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OK. Good afternoon folks. Welcome to the eleven fifteen public forum public comment day June 24th 2019. It's my pleasure to welcome you. My name is Phil Alotti I'm with the Department of Health Office health insurance programs waiver management unit and I'm going to spend a few minutes providing a an overview of the eleven fifteen and the New York State M.R. to waiver just to give you some background information on the eleven fifteen waiver. And then I'm gonna turn it over to Greg to do some final presentation slides. Okay. Eleven fifteen demonstration waiver also known as Section eleven fifteen of the Social Security Act which gives the secretary of Health and Human Services the authority to waive certain provisions and regulations and also allows Medicaid funds to be used in a way that are not otherwise allowed under federal rules. The eleven fifteen demonstration waiver grants flexibility to states for innovative projects that advance the objectives of Title 19 of the Medicaid program and thus waive certain compliance requirements of federal Medicaid laws. A waiver can be approved for up to five years and the state may request subsequent extensions. Special terms and conditions also known as the STCs outline the basis of an agreement between the state and CNS including waiver expenditure authorities STCs specify the state's obligation to CNS during the during the life of the demonstration including the general and financial reporting requirements and the time table of state deliverables quarterly and annual reports are required. And an independent evaluation is completed at the end of the demonstration program. Federal Medicaid expenditures with a waiver cannot be more than federal expenditures without the waiver during the course of the demonstration. Also known as budget neutrality or budget neutral. The New York state Medicaid redesign team MRT waiver formerly the partnership plan has been in operation since 1997. New York's eleven fifteen MRT waiver was renewed on December 6th 2016 and is effective through March 31st 2021. Key goals for the waiver are to improve access to health care, improve the quality of health services, expand coverage with resources generated through Medicare manage care efficiencies to additional low income New Yorkers. Medicaid managed care. This provides comprehensive health care services including all benefits available through the Medicaid state plan to low income uninsured individuals. It provides an opportunity for enrollees to select a managed care organization also known as MCOs whose focus is on preventive health care. Programs include mainstream Medicaid managed care. Don't ask me to say that fast, MMC health and recovery plans also known as HARPs. And home and community based services also known as HCBS. Managed long term care and long term services and supports. And finally delivery system reform Incentive Program also known as DSRIP. This provides incentives for Medicaid providers to create and sustain an integrated high performance health care delivery system that can effectively meet the needs of Medicaid beneficiaries and low income uninsured individuals in their local communities and thereby improving quality of care, improving health outcomes and reducing cost also referred to as the CNS Triple Aim. At this time I'd like to turn over the presentation to my DOH colleague Greg Allen the director of program development and management to talk about New York's pending amendments and some projects that DOH is currently working on.

Thank you very much Phil. Thanks everybody for coming today. Just want to shout out to our waiver unit for all the hard work that goes into managing multiple aspects of the waiver including today's meeting. And thanks to Phil for a lead off batting here really appreciate it Phil. My name is Greg Allen I direct policy in the Medicaid program I work for Donna Frescatore to my immediate right Donna is the Medicaid director and to her right is Peggy Chen who directs the district program for those of you who were at our project approval and oversight panel earlier today we've been working through district. This is our second phase today receiving public comment on on the waiver. I just want also reference there

are several OHIP team members here to also listen to your comments so appreciate you taking time from your busy lives on a absolutely stunningly gorgeous day to come into a windowless government room underground to give us your public comments for especially vulnerable populations. So we appreciate that very much. So without further ado my slides and then we will get to your comments which we will document importantly here. So first up on our pending waiver amendment. So though this waiver is a living breathing document it gets updated on a regular basis. One key system transformation piece that we've been working on for many years now with multiple state partners and local provider and member advocate partners is the children's system transformation. This transformation has many components one of which are changes to the 11 15 waiver for those of you who've been following this more of the body of these changes that's been happening in other other waiver instruments. But in the eleven 15 particular Lee is the authority to mandatorily enroll these children in the participating children's waiver if qualifying enrolling them into Medicaid managed care. This is also technically adds the home and community based services that those children qualify for under the Children's waiver again and bolts that into the Medicaid managed care benefit package. And this is very exciting because it makes those services more ubiquitously available to children meeting a level of care and level in need over time rather than having very specific caps under the old waivers. We also are aligning the services for those children under under multiple specialty waivers before under one larger waiver. Also part of this are our foster care services and the children in foster care. These waiver amendments will give us the authority to mandatorily enroll foster children placed in a voluntary foster agency and then the ability to roll them specifically into Medicaid managed care under specialized services specialized rules and guidelines. And again it adds the services that are provided by the license voluntary foster care agencies to those children again in a Medicaid managed care benefit package. And we've been working carefully with the foster care industry on a series of changes in the waiver implement just a portion of those. So the next slide. The other pending waiver amendment is to the OPWD voluntary managed care transition. So this adds We've been working on various reform and redesign components in collaboration with the OPWD's Commissioner transformation panel and there's been that transformation panel and other vehicles have been giving us more stakeholder engagement. So there's much more work that's happening and we are reviewing an active managed care transition plan for individuals meeting IED criteria under under the state. State and federal criteria. And so that that work continues and is in is progressing now. So next slide. So there are a couple of changes here on the partial cap the manage long term care and we say partial cap to differentiate it and we'll talk about that in the second bullet but very specifically the nursing home benefit in that MLTC plan benefit. And we put in front of CMS a modification to the partial Capitation or the payment for those managed long term care plans that would include only three calendar months of permanent nursing home care for individuals who are permanently placed. This has been subject to many discussions with with stakeholders both provider plan and member representatives and include some procedural changes that have been coming out of that stakeholder engagement and some increased monitoring activities that would be required. Additionally, just clarification that this limit does not apply to mainstream managed care or any of the more integrated managed long term care products including FIDA, MAP and PACE programs. So those programs are not the subject of this amendment. We received many questions about that so just to clarify that. The next slide. We also aligning with what's happening and has happened for quite some time in mainstream managed care where most of our members are enrolled. We would apply some lock in provisions it might be an unfortunate name but this is these lock in periods require a member after some some period of choice to then stay with a plan for a while to allow the work at that point in its networks to better affect member health. So we are working now at CMS to apply this lock in period to new enrollments So prospectively to

new enrollments in the MLTC partial plans. And just to clarify members who switch from one MLTC plan to another MLTC plan do have a 90 day grace period to make another plan transfer. So if there are things that would trigger change for the member during that period they can execute on that. But after that 90 day period there would be a continuity period of nine months after the end of that grace period where they'd be required to stay in that plan. These as I mentioned at the outset align with the criteria that are now in place for mainstream managed care. They've been in place for quite some time and and tend to work rather well. The lock and provisions again do not impact the integrated products that I mentioned before FIDA, MAP and PACE or the enrollees in those plans. So the last slide and you know there's quite a bit of interest here. The first bullet on DSRIP we we do plan. There's been a lot of questions about whether based on the success that we've seen in the district waiver that has a running period that ends slightly before the conclusion of the current waiver that we're talking about which ends in 2021 district officially ends in the end of March 2020. So we do plan to seek federal authority for some form of extension. I would just say that you know hitting the high points of the discussion based on a lot of stakeholder input A we want to focus on our most promising district practices which Chad shear from the United Hospital Fund went through with us in our earlier meeting today. We want to give some flexibility for PPS reorganization but we would be funding PPS is likely but there will be some chance for flexibility of the network that those PPS would represent we since we do believe one of the main reasons we need to ask for this extension is that value based payment has not matured on the same schedule that we thought it would when we implemented our very specific focus would be building these promising practices in the value based payment. And so we very accordingly think it is critical to bring our managed care plan partners into the discussion with the PPS colleagues so that the end product at the end of whatever the extension period would be which is still open to input and dialogue and decision that by the end of that period we would indeed be carrying these most promising practices in value based payment and we require a planned partnership to be able to do that. And then lastly there has been some discussion of the need to more specifically engage community partners especially community based organizations. And so we would very likely focus efforts on making sure that those networks double down on the engagement of of social providers as the whole social determine of health equation is so critical to the success of those initiatives. And we will review a timeline on this in a minute. So Criminal Justice also another piece of work in progress. We are planning to submit a waiver amendment which would authorize federally matched Medicaid for targeted high risk incarceration members, HIV members, members with serious mental illness, substance use disorder including opiates, Hepatitis C and other high risk chronic disease. The idea would be to do to bring Medicaid to BEAR 30 days prior to release. Leveraging activities that we've already done on optimization of enrollment. The next piece is our generalized MRT waiver renewal that expires as mentioned at the end of March in 2021. So we have to target renewal application by next by September of next year so there will be a set of activities and public comment that are kicking off for that renewal. And then supportive housing many of you have been watching a national conversation around the importance of supportive housing to Medicaid and advancing the aims of Medicaid to improve health and well-being of Medicaid members. So we are working on an application that would not specifically be an eleven fifteen but would be a night a 1915 I state planned amendment to CNS to achieve federal support in providing supportive housing where New York has a rich track record of using our state Medicaid resource resources to finance those critical supportive housing pieces. So this would bring federal partnership in those sets of activities and services for the four for high risk members. So on the next slide. Is our. Previously mentioned our district renewal process and timeline so we will be putting out a concept paper that has been requested by our federal partners this summer we would be targeting July but there will definitely be out

