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GLOSSARY OF NEW YORK MEDICAID POLICY

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Sachs Policy Group

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INTRODUCTION

This glossary is a reference tool for the major policy components of New York's Medicaid service system, including mainstream managed care, behavioral health, children's services and foster care, long-term care, and services for people with intellectual and developmental disabilities (I/DD).

New York State's (NYS) Medicaid system is one of the nation's largest, regularly serving 30 percent or more of the state's residents. It is also one of the most expensive—the most expensive state Medicaid program by more than 25 percent on a per resident basis, according to one analysis.

In 2011, the first Medicaid Redesign Team (MRT) was convened to consider reforms to the Medicaid system. The MRT found that the NYS Medicaid system was seeing "runaway cost growth" even as New York had middling quality outcomes, including the lowest ranking of any state in the nation for avoidable hospitalizations. At the same time, New York's health care ecosystem included a significant number of financially failing safety net hospitals and other institutions which needed support. This resulted in recurring disputes between stakeholders over responsibility for rising costs.

The MRT sought to address these issues with a wide-ranging array of reforms, starting with the establishment of annual limit on the growth of the state share of Medicaid—the Global Cap. The MRT intended to control costs by bringing managed care to all Medicaid populations, to create additional health system capacity through new care delivery models, and to align incentives across the system by encouraging the development of value-based payment (VBP) contracts.

To facilitate this, NYS sought a new Section 1115 Medicaid waiver demonstration, named after the MRT, which would provide the federal authority and investment needed to enact these reforms. In 2014, the Centers for Medicare and Medicaid Services (CMS) approved a waiver built around a $6.4 billion pay-for-performance Delivery System Reform Incentive Payment (DSRIP) program. DSRIP's vision was to create integrated networks of providers that would build capacity for care management at all levels, from the independent physician office to the academic medical center, while integrating non-medical supports—in particular, behavioral health care—into the workflow. Integrated provider networks would be equipped to participate in VBP arrangements, taking on shared risk on their Medicaid populations and aligning their incentives with those of their payers to achieve higher quality outcomes and lower costs.

The DSRIP component of the MRT waiver ended in March 2020, just as the first wave of the Covid-19 pandemic struck New York. In terms of Medicaid policy, the most notable changes were the expansion of telehealth and additional federal support, including substantial new emergency and one-time funds for home and community-based services (HCBS). NYS has also sought to establish a new foundation for its hospital safety net payments.

Although the DSRIP program itself is over, NYS continues to develop many related initiatives. Today, NYS is preparing to submit a new 1115 waiver that would make further reforms to the Medicaid program, aiming to create a post-Covid-19 health care system that will involve a bigger, more integrated role for social care and social determinants of health interventions while furthering the push towards meaningful VBP arrangements.

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MANAGED CARE AND CARE MANAGEMENT

Medicaid Managed Care Plans

Since 1997, NYS has mandated that most "mainstream" Medicaid beneficiaries—individuals without special needs—must enroll in a managed care plan. New York's Medicaid managed care (MMC) plans, or managed care organizations (MCOs), are run by private entities (which may be for-profit or not-for-profit) with a license under Article 44 of the Public Health Law, either as a health maintenance organization (HMO) or prepaid health services plan (PHSP).

Mainstream MMC plans provide comprehensive health coverage, including coverage of all services approved in the Medicaid State Plan, to their enrollees. The NYS Department of Health (DOH) pays MMC plans a per-member, per-month (PMPM) capitation rate. Rate cells are divided by region, category of aid (most enrollees now qualify by income), age group, and maternity status. Capitations are further adjusted based on the acuity and claims history of the plan's enrolled members. DOH uses the 3M Clinical Risk Group (CRG) system to perform risk adjustment.

MMC plans are also in the MMC Quality Incentive Program, which measures plan performance based on Quality Assurance Reporting Requirements (QARR), Prevention Quality Indicators (PQIs), and patient satisfaction surveys. The Program typically offers $120 million of incentive payments per year.

As of 2022, the major populations that remain exempt or excluded from mainstream managed care are:

- Populations eligible for specialty managed care products (such as the long-term care population, individuals with serious mental illness, and individuals with HIV/AIDS);
- Individuals dually eligible for Medicare and Medicaid;
- Individuals in the Traumatic Brain Injury (TBI) or Nursing Home Transition and Diversion (NHTD) 1915(c) waivers; and
- Individuals with I/DD.

Services that are entirely carved out of MMC include:

- Non-emergency medical transportation services;
- Certain services for children, such as school-based health centers (SBHCs), Early Intervention (EI) services, and School Supportive Health Services for children in special education; and
- Assisted Living Programs (ALPs).

In 2020, the second Medicaid Redesign Team (MRT II) proposed to carve out the pharmacy benefit to be administered on a fee-for-service basis. This carve-out is currently delayed until April 1, 2023.

As of January 2022, there are 15 MMC plans (including 3 HIV SNPs) statewide. Nearly 5.3 million Medicaid beneficiaries are actively enrolled in MMC in New York, out of a total of about 7.4 million enrollees.[1] During the Covid-19 pandemic, CMS has provided enhanced funding for Medicaid programs that have halted Medicaid disenrollment processes during the federal public health emergency (PHE). NYS expects Medicaid enrollment to decrease roughly back to pre-Covid-19 levels in the next year. In January 2020, total MMC enrollment was about 4.2 million out of a total of 6.1 million.

[1] DOH reports Medicaid managed care enrollment based on roster reports, while it reports total Medicaid enrollment based on the Medicaid Data Warehouse.

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Health Homes

A Health Home is a care management service model for Medicaid-eligible individuals with chronic health conditions. Under this model, a care coordinator, who may be employed directly by the Health Home or by a downstream 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 Supports
- Use of Health Information Technology to Link Services

Most of New York's 30 Health Homes are collaborations between multiple organizations, which may include hospitals, community providers, health plans, and others. Health Homes receive a PMPM payment for each month in which they provide at least one core Health Home to the enrollee. Individuals in the long-term care population (receiving more than 120 days of LTSS) are excluded.

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).

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.

In July 2018, NYS expanded the Health Home model to serve individuals with I/DD through the establishment of specialized I/DD Health Homes, also known as Care Coordination Organizations (CCOs), which are described further under the OPWDD section of this Glossary. Additionally, NYS added a list of qualifying I/DD chronic conditions to the Health Home criteria, which include conditions falling under Intellectual Disability, Cerebral Palsy, Epilepsy, Neurological Impairment, Familial Dysautonomia, Prader-Willi Syndrome, or Autism.

Individuals with I/DD who choose to receive OPWDD HCBS waiver services must enroll in a CCO. However, individuals who are not eligible for or decline OPWDD HCBS may choose to enroll in standard Health Homes serving adults or children if they are eligible and meet Health Home appropriateness criteria. To be eligible, they must have an I/DD qualifying condition and also at least one other non-I/DD qualifying chronic condition. DOH guidance on this overlap is available here.

