs making spends in workforce to meet commitments rather than making strategic investments to meet workforce needs.  |

<sup>3</sup> HANYS is working to convene a separate workgroup on the topic of the PIT tool.



Thank you for the opportunity to comment on the DSRIP Mid-Point Assessment initial reports and recommendations. 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.

HWCLI would like to take this opportunity to comment on present and future CBO engagement in DSRIP.

While the Mid-Point Assessment found that all PPS's have begun contracting with and engaging partner organizations, the report also clearly reinforces the need for PPS's to create strategies to continue to engage Community Based Organizations on all projects. 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.

New York State recently announced 2 of the 3 awardees of the CBO Strategic Planning Grant. While this grant presents an excellent opportunity for Community Based Organizations to address organizational and capacity issues related to their potential involvement in DSRIP, HWCLI urges New York State to start planning now for the next steps once the grant period for this project is complete.

While HWCLI and its partners recognize that DSRIP dollars have been allocated to PPS's, it strongly encourages the State and the PPS's to request allowance from CMS to allocate 5% of DSRIP funds in DSRIP Years 3 through 5 for the creation of a DSRIP Innovation Fund for the implementation of projects proposed and undertaken by local community groups as an integral component of each PPS's focus and strategy. The Innovation Projects can both use local assets as well as address the social determinants of health in a way that has been largely impossible so far---despite the recognized need for community-based services that are accessible, trusted and that strategically recognize community needs. 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. 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. The CBO Strategic Planning Grant funding is designed to assist CBO Consortiums in planning activities to identify business requirements and formulate strategies for short-term needs as well as longer term plans that the CBO consortium may envision for sustainability in system transformation. The funding is not intended to assist CBOs in making these structural and organizational changes. HWCLI recommends the State, in partnership with the PPS's across the State, request allowance from CMS to allocate funding for CBOs to facilitate their participation in DSRIP projects and implement the short and long term needs identified by each CBO Consortium as part of the CBO Strategic Planning Grant.

In closing, we are appreciative of the opportunity to provide comments and recommendations.



December 20, 2016

Independent Assessor  
Public Consulting Group

**RE: DSRIP Mid-Point Assessment Recommendations**

Dear Independent Assessor:

The Home Care Association of New York State (HCA) appreciates this opportunity to comment on the Mid-Point Assessment Reports published November 29, 2016 regarding each PPS and its progress toward program goals offers the following.

HCA is the statewide association representing nearly 400 health care providers, organizations and individuals involved in the delivery of home and community-based care services to over 400,000 Medicare and Medicaid patients throughout New York State. HCA's provider members comprise the continuum of home care services, including Certified Home Health Agencies (CHHAs), Licensed Home Care Services Agencies (LHCSAs), Managed Long Term Care (MLTC) plans, Long Term Home Health Care Programs (LTHHCPs), Hospices and waiver program providers. HCA's home care providers are sponsored by hospitals, nursing homes and free-standing nonprofit, public and proprietary agencies.

HCA member home care agencies are engaged partners to one degree or another across every PPS in the state, with many participating in multiple PPS networks. These agencies are involved with various aspects of DSRIP projects including, but not limited to:

- 2.a.iii Health Home At-Risk Intervention Program: Proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services
- 2.b.iii ED care triage for at-risk populations
- 2.b.iv Care transitions intervention model to reduce 30 day readmissions for chronic health conditions
- 2.b.viii Hospital-Home Care Collaboration Solutions
- 2.c.i Development of community-based health navigation services
- 2.d.i Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care
- 3.a.iii Implementation of evidence-based medication adherence programs (MAP) in community based sites for behavioral health medication compliance
- 3.d.ii Expansion of asthma home-based self-management program
- 3.f.i Increase support programs for maternal & child health (including high risk pregnancies) (Example: NurseFamily Partnership)
- 3.g.i Integration of palliative care into the PCMH Model

- 3.g.ii Integration of palliative care into nursing homes
- 4.b.ii Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings

## Overview

HCA members have been working diligently to participate in their respective PPS networks since DSRIP's inception, responding to the state's DSRIP reform goals to partner to reduce hospital inpatient and emergency department utilization through substantial shift to community based care. Home care providers have sought to meet the anticipated significant increase in role and demand for home and community-based services inherent in these reforms for both patients and the broader system. HCA has worked extensively to assist providers in support of DSRIP participation and achievement of the state reform goals. HCA has led regional member meetings focused on experiences with DSRIP/PPS, conducted multiple HCA member surveys to gather data in this area to gauge progress and areas of policy and technical assistance need, and assisted in numerous additional ways.

Thus far, despite extensive outreach by individuals providers to PPS leads and active provider participation in the PPS committee process, home care provider feedback points to the fact that, in large part, the widespread commitment of time and resources has netted uneven, mostly limited and less than optimal or expected PPS engagement across most of the state.

HCA and the membership have critical concerns about DSRIP implementation, and most of those concerns are evidenced in the results of the Mid-Point Assessments and the IA's associated recommendations.

A troubling factor requiring state inquiry and redress is the apparent lack of PPS understanding and ultimately adherence to the statutory parameters governing the provision of in-home care in New York State.

The provision of in-home care is extensively and strictly regulated under parameters stipulated by Article 36 of the Public Health Law. Article 36 specifies the credentials for who may provide these services and how. Article 36 outlines home care's scope of services and prohibits entities not credentialed (i.e., licensed or certified) under Article 36, or individuals other than solo practitioners specified in that article, from providing such services.

A fundamental legal and policy foundation underlying the enactment of the Article 36 licensure law was to provide for the assurance of quality and uniform regulation of services provided in the home under New York's health care system, for the protection of patients and the integrity of the system. Moreover, federal laws and regulations require yet additional parameters, necessitating federal certification of home care providers under Medicare and Medicaid. These additional federal parameters further reinforce the strict conditions under which home care is authorized.

Despite this, PPS Network members widely report that PPS appear to not be abiding, and/or actively working to circumvent, these state and federal parameters for in-home care. HCA has received and shared with State Health officials innumerable example examples of PPS leads and

other entities under DSRIP working to repurpose and redeploy, or to otherwise provide outside of Article 36, their own staff and resources that replicate and provide services which are the specific statutory domain of home care agencies under state and federal law. Aside from the contradiction with statute, PPS activity of this type does not appear to be in line with the spirit of DSRIP, which is to network and coordinate the participation of the continuum of providers and services – hospitals, home care, physicians, behavioral health, et al – to meet the express cost, quality and value goals of the restructured system. This “reinvention of the wheel” wastes resources, duplicating existing community services (and without the credential or expertise), and contrary to federal intent of the use of DSRIP funds. Moreover, it circumvents an entire cohort of the provider community specifically credentialed, regulated and experienced for providing, managing and coordinating the home and community based care component of the PPS. The home care sector’s existing infrastructure, community presence, staff expertise and clinical portfolios, developed in many cases over decades of effort and mission, and should instead be being incorporated as core and unique assets in every PPS. These agencies should be being enthusiastically engaged, leveraged, and strengthened for project and program success; not replaced with other health care system services designed to mimic what has already been tested and proven to succeed.

A contributing factor to this duplication and overlooking of the existing community based infrastructure appears to also be the significant lack of knowledge and understanding evidenced by PPS about the roles and extent of services available and provided by home and community-based service providers. New York State has long had the most comprehensive and diverse home and community based care system nationally. Home care agencies and programs provide a broad array of skilled health, multidisciplinary, care management and broad support services for patients.

This includes helping to coordinate major health and social support needs and enabling effective care transitions from hospitals and nursing homes to home, partnering with physicians for medical management that includes primary, post-acute, chronic, and palliative care. Home care’s design, capabilities and goals are inherently synchronized to DSRIP and, yet the engagement from PPS leads has thus far been so very mixed and lacking.

A “mixed cue” in the DSRIP messaging is that while home and community-based care is presented under the DSRIP concept as essential to purpose and goal achievement, DSRIP documents have folded the home care sector under the “All Other” Category. This categorization certainly contributes to PPS under-recognition of home care in DSRIP, and along with the references to home and community based providers as “downstream,” it under-represents both the value of these providers and the DSRIP goal to “re-right” the system through the emphasis on primary and community care management .