this summer in our first official step after that concept paper goes out and we we open up the cascade of of required transparency regulations satisfaction requirements first is noticing the tribes which is important piece to us and we get feedback. Starting on September 16th from the tribes. Then we have to have our draft waiver proposal to CMS Honor before September 30th in order to have discussion in advance of getting our official waiver submitted sort of on the clock in the parlance of our discussion with federal colleagues on November twenty ninth to be able to have a renewal in place by March 31st 2020. So busy time lots of discussion we've been working with with our team has been in discussion with several of you who've been providing us some informal feedback. The last official slide before we go into our guidelines here we have their waiver resources that are on slide 13. We encourage all of you to access these and share them with friends and family members because it is a fascinating website Saturday by the pool and a laptop with good Wi-Fi connection. But seriously there are several materials here and we tried to continue to iterate the best of what we're doing and keep everybody on the same page using our website that continues on to Slide 14 where we list some more. A waiver resources very specifically our terms and conditions or quality strategy is there. And then some other more generalized links to see them CMS and Medicaid. And then I'm going to toss it back to my friend Phil to help run us through the public commentary.

Sure. Thanks Greg. So just some framework for public comment today. If you wish to speak please sign up at the registration table just outside the doors. When your number is called please come up to the microphones or if you need a microphone pass for it to you please just raise your hand I'll be happy to bring it over. Comments will be timed. You will have five minutes to speak. Our time keepers here to my left and please return your minutes to the registration desk before you leave. We sometimes we lose some numbers along the way somehow But they're much appreciated. And then finally written comments can be left at the registration desk and we'll be happy to collect them. And if you'd like you can also submit written comments to our BML at eleven fifteen waivers at health dot NY dot gov. Subject in the email that you send should say MRT public comment. Does any questions about the framework of public comment this afternoon before we get started. No. OK. So Greg I believe we have 15 speakers so far signed up so I'll turn over to you.

OK so number one if you're ready you'll lead off.

Good afternoon and thank you to the Department for arranging for this time for us today to give you comment. First let me start by identifying myself. I'm Pastor Kinzer and pointer. I am the pastor of Agape Fellowship Baptist Church. The last time I was here you may have noted I was a member of the board of Millennium collaborative care PPS. I'm one of two PPS' in eight counties in western New York. Since then I don't know if there was any wisdom involved but I am now the chair of the board of Millennium collaborative care. I am in constant prayer about that. I just needed one more thing to do. But I must encourage the department. What you what you have outlined for us as a going forward with regard to a another waiver under eleven fifteen is encouraging. I've had multiple conversations with my brilliant and lovely wife about why there isn't more focus on children as we've been doing DSRIP. And when I get home and report that to her she's going to think I'm some kind of influencer and genius to bring those things forward. So I'd be happy to share that with her. And as a foster adoptive parent I am thrilled that you are also focusing on that area and I will be happy to share that with not just my wife but the nine children that we are parents to four of whom are adopted. And I think it's critical now having said those things and attempting to encourage you. Let me just tell you about a couple of things we are doing that are really important but will not meet the timeline that we currently have for this DSRIP project. We've developed and do a project three projects actually to get community

based organizations ready for the value based prop proposition that becomes critical because we know that every project that we do that looks to impact and change outcomes if you don't have grass roots participation there will be no change. So it becomes critical. We've developed three programs that offer technical assistance to community community based organizations supporting integrated person centered solutions and health outcome improvement directed at participating CBOs that provide direct services related to the social determinants of health. Food, housing, transportation, child care, employment, and education. We're attempting to prepare agency partners to participate in the future and deliver in the future state delivery system with regard to value based payment. Those the objectives are to help them strengthen their internal infrastructure at the operational level to ensure that there is high quality delivery of care that there are improve outcomes and that there is a survival for the CBOs and value based payment in the the operational world of value based payments. We also want to assist those organizations to identify what exactly is their value based proposition and recognize and respond to business opportunities that may arise from it. Finally to ensure organizations are positioned for successful success relating to the BPP roadmap. From the Department. Those three options are have engaged 58 community based organizations. Option 1 is our value base get set readiness program which is a 24 month intensive program based on the Health Foundation for western and central New York. Option two was developed in collaboration with the community partners of western New York and it CBO some self-selecting. And then finally Option 3 is the millennium value based proposition program that lasts for 12 months. We know that we will not complete these processes by 2020. The end of March. We also know that is going to be critical for our health care system that these organizations are in able to participate. So let me thank you for applying for another waiver. Let me encourage you that I believe you're on the right track. I will also cover you in prayer and get you through this. And I will be on the other side waiting to work collaboratively with you. Thank you for listening to my comments today.

Thank you so much.So speaker number two.

How do I follow my board chair. That was great. Al Hammonds executive director, millennium collaborative care I just want to share a couple of things I want to share a promising practice that we're doing. That's part of our innovation program and we provided funding to the community to help us meet the deliverables and the pay for performance measures for measurement year five. And to continue the transformation in in western New York the behavior health population is tremendous and impacts everything that we do. So what we have what we have put together or what the behavior health partners actually have put together with the assistance of the PPS is a behavior health collaborative initiative to help. It's an innovation funding. It's the the behavior health the BHCC value network IPA that involves Horizon Health, spectrum endeavor best self and in the anchor organization is Erie County Medical Center which is the parent hospital of our PPS which houses CPAP and is a Behavior Health Center of Excellence in western New York. All of this is coming together and we are funding this initiative with nearly 2 million dollars across multiple partners. We're looking at driving outcomes through this initiative. There's a Behavior Health After Hours program, a behavior health transportation initiative, and we're also looking at expanding hours in different pockets so we've broken down the whole network in Erie County into various zip code hotspots to make sure that we address the behavior health populations need to address ultimately avoidable hospitalizations. It's already been a success. We're probably only a third of the way through the program. And and I'm very excited to see that program through. To shift gears, I want to talk a little bit about District 2.0. We are part we millennium collaborative care are part of an upstate performing provider PPS collaborative. There's 10 of us upstate PPS' that have met. We

just recently met in Syracuse and we are in a unified way. We have some high level concepts that we'd like to present today. I'm just one of many that will present some of those. One that's really critical is the to encourage purposeful alignment in each region. Inclusive of stakeholders such as health homes behavior health care collaborative is the population health improvement programs of Phipps the coordinate care coordination organizations the CCOs, CBO consortiums, the health systems the larger health systems, the primary care providers and other health care entities relevant all of these entities must come together and we must work together as best we can in a district 2.0. And we've got to figure out how to get the payers along with the PPSs working with all of these other entities that are state driven so we can really make the best impact possible on the Medicaid population. Thank you.

