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NYS Health Equity Reform 1115 Waiver Amendment Proposal

OVERVIEW

~~On April 13th~~On September 2nd, the New York State Department of Health (DOH) ~~published~~ submitted its proposal for a new 1115 Waiver amendment entitled "~~Strategic Health Equity Reform Payment Arrangements" (SHERPA),~~ New York Health Equity Reform" (NYHER) ~~which is based on the concept paper DOH submitted~~ to the Centers for Medicare and Medicare Services (CMS) ~~in August 2021~~. DOH is requesting $13.52 billion to be reinvested over five years, structured around a central ~~with the~~ goal to ~~of~~ "reduce health disparities, advance health equity, and support the delivery of social care."~~addressing health disparities and systemic health care delivery issues" and transforming the Medicaid program's approach to paying for services to address both health needs and social care needs (SCN)~~. Specifically, the waiver proposal seeks to achieve the following four goals:

1. Build a more resilient, flexible, and integrated delivery system ~~that reduces racial disparities, promotes health equity, and supports the delivery of social care~~;
2. Develop and strengthen supportive housing services and alternatives to institutions for the homeless and long-term care populations;
3. Redesign and strengthen system capabilities to improve quality, advance health equity, and address workforce shortages; and
4. Create statewide digital health and telehealth infrastructure.

This waiver is distinct from the $8 billion Delivery System Reform Incentive Payment (DSRIP) waiver, which ended in 2020, but would seek to further advance similar goals. In particular, the ~~SHERPA~~ NYHER waiver notes "improvements in the way that [DSRIP] could have been structured to achieve more holistic and longer-lasting delivery system reform" and proposes to address the need to:

- Promote regional alignment on objectives;
- Provide more direct investment in services rendered by community-based organizations (CBOs) that address social care needs (S~~S~~CNs);
- Develop VBP arrangements that involve behavioral health providers in governance and design;
- Promote regional coordination of initiatives to address workforce shortages;
- Simplify administrative requirements and avoid new intermediaries between plans and providers;
- Leverage and avoid duplication of existing public health planning activities, such as those conducted through the State's Prevention Agenda; and
- Achieve deeper alignment of provider and payment incentives, including greater use of subcapitation or global budgets as the highest level of VBP.

DOH proposes for the waiver amendment to go into effect on January 1, 2023.

The full text of the ~~draft amendment~~final proposal is here. ~~DOH is holding two virtual hearings as opportunities for public feedback, on April 28th from 1pm-4pm (registration here) and May 3rd from~~

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~~1pm-4pm (registration here). DOH will accept written comments or requests to testify at the hearings at 1115waivers@health.ny.gov.~~

HEALTH AND SOCIAL CARE DELIVERY SYSTEM REFORM

As previously announced by DOH, the State intends to develop Health Equity Regional Organizations (HEROs) and social determinants of health networks (SDHNs) to support targeted investments in social care and non-medical, community-based services. Each entity is described in detail below.

HEROs

DOH is requesting $32.5 million in the first year and $65 million per year afterwards ($293~~325~~ million total) to fund the creation of nine regional HEROs. A HERO is a collaborative multi-stakeholder organization that will provide a regional, centralized platform for different types of stakeholders to collaborate in efforts to address the health and SCN of underserved communities. Although HEROs will provide some similar functions as PPSs, such as formalizing connections among regional networks of providers and CBOs, they are not intended to be primary recipients of waiver funding or implementers of waiver projects.

Governance

DOH will require HEROs to be coalitions of many different types of health and social care stakeholders, including:

- Managed care organizations (MCOs);
- Local health departments;
- Hospitals and health systems;
- Community-based providers (including primary care providers);
- Population health vehicles, such as Accountable Care Organizations (ACOs) and Independent Provider Associations (IPAs)
- Behavioral health (BH) networks and BH IPAs;
- Providers of long-term services and supports (LTSS), including those that serve individuals with intellectual and/or developmental disabilities (I/DD) or physical disabilities;
- CBOs, organized through SDHNs;
- Qualified Entities (QEs/HIEs) and Regional Health Information Organizations (RHIOs); ~~and~~
- Consumer representatives and other stakeholders;
- Nursing homes;
- Providers of rehabilitative and mobility services;~~.~~
- Perinatal services providers; and
- Children's services providers.

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HEROs would be required to have governance participation ~~from each class of participant~~from a wide range of participants, not limited to the above. The HERO lead entity could be a new entity or an existing one, such as a former DSRIP Performing Provider System (PPS) or a local department of health.

Geography

The State anticipates that there will be a single HERO in each of nine regions, based on the eight historical ~~regional~~ divisions used by DOH for Medicaid rate setting. However, DOH has not yet finalized these regions and will continue to consider possible subdivisions.~~will consult with local health departments to determine whether any of these regions should be further subdivided. In particular, DOH expects that New York City might be appropriate to subdivide into multiple sub-regions.~~

Responsibilities

A HERO's primary deliverable will be a Regional Plan, to be updated annually, that will create the foundation for the region's providers to address the needs of its vulnerable populations through value-based payment (VBP) arrangements. The Regional Plan will identify regional priorities for interventions based on local needs, such as service gaps and specific populations of concern, including subpopulations such as children or people with I/DD, and VBP contractors would use this information to guide the design of their VBP arrangements.