While the circumstances detailed above do not characterize the experiences of all HCA members, nor the reported actions of all PPS Networks, these are the overarching themes of the majority of feedback HCA has received from the field over the last 18 months related to DSRIP experiences of home care providers.

## Independent Assessor's Overall Mid-Point Assessment Conclusion

The IA's general recommendations for the 25 PPS summarized some of the most frequent recommendations for both PPS Organizational and Project areas. Of those, several were of particular significance to HCA and the home care industry.

- Comments on Relevant Organizational Recommendations
  - Governance
  - Financial Sustainability and VBP
    - “Generally, the IA found that many PPS have not focused on detailed arrangements for sustainability.”
      - HCA members across New York State have echoed this sentiment, with most unclear about payment arrangements and mechanisms from their PPS.

While not all HCA members have received payment from their PPS networks, those who have been issued funds have received funds for their participation in the planning process, with no notice in advance. These funds are also, very often, in such small amounts that the extent of uncompensated staff time and intellectual capital expended by agencies to remain involved in the DSRIP/PPS process in hope of future success far exceeds the reimbursement. Continued expenditure at similar levels with little or no certainty about future arrangements is simply unsustainable.

There is a wide lack of clarity around what future payments may look like. This needs to be an area of extensive focus on the part of the PPS.
    - “Furthermore, the PPS needs to work to educate their partners as to their role with VBP in NY Medicaid.”
      - This recommendation is not clear, but the concept of further education and discussion between contracting partners and payors related to VBP arrangements is certainly valid. Prior to this though, should be the recommendation that PPS lead entities truly explore the existing payment mechanisms and reimbursement frameworks that exist amongst their network members, particularly with their home and community based providers for which the reimbursement streams may not be as familiar to hospitals. They should then utilize this information to help consider, develop and educate partners about VBP in a tangible way.
  - Partner Engagement

In the Companion Document, the IA explained that “The level of partner engagement by the PPS was used as an indicator of potential risks for the successful implementation of projects.”



- “A majority of the PPS are behind on their Partner Engagement goals at this point in DSRIP. Most PPS need to focus their attention and funding to engage key partners.”
  - HCA and its members echo this recommendation, but request that the IA consider further defining the concepts of engagement and key partners.

Key partners may already be part of the PPS Network, but not active or not fully utilized because the PPS has not made efforts to fully realize the potential of particular partners/providers to contribute toward project goals.

This builds on the previous points regarding lack of knowledge and understanding of home care and associated services, regulations, and reimbursement streams and relates to HCA’s initial comments above regarding duplication of services. As an example, many PPS have not expressed what should be an obvious course to involve home care in their Care Transitions projects. Care transitions services are a core service of home care provider agencies and one that they have developed extensive expertise in over many years of community service. Hospital efforts to recreate existing service lines is wasteful and detrimental to the existing health system.

○ Funds Flow

- “PPS will need to fund their networks partners at a meaningful level going forward. For example, the PPS must execute their plans to develop and design contacts with their downstream partners to ensure that they maximize engagement across the networks as soon as possible.”
  - Again, this is related to the critical point that network providers with longstanding community relationships and infrastructures cannot be replaced or circumvented by hospital/PPS efforts to repurpose their own staff and use DSRIP dollars for in-house programs. Home care, and other “downstream partners”, across the state have reported many cases of this.

Home care provider agencies have been coming to the DSRIP/PPS table since 2014, participating in meetings and committees, with limited to no return on the investment of staff time, resources and planning. Further, most still have no indication of whether or how their service lines will be engaged, utilized, and reimbursed as DSRIP continues. While providers affiliated with hospital systems have tended to experience more meaningful engagement, even that is not without exception.

The lack of communication and meaningful connection between lead entities and “downstream providers” is a significant barrier to

success. It will require lead entities to meet with community providers and receive feedback and insight from them, as opposed to presuming to know service, payment and regulatory dynamics.

- Comments on Common Themes Throughout IA Recommendations Across PPS
  - Communication
    - A lack of communication or miscommunication was noted by several PPS networks in their narratives as a common barrier to progress both within and outside of hospitals. The investment by PPS in communication and research related to downstream provider services and regulations will address these issues and also assist with successful engagement and partnerships with community based providers.
    - Further, documentation requirements and methods vary between provider sectors. These points echo concerns addressed earlier in these comments related to lack of understanding and knowledge of downstream providers on the part of lead entities.
    - The IA recommends that many PPS:
      - continue to increase partner engagement of providers across projects,
      - develop clear strategies to contract and accelerate contracting with partnering community based service providers for project implementation,
      - assess current VBP involvement of partners and subsequently establish plans to further educate and support their partners in the move toward VBP arrangements.
    - Clear PPS understanding of the aforementioned positions of network partners (services, regulatory structures, and payment/reimbursement mechanisms) is critical to following these IA recommendations. Perhaps there were unknown or unrecognized gaps in the initial Community Needs Assessments that can be revisited with new perspective in an effort for PPS to gain a fuller picture and appropriate insight into the existing structures that govern downstream providers and thus impact services already being provided in the PPS region.
  - Information Technology
    - Many PPS narratives referenced IT risks across projects, often noting that EHR systems are very different and do not make engagement tracking, provider alerts, certain project components like interact principles, zone sheets, etc. simple across a network. HIT for Clinical Integration require significant interoperability that is exceptionally difficult to achieve with little capital investment in this area.
    - There is no money available to home care providers for technology investment or quality innovation that are necessary for participation in

Medicaid Redesign reforms like DSRIP reforms and for overall improvement in performance, quality and return on investment in high need and high risk areas. This sets the industry at yet another disadvantage. For example, agencies who may have invested significant money in the acquisition of EHR software or telehealth solutions prior to the inception of DSRIP are left in difficult positions now when they are required to utilize the same EHR or telehealth vendor their lead entities use in order to meaningfully participate in things like care coordination and other project areas. This is exacerbated for agencies involved with multiple PPS utilizing different vendors.

- In many cases, the costs of connecting to RHIOs for true data exchange are also prohibitive for home care providers and the money that PPS have received from the state for this type of connectivity has not been distributed to home care providers. Technology is central to success in DSRIP and VBP, there needs to be further exploration and investment in interoperability and support for providers with less capacity to fund necessary technological advancement.
- HCA has drafted legislation for potential inclusion in the 2017-2018 budget to address these areas of significant need for the industry and equip providers with the ability to meaningfully participate in the current marketplace and delivery system.
- Workforce Issues
  - Several PPS noted workforce issues in their narratives, including those operating in areas designated as Health Providers Shortage Areas, which negatively impact critical services and patient access to care. This is a significant and ongoing issue in home care, and one that is targeted by several organizations this year including HCA. The New York Statewide Senior Action Council has even dubbed this shortage of home care staff the “Home Health Care Crisis.”
  - The IA recommends workforce efforts related to home care for many PPS including:
    - increasing the number of board certified palliative care professionals, or exploring other arrangements that assist with training PCPs in this area
    - the development of strategies to recruit home health aides, asthma educators, and care coordinators
    - encouraging PPS to pursue workforce solutions to foster a pipeline of workforce with appropriate skillsets
    - develop plans to address staffing shortages
  - Throughout the state there are many areas where the home care workforce and capacity is not sufficient to meet the current, and certainly not the growing need. As the population ages, and care delivery reforms continue efforts to keep patients in the community longer, the need for a strong workforce is vital. The related IA recommendations strengthen the argument HCA continues to make to the legislature, Governor’s office,

and state Department of Health related to workforce issues which urges the development of a plan to ensure sufficient workforce and capacity to meet the increasing need for home care services, with special focus on underserved areas (particularly upstate) and populations (such as pediatrics, palliative care, etc.).

## **Conclusion**

HCA again thanks the Independent Assessor for the opportunity to review and comment on the Mid-Point Assessment Recommendations for PPS networks. While the comments above do not reflect the experiences of each and every HCA member, they are reflective of a large population of home care providers across the state. HCA is hopeful that the IA will consider our comments and perhaps modify recommendations to incorporate some of this feedback.

Additionally, HCA will continue our own efforts on behalf of the industry, including modifying some of the regulatory and payment mechanisms that are currently presenting obstacles to more robust participation in DSRIP in order to facilitate flexibility and innovation in care provision and savings to the system.

