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Glossary of New York State Health Reform

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Current as of March 13, 2018

BEHAVIORAL HEALTH (BH) TRANSFORMATION

Medicaid BH services are included in the mainstream Medicaid managed care (MMC) package. Medicaid managed care plans either manage BH services themselves or partner with an organization with experience, such as a Behavioral Health Organization (BHO).

The carve-in of BH services for adults went into effect on October 1, 2015 in NYC and on July 1, 2016 in the rest of the State. A carve-in of currently-excluded BH services for children is planned as part of the Children's Medicaid System Transformation.

Health and Recovery Plans (HARPs)

A Health and Recovery Plan (HARP) is a specialized managed care plan for people with significant BH challenges or substance use disorders (SUD). HARPs receive a much higher capitation rate than MMC, reflecting the significant spending of the Medicaid program on such individuals. In addition to the comprehensive MMC physical and behavioral health benefit package, HARPs include an array of BH Home and Community Based Services for individuals who are assessed to need such services.

HARP Home and Community Based Services (HCBS) include psychological rehabilitation, community psychiatric support and treatment, respite, and peer supports. Non-dual eligible Medicaid beneficiaries who are over 21 and eligible for MMC may qualify for HARPs if they have a serious mental illness (SMI) or SUD diagnosis. Individuals enrolled in a program with the Office for People with Developmental Disabilities (OPWDD) are not eligible for HARPs.

To determine eligibility, the State and HARPs perform quarterly data reviews of historical service usage to identify members who meet one of thirteen HARP risk factors. Additionally, individuals may be referred to the HARP by providers who identify them as having serious functional deficits, either through individual case review (using the HARP risk factors) or through a HARP eligibility screen.

Individuals who are deemed to be HARP-eligible will be offered enrollment in a Health Home where they will receive a functional assessment to determine which services should be provided. HARPs also contract with Health Homes to provide the care management function to HARP enrollees.

As of December 2017, there were 54,613 enrollees in HARPs in NYC and 45,303 in the rest of the State, for a total of 99,916 HARP members.

Behavioral Health (BH) HCBS

The Behavioral Health Home and Community Based Services (BH HCBS) service package, now part of the State's 1115 waiver, is designed to provide community-based support to adult Medicaid beneficiaries with serious mental illness (SMI) and/or substance use disorder (SUD). Enrollees in HARPs who are over the age of 21 (as all HARP enrollees currently are) or HARP-eligibles in HIV Special Needs Plans (SNPs) may be determined to be eligible for BH HCBS by a Health Home care manager through an HCBS assessment process. Originally, this process involved two steps, an initial NYS Eligibility Assessment and the full NYS Community Mental Health Assessment, but in March 2017, the requirement to perform a full assessment was removed to streamline access and improve service uptake.

Starting in April 2018, HARPs will also contract with State Designated Entities (SDEs), who will perform the NYS Eligibility Assessment for HARP enrollees who opt out of Health Home enrollment. The entities eligible to become SDEs include Health Homes and downstream Health Home care management agencies, and will provide only the NYS Eligibility Assessment and care planning services.

Services in the BH HCBS package include:

- Psychosocial Rehabilitation (PSR);
- Community Psychiatric Support and Treatment (CPST);
- Habilitation/Residential Support Services;
- Family Support and Training;
- Short-Term Crisis Respite;
- Education Support Services;
- Empowerment Services-Peer Supports;
- Non-Medical Transportation;
- Pre-vocational Services;
- Transitional Employment;
- Intensive Supported Employment;
- Ongoing Supported Employment; and
- Self-Directed Care (to be implemented at a later time as a pilot program).

The adult BH HCBS Provider Manual describes the basic requirements for any entity that is interested in providing BH HCBS and information regarding services that are allowable and reimbursable as approved by CMS. As of December 2017, 118 providers in NYC and 199 in the rest of the State have been designated to provide adult BH HCBS. Utilization has been lower than originally projected to date.

Behavioral Health Care Collaboratives (BHCCs)

To help meet the Value-Based Payment (VBP) Roadmap goal that at least 80 percent of Medicaid managed care spending will run through VBP models by April 2020, the State has launched a $60 million BH VBP Readiness initiative to prepare BH providers to engage in VBP arrangements. Through this initiative, community-based Article 31, Article 32, and BH HCBS providers have formed networks known as Behavioral Health Care Collaboratives (BHCCs). Network members must fall into one of the above categories, but other types of organizations may join as affiliate members.

BHCCs are expected to help prepare their members to engage in VBP contracting by:

- Creating a contracting legal entity, such as an independent practice association (IPA);
- Develop the capability to handle data collection and analysis functions;
- Improving behavioral and physical health outcomes and quality measurement; and
- Enhancing care delivery through clinical integration.

By April 2020, each BHCC is expected to have negotiated at least one VBP arrangement with a managed care organization (MCO). To fulfill this requirement, a BHCC may either (a) participate in a Level 2 or higher VBP arrangement as a Level 1 provider network or (b) become a contracting entity in a Level 2 or higher arrangement.

Statewide, 19 BHCCs have been selected to receive funding through the initiative, with seven operating in NYC and Long Island.