~~A second major function of~~ HEROs will also play a role in ~~be to centralize~~ data collection and aggregation. HEROs will use data from the State's standardized SCN assessment, likely to be CMS's Accountable Health Communities screening tool, to inform their Regional Plan. They also may serve functions such as ~~This includes the assessment~~assessing ~~of~~ current data collection capabilities and ~~;~~ providing technical support for data collection activities~~; and interpreting regional data to inform priorities for targeted interventions.~~.

HEROs will also be responsible for:

- ~~Developing a strategy to conduct a standardized SCN assessment, likely to be CMS's Accountable Health Communities (AHC) screening tool, for Medicaid members in its region;~~
- Selecting appropriate health equity quality improvement measures (or stratification approaches to existing measures) to monitor the achievement of regional priorities; ~~and~~
- Building regional consensus around a retooled VBP approach and design for services integration and care management with a focus on specific target populations, including the identification of regionally appropriate quality measures that will be stratified by ethnicity and race, and the selection of "optional" VBP measures from a State-designed menu; and~~.~~
- Identifying regional workforce needs in collaboration with Workforce Investment Organizations, including needs for community health workers (CHWs) and peer support staff.

Funding

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HEROs will receive limited planning grants (about $7 million per year) to support their planning, data collection, and other activities. They will not receive or distribute waiver funds, although in certain cases, they may identify spending priorities for which NYS would seek federal approval for funding allocation (such as state-directed payments). The State anticipates that HEROs will become self-sustaining entities that continue to act as coordinating bodies beyond the waiver demonstration period.

SDHNs

DOH is requesting a total of $860 million for SDHNs and related activities. This includes ~~-~~$92.5 milion in the first year and $185~~116~~ million per year afterwards ($832.5~~580~~ million total) to fund the creation of nine regional SDHNs. An SDHN will be a regional network of CBOs that will:

- Develop a coordinated approach to address the full spectrum of SCN in a specified region;
- Create a supportive IT and business processes infrastructure; and
- Adopt interoperable standards for a social care data exchange.

Governance and Geography

Lead applicants for SDHNs may be a CBO or a network of CBOs (such as an IPA composed of CBOs, or a former DSRIP PPS converted into an SDH-focused network). The State will designate SDHNs within each region (which would be aligned with the HERO regions and sub-regions).

Responsibilities

SDHNs in each region will be responsible for:

- Formally organizing CBOs to perform SCN interventions;
- Piloting new types of SCN interventions, with DOH approval;
- Coordinating a regional referral network with multiple CBOs and an array of partners, including health systems and other health care providers, behavioral health providers, and local government agencies;
- Creating a single point of contracting for SCN interventions in VBP arrangements or with other providers; and
- Advising on the best structure for screening Medicaid members on key SCNs and making appropriate referrals based on the results of SCN assessments.

SDHNs can also provide support to CBOs around business and operational practices (such as adopting and utilizing technology, service delivery integration, workflows, and billing and payment).

Funding

DOH would likely direct $152~~2~~ million per year of waiver funding to the SDHNs in each region, and $2~~1~~5 million for NYC, totaling $185~~11~~ million per year. SDHNs will use these funds for infrastructure

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development, (including IT and business processes), coordination of CBOs, capacity building of CBOs, and contracting. CBOs in the networks will also receive funding to integrate into the network.

DOH envisions that CBOs providing SCN services would be reimbursed in VBP arrangements and other partnered contracts on a fee-for-service basis, through a fee schedule. However, SDHN funding may also be used to fund services related to identified gaps not covered by VBP arrangements or other contracts.

~~Statewide IT Platform~~Referral Platform Interoperability

DOH will specify standards for interoperability to qualify existing and future SCN referral systems to be used by SDHs. Referrals will be required to include a standard "minimum set of data elements" to enable standardized reporting and analysis. Information on SCN resources, referrals, and outcomes will be collected and stored in a "statewide data store" using existing infrastructure of the Statewide Health Information Network for New York (SHIN-NY). This information will be used to "provide the State with near real-time insights" into these activities.

~~DOH seeks to procure a statewide IT platform to handle SCN data and referrals. This infrastructure would connect SDHNs, HEROs, and VBP contractors to address the SCNs of Medicaid members. It would also coordinate and report SCN-related assessment data and outcomes. Up to $30 million of waiver funding over the five-year waiver period would fund this initiative.~~

VBP MODEL INVESTMENTS

DOH is requesting $6.755 billion to continue and expand the Medicaid program's VBP transformation and incentivize the implementation of advanced VBP models. Under this initiative, compared to previous efforts NYS will focus more on:

- Population-specific VBP arrangements;
- Arrangements addressing SCNs, including adjusting for physical, BH, and SCN risk;
- Prepaid and fully capitated approaches, including for downstream providers who are not the lead VBP contractor; and
- Specific authorities for global prepayment models in selected regions.