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Provider-Based Care Management

NYS Patient-Centered Medical Home (PCMH)

The Patient-Centered Medical Home (PCMH) is a primary care model under which the PCMH practice's primary care team is responsible for managing a patient's full spectrum of health care needs. PCMHs are expected to provide for the patient's primary health care needs and to provide care coordination for other required services that cannot be delivered in a primary care setting. They are also held accountable for a set of quality measures and must achieve meaningful use of electronic health records (EHRs). Nationally, the PCMH standards are maintained and PCMH practice certifications are issued by the National Committee for Quality Assurance (NCQA).

NYS also used funding from a CMS State Innovation Model award to promote the Advanced Primary Care (APC) model, a related primary care model intended to promote cross-payer engagement. In April 2018, NYS announced the transition of both the PCMH and APC programs into a new model called NYS PCMH. The NYS PCMH model, which was built in collaboration with the NCQA, is intended to unify these two approaches and to gradually transition from process-oriented measures to outcomes and performance. NYS PCMH recognition is open to all primary care practices in NYS. To maintain NYS PCMH recognition, practices must undergo an annual reporting process and pay NCQA an annual reporting fee.

Providers that achieve PCMH recognition may receive additional incentive payments for services provided to Medicaid or Child Health Plus (CHP) enrollees. For MMC and CHP members, plans pay PCMH practices a monthly add-on payment (currently $6 PMPM). For Medicaid fee-for-service (FFS) members, eMedNY provides a per-claim supplemental payment (currently $29 for professional claims and $25.25 for institutional claims). Statewide, as of December 2019, 2,614 practices with 9,518 practitioners were recognized as a PCMH, including 1,460 practices with 5,718 practitioners as NYS PCMH.

Accountable Care Organizations (ACOs)

In 2014, New York passed legislation to define and create a certification process for "accountable care organizations." Under this legislation, Accountable Care Organizations (ACOs) are regulated under Section 2999-p of the Public Health Law. ACOs are defined as a clinically integrated organization of health care providers that serve and coordinate care for a defined population. Under New York law, they are one of the types of entity that may enter risk-based contracts with third-party health care payers, including Article 42, 43, and 44 insurers. ACOs are also potentially eligible for certain protections against antitrust action related to their collaborative activities, although federal authorities raised concerns about these protections in 2015 and they have not been tested in practice. The ACO model was intended in part to be a sustainability avenue for Performing Provider Systems (PPSs) under the DSRIP program to become integrated provider networks.

DOH may issue an ACO Certificate of Authority to an entity that meets the State's criteria to operate as an ACO. ACOs designated by CMS, such as through the Medicare Shared Savings Program (MSSP), are eligible to receive a Certificate of Authority from DOH through an expedited process as "Medicare-only ACOs." Medicare-only ACOs taking on more downside risk of more than 10 percent are subject to a reserve requirement of 25 percent of their maximum loss.

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Independent Practice Associations (IPAs)

An Independent Practice Association (IPA) is a special purpose legal entity formed to enable a group of health care providers to jointly contract with MCOs or other payers. IPAs may be owned and organized by one or more physicians, providers, practices, medical groups, health systems, or Federally Qualified Health Centers (FQHCs). IPAs may be formed as a business corporation, not-for-profit, or LLC and must receive approval from DOH. The IPA structure is intended to allow independent entities to collectively participate in value-based payment arrangements and perform population health functions.

An IPA is permitted to jointly negotiate contracts with payors on behalf of the IPA network. The IPA entity may hold an "upstream" contract with an MCO while executing "downstream" contracts with independent physicians and other community providers, such as behavioral health providers and community-based organizations, to provide services to the MCO's enrollees.

However, IPAs must demonstrate a degree of financial and/or clinical integration among their network members to comply with antitrust law. IPAs may also be formed using a "messenger model," in which the IPA serves as an intermediary between providers and MCOs without jointly negotiating their contracts. Through a contract with an MCO, IPAs may take on shared risk and be responsible for administrative functions.

Behavioral Health Transformation

In 2015, New York's system of Medicaid-funded licensed behavioral health (BH) services, which include inpatient psychiatric hospitals and residential facilities, outpatient clinics, and substance use disorder (SUD) services, were carved into the mainstream MMC package. The carve-in of BH services to the MMC benefit package occurred as follows:

Effective Date	Population
October 1, 2015	Adults in NYC
July 1, 2016	Adults in the rest of the state
July 1, 2019	Children/youth under age 21
July 1, 2021	Children/youth under age 21 placed in foster care

Health and Recovery Plans (HARPs)

A Health and Recovery Plan (HARP) is a specialized managed care plan for people with significant BH or SUD challenges.

Benefit Package

In addition to the comprehensive MMC physical and behavioral health benefit package, HARPs include an array of additional community-based specialty BH services for individuals assessed to need them. Due to very low uptake, in 2021, NYS began a process to streamline and simplify this service array and the process of determining eligibility for it (see below on "BH HCBS and Transition to CORE").

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Eligibility

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. However, the following populations are excluded:

- Individuals enrolled in a program with the Office for People with Developmental Disabilities (OPWDD); and
- Individuals participating in the TBI or NHTD 1915(c) waivers.

Previously, individuals dually eligible for Medicare and Medicaid were also excluded from HARP enrollment. However, effective April 1, 2021, NYS implemented the Integrated Benefit for Dually Eligible Enrollees (IB-Duals) process. Under IB-Duals, upon gaining Medicare eligibility, individuals in a participating HARP plan will be automatically enrolled in that plan's aligned Medicare Dual Eligible Special Needs Plan (D-SNP). This will not affect beneficiaries who were previously disenrolled from or never enrolled in a HARP.

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. The Health Home will conduct a functional assessment to determine a service plan. HARPs also contract with Health Homes to provide the care management function to HARP enrollees.

As of January 2022, there were 11 HARP plans statewide, with a total enrollment of 162,170. This includes 77,249 HARP enrollees in NYC and 84,921 in the rest of the state.

BH HCBS and Transition to Community Oriented Recovery and Empowerment (CORE) Services

Original Design

The HARP benefit package included a set of new services intended to provide community-based support for individuals with significant BH needs, called Behavioral Health Home and Community Based Services (BH HCBS). As originally designed, Health Homes would conduct HCBS assessments of adults eligible for and enrolled in a HARP or HIV Special Needs Plan (HIV SNP), to determine whether they were eligible for BH HCBS. The New York State Office of Mental Health (OMH) operated a designation process to select community-based providers who would be eligible to provide the BH HCBS service package.

For those opting out of Health Home, a State Designated Entity (SDE)—which would also be a Health Home or downstream care management agency—would conduct the BH HCBS assessment. However, in their role as an SDE, they would only provide the assessment and associated care planning services.

Transition to CORE

In October 2021, CMS approved the State's request to transition four of the BH HCBS services to a new service array called Community Oriented Recovery and Empowerment (CORE) services, with the goal of increasing eligibility and uptake.

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To be eligible for CORE services, individuals must meet the NYS high-needs behavioral health criteria (i.e., the HARP eligibility algorithm) and be enrolled in either a HARP or HIV SNP. Medicaid Advantage Plus (MAP) plans will cover CORE services when specialty BH benefits are carved into the MAP benefit package.