CHILDREN'S MEDICAID SYSTEM TRANSFORMATION

New York has proposed a comprehensive reform of children's services in its Medicaid system called the Children's Medicaid System Transformation. This transformation would include:

- The transfer of six existing 1915(c) waivers serving children into a single component of the State's 1115 waiver;
- The creation of Health Home care management, including the transition of existing care management services and enrollment of new children's populations;
- The creation of a single Home and Community Based Services (HCBS) package, incorporating new services and existing 1915(c) services, with expanded eligibility criteria;
- The creation of six new State Plan Amendment (SPA) services, incorporating new services and existing waiver services, open to all Medicaid children meeting medical necessity criteria;
- The carve-in of the 1915(c) and foster care children populations into managed care; and
- The carve-in of additional children's behavioral health services into managed care.

The Transformation was originally scheduled to begin in 2018, but the State has currently proposed a two-year delay in the implementation of most of its major components except for children's Health Home services, which are already operational under existing authority through the Affordable Care Act. As of March 13, 2018, the delay is being negotiated among the executive and legislative branches as part of the 2019 budget. All dates described in the below subsections are therefore subject to significant potential change. Until the Transformation is implemented, the existing 1915(c) waivers will continue to operate.

HCBS for Children

A single package of Home and Community-Based Services (HCBS) will be available to children enrolled in Medicaid who meet level of care determinations. The package will incorporate both new services and existing 1915(c) services, and eligibility will be expanded to include children who either meet institutional need criteria or are at risk of institutional placement. All HCBS-eligible children will be eligible to enroll in a children's Health Home, which will screen the child for eligibility and develop his or her plan of care. If the child opts out of Health Home enrollment, a statewide Independent Entity will provide these functions.

If approved by CMS, this package would be available through both fee-for-service (FFS) and managed care, as applicable, initially proposed to begin July 2018. The HCBS package will include 11 services:

- Habilitation;
- Caregiver/Family Supports and Services;
- Respite;
- Prevocational Services;
- Community Self-Advocacy Training and Supports;
- Supported Employment;
- Non-Medical Transportation;
- Adaptive and Assistive Equipment;
- Accessibility Modifications;
- Palliative Care; and
- Customized Goods and Services.

The current HCBS eligibility criteria, using the Child and Adolescent Needs and Strengths Assessment for New York (CANS-NY), will be used until the transition takes place. The State plans to implement the new HCBS Level of Care (LOC) eligibility criteria, which determines if a child is eligible for or deemed at risk of institutional placement and will replace the current criteria used under the 1915(c) waivers. In addition, as part of the transformation agenda, the State aims to expand access to HCBS to

more children by implementing new Level of Need (LON) eligibility criteria, which will target children who are not yet at risk for institutional placement but who have extended functional impairments, seeking to prevent escalation to LOC. The LOC target populations are current 1915(c) waiver populations, while the LON target populations will include Serious Emotional Disturbance (SED) and Abuse, Neglect, Maltreatment, or Complex Trauma as defined by Health Homes.

Children who are eligible for existing HCBS will automatically be eligible for Health Home services; however, children who are eligible for Health Home services are not automatically eligible for HCBS and must be determined HCBS-eligible by Health Home care managers (or the statewide Independent Entity, if not enrolled in a Health Home). Children transitioning from an existing waiver will be grandfathered into HCBS eligibility for one year from their last completed CANS-NY assessment.

Medicaid State Plan Amendment (SPA) Services for Children

As part of the transition to managed care, new Medicaid SPA services will be available for children and youth eligible for Medicaid and who meet medical necessity criteria. These new services include:

- Crisis Intervention;
- Community Psychiatric Supports and Treatment;
- Other Licensed Practitioner;
- Psychosocial Rehabilitation Services;
- Family Peer Support Services; and
- Youth Peer Support and Training.

These services were proposed in two SPAs submitted to the Centers for Medicare and Medicaid Services (CMS) in December 2016. SPA services, rates, and rate codes have been approved by CMS but cannot be accessed until the effective start date of the transition on July 1, 2018.

The State has released a guidance document outlining utilization management guidelines for all services that may be provided to children in Medicaid (available here). The State intends for MCOs to use these documents to develop policies for these services. The State intends for plans not to use more restrictive criteria than these guidelines.

FULLY-INTEGRATED DUALS ADVANTAGE (FIDA)

The Fully-Integrated Duals Advantage (FIDA) demonstration is a managed care model which implements specialized health plans that provide a comprehensive Medicare and Medicaid benefit to dually-eligible adult individuals who reside in a nursing home or need more than 120 days per year of long-term care. FIDA plans cover all health care, behavioral health, long-term care, and all other benefits included in the Medicare and Medicaid service packages. They also provide care management through an interdisciplinary team (IDT) model. As of 2016, there were about 170,000 dually-eligible individuals living in the eight-county demonstration region (New York City, Long Island, and Westchester County) who were eligible to join a FIDA plan.

Enrollment in FIDA plans began in 2015 in New York City and Nassau County and expanded to Suffolk and Westchester Counties on March 30, 2017. Enrollment has been lower than expected, with a total of 4,405 members enrolled as of December 2017, while over 50,000 individuals have opted out. As of January 2018, a total of 10 plans are still participating in the program, compared to 21 plans that were participating in 2015. The State has addressed enrollment issues in a series of stakeholder sessions

entitled "The Future of Integrated Care in NYS," which discuss the State's plans for FIDA and other integrated care programs after 2019. The FIDA Demonstration has been extended through December 31, 2019.

FIDA for Intellectual and Developmental Disabilities (FIDA-IDD)

In November 2015, CMS and New York State announced the Fully-Integrated Duals Advantage for individuals with Intellectual and Developmental Disabilities (FIDA-IDD) program, which expands on the original FIDA demonstration to create a specialized managed care option for dually-eligible adult individuals with I/DD. People with I/DD are not eligible for the original FIDA program. The State and CMS have contracted with one organization, Partners Health Plan, to operate the first pilot FIDA-IDD plan. Enrollment in the FIDA-IDD demonstration began on April 1, 2016. A total of 719 individuals are enrolled in Partners Health Plan as of December 2017.

