spg SACHS POLICY GROUP
60 East 42nd Street, Suite 1762
New York, NY 10165
Phone: 212 827 0660
Fax: 212 827 0667

# DSRIP 1115 Medicaid Waiver Amendment Request

## FORMAL AMENDMENT UPDATE

On November 27th, the New York State Department of Health (DOH) formally submitted a waiver amendment request to the Centers for Medicaid and Medicare Services (CMS) for the 1115 Medicaid Redesign Team (MRT) Waiver that would extend and renew the Delivery System Reform Incentive Payment (DSRIP) program for a total of four years. DSRIP Year 5 is currently scheduled to end on March 31, 2020. In the amendment request, DOH proposes a new federal investment of $8 billion over a four-year time period, consisting of a one-year extension through March 2021 followed by a three-year renewal period through March 2024. This $8 billion would be invested in four program areas:

- DSRIP Performance ($5 billion);
- Workforce Development ($1 billion);
- Social Determinants of Health ($1.5 billion); and
- A second Interim Access Assurance Fund ($500 million).

The formal amendment request to CMS follows a public comment period on the initial draft proposal, which was released in September 2019. While the total funding request and amount for each program remains the same, the distribution of funds over time has changed significantly. The submitted proposal now requests only the rollover of existing federal funding during the one-year extension period ($625 million), with the balance of the request ($7.375 billion) to come in the renewal period. Additionally, the Value Driving Entities from the draft proposal have been renamed Value Management Organizations (VMOs), and the submitted request contains significantly more details on the program design of VMOs and the new Social Determinants of Health Networks (SDHNs), including:

- Funding mechanisms;
- Governance requirements;
- Organizational structures; and
- Performance measurement.

The formal 1115 Waiver Amendment Request is available here. SPG has summarized key provisions of the waiver renewal and extension request below.

## OVERVIEW

The renewed DSRIP program would focus on sustaining and expanding “Promising Practices” identified during the first DSRIP period. It would offer more time and funding to integrate such practices into value-based payment (VBP) contracts. New DSRIP funds would flow to collaborations called VMOs, which will expand on the Performing Provider System (PPS) concept to include managed care

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organizations (MCOs), community-based organizations (CBOs), and Qualified Entities (i.e., health information exchanges). Each VMO's overarching goal would be to create VBP contracts that fully fund and support DSRIP Promising Practices and other high-need projects by the end of the renewal period in 2024, which would effectively be DSRIP Year 9 (DY 9).

Other notable alterations to DSRIP under the amendment request include:

- Closer alignment with federal priority initiatives, including projects in the following areas:
  - Substance Use Disorder (SUD) Care and the Opioid Crisis;
  - Serious Mental Illness (SMI)/Serious Emotional Disturbance (SED);
  - Social Determinants of Health (SDH);
  - Primary Care Improvement; and
  - Alternative Payment Models.
- A narrower set of high-value projects and associated performance measures that are aligned with federal priorities, such as the CMS Meaningful Measures Framework.
- Implementation of three new priority areas for DSRIP outcomes:
  - Reducing maternal mortality;
  - Children's population health; and
  - Long-term care reform.

## WAIVER FUNDING REQUEST

The amendment requests a total of $8 billion in federal funds over four years (see table below). The State would provide matching funds, although only the federal funding would represent new funding if the matching funds would once again be generated through intergovernmental transfers (IGTs). These IGTs would have to comply with more stringent federal regulations proposed on November 18th. The State proposes that, as with the original DSRIP program, the federal investments would be supported by the reinvestment of savings achieved through other 1115 waiver programs (e.g., mandatory managed care) to achieve budget neutrality. The State's calculated budget neutrality projection by waiver year is available here.

| Program (Federal $ Millions) | Year 1 | Year 2 | Year 3 | Year 4 | Total |
|---|---|---|---|---|---|
| **DSRIP Performance** | $605 | $2,419 | $948 | $948 | **$4,920** |
| **Waiver Administration** | $20 | $20 | $20 | $20 | **$80** |
| **Workforce Development** | $0 | $500 | $250 | $250 | **$1,000** |
| **Social Determinants of Health** | $0 | $600 | $450 | $450 | **$1,500** |
| **Interim Access Assurance Fund** | $0 | $500 | $0 | $0 | **$500** |
| **Total** | **$625** | **$4,039** | **$1,668** | **$1,668** | **$8,000** |

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## TIMELINE

### Phase One – Waiver Extension

During the Waiver Extension Phase (April 1, 2020 – March 31, 2021), the State will continue existing PPS efforts but will streamline processes. Current PPSs will continue working on projects and initiatives that have proven successful in achieving DSRIP program goals. Performance rewards will be provided to the PPSs exclusively through pay-for-performance on a narrower set of higher priority performance and VBP-aligned measures. These measures will remain fully connected to existing PPS projects and no new measures will be introduced. Only four pay-for-reporting measures will remain.