Unlike the adult BH HCBS services, CORE services do not require an independent eligibility assessment or Level of Service Determination. Instead, CORE services may be provided to any eligible beneficiary upon recommendation by a Licensed Practitioner of the Healing Arts (LPHA).

As part of this transition, the following adult BH HCBS will transition to CORE:

- Community Psychiatric Support and Treatment (CPST)
- Psychosocial Rehabilitation (PSR)
- Family Support and Training (FST)
- Empowerment Services – Peer Support

CORE services will be jointly overseen and monitored by OMH and the Office of Addiction Services and Supports (OASAS). Providers will be designated by both agencies and will be assigned to either OMH or OASAS as their host agency. Providers who are currently designated for BH HCBS CPST, PSR, FST, and Peer Support will receive provisional designation for CORE services to ensure continuity of care. Provisional designation will be effective from February 1, 2022 through July 31, 2022. To obtain full designation, the provider must complete the CORE Services Provider Attestation by July 31, 2022.

The remaining BH HCBS will continue to be provided in accordance with the original design, as described above. Providers of BH HCBS may apply to add a CORE PSR designation through a special application process.

Behavioral Health Care Collaboratives (BHCCs)

In 2017, NYS launched a $60 million BH VBP Readiness initiative to help BH providers build the infrastructure they needed to engage in VBP arrangements by forming networks known as Behavioral Health Care Collaboratives (BHCCs). BHCC network members must be community-based Article 31, Article 32, or BH HCBS providers, 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);
- Developing 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 was expected to have negotiated at least one VBP arrangement with a MMC plan. To fulfill this requirement, BHCCs were expected to 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 were selected to receive funding through the initiative, with seven operating in NYC and Long Island.

In August 2021, New York's spending plan for enhancing HCBS using federal aid from the American Rescue Plan included a proposal for an additional $8 million to continue supporting the BHCCs.

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CHILDREN'S MEDICAID SYSTEM TRANSFORMATION

NYS has enacted a comprehensive reform of Medicaid children's services called the Children's Medicaid System Transformation. This transformation included the following, completed on the indicated implementation date:

- The creation of Health Home care management, including the transition of existing care management services and enrollment of new children's populations (November 2018);
- The implementation of six new State Plan Amendment (SPA) services called the Children and Family Treatment and Support Services (CFTSS), incorporating new services and existing waiver services, open to all Medicaid children meeting medical necessity criteria (January 2019 through January 2020);
- The consolidation of six existing 1915(c) waivers serving children into a single component under the 1915(c) Children's Waiver (April 2019);
- The creation of a single HCBS package with expanded eligibility criteria, and the removal of the exemption from mandatory enrollment in MMC for participation in the Children's Waiver; (October 2019); and
- The carve-in of the 1915(c) and foster care children population into managed care (July 2021).

HCBS for Children

Currently, a single package of Home and Community-Based Services (HCBS), incorporating new and previously-existing 1915(c) services, is available to all Medicaid-enrolled children (individuals under the age of 21) who are determined to be eligible. The eligibility criteria have been expanded to include all 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 their plan of care. If the child opts out of Health Home enrollment, the statewide Independent Entity, called the Children and Youth Evaluation Services (C-YES), will provide these functions. Please note that although all HCBS-eligible children are Health Home-eligible, not all Health Home-eligible children are HCBS-eligible; they must be separately assessed to determine this.

This package was approved by CMS in November 2018 and is available through both FFS and MMC, as applicable. The HCBS package includes the following services:

- Community Habilitation
- Day Habilitation
- Caregiver/Family Supports and Services
- Respite
- Community Self-Advocacy Training and Supports
- Supported Employment
- Non-Medical Transportation
- Adaptive and Assistive Equipment
- Vehicle Modifications
- Environmental Modifications
- Palliative Care, including:
  - Expressive Therapy
  - Massage Therapy
  - Bereavement Service
  - Pain & Symptom Management

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Previously, HCBS eligibility was determined using the Child and Adolescent Needs and Strengths Assessment for New York (CANS-NY). In April 2019, the State implemented the new HCBS Level of Care (LOC) eligibility criteria, which determines if a child is eligible for or deemed at risk of institutional placement, to replace the criteria used under the 1915(c) waivers. The State aims to expand access to HCBS to more children by also implementing a 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. To date, the LON eligibility criteria has not been implemented.

The LOC target populations include individuals under 21 who have or are classified as:

- Serious Emotional Disturbance (SED)
- Medically Fragile (MF)
- Developmental Disability and Medically Fragile (DD/MF)
- Developmental Disability and in Foster Care (DD/FC)

Children and Family Treatment and Support Services (CFTSS)

Children and Family Treatment and Support Services (CFTSS) are Medicaid state plan services that have been implemented under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit to address behavioral health needs earlier in an individual's life and prevent the onset or progression of behavioral health conditions. CFTSS are available to all Medicaid-eligible children/youth under age 21 who meet medical necessity and their families/caregivers. Services are delivered within the community where the child or youth lives, attends school, and/or engages in services. The CFTSS program includes six services, which became part of the Medicaid benefit on the indicated implementation date:

- Other Licensed Practitioner (January 2019)
- Psychosocial Rehabilitation (January 2019)
- Community Psychiatric Treatment and Supports (January 2019)
- Family Peer Support Services (July 2019)
- Youth Support and Training (January 2020)
- Crisis Intervention (January 2020)

CFTSS are intended to be individualized to the needs of children at any point in their development or treatment trajectory. A behavioral health need can be identified by multiple sources, including: parents or other caregivers; pediatricians; care managers; clinicians; school personnel; or the child themselves. Medical necessity determinations are completed by licensed practitioners.

OMH has released guidance on the licensure process for providers designated to provide Other Licensed Practitioner (OLP) and Community Psychiatric Support and Treatment (CPST) services and for providers interested in pursuing designation for OLP and CPST. Effective July 2019, such providers require OMH licensure under a new category called the Children's Mental Health Rehabilitation Services (CMHRS) Program. Under this new licensure category, OLP and CPST must be provided directly by the licensed CMHRS Program. Psychosocial Rehabilitation (PSR), Family Peer Support Service (FPSS) and Youth Peer Support and Training (YPST) may be provided directly by the CMHRS Program or via agreement with another agency who is designated to provide these services.

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Article 29-I Foster Care Services

Children/youth who are placed in foster care statewide are mandatorily enrolled in MMC unless otherwise exempt or excluded. Voluntary Foster Care Agencies (VFCAs) are now licensed as Article 29-I facilities and provide the following services:

- Mandatory Core Limited Health-Related Services (CLHRS)
  - Skill Building Services
  - Nursing Supports and Medication Management
  - Medicaid Treatment Planning and Discharge Planning
  - Clinical Consultation and Supervision
  - Managed Care Liaison/Administration
- Optional Other Limited Health-Related Services (OLHRS)
  - Physical and Behavioral Health Screening, Diagnosis, and Treatment Services

VFCAs that are licensed under Article 29-I no longer have a cost-based, roster per diem reimbursement structure. Instead, Article 29-I providers will submit claims to Medicaid FFS or MMC plans for all services provided.