Like the original FIDA, the FIDA-IDD plan covers all services included in the Medicare and Medicaid service packages. The FIDA-IDD plan will receive per member per month (PMPM) capitated payments and possibly financial performance-based incentives in later years.

HEALTH HOMES

A Health Home is a care management service model for Medicaid-eligible people with chronic health conditions. Under this model, a care coordinator working for the Health Home or a contracted agency creates enrollees' plans of care, helps them access services, and coordinates treatment with all their caregivers. Health Homes are required to provide the following six core services:

- Comprehensive care management;
- Care coordination and health promotion;
- Comprehensive transitional care;
- Individual and family support services;
- Referral to community and social support services; and
- Use of health information technology to link services.

In general, Health Homes are collaborations between a number of organizations, which may include hospitals, community providers, health plans, and others. Health Homes receive a per-member per-month (PMPM) payment on a fee-for-service basis.

Individuals receiving more than 120 days of long-term services and supports (LTSS) are excluded. The State plans to expand the Health Home model to serve individuals with intellectual and developmental disabilities starting in July 2018.

Health Homes Serving Adults

To receive Health Home services, adult Medicaid members must have one of the following:

- Two or more qualifying chronic conditions; or
- HIV/AIDS; or
- Serious mental illness (SMI).

The program is currently operating statewide, with 31 Health Homes serving adults as of November 2017. Approximately 166,000 adults and children are served by Health Homes as of December 2017.

Health Homes Serving Children

Health Homes Serving Children provide the same core services as adult Health Homes, tailored to serve the needs of children and families. To receive Health Home services, children or youth under the age of 21 who are enrolled in Medicaid must have:

- Two or more qualifying chronic conditions; or
- HIV/AIDS; or
- Severe Emotional Disturbance (SED) or Complex Trauma.

The program is currently operating statewide, with 16 Health Homes serving children as of December 2017.

HOME AND COMMUNITY BASED SERVICES (HCBS)

States may apply for Home and Community Based Services (HCBS) Medicaid waivers to expand the range of services that Medicaid enrollees can receive in their own home or community. The goal of most HCBS waivers is to decrease the need for inpatient or institutional care. HCBS target populations include people with intellectual or developmental disabilities, physical disabilities, mental illness, and/or substance abuse disorders.

The Centers for Medicare and Medicaid Services (CMS) may approve HCBS waivers under various types of federal Section 1915 authority, including subparts (c), (i), (j), and (k). HCBS may also be approved as part of a larger Section 1115 demonstration waiver. New York operates a number of 1915(c) waivers, including:

- Four separate Care at Home (CAH) waivers, run through the Department of Health (DOH) or Office for People with Developmental Disabilities (OPWDD);
- The OPWDD Comprehensive Waiver;
- The Office of Mental Health (OMH) Serious Emotional Disturbance (SED) waiver;
- Three Bridges to Health (B2H) waivers for children with SED, developmental disabilities, or who are medically fragile;
- The Nursing Home Transition and Diversion (NHTD) waiver; and
- The Traumatic Brain Injury (TBI) waiver.

New York also provides various HCBS through its 1115 Medicaid Redesign Team (MRT) waiver, including the Behavioral Health (BH HCBS) package, and has an approved 1915(k) Community First Choice Option (CFCO) State Plan Amendment.

1915(k) Community First Choice Option

The Community First Choice Option (CFCO) program allows states to provide home and community-based services to individuals who are Medicaid-eligible; have an income less than 150 percent of the Federal Poverty Level; and require an institutional level of care, such as care provided in a hospital, nursing facility, institution for mental diseases (IMD), or intermediate care facility (ICF).

The CFCO program requires participating states to offer services by direct-care workers to assist in accomplishing activities of daily living, instrumental activities of daily living, and health-related tasks.

Attendant services include hands-on assistance, safety monitoring, and cueing. CFCO also must include a training program to assist individuals in selecting, managing, and dismissing personal care attendants.

The CFCO SPA in NYS was approved by CMS in July 2015. New York State has convened a series of workgroups and identified a list of prospective providers for CFCO services. The implementation date for CFCO has been pushed back several times. Currently, CFCO services are scheduled to be included in the Medicaid managed care and managed long-term care (MLTC) benefit packages in April 2018.

Conflict-Free Case Management

CMS is implementing mandatory conflict-free case management policies in states like New York that are receiving Medicaid funds from the Balancing Incentive Program (BIP), the Community First Choice 1915(k) state plan option (CFCO), or the HCBS state plan option. Conflict-free case management requires the separation of clinical eligibility determinations and care planning assessments from the direct provision of services. Providers are expected to implement conflict of interest standards.

In particular, Health Homes, which provide care management services for individuals with chronic conditions, are often composed of networks of service providers. In order to fulfill this requirement, the Health Home is legally separate from the downstream providers and protocols are implemented to address potential conflicts of interest.

HCBS Transition Plan

New York has created an HCBS Transition Plan in response to the HCBS Final Rule issued by CMS in 2014. This Final Rule, among other items: (1) requires all HCBS settings to meet criteria for community integration, individual choice, privacy, and other consumer protections; (2) updates requirements for compliance assessments; and (3) identifies certain settings as presumptively not qualified for Medicaid HCBS.

