

## **A Letter from Community and Labor about the Direction and Planning of the DSRIP Program**

April 13, 2015

### **Jason Helgerson**

State Medicaid Director, Deputy Commissioner  
State of New York, Department of Health  
Empire State Plaza, Corning Tower, Room 1466  
Albany, NY 12237

Dear Mr. Helgerson:

We are writing to share information with you in preparation for the meeting requested on our behalf by Judy Wessler, Dr. Jaime Torres, Lara Kassel, and Sheryl Suttler -- members of the DSRIP Project Accountability and Oversight Panel,. We want to discuss urgent changes to the PPS implementation process needed to make sure that the health system transformation works for Medicaid beneficiaries and the uninsured, not just the traditional medical providers. Specifically, the undersigned believe that community-based organizations, local communities, and the frontline workforce have to be effectively integrated as equal partners with hospitals/medical providers in the Delivery System Reform Incentive Payment (DSRIP) Program. We want successful execution of public dollars to have far-reaching positive impact on patients, direct care workers, and local communities, especially low-income, immigrant, communities of color and other underserved populations. Accordingly, we have several concerns with the direction and planning for DSRIP. In particular, the following two urgent issues must be addressed now, taking advantage of the time still available before the PPSs have to submit their project implementation plans on May 1st:

1. A disproportionate amount of the financial and human capital made available through DSRIP focuses on the institutional needs and use of hospitals. No resources have been allocated for community-based health care providers such as Federally Qualified Health Centers (FQHCs) and Community-based social service organizations (CBOs). DSRIP will not succeed if it leaves the most promising aspect of healthcare transformation off the table: leveraging the social determinants of health:<sup>i</sup> This is best accomplish by supporting and sharing power with culturally competent community based social service and primary care service partners.<sup>ii</sup> There is a large and diverse body of practical work and research demonstrating that community engagement is a critical ingredient in efforts to improve the social determinants of health and the built environment.
2. Already disadvantaged by ineligibility for the State Department of Health's Capital RFP as well as any of the prior rounds of health information technology funding, CBOs find themselves unduly pressured by the one-sided contracts/Master Service Agreements (MSAs). They are being asked to sign contracts without clarity about project implementation and availability of funds for actively contributing to DSRIP project goals and metrics (i.e. Mt. Sinai PPS, and

Maimonides PPS). These MSAs do not consider the implications for CBOs that serve broad geographic areas which require them to participate in multiple PPSs.

The terms and conditions of the Medicaid waiver/ DSRIP program recognizes that involving the community and collaborating with its members are cornerstones of efforts to improve public health. However, that has not fully materialized in the actions of the state and has varied by PPS. We understand the stakes and the need for responsible partners. That can only be accomplished if we can have input, build trust, enlist new resources and allies, create better communication, and improve overall health outcomes so that successful projects can evolve into lasting collaborations. We request the following be addressed in order to develop a more equitable and collaborative process:

1. Funding and other resources must be available for CBO-centric efforts to complete a comprehensive planning process that will allow them to map their strengths, capacity and abilities to provide preventive care in the community to reduce hospitalizations and emergency room usage. Such a planning process will allow CBOs to navigate the current contracting requirements and be a strong partner in the efforts to improve health care service delivery and support the needs of Medicaid beneficiaries, which could assist in the state's aim to reduce Medicaid dollars. Present strategies for how to leverage the strengths of CBOs have been recognized by many, including the Institute of Medicine.<sup>iii</sup>

2. Community based organizations should be given more time to review contracts/MSAs. Signing should occur only at the point that the PPSs provide more clarity on project implementation, partnership, and availability of funds. The PPSs were given an extension from April 1<sup>st</sup> to May 1<sup>st</sup> to submit their project implementation plan details to the state. PPSs should allow for CBO's to review and sign contracts after the May 1<sup>st</sup> deadline. Currently, PPSs have been given the opportunity for potential CBO partners to comment on their MSAs. However, CBOs have been given little guidance, support, and time to review and sign, putting vital community resources at risk. This is especially a reality for CBOs who can be critical partners but whose capacity does not include resources to adequately evaluate if the contract works for their organization and it will benefit the community they serve.

3. CBO participation involves the ability to enter data into a separate web-based solution built around acute care systems. CBOs should be able to explore alternatives that reflect their clients' needs and current staffing/IT capabilities.

Given the opportunities and the unknown impact of this program, it is unacceptable that the process will continue to be driven and controlled solely by the medical providers and external and internal consultants who have been too often the recipients of these grants and lack experience and knowledge of effective community engagement strategies. We want to work with the state and PPSs to ensure transparency and provide meaningful public oversight and input in the DSRIP Process.

Sincerely, (see list of sign-on at the end)

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<sup>i</sup> Bradley E Elkins B Herrin J et al. Health and social services expenditures: association with health outcomes. *BMJ Qual Saf* published online March 29, 2011 doi: 10.1136/bmjqs.2010.048363

<sup>ii</sup> “The healthcare sector is bearing the brunt of a missing or under-resourced social services sector; front-line personnel with limited resources are stretched to respond to patient concerns; the need for a holistic approach to caring for people’s health and social needs is widely acknowledged but requires professional collaboration between health and social services; and many barriers and difficulties exist in establishing relationships between health and social services.” Bradley E Taylor L *The American Healthcare Paradox: Why Spending More is Getting Us Less*, 2013, p. 78.

<sup>iii</sup> Institute of Medicine, *The Role and Potential of Communities in Population Health Management*. Last Accessed 3/31/2015 [www.nap.edu/catalog.php?record\\_id=18946](http://www.nap.edu/catalog.php?record_id=18946).

## **Sign-On List**

Maha Attieh, Health Program Manager, Arab American Family Support Center

Anne Bové, RN, President, New York State Nurses Association, HHC Executive Council.

Humberto Brown, Dir. Health Disparities Initiative & New Constituency Development, Arthur Ashe Institute for Urban Health

Steve Choi, Executive Director,, New York Immigration Coalition

Hewett Chiu, President & CEO, Academy of Medical & Public Health Services

Tung Fund Cheung, United Chinese Association of Brooklyn

Steve Chung, President, United Chinese Association of Brooklyn

Anthony Feliciano, Director, Commission on the Public’s Health System

Sheelah A. Feinberg, Executive Director, Coalition For Asian American Children and Families

Stephanie Friot, Director of Community Engagement, Diaspora Community Services

Michele Giordano, Executive Director, Choices in Childbirth

Georgiana Glose, Executive Director, Fort Greene Strategic Neighborhood Partnership

Mercedes Vieira Gomes, JCC of Staten Island

Peg Graham, Health Advocate

Ms. Maria Guevara-Friedman, Program Director, Northern Manhattan Perinatal Partnership

Cheryl A. Hall, Executive Director Caribbean Women's Health Association

Dr. Mathew Hurley 1sr Vice President /Executive Director, Doctor’s Council-SEIU

Marjorie Momplaisir-Ellis, Executive Director, Greater Brooklyn Health Coalition

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Ngozi Moses, Executive Director, Brooklyn Perinatal Network

Kevin Muir, Vice President, CAMBA's Health Link Program

Chris Norwood, Executive Director, Health People

Heidi Siegfried, Health Policy Director, Center for Independence of the Disabled NY

Mon Yuck Yu, Chief of Staff, Academy of Medical & Public Health Services