If you have any questions or need further information, please contact the HCA Policy Staff at





**Mental Health Association in New York State, Inc.**  
Glenn Liebman, CEO

Jeffrey Rovitz, Board Chair

**Mental Health Association in New York State, Inc.**

**Response to DSRIP Independent Assessor: Mid-Point Assessment Report**

**December 21, 2016**

**Glenn Liebman, CEO**

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**HEALTHY MINDS FOR A HEALTHY NEW YORK**

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The Mental Health Association in New York State (MHANYS) is a not for profit mental health agency comprised of 26 affiliates in fifty counties throughout New York State. Many of our members provide community based mental health services and have worked for years to keep people in the community and out of hospitals and correctional settings.

As part of our organization's mission, members are also very involved with anti-stigma efforts, education, training and advocacy in their communities.

As mental health advocates, we believe that the PPS networks can deliver better integrated health care by embedding behavioral health as an integral service across all sectors of health care. We were pleased to see that all 25 PPS's identified 3 a.i. as one of their initiatives. Breaking down a siloed system of care is in the best interest of all individuals with mental health related issues.

Our organization has been very supportive of the collaborative PPS model evidenced by our robust member involvement with their various PPSs lead agencies around New York State. We strive for an integrated person centered approach with flexible dollars to enhance personal recovery through clinical services, peer support, family engagement, supported employment and supported education. We embrace the approach of recovery and community integration for which the waiver holds great promise

Unfortunately, in the two and a half years of DSRIP, we have not yet seen this vision come to fruition. There are certainly some excellent and innovative practices and emerging networks that hold possibilities for greater mental health integration. These innovations and best practices are best driven by collaborations with Community Based Organizations (CBO's) and PPS lead agencies. This collaboration must expand if we want to witness success in DSRIP milestones.

The first half of the five years has been driven by process. The rubber now meets the road as we move more aggressively into contracting and achieving programmatic milestones through working with the not for profit sector. We hold hope that this will create a sea change within the framework of DSRIP. Based on the comprehensive Mid-Point Assessment Report, we see three major themes that impact implementation.

- 1) Role of Community Based Organizations in Provider Networks**
- 2) Successfully Utilizing Workforce Funding**
- 3) Training Needs**

### **A) Role of Community Based Organizations in Provider Networks:**

A consistent theme throughout the report was the clear lack of provider engagement. According to the report, "While the PPS do not need to demonstrate 100% engagement of participants in a project until project milestone completion, it is important that the PPS demonstrate engagement with partners through project implementation efforts."

In Section IV of the report, the Independent Assessor (IA) makes a specific recommendation around partner engagement, stating, “A majority of the PPS are behind on their Partner Engagement goals at this point in DSRIP. Most PPS need to focus their attention and funding to engage key partners.” In addition, it was stated that, “The PMO and Hospitals have received over 70% of DSRIP funds to date across all PPS. PPS will need to fund their network partners at a meaningful level going forward.”

This recommendation was consistent with the findings across the PPS networks.

- Adirondack Health Institute - ‘The IA recommends the PPS develop a strategy to educate the CBO’s about their role in DSRIP’
- Albany Medical Center - “The IA recommends that the PPS develop a clear strategy of contracting with the CBOs”
- Alliance for Better Health Care - “The IA recommends the PPS to develop an action plan to increase partner engagement in particular for PCPs and Behavioral Health Partners”
- Care Compass Network - The IA recommends that PPS develop a strategy to increase partner and community engagement
- Central New York Collaborative - “The IA recommends that the PPS develop a clear strategy of contracting with CBOs
- Community Partners of Western New York - The IA recommends that the PPS develop a strategy to increase partner engagement throughout the PPS network
- Finger Lakes PPS - The IA recommends the PPS develop an action plan to increase CBO and other partner participation in the project
- Leatherstocking Collaborative Health Partners - “The IA recommends LCHP strengthen their community and partner education and engagement, in particular, with entities outside the lead entity,”
- Millennium Collaborative Care- “The PPS must develop a plan for more actively engaging its network partners across all projects to ensure the successful completion of project milestones
- Mount Sinai PPS - The IA recommends that the PPS develop a strategy to increase partner engagement across all projects being implemented
- Nassau Queens Performing Provider System - “The IA recommends the PPS develop a strategy to increase partner engagement to support the successful implementation of this project and in meeting the PPS DSRIP goals.”
- NYU Lutheran PPS - “The PPS must also create a plan to engage the requisite partners needed to successfully implement the milestones.”
- OneCity Health - The IA recommends that the PPS develop an action plan to increase partner engagement across all projects
- Suffolk County Collaborative - The IA recommends that the PPS review its Partner Engagement reporting and develop a plan for engaging network partner across all projects to ensure the successful implementation of DSRIP projects
- The New York and Presbyterian Hospital - The PPS needs to demonstrate effective collaboration with CBO’s and other resources to ensure appropriate access to substance abuse treatment
- Westchester Medical Center - The IA requires the PPS to develop an action plan to increase partner engagement. The plan needs to provide specific detail by each project for partner engagement.

16 of the 25 PPS were identified as needing remedial steps to engage CBO's as core members of the PPS. This is not a surprise to MHANY as most of our members are part of PPSs in their communities, and despite being part of the network, many members have not been meaningfully engaged or seen funding flow from the lead agencies.

In a survey to our members, several voiced concern that though they are part of PPS networks and provide vital services that can reduce the stated goals of reducing unnecessary hospitalizations, they have not had any contracts with their PPS to insure implementation.

We urge the State to work with the PPSs to insure that downstream providers receive funding for projects that address needs in their community around training, education and support. Through the leadership of the MHAs and other Community Based Organizations, there is a lot of work that is being done around peer support, family engagement, supported employment, education, crisis services and training. All of these tools are utilized to keep people in recovery in their communities and out of the hospitals.

In addition, many of our members are concerned that the lead PPS will replicate the successful models that we have implemented in our community mental health programs. These models that have been created by MHAs and other CBO's are successful because we have worked for many years with the population of people who are being impacted. Most CBOs have been embedded in their communities for many years and know the people they have been working with. A replication of their efforts by the lead agency would not provide the results or meet the expectations of the DSRIP.

When you are an individual in need in a mental health care setting, are you better off working with a long experienced mental health provider, who knows how to engage people in the community that are released from prisons and jails, discharged from hospitals, have been homeless, coming out of adult homes or living with aging parents or are you better off building an entirely new system that has not built up credibility or support in the community? I believe the answer is obvious and speaks volumes as to why you want to insure a contractual relationship between the lead agencies and existing CBO's.

A concern raised from doctors is that when a mental health issue is detected that there be adequate and timely referrals to mental health providers. In order to have successful integration through 3 a.i., you need a robust network of behavioral health providers to respond to referrals. This can be best accomplished through contracts with existing downstream behavioral health providers.

#### Specific Recommendations:

- 1) The State should play a stronger role in ensuring that there is a better, more systemic financial flow to not for profits from the PPS lead agencies. The State must monitor and incent PPS lead agencies to insure contracts with CBO's to enhance milestones and metrics.

#### **B) Workforce Development:**

It is clear from the recommendations of the Independent Assessor that workforce issues are of great concern.



The specific DSRIP language states:

1.08 Billion for other Medicaid redesign purposes---this funding will support Health Home development, and investments in long term care, workforce and enhanced behavioral health services.

The recommendations of the Independent Assessor as stated in the report, "The IA recommends the PPS develop a plan to address the workforce challenges with licensed behavioral health specialists and care coordinators"

MHANYS Perspective:

There is \$1.08 billion from DSRIP funding earmarked for the workforce. To this point, it is unclear what if any of the funding has been expended. Despite this available funding, there continues to be a workforce crisis in New York. The not for profit mental health sector has received only two Cost of Living Adjustment in the last eight years. One of them was last year when there was a rate increase for not for profits that amounted to only .02 percent

The financial impact to this sector in regard to the minimum wage increase dramatically impacts both the financial stability of an organization and its ability to retain a quality staff. Not for profits are the safety net for the community. Too not provide equitable funding results in less effective services for those most in need.

Recommendation:

- 1) Provide funding transparency for the workforce in DSRIP to insure that it prioritizes spending on behavioral health workforce
- 2) Use the DSRIP dollars as a five percent funding increase for the not for profit workforce over the duration of DSRIP. Most of the PPSs are populated with not for profit agencies so it would be consistent with the language and spirit of the waiver. Five percent increase in funding for not for profits would be approximately \$155 million per year.
- 3) Utilize the DSRIP funding to help provide tuition reimbursements to mental health workforce. Replicate the successful Doctors Across New York Program but populate the program with behavioral health staff including direct care staff, supervisory staff and clinicians.

