



AVillage..., Inc.

3 Lincoln Sq.
Albany, NY 12202

... working to enrich, educate, and empower ... our communities

DSRIP Administration
New York State Health Department

February 11, 2015

To Whom It May Concern,

AVillage..., Inc., a grass roots community organization in the South End of Albany, are concerned that there has not been adequate opportunity for comment for residents of the South End of Albany and other low-income, severely impacted neighborhoods that are the focus of the current needs assessments by the two PPS providers that serve our areas, or even to fully comprehend the broad impact of the DSRIP process. There has been extremely limited public outreach by either Albany Medical Center or Ellis Medicine/St. Peter's Health Partners. The documents show that the process itself has been almost entirely governed by top-level management at the health care institutions.

We are requesting a new community outreach process that would enable neighborhood residents, the community organizations that serve us and our local governments first to become educated about this dramatic new approach to community health, and then to participate in meaningful planning on community-based approaches to improving health and wellness in our communities.

While the following agencies all have long standing relationships in the South End and are actively engaged in improving the health and well being of the residents of the South End, they were neither consulted nor invited to participate in the needs assessment or planning process. They include Trinity Alliance, the South End Improvement Corp., the South End Neighborhood Association, AVillage..., Inc., The Albany City Mission, Salvation Army, the South End Community Outreach Center, Peter Young Industries and the Altamont Programs, Albany Housing Authority, Cathedral Outreach Center and St. John's/St. Ann's Outreach Center.

Failure to include them in the planning process to improve the health of the community will not yield the expected healthcare outcomes to reduce hospitalization or emergency room utilization rates, nor provide the anticipated Medicaid savings in the future.

As noted in the Community Assessment reports, there are many issues and barriers that contribute to poor health in our neighborhood. They do not all lend themselves to traditional health care solutions. At a minimum, the planning process for low-income neighborhoods should consider enhanced community-based outreach, more coordination of services and case management, access to healthy food and improved infrastructure to accommodate programs for health and fitness.

After reviewing the documents and needs assessments, it is clear that the existing assets, initiatives and strengths of our community were not considered in this process. We have strong community organizations. As you may know, the new Capital South Campus Center has attracted many professionals and offerings coming from regional universities and businesses. The new Albany County Land Bank will start to address our blighted housing stock and vacant land and engage residents in planning for their future. Community organizations have already started gardening, nutrition and youth entrepreneur training programs. We do not feel it is appropriate to use the money for DSRIP simply to treat us for our illnesses, but rather that it be used by the community to strengthen our current and developing programs. The best solutions for a healthy neighborhood will come from the community itself.

Sincerely

Willie White
Executive Director

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Southern Tier Independence Center

Access your world.

February 12, 2015

Southern Tier Independence Center (STIC) comments on NY Delivery System Reform Incentive Payment (DSRIP) Program United Health Services/Southern Tier Rural Integrated Performing Provider System (STRIPPS) Organizational Application:

Southern Tier Independence Center, Inc. (STIC) is a Center for Independent Living. We are a non-residential not-for-profit community based agency serving people with all types of disabilities of all ages as well as their family members and service professionals. We are dedicated to empowering people with disabilities to live independent, fully integrated lives in their communities. Established in 1983 and located in Binghamton, NY, our services cover many of the south-central NY counties.

STIC comments on United Health Services (Southern Tier Rural Integrated Performing Provider System) Organizational Application:

PPS Organizational Application

Section 1.1 – Executive Summary:

Regulatory Relief: STRIPPS is applying for regulatory relief and explains how such regulatory waivers will not risk patient safety, and we are pleased by this. Preserving patient safety is a top priority in the application, which will hopefully mean a merger with protecting patients' rights and offering patient centered care. Patient safety should be maintained throughout the DSRIP five year term and after, which means frequent and ongoing monitoring and reporting of the impacts of such regulatory waivers.

Section 2.0-2.7 – Governance:

Section 2.1 – Organizational Structure:

**Structure 1-4:* This section is clearly defined, especially considering the complexity of it.

Section 2.2 – Governing Processes:

**Process 1-8:* STRIPPS has demonstrated stakeholder engagement by sharing agendas and pending actions from the Governance Design team, along with requesting stakeholders' feedback. STRIPPS application states this approach will continue with the implementation of the formal governance structure. This is a strong point of STRIPPS and will encourage stakeholder connectedness going forward.

Section 2.3 – Project Advisory Committee:

**Committee 1-4:* STRIPPS reports having a PAC that includes all partners and community organizations in the PPS network. This means full representation and engagement of the PPS network, which is very important moving forward into DSRIP year one and beyond.

Section 2.4 – Compliance:

**Compliance 2:* “STRIPPS will have a policy to sanction staff and participants for failure to report and for compliance violations determined to contribute to poor performance” but does not state who will determine if compliance violations contributed to poor performance and how it will be determined that the compliance violation was the direct cause for poor performance. The application does not explain how STRIPPS will monitor for providers who may be running the risk of low performance.

Section 2.6 – Oversight:

**Oversight 2:*

“A plan of correction will be developed and submitted by the low performing member, and approved by the Clinical Performance Committee” but there is no party named to assess if the low performing provider’s proposed plan of correction is achievable.

**Oversight 3:*

When choosing members of the Clinical Performance Committee, Performance Review Panel, and Board of Directors STRIPPS must refrain from choosing members that have any conflicts of interest. A check list should be in place confirming that those members are not in competition with STRIPPS providers and will not discriminate against other STRIPPS providers based on negative history or for any other reason. This will guard against the potential that providers may be unjustly sanctioned or removed.

**Oversight 4:*

“STRIPPS will establish and promote feedback opportunities through the STRIPPS public website.” This will allow for widespread engagement as long as it’s well advertised and individuals have internet access. “For those beneficiaries engaged in

care coordination, a feedback mechanism will be incorporated into care plan update process.” This is an excellent approach for encouraging beneficiary engagement.

**Oversight 5:*

“If a provider is removed from the network, the participating provider list on the STRIPPS website will be updated.” The application does not specify how soon after a provider is removed from the network that STRIPPS’ website will be updated.

We are pleased that STRIPPS application mentions “beneficiaries and their care coordinators will be sent a letter informing them of the change in their provider’s participation status. The letter will offer alternative participating providers. Letters or notices will be made available at the transitioning provider’s location.” STRIPPS should also specify the required time frame of these letters in relation to the date the provider is removed from the network. Though the application mentions having telephonic contact and facilitating provider transition when possible, having to change providers may be very stressful and upsetting for beneficiaries. There should be a way to avoid beneficiaries having to switch providers. A procedure should be in place for beneficiaries and advocates to give feedback on their health care experiences so concerns may be addressed and improvements made. DSRIP Program should always have a positive impact on beneficiaries’ health care as opposed to negative or adverse effects.

Section 3.0-3.8 – Community Needs Assessment:

STRIPPS conducted an in depth CNA that yielded comprehensive findings. We are hopeful that STRIPPS project selection and implementation will resolve the health care barriers revealed in the CNA. Measuring patient health care experiences and making improvements accordingly should be a top priority. There must be a strong focus on protecting beneficiaries’ rights and the health care services upon which they depend, including community based services.

Section 5.0 -5.8 – PPS Workforce Strategy:

DSRIP Program should not affect workforce in terms of wage and benefits as anticipated. Redeployment should be done on voluntary bases instead of resulting in termination when designated staff refuses redeployment.

Section 6.0-6.2 – Data-Sharing, Confidentiality & Rapid Cycle Evaluation:

“Each STRIPPS Participant will be required to participate with STRIPPS Partner RHIOs via the STRIPPS’s RHIO Provider Organization Participation Agreement. Implementation of the Provider Organization Informed Consent will be required by July 2015 by all participants, and data submission for practices with RHIO supported EHRs

will be required by January 2016. For STRIPPS participant types not able to submit to a RHIO (because of interface or EHRs limitations) a minimal data standard will be specified by STRIPPS. At each care transition or time interval specified by the STRIPPS, the participant will be required to submit data via a standard form sent by Direct Message or via a web based form. Data submitted via this form will be integrated into the RHIO alongside EMR data and available to PPS participants involved in each patient's care." The application does not explain the course of action when a STRIPPS provider chooses not to follow the "requirements" described above. Not all providers have the funding to set up an interface to contribute to a RHIO and they may not be eligible for incentive payments to do so.

Literacy 7.0-7.3 – PPS Cultural Competency/Health Literacy:

Health care should be delivered in a culturally competent way, in the patient's primary language, along with health care hours that accommodate the patient's lifestyle beyond what the current health care delivery system offers. STRIPPS' application describes a solid approach for assessing, monitoring, and ensuring cultural competency and health literacy in health care delivery. STRIPPS plans to use the Nathan Kline Assessment Scale (NKAS) to get a baseline and determine ways for an organization to improve cultural competence. STRIPPS also plans to use the Linguistically Appropriate Services (CLAS) Standards. This will allow for monitoring and responding to changing community cultural needs, eliminating racial and ethnic health disparities, and improving beneficiaries' health. STRIPPS Cultural Competency Committee working with the Broome County Culturally Competent Committee (BCCCC) is also a great idea for meeting the goal of cultural competency and health literacy.

STRIPPS acknowledges that they may need to contract for translation services and mentions telephonic, video conferencing, and face-to-face as potential modalities. The application also mentions use of Language Identification Flashcards to assist with non-English speaking. These are important, and STRIPPS should also consider contracting for interpreters for individuals with disabilities (e.g., sign language interpreters).

Thank you for the opportunity to submit comments on behalf of STIC.

Sincerely,

Elizabeth Berka,
Health Information Specialist

☞South End Neighborhood Association☞
Albany, New York 12202

DSRIP Administration
New York State Health Department

To Whom It May Concern,

The South End Neighborhood Association is concerned that there has not been adequate opportunity for comment for residents of the South End of Albany and other low-income, severely impacted neighborhoods that are the focus of the current needs assessments by the two PPS providers that serve our areas, or even to fully comprehend the broad impact of the DSRIP process. There has been extremely limited public outreach by either Albany Medical Center or Ellis Medicine/St. Peter's Health Partners. The documents show that the process itself has been almost entirely governed by top-level management at the hospitals.

We are requesting a new community outreach process that would enable neighborhood residents, the community organizations that serve us and our local governments first to become educated about this dramatic new approach to community health, and then to participate in meaningful planning on community-based approaches to improving health and wellness in our communities.

The South End Neighborhood Association is actively engaged in the South End and we were neither consulted nor invited to participate in the needs assessment or planning process. Failure to include the South End community based organizations in the planning process to improve the health of the community will not yield the expected healthcare outcomes to reduce hospitalization or emergency room utilization rates, nor provide the anticipated Medicaid savings in the future.

As noted in the Community Assessment reports, there are many issues and barriers that contribute to poor health in our neighborhood. They do not all lend themselves to traditional health care solutions. At a minimum, the planning process for low-income neighborhoods should consider enhanced community-based outreach, more coordination of services and case management, access to healthy food and improved infrastructure to accommodate programs for health and fitness.

After reviewing the documents and needs assessments, it is clear that the existing assets, initiatives and strengths of our community were not considered in this process. We have strong community organizations. As you may know, the new Capital South Campus Center has attracted many professionals and offerings coming from regional universities and businesses. The new Albany County Land Bank will start to address our blighted housing stock and vacant land and engage residents in planning for their future. Community organizations have already started gardening, nutrition and youth entrepreneur training programs. We do not feel it is appropriate to use the money for DSRIP simply to treat us for our illnesses, but rather that it be used by the community to strengthen our current and developing programs.

The best solutions for a healthy neighborhood will come from the community itself.

Regards

JoAnn Morton
President,
South End Neighborhood Association

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DSRIP Project Plan Application Comments

The Community Health Care Association of New York State (CHCANYS) respectfully submits these comments on New York’s Delivery System Reform Incentive Payment Program (DSRIP) and the DSRIP Project Approval and Oversight Panel (PAOP). CHCANYS is supportive of the overall goals of DSRIP and its recognition of the need for a transformed health care system in New York—one that sustains and enhances our primary care foundation and shifts away from the historic emphasis on inpatient care. As major Medicaid safety net providers and comprehensive care providers, federally qualified health centers (FQHCs) are well-equipped to play a central role in the development and implementation of DSRIP projects that drive transformation. Primary care should be the foundation of the new systems of care for DSRIP Performing Provider Systems (PPS). Despite this, the vast majority of PPS are hospital led, with only one led by an FQHC—Refuah Health Center. Considerations for how best to support and enhance primary care and implement primary care-focused projects should be woven throughout the project design and implementation process, not siloed into a single work group. This integration will help ensure true transformation of the health care system and achieve DSRIP goals. We ask the Panel to pay particular attention to and question how or whether the Independent Assessor measured whether applications demonstrated true integration of and collaboration with community based partners.

Flow of Funds

Transformation of New York’s healthcare delivery system through DSRIP is a massive undertaking which relies on FQHCs and other community based safety net providers to design and implement a variety of intensive projects. FQHCs and other community partners have expended extensive staff time and financial resources preparing for the implementation of DSRIP projects. However, because DSRIP planning dollars are only available to PPS leads (the vast majority of which are hospital systems), at this time no downstream community partners have received any funding under DSRIP, despite the Department of Health’s expectation and

urging that they be active participants in the project planning phase. CHCANYs is concerned about a lack of transparency regarding flow of funds, especially in light of the anticipated expenditures by FQHCs to meet clinical deliverables required under DSRIP. When evaluating PPS Project applications, PAOP Members should consider and question the Independent Assessor on how the PPS will ensure that funds are allocated appropriately to FQHCs, and to other providers across the continuum of care, and that these funds distributed in a timely manner. FQHCs who lead or participate in programs should receive incentive payments based on their contributions to the improvements and the level of investment in project implementation.

Integration of Provider Expertise and Systems of Care

The State has emphasized repeatedly that DSRIP is about collaboration and clinical integration between providers in New York's health care system. However, in multiple places throughout the application the required benchmarks focus on what appears to be nominal inclusion of partners rather requiring demonstrated meaningful partnerships with providers. For example, in the Governance section applicants were required only to describe a governance model and list the types of providers included, but were not asked to comment on how a PPS's governance model ensures meaningful contributions from and includes the voices of PPS members.

Similarly, applicants are only required to identify a lead or partner with experience, not to describe how these capabilities will be used in a meaningful way. For example, many FQHCs already have deep expertise and existing systems that serve special populations, including populations who experience homelessness, have HIV/AIDS, live in public housing, have developmental disabilities, are migrant and seasonal farm workers, and are LGBT. The unique circumstances of these populations are often significant drivers of poor health outcomes and avoidable costs. Performing Provider Systems should include an emphasis on the needs of special populations and build on the expertise and systems of care already in place to serve these special populations.

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

based primary care. PAOP Members should question the Independent Assessor about whether and how it assured that applications incorporated substantive and ongoing participation from PPS community partners.

Community Needs Assessment and Special Populations

The Community Need Assessment is a critical portion of the DSRIP application, the findings of which inform the design of all PPS projects. However, community needs assessments tend not to identify the particular needs of special populations, including people who experience homelessness, have HIV/AIDS, live in public housing, have developmental disabilities, are migrant and seasonal farmworkers and/or are LGBT. The presence and prevalence of special populations should be an important part of PPS deliberations concerning medical service constellations and deployments of other essential services designed to facilitate access to needed care, promote good health outcomes and avoid unnecessary costs. The Panel should question how or whether the Independent Assessor evaluated applications as to how the PPS will serve special populations, including identifying the systems of care that are already in place for these populations. Within these areas it is essential that they describe how PPS services will be integrated with and build on these existing systems of care.

Technological Resources

PPS leads should be aware of existing HIT resources as well as other PPS partners' current IT capabilities and leverage those systems to advance their objectives rather than ask partners to create new data reporting systems.

As part of its Center for Primary Care Informatics (CPCI), CHCANYS operates a statewide data warehouse which reports on many of the DSRIP required measures and includes functions that support population management and advanced care delivery models. Currently, 34 FQHCs are connected to the CPCI, which is over half of all FQHCs in the state, and 17 more are in the pipeline. This represents over a million lives.

Any technology (e.g., health information exchange, care management software) that will be available and/or required by DSRIP outside of RHIO services should be made available at an affordable rate or at no-cost to FQHCs and other community-based providers. The Panel should

explore how the Independent Assessor evaluated the applications to ensure unfettered access to technology will enable a system to operate as an integrated delivery system and should be considered a core operating cost.

Ongoing and Expanded Project Evaluation

Finally, CHCANYS recommends that the PAOP serve as ongoing monitors throughout the DSRIP implementation and evaluation period to ensure that PPS projects continue to be aligned with their stated objectives and progress appropriately towards goals and objectives. As project implementation begins, we also suggest integrating a “360 evaluation” type component into assessment of DSRIP projects in which the non-lead partners are interviewed and asked about their experience with substantive participation in governance, project development, project execution, communication with and between the lead and other partners, conflict resolution, dollar flow, and general satisfaction with the lead PPS.

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

COMMUNITY DEVELOPMENT ALLIANCE OF THE CAPITAL DISTRICT
225 Orange Street, Albany, NY 12210 518-434-1730x405

February 12, 2015

DSRIP Administration
New York State Health Department
Via email: DSRIPApp@health.ny.gov.

To Whom It May Concern,

We are writing to express our concerns about the inadequate public outreach and limited opportunity to comment on a proposed redesign of healthcare that will dramatically impact our community. Community-based organizations, like ours, have just learned about DSRIPA. The low-income neighborhoods and residents we work with have not been engaged at all in the process.

We are requesting a new community outreach process that would enable neighborhood residents, the community organizations that serve us and our local governments to participate in meaningful planning of community-based approaches to improving health and wellness in our communities.

Our agencies, the Affordable Housing Partnership, Albany Community Land Trust, Community Loan Fund of the Capital Region and United Tenants, are actively involved in improving disinvested neighborhoods and creating healthier environments for low income families. None of us were consulted nor invited to participate in the needs assessment or planning process.

As noted in the Community Assessment reports, there are many issues and barriers that contribute to poor health in our neighborhood. They do not all lend themselves to traditional health care solutions. At a minimum, the planning process for low-income neighborhoods should consider enhanced community-based outreach, more coordination of services and case management, better & safer housing, reduction of blight, access to healthy food and improved infrastructure to accommodate programs for health and fitness. We have strong community organizations throughout the Capital Region actively working to improve the health of our neighborhoods. We do not feel it is appropriate to use the money for DSRIP simply to treat us for our illnesses, but rather that it be used by the community to strengthen our current and developing programs.

The best solutions for a healthy neighborhood will come from the community itself.

Sincerely,



Affordable Housing Partnership Homeownership Center ♦ Albany Community Land Trust
Community Loan Fund of the Capital Region ♦ United Tenants of Albany

February 13, 2015

We, the Long Island Center for Independent Living, Inc. (LICIL), a community based organization specializing in advocacy on behalf of people with disabilities, respectfully submit the following as our public response to the DSRIP application presented by the Nassau Queens PPS:

Overall, the scope of the Nassau Queens DSRIP Project Plan appears well thought out and comprehensive in nature, however; there are a few points that we think need to be brought to the attention of the planning committee.

Throughout the Executive Summary, there are references made to being “culturally competent,” “culturally appropriate,” and “culturally sensitive” in regard to trainings and patient interactions. These trainings and interactions should be inclusive of people with disabilities (i.e., awareness, etiquette, etc.) and consultation should be made either with local independent living centers or CBOs who can be resources for such trainings. In addition, all signage, videos, trainings, brochures, websites etc. should be available in alternative formats including but not limited to closed captioning, sign language, Braille, large print, screen reader-accessibility and plain language. Alternative/accessible formats should also be made available for the compliance reporting materials that are mentioned in the Governance section. This will ensure that all people who utilize the N/Q PPS services can report on compliance issues independently and without hindrance.

The above issue comes up again toward the end of the application in the Cultural Competency/Health Literacy section. The application doesn’t specifically address people with disabilities – in particular, individuals with sensory conditions like those who are Blind, Low Vision, Deaf, and Hard of Hearing. Outreach efforts need to be made in formats that are accessible and relatable to all populations affected.

Within the Executive Summary there is discussion of care transitions to reduce 30-day re-admission. There doesn’t appear to be enough detail about how the care transitions will be implemented to reduce recidivism. It is our suggestion that the transition care plans should be standardized across the N/Q PPS entities, with some form of quality assurance that they are being implemented appropriately by assigned staff. For example, within an inpatient behavioral health setting, a recovery plan with 30-day discharge instructions could be developed by multiple disciplines, signed off by an assigned social worker and followed up at 15 and 30 day intervals. Peer specialists/bridgers should also play an important role in the transition plan to reduce the 30-day re-admission rate and to optimize opportunities to thrive once (back) in the community.

The Executive Summary further suggests that CBOs will assist in identifying low/non-utilizers of insurance. Which CBOs will be involved and how will they identify these particular consumers/non-consumers? What will be the reporting mechanism utilized? Will the non-consumers be encouraged to obtain health insurance or approached by health homes, etc?

As part of the health literacy campaign mentioned in section 11 of the Executive Summary, diversity in hiring is mentioned. The N/Q PPS should partner with CBOs involved in vocational rehabilitation for people with disabilities, including ACCES-VR and the vendors with whom they partner, including those agencies who utilize job coaches. Not only would this demonstrate a commitment to hiring people with disabilities, but also a commitment to those who are “most significantly disabled.”

The Community Needs Assessment section doesn't address the significant barriers to healthcare access for people with disabilities (i.e., diagnostics and exams for people who use wheelchairs, lack of ASL interpreters, etc.) There must be discussion and solutions within the N/Q PPS to address this pervasive issue. Such discussions will yield the best results if they carefully consider the consumer perspective by way of thoughtful consultation with CBO's specializing in the Disability experience. We would anticipate that the data and knowledge gained from such communication could lead to comprehensive gap analysis, particularly with respect to outpatient facilities.

Additionally, we think it important to show support for a waiver of limitations on billing for multiple services on same day as mentioned by the N/Q PPS. We are familiar with how this positively affects individuals receiving behavioral health services, and can see it being a benefit for those receiving general health services as well. We would also like to voice support for payment for Telemedicine as mentioned by the N/Q PPS. There could be many advantages to using this type of service, including but not limited to counseling for people who are unable to leave their homes, initial diagnostics, intakes and referrals.

Thank you for providing a forum for public commentary and for your kind consideration of the testimony herein. We are confident that with the appropriate considerations, DSRIP Project Plans can be successful and beneficial in their transitions.

Sincerely,

Therése E. Aprile-Brzezinski, M.A.
Director, Planning and Public Policy

Kelly D. McClean, MS, CRC, LMHC
Community Policy Advocate

LICIL is a 501(c)3, non-residential, cross-disability advocacy organization with more than 30 years experience in direct services to people with disabilities and their families. The Center is committed to shaping public policy that promotes full community access and seamless integration of people with disabilities into the fabric of society. Further information about LICIL programs and services may be found at www.LICIL.net.



February 13, 2015

Jason Helgerson
New York State Medicaid Director
NYS Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

RE: Comments on DSRIP PPS Applications

Dear Mr. Helgerson:

On behalf of LeadingAge New York, I am writing to share our comments on the Delivery System Reform Incentive Payment (DSRIP) program Performing Provider System (PPS) Project Plan applications. LeadingAge NY has reviewed the applications and provided some general comments on themes we see throughout the 25 PPS project plans. We commend the provider community for coming together to plan in new and innovative ways, particularly during a period of major change at both the state and federal level. The applications show a great deal of thought and creativity, although the undertaking is complex and the timeframes ambitious.

The Role of Long-Term and Post-Acute Care Providers

In reviewing the applications, there is evidence of a concern we have consistently voiced; namely, Long-term and Post-acute Care (LTPAC) providers do not have as great a presence as they should in the PPS Project Plans. The project selections and key providers noted in the application materials strongly suggest that there is not a significant engagement of LTPAC providers, with a few exceptions. We fear that this will significantly compromise the likelihood of achieving DSRIP objectives.

First and foremost, LTPAC providers are well-suited to manage the health care needs of chronically ill, disabled and frail elderly individuals who are at elevated risk of hospitalization, and thus their under-representation could negatively impact the ability of PPSs to reduce hospitalization and emergency room visits. Further, if the ultimate goal is to reform the service delivery and payment systems, the failure to meaningfully include LTPAC service providers will result in major gaps in both service delivery transformation and payment reform.

Health Information Technology Milestones

We are extremely concerned about the overly ambitious goals in Project 2.a.i., which was selected by 22 of the 25 PPSs. As a whole, it does not appear that enough resources and focus have been given to fully bridge the gap between the current state and the vision for year 3 for Health Information

Technology (HIT) and Health Information Exchange (HIE) penetration levels. While there is clear value in the objectives, there are insufficient resources dedicated to accomplish them.

LeadingAge NY's understanding of the DSRIP Project Plan application is that all Safety Net Providers in the PPS have Electronic Health Records (EHRs) that meet the HIE requirements for Regional Health Information Organizations (RHIOs), as well as SHIN-NY requirements by DSRIP Year 3. First and foremost, we urge the Department of Health (DOH) to be very explicit about what exactly this benchmark means, and confirm that our understanding is accurate. There is confusion in the field about what the requirements mean among providers who will need to achieve the benchmark. Further, the DSRIP metrics call for satisfaction of "meaningful use standards" by Year 3. LTPAC providers have been excluded from the federal EHR meaningful use incentive program. As a result, they have not had to meet the standards and EHR products designed for the LTPAC sector may not meet those standards. Accordingly, we are assuming that this metric does not apply to the LTPAC sector; but again this must be explicitly clarified.

Presuming that our understanding of the metrics is accurate, this requirement is overly ambitious given current levels of EHR and HIE penetration, lack of true interoperability among EHR products and challenges for LTPAC EHRs in connecting to the RHIOs. To date, RHIOs and EHR vendors have focused on connecting hospitals and physicians due to the need to satisfy meaningful use standards.

LeadingAge NY recently conducted an HIT survey of its members, which span the continuum of aging services providers. Based on the results, which we would be pleased to discuss with the DOH, we have a very long way to go before the LTPAC community is actively exchanging information through RHIOs. Nursing homes are furthest along, with 60 percent of the respondents reporting full or partial adoption of EHRs (note: these results represent a self-selected sample that may well be skewed towards providers that are adopters). Home care agencies had lower adoption rates; while assisted living and adult day health care adoption were extremely low. Importantly, all of these provider types are named as DSRIP Safety Net providers.

While EHR adoption is relatively low, the rate of HIE is even lower. Only 31 percent of respondents to the LeadingAge NY survey reported exchanging information with a RHIO. Just over half of respondents indicated that they exchange information with a hospital. However, in almost half of those cases the "exchange" is merely "viewing" the health information in the hospital record; they do not receive or transmit information. Only 25 percent of respondents receive electronic transfer documents when a patient transitions to their care, and only 13 percent generate such a document when a patient is transferred from their care. Only 8 percent receive electronic alerts when a patient or resident presents in an emergency room, is admitted to a hospital or is treated by another provider. Surprisingly, most of the HIE is occurring independently of the RHIOs, presumably through direct connections with other providers. Again, please note that not all of LeadingAge NY's members responded to the survey, and the responses are likely biased towards those providers that have made more progress in this area than others.

Further, EHR adoption is only part of the issue. There must also be the ability to exchange information bi-directionally with other providers within the PPS network, and with the RHIO. Enhancing systems to

enable this connectivity is also likely to have a significant cost as EHRs have been implemented piecemeal in regions.

While the formal Capital Restructuring Financing Program will likely address some of these needs, the capital funding request summaries suggest an intention among multiple PPSs to make investments in technology infrastructure, but they are unlikely to be sufficient. We caution that, without sufficient investment, the 22 PPSs that selected Project 2.a.i. will not achieve the HIT/HIE milestones, and federal monies could very well be left on the table.

Regulatory Flexibility

LeadingAge NY sees many opportunities to provide services in a more flexible and efficient manner, some of which were discussed in the projects, as well as others we have recommended to DOH. As providers attempt to furnish services in a more integrated manner, they will certainly need greater flexibility on “siloeed” regulations that do not contemplate the collaborative approaches DSRIP requires. In this regard, we support a variety of waiver requests intended to allow the Certificate of Need (CON) process to move expeditiously; allow for physician home visits; provide more flexibility in home care ordering authority; and expand the use of telemedicine and telehealth. At the same time, LeadingAge NY asks that DOH consider certain concerns and mitigating factors in reviewing regulatory waiver requests:

- We are concerned about requests to waive the CON process and need methodologies for establishment of services that already exist in the region of the PPS. In the circumstance that there are existing providers in the service area, those providers should be brought into the PPS, rather than creating an entirely new infrastructure. Given the speed with which DSRIP milestones need to be accomplished, it makes more sense to rely on the experience and expertise of existing providers. Examples include:
 - a waiver of the CON regulations to allow a hospital to develop a new Certified Home Health Agency (CHHA) in a region where CHHAs are already established; and,
 - a waiver to allow expansion of transitional care units, which could be duplicative of skilled nursing facility and home care services in that region.
- We have concern about the waiver of admission/discharge/transfer regulations designed to facilitate referrals within the PPS network. It is important for consumers to be able to make informed choices about their care and providers, and objective information should be made available as a part of this selection. A waiver of this regulation could limit choice, and the consumer may not have access to objective information about the array of options. Given the apparent under-representation of LTPAC providers in PPS networks, this could compound the issue further. We also question whether the DSRIP networks will correspond with the Medicaid managed care networks that have already been formed, and whether this could cause further problems with the admission/discharge/transfer processes.
- We question how a waiver of policy prohibiting Medicaid beneficiaries from participating in Health Homes and Managed Long Term Care plans simultaneously will work. Specifically, which entity would ultimately be responsible for care management functions?

Allowing for Meaningful Public Input

We appreciate the amount of information that has been made available regarding DSRIP. It should be noted, however, that there is no publicly available complete partner list for each of the 25 PPSs. We question why that information is not available and respectfully urge DOH to make the lists available.

Additionally, while we appreciate the opportunity to review the 25 PPS applications, 30 days was not a sufficient amount of time to review and provide comment given the complexity and breadth of the information presented. Providing more information, and more time to review and comprehend the information, may have resulted in more meaningful input.

Nonetheless, we appreciate the opportunity to provide input on the DSRIP applications. We would be happy to discuss any of the above issues in greater detail.

Sincerely,

A handwritten signature in black ink, appearing to read "Daniel J. Heim", with a long horizontal flourish extending to the right.

Daniel J. Heim
Executive Vice President



137-139 West 25th Street
12th Floor
New York, NY 10001
(212) 627-2227
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The New York Immigration Coalition

Comments Submitted to the DSRIP Project Approval and Oversight Panel

February 15, 2015

Thank you for the opportunity to provide feedback on New York's Delivery System Reform Incentive Program (DSRIP). We have been encouraged by the level of transparency provided by the state in developing DSRIP and are also pleased to note the presence of experienced and community-oriented health care consumer advocates on the Project Approval and Oversight Panel.

The New York Immigration Coalition (NYIC) has followed the development of DSRIP closely. We have been particularly involved in the development of OneCity Health, New York City Health and Hospital Corporation's PPS and the NYIC serves on the Executive Committee of OneCity Health. We have been very gratified by HHC's commitment to incorporating community feedback into their planning process.

The state has made important progress on implementing DSRIP and the NYIC is optimistic about the potential for improvement in health outcomes in immigrant communities, particularly those that remain uninsured because their immigration status renders them ineligible for publicly financed insurance. We are also hopeful that the Performing Provider System (PPS) structure will encourage large hospitals to engage meaningfully with community-based organizations that serve immigrant communities. We believe that PPSs that incorporate community input into governance, collaborate in project development with CBOs, and provide appropriate remuneration to CBOs for their work in supporting the PPS are more likely to be successful in meeting their DSRIP goals.

With that in mind, we remain concerned about the fact that at the state level there may be missed opportunities incorporate meaningful, bi-directional relationships with CBOs into all the PPSs. Based on these concerns, we recommend that the state consider doing the following:

1. Require and ensure consumer/community-based organization involvement in all levels of decision-making by:
 - Setting up a working group made up of representatives from the PPSs, community based organizations, and consumers not represented on the state Oversight and Approval Panel to make recommendations to the state with a special focus on outreach, engagement and cultural competency
 - Ensuring that the community infrastructure to support the PPS goals exists. To do this, a state human capital support fund could be established (much like the hospital capital fund) to support community-based organizations as they implement the community-based prevention and support critical to DSRIP success
 - Requiring the PPSs to use their advisory committees (PAC) to develop outreach/education and cultural competency plans; and require PPSs to dedicate

resources to subcontracts with CBO's to do outreach, education, and provide cultural competence training and technical assistance within the PPS

- Requiring the PPSs to diversify their governance structures. At a minimum, executive committees or workgroups of all PPS's should include:
 - a health care provider who is knowledgeable about chronic disease care and prevention;
 - a representative of a CBO for groups working to address social determinants of health (i.e. housing, food insecurity, economic security, age, violence, open spaces/environment, education, workforce development, etc.)
 - one or more local consumer who receive Medicaid or is uninsured
 - a front-line worker knowledgeable about patient engagement and education (CHW, peer educator, peer specialist etc.)
- Scheduling Project Oversight and Approval Panel meetings alternately between Albany and NYC with at least a half an hour for public comment at each meeting.

2. Identify ways to expand DSRIP projects beyond biomedical framework, by:

- Ensuring that the key components of a community-driven health program address the social determinants of health
- Focusing on core strategies of cultural competency, especially for the populations served by each PPS

3. Community Health Needs Assessments (CHNAs) should be subject to professional standards, intense review, and relevance to the community served. PPSs that did internal assessments without external guidance from contractors with expertise in addressing social determinants of health and improving health outcomes should be subject to careful scrutiny and possible deductions in the scoring. Even PPSs that engaged external public health contractors with this expertise for their CHNA should be subjected to quality review on their CHNA.

Thank you for the opportunity to provide feedback on the progress of DSRIP to date and for all the work that has been done. We look forward to continuing to collaborate to make DSRIP a success.



February 13th 2015

William G. Leung, Chair
TD Bank

Jan He, Vice Chair
EMO America Productions

Jeffrey D. Leong, Vice Chair
Life Financial Management

Tony Wong, Treasurer
Wong & Co., CPA

William Huang, Secretary
HSBC

Deborah Chan, Esq.
Law Office of Deborah Chan, P.C.

Suzanne Goon Mark
Time Inc.

Hans Johannsen
First American International Bank

Richard Leung, LUTCF
New York Life

Patrick Ng
Po Wing Hong Food Market

Virginia S. Tong, MSW
Lutheran HealthCare

Alison Yu
Hearst Foundations

Hong Shing Lee, LMSW
Executive Director

Stephanie Lau, MPA
Assistant Executive Director

Our Mission:
CMP promotes economic self-sufficiency and career advancement. We serve communities of diverse backgrounds, with a strong track record in supporting the Asian immigrant population.

NYS Department of Health
Delivery System Reform Incentive
Payment Project (DSRIP)

To whom it may concern,

I am writing in support of the Advocate Community Partners' (AW Medical) DSRIP PPS organization application.

The Advocate Community Partners (ACP) application features physician led governance and delivery structures with demonstrated cultural competence and language access that are vital to the "Triple Aim" objective of better care for individuals, better health for the target population, and at lower costs. Its Patient-Centered Medical Home (PCMH) model of care ensures a holistic approach of care, centering the whole patient, with involvement of family and friends; while at the same time, the adaptation of a value-based payment system allows for a efficient and effective use of health care resources.

For more than 40 years, CMP works at facilitating economic self-sufficiency among low income, Asian immigrants by building their employability assets, providing job skills training and placement, as well as offering support to small business startup and expansion. CMP offers health care career pathway programs that feature, currently and in the short future, skill training and job placement in Certified Nurse Aide, Phlebotomist, EKG Technician, Patient Care Technician, and Medical Assistant positions. We witness firsthand how new immigrants often have to choose between addressing their health care concerns and surviving in their adopted country, without realizing that the two are not mutually exclusive.

ACP's ethnically and linguistically diverse providers and support staff, many of them members of this particular target population, will prove to be a uniquely competent health care entity to not only provide care, but also effects a long-term health care attitude and behavioral change of this population group.

The NYS Department of Health's favorable consideration towards ACP's DSRIP PPS application will place a valuable partner and care provider in our community.

Thank you.

Sincerely,

Hong Shing Lee, LMSW
Executive Director



February 13th 2015

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Sincerely,

Hong Shing Lee, LMSW
Executive Director



MergerWatch Project

Protecting Patients' Rights
When Hospitals Merge

475 Riverside Drive, Suite 1600
New York, NY 10115
212-870-2010

www.MergerWatch.org

February 13, 2015

DSRIP Project Approval and Oversight Panel
New York State Department of Health
Corning Tower
Empire State Plaza,
Albany, NY 12237

Dear members of the DSRIP Project Approval and Oversight Panel:

We write to provide comments on the Project Plan applications submitted in connection with the New York State Delivery System Reform Incentive Payment Program (DSRIP). New York State's DSRIP program cannot achieve the "Triple Aim" (improving the health of a population, enhancing the experience and outcomes of the patient and reducing the per capita cost of care) without focusing on women's health care needs, including the provision of comprehensive reproductive health services.

The MergerWatch Project has 17 years of experience working with communities across the nation, including here in New York State, to protect patients' rights and women's access to reproductive health care in health system mergers, particularly when secular hospitals form partnerships with religiously-sponsored hospitals. Through our Raising Women's Voices initiative, we have also worked to ensure that women's reproductive health services are covered in health insurance programs, including Medicaid, and that provider networks include sufficient numbers of qualified reproductive health providers.

Prioritize Women's Health in each PPS

In order to maximize the benefits of DSRIP, it is imperative that the New York State Department of Health require all PPSs to prioritize reproductive health care as a fundamental focus of overall health service provision. Two-thirds of all adult Medicaid beneficiaries are women, and nearly three-quarters of them fall within the reproductive age (15-44) group. So, a significant proportion of the PPS-attributed patients will be women and adolescent girls requiring reproductive health services. For many Medicaid enrollees who are women/girls of reproductive age, their point of entry into the health care system is their women's health or family planning provider. According to the Guttmacher Institute, 6 in 10 women view their gynecological provider as their primary care provider, and for 4 in 10 women, gynecological services are their only point of medical contact.

Reproductive health providers are often gateways to providing women with a broader range of medical services.

We urge the NYS DOH to ensure that comprehensive reproductive health services are offered within all Performing Provider Systems funded through the NYS DSRIP program. Studies have consistently shown that the provision of preventive services such as well-woman visits, STI screening and counseling, contraceptive counseling, supplies and procedures (including voluntary tubal ligations), gestational diabetes testing, breast-feeding supports, and interpersonal and domestic violence screening and counseling improve women's health and can also lead to significant cost savings in averted services. It is imperative that the NYS DOH ensure that family planning providers and other essential health benefit providers are included in each PPS. Without inclusion and promotion of these services, the NYS DSRIP cannot achieve its goals of improving the overall health of New Yorkers served by the Medicaid program, while achieving real cost savings.

Potential for religious/ethical restrictions on provisions of women's health care services

Since 1997, the New York-based MergerWatch Project has been working to ensure that women's access to reproductive health care is not impeded by religious or ethical restrictions imposed by health providers or payors. With the rise of integrated delivery systems and collaborative care networks like Performing Provider Systems, there is a potential that the religious or ethical policies of one participating provider (such as a Catholic hospital or health system) could be extended to other providers participating in a PPS. Given the wide geographic coverage of the PPS systems, many thousands of women in multiple counties could then encounter difficulty in obtaining needed reproductive health coverage.

It's important to recognize that Catholic affiliated hospitals and health systems are required to operate in accordance with *The Ethical and Religious Directives for Catholic Health Care Services (Directives)*. The *Directives* do not merely restrict the provision of particular services; they also ban the provision of information about, counseling on, and referrals for the restricted services. The *Directives* prohibit the use of contraceptives, and so Catholic health systems are restricted from providing contraceptive counseling and services, including tubal ligations. Additionally, there are documented examples of hospitals that adhere to the *Directives* preventing physicians from following accepted standards of medical care to promptly and appropriately treat premature rupture of membranes and ectopic pregnancies. It is crucial for the provision of women's health that New York State take actions to ensure that women whose care will be entrusted to a PPS do not encounter barriers when seeking such reproductive health care, especially in cases of emergencies.

Ensuring Transparency and Protection of Patients' Rights

We urge the NYS DOH to have measures in place to ensure that patients are informed that their health care provider is now part of a PPS and are given clear explanations of what this means for the provision of health care. When health care providers are incentivized to substantially reduce costs, there is a concern that the best care may not be provided if those services are associated with higher costs. Therefore, patients must be informed of these financial incentives, as well as the

quality measures that their providers are required to meet. This level of transparency would allow patients to make the best possible choices for themselves. All information should be designed for those with low literacy and in multiple languages.

Ensure Ongoing Engagement of Women in Assessing PPS Performance

We firmly believe that to be successful, New York's Performing Provider Systems must engage women and women's health organizations on an ongoing basis, so as to identify barriers to care and address those barriers promptly. We urge that such engagement be assured at both the community level, for each PPS, and on a statewide level for consideration of policy implications.

Thank you for the opportunity to submit these comments. We are available to answer any questions you may have and to provide ongoing suggestions about how to ensure that New York's pioneering Medicaid redesign program improves women's health through timely access to quality care from trusted providers.

Sincerely,

A handwritten signature in dark ink, appearing to read "Lois Uttley", is written over a light gray circular background.

Lois Uttley, M.P.P.
Director

Christine Khaikin, J.D.
Advocacy Coordinator

Public Comment

Performing Provider Systems Project Plan Application

PPS Applicant: Catholic Medical Partners-Accountable Care IPA INC

Commenter: WNY Integrated Care Network

The following comments are directed to **Project 2.b.iv** Care Transitions Intervention Model to Reduce 30-day Readmissions for Chronic Health Conditions.

Key Points:

- Current community resources should be used to their maximum effect.
- These resources include a project-ready cadre of care transitions coaches.
- Partnering with Area Agencies on Aging will magnify the reach of an Erie-centric PPS.
- Local hospital discharge planners indicate that social factors get in the way of successful and sustained transitions.
- Existing IT solutions used by Area Agencies on Aging can be leveraged to meet project needs.

The DSRIP Scoring Summary for Catholic Medical Partners indicates that the applicant sufficiently conveyed project needs but did not adequately address project design (NYS Department of Health, February 2015). As this PPS addresses this shortcoming during its implementation planning phase, we wish to encourage current community resources be used to their maximum effect.

Current community resources: The region's Area Agencies on Aging and the community-based service providers it has traditionally partnered with to deliver high quality programs and services, including care transitions coaching, will be critical partners to ensuring that this project reaches scale quickly and that it is delivered with the level of comprehensiveness that the project plan promises. As a service network, we have more than four decades of experience delivering services and programs to high risk older adults and the disabled. We have particular expertise in targeting populations that are considered "hard to serve" including those living in poverty, the frail homebound, ethnic and racial minorities, and those who live in rural communities where services are often in short supply. Particularly noteworthy is our experience providing case management and care planning services to frail elderly living alone in the community.

There is an Area Agency on Aging, and a corresponding Aging and Disability Resource Center, with a well-developed service delivery system in every county in NY State that can guarantee the reach that Catholic Medical Partners will need in order to effectively cover its entire PPS region.

Care Transitions in the Community: The Care Transitions Intervention Model (aka the Coleman Model) is not an unknown program in Western New York. Several local service providers came to know the Coleman Model as part of an effort by the Health Foundation of Western and Central New York to encourage care transition use. Later, the P2 Collaborative was instrumental in extending care transitions use in our rural counties through a successful application to the CMS Innovation Center. These efforts have resulted in a project-ready cadre of care transitions coaches that can be utilized by Catholic Medical Partners.

Project Design: When more fully developing the project design, it is imperative that Catholic Medical Partners incorporate lessons learned by those who have broken trail on care transitions use in Western New York and across the country. The Coleman model is patient education centered to empower the patient to take control of their healthcare by using transition coaches. This model, even when augmented by Project BOOST, primarily focuses on the medical aspects of the discharge. While very important, this focus often fails to take into account other problems that exist with patients including psychosocial concerns such as limited financial or community resources, adjustment to having an illness, low health literacy, caregiver stress, and the need for homecare or residential placement, all of which can contribute to problems during transitions of care and increase risk of medical complications. (“Psychosocial factors”, n.d. <http://www.transitionalcare.org/-transitional-care/psychological-factors/>, p.1)

These psychosocial factors can have a direct effect on the success of the transition home because without the added support from community services many patients and their family/caregivers, though “empowered” with their medical care, do not have many of the resources needed to sustain the transition. A study by Popejoy (2008) found that it is important for a care transition model to: understand the broader social problems that affect older adults at the time of hospital discharge, such as difficulty understanding home treatments and medications, problems with family caregiving, competing demands on family caregivers, and the overall effect of chronic conditions on daily life. (p.327)¹

Local hospital discharge planners agree that social factors often get in the way of a successful and sustained transition back home. In 2014, the Erie County Department of Senior Services surveyed eight Erie County hospitals to assess current care transition activity in the county and the perceived gaps in service. Although all respondents indicated that they were using some form of care transitions in their hospitals, only half indicated that those efforts had resulted in a discernible difference in readmissions. In addition, respondents were asked if they believed that the way their institution uses its care transition model on a day to day basis could be improved and more than

¹ Popejoy, L. (2008). Adult protective services use for older adults at the time of hospital discharge. *Journal of Nursing Scholarship*, 40(4), 326-332.

half (62.5%) said yes. When respondents were asked what the greatest hindrance was to a successful hospital discharge, just over one third (37.5%) singled out a lack of social supports (home delivered meals, in-home personal care, and transportation to doctors' appointments) as the greatest hindrance. Interestingly, respondents of this survey tended to disregard the instructions to choose only one option among the response set for this question. When taking into account multiple-selection respondents, 100% indicated that lack of social supports was the greatest hindrance [multiple-selections tended to combine this with medication management, follow-up care by a primary physician or specialist, and coordination of care between health care providers].

Although Catholic Medical Partners does indicate it will be mindful of social factors that impact the likelihood of a sustained discharge, we strongly encourage this PPS to leverage to the fullest extent possible existing expertise in the community, and especially in the aging network. When PPS-funded Care Transition programs are combined with the expertise and resources of Area Agencies on Aging, Aging and Disability Resource Centers, and the community organizations that have been working with them to address social needs, the program will have a greater chance of reaching the outcomes it desires.