This Waiver Extension Phase will be fully funded by the approximately $625 million in unspent federal funding from the prior waiver period. There will be two performance pools:

- Base performance pool (80% of the unspent funding); and
- High-performance pool (20% of the unspent funding).

As in the prior waiver, PPSs will earn awards from the pool through gap-to-goal performance, but performance will be ranked so that the pool funds are liquidated and paid based on relative PPS performance for each measure in each pool.

Each PPS seeking funds during the Waiver Extension Phase must submit a Phase Two implementation plan to the State. This plan must demonstrate ongoing readiness to continue transformation efforts and associated partner payments, explain how the PPS will refocus efforts on Promising Practices (described below), and include how the PPS will begin conversations to prepare stakeholders for the renewal phase.

### Phase Two – Renewal

The Renewal Phase (April 1, 2021 – March 31, 2024) will focus on transitioning the PPS structure into Value Management Organizations (VMOs), which will further integrate MCOs and CBOs in their operations. VMOs will be structured as legal entities that may be either newly formed or modified from an existing PPS structure. VMOs will contract with and receive funds from the State and distribute funds to their downstream partners. These funds are intended to support VBP contracts that further the State's identified Promising Practices and provide additional support for SDOH activities.

VMOs will function as support or services organizations and will include providers, MCOs, and CBOs as part of their governance, management, and operational structure. Specifically, the VMO governance structure must include representatives from each provider type (i.e., health systems, behavioral health, children), MCOs, local departments of health and public health, and CBOs/SDHNs. Additionally, Medicaid members will need to have voting representation in the governance structure. VMOs will also be integrated with Qualified Entities (QEs) to enhance data exchange capabilities.

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## Value Management Organizations (VMOs) Initiatives and Selection

Each VMO will be required to select Promising Practices that are most appropriate for the population it serves based on a community needs assessment. VMOs will be required to implement five high-priority Promising Practices focus areas, which include:

- Transforming and Integrating Behavioral Health (peer outreach and expansion of crisis capacity);
- Care Coordination, Care Management, and Care Transitions (hot spotting, development of transitional care teams, and leveraging telehealth);
- Addressing Social Needs, Community Partnerships, and Cross-Sector Collaborations (use of community health workers and linkage to SDHN high-priority social care);
- Addressing the Opioid Crisis (Medication-Assisted Treatment expansion to primary care and emergency department care, and SUD peer bridging); and
- Addressing High Utilizers of Care (rapid-cycle continuous improvement processes).

Like the first-generation PPSs, VMOs will operate with a specific attributed population within a certain geographic region/market. The state intends to simplify attribution to VMOs to better align with MCO enrollment and quality programs, and distribute funds in a manner that better recognizes community impacts. While current VBP arrangements are built exclusively around primary care provider attribution, the State recognizes that in order to achieve comprehensive, integrated care, VBP contracts must mature to add more partners and include payment models that share accountability, performance, and payment risk across a broader continuum of providers.

The State will specifically approve VMOs based on the following criteria:

- Size of Medicaid attribution
- History of performance improvement by VMO participants;
- Strength of partnerships with MCOs, CBOs, and providers;
- Governance structure that includes a range of providers; and
- Potential to sustain DSRIP Promising Practices under VBP arrangements.

## Renewal Phase Funding Distribution

The State will allocate waiver funds to support VMOs and their partners through two performance-based pools:

- VMO Performance Pool:
    - VMOs will receive funds to implement population health projects/infrastructure, proportional to member attribution and other factors, and contingent on performance.
    - About 65% of these funds will be awarded to VMOs based on the performance on measures for their attributed population, similar to the original waiver. The remaining 35% will be awarded based on the overall performance of each region in which a VMO

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has meaningful attribution. This is intended to reward VMOs for projects that are not targeted, or unable to be targeted, to their attributed populations only.
    - A portion of the VMO Performance Pool will be set aside for high performers.
- VBP Incentive Pool:
    - MCOs (and by extension SDHNs and provider partners) will receive funding for entering into new VBP arrangements or enhancing existing arrangements.
    - To be eligible for this pool, an MCO must meaningfully participate in at least one VMO. Also, as a sustainability measure for VMOs, MCOs will be required to enter contracts with VMOs that will pay for the VMOs' infrastructure services (e.g., data exchange/reporting) that support their VBP arrangements.
    - Incentive funds would be used for, among other things, funding financial reserve requirements for VBP arrangements.

### Social Determinants of Health Networks (SDHNs)

The State is encouraging the development of SDHNs that will convene CBOs, coordinate CBO activities, and provide infrastructure to support the delivery of socially focused interventions to individuals with complex needs. SDHNs will be responsible for developing and scaling comprehensive SDH interventions in alignment with the population health agenda of their regional VMOs. Each network will operate in a State-designated region and will be selected through a competitive procurement process. Eligible lead applicants of SDHNs will be CBOs or network entities composed of CBOs, such as an IPA.