Taking a cue from the reverend here. My apologies to the time he ran at about six minutes or so. Hi. Thank you for the opportunity to come in today. My name is Amy White Stauffer and I'm the director of the project management office for community partners of Western York also known as the Buffalo Sisters of Charity Hospital PPS. I came here to today to tell you that our district PPS is strong. Simply put has been successful in helping its partners and patients understand the changes to the health care system and Medicaid Service Delivery. Our PPS is a collaborative group of about seven hundred primary care providers. Many specialty providers and hospitals over 60 community based organizations just over 80 mental health care providers. There are 14 hospital partners including our lead safety net hospital Sisters of Charity our PPS is locally focused and locally led with its primary safety net hospital proud member of the Catholic health system. We are among the smallest PPS states, PPS teams in the state but we make significant impacts working collaboratively with providers and patients in Erie, Niagara, and Chautauqua Counties. Together we've accomplished a 13 percent reduction in preventable ED visits and a 24 percent reduction in avoidable readmissions. That's through measurement year three. Three hundred and forty providers have achieved patient centered medical home recognitions. We have 10 integrated primary care and behavioral health sites. We initiated two formal nurse family partnership programs and in the last 15 months we have flowed over 2.5 million dollars to a unique provider performance improvement program in behavioral health primary care and OBGYN in that primary care includes pediatric practices. That program aligns with network and provider managed care and quality programs. We've trained 1000 professionals in cultural competency health literacy and additionally we have engaged community based organizational partners otherwise known as CBOs in provider quality programs. These CBOs are now well-positioned to seek further support through provider based managed care risk bearing activities and contracts. We are building trust an energetic energetic engagement in patient centered care transformation. Our PPS and its PML group Catholic medical partners IPA have a respected leadership role both locally and nationally in population health. We are essential to New York state's Medicaid program and your goals around quality and cost management. But this is regardless of the future of 11 15 waiver in our state. We know that this work is important and must continue. Our PMO has extensive experience in managed care contracting including managing upside and downside risk contracts. Additionally the PMO is 20 plus years experience with population health management efforts including working with hospital partners in an accountable care or ACL format. We are efficient and share operations with our largest partner health system Catholic health. We have an emphasis on lean system management and shared administration restorative functions. We also already share data with managed care in the market. Through these efforts community partners is committed to our network's adaptation to the value based world. Nonetheless the reality is that partners with the largest cost risk continue to face ongoing challenges balancing value programs in tandem with a fee for service model that

simply does not cover the cost to serve Medicaid beneficiaries. To continue this transition work provider strategic objectives must be a consideration in the process to adopt change and while collaboration is essential for health care change in any population collaboration will be jeopardized if it means exposing provider or system market advantage. Therefore it is important that committee partners of Western New York PPS team remain aligned with its key provider and hospital networks. This structure is especially important if those providers and networks are expected to support and manage populations with cost risk such as those within a value based payment arrangement. And for this reason and for sustainability to PPS groups need to remain in the Buffalo Niagra region. Historically having two PPS teams working both independently and collaboratively collaboratively has been successful model for our community. At the onset of DSRIP work the teams determine which primary care and hospital partners had significant engagement with each PPS entity. This decision made made early on prevented provider confusion and duplication of effort and for behavioral health and CBO partners. We welcome the collaborative PPS work and shared teams resulting in quality improvement and partner engagement for which we are very proud. As part of future planning new york state should work to maintain patch patient attribution models that support primary care as the most significant driver of patient assignment to the PPS is this attribution ensures community partners is aligned with the networks and systems most responsible for these populations and supports provider Biden to change. Additionally we do know the work of primary care enhancement to behavioral health and substance use disorder screening and treatment is critical for the future of our care redesign work. Ongoing support should be considered for providers who want to collaborate formally and informally between primary care and behavioral health providers who want to combine services need to be assured of an additional program one way for managing different integration levels between PCPs and behavioral health. We recommend more flexibility in project program design for the future district efforts including consideration. This is important of performance projects which are tied to risk bearing contracts between providers their networks and managed care organizations. Finally please just allow me one more moment to speak about our CBO relationships which are critical to patient centered care and must continue. CBOs as we know work in their own neighborhoods representing community interests that are not always well served with in direct care environment. While we've achieved much progress and Care Redesign it feels as if we have just begun. In fact our CBO relationships are blossoming especially in the context of managed care contracting. CBOs are proving their value in a language understood by patients providers and managed care. We know CBOs are a pipeline to services beyond the health system walls. They have programs targeting social determinants of health. But we have more work to do to help them represent their market value to the greater health care system. So with that I'll say thank you for your consideration and my comments today. We are eager to continue our work. This is important work raising the bar on access quality and value for the patients we serve.

Thank you very much. So Speaker four.

I cede one minute of my time to my predecessor.

Thank you.

Therefore I have four minutes. First some feedback for Greg, if you could use short links because it's really hard to type in when you put up the links for Medicaid. Right. The resource link.

We'll put the PowerPoint up to seek out a link from there.

Short short links would be great.

We will consider short links. Thank you.

Thank you. Jacob Ryder CEO of Alliance for Better Health. One of the two PPS in the Capital District of New York State where we all stand at the moment. Since we're approaching the end, you know I thought about how the beginning is all about our ABCs, right. So my comments today not quite you know X Y and Z. It's P Q R S. So the letters of the day are P, Q, R and S. P and I'm mostly commenting about the waiver extension or renewal and what the future might hold. So our request to DOH as you all consider your conversations with CMS we implore you to preserve. That's the first P, preserve what has worked. The infrastructure the people products and processes that we have created. The performance focus and focus on achieving the triple aim and the creation of pull and I'll detour for a moment in our community we talk about creating pull rather than pushing and it's something that we think we need to do with our community with the providers and the community with the CBOs and also the people we serve and we implore you to think about how to create pull rather than push and to continue to preserve our access to data. We think that's an important piece of a successful set of PPS in a network. So that's P. Onto Q. Question the ability of organizations to change who they are and for those of you who witnessed my comments at the payoff meeting about 18 months ago I put up a slide of Serena Williams. Anybody remember that slide? Yeah so my comment about Serena Williams was she's great at what she does but I wouldn't have her do my taxes. I don't believe that we should expect care delivery organizations that have been folks so focused on fee for service to lead the charge toward value based payment. I think it is the job of the PPS' collaborating with those in the community to find change that's going to happen perhaps to our parent organizations and not seek that they be the source of that change in our organization where we're owned by five care delivery organizations and it's I think we have been we the PPS have been the Knights for change rather than allowing them to seek change. Question number two is question assumptions about where we solve the problems. I believe that we're going to solve the problems upstream in the community with community based organizations as the leaders of that change rather than downstream in the hospitals or or even in the primary care practices. I hope I don't lose my family doctor card for that. Onto R. Reduced barriers to true regional collaboration and the geographic overlap of PPS. Perhaps I I differ a little bit with my predecessor Amy for to whom I donated one minute. I don't believe there should be a geographical overlap of PPS'. Geographic overlaps create silos of activity and the cracks through which the most vulnerable are going to fall occur in those silos and reduce the medicalization of social problems. I think we need to address social problems as social problems rather than let them cascade into the medical problems that they will become. And now on to S in my one minute Oh no. Did I take her minute that I gave her. Solve alignment of Behavioral Health and Behavior Health Care Collaborative. Sign. Solve the alignment of PPS and and health plans. We need to work together with them. And it's been hard to do that solve the alignment of PPS and the QEs slash RIOs whatever we call them this week. Solve how to grow the PPS network as a public utility that will serve horizontally in a health system agnostic health plan agnostic manner. Thank you.

Thank you very much.

No pressure to use the alphabet on any other speakers. But that was that was that was engaging. Speaker number five.

Hello good afternoon and thank you for the opportunity speak today. You get two for one here. I'll stay within our five minutes. Hi good afternoon. This is Ben Goldstein from one city health PPS with my colleague here Molly you get two for one. We'll stay within our five minutes but we wanted to speak with you jointly.

Hi Molly Chidester, Chief Strategy Officer with One City health PPS as one of the state's partners in establishing the first district program in New York, One City commends the state for their pursuit of mechanisms to extend the benefits of the original eleven fifteen waiver. We fully support these efforts and pledged to serve as your continued partners in this endeavor. As you refine elements of the extension, we are eager to share learnings from the first district program with you as the PPS for New York City Health and Hospitals the largest public health system in the United States. SUNY Downstate and a network of over 200 community partners. We believe the state should continue to invest in the health of New Yorkers by reforming the current care delivery system and payment system to increase quality and efficiency redesign care around the whole person and reduce health care costs. Having just conducted the community health needs assessment for New York City Health and Hospitals last week we know that there is a lot of work that needs to continue to be done through a collective impact approach. While many alternative payment models have historically relied exclusively on coordination within the walls of the clinic or the hospital. We applaud the state for working to change that standard by establishing a new framework that integrates traditional care providers and community partners in an effort to better address a patient's needs and rethink the system around the community and the patient. We are encouraged that as outlined in the VBP roadmap the state as state is proposing MCOs and providers engage in VBP arrangements that work with a third party partner to identify and secure investments to address social and socioeconomic risks. In addition to new interventions that address social risk factors we know that providing clinical care begins at the front lines and then the patient provider relationship to support the integration of clinical services non-traditional healthcare services and finances. Partnerships should be structured across traditional healthcare providers PPS' CBOs and managed care plans. Since the inception of the district program we have seen a decline in avoidable hospital utilization in our PPS. Improvements in access to care for children and adults and better outcomes for patients living with chronic conditions and behavioral health needs. Significant investments have been made in the workforce leading to higher quality more patient centered care and staff with the necessary skills to build the health care system of the future. Further providers and community based organizations are working together in ways that are unprecedented enabling us to address the community's holistic health needs to ensure partnerships between CBOs, providers, and MCOs are successful under VBP arrangements. We recommend additional time and investment and capacity building for CBOs.