For CLHRS, MMC plans are required to reimburse Article 29-I providers at the NYS Medicaid FFS rates (residual per diem) during the four-year transition period from July 1, 2021 through June 30, 2025. During the transition period, the Medicaid residual per diem rate is not included in the MMC plan premium capitation rate; the MMC plan bills the State for the Medicaid residual per diem as a pass through to the Article 29-I facility upon claim submission. At the end of the transition period, the State will reassess progress of the implementation and determine if transitional requirements should be extended.

For OLHRS, MMC plans must reimburse Article 29-I providers at a set OLHRS fee schedule during the transition period, unless alternative arrangements have been made between plans and providers and have been approved by the State (e.g., VBP arrangements). OLHRS are included in the MMC plan premium capitation rate (at-risk).

Plans are prohibited from conducting prior authorization for mandated assessments or CLHRS.

Long Term Care

In New York, the Medicaid long-term care population is defined as individuals who are assessed to need more than 120 days of long-term services and supports (LTSS). LTSS may be delivered in a residential setting, such as a nursing home or assisted living facility, or through community-based LTSS as supports to individuals living in community housing or their own homes. Assessments are performed by the independent statewide Conflict-Free Evaluation and Enrollment Center (CFEEC), run by Maximus, which conducts an assessment of each enrollee using the NYS Universal Assessment System (UAS-NY).

Under the first Medicaid Redesign Team's Care Management for All initiative, NYS began transitioning the long-term care population into mandatory managed long-term care (MLTC) in 2011. Since then, New York's Medicaid long-term care population has grown to nearly 300,000 beneficiaries. As of 2019, most of these individuals (about 85%) are also eligible for Medicare by age or disability.

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Managed Long Term Care Plans (MLTCPs)

Partially capitated managed long-term care plans (MLTCPs) manage the delivery of community-based LTSS for Medicaid enrollees with significant long-term care needs who wish to remain in their home/communities. MLTCPs are approved by DOH to provide coordinated delivery of care management services and a contracted network of LTSS. Enrollment in an MLTCP (or a fully-capitated LTC plan) is mandatory for those who are over 21 and dually eligible for Medicare and Medicaid.

The benefit package of an MLTCP includes Medicaid-only long-term care (e.g., home care, personal care, and adult day care), ancillary, and some ambulatory services, although the specific array of services available to an enrollee depends on the MLTCP and on the enrollee's care plan.

As of January 2022, there are 25 MLTCPs statewide, with a total enrollment of 245,015. DOH's current intention is to move as many enrollees as possible into integrated plans for dual eligibles while concurrently working to wind down the partially-capitated MLTCP program. As such, DOH has established a moratorium on new MLTCPs effective through March 2022 and imposed plan-specific enrollment cap.

Medicaid Advantage Plus (MAP)

The Medicaid Advantage Plus (MAP) program is an integrated managed care plan type for dually eligible adults (18 and over) that require LTSS for more than 120 days. While Medicare-Medicaid plan (MMP) demonstrations integrate the Medicare and Medicaid benefits at the plan level, consisting of a single plan with a single enrollment process and benefit, the MAP model is integrated at the organizational level, consisting of two side-by-side products offered by the same organization. NYS engaged in a full MMP demonstration, the Fully Integrated Duals Advantage (FIDA) demonstration, from 2014 to 2020, but FIDA suffered from persistently low enrollment.

The MAP Medicare product is a Dual-Eligible Special Needs Plan (D-SNP), while the Medicaid product covers the MLTCP benefit described above. The MAP Medicare product meets the federal definition of a Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP). It includes all standard Medicare benefits, including inpatient and outpatient hospital services, primary care and specialty physician services, prescription drugs covered under Medicare Part D, and ancillary services. The MAP Medicaid benefit covers all services covered in the MLTCP benefit package; services beyond the Medicare limits, such as home health services not covered by Medicare; and all Medicare cost-sharing. Services not included in the MAP benefit include hospice services, certain Medicaid behavioral health services, and services carved out of Medicaid managed care (e.g., assisted living programs). These services may be available through Medicare or Medicaid FFS. NYS planned to carve Medicaid behavioral health services into the MAP benefit in 2022, but the carve-in is currently delayed until January 1, 2023.

MAP plans currently still involve separate enrollment processes, revenue streams, and review of marketing materials. However, further integration efforts are underway, including:

- CMS's CY 2023 Medicare Advantage (MA) rule proposes several new requirements for all FIDE SNPs, including implementation of an integrated grievances and appeals process.
- Effective April 1, 2021, NYS has implemented default enrollment processes, such that Medicaid members with LTSS needs may be directly enrolled into a MAP plan upon becoming newly eligible for Medicare, if they are already enrolled in a participating MMC plan.

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Program of All-Inclusive Care for the Elderly (PACE)

A Program of All-Inclusive Care for the Elderly (PACE) is a fully-capitated payment and service model in which a PACE Organization provides a community-based alternative to nursing homes. PACE programs center on a physical site location called a PACE Center, where the PACE Organization directly provides an array of community-based long-term care and medical supports. These services are supplemented by in-home and referral services as needed by the PACE enrollee.

The PACE program was permanently authorized in federal regulation in 1997, making it the oldest type of integrated plan. PACE programs have a single, integrated enrollment process, regulatory framework, approval stream for marketing materials, grievances and appeals process, and a combined Medicare and Medicaid revenue stream. Individuals eligible to enroll in PACE must:

- Be 55 years of age or older;
- Have Medicaid and/or Medicare and/or a willingness to pay privately;;
- Require a nursing home level of care; and
- Live in the service area of a PACE program.

In practice, the vast majority of PACE enrollees are dual eligibles.

All PACE services are coordinated by an interdisciplinary care management team (IDT), usually located at the PACE Center. The comprehensive PACE benefit includes all Medicare and Medicaid benefits, including inpatient and outpatient hospital services, primary care and specialty physician services, outpatient prescription drugs covered under Medicare Part D, ancillary services, and long-term care services, including nursing home stays when necessary. PACE programs may also cover other services if the IDT deems them necessary.

The NYS FY 2023 Executive Budget proposes to create a unified state-level licensure process for PACE Organizations, which would consolidate the requirements under Article 28, Article 36, and Article 44, as well as other regulatory requirements required for the establishment of a PACE Center.

LTSS Providers

Acute, Residential, Institutional, and Site-Based Providers

Long-Term Acute Care Hospital (LTACH)

LTACHs are certified acute care hospitals that provide care for patients with multiple serious medical conditions that require lengthy inpatient stays. An LTACH's average length of stay must be 25 days or greater, and residents must require intensive medical care. Medicare reimburses LTACHs through a special LTACH Prospective Payment System (PPS).

Skilled Nursing Facility (SNF)

A SNF (or nursing home) is an inpatient residential health facility staffed by licensed nurses and other medical professionals on a 24/7 basis. Along with skilled nursing, nursing homes provide short-term rehabilitation and/or long-term residential care for individuals who need help with activities of daily living (ADLs). Nursing homes are licensed under Article 28 of the Public Health Law. As of January 2022, there are 615 active nursing home operating certificates across New York.