### **C) Mental Health Training**

One of the other consistent themes brought up by the IA was the lack of training around mental health issues. The survey indicated that mental health was third to last in satisfaction in working with the PPS. Much of that can be generalized as an issue around getting vital funding to downstream providers, but another reason for the dissatisfaction may lay in the lack of knowledge in most provider communities about behavioral health and stigma associated with the illness.

One way to get around the stigma and lack of knowledge about mental health is through Mental Health First Aid (MHFA). MHFA is an eight hour training program designed for the general population

to educate them about mental health and how to best respond to a mental health crisis. This evidenced based model has been responsible for training close to a million people nationwide.

Specific examples among the PPSs in regard to lack of training in mental health were among the concerns voiced by the IA in seven different PPSs.

Recommendations:

- 1) Mental Health First Aid is especially relevant in implementation around 3 a.i, the integration of primary care and behavioral health services.

The IA report specifically says, "Project 3 a.i. is one of the most important projects in DSRIP thus it is critical that the project is implanted successfully"

Given the comments of the IA, it is very important that within this integration, there will be a new structure in regard to working with people with mental health issues. Many of the staff in primary care may not have dealt with this population of people in the past. Due to stigma and lack of information, they may have preconceived notions about these individuals. MHFA helps dispel myths while also providing support in responding to a mental health crisis

Hot Spots: All the PPSs, through their environmental scans, have identified areas of 'hotspots' where there are a higher percentage of individuals who end up hospitalized. Many of these individuals have underlying mental health issues. MHFA would be an ideal training to help support the workforce staff dedicated to working with individuals with the highest need in the community. This will greatly enhance their ability to engage individuals with mental health related issues.

- 2) Prevention Agenda: Domain IV of DSRIP is dedicated to the Prevention Agenda. Prevention funding has never been a staple of funding in behavioral health and that is why we were very pleased to see the Prevention Agenda highlighted as an integral part of PPS.

The fundamental key to prevention is education. Though not discussed on the IA review, it is clear that mental health education impacts virtually the entire prevention agenda whether talking about diabetes, asthma, heart disease, obesity or any other health related concern. Bringing a greater understanding of mental health to individuals in the DSRIP, through MHFA, will help lead to greater wellness strategies for population health, which is clearly a major objective of the Prevention Agenda.

We have also had conversations with the New York State Office of Mental Health and they recognize the importance of Mental Health First Aid as an integral training in working to dispel myths about mental illness and to help in responding to an individual in a mental health crisis.

## Summary

- 1) Insure that the PPSs commit to providing funding to downstream providers so that those agencies embedded in their communities are properly incented to continue efforts to support the DSRIP goals. Also insure that not for profits can provide the programming without concerns that the larger PPS will replicate the programs and not fund existing downstream providers.

- 2) Utilize the Workforce funding of DSRIP to help provide funding incentives to not for profits including across the board pay increases for human services as reflected in the large number of network providers in the PPS. Also use PPS funding to provide tuition reimbursements for individuals in the behavioral health sector.
- 3) Insure that appropriate behavioral health training through is available through MHFA to respond to 3 a.i and also for Domain IV, The Prevention Agenda as well as for any other appropriate sector.

We thank you very much for your time and consideration.



## **NYASAP**

### **President**

Robert Ross  
St. Joseph's  
Rehabilitation Center

### **1st Vice President**

Douglas Apple  
Samaritan Village, Inc

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#### **Bill Bowman**

Alcohol and Substance  
Abuse Council of  
Jefferson County

#### **Martin Teller**

Finger Lakes Addictions  
Counseling and Referral  
Agency, Inc.

The New York Association of Alcoholism and Substance Abuse Providers, Inc. (ASAP) appreciates the opportunity provided by the New York State Department of Health to comment on the Public Consulting Group's NYS Delivery System Reform Incentive Payment (DSRIP) program Mid-Point Assessment of Performing Provider Systems. The areas of the Mid-Point Assessment that ASAP will focus upon in our comments is specifically the assessment of project governance, composition of the performing provider system network/provider engagement, and funding flow.

### ***Governance***

ASAP was very encouraged that initial DSRIP guidelines called for PPS governance structures that included a meaningful role for community-based organizations (CBO). As DSRIP proposals were developed across the state, many CBOs described enthusiasm at being invited to help design a PPS. As the process transitioned from proposal development to implementation and development of governance structures, CBOs, almost universally reported less involvement, confusion about their roles, and uncertainty about expectations for their engagement and responsibilities. It is disturbing that a prominent theme across almost every PPS Mid-Point Assessment is that CBOs do not play a meaningful role in governance. ASAP is pleased that the Independent Assessor (IA) has identified this structural flaw in the PPSs and would welcome the opportunity to be a part of the remedy.

ASAP recommends a governance focused meeting with every PPS to identify, specifically, how substance use disorders services providers can more meaningfully participate in the governance of local PPSs.

### ***Partner Engagement***

DSRIP was designed with an expectation that the engagement of CBOs as PPS network partners was vital for the successful implementation of the PPS projects. PPSs were expected to identify the partners they would be engaging during the DSRIP Project Plan Application process. As part of the Mid-Point Assessment, when the IA reviewed the partner engagement data for each PPS, they found that a majority of the PPSs are behind on their partner engagement goals and that "Most PPS need to focus their attention and funding to engage key partners." ASAP conversations with substance use disorders (SUD) services providers across the state confirm this IA finding. The majority of PPS leads have failed to engage SUD service providers, seriously compromising the likelihood that they will be able to accomplish their project's deliverables.

ASAP offers its assistance to all of the PPSs to work with them to insure network adequacy as it relates to SUD prevention, treatment, and recovery support services.

### ***DSRIP Funds Flow***

DSRIP intended that PPS leads would resource their network partners to support the accomplishment of project goals. PPS leads were expected to develop contracts with network partners and compensate them for their work toward project deliverables. The IA Mid-Point Assessment found that a majority of PPSs had not contracted with their CBO "partners" and consequently, had not compensated them for their PPS work. The IA found that funding had not been distributed to key partners who are vital to the success of Domain 3a projects, where substantial performance and high performance funding is available to the PPS.

ASAP urges NYS DOH and the IA to establish deadlines and payment timelines to ensure that all network partners receive contracts and payment for their work.

ASAP is very concerned that basic component parts for a successful DSRIP project, such as meaningful participation in governance by CBOs, engagement of CBOs in the work of the PPS, executed contracts, and payment schedules are not in place. These serious shortcomings suggest significant challenges for PPSs as they relate to accomplishing expected project outcomes. ASAP strongly recommends engagement of key stakeholder groups like ASAP to support ongoing implementation of assessment and corrective action plan implementation. We are concerned about the problems and challenges identified by the IA and described in the Mid-Point Assessment report and we offer our assistance in addressing those problems and challenges.



NEW YORK CITY DEPARTMENT OF  
HEALTH AND MENTAL HYGIENE  
Mary T. Bassett, MD, MPH  
*Commissioner*

Oxiris Barbot, M.D.  
First Deputy  
Commissioner

December 9, 2016

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**Via Electronic Submission**  
New York State Department of Health  
Medicaid Redesign Team  
[dsrip@health.ny.gov](mailto:dsrip@health.ny.gov)

To Whom It May Concern:

The New York City Department of Health and Mental Hygiene (DOHMH) applauds the focus of the Performing Provider Systems (PPSs) on strengthening primary care, which is proven to improve the public's health and reduce disparities. We support expanding comprehensive, high-quality, affordable primary care to all New Yorkers, while providing additional resources to communities that have historically faced disinvestment.

DOHMH appreciates the opportunity to comment on the PPS Primary Care Plans and Midpoint Assessment Results. We have reviewed and have the following comments.