Further we believe that time is required to build out the underlying further time is required to build the underlying infrastructure that will support new models of care including the infrastructure for the timely flow of data between partners. What we want to emphasize is that the infrastructure is just not it's not just technology but it is the people it is the processes it is the relationships and the shared goals. And these took a lot of time to build up over the past few years. And so any disruption any break in continuity would be I think very challenging to rebuild after if there was any sort of break in the program. It wouldn't be starting from scratch but we would definitely lose a lot of time getting to where we are and where we invested to get to. And we have achieved a lot through this time progress to date has been achieved reduced the overall. And transitioning to a system that rewards volume to one that incentivizes high value services to ensure that these beneficial games transform into lasting change. We emphasize the need for more time to maximize and

solidify the transition from the current district program to this future of VPB state that we've been working towards. Without the continuation of the district funding beyond 2020 and the other programs support that goes with it. These advancements in patient care are at risk of not being sustained.

Thank you very much. And thank you for showing the spirit of partnership by consolidating to one five minute block. It was nice of you. So Speaker six.

Looks like I'm holding it. OK thank you. My name is Carol Tagus, executive director of FLPPS the Finger Lakes PPS. Thanks for providing the opportunity to speak today and celebrate our DSRIP 1.0 work and provide insight as the state looks toward DSRIP 2.0. I wanted to highlight some of the great successes we've had over the last four years in the Finger Lakes region to show the depth and breadth of the work that we've done the system transformation work that our partners have done and how we've actually evolved from their initial work. So as you know our PPS is the second largest across the state with 13 counties over 300,000 lives and 10,000 square miles. We organized our work by leveraging existing naturally occurring care patterns in our region and we created five NOCNs, naturally occurring care networks, in order to manage our work. Our district journey got off to a great start with an incredible effort to engage partners in our vast region and build an infrastructure to stand up the projects. I'm proud to say that we accomplished about 99 percent of our project requirements and milestones and our partners have engaged over 340,000 patients through the projects. We took on many challenges as we shifted to focus on clinical outcome metrics. We had a very large network with competing partners as well as data issues related to data state privacy rules and data sharing. Over the last year we adapted we were creative and we determined that what we needed to do was leverage the existing networks that had started to form the existing IPAs the BHCCs a newly formed IPA and health homes to really bring them together and create a North Star for them to work on clinical outcome metrics. And I'm pleased to say based on our partner reporting that we've made some changes improvements in clinical outcome gap closure. So I think the the point is that the PPS is really the only organization in our region that has the capability to bring all of these networks together to work toward common goals in closing clinical outcome gaps. Also you may recall and I think I said this about 18 months ago that we were the only PPS that selected the housing project and we know why because it's so difficult. We did successfully complete that project and we evolve that into a housing pilot. And in this pilot we're connecting Hospitals and homeless shelters to create workflows to ensure that a homeless individual once they are discharged from the E.D. are successfully and safely placed in a shelter with appropriate wraparound services. That's going to take infrastructure building on the shelters part as well. So we've developed that collaboration that needs to take us to the next level from this house housing project the patient activation project, 2DI. We took that to the next level. We developed a community navigation program in which our partners both community and clinical alike are linking people to the services that we need. We're using this program to standardize the role of the community navigator in our region and identify high performing practices. We believe this program has contributed to our reduction in ED visits. Cultural competency and health literacy work stream. We've completed we're completing those requirements very well and we've created a CCHL operation specialist program. We're leveraging the expertise that CBOs have in this space and understanding the population. We funded training for these specialists who are employees of the CBOs themselves and they are going out into our community and training other partners in how to serve the population in a culturally competent manner. We've been successful in our VBP readiness work by implementing a CBOVBP pilot similar to what Millennium has done in partnership with our united way

using the get set model developed by the Health Foundation for western and central New York. We have 15 large CBOs that are working to build capacity for VBP and understanding their value proposition. I'm pleased to say we've had an overwhelming response. The CBOs are lining up to be able to work in this space and we've got eight of these organizations that translated their work into system transformation awards. I also wanted to highlight our max work. We've had four hospitals involved in the max our rapid cycle improvement work focusing on how utilizes one hundred and forty patients across those four hospitals with reductions in utilization of inpatient by 58 percent 86 percent 75 percent and 89 percent incredible of results in our max work. We've got twenty five and a half million dollars allocated to our system transformation projects with over over 70 partners participating with six IDD partners involved in that as well that we're bringing together to work on this practice. We were able to acquire the Greater Rochester Health home network leveraging the notion that care management is central to the district work that we're doing. We do have a plan for sustainability within our PPS. We're going to be continuing to invest in areas that the partners are looking for additional support. We're also going to be building a network for community care coordination. It's really important as Anne said that we get passed now care management and actually coordinate the care managers. I'm really pleased to see that the state is moving forward with district 2.0 application because really, this is about the people and the system will not change until the people change. So appreciate the comments.

Thank you very much. Speaker number seven.

Good afternoon. Lydia Virgil, chief operating officer of SOMOS Community Care. I want to first start out by thanking the state for the DSRIP opportunity because through the district we have been able to bring together the most diverse group of providers ever. We have at almost twenty five hundred providers of different nationalities, mainly immigrant immigrants themselves serving immigrant and vulnerable populations. Forty one percent of our providers are of Chinese descent and speak fluently Mandarin and Cantonese. 46 percent are of Hispanic descent and are fluent in Spanish and the cultures the different Hispanic cultures. But beyond that we our providers also speak Bengali, and Creole French, and Hindi, and Russian, and Urdu. And what is important is not just do they speak the language. It's not even a second language for them. They are of the same culture of the patients which in several studies and including one very special one that's almost itself did in 2018. The state of Latino Health. We found through our surveys that one of the biggest barriers that our patients identify is the lack of a common culture the lack of having providers that speak their language that understand where they're coming from and what their needs are. In the Bronx for instance, 60 percent of the population is Spanish speaking while 10 percent of the providers are Hispanic or Spanish speaking. So through this we've been able to identify and bring forward not just a great amount of cultural competency that will help our people but also we've been able to intervene and provide a much greater level of health literacy to the patients. We have been able to partner with CBOs that will address their social determinants. And one of those being just how to educate them how to navigate the system. How how do they apply for the different benefits. How do they work their way around which as we know New York has a very complex health care system and our patients need help in navigating that. DSRIP has afforded us this the opportunity to not just bring together this vast network of providers of diverse provider types and situations but we've been able to create a verbal succinct patient centered system. We have over 600 practices that are PCMH level three certified that we have been able to bring together and tie together. We have been able to bring about an actual health information exchange with centralized I.T. supports providing our program our providers with a connectivity to the real which they in being independent

providers were not capable of doing on their own. We have been able to bring together we have been able to help them connect with event notifications being able to ensure that their patients receive more timely care. When we speak about for instance hospital readmissions SOMOS has been able to through this connectivity through the partnerships with the hospital we have been able to make a very big dent in the hospital readmissions amongst our population. We have been able to engage and provide screenings and care through five hundred forty seven thousand patients engaged in the Behavioral Health Project itself doing screenings not just the PHQ2s and nines but also as we spoke today with the alcohol use and with the drug use. We have been able to reach out to that many people and provide better care. We've been able to implement throughout our twenty five hundred providers the New York State prevention agenda. We have a very successful smoking cessation project which starts at the providers office with identifying through the five ways of identifying the need for tobacco cessation. We've been able to increase in accordance with the New York State prevention agenda the vaccination rates including HPV vaccinations which have been difficult otherwise to be able to administer to many young patients that need it. We've been able to increase our cancer screenings and our HIV screenings. Our providers are at a great level now with the help of the district program where we have been placed a special focus on the district requirement of financial sustainability and we have prepared our providers for value based payments where they are now putting the emphasis on the quality of the care they're giving the patients and not the amounts of visits but making sure that every visit counts that every visit is a successful one. And in doing so we have been able to be one of New York State's pilot programs for value based payment. We are now at our innovator level which is a level three value based payment with taking risk. So I am going to leave it at that and thank you very much.