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Adult Care Facilities (ACFs) and Assisted Living Programs (ALP)

An ACF is a residential care program for people who do not meet a nursing home level of care, but still need assistance with ADLs and/or are unable to live independently. An ALP is defined as an ACF that arranges for home health services and other skilled help for its residents. ACFs are regulated under Article 46-B of the Public Health Law. As of December 2021, there are 555 ACFs licensed by DOH.

Hospice Agency

A hospice program is a coordinated home-based and inpatient care model that offers palliative care for end-of-life patients and their families. Hospices offer medical care to help someone with a terminal illness (with a life expectancy of less than one year) to live as well as possible for as long as possible. Hospices are licensed by DOH under Article 40 of the Public Health Law. As of January 2022, there are 42 licensed hospice agencies in New York.

Adult Day Health Care (ADHC)

ADHC programs provide a program of medically-supervised day services for individuals who have functional impairments. Services may include nursing, transportation, leisure activities, physical therapy, nutrition assessment, and medical social services, among others. ADHC programs may be co-located with a nursing home or be separately established offsite. As of January 2022, there are 36 independently established ADHC programs in New York.

Social Adult Day Care (SADC)

SADC programs provide day services for individuals with functional impairments. Although an SADC program provides a structured and protective setting for these individuals, they do not have medical supervision like an ADHC. SADC programs are not licensed by DOH. In June 2015, DOH, the State Office for Aging, and the Office of the Medicaid Inspector General (OMIG) adopted a certification process for SADCs that contract with MLTCPs, in which SADCs register with OMIG.

Home and Community-Based Service Providers

Certified Home Health Agency (CHHA)

A CHHA is a Medicare-certified home health agency that provides part-time, intermittent services to individuals who need intermediate and skilled home health care. A CHHA typically offers post-acute services after an individual is discharged from a hospital. CHHAs may also provide longer-term nursing and home health aide services and can provide or arrange for other services including physical, occupational, and speech therapy, medical supplies and equipment, and social worker and nutrition services. CHHAs are licensed by DOH under Article 36 of the Public Health Law and under federal law.

Licensed Home Care Service Agency (LHCSA)

A LHCSA is a home health agency that may provide hourly nursing, personal care, and other related services to individuals who require assistance with ADLs. LHCSAs are licensed by DOH under Article 36, but not under federal law. NYS has sought to limit the growth in LHCSAs in recent years through licensure moratoria, limits on MLTCP networks, and demonstration of need requirements. Currently, DOH plans to release a Request for Offers (RFO) that would select a limited number of LHCSAs for ongoing participation in the Medicaid program.

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Consumer Directed Personal Assistance Program (CDPAP)

CDPAP allows individuals to choose their own personal care aide to address their home health needs. CDPAP is available to chronically ill or physically disabled individuals who have a medical need for help with ADLs or skilled nursing services. A consumer-directed aide may provide any of the services provided by personal care and home health aides. The consumer will work with a Fiscal Intermediary (FI) organization, which manages hours and payroll for the CDPAP aide on the consumer's behalf, but the consumer has responsibility for hiring, training, and supervision.

The CDPAP program grew exponentially in size and expense during the period leading up to the establishment of MRT II in 2020, which proposed several changes to the program, including restructuring FI rates, tightening CDPAP eligibility standards, and conducting an RFO to select FIs that would be authorized to continue. The RFO was issued in 2020, and DOH announced the selection of 68 FIs in February 2021. However, a provision in the FY 2022 Budget required DOH to reopen the RFO to make additional awards to meet certain geographic and population needs. The contracting process is on hold until after this is completed.

OPWDD System Transformation

The OPWDD service system consists of State-operated services and voluntary agencies that provide services to people with I/DD through the OPWDD Comprehensive 1915(c) HCBS waiver. In general, OPWDD services include residential services, day programs, clinical services and therapy services, and other ancillary supports.

In February 2018, OPWDD published a "Draft Transition Plan for HCBS, Health Home Care Management for Individuals with I/DD, and the Development of Specialized Managed Care," outlining a multi-year pathway to create specialty provider-led managed care plans. These initiatives began with the implementation of I/DD Health Homes, or Care Coordination Organizations (CCOs) and the consolidation of services under the OPWDD Comprehensive Waiver. The Transition Plan further states that OPWDD would pursue a further amendment to the broader MRT 1115 waiver that would authorize the creation of a new managed care model under which the enrollment of people with I/DD in qualified plans, called Specialized I/DD Plans – Provider Led (SIPs-PL), would eventually become mandatory.

OPWDD Comprehensive HCBS 1915(c) Waiver

The current version of the OPWDD Comprehensive 1915(c) Waiver was approved on October 1, 2019 for a five-year period. To be eligible for HCBS waiver services, individuals with I/DD must:

- Be eligible for Medicaid;
- Meet the standard for an institutional Level of Care (LOC); and
- Choose to receive HCBS waiver services rather than institutional care.

People who choose to live in an Intermediate Care Facilities for Individuals with Intellectual and Developmental Disabilities (ICF/IIDs or ICFs) are <u>not</u> enrolled in the OPWDD Waiver. ICFs are considered inpatient institutions and paid an all-inclusive per diem rate. However, individuals enrolled in the OPWDD Waiver must meet the same LOC standards as an ICF. Such individuals may be supported residentially through alternative options, including Individualized Residential Alternatives (IRAs) and Community Residences (CRs), or may live in their own home.

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Services that may be available under the OPWDD waiver include:

- Residential Habilitation services to support individuals in an IRA;
- Day services, including Day Habilitation and Community Habilitation;
- Vocational services, including Prevocational Services, Supported Employment (SEMP), and Pathway to Employment; and
- Durable goods and modifications, such as Assistive Technology – Adaptive Devices, Environmental Modifications, and Vehicle Modifications.

Services may also be delivered through self-direction. Under this option, the waiver participant may work with a Fiscal Intermediary to pay staff that they hire, including live-in caregivers and individual-directed goods and services. The full array of OPWDD Waiver services and accompanying definitions may be found in Attachment G here.

Currently, about 100,000 people are projected to be enrolled in the OPWDD Waiver each year, with total expenses of roughly $7 billion. The Waiver was last amended in July 2021 to make permanent certain provisions that were temporarily adopted through Appendix K waivers to address the Covid-19 emergency. In particular, the Waiver now allows day services and vocational services to be provided through telehealth.

Health Homes/Care Coordination Organizations (HH/CCOs)

In July 2018, NYS established a new model of Health Homes specifically for people with I/DD, also known as Care Coordination Organizations (HH/CCOs or CCOs) to replace and expand the function of Medicaid Service Coordination (MSC) previously available under the OPWDD Waiver. Over 350 agencies providing MSC were consolidated into seven regional CCOs (which remain controlled by providers with experience serving the I/DD population) that provide Health Home Care Management. CCOs are not themselves a component of the OPWDD Waiver, but any individual seeking OPWDD Waiver services must enroll in a CCO.