The Transition Plan details how New York intends to ensure that all HCBS settings come into compliance with these rules during the transition period, which has recently been extended to last until March 2022. This plan includes a separate transition plan from each agency that regulates HCBS, including the DOH, OMH, OPWDD, the Office of Alcoholism and Substance Abuse Services (OASAS), the Office of Children and Family Services (OCFS), and others. New York last updated its Plan in September 2017 in response to CMS comments on the previous plan, with approval for these updates still pending as of March 2018.

MEDICAID REDESIGN TEAM WAIVER

Much of New York's Medicaid program operates under a comprehensive Section 1115 waiver, now known as the Medicaid Redesign Team (MRT) Waiver. This demonstration waiver enables the New York Medicaid program to create various managed care programs, including: mainstream managed care (MMC) plans, which serve over five million New Yorkers; special Health and Recovery Plans (HARPs) for individuals with serious behavioral health needs; and partially-capitated managed long-term care (MLTC) plans.

In 2014, CMS approved an amendment to this waiver that would enable New York to draw down up to $8 billion for various Medicaid reform initiatives, including the Delivery System Reform Incentive Payment (DSRIP) program, Health Homes, implementation of Behavioral Health Home and

Community-Based Services (BH HCBS), and MLTC workforce programs. The overall waiver was subsequently extended until 2021, though the DSRIP program was not extended beyond its original term.

Delivery System Reform Incentive Payment (DSRIP) Program

New York's DSRIP program is the primary component of the 2014 amendment to the State's 1115 waiver. DSRIP makes available $6.4 billion of federal funds to redesign the State's Medicaid program and achieve the Triple Aim of improved care, enhanced quality, and reduced costs. The overall goal of DSRIP is to reduce avoidable hospitalizations in the State by 25 percent within its five-year lifespan. Through DSRIP Year 2, about $2.5 billion has been distributed, along with about $550 million in supplemental State funding.

DSRIP Year 3 ends March 31, 2018. The program is scheduled to end on March 31, 2020.

Performing Provider System (PPS)

To participate in DSRIP, providers formed coalitions referred to as Performing Provider Systems (PPSs). Most PPSs are led by large safety net hospitals and/or public hospital systems and incorporate large networks of health care providers spanning the spectrum of services. Medicaid beneficiaries and, in limited cases, the uninsured are attributed to a specific PPS, generally based on where they receive the plurality of their care. There are 25 PPSs:

New York DSRIP PPSs				
Adirondack Health Institute	Advocate Community Partners (ACP)	Albany Medical Center Hospital	Alliance for Better Health Care (Ellis)	Bronx Partners for Healthy Communities (St. Barnabas)
Bronx-Lebanon Hospital Center	Care Compass Network (UHS)	Central New York PPS (SUNY Upstate)	Community Care of Brooklyn (Maimonides)	Community Partners of WNY (Sisters of Charity)
Finger Lakes PPS (RRHS & UR)	Leatherstocking Collaborative (Bassett)	Millennium Collaborative Care (ECMC)	Montefiore Hudson Valley Collaborative	Mount Sinai Hospitals Group
Nassau-Queens PPS (NUMC)	New York Presbyterian Hospital	NY Hospital Medical Center of Queens	NYU Lutheran Medical Center	OneCity Health (NYC Health + Hospitals)
Refuah Community Health Collaborative	Samaritan Medical Center	Staten Island PPS (RUMC & SIUH)	Stony Brook University Hospital	Westchester Medical Center

Each PPS has designed a Project Plan that incorporates between five and ten DSRIP projects that aim to create system transformation, improve clinical services, and address population-wide health issues. Certain PPSs had the opportunity to undertake a special 11th project to engage people who are not well-connected to the health care system into community-based care.

The State has set a "maximum application value" for each PPS. The maximum application value is the total potential federal funding that each PPS can earn. High-performing PPSs are also eligible to earn bonus funding from the federally-funded High Performance Pool (HPP) and State-funded Additional High Performance Pool (AHPP). In addition, PPSs may earn supplemental payments from State funding pools called the Equity Infrastructure Program (EIP) and Equity Performance Program (EPP).

To receive DSRIP payments, PPSs must meet various performance metric targets by making a 10 percent gap-to-goal improvement each year. Beginning in DSRIP Year 3, total waiver funding is also subject to a penalty if the aggregate performance of all PPSs statewide does not meet benchmarks. Two payments are made annually, based on the performance reports submitted in the second and fourth quarters of the previous DSRIP year.

Project Approval and Oversight Panel (PAOP)

The Project Approval and Oversight Panel (PAOP) is a federally-mandated advisory panel whose members have been tasked with reviewing PPS Project Plans. After PPS Project Plans were objectively scored by an independent assessor, the PAOP reviewed each Plan based on subjective measures such as project justification, cultural competence, and financial sustainability. The PAOP will continue to monitor PPS progress throughout the five-year program.

Capital Restructuring Financing Program (CRFP)

The Capital Restructuring Financing Program (CRFP) awarded $1.2 billion in New York State funds for capital grants to support DSRIP projects. Capital grant projects include but are not limited to: closures; mergers; restructuring; improvements to infrastructure; development of primary care service capacity; development of telehealth infrastructure; and the promotion of integrated delivery systems that strengthen and protect continued access to essential health care services and other transformational projects.

CRFP awards were made in March 2016, alongside an additional $355 million for the Essential Health Care Provider Support Program (EHCPSP). Contracts are scheduled to last for three years, through May 2019.