Thank you so much. Speaker number eight.

Good afternoon. For the record. My name is Ricardo Rivera Cardona. I am the chief business development officer for SOMOS community care and the former Medicaid director for Puerto Rico for four years. So with that lens I'm going to give some views on DSRIP and the future. One. One of the things that in my mind is very important and I'm and I think Lydia covered what we have done so I'm going to be more focused on. What is next. And one of the most important things a in in this journey because he has been a very long journey is sustainability. And I'm very glad when I heard a Greg say that the Department of Health is thinking about extending DSRIP and also with emphasis in the VBP portion. And to make sure that we bring the managed care organizations the MCOs in a more active role and co-operative role in this process. Five years is a very short time when you are doing such a big transformation as New York a is trying to do. So one of the things I'm on all the infrastructure that we have built in incorporating all these 2500 providers into their future is that they the entire infrastructure the operation is very hungry for data and data sharing is one of the challenges. Looking into the future and making sure and I'm not pointing at anybody's I'm not pointing my finger to anybody and I'm going to speak in general terms. There are so many CBOs are very cooperative. They are other MCOs that well they are. They have a resistance to change. Nevertheless in general terms and I'm being diplomatic here. But in general terms that they are chairing in my mind has two prongs. One is the structure right. The how that data is going to be shared. There's many MCOs and they are. And they are. And if we are going to have data from each of the MCOs or let me put it this way. Each MCO has their own layout of files their own systems. So for providers system to capture that one operation or one program for example the pilot program for us it turned out to be six different operations because even though it was the same program the rules of engagement with each of the MCOs were different. The data I shared was different. Different formats. So that pose a challenge. So more guidance into

how that data is going to be shared is important and the other thing is that resistance to share data. We were often especially in the innovation negotiations. There is a challenge in their sharing of data. You are trying to manage risk and you have to make sure that you have all the data your hands in order to make conscious choices. But in some cases their resistance to share that data even though they are our patients is because there's confidentiality there's confidentiality and all their issues are brought up. And I think that guidance as well I mean if we are going to negotiate and we are going to look into each other's eyes we have to have the same data and come to terms into the different agreements. And it has to be transparent. And the second thing that we need to have in consideration is that when you are talking to an entity and you are saying as part of the innovation program you are you are telling them OK the guideline is that depending the administrative functions that we are going to a be in charge of then you letting go 90 to 95 percent of their premium is a challenge financially from the MCO standpoint. So there are some MCOs that are reluctant to give away or they are resistant to give away a that amount of the premium because if your MLR is under 85 percent then there's a lot of profits that they are letting go by by giving the providers the opportunity to share that risk. So in conclusion I think that it is and we are in the right direction in extending DSRIP. I think that we need to a everything that we have built for four five years. We have to make sure that we keep it in a sustainable way. But as we move forward let's make sure that we have very clear guidance on how to bring that MCOs to the table and make sure that that those conversations are extremely transparent and extremely over the table. So the beneficiary of all that is our patients and our communities. Thank you.

Thank you very much. Speaker number nine.

Good afternoon. Dr. Perrello and I will be sharing our five minutes of fame. We would like to thank everyone that was involved in developing the DSRIP program. Since we believe as primary care providers in communities of with underserved patients. Value based payment has been a blessing for us because now as providers we can concentrate on providing high quality care to our patients and not be concerned about cutting cutting corners to try to see 50 or 60 patients a day. All our group now can concentrate on providing the highest quality of care. And we know that the best way to get paid is by what you offer to our patients. So we think that value based payment has been the best thing that has happened to medicine. Thank you.

Good afternoon. My name is Dr. Robert Parello. I've known Dr. For about 25 years. But I started working with him seven years ago. Our pediatric practice is in a poor section of New York City. We are members of the SOMOS PPS. Our patients are about 95 percent Medicaid and because of the district program SOMOS has helped us transform our clinical practice. It helped us become a patient center medical home level 3 which is probably one of the highest destination for for a doctor. We we are providing the highest quality of care to the most vulnerable sectors of society. With SOMOS help we are practicing. With SOMOS help there's more emphasis on prevention of disease both physical and mental. We practice evidence based medicine that will ultimately reduce the costs of giving care. We are also providing the highest quality of care which should result in positive outcome for our patients. Doing all of this costs money. Reimbursement for the primary care doctor especially pediatrician have remained stagnant for about 10 or 15 years. Our costs of living especially in New York City where renting a little office space cost tens of thousands of dollars. I could say 25 30 thousand dollars is really a financial burden especially when our patients are poor patients and like I said we take care of Medicaid patients which is about 95 percent of our practice. The district program has

helped us absorb some of this expenses and without that extra money that we've received from the district program it will put a financial burden on our small business. Thank you.

Thank you very much. Again thanks for the sharing and uh speaker slot 10.

Thank you. I am speaker slot 10. My name is Victor Peralta. I am a pediatrician in Queens New York. I have to thank you for clearing up a misconception that I had walking in today as I was invited to come in and comment. And it's that I thought I was talking to people who needed to be convinced that DSRIP had to be continued. I see from your previous presentation on the slides that the efforts are already underway and the plans are in place to try to keep DSRIP going. So. I wanted to use my few minutes to talk for my patients. They can't be here but when you're involved in managing these kind of programs you can I guess get lose your sight of what is really important and why we're doing this. If we can look through the jungle of acronyms through the years I've been in practice for 35 years in Queens and I was there before there was p pack when the physicians were getting paid seven dollars to see a patient and they had to see a lot of patients to be able to make it. And I'm seeing I'm saying seeing patients not taking care of or providing good care for patients because it was not possible. Over this 35 years I've seen programs come and go. I've seen different ways of trying to fix the problem of health care in New York State. This is the first time in this first in the last four years that I see that I have hope in what is happening because I see what DSRIP has done has begun to do for the health of our patients, and I can see what it could become for the health of our patients. It would be a shame to lose this just when it started to make a difference. I want to thank you for the opportunity to talk to you. And please continue with your efforts to try to extend the DSRIP program. Thank you.

Thank you very much. Thanks Rose. Thanks for thosw thirty five years in Queens. Appreciate that. So Speaker number 11.

Good afternoon everybody. Good to see you guys. My name is Mark Rowe Pecky I'm the executive director of the care company network PPS and I've been there since the early part of 2015. So since the very beginning of when the DSRIP program kicked off and I'd like to thank state team today for sticking around and listening to the comments and for everything that you guys have done as well as some of the payout members that I know of made their way into the into the chairs here and Jason and team for all the data that you guys have done has been really tremendous. I'm going to speak to you guys today on two things that I'd like to present and one of them is a little bit about our journey of the DSRIP program and a little bit about what the upstate PPS' have started to see and notice and we would recommend on a DSRIP 2.0 extension. And the reality is this started on these isolated projects and we are looking at how do we get these things off the ground how do we put these out into practice and a lot of what we're seeing today is the result of the measurement of those projects and also some innovation programs that we've made along the way. And I won't go into all the details I think Greg slides earlier today do a lot to show about the progress and the results that we've seen thus far but what we're starting to see is what started off on programs and getting some of these little initiatives I'll call them off the ground although some of them were a big headache we've started to see in the culture of our community shift we've started to see collaboration not just around how to do individual projects but how can we think differently as a community. And that's really been the biggest potent piece of DSRIP is that so far the early few years was really formative and building and getting the infrastructure together to do the DSRIP program. And now we've started to do is tie that together so that we can really start to see how the collaborative nature of the PPS is working their communities together can start to add