**Tobacco**

Tobacco cessation is one of the most important modifiable risk factors for chronic diseases. We recommend that PPSs provide details of their tobacco screening and treatment work as examples of their ongoing strategies and opportunities for primary care transformation, especially for those PPSs working on Domain 4.b.i. For example, tobacco screening and cessation quality measures might be part of a larger Patient-Centered Medical Home (PCMH) strategy related to Fundamental Question 2. Additionally, given the high burden of tobacco smoking among behavioral health populations, specific attention to tobacco cessation metrics and strategies related to Fundamental Question 6 would highlight the importance of addressing tobacco use in these populations. Tobacco remains the leading cause of preventable death in New York State and primary care providers are on the front lines of addressing smoking. We encourage the PPSs to use the platform of the Primary Care Plan to highlight their efforts and inspire others to action.

**Healthy Eating**

Diet is a key modifiable risk factor for many chronic conditions, and improving population nutrition can support the DSRIP goal of improving population health. The food environment in health care settings impacts patients, visitors, and staff, and providing healthier food options can help model and support improved nutrition and diets. In NYC, one quarter of adults are obese (24.1%), more than one in nine adults (11.6%) currently have diabetes, and nearly 30% of adults report having high blood pressure (28.8%). The NYC Food Standards were created by mayoral executive order in 2008 with the goal of improving the health of all New Yorkers served by City agencies by decreasing risk of chronic disease related to poor nutritional intake. Food Standards exist for meals and snacks served, for food and beverage vending, and for meetings and events. NYC's H+H hospitals are already required to follow the NYC Food Standards, demonstrating the feasibility of implementing these standards in a healthcare setting. Voluntary food standards for cafes and cafeterias are also available as part of the Healthy Hospital Food Initiative. We recommend that other PPSs adopt the NYC Food Standards to support population health by offering healthy food in their facilities and incorporate this adoption into their primary care plans for the coming year. We also recommend that implementation of these food standards in primary care practices become a part of all primary care plans, creating models of healthy eating in the clinical environment that can serve as a model of patients and providers.

### **Hypertension**

One out of four New Yorkers have hypertension, a leading cause of cardiovascular disease. To prevent and control hypertension, we recommend PPSs work with their primary care practices and systems to adopt a standardized workflow that encourages team-based care and integrates evidence based treatment guidelines. While some PPSs reference addressing hypertension in their primary care plans, few identify how critical the role of primary care is in preventing, diagnosing, treating, and controlling hypertension. The model used for HTN applies to many other chronic diseases and thus testing this model using DSRIP will have broad applicability.

There are several elements that are critical to a successful workflow: accurate blood pressure measurement; utilization of evidence based treatment guidelines including simplified medication regimens; reinforcing on-going self-management by providing at-home tools like self-monitoring blood pressure cuffs and partnering with patients, families, caregivers and community resources; and monitoring health system performance to drive improvement. First, the diagnosis and treatment of hypertension is based on blood pressure measurements. PPSs should train and evaluate direct care staff on accurate blood pressure measurement and technique. Second, PPSs should systematically implement a hypertension treatment guideline that is evidence based. A treatment guideline should include appropriate recommendations for the diagnosis of hypertension, escalation in care to prevent treatment inertia, strategies to assess and address medication adherence, and effective use of self-measured blood pressure monitoring. To implement, PPSs should consider ways of embedding the treatment guidelines into the electronic medical records to optimize adoption; for instance, use a patient registry specific to the treatment guideline to identify patients with uncontrolled or undiagnosed hypertension. Third, reinforce the prevention and control of hypertension by partnering with patients, families, caregivers and community resources. PPSs should support self-management through patient education and referrals to community resources; for instance, in-between face-to-face encounters with the health care provider, encourage blood pressure monitoring using a home blood pressure monitor or by visiting a pharmacy that provides free blood pressure monitoring. Last, PPSs should monitor performance to drive improvement in primary care practices. PPS should support primary care teams to determine and review performance metrics on a routine basis to determine goals and gaps in care.

### **Community Health Workers Concerns**

The shortage of CHWs would be best addressed with a concerted effort of PPSs to fund training. Ideally a partnership between local institutions and public agencies would build out a shared training center that the large health systems and PPSs support, and which CBOs can access at reduced or no cost. It should include coaching / communication skills (e.g., motivational interviewing) and social determinants of health assessment / advocacy (at least individual) training. Existing training is often about specific diseases, which is necessary but not sufficient. PPSs should also pursue models of delegating (with compensation) CHW work to partner CBOs instead of hiring everyone internally. The CHW shortage can also be addressed by adjusting down minimum education and/or training requirements in job descriptions and assuming that training will be done "on-the-job." They may be struggling to fill "case management" roles by looking for over-qualified personnel, and could be accomplish much of this work with CHWs with proper support. Bronx Partners for Healthy Communities (Health Home 2.a.iii) noted these issues. To convince hospitals & clinics, refer them to the recent [NYU document](#) that includes estimates of return on investment. Bronx Health Access said they were unsure they had the capacity and needed to build incentives to hire CHWs (Health Home 2.a.iii).

### **Referral system**

Regarding a referral system, we recommend separating case management and referral functions. Most case management can be done within the EHR, and/or through a connected case management software solution. There are not a lot of good options that fill the needs of both case management and referral, because few referral options have a robust resource directory, are user-friendly, and are interoperable with both low-tech and hi-tech client records. Bronx Partners for Healthy Communities (Health Home 2.a.iii) noted these issues.

### **CBO Concerns**

There needs to be more investment in CBOs regarding value-based payment / changes in reimbursement that CBOs may have access to if they are helped to navigate the health reimbursement bureaucracy that many are unfamiliar with.

**PPS Acknowledgements**

*New York Presbyterian 3.e.i Project:* This assessment is of NYP's REACH project, which is incredibly impressive in its approach to system-wide changes to improve HIV outcomes in their PPS. Their focus on settings such as Emergency Departments and improvements to their IT systems is both appropriate and incredibly impressive. We have seen them present project REACH logic models and plans on several occasions, including at NY State-organized NY Links meetings, where their approach was received by an audience of their peer organizations with great interest and enthusiasm. Further, the DSRIP HIV Coalition, which was initially comprised of only 4.c.ii projects, decided to invite them to join the coalition, in large part due to how impressive their peers find this program model. Their self-reported challenges indicate that they are making progress, and doing substantial work to address any challenges. Further, their low scores on CBO and clinical engagement are being measured against their own (very ambitious) targets rather than an objective measure. There are no other HIV 3ei projects, nor is there an industry standard, so there is nothing to which to compare them. They set ambitious goals for their project, and are being transparent about challenges that are characteristics of a rapidly growing program.

**Public Health Principles:** We would like to specifically mention some PPSs that have successfully implemented some core public health principles that our agency supports. We set forward the following principles that we feel should be adopted by all PPSs.

| <b>Principle</b>  | <b>Benefits for Public Health</b>   |
|---|---|
| Invest in community health worker workforce development, in partnership with existing training resources                  | Community health workers understand patients and their context, and are effective in providing cost-effective support. Local educational institutions are responsive to their learners' needs.<br><br><b>Supporting PPSs:</b><br>Staten Island, Community Care of Brooklyn, OneCity Health and ACP. |
| Invest in and deploy community health workers in settings outside the clinic walls  | Patients with the worst outcomes and highest utilization benefit from community health workers who are able to meet patients where they are located.<br><br><b>Supporting PPSs:</b><br>New York Presbyterian, OneCity Health, Advocate Community  |
| Optimize partnerships with community-based organizations (CBOs), particularly in addressing social determinants of health | CBOs are responsive to community needs and priorities, providing a local, trusted, cost-effective source of services.<br><br><b>Supporting PPSs:</b> Staten Island, NYP, and Community Care of Brooklyn, Bronx Partners for Healthy Communities, OneCity Health and ACP.                            |
| Engage primary care in value based payments (VBP) (Especially small practices)  | Smooth transition to VBP for PPSs will depend on institutional investment in IT and personnel and engagement of all practices in the care delivery system.<br><b>Supporting PPSs:</b> NY Presbyterian, and OneCity Health   |
| Optimize partnerships with public institutions  | Health in all planning includes health as a key outcome of policies across public sectors.<br><b>Supporting PPSs:</b> Community Care of Brooklyn  |
| Investment in resources to support expansion of primary care  | Institutional financial commitment and detailed plans of implementation can assure sustainability beyond DSRIP.<br><b>Supporting PPSs:</b> OneCity Health and New York Presbyterian   |
| Outreach for engagement of patients not engaged in primary care   | Connecting patients with primary care can dramatically reduce preventable hospitalizations and ED visits.<br><b>Supporting PPSs:</b> OneCity Health   |



| <b>Principle</b>  | <b>Benefits for Public Health</b>  |
|---|--|
| Strengthen Primary Care to develop Integrated Delivery System (IDS) | Development of IDS will position PPS for success in DSRIP initiative and will prepare it for transition to Value Based Payments.<br><i>Supporting PPSs: New York Presbyterian and OneCity Health</i> |

DOHMH appreciates the opportunity to comment on the PPS Primary Care Plans and Midpoint Assessment Results, and we thank you for your consideration.