Equity Infrastructure Program (EIP)

The Equity Infrastructure Program (EIP) is a supplemental DSRIP program that will provide an additional $938 million in payments to certain PPSs, most of which were not eligible to undertake the 11th project. To be eligible for EIP payments, PPSs must demonstrate participation in four of nine DSRIP-related activities:

- IT Target Operating Model (TOM) initiatives;
- Medicaid Accelerated eXchange (MAX) Series projects;
- Health Home enrollment expansion;
- EHR implementation investment;
- Capital spending on primary/behavioral health integration;
- Tobacco cessation programs;
- Efforts to end HIV/AIDS;
- Fraud deterrence and surveillance; or

- Statewide Health Information Network of New York (SHIN-NY) infrastructure spending.

Participating PPSs are required to contract and work closely with an assigned Medicaid managed care organization (MCO) to ensure that EIP activities are aligned with the State's transition to value-based payments (VBPs). EIP payments are disbursed monthly or quarterly (depending on PPS reporting schedules) through the assigned MCO and are contingent on the PPS meeting program requirements.

Of the total possible funding, $738 million is allocated for safety net PPSs and $200 million for public PPSs. As of April 2017 (the end of DSRIP Year 2), $375 million has been earned across all PPSs. As such, all participating PPSs met requirements and have received two full years of EIP funding.

Equity Performance Program (EPP)

The Equity Performance Program (EPP) is a supplemental DSRIP program that will provide an additional $642 million in payments to certain PPSs to improve their performance on a subset of critical DSRIP metrics. The same PPSs eligible for the EIP are also eligible for the EPP. The State has proposed to base EPP payments on 18 DSRIP measures that are applicable to a significant portion of the Medicaid population, are related to important subpopulations, and/or support VBP activities. To receive EPP funding, PPSs must select and meet performance requirements on six of these eighteen measures.

Participating PPSs are required to contract and work closely with an assigned MCO to ensure that EPP activities are aligned with the State's transition to VBPs. EPP payments are disbursed monthly through the assigned MCO and are contingent on the PPS meeting its chosen performance metrics.

Of the total possible funding, $492 million is allocated for safety net PPSs and $150 million for public PPSs. As of April 2017 (the end of DSRIP Year 2), $128 million has been earned across all PPSs. As such, all participating PPSs met requirements and have received one full year of EPP funding.

OPWDD SYSTEM TRANSFORMATION

The Office for People with Developmental Disabilities (OPWDD) Transformation Panel is a group of stakeholders that OPWDD has convened to advise on the implementation of OPWDD's Transformation Agenda. The Transformation Agenda, also called the OPWDD Road to Reform, is an initiative to modernize the Intellectual/Developmental Disability (I/DD) service system and create a more person-centered approach by encouraging increased employment options, self-direction options, transitions into community-based residential care, and managed care for people with I/DD.

The Panel's main tasks include reviewing proposals for the transition to managed care. The Panel also holds forums to receive input from the general public. The Panel's process, recommendations, and vision are available in the Transformation Panel Report, which OPWDD is incorporating into its transformation plans.

OPWDD People First Care Coordination 1115 Waiver

In August 2017, the State submitted a proposed amendment to the 1115 Medicaid Redesign Team (MRT) Waiver that would authorize the transition of individuals with I/DD, and of the OPWDD service system, into managed care over the next seven years. Under this amendment, current OPWDD services and populations (both Medicaid-only and dually eligible) will be incorporated into the 1115 MRT Waiver. This includes I/DD residential services, OPWDD Home and Community Based Services

(HCBS) Waiver (including the developing Health Home for Individuals with I/DD services), and the Community First Choice Option (CFCO).

If approved by CMS, in July 2018, individuals with I/DD will begin to enroll in I/DD-specific Health Homes, also known as Care Coordination Organizations (HH/CCOs). HH/CCOs will be controlled by providers with experience with the I/DD population, and will take over and expand the current function of Medicaid Service Coordination (MSC), developing person-centered Life Plans that will serve as the plan of care for individuals with I/DD. Once the OPWDD system transitions to managed care, the State intends for HH/CCOs to either (1) begin to operate their own specialized I/DD managed care plans or (2) to partner with existing managed care plans to provide care management services to their enrollees who have I/DD.

For individuals who opt out of HH/CCO care coordination, the HH/CCOs will provide a lower level of services called HCBS Care Management, which will be reimbursed at a lower, quarterly rate. HCBS Care Management will entail handling only essential HCBS care planning and assessment services for individuals with I/DD.

As of February 2018, along with the 1115 MRT waiver amendment, the has State also submitted an amendment to the current OPWDD 1915(c) Comprehensive Waiver and a corresponding State Plan Amendment (SPA) to wind down existing services and implement the transition. However, CMS has not yet approved any of these amendments. The State also released a final version of its draft Transition Plan with more details and submitted Six organizations have submitted Letters of Intent to become HH/CCOs.

OPWDD Managed Care

Under the State's proposed 1115 waiver amendment, starting in 2019 in the downstate area, and in 2020 in the rest of the State, individuals with I/DD (both Medicaid-only and dually eligible) will begin to enroll in provider-led managed care plans called Specialized I/DD Plans (SIPs-PL). Enrollment in SIPs-PL will be voluntary-only during this period. All individuals who do not choose to enroll in a SIP-PL will remain in fee-for-service (FFS). Starting no earlier than in 2021 in the downstate area and in 2022 in the rest of the State, enrollment in a managed care plan will become mandatory for individuals with I/DD (both Medicaid-only and dually eligible).

