New York State
NURSES
ASSOCIATION One strong, united voice for nurses and patients

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, soft-ware 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 any 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 is 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 completion 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 in 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 purse 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.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.

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 it 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.
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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 2011St 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 financers 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 NCHSCR 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 NCHRSC 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 Faxton-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 profess 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 Start 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 positons. 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.