Sincerely,



Oxiris Barbot, M.D.  
First Deputy Commissioner



## ***COMMENTS BY THE NYS COUNCIL ON THE DSRIP MID-POINT REPORT***

On behalf of the New York State Council for Community Behavioral Healthcare, I am writing to you in regards to the DSRIP Mid-Point Report. The NYS Council is a statewide non-profit membership association representing the interests of nearly 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 believes that the PPS networks can deliver better integrated health care by embedding behavioral health as an integral service across all sectors of health care. We were pleased to see that all 25 PPS's identified 3 a.i. as one of their initiatives. Breaking down a siloed system of care is in the best interest of all individuals with mental health and addiction related issues.

Our organization has been very supportive of the collaborative PPS model. We strive for an integrated person centered approach with flexible dollars to enhance personal recovery through clinical services, peer support, family engagement, supported employment and supported education. We embrace the approach of recovery and community integration for which the waiver holds great promise.

Unfortunately, in the two and a half years of DSRIP, we have not yet seen this vision come to fruition. There are certainly some excellent and innovative practices and emerging networks that hold possibilities for greater mental health and chemical dependency integration. These innovations and best practices are best driven by collaborations with Community Based Organizations (CBO's) and PPS lead agencies. This collaboration must expand if we want to witness success in DSRIP milestones.

The first half of the five years has been driven by process. Now is when we need to move more aggressively into contracting and achieving programmatic milestones through working with the not for profit sector. We are hopeful that this will create a change within the framework of DSRIP.

Based on the comprehensive Mid-Point Assessment Report, we see three major themes that impact implementation.

- 1) Role of Community Based Organizations in Provider Networks
- 2) Successfully Utilizing Workforce Funding
- 3) Training Needs

### ***ROLE OF COMMUNITY BASED ORGANIZATIONS IN PROVIDER NETWORKS***

A consistent theme throughout the report was the clear lack of provider engagement. According to the report, "While the PPS do not need to demonstrate 100% engagement of participants in a project until project milestone completion, it is important that the PPS demonstrate engagement with partners through project implementation efforts."

In Section IV of the report, the Independent Assessor (IA) makes a specific recommendation around partner engagement, stating, “A majority of the PPS are behind on their Partner Engagement goals at this point in DSRIP. Most PPS need to focus their attention and funding to engage key partners.” In addition, it was stated that, “The PMO and Hospitals have received over 70% of DSRIP funds to date across all PPS. PPS will need to fund their network partners at a meaningful level going forward.” This recommendation was consistent with the findings across the PPS networks.

Of the 25 PPS, 16 were identified as needing remedial steps to engage CBO’s as core members of the PPS. This is not a surprise as most of our members are part of PPSs in their communities, and despite being part of the network, many members have not been meaningfully engaged or seen funding flow from the lead agencies.

We urge the State to work with the PPSs to ensure that downstream providers receive funding for projects that address needs in their community around training, education and support. There is a lot of work that is being done around peer support, family engagement, supported employment, education, crisis services and training. All of these tools are utilized to keep people in recovery in their communities and out of the hospitals.

In addition, many of our members are concerned that the lead PPS will replicate the successful models that we have implemented in our community mental health and chemical dependency programs. These models are successful because we have worked for many years with the population of people who are being impacted. Most CBOs have been embedded in their communities for many years and know the people they have been working with. A replication of their efforts by the lead agency would not provide the results or meet the expectations of the DSRIP.

A concern raised from doctors is that when a mental health or addiction issue is detected that there be adequate and timely referrals to mental health and chemical dependency providers. In order to have successful integration through 3 a.i., you need a robust network of behavioral health providers to respond to referrals. This can be best accomplished through contracts with existing downstream behavioral health providers.

*Recommendation:*

- 1) The State should play a stronger role in ensuring that there is a better, more systemic financial flow to not for profits from the PPS lead agencies. The State must monitor and incent PPS lead agencies to insure contracts with CBO’s to enhance milestones and metrics.

*SUCCESSFULLY UTILIZING WORKFORCE FUNDING*

It is clear from the recommendations of the Independent Assessor that workforce issues are of great concern. The specific DSRIP language states that there is \$1.08 billion for other Medicaid redesign purposes, including Health Home development, investments in long term care, workforce, and enhanced behavioral health services.

It is unclear at this point what, if any, of the funding has been expended. Despite this available funding, there continues to be a workforce crisis in New York. The not for profit mental health and chemical dependency sector has received only two Cost of Living Adjustment in the last eight years. One of them was last year when there was a rate increase for not for profits that amounted to only .02 percent

The financial impact to this sector in regard to the minimum wage increase dramatically impacts both the financial stability of an organization and its ability to retain a quality staff. Not for profits are the safety net for the community. Equitable funding is needed to provide effective services for those most in need.

*Recommendations:*

- 1) Provide funding transparency for the workforce in DSRIP to insure that it prioritizes spending on behavioral health workforce
- 2) Use the DSRIP dollars as a five percent funding increase for the not for profit workforce over the duration of DSRIP. Most of the PPSs are populated with not for profit agencies so it would be consistent with the language and spirit of the waiver. Five percent increase in funding for not for profits would be approximately \$155 million per year.
- 3) Utilize the DSRIP funding to help provide tuition reimbursements to the behavioral health workforce. Replicate the successful Doctors Across New York Program but populate the program with behavioral health staff including direct care staff, supervisory staff and clinicians.

*MENTAL HEALTH TRAINING*

One of the other consistent themes brought up by the IA was the lack of training around mental health issues. Much of that can be generalized as an issue around getting vital funding to downstream providers, but another reason may lay in the lack of knowledge in most provider communities about behavioral health and stigma associated with mental health and addiction illnesses.

One way to get around the stigma and lack of knowledge about mental health is through Mental Health First Aid (MHFA). MHFA is an eight hour training program designed for the general population to educate them about mental health and how to best respond to a mental health crisis. This evidenced based model has been responsible for training close to a million people nationwide.

Specific examples among the PPSs in regard to lack of training in mental health were among the concerns voiced by the IA in seven different PPSs.

*Recommendations:*

- 1) Mental Health First Aid is especially relevant in implementation around 3 a.i, the integration of primary care and behavioral health services.

The IA report specifically says, “Project 3 a.i. is one of the most important projects in DSRIP thus it is critical that the project is implanted successfully.” Given the comments of the IA, it is very important that within this integration there be a new structure in regard to working with people with mental health issues. Primary care staff may not have dealt with this population in the past. Due to stigma and lack of information, they may have preconceived notions. MHFA helps dispel myths while also providing support in responding to a mental health crisis

All the PPSs, through their environmental scans, have identified areas of ‘hotspots’ where there are a higher percentage of individuals who end up hospitalized. Many of these individuals have underlying mental health issues. MHFA would be an ideal training to help support the workforce staff dedicated to working with individuals with the highest need in the community. This will greatly enhance their ability to engage individuals with mental health related issues.

- 2) Prevention Agenda: Domain IV of DSRIP is dedicated to the Prevention Agenda. Prevention funding has never been a staple of funding in behavioral health and that is why we were very pleased to see the Prevention Agenda highlighted as an integral part of PPS.

The fundamental key to prevention is education. Though not discussed on the IA review, it is clear that mental health education impacts virtually the entire prevention agenda whether talking about diabetes, asthma, heart disease, obesity or any other health related concern. Bringing a greater understanding of mental health to individuals in the DSRIP, through MHFA, will help lead to greater wellness strategies for population health, which is clearly a major objective of the Prevention Agenda.