PROVIDER COLLABORATIONS

In addition to PPS collaborations organized under the DSRIP program, there are two main types of provider collaborations in which separate legal provider entities can partner for purposes of care coordination and payer contracting.

Accountable Care Organizations (ACOs)

An Accountable Care Organization (ACO), as defined both by CMS and by New York State, is an organization comprised of independent but clinically-integrated health care providers that work together to manage and coordinate health care for a defined population. An ACO has a shared governance structure with the ability to negotiate, receive, and distribute payment, and is accountable for the quality, cost, and delivery of health care to the ACO's patients.

Originally created under the Affordable Care Act with a focus on Medicare, the State has issued regulations establishing its own standards for certification of ACOs. Under these regulations, ACOs must establish a representative governing body and management structure to provide oversight and strategic direction, and are required to implement quality management programs and report to the State on their performance on quality metrics. A state ACO may apply for state action immunity, which provides certain protections from being prosecuted under federal and state antitrust laws. Existing Medicare ACOs, which participate in the Medicare Shared Savings Program (MSSP) and are approved by the Centers for Medicare and Medicaid Services (CMS), do not have to submit an application and may receive state ACO certification through an expedited process. However, these certificates apply only to their actions related to Medicare beneficiaries.

Independent Practice Associations (IPAs) and Delivery System Reform Incentive Payment (DSRIP) Performing Provider Systems (PPSs) are among those organizations eligible to seek ACO certification. Applications are reviewed on a rolling basis. As of May 2017, fifteen Medicare ACOs have received a State Medicare-only ACO certification and seven ACOs (some of which are also Medicare ACOs) have received a general State ACO certification.

Independent Practice Associations (IPAs)

An Independent Practice Association (IPA) is a special purpose legal entity that enables a group of independent health care providers to contract and negotiate with employers, Accountable Care Organizations (ACOs), and/or managed care organizations (MCOs). IPAs enable networks of independent providers to participate in value-based payment (VBP) arrangements and share financial risk for the care they provide. The providers in an IPA are generally expected to integrate financially (e.g., sharing risk as a network) and/or clinically (e.g., shared functions such as quality assurance) if they contract as a group. An IPA can be formed as a not-for-profit organization, a limited liability company (LLC), or a business corporation.

Under New York State law, IPAs are able to perform the following two special functions that other legal entities may not:

1) Engaging in coordinated negotiating and contracting with MCOs on behalf of downstream independent providers; and
2) Taking risk for health care costs (by entering into risk-sharing arrangements with MCOs) without insurance or an MCO license.

VALUE-BASED PAYMENT (VBP) ROADMAP

As part of the Delivery System Reform Incentive Payment (DSRIP) program, New York was required to submit a five-year plan, the Value-Based Payment (VBP) Roadmap, to move away from fee-for-service (FFS) and towards value-based payment models in its Medicaid program. The use of VBP models is intended to allow plans and providers to sustain improvements to the health care delivery system that were made by one-time DSRIP funding. All VBP models involve the creation of a target budget for providing a set of services to a specific attributed population, with providers eligible to receive shared savings if they meet quality metrics with costs below the target budget.

The State's overall goal is to move at least 80 percent of Medicaid managed care payments into value-based methodologies by DSRIP Year 5. The services that would be included under this goal are estimated to represent about $32 billion of expenditures annually.

The Roadmap was initially approved by CMS in July 2015 and is updated roughly annually; the most recent version was approved March 30, 2017.

The State envisions that MCOs and provider networks will negotiate with each other to develop VBP arrangements. DSRIP PPSs may play a major role in this process, but contracts may only legally be formed by a single provider entity or an authorized group entity, meaning an independent practice association (IPA) or accountable care organization (ACO). The State has proposed a set of guidelines for the following "menu" of VBP models:

- Total Care for the Total Population;
- Integrated Primary Care and Chronic Conditions Bundle;
- Maternity Care Bundle; and
- Total Care for Special Needs Subpopulations.

These guidelines include recommended levels of shared savings (and losses, if applicable), attribution mechanisms, and a set of quality metrics for each type of arrangement. These quality metrics are updated annually for each DSRIP Measurement Year (MY). MCOs and providers will be able to combine receive approval to implement "off-menu" payment models in certain circumstances.

Under each payment model, MCOs and providers may choose to take on the following levels of risk: FFS with potential outcome-based quality incentives and no risk-sharing (Level 0); FFS with the potential for upside-only shared savings (Level 1); FFS with the potential for upside and downside risk sharing (Level 2); and prospective payment, such as per member per month (PMPM) capitation or in the case of Maternity Care, care bundles (Level 3). The Roadmap specifies minimum and maximum ranges of cost-sharing for each level.

VBP Workgroup

The VBP Workgroup is a group of stakeholders convened by the State to develop and implement the VBP Roadmap. Members include representatives from State agencies, insurers, providers, advocacy groups, and labor unions. The VBP Workgroup has established subcommittees and Clinical Advisory Groups (CAGs) to administer the State's transition to VBP.

The subcommittees generated a recommendation report providing guidance and standards related to the above topics, which was incorporated into the revised VBP Roadmap. Additional workgroups may be established to assist with the next annual VBP Roadmap update and other related goals.