IT-Ready: County-based Area Agencies on Aging can also help the PPS to meet its need to document program activity and collect data to demonstrate program impact. We have existing cloud-based client-tracking software that allows us to send and receive electronic referrals, query clients based on demographics or risk factors, collect program data, and easily produce performance metrics to demonstrate program outcomes. Not only would leveraging an existing IT solution be a low-cost, quickly-implemented, strategy for rolling out this project, it would provide the additional benefit of giving the PPS access to the psychosocial record of the patient, thereby enhancing the stand alone medical record.

WNY Integrated Care Network is a cross-sector collaboration of Area Agencies on Aging and non-profit community-based organizations that deliver home and community based services, including case management and care coordination, Care Transition Intervention Model coaching, caregiver support, and evidence-based disease management education. Represented agencies that participated in this public comment include: the Erie County Department of Senior Services, the Niagara County Office for the Aging, Catholic Charities of Buffalo, Community Concern of Western New York, The Dale Association, Healthy Community Alliance, and the United Way of Buffalo and Erie County.

For more information regarding information contained in this public comment, please contact Diane Oyler at the Erie County Department of Senior Services. diane.oyler@erie.gov

Comments of 1199SEIU on the DSRIP Applications

For more information:

Helen Schaub, New York State Director of Policy and Legislation

helen.schaub@1199.org

(212) 603-3782

1199SEIU United Healthcare Workers East represents over 300,000 workers in New York State who will play a vital role in achieving the transformation of our healthcare delivery system sought by DSRIP. We represent a wide spectrum of the healthcare workforce, from physicians, nurses and pharmacists to certified nursing assistants and home health aides. Our members work in every setting, from inpatient hospitals to nursing homes, clinics, pharmacies and homes.

Our members provide healthcare. But they are also patients, family members and neighborhood residents. Many come from communities which experience high rates of chronic disease and poor health care outcomes due to structural inequality. It is for this reason that we support the broad goals of DSRIP and will work hard to ensure its success. But as this transformational project is implemented, the savings generated by system reform must be reinvested in initiatives that encourage and support the health of the communities served and in the workforce that delivers this care. The workforce should be seen as part of the continuous improvement infrastructure, and as the core of efforts to achieve high-value care. Workforce competence, training, satisfaction, health, insight, expertise, communication and team dynamic directly influence patient experience and health outcomes. Worker safety is patient safety. Worker satisfaction is patient satisfaction. Workforce stability is care continuity.

Building a High-Quality Delivery System

As DSRIP is implemented, PPSs must take responsibility for the consequences of their decisions for our communities. Transforming our delivery system from an emphasis on in-patient, acute care to one centered on preventative, community-based care has the potential to save billions of dollars. But community-based care should be lower cost because it keeps people healthier and avoids expensive interventions, not because it relies on cheap labor or high caseloads. A number of Community Needs Assessments, from the Bronx to the Adirondacks, recognized that poverty and unemployment are contributors to the poor health of a community. **We must not let the DSRIP program, designed to improve community health, undermine the quality of jobs in the healthcare sector.** Not only will this increase the already dramatic income inequality in our state and add significant stress in communities where healthcare is the largest employer, it will not achieve the desired results. A poorly paid, low benefit workforce is likely to have high turnover, undermining the experience and continuity needed to provide high-quality community-based care.

As PPSs from New York City to the Adirondacks and everywhere in between acknowledged in their applications, there are significant disparities between the sectors. For example, Masters-level social workers who are members of our Union employed by New York City hospitals make an average of \$36 per hour, or \$67,000 per year, with no-cost healthcare and education benefits. Care coordinator and case manager jobs at community-based organizations in New York City – which often require the same

level of education -- are being advertised at just \$15-17 per hour. Community healthcare workers can make just \$10 per hour.

We often speak of our State's experience with the home care industry. We were a progressive leader in the 1970's, funding innovative programs to allow seniors and people with disabilities to receive needed supports and services at home rather than being forced to stay in institutions. But this system was built on the assumption that the workers providing those services would be making minimum wage. It has taken forty years to begin to invest the savings generated from reducing reliance on institutional care back into those providing home care services. In the meantime, hundreds of thousands of clients received lower-quality care than they should have because of a high-turnover, poorly-trained workforce. And home health aides, from communities already struggling with poverty and other drivers of poor healthcare outcomes, were unable to house and support their families. We cannot make the same mistakes as we build the new ambulatory sector. In particular, we cannot assume that either upfront investments or savings generated will flow to frontline caregivers without policies designed to achieve that outcome.

Very few PPSs addressed this issue explicitly in their proposals, as the independent assessors noted. Montefiore Medical Center was one of them, by setting a goal of creating jobs at a living wage. Others, like Westchester Medical Center, simply acknowledged that pay scales are historically lower in the ambulatory sector. The independent assessor also noted specifically the need for more detail on salaries at partner organizations from many PPSs. All PPSs will be required to perform a detailed wage and benefit analysis both for new hires and incumbent workers being retrained and redeployed as part of their implementation plans. **We ask both the Department of Health and the Project Advisory and Oversight Panel to monitor the trends carefully, particularly in cases where work is shifting extensively to PPS partner organizations and CBOs.**

Worker Engagement is Key to Transformation

Some PPSs have clearly recognized the vital role frontline workers like our members will play in implementing project plans and achieving DSRIP goals. The leaders of these PPSs understand that it is those providing the care who know where the gaps are and what it will take to transform the system. They also bring their knowledge of the communities they serve and, in many cases, come from. **When frontline workers are encouraged to bring this expertise to the table as part of governance structures and through innovative labor-management problem-solving, they can make the difference between success and failure.**

Performing Provider Systems like Bronx-Lebanon, Lutheran, Maimonides, Montefiore, Mount Sinai, Refuah and Westchester have worker representation on the main decision-making body for the PPS, recognizing the importance of the frontline caregiver perspective to the overall PPS strategy. They also have put caregiver representatives on a broad range of committees, including clinical ones where key project design decisions will be made. Allowing those who will be implementing these projects to have a hand in their design can help avoid costly mistakes. For example, in a recent health home project at Maimonides Medical Center, it was Care Managers at who identified gaps in housing services as having a significant detrimental impact on the implementation of care plans and outreach workers who developed strategies to support patients in overcoming fears about working with care managers.

PPSs like Lutheran Medical Center have also committed to using the skilled facilitators of the 1199SEIU Labor-Management Project to help manage change within their institutions. The LMI, jointly supported by employers and labor, has extensive experience running quality improvement projects as an “internal consultant”. They bring together frontline managers and workers to identify a problem, brainstorm together about its causes and potential solutions, implement an intervention and evaluate its results. In our experience, the need for this kind of careful, collaborative process when implementing major changes should not be underestimated.

Other PPSs have chosen a different route. They have made it very difficult for worker representatives to participate, like at Albany Medical Center and Catholic Medical Partners, or segregated caregiver representation only to a “workforce” committee, tasked with managing workforce impacts of decisions already made at a steering committee or clinical committee level. The communication they describe is entirely one-way, with webinars or newsletters announcing change to workers rather than engaging them in transforming the system. This is not a recipe for success.

Successful Workforce Development

Investment

The PPSs were asked to discuss their workforce plans in some detail in the applications, and we applaud the DOH for recognizing the importance of this aspect of DSRIP implementation. We were also very pleased to see that PPSs cumulatively budgeted over \$500 million for workforce development. There are significant differences between the PPSs, however.

To take into account the varying sizes of the PPSs, we divided the total workforce budget by the attributed population. The budgets range from a low of \$9.16 in workforce investment per life in the Southern Tier to a high of \$356 at the Central New York PPS¹. Those at the low end, including New York Presbyterian and New York Hospital Queens, are significantly underinvesting in the workforce strategies they need to carry out these projects.

Experienced Workforce Strategy Vendor and Bonus Points

We have strongly encouraged PPSs to engage an overall workforce strategy vendor with experience in modeling workforce change and designing robust systems to prepare and support workers through that change. We were pleased that many PPSs chose the 1199SEIU Training and Employment Funds, an industry-wide partnership governed by half management and half union leaders, to assist them with these efforts. The Training Funds have not only developed training for new roles in healthcare, such as community health workers, care managers and patient navigators, but also have decades of experience supporting workers in career pathways and providing employment and other services to support transitions to new jobs.

The role of the Funds is not solely as to act as a training vendor but more importantly to support workforce development within and across PPSs. They have expertise in working high quality training providers like CUNY and others to ensure curricula is aligned to industry needs, thereby creating

¹ We discounted Ellis’s number of \$689.70 as we understand they made a mistake in the chart.

economies of scale and avoiding duplication of effort. As an example, TEF is developing a strategy to address the likely shortage in asthma certified specialists. With only 387 asthma educators currently certified in New York State, and the popularity of Project 3.d.ii, the expansion of a home-based asthma management program, the need to assist culturally and linguistically competent people in moving into these occupations is clear. Likewise, many PPSs acknowledge the need to diversify their workforces, and particularly to recruit more bilingual staff. This is much easier said than done. Ensuring that there is an adequate supply of workers, particularly bilingual professionals, will require multi-year, highly coordinated strategies like those being employed by the TEF-led Bronx Project, which is a collaboration between employers, the Union and CUNY to increase the number of Spanish-speaking healthcare professionals in the Bronx.

We are concerned that the PPSs, like Mount Sinai, who have entered into an agreement with the Training Funds to provide coordinated services and are taking advantage of their multifaceted and extensive experience, were not awarded the full bonus points in Section 10. The independent reviewers seem to have based the number of points they awarded on the tense of the verb used to describe the contractual relationship – whether the vendor had already been contracted or would be in the future – rather than whether the vendor has been brought in as a high level consultant to help develop overall strategy. We believe that is the crucial distinction – whether the PPS intends to work with “a proven and experienced entity to help carry out the PPS' workforce strategy of retraining, redeploying, and recruiting employees.” This overall strategic role is different from hiring a series of vendors to provide training, regardless of how experienced they are.

Based on this criteria, we believe that Advocate Community Partners, Bronx-Lebanon, Lutheran, Montefiore, Mount Sinai, New York Hospital Queens, New York Presbyterian, Refuah and Westchester should receive the full 3 bonus points.

Labor-Management Approach towards Retraining and Redeployment

It is clear that all PPSs have significant work to do in the implementation plan phase to further refine and clarify their workforce plans. Still, we can see both positive and negative trends in the applications. While many applications were not explicit in their discussion of potential displacement, those that did indicated a potential for 7,000 workers statewide to lose their jobs because of DSRIP-related changes.

Some PPSs, describe an often-punitive, entirely management-driven approach to managing these disruptions. They suggest that workers will be offered one “take it or leave it” opportunity to avoid layoff. Other PPSs, including Advocate Community Partners, Staten Island and Maimonides were more thoughtful in their planning for potential displacement of workers. They indicated that they would seek to identify workers at risk of being laid off jobs early in the planning and implementation process and prioritize them for training and redeployment to the emerging healthcare jobs. They also committed to seek job applicants from the pool of displaced healthcare industry workers. Downstate, under our agreement with the League of Voluntary Hospitals, there is a labor-management Job Security Fund, which provides additional support and training for laid-off workers and a commitment to interview those workers for available positions for which they qualify in any signatory institution. **It is possible for any PPS to set up a similar system, and we would urge them to do so to help protect the economic health of vulnerable communities.**

Similarly, some PPSs took a collaborative labor-management approach towards training, recognizing the value of building career pathways to keep experienced workers with their organizations. They recognized the key role that colleges can play in ensuring that workers who upgrade their skills are able to get credit and work towards a degree which can improve their earning power. Others, like Stonybrook, said explicitly that their strategy is not to create “upward” career pathways but to keep workers in their current jobs. The former strategy is much more likely to engender support among the workforce for DSRIP-related changes.

Team Building

In their workforce plans, few PPSs seem to recognize the investment in training and facilitation it will take to build functioning multi-disciplinary teams, especially across different sites of care. There is – or ought to be – a recognition that there are not enough primary care physicians and nurse practitioners to treat the necessary population without engaging a team of both licensed professionals and paraprofessionals to extend the work of the physicians and NPs. Some PPSs are perhaps still learning this, when they claim that they will be able to hire 1,000 nurse practitioners in a state which only graduates 500-700 annually. Hiring the members of the team is only the beginning of the process, however. Most healthcare workers are used to operating in a highly structured hierarchy. **In our experience, the creation of successful multi-disciplinary teams requires significant time and effort to build trust, mutual respect and a new way of relating to each other that values each member’s contribution.** This is no less a culture change than that needed to create more performance and data-driven organizations, and we urge you to make sure that PPSs are investing in it.

Leveraging the expertise of workers at all levels

In reviewing the project descriptions we felt that many PPSs are missing opportunities to leverage the experience of existing workers, especially in long-term care, to help achieve DSRIP goals. Of any healthcare provider, it is home health aides and certified nursing assistants who spend the most time with their home care clients and nursing home residents. They are the first to know when the patient’s condition changes, potentially signaling worsening health. Ensuring that this information gets to other members of the care team, through telemedicine or other structured communication, has significant potential to help avoid unnecessary hospitalizations. And giving aides the skills to coach their clients to healthier decisions can build on long-standing, trusting relationships to achieve positive outcomes. None of the PPSs who chose the INTERACT project in nursing homes specifically discussed the role of certified nursing assistants in early identification of potential declines in health, despite research showing that CNAs were able to pick up such signs at least 3 days before they appeared in a residents’ medical chart.² Similarly, many PPSs missed the opportunity to discuss the role of home care workers in achieving the goals of transitions in care and chronic disease management projects.

Other Considerations

² Boockvar K, Brodie H, Lachs M. “Nursing Assistants Detect Behavior Change in Nursing Home Residents that Precede Acute Illness: Development and Validation of an Illness Warning Instrument.” *Journal of the American Geriatrics Society*, Volume 48, Issue 9 (September 2000)

In addition to the specific governance and workforce sections of the application, we offer the following comments on the larger program design.

Financial stability

Almost all PPSs recognize the potential for destabilization among their partners because of revenue loss due to the success of DSRIP projects. **It is vitally important that there be a recognition of the differential threat that some safety-net providers face because of this revenue loss, and that both PPSs and, if necessary, the Department of Health act accordingly to ensure that these providers are able to survive through the transition to a new delivery system.** Given the range of commitments that PPSs made to revenue loss funding (from 3% to 44%), this bears watching by the Oversight Panel. To give one example of the potential consequences, think of Interfaith Hospital. This historic hospital, in a high-need community in Brooklyn, recently went through bankruptcy and has been in a constant state of threatened closure. Our Union, together with the New York State Nurses Association, has been working for several years with a community coalition to assess local needs and come up with proposal to transform Interfaith into a center for services to address those needs. Everyone recognizes that this will look very different than the current inpatient hospital. This can be a success story of delivery system change. But it must be given a chance to work.

Regulatory relief

Scope of Practice

1199SEIU supports modifications to scope of practice to assure that the state's caregivers are able to support the goals of DSRIP by practicing at the top of their license. For example, 1199 supports amendment of 10 NYCRR § 766.4(a), (b) to allow physician's assistants (PAs) to order licensed home care services, in addition to doctors, midwives, and nurse practitioners. In addition, we strongly support necessary statutory changes such as the Executive Budget Proposal's proposition to create an "advanced home health aide" title and allow for registered nurses to assign some tasks, including medication administration, to advanced aides.

Home Visits

Care management is an essential component of a number of DSRIP projects, and may be best accomplished through home visits by physicians, nurses, care managers and other caregivers. In cases where operators have protocols and processes to ensure the same levels of quality of care and caregiver safety in a home setting as they would in a traditional setting, 1199SEIU supports waivers of NYCRR § 401.2(b), which provides that an operator may provide services listed on its operating certificate only for the designed site of operation and promulgation of new regulations and filing of a Medicaid State Plan Amendment (SPA) to the Centers for Medicare and Medicaid Services (CMS) as needed to permit reimbursement. Without this waiver, home services could move away from licensed providers and operators and their higher levels of oversight, with potentially detrimental effects on patient care and workforce safety.

Integrated Outpatient Services

New York State's recently adopted Integrated Outpatient Services regulations are a crucial step in the right direction to integrate behavioral and physical health services, along the lines of the waivers suggested.³ 1199SEIU also supports state level licensure for increasingly common forms of physician practice structure – i.e. office based surgery and urgent care facilities.

In addition, we support selected waivers to allow DSRIP projects to integrate care among medical and behavioral health providers as long as the entities have an integrated workforce covered by the same policies and standards (for example the same collective bargaining agreement). Such policies and standards should include comprehensive workforce training by a proven workforce training vendor, to help ensure the robust communication between team members necessary for high quality patient care.⁴

Certificate of Need

The current Executive budget proposes to streamline the Certificate of Need (CON) process, in some cases along the lines of some of the waivers requested,⁵ 1199SEIU supports some streamlining, as long as it does not result in decreased access, particularly for Medicaid patients, and preserves strong oversight and an open public process. **We do not support elimination or limited CON for approval of new Article 28 Facility construction in conjunction with downsizing or of administrative review for decertification of services or bed reductions.**⁶ The downsizing or decertification of beds without full, independent review may undermine attempts to ensure access to quality healthcare.

Certificate of Public Advantage

Several PPSs have indicated their intention to apply for a Certificate of Public Advantage and it is likely that more will follow suit. The regulations outlining the review process for a COPA application reserve the right of the DOH to request information from applicants beyond that required in the formal application. Additionally, subpart 83-2.5 cites the “inability of healthcare providers to negotiate reasonable payment and service arrangements”⁷ as a potential contravening factor in the consideration of COPA requests. Consideration of COPA applications must include the expected effects of consolidation on the workforce, including the potential depression of wages if one provider exercises market control. Where a COPA applicant's workforce plan included in the DSRIP application is insufficient to allow for evaluation, the applicant should be required to supply more detailed information.

³ Given DOH newly adopted regs on January 1, 2015: http://www.health.ny.gov/regulations/recently_adopted/docs/2015-01-01_integrated_outpatient_services.pdf

⁴ See for example 10 NYCRR §§ 401.2(b), 401.3(d); OMH: 14 §§ NYCRR 599.3(b), 599.4(r), (ab); OASAS: 14 NYCRR §§ 800.2(a)(6),(14), 810.3, 810.3(f), (l). OASAS: 14 NYCRR 814.7 general facility requirements for shared facilities

⁵ Include but not limited to 10 NYCRR §§ 670.1, 670.2, 670.3, 709.1, 709.2, 709.3, 710.1, 10 NYCRR 401.3(e).

⁶ (See for example Sinai request)

⁷ 10 NYCRR Subpart 83-2.5

Albany Community Land Trust
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www.albanyclt.com

February 15, 2015

DSR Administration
New York State Health Department

DSRIPApp@health.ny.gov

To Whom It May Concern:

The Albany Community Land Trust (ACLT) is very concerned about the inadequate outreach to residents in low-income neighborhoods in Albany for participation in current needs assessments in the DSRIP process by two PPS providers, Albany Medical Center and Ellis Medicine/ St. Peter's Health Partners. We request that this outreach process be greatly expanded to enable neighborhood residents, businesses, churches, and social service providers throughout Albany.

Since 1987 the ACLT has been working to improve housing conditions in a variety of neighborhoods by acquiring and rehabilitating deteriorated vacant properties and converting them into affordable homes and apartments. We are disturbed that to date the DSRIP process has not been visible in the communities or populations involved in our work. ACLT staff, board, and volunteers work involves networking with a wide cross section of community residents and professionals, and we very much want to participate in planning efforts to improve public health and medical care services.

The potential for positive changes in medical care delivery and community conditions affecting our health is extremely compromised by the failure to seriously involve people living in low-income areas and working in grass roots settings in the DSRIP planning process. As a minimum the DSRIP process needs to be expanded to include the large numbers of people in our neighborhoods who have been left out.

Roger Markovics
Secretary, ACLT

PRIMARY CARE DEVELOPMENT CORPORATION COMMENTS PRESENTED
TO THE DSRIP PROJECT APPROVAL AND OVERSIGHT PANEL

FEBRUARY 17, 2015

DSRIP MUST DELIVER ON THE PRIMARY CARE PROMISE

Today, more than 2 million New York State residents lack access to primary care. As a state, we invest less than 6% of total healthcare spending in primary care. It will take more than 1,100 new primary care providers and more than \$1 billion in capital to build the primary care capacity to meet this need. Our primary care shortage is the chief reason why New York ranks highest in the nation in avoidable hospital use and cost, fourth highest in emergency room wait times, and sixth highest in total health care spending, yet only the middle of the pack in health outcomes. More than 40% of emergency room visits and 24% of hospital admissions or readmissions statewide are for primary care preventable conditions.

New York State and all 25 DSRIP Performing Provider Systems (PPSs) have committed to ensuring access to quality primary care for the patients they are serving. Our expectation is that at the conclusion of DSRIP:

- The vast majority of New York State residents currently without primary care will have regular and unfettered access;
- The vast majority of primary care providers will be practicing as true Patient Centered Medical Homes (PCMH) or Advanced Primary Care (APC) models;
- Spending on primary care as a proportion of total health spending will at least double from current levels;
- Evidence of primary care value to health care quality, outcomes and costs will be clearly demonstrated and reflected in value-based payment models.

Five Principles for Primary Care Success should be followed to ensure DSRIP delivers on the Primary Care Promise:

- 1. Every PPS should have a Primary Care Plan**
- 2. Measure true primary care access and quality throughout DSRIP Implementation**
- 3. Meaningfully represent primary care in PPS governance**
- 4. Prepare the workforce to support new care models**
- 5. Ensure sufficient resources for primary care impact**

These principles are presented in detail following our comments.

Why we are encouraged about DSRIP and primary care

There are reasons to be hopeful about what DSRIP means for primary care, and we are encouraged by the enthusiasm and commitment to primary care demonstrated by New York State and in most of the PPS project applications.

Strong Emphasis on Primary Care: New York State leaders have repeatedly emphasized that PPSs are expected strengthen primary care as a means of achieving DSRIP's goals, and are committed to seeing a fundamental transformation in how New York State healthcare providers organize and deliver care to patients and communities.

Near Universal Inclusion of Patient Centered Medical Home/Advanced Primary Care: There are nearly 16,000 primary care providers participating in DSRIP projects. Every PPS has selected projects that require all participating primary care providers to become NCQA Level 3 PCMH or APC practices.

Full Inclusion of Primary Care/Behavioral Health Integration: All 25 PPSs have selected projects that integrate primary care and behavioral health – critical to improving health outcomes, as patients behavioral or social problems often contribute to health issues and vice versa.

Concerns about DSRIP and primary care

There are also reasons for concern as New York's healthcare system embarks on the DSRIP journey. Our concerns focus on the elements of implementation that will have the greatest impact on success.

Require a Primary Care Plan: While primary care is integrated into DSRIP, PPSs are not required to produce an actionable plan to increase primary care capacity and access (unlike the requirement of a workforce plan from each PPS). There have been too many initiatives in the past that assumed a significant role for primary care, only to have it subsumed and fade into a minor role. Primary care is a foundational element of DSRIP, and should be treated as such.

Measure True Primary Care Access and Capacity: While all submitted community needs assessments, PPSs were not required to systematically measure true primary care access and capacity. Metrics should include: ratio of patients to providers and exam rooms, panel size and payor mix, physicians accepting new Medicaid/uninsured patients, timeliness and availability of appointments (including same-day), hours of operation, use of telemedicine and other non-facility based engagement and cultural competencies that reflect the needs of their communities. We also need to know how much additional capacity will be needed, where and at what cost, and how much capacity can be gained by improving provider performance versus adding new capacity.

Measure Primary Care Performance to Ensure Effective Implementation: Likewise, PPSs need to assess the performance level of their primary care providers. Every single primary care provider in a PPS is essential to the success of DSRIP, yet not all are equally prepared to begin the work. Only about 25% are currently NCQA-recognized PCMHs and fewer still are truly operating as a PCMH. PCMH is a rigorous model that requires primary care practices to work in ways that are

comprehensive, team-based, coordinated, accessible, and focused on continuously improving quality. We can expect that implementation will be particularly difficult for practices currently without this experience. PPS implementation plans should include an assessment of where practices are starting from and what it will take for them to become part of an integrated delivery system.

Meaningfully Represent Primary Care in PPS Governance: The PPS governance and decision making processes will play a major role in priority setting, deployment of operating and capital resources, establishment of clinical guidelines and structure of financial incentives. Given the central role of primary care in a transformed healthcare system, those having clear experience with and commitment to advanced primary care models must have tangible influence in how decisions are made and resources allocated. Primary care should be meaningfully represented in PPS Steering Committees, Clinical Governance Committees, Finance and Budget Committees (funds flow decisions).

Ensure Sufficient Financial Resources: Upfront and continuous investment in expanding primary care capacity and transforming the model toward PCMH/APC is critical to achieving overall DSRIP goals. In most cases, it is not clear how these resources will be directed for these purposes. PPSs should prioritize this investment by dedicating a substantial portion of funds (including incentive payments) to primary care expansion and transformation. Consideration needs to be made for the cost of practice transformation at the primary care practice site, including revenue losses during the transition.

Provide Effective Technical Assistance: Primary care transformation can be difficult, particularly for busy practices juggling multiple requirements. Outside technical expertise can have a substantial impact on a practice's success. With some exceptions, PPS project plan applications are vague at best about whether, how and where technical assistance will be organized and deployed to contribute to the success of primary care transformation projects.

Prepare the Workforce to Support New Care Models: Transformation will require fundamental change in the skills, competencies and deployment of the healthcare workforce. The ability to work in multidisciplinary teams, the engagement of patients by nonclinical staff, and the communication between staff and clinicians within and across organizations pose enormous challenges. Some PPS plans address workforce better than others, and we are concerned that an underestimation of time and resources directed toward these efforts may impede workforce transformation – and the achievement of DSRIP goals.

Ensure Access to Capital: We will never transform the healthcare delivery system without major capital investment in community based healthcare. Estimates are that more than \$1 billion in capital is required to build community based capacity necessary to meet the needs of those who lack sufficient access to care. Community-based primary care providers must compete with institutional providers for \$1.2 billion in state funding through the Capital Restructuring Financing Program (CRFP). An additional \$1.4 billion in the Executive budget appears targeted exclusively for hospitals.

Affordable financing options for community-based providers are limited, as are government-backed credit programs like those used to finance hospitals and affordable housing.

Accelerate Value-Based, Primary Care-Focused Payment Reform: Today, less than 6% of healthcare spending goes to primary care. Without comprehensive payment reform that places value of care ahead of volume of care, all of DSRIP's good intentions and \$6.4 billion will fail to bring meaningful healthcare transformation. We support the Cuomo Administration developing value-based reimbursement methodologies and authorizing managed care organizations to contract with providers for value-based payment arrangements. This work should proceed quickly and cover public and private payers alike.

Payment reform must address the form of payment and its adequacy. It should explicitly include alternatives to fee-for service reimbursement; payments that value primary care, care coordination, telehealth, group visits, health information exchange and other enabling services. We will never achieve true transformation if we continue to undervalue parts of the system that are essential to improving health and reducing costs. Given the very low base of current primary care spending, doubling primary care spending would entail a minor spending shift but be enormously significant to sustaining the key elements of true PCMH/APC.

About the Primary Care Development Corporation (PCDC)

Founded in 1993, PCDC is a nationally recognized nonprofit organization dedicated to expanding and transforming primary care in underserved communities to improve health outcomes, lower health costs and reduce disparities through three key program areas: Capital Investment, Performance Improvement, and Policy and Advocacy. PCDC's impact includes more than \$515 million invested in low-income communities, 1 million square feet of primary care capacity developed, 900 healthcare organizations strengthened to deliver patient-centered primary care, 7,000 healthcare workers trained and 765,000 patients with improved access to primary care.

For more information: Dan Lowenstein, PCDC Senior Director of Public Affairs: dlowenstein@pcdc.org

DSRIP MUST DELIVER ON THE PRIMARY CARE PROMISE: FIVE PRINCIPLES FOR PRIMARY CARE SUCCESS

Five Principles For Primary Care Success should be followed ensure DSRIP delivers on this Primary Care Promise:

- 6. Every PPS should have a Primary Care Plan.** Primary care plans should specify how the PPS will ensure access to quality primary care for their population. All plans should include:
 - a. An assessment of current primary care capacity, performance and needs, and a year-by-year plan for addressing those needs;
 - b. How primary care expansion and practice and workforce transformation will be supported with training and technical assistance;
 - c. How primary care will play a central role in an integrated delivery system;
 - d. How value-based payments will enable primary care to achieve quality outcomes and cost savings;
 - e. How these efforts will be supported financially throughout and beyond DSRIP.
- 2. Measure true primary care access and quality throughout DSRIP Implementation.** Access metrics should determine: ratio of patients to providers and exam rooms, panel size and payor mix, physicians accepting new Medicaid/uninsured patients, timeliness and availability of appointments (including same-day), hours of operation, use of telemedicine and other non-facility based engagement and cultural competencies that reflect the needs of their communities. Quality metrics should determine: impact of primary care, care coordination and care management on health care quality, outcomes, utilization and cost.
- 3. Meaningfully represent primary care in PPS Governance.** Given the central role of primary care in a transformed healthcare system, those with clear experience in and commitment to advanced primary care models must have tangible influence at all levels of the PPS, including its Steering Committees, Clinical Governance Committees, Project, Finance and Budget Committees.
- 4. Prepare the workforce to support new care models.** True PCMH or APC require fundamental change in the skills, competencies and deployment of the healthcare workforce. Workforce development plans should demonstrate how the PPS will ensure the healthcare workforce can fill new job categories, work in multidisciplinary teams and participate meaningfully in the management of patient and population health.
- 5. Ensure sufficient resources for primary care.** Less than 6% of the health care dollar is now spent on primary care. PPS budgets should clearly identify up-front and ongoing resources dedicated to expanding and transforming primary care. This includes practice transformation and workforce support, DSRIP incentive payments, value-based reimbursement and capital funding for expansion and modernization.

**DSRIP MUST DELIVER ON THE PRIMARY CARE PROMISE:
FIVE PRINCIPLES FOR PRIMARY CARE SUCCESS**

More than two million New York State residents lack sufficient access to primary care. The Delivery System Reform Incentive Program (DSRIP) is our best opportunity to strengthen and expand primary care, which is central to achieving better health for patients and communities, and lower costs for everyone. New York State and all 25 DSRIP Performing Provider Systems (PPSs) have committed to this vision, including ensuring every primary care provider in their network is a high-performing Patient Centered Medical Home (PCMH)/Advanced Primary Care (APC) practice. Our expectation is that at the conclusion of DSRIP:

- The vast majority of New York State residents currently without primary care will have regular and unfettered access;
- The vast majority of primary care providers will be practicing as true PCMHs/APCs;
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Quality metrics should determine: impact of primary care, care coordination and care management on health care quality, outcomes, utilization and cost.

3. **Meaningfully represent primary care in PPS Governance.** Given the central role of primary care in a transformed healthcare system, those with clear experience in and commitment to advanced primary care models must have tangible influence at all levels of the PPS, including its Steering Committees, Clinical Governance Committees, Project, Finance and Budget Committees.
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5. **Ensure sufficient resources for primary care impact.** Less than 6% of the health care dollar is now spent on primary care. PPS budgets should clearly identify up-front and ongoing resources dedicated to expanding and transforming primary care. This includes practice transformation and workforce support, DSRIP incentive payments, value-based reimbursement and capital funding for expansion and modernization.

What You Can Do to Ensure DSRIP Delivers on the Primary Care Promise

The ability of DSRIP to deliver on the Primary Care Promise impacts all of us. If you want to DSRIP to work for primary care and transform healthcare for the benefit of all families and communities, take action now:

- Adopt these principles into your advocacy message.
- Read the PPS DSRIP applications and their scoring, which are now online.
- Follow the DSRIP Project Approval and Oversight Panel, which will be holding public meetings February 17-20. (Public comments on Feb 17th. All meetings webcasted.)
- Read and comment on the DSRIP PPS Implementation Plans, due on March 1.
- Meet with PPS leads in your community and attend open sessions of their governance bodies.
- Discuss your concerns with New York State DSRIP officials and your elected representatives.

For more information: Dan Lowenstein, PCDC Senior Director of Public Affairs: dlowenstein@pcdc.org

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Comments and Recommendation on the New York City PPS Proposals

As a citywide health advocacy organization, CPHS feels the importance for DSRIP to critically increase the engagement of communities in the process and their local PPS's. CBO involvement on various committees does not necessarily mean CBO equity. Equity involves: shared decision making and power; using CBO expertise as a resource to help develop programming; and creating a transparent flow of funds and a system where all can monitor accountability. We hope that the state, Independent Accessor and its six reviewers, including the Oversight and Approval Panel carefully scrutinize and ask questions of the PPSs about how these areas above have been addressed.

It is unfortunate that a hearing is not scheduled in New York City. However, CPHS will be participating in the Feb 17th public hearing in Albany. We wanted to be on record with these recommendations that were carefully designed in consultation with other community-based organizations. We will be providing more detailed comments on the various PPS proposals coming from NYC. We strongly believe at a least these recommendations would be useful to assure DSRIP reaches the potential---and goals---we all want it to reach.

1. Require and ensure consumer/community-based organization involvement in all levels of decisions by:
 - The state set up a working group made up of representatives from the PPS's, community based organizations, and consumers who are not now represented on the state Oversight and Approval Panel, to generally make recommendations to the state with a special focus on outreach, engagement and cultural competency.
 - Ensuring the community infrastructure to support the PPS goals is critical.
 - ✓ Planning dollars for CBOs: All planning money has been targeted toward developing the PPS centrally. Partners in the community need to prepare as well and are often far more under resourced. During this critical develop phase of DSRIP, money has not been available for strategic planning, program development, and technical assistance for the PPS partners.
 - ✓ Infrastructure & Capital \$\$\$: Need to develop community based resources to support DSRIP goals. Making it possible for CBO to access capital dollars and expand infrastructure to support. Focus appears to be strictly on Medical providers and we know this is not necessarily where the solution lies. Many CBOs were either not eligible or were not prepared to respond to the capital RFP yet the need remains.
 - ✓ Expansion needs – services offered by CBOs: In order to reduce unnecessary hospital use, community based services need to be in place to support individuals redirected from but interconnected to the hospital. There is a cost to do this that is not being considered in the current model
 - That the state require the PPS's to use their advisory committees (PAC) to develop outreach and education plans and cultural competency plans, and require PPS's to use some of their resources to subcontract CBO's to do basic outreach, education and cultural competency trainings/ efforts related to DSRIP projects and the process.

- Require the PPP's to diversify their governance structures. At a minimum, executive committees of all PPS's should include one social worker, physician, nurse, and other profession (i.e. mental health provider) knowledgeable about chronic disease care and prevention. At least one community group for each of the identified social determinants of health (i.e. housing, food insecurity, economic security, age, violence, open spaces/environment, education, workforce development, etc.). It should also include more than one local consumer on Medicaid and uninsured, and a front-line worker knowledgeable about patient engagement and education (CHW, peer educator, peer specialist etc.).
- Assure equal ability to access PPS advisory and committee meetings, Oversight and Approval Panel meetings should occur alternately between Albany and NYC and always contain at least ½ hour for public comment.

2. Recognize DSRIP Projects must expand beyond an academic and clinical framework, by:

- Ensuring that the key components of a community-driven health program address the social determinants of health.
- Focusing its core strategies on cultural competency, especially for the populations to be served.

3. CNHA should be subjected to professional standards, intense review, and relevance to the community served. Assessments done without any independent expertise should be subject to careful scrutiny and possible deductions in the scoring. (I.e. NY Presbyterian and Mt Sinai did not do a formal CHNA and did it internally). And even the independent expertise should be subjected to quality review on how well they did the CHNA, especially if the purpose was in helping to select DSRIP projects.

4. The "all or nothing" funds flow "formula" will destabilize the whole system from the beginning. Reimbursement should be proportional to effort achieved for each goal, not a complete loss for missing the goal even by a minor amount.

Thank you

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DISTRICT COUNCIL 37, AFSCME COMMENTS ON HHC DSRIP
PARTICIPATING PROVIDER APPLICATION- WORKFORCE
STRATEGY- FEBUARY 15, 2015

It is critical that as the New York City Health and Hospitals Corporation works to transform in a changing health care environment relying less on in-patient visits replaced by an ambulatory care and community focused patient care environment that all stakeholders be involved in this change for HHC to continue to provide quality accessible care to New Yorkers.

This means that labor unions representing the impacted workforce, patients, advocates and community partners and other key allies must be a part of process and the solution.

The HHC application to become a Participating Provider Organization under the New York State Department of Health Delivery System Reform Incentive Payment Project (DSRIP), provides both challenges and an opportunity for HHC to meet its mandate of providing quality public health care to those most vulnerable in our midst (i.e., the uninsured, underinsured, chronically ill patients, communities of color in catchment areas of poor access to quality health care).

Following are comments regarding Section 5 of the PPS Workforce Strategy for your review:

- Detailed workforce strategy identifying all workplace implications of PPS

This will require an analysis of the existing workforce and the needs for future jobs in growing areas in the ambulatory care realm including, but not limited to, Social Workers, Psychiatrists, Behavioral Health workers. Over the last several years HHC and the local unions representing employees in DC 37 titles have addressed issues regarding recruitment, retention and training of staff and expect to continue to do so in the DSRIP framework. We plan to engage in even more collaborative partnerships with this opportunity.

- Retraining Existing Staff

HHC proposes \$50 million over 5 years to train 20% of the impacted workforce. It must be clear amount whether this applies to the direct workforce of HHC or the much larger workforce of all PPS partners. We must ensure that there are also adequate tools for accessing retraining funds and training resources such as the DC 37 Education Fund, CUNY, College of New Rochelle and other new and innovative programs that we can partner and develop to meet the needs of the members we represent. There also must be clear bench marks and levels of accountability. Clear assessments of the job need and growth should be done by HHC and shared with the Union

to develop sensible retraining programs. Critical to retraining is adequate funding for remedial skills, high school and college preparation and culturally sensitive training must be a part of this retraining effort after full assessment of the impacted workforce.

- Redeployment of Existing Staff

DC 37 and HHC have successfully negotiated several redeployment agreements when circumstances have required the movement of staff, including the recent closure of Brooklyn Central Laundry and the Goldwater facility. Written agreements and clear procedures respecting seniority and job classifications allowed staff to maintain wages and benefits in new locations.

The redeployment of staff must be aligned with the workforce development strategic plan (i.e., where the jobs are now and in the future, what are the retraining necessary, if any, for these jobs, what are the facility settings, who will this impact the patient care satisfaction and workforce). As we face the challenge of the transformation of HHC and the rightsizing of the workforce, we must be sensitive to balancing the needs of the workers and patients and the community. We must develop a structure to devise a fair and equitable redeployment process that protects the impacted workers and maintains the principal of quality public health care provided by the public sector. Affected titles in clerical, blue collar, dietary, central supply and related titles need to be retrained in a timely manner to anticipate the redeployment needs.

Staff who are currently engaged in support activities for in patient care will be excellent candidates for working in an out patient, patient engagement environment based on their current familiarity with the community and commitment to HHC's principles.

- New Hires

We must assess the needs of where hiring will increase and where it will fall and ensure that the use of full-time positions with benefits and decent wages in union represented titles is the guiding principle. Recently implemented adjustments in Social Worker salaries should assist in the recruitment and retention of the 100 identified new Social Workers. However, caseload remains a concern as the need for behavioral health programs accelerates faster than staffing can accommodate.

- State Program Collaboration Efforts

All state programs that provide effective collaborations that are best practices should be available and maximized for an effective use of funding for this important transformation project.

The Health Home model is an example where clearer definitions from the State, and closer collaboration between the Unions and HHC may generate better outcomes. Caseload, and changing requirements make this a challenging area to work in.

- Stakeholder & Worker Engagement

It is critical that worker engagement models must be a major prong of the development of the PPS process. By replicating the successful HHC Joint Labor Management Committee model, this best practice can be re-aligned to meet the needs of the DSRIP goals and objectives at each impacted HHC facility and on a Corporate-wide basis to meet the workforce strategic needs on a global and local level. Much more frontline worker engagement and education on the process will be required to successfully implement the programs. Thus far, DC 37 has recommended a Social Worker and a Service Aide to serve on local borough hubs, as well as the participation of Union staff.

- Workforce Process Measures

These measures must be clearly defined, measurable and transparent. They must be shared in sensible data so that all stakeholders understand and use them effectively to meet the workforce strategic plan benchmarks and goals.

A title by title analysis of current state and projected future state should be jointly prepared and used to create benchmarks. All facilities must agree to cooperate and follow the plans. In the past the Union has been frustrated by the decentralized actions of some facilities.

February 14, 2015

Ms. Ann F. Monroe, Co-Chair
Mr. William Toby Jr., Co-Chair
DSRIP Project Approval and Oversight Panel
New York State Department of Health
DSRIP Program

Re: DSRIP PPS Applications

To Whom It May Concern,

The New York State Nurses Association is the union that represents 37,000 registered nurses in New York State and a committed advocate for improving the quality of care, providing universal access to care to all residents of the State of New York, and addressing the health care needs of the people of New York State.

We have reviewed the applications submitted by the 25 Performing Provider Systems that are seeking approval for funding under the DSRIP program. We have also reviewed the overall implementation procedures and processes as they have been developed pursuant to the terms of the 1115 Waiver amendment agreement and protocols established by CMS and the state of New York.

The basic goals of the DSRIP program are (1) to improve the quality of care for Medicaid patients and within the broader healthcare delivery system, (2) to improve actual health outcomes and indicators of New York communities and their residents, and (3) to reduce costs of care per patient by reducing unnecessary hospital usage. The implementation of these general principles is expressed in a programmatic goal of reducing unnecessary or avoidable hospital usage by Medicaid, dual eligible and uninsured patients by 25%. A second programmatic goal is to use the DSRIP process and increased funding streams to assist our safety-net providers in becoming financially sustainable.

NYSNA supports the general goals and principles embodied in the DSRIP process will continue to monitor and intervene to ensure that all patients and communities have access to high quality care that is clinically appropriate and evidence based. We also support efforts to provide necessary resources to implement health education and primary care networks that will work directly with communities to improve overall levels of health.

NYSNA further supports the application of 1115 Waiver funding to stabilize the finances of safety-net hospitals and other providers and to increase the availability of primary care and ambulatory services to underserved communities throughout the state.

NYSNA also has stated its appreciation for the efforts of the CMS and the State of New York to create a waiver process that has been unprecedented in the degree of transparency and opportunity for public review and input.

This effort to promote transparency has been evident in the initial design and implementation of the DSRIP program and in the actual workings of the various Performing Provider Systems (PPS) that have submitted applications for DSRIP funding. The requirement that each PPS include community and labor representatives on the PPS Project Advisory Committees, in the drafting of Community Needs Assessment and in other governing bodies has laid the groundwork for a more open process and created the possibility of meaningful participation by front-line nurses and other healthcare workers, by affected communities and by patient care advocates in the design and implementation of DSRIP programs.

Notwithstanding these positive elements of the 1115 Waiver and DSRIP program, however, we have also expressed concern that there remain significant shortcomings and potential pitfalls in the ongoing implementation of the DSRIP program.

NYSNA has the following general comments and concerns regarding the DSRIP process and the specific PPS applications that have been submitted for approval:

1. Inadequate Opportunity for Public Comment on the DSRIP Applications

The final applications by the 25 PPSs were posted on the DOH website on January 15, 2015 and the public was afforded, under the terms of the DSRIP protocols, a 30 day period to review and comment upon the applications.

The applications have been scored by the private vendor hired by the State to assist in DSRIP implementation and those scores have been released on the DOH website. It should be noted that the assessor scoring is largely limited to the narrow technical aspects of the applications and does not provide any analysis regarding the broader implications of the various applications to the future structure of the healthcare system or the possible impact of individual applications on community health needs beyond the DSRIP program.

The DSRIP Project Approval and Oversight Panel (PAOP), which is tasked with reviewing each application and deciding on whether to recommend approval or disapproval to the DOH is meeting in Albany for four days from February 17-20, 2015.

According to the published agenda and schedule of PAOP, one day of meeting time will be allocated to public comment on the applications (February 17th). The agenda further indicates that there will be a total of 4 ½ hours of time allotted for public comments on that day (11:00 am to 12:30 pm, 1:30 pm to 3:00 pm and 3:30 pm to 5:00 pm).

Following the hearing of public comments on day one, the PAOP will devote three days of time to discussing and deciding upon recommendations for each of the 25 submitted applications. According to the agenda, each project application will be allotted a total of 50 minutes of time. This 50 minute block will include a short presentation by the applicant (5 minutes), a presentation by the independent assessor

(15 minutes) and then an opportunity to ask questions and a discussion and vote on motions to approve or disapprove each application (30 minutes).

This process raises serious questions about the effectiveness of the opportunity for public input and the depth of the review and analysis that will be conducted by the PAOP.

With respect to issue of the adequacy of the opportunity afforded for the public and affected communities to have meaningful comment and input, we note the following concerns:

- a) The posted applications lack clarity and crucial details as to the nature of the proposed programs and their impact on the continuing availability of local services as the DSRIP projects are implemented. The posted applications provide only general descriptions of the various projects that are expressed with technical jargon and often conclusory generalizations. Many of the projects call for closures of beds, elimination of services, relocation of services and the creation of new services, but do not disclose any meaningful information about the specifics related to the particular existing programs and services that will be eliminated or reduced or the locations to which they will be moved. There is similarly little or no information about where new or expanded services will be sited or how they will meet particular local needs.

The lack of detail in the applications deprives the public of necessary information to provide meaningful comment or input in the decisions of the PAOP and the final action by the DOH.

- b) The posted applications do not provide information about the specific partner organizations and their role in the DSRIP projects. The applications that were available for review by the public specifically failed to include complete lists of collaborating providers and of the scale and nature of their role in the DSRIP projects being submitted. The posted applications apparently included detailed lists of collaborating providers, but the link to those lists that was provided was not active. The public was thus left only with a generic chart listing the number of providers participating grouped by general category (i.e., 5 hospitals, 1 FQHC, 843 primary care physicians, etc.).

The lack of detail in this area is of grave concern because the public will not know whether providers in their particular communities are participating or will be affected by the DSRIP projects. The public is also unable to form any informed opinion as to whether the proposed projects will be beneficial or harmful or in keeping with local needs.