value and some of those slides really showed how we're starting to see some of that result. Now what we have behind me the upstate PPS executive directors as many of them have already spoken have come together and really looked at what is it that we've seen. What is it that we've noticed that we've been in a unique position of trying to administrate the DSRIP program in each of our regions. And there's a series of best practices that we've identified and I wanted to share some of those with you today. And one of them really is the purposeful alignment of the PPS' with the regional stakeholders and that's been a critical success factor to DSRIP 1 and has to be a part of what we consider for DSRIP 2.0 and that includes all of the different regional stakeholders not just the providers and the CBOs and the health systems and the hospitals but also all of these other entities that are out there and I will emphasize the payers, the MCOs as well as the health home's Behavioral Health Collaboratives, the Phipps the CCOs and the like. Again to reiterate some of the comments that were made earlier the data is really key. We're finding ourselves helping organizations that have never built baselines determined baselines and I'm speaking about some of our CBO partners and also helping to support how to build partnerships between them and our health systems and the need for that data is really really really critical especially the gap here. So the need for that plan and health system helping to support PPS with data exchange is really critical. And also to support the ability for us to receive quality reporting transparency and expenditures and also service utilization. If I had to pick one of the programs that stood out to me from the first round of DSRIP so far it would really be the max program and a lot of the projects were identified to fill gaps but really from a robust standpoint the max program allowed us to get to the workflow level like very easily and that was really a well executed program. And if the state had to have a method by which different initiatives and efforts were rolled out in DSRIP 2 I think the max playbook would suit itself very well. At Care Compass we liked it so much we kind of took it and created our own program off of it called the cohort management program. I won't go into all those right now. There's another effort that we really identified and it's the continuation to remove barriers imposed by health care regulations that may unintentionally limit care coordination and accessibility to the right care at the right time. The state that a lot of this with the waivers that came out in the first round we do think that there's more that can be done but continuing the effort on this front is really critical to our ability to innovate under the 11 15 waiver. And lastly I'll share with you to insure flexibility to pursue future federal and state initiatives that align with DSRIP 2.0 goals and its objectives. We thank you so much for the opportunity to comment and for having us here today.

Thank you very much. So now we're on the speaker 12.

Good afternoon. I'm looking for my support group. Apparently it's not there.

It's all of us.

All right. Thank you very much. I appreciate the opportunity to speak to you today. Can anybody hear me now. I appreciate the opportunity to speak today. My name's Walt Priest and I'm the president of Family Health Network and I'm here today to represent Care Compass network and to add a few comments and I'm going to work very hard to stay within my time lines. I'm also going to work hard not to repeat things that Mark has already said or that Catherine who follows me is going to be saying personally because I respect them so much and personally because I didn't drive I'm riding in their car so I have to be nice. I am proud to be here and I am proud to represent care compass network. If you're not familiar with care compass it is a large geographic area much like flips it covers about one eighth of New York State which is about twelve point five percent my global reason for

being there is first of all to add my voice to the cacophony of voices that have already been heard about pursuing the DSRIP 2.0. It would truly be tragic if at this point all the work that's gone into creating the networks the infrastructure and and the other aspects of this trip were Truncated and we'd manage somehow to snatch defeat from the jaws of victory. I'm thrilled to death that we're looking to do 2.0. Having said that I would like to make a couple of comments. First of all I'd like to talk about some of the innovative things done by CCN then meander off on the social determinants and finally talk about pair engagement real briefly. In terms of care compass network, One of the issues we have are called cohorts and they are small networking groups that includes the value lead. Tier 1 CBO referral source and another member with a minimum of four and FHNs involved in 3 at this point one is on obesity and diabetes. Another one is on congestive heart failure and heart disease and the third one is on behavioral health interventions including taking a look not only assessment treatment but also looking at hospice taking a look at home care etc. Members that are make up these cohorts at least in the ones we're in. Include the hospitals county mental health hospice YWCA Liberty Resources Catholic charities and others. Within CCN, we currently have 18 cohorts and there's over 80 organizations that are part of that initiative. One of one of the initiatives tied to the efforts from DSRIP although not directly so but I consider an offshoot is it currently an investigation into social determinants. We're thrilled to be part of that and specifically its impact of social determinants and interventions by rural providers. And that is consists of a group of providers. 8 Separate pilot programs and is really taking a look at the efficacy and the return on investment for social determinants. I'm not sure if everybody saw the article it was in the New York Times in May. It was fairly short but it made the point that the U.S. currently spends 17 percent of the Gross Domestic Product on health care. Other countries right now ever drawn 9 percent. And part of the reason for that. Then reference makes the article makes reference to it is because of the social turbulence support that is so much more prevalent in other countries. There are two studies one in Los Angeles and one in Chicago that have implemented social determines intervention. Currently those studies are yielding results such as 75 percent cost reduction in in patient stays in the 20 percent overall cost reduction. So the impact cannot be understated. By length I did want to mention the pairs. Derek mentioned the pairs are related to the pairs. Family Health Network has three value based agreements currently. We have two throw our Upstate IPA in one singular and we're pleased to have those but there are some challenges I'd like to bring up. One typical contracts are constructed around clinical measures that are picked either he just one car or car car and those typically pick clinical measures that the payer is looking for. They aren't necessarily the measures that are going to have the greatest impact. That's tied into a threshold that then as you're doing your contracts in order to qualify for any shared savings typically you have to get 50 to 60 percent to initiate those shared savings where the difficulty lies is the provider can make substantial changes and change the outcomes for a great many individuals. But if they don't hit the necessary thresholds the savings which can accrue to the pair stay with the pair they don't necessarily come back. And I've seen and I also serve on Concordia which is a super CIN and I'm finishing up very quickly and ECPO which is a county physician organization, and I can tell you from personal experience we've had quite a few contracting entities work with us or come in and make pitches that have novel approaches that I would encourage the state to take a look and because once the pair some players can really become engaged get the providers involved. I think you see a completely different level of involvement. Thank you very much.

Thank you very much. We're on to speak speaker 13.

Good afternoon My name is Kathy Conerton. I'm the CEO of Our Lady of Lourdes in Binghamton New York a health care system and I'm also the chairperson for care compass network in the southern tier. I'm here today to say thank you very much for your fortitude to keep moving forward and to request the next waiver extension and if there was ever a time Peggy and Greg and others that we need your leadership and your leverage it's now. And why is it so important? My lens is one of a CEO of a hospital that last year did 58 million dollars in cure the poor. But I also recognize every time I read our community health index that our health index is not getting better in upstate New York. If you look at the Robert Wood Johnson index you would say we have a long way to go. DSRIP is the hope at the end of that for us. DSRIP has enabled us to understand that clinical care isn't going to lead and solve the issue without having an approach around social determinants health care systems across our state can continue to spend a lot of money but we won't change that Health Index it's the community based organizations that are partnering with us today that are leading that way and helping us to understand that there's much more than clinical care if we're ever going to really approaches in a meaningful way. The other piece to that that's important that hasn't necessarily been talked about today but at least in our health system is important is that we've taken cohort management and combining community based organizations in our clinical practices to our practices where our residents are, and family practice and internal medicine residents need time to understand with this changing health care paradigm is coming to. We're bringing in new agencies that act different than us that provide services that we don't understand and we don't know how to run but they're seeing firsthand that they're a critical partner and making sure that the clinical approach can actually be carried out. So it's important to continue this not just for the health systems as it exists today but for future doctors and providers of tomorrow but to be meaningful in this new world and in the next round of DSRIPt 2.0 because for most of us we're assuming you're going to get there. But when we do get there we need help with some things and here's the things that I think we need to focus on. One we still don't have anything meaningful around antitrust and what that means in terms of guidance. So we are asking that there be time spent with the FTC and New York State Department of Health to really understand what that what that means and how far we can go If collaboration is going to be meaningful then we've got to get some real guidance around it and we've got to have some leeway to enter into areas that we have been precluded from in the past. Second and it's been said many times today I meet with payers many many times during the course of a month and they all acknowledge that social determinants are terrible and that it's going to take a lot to get around it but not one is putting their hand in their pocket to help us solve it. They look at us and they can encourage us to keep moving forward and they're grateful for DSRIP. But we've need your leverage to get them to the table to bring not just monetary resources but to bring data resources. Secondly we're, Thirdly, excuse me we're just starting to understand social determinants we need to understand how to measure it effectively we need to think about standardization guidelines that will help us so that we all don't go off into our own way of doing it and then find at the end we can't aggregate data in a meaningful way. We also need time and energy spent around accelerating best practices and understanding what those best practices are across the state. We also need time in understanding capacity of our community based organizations that want to partner with us and how we can really bring meaningful speed and scale to social determinant mitigation to make value based purchasing a reality and successful for us. And lastly and somewhat importantly we also need access into statewide data about how many state agencies or government agencies individual patients interact with on a daily basis. There states around the country that are starting to risk adjust Medicaid according to how many age government agencies a patient has contact with. As that starts to tell us a story about their risk adjustment score. We are just learning this. We don't have the tools yet to bake this into our everyday fabric so we need your

continued leadership and we thank you for your leadership in taking this waiver on but there is much to be learned much to be done and still a lot of data to understand before we can cry victory. So thank you for your time today.