In conclusion, our recommendations include the following:

- 1) Ensure that the PPSs commit to providing funding to downstream providers so that those agencies embedded in their communities are properly incented to continue efforts to support the DSRIP goals. Also ensure that not for profits can provide the programming without concerns that the larger PPS will replicate the programs and not fund existing downstream providers.
- 2) Utilize the Workforce funding of DSRIP to help provide funding incentives to not for profits including across the board pay increases for human services as reflected in the large number of network providers in the PPS. Also use PPS funding to provide tuition reimbursements for individuals in the behavioral health sector.
- 3) Ensure that appropriate behavioral health training is available through MHFA to respond to 3 a.i and also for Domain IV, the Prevention Agenda, as well as for any other appropriate sector.

Thank you for your consideration.

Sincerely,

*Lauri Cole*

Lauri Cole  
Executive Director

### **NYSNA Comments on Mid-Point Assessment for DSRIP**

The New York State Nurses Association is the union that represents 40,000 registered nurses in New York State. We are a committed advocate for improving the quality of care, providing universal access to care to all residents of New York State, and addressing the health care needs of New Yorkers.

We have been actively participating in twenty Performing Provider Systems across New York State, serving on workforce committees, clinical committees, PACs, and Boards, which we believe gives us a particularly helpful vantage point to comment on the mid-point assessment.

We have the following comments to make on the mid-point assessment:

#### **1. The 360 degree reviews did not go far enough**

First, we want to praise the independent assessor for including a 360 degree review as part of the process. In our initial comments on the mid-point assessment plan, we called for more input from community stakeholders and other partners to have a better sense of how the PPS is performing. We wish the assessor had taken these ratings more into account as they commented on PPS performance and made recommendations, however.

We are distressed, though, that no front-line staff or their representatives were included as part of the 360 degree reviews. These are the people who have to actually enact these projects. They certainly have information to share about how well the process is succeeding.

For example, NYSNA can report that very few of our members have been trained on any new DSRIP initiatives and that there has been relatively little hiring of nursing staff across the hospitals we represent to carry them out. We can also report, as we have commented to the Project Approval Oversight Panel, that we do not always feel that our participation on DSRIP committees has been valued and that our concerns about care have been dismissed. Most recently, when we raised concerns that the position of transitional care manager in the Staten Island PPS did not require a clinical background despite performing clinical functions, we were brushed aside.

More broadly, we are concerned that the decision-making does not take place at the PPS committee level. Even at a PPS like Mt. Sinai, where we are on both the workforce committee and on the Board, it is clear that the big PPS decisions have been made before

the committee meetings start. NYSNA is eager to bring our expertise to shaping PPS projects, but it is difficult to do so when our input does not appear to matter. The governance review performed during the mid-point assessment was not able to bring to light these issues. We would like the Department of Health to focus on them.

## **2. The assessment did not discuss workforce impact**

In our previous comments on the mid-point assessment plan, we raised concerns that the workforce reporting milestones were unlikely to be completed on time for the assessment. Those fears appear to have been justified, as some workforce reporting deadlines were pushed back. As a result, the mid-point assessment did not touch on workforce impact at all. Since many of the PPS's appear to be struggling to recruit enough providers to participate in the projects, it would make sense for the independent assessor to evaluate their target state analyses and training plans to see if their plans are reasonable to fix their recruitment issues. It is unfortunate that they were not able to do so.

We are also disturbed that these workforce reports have not been made available to the public. In many cases, they have not even been distributed to the workforce committee. NYSNA has requested copies of the current state and target state reports from all the PPS's that we participate in, but several have not shared them with us or have shared heavily redacted versions. We should have input into these reports at least on the committees that we participate in. As the representative of a significant portion of the workforce, we should, at minimum, get to see the reports.

This is particularly important because, for some reports that have been shared with us, there are workforce reductions projects. Advocate Community Partners, Community Care of Brooklyn, and Bronx Partners for Healthy Community all project significant reductions in frontline staff in their target state reports. The assessor should ask for more explicit mitigation plans from PPS's projecting such reductions.

## **3. There appear to be several significant issues across the PPS's that could put the DSRIP program at risk**

The mid-point assessments reveal several areas of concern. For one, the PPS's as a whole have not spent nearly enough money on DSRIP projects to make them effective. With a statewide average of only 56% of funds spent and, of those, 43% being spent on the project management organizations, a great deal of money remains on the table. The PPS's need to invest in these projects and distribute money to CBO's and other community partners if they are to be successful. The projects all rely on these partners being able to execute them, and they need to be supported.

Overall, the upstate PPS's had the most projects at risk and earned the most recommendations from the independent assessor. Many of these and other PPS projects

seemed to be foundering due to a lack of primary care and behavioral health providers. While the independent assessor recommends that they make plans to increase recruitment of these providers, it might end up being a difficult task in some of the most rural areas of our state. Alliance for Better Health Care PPS has suggested training existing staff to gain advanced practice credentials. We think this is an excellent idea and would like to suggest that other PPS's pursue this as well. New York's nurses are eager to help close gaps in primary care and behavioral health. Current registered nurses can, with training, become nurse practitioners and take on primary care and behavioral health roles. NYSNA would be happy to partner with individual PPS's or with the Department of Health to facilitate this process. We hope to generate a discussion on this moving forward.

Information technology also remains a big problem across all PPS's, as the PPS's have been struggling to come up with compatible technology that works for all of their providers. Perhaps the State could help PPS's get this right, maybe by setting standards to make the RHIO's more compatible with a broader array of providers. It is very frustrating for frontline staff to have to constantly learn new EMR systems. It takes up a great deal of time that would be better spent on patient care.

#### **4. OneCity should receive its intergovernmental transfer funds promptly**

OneCity, the PPS for Health + Hospitals, was able to spend very little of its DSRIP money due to delays in intergovernmental transfer funds. In the future, the Department of Health should ensure that this money is available to them promptly so they are most effectively able to execute projects.

Health + Hospitals is a key safety net provider for New York City. NYSNA firmly believes that it and other safety net providers should receive the funding they need to meet the growing needs of New Yorkers. The current distribution of public money does not go far enough to protect these vital institutions. DSRIP funds must be distributed promptly to the hospitals that most need them.

We hope, as we move forward into the second half of the DSRIP process, that our concerns about governance and oversight will finally be taken seriously. NYSNA wants to be involved in making DSRIP as successful as possible and firmly believe that as frontline care providers, we can give helpful input. We also hope to be more involved in training up current nursing staff to provide primary and behavioral health care in areas where it is desperately needed. Thank you for allowing us to comment on these important matters. We look forward to continued discussions as the mid-point assessment process moves forward.





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December 21, 2016

**Submitted Electronically: Comments on the DSRIP Independent Assessor Mid-Point Assessment Report**

Thank you for the opportunity to comment on the Delivery System Reform Incentive Payment (DSRIP) Independent Assessor (IA) Mid-Point Assessment Report. As an organization dedicated to excellence in primary care, the Primary Care Development Corporation (PCDC) is deeply committed to the success of the NYS DSRIP demonstration program. With the ultimate goal of transforming our Medicaid delivery system, the Performing Provider Systems (PPS) will be able to deliver on the promise of high-quality care, lower costs, and better outcomes.

We appreciate the opportunity to support the strengthening of the DSRIP program, and particularly, the PPSs at this time of a midpoint assessment. In our view, primary care should be the bedrock on which delivery system and payment system reform rests. Without a strong and vibrant primary care system that is adequately resourced, technologically enabled, and integrated with other components of the health and behavioral health care systems, the triple aim will not be achievable. That is the reason PCDC advocated that each PPS should have a primary care plan that would outline goals and activities toward needed primary care access, capacity, and quality.

This mid-point assessment comes at an important time. The PPSs have had two years to develop their governance structures, do planning with their expanded networks, and begin implementation. While this is a short time frame to create fundamental change, this assessment moment offers an important opportunity to review progress to date and assess what mid-course corrections may be needed.