It is particularly a matter of concern that the lack of information about particular providers included in the PPS application prevents any public comment or input regarding quality of care, access to care, abusive practices or other problems related to the past record of particular providers that should be known before they are included in a publicly funded program that will give them access to a share in a multi-billion dollar public program.

It would seem to us that the public comment period would have served as a critical opportunity for such information to be brought forth and, further, that such information would be invaluable to both the POAC and the DOH in deciding on particular applications.

The failure to make available the complete list of providers deprived the public of the opportunity to participate in a meaningful way in the DSRIP process and could result in decisions that allow inappropriate opportunities for abusive or inadequate providers to receive financial windfalls at the expense of the public.

- c) The DOH and the PPS providers in general have failed to mount a serious public information campaign to make the general public and affected patients and communities aware of the implications of the DSRIP process and its possible effects on their existing and future access to healthcare services.

The stated intent of the DSRIP program is to massively restructure the entire healthcare delivery system. The program includes an allocation of \$8 billion in public funding for DSRIP and an additional \$2.6 billion in approved or proposed state funds for capital needs in support of DSRIP.

Given the sweeping intent and implications, the State and the PPS applicants should have engaged in a systematic campaign to inform the general public of the program and encourage broad input and participation in the approval process and in the workings of the PPS applicants.

To our knowledge, it appears that no such efforts were undertaken. The DSRIP program has been the subject of some reporting in the press (though much of this coverage has been carried out in trade or business organs that are read by industry insiders). The State has made no public information efforts beyond the creation of a DOH website and the posting of material in accordance with the terms of the agreement and protocols with CMS.

The PPS systems themselves have been required to include the public and local communities in their Community Needs Assessment process and in the formation of their Project Advisory Committees. The effectiveness of these PPS efforts has been uneven and in many cases inadequate. It also reflects an ongoing failure by the state to exercise oversight and community engagement in favor of allowing private providers to self-regulate and determine the adequacy of their efforts to comply with the requirement to act transparently and to include the public in the process.

The failure to systematically engage and inform the public and affected communities about the DSRIP process and particular PPS applications undermines the stated intent of the DSRIP program to provide meaningful input and control over their healthcare needs.

- d) We have noted that the 30-day public comment period on the DSRIP applications started when the applications were posted on January 15th. We have also noted that the public did not have full access to the applications and was thus deprived of an opportunity to fully understand and comment on the process in writing.

The public comment period provided by the DOH expires on February 15th and the PAOP will be holding the only open public comment meeting on February 17th. The PAOP will committee will be issuing its decisions on the applications between February 18th and 20th.

Given the large volume of materials, the lack of specificity regarding the actual implications and impacts of the proposed programs of the various PPSs, and the short time between the end of the public comment period and the actual decisions of the PAOP, it appears that any comments that are submitted will be unlikely to receive full consideration by the members of the PAOP and that the comments will be effectively rendered irrelevant to the decision making process.

The speed with which the DSRIP process is being implemented and decided upon renders meaningless or severely undermines the validity and effectiveness of the public comment process.

- e) The only public opportunity to present spoken comments in the DSRIP decision-making process will be the public meeting of the PAOP on February 17th.

The way in which this public meeting is being handled also acts to effectively undermine the role and input of the public in the DSRIP process. As was noted above, the public comment meeting will provide a total of 4 ½ hours to hear public comments (in three 1 ½ hour blocks of time). There will be no public comment allowed during the consideration and discussions of the project applications on the three days of meetings devoted to approving the plans on February 18-20.

This provides the public with a total 270 minutes of comment time. Given that there are 25 individual PPS applications to be considered, this amounts to a total time per application of 10 minutes and 48 seconds. This would allow at most four or five comments lasting no more than 2 minutes to address a total of 25 PPS systems and 250 discrete project proposals. There will be little or no time for questions or deeper discussion of any concerns or issues that are raised by individuals or organizations.

It is also extremely problematic that the only hearing being scheduled during the decision-making process is occurring in Albany and there are no local hearings scheduled.

Given the distances and travel times involved for many residents of New York and the short amount of time allotted for comments, it is likely that few will be willing to spend a day or more traveling to the hearing in order to make a 1 or 2 minute statement that will receive little or no attention.

The grossly inadequate allotment of time for public comment effectively relegates the public to a process that creates the appearance or a façade of involvement but is essentially a meaningless formality.

Given the inadequate and merely formal compliance with the DSRIP protocols and agreements requiring public input and comment, and the speed with which the process is being implemented, NYSNA believes that the public should be included in a real and meaningful manner and that the process should be slowed down to allow full public engagement in the decision-making process regarding review, approval and implementation of DSRIP projects.

2. Lack of Democratic Input in PPS Structures

NYSNA has noted its support for the relatively high degree of democratic input and public transparency that is embedded by the DSRIP agreement and protocols. Unlike past waiver programs, DSRIP is required to include health care workers, patients, local communities, and healthcare advocates in design, implementation and ongoing operation of the PPSs and their concrete projects. This is a welcome and positive development.

We are concerned, however, that the ongoing DSRIP process is not living up to either the letter or the spirit of the protocols and our expectations on this issue.

The DSRIP process as it has unfolded thus far does not go nearly far enough in providing a meaningful voice and degree of democratic input into the process.

Based on our experiences to date, it appears that the inclusion front-line RNs and other workers, community groups, patient advocates and other key stakeholders in the Project Advisory Agreements has been very unevenly applied.

While some PPS PACs have been very open to outside involvement, many others have been resistant or have afforded limited participation. In many cases the PACs have largely limited participation to partner provider organizations and have given little or no opportunity for participation by other affected groups. This is evident in the applications submitted by many of the PPSs, which clearly give control over decision-making relating to governance and implementation to the lead provider and include only representatives of other partner providers.

We also note that even those PPS applicants that have allowed broader participation have treated the PACs as more of a chore than as a real advisory and decision-making body. In many cases, the PAC meetings are convened on monthly or infrequent basis and are merely given short updates and power points about the general progress and direction of the PPS. The PACs are thus effectively relegated to a secondary status, without any real role in the shaping of the PPS or its projects. The convening of PAC meetings and the presentation of surface or shallow briefings thus is treated as more of an exercise in public relations than as a meaningful opportunity to include a broad spectrum of workers and community members in the actual operation of the PPS and the implementation of the actual DSRIP projects.

We have also noted that many PPS PACs are attempting to relegate worker representatives to participating in PAC sub-committees addressing the effects of workforce displacement. Though workers should be included in any committees having responsibility over workforce issues, it is improper and violative of the DSRIP program guidelines to exclude workers from decision-making bodies that will oversee specific PPS projects and committees charged with clinical issues and broader PPS structure and implementation.

The fundamental decisions regarding the design of the programs and projects to be implemented in most PPSs remain the exclusive province of the lead provider and partner provider executives and managers who comprise the Executive Committees of the various PPSs. Front-line workers, patients and the communities are in most cases not integrated into the committees and other PPS bodies with real power to shape the projects and oversee ongoing design and implementation.

NYSNA believes that the general lack of inclusion of workers, community and patient advocates in the governing bodies violates the terms of the DSRIP program and raises serious concerns about the ongoing implementation of this government program.

We note that the entire healthcare system is largely funded directly or indirectly by public funds that are delivered to private entities to deliver healthcare services (including both non-profit hospitals and for-profit businesses). If we include Medicaid, Medicare and direct subsidies to private health coverage on the ACA exchanges, and indirect tax subsidies to employer based health insurance, about 70-80% of health spending is paid for by the government. Most of this money flows into the hands of private corporations and other private interests.

In the context of the DSRIP program and the target populations of Medicaid patients, the entire \$6.2 billion program is paid for by tax payers.

Given this public role in the disbursement of monies, it should follow that the broader public, which will be directly affected by this process, should have a seat at the table. The public has paid for healthcare services, has provided all of the money being disbursed by DSRIP, but the decisions about how to use this money and how it will affect local communities is left entirely in the hands of the corporate executives and other private entities that control the PPS boards.

In reviewing and making decisions about the PPS applications, the PAOS and DOH should closely scrutinize the level of participation given to the public, local communities and front-line health workers.

Approval of applications should be made contingent upon a specific requirement that each PPS:

- (1) Includes representatives of local communities, patients, independent advocacy groups and direct care workers in PACs and all other governing committees; and
- (2) Provides such representatives with a meaningful advisory and decision-making role in the operation of the PPS and the design and implementation of DSRIP projects.

3. Adequacy of Community Needs Assessments

The approval and scoring of PPS applications and projects is required to include an evaluation of the adequacy of the Community Needs Assessments (CNAs) that informed the selection and design of specific PPS projects.

In assessing the PPS application, the PAOP and DOH are required to evaluate the completeness and depth of the CNA and the degree to which it included the community in conducting the needs assessments.

In reviewing the CNAs, we found that they varied widely in quality and depth of assessment of local needs. Some PPSs went to great lengths to survey community members and Medicaid patients, but many did not. The CNAs should be based upon and to incorporate a high level of community engagement and input, as they serve as a main nexus to allow affected communities to assert their preferences and interests in the design of projects to address their needs. It appears, however, that many CNAs were developed with little or no effective contribution by the communities. Much of the

ostensible involvement of the community in developing the CNAs appears to have consisted of little more than the scheduling of a few public forums at which briefings or summaries of the CNAs were provided to attendees after the fact.

We note the following areas of concern in the CNAs that have been submitted with the applications:

- 1) Many CNAs merely cataloged already widely known deficiencies or gaps in local healthcare services and population health levels. These gaps or deficiencies are then addressed through various specific project proposals that are aimed at correcting or ameliorating the given problem area. Though this is an important element of a CNA, it is not sufficient to address the underlying failures or inadequacies of the health and healthcare of communities in a systematic way and in a manner that recognizes and addresses the inter-related co-factors that contribute to or cause the problems. The CNAs should have undertaken a more systemic analysis to create complementary and coordinated programs to be designed.
- 2) Many CNAs did not adequately include input from community, patients and direct care givers. Some merely collected various data sets about the prevalence of various diseases, the numbers of providers in an area and other general statistics. It is also noted that many of the CNAs that did include direct input from affected members of the community, care givers and other sources, generally did so in a less than rigorous manner.
- 3) Few if any CNAs engaged in a dynamic analysis of demographic and economic factors that might determine future community needs or how the implementation of specific projects would affect future need for services. As noted above, the CNAs generally compiled existing data regarding the prevalence of disease, health care and health infrastructure usage and other factors (all of which provide merely a static snapshot of past conditions). On this basis of this static analysis many PPS applicants proceed to design programs that will be implemented over the next five years. Many PPS application then take the additional leap of using this static analysis to make determinations about closing or reducing services and infrastructure without having accounted for how DSRIP and other relevant factors such as aging of the population, greater access to healthcare, improved primary care and early diagnosis, etc., might contribute to increased future need or demand for certain in-patient and other services.

4. Correlation of CNAs with Proposed Reductions of Existing Services and Infrastructure

Many of the PPS project proposals include clearly articulated or implied plans to close or reduce services, to close or reduce in-patient beds, to relocated services and infrastructure, to consolidate services and infrastructure and make other far-reaching and in some cases permanent changes to the healthcare system.

These decisions are largely based on CNAs that do not serve as an adequate objective basis for making such determinations. As noted above, many of the PPS CNAs are just compendiums of data that is already becoming stale. For example, much of the data on “excess” capacity in hospitals and other provider settings that is relied upon predates the implementation of the ACA, the increase in insurance through the state exchange and expansion of Medicaid. It thus fails to account for increased demand that will flow from the expansion of the numbers of people who have recently gained insurance coverage and are now able to seek treatment for previously undiagnosed or untreated health conditions.

The CNAs also largely failed to account for the increasing age of the populations of many areas of the state and the impact of the retirement of the “baby boom” population bulge and higher usage of medical services that this demographic shift will entail.

It should also be noted that most of the CNAs that did address issues of “excess” beds and infrastructure also relied on data that seems to define hospital “occupancy” rates on the basis of licensed beds rather than on staffed beds. Indeed, the DOH approved project application kit specifically requires providers who select one of the “medical village” projects to state how many “staffed” beds will be reduced and precludes that project from receiving credit for decertifying licensed beds that are not being used.

In this context, the CNAs that have been produced to support the DSRIP goal of reducing “avoidable” usage by 25% do not provide a valid empirical or logical basis to conclude that existing beds or capacity should be reduced.

In the absence of a valid empirical analysis of existing needs and projected future needs, taking into account all relevant data and demographic projections, and applying the data in a dynamic way to account for changes in current conditions, the PAOP and the DOH should not approve any proposed closures or reductions in service.

5. Capital Funding Needs Are Not Included in the PPS Applications

Many of the PPS applications that are being considered make references to various needs for capital funding. The capital funding requests, however, are not specifically stated in the application and there is no clear detail provided as to how capital funding each PPS will need to carry out its projects and its source.

Among the specific areas in which capital spending will be required to implement programs are the following: EMR and HIT technology funding to create integrated systems and coordination of services; construction costs for new or expanded facilities; investment in transportation and other supportive services, and acquisition of tele-health equipment and infrastructure.

It appears that requests for capital funding will be subject to separate applications that will be considered later this year.

It seems improper or premature to approve DSRIP applications and establish PPSs in the absence of a clear understanding of what the capital needs of each applicant will be and of the source and timing of the receipt of such funding.

This is particularly a matter of concern because the applicants will be selected and the DSRIP clock regarding compliance with goals and performance metrics raise the possibility that the entire program will suffer “claw backs” of funding if the program as a whole or individual PPSs fail to meet performance targets.

Given that meeting the capital needs of each PPS will likely play a significant role in their individual and collective ability to meet the requirements of the program, we would argue that the selection of PPS

applicants and the implementation of the program be delayed to allow the capital funding applications to be included in the final approvals.

6. Lack of Information Regarding Collaborative Providers and Their Specific Roles

We have previously noted that the PPS applications did not provide information to the public about specific health care providers and other collaborators participating in each PPS. This presented a problem in that the public was unable to determine if any of the PPS providers posed concerns regarding quality of care, abusive business practices, issues of fraud or waste of resources or other factors that might raise questions about their suitability to participate in the DSRIP program. This limited the ability of the public and other stakeholders to fully participate in the review process and to raise issues that might be of use to the PAOP and the DOH in reviewing the applications.

We believe that the PAOP does have access to the lists and further assume that the PAOP and the DOH will review the provider lists to ensure that inappropriate persons or entities are not receiving public monies.

We are concerned, however, that even if the providers and collaborators participating in each PPS are reviewed and found acceptable to receive DSRIP funding, there appears to be no opportunity for the PAOP to review the exact nature of their participation. The exact role, the scope of the services they will provide, and the terms of their reimbursement or payment will presumably be laid out in specific contracts executed with the lead PPS or in sub-contracts with individual providers or collaborators within the PPS.

It appears that these contracts and their specific terms, many of which have already been executed and many more of which will necessarily have to be negotiated and executed or modified during the implementation of the PPS projects, will not be reviewed prior to approval of the applications.

It also appears that the PPS applications will be approved by the PAOP and DOH without a prior determination of how the public monies provided by the DSRIP program will flow and who will receive public money within the PPS structure. There also appears to be no process in place to monitor the flow of money and revenue within the PPSs on an ongoing basis.

We believe that the approval process should include the imposition of specific conditions requiring the full public disclosure of all contracts and of regular and ongoing financial reports detailing operations and disbursements of funding for services.

7. Patient Privacy and Other Issues Related to EMR/HIT

Most of the PPS applications place a heavy emphasis on the use of Electronic Medical Records (EMR) and Health Information Technology (HIT) to integrate their PPS providers and improve the coordination of care. This is not a new concept, and has been heavily promoted by the federal government and the State as part of the ongoing effort to improve the delivery of care.

NYSNA supports the use of new technology to improve patient care, but we have concerns about the manner in which EMR and HIT are being addressed in the DSRIP process.

We have already noted that it appears that EMR/HIT will require significant expenditures of capital funds and that the amounts and sources being sought by the PPSs are not clearly explained in the applications.

We are concerned with some additional issues related to EMR/HIT which we believe should be addressed in the application approval process and during the implementation phase of the DSRIP program.

We first note that the PPS applicants are generally being led by large hospital networks that have already received significant funding and support to acquire technology and related infrastructure. Though EMR/HIT will continue to be a major capital cost for these large systems, we believe that many have the capacity to handle these costs.

What is less clear is how the formation of integrated systems with common EMR and HIT platforms will affect the large numbers of smaller health providers and community service providers who will have to make significant expenditures up front to join the PPSs. We believe that many such providers will have to make expenditures to join that will be very heavy in relation to their organizational income flows. This may also entail the assumption of debt loads that will depend on continued and successful participation in the PPSs with which they are aligned.

These entities often play a vital role as providers of health care or as providers of ancillary/supportive services that are vital to many communities. If they are forced to assume large debt loads or deplete their operating reserves to make these purchases and up front investments in equipment, software and staff training they may find themselves exposed if the DSRIP process encounters difficulties, or if their PPS system contracts with a different provider during the implementation process.

If the funding is terminated or otherwise reduced or interrupted for any reason, or if current cost and revenue projections are incorrect, many of these critical providers may find themselves in a precarious financial position and could be faced with closure or downsizing of operations. This could be catastrophic in some communities or among specific patient populations.

A second area of concern relates to the amount of public DSRIP funding that will be diverted from patient care to padding the revenues and profits of for-profit manufacturers of IT equipment, software and providers of ongoing support and training services. We are concerned that inordinate amounts of money will be sucked out of the DSRIP program by these private for-profit entities without any oversight and control.

Finally, we believe that the intensification and broadening of the application of HIT/EMR systems will pose ongoing and increasing risks of security breaches that will impact patient privacy and possibly allow greater incidence of fraud within the healthcare system and against individual patients.

None of these factors are directly addressed in the PPS applications. The approval of any applications should include conditions requiring PPS systems to address indemnification or support of small non-profit providers for the costs of EMR/HIT, limits on the abusive contractual terms and the amounts of profits or financial burdens that for-profit EMR/HIT providers can extract from small non-profit

providers participating in each PPS, and an explanation of the steps that each PPS will take to maintain EMR/HIT security.

8. Waivers of Regulation

Sections 2807(20)(e) and 2807(21)(e) of the Public Health Law permit the DOH, OMH, OASAS and OPWDD to waive or modify regulatory requirements to allow the implementation of approved DSRIP projects.

The statute contains the following provisions regarding waivers of regulatory requirements:

Notwithstanding any provisions of law to the contrary, the commissioners of the department of health, the office of mental health, the office for people with developmental disabilities, and the office of alcoholism and substance abuse services are authorized to waive any regulatory requirements as are necessary, consistent with applicable law, to allow applicants...to avoid duplication of requirements and to allow the efficient implementation of the proposed project; provided, however, that regulations pertaining to patient safety may not be waived, nor shall any regulation be waived if such waiver would risk patient safety. Such waiver shall not exceed the life of the project or such shorter time period as the authorizing commissioner may determine.

According to the terms of the statute, only *regulations* issued by the various departments can be waived. The statute does not authorize waivers of any other statutes or laws. It also does not authorize the waiver of federal law or regulation. Though this is not specifically addressed, it would also seem to prohibit the waiver or modification of any local law or regulation.

The exercise of the authority to waive state health regulations is narrowly tailored and can only be considered if it is “necessary” to “avoid duplication of requirements *and* to allow efficient implementation of the proposed project.”

The statute, however, explicitly limits the discretion of the DOH and other agencies to waive or modify any regulations, even if they are “necessary to avoid duplication of requirements and to allow efficient implementation” if either (a) the regulation “pertains to patient safety” and/or (b) the waiver “would risk patient safety.”

These provisions thus prohibit the granting of any waiver of patient safety regulations, even if it is necessary to avoid duplication of effort or to allow efficient implementation of DSRIP. In addition it also prohibits waiver of regulations that do not “pertain to patient safety” if waiver of that regulation would “risk patient safety.”

Every one of the PPS applications submitted includes numerous requests for waiver of regulations. Some applicants are at this point only seeking a small number of waivers (ten or fewer) and have carefully tailored their requests to the parameters set by the statute. Other applicants, however, are seeking a sweeping array of waivers (90 or more) that are clearly inappropriate and do not meet the statutory criteria. It should be further noted that many applicants have indicated that they might seek new or additional waivers in future, if the need arises.

We have the following concerns regarding the issue of waivers:

I. Public Review and Comment on Proposed Waivers:

The DSRIP protocols and the application “tool kit” requires PPS applicants to submit their waiver requests as an integral part of their DSRIP application. These applications, including the waiver requests, were filed in December and posted for the mandatory public review on January 15th.

The mandated period of public comment on the submitted applications remains open through February 15th according to the DSRIP timeline posted on the DOH website.

The protocols require a public comment period and it is commonly understood and legally expected that the underlying premise of any mandatory public comment process is that the public will (a) have an opportunity to comment before the matter is decided and (b) that the decision making body will consider such comment prior to making its determination.

Notwithstanding this common understanding and legal expectation, it appears that the State DOH has already considered and issued decisions on the waiver requests without providing the required minimum of 30 days for public comment. According to information obtained on a recent conference call held by the State DOH, providers were informed that the decisions had been made and that letters of approval were being sent out.

The DOH has thus improperly decided on waivers without affording the public an opportunity to provide comment.

According to the DSRIP protocols agreed to by the State and CMS, “the state will make its official, initial determination on each timely submitted DSRIP Plan based on the findings of the independent assessor and the outside review panel.”

It thus further appears that the DOH has usurped the authority and role of the PAOP by predetermining the waiver requests without first receiving the finding of the outside review panel mandated by the protocols.

II. Waivers of Professional Practice Standards:

The DOH does not have authority to waive professional practice standards that are imposed by the statutory provisions of the Higher Education Law and by any regulations issued by the agencies with oversight of professional standards of practice.

We are concerned that several applications seek waivers from restrictions on activities and functions by non-professionals that are within the scope of practice applicable to registered nurses, nurse practitioners, physician assistants, and other licensed professionals.

We are further concerned that many of the applications include proposals to employ various new or ambiguous titles (such as “care managers,” “case managers,” “patient educators” and

“navigators”) that would seem to include such RN functions as assessment and teaching of patients.

The PAOP and DOH must carefully scrutinize and reject any requests for waiver of regulations relating to professional practice standards. The PHL sections cited above clearly prohibit any such waivers or modification of existing law and regulation.

III. Waivers of Certificate of Need Regulations:

Most of the applicants are seeking waivers or modifications of existing regulations regarding CON review of applications to close or reduce existing services or capacity.

The CON regulations general require review of any request to establish or construct new facilities, to close or change the manner of delivery of certain services, to decertify or add licensed beds, to construct new facilities and to establish a new operator for existing services.

Depending on the type of changes being implemented, the CON process may require full review, or may be subject to administrative or limited review without public hearings before the PHHPC.

We believe that there should be no waivers of CON regulations provided. The CON process requires the DOH to review various factors, including economic viability, public need for the services, the record and competence of the applicant in providing care and compliance with various regulations relating to building/architectural and similar minimum safety standards.

The applications for waiver of existing CON regulations do not meet the statutory criteria for granting a waiver.

First, it is noted that none of the applications have met the threshold of demonstrating that a waiver is “necessary” to avoid duplication of efforts or is “necessary” to allow efficient implementation of specific DSRIP projects. In each case the applicants seem to be requesting broad waivers from CON merely on the basis of a preference to avoid compliance. Given the lack of detail about specific projects that is prevalent in the application, the finding of “necessity” is not established.

Second, it is noted that the CON rules clearly “pertain to patient safety.” The construction or alteration of existing facilities without review to ensure compliance with applicable patient safety codes directly “pertains” to patient safety and also fails the second criterion of posing a “risk to patient safety.”

If applicants are concerned that CON review will result in delays, then the DOH can provide a mechanism for expediting the review.

The PAOP should recommend that the DOH reject any CON waiver applications. In the alternative, it should recommend that CON waiver applications should be closely scrutinized and tailored to waive only that portion of the CON process that does not pertain to or pose a risk to patient safety.

IV. Other Waivers of Regulation:

Many of the applications seek waivers related to billing practices, co-location of services in existing licensed Article 28 facilities, removal and transfers of patients to other providers or locations, and other similar matters.

These requests should also be subject to close scrutiny and should only be approved if they are (i) necessary (rather than convenient or desirable) and (ii) do not directly or indirectly raise patient safety issues.

9. Certificate of Public Advantage and Anti-Trust Issues

Some applications have requested that the DOH provide them with protection from anti-trust liability in the form of a Certificate of Public Advantage (COPA).

Article 29-F of the PHL states the general principle that the policy of the state is to encourage the creation of integrated, cooperative, collaborative healthcare systems that can more effectively to promote better quality of care, access to care in underserved areas, and improved health outcomes. To achieve these health-related goals, the state will extend “state action immunity” to healthcare provider networks that might otherwise face scrutiny for anti-competitive actions.

Pursuant to 10 NYCRR 83-2.6, the DOH may not issue a certificate of public advantage (COPA) to a healthcare system without first consulting with the Attorney General and receiving a recommendation of approval from the PHHPC. All applications are subject to public notice and comment.

In determining whether to issue a COPA the State is required to analyze the impact of the cooperative agreement and must determine that the “benefits likely to result from the agreement or planning process outweigh the disadvantages.”

For the purposes of issuing a COPA, the analysis must determine that it will serve the state purpose of improving “health care quality, access, efficiency and clinical outcomes.”

The state is further required to impose appropriate conditions on any COPA applicant, all of which clearly relate to and address specific health care needs, including the following:

1. Implementation of a clinical integration plan;
2. Achievement of quality benchmarks, implementing evidence-based practices and clinical protocols, reducing preventable admissions and readmissions and sub-optimal emergency department use, and achieving other outcomes as identified by the department;
3. Maintaining or expanding certain services or levels of access by under-served populations;
4. Investment in primary care and population health activities;
5. Improvement in population health benchmarks;
6. Measures to prevent unwarranted price increases and achieve savings;
7. Measures to promote efficiencies and achieve savings, including reductions in duplication of services, unnecessary or preventable utilization, capital expenditures, and administrative overhead;

8. Improvement in recruitment and retention of needed health care professionals; and
9. Conditions reasonably necessary to ameliorate likely disadvantages, including potential disadvantages identified in section 83-2.5(d) of this Subpart.

One of the terms that can be imposed by the State as a condition for issuance of a COPA is that the applicant must take steps to further the “recruitment and retention of needed health care professionals.”

The imposition of this condition in any COPA decision should be seriously considered because many of the PPS applicants have a history of conduct that raises serious concerns about granting them immunity from anti-trust regulation. The lead applicants of the two capital area PPSs (Ellis Hospital and Albany Medical Center) were recently accused of engaging in anti-competitive labor practices aimed at depressing the wage of RNs and ended up entering into settlements of those claims. The Westchester Medical Center PPS lead entity has engaged in an aggressive campaign of labor cost reductions, including the wholesale layoffs of entire classes of patient care and support personnel and their reliance on private employment agencies to provide health care services with temporary employees.

Other applicants or their partners (NYU Langone, e.g.) have engaged in business practices that generate very high profits while limiting their services and care for low-income Medicaid and uninsured populations and, it has been alleged, steering such patients to neighboring public hospitals. These types of practices contradict the premises for granting a COPA that specifically require that COPA recipients will increase access to care for underserved populations rather than shunting them to true safety-net providers.

Given the past practices and abusive practices of some applicants, we thus believe that the PAOP and DOH should closely scrutinize any requests for COPA status (or in the alternative for the approval of the creation of a large scale ACO entity as an alternate means of securing anti-trust protections).

In order to further the goals of DSRIP and the terms of the COPA statute all PPS applicants seeking anti-trust protection should be subject to stringent conditions to (a) prevent labor market abuses that will negatively affect recruitment and retention of existing RN workforces and (b) to increase profits by evading their obligations to care for patients regardless of ability to pay or source of insurance coverage.

10. Tendencies to Create a Two-Tiered Healthcare System

In reviewing the applications we noted that many PPSs are seeking exemption from regulations that prohibit the discharge or transfer of patients based on their insurance payer status.

We have also noted that some of the lead providers or participants involved in PPS applications have a pursued a business strategy of generating large profits by minimizing their exposure to Medicaid and uninsured populations.

We are concerned that some applicants may view the DSRIP process as an opportunity to continue these practices and to use DSRIP funding, ironically, as a means of expanding or furthering this approach.

We also note that many applicants may seek to lower costs and “unnecessary” usage of healthcare resources by Medicaid patients through “innovations” that will entail diversion from more expensive services and the use of cheaper labor personnel through deskilling and other similar techniques.

We are concerned that this phenomenon will result in the de facto solidification of a two-tiered healthcare delivery system in which the existing disparities in access to and quality of care are exacerbated rather than lessened, notwithstanding the explicit principles and goals of DSRIP.

One of the stated goals of the DSRIP program is to address disparities by increasing primary and outpatient infrastructure and reducing the incidence of hospital usage by Medicaid and uninsured patients. It is possible, however, that the creation of large networks of integrated hospital systems will be used to further the current disparate and stratified health care system in which wealthy and well-insured patients have easy access to a plethora of specialty services in “premier” facilities while poor and working class patients are relegated to under-funded and resource strapped local facilities that are increasingly under threat of closure. In this context, the DSRIP goals of closing unnecessary or excess in-patient capacity, of relocating the site of care to alternative out-patient and primary care settings and reducing facility usage by Medicaid patients may have the perverse effect of further exacerbating these disparities, as they are slowly driven away from the premier facilities and diverted to out-patient services in their neighborhoods and are transferred to “appropriate” hospitals within the broader network.

11. DSRIP and Corporate Business Strategies

A common theme that has emerged in the review of the DSRIP applications is the incorporation of pre-existing business plans and corporate market strategies into the PPS projects and general organizational structure.

It thus appears that many PPS applications are using the DSRIP process and the flow of DSRIP money to further their own general corporate interests. The structure and governance of the PPS and the selection of programs, all ostensibly aimed at improving community health, quality outcomes and reducing costs of Medicaid care, have often been implemented in a manner that complements and furthers these organizational interests and strategic goals that is unrelated to the core principles of the DSRIP program. In many cases it is apparent that the DSRIP program is being used as a means to attaining these unrelated ends that is only tangentially related to improving the quality of care, expanding access and improving community health.

Geographic Expansion Into New Markets

Many PPS systems appear to be using DSRIP to subsidize and support efforts to expand the presence of the lead provider in key markets. The goals of this geographic expansion seems to be aimed at increasing market share in certain areas, seizing a larger share of patient revenues flowing from those areas, undermining or countering the efforts of competitor systems, and increasing the ability of the PPS lead entity and its key partners to gain access to more profitable or potentially profitable population segments and types of procedures or patient care.

The establishment of new or expanded DSRIP funded networks of primary and ambulatory care in these new markets, coupled with the creation and solidification of integrated systems through ongoing mergers and acquisitions with local providers in the target areas, allows many already ambitious and expansionary hospital systems to engage in more rapid and intensive movement toward these business goals. The funding, regulatory relief and anti-trust exemptions provided by the DSRIP program allow this process to accelerate.

Examples of this approach include:

- Montefiore PPS is expanding into the Hudson Valley, in tandem with the ongoing acquisition of smaller hospitals in that region, and continuing to march northward as far as the Capital region (based on information that it continues to explore a merger or affiliation with the Albany Medical Center PPS). Montefiore has been aggressively expanding its portfolio of hospitals in the Hudson Valley in direct competition with the Westchester PPS and the NY Presbyterian system (which has not used DSRIP directly in that region, but which has acquired several hospitals on its own initiative)
- North Shore/LIJ, which is already the dominant system in the Long Island area, is actively and aggressively seeking to expand its presence in New York City. The NS/LIJ system is the lead operator in the Nassau-Queens PPS which will further solidify its position in its core market niche. NS/LIJ is also the driving or controlling force in the Staten Island PPS (RUMC-SIUH), thus giving it exclusive influence over that area of New York City; NS/LIJ announced that it was joining the only non-hospital PPS, Advocate Partners PPS in New York City, and according to the PPS application its role will grow over the course of the DSRIP program to a 50% controlling share, giving it effective control of a large physician network and allowing it to directly attack patient and revenue flows in the markets of such competitors as Montefiore, Mount Sinai, Presbyterian and NYU-Langone. The seizure of control of the Advocate Partners PPS is a major coup in light of NS/LIJ's corporate strategy of rapidly expanding and consolidating direct ownership or indirect control of primary care and specialty physician practices. NS/LIJ has also assumed a major, but still not fully defined role in the Maimonides-led PPS in Brooklyn following the recent announcement of an affiliation and possible organizational integration or merger with that hospital. The use of various PPS projects and ongoing acquisition of physician practices in New York to expand its market share in New York is closely linked to the creation of an in-house insurance operation which will allow NS/LIJ to leverage its expanding share of health care and increase the market of its insurance products, and thus to further accelerate its direct market power as a provider. We would also point out that the flag-ship of the NS/LIJ system, North Shore University Hospital did not meet the rather generous criteria to qualify as a safety-net hospital, but it too is seeking an "exception" to allow it to receive full DSRIP funding.
- The Adirondack PPS proposes to create a large integrated network of hospital and other providers in the North Country, but appears to be a vehicle for an out-of-state provider system to penetrate the NY market in a big way.
- In the Southern Tier area, it appears that several of the PPS systems in that region are to some extent motivated by a need to form defensive alliances to counter or defend against the encroachment and expansion of large systems from Pennsylvania.
- The Lutheran PPS is indirectly controlled by NYU Langone and is being used to further NYU's already established pattern of sucking lucrative patients and types of procedures out of Brooklyn and into its Manhattan based and highly profitable system. We have noted elsewhere that NYU has played a very negative role in the ongoing hospital crisis in Brooklyn by stripping out the kinds of patients and procedures that are needed by local hospitals to maintain positive revenue flows, leaving them to deal with the losses and financial burdens of caring for the patients that do not interest NYU. It now appears that NYU will seek an "exception" to be treated as a safety-net provider for the purposes of receiving *full* DSRIP funding as part of the Lutheran PPS. It further appears that the organization and programs of the Lutheran PPS are structured in a way that will

allow NYU Langone to more effectively implement its business plan of bringing more profitable procedures and patients into its Manhattan flagship hospitals, while shifting local Medicaid populations to the Lutheran FQHC network and leaving the uninsured to be care for by HHC and the struggling community hospitals of that county.

The DSRIP program is being used, in short, as a convenient cover to intensify and expand the pre-existing corporate strategies of many large healthcare systems in a manner that is only tangentially secondarily related to the goals of improving patient care quality, increasing access to care and improving community health.

The structure of the DSRIP program was built by design to encourage mergers, acquisitions and the formation of very large integrated care delivery systems. The ACO and COPA rules provide anti-trust cover for this movement that would otherwise have presented a severe impediment to consolidation and centralization of such large systems, and it provides funding to support the consolidation process.

NYSNA is not opposed to this approach as a matter of principle, as the prior system of smaller hospitals and other providers “competing” with each other on the basis of “free market” principles was clearly a costly failure. We further believe that the creation of large networks of integrated service providers lays the foundation for the next necessary phase of healthcare reform – the shift from our current market-based system to a universal coverage, single payer system that will create a coordinated and democratically controlled state-wide system of health care that effectively and more efficiently meets the needs of the people of New York.

In reviewing and approving the applications, the PAOP and DOH should pay close attention to the potential for abuse and misuse of DSRIP programs and DSRIP monies to further corporate/system interests that are unrelated to the core goals of improving access to care and quality.

The DSRIP PPS applications should be closely scrutinized to ensure that the core goals are being implemented and approval of plans should contain stringent conditions and explicit warnings that the manipulation of the DSRIP to attain unrelated organizational goals will be monitored and subject to ongoing controls.

12. DSRIP Funds Flowing to Non-Safety Net and For-Profit Providers

DSRIP program is supposed to encourage and provide financial support/incentives for safety-net providers to improve their efficiency and become self-sustaining. This element of the program is an acknowledgement of the importance of these providers to meeting the needs of a large segment of the population that suffers from inadequate access to healthcare resources and the real human suffering that this entails. It is also indirectly an acknowledgement of the financial stress that accompanies the provision of care in the safety-net segment of the system.

The ongoing cuts in reimbursement rates for Medicaid patients and the inadequate support for the cost of caring for the uninsured or underinsured have played a large role in the crisis facing this sector. Looming cuts in support for treating the uninsured and the increasing prevalence of cost-shifting for those who do have insurance will further increase the financial stress of safety-net providers, even as the ACA brings more people into the sphere of private insurance coverage.

We know that the Medicaid insurance reimbursement rate is insufficient to cover the costs of treatment (or at least the costs of high quality treatment). Every Medicaid patient who walks in the door of a provider will generally result in an increase in the amount of losses on that providers ledger books. That is why many physician practices refuse to take Medicaid patients, and it also explains the business practices of many profitable large hospital networks.

Within this context, the diffusion of DSRIP funding through the use of a very wide and liberal interpretation of qualified “safety-net” providers allows funds to be diverted to entities that neither merit nor need the DSRIP subsidy.

This dilution of the impact of the DSRIP funding to assist safety-net providers is further exacerbated by the apparent inclusion in the program of non-safety net providers through the grant of direct exceptions (most notably for NYU-Langone and North Shore University Hospital).

An additional area of concern is the degree to which the broad PPS networks will include large numbers of partner organizations or individuals who will be recipients of significant DSRIP funding.

We have already noted that the public has not been afforded the opportunity to examine the specific lists of PPS collaborators/participants. We have also noted that we have no information or access to the contractual and payment relationships that will be employed by the PPSs as they implement their specific programs, so we have no way of knowing how much funding will end up in the hands of providers in the form of revenue and profits that are inappropriate or only tenuously related to the purposes of the program.

The potential areas of concern regarding the inappropriate diversion of public DSRIP monies to non-safety net providers or for purposes that are antithetical to or contradict the purposes of DSRIP include the following:

- The lack of transparency in the PPS contracting and structural integration presents opportunities for fraud, waste and extraction of exorbitant profits by non-safety net providers and for-profit entities. Numerous studies indicate that fraud, waste, unnecessary billing and corporate profits account for about 50% of healthcare spending in the US. This is great for the beneficiaries of government largess who get a cut of the action. It is not so great for the patients who pay the price financially or through poor care, lower quality of life and shorter life spans.
- The dispersion of money to large hospitals and other providers who are already profitable and/or are not safety-net providers in order to allow them to further their private business interests and planning leaves less money in the DSRIP pool to assist true safety net institutions that have greater need for the support.
- The use of DSRIP funding by public healthcare providers to carry out de facto privatization of services through sub-contracting and assignment of patients or patient care services to private (for-profit and/or non-profit providers). There is substantial evidence that indicates that public hospitals and primary care providers operate more efficiently than private institutions. In the care of for-profit companies, there is the added issue of healthcare funding is being removed

from the system to generate profits that are then distributed to investors and end up serving no function in the actual provision of care.

We are particularly concerned about this issue in light of our experience with the NYC HHC system, which has increasingly sought to privatize core services such as dialysis without concern for patient safety and motivated solely by a desire to cut costs. We have also observed the ongoing transformation of the Westchester County Medical Center (now called Westchester Medical Center) to transform itself from a safety-net operator to an essentially private corporation motivated by the desire to cut costs and generate profits. To this end, Westchester has engaged in wholesale termination of classes of employees and the use of private, for-profit labor agencies to provide temp workers on a permanent basis, without regard for the impact on patients and local communities. It has also embarked on an expansion campaign through its PPS and the independent acquisition of new hospitals and other providers to the north of Westchester County.

- The imposition of large up-front outlays for EMR/HI, planning and start-up costs, and ongoing compliance with DSRIP program requirements appears to be leading to large expenditures for private consultants and services companies that will drain funds, particularly for smaller already struggling safety-net hospitals and key community organizations and providers.
- The use of DSRIP funding for purposes that are unrelated to DSRIP purposes through the blurring of the distinction between safety-net functions related to DSRIP and broader corporate interests of PPS system members to promote other business interests. For example, DSRIP expenditures intended to help Medicaid patients gain access to needed services could also be used to advertise or market money-making services to more affluent patients and solidify the branding of key providers. It is unclear to us what safe guards will prevent such “dual use” of public DSRIP money.

Given these issues, we believe that the DSRIP program presents real concerns that the already wide dispersion of DSRIP funds to non-safety net providers and its further dilution through the flows within PPSs and their components will further reduce the amounts of money available to provide assistance and support to true safety-net hospitals and small providers that play a key role and are not currently adequately funded.

To address this issue, it is imperative that the PAOP and DOH impose stringent conditions on all PPS systems that will:

- Target DSRIP funds to non-profit or public providers who meet safety-net definitions;
- Impose limits and caps on the amounts of profits that may be earned by any direct or indirect recipient of public DSRIP money;
- Prevent any participants in the DSRIP program from engaging in unfair labor practices or other abusive practices such as sub-contracting and use of temporary workers to provide direct or indirect healthcare services;
- Bar back-door privatization of public services; and
- Stringently impose existing caps provided in law on executive compensation to prevent or limit unjust enrichment, fraud and waste of public funds.

13. Ongoing Oversight and Public Participation

NYSNA has previously pointed out its support for the goals of transparency, public oversight and the expansion of the public role in the design and ongoing implementation of DSRIP in particular and in the operations of the healthcare system in general.

We believe that any meaningful reform of healthcare will be ineffective and unsuccessful if it is not carried out in conjunction with a thorough democratization of the decision-making process when it comes to the allocation and provision of healthcare.

The current system, which is universally acknowledged to be failing and expensive, relies almost exclusively on a structure in which public needs for healthcare and the services that are provided are entirely in the control of private business entities that do not have the interests of patients as their primary goal.

This is most obvious in those sectors of the system that are dominated by private, for-profit operators (insurers, device and equipment makers, pharmaceutical manufacturers, private doctor networks and practices, the consultant industry, the healthcare capital investment industry and other segments). These for-profit providers are in the business to make money. The provision of care to patients is merely the means by which this primary goal is to be achieved. This principle is actually embedded in the law when it comes to corporations, for example, which are legally obligated to focus their activity on promoting the interests of shareholders and the company to make profits.

The private nature of the healthcare delivery system increasingly creates pressure or provides opportunity for non-profit and public providers to assume a for-profit mentality and business approach. This tendency arises both from the operation of market pressures to compete with for-profit providers and from an increasing permeation of for-profit market ideologies and economic doctrines in the ranks of the MBAs and accountants who control the operations of the non-profit and public sectors of the industry.

The result is that fundamental decisions about the types of services and the manner in which they will be provided, decisions that deeply impact patients, direct care workers and local communities, are made by private entities and are often motivated by the desire to further the economic and organizational interests of the provider rather than the needs of the people who carry out the care and receive the services.

In short, the real decisions are made in corporate boardrooms, often shrouded in secrecy, and the workers, patients and public are completely excluded from the process.

These private business decisions are then relayed to the various government bodies that exercise some level of oversight for approval. With the exception of the narrow public oversight and participation provided by the CON process, the public and affected local communities have little or no role in the review and approval of these private decisions that have such a wide and deep public impact, and which it should be remembered, are largely paid for directly or indirectly by the public.

The DSRIP process has imposed certain requirements on participants, including the inclusion of the public in the CNA process, the inclusion of workers, advocacy groups and local communities in the

PACs and in the DSRIP governance process, and the requirement that the entire DSRIP process be subject to transparency.

Given the importance of an ongoing and meaningful role for healthcare workers, patients, local communities and the general public in the real decision-making power in the reform of our healthcare system, NYSNA urges the PAOP and DOH to require all PPS applications contain the following requirements regarding their governance:

- a. All DSRIP governance committees established, including not only the PACs, but also the Executive Committees, the various project committees, and any other “hub” or provider sub-committees, be operated in accordance with the NY State Open meetings law, with advance public notice and opportunity to attend and observe its operations, including provision for simulcasting/teleconferencing;
- b. Minutes and/or videoconference archives of all such meetings should be kept and publicly posted on PPS websites;
- c. PAC committees should be monitored and audited to ensure that each PPS is including all interested worker, community and patient advocacy organizations and that their operations provide opportunity for meaningful input in accordance with the “advisory role” required by DSRIP protocols – the PACs must not serve as mere window dressing in which the public merely receives power point updates in order to create a cursory and shallow façade of involvement; and
- d. Each PPS must include in its *governance or decision-making* bodies representatives of the workforce, independent local patient advocates and local communities, to be selected by a specially created sub-committee of such groups and representatives.

In addition, given the number of PPSs, the complexity and scope of the DSRIP program, the vast sums of public money involved, and the shortcomings in the level of democratic control and public input that has thus far been apparent, NYSNA proposes that each PPS should be required as a condition of approval to create a special independent “Public Advocate” to act in the interest of the public, local communities, patients and front-line workers to monitor, oversee and participate as necessary in the design and ongoing implementation of DSRIP projects and PPS governance.

The “Public Advocate” to be created for each PPS shall have the following responsibilities and powers:

- a) To monitor and audit as necessary all DSRIP PPSs to ensure full compliance with all State and CMS programmatic requirements;
- b) To ensure that each PPS fully integrates community, patient and healthcare workers in the decision making process at all levels so as to maximize the democratic operation of the DSRIP process;
- c) To investigate complaints from patients, members of the public and healthcare workers relating to the manner in which DSRIP programs and policies are designed and implemented;
- d) To act to enforce the rights of patients and local communities to quality of care, access to care, maintenance of services and infrastructure necessary or desirable to protect the healthcare

interests of local communities, categories of patients and/or on the basis of findings as to community healthcare needs;

- e) To monitor and enforce improper or abusive grant of anti-trust protections through the Certificate of Public Advantage process or through applications for exemption from regulations;
- f) To act as the guardian and protector of the public interest generally and of local communities in all matters related to the implementation of DSRIP programs;
- g) The PPS “Public Advocate” shall be selected by and shall report to the non-provider members of each PPS PAC; and,
- h) The PPS “Public Advocate” shall be paid and may hire additional staff to assist as necessary in carrying out these functions, funding provided by the PPS lead provider as a determined percentage of DSRIP funding to the PPS (NYSNA proposes this percentage be set at an amount that will yield an average of funding in the amount of \$250,000 per year for each PPS, with more being generated for larger PPSs and less for smaller ones)..