Thank you very much. I think we're getting there. Speaker 14.

Hi. I don't have formal remarks as everybody else has. My name is Judy Weschler and I am a member although certainly not speaking for them of the state project approval and oversight panel and. Or some of my thought about this came in talking to Lara Castle who's here another member of the pay up. I was raising concerns that starting from the very beginning the PPS' were able to choose which of the issues they were going to work on allegedly based on community needs assessment. But. From our perspective not always. So that for example. The African-American maternal mortality rate is something that people were working on and there's a phenomenal anthropological study from 25 years ago looking at African-American women in Central Harlem and in with children or child rearing and lots of good information from that could have been used but it wasn't a medical documented. So it was not it has not been incorporated. And finally now and probably there were other examples too. Twenty five years later there's we look at that issue and not just from a medical model. As Lara said maybe at the end and I hope I'm quoting her correctly there could be a community survey or community interviews and evaluation of what has happened. In the five year interim and looking at what was chosen initially and what were the outcomes and I think it's great idea that they were a lot of other wonderful ideas that were not getting placed on the table but need to be. I donated my files and papers to Columbia School of Public Health for their archives and have I don't know if it's pleasurable but somewhat enjoyed going and visiting my documents and looking through stuff and remembering stuff and I know we shouldn't just be looking backward but there are some times in the history of the state where there's some really wonderful things from my perspective have happened and, in particular, David Axelrod was the commissioner of health, and Mario Cuomo. Daddy was the governor. And there were some really wonderful work between the department providers and community based organizations and some programs that came out of that. And I don't see that happening now. Maybe I just don't know about it but I I think I do and I don't see it happening I just want to recommend that we think about doing that and some of the issues, I know we worked on. Were DOGs and how to protect patients and communities. Discharge planning prenatal care programs in the state and so on and so forth. And it was done as a joint venture not as being told what should happen and that we should support it and then become part of it after the fact. And so I would like to recommend that as we move to, and I know people here have heard me on this, DSRIP 2 that if it's going to happen that it happen differently than DSRIP 1 did and that we not just build on what's there but take the good things that are there and perhaps think about how it could be built differently. Particularly if we're serious we are really reaching what I call at risk populations. So. And I know that Donna and Peggy have heard me on this that there needs to be discussion and funding for CBOs to make sure that their thoughts and their experiences are built into what ever gets built and is maintained. So as I said these are just fragments because I hadn't planned in advance but it just there were just a couple of things that I wanted to put on the table and the pay up agenda was packed good. So there wasn't time to raise these issues and hopefully instead of just coming here and talking in a public session there will be meetings and discussions where not me but lots of people sit down and really come up with very creative ideas. So thank you for this opportunity.

Thank you very much. Speaker 15.

Hi my name is Swanpin Sun. I'm the director of health services at the committee service society and I would like to thank the Department of Health for the opportunity to throw out these comments. For over two decades CSS has worked in partnership with the Department of Health to build capacity in nearly 100 community based organizations to ensure that consumers are able to find and use quality healthcare. Our role in this network network has included technical assistance capacity building and planning for sustainability. Today I would like to center my comments around the role of CBOs in addressing social determinants of health. As part of this group and they need to make further investments in building their capacity to succeed in value based based in a value based payment environment. It has been demonstrated that social determinants significantly contribute to avoidable illness and premature death. Yes I believe that CBO is our best position to help the health care deliberations system address also eminence because they provide vital social support services and often reach the hardest to reach communities. To this to this end CSS recently work closely with our colleagues from one city health to increase CBO engagement and readiness to participate in value based purchasing agreements. Through this partnership we had the opportunity to assess the capacity of 50 to 1 city halls to be your partners through an organizational assessment followed by a Learning Collaborative Program. And we like to thank the one city health team for having the foresight to partner with us on this project. Our work with one city helped lead us to believe that New York state should consider renewing the DSRIP program to better address suggested social detriments of health through direct funding of CBO projects and capacity building. North Carolina's eleven fifteen Medicaid Waiver recently approved by CMS could serve as a model for the CBO program. As part of this waiver CMS has approved 650 million healthy opportunities pilot program to address social determinates of mental health. 100 million of which will be allocated for capacity building of services providers including CBOs and social service agencies. DSRIP 2.0 represents an important opportunity to build capacity in well place a small and mid-sized non Medicaid building CBOs who are best positioned to meaningfully build trust in vulnerable populations who are most affected by social determinants. Our work indicates that New York State CBOs like those in North Carolina would benefit from a dedicated stream of funding to build capacity in the following three areas. First of all New York should consider creating a technical assistance program to focus on building business acumen and the capacities needed for CBOs to successfully partner with the healthcare sector in the environment. Most CBOs who completed their one city health assessment reported struggling in the areas around market analysis marketing prospecting building an evidence base for services pricing and demonstrating return on investment. New York State this waiver should provide financial support to establish a regional peer lending communities that would offer technical assistance and capacity building in these areas. Second the state should consider allocating capital funding and technical support for I.T. systems to track processes and outcome data. The one city health readiness assessment validated they believe that CEOs need additional capital and technical support, develope I.T. systems that track outcomes and interact with the healthcare providers and payers that assesment revealed that many of the smaller and non Medicaid billing CBOs need help implementing basic I.T. and data entry systems to collect share and manage data for programmatic and reporting purposes. The new DSRIP waivers should provide dedicated capital funding for CBOs to build a uniform I.D. system that can monitor and track the CBO efforts to help their Health Care Partners address those determinates and our health objectives. Finally the state should consider encouraging and funding former CBO partnerships as part of a continuation of DSRIP. New DSRIP waivers should support formal partnerships among CBOs to reduce administrative burden and provide contracting support as they enter into BP contracts with MCOs. CBOs indicate that it will be easier for contracting purposes for health partners to deal with networks of providers and it would make evaluations more likely to produce

enough data to capture meaningful results. CBO network model could provide services for the CBOs who need help negotiating agreements collecting and aggregating data and managing the legal and administrative burdens that participate in such big BP projects might require. Thank you for considering our comments.

Thank you very much. Speaker 16.

That is I. Good afternoon. I'm Lori Cole from the New York State Council for Community Behavioral Health Care. Thank you for the opportunity to be here today and to share with you some of our comments which I've also written down for the record. I'm gonna vary from the topic today and I'm going to talk a little bit about the Medicaid managed care implementation for behavioral health clients around the state. We have had certainly an interesting ride in terms of the activities and the and the the the availability of opportunities to work constructively with the MCOs and the behavioral health organizations that represent them. And we have certainly had our problems in terms of payment and claims denials across the system beginning in late 2015 and the first time I spoke to the Department about these matters was in February of 2016 it's now 2019. And recently the department took some steps to address MCOs that are failing to surveil and monitor and address their BHOS that are not paying claims in a timely way at or and or denying claims in an almost wholesale way. There have been inappropriate denials of claims that negatively impact access to and continuity of care use of prohibited clauses and some MCO contracts failure by some MCOs to adequately oversee and address BHO failure to perform. Failure by the state to systematically address high rates of denials of claims from the beginning of the Carvin until recently December 2018 and failure by Department of Financial Services to respond in a timely manner to prompt pay complaints. All of this to say that it certainly wasn't a perfect implementation and we know that the department and Ohip are working hard to resolve these issues but we have some recommendations about how to improve the process for new carbons coming online shortly and they would include that the state should reconsider current Medicaid managed care models in which BHO can act on behalf of MCOs to pay claims. The state should formalize and strengthen its readiness assessment process of all BHOs and MCOs for implementation of a carvin of any special special population. State agency leaders the Department of Budget and the executive should reassess current staffing levels at the Department of Health and Department of Financial Services to ensure adequate staffing is available to perform substantial surveillance monitoring and enforcement activities. When a health plan breaks the law state penalties should be swift and should impact the financial bottom line of the plan as we believe this is the only way to really get their attention. And finally BHOs like Beacon health options who now have a significant history of failure to pay claims on time or in full should be should not be permitted to continue to participate in current or future carvins for a period of no less than three years. And finally this is my real finally. When the attorney general's office issues an enforcement against a BHO or MCO shortly before Carvin begins of a special population population for which that same BHO has significant responsibilities the BHO should not be permitted to enter into the newly carved in market for a minimum of two years. I don't know where I am on time but I'm going to very briefly just discuss DSRIP and say that we are very supportive of DSRIP continuing. We are very anxious to see a different process lead to increased and improved outcomes. We think there needs to be a greater level of transparency in the deliberations around the model for DSRIP 2.0 and we also believe that the community based health sector should have a more meaningful part and role in in in DSRIP both in terms of the activities that they perform the outcomes that they create as well as the payments that they receive. And finally with regards to the state's value based payment initiative. Recent reports at the at the value based payment workgroup table have indicated that the majority if not all of the