The State will engage with MCOs, VMOs, and SDHNs to measure and establish goals for the percent of Medicaid funds spent on SDH services. This may factor into future targets of Medical Loss Ratio (MLR) as a percent of total premium that can be carried as either health care quality improvement activity or direct clinical intervention funding. Funding would flow both directly to SDHNs (for capacity building) and to MCOs (to pay SDHNs for services).

SDHN governance must include CBOs that work across all five of the major SDH areas (housing, nutrition, transportation, interpersonal safety, and toxic stress), as well as representatives of regional VMOs. The renewal period also aims to incorporate downstream, non-clinical providers to engage in value-based care, particularly as partners in addressing SDH. Such non-clinical providers should include local health departments and their community health coalitions.

## WORKFORCE

VMOs will submit a comprehensive workforce plan that identifies the skills and positions needed to implement Promising Practices, what gaps exist in the workforce, and strategies to address these gaps. This plan will guide the continuation of the work of current DSRIP initiatives that have helped expand the non-traditional, non-clinical workforce, including community health workers, peers, and patient navigators. During the renewal period, VMO partners will need to assess intervention costs and savings

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of workforce-related activities for purposes of future VBP. Portions of VBP bonus payments could be based on integrating non-traditional workforce into higher level VBP arrangements.

## ADDITIONAL HIGH PRIORITY AREAS

The State has additionally identified other priority areas for VMOs to address the needs of high-cost, high-need populations.

### Reducing Maternal Mortality

VMOs will be required to develop initiatives that improve maternal outcomes, which could include the adoption of a maternity care VBP arrangement. Such initiatives should:

- Improve access to and attendance at prenatal and postpartum visits, with a focus on prenatal education and social support;
- Address the leading causes of maternal death; and
- Reduce the racial disparities in maternal outcomes.

To implement these initiatives, VMOs should consider working with CBOs that focus on maternal and infant health, providing universal access to birth preparedness classes, incorporating the behavioral health needs of women in prenatal and postpartum settings, and promoting the diversity of their maternal health provider workforce, among others.

### Children's Health

The proposed renewal would seek to create a new focus on children's services by expanding DSRIP Promising Practices that primarily served the adult population. Promising Practices would be adapted for children's services in the following areas, among others:

- Chronic care management;
- Behavioral health integration;
- Pediatric-focused patient-centered medical homes;
- Expansion of transitional care teams and care management services in collaboration with Health Homes Serving Children;
- Integration of community health workers into provider teams;
- Infant/early childhood mental health consultations and Dyadic Therapy;
- VBP arrangements to support children's health;
- Use of telemedicine for residential populations for emergency department triage; and
- Expansion of crisis stabilization programs.

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## Long-Term Care Reform

The State recognizes the need to address shifting demographic patterns that will increase the need for long-term care (LTC) services in New York. VMOs will be required to focus on expanding best practices to include institutional and community-based LTC. LTC areas of focus include:

- Workforce recruitment and retention;
- Incentives for providing integrated care for duals;
- Reduction of hospital and nursing home admissions and improving discharge planning;
- Increased access to palliative care programs and hospice for individuals with serious illnesses and those at end-of-life; and
- Improved LTC and post-acute care IT infrastructure.

## PERFORMANCE MEASUREMENT

In the extension period, PPS performance measurement will be simplified, focusing only on Domain 3 (clinical improvement) measures and potentially preventable emergency department visits and readmissions. During the renewal period, a number of technical improvements will be made to facilitate reporting, including:

- The measurement period will align with MCO reporting requirements (January to December); and
- Unlike PPSs, which missed out on payment if they missed goals even by slim margins, VMOs will be eligible for partial payment in some circumstances.

During the renewal period, VMO performance measurement for the general population will be based largely on the State's existing Total Care for General Population (TCGP) VBP measure set. It will also include avoidable utilization and efficiency measures. The TCGP measure domains will include:

- Primary care;
- Children's care;
- Behavioral health;
- SUD;
- HIV/AIDS; and
- Maternal health.

Separately, VMOs will also be measured on three additional quality domains:

- Palliative care;
- Long term care; and
- Social determinants of health.

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## INTERIM ACCESS ASSURANCE FUND 2.0

The amendment request would create a second round of the Interim Access Assurance Fund (IAAF), offering another $500 million to financially distressed hospitals. This funding would provide supplemental payments able to exceed limitations on hospital funding such as the Upper Payment Limit (UPL), DSH limitations, or state plan payments. IAAF payments will be limited to providers that service significant numbers of Medicaid beneficiaries and that face financial hardship in the form of financial losses or low margins, as determined by the State.