14. Transition to a Universal Single Payer Health System

Finally, we wish to note our general concern that the DSRIP program, however well-intentioned it may be, is not in itself sufficient to truly address the short-comings of our healthcare delivery system.

It has been widely observed that healthcare costs in the US account for about 18% of GDP (or nearly \$3 trillion). The bulk of this spending comes directly or indirectly from government support (in the form of direct Medicaid, Medicare, VA and other health programs or in the form of tax-payer subsidized private insurance exchanges and employer provided coverage).

In comparison to the other similar industrial economies, the US spends about twice the amount of money on a per capita basis but produces much worse results in terms of actual health indicators. Much of the comparatively higher cost and lower performance of our system is attributable to the prevalence of a market model for delivering health care that overly relies upon private providers, most of whom are operating on a for-profit basis in competition with each other under market mechanisms that generate waste, duplication of efforts, fraud, excessive administrative costs, the payment of high profit rates that inure to the benefit of investors and capital providers, and a tendency to treat healthcare needs as a means of making money rather than addressing social needs.

Ironically, this entire “free market” structure is built upon a foundation of public spending in the absence of which the entire system would collapse and cease to operate, along with the vast sums of profits skimmed from the system by the loudest proponents of efficiency and free-market principles of organization.

It is our view that the DSRIP and other reform efforts (the ACA, MRT, etc.) will be unable to address these core underlying causes of the problems that we face.

We believe that the only solution is to move toward the creation of a system of universal coverage that will provide uniform quality healthcare to all New York residents and will remove the forces that have caused our system to fail at their root.

NYSNA support currently pending legislation that will create a single payer system in New York (the New York Health Act, A5062/S3525).

We further believe that the DSRIP program and the funding being provided could have been structured as a process to begin the transition to such a system and that this would have constituted the basis for truly reforming the system and attaining the core goals of DSRIP.

We urge the PAOP and DOH acknowledge this reality, urge passage of the New York Health Act, and direct all PPS systems that are approved for DSRIP funding to begin to consider and prepare for such a transition in the way in which their networks are being structured and their projects are being implemented.

New York State Nurses Association

Comments on PPS Applications

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1. Advocate Community Partners PPS

Region: New York City

Counties of Operation: New York, Kings, Queens, Bronx

Attributed population: 769,089

Areas of Concern:

1. Governance Structure:

The PPS is employing a “delegated governance model” under which it appears that the newly formed PPS business entity will govern and oversee the various members.

This PPS applicant originated as a system that was controlled by a large collection of physician practice groups, led by AW Medical Group. Though it is not clear from the application which hospitals or hospital systems are participating, it appears to include Medisys and Flushing hospitals in Queens. It was recently expanded to include North Shore-LIJ, a very large system based and operating primarily on Long Island. According to the application, however, it appears that NS-LIJ will over the course of the DSRIP process assume a 50% controlling stake in the PPS, thus becoming the dominant participant and supplanting AW Medical Group and the other hospitals as the controlling entity.

2. Possible Misuse of DSRIP to Further Corporate Goals:

The role of North Shore LIJ raises questions about the degree to which its involvement and control over the PPS will use the DSRIP process and funding in furtherance of its own corporate business strategies rather than to improve access and quality of care for Medicaid patients.

NS/LIJ has engaged in a long-term strategy of acquiring medical practices, expanding the cadre of directly employed physicians and seeking to expand its operations in the New York City area. “North Shore-LIJ continues to focus on improving operating performance despite the challenges and factors pressuring operating margins....continuing to reduce operating expenses with operational efficiency efforts, program consolidation and supply chain initiatives, and create additional revenue opportunities through new and enhanced facilities, physician recruitment efforts, and initiatives to prepare for the migration from fee-for-service to value and risk-based payment models, including the formation of North Shore-LIJ CareConnect. North Shore-LIJ continues to invest in strategic capital projects and technology, including electronic health record and other clinical software, to maintain what management believes is a competitive advantage regarding physician satisfaction and retention....[and] making strategic investments in physicians who support key clinical service lines and staff to support the growth in the ambulatory network and outpatient volume....” See: North Shore/LIJ Management’s Discussion and Analysis of Financial Performance for the 6 months ended June 30, 2014 and 2013 (<http://emma.msrb.org/ER797014-ER620339-ER1022058.pdf>).

In implementing this strategic approach, NS/LIJ has specifically sought to gain market share within New York City and in particular in Manhattan. See: <http://content.hcpro.com/pdf/content/257025-4.pdf>. The system has aggressively recruited physicians and now directly employs about 2,500 and is affiliated with about 7,500 more in what is characterized as a “buying spree.” See: <http://www.crainsnewyork.com/article/20121125/SMALLBIZ/311259990/health-cares-shrinking-dollar-squeezes-doctors>. One of the techniques used is to offer to integrate physician practices with its EMR

systems with substantial subsidies, thus enticing affiliation and binding them to NS/LIJ through the NS/LIJ EMR system. See: <http://www.prnewswire.com/news-releases/north-shore-lij-health-system-investing-400m-to-connect-up-to-7000-physicians-13-hospitals-with-electronic-health-records-system-64391457.html>.

Another troubling aspect of this PPS application is that the PPS is seeking to designate North Shore University Hospital, the flag-ship of the NS/LIJ system as a “safety-net” hospital so that it can be eligible for full DSRIP funding through this and other PPS applications. North Shore clearly failed to meet the otherwise quite liberal standards for inclusion in the “safety-net” category and granting it this exemption will allow it to draw unwarranted DSRIP funding to the detriment of other hospitals that are truly playing a safety-net role and which will now see their share of the DSRIP funding pool decreased for the benefit of NS/LIJ and its pursuit of its pre-existing business strategies.

3. The DSRIP Projects Selected by the PPS

The broader corporate interests of the NS/LIJ system discussed above are further evidenced in the selection of programs by the PPS. In Domain 3 this PPS has selected coronary care (Project 3.b.i) and in Domain 4 it has selected prevention and management of cancer (Project 4.b.ii). Both of these selections afford opportunities to expand network infrastructure and increase revenues from these “key clinical service lines” that generate much of the system’s operating surpluses.

It is further noted that many of the other projects selected by the PPS highlight the expanded use of EMR and IT systems to improve coordination. The 2.a.i project, for example, calls for expansion of EMR, HIT and the creation of an integrated technology platform and will seek capital funding to expand this platform, thus complementing the ongoing strategic approach of NS/LIJ to use EMR/HIT to recruit and retain physicians. DSRIP and state capital funding will be used to subsidize this corporate strategy.

4. Regulatory Exemption/Waiver Requests

This PPS is seeking exemptions or waivers from a total of 17 regulations, including several related to restrictions on referrals and/or revenue sharing, issues of patient releases for sharing of medical information, issue of obtaining operating certificates for sites at which care is being provided on an out-patient basis, and licensing for mental health services.

The applicant is not at this time seeking anti-trust exemptions under Certificate of Public Advantage (COPA) provisions, presumably because of the high concentration of competitors in the NY City area.

Several of the requests for regulatory exemption, however, are possibly inappropriate and should be closely scrutinized. The applicant is seeking exemption from restrictions on referrals and transfers based on patients’ payer source (i.e., Medicaid or uninsured) status. The applicant claims this type of waiver is needed to allow it to discharge or transfer patients out of in-patient or ED units. This exemption should not be granted, as it risks giving the entire PPS the right to provide different levels of care that are motivated solely by their Medicaid or uninsured status. This could create conditions in which such patients are subject to different or inferior levels of care than is provided to non-Medicaid patients. This is potentially dangerous and antithetical to the premise of improved quality and access.

5. Reductions or Closures of Services and Capacity

The PPS application does not seem to foresee closures or reduction of infrastructure or beds. It also has not sought any exemptions or waivers from regulation related to closures or reductions of services.

6. Workforce Implications

The application indicates that it expects only a slight reduction in staff during the first few years of implementation and perhaps a “moderate” reduction in the last few years. The application does not provide clear information about the nature of these reductions, which are largely assumed to follow from future reductions in admissions and ER visits.

The lack of detail makes it difficult to assess the full extent of the impact on workers and patient care.

The applicant states that it will hire care managers, patient educators, care coordinators and patient advocates. The application does not seek any exemptions from existing professional practice standards, but it is unclear what its intentions are regarding the types of personnel that will be utilized. Many of the functions that will be assigned to these personnel involve nursing functions and there is thus a question as to whether these positions must be filled by RNs.

7. Participation by Community, Advocates and Workers on the PAC and other Committees

The PAC operated by the applicant is very small in number and is dominated by representatives of providers who are participating in the PPS.

The PAC does not contain significant representation by worker representatives and community advocacy groups that are not related to the PPS network but who will be affected by its decisions.

We also note that there is no representation of workers or community groups in any of the clinical or other decision-making committees established by the PPS.

8. Other Areas of Concern

No other concerns are noted at this time.

2. New York City Health and Hospitals PPS

Region: New York City

Counties of Operation: New York, Kings, Queens, Bronx

Attributed population: 634,789

Areas of Concern:

1. Governance Structure:

The PPS is employing a “collaborative contracting” model in which the HHC system and the other PPS partners will maintain their organizational independence. The PPS will further employ a master-hub structure in which its projects will be implemented with oversight by sub-committees in each of the four boroughs of the City.

HHC will serve as the lead entity and will chair the Executive Committee.

We note that one of the Executive Committee positions is held by a VP from the FEGS community services organization which has recently announced its full closure. This development raises concerns about the extent of the role of FEGS in the application and the impact of the termination of this large non-profit organization on the PPS proposals.

2. Possible Misuse of DSRIP to Further Corporate Goals:

Given that the main element of this PPS is the public hospital system and that it is bound by its enabling statute and governing protocols to provide care to all without consideration of immigration status or ability to pay, we do not note, at this time, any areas of concern regarding the intent and implications of the PPS application and proposed projects.

We do note, however, that the formation of a PPS system that includes non-public entities might create pressures or present an opportunity to shift patient care to private and/or for-profit providers and thus raise questions related to HHC’s compliance with legal obligations to directly provide care services in accordance with its charter and/or requirements under City law regarding review and approval of contracts and sub-contracts with vendors.

3. The DSRIP Projects Selected by the PPS

The various projects selected by the PPS appear to be consistent with the DSRIP goals of improving quality of care, improving community health outcomes and reducing unnecessary usage by expanding primary and ambulatory care services and increasing the coordination of patient care.

4. Regulatory Exemption/Waiver Requests

This PPS is seeking exemptions or waivers from a 10 regulatory requirements.

The exemption requests include waiver of licensure requirements for existing Article 28 facilities that will increase mental health visits, allowing existing Article 28 operating certificates to apply to co-located providers or lessees participating in the PPS, regulation, waiving approval by OMH and OASAS for expanded primary care services or sites operated by Article 31 and 32 providers, waiver of design, construction and survey requirements for Article 28 hospitals and free-standing ambulatory care

facilities, exemption from restrictions on referrals and/or revenue sharing to non-established provider partners, exemption from restrictions on discharging or transferring patients based on type of insurance, allowing ambulatory care facilities to bill for off-site services, and expanding the right of PAs to order licensed home care services.

The application does not indicate at this time that any requests will be made to waive CON and other relevant regulations providing for review and public comment of applications for closures or reductions of beds or licensed services.

The applicant is not at this time seeking anti-trust exemptions under Certificate of Public Advantage (COPA) provisions, presumably because of the high concentration of competitors in the NY City area.

Several of the requests for regulatory exemption, however, are possibly inappropriate and should be closely scrutinized. The applicant is seeking exemption from CON approval for construction of new or expanded primary care, urgent care and mental health care facilities, for HIT/EMR expenditures, or in the alternative for expedited CON review. The requests for waiver of CON are problematic, as there should be oversight and opportunity for public review and comment over any decisions to expand services in order to insure that there is oversight over the location and scope of such services and their correlation to the needs identified in the CNA. If CON review is called for, the DOH can provide it on an expedited basis.

We are also concerned that the request for exemption from regulations prohibiting discharges and transfers based on patients' payer source (i.e., Medicaid or uninsured) status raises the possibility of abusive practices. This exemption should not be granted, as it risks giving the entire PPS the right to provide different levels of care based solely on Medicaid or uninsured status. This could create conditions in which such patients are subject to different or inferior levels of care than is provided to non-Medicaid patients. This is potentially dangerous and antithetical to the premise of improved quality and access.

5. Reductions or Closures of Services and Capacity

The PPS application does not seem to foresee closures or reduction of infrastructure or beds. It also has not sought any exemptions or waivers from regulation related to closures or reductions of services.

6. Workforce Implications

The application indicates that there will be no net reduction in current staffing, but that there will be a "rebalancing" of staff tasks through attrition and new hiring, retraining and/or redeployment.

The PPS also indicates that it will have to hire significant amounts of new care workers, including RNs, Nurse Practitioners and Care Managers/Coordinators/Navigators.

The hiring of Care Managers/Coordinators/Navigators raises issues relating to scope of nursing practice, as it is our understanding that the PPS intends to use nurses for Care Management and Care Coordinator roles, given the need for clinical practice skills associated with these job functions. It also appears that the navigator role is undefined and may raise issues if the PPS intends to have non-nurses fill those roles and engage in practice within the RN scope.

We note that the PPS indicates that it will participate in organizing a City-Wide committee covering other PPSs to convene and determine uniform definitions of job titles and duties to avoid ambiguities or improper assignment of duties that are beyond the scope of practice of non-RN personnel. We would expect that NYSNA and other appropriate organizations be included in the work of this committee to ensure that there are no violations of scope of practice standards.

7. Participation by Community, Advocates and Workers on the PAC and other Committees

The PPS PAC is apparently limited only to PPS members and providers who have entered into written service agreement. Though unions and community groups that are not part of the PPS as providers are also considered PAC members, the PAC has relegated the labor representatives to participation in a separate workforce committee.

Nurses and other representatives of direct care workers have not been included in any of the committees that are involved in the decision-making process.

8. Other Areas of Concern

No other concerns are noted at this time.

3. Mount Sinai PPS

Region: New York City

Counties of Operation: New York, Kings, Queens

Attributed population: 279,751

Areas of Concern:

1. Governance Structure:

The PPS is employing a “delegated” model and the creation of a separate LLC that will include the seven hospitals in the Mount Sinai Group, Brooklyn Hospital, several other hospitals and 175 other provider organizations. The Mount Sinai PPS is also financially backing the Bronx-Lebanon PPS in the Bronx. The PPS Leadership Committee is composed of 25 members that will oversee the operations and various technical committees (Clinical, IT, Workforce and Finance).

As the PPS begins to implement its programs, the LLC that has been created will be restructured to give more control to “equity partners” (i.e., partners that are assuming “risk” in the operations of the PPS) and will establish an Executive Board to control and operate the PPS.

It further appears that the PPS will seek to solidify its ties to its non-safety net provider partners through grants and the use of managed care contracts for services.

This structure implies that the Mount Sinai Group will use the PPS structure to expand and consolidate its existing seven hospital network with the ultimate goal of adding the Bronx-Lebanon hospital PPS system in the Bronx (thus giving it a foothold in that borough) and Brooklyn Hospital to its core hospital network.

2. Possible Misuse of DSRIP to Further Corporate Goals:

In the context of the recent acquisition by Mount Sinai of the Continuum hospital system (including Beth Israel, St. Lukes-Roosevelt, and NY Eye and Ear), it appears that the Mount Sinai Group views the DSRIP process as an opportunity to continue its corporate strategy of expanding existing market share in Manhattan and Brooklyn and a new market in the Bronx.

Mergers and acquisitions to expand the geographic reach and total patient population in the system’s orbit are view by Mount Sinai as a key element of the group’s business strategy. According to Mount Sinai CEO Kenneth Davis, to manage risk and maintain operating surpluses, “hospitals need to broaden the populations they serve and offer services that cover a larger geographic area.” See: <http://www.wsj.com/articles/kenneth-l-davis-hospital-mergers-can-lower-costs-and-improve-medical-care-1410823048>.

We are thus concerned that the DSRIP process is being used by the Mount Sinai Group to continue to acquire new hospital and other provider networks in furtherance of its strategic goals and that the improvement of community health and quality of care for Medicaid patients is a secondary consideration.

3. The DSRIP Projects Selected by the PPS

The selection of projects by the Mount Sinai PPS reflects its underlying business strategy. Projects 2.a.i (integrated systems focused on population management), 2.b.iv (implementing care transition to reduce re-admissions) and 2.c.i (development of community based “navigation” services) are consistent with the goals of increasing its patient population and reducing costs of care. The selection of Project 3.a.i (integration of primary care and behavioral health services) and 3.a.iii (behavioral health medication adherence programs) allows the system to consolidate and ultimately reduce its unprofitable mental health in-patient services. Projects 3.b.i (heart disease management) and 4.b.ii (prevention and management of cancer) offer opportunities to expand the volume of profitable surgical, ambulatory treatment and imaging procedures.

4. Regulatory Exemption/Waiver Requests

This PPS is seeking exemptions or waivers from 27 regulatory requirements.

The exemption requests include waivers to allow multiple billings for single visits to out-patient clinics and other “one stop” facilities, payment for services that are provided off-site, modification of reimbursement rules, co-location of services in licensed Article 28 facilities without CON review, waiver of CON for construction of new or expanded facilities that are accompanied by concurrent “downsizing” (which would only be subject to administrative review), self-certification of plans for new construction, decertification of services without full CON review, addition of new behavioral health services without CON review, allowing the expansion of hospice service areas without approval, allowing home care partners to accept any PPS referral without regard to licensed geographic coverage, addition of new services to existing Article 28 facilities without CON or licensure, decertification of services and beds with only limited CON review, creation of new out-patient services without an operating permit, and waiving approval by OMH and OASAS for expanded primary care services or new sites offering behavioral health services.

The applicant is not at this time seeking anti-trust exemptions under Certificate of Public Advantage (COPA) provisions, presumably because of the high concentration of competitors in the NY City area.

Several of the requests for regulatory exemption, however, are possibly inappropriate and should be closely scrutinized. The applicant is seeking exemption from CON approval for expansion of existing services, creation of new sites and alterations to existing facilities. In many cases, the applicant proposes to have the right to make significant changes to programs and physical infrastructure with only minimal oversight.

More troubling, the applicant is proposing to be exempted from CON review for closure/elimination of existing services, for decertification of bed and licensed services and for relocation of existing services/facilities. These sweeping powers to move or eliminate services are highly problematic and reflect an ongoing business plan to substantially restructure the Mount Sinai Group hospital services that is unrelated to the goal of DSRIP.

The Mount Sinai Group has clearly embarked on a concerted effort to close existing services in its various hospitals and to consolidate them in fewer locations (see above cited statement by CEO Kenneth Davis regarding such closures and consolidations). The emphasis in this effort is on shedding unprofitable core services such as pediatric, in-patient psychiatric and maternal-child services. During Hurricane Sandy, for example, Mount Sinai used the crisis to abruptly closed peds units in its St. Lukes-

Roosevelt hospital without prior CON review. The PPS seems to be using the DSRIP process as a means to accelerate its pre-existing corporate business plan to carry out such closures and consolidations of service without undergoing a public CON process and affording an opportunity for affected community members to monitor and comment upon these moves and without review of the impact on the communities that use these services.

The requests for exemption from CON are an improper attempt to manipulate the DSRIP process to accomplish unrelated goals and avoid a transparent public need analysis and review.

5. Reductions or Closures of Services and Capacity

The PPS application does not identify specific services that will be reduced or eliminated or provide any details regarding future in-patient bed reductions. The application speaks generically of possible future bed reductions as in-patient volume decreases through the implementation of DSRIP programs, but also notes that such reductions might be offset by increased demand for services as more New Yorkers become insured through the ACA. The application does state that there is a “goal to reduce overall bed capacity” but provides that the specifics will be addressed in an “institutional needs assessment” at some future date.

As noted in the preceding section, however, the requests for exemption from CON review for closures, decertification and relocation of services, coupled with the past behavior and stated organizational goals of the Mount Sinai Group raise questions about the intent of the PPS to engage in serious restructuring along these lines.

The impact of such closures and reductions in service upon local communities and existing service networks could be serious and the DSRIP application should be closely monitored to prevent any inappropriate and unsupported changes in existing services.

6. Workforce Implications

The PPS application indicates that there will be about 2,350 new positions required to implement DSRIP, including 1,000 nurse practitioners. It is unclear how many new RN positions will be created. The application indicates that there are currently about 3,000 vacancies in the system and that about 22% (660) are RN positions.

There will also be substantial retraining (12,000 personnel) and redeployment (600) of existing staff, but the application does not clearly spell this out in any detail.

7. Participation by Community, Advocates and Workers on the PAC and other Committees

The PPS PAC and other committees have included NYSNA representatives. We are concerned however that the involvement of community and patient advocacy groups is inadequate and that participation in the PAC and other committees is apparently limited only to PPS members and providers who have entered into written service agreements. We further note that frontline nurses and other representatives of direct care workers have not been included in any of the committees that are involved in the core decision-making process of the PPS.

8. Other Areas of Concern

No other concerns are noted at this time.

4. New York and Presbyterian Hospital PPS

Region: New York City

Counties of Operation: New York, parts of Queens and the Bronx

Attributed population: 80,902

Areas of Concern:

1. Governance Structure:

The PPS is employing a “collaborative contracting” model in which the existing network of hospitals operated by the NYP system will remain largely in their current configuration. Outside providers participating in the PPS will be linked through service contracts.

The PPS Executive Committee will include representatives of collaborating providers, but with majority control in the hands of the NYP system members.

2. Possible Misuse of DSRIP to Further Corporate Goals:

Unlike some of its main competitors, the NYP system does not seem to be focusing on rapid expansion of its existing hospital network, though it has recently expanded into the lower Hudson Valley with the acquisition of Lawrence and Hudson Valley hospitals in Westchester.

Its corporate strategy is focused more on increasing its existing specialty services and surgical volume through intensification of existing core infrastructures rather than through large scale geographical expansion. It also appears that the system is not interested in pursuing the creation of its own insurance arm. See: <http://www.capitalnewyork.com/article/city-hall/2015/02/8561072/new-yorks-leading-health-systems-differ-growth-strategy>.

The DSRIP proposal of the NYP PPS thus is much less ambitious than that of some of its large competitors.

3. The DSRIP Projects Selected by the PPS

The selection of projects by the NYP PPS reflects its more conservative business strategy.

Projects 2.a.i (integrated systems focused on population management), 2.b.iv (implementing care transition to reduce re-admissions) and 2.b.i (development of ambulatory ICU units), 2.b.iii (ED triage/diversion program), are all aimed at reducing in-patient usage along the lines proposed by DSRIP and to address costs associated with providing services to the surrounding low income communities in which some campuses are located.

The NYP PPS is the only one in the state that selected Projects 3.e.i (HIV/AIDS prevention) 4.c.i (Reduce AIDS morbidity).

4. Regulatory Exemption/Waiver Requests

This PPS is seeking exemptions or waivers from 6 regulatory requirements.

The specific exemption requests are centered largely on issues related to payment methodologies, including waivers to allow multiple billings for single visits or on a single day, and related to issues of co-locating behavioral health with primary or ambulatory care services. The application also raises issues that might require regulatory relief or clarification from the DOH regarding expansion of primary and behavioral care without additional licensing, billing by Article 28 facilities for off-site services, increasing the number of visits that can be billed by crisis intervention teams, and flexibility in the use of existing beds as “crisis utilization beds.”

The applicant is not seeking anti-trust exemptions under Certificate of Public Advantage (COPA) provisions, presumably because of the high concentration of competitors in the NY City area.

5. Reductions or Closures of Services and Capacity

The PPS application does not identify any significant restructuring. There are not closures or reductions in services specified or implied in the application.

6. Workforce Implications

The PPS application indicates that there will be about 137 new positions required to implement DSRIP, including 22 “care managers” and possible additional RN positions. Most will be filled through new hiring, with some retraining and/or redeployment.

The application does not indicate an intent to engage in any reductions/layoffs of staff. Staff who are identified as “redundant” will be trained for new occupations. Redeployments will be made on voluntary basis, indicating that expected workforce implications will be limited in scope.

7. Participation by Community, Advocates and Workers on the PAC and other Committees

The PPS PAC and other committees have included NYSNA representatives.

8. Other Areas of Concern

No other concerns are noted at this time

5. Community Care of Brooklyn (Maimonides) PPS

Region: New York City

Counties of Operation: Kings and Queens

Attributed population: 477,612

Areas of Concern:

1. Governance Structure:

The PPS is employing a “collaborative contracting” model in which Maimonides and other participating providers will retain their organizational independence. Outside providers participating in the PPS will be linked to the system through service contracts.

Maimonides will, however, create an LLC to provide administrative services to all of the participants.

The PPS Executive Committee will include representatives of collaborating providers and will include union representation, but ultimate decision making control will be in the hands of Maimonides. There will be “hub” sub-committees having oversight over local geographic areas within the PPS.

2. Possible Misuse of DSRIP to Further Corporate Goals:

We are concerned that the recent announcement of an affiliation process between Maimonides and North Shore/LIJ could create pressures to use the DSRIP process and linkages with the Maimonides PPS to further the corporate strategies of the NS/LIJ system. See:

<https://www.northshorelij.com/about/news/maimonides-medical-center-north-shore-lij-health-system-sign-memorandum-understanding>.

Presumably the linking of the two systems will be accompanied by pressure to incorporate NS/LIJ EMR/HIT systems and to integrate Maimonides with the NS/LIJ insurance arms.

This affiliation also raises concerns that Maimonides will shift its emphasis to focus on more profitable patient care lines and to start to shed less profitable services.

3. The DSRIP Projects Selected by the PPS

The projects selected by the Maimonides PPS include Projects 2.a.i (integrated systems focused on population management), 2.a.iii (health home at risk intervention strategies), 2.b.iv (implementing care transition to reduce re-admissions) and 2.b.iii (ED triage/diversion program), and 3.a.i (integration of primary and behavioral care services), all of which consistent with the goals of DSRIP.

The PPS will collaborate with other PPSs to develop programs to improve behavioral health infrastructure which can be applied city-wide (Project 4.a.iii) and to develop a program to reduce HIV/AIDS morbidity (Project 4.c.ii) by providing increased supportive services.

4. Regulatory Exemption/Waiver Requests

This PPS is seeking exemptions or waivers from 10 regulatory requirements.

The specific exemption requests include waiver of OMH or OASAS licensure for Article 28 facilities that exceed the threshold for mental health visits, co-locating of primary, ambulatory and behavioral health services by separately licensed Article 28 providers, or by Article 28 and Article 31 providers, waiver of CON regulations for construction and expansion of services, including expanded primary care, ambulatory care, urgent care and cardio-vascular services, OMH and OASAS approval for expansions of caseloads and new satellite locations for behavioral health services, waiver of construction standards and pre-opening surveys for primary care infrastructure, waiver of restrictions on revenue sharing, waiver of restrictions on discharge/transfer of patients based on source of insurance coverage, allowing payment for offsite care, and allowing home care orders to be written by Pas.

The applicant is not seeking anti-trust exemptions under Certificate of Public Advantage (COPA) provisions, presumably because of the high concentration of competitors in the NY City area.

The request to waive CON review for construction of new facilities and for new services is cause for concern. The CON process is the only opportunity for the public and affected communities to intervene if the changes proposed will have an adverse impact. The CON process also provides an opportunity to ensure that services are not being located in underserved areas or areas where the service is needed.

5. Reductions or Closures of Services and Capacity

The PPS application assumes that a 25% reduction in preventable admissions will result in a reduction in in-patient capacity of 104 beds, presumably mostly comprised of med-surg units.

There are no indications that current services will be eliminated or relocated during the DSRIP process.

It should be noted that the bed reduction, while quite precise, is entirely conjectural and that it does not account for the possible effects of a dynamic health care environment in which increasing access to health insurance and primary care services combine to create counter-acting increases in demand for services, including in-patient services. The projection also appears to not take into account the effect of an aging population, which will also tend to lead to increased need for in-patient beds.

6. Workforce Implications

The PPS application indicates that there will be about 1,500 new positions required to implement DSRIP, including 1,315 mental health providers and case managers. It is unclear how many of these new positions will require RN licensed personnel.

The application estimates that the anticipated closure of the 104 beds will result in a decrease in existing personnel of about 500 positions. It is expected that 30% of existing outpatient staff and 15% of inpatient staff will require retraining. It is unclear how many staff, if any, will be laid off.

7. Participation by Community, Advocates and Workers on the PAC and other Committees

The PPS PAC and other governing committees have been noteworthy for their inclusiveness. NYSNA representatives have been included in the PAC and in the working of the various decision-making committees.

8. Other Areas of Concern

No other concerns are noted at this time.

6. New York Hospital Queens PPS

Region: Queens

Counties of Operation: Queens

Attributed Population: 25,406

Areas of Concern:

1. Governance Structure:

The PPS is employing a “collaborative contracting” model in which the existing network of hospitals operated by the NYP system will remain largely in their current configuration. Outside providers participating in the PPS will be linked through service contracts.

2. Possible Misuse of DSRIP to Further Corporate Goals:

NY Hospital Medical Center of Queens is currently in the process of entering into an active parent relationship with New York Presbyterian. This is of concern, as New York Presbyterian already has an active DSRIP application in Manhattan and Westchester. New York Presbyterian has been actively acquiring new facilities and entering into active parent relationships.

3. The DSRIP Projects Selected by the PPS

These projects focus primarily on expanding access to primary care and improving performance at skilled nursing facilities. There is also a project that mentions expanding the use of telemedicine. The project descriptions do not include the idea of using more nurses there, as at least the Nassau Queens PPS application does.

4. Regulatory Exemption/Waiver Requests

This application requests three regulatory waivers. The applicant is proposing to be exempted from CON review for closure/elimination of existing services, for decertification of beds and licensed services and for relocation of existing services/facilities.

5. Reductions or Closures of Services and Capacity

This application does not specifically address service closures or reduction in capacity.

6. Workforce Implications

They estimate that 100 licensed and 100 un-licensed staff will need to shift to outpatient or community roles as inpatient utilization declines. The greatest impact will be to the categories of Clinical Support Staff—which includes nurses—and Patient Support Staff as the focus moves from an inpatient acute care treatment situation to ambulatory and home care.

It is still unclear how these nurses will be deployed in the community setting and what their roles will be. It is important that the applicant be more transparent about this, especially in regard to their ambitious cardiovascular care project.

7. Participation by Community, Advocates and Workers on the PAC and other Committees

The PAC is composed of 35 members that represent a diverse group reflecting the composition of the network. The PAC includes members in the following categories: 1 Labor, 17 SNF, 4 Home Health, 3 Clinics, 3 Behavioral health, 3 CBO, 1 Developmentally Disabled, 2 NYCDOH, 1 Hospice, and 1 Hospital.

8. Other Areas of Concern

No other concerns are noted at this time.

7. Lutheran Medical Center (a.k.a. “Brooklyn Bridges PPS”)

Region: New York City

Counties of Operation: Kings

Attributed population: 104,415

Areas of Concern:

1. Governance Structure:

The PPS is employing a “collaborative contracting” model in which Lutheran Medical Center and NYU Langone Medical Center will enter into an agreement with the other PPS partners that will allow organizational independence.

Lutheran Medical Center will serve as the lead entity and appoint all members of the governing body as well as every sub-committee. As noted in the DOH’s scoring, the application also did not clearly define the roles or responsibilities of the governing body. Together, this raises the natural concern that the PPS will be managed exclusively to the benefit of Lutheran/NYU and that not in the community’s interest.

Conversely, the initial governing body does include representation from 1199SEIU as well as a Medicaid beneficiary, which is more non-provider representation on a governing body than in many other applications.

2. Possible Misuse of DSRIP to Further Corporate Goals:

The proposal to locate the proposed new observation unit in the Lutheran Augustana skilled nursing facility is troubling, given that it displaces 40 nursing home beds. Potentially, this proposal could represent an effort to replace low-margin services rather than a response to the community’s need. Although the application anticipates that these beds will no longer be needed because of reductions in preventable admissions, this is a considerable reduction (17%), and may be both unrealistic and inconsistent with DOH’s existing system for determining bed need. For instance, the community needs assessment did not note any excess utilization of nursing home care, and Lutheran Augustana’s most recently reported occupancy rate is 92.5%.¹ Further, the application’s description of the new unit as a “Medicaid OU” and anticipation of admitting “Medicaid patients from other Brooklyn PPSs” -- without mentioning patients of any other insurance status -- naturally raises the concern that the PPS is intending both to segregate patients and deliver different levels of care based on insurance in order to capitalize on DSRIP funds.

We are also concerned that the major role played in this PPS by NYU Langone will lead to abuse of the DSRIP process to further that system’s corporate goals.

NYU Langone is not a safety-net provider and is among the lowest performing hospital systems in New York on this score. It has in the past been subject to accusations of purposely avoiding Medicaid and uninsured patients and of shunting them to neighboring public hospitals.

¹ New York State Department of Health. (2015). *Nursing Home Profile*. Available at: http://nursinghomes.nyhealth.gov/nursing_homes/overview/413. Accessed on February 12, 2015.

There are also concerns that the NYU Langone business strategy of seeking out well insured and profitable patient service lines, coupled with its low rates of service to Medicaid and uninsured populations has been a major source of its high revenue streams and profitability while also leaving competing health systems to shoulder a disproportionate burden for such patients.

We believe that this activity has contributed heavily to the financial pressures on hospitals in Brooklyn and the ongoing crisis in that county.

We also note that NYU Langone, notwithstanding its failure to meet the criteria for inclusion in the category of safety-net providers is seeking an exception to allow it to receive full DSRIP funding as part of this PPS.

We are thus concerned that this PPS application will be used by NYU Langone to further its own corporate interests to the detriment of patients, local communities and its competitors in the Brooklyn market.

3. The DSRIP Projects Selected by the PPS

Aside from concerns regarding the observation unit, noted above, the remaining projects selected by the PPS appear to be consistent with the DSRIP goals of improving quality of care, improving community health outcomes and reducing unnecessary usage by expanding primary and ambulatory care services and increasing the coordination of patient care.

4. Regulatory Exemption/Waiver Requests

This PPS is seeking exemptions or waivers from 10 groups of regulatory requirements.

The exemption requests include allowing Article 28 providers to perform a high volume of behavioral health services without licensure/ certification from OMH/OASAS, allowing behavioral health care providers to deliver services in Article 28 spaces, allowing DSRIP projects to proceed without first obtaining certificates of need, allowing behavioral health providers to expand services and locations without prior approval from OMH/OASAS, waiving hospital and nursing home construction standards and pre-opening surveys, allowing children and adults to be treated in the same observation unit, allowing the distribution of funds to individuals/entities other than approved owners, allowing hospitals to discharge or transfer patients based on source of payment, allowing ambulatory care facilities, Article 28 providers, and behavioral health providers to provide and bill for services delivered off-site, and allowing physicians assistants to order home care.

We are unaware if applicant at this time is seeking anti-trust exemptions under Certificate of Public Advantage (COPA) provisions.

The requests for waiver of CON are problematic, as there should be oversight and opportunity for public review and comment over any decisions to expand or reduce services in order to insure that there is oversight over the location and scope of such services and their correlation to the needs identified in the CNA. If CON review is called for, the DOH can provide it on an expedited basis.

We are also concerned that the request for exemption from regulations prohibiting discharges and transfers based on patients' payer source (i.e., Medicaid or uninsured) status raises the possibility of

abusive practices. This exemption should not be granted, as it risks giving the entire PPS the right to provide different levels of care based solely on Medicaid or uninsured status. This could create conditions in which such patients are subject to different or inferior levels of care than is provided to non-Medicaid patients. This is potentially dangerous and antithetical to the premise of improved quality and access.

5. Reductions or Closures of Services and Capacity

The reduction of 40 nursing home beds is the only specific reduction mentioned in the application.

6. Workforce Implications

The application indicates that 20% of the existing staff will be retrained. Of these, 55% will be compensated in their new position at 95% or more of their previous compensation, and 12% will be compensated at between 75% and 95% of their previous compensation. Presumably, the remainder (67%) will be compensated at less than 75% of their previous compensation. This suggests a significant degradation in job standards and de-skilling of the workforce and compares unfavorably to many other applications.

The PPS also indicates that it will have to hire significant amounts of new care workers, including RNs, Nurse Practitioners and Community Health Workers/Care Managers/Coordinators/Navigators. The hiring of Community Health Workers/Care Managers/Coordinators/Navigators raises issues relating to scope of nursing practice. These roles are undefined and if the PPS intends to have non-nurses fill these positions they may be engaging in practice within the RN scope.

As noted by the DOH's scoring of the application, the application had several weaknesses concerning its workforce strategy:

- Application was unclear if a formal assessment has been conducted (or will be conducted) to fully understand the impact on existing employees' current wages and benefits.
- Path for those employees who refuse their retraining assignment was not yet established at the time of application.
- The application did not make clear whether the redeployment will be voluntary.
- The intersection of the workforce strategy and specific existing state programs was not clearly described.

7. Participation by Community, Advocates and Workers on the PAC and other Committees

The PPS PAC will consist of 25-30 individuals and will be representative of partners in the PPS and community organizations, "who will be selected based on their commitment to the PPS, their areas of expertise relative to the DSRIP projects being implemented, their leadership roles in the community, and consistent with any other DSRIP-related requirements."

The lack of specificity in this description, in combination with Lutheran's concentration of control over selection of committee members, raises the concern that the PAC may not be a truly independent body representative of the community.

The application does not guarantee that nurses will be included in any committees involved in the decision-making process.

8. Other Areas of Concern

We also wish to bring to the attention of the PAOP and DOH the additional concern that NYU Langone will act in ways that are inimical to one of the core goals of DSRIP to protect healthcare workers and insure that quality of care is not negatively impacted by bad labor practices.

NYU Langone is a wholly owned subsidiary of NYU. NYU has an extremely troubling history as an employer and user of contractors to provide services. This problem has surfaced most notably and alarmingly in recent reporting related to the construction and opening of foreign campuses and the employment of contractors who have engaged in egregious labor and human rights abuses of poor migrant workers. See: http://www.nytimes.com/2015/02/11/nyregion/report-details-the-worker-complaints-that-blurred-nyus-emirates-vision.html?emc=eta1&_r=2.

We also note that NYU and NYU Langone have histories of anti-union animus that also are cause for concern on this score. NYSNA has recently filed Unfair Labor Practice charges against NYU Langone based on discrimination in the employment of highly qualified nurses to work in the free-standing ER at the site of the former LICH.

8. Staten Island PPS (Richmond University Medical Center)

Region: Staten Island

Counties of Operation: Richmond

Attributed population: 68,693

Areas of Concern:

1. Governance Structure: The Staten Island Performing Provider System, LLC, (SI PPS, LLC) consisting of two members, Staten Island University Hospital (SIUH) and Richmond University Medical Center (RUMC), will oversee the PPS. Day to day operations of SI PPS, LLC will be vested in a Board of Managers ("Board") appointed by the two members, and certain fundamental decisions will be reserved for member vote.

2. Possible Misuse of DSRIP to Further Corporate Goals:

Staten Island University Hospital is part of the North Shore – LIJ Health System and RUMC has ties to Mount Sinai Health System. There have been anti-competitive criticisms levied against North Shore – LIJ in the past when RUMC was in discussions to join the health system. That would have made North Shore – LIJ the only operator of full services hospitals on Staten Island. This collaboration between RUMC and SIUH must therefore be monitored carefully in order to ensure that it is a true partnership between the two providers. North Shore – LIJ is part of other significant applications in New York City and Long Island, and it is important that the community of Staten Island's needs are addressed by this project as opposed to the corporate needs of North Shore – LIJ.

3. The DSRIP Projects Selected by the PPS

The projects selected by this PPS are targeted to expand home and community based care, especially for rehabilitation and long-term care. One project specifically targets expanding detoxification services in existing ambulatory care sites across the PPS, which addresses some of the concerns raised by the community needs assessment. RUMC recently closed its inpatient detox at its Bayley Seton campus, which removed detox services from the facility. This particular project, although focused on outpatient, should ameliorate some of the loss from that particular closure.

The projects seem to be focused specifically on ensuring that patients can be discharged directly from an acute care setting to their homes, and not an intermediary facility like a skilled nursing facility or long-term acute care facility. In these cases, registered nurses are likely going to be involved and necessary in order to ensure that patients are educated properly once discharged.

4. Regulatory Exemption/Waiver Requests

Staten Island PPS has requested 20 waivers for regulatory relief, mostly focused around streamlining services, and focusing on integration of the members of the PPS. Unfortunately, as part of their efforts to streamline they are also asking for significant reprieve from the Certificate of Need process. They

claim they need this relief in order to facilitate construction and placing renovated facilities in service as quickly as possible. In addition, they are looking for a waiver that would allow them to transfer patients from different payer sources between the facilities in the PPS. In addition, they are looking for relief in regard to telemedicine in order to facilitate care transitions, which is of concern relative to the delivery of care and assessment of patients in the home based setting.

5. Reductions or Closures of Services and Capacity

The Staten Island PPS application does not identify any closures of services or capacity. There are references to reduction in volume in EDs and potential reduction of inpatient employment opportunities, presumably associated with bed/service reductions. It is unclear what the impact of the required 25 percent reduction in avoidable hospital use will be on hospital operations. We are concerned that there is no specific information on how the participating partner hospitals will be impacted.

6. Workforce Implications

The application indicates that there will be approximately 400 positions will be created as a result of DSRIP-related activity. They indicate that 43% of the existing workforce will have to be retrained to fulfill the needs of the projects. 3% of the workforce will be redeployed and 3% of the current workforce will have to be hired from outside the PPS. 75% will receive full placement, and 25% will receive partial placement. The application acknowledges that there will be a need for registered nurses despite the fact that the primary aim of the application is to reduce inpatient capacity. RNs will fulfill new positions as “Care Managers”, “Nurse Educators”, and for the expansion of primary care and ambulatory detox sites. However, the application is vague as to how these nurses will be deployed throughout the PPS, and does not give specifics.

7. Participation by Community, Advocates and Workers on the PAC and other Committees

The Staten Island PPS PAC was formed over the past few months (during the DSRIP planning process) and is comprised of representatives from more than 30 PPS Partners (includes representatives from mental health, substance abuse, nursing homes, and home care agencies), employee labor unions, and community interest organizations to achieve even representation of provider, employee, and beneficiary needs and to represent the interests of different subsets of collaborators. The labor unions, such as 1199 SEIU, New York State Nurses Association and the Federation of Nurses, and UFT represent the staff across multiple collaborator organizations. The PAC will meet monthly and/or as needed prior to DSRIP Year 1 and throughout the DSRIP implementation. Going forward the PAC's role will include advising the Workforce Committee on training and redeployment of existing staff as well as new hires. The PAC includes human resource representatives from the key PPS provider network as well as Staten Island labor representatives. Representations from numerous provider organizations included in the PPS network are represented in the PAC including mental health and substance abuse providers, primary care providers, hospitals, skilled nursing facilities, homecare agencies, federally qualified health centers, and community based organizations, among others.

9. Bronx Partners of Healthy Communities PPS (St. Barnabas)

Region: Bronx

Counties of Operation: Bronx

Attributed Population: 344,479

Areas of Concern:

1. Governance Structure:

There will be an Executive Committee, along with four standing committees: The Finance and Sustainability Subcommittee, the Quality and Care Innovation Subcommittee, the IT subcommittee, and the Workforce Committee. There will also be four rapid deployment collaboratives to identify best practices for DSRIP projects. Partners participating in each project will be contractually obligated to participate in the RDCs.

2. Possible Misuse of DSRIP to Further Corporate Goals:

Although St. Barnabas is the lead entity, Montefiore Medical Center's Bronx based facilities are a part of the application and Montefiore is also listed as a key partner. In the event that St. Barnabas is unable to fulfill its fiduciary role Montefiore has agreed to assume responsibility.

3. The DSRIP Projects Selected by the PPS

Many of the projects echo other citywide applications, including expanding access to primary care and creating an integrated delivery system. However, one important project is adding telehealth and IT solutions for behavioral health. Another project of note is the use of Methodist Home as a stepdown unit for patients discharged from the hospital that need short-term care. This project must be monitored and developed with the insight of registered nurses. Although it is taking place outside an acute care facility, this project must be staffed accordingly and safely by RNs.

They also want to build a mixed-use affordable housing development that also includes primary, urgent care, and behavioral health space; and commercial wellness facilities, including a pharmacy, day care center, gym, and supermarket. They plan to open at least one additional urgent care center and one respite facility.

4. Regulatory Exemption/Waiver Requests

This application requests ten regulatory waivers. We are concerned that the request for exemption from regulations prohibiting discharges and transfers based on patients' payer source (i.e., Medicaid or uninsured) status raises the possibility of abusive practices. This exemption should not be granted, as it risks giving the entire PPS the right to provide different levels of care based solely on Medicaid or uninsured status. This could create conditions in which such patients are subject to different or inferior levels of care than is provided to non-Medicaid patients. This is potentially dangerous and antithetical to the premise of improved quality and access. The applicant is seeking exemption from CON approval to avoid delays in implementation as well.

5. Reductions or Closures of Services and Capacity

This application does not specifically address service closures or reduction in capacity.

6. Workforce Implications

St. Barnabas' recognize that their projects will involve hiring staff. Some of the new clinic and ED staff will be nurses, but mostly they intend to hire care managers, who will not be nurses. They expect a great deal of competition for good staff, however. They do expect to lose some nurses at inpatient hospital facilities through attrition.

They estimate that a "small number" of nurses will be redeployed from inpatient settings, but it is unclear in what capacity.

7. Participation by Community, Advocates and Workers on the PAC and other Committees

BPHC chose to pursue an alternative PAC structure. They created a planning PAC with 163 members, including primary and specialty care providers; mental health and substance abuse providers; community based physicians; home care, long-term care and rehabilitative services; labor; and housing, social service and community-based organizations. During the implementation phase, however, the PAC will consist of the members of the Executive Committee and all subcommittees, having about 70 members. We must ensure that nurses will continue to have a place in the PAC.

8. Other Areas of Concern

No other concerns are noted at this time.

10. Bronx Lebanon Hospital Center PPS

Region: New York City

Counties of Operation: Bronx

Attributed population: 133,177

Areas of Concern:

1. Governance Structure:

The PPS is employing a “collaborative contracting” model for 2015, but plans to convert to a “delegated model” in 2016. Under the delegated model, the PPS will be governed by an LLC with Bronx-Lebanon Hospital Center (BLHC) having at least 51% control.