Clinical Advisory Groups (CAGs)

Clinical Advisory Groups (CAGs) were established by the VBP Workgroup to define parameters and quality measures for specific VBP models. Each CAG is comprised of clinical experts who are tasked with designing a targeted approach for a specific population or condition. CAGs have been established for the following populations and conditions:

- Maternity;
- Behavioral Health;

- HIV/AIDS;
- Chronic Pulmonary Conditions;
- Chronic Heart Disease;
- Diabetes;
- Managed Long Term Care;
- Intellectual and/or Developmental Disabilities; and
- Children's Health (a combination CAG and Subcommittee).

The CAGs have made recommendations to the State on quality measures, data, and support required for providers to be successful in VBP, which were included in the updated VBP Roadmap. CAGs will continue to reconvene annually to provide recommendations and review VBP design models. Additional CAGs may also be established over time to assist with the successful implementation of VBP.

VBP Quality Improvement Program (QIP)

The VBP Quality Improvement Program (QIP) was developed to support financially-strained hospitals in the transition to VBP by partnering each distressed hospital with a PPS and giving them the opportunity to collaborate with Medicaid MCOs on the development of Facility Transformation Plans (QIP Plans). These plans outline the distressed hospital's overall approach to improving quality of care and the wellbeing of individual Medicaid beneficiaries that they serve.

QIP funding is allocated from the State to the MCO and then funneled through the PPS to the hospital. In addition to flow of funds, the MCO and PPS ensure that the hospital's QIP Plan is aligned with DSRIP goals and the VBP Roadmap. Updated QIP plans for all facilities participating in VBP QIP were established and submitted on April 1, 2017, the start of DSRIP Year 3 (DY 3). Facilities are expected to have at least 80 percent of their total Medicaid MCO contracted payments tied to a Level 1 or above VBP arrangement by June 30, 2018. Facilities that fail to meet this metric will lose part of their VBP QIP award (20 percent in DY 4, 50 percent in DY 5).

Social Determinants of Health (SDH)

All Level 2 and Level 3 VBP contracts must describe at least one designated SDH which the parties to the contract will address, consistent with a set of standard SDHs and intervention options. VBP contractors must involve at least one community benefit organization (CBO) to implement the SDH intervention. If a provider contracts with the CBO, the MCO must provide a bonus payment or advance payment to the VBP provider to fund the intervention. Starting January 2018, at least one of the CBOs in the VBP arrangement must be designated as a Tier 1 CBO, defined as a CBO that does not bill Medicaid (it does not submit Medicaid claims for covered benefits). Reimbursement to the CBO need not include performance-based risk but must be reasonably designed to result in improved health outcomes.

The MCO must report on compliance with these and other requirements in its VBP contract submission to receive credit for a Level 2 or Level 3 contract. Additional requirements include: a plan for implementing the SDH intervention, an explanation for why the intervention was selected, a report of SDH funds utilization, and an identification of metrics used to track success.

VBP Innovator

The VBP Innovator program is for experienced VBP contracting providers who wish to take on Level 3 or high amounts of Level 2 risk, as well as substantial administrative and care management functions, in return for a guaranteed minimum pass-through of MCO premium. The Innovator program is available

only to those contracting under Total Care for the General Population (TCGP), or Total Care for Special Needs Subpopulation (Subpopulation) options. Successful Innovators can receive between 90 and 95 percent of the relevant managed care premium. The amount of this pass-through depends on negotiations with the MCO and the number and scope of functions assumed by the provider.

To become an Innovator, the lead contracting entity must perform Utilization Review, Utilization and Care Management, and Disease Management. The Innovator must also have at least four of the following partially or fully delegated to it: Drug Utilization Reviews, Appeals and Grievances, Member/Customer Service, Network Management, Provider Services Helpdesk, Provider Relations, and/or Data Sharing. To receive the highest share of premium pass-through, the Innovator must also solely perform Claims Administration and Credentialing.

OTHER PROGRAMS

Advanced Primary Care (APC)

The Advanced Primary Care (APC) model is a variation on the patient-centered medical home (PCMH) primary care model in an all-payer setting. The APC model is defined in terms of the following four components:

- A defined set of practice capabilities that promote integrated care and care coordination;
- A set of core measures to ensure consistent reporting and incentives;
- Common milestones, linked to payments, that define a practice's capabilities over time; and
- Outcome-based payments that support team-based care and allow for shared savings.

About $67 million of State Health Innovation Plan (SHIP) funding is available to provide practices with technical assistance in transitioning towards APC models and achieving APC milestones. APC is specified by DOH as a type of practice that may engage in the Integrated Primary Care option for VBP contracts, and PPS primary care practices must qualify as either PCMH or APC by March 2018.

As of September 2017, the State is planning to simplify its efforts to transform primary care practices by aligning the various primary care transformation programs it is engaging in, including PCMH and APC, under one model, the New York State PCMH (NYS PCMH) program.

First 1,000 Days on Medicaid Initiative

First 1,000 Days on Medicaid is a collaborative initiative between the New York Department of Health (DOH), the State Department of Education (SED), and other stakeholders whose goal is to improve access to health and social services for children in their first three years of life. The First 1,000 Days workgroup met during 2017 to develop a set of 10 proposals. Seven of these will require State budget requests:

- Promotion of early literacy through local strategies using the Reach Out and Read (ROR) program;
- Expansion of the Centering Pregnancy Model of prenatal care;
- Statewide home visiting;
- Data system development for cross-sector referrals;
- Braided funding for early childhood mental health consultations;

- Parent/caregiver diagnosis as eligibility criteria for dyadic therapy; and
- Pilot programs to provide and evaluate family navigators in multiple settings.