To be eligible for enrollment in a CCO, a Medicaid-enrolled individual must:

- Present with a diagnosis of a condition in the Major Category of Developmental Disabilities;
- Meet the institutional ICF LOC methodology; and
- Be determined by OPWDD or its designee to meet the definition of "developmental disability" in the Mental Hygiene Law.

CCOs, like other Health Homes, are required to provide the six core Health Home services, including Comprehensive Care Management. In a CCO, this is provided by a care manager who works with individuals with I/DD and their families to bring together health care and developmental disability service providers to develop an integrated Life Plan that includes OPWDD, medical, behavioral health, community and social supports, and other services.

Individuals in the OPWDD Waiver may opt out of receiving full Health Home services. In that case, they will still need to enroll with a CCO to receive Basic HCBS Plan Support. This service provides the necessary assistance to conduct timely reviews of and updates to the individual's Life Plan. However, it does not include care management and coordination of medical, behavioral health, dental, and other services.

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Specialized I/DD Plans – Provider Led (SIPs-PL)

In February 2020, OPWDD released a draft document outlining qualifications for specialty provider-led managed care plans called Specialized I/DD Plans – Provider-Led (SIPs-PL). Organizations would need to have an Article 44 MMC license and meet additional criteria as outlined in the document to offer a SIP-PL.In particular, organizations seeking to establish a SIP-PL will need to be majority-controlled by not-for-profit entities that demonstrate experience providing or coordinating health and long-term care services for I/DD populations. The document did not identify a specific timeline for the transition, other than that it would depend on SIP-PL readiness and that mandatory enrollment would begin no sooner than one year after voluntary enrollment.

To be eligible to enroll in a SIP-PL, an individual should be:

- Enrolled in the OPWDD 1915(c) Comprehensive HCBS Waiver;
- A resident of an ICF; or
- Another type of Medicaid-enrolled individual also eligible for OPWDD services.

Individuals with I/DD who are eligible for Medicaid through a "spend-down" program would be eligible to enroll in a SIP-PL by offsetting excess income with medical expenses. MMC-eligible family members of SIP-PL enrollees who do not have I/DD would be able to enroll in a separate comprehensive MMC program also operated by the SIP-PL.

In addition to Medicaid-only beneficiaries, those who are dually eligible for Medicaid and Medicare and those with comprehensive Third-Party Health Insurance (TPHI) would be eligible for SIP-PL enrollment. However, voluntary enrollment would start with individuals with Medicaid only, and would subsequently be expanded to include dual eligibles and those with TPHI. Dual eligibles would be able to choose between:

- Remaining in Medicare FFS and enrolling in a SIP-PL that will manage the comprehensive Medicaid benefit, including Medicaid coverage of Medicare co-insurance and OPWDD HCBS;
- Enrolling in an MA plan and separately enrolling in a SIP-PL that will manage Medicaid-only services, including OPWDD HCBS; or
- Enrolling in a specialized product for duals, such as the Fully Integrated Duals Advantage for Individuals with I/DD (FIDA-IDD).

The following populations would not be eligible to enroll in a SIP-PL:

- Individuals in Developmental Centers or Small Residential Units;
- Individuals in residential schools and specialty hospitals;
- Individuals who are residents of a residential healthcare facility at the time of enrollment;
- Individuals who are eligible for and/or enrolled in a HARP; and
- Individuals otherwise excluded from enrollment in a comprehensive MMC plan, except where specifically identified as eligible for SIP-PL enrollment.

As of 2022, no SIP-PL organizations have yet been established. The proposed FY 2023 Executive Budget states that "the State continues to assess the potential effectiveness and sustainability of the proposed delivery system to ensure individuals continue receiving appropriate services in the most cost-effective manner."

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The SIP-PL benefit package would initially consist of:

- All standard State Plan services in the mainstream MMC benefit, including medical services, BH services, long-term care supports, and other services;
- All OPWDD-specialized State Plan services, including I/DD community-based ICF services, Day Treatment, Article 16 clinic services, and Independent Practitioner Services for Individuals with I/DD (IPSIDD);
- I/DD Health Home Care Management; and
- OPWDD non-residential HCBS.

The OPWDD residential benefit is expected to be carved into the SIP-PL capitated benefit package no less than two years after voluntary enrollment begins, subject to the State's determination that plans have the capacity to manage the benefit. Savings achieved through the management of residential services must be sufficient to offset any costs associated with the management of this benefit.

FIDA for Intellectual and Developmental Disabilities (FIDA-IDD)

In November 2015, CMS and NYS announced the Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD) program, which established a specialized integrated Medicare-Medicaid plan (MMP) demonstration for dually-eligible adult individuals with I/DD. An integrated MMP consists of a single plan product that integrates both the Medicare and Medicaid benefit, unlike a D-SNP model, which retains the structure of two products. NYS and CMS contracted with one organization, Partners Health Plan (PHP), to operate a FIDA-IDD plan.

In January 2022, there were 1,698 individuals enrolled in PHP statewide.

PAYMENT REFORM

Section 1115 Waivers

Every state's Medicaid program operates under a comprehensive Medicaid State Plan, which describes the Medicaid program's eligibility standards, covered benefits, and reimbursement standards. Various operating requirements apply under a standard State Plan. For example, Medicaid services must be available on a comparable basis to all enrollees, and enrollees must have the freedom to choose among all Medicaid-participating providers. States wishing to implement more flexible policies for a given Medicaid population must seek approval of a waiver from CMS.

Most of New York's Medicaid program operates under a Section 1115 demonstration waiver, currently known as the Medicaid Redesign Team (MRT) Waiver, which provides the authority for NYS to operate the mandatory statewide managed care programs described elsewhere in this Glossary, including MMC plans, HARPs, and partially-capitated MLTC plans. In March 2021, CMS approved a temporary extension of the MRT Waiver, without new programmatic elements, through March 31, 2022.

Section 1115 waivers must demonstrate "budget neutrality," meaning that they create federal savings compared to a scenario without enactment of the waiver. Under this constraint, CMS may agree to reinvest a portion of federal savings into the Medicaid system. In 2014, pursuant to this process, CMS approved an amendment to NYS's waiver that reinvested $8 billion into various Medicaid reform initiatives, including the DSRIP program, Health Homes, implementation of BH HCBS, and MLTC workforce programs.

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DSRIP

The DSRIP program, which ran through March 2020, made $6.4 billion of federal funds available to redesign the State's Medicaid program to help achieve the Triple Aim of improved care, enhanced quality, and reduced costs. DSRIP's overall goal was to reduce avoidable hospitalizations statewide by 25 percent over five years, with several other subsidiary goals. DSRIP also established the Value-Based Payment (VBP) Roadmap, which set a goal of transitioning at least 80% of Medicaid managed care payments into VBP arrangements by the end of the waiver period.