In order to provide the public with the ability to assess PPS performance, PCDC believes that **comparisons across PPSs** would be very useful and should be provided by the IA, including:

- Funding spent per attributed life
- Proportion of funding spent on administration/PMO costs (as was shown in the October 7, 2016 PPS progress report) and categorize the use of these funds (e.g., administrative costs, contracts for technical assistance, support for primary care, etc.)
- Percentage and amount of contracts executed by sector and project
- Percentage and amount of funds flow by sector and project

- Number and percentage of primary care providers or practices that have received concrete support through DSRIP, including practice transformation and additional staff (nurses, care managers, care coordinators, community health workers, etc.)
- Comparisons across PPSs by project

A consistent concern raised throughout the DSRIP process, and validated through this Mid-Point Assessment Report, has been that the primary care system is not currently receiving adequate financial support through this mechanism as demonstrated by the 30 percent funds flow. PCDC supports the IA recommendations for broader contracting and engagement with primary care providers as the primary care system continues to be under-resourced. In addition, PCDC suggests that future assessments should include how each PPS provides concrete support (e.g., paying for technical assistance either through the PPS or a contractor) for a variety of needs of primary care providers, and this support should be prioritized, tracked, and reported by each PPS.

The 360 degree survey of PPS partners provided useful feedback from those who are carrying out the PPS projects, and is an important qualitative assessment. However, the significant variance in response rates (and often very small sample size) within a particular sector for a particular PPS, such as from primary care providers, renders the quantitative scoring less useful than the qualitative feedback and trends that were identified through the comments. That this section had a numeric score and was collated across PPSs makes it appear that the results are comparable; yet, it is unclear what the average score represents.

Impact on partners that would be useful to further understand includes: slow contracting, a 30 percent funds flow, communication between the PPS and their networks, and complex governance and meeting structures.

#### **Independent Assessor's Recommendations:**

- *Recommendations 1, 5, 13, 20, 42, 61, 109:* PCDC is concerned that a number of IA recommendations focus on educational campaigns for patients, particularly around health care utilization, which have not been shown to be effective. PCDC suggests that the IA recommend that PPSs pay for staff (including nurses, other clinical staff, or community health workers) to support patients and their families at the point of care to support decision-making on a variety of utilization issues, including palliative care/hospice and emergency department (ED) utilization. In addition, PPSs should invest in strategies such as access to urgent care, after hours/weekend access, and building primary care centers co-located with emergency rooms to help reduce ED visits by financially supporting additional hours during a period of ramp-up at primary care providers. Finally, support by the PPSs for workflow development for issues that cross providers in the integrated network (such as transitions of care) would be useful.
- *Recommendations 2, 17, 18, 55, 67, 82, 114, 125:* PCDC agrees with the IA assessment that PPSs should contract with community-based organizations (CBOs) to support patient and consumer engagement. Once there are formal contracts and payments that would enable these CBOs to invest in additional staff for services, which have no other funding stream, we anticipate that many CBOs would be glad to participate, and educational campaigns would not be necessary.

- *Recommendation 19, 26, 30, 37*: PCDC agrees with the IA that training should be provided to improve staff capacity to provide needed education and services to patients. Standard curricula should be provided by the SDOH from among the many nationally available, evidence-based curricula on asthma and other chronic disease programs for training and use by community health workers (CHW), navigators, and others, which would support each PPS to more quickly adapt and put into practice chronic disease prevention work.
- *Recommendation 35, 113*: PCDC agrees that CHW are an effective tool to support better outcomes. PPSs should hire CHW either directly, on contract, or through providing resources to primary care providers to hire them to provide home visits for asthma or other chronic diseases. There is ample evidence in the public health literature that culturally and linguistically competent and appropriately trained CHW are welcomed into the home, and are effective in teaching asthma and other chronic disease self-management.
- *Recommendation 36, 45, 46, 49, 50, 54, 60, 73, 81, 82, 87, 97, 100, 108, 115, 116, 119, 120, 123, 132*: PCDC agrees with the IA that partner -- and particularly primary care -- engagement is not yet at needed levels for success. However, engagement would likely be higher if funds were flowing. It is unclear if an educational strategy or one based on additional governance and meetings would be successful.

We appreciate the opportunity to comment on this mid-point assessment, and look forward to the continued availability of public assessment information as the DSRIP program continues. We hope that NYS DOH will consider our comments to help create a more transparent and easily comparable system.

Sincerely,



Louise Cohen, MPH  
CEO, Primary Care Development Corporation



# Southern Tier Independence Center

*Access your world.*

December 20, 2016

## **Southern Tier Independence Center (STIC) comments on DSRIP Independent Assessor Mid-Point Assessment Report for Care Compass Network (CCN):**

Southern Tier Independence Center (STIC) is a Center for Independent Living (CIL), a non-residential not-for-profit community based organization serving people with all types of disabilities of all ages as well as their family members and service professionals. We are dedicated to empowering people with disabilities to live independent, fully integrated lives in their communities.

Thank you for the opportunity to submit comments on DSRIP Independent Assessor Mid-Point Assessment Report for Care Compass Network (CCN).

The Report's Introduction states that Care Compass Network PPS (Co-led by United Health Services and Cortland Regional Medical Center) serves six counties in the Southern Tier of New York: Broome, Chemung, Chenango, Cortland, Delaware, Schuylers. Our understanding is that Care Compass Network is a nine county PPS including Broome, Chenango, Tioga, Chemung, Cortland, Delaware, Schuylers, Steuben, and Tompkins. Please look into this discrepancy.

**Community Based Organization Contracting:** "While the PPS indicated that it would be contracting with and compensating the CBOs with which it contracts, the funds flow data indicates these efforts have been limited, to date. It will be important for the PPS to expand its fund distributions across all of its CBO partners to maintain engagement of these key partners." STIC is pleased to see this recommendation. Also encouraging is the recommendation that Care Compass Network develop a strategy to increase partner engagement throughout the PPS.

**Cultural Competency and Health Literacy:** The IA notes that the PPS appears to have taken limited steps toward the implementation of the training strategy published in June 2016. The extent to which it will be measuring how it is engaging Medicaid members as part of its CCHL strategy is unclear. We're pleased that the IA recommends the PPS develop an action plan to implement its trainings to its workforce and partners and recommends that the PPS develop metrics to assess its most effective strategies to engage Medicaid members and the uninsured.

**Funds Flow:** The IA notes that in comparison to other PPS the distribution of 8.43% of the funds earned places Care Compass last of the twenty five PPSs compared to the statewide average of 56.20%. IA mentions that the little distributions Care Compass has made are heavily directed towards the PPS Project Management Office (93.6% of the funds directed to this partner category). This is a key finding and the IA's recommendations are appropriate.

**Patient Engagement AVs:** The IA notes that the continued limited Patient Engagement efforts raise a concern for Care Compass Network's ability to meet DSRIP goals. The IA states that the PPS had Patient Engagement commitments in eight projects in DY1 and the PPS failed to report any Patient Engagement for seven of the eight projects in DY1. Also, in DY2, Q2, the PPS did not meet their Patient Engagement targets for seven of eight projects based on the data submitted by the PPS. STIC is pleased the IA requires the PPS to create a plan to increase patient engagement for all projects.

**Partner Engagement:** "The PPS has made commitments to engage PCPs across each project, up to 285 PCPs for project 2.a.i., yet has only indicated the engagement of no more than two PCPs for any project through the DY2, Q2 PPS Quarterly Report. For project 3.a.i., the PPS committed to engaging 37 Mental Health partners and 163 PCP partners to implement this significant project, however, through the DY2, Q2 PPS Quarterly Report, the PPS has only indicated engagement of five Mental Health partners and zero PCP partners. This lack of partner engagement across projects presents a significant risk to the PPS' successful implementation of the DSRIP projects." This is a key finding and steps are necessary to increase outreach and attract the required number of partners.

**PPS Narratives for Projects at Risk:** The IA states that for project 2.c.i. the PPS indicated challenges of tracking patients engaged that is critical to the success of navigation work. "The PPS noted that CBOs are not traditionally accustomed to working with health care providers which has caused tension among partners. The PPS indicated that they are facing challenges with educating partners about DSRIP, and are finding contract negotiations difficult." Do we know from CBOs that there is tension and the cause is because CBOs are not accustomed to working with health care providers? Factors such as low reimbursement to CBOs may have stopped contract negotiations. Promises have been made but few have been realized. We are disappointed in the lack of movement thus far.

**Financial Sustainability and VBP:** The IA recommends that the PPS create an action to address the assessment of its network partners for VBP readiness and that the PPS establish a plan to further educate and support their partners move toward VBP arrangements. These are vital recommendations, and STIC is pleased to see this. After all this time, it still isn't clear how "Value-Based Payments" will be made, what they will be based on and what outcomes will need to be achieved before payments are issued.

On behalf of STIC thank you for the opportunity to comment.

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