actually all of the 53 contracts that at the as of May 10th were approved by the department were total cost of care general population contracts and these are contracts where behavioral health and other specialty populations are swept into general population contracts with little to no. In some cases quality metrics that that follow them. I know that the state is working on this and we believe in you we believe that this will be better but for the for the moment it should be noted that there is no significant meaningful participation by behavioral health and other community based organizations in value based payment at this time. Thank you for your opportunity to speak to you today.

Thank you very much. So here's where I run out of. Do we know if we have more speakers. Did anyone suddenly get a 17.

Feel free to approach the podium.

Hi I'm Anne Monroe. I'm co-chair of the pay up resident of western New York and I wanted to take the opportunity to talk about two specific things. First of all I think the demographics of New York state are changing and we're getting older. We're one of the older states in the nation particularly in upstate New York and many of the participants in Medicaid activities today will be duly eligible tomorrow. And I appreciate that Medicare is the primary payer for older people. But I think to not have them in the mix of what we're talking about really runs the risk of not being prepared in a sustainable thoughtful way for long term impact with the population. The other kind of special population and someone alluded to it earlier today are individuals with intellectual and developmental disabilities. You know it's pretty amazing to me that HERSA on the national level does not look at that population as a special population. If you are looking to create a federally qualified health center yet we know that their needs and the time that it takes to care for them appropriately goes far beyond what a regular primary care setting can provide within the payment structure that we have. So I do think just as it's an opportunity to demonstrate promising practices it's an opportunity to demonstrate outreach to new and to this point relatively neglected populations take all of these great ideas and apply them more broadly than they have. My second point it's a little bit the reverse. As we look at doing all the best practices and. Looking at new populations what is it we're not going to be doing. And I think that will become just as important because if what what you're looking for from the PPS as we've heard from today is everything they've been doing plus more I think you will burn out their capacity and sub optimize their ability to impact the metrics that we have. There is a very small intervention that's used that's called GROSS and I don't know who that guy was who had SPRL or whatever but this is GROSS which stands for get rid of the stupid stuff. And I think there needs to be some attention to that. If we polled all the people who came here today and said Give me two stupid things that you do that you don't think add any value I believe we'd get a fine list of things that would be you know low hanging fruit that could easily be eliminated and aave time, energy and effort. So I really think while you are designing and thinking about and hearing from people about what we should be doing I would encourage you to also be thinking about what perhaps have we learned is just not useful and therefore it should be moved out of the process. Thank you.

Thank you very much.

Loud claps from people with a couple of stupid ideas to suggest for dropping probably.

Stupid stuff.

So I believe we have one more speaker. Welcome Speaker 18 which I believe concludes.

So does that mean I don't have a five minute time limit.

It means you have high pressure to bring us home strong.

All right. Well I first want to thank everyone for allowing us the opportunity to comment. My name is B.J. Hannigan. I am the director of communications at the Center New York Care Collaborative. I'm being joined here by our Interim Executive Director Kathy Homkey. Kathy has been with us since January. She has been. She's hit the ground running working very closely with both our staff and our governance and getting up to speed and she's allowed me the opportunity here just to tell you a little bit about some of the things that are happening at the Central New Care Collaborative so to get right into it. I want to reiterate something that we've been hearing quite a bit from some especially our upstate PPS partners about the importance of the work that is taking place up to this point and the need to continue that work through the extension of the DSRIP program. Kathy in addition to working very closely with us has been working very closely with the upstate collaborative and all of the executive directors of the 10 PPS' upstate in making sure that we forge a strategic direction to help inform this renewal of the DSRIP program. And what I want to do is to spend a few minutes and talk just a little bit about from this CNYCC lens how the DSRIP program has had really a tremendous impact. So just to tell you a little bit about our particular PPS we have one hundred and thirty partner organizations that we work very close with. We cover six counties in central New York. We have over 2000 health care and community based providers that are working with us through the DSRIP program. And in addition to that, we really focused on very several strategic focus areas for our entire PPS network. I'm going to touch on just a couple of those here very briefly. We've partnered with four of our central York hospitals on the Medicaid exchange accelerated exchange program excuse me the Max series. Those four hospitals are St. Joseph's Krauss upstate University in Rome hospital. So three of our four largest health care providers in the region have participated in the MAX program and Rome is one of our rural hospitals that also participated. And I can tell you just from working closely with each of those organizations individually the impact that the max has had on their high utilize our population. But even more so than that to see those four institutions kind of work collaboratively towards looking at the patients that they all share maybe that have been utilizing the emergency department and in a less than effective manner has been fantastic. They're sharing best practices amongst each other. And if you know anything about the history of some of the health care organizations in upstate that is a huge win for us to say the least and Rome hospital. In itself through the max series was able to reduce their admissions and readmissions by 56 percent by their high utilizes and a very small window of time. So we're talking about 8 to 12 months being able to reduce that population by 56 percent. We also worked very closely with some of our organizations on expanding behavioral health services so including things like the work that we did in our three I project which was the integration of primary care and behavioral health. We were able to successfully integrate 16 practices with both primary care and behavioral health. And I'll talk about one of those in here in a few minutes more specifically. We've also been able to expand our behavioral health crisis services through our three A I project as well including things like mobile crisis units expanding services for existing mobile crisis creating new mobile crisis teams but then also being able to develop programs where we offer peer respite programs as well. That has really had a tremendous impact on our region as well as we've been able to reduce avoidable behavioral health emergency department visits by about twenty three point four percent since the beginning of the DSRIP program. So certainly a significant number of patients that have been impacted by that. Our region has also been able to work very closely with several partner organizations for PCMH

recognition. So we currently have 16 organizations that have 2014 PCMH recognition because of the efforts of the district program. We have staff that work very closely with each of these organization and making sure that they understand the training that's needed and the requirements. And while 16 sites may not sound like a lot that equates to about 380 individual providers over the course of the DSRIP program and then we've also worked very closely in trying to help our partners prepare for value based payment. So in addition to providing funding to our clinical partners to develop the infrastructure needed for VDP we're also very excited about the work that we're currently doing with our CBO partners. So we're offering not only funding for CBO partners but technical assistance and resources and training. To help them not only assess their value and come up with a value proposition but look at both strategic planning and implementation efforts as well as working very closely with systems to be able to develop downstream relationships for value based payment. So anecdotally I mean those are all the numbers that I think are very very impressive and speak to the need to continue the DSRIP program. But I'd like to end on a more personal note. I recently had an opportunity to work very closely with one of our partners Mohawk Valley Health Systems out in Utica and they talked a lot about their integrated primary care behavioral health programs. And while I only named 15 agencies and VHS was one of those 15 15 agencies and they actually only had they actually had 16 separate sites under their organization that had some type of integration efforts that are taking place. And one of the things that one of the providers talked to me about during our interviews were in years past they would have someone who was presenting with some type of behavioral health episode and wouldn't even want to continue to go down the path of trying to figure out what was taking place with that individual because there was nothing in his words there's nothing I could do about it. So why even diagnosis why go down that road. And because of the DSRIP program not only do they now have a solution for those folks but they're working very closely with experts in the field to be able to provide and deliver care at a very efficient manner. So thank you for your time and let's continue this district 2.0. Thank you.

Well thank you. Does that close our slotted speakers, Phil?

I believe that concludes our speakers.

OK. I just want to thank everybody for your time and attention attending. Thank everybody who provided comments and to those all of you who have been listening. Thank you very much and have a great rest of your afternoon maybe seek sunshine would be a good order. Thanks Rick. We'll close the session now.