DSRIP funding was made available to Performing Provider Systems (PPSs), which were regional networks of providers, typically led by a major hospital or health system, that were responsible for enacting a set of delivery system redesign projects from a pre-approved menu. Commonly implemented projects included primary care practice transformation and PCMH certification and the integration of behavioral health services. PPSs earned incentive payments based on achieving process and outcome metrics related to their projects. Once earned, incentive payments could be used for further investment in projects and other purposes, such as covering revenue losses due to lower hospitalizations.

The DSRIP Independent Assessor's Final Summative Evaluation was approved in December 2021. CMS noted that it found a "significant reduction in potentially preventable readmissions," and that "[a] majority of the behavioral health and population health measures evaluated demonstrated statistically significant improvements […] including key primary care indicators."

In November 2019, the State submitted to CMS a waiver renewal request, which included a 4-year extension of the DSRIP program. However, CMS declined the request in February 2020, citing the "one-time" nature of DSRIP, and stating that it intended to rebase the MRT demonstration's budget neutrality calculation, limiting NYS's potential room for reinvestment. The denial was seen as related to the Trump Administration's stated policy of moving away from "open-ended, one-off DSRIP waivers."

New 1115 Waiver Proposal

In August 2021, DOH submitted a concept paper for a new Medicaid 1115 waiver demonstration to CMS. Through this proposal, the State is requesting $17 billion to be reinvested over five years to support a transformational effort to address health equity by reforming systemic health care delivery issues that are linked to health disparities and have been exacerbated by the Covid-19 pandemic. The waiver would seek to incorporate lessons learned from DSRIP while still being a distinct program. In particular, the new waiver proposal would explicitly target health equity goals and would promote greater adoption of deeper VBP arrangements, including subcapitation and global budgets.

The FY 2023 Executive Budget notes that NYS plans to submit a complete waiver application to CMS in March 2022.

Value Based Payment (VBP) Roadmap

Under DSRIP, NYS was required to submit the five-year VBP Roadmap as part of a sustainability plan to maintain post-DSRIP improvements. The VBP Roadmap outlined how NYS would seek to move at least 80% of Medicaid managed care payments into VBP models, and at least 35% of payments through models involving downside risk. As of April 2020, NYS found that these goals had been met, with 86% of payments made through VBP models and 56% of payments involving downside risk.

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All VBP models involved 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 met quality metrics and if costs were below the target budget. This definition was more stringent than the corresponding Medicare definition by excluding FFS payment models with quality bonuses not tied to a target budget.

The VBP Roadmap included a menu of VBP arrangements acceptable to NYS. The menu originally included four broad categories, but in the current Roadmap, it has been consolidated to a list of seven specific designs, including Total Care for the General Population (TCGP), under which the target budget incorporates the cost of all Medicaid-covered services; five subpopulation arrangements, under which the target budget incorporates total cost of care for a population of HARP enrollees, MLTC enrollees, people with I/DD, people with HIV/AIDS, or children; and the Maternity Care bundle. "Off-menu" arrangements are also be permitted, subject to State approval. The Roadmap also specifies various requirements for such contracts, such as levels of risk and shared savings/losses.

In January 2022, DOH released for public comment an updated draft of the Roadmap, which had not been updated since the conclusion of DSRIP in March 2020. DOH stated that this update to the Roadmap would rearticulate its "continued expectations for Medicaid plans and providers to engage in VBP." The update did not contain material changes to existing VBP contracting requirements, but did significantly streamline and restructure the Roadmap's content. The update also:

- Simplified certain requirements, such as eliminating the "tiers" of community-based organizations that were based on whether the organization is eligible to bill Medicaid;
- Removed references to unused models, such as the IPC model and associated requirements; and
- Changed the VBP parameters for MLTCP plans from requirements to guidelines, and discontinued related quality reporting support, because DOH concluded that the MLTCP model structure "does not reflect current VBP principles."

As part of the update, DOH also sought feedback for a forthcoming, more substantial update to the VBP Roadmap to be released in conjunction with its application for a new 1115 waiver amendment.

Clinical Advisory Groups (CAGs)

As part of the VBP Roadmap, NYS formed a series of stakeholder groups, called CAGs, to help develop the quality measures and other parameters to be used in VBP arrangements. The initial CAGs were convened in 2015, after which various CAGs were reconvened on a roughly annual basis to update their recommendations as needed.

DOH most recently convened seven CAGs in 2019: Maternity; Physical Health and Chronic Conditions; Behavioral Health; HIV/AIDS; Managed Long-Term Care; I/DD; and Children's Health.

VBP Innovator Program

The VBP Roadmap established a VBP Innovator program for providers with significant experience in VBP contracting who sought to take on VBP models involving fully-capitated risk or substantial downside risk within shared savings arrangements. To be designated as a VBP Innovator, an organization must demonstrate that they can perform substantial administrative and care management functions and that taking on significant or full risk will be financially viable for the organization. Innovator contracts must involve the total cost of care for a population or subpopulation, and "are eligible for up to 95 percent of the total dollars traditionally paid from NYS to the MCO."

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Social Determinants of Health (SDH) and Community-Based Organizations (CBOs)

The VBP Roadmap requires VBP contracts that involve downside risk (a Level 2 VBP arrangement) or subcapitation (a Level 3 VBP arrangement) to implement at least one SDH intervention that aligns with at least one of the five key domains of SDH. These domains are defined in line with the federal Healthy People 2030 project's definitions:

- Education
- Social and Community Context
- Health and Health Care
- Economic Stability
- Neighborhood and Built Environment

For a Level 2 contract, MMC plans and VBP contractors are expected to share the costs and responsibilities associated with implementing the SDH intervention. For a Level 3 contract, the VBP contractor is fully responsible for implementing the SDH intervention. Notably, the VBP Roadmap specifies that MMC plans may classify expenses for SDH interventions as "Other Medical" expenses in their operating reports, meaning that they may be included as part of the plan's medical loss.

The VBP Roadmap also requires that a Level 2 or Level 3 contract includes at least one CBO to help implement the relevant SDH intervention. A CBO is defined as a not-for-profit 501(c)(3) corporation and charitable organization that works at the local level to meet community needs. The Roadmap does not specify a contract structure; the CBO may contract with the VBP contractor, the MMC plan, or both.

The VBP Roadmap notes that because SDH interventions may not involve short-term savings, MMC plans should provide upfront incentives for their implementation. If a CBO is implementing the SDH intervention, it must receive startup funds or seed money in addition to service payments. MMC plans must report on compliance with these and other requirements in their VBP contract submissions to receive credit for a Level 2 or Level 3 contract.

Safety Net and Supplemental Payments

Medicaid Disproportionate Share Hospital (DSH) Payments

Federal law requires state Medicaid programs to make Disproportionate Share Hospital (DSH) payments to hospitals to offset their uncompensated care costs and improve the financial stability of safety net hospitals. Each state has its own annual DSH allotment, which limits the amount of federal funds that they can provide through DSH hospital payments. Federal law also establishes a cap on the amount of DSH payments that a state can make to any single hospital. In general, this prohibits payments that exceed the hospital's eligible uncompensated costs. States have broad flexibility in determining which hospitals receive DSH payment and how the payments are calculated.