The Board of Managers, as governing body of the LLC, will contain at least one representative of every major provider type in the PPS, including social service providers, and a majority of seats will be held by community providers. The PPS is currently being managed by a Steering Committee, whose members are expected to continue also serve on the Board of Managers following conversion of the delegated model. A representative from 1199SEIU currently is on the Steering Committee. NYSNA is a member of the Project Advisory Committee.

The PPS, as of the application, appeared to be somewhat behind other applicants in terms of the planning process, and the governance portion of the application could use more detail. However, the composition of the Steering Committee, with strong labor and community provider representation, compares favorably to other applicants.

2. Possible Misuse of DSRIP to Further Corporate Goals:

Though we do not have any specific concerns at this time, it is unclear why this application projects such a large workforce expansion compared to others, and further clarification on that point would be helpful.

3. The DSRIP Projects Selected by the PPS

The various projects selected by the PPS appear to be consistent with the DSRIP goals of improving quality of care, improving community health outcomes and reducing unnecessary usage by expanding primary and ambulatory care services and increasing the coordination of patient care.

4. Regulatory Exemption/Waiver Requests

This PPS did not seek any regulatory waivers, even though it is pursuing many of the same projects as other hospitals that did request extensive relief. This raises the concern that some regulatory relief may, in fact, be necessary in order to successfully implement the projects, and that this omission from the application will ultimately prove an obstacle later on.

5. Reductions or Closures of Services and Capacity

“Bed reduction” was identified as a goal in the application, and the PPS plans to take part in the “mini-Burger bed process” that takes place regularly under state direction. The only specific reduction noted in the application is closure of “one bedded unit to decertify 20

medical beds on or before the end of DSRIP Year 3,” with personnel (including R.N.s) being reassigned to other units.

6. Workforce Implications

As noted above, the application projects a surprisingly large increase in the workforce. The application is also notable in that it emphasizes nurses and social workers as among the workers most needed to fulfill new positions, and even notes an existing nursing shortage as an obstacle.

However, the application projects that 40% of retrained workers will receive at least 95% of their existing compensation and 20% will receive between 75% and 95% of their existing compensation, implying that the remaining 40% will receive less than 75% of their existing compensation. This suggests a significant degradation in job standards that does not square easily with the application’s narrative sections.

The hiring of Community Health Workers and Care Managers, like many other applications, raises issues relating to scope of nursing practice. These roles are undefined and if the PPS intends to have non-nurses fill these positions they may be engaging in practice within the RN scope. However, particularly in its project to increase support for maternal and child health, the PPS application exhibits welcome (and unusual) attention to how these newer roles can be used to complement licensed professionals (including R.N.s) to ensure that patients receive appropriate care.

7. Participation by Community, Advocates and Workers on the PAC and other Committees

As noted above, the initial Steering Committee has comparably community-focused composition.

8. Other Areas of Concern

The application noted that the PPS was considerably behind in the planning process as of the time of the application, and received a relatively low score in part because many of the answers it provided were too vague. However, the PPS proposes to be attributed a population in perhaps the highest-need zip codes in the state, and is also noteworthy in the emphasis the application placed on the use of skilled professionals in transforming its delivery system. It would be a shame if the PPS was unable to receive the resources it needed to expand community-focused care due to shortcomings in its ability to jump through the application hoops.

11. Nassau Queens PPS

Region: Long Island/New York City

Counties of Operation: Queens, Nassau

Attributed population: 354,665

Areas of Concern:

1. Governance Structure:

The PPS is employing a “delegated governance model” under which the newly formed PPS business entity will govern and oversee the various members. The LLC will be governed by an Executive Committee composed of 21 voting members drawn from the safety net entities and their partners, appointed by NUMC/Unhealthy (with 11 members), LIJ (with 5 members) and CHS (with 5 members). There is also a Hub system, in which each lead hospital will manage its facilities and the participating partners.

Should NUMC/NuHealth prove unable to carry out the operational or financial requirements of DSRIP, LIJ will step in as the PPS Lead. With North Shore eventually gaining a 50% controlling stake in the Advocate Community Partners PPS, North Shore/LIJ could have control over two different PPS’s.

2. Possible Misuse of DSRIP to Further Corporate Goals:

The role of North Shore LIJ raises questions about the degree to which its involvement with the PPS will use the DSRIP process and funding in furtherance of its own corporate business strategies rather than to improve access and quality of care for Medicaid patients.

NS/LIJ has engaged in a long-term strategy of acquiring medical practices, expanding the cadre of directly employed physicians and seeking to expand its operations in the New York City area. “North Shore-LIJ continues to focus on improving operating performance despite the challenges and factors pressuring operating margins....continuing to reduce operating expenses with operational efficiency efforts, program consolidation and supply chain initiatives, and create additional revenue opportunities through new and enhanced facilities, physician recruitment efforts, and initiatives to prepare for the migration from fee-for-service to value and risk-based payment models, including the formation of North Shore-LIJ CareConnect. North Shore-LIJ continues to invest in strategic capital projects and technology, including electronic health record and other clinical software, to maintain what management believes is a competitive advantage regarding physician satisfaction and retention....[and] making strategic investments in physicians who support key clinical service lines and staff to support the growth in the ambulatory network and outpatient volume....” See: North Shore/LIJ Management’s Discussion and Analysis of Financial Performance for the 6 months ended June 30, 2014 and 2013 (<http://emma.msrb.org/ER797014-ER620339-ER1022058.pdf>).

In implementing this strategic approach, NS/LIJ has specifically sought to gain market share within New York City. See: <http://content.hcpro.com/pdf/content/257025-4.pdf>. The system has aggressively recruited physicians and now directly employs about 2,500 and is affiliated with about 7,500 more in what is characterized as a “buying spree.” See: <http://www.craigslistnewyork.com/article/20121125/SMALLBIZ/311259990/health-cares-shrinking-dollar-squeezes-doctors>. One of the techniques used is to offer to integrate physician practices with its EMR systems with substantial subsidies, thus enticing affiliation and binding them to NS/LIJ through the

NS/LIJ EMR system. See: <http://www.prnewswire.com/news-releases/north-shore-lij-health-system-investing-400m-to-connect-up-to-7000-physicians-13-hospitals-with-electronic-health-records-system-64391457.html>.

3. The DSRIP Projects Selected by the PPS

Many of the projects selected by the PPS highlight the expanded use of EMR and IT systems to improve coordination. The 2.a.i project, for example, calls for expansion of EMR and the creation of an integrated technology platform and will seek capital funding to expand this platform, thus complementing the ongoing strategic approach of NS/LIJ to use EMR/HIT to recruit and retain physicians.

4. Regulatory Exemption/Waiver Requests

This PPS is seeking exemptions or waivers related to restrictions on referrals and/or revenue sharing, issues of patient releases for sharing of medical information, issue of obtaining operating certificates for sites at which care is being provided on an out-patient basis, waiver of hospice need methodology, and licensing and co-locations for mental health and substance abuse services. They are also seeking waivers from Certificate of Need regulations and from anti-trust exemptions under Certificate of Public Advantage (COPA) provisions, presumably because of the high concentration of competitors in the NY City area.

Several of the requests for regulatory exemption are possibly inappropriate and should be closely scrutinized. The applicant is seeking exemption from restrictions on referrals and transfers based on patients' payer source (i.e., Medicaid or uninsured) status. The applicant claims this type of waiver is needed to allow it to discharge or transfer patients out of in-patient or ED units. This exemption should not be granted, as it risks giving the entire PPS the right to provide different levels of care that are motivated solely by their Medicaid or uninsured status. This could create conditions in which such patients are subject to different or inferior levels of care than is provided to non-Medicaid patients. This is potentially dangerous and antithetical to the premise of improved quality and access.

The waivers from CON regulations are troubling, as there should be oversight and opportunity for public review and comment over any decisions to expand services in order to insure that there is oversight over the location and scope of such services and their correlation to the needs identified in the CNA. If CON review is called for, the DOH can provide it on an expedited basis.

Especially concerning is the waiver of the Certificate of Public Advantage. Our anti-trust laws were put there for a reason and the DSRIP process should not be an excuse to put them aside.

5. Reductions or Closures of Services and Capacity

The PPS application does not seem to foresee closures or reduction of infrastructure or beds. It also has not sought any exemptions or waivers from regulation related to closures or reductions of services.

6. Workforce Implications

The application indicates that it expects a reduction in staff, including in the RN workforce, which will largely be accomplished through attrition. Additionally, NQP expects that some unknown percentage of nurses will be redeployed and retrained to provide nursing services in outpatient settings, as well as in care management. The application acknowledges that pay in outpatient settings has been lower,

historically, but optimistically states that “wages and benefits are likely to rise with the new demand for outpatient workers.”

The application does recognize a need to increase the number of nurse practitioners in the area to reach an average level. The PPS would like to hire 365 nurse practitioners.

The applicant states that it will hire care management teams to follow patients. These teams include clinical staff, as well as EMTs and pharmacists. It is unclear what its intentions are regarding these non-clinical personnel. It is possible that some of the functions assigned to these personnel involve nursing functions and there is thus a question as to whether these positions must be filled by RNs. Additionally, the applicant does seek a scope of practice waiver to allow home health aides to administer insulin, a plan which raises some red flags.

7. Participation by Community, Advocates and Workers on the PAC and other Committees

The PAC appears to include a wide swath of representation. We have no concerns about it at this time.

8. Other Areas of Concern

No other concerns are noted at this time.

12. Suffolk PPS (Stony Brook University Hospital)

Region: Long Island

Counties of Operation: Suffolk

Attributed population: 148,118

Areas of Concern:

1. Governance Structure:

The PPS is employing a “delegated governance model” under which the newly formed PPS business entity will govern and oversee the various members. The LLC will be governed by an Executive Committee composed of 21 voting members, with 11 of them representatives of Stony Brook. There are also two hubs, with one associated with Stony Brook and the other with North Shore/LIJ.

2. Possible Misuse of DSRIP to Further Corporate Goals:

Both Stony Brook and North Shore/LIJ have been looking to merge with hospitals in Eastern Long Island. Stony Brook and Southampton have been undergoing the affiliation process for two years. Meanwhile, press recently reported that both Stony Brook and North Shore/LIJ are looking to merge with Peconic Bay Medical Center and Eastern Long Island hospital. DSRIP could be a way to ease the merge processes.

3. The DSRIP Projects Selected by the PPS

Project 2.b.iv involves hiring a variety of case managers to follow at-risk patients. It is unclear exactly who is expected to a case manager, but it is important that they have the necessary clinical skills to do so.

4. Regulatory Exemption/Waiver Requests

This PPS is seeking exemptions or waivers related to restrictions on referrals and/or revenue sharing, issues of patient releases for sharing of medical information, issue of obtaining operating certificates for sites at which care is being provided on an out-patient basis, waiver of hospice need methodology, waivers to allow non-emergency transportation authorization, waivers for telepsychiatry services, waivers to allow more observation beds, and waivers related to licensing and co-location requirements for mental health and substance abuse services. They are also seeking waivers from Certificate of Need regulations.

Several of the requests for regulatory exemption are possibly inappropriate and should be closely scrutinized. The applicant is seeking exemption from restrictions on referrals and transfers based on patients’ payer source (i.e., Medicaid or uninsured) status. The applicant claims this type of waiver is needed to allow it to discharge or transfer patients out of in-patient or ED units. This exemption should not be granted, as it risks giving the entire PPS the right to provide different levels of care that are motivated solely by their Medicaid or uninsured status. This could create conditions in which such patients are subject to different or inferior levels of care than is provided to non-Medicaid patients. This is potentially dangerous and antithetical to the premise of improved quality and access.

The waivers from CON regulations are troubling, as there should be oversight and opportunity for public review and comment over any decisions to expand services in order to insure that there is oversight over

the location and scope of such services and their correlation to the needs identified in the CNA. If CON review is called for, the DOH can provide it on an expedited basis.

5. Reductions or Closures of Services and Capacity

The PPS application does not seem to foresee closures or reduction of infrastructure or beds. It also has not sought any exemptions or waivers from regulation related to closures or reductions of services.

6. Workforce Implications

The application indicates that it expects a reduction of about 150 staff, including some unknown number of RNs, which will be accomplished through attrition. The applicant also expects to hire NPs, RNs, and LPNs; they believe there is currently a shortage in nurses.

The applicant states that it will hire case managers to follow at-risk patients. The application implies that these might be filled by a variety of clinicians, as well as pharmacists and “others”. It is unclear what its intentions are regarding these non-clinical personnel. It is possible that some of the functions assigned to these personnel involve nursing functions and there is thus a question as to whether these positions must be filled by RNs.

7. Participation by Community, Advocates and Workers on the PAC and other Committees

The PAC appears to include a wide swath of representation. We have no concerns about it at this time.

8. Other Areas of Concern

No other concerns are noted at this time.

13. Westchester Medical Center PPS

Region: Hudson Valley

Counties of Operation: Westchester, Rockland, Putnam, Orange, Dutchess, Sullivan, Ulster, and Delaware

Attributed population: 120,232

Areas of Concern:

1. Governance Structure:

The PPS is adapting a “collaborative contracting” model governed by a Master Hub and Services Agreement. Other PPS partners will maintain their organizational independence. The PPS will further employ a master-hub structure in which its projects will be implemented with oversight by sub-committees in each of four hubs around the Hudson Valley.

WMC is creating the Center for Regional Healthcare Innovation as a subsidiary to provide centralized services and operational support to the PPS and its partners. One of its duties appears to be providing staff to PPS partners, though the application is not clear if staff will be employees of the partners or of CRHI. We would be concerned about the latter; staff should be official employees of their institutions who have responsibility for them, not of staffing agencies.

2. Possible Misuse of DSRIP to Further Corporate Goals:

Westchester Medical Center has entered into serious talks about affiliation agreements with the HealthAlliance and Bon Secours hospital systems. It recently bought St. Francis Hospital, now named the Mid-Hudson regional hospital. All of those entities are in its PPS, which would seem to be just a first step towards tighter collaboration.

As a public hospital, Westchester Medical Center should not be working to further corporate goals. It is concerning that the hospital is acquiring private providers, which might provide incentives to shift patient care away from serving the community. It has begun its expansion without true public input or accountability, and DSRIP will help it to continue to enact these plans without community oversight.

3. The DSRIP Projects Selected by the PPS

The broader corporate interests of WMC discussed above are further evidenced in the selection of programs by the PPS. In Domain 4 it has selected prevention and management of cancer (Project 4.b.ii). This selection affords opportunities to expand network infrastructure and increase revenues from these services lines, which tend to generate significant hospital profits.

WMC is also implementing the medical village project (2.a.iv) to repurpose hospital beds. We’re extremely concerned that this will lead to a reduction in services in the Kingston and Port Jervis communities (see below).

4. Regulatory Exemption/Waiver Requests

The exemption requests include waiver of licensure requirements for existing Article 28 facilities that will increase mental health visits, allowing existing Article 28 operating certificates to apply to co-located providers or lessees participating in the PPS, waiving approval by OMH for expanded primary

care services or sites operated by Article 31 providers, exemption from restrictions on referrals and/or revenue sharing to non-established provider partners, exemption from restrictions on discharging or transferring patients based on type of insurance, allowing ambulatory care facilities to bill for off-site services, and expanding the right of PAs to order licensed home care services. It is also seeking to waive CON requests, including requests to decertify beds.

The requests for waiver of CON are problematic, as there should be oversight and opportunity for public review and comment over any decisions to eliminate services. WMC wishes to decertify beds at hospitals in Kingston and Port Jervis, which will have a significant impact on those communities and should be more fully studied via a CON process.

We are also concerned that the request for exemption from regulations prohibiting discharges and transfers based on patients' payer source (i.e., Medicaid or uninsured) status raises the possibility of abusive practices. This exemption should not be granted, as it risks giving the entire PPS the right to provide different levels of care based solely on Medicaid or uninsured status. This could create conditions in which such patients are subject to different or inferior levels of care than is provided to non-Medicaid patients. This is potentially dangerous and antithetical to the premise of improved quality and access.

5. Reductions or Closures of Services and Capacity

WMC plans to create Medical Villages at Bon Secours Community Hospital in Port Jervis and at the Health Alliance Broadway Campus in Kingston. HealthAlliance has developed a plan to consolidate services into the Benedictine campus, reduce licensed beds from 300 to 200, and use the vacated facility to create a Medical Village. Bon Secours Community Hospital plans to reduce 25 staffed beds and decertify 36 licensed beds, including six intensive care unit beds and 30 medical/surgical beds. These will be replaced with primary and behavioral care facilities and, at Bon Secours, a six-bed observation unit.

These reductions in hospital capacity might have significant effects on the communities in which they are located. By reducing capacity via the DSRIP process, it seems that WMC and its partner hospitals are attempting to duck necessary oversight.

6. Workforce Implications

The application appears to have significant impacts on its workforce, with 73% of them requiring retraining. Of those being retrained, WMC estimates that only 45% will receive full placement, while just another 25% will receive partial placement. It expects that more of their staff will be employed in ambulatory care facilities where, the application says, "pay scales are historically different." Such an impact on the current workforce is extremely troubling. The overall health of the region will not be served if one-fifth of the staff in the PPS are expected to have significantly worse jobs than they began with.

The hiring of "care managers," as proposed in multiple WMC projects, raises issues relating to scope of nursing practice if the PPS intends to have non-nurses fill those roles and engage in practice within the RN scope.

7. Participation by Community, Advocates and Workers on the PAC and other Committees

The PAC consists of one representative of each PPS Participant, as well as representatives of community-based organizations and unions. While labor unions were represented on the PAC, it is unclear how frontline non-union workers—who are likely to be significantly affected by the application—were engaged, as even the DSRIP scoring summary points out.

The PAC is planned to meet only twice annually in the future, which seems like a limited amount of time to get feedback from local communities and workers.

8. Other Areas of Concern

No other concerns are noted at this time.

14. Montefiore Hudson Valley Collaborative PPS

Region: Hudson Valley

Counties of Operation: Westchester, Rockland, Orange, Sullivan, Putnam, Dutchess, and Ulster

Attributed population: 213,505

Areas of Concern:

1. Governance Structure:

The PPS is employing a “collaborative contracting” model in which Montefiore and the other PPS partners will maintain their organizational independence. Montefiore will be the ultimate fiduciary and decision-maker.

2. Possible Misuse of DSRIP to Further Corporate Goals:

Montefiore has been aggressively expanding into Westchester and the Hudson Valley. They purchased the bankrupt Soundshore system in 2013, adding New Rochelle and Mount Vernon hospitals to their portfolio. It has since affiliated with White Plains Hospital and Nyack Hospital (<http://www.lohud.com/story/news/health/2014/09/18/white-plains-montefiore-merger-approved/15823983/>). Montefiore has also been opening health centers and affiliating medical practices in the area. Adding additional hospitals and other providers to its PPS network could be a first step to accreting them.

Montefiore’s PPS is also collaborating with Albany Medical Center on implementation. The applications are unclear on this point, but it seems possible that both PPS’s could merge into a multi-regional system.

3. The DSRIP Projects Selected by the PPS

The broader corporate interests of Montefiore discussed above are further evidenced in the selection of programs by the PPS. In Domain 3 this PPS has selected coronary care (Project 3.b.i) and in Domain 4 it has selected prevention and management of cancer (Project 4.b.ii). Both of these selections afford opportunities to expand network infrastructure and increase revenues from these services lines, which tend to generate significant hospital profits.

Montefiore is also implementing the medical village project (2.a.iv) to repurpose hospital beds. They estimate that by 2019, “more than 1000 licensed hospital beds will be unutilized.” They offer little evidence for this assertion and acknowledge that “reduction in hospital capacity could face resistance within the community due to public misperceptions about the need for that capacity,” without crediting the possibility that the community might have a point. Montefiore’s project also lacks specifics; the PPS does not yet appear to know where the medical villages will go or what they will be used for. It is difficult to fully opine on their necessity without more information.

4. Regulatory Exemption/Waiver Requests

This PPS is seeking exemptions or waivers from at least 27 regulatory requirements, while leaving the door open for future waiver requests.

The exemption requests include waiver of licensure requirements for existing Article 28 facilities that will increase mental health visits, allowing existing Article 28 operating certificates to apply to co-located providers or lessees participating in the PPS, regulation, waiving approval by OMH and OASAS for expanded primary care services or sites operated by Article 31 and 32 providers, waiver of design, construction and survey requirements for Article 28 hospitals and free-standing ambulatory care facilities, exemption from restrictions on referrals and/or revenue sharing to non-established provider partners, exemption from restrictions on discharging or transferring patients based on type of insurance, and allowing ambulatory care facilities to bill for off-site services. It is also seeking to waive CON requests.

The requests for waiver of CON are problematic, as there should be oversight and opportunity for public review and comment over any decisions to expand services in order to insure that there is oversight over the location and scope of such services and their correlation to the needs identified in the CNA. If CON review is called for, the DOH can provide it on an expedited basis.

We are also concerned that the request for exemption from regulations prohibiting discharges and transfers based on patients' payer source (i.e., Medicaid or uninsured) status raises the possibility of abusive practices. This exemption should not be granted, as it risks giving the entire PPS the right to provide different levels of care based solely on Medicaid or uninsured status. This could create conditions in which such patients are subject to different or inferior levels of care than is provided to non-Medicaid patients. This is potentially dangerous and antithetical to the premise of improved quality and access.

5. Reductions or Closures of Services and Capacity

As discussed above, the PPS application plans to creative Medical Villages in unused hospital space, and estimates that there more than 1000 beds will be unutilized by 2019. They plan to “repurpose this capacity,” but give little detail as to how. More information is needed.

6. Workforce Implications

The application indicates that minimal portions of the workforce will need redeployment or retraining. They estimate “minimal net job loss,” and articulate a “commitment to a fair and living wage.” They do expect that acute care clinical staff, including nurses, will be affected by acceleration in declining volumes. They expect that they will need to move to new care settings and will need training to prepare for new roles.

The PPS application anticipates hiring for nurses, nurse practitioners, and nurses assistants in ambulatory clinics.

The hiring of “patient navigators” raises issues relating to scope of nursing practice. The PPS acknowledges that currently at Montefiore, the navigator is clinically trained as a nurse or social worker. The application is unclear if the position will require such credentials throughout the PPS. It may raise issues if the PPS intends to have non-nurses fill those roles and engage in practice within the RN scope.

7. Participation by Community, Advocates and Workers on the PAC and other Committees

HVC created PACs in 4 regions: Westchester, Rockland, Orange/Sullivan, and Putnam/Dutchess/Ulster. Any PPS member can join the PACs, as well as community based organizations, local government officials, and representatives from 1199SEIU, NYSNA, and CSEU. 1199 is also on the Leadership Steering Committee.

8. Other Areas of Concern

No other concerns are noted at this time.

15. Refuah Health Center PPS

Region: Hudson Valley

Counties of Operation: Orange, Rockland

Attributed population: 39,443

Areas of Concern:

1. Governance Structure:

The PPS is employing a collaborative contracting model. Refuah and Ezras Choilim jointly have majority control of the governing body. Other parties have representation on the committee but lack power.

2. Possible Misuse of DSRIP to Further Corporate Goals:

We have no concerns at this time.

3. The DSRIP Projects Selected by the PPS

Refuah proposes to establish a birth center inside “one of the hospital partners.” This is not one of the DSRIP projects, but the application nonetheless seeks exemption from CON processes in order to do so. The application argues that a birth center located inside a hospital is cheaper than full inpatient hospital births, but we’re concerned it might sacrifice patient care.

4. Regulatory Exemption/Waiver Requests

The PPS seeks exemptions from regulations limiting the co-location of behavioral health and primary care facilities. It also seeks exemptions from CON related to its projects, including to its birthing center. Considering that the birthing center is not even a DSRIP project, the idea that a CON exemption should be granted seems especially unwarranted.

5. Reductions or Closures of Services and Capacity

The PPS application does not seem to foresee closures or reduction of infrastructure or beds. It also has not sought any exemptions or waivers from regulation related to closures or reductions of services.

6. Workforce Implications

The application expects job increases, not job losses and little to no redeployment of existing staff. They do expect to hire health navigators, who do not appear to be nurses. There could be scope of practice issues if the health navigators engage in clinical tasks.

7. Participation by Community, Advocates and Workers on the PAC and other Committees

The PAC has limited community representatives and stakeholder efforts are noticeably thin.

8. Other Areas of Concern

No other concerns are noted at this time.

16. Albany Medical Center PPS

Region: Capital District

Counties of Operation: Albany, Columbia, Greene, Saratoga, Warren

Attributed population: 64,363

Areas of Concern:

1. Governance Structure:

AMC PPS selected a Collaborative contracting model. This is the same model as Montefiore PPS, with which AMC has had discussions about merging, which did not transpire because of time constraints and with which AMC now has an affiliation that they refer to as “a virtual partnership”. The expectation appears to be eventual merger. While they both share the same governance model at this time (Montefiore indicated they may change), the implications for changes in governance have not been addressed.

The PPS has delegated governance functions to the PAC, lead applicant and PMO responsibilities to AMCH, and project development activities to its various committees, which continue to meet and approve items of importance.

The Executive Committee of the PAC is the governing body of the PPS whose members are responsible for policy making, executive decision making, approving the reports and activities of each subcommittee, reviewing financial statements, approving the annual budget and audit and disciplining members pursuant to the code of conduct and compliance requirements.

2. Possible Misuse of DSRIP to Further Corporate Goals:

As the AMC PPS is the smaller of the two Capital District PPSs (3 hospitals vs. 13; 64,000 attributed lives vs. 116,000), the immediate opportunities for this PPS to enhance its corporate influence are moderate. However, an eventual merger with Montefiore would incorporate AMC into a behemoth network with 30 hospitals stretching from Westchester County to the North Country.

The Medical Village project, which includes the creation of an Urgent Care clinic, in conjunction with regulatory waivers, appears to facilitate the opening of such a service in the Capital District where there has been much competition and oversight by DOH and PHHPC of such ventures. DSRIP should not be a means to avoid appropriate needs review if profit is the underlying motive.

2. The DSRIP Projects Selected by the PPS

The selection of projects by the AMC PPS reflect the general theme of integrating healthcare infrastructure to increase the use of primary care and community based treatment, including :2.a.i Create an Integrated Delivery System focused on Evidence-Based Medicine and Population Health Management; 2.a.iii Health Home At-Risk Intervention Program: Proactive Management of Higher Risk Patients Not Currently Eligible for Health Homes through Access to High Quality Primary Care and Support Services; 2.a.v Create a Medical Village/Alternative Housing Using Existing Nursing Home Infrastructure; 2.b.iii ED Care Triage for At-Risk Populations 2.d.i Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care.

The projects include several directed at behavioral/substance abuse populations:

3.a.i Integration of Primary Care and Behavioral Health Services; 3.a.ii Behavioral Health Community Crisis Stabilization Services; and 4.b.i Promote tobacco use cessation, especially among low SES populations and those with poor mental health. Remaining projects are: 3.b.i Evidence-Based Strategies for Disease Management in High Risk/Affected Populations (Adults Only); 3.d.iii Implementation of Evidence Based Medicine Guidelines for Asthma Management; and 4.b.ii Increase Access to High Quality Chronic Disease Preventative Care and Management in Both Clinical and Community Settings

4. Regulatory Exemption/Waiver Requests

AMC PPS has requested 22 regulatory waiver requests. These requests include: a determination that the activities of the PPS do not constitute corporate practice of medicine; an exemption from becoming an established operator; authorization to distribute revenue among its partners; relief the requirements of the need for new CONs and review of public need and prior review and approval for changes in capacity/services/relocation; easing of existing procedural and licensing, physical plant regulations to permit integration of behavior/substance abuse and primary care and co-location of these services; ability to increase the number of observation beds without prior review; replacement of existing regulations on nursing home discharges with PPS protocols; shared credentialing; and to permit clinical treatment staff to make and bill for home visits.

We are concerned that some of the regulatory waivers are overly broad in scope and preempt public input on changes in services that affect the community's health and right to transparency about these changes.

AMC PPS is not seeking anti-trust exemptions under Certificate of Public Advantage (COPA).

5. Reductions or Closures of Services and Capacity

The only bed reductions identified in the PPS application are 100 unstaffed Skilled Nursing Home beds that will be converted into a Medical Village.

It is unclear from the application what impact the 25% reduction of avoidable inpatient admissions and avoidable emergency room use will have on existing hospital services and beds.

6. Workforce Implications

The AMC PPS will create 983 new jobs, one third of which are administrative. The PPS indicates that additional workers will be required in primary care setting where care coordination will become important. Nurses will be needed in the Medical Villages.

While the total impacted staff is estimated to be relatively small, nurses will be impacted most, there is no detail on where these impacts will be, other than a reference to reductions in admissions and emergency department utilization requiring fewer staffing requirements in these settings. There is no identification of bed reductions other than the unstaffed nursing home beds.

The PPS has committed to no layoffs.

The workforce chart indicating percentages of staff that will be redeployed and retrained shows 7% retraining, but the application states that all staff will need training (voluntary, no cost) in order to understand the changes and how their roles may be modified within an integrated delivery system. This is inconsistent.

There is no discussion of any impact on wages of employees shifting from hospital to community based positions. The chart indicates that 5% of retrained employees will have a significant salary impact, but it is not clear how this was determined.

7. Participation by Community, Advocates and Workers on the PAC and other Committees

The PPS is now governed by the Executive Committee of the PAC comprised of 21 members elected by the PAC. The membership of the Executive Committee and the larger PAC is not specified. The application claims to have numerous stakeholders serving the poor, a variety of community based organizations and advocacy organizations, but there is no documentation. While not addressed specifically in the application, there is labor participation on the PAC. Unions are involved in the Workforce Development Committee, but participation in other committees is unknown.

8. Other Areas of Concern

The tables in the application on community resources and network participation raise some issues. There is extremely limited participation of community resources. The network table indicates that almost every physician in the region and most specialty providers are part of the PPS. This is difficult to believe, but can't be substantiated because there is no list of providers.

17. iHANYs PPS (Ellis)

Region: Capital District

Counties of Operation: Albany, Fulton, Montgomery, Rensselaer, Saratoga, Schenectady

Attributed population: 116,624

Areas of Concern:

1. Governance Structure: The Ellis PPS has selected a Delegated Governance structure. The application indicates the pending formation of an LLC, which has since been formalized as the Alliance for Better Health Care (AFBHC). The composition of the governing body will include two representatives from each of the 7 member organizations, two independent providers who are not employed by any member and a member of the Project Advisory Committee (PAC) appointed by the PAC.

Governing body committees will include both governing body members and others who can contribute special expertise to the committee's function, but who may not serve on the governing body.

2. Possible Misuse of DSRIP to Further Corporate Goals:

While St. Peter's Health Partners is not the lead entity in this PPS, it is the largest of the seven key partners: Ellis Hospital, St. Peter's Health Partners, St. Mary's Healthcare (Amsterdam), Whitney M. Young Jr. Health Center, Hometown Health Centers, Capital Care Medical Group, and Community Care Physicians. St. Peter's has been increasing its influence in the Capital District for several years. In 2011 St. Peter's Health Partners was formed, when St. Peter's Health Care Services, Northeast Health and Seton Health merged. With the merger SPHP became the region's largest and most comprehensive network of advanced medical care, primary care, rehabilitation and senior services. Hospitals in SPHP include St. Peter's Hospital, Albany Memorial Hospital, St. Mary's Hospital (Troy), Samaritan Hospital (Troy), and Sunnyview Hospital and Rehabilitation Center. The partnership with Ellis Hospital and St. Mary's Hospital (Amsterdam) in the PPS and LLC further increases their influence in this region. St. Peter's Hospital and Seton Health did not meet the DSRIP standards for Safety Net Providers, achieving that designation only through the January 14 CMS determination for the LLC. This provider's history of not addressing the needs of the Medicaid population in the Capital District makes their participation in this PPS troublesome.

There is considerable overlap and cooperation with the other Capital District PPS, Albany Medical Center.

3. The DSRIP Projects Selected by the PPS

The selection of projects by the Ellis PPS reflect the general theme of integrating healthcare infrastructure to increase the use of primary care and community based treatment, including :2.a.i Create an Integrated Delivery System focused on Evidence-Based Medicine and Population Health Management; 2.b.iii ED Care Triage for At-Risk Populations; 2.b.iv Care Transitions Intervention Model to Reduce 30-day Readmissions for Chronic Health Conditions; 2.b.viii Hospital-Home Care Collaboration Solutions; and d.i Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care.

There are several projects that deal with overlapping services for behavioral health/substance abuse populations: 3.a.i Integration of Primary Care and Behavioral Health Services; 3.a.iv Development of Withdrawal Management(e.g., ambulatory detoxification, ancillary withdrawal services) Capabilities and Appropriate Enhanced Abstinence Services within Community-Based Addiction Treatment Programs ; and 4.a.iii Strengthen Mental Health and Substance Abuse Infrastructure across Systems 4.b.i Promote tobacco use cessation, especially among low SES populations and those with poor mental health.

In addition, this PPS will undertake asthma and palliative care projects.

Many of the projects include the use of care coordinators and navigators, the description and scope of practice for which are vague. We are concerned about maintaining professional standards for these positions.

4. Regulatory Exemption/Waiver Requests

Ellis PPS is requesting a modest number of regulatory waivers. They are listed as eight requests, but they batch multiple regulations on similar topics within some of the requests. These requests include: allowing existing Part 816 inpatient (chemical) detox units to offer ambulatory detox programs; reimbursement for collaborative team meetings; establish an exception to the 90 day time limitation for Medicaid billing; coordinate the assessments needed as patients move within and Integrated Delivery System; allowing a Nursing Home to admit someone without requiring a PRI and Screen; billing limitations for one threshold visit per day, as well as requests for new regulatory language to expand nursing home services and amend state licensure threshold policies to allow physical location at the same address and use of shared space for primary care and behavioral health services.

These requests are notable for their concentration on clinical operations and not seeking sweeping authorization to avoid existing Certificate of Need regulations to change and decrease inpatient services and beds.

Ellis PPS is not seeking anti-trust exemptions under Certificate of Public Advantage (COPA).

5. Reductions or Closures of Services and Capacity

The Ellis PPS application does not identify any closures of services or capacity. There are references to reduction in volume in EDs and potential reduction of inpatient employment opportunities, presumably associated with bed/service reductions. It is unclear what the impact of the required 25 percent reduction in avoidable hospital use will be on hospital operations. We are concerned that there is no specific information on how the participating partner hospitals will be impacted.

6. Workforce Implications

The application indicates that there will be 220 new jobs, including 49.8 Registered Nurses. The emphasis of these positions will be IDS, ED triage and ambulatory care. It is unclear specifically where in the network these new positions will be occurring. The PPS will employ undefined titles including Home Health navigators, care managers and patient navigators. The roles, scope of practice and description of these jobs is not available.

A very small percentage of the workforce will be impacted by redeployment or retraining. While some inpatient job reductions are anticipated, their impact will be minimalized because of the high job vacancy and turnover rates, with most job reductions being met through attrition. Agency or temporary workers fill are considered vacant positions.

The PPS does identify the nursing staff at Ellis Hospital to be the only union workforce that will be impacted to any degree, but indicates that RN jobs of various titles are subject to reductions but this is offset by the highest vacancy rates among RN positions.

No employees are expected to suffer reductions in compensation as a result of retraining.

7. Participation by Community, Advocates and Workers on the PAC and other Committees

The 7 key member steering committee was expanded to a 37 member PAC which includes representatives of labor unions and local Community Based Organizations (CBOs). It is unclear to what extent CBOs are represented on various committees or whether labor unions were represented on any committees other than the Workforce Development Committee.

8. Other Areas of Concern

There are no other areas of concern at this time.

18. Adirondack Health Institute, Inc. PPS

Region: North Country

Counties of Operation: Clinton, Essex, Franklin, Fulton, Hamilton, Saratoga, St. Lawrence, Warren, & Washington Counties

Attributed population: 74,941

Areas of Concern:

1. Governance Structure:

The PPS is employing a Delegated Governance model and the creation of a separate LLC, the AHI North Country Performing Provider System, LLC ("AHINCPPS"). The LLC will function as the Leadership Board, setting overall direction and oversight. It will consist of Member Managers, Attributed Lives Managers and Nominated Managers (including CBOs). Member Managers include the corporate financiers of the PPS, Adirondack Health, Glens Falls Hospital, and Hudson Headwaters Health Network, which have reserved powers on the AHI Board of Directors. It is unclear what other partners will be on the Leadership Board.

2. Possible Misuse of DSRIP to Further Corporate Goals:

Adirondack Health Institute, a joint venture of Adirondack Health, Glens Falls Hospital, Hudson Headwaters Health Network and UVM Health Network-Champlain Valley Physicians Hospital (CVPH) is a major power in the provision of healthcare in the North Country. The UVM Health Network includes the University of Vermont Medical Center, CVPH and Elizabethtown Community Hospital and partners with Alice Hyde Medical Center, Canton-Potsdam Hospital and Inter-lakes Health (Moses Ludington Hospital). The stated vision of the PPS "is to realize the primary recommendation of the North Country Health Systems Redesign Commission (NCHSRC), "to ensure that New Yorkers in the North Country achieve high quality care, better health outcomes, and lower costs, both now and into the future." The NCHSRC found an above average number of hospital beds, low usage and precarious hospital financial conditions, but provided vague recommendations as to how a proposed integration of services would be achieved. The AHI PPS application similarly reflects a vague integration of 70% of the region's hospitals with regional behavioral health and substance abuse provider networks, thus broadening their patient base and influence in the region.

3. The DSRIP Projects Selected by the PPS

AHI PPS choice of projects reflect many of the recommendations of the NCHSRC to integrate care, improve primary care, and integrate behavioral care: 2.a.i Create an Integrated Delivery System; 2.a.ii Increase Certification of Primary Care Practitioners with PCMH Certification and/or Advanced Primary Care Models; 2.a.iv Create a Medical Village Using Existing Hospital Infrastructure; 2.d.i ("Project 11") Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care; 3.a.ii Behavioral Health Community Crisis Stabilization Services, 3.a.iv Development of Withdrawal Management (e.g., ambulatory detoxification, ancillary withdrawal services) Capabilities and Appropriate Enhanced Abstinence Services within Community-Based Addiction Treatment Programs; 3.g.i Integration of Palliative Care into the PCMH Model; and 4.a.iii Strengthen Mental Health and Substance Abuse Infrastructure across Systems.

4. Regulatory Exemption/Waiver Requests

AHI PPS is seeking exemptions or waivers from 91 regulatory requirements, the equivalent of over eight waivers for each of the 11 proposed projects. This is significantly more than any other PPS. The length and breadth of these waiver requests suggests that AHI sees DSRIP as a mechanism to quickly implement a transformation of the North Country's health care system beyond what is described in the application, without the transparency and public scrutiny that are provided to some measure by existing regulations.

The PPS is seeking to preempt or accelerate as to make meaningless most regulatory review for closures, changes in services, bed reductions, co-location and operation of services, as well as scope of practice, billing, requirements for services being provided by specific healthcare professionals, IT acquisition and installation, and other provisions. They would preclude the need for public review for changes in the method of service, decrease in bed capacity and change in the physical plant. They are requesting accelerated and consolidated reviews to speed up the implementation of the DSRIP projects.

AHI is requesting waivers even when there are identified patient safety issues. They justify ignoring these concerns: by stating their intention to follow protocol; because qualified professionals will be operating the program; or because the DSRIP project has undergone sufficient review. This is a clear violation of the guidelines for regulatory waiver identified in the PPS application.

It is troubling that although the PPS has specified the reduction of 31 beds in 4 participating hospitals, the PPS is requesting sweeping authority to accomplish bed and service reductions on a much more ambitious scale. For example, the PPS requests the 90-day timeline for DOH to consider facility closure be reduced to 30 days to "facilitate timely closures where it is necessary due to the PPS achieving its goals". This, in conjunction with reference to "begin[ning] the transformation of traditional inpatient hospital space, indicates an undisclosed plan for more far-reaching impact on hospital services than is set forth in the PPS application.

The scheduled pace of these bed reductions: 4 in DSRIP Year 2; 25 in Year 3; and 4 in Year 4, do not justify the need for accelerated and minimal review. The complete closure of inpatient operations at Moses Ludington Hospital, which would be completed in Year 3, would be accomplished without any public input.

Other waiver exemptions would protect AHI from anti-trust regulations and prevent patients from seeking relief from improper use of patient information. AHI intends to seek anti-trust exemptions under Certificate of Public Advantage (COPA) after adoption of proposed anti-trust regulations.

5. Reductions or Closures of Services and Capacity

As noted above, the PPS has identified 31 bed closures over the course of the 5 year DSRIP program, associated with the creation of Medical Villages utilizing hospital infrastructure. However, comments and proposed regulatory waivers imply the expectation of additional unidentified bed reductions and hospital closures.

The impact of such closures and reductions in service upon local communities and existing service networks could be serious and the DSRIP application should be closely monitored to prevent any inappropriate and unsupported changes in existing services. This is particularly true in the North Country, where weather and geography make access to inpatient services a challenge.

We are very concerned about the impact of the closure of Moses Ludington Hospital, which will remove the resource of a Critical Access Hospital, which is at least 45 minutes from the next closest hospital in good weather. The proposed Medical Village will have a free-standing ER (it is not identified what the operating hospital will be), with patients needing admission needing ambulance transport to a distant hospital. This will have particular impact on patients requiring a short stay, who may opt to go home rather than be transferred far from family, and may deter patients from seeking medical assistance.

6. Workforce Implications

The PPS application indicates that there will be about 870 new positions required to implement DSRIP, more two thirds of which are in the “other” category. It is unclear how many new RN positions will be created. The PPS indicates it will be using undefined titles of Care Manager and Patient Navigators, for which the scope of practice and professional requirements are unknown.

An additional 900 workers will either be retrained or redeployed, but the application does not provide adequate detail about who will be affected. It is indicated that Nursing staff will need additional behavioral health training and certification as Certified Hospice and Palliative Care Nurses. As employees in affected hospitals move into employment in community-based services, there is a risk of lower salaries. The application indicates that 25% of retrained employees will have a decrease in compensation, earning between 75% and less than 95% of their previous total compensation.

The application states that positions within acute care settings will decrease minimally over time, accomplished primarily due to attrition and unfilled positions. It does not indicate if redeployments are voluntary, nor does it identify what the role of labor representatives will be in the redeployment process.

7. Participation by Community, Advocates and Workers on the PAC and other Committees

While the PPS invited all stakeholders to large forums, the intimal PPS PAC included only 25 individuals, which was later reduced to a 20 member Interim Steering Committee. The PPS established five Regional Health Innovation Teams (RHITs), local planning groups that make recommendations to the Interim Steering Committee, which in turns makes recommendations to the AHI Board and Members. It is unclear who is represented on the RHITs, but the arm’s length distance of stakeholders from decision makers is troubling. We are concerned that the involvement of community and patient advocacy groups is inadequate and that participation in the PAC and other committees is apparently limited only to PPS members and providers who have entered into written service agreements.

8. Other Areas of Concern

The AHI PPS application shows a significant lack of community resources in PPS other than not- for-profit health and welfare agencies. This is particularly overt for behavioral health resources, which is not in alignment with the projects for this service gap. Only one transportation service is included in the provider network, a particular concern in the North Country, where transportation is a significant obstacle to receiving health care.

19. Samaritan Medical Center PPS

Region: North Country

Counties of Operation: Jefferson, Lewis, St. Lawrence

Attributed population: 39,049

Areas of Concern:

1. Governance Structure:

The PPS is employing a delegated governance model. Physician and hospital representatives will have equal representation on the board of the newly-formed LLC.

2. Possible Misuse of DSRIP to Further Corporate Goals:

We have no concerns at this time.

3. The DSRIP Projects Selected by the PPS

The PPS proposes to reduce 6-8 staff beds and create medical villages in Watertown, Carthage, Massena and Alexandria Bay. We're concerned about any reductions in beds in a region that already has limited hospital capacity. The medical village projects being proposed are extensive and, while the application only notes the reduction of 6-8 beds, we're concerned that more bed reduction could follow.

4. Regulatory Exemption/Waiver Requests

The application requests waiver of most CON requirements, including the waiver of various regulations around reducing beds and closing hospitals. There should be oversight and opportunity for public review and comment over any decisions to expand or contract services in order to insure that there is oversight over the location and scope of such services and their correlation to the needs identified in the CNA.

The application also requests waiver of anti-trust violations under Certificate of Public Advantage. Anti-trust laws are important protections for public health and should not be waived without good reason.

The application also seeks scope of practice waivers for the professions of social work, psychiatry, and mental health practitioners. Scope of practice waivers can be dangerous to patient health and we are concerned about any erosion of these regulations.

5. Reductions or Closures of Services and Capacity

The application expects a reduction of just 6-8 beds. However, Samaritan PPS is seeking to waive most regulatory review for closures, changes in services and bed reductions. This would preclude the need for public review for changes in the method of service, decrease in bed capacity and change in the physical plant. We're concerned that this could indicate bed reductions or hospital closures that are not being disclosed.

6. Workforce Implications

The application expects some small degree of job loss, primarily through attrition. They are in a recognized health professional shortage area, and would like to try to attract new primary care staff. Existing staff might be retrained but should not see changes to their compensation.

7. Participation by Community, Advocates and Workers on the PAC and other Committees

The PAC includes primary care, chronic disease specialty and psychiatric physicians, as well as organizational representatives by knowledge area from each health sector and by geographic location. It also includes labor and other representatives of workers. We believe it has strong community engagement.

8. Other Areas of Concern

No other concerns are noted at this time.

20. Mohawk Valley PPS (Bassett/Leatherstocking Collaborative Health Partners)

Region: Mohawk Valley/Central NY

Counties of Operation: Delaware, Herkimer, Madison, Otsego, Schoharie

Attributed population: 38,406

Areas of Concern:

1. Governance Structure:

The Mohawk Valley PPS has selected a Collaborative Contracting model. According to the application this model was chosen to reflect the diversity of partners in its geographical area and to foster engagement among said partners, however the members of the governing body and the details about how it will function are not provided. Bassett appears to have principal control over most functions.

2. Possible Misuse of DSRIP to Further Corporate Goals:

As the application does not provide adequate detail about the participating partners it is difficult to assess how this PPS may be used to further corporate goals. The list of regional providers and network participants indicates that 7 of the 14 hospitals in the service area are partners in the PPS, but they are not identified.