The proposed FY 2018-19 Executive Budget has allocated $2.9 million to implement some of the above initiatives. Final funding allocations will be made in the Enacted FY 2018-19 Budget in April.

The other three non-budgetary requests are anticipated to be implemented by DOH and SED in 2018. These are:

- Creation of a Preventive Pediatric Care Clinical Advisory Group;
- Creation of a New York State Developmental Inventory upon kindergarten entry; and
- A requirement that managed care plans develop a two-year performance improvement plan for children's services called the Kids Quality Agenda.

Patient-Centered Medical Home (PCMH)

The Patient-Centered Medical Home (PCMH) is a primary care model under which each patient has an ongoing relationship with a personal physician and a team of providers. PCMHs are expected to provide for most of the patient's health care needs and to provide care coordination for other required services. They are also held accountable for a set of quality measures and must achieve meaningful use of electronic health records (EHRs).

In New York, PCMH practices generally seek recognition by the National Committee for Quality Assurance (NCQA) because the Medicaid program offers incentive payments to NCQA-recognized PCMH providers. Since its initial release of the recognition program in 2008, NCQA has updated its standards three times, most recently in April 2017. Under 2011 and 2014 standards, providers were able to achieve one of three levels of recognition in each 3-year-cycle, with Level 3 being the highest. Under the redesigned 2017 standards, levels have been eliminated and providers annually check-in by submitting reporting requirements.

Effective July 1, 2017, providers who receive recognition under the redesigned standards receive payments that are equal to those under NCQA's 2014 Level 3 standards (see pg. 1). All incentive payments for providers recognized under NCQA's 2011 standards have been eliminated for both Medicaid Managed Care and Medicaid Fee-For-Service.

State Health Innovation Program (SHIP)

The State Health Innovation Plan (SHIP) is a plan that New York submitted to the CMS Innovation Center as part of the federal State Innovation Models (SIM) program. In 2014, New York received $99.9 million in federal funding through this initiative to implement programs that improve statewide access to care across all payers. The project period for the grant began on February 1, 2015 and will continue for four years. The SHIP's goal is to enhance and bring to scale a model similar to the patient-centered medical home, supported by a value-based payment system. As such, SHIP and the Delivery System Reform Incentive (DSRIP) programs are intended to be complementary, with SHIP supporting the expansion of value-based primary care for both Medicaid and non-Medicaid providers while DSRIP focuses on transformation of safety net providers. The SHIP funding will be used to:

1. Transform primary care practices on a regional basis to prepare for adoption of the Advanced Primary Care (APC) model;

2. Expand value-based care to 80 percent of New Yorkers by 2020;
3. Support workforce performance improvement through professional education and training;
4. Integrate Advanced Primary Care (APC) with regional population health;
5. Develop standard quality metrics and enhanced analytics; and
6. Provide state-funded health information technology.

Transforming Clinical Practices Initiative (TCPI)

The Transforming Clinical Practices Initiative (TCPI) is a federal learning initiative by the CMS Innovation Center that helps clinicians share, adapt, and develop comprehensive quality improvement practices. Under the TCPI, organizations develop Practice Transformation Networks or Support and Alignment Networks. Practice Transformation Networks provide peer-to-peer technical assistance and learning opportunities for clinicians to develop skills related to practice transformation. Support and Alignment Networks use national and regional professional associations and public-private partnerships to develop the workforce and to support the recruitment of clinicians to practice in medically underserved communities.

The CMS Innovation Center announced awards for Practice Transformation Networks in September 2015. Three networks operate wholly in New York: the National Council for Behavioral Health, which received $7.7 million; the New York eHealth Collaborative, which received $48.5 million; and the New York University School of Medicine, which received $6.9 million. Each grant will last for four years, through September 2019.

CMS announced cooperative agreement funding for the second round of the Support and Alignment Networks on September 29, 2016. Awardees leverage primary and specialist care transformation work in order to identify, enroll, and provide technical assistance to clinician practices on a large scale to successfully participate in Alternative Payment Models. The period of performance for this initiative is three years, through September 2019.

KEY DATES

DSRIP

Activity	Date
DSRIP Year 4 Begins	April 1, 2018
DSRIP Measurement Year 5 Begins	July 1, 2018
DSRIP Year 3 Second Performance Payments Disbursed	July 2018

OPWDD Transformation

Activity	Date
HH/CCO Operations Begin; MSC Transitions to HH Care Management	July 1, 2018
Draft RFQ for Early Adopter I/DD Plans Released for Public Comment	August 2018
Final RFQ for Early Adopter I/DD Plans Released	November 2018
Managed Care Transition Policy Published	Spring 2019
Early Adopter I/DD Plans Selected and Certified	June 2019
End of MSC Transition Period; All MSCs Employed by HH/CCOs	July 1, 2019

VBP Roadmap

Milestone	Date
10% of MCO Payments through Level 1+ VBPs	April 2018
50% of MCO Payments through Level 1+ VBPs 15% of MCO Payments through Level 2+ VBPs	April 2019
80% of MCO Payments through Level 1+ VBPs 35% of MCO Payments through Level 2+ VBPs (15% through Level 2+ for Partial Capitation Plans)	April 2020

Note: In 2017, DOH changed the requirements for MLTCs to mandate that all MLTC contracts meet modified VBP Level 1 standards as of 1/1/2018.

Other Reforms

Activity	Date
CFCO Services Scheduled to be Implemented	April 2018
NHTD/TBI Waivers Transition to 1115 Waiver	April 2019
End of FIDA Demonstration	December 2019