In federal FY 2022, New York has a total state and federal DSH allotment of about $3.9 billion, although this amount will be reduced to about $3.5 billion due to enhanced federal matching funds (which decrease the State contribution to DSH). The Affordable Care Act (ACA) included cuts to Medicaid DSH payments as a funding offset, but these cuts have been repeatedly delayed, most recently in December 2020. Under current law, $8 billion of DSH cuts per year are scheduled to take place from FY 2024 through FY 2027, totaling $32 billion of cuts.

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NYS distributes its annual DSH allotment through four major programs:

- The Indigent Care Pool (ICP);
- The Indigent Care Adjustment (ICA);
- DSH Intergovernmental Transfers (IGTs); and
- DSH for Institutes for Mental Disease (IMDs).

The ICA and DSH IGT payments, which represent the bulk of these payments, are provided to public hospitals only, while DSH for IMDs is provided to specialty psychiatric hospitals operated by OMH.

Indigent Care Pool (ICP)

The Indigent Care Pool (ICP) makes Medicaid DSH funding available to hospitals statewide. The distribution of ICP funding has been a subject of long-term ongoing controversy. Multiple reports have found that ICP payments are not sufficiently tied to the actual delivery of uncompensated care. In 2013, the ICP formula was changed to exclude provisions for bad debt and teaching hospitals so that it would, in future, be based solely on the amount and cost of services that a hospital provides to uninsured and Medicaid patients. However, the formula included a "transition collar" which limited the rate at which a hospital's ICP payments would change. As a result, the effective change in distributions was limited.

In 2020, in connection with recommendations by the MRT II, the ICP distribution was overhauled further. For the years from 2020 through 2022, the transition collar has been eliminated, and the pool for voluntary hospitals was reduced by a total of $175 million, targeted at hospitals with a below-average public payer mix (Medicare and Medicaid). However, hospitals that qualify as enhanced safety net hospitals (ESHNs) are protected from these reductions, and may qualify for an additional $64.6 million pool to mitigate any reductions to their ICP payments due to the end of the transition collar. An ESHN must meet all of the following criteria in at least one of the last three years:

- At least 50% of the hospital's overall patient population is Medicaid or uninsured patients;
- At least 40% of the hospital's inpatient discharges have been covered by Medicaid;
- At least 3% of the hospital's overall patients are uninsured;
- No more than 25% of the hospital's inpatient discharges are commercially insured; and
- The hospital provides care to the uninsured through the emergency department, hospital-based clinics, and community-based clinics.

Public hospitals, Critical Access Hospitals (CAHs), and Sole Community Hospitals (SCHs) also qualify as ESHNs.

An ICP methodology for the 2023 year and afterwards has not yet been established in regulation.

State-Directed Payments to Financially Distressed Hospitals

In 2021, NYS applied to CMS for approval of a Section 438.6 state-directed payment preprint to direct additional funds to financially distressed safety-net hospitals. The state-directed preprint provides federal authority for NYS to direct MMC plans to make payment at enhanced rates to a class of providers. This payment authority would serve as a replacement for the VBP Quality Improvement Program (VBP QIP), which was authorized as part of the DSRIP program and served a similar purpose. Under this program, safety net hospitals are defined as not-for-profit hospitals that have a payer mix by volume of at least 36% Medicaid. An estimated $960 million would be available to hospitals annually.

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The Upper Payment Limit (UPL) and Other Supplemental Payments

States may choose to make further Medicaid supplemental payments to providers, but federal regulations prohibit matching funds from being used for FFS payments above an Upper Payment Limit (UPL). The UPL is meant to ensure that Medicaid pays no more than Medicare would pay for the same services. Rather than being applied at the claim level, the UPL applies to aggregate classes of providers, such as hospital inpatient services, hospital outpatient services, nursing homes, ICF/IIDs, and freestanding clinics. UPLs are also calculated separately for each category based on ownership type (state, non-state government, and voluntary private).

States are required to make annual reports of their UPL calculations to CMS. Because a state's UPL is calculated based on FFS utilization, transitioning populations to managed care tends to decrease the UPL. UPL amounts are adjusted by State Plan Amendment on a regular basis. For FY 2022, the voluntary hospital inpatient UPL is set at about $275 million and the voluntary hospital outpatient UPL is set at about $144 million.

NYS may elect to make further safety net payments to hospitals, but in general, any such payments would not be matchable by federal funds through Medicaid and would have to be funded through State-only funds. Various programs, such as the Vital Access Provider Assurance Program (VAPAP), have been established for this purpose in the past. The FY 2023 Executive Budget proposes a $100 million Distressed Hospital Pool and a continuation of last year's $250 million Distressed Intercept Fund which may be usable for associated purposes.

Global Budgets and Rate-Setting

NYS has previously implemented other approaches to Medicaid financing and health care payment. In the 1980s and 1990s, NYS operated under the New York Prospective Hospital Reimbursement Methodology (NYPHRM), a multi-payer payment methodology under which DOH was authorized to directly set inpatient hospital rates. The first NYPHRM, implemented in 1983, included Medicare, Medicaid, and all commercial payers, including Empire Blue Cross, which already received favorable treatment for hospital rates in return for maintaining a policy of community rating individual and small group policies. When NYPHRM was renewed, the Medicare waiver was dropped in favor of adopting the then-new system of Medicare Prospective Payment System (PPS) case-based payments. Overall, NYPHRM went through six evolutions, ending in 1997, when the Medicaid program was moved to an 1115 waiver, then called the Partnership Plan.

Another alternative financing system existed regionally in Rochester. From 1980 to 1987, the Rochester metropolitan area operated under a community-wide spending cap, under which the three major area payers (Medicare, Medicaid, and Blue Cross) provided a guaranteed annual budget for hospitals. This model, known as global budgeting, has also been implemented in other areas outside of New York, most notably in Maryland. In 2014, Maryland hospitals began receiving all-payer global budgets under a CMS Innovation Center demonstration. This demonstration was expanded in 2019 to incorporate non-hospital health care providers and to make participants responsible for the total cost of care.

Currently, rate-setting and other types of alternative financing approaches are again a topic of discussion in New York. The NYS FY 2021 budget gave DOH the authority to implement two types of global budgeting pilot projects:

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- The first provision allowed DOH to implement one or more five-year, regional multi-payer (Medicare, Medicaid, and commercial) global budgeting demonstrations. In the FY 2022 budget, this was amended to specify that any such demonstration must include at least one project located in the Western, Central, Southern Tier, or Capital Region.
- The second provision allowed DOH to implement a specific five-year demonstration starting January 2022 to conduct a Medicaid global budgeting demonstration.

Both authorizations were contingent on federal approval and funding. These authorities have not yet been invoked, but NYS has continued to explore the concept of global budgeting pilots, including in its August 2021 waiver concept paper. In the concept paper, NYS stated that it would seek "specific authorities" for "global prepayment payment models in selected regions," in which a regionally dominant health system or financially integrated provider organization would enter into a multi-payer VBP contract, including Medicaid (FFS and MMC), Medicare (FFS and MA), and/or commercial plans.