The application refers to collaboration with competing PPSs but does not provide any details.

3. The DSRIP Projects Selected by the PPS

The Mohawk Valley PPS has selected projects which reflect the general theme of integrating healthcare infrastructure to increase the use of primary care and community based treatment, including: 2.a.ii Increase Certification of Primary Care Practitioners with PCMH Certification and/or Advanced Primary Care Models; 2..vii Implementing the INTERACT Project; 2.b.viii Hospital-Home Care Collaboration Solutions; 2.c.i To Develop a Community Based Health Navigation Service to Assist Patients to Access Healthcare Services Efficiently; 2.d.i Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care. They have chosen several projects which integrate primary care and behavioral health care: 3.a.i Integration of Primary Care and Behavioral Health Services; 3.a.iv Development of Withdrawal Management (e.g., ambulatory detoxification, ancillary withdrawal services) Capabilities and Appropriate Enhanced Abstinence Services within Community-Based Addiction Treatment Programs; and 4.a.iii Strengthen Mental Health and Substance Abuse Infrastructure across Systems, as well as asthma management, palliative care, and tobacco use cessation projects.

The project descriptions are vague, without detailed milestones it is unclear how these projects will achieve the required 25% reduction in avoidable hospital use.

4. Regulatory Exemption/Waiver Requests

The Mohawk Valley PPS has request four regulatory waivers: to permit the lead agency to distribute DSRIP funds to its non-established PPS Partners; to allow Certified Home Health Agencies (CHHA) to operate outside of their permitted geographic service areas; to allow co-location of primary care services

at behavioral health sites under a single license or certification ; and for sharing of space by primary care providers and behavioral health service providers (detox) .

These requests are notable for their concentration on clinical operations and not seeking sweeping authorization to avoid existing Certificate of Need regulations to change and decrease inpatient services and beds.

Mohawk Valley PPS is not seeking anti-trust exemptions under Certificate of Public Advantage (COPA).

5. Reductions or Closures of Services and Capacity

The Mohawk Valley PPS application does not identify any closures of services or capacity. It is unclear what the impact of the required 25 percent reduction in avoidable hospital use will be on hospital operations, other than a statement that the total number of reduced admissions and ER visits will be relatively small. We are concerned that there is no specific information on how the participating partner hospitals will be impacted.

6. Workforce Implications

Mohawk Valley PPS estimates 260 new jobs. Direct patient care positions are identified as possibly including physicians, nurses (e.g., RN care coordinators for several LCHP projects), case managers, navigators and other health care providers.

While the application states that workforce reductions are not likely, it identifies a 10% redeployment rate. Inpatient positions will move into the community, but it is not clearly stated if redeployments will be voluntary.

It does not appear that the PPS conducted a thorough or realistic analysis of the impact on employees who are redeployed or retrained.

Considerable emphasis is placed on retraining staff to accommodate increased use of outpatient care without identifying the impact. The PPS estimates that 55% of the workforce will need to be retrained. There is an implied threat to employees not availing themselves of training opportunities (“at their own risk”). The PPS identifies that only an estimated 5% of the retrained workforce will suffer from reduced compensation of 75-95% of current salary, but also maintains the possibility that employees who are redeployed to a different organization may be subject to salary and benefits structures that differ relative to their original organization and that their accrued benefits may not carryover. The PPS further suggests that training opportunities will enhance employee skills and roles, affording them a potential for increased salaries while maintaining similar benefits. This is a welcome prospect, but without details to demonstrate its feasibility it is not reliable.

The description of navigator positions (at a minimum a mixture of clinical and social work tasks) suggests there may be scope of practice issues.

7. Participation by Community, Advocates and Workers on the PAC and other Committees

The PPS purports to have ample representation of providers and CBOs on the PAC but there is no detail to document this. The application makes reference to one non-managerial employee from among the partner organizations and an employee from a unionized partner; this is not adequate representation of the workforce.

8. Other Areas of Concern:

The chart of Community Resources supporting the PPS shows a low level of engagement for community-based organizations, particularly among behavioral health CBOs, which does not suggest buy-in for behavioral health projects.

21. Central NY PPS

Region: Central New York

Counties of Operation: Oswego, Lewis, Oneida, Madison, Onondaga, Cayuga

Attributed population: 167,136

Areas of Concern:

1. Governance Structure: The Central NY PPS has selected a Delegated Governance structure. The application indicates the pending formation of a 501(c)(3). CNYCC governance is by the Board of Directors of the 501(c)(3) organization having 22 Directors equally divided between Hospital and Community Partners. Board meetings will be open to the public. Board and Committee work will be available to the PAC and Regional PACs. Minutes, work plans and budgets will be posted on CNYCC's interactive website. Public information will include Project Team reports, DOH communications, audit findings, minutes, and other pertinent documents. Board committees will include PAC members. The PAC itself reports directly to the Board. To foster communications and transparency, two Directors (one representing an FQHC) will be elected to attend Member meetings.

2. Possible Misuse of DSRIP to Further Corporate Goals:

There are four co-leads for this project because this project is the end result of the consolidation of several individual PPSes that were proposed by separate lead facilities. Among the four is Faxon-St. Luke's which has recently completed a merger with St. Elizabeth's. St. Joseph's has recently joined the CHE Trinity network, which is a nationwide network that claims 82 hospitals in 21 states. In light of this activity, the continued cooperation during the implementation of the PPS must be monitored.

3. The DSRIP Projects Selected by the PPS

The selection of projects by the CNY PPS reflect the general theme of integrating healthcare infrastructure to increase the use of primary care and community based treatment, including :2.a.i Create an Integrated Delivery System focused on Evidence-Based Medicine and Population Health Management; 2.b.iii ED Care Triage for At-Risk Populations; 2.b.iv Care Transitions Intervention Model to Reduce 30-day Readmissions for Chronic Health Conditions; 2.b.viii Hospital-Home Care Collaboration Solutions; and 2d.i Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care. There are several projects that deal with overlapping services for behavioral health/substance abuse populations: 3.a.i Integration of Primary Care and Behavioral Health Services; 3.a.ii Behavioral Health Community Crisis Stabilization; and 4.a.iii Strengthen Mental Health and Substance Abuse Infrastructure across Systems.

These projects however, note that based on the community needs assessment there are severe shortages of providers and the tools patients need to access to care including affordable housing and transportation.

4. Regulatory Exemption/Waiver Requests

CNY PPS has requested 22 waivers for regulatory relief, mostly focused around streamlining services, and ensuring that certain kinds of facilities can bill for new services. Unfortunately, as part of their

efforts to streamline they are also asking for significant reprieve from the Certificate of Need process. Multiple times throughout their application they note that The CON application process is a significant barrier to the level of integration that CNYCC seeks to achieve through its projects. Specifically, they are requesting relief from the CON process when it comes to new construction (they are looking to build a new facility to facilitate their application's goals), and service realignment.

5. Reductions or Closures of Services and Capacity

The CNY PPS application does not identify any closures of services or capacity. There are references to reduction in volume in EDs and potential reduction of inpatient employment opportunities, presumably associated with bed/service reductions. It is unclear what the impact of the required 25 percent reduction in avoidable hospital use will be on hospital operations. We are concerned that there is no specific information on how the participating partner hospitals will be impacted.

6. Workforce Implications

The application indicates that there will be approximately 275 positions will be created as a result of DSRIP-related activity. They indicate that 55% of the existing workforce will have to be retrained to fulfill the needs of the projects. 1% of the workforce will be redeployed and 1% of the current workforce will have to be hired from outside the PPS. The application acknowledges that there will be a need for registered nurses despite the fact that the primary aim of the application is to reduce inpatient capacity. The application also mentions that there will be 30 behavioral health specialists needed to fulfill the behavioral health goals of the applications. Some of these behavioral health specialists could be registered nurses, and in fact the application calls for 21 new nurse practitioner positions to be created.

The applications claims that all labor groups involved have been contacted and engaged in the PPS planning process at the PAC level, and that 8,000 workers are represented by various unions across the PPS.

7. Participation by Community, Advocates and Workers on the PAC and other Committees

Because this PPS is the result of the merger of four individual applications the PAC is large, and has four regional sub-PACs based on the four prior applications. They meet monthly regionally to discuss regional issues, and the full PAC meets quarterly. PAC membership is representative of the diversity of the six-county region. There is regional representation that reflects the rural and urban settings. Members represent primary care, behavioral health, community-based, and peer-support organizations such as transportation and housing. Membership includes hospitals, OMH-licensed, OPWDD-licensed, and OASAS-licensed providers; Skilled Nursing Facilities, Home Care agencies, and Health Homes. In addition, the health care workforce is represented including unions.

8. Other Areas of Concern

There are no other areas of concern at this time.

22. United Health Services Hospitals PPS / Southern Tier Rural Integrated PPS

Region: Southern Tier

Counties of Operation: Broome, Chemung, Chenango, Cortland, Delaware, Schuyler, Steuben, Tioga and Tompkins

Attributed population: 95,489

Areas of Concern:

1. Governance Structure:

The Southern Tier Rural Integrated PPS (STRIPPS) plans to operate using the Delegated Governance model. STRIPPS will be formed as a non-charitable not-for-profit New York Corporation and will seek to qualify as 501(c)(6). The (executive governance) Board is comprised of five distinct healthcare system members, one FQHC member and five community based organization (CBO) members.

2. Possible Misuse of DSRIP to Further Corporate Goals:

The lack of detail about the provider network makes it difficult to assess how DSRIP may be used to further the corporate goals of participating providers. The regulatory waivers requested (below) suggest that DSRIP will provide opportunities to enhance the corporate influence of these providers in this region with minimal transparency.

STIRRPS was granted Vital Access Provider (i.e. safety net) exception by CMS on January 14th. Any funding to providers that do not have a documented history of providing services to low-income, uninsured and underinsured populations is contrary to the intended purpose of DSRIP and should receive particular scrutiny.

3. The DSRIP Projects Selected by the PPS

STRIPPS has selected the following projects: 2.a.i Create an Integrated Delivery System focused on Evidence-Based Medicine and Population Health Management; 2.b.iv Care Transitions Intervention Model to Reduce 30-day Readmissions for Chronic Health Conditions; 2.b.vii Implementing the INTERACT Project (Inpatient Transfer Avoidance Program for SNF); 2.c.i To Develop a Community Based Health Navigation Service to Assist Patients to Access Healthcare Services Efficiently; 2.d.i Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care; 3.a.i Integration of Primary Care and Behavioral Health Services; 3.a.ii Behavioral Health Community Crisis Stabilization Services; 3.b.i Evidence-Based Strategies for Disease Management in High Risk/Affected Populations (Adults Only); 3.g.i Integration of Palliative Care into the PCMH Model; 4.a.iii Strengthen Mental Health and Substance Abuse Infrastructure across Systems ; and 4.b.ii Increase Access to High Quality Chronic Disease Preventative Care and Management in Both Clinical and Community Settings.

There is lack of clarity in some aspects of these projects, for example, the uses and limitations of telehealth are not clearly delineated, and the role of patient navigators and care coordinators is unclear and raises scope of practice issues.

4. Regulatory Exemption/Waiver Requests

STRIPPS has requested over 30 regulatory waivers. They are requesting Certificate of Public Approval and other exemptions from several actions that would grant broad exemptions from anti-trust regulations that protect the public from anticompetitive mergers and business practices, including the oversight inherent in the requirement of becoming an established operator, and the provisions restricting fee-splitting or sharing in gross revenues of non-established entities.

We are also concerned about waiver from regulations restricting the corporate practice of medicine. DSRIP should not be a backdoor entry for insidious for-profit ownership of healthcare services that New York has wisely prevented to date.

The PPS is also seeking to avoid the public oversight currently required through Certificate of Need for the expansion of capacity, adding or changing existing services and changes in capacity/relocation. The requested alternative of Limited Review would also eliminate the ability of the affected community to provide input on such changes to their healthcare services. DSRIP should not be a vehicle for removing public input from significant changes to the provision of healthcare in a community.

STRIPPS also requests several regulatory waivers that will impact scope of practice without adequate review. We urge that these requests be reviewed for negative impacts on patient safety.

5. Reductions or Closures of Services and Capacity

The STIRRPS application provides does not provide details about excess bed capacity or how hospitals will be impacted by the required 25% reduction in avoidable hospital use.

There are no details about locations for the bed reductions that would be associated with the anticipated loss of jobs in EDs and acute care departments. None of the projects have immediate impact on bed or service reductions (i.e., formation of Medical Village)

6. Workforce Implications

The PPS estimates 160 new hires, including Advanced Practice Nurses and Registered nurse care managers, and RNs for various community based projects.

While NYSNA members are anticipated to be minimally impacted by DSRIP, the PPS notes a reduction of about 135 in the acute care area.

The application shows a very high percentage of employees that will be impacted by redeployment (34%) and retraining (58%), without much detail about who will be impacted. It is concerning that 58% of the workforce will be impacted by retraining, but only 37% of them will achieve full placement after retraining, suggesting that there is a substantial shift into community based employment with lower salaries and/or part time status. The narrative notes that NYSNA positions will be minimally impacted and that there will be new nursing hires (they may, however, be in the community at lower salaries).

The PPS anticipates avoiding layoffs. Nurse specific impact is noted that although over 35 RNs are needed to fully implement the projects only 20 will be displaced from acute care facilities. It is not clear if redeployment or retraining will be voluntary.

7. Participation by Community, Advocates and Workers on the PAC and other Committees

The overall PAC has over 130 organization members, including workforce representatives from participating organizations. It is unclear if unions participated in any committees other than Workforce Development.

8. Other Areas of Concern

There is no discussion of how the PPS will contract with CBOs.

There are a very limited number of community resources related to behavioral health in the PPS considering the number of projects affecting this population (e.g., none of the seven NAMI chapters are in the PPS).

23. Finger Lakes PPS

Region: Hudson Valley

Counties of Operation: Chemung, Steuben, Ontario and Monroe, Allegany, Genesee, Orleans, Wyoming, Cayuga, Seneca, Yates, Wayne

Attributed Population: 279,678

Areas of Concern:

1. Governance Structure:

The PPS is employing a “delegated” model in which Rochester Regional Health System and University of Rochester Medical Center will serve as co-leads of the PPS. They are the sole corporate members and leads of the PPS.

2. Possible Misuse of DSRIP to Further Corporate Goals:

The Rochester Regional Health System has recently completed a merger with United Memorial Medical Center in Batavia and Clifton Springs Hospital. It is rapidly growing. The University Of Rochester Medical Center operates Strong Memorial in addition to its own academic medical center. This PPS is one of the most geographically expansive in the state, and both these large Rochester based health system are competitors, but are now poised to be collaborators under this PPS. This is concerning due to the concentration of market share between these two large providers.

3. The DSRIP Projects Selected by the PPS

FLPPS will focus on better care transitions so that patients with unstable housing are identified early after hospital admission: establish formalized protocols to link community housing provider and appropriate care manager or patient navigator; coordinate medical care management using telemedicine or home care providers on-site. Several skilled nursing homes have expressed interest in downsizing their beds to create affordable supportive transitional housing, which is less costly than skilled nursing.

Hospitals will partner with small, local hotels to develop transitional supportive housing needs, as well as giving limited access to housing for patients needing housing and some standard home care services to avoid placements in skilled nursing facilities.

Although this is an interesting idea, it is unclear how the partner facilities will be staffed and how the existing workforce will be developed to accommodate this.

4. Regulatory Exemption/Waiver Requests

This application only requests eight regulatory waivers. However, two of them specifically ask for relief from the CON process for moving and establishing services within the PPS. There is also a waiver for relief from the CON process for establishing home healthcare geography. In light of the expansive market covered by the two systems that are leading the application this could be dangerous and encourage destructive service changes.

5. Reductions or Closures of Services and Capacity

This application does not specifically address service closures or reduction in capacity.

6. Workforce Implications

The application indicates that there could be up to 1% reduction in the workforce of the PPS, 4,900 workers affected by redeployment and 21,120 workers affected by retraining. Registered nurses are among those impacted but the application does not specify how many. Also, the impact on worker salaries is very vague, especially in light of the significant number of workers that need retraining and placement.

7. Participation by Community, Advocates and Workers on the PAC and other Committees

The number of FLPPS partner organizations with organized labor is relatively small, but labor union representatives of these partners have been invited and engaged in PAC meetings, NOCN workgroups and planning sessions

8. Other Areas of Concern

No other concerns are noted at this time.

24. Catholic Medical Partners-Accountable Care IPA INC PPS

Region: Western NY

Counties of Operation: Chautauqua, Erie, Niagara

Attributed population: 80,618

Areas of Concern:

7. Governance Structure:

Catholic Medical Partners PPS selected the Collaborative Contracting Model of governance. Primary control of funding flow and network oversight rests with Sisters of Charity Hospital.

8. Possible Misuse of DSRIP to Further Corporate Goals:

As indicated below, the requests for regulatory waiver suggest that DSRIP will provide an opportunity to expand the influence of SOCH with limited public review and oversight.

9. The DSRIP Projects Selected by the PPS

The CMP PPS has selected the following projects: 2.a.i Create an Integrated Delivery System focused on Evidence-Based Medicine and Population Health Management; 2.b.iii ED Care Triage for At-Risk Populations; 2.b.iv Care Transitions Intervention Model to Reduce 30-day Readmissions for Chronic Health Conditions; 2.c.ii Expand Usage of Telemedicine in Underserved Areas to Provide Access to Otherwise Scarce Services; 3.a.i Integration of Primary Care and Behavioral Health Services; 3.b.i Evidence-Based Strategies for Disease Management in High Risk/Affected Populations (Adults Only); 3.f.i Increase Support Programs for Maternal and Child Health (Including High Risk Pregnancies); 3.g.i Integration of Palliative Care into the PCMH Model; 4.a.i Promote mental, emotional, and behavioral (MEB) well-being in communities (Focus Area 1); and 4.b.i Promote tobacco use cessation, especially among low SES populations and those with poor mental health .

Overall the project descriptions are vague.

We are pleased by the inclusion of the evidence-based home visitation model, Nurse-Family Partnership (NFP) which has demonstrated positive impact on maternal and child health.

4. Regulatory Exemption/Waiver Requests

Catholic Medical Partners' requests for regulatory relief include several actions that would grant broad exemptions from anti-trust regulations and, inappropriately laws, that protect the public from anticompetitive mergers and business practices. The PPS will apply for a Certificate of Public Advantage, and seeks exemption from Federal Anti-Kickback statute, Federal Stark Law and PHL Section 238-a. We are concerned that such exemptions will establish overly broad market insulation from public oversight.

We are also concerned about waiver from regulations restricting the corporate practice of medicine. DSRIP should not be a backdoor entry for insidious for-profit ownership of healthcare services that New York has wisely prevented to date.

Scrutiny must be applied to the PPS' request for the enabling of "substantial workforce flexibility", applicable to all projects, which is overly broad in intent. Equally worrisome is the request to allow an

unspecified broader range of clinicians to perform home health aide supervision, which is appropriately the purview of nurses and has serious implications for compromising patient safety. Patient safety concerns are also raised by the request for modification of Nursing home regulations that establish when patients should be transferred to hospitals.

5. Reductions or Closures of Services and Capacity

Other than the mention of indicate an excess need and deactivation of 499 SNF beds, there is no explanation of how or where the PPS will meet the required reduction of 25% avoidable hospital use.

6. Workforce Implications

Catholic Medical Partners PPS estimates 158 new hires. The application states that this is expected to change as projects are implemented, but there are few specifics as to how this might change, in what projects, or for what positions. New hires include RNs, but there are no details about numbers or what locations

Ten percent of the workforce is estimated to be impacted by redeployment, and another 40% subject to retraining. The application makes assurances of no adverse impact on compensation, and of opportunities for retraining/education/increased competency opportunities, but without any details to document this benign impact. Compensation, benefits and the opportunity for union representation in community-based programs is typically lower than in hospital settings but movement of employees from hospital settings to the community is not addressed. As there is no discussion of the details of reducing bed capacity it is impossible to accurately assess the impact on the workforce.

The application makes reference to a potential limited supply of nurses meeting experience/educational qualifications for implementation of project 3.f.i Increase Support Programs for Maternal and Child Health (Including High Risk Pregnancies). There are no identified strategies for addressing this challenge.

7. Participation by Community, Advocates and Workers on the PAC and other Committees

The application indicates that the PPS has included in the PAC membership community organizations, providers, and managed care health plans that serve a high volume of Medicaid beneficiaries. Without a detailed list of participants it is not clear if appropriate representation is accomplished. It is similarly unclear if the PAC includes the required union representation and what the extent of union participation is on PAC committees.

8. Other Areas of Concern

The PPS includes very few community resources. There are no community based health education programs, no not for profit health and welfare agencies, no peer and family mental health advocacy organizations, and no peer supports, nor is NAMI included in the PPS. The lack of patient advocacy groups is particularly concerning as the PPS has included two MEB projects.

25. Erie County Medical Center PPS

Region: Western New York

Counties of Operation: Erie, Niagara, Orleans, Genesee, Wyoming, Allegany, Cattaraugus, Chautauqua

Attributed population: 230,975

Areas of Concern:

1. Governance Structure:

The PPS is employing a “collaborative contracting” model in which the ECMC system and the other PPS partners will maintain their organizational independence.

ECMC will serve as the lead entity and will chair the Executive Committee.

2. Possible Misuse of DSRIP to Further Corporate Goals:

Given that the main element of this PPS is the public hospital system and that it is bound by its enabling statute and governing protocols to provide care to all without consideration of immigration status or ability to pay, we do not note, at this time, any areas of concern regarding the intent and implications of the PPS application and proposed projects.

We do note, however, that the formation of a PPS system that includes non-public entities might create pressures or present an opportunity to shift patient care to private and/or for-profit providers and thus raise questions related to ECMC’s compliance with legal obligations to directly provide care services in accordance with its charter and/or requirements under City law regarding review and approval of contracts and sub-contracts with vendors.

3. The DSRIP Projects Selected by the PPS

The various projects selected by the PPS appear to be consistent with the DSRIP goals of improving quality of care, improving community health outcomes and reducing unnecessary usage by expanding primary and ambulatory care services and increasing the coordination of patient care.

4. Regulatory Exemption/Waiver Requests

This PPS is seeking exemptions or waivers from a 30 regulatory requirements.

Several of the requests for regulatory exemption, however, are possibly inappropriate and should be closely scrutinized. This application requests that the applicant receive a waiver that will allow them to relocate and close beds and facilities with only a notification to DOH.

The applicant is also seeking exemption from CON approval for construction new facilities. The requests for waiver of CON are problematic, as there should be oversight and opportunity for public review and comment over any decisions to expand services in order to insure that there is oversight over the location and scope of such services and their correlation to the needs identified in the CNA. If CON review is called for, the DOH can provide it on an expedited basis.

We are also concerned that the request for exemption from regulations prohibiting discharges and transfers based on patients’ payer source (i.e., Medicaid or uninsured) status raises the possibility of

abusive practices. This exemption should not be granted, as it risks giving the entire PPS the right to provide different levels of care based solely on Medicaid or uninsured status. This could create conditions in which such patients are subject to different or inferior levels of care than is provided to non-Medicaid patients. This is potentially dangerous and antithetical to the premise of improved quality and access.

5. Reductions or Closures of Services and Capacity

The PPS application does not seem to foresee closures or reduction of infrastructure or beds. It also has not sought any exemptions or waivers from regulation related to closures or reductions of services.

6. Workforce Implications

The application does not indicate a net loss in employment for the workforce, and is specific about the number of RNs that will be impacted. MCC asserts it will work with union representatives throughout the redeployment process, and that union officials have been able to provide input throughout, "employees will be allowed to exercise their union rights for representation at any point in this process."

Employees' wages and benefits may be affected. Workforce Development Work Group will respond to labor representatives' articulation of the importance of their involvement, and attempt to address issue of how long it takes to complete certificates, and to give employees credit for existing skill sets.

The PPS recognizes the shortage of skilled workforce. It notes a study that asserts "recruitment for nurse managers, RNs, clinical lab technicians... continue to be most difficult occupations to recruit..." Some or all of these positions will be affected by project implementation. We believe that MCC must continue to be as transparent as possible when it comes to the impact on registered nurses and all workers across the PPS.

7. Participation by Community, Advocates and Workers on the PAC and other Committees

The PAC had representation from various stakeholders including organized labor.

8. Other Areas of Concern

No other concerns are noted at this time.

From: Waldo Jackson
Sent: Wednesday, February 11, 2015 10:43 AM
To: dsripapp@health.ny.gov
Subject: RE: Public Comments for the PPS Project Applications

Dear Mr. Helgersen,

DSRIP: A selected review of New York City PPS Proposals

Require and ensure consumer/community-based organization involvement in all levels of decisions by:

- The state setting up a working group made up of representatives from the PPS's, community-based organizations and consumers not now represented the state governance structures to generally make recommendations to the state with a special focus on outreach, engagement and cultural competency.
- Ensuring the community infrastructure to support the PPS goals is critical. To do this, a state human capital support fund must be established (much like the hospital capital fund) to support, and make the continuing viability of community-based organizations a reality as they implement the community-based prevention and support critical to DSRIP success.
- Requiring the PPS's to use their advisory committees to develop outreach and education plans and cultural competency plans and require PPS's to use some of their resources to subcontract CBO's to do basic outreach, education and cultural competency trainings/ efforts related to DSRIP projects and the process.
- Require the PPP's to diversify their governance structures. At a minimum, executive committees of all PPS's should include one social worker, physician, nurse, and other profession (i.e. mental health provider) knowledgeable about chronic disease care and prevention. At least one community group for each of the identified social determinants of health (i.e. housing, food insecurity, economic security, age, violence, open spaces/environment, education, workforce development, etc.). It should also include more than one local consumer on Medicaid and uninsured, and a front-line worker knowledgeable about patient engagement and education (CHW, peer educator, peer specialist etc.).
- Assure equal ability to access PPS advisory and committee meetings, Oversight and Approval Panel meetings and overall advisory meetings should occur alternately between Albany and NYC and always contain at least ½ hour for public comment.

2. Recognize DSRIP Projects must expand beyond an academic and clinical framework, by:

- Ensuring that it has key components of a community-driven health program that addresses the social determinants of health.
- Focusing its core strategies on culturally competency, especially for the populations to be served.

3. CNHA should be subjected to professional standards, intense review, and relevance to the community they served. Assessments done without any independent expertise should be subject to careful scrutiny

and possible deductions in the scoring. (I.e. NY Presbyterian and Mt Sinai). And even the independent expertise should be subjected to quality review on how well they did the CHNA.

4. The “all or nothing” funds flow “formula” will destabilize the whole system from the beginning. Reimbursement should be proportional to effort achieved for each goal, not a complete loss for missing the goal even by a minor amount.

i would like to thank you for this opportunity to make my voice heard.

Sincerely,
Mr. Waldo Jackson

From: Kevin Holmes
Sent: Wednesday, February 11, 2015 10:52 AM
To: dsripapp@health.ny.gov;
Subject: RE: Public comments for the PPS's Project Applications

Dear Mr. Helgersen,

I would like to first say thank you for this opportunity to comment on the Project Applications.

Dear Mr. Helgersen,

DSRIP: A selected review of New York City PPS Proposals

Require and ensure consumer/community-based organization involvement in all levels of decisions by:

- The state setting up a working group made up of representatives from the PPS's, community-based organizations and consumers not now represented the state governance structures to generally make recommendations to the state with a special focus on outreach, engagement and cultural competency.
- Ensuring the community infrastructure to support the PPS goals is critical. To do this, a state human capital support fund must be established (much like the hospital capital fund) to support, and make the continuing viability of community-based organizations a reality as they implement the community-based prevention and support critical to DSRIP success.
- Requiring the PPS's to use their advisory committees to develop outreach and education plans and cultural competency plans and require PPS's to use some of their resources to subcontract CBO's to do basic outreach, education and cultural competency trainings/ efforts related to DSRIP projects and the process.
- Require the PPP's to diversify their governance structures. At a minimum, executive committees of all PPS's should include one social worker, physician, nurse, and other profession (i.e. mental health provider) knowledgeable about chronic disease care and prevention. At least one community group for each of the identified social determinants of health (i.e. housing, food insecurity, economic security, age, violence, open spaces/environment, education, workforce development, etc.). It should also include more than one local consumer on Medicaid and uninsured, and a front-line worker knowledgeable about patient engagement and education (CHW, peer educator, peer specialist etc.).
- Assure equal ability to access PPS advisory and committee meetings, Oversight and Approval Panel meetings and overall advisory meetings should occur alternately between Albany and NYC and always contain at least ½ hour for public comment.

2. Recognize DSRIP Projects must expand beyond an academic and clinical framework, by:

- Ensuring that it is has key components of a community-driven health program that addresses the social

determinants of health.

- Focusing its core strategies on culturally competency, especially for the populations to be served.

3. CNHA should be subjected to professional standards, intense review, and relevance to the community they served. Assessments done without any independent expertise should be subject to careful scrutiny and possible deductions in the scoring. (I.e. NY Presbyterian and Mt Sinai). And even the independent expertise should be subjected to quality review on how well they did the CHNA.

4. The “all or nothing” funds flow “formula” will destabilize the whole system from the beginning. Reimbursement should be proportional to effort achieved for each goal, not a complete loss for missing the goal even by a minor amount.

I would like to thank you again for this opportunity to voice my opinion, I just hope the State consider my thought so that the overall goal of DSRIP can be accomplished.

Thank You,
Kevin Holmes

From: sherry rivers
Sent: Wednesday, February 11, 2015 11:05 AM
To: dsripapp@health.ny.gov;
Subject: RE: Public Comments

Dear Mr. Helgersen,

Require and ensure consumer/community-based organization involvement in all levels of decisions by:

- The state setting up a working group made up of representatives from the PPS's, community-based organizations and consumers not now represented the state governance structures to generally make recommendations to the state with a special focus on outreach, engagement and cultural competency.
- Ensuring the community infrastructure to support the PPS goals is critical. To do this, a state human capital support fund must be established (much like the hospital capital fund) to support, and make the continuing viability of community-based organizations a reality as they implement the community-based prevention and support critical to DSRIP success.
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- Ensuring that it is has key components of a community-driven health program that addresses the social determinants of health.
- Focusing its core strategies on culturally competency, especially for the populations to be served.

3. CNHA should subjected to professional standards, intense review, and relevance to the community they served. Assessments done without any independent expertise should be subject to careful scrutiny and possible deductions in the scoring. (I.e. NY Presbyterian and Mt Sinai). And even the independent expertise should be subjected to quality review on how well they did the CHNA.

4. The "all or nothing" funds flow "formula" will destabilize the whole system from the beginning. Reimbursement should be proportional to effort achieved for each goal, not a complete loss for missing the goal even by a minor amount.

I would like to thank you again for this opportunity to voice my opinion, hope the State consider my thought so that the overall goal of DSRIP can be accomplished.

Best,
Ms. Sherry Rivers

From: Loretta Fleming
Sent: Wednesday, February 11, 2015 11:21 AM
To: dsripapp@health.ny.gov;
Subject: RE: public comments

Dear Mr. Helgersen,

1. Require and ensure consumer/community-based organization involvement in all levels of decisions by:

- The state setting up a working group made up of representatives from the PPS's, community-based organizations and consumers not now represented the state governance structures to generally make recommendations to the state with a special focus on outreach, engagement and cultural competency.
- Ensuring the community infrastructure to support the PPS goals is critical. To do this, a state human capital support fund must be established (much like the hospital capital fund) to support, and make the continuing viability of community-based organizations a reality as they implement the community-based prevention and support critical to DSRIP success.
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4. The “all or nothing” funds flow “formula” will destabilize the whole system from the beginning. Reimbursement should be proportional to effort achieved for each goal, not a complete loss for missing the goal even by a minor amount.

Thank You,
Loretta

From: robert williams
Sent: Wednesday, February 11, 2015 11:44 AM
To: dsripapp@health.ny.gov;
Subject: RE: DSRIP Project Application/Public Comment

Dear Mr. Helgersen,

1. Require and ensure consumer/community-based organization involvement in all levels of decisions by:

- The state setting up a working group made up of representatives from the PPS's, community-based organizations and consumers not now represented the state governance structures to generally make recommendations to the state with a special focus on outreach, engagement and cultural competency.
- Ensuring the community infrastructure to support the PPS goals is critical. To do this, a state human capital support fund must be established (much like the hospital capital fund) to support, and make the continuing viability of community-based organizations a reality as they implement the community-based prevention and support critical to DSRIP success.
- Requiring the PPS's to use their advisory committees to develop outreach and education plans and cultural competency plans and require PPS's to use some of their resources to subcontract CBO's to do basic outreach, education and cultural competency trainings/ efforts related to DSRIP projects and the process.
- Require the PPP's to diversify their governance structures. At a minimum, executive committees of all PPS's should include one social worker, physician, nurse, and other profession (i.e. mental health provider) knowledgeable about chronic disease care and prevention. At least one community group for each of the identified social determinants of health (i.e. housing, food insecurity, economic security, age, violence, open spaces/environment, education, workforce development, etc.). It should also include more than one local consumer on Medicaid and uninsured, and a front-line worker knowledgeable about patient engagement and education (CHW, peer educator, peer specialist etc.).
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- Focusing its core strategies on culturally competency, especially for the populations to be served.

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4. The “all or nothing” funds flow “formula” will destabilize the whole system from the beginning. Reimbursement should be proportional to effort achieved for each goal, not a complete loss for missing the goal even by a minor amount.

I look forward to the state making preservations to bring the in person meeting's to the people who count, again thank you!

Sincerely,

Robert Williams

From: Isaac Rubin
Sent: Wednesday, February 11, 2015 3:06 PM
To: DSRIPApp@health.ny.gov
Subject: Comment

I would like to comment on AWMedicals application. I was involved from the very beginning and can attest that AW is Competent and sensitive to the cultural diverse population attributed lives they serve. The projects selected reflected the CNA and projects chosen were based on where they can have the best and most efficient impact on the Medicaid lives. They have a stellar and committed team and I'm sure that they can raise the bar even higher than the 25% reduction in hospital recidivism; given that they as PCPs have direct and trusted interaction with their patients. AW's impact will impact NYC overall HC transformation in a positive way.

Thank you,

Isaac Rubin
VP of Business Development and Managed Care Initiatives
Centers Health Care
TEL 718.931.9700 ext 225
Cell 917.618.4869
FAX 347.802.4274

From: Isaac Rubin
Sent: Wednesday, February 11, 2015 3:24 PM
To: DSRIPApp@health.ny.gov
Subject: Comment
Importance: High

I would like to comment on the Mount Sinai application. I was involved from the very beginning as a provider group and as a PAC member. Firstly the MSPPS's team is professional, dedicated and a team that is focused on the success of their PPS. MSPPS is competent and sensitive to the cultural diverse population/attribution lives they serve. The projects selected reflected the CNA and projects chosen were based on where they can have the best and most efficient impact on the Medicaid lives. Again they have a stellar and committed team and I'm sure that they can raise the bar even higher than the 25% reduction in hospital recidivism; given their existing proven programs that have proven to reduce unnecessary return to hospital.

Even though this is a Medicaid Program, they will have an impact on everyone. The leadership at the MSPPS understands and appreciates the eventual transformation to a risk environment.

Thank you,

Isaac Rubin
VP of Business Development and Managed Care Initiatives
Centers Health Care
TEL 718.931.9700 ext 225
Cell 917.618.4869
FAX 347.802.4274

From: Isaac Rubin

Sent: Wednesday, February 11, 2015 3:34 PM

To: doh.sm.DSRIPApp

Subject: PPS comment

I would like to comment on the Maimonides led CCB PPS application. I was involved from the very beginning as a provider group and as a PAC member. Firstly their team is professional, dedicated and a team that is truly focused on the success of their PPS and the bigger picture of NY healthcare. CCB is super sensitive to the culturally diverse population/attributed lives they serve. The projects selected reflected the CNA and projects chosen were based on where they can have the best and most efficient impact on the Medicaid lives. Again they have a stellar and committed team and I'm sure that they can raise the bar even higher than the 25% reduction in hospital recidivism; given their existing proven programs that have proven to reduce unnecessary return to hospital.

Even though this is a Medicaid Program, they will have an impact on everyone beyond the caid population. The leadership at the CCB team understands and appreciates the eventual transformation to a risk environment and see this as an opportunity.

It is an honor to be part of CCB.

Thank you,

Isaac Rubin

VP of Business Development and Managed Care Initiatives

Centers Health Care

TEL 718.931.9700 ext 225

Cell 917.618.4869

FAX 347.802.4274

From: Mark Tauber
Sent: Wednesday, February 11, 2015 11:10 PM
To: DSRIPApp@health.ny.gov
Subject: AW Medical PPS DSRIP Application

Hi,

To whom this may concern:

I'd like to take this opportunity to express my endorsement for the AW Medical PPS DSRIP Application, my past experience as VP of Business Development and operations at Doctors On Call, a medical practice caring for the chronic homebound Geriatric population in all of NYC and my current position as the president of Preventive Diagnostics a portable x-ray company servicing nursing homes and homebound patients in NYS, I can tell firsthand how important and unique a physician led PPS is!

By selecting a physician led PPS you are putting the high risk Medicaid population in the hands of the front door of care: that is the primary care doctor! As AW Medical PPS demonstrated by creating a care management team that understands and knows the need of their patients!

Compared to a hospitals approach, they only get to know the patient when they end up in the emergency room and start to treat the patient when the medical situation is bad, AW Medical a physician led PPS has the ability and experience to PREVENT and REDUCE the hospitalizations.

Being that I've seen firsthand the systems and plans that AW Medical has I'd like to take this opportunity and strongly endorse AW Medical, as we all know the most important factor in this project is "implementation" yes! AW Medical can and will do it with great success!!!

My contact information is below for any questions or concerns!

Thanks,

Mark Tauber

Preventive Diagnostics Inc.
544 Park Ave. suite 620
Brooklyn, NY 11205
t-718-388-3300
f-718-228-9317

From: Susan Katz
Sent: Thursday, February 12, 2015 5:07 AM
To: DSRIPApp@health.ny.gov
Subject: ACP/AW Medical PPS - public comment

Thank you for the opportunity to provide feedback and comments. We are a licensed home care services agency, participating members of the ACP/AW Medical PPS. I am honored to be working with such a diverse and dynamic group. The energy and synergy of the group is palpable. The collective expertise of the participating members and the strong leadership of the PPS is a winning combination.

As a physician-led project, the ACP/AW Medical PPS is positioned well to reach a wide range of communities and to address their culturally-specific health care needs and concerns. The disease-specific projects, such as diabetes and heart disease are largely influenced by outreach efforts, proper education and continuous monitoring. The PPS has therefore built a corresponding culturally competent network so that cultural barriers to care are tremendously minimized. This unique approach will in fact impact the health and safety of its Medicaid population by engaging the consumers in the community and providing them with the tools necessary to focus on their health and well-being.

I am thrilled to be a part of this medical community and am confident that the individual effort of our home care agency and the collective efforts of the ACP/AW Medical PPS members will keep Medicaid consumers in the community and reduce re-hospitalizations.

Sincerely,

Susan Katz
CEO
Summit Home Health Care

From: Monique Wahba
Sent: Thursday, February 12, 2015 9:02 AM
To: DSRIPApp@health.ny.gov

Subject: DSRIP Process - Public Comment

DSRIP Administration
New York State Health Department
Via email: DSRIPApp@health.ny.gov.

To Whom It May Concern,

The South End Improvement Corporation is concerned that there has not been adequate opportunity for comment for residents of the South End of Albany and other low-income, severely impacted neighborhoods that are the focus of the current needs assessments by the two PPS providers that serve our areas, or even to fully comprehend the broad impact of the DSRIP process. There has been extremely limited public outreach by either Albany Medical Center or Ellis Medicine/St. Peter's Health Partners. The documents show that the process itself has been almost entirely governed by top-level management at the hospitals.

We are requesting a new community outreach process that would enable neighborhood residents and grassroots organizations like ours to become educated about this dramatic new approach to community health, and then to participate in meaningful planning on community-based approaches to improving health and wellness in our communities.

The South End Improvement Corporation has been serving the South End of the City of Albany for over 35 years. Our repair and rehabilitation programs help prolong the life of houses in the South End, allowing our residents to stay in their homes longer and live in a safer and healthier environment. We address emergencies like failed heating systems and plumbing disasters. We also provide moderate to substantial rehabilitation assistance to address health and safety as well as code issues, remediate environmental conditions like lead, mold and asbestos, implement energy efficiency measures, and make accessibility improvements to help keep the frail elderly and the disabled comfortably in their homes.

These services are clearly aligned with improving health outcomes. We therefore request inclusion in a new community outreach process so we can work together toward our common goals.

Sincerely,

Monique Wahba, Executive Director
South End Improvement Corporation
38 Catherine St.
Albany, NY 12202
(518) 436-8777 (phone) (518) 436-7656 (fax)

From: Stacy Pettigrew
Sent: Wednesday, February 11, 2015 7:04 PM
To: DSRIPApp@health.ny.gov
Subject: DSRIP Community Inclusion Insufficient

DSRIP Administration
New York State Health Department
To Whom It May Concern,

The Radix Ecological Sustainability Center is concerned that there has not been adequate opportunity for comment for residents of the South End of Albany and other low-income, severely impacted neighborhoods that are the focus of the current needs assessments by the two PPS providers that serve our areas, or even to fully comprehend the broad impact of the DSRIP process. There has been extremely limited public outreach by either Albany Medical Center or Ellis Medicine/St. Peter's Health Partners. The documents show that the process itself has been almost entirely governed by top-level management at the health care institutions.

We are requesting a new community outreach process that would enable neighborhood residents, the community organizations that serve us and our local governments first to become educated about this dramatic new approach to community health, and then to participate in meaningful planning on community-based approaches to improving health and wellness in our communities.

While the following agencies all have long standing relationships in the South End and are actively engaged in improving the health and well being of the residents of the South End, they were neither consulted nor invited to participate in the needs assessment or planning process for this project. They include Trinity Alliance, the South End Improvement Corp., the South End Neighborhood Association, AVillage..., Inc., The Albany City Mission, Salvation Army, the South End Community Outreach Center, Peter Young Industries and the Altamont Programs, Albany Housing Authority, Cathedral Outreach Center and St. John's/St. Ann's Outreach Center.

Failure to include them and their constituents in the planning process to improve the health of the community will not yield the expected healthcare outcomes to reduce hospitalization or emergency room utilization rates, nor provide the anticipated Medicaid savings in the future.

As noted in the Community Assessment reports, there are many issues and barriers that contribute to poor health in our neighborhood. They do not all lend themselves to traditional health care solutions. At a minimum, the planning process for low-income neighborhoods should consider enhanced community-based outreach, more coordination of services and case management, access to healthy food and improved infrastructure to accommodate programs for health and fitness.

After reviewing the documents and needs assessments, it is clear that the existing assets, initiatives and strengths of our community were not considered in this process. We have strong community organizations. As you may know, the new Capital South Campus Center has

attracted many professionals and offerings coming from regional universities and businesses. The new Albany County Land Bank will start to address our blighted housing stock and vacant land and engage residents in planning for their future. Community organizations have already started gardening, nutrition and youth entrepreneur training programs. We do not feel it is appropriate to use the money for DSRIP simply to treat us for our illnesses, but rather that it be used by the community to strengthen our current and developing programs.

The best solutions for a healthy neighborhood will come from the community itself.

Thank you,

Stacy Pettigrew

Executive Director

The Radix Ecological Sustainability Center

<http://radixcenter.org>

From: Margaret Hirst
Sent: Tuesday, February 10, 2015 12:40 PM
To: DSRIPApp@health.ny.gov
Subject: Comment on PPS Applications

The Dutchess County Department of Mental Hygiene (DMH) is the Local Governmental Unit which, under Article 41 of Mental Hygiene Law, is authorized to provide local planning, monitoring and oversight of behavioral health (mental health, chemical dependency and intellectual and developmental disabilities) services.

Recently, both Westchester Medical Center PPS and Montefiore PPS have submitted DSRIP applications which include requests to waive the requirement of Part 551 and Part 810 of Title 14 of NYCRR which mandates LGU input into new/changing services.

DMH objects to waiving these regulations because it eliminates a valuable coordination and collaboration with the local authority that knows the local continuum of care, the local needs and the local feasibility for new/changing services. The LGU input is a valuable part of planning and should be integral in local DSRIP implementation

DMH requests that these regulations not be waived in the DSRIP planning/local implementation process

Margaret Hirst, LCSW

Margaret Hirst, LCSW
Division Chief for Clinical Services
Dutchess County Department of Mental Hygiene
230 North Road
Poughkeepsie, NY 12601
Phone: 845-486-3791 Fax: 845-486-2829

www.dutchessny.gov

From: peggy Lloyd

Sent: Wednesday, February 11, 2015 11:21 AM

To: jah23@health.state.ny.us; dsripapp@health.ny.gov; michaelmelendez@cms.gov

Subject: RE: public comments

Dear Mr. Helgersen,

2. Require and ensure consumer/community-based organization involvement in all levels of decisions by:

- The state setting up a working group made up of representatives from the PPS's, community-based organizations and consumers not now represented the state governance structures to generally make recommendations to the state with a special focus on outreach, engagement and cultural competency.
- Ensuring the community infrastructure to support the PPS goals is critical. To do this, a state human capital support fund must be established (much like the hospital capital fund) to support, and make the continuing viability of community-based organizations a reality as they implement the community-based prevention and support critical to DSRIP success.
- Requiring the PPS's to use their advisory committees to develop outreach and education plans and cultural competency plans and require PPS's to use some of their resources to subcontract CBO's to do basic outreach, education and cultural competency trainings/ efforts related to DSRIP projects and the process.
- Require the PPP's to diversify their governance structures. At a minimum, executive committees of all PPS's should include one social worker, physician, nurse, and other profession (i.e. mental health provider) knowledgeable about chronic disease care and prevention. At least one community group for each of the identified social determinants of health (i.e. housing, food insecurity, economic security, age, violence, open spaces/environment, education, workforce development, etc.). It should also include more than one local consumer on Medicaid and uninsured, and a front-line worker knowledgeable about patient engagement and education (CHW, peer educator, peer specialist etc.).
- Assure equal ability to access PPS advisory and committee meetings, Oversight and Approval Panel meetings and overall advisory meetings should occur alternately between Albany and NYC and always contain at least ½ hour for public comment.

2. Recognize DSRIP Projects must expand beyond an academic and clinical framework, by:

- Ensuring that it has key components of a community-driven health program that addresses the social determinants of health.

- Focusing its core strategies on cultural competency, especially for the populations to be served.

3. CNHA should be subjected to professional standards, intense review, and relevance to the community they served. Assessments done without any independent expertise should be subject to careful scrutiny and possible deductions in the scoring. (I.e. NY Presbyterian and Mt Sinai). And even the independent expertise should be subjected to quality review on how well they did the CHNA.

4. The “all or nothing” funds flow “formula” will destabilize the whole system from the beginning. Reimbursement should be proportional to effort achieved for each goal, not a complete loss for missing the goal even by a minor amount.

Thank You,
Ms. Llyod

From: "Whiteford, Debra"

Date: 02/12/2015 3:50 PM (GMT-05:00)

To: DSRIPApp@health.ny.gov

Cc:

Subject: Comments on Regulatory Relief Requests- CNYCC application



**Anthony J. Picente, Jr., County Executive Debra A. Whiteford, Interim
Commissioner**



Phone: (315) 768-3660
Fax: (315) 768-3670
Website: www.ocgov.net

**120 Airline Street
Suite 200
Oriskany, New York 13424**

In response to the regulatory relief requests made by the Central NY Care Collaborative (CNCYCC), the Oneida County Department of Mental Health (OCDMH) expresses the following areas of concern and support:

With regard to the request for services the Department agrees with the Conference of Local Mental Hygiene Directors in their rejection of the notion that Local Governmental Unit (LGU) review will cause substantial delay in innovation. OMH regulations require a response within 20 days for Comprehensive PARs and in 10 days for EZ-PARs. OASAS regulations require such a response in a reasonable time. With that standard for turn around there is no evidence that LGU review causes undue delay in innovation.

The CNY Care Collaborative has also sought a waiver seeking relief from OASAS requirements for prior approval to open a new location (14NYCRR & 822-4.9). The Department's assessment of this request resulted in the following concerns:

1. How will new locations be chosen? Traditionally the Department provides support with regard to what neighborhoods that will sustain services with considerations for transportation, accessibility, high density residential and existing infrastructure.
2. What about the city laws regarding zoning requirements? The Department has in the past served as a liaison between potential providers and city officials.
3. Will new providers be allowed to open new locations or is the waiver request for existing providers only? The LGU reviews the applications for new services to ensure that the need for the service is present and the provider has the financial and operational capacity to perform the services in compliance with regulations.

We maintain that NYS OMH, NYS OASAS and the County Departments of Mental Health are the best gatekeepers for our local communities. Any waiver granted regarding new locations has the potential to create a shift in responsibility for program locations that did not succeed and remain after the completion of the DSRIP initiative. LGU involvement at the onset of these changes to programs is imperative.

The OCDMH is in support of the CCNCC request for relief from physical plant requirements that inhibit the sharing of space (4 NYCRR §§ 814.2, 814.3(d), 814.6, 814.7, & 814.8). Having integrated mental health, medical and substance abuse services is a move in the right direction for all patients. By allowing current providers to serve patients without having to be concerned about different waiting rooms, offices and record storage would allow for high risk, high needs patients to access their providers in one place.

In conclusion local governmental units have greater knowledge of both the needs of the community and the competency of providers in the community seeking to open new programs. The CNYCC is representative of multiple counties and hundreds of providers. Knowledgeable LGU input is crucial to the successful implementation of community based services for all patients including Medicaid and non-insured patients. The LGU will also be responsible for long term governance of the projects created by the PPS workgroups beyond the 5 years of DSRIP incentives. The LGU provides oversight, accountability and collaboration for mental health and substance abuse providers. The LGU prevents the duplication of services, assures quality of life issues are considered for all patients and families and remains person centered in its approach. The Department will remain a strong guardian for the interests of individuals and agencies located in our community.

Thank you for your attention to the department's concerns.

Debra Whiteford, MS
Interim Commissioner
Oneida County Department of Mental Health
120 Airline Street Suite 200
Oriskany, NY 13424
315 768-3660
Fax: 315 768-3670

From: "Reyes, Lucinda"

Date: 02/12/2015 3:56 PM (GMT-05:00)

To: DSRIPApp@health.ny.gov

Subject: Public Comment

I am Joanne King, Administrative Director of Harlem East Life Plan (HELP) is excited energetic and fully supportive of A & W Medical Group PPS. The opportunity to partner with A & W Medical Group PPS will serve as an invaluable resource to assist and improve the treatment outcomes of the challenging inner city population that HELP serves.

As an integrated care organization this partnership makes "so much sense" and is the opportunity for HELP to coordinate with partner agencies and improve and save more lives.

Sent: Thursday, February 12, 2015 4:19 PM

Subject: Public Comment on AWMedical

Hello,

I think AW Medical vision of reducing avoidable services while ensuring access to primary care is achievable. They are a strong group of physicians that is based within different sections of the communities. They already service the population of interest. They have partnered up with the community based organizations and have begun a partnership in addressing all the needs of the patients they serve.

Maria Mendez, CASAC

Executive Vice President/COO

Executive Office

6 East 39th Street Suite 400

NYC, NY 10016

212-837-2013

917-526-2456(cell)

www.thepacprogram.com

Facility Locations

The PAC Program of Queens

40-11 Warren St

Elmhurst, NY 11373

718-729-6868/8686

The PAC Program of Brooklyn

7 Debevoise St.

Brooklyn, NY 11206

718-388-5950

The PAC Program of The Bronx

1215-1217 Stratford Ave

Bronx, NY 10472

718-328-2605

The PAC Program of Manhattan

6 East 39th Street Suite 400

NYC, NY 10016

212-837-2013

From: Chris Norwood
Sent: Thursday, February 12, 2015 5:15 PM
To: DSRIPapp@health.ny.gov
Subject: FW: DSRIP Comments

Dear State Department of Health and DSRIP Oversight Panel,

Thank you for the opportunity to comment. As we proceed toward this promising era of reform, my concern is to assure that there is the kind of constant consumer and community-based involvement in DSRIP that will assure its success. This will involve more effort to assure that the communities and people most impacted by DSRIP also participate in implementing the overall program and PPS projects. Specifically:

- 1. The state should set up a working group with representatives from the PPS's, community-based and organizations, true Medicaid consumers, front-line health educators and other stakeholders not now represented on the oversight panel to generally make recommendations to the state, especially focusing on outreach, engagement and cultural competency.**

In this regard, the state should also require the PPS's to use their advisory committees to develop outreach and education plans and cultural competency plans and require PPS's to use some of their resources to subcontract CBO's to do basic outreach, education and cultural competency trainings/ efforts related to DSRIP projects and the process.

2. As important services move to communities to be more effective, it is critical that community-based organizations have the infrastructure to support PPS goals. In the same way that the state provided a capital fund for clinical partners, it needs to provide a "human infrastructure fund" for community partners, enabling them to have start-up staff and infrastructure support to implement the community-based prevention, self care and outreach critical to DSRIP success.

3. PPS's need to diversify their governance structures. At a minimum, executive committees of all PPS's should include one social worker, physician, nurse, and other profession (i.e. mental health provider) knowledgeable about chronic disease care and prevention. At least one community group for each of the identified social determinants of health (i.e. housing, food insecurity, economic security, age, violence, open spaces/environment, education, workforce development, etc.). It should also include more than one local consumer on Medicaid and uninsured, and a front-line worker knowledgeable about patient engagement and education (CHW, peer educator, peer specialist etc.).

4. For the state to hold DSRIP Oversight and Approval Panel meetings only in Albany is simply to deny the majority of Medicaid consumers in the state equal access to attending these meetings and understanding DSRIP. Oversight and Approval Panel meetings and overall advisory meetings should occur alternately between Albany and NYC and always contain at least ½ hour for public comment.

5. The “all or nothing” funds flow “formula” will destabilize the whole system from the beginning. Reimbursement should be proportional to effort achieved for each goal, not a complete loss for missing the goal even by a minor amount. Not only will it really discourage PPS participants to receive no credit toward funding if, say, they reach the majority of a goal but this formula will actually injure prospects for the innovation we want. Implementation of new programs can go awry for many reasons---even the illness of a key person---but, often, persevering will get the program where it should be. That can't happen if the funds flow formula is outrightly punitive!

Thank you for your kind attention,

Chris Norwood
Executive Director
Health People
552 Southern Boulevard
Bronx, NY 10455
718-585-8585 ext. 239
www.healthpeople.org

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

Sent: Friday, February 13, 2015 8:30 AM

To: DSRIPApp@health.ny.gov

Subject: Public Comment

I am a resident of zip 10002 and have lived here for many years.

According to the Health and Hospitals Corporation Community Needs Assessment Final Report, December 16, 2014, Prepared by HHC Corporate Planning Services page 3 Urgent care and ambulatory surgery centers are unequally distributed across the service area, with few located in ZIP codes with high numbers of Medicaid beneficiaries.

I can remember that Gouverneur Health had Urgent care services before Urgent care was the title.

I would like Gouverneur Health in zip 10002 to be considered for usage as a site for an Urgent care and ambulatory surgery center.

Vaylateena Jones, RN, LMHC, CASAC

From: Kathy Gallinger
Date:02/13/2015 9:21 AM (GMT-05:00)
To: DSRIPApp@health.ny.gov
Cc:
Subject: Healthy Families NY

It is with frustration and sadness that an evidence based program serving families in both the Finger Lakes Region and Central New York Region would not be an integral part of this endeavor. For 20 years we have successfully improved maternal and infant outcomes throughout NYS. Healthy Families NY offers measurable outcomes for all of the criteria you are looking for in the area of maternal, infant health. We also offer a sincere commitment to optimal service for the entire family that we serve. It is not only first time mothers that are interested in the support that long term home visiting provides. Father's, father figures, grandparents and other primary caregivers all are eligible and expected to actively participate in our shared goals. (Optimal child health & development....) I ask only, that you not overlook an effective proven program that is currently functioning in the capacity you are looking for and doing it WELL!

Sincerely,
Kathy Gallinger

From: "J. O'Grady, H. Klaeyesen"
Date:02/13/2015 10:00 AM (GMT-05:00)
To: DSRIPApp@health.ny.gov
Cc:
Subject: Project Plan Application

To DSRIP Policymakers:

I believe that the goals of your project cannot be achieved in our community, because of the inadequate length of time allowed for public comment.

Understanding how the funds allotted to New York State will be most effective statewide, requires an understanding of the health and wellness needs of all of its communities. In my city I am aware of no neighborhood health clinic, neighborhood association, YMCA, human service agency, or mental health provider who has been notified of the opportunity to comment on this plan. (I mention the Y because they began spearheading a wellness program in the city about a year ago.) In my part of the city alone, the Whitney M. Young Health Center and the Koinonia Health Center (staffed by one physician) serve thousands of households of the poor and working-poor.

I ask that a period of public outreach be instituted. The applications you now have reflect a great deal of ignorance of the available assets in our community, and of what it truly takes to encourage wellness in our neighborhoods.

John W. O'Grady, LCSW

President, West End Neighborhood Association
Board Member, Council of Albany Neighborhood Associations

Albany, NY

From: Jessica Gorman
Sent: Friday, February 13, 2015 10:44 AM
To: DSRIPApp@health.ny.gov
Subject: DSRIP Public Comment

Dear Sir or Madam,

I am a resident of Albany's South End. I also work and volunteer in the South End, and I am typically well-informed of issues that affect my community. However, it was not until yesterday that I learned about the DSRIP submissions by Albany Medical Center and Ellis/St. Peter's Health Partners, which directly impact me and my community. It appears that I was not alone in not hearing about these submissions until the eleventh hour.

Given Albany Medical Center and Ellis/St. Peter's Health Partners' extremely limited outreach to, and engagement of, the community in this process thus far, and the critical impact their submissions and the DSRIP program will have on my community, I am requesting that the public comment period, which ends on February 15, be extended.

I am also requesting that Albany Medical Center and Ellis/St. Peter's Health Partners meaningfully engage and include South End residents in their DSRIP processes.

Thank you.

Jessica Gorman

From: Lowney, Matthew T

Sent: Friday, February 13, 2015 10:52 AM

To: DSRIPApp@health.ny.gov

Subject: Community Outreach to Improve Health and Wellness in Our Communities

To Whom It May Concern,

I am writing to show my concerns on extremely limited public outreach by either Albany Medical Center or Ellis Medicine/St. Peter's Health Partners on DSRIP project that will dramatically affect our community.

NYS Health Department must request their health partners to launch a new community outreach process that would enable neighborhood residents and the community organizations to participate in meaningful planning on community-based approaches to improving health and wellness in our communities.

Failure to include the community in the planning process to improve the health of the community will not yield the expected healthcare outcomes to reduce hospitalization or emergency room utilization rates, nor provide the anticipated Medicaid savings in the future.

Thank you,

Matt Lowney

From: Dorcey Applyrs
Sent: Friday, February 13, 2015 11:03 AM
To: DSRIPApp@health.ny.gov
Subject: Extend Public Comment Period for DSRIP

To Whom It May Concern,

I am writing to show my concerns regarding the extremely limited public outreach by either Albany Medical Center (AMC) or Ellis Medicine/St. Peter's Health Partners to discuss the DSRIP project. This project has many implications for community residents. As the Common Council Member for the First Ward in the City of Albany, I have received numerous complaints about the lack of community engagement and transparency with regards to DSRIP related decisions. Many of the community members I represent frequent AMC and Ellis for care. Without these residents, the doors would close. In the true spirit of public health and the Affordable Care Act, communities must be considered partners and involved in decision making if we truly want to improve the "business" of health care and most importantly population health.

The NYS Department of Health must request their health partners to launch a new community outreach process that would enable neighborhood residents and the community organizations to participate in meaningful planning on community-based approaches to improving health and wellness in our communities.

Failure to include the community in the planning process to improve the health of the community will not yield the expected health care outcomes to reduce hospitalization or emergency room utilization rates, nor provide the anticipated Medicaid savings in the future.

On behalf of myself and the residents of the First Ward, I strongly urge you to extend the comment period and/or implement new comprehensive community engagement strategies. Let's do what is right on behalf of our communities.

I welcome a conversation.

Sincerely,

Dorcey Applyrs, DrPH, MPH
Common Council Member-First Ward
phone: 518-894-8981

From: Yelena Schmidt
Sent: Wednesday, February 11, 2015 3:52 PM
To: DSRIPApp@health.ny.gov
Subject: AWMedical/ACP PPS

To Whom It May Concern,

As an attorney and licensed home care agency owner, I am a huge advocate and supporter of the initiative set forth by the AWMedical/ACP PPS.

The AWMedical/ACP PPS seeks to serve and greatly better the lives of the highly underserved Medicaid population of New York City. Through education, medical and community resources, and the sheer will to better our community, this physician led PPS will create an initiative to keep patients out of hospitals by providing them with personalized and preventative care.

The AWMedical/ACP PPS will greatly reduce hospitalizations by providing patients with the preventative care that they need, such as access to cardiologists, physical therapists and home care. With access to preventative and personalized care, patients are less likely to reach the imminence of hospitalization. Moreover, as a physician led PPS, AW Medical/ACP has the unique ability to recognize and directly address the medical needs of the community in a timely and efficient manner.

I am confident that the AWMedical/ACP PPS has the resources, know-how, and extensive network of highly competent providers which would allow this particular PPS to make a huge difference in the highly underserved Medicaid community which it seeks to serve.

Yelena Schmidt
President

890 Garrison Avenue, 2nd Floor
Bronx, NY 10474
Telephone: (212) 476-0905
Fax: (646) 349-4015

From: Jordan Lin
Sent: Friday, February 13, 2015 10:57 AM
To: DSRIPApp@health.ny.gov
Subject: Please don't leave public aside from DSRIP

To Whom It May Concern,

I am writing to show my concerns on extremely limited public outreach by either Albany Medical Center or Ellis Medicine/St. Peter's Health Partners on DSRIP project that will dramatically affect our community.

NYS Health Department must request their health partners to launch a new community outreach process that would enable neighborhood residents and the community organizations to participate in meaningful planning on community-based approaches to improving health and wellness in our communities.

Failure to include the community in the planning process to improve the health of the community will not yield the expected healthcare outcomes to reduce hospitalization or emergency room utilization rates, nor provide the anticipated Medicaid savings in the future.

--

Yen-Fu, Lin (Jordan Lin)
Rockefeller College of Public Affairs & Policy, University at Albany
Master of Public Administration
Concentration: Nonprofit Management and Leadership

From: Butler, Francis
Sent: Friday, February 13, 2015 12:29 PM
To: DSRIPApp@health.ny.gov
Subject: PLEASE GIVE ALBANY'S COMMUNITY A VOICE

To the NY State Department of Health and DSRIP Management Division,

It has come to my attention that the local hospitals of the city and county of Albany have not reached out in an effective manner to account for the voice of the community, especially in neighborhoods where acute health disparities currently exist. As a concerned citizen and active member of Albany's wider community, I am asking the NY State Department of Health to please reconsider its current DSRIP proposal.

I ask that this proposal be restructured to incorporate the voice of Albany's community, especially the concerns and ideas of those people who live in areas impacted by a high level of health and wellness problems.

I believe that the goals of your project cannot be achieved in our community, because of the inadequate length of time allowed for public review and comment. The DSRIP process is too important to the health of our community to ignore the voices of those it is intended to help.

It is my belief that only through collaboration and cooperation with the people DSRIP hopes to impact will results and effective solutions to today's problems be realized.

Thank you for your respectful consideration of my statement and I look forward to following the initiatives of the NY State Department of Health and the DSRIP program in the future. I truly believe this initiative has the power to change lives for the better.

Sincerely,

Francis Butler
Concerned Citizen

--

Siena College
Class of 2015
Program Assistant, McCormick Center for the Study of the American Revolution
History Major, Revolutionary Studies Certificate
Duke Fellow, Undergraduate
President, History Club
Urban Scholars Mentor, Spring 2012, Spring 2013, Spring 2014

From: Alvaro Carrascal
Date:02/13/2015 1:51 PM (GMT-05:00)
To: DSRIPApp@health.ny.gov
Cc:
Subject: DSRIP PPS Application Review: Comment

The Advocate Community Providers (AW Medical) DSRIP application, in its Project Plan (page 82), includes cancer screening recommendations that are either non-existent or totally inconsistent with those recommended by the United States Preventive Services Task Force (USPSTF), the American Cancer Society or any other professional/scientific organization. Specifically, colon cancer and breast cancer screening recommendations are not properly quoted in either tools used or frequency; “rectal prostate exam” is not recommended for prostate cancer, and there are no screening tools available or recommended for uterine cancer.

This seems to be part of 4.b.ii component. Surprisingly, this application received the highest score possible in this section.

Thanks

Alvaro Carrascal, MD,MPH | Vice President, Eastern Division Health Systems
Eastern Division | American Cancer Society, Inc.
1 Penny Lane
Latham, NY 12110
Phone: 518.220.6915
cancer.org | 1.800.227.2345

From: "Booth, Taylor"

Date: 02/13/2015 1:59 PM (GMT-05:00)

To: DSRIPApp@health.ny.gov

Cc:

Subject:

To the NY State Department of Health and DSRIP Management Division,

It has come to my attention that the local hospitals of the city and county of Albany have not reached out in an effective manner to account for the voice of the community, especially in neighborhoods where acute health disparities currently exist. As a concerned citizen and active member of Albany's wider community, I am asking the NY State Department of Health to please reconsider its current DSRIP proposal.

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It is my belief that only through collaboration and cooperation with the people DSRIP hopes to impact will results and effective solutions to today's problems be realized.

Thank you for your respectful consideration of my statement and I look forward to following the initiatives of the NY State Department of Health and the DSRIP program in the future. I truly believe this initiative has the power to change lives for the better.

Sincerely,

Taylor Booth

From: David Liss
Date: 02/13/2015 4:30 PM (GMT-05:00)
To: DSRIPApp@health.ny.gov
Cc:
Subject: Support for ACP DSRIP Proposal

BioReference Laboratories is the nation's third largest commercial lab and its most innovative. We have pioneered development in women's health, cancer care, and rare diseases. In addition to providing a complete menu of clinical testing services, we are one of the largest genetic sequencing centers in the world. We are acutely aware of the role that doctors play in their communities, not only providing patient care but also serving as the guiding hand of healthcare for their neighborhoods. The control of health spending requires the active participation of the community physician and the primary care provider.

This is why we enthusiastically support the Advocate Community Partners Performing Provider System application. ACP is the only physician-led, primary care-driven applicant for DSRIP. The principle physician networks included under the ACP umbrella have a proven track record for providing high quality continuity of care services to their patients while reducing excessive high cost utilization of health care resources.

Further, the diversity of the ACP providers, who mirror the cultures, languages, races and religions of the varied communities they serve represent the best hope of meeting the program goal of reducing unnecessary inpatient admissions by 25 percent. Their cultural competence will make them effective at addressing utilization in the areas where it is most necessary. The intimate relationship their providers have with their community members helped shape their Community Needs Assessment and the clinical projects they are pursuing.

BioReference is a member of the Board of the New York eHealth Collaborative and we are familiar with the role informatics and health information exchange and analytics will play in a successful DSRIP project. ACP has a well-considered approach to HIE and analytics. They have the potential to use HIT to integrate community physician practices, a historically difficult target for health information exchange.

We strongly encourage the DSRIP assessment team and the State of New York to select ACP as a PPS.

Sincerely,

J. David Liss

--J. David Liss
Vice President
External Relations
BioReference Laboratories, Inc.
Office: 201 791-2600 ext. 7500

From: Remache, Jessica
Sent: Friday, February 13, 2015 5:14 PM
To: DSRIPApp@health.ny.gov
Cc: Burke, John
Subject: AW Medical DSRIP

Sent on behalf of John Burke:

On behalf of WellCare of NY, we have had a long standing relationship with the providers who make up AW Medical, specifically Dr. Tallaj. We know from experience that they build partnerships within the provider community that collaboratively focus on quality and efficiency based activities for the care of our patients. This particular DSRIP application is a strong application because it is a group of physicians who provide direct care to the poor, elderly, uninsured and diverse population. We are an active partner with representation at the planning meetings in the DSRIP efforts with AW Medical and their affiliates. We are supportive of the projects they've chosen to pursue, such as System Transformation. We recently participated in a forum where we discussed the approach of an Integrated Delivery System. We look forward to continuous development of the DSRIP Initiative within this group and PPS and will continue to explore avenues to build on this partnership to enhance DSRIP specific goals

John Burke
State President, NY
917-229-1910

Jessica Remache
Executive Assistant to:
John Burke, NY State President
Elizabeth Rosado, VP, LTC Product
110 Fifth avenue, 3rd Floor
New York, NY 10011
Direct: 917-229-1916
Fax: 813-262-2967


From: Regina Dew
Date:02/13/2015 6:26 PM (GMT-05:00)
To: DSRIPApp@health.ny.gov
Cc:
Subject: redesigns of health care

To Whom It May Concern,

I am writing to show my concerns on extremely limited public outreach by either Albany Medical Center or Ellis Medicine/St. Peter's Health Partners on DSRIP project that will dramatically affect our community.

NYS Health Department must request their health partners to launch a new community outreach process that would enable neighborhood residents and the community organizations to participate in meaningful planning on community-based approaches to improving health and wellness in our communities.

Failure to include the community in the planning process to improve the health of the community will not yield the expected healthcare outcomes to reduce hospitalization or emergency room utilization rates, nor provide the anticipated Medicaid savings in the future.

From: "Comuniello, Felicia"
Date: 02/13/2015 9:14 PM (GMT-05:00)
To: DSRIPApp@health.ny.gov
Cc:
Subject: DSRIP

To the NY State Department of Health and DSRIP Management Division,

It has come to my attention that the local hospitals of the city and county of Albany have not reached out in an effective manner to account for the voice of the community, especially in neighborhoods where acute health disparities currently exist. As a concerned citizen and active member of Albany's wider community, I am asking the NY State Department of Health to please reconsider its current DSRIP proposal.

I ask that this proposal be restructured to incorporate the voice of Albany's community, especially the concerns and ideas of those people who live in areas impacted by a high level of health and wellness problems.

I believe that the goals of your project cannot be achieved in our community, because of the inadequate length of time allowed for public review and comment. The DSRIP process is too important to the health of our community to ignore the voices of those it is intended to help.

It is my belief that only through collaboration and cooperation with the people DSRIP hopes to impact will results and effective solutions to today's problems be realized.

Thank you for your respectful consideration of my statement and I look forward to following the initiatives of the NY State Department of Health and the DSRIP program in the future. I truly believe this initiative has the power to change lives for the better.

Sincerely,
Felicia Comuniello

--

Felicia R. Comuniello '17
Program Associate
Bonner Service Leader
Academic Community Engagement
Siena College
515 Loudon Road
Loudonville, NY 12211
P: 516.439.8447

From: Lisa Galatio
Date:02/14/2015 4:39 PM (GMT-05:00)
To: DSRIPApp@health.ny.gov
Cc:
Subject: Comment on FLPPS application

I would like to offer some comments on the Finger Lakes PPS application, particularly in regard to Project 3.f.i. - improving maternal and infant health. My comments are actually more about the process than the application itself. I have been involved in several of the work group conversations around this project. The very large region covered by the Finger Lakes PPS includes six counties with Healthy Families New York programs. Healthy Families New York is a proven, evidence based program that focuses on the same outcomes that Project 3.f.i. desires. Although Finger Lakes PPS notes Healthy Families as a resource in the application, they have made it obvious that they know very little about the program, what it does, and where it is located. During workgroups, they have had to be reminded several times about the programs existence and its wide presence in our region. Although the Finger Lakes PPS covers a wide region, the group's familiarity with resources and services seems skewed to those offered in Monroe County. One plan on the table is that a Rochester based group will expand their NFP program to all counties in our region. I am in favor of the agencies getting NFP and CHWs that want them but I think it is a mistake not to look at the needs of communities and the resources they already have. I realize that a CHW could funnel people into our program but we already have outreach and intake staff built into our program. It seems a waste of money to duplicate efforts, as well as add another layer between families and services. There seems to be little acknowledgement of existing programs offered throughout the region already doing the work of improving maternal and infant health outcomes. I believe getting to know these programs and determining what gaps need to be filled first would have been a better strategy than coming up with a blanket strategy to fit across the region. DSRIP funding is an opportunity to make a difference in the health of our communities and I fear that we are not maximizing the potential of the money by duplicating services and failing to come up with a comprehensive and collaborative plan that meets the needs of individual communities. Healthy Families has had a significant impact on health outcomes for mothers and babies across New York State. We have extensive expertise in the communities in which we are based, the families this project hopes to reach, and in home visiting services. We know that maternal and child health is not limited to first time pregnancies and that all families who are expecting or have newborns need support in accessing appropriate health care. I believe it is important for the Finger Lakes PPS, as well as other applicants across the state who have chosen this project, to support the efforts of existing programs like Healthy Families. In order to get the desired outcomes, it will be necessary for PPSs to truly become familiar with existing programs and engage them collaboratively in a comprehensive plan that meets the needs of all areas of their region.

Lisa Galatio
Director
Healthy Families Steuben/
Kinship Family and Youth Services
at Catholic Charities of Steuben
6251 County Route 64, Suite 102
Hornell, NY 14843
607-324-6027 ext 2015
607-324-0983 - fax

From: Anderson Torres
Date: 02/14/2015 6:30 PM (GMT-05:00)
To: DSRIPApp@health.ny.gov
Cc:
Subject: DSRIP

As CEO of R.A.I.N. Inc., I am in support of the DSRIP application for AW Medical, which has involved New York Community Preferred Providers. This is a comprehensive network focusing on a multiethnic collaboration of more than 1,600 community-based physicians who serve 750,000 Medicaid patients. This is impressive given the diversity in our community. This network should also be able to engage in a clinical integration that is needed in order to move forward with DSRIP. Had it physicians not engaged in quality measures, it would not have scored as high among other applicants. Dr. Tallaj has been a leader in the community addressing health disparities and his compassion and vision have led him this far, and he will go further with his community partners.

R.A.I.N. is in full support of this application and look forward to addressing the Panel on Tuesday in Albany on the 17th.

Regards,

Anderson Torres, Ph.D., LCSW-R
Chief Executive Officer
www.RainInc.org

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Serving the Community Since 1964

Regional Aid for Interim Needs, Inc.
811 Morris Park Avenue
The Bronx, New York 10462

From: Judy Wessler
Date: 02/15/2015 11:35 AM (GMT-05:00)
To: dsripapp@health.ny.gov
Subject: Fwd: DSRIP Comments

Please see below, testimony from Mary Mitchell, Executive Director of the M/SI AHEC. I presented at a health workshop at the Black, Latino, and Asian Caucus conference yesterday. People attending were very interested in DSRIP, although many had no information. I encouraged people to come and testify or submit testimony. Ms. Mitchell sent her testimony through me.
Judy Wessler

-----Original Message-----
From: Mary Mitchell

Sent: Sat, Feb 14, 2015 5:45 pm
Subject: DSRIP Comments

Judy,
It was great to see you today. I really wish I could be in Albany for the public comment hearings. I am very glad to have heard that I can submit my comments through you.

As I mentioned at the workshop, I am very concerned about educating health care consumers. In my opinion, this is a vital component for the implementation of DSRIP. I strongly encourage this panel to "require" community education be incorporated in every PPS application. I further submit that community organizations such as the Area Health Education Centers (AHEC) are well positioned to assist this effort.

AHECs are involved in the elimination of health disparities and improved health outcomes.

I am available for any further discussion on this important issue.

Mary Mitchell
Executive Director
MSI AHEC

From: Latisha Gibbs
Date: 02/15/2015 1:52 PM (GMT-05:00)
To: DSRIP Support Team <DSRIPApp@health.ny.gov>
Cc:
Subject: RE: Public comment

Dear State Department of Health and DSRIP Oversight Panel,

Thank you for the opportunity to comment. As we proceed toward this promising era of reform, my concern is to assure that there is the kind of constant consumer and community-based involvement in DSRIP that will assure its success. This will involve more effort to assure that the communities and people most impacted by DSRIP also participate in implementing the overall program and PPS projects. Specifically:

1. **The state should set up a working group with representatives from the PPS's, community-based and organizations, true Medicaid consumers, front-line health educators and other stakeholders not now represented on the oversight panel to generally make recommendations to the state, especially focusing on outreach, engagement and cultural competency.**

In this regard, the state should also require the PPS's to use their advisory committees to develop outreach and education plans and cultural competency plans and require PPS's to use some of their resources to subcontract CBO's to do basic outreach, education and cultural competency trainings/ efforts related to DSRIP projects and the process.

2. As important services move to communities to be more effective, it is critical that community-based organizations have the infrastructure to support PPS goals. **In the same way that the state provided a capital fund for clinical partners, it needs to provide a "human infrastructure fund" for community partners, enabling them to have start-up staff and infrastructure support to implement the community-based prevention, self care and outreach critical to DSRIP success.**

3. **PPS's need to diversify their governance structures.** At a minimum, executive committees of all PPS's should include one social worker, physician, nurse, and other profession (i.e. mental health provider) knowledgeable about chronic disease care and prevention. At least one community group for each of the identified social determinants of health (i.e. housing, food insecurity, economic security, age, violence, open spaces/environment, education, workforce development, etc.). It should also include more than one local consumer on Medicaid and uninsured, and a front-line worker knowledgeable about patient engagement and education (CHW, peer educator, peer specialist etc.).

4. **For the state to hold DSRIP Oversight and Approval Panel meetings only in Albany is simply to deny the majority of Medicaid consumers in the state equal access to attending these meetings and understanding DSRIP.** Oversight and Approval Panel meetings and overall advisory meetings should occur alternately between Albany and NYC and always contain at least ½ hour for public comment.

5. The “all or nothing” funds flow “formula” will destabilize the whole system from the beginning. Reimbursement should be proportional to effort achieved for each goal, not a complete loss for missing the goal even by a minor amount. Not only will it really discourage PPS participants to receive no credit toward funding if, say, they reach the majority of a goal but this formula will actually injure prospects for the innovation we want. Implementation of new programs can go awry for many reasons---even the illness of a key person---but, often, persevering will get the program where it should be. That can't happen if the funds flow formula is out rightly punitive!

Thank you for your kind attention,

Thank You,

Latisha Gibbs
Coordinator of Special Projects/Community Advocate/Health Educator
Health People
552 Southern Boulevard
Bronx, NY 10455
718-585-8585 ext. 245
www.healthpeople.org

From: anisa greene
Date: 02/15/2015 1:59 PM (GMT-05:00)
To: dsripapp@health.ny.gov
Cc:
Subject: RE: DSRIP Project Applications/ Public comment

Dear State Department of Health and DSRIP Oversight Panel,

Thank you for the opportunity to comment. As we proceed toward this promising era of reform, my concern is to assure that

there is the kind of constant consumer and community-based involvement in DSRIP that will assure its success. This will involve

more effort to assure that the communities and people most impacted by DSRIP also participate in implementing the overall program and PPS projects. Specifically:

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3. **PPS's need to diversify their governance structures.** At a minimum, executive committees of all PPS's should include one social worker, physician, nurse, and other profession (i.e. mental health provider) knowledgeable about chronic disease care and prevention. At least one community group for each of the identified social determinants of health (i.e. housing, food insecurity, economic security, age, violence, open spaces/environment, education, workforce development, etc.). It should also include more than one local consumer on Medicaid and uninsured, and a front-line worker knowledgeable about patient engagement and education (CHW, peer educator, peer specialist etc.).

4. For the state to hold DSRIP Oversight and Approval Panel meetings only in Albany is simply to deny the majority of Medicaid consumers in the state equal access to attending these meetings and understanding DSRIP. Oversight and Approval Panel meetings and overall advisory meetings should occur alternately between Albany and NYC and always contain at least ½ hour for public comment.

5. The “all or nothing” funds flow “formula” will destabilize the whole system from the beginning. Reimbursement should be proportional to effort achieved for each goal, not a complete loss for missing the goal even by a minor amount. Not only will it really discourage PPS participants to receive no credit toward funding if, say, they reach the majority of a goal but this formula will actually injure prospects for the innovation we want. Implementation of new programs can go awry for many reasons---even the illness of a key person---but, often, persevering will get the program where it should be. That can't happen if the funds flow formula is out rightly punitive!

Thank You,

Levette Mcray

From: Louise McNeilly
Date:02/13/2015 2:21 PM (GMT-05:00)
To: DSRIPapp@health.ny.gov
Cc:
Subject: Public comments from Community Development Alliance

Hello,

Attached are comments from the Community Development Alliance of the Capital District on the DSRIP process.

Thank you for your attention to this matter.

Louise McNeilly

Community Development Alliance

255 Orange Street

Albany, NY 12210

Jason Helgeson
State Medicaid Director
New York State Department of Health
Albany, New York

February 12, 2015

Dear Mr. Helgeson:

As a diverse group of hospital-based clinicians, direct service providers and child advocates, we are encouraged by the Administration's work to improve care coordination and timely access to community-based services through New York's Delivery System Reform Incentive Payment program (DSRIP). We are concerned, however, that the short timeframe between implementation and evaluation, coupled with the focus on adult-specific health conditions, will dramatically limit the impact DSRIP can have on children's health outcomes.

To this effect, we urge you to consider the following recommendations that would help the DSRIP Performing Provider Systems (PPS) to better address children's needs and place them on the path to becoming healthy adults.

- 1) **Ensure that all PPS plans contain at least 1 project that focuses on disease prevention, screening and early treatment for children.** Currently, the PPS proposals overwhelmingly favor projects that address chronic health conditions such as cardiovascular disease and diabetes, because clear clinical measures exist for evaluating disease management and treatment success. While these plans are likely to succeed in reducing hospitalizations in the short-term, their exclusive focus on adult health conditions and treatment could inadvertently contribute to future generations of high-need, high-cost health care users as project-related services will not benefit children.
- 2) **Develop a mechanism to assess the impact of DSRIP PPS networks on community-based provider sustainability and consumer access to services.** The success of the DSRIP initiative depends on the ability of community-based providers to meet the needs of traditional hospital users. DSRIP's payment model disperses funding to the PPS' lead, often a hospital, that is then responsible for distributing payments to downstream community-based providers. As DSRIP projects reduce hospital-use, it is critical that payment flows to community providers in a timely manner to ensure that they have the capacity to meet the new emerging demand.
- 3) **Grant bridge funding to community-based providers that serve our most vulnerable communities to support fiscal stability and ensure service capacity.** CMS requires selected projects to be new and innovative to the PPS. As a result, providers are likely to incur costs for project start-up and implementation including health information infrastructure and workforce development. Our health delivery system is already facing significant financial challenges and we are concerned that many providers are likely to experience additional stress fulfilling these DSRIP-related requirements.

We appreciate the State Department of Health's efforts to improve health care delivery for New Yorkers and we look forward to working together to successfully achieve the triple aim of more effective, higher quality, and less expensive care for children and families.

Sincerely,

Jennifer March, Stephanie Gendell, and Alana Leviton
Citizens' Committee for Children of New York

Alan Mucatel
Leake and Watts

Gail Nayowith

Luisa Sanchez
SCO Family of Services

Phillip Saperia and Heather Mermel
The Coalition for Behavioral Health Agencies

Melanie Hartzog, Lorraine Gonzalez, and Andrew Leonard
Children's Defense Fund – New York

United Tenants of Albany

33 Clinton Avenue, Albany, NY 12207
(518) 436-8997; utalb@verizon.net

February 15, 2015

DSR Administration
New York State Health Department

DSRIPApp@health.ny.gov

To Whom It May Concern:

The United Tenants of Albany is very concerned about the inadequate opportunity for tenants throughout the region to contribute to current needs assessments in the DSRIP process by two PPS providers, Albany Medical Center and Ellis Medicine/ St. Peter's Health Partners. We request that this outreach process be greatly expanded to enable neighborhood residents, particularly including tenants, and grass roots organizations providing services that enhance people's health in various locations.

The United Tenants has been actively working with thousands of tenants, landlords, and homeowners to improve housing conditions for over 40 years. However, to date the DSRIP process has not been visible in the communities or populations (particularly low-income tenants). This is very troublesome because housing and community conditions are essential factor in our health, but is seldom taken into account in meaningful ways by the health care institutions. The United Tenants staff, board, and volunteers work involves a wide cross section of community residents and professionals, yet the DSRIP process has not been evident in the areas of our housing work.

This failure to seriously involve people living in low-income areas and working in grass roots settings in the DSRIP planning process regarding community health will minimize the potential effect any follow up changes may have in our system of medical care. We want to be heard and to be involved for the sake of us all.

Maria Markovics
Co-Director
United Tenants of Albany

An Open Letter to the DSRIP Project Advisory and Oversight Panel

Conditions To Be Imposed on All PPS Applications to Ensure Transparency and Provide Meaningful Public Oversight and Input in DSRIP Process

Following yesterday's public comments before the PAOP, it has become clear to NYSNA that the Panel will not be able to fully analyze and monitor the workings of the 25 systems that have filed applications under the \$6.4 billion DSRIP program and that the process is being controlled and driven by the large healthcare systems that compose the various PPSs, the private consultants hired by the PPSs and the DOH, and by the staff of the DOH.

The public and local communities are not being effectively integrated in the decision-making process, and the PAOP does not have the time or the resources to effectively monitor the ongoing implementation of the DSRIP program.

The DSRIP program as it has unfolded thus far will have a huge and far-reaching scope and the consequences of its design and implementation will have a deep impact on patients, direct care workers and local communities throughout the state. The agreed upon protocols for implementing DSRIP require a high degree of transparency and broad and meaningful public input in decision-making.

It appears to NYSNA that the vast scale and complexity of this program will hinder or preclude the PAOP from exercising its independent role in the process and will not allow more than a cursory review and more or less automatic approval of the applications that have been submitted. It further appears that the role of the PAOP in monitoring and overseeing the ongoing implementation process will be similarly limited.

Given the stakes and impact of this program, it is not acceptable that the process will continue to be driven and controlled by the insiders who will be the recipients of these grants.

We must create a truly transparent and more democratic structure that guarantees that information and power is broadly shared and includes local communities, nurses, doctors and other direct care workers, and the patients who will be directly affected.

In order to provide the opportunity for meaningful and broad participation, NYSNA urges the PAOP to impose the following conditions on all PPS applicants:

1. Each PPS must (a) include representatives of local communities, patients, independent advocacy groups and direct care workers in all committees and governing bodies, (b) provide these representatives with a meaningful advisory and decision-making role in the operation of the PPS and the design and

implementation of DSRIP projects and (c) create a process for the democratic selection of such representatives.

2. All DSRIP governance committees established by each PPS, including not only the PACs, but also the Executive Committees, the various project committees, and any other “hub” or provider sub-committees, must be operated in accordance with the NY State Open Meetings law, with advance public notice and opportunity to attend and observe its operations, including provision for:

- a) Simulcasting/teleconferencing of meetings;
- b) Keeping of minutes and/or videoconference archives of all such meetings that are publicly posted on PPS websites; and,
- c) Monitoring and auditing all committees to ensure that each PPS is including all interested worker, community and patient advocacy organizations and that their operations provide opportunity for meaningful input in accordance with the “advisory role” required by DSRIP protocols.

3. Requiring that each PPS creates a special independent “Public Advocate” to act in the interest of the public, local communities, patients and front-line workers to monitor, oversee and participate as necessary in the design and ongoing implementation of DSRIP projects and PPS governance with the following duties and powers:

- a) To monitor and audit as necessary all DSRIP PPSs to ensure full compliance with all State and CMS programmatic requirements;
- b) To ensure that each PPS fully integrates community, patient and healthcare workers in the decision making process at all levels so as to maximize the democratic operation of the DSRIP process;
- c) To investigate complaints from patients, members of the public and healthcare workers relating to the manner in which DSRIP programs and policies are designed and implemented;
- d) To act to enforce the rights of patients and local communities to quality of care, access to care, maintenance of services and infrastructure necessary or desirable to protect the healthcare interests of local communities, categories of patients and/or on the basis of findings as to community healthcare needs;
- e) To monitor and enforce improper or abusive grant of anti-trust protections through the Certificate of Public Advantage process or through applications for exemption from regulations;
- f) To act as the guardian and protector of the public interest generally and of local communities in all matters related to the implementation of DSRIP programs;
- g) The PPS “Public Advocate” shall be selected by and shall report to the non-provider members of each PPS PAC;
- h) The PPS “Public Advocate” shall be paid and may hire additional staff to assist as necessary in carrying out these functions, funding provided by the PPS lead provider as a determined percentage of DSRIP funding to the PPS (NYSNA proposes this percentage be set at an amount that will yield an average of funding in the amount of \$250,000 per year for each PPS, with more being generated for larger PPSs and less for smaller ones); and
- i) To regularly report to and consult with the members of the Project Advisory and Oversight Panel.



New York

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February 20, 2015

Jason Helgersen, Executive Director
Delivery System Reform Incentive Payment Program
New York State Department of Health
Empire State Plaza, Corning Tower, Room 1466
Albany, New York 12237

RE: AARP New York public comments on the New York State Draft DSRIP PPS Plan

Dear Mr. Helgersen:

AARP New York respectfully submits these comments in response to New York State's Draft DSRIP PPS Plan Application and materials. We appreciate the opportunity to comment. AARP understands that numerous proposals have been put forth, and our chief concern is ensuring that a patient's family caregiver is involved during all phases of their loved one's institutional and community based care, particularly during and after hospital discharge.

The DSRIP program is designed to achieve a 25 percent reduction in avoidable hospital use among the Medicaid population, including avoidable readmissions, admissions for ambulatory-sensitive conditions, and avoidable emergency department visits. An explicit goal of New York's DSRIP program is the transformation of the health care delivery system, directing care away from hospital use and toward a community-based delivery system.

POTENTIALLY PREVENTABLE HOSPITAL READMISSIONS ARE PREVALENT AND COSTLY

With these goals in mind, we would like to point out that in a recent AARP analysis of potentially preventable readmission rates for the years 2009 through 2012, data from the New York State Department of Health indicates that potentially preventable hospital readmissions are "prevalent and costly." This analysis, which took into account all payers, finds that although the statewide rate of readmissions "decreased slightly," both the total charges and total costs "steadily increased" during this period. The report estimates that the total costs of potentially preventable readmissions statewide in 2011, the most recent year for which the requisite information was available, was over \$2.5 billion.¹

AVOIDABLE READMISSIONS IN MEDICARE

We next draw your attention to the Hospital Readmissions Reduction Program established under the Affordable Care Act that applies a penalty for hospitals that have an excess number of potentially

¹ NYS Department of Health, Bureau of Health Informatics, "Statistical Brief #3: New York State All Payer Potentially Preventable Readmission Rates 2009–2012" (Oct. 2014), pp. 3–4 and 6.

preventable readmissions for Medicare patients. The most recent penalty data from the Centers for Medicare and Medicaid Services, as analyzed by *Kaiser Health News*, reveals that:

- Roughly four out of five hospitals in New York have been assessed a penalty for fiscal year 2015 because of their high readmission rates, making New York (tied with Massachusetts) the fourth most penalized state in the nation for excessive readmissions.
- New York also ranks in the top 20 worst states (at No. 12) for the average penalty assessed on Medicare payments to its hospitals. While New York's average penalty of 0.73% for fiscal year 2015 is better than some other states with large urban areas, such as Illinois (0.78%), Massachusetts (0.78%), and New Jersey (0.82%)—it compares poorly with others, such as California (0.41%), Florida (0.58%), and Pennsylvania (0.63%).
- In 2013, 166 New York hospitals were penalized for excessive readmissions – that's 85% of all hospitals in the state. Among the top ten worst penalties in the first year of the program (fiscal year 2013), half of those hospitals remained in the top ten in fiscal year 2014 and fiscal year 2015, even though CMS had expanded the list of conditions for which high readmission rates would be penalized.²

AVOIDABLE READMISSIONS IN MEDICAID

Turning our attention to Medicaid, hospitals in New York also have a significant need to improve their readmission rate because Medicaid rates of payment to hospitals that have an excess number of potentially preventable readmissions are subject to reductions under a New York State readmission penalty program that began in state fiscal year 2010.³ In the nine month period from July 2010 through March 2011 (the most recent information publicly available), reductions in payments under New York State's Medicaid program to hospitals as penalties for potentially preventable readmissions totaled \$34.7 million, with penalties to individual hospitals ranging from zero to \$3.5 million.⁴

AARP New York believes that the analysis, data and the findings from these reports clearly demonstrates that readmission rates in New York's hospitals, regardless of the payer source, have significant room for improvement. We would like to recommend a few simple steps that can help address this significant

² See J. Rau, "Medicare Fines 2,610 Hospitals in Third Round of Readmission Penalties," *Kaiser Health News* (Oct. 2, 2014) (available at <http://kaiserhealthnews.org/news/medicare-readmissions-penalties-2015/>, accessed Jan. 12, 2015).

³ 10 NYCRR §86-1.37(d) and (e). The expected rate of potentially preventable readmissions is calculated as 33.3% of the hospital's 2007 Medicaid and managed care data for 2007 discharges (in other words, the year 2007 is used as the baseline for measuring improvement). Excess readmission rates are then calculated based on the difference between the actual observed and the expected rates of Potentially Preventable Readmissions for each hospital for the given year. Finally, a "hospital specific readmission adjustment factor" is computed as one minus the ratio of the hospital's relative aggregate payments associated with the excess readmissions and the hospitals relative aggregate payments for all non-behavioral health Medicaid discharges, and this factor is used to reduce the hospital's Medicaid payments for non-behavioral health-related Medicaid discharges. 10 NYCRR §86-1.37(d)(1), (d)(2), (d)(3), (e)(2) and (e)(3). The NYSDOH defines a "Potentially Preventable Readmission" as "a readmission to a hospital that follows a prior discharge from a hospital within 14 days and that is clinically related to the prior hospital admission." 10 NYCRR §86-1.37(b)(1). See also, NYS Department of Health, "Comments on the Office of the State Comptroller's Follow-Up Report 2012-F-11 on Medicaid Overpayments for Hospital Readmissions" (April 24, 2013) (available at <http://osc.state.ny.us/audits/90day/12f11r.pdf>, accessed Jan. 12, 2015).

⁴ NYSDOH, "Potentially Preventable Readmissions for the Period July 1, 2010 Through March 31, 2011 (Initial Model)" (undated) (document received through a Freedom of Information Request, Jan. 21, 2015).

problem, which we believe will help to further DSRIP's goal of achieving a 25 percent reduction in avoidable hospital use among the Medicaid population.

RECOMMENDATIONS

New York State should become a leader in establishing a strong statewide policy on the direct involvement of patients' family caregivers in discharge planning and instructing patients' family caregivers in post-discharge tasks. To that end, it is our recommendation that where applicable and to the fullest extent possible, all NY DSRIP approved plans and projects should include a three step process for general hospitals to follow:

1. All hospitals should be required to:
 - Establish effective discharge planning policies that include early identification of the patients' family caregiver as well as engaging such caregivers in discharge planning that includes timely notification of the date and time of discharge or transfer to another facility;
 - Include family caregiver contact information in the patient's medical record, coupled with prompt efforts to address any language translation needs that may arise during hospitalization;
 - Facilitate communication with family caregivers during hospitalization and with the patient's healthcare providers after discharge; and
 - Provide in-person instruction for both patients and their family caregivers in necessary post-discharge tasks.
2. Every hospital's written discharge policy should clearly emphasize the importance of identifying and consulting with the patient's caregiver(s) during the discharge process and providing direct instructions, including task demonstrations, to family caregivers in post-discharge care.
3. Every hospital in New York should post its discharge policy on its website, along with its discharge planning checklist, and should also provide the discharge planning checklist to the patient and those whom the patient identifies as his or her caregivers. This checklist should include questions about home care needs and family caregivers.

RATIONALE

Once a patient leaves the hospital, family caregivers become the front line of defense against avoidable and costly readmissions. While most family caregivers are asked to assist an individual with basic activities of daily living, such as mobility, eating, and dressing, many are now expected to routinely perform complex medical and nursing tasks such as administering multiple medications, providing wound care, and operating medical equipment.

In fact, at any given time, an estimated 4.1 million New Yorkers provide varying degrees of unpaid care to adults who have limitations in their daily activities. Based on 2009 data, the total value of the unpaid care provided to individuals in need of long-term services and supports amounts to an estimated \$32 billion every year.

Despite the vast importance of family caregivers in the individual's day-to-day care, many family caregivers find that they are often left out of discussions involving a patient's care while in the hospital and, upon the patient's discharge, receive little to no instruction on the tasks they are expected to perform. According to health care experts, caregiver training and engagement are vital to improving care transitions.

New York's Public Health Law does not reflect the current state of healthcare delivery, which has shorter hospital stays and a greater reliance on families and friends to provide home care. It fails to address the need to identify, engage, and train family caregivers in hospital discharge planning and implementation.

There are no current New York laws or regulations that require hospitals to offer a patient the opportunity to identify a family caregiver to be recorded in his or her medical record. This is especially troubling given the fact that the actual caregiver is often not the "next of kin," "health proxy," or the person who happens to be taking the patient home on the day of discharge.

In addition, there are no requirements for hospitals to consult directly with a patient's caregiver(s) in discharge planning. While some hospitals have participated in programs to improve their interaction with family caregivers, such programs have not been implemented widely and depend entirely on voluntary commitments that could change with management, staff turnover, and shifting institutional priorities.

Furthermore, nothing currently requires hospitals to instruct the family caregiver in post-discharge tasks. This is true even though a study by AARP's Public Policy Institute entitled *Home Alone: Family Caregivers Providing Complex Chronic Care* found that two thirds of caregivers who performed wound care tasks found it hard to do. Half of those who needed to operate mechanical equipment, such as ventilators, feeding tubes, or home dialysis equipment found it difficult, and nearly one fourth of family caregivers who managed patient medicine felt training would be helpful.

Thank you again for the opportunity to submit comments. Should you have any questions or need additional information, please contact David McNally, Manager of Government Relations and Advocacy, at (518) 434-4194.

Sincerely,

A handwritten signature in cursive script that reads "Beth Finkel". The signature is written in dark ink and is positioned above the printed name and title.

Beth Finkel
State Director, AARP New York



Testimony Submitted to the DSRIP Project Approval and Oversight Panel (PAOP)
Meeting on the Review of PPS Project Plan Application Scores as Presented by the
Independent Assessor
February 17, 2015

Members of the DSRIP Project Approval and Oversight Panel, thank you for the opportunity to testify on behalf of Amida Care. My name is Jason Lippman, and I am the Director of Public Policy and Government Relations. Amida Care is a New York City wide community-sponsored nonprofit Special Needs health Plan (SNP). Our mission-driven approach is based on working closely with each member and surrounding him or her with a community of committed providers – providers who direct their care, social workers, health navigators, behavioral health specialists and a designated medical home. We specialize in providing comprehensive medical, behavioral and psychosocial support services to people with multiple chronic conditions.

Amida Care plays an essential role in State Medicaid redesign and policy initiatives aimed at improving health outcomes and reducing avoidable hospital admissions that will derive further Medicaid cost savings. Through DSRIP planning grant

funding, we developed a set of community-based interventions to reform the delivery of services for people with chronic care needs, and have shared them with a variety of New York City-based PPSs, offering our technical assistance and support on implementation. Amida Care is also an active partner in Governor Cuomo's Task Force to End the AIDS Epidemic (EtE) in New York State by 2020, and its forthcoming plan. By providing improved access and retention in care to our members, Amida Care prevents avoidable hospitalizations and emergency room visits, which results in substantially lower Medicaid costs overall.

Amida Care's DSRIP planning efforts focused on improving the health care delivery system for the State's most acute, high-need, high-cost utilizers of Medicaid – people living with HIV/AIDS, severe mental illness and substance use disorders. In our final report which was submitted to the State and shared with New York City-based PPS leads, detailed justification is provided to implement the following initiatives: 1) peer health navigation services; 2) viral load suppression programs; 3) crisis bed diversion and hospital step-down transitional housing units; and 4) integrated care learning collaboratives. All of these proposals focus on ensuring access to a more proactive, integrated system of care that addresses the multi-faceted health and social service needs of Medicaid beneficiaries, many of whom face significant health disparities and socioeconomic factors such as housing instability.

Peer Health Navigation Recommendation

With a focus on system transformation (Domain 2) we recommend the development of health navigation services that would simultaneously contribute to DSRIP goals, but would also empower people living with HIV/AIDS, severe mental

illnesses (SMI) and substance use disorders (SUD). The recommendation calls for an education, certification or credentialing and employment program for peers to provide health navigation services. This recommendation surpasses the traditional boundaries of peer-based programs, as the end goal is to create a uniform pathway for individuals to utilize their lived experience and enter the workforce as full-time employees. While traditional peer-based programs employ peer workers as stipend support staff, peer health navigators will receive a living wage and benefits and be integral member of the care coordination team. Additionally, by providing enhanced peer supports within the context of DSRIP system integration and disease-specific projects, peer services will address the social barriers to chronic disease management, improve care coordination across systems, and increase access to culturally and linguistically appropriate supports for improved disease self-management. This project will decrease avoidable hospitalizations and the use of inappropriate detox and rehabilitation services by improving access to community-based medical and behavioral services.

Integrated Care Learning Collaboratives Recommendation

Amida Care would like to emphasize the importance of advancing integrated mental health, substance use and primary care service delivery by strengthening community-based delivery models. We are deeply concerned that small to medium sized community-based providers that serve niche, high-need populations and are vital partners to the successful implementation of DSRIP, often face significant challenges integrating services and remaining financially viable. We have developed

two models of Learning Collaboratives to promote care integration and build capacity of community-based agencies:

1. **Model A Collaborative** emphasizes the development of robust collaborative service agreements and possible mergers among small organizations serving consumers with SMI, SUD and physical health needs.
2. **Model B Collaborative** is intended for agencies within a PPS holding at least two NYS licenses (DOH, OASAS and OMH), but are not currently operating as a fully integrated provider of behavioral health and primary care services.

Both Collaboratives, with support of the PPS leads, will assess agency capacity and needs. The Model A Collaborative will then facilitate partnerships and possible mergers between behavioral health organizations and primary care practices. The Model B Collaborative will facilitate re-engineering and redesigning of the agency's delivery model, including acquiring additional licenses, adopting advance EMR systems and technical assistance to assist with transforming their practice into a single-access point provider. Both models will allow participating agencies to grow their operations and strengthen their revenue streams so they can better serve their patients and achieve DSRIP goals.

Crisis Bed Diversion and Hospital Step-Down

Preventing avoidable hospital admissions and emergency room visits throughout NYS there will require integrated, community-based transitional housing and social supports for individuals who experience reoccurring behavioral health crises. With the same intent as NYC's innovative Parachute NYC program, we propose short-term, crisis diversion housing units offering stabilization services and strong linkages to community-based services and medical homes. Research has shown such

models to be effective in improving health outcomes while costing significantly less than hospital-based services. In addition, we propose the creation of hospital step-down units to help break the cycle of recurring admissions, by easing the transition process for individuals who are medically cleared for discharge but lack the proper medical and behavioral health supports for a full return to the community.

Developing short-term crisis and hospital step-down units will not only provide for more appropriate care, but help to prevent future crisis episodes that result in repeated, high use of the emergency department and avoidable hospital admissions if no interventions are executed.

HIV/AIDS Projects

Lastly, Amida Care applauds PPSs throughout the State for choosing HIV/AIDS-related population health projects. These initiatives will prove instrumental to jointly achieving Governor Cuomo's *Ending the Epidemic* and DSRIP goals. Amida Care strongly urges all PPSs and the Project Approval and Oversight Panel to commit the maximum support and available financial resources to Domain 4 HIV/AIDS projects. Specifically, we advocate for the expansion of viral load suppression initiatives based on *The Undetectables* program at Housing Works. Integrated with the peer health navigator recommendation, together these two initiatives have the critical potential to make a significant impact in reduction HIV/AIDS incidence and morbidity. Research shows that intensive ARV adherence supports have been associated with significant decreases in hospital days and found to be cost saving when adherence program costs were compared to savings in health care utilization. Preliminary results at 9 months (including a peer-based

component) indicate a statistically significant increase pre- to post-enrollment in the proportion of participants virally suppressed at all points in time. Thus, this initiative has real potential to assist the State in achieving DSRIP and *Ending the Epidemic* goals.

Conclusion

On behalf of Amida Care, I thank you for the opportunity to testify to PAOP. We will continue to support the implementation of projects and maintain active participation on the State's efforts to End the Epidemic and reform the healthcare system. Again, Amida Care strongly urges the Panel and all PPSs to implement proactive projects that strengthen community-based providers. prioritize HIV/AIDS interventions including viral load suppression and peer workforce development, and creates a collaborative system that empowers individuals with severe behavioral health conditions to maintain housing stability and avoid preventable behavioral health crises. We are available to inform and answer any questions that you may have.

Respectfully submitted,

Jason Lippman
Director of Public Policy and Government Relations
Amida Care
14 Penn Plaza, 2nd Floor
New York, NY 10122
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HOSPICE AND PALLIATIVE CARE ASSOCIATION OF NYS

DSRIP Project Approval and Oversight Panel

Tuesday, February 17, 2015

Public Comments

Triple Aim – Hospice and palliative care embody the Triple Aim—patient-centered, quality, cost-effective care. Using an interdisciplinary model, Hospice and palliative care provide case management and quality patient centered care—they are the perfect partners to help advance the DSRIP’s objectives, and they bring great value to the Performing Provider Systems (PPS’s).

Partnerships – Though very few PPS’s chose palliative care projects, all will need robust palliative care and hospice partnerships to realize their goals. These partnerships are the keystone of success. In order to assure that hospice and palliative care providers are true partners—and not just "in name only"—it is imperative that programs providing these services are not marginalized. These programs, some of which are designated as Vital Access Providers (VAP), should not be excluded from project funds. Hospice and palliative care providers will need greater access to capital funds to expand technical capacity and assure clinical capacity and sustainability.

Determining How PPS’s Will Be Paid – Of major concern is the fact PPS’s have a relatively short period in which to determine how providers will be paid for their contributions in achieving the DSRIP’s goals. We’re concerned that not enough training and guidance has been provided to determine how community organizations should value their services. If done incorrectly, this could adversely affect long-term sustainability.

- We urge that there be transparency in how funds will be distributed. Who will make final decisions?
- This issue is especially concerning since the low metrics assigned to the palliative care projects could negatively impact access to adequate funding.

Transitions of Care – Appropriate and seamless transitions of care are a key component to the success of the PPS’s. We are greatly concerned that the “transitions of care” project, like the federal Community Care Transitions Project, does not recognize the key role of palliative care in helping people with chronic illness avoid unnecessary readmission to the hospital.

Managed Care and DSRIP – Crucial to the success of DSRIP is the relationship between managed care and Hospice and palliative care. “The devil is in the details,” and it is strategically imperative that assuring seamless access to hospice and palliative care within the managed care environment be made a priority. HPCANYS offers its support through its Innovations/Managed Care Task Force and a new Hospice/Palliative Care/Managed Care Collaborative to be launched this spring.

Best Practices – I urge you to consider the PPS’s use of hospice and palliative care as a best practice:

- Setting aside dollars for hospice to integrate their electronic health record with the regional data sharing systems needs to be implemented across all PPS’s
- All PPS’s should be encouraged to use their local hospice and palliative care providers as a resource.

New York State’s Low Hospice Utilization – Hospice utilization in New York is abysmally low. Nationally, hospice utilization is 44.4%; in New York State it is 28.7%, and in some counties (Oneida) as low as 16.3%. Median length of stay (LOS) is 24 days nationally and 18 days in NYS, based on 2012 Medicare data. According to National Government Services 2014 statistics, median LOS in New York is closer to 11 or 12 days. Making a concerted effort to increase hospice utilization and length of stay will likewise contribute to the success of the PPS’s.

Data – Although there is a body of research on the savings to Medicare that come from palliative care and hospice, we have little information on how this translates into the value those programs provided to the Medicaid population. Medicare data could be used to extrapolate projected Medicaid savings, and HPCANYS offers its resources and expertise to assist with such a project.

Contact Information:

Kathy A. McMahon
President and CEO
Hospice and Palliative Care Association of NYS
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New York Public Welfare Association

NYPWA Commentary on Delivery System Reform Incentive Payment Program (DSRIP)

February 24, 2015

Introduction

Local Departments of Social Services are essential to the success of DSRIP. In some areas, the planning process has been inclusive, and social services administrators have been engaged in the dialogue and have put forth recommendations. But overall, social services departments are not well represented across the state on the vital governing groups which ultimately determine the priorities.

These departments are the missing link in understanding and addressing the social determinants of health. They have the expertise on the vast and various reasons people use the Emergency Room for care, and they have experts who can help guide the community on more effective ways of managing the population. Social services commissioners understand how the lack of safe, affordable housing, despite all the care coordination efforts, negatively impacts the access individuals have to health care and by extension, their health outcomes.

If DSRIP succeeds, it will have a tremendous positive impact on the vulnerable people who are served by local departments of social services. In order for that success to occur, it is important to learn from what local social services commissioners have to say. Toward that end, we are distributing remarks presented by John E. Imhof, PhD, DSS Commissioner, Nassau County, 3rd Vice President, New York Public Welfare Association, on February 17, 2015, to the DSRIP Project Approval and Oversight Panel (PAOP).

The New York Public Welfare Association represents all fifty-eight local departments of social services statewide. Our members are dedicated to improving the quality and effectiveness of social welfare policy so that it is accountable to taxpayers and protective of vulnerable people.

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Testimony of the
New York Public Welfare Association
to the
DSRIP Project Approval and Oversight Panel (PAOP)

Tuesday, February 17, 2015

Albany, New York

Presented by

John E. Imhof, PhD

DSS Commissioner, Nassau County

3rd Vice President

Board of Directors

New York Public Welfare Association

New York Public Welfare Association

Sheila Harrigan

Executive Director

Michael A. Fitzgerald

DSS Commissioner, Madison County

President, Board of Directors

My name is John Imhof. I'm the Commissioner of Social Services for Nassau County, and a member of the Board of Directors of the New York Public Welfare Association (NYPWA).

We appreciate you having made the opportunity possible in order to present a wide variety of views, opinions and recommendations regarding the evolution and current status of DSRIP in New York.

In particular, I'm here to express a concern that all DSRIP providers, essentially hospitals and related health care organizations have not sufficiently recognized the essential role that Department of Social Service can and must have in the development and implementation of DSRIP projects.

In the recent DOH presentation to the New York Public Welfare Association conference on January 28, 2015, it was noted that one of the five major DSRIP Program Principles is Collaboration, as "collaborative process reflects the needs of the communities and inputs of stakeholders."

It was further noted that the essential partners of the local DSRIP processes should include "Hospitals, Health Homes, Skilled Nursing Facilities, Clinics and FQHC's, Behavioral Health Providers, Home Care Agencies and 'Other Key Stakeholders.'"

The exclusion of Departments of Social Services as key partners in the DSRIP process is indeed a major concern, as it would appear that little if any original consideration was ever given to the essential and vital role that Departments of Social Services can play in the development and ultimate success of DSRIP projects and processes.

Specifically, if the DSRIP process is intended to ultimately reduce under-30 day Emergency Department and hospital re-admissions, and the vast majority of DSRIP-targeted patients statewide are Medicaid and/or Medicaid eligible, then it is the 58 New York State social service departments that have the on-going and interaction experience with this population to play vital roles in achieving the DSRIP objectives.

Specifically:

- Local social service departments include and provide a wide range of services to those Medicaid and Medicaid-eligible populations having the highest utilization of hospital care.
- Local social service districts should be key partners in DSRIP planning in order to achieve the stated outcomes for individuals at-risk.

- Social services department are the major conduits to post-discharge housing assistance and food security, which are indeed critical factors in reducing time in reducing readmissions to hospital ED's.
- Beyond housing and insuring food security, DSS provides a wide range of programs essential for vulnerable adults to manage themselves outside of the hospital system, including but not limited to domestic violence, guardianship and child and adult protective services.
- Social services expertise is valuable to guide PPS implementation plans and to ensure that the goals of system transformation, clinical improvement and enhanced health care are achieved.

Finally, we urge not only the inclusion but programmatic and financial support of the DSRIP projects and NYS DOH and OTDA in working with social service departments to establish what we refer to as the "Medical Shelter" concept, a post-discharge shelter for homeless individuals that would provide basic health-related services which in our judgment can forestall if not avert the necessity of return visits to the Emergency Departments or the need for turn-around hospital re-admissions. Furthermore, the "Medical Shelter" can begin to collaborate with and when necessary refer shelter residents to the rapidly expanding urgent care centers as resources for interim health-related events that would otherwise historically have resulted in re-visits to emergency departments.

Shelters will not accept homeless individuals with attendant medical issues, and often a motel placement is the only discharge option for a hospital. Furthermore, a hospital's inability to appropriately discharge homeless Medicaid patients with attendant medical issues will cause hospitals to incur financial penalties, which will only negate any potential cost savings or financial incentives intended through DSRIP.

Departments of Social Services are much more than organizations that simply process Medicaid and SNAP applications. Our departments are on the front lines of assisting the most vulnerable and neediest of our citizens and can play a vital role in working with DSRIP project applicants state-wide to reduce early emergency department and hospital re-admissions.

Thank you for your consideration.

Testimony of James Morgan, RN
Before the:
Department of Health
DSRIP Project Approval and Oversight Panel

February 17, 2015

My name is James Morgan and I am a registered nurse at Syosset Hospital. I am a member of the New York State Nurses Association. My field is behavioral health and my experience with Medicaid patients is considerable. Prior to being a nurse, I served as a firefighter in the Bronx.

Thank you for the opportunity to testify. My comments are directed at the **Nassau Queens PPS**.

It is unclear how the organizational structure of this PPS will play out. There are multiple partners, including North Shore/LIJ.

Flags have been raised about North Shore's participation in DSRIP in any fashion, given its status as a non-safety net entity and its aggressive posture in achieving revenue. Strategic investments, seeking competitive advantage and new payment models would seem to be at odds with the DSRIP's stated goals of enhanced care for Medicaid and uninsured patients.

The PPS is seeking exemptions or waivers on a range of practices, some related to restrictions on referrals and revenue sharing, others on licensing and co-locations for mental health and substance abuse services. These should be examined.

Waivers from Certificate of Need regulations are also of concern, as public review of and comment about matters that ought to emanate from Community Needs Assessments should not be sidestepped. These reviews are consistent with the protection of medically under-served communities, a goal of DSRIP.

The PPS also foresees an enhanced role for non-clinical personnel, raising questions about conflicts with RNs and their professional practices.

Thank you.

Testimony of Joan Rowley, RN
Before the:
Department of Health
DSRIP Project Approval and Oversight Panel

February 17, 2015

I am Joan Rowley and I am a registered nurse and a member of the New York State Nurses Association. Please accept my testimony today regarding **Staten Island PPS**.

My fellow nurses and I want to participate in the DSRIP process, to meet its stated goals and bring these critical funds to Staten Island in an effective way. Access to quality care for Medicaid and uninsured patients is a very high priority for nurses.

Staten Island University Hospital is part of the North Shore – LIJ Health System. Richmond University Medical Center has ties to Mount Sinai Health System. Joining these larger systems may not be consistent with meeting the needs of the community on Staten Island. In particular, concerns have been raised about putting the corporate needs of North Shore – LIJ before our communities.

Another concern raised by this application is its vagueness as to how nurses will be deployed. Whether in new positions with new titles, or in expanded primary care or ambulatory detox sites, RN roles are not articulated. Limiting the professional care RNs provide serves neither patients nor the community.

I want to raise my special concerns in behalf of behavioral health nurses. I am a board member of Staten Island's National Alliance of Mental Health. The Staten Island PPS has not allowed sufficient inclusion of behavioral health professionals, patients and families. The PPS has not heard voices instrumental to this important sector of healthcare.

I can only hope, in hearing this testimony, that new efforts will be undertaken by the PPS so that we are not left out of the process.

Thank you.



Comments to the DSRIP Project Approval and Oversight Panel

Thank you for the opportunity to address you today. My name is Alissa Wassung and I am the Director of Policy & Planning at God's Love We Deliver. God's Love is New York City's leading not-for-profit provider of medically-tailored meals and nutritional counseling for people living with life-threatening illnesses. We are dedicated to cooking – and delivering – the specific, nutritious meals a client's severe illness and treatment so urgently require. We employ 6 Registered Dietitians who tailor each meal to the unique dietary needs, medication interaction and nutrient requirements of our clients. Last year, we delivered over 1.3 million meals to 6,000 individuals in NYC.

For those we serve, food is medicine. Food and nutrition services, or FNS, promote positive health outcomes, save precious health care dollars by facilitating access, maintenance and adherence to care, and keep people in their homes and out of more expensive institutions. We already partner with 34 Medicaid managed long term care (MLTC) plans in NYC to deliver meals to beneficiaries with multiple co-morbidities, activities of daily living (ADL) limitations, and risk factors for possible institutionalization or re-hospitalization. Because of our success with this program, we know that access to FNS is critical to accomplishing the 25% reduction in hospitalization that is the goal of DSRIP.

FOOD IS MEDICINE

The concept of 'food is medicine' has a long history, as illustrated by the Haitian proverb, popularized by Paul Farmer, "Giving drugs without food is like washing your hands and drying them with dirtⁱ." While adequate food and nutrition are essential to maintaining health for all persons, good nutrition is crucial for the management of chronic illness. Proper nutrition is needed to increase absorption of medications, reduce side effects, and maintain healthy body weight. Good nutrition reduces the risk of or helps manage some of the most costly chronic diseases to treat: heart disease, diabetes, hypertension, COPD, HIV/AIDS and, in most cases, cancer. Food and nutrition service providers support clients throughout the trajectory of their illness from diagnosis through treatment and maintenance.

A growing body of rigorous research demonstrates that FNS are good policy along the continuum of care from prevention to treatment, even in healthcare rich environments. For example, for a year following initiation of medically-tailored meals, healthcare costs were \$12,000 less per month on average for clients on a food and nutrition program, compared to a matched sample of those not receiving servicesⁱⁱ. If hospitalized, nourished clients' costs were 30% lower and their hospital length of stay was cut 37%. In the reverse, malnourished clients were almost twice as likely to be readmitted to the hospital within 15 daysⁱⁱⁱ.

The healthcare system saves precious dollars when individuals are discharged to their homes and supported there. 93% of nourished clients who were hospitalized were discharged to their home rather than to long-term care or health care facilities (only 28% of the comparison group was discharged to home)^{iv}. A study in *Health Affairs* demonstrated that a small increase in the number of people who received home-delivered meals nationwide would have saved Medicaid programs over \$109M in nursing home costs^v.

Finally, food and nutrition services are a low cost, high impact intervention. You can feed someone a medically tailored diet for half a year by avoiding just one night of hospitalization, and once on program, impact on health markers is seen in weeks not months.

FNS ARE ESSENTIAL TO ACCOMPLISHING KEY DSRIP GOALS

Medically tailored home-delivered meals are key to creating and sustaining the integrated, high performing health care delivery system required by DSRIP. Medically tailored home-delivered meals form a medical support system for many of the programs on the DSRIP Project Menu, from care transition models designed to reduce hospital readmission, to medication adherence programs, to disease management for high risk, high need populations.

We have been part of the planning process for DSRIP from the beginning, and all of the NYC-based PPS have included us as a partner for their design grants. During this time many PPS, like Advocate Community Providers, Bronx Lebanon, and New York Presbyterian, have been educated on the benefits of including FNS in their DSRIP structure.

There is a reimbursement mechanism in Medicaid for high-risk populations in MLTC plans, but incorporating this benefit for beneficiaries in mainstream Medicaid, essentially catching high-risk beneficiaries before they fall off the treatment cliff, is more difficult. We urge the state to provide clarity to PPS on the importance of integrating medically tailored home-delivered meal supports with other healthcare services, such as mental health, home health, and hospital discharge, within the DSRIP model to help the state achieve maximum cost-savings and positive health outcomes.

Thank you for your time and consideration.

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ⁱ Kidder T. Mountains Beyond Mountains: The Quest of Dr. Paul Farmer, A Man Who Would Cure the World. New York: Random House, Inc. 2003.

ⁱⁱ Gurvey J, Rand K, Daugherty S, Dinger C, Schmeling J, Lavery N. Examining Health Care Costs Among MANNA Clients and a Comparison Group. OMG Center for Collaborative Learning, Philadelphia, PA, USA. J Prim Care CoMMCunity Health. 2013 Jun 3. [Epub ahead of print].

ⁱⁱⁱ Su Lin Lim, Kian Chung Benjamin Ong, Yiong Huak Chan, Wai Chiong Loke.

Maree Ferguson, Lynne Daniels. Malnutrition and its impact on cost of hospitalization, length of stay, readmission and 3-year mortality. Clinical Nutrition 31 (2012) 345-350. 348

^{iv} J Prim Care Community Health. 5

^v Thomas KS, Mor V. "Providing More Home-Delivered Meals Is One Way To Keep Older Adults With Low Care Needs Out Of Nursing Homes." Health Affairs 32, No. 10, October 2013

Testimony of Julie Semente, RN

Before the:

Department of Health

DSRIP Project Approval and Oversight Panel

February 17, 2015

My name is Julie Semente and I am a registered nurse and member of the New York State Nurses Association. I have worked as a nurse in Brooklyn for more than 30 years. My testimony today is about **Community of Care PPS**.

We all want to work with DSRIP to improve care for patients and to make the most of this important funding source.

There are a number of objections that we have, and have outlined in our submissions, regarding this PPS. For one, we would point to a recent announcement of an affiliation process between Maimonides and North Shore/LIJ. That latter is a non-safety net provider engaged in an extensive campaign of expansion. How exactly would these increased revenues be divided? Their uses may well be antithetical to the stated goals of DSRIP.

But I want to take this opportunity before you today to focus on another dimension of this PPS application, for its implications to the nursing profession, to evidence-based standards, to professional disease management and better patient outcomes.

I am talking about scope of practice by law. This has a basis in both the ethics of my profession and in the laws of the State of New York. In the details of this PPS there appear to be a very real prospect of a shift of care away from those with licensure to others whose skills and experience are not those of registered nurse.

We, registered nurses, bring a range of professional skills and knowledge to our work as patient advocates. Assessment is part of what registered nurses do.

This application estimates a decrease in existing personnel of approximately 500, to be accompanied by a substantial amount of retraining. Does this serve the healthcare needs of patients and their communities?

At the same time, the application indicates that there will be about 1,500 new positions required to implement DSRIP. What is unclear is how many of these new positions will require licensed registered nurses.

Taken together, these shifts in personnel and the lack of clarity surrounding these proposals in the PPS can only raise suspicions that our nurses' scope of practice is the target.

This would undercut the legitimacy of DSRIP in the context of the Community of Care PPS and threaten harm to patients.

Thank you for your attention.



One strong, united voice for nurses and patients

Testimony of Cecilia Jordan, RN

Before the:

Department of Health

DSRIP Project Approval and Oversight Panel

Thank you for the opportunity to testify today regarding the **New York City Health and Hospitals Performing Provider System.**

My name is Cecilia Jordan and I am a registered nurse and director of the Health and Hospitals Corporation division of the New York State Nurses Association. NYSNA represents 8,000 RNs in the public hospitals in New York City... We are the largest public hospital system in the country.

We support DSRIP and its stated goals and very much want to work with you to make sure that communities in need receive this critical funding.

Our public hospitals care for one in six New York City residents.. more than one million patients. Our doors are open to anyone in need of care—no matter their condition, no matter their immigration status, no matter their ability to pay.

No matter.

DSRIP is so important to funding the communities we serve, as Medicaid is the foundation of funding for this patient population. Across the board, in all the units of all the public hospitals, Medicaid recipients receive the care essential to their health. On this basis, we believe that our PPS deserves substantial DSRIP funding.

One concern we have is that the diffusion of DSRIP funding through the use of a very wide and liberal interpretation of qualified "safety net" providers allows funds to be diverted to entities that neither merit nor need the DSRIP subsidy.

Another concern is that a PPS system that includes non-public entities might end up shifting patient care to private or for-profit providers and raise questions about meeting legal obligations of HHC.

The requests for waiver of CON are problematic as public review of Community Needs Assessment should not be shortchanged.

We are also concerned that changes in patient discharges and transfers based on payer source status might lead to abuse.

Finally, we urge that any effort to interfere with nurses' scope of practice undercuts our professionalism at the expense of patient care, and falls outside the law.

Thank you.

Testimony of Anthony Ciampa, RN

Before the:

Department of Health

DSRIP Project Approval and Oversight Panel

Thank you for the opportunity to testify today regarding the **New York and Presbyterian Hospital PPS**.

My name is Anthony Ciampa and I am a registered nurse at New York Presbyterian Hospital; I am also a member of the board of the New York State Nurses Association, representing 37,000 RNs statewide.

We very much want to play a meaningful role in the DSRIP process and share the goals of improved quality care for Medicaid patients, improving actual health outcomes and lowering costs of care per patient by reducing unnecessary hospital usage.

As with all applications, we urge that the community be brought to the table and all decisions be carried out with careful attention to needs. In this way, DSRIP fulfill its mission. NYSNA very much shares this mission of utilizing these Medicaid funds to address real community need and wants an active role in DSRIP. That's why we're here today.

I would also urge, as a NYSNA board member and on behalf of those who could not attend today, that these public hearings be expanded and dates set in New York City for additional time. Too much is riding on this critical funding effort, in the billions of dollars of public money, to limit public comment to a single day in Albany.

Regarding this PPS, I would draw your attention to the exemptions and waivers being sought from six regulatory requirements. Requests surround issues of payment methodologies, such as multiple billings; the application also seeks an expansion of primary and behavioral care without additional licensing and the creation of "crisis utilization beds". The exemptions and waivers should be closely examined.

Thank you very much.

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Testimony of Vickie Decker, RN
Before the:
Department of Health
DSRIP Project Approval and Oversight Panel

February 17, 2015

My name is Victoria Decker and I am a registered nurse at Bellevue Woman's Hospital in Schenectady. I have been a nurse for 37 years.

I am here today to testify about the **iHANYs Performing Provider System**.

Our communities have many people living in poverty. I see many patients who do not have money for medications. Some women do not receive regular pre-natal care.

We very much welcome DSRIP and hope, with your attention and input from our communities, we can work together for more access to healthcare and better outcomes. We want to be a part of this important effort to provide additional resources for Medicaid and uninsured patients.

The makeup of this PPS presents some potential problems.

St. Peter's Health Partners is not the lead entity in the PPS. However, it is the largest of seven key partners. It was formed recently – in 2011 – through a merger of several healthcare entities. Neither St. Peter's nor a merged company, Seton Health, initially met DSRIP standards for safety net provider. In other words, in our view neither of these healthcare entities has shown initiative in addressing the needs of Medicaid patients.

We are also concerned about maintaining professional nursing standards at this PPS. New positions, whose descriptions are vague, may conflict with scope of practice laws in New York, undercutting RN practices and standards. Patients are not served by these changes.

Finally, the composition of Community Based Organizations is not fully known. It is unclear in the PPS application to what extent the extent to which Community Based Organizations are represented on various committees or whether labor organizations participate on any committees other than the Workforce Development Committee. But the involvement of community organizations and labor unions are key to DSRIP meeting its stated goals: to improve the quality of care for Medicaid patients, improve outcomes and indicators of New York communities and their residents, and to reduce costs of care per patient by reducing unnecessary hospital usage.

We can only achieve these goals by working together.

Thank you.

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Testimony of Benjamin Stanford, RN
Before the:
Department of Health
DSRIP Project Approval and Oversight Panel

February 17, 2015

My name is Benjamin Stanford and I am a registered nurse at Erie County Medical Center, in Buffalo. Thank you for the opportunity to speak today. I am directing my remarks at the **Erie County Medical Center PPS**.

Our Medical Center is THE public hospital for all of Western New York. I am proud of the work we do; we meet considerable challenges and support a population with high levels of poverty. This is precisely the setting that merits DSRIP support.

We want to work closely with DSRIP to access these new funds and provide more for our Medicaid and uninsured patients.

A high percentage of our patients are Medicaid eligible. DSRIP represents a way to better serve these New Yorkers.

Local community organizations are key to an effective DSRIP and we acknowledge this essential element to fair and effective DSRIP funding.

Waivers and exemptions sought by this PPS should be examined closely. Specifically, the applicant requests that a waiver be granted that will allow relocation or closing of beds and facilities with notification limited to the Department of Health. We disagree with this limitation.

The application also seeks an exemption from Certificate of Need approval process for construction of new facilities. Why put aside the oversight that the CON process provides? Public review and comment regarding location and scope of services serve the interests of the community, in this case, a population with substantial numbers of Medicaid recipients. These are precisely the people DSRIP is directed to consider and allocate funds for patient care.

Another issue for consideration: Regulations that prohibit discharges and transfers based upon patients' payer source status – such as Medicaid or uninsured patients – invites abuse. Different levels of care may result. Yet the PPS seeks an exemption from these rules.

No healthcare institution in Western New York is more important to Medicaid patients and the uninsured than Erie County Medical Center.

Your scrutiny of this PPS, and attention to voices in the community, will support this critical healthcare resource, DSRIP funding.

Thank you.

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Testimony of Mary Thompson, RN
Before the
Department of Health
DSRIP Project Approval and Oversight Panel
February 17, 2015

My name is Mary Thompson and I am a registered nurse at St. Elizabeth's Medical Center in Utica. I am a member of the New York State Nurses Association. My testimony is directed at the **Mohawk Valley PPS**.

Our communities have many people living in poverty. I regularly see patients who are Medicaid dependent and still cannot afford all of their necessary medications. They tell me stories of having to make the hard decisions of buying medications or having to pay their rent. This is just heartbreaking. And it's bad healthcare. I have even seen patients whose failure to take their meds results in heart attacks or other serious conditions – resulting in unnecessary hospital admissions.

Thus we very much welcome DSRIP and hope, with your attention and input from our communities, we can work together for more access to healthcare and better outcomes. We want to be a part of this important effort to provide additional resources for Medicaid and uninsured patients.

We very much want to be part of DSRIP, for the good of our patients and communities.

However, the lack of detail in this PPS makes it very difficult to assess. Seven of the 14 hospitals in the service area are PPS partners, but they are not identified. Project descriptions are vague.

More resources can be an excellent opportunity. But if they are not steered in the

right directions, it can be money wasted.

The PPS failed to conduct a thorough or realistic analysis of the impact on employees who are to be redeployed or retrained, other than to offer an estimate that 55% of the workforce will need to be retrained.

A fair amount of additional information, detail and focus is required to bring this application to completion.

Thank you.

February 17, 2015

Testimony

Department of Health

DSRIP Project Approval and Oversight Panel

Judy Sheridan-Gonzalez, RN

President, New York State Nurses Association

I am here on behalf of the 37,000 registered nurses who make up the membership of the New York State Nurses Association – “NYSNA”.

My name is Judy Sheridan Gonzalez; I am a registered nurse who has worked in the Emergency Department at Montefiore Hospital in the Bronx for more than 30 years; I am also president of the board of NYSNA and I am testifying today in behalf of our members throughout the state and the communities whose patients we care for.

NYSNA supports these goals of DSRIP: Quality care for Medicaid patients, better health outcomes, reduction of unnecessary hospital usage.... We want to work on these goals; we want to be integral to this process—planning, participating and integrating in close collaboration with community leaders and groups at every stage... for real improvements for our patients.

Inequality is the most compelling issue of our time. On that short list of terrible wrongs-- healthcare disparities stand out.

Ending healthcare disparities is NYSNA's top priority.

I regret that so little time has been committed to public comment on DSRIP, a major commitment of billions of dollars of public money in an area of such critical concern and need: meeting the healthcare needs of New Yorkers.

So many New Yorkers are affected by DSRIP, with high stakes in the outcome. Are they truly a part of this process? Have we done the best job involving the community? If this were true there would be more than a scant few minutes devoted to each application.

Why not open up this discussion? Schedule several more days in New York City, where more can attend, and enhance this critical public discussion?

Why so little outreach to the public over the last weeks and months, so little explanation and engagement? Transparency, public review and input, as put forward by CMS and New York State, were promised. I do not believe that promise has been kept.

I would ask in behalf of NYSNA, our patients and the many public health advocates with whom we interact: more public comment is imperative.

A complete list of flaws in many of the applications is too long to share, given my time today. NYSNA's submission to you details these flaws. But here are some key issues:

- Posted applications fall far short in clarity and crucial details. There are few details on elimination of services and similarly little or no information about new or expanded services.
- What about specific partner organizations? The quality of care they provide or track records?
- The inclusion of front-line RNs and other workers, community groups, patient advocates and other key stakeholders in the Project Advisory Agreements is uneven, at best. Excluding workers from decision-making bodies flies in the face of DSRIP's fundamental organizing principles.
- Community Needs Assessments, the underpinnings of allocation, vary widely in quality and depth. It appears that many of the Assessments were developed with little or no community input.
- If these Assessments are incomplete or skewed, what about plans drawn from them? For example, data on "excess" capacity in hospitals predates the ACA. We now know that demand has increased because many Americans forewent healthcare in past years because of costs or insurance barriers, and are now showing up at hospitals, **particularly in Emergency Rooms, like the one I work in.** Their acuties are high, too. This is a reality of healthcare in our state that is not reflected in DSRIP applications.
- Capital funding for new technology, infrastructure that DSRIP favors, is not part of this process, but a subsequent one.
- Patient privacy issues in the context of new technologies are not addressed.
- Waivers for Certificate of Need, billing and other healthcare regulations raise additional concerns.

- Anti-trust issues and Certificate of Public Advantage processes need to be considered.
- Some applicants are seeking DSRIP funding as an opportunity to expand business when, ironically, these same applicants have sought to minimize care for Medicaid patients and the uninsured. Why are they even under consideration? Aren't you concerned that these actions support a "two-tier" healthcare system, where poor and working-class patients are relegated to underfunded, resource-strapped facilities? Doesn't that contradict DSRIP's basic goal?
- For that matter, why are health systems that are **NOT** safety net providers qualified for DSRIP at all?
- Finally, PPS contracting may allow perpetrators of fraud, waste and extraction of exorbitant profits by non-safety net providers and for-profit entities to access DSRIP.

NYSNA is vigilant in the protection of our patients. We are prepared with other patient advocates, public health experts, other unions and community organizations to re-orient DSRIP away from those seeking to profit from it.

A single payer system is very much on the agenda of many in our state- patients, legislators, city officials, unions, including NYSNA, consumer groups and public health experts. Its results are evidence-based, and in many countries single payer systems are achieving better healthcare outcomes, while demonstrating cost efficiency at the same time. This is consistent with the stated goals of DSRIP and should be high on this body's agenda.

Access to high quality care is grounded upon two principles:

What is **clinically appropriate** and what is **evidence-based**.

We are here, as nurses, to make certain that both of these principles are at work in the DSRIP process, to assure that all decisions have an empirical basis and that funds reach real need. It is well within our combined abilities – organizational and political – to make DSRIP work.

To that end, nurses will monitor this process closely and intervene when necessary.

It would appear that that necessity is upon us.

[END]

Testimony of Ethel Mathis, RN
Before the
Department of Health
DSRIP Project Approval and Oversight Panel
February 17, 2015

My name is Ethel Mathis and I am a registered nurse at St. Elizabeth's Medical Center in Utica. I am a member of the New York State Nurses Association. My testimony is directed at the **Central NY PPS**.

I began working as an RN at Saint Elizabeth Medical Center in 2005. However, prior to my position as an RN, my career has always been in Human Services. I was a Case Planner for at risk children and families, Youth Program Coordinator, Deputy Director of a Substance Abuse Program at a correctional facility and a Program Director/Executive Director for homeless and runaway teens ages 16-21.

I mention this because I have a great deal of experience working with at risk populations, often dependent on Medicaid. The majority of our patients are dependent on a form of government assistance, either Medicaid or Medicare.

Recently St. Elizabeth Medical Center acquired property in the town of New Hartford and moved a number of outpatient services there, such as X-rays, and outpatient lab work. However, following the expansion, access these services at main hospital of St. Elizabeth's – where they had traditionally been available – became more difficult for inner city patients to access. This is our Medicaid population. They were then required to seek those services in New Hartford, where many of them were unable to travel to, without cars or access to transportation. Thus the "expansion" resulted in a reduction of services and access to care for the Medicaid population.

This kind of “expansion” is emblematic of the proposals in the application.

The community needs assessment that was conducted for this application shows two prominent issues in Central New York: access to care and a shortage of providers, especially primary care providers. However, I feel that reducing patients' access to hospital based care to expand community based care can have dangerous implications based on what I have seen in my own facility. That is why it is imperative that as this program moves forward that the Central New York Care Collaborative remember that in its own assessment of the region it noted the provider shortage, lack of access, and the importance of the continued role of registered nurses in providing care to those that need it.

Thank you.

Testimony of Mike Pattison, RN
Before the
Department of Health
DSRIP Project Approval and Oversight Panel
February 17, 2015

My name is Mike Pattison and I am a registered nurse at St. Elizabeth's Medical Center in Utica. I am a member of the New York State Nurses Association. My testimony concerns both the **Mohawk Valley PPS** as well as the **Central NY PPS**.

I have been an RN for just shy of 3 years, though I have also worked as a Paramedic for the last decade. I work in the Emergency Department – in fact I am here after working for the last 24 hours.

Despite this, I felt it was important to be here today because I am dedicated to my patients, and NYSNA is dedicated to quality patient care.

As an ER nurse, I have a first hand perspective on the entry point for healthcare services for many patients that are dependent upon Medicaid.

It is well known that providing care in the ER is far more expensive and results in worse health outcomes than simply providing adequate preventive care in areas where it can be accessed by those who need it. That last part is key and highly relevant to the discussion today.

Our ER is generally overflowing with patients in hallways, excessive wait times, and generally not enough nurses to provide the proper timely care. On top of this, a large percentage of the patients are dependent upon Medicaid for accessing healthcare, yet the ER is still their entry point. Meanwhile, those who are in need of actual emergency care, have to contend with receiving care in this environment.

As a nurse, and member of NYSNA, I can say unequivocally that the prospect of more resources for our patients is a good thing and we look forward to that. However, as my colleagues from ST. Elizabeth noted in the prior comments, we are very concerned about how this money will be spent, the lack of transparency in this process, as well as the rushed manner by which these decisions are being made. I.E. – one day of public comment in Albany for this committee seems woefully inadequate.

The community needs assessments are incredibly vague and undetailed when we consider the amount of money we are talking about dedicating to these applications.

Overall, my concern can be summarized as follows – Improvements are needed. Clearly. Yet they must not come at the expense of our patients, or quality care delivered by trained RNs like myself.

Thank you.