- Examples of qualifying arrangements may include episodic arrangements focusing on maternal health (including maternal substance use treatment), alternative payment models for Federally Qualified Health Centers (FQHCs), and arrangements focusing on individuals with significant BH needs.

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Funding Mechanisms

Incentive funds would be made available to MCOs and providers upon presentation and approval of a qualifying VBP contract. Funds flow would occur through two mechanisms:

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1. Funds would be incorporated into the MCO premium to reflect plan administrative costs related to VBP.
2. An incentive payment pool would be available to fund participating providers directly.

Organizations designated as VBP Innovators under the DSRIP waiver may be eligible for upfront VBP incentive funding, in recognition that their existing infrastructure would allow them to expand their VBP footprint and incorporate the new goals of this waiver more rapidly.

Advanced Contracts Addressing SCN

The State will incentivize MCOs to form advanced VBP contracts, using prepaid or capitated payment models, that address local needs as identified by the regional HERO. Such contracts would include contracting with providers or SDHNs to provide care coordination and other activities to support HERO-identified goals. A portion of funding will be dedicated to the provision of uniform screening and social care services. Funding preference would be given to arrangements using SDHNs, although in recognition of existing arrangements, SDHN participation would not be mandatory.

NYS will establish a fee schedule for SCN interventions, so that CBOs can receive per-service reimbursement rather than relying on retrospective shared savings, as is currently common in VBP arrangements. This fee schedule will be based on the schedule developed under North Carolina's Healthy Opportunities Pilot Program.

Primary Care

The waiver will continue to leverage past investments in the Patient-Centered Medical Home (PCMH) model. Under VBP arrangements, including those for specific populations, PCMH practices will continue to play a coordination and service role for patients' medical needs.

Specialty Populations

For contracts involving specialty populations, MCOs will be incentivized to engage with experienced, population-specific provider networks. For example:

- VBP contracts that target individuals with serious mental illness would be required to include behavioral health IPAs or other provider networks along with primary care providers. Rather than a primary care-only attribution, waiver incentive funding would be awarded based on "differential attribution methodologies" using the individual's primary behavioral health provider (such as an Article 31 clinic) or Health Home.
- Similarly, for individuals with I/DD, attribution may occur based on the Care Coordination Organization (CCO).
- For individuals with physical disabilities, attribution may occur based on the individual belonging to a specialized Health Home.

Global Budget Model

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The waiver proposal contains new details on how DOH would implement global budgeting models. DOH would seek to employ this model in "logical" regions, where a single provider or a financially integrated provider network has a dominant position and has demonstrated its ability to manage both physical and behavioral care for a targeted regional population. DOH would intend for the global budget to be implemented on an all-payer or multi-payer basis (including Medicare, Medicaid, and/or commercial plans).

Under the model, the lead entity would be responsible for working with a continuum of providers and all relevant health plans. It would be responsible for managing the total cost of care, establishing provider-payer relationships, and providing data and analytics for performance measurement. Furthermore, it would negotiate payments, on either a fee-for-service or capitated basis, with downstream providers entities.

DOH would implement the model using directed payments. As such, payments would continue to flow through MCOs, but they would pay the lead VBP provider based on a minimum fee schedule. As utilization decreases (or increases), DOH would increase (or decrease) the fee schedule accordingly on a quarterly basis to reconcile payments with the overall fixed global budget.

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ACCESS FOR CRIMINAL JUSTICE-INVOLVED POPULATIONS

As part of the health equity goals of this proposal, the State seeks to improve access for the criminal justice-involved population. DOH is requesting $748~~5~~ million of waiver funding over five years as well as CMS approval to expand enrollment criteria to enable incarcerated individuals to enroll in Medicaid 30 days prior to their release and to provide them with a targeted set of services to assist with re-entry. These services would include:

- Care management and discharge planning;
- Clinical consultant services;
- Peer services; and
- Medication management and delivery for high-priority medications.

Eligible individuals would meet Health Home criteria of having:

- Two or more qualifying chronic conditions (e.g., diabetes~~ or hepatitis C~~); or
- One single qualifying condition, including HIV/AIDS, a serious mental illness (SMI), ~~or a~~an ~~opioid~~ substance use disorder (S~~O~~UD), Hepatitis C, sickle cell disease, or I/DD.

Services would be phased in over two years, starting with State facilities in the first year and local jails in the second. DOH projects that approximately 100,000 individuals discharged from jails or prisons would be eligible for this program.

~~SUPPORTIVE~~ TRANSITIONAL HOUSING AND ALTERNATIVES TO INSTITUTIONS

The State requests $1.56 billion over five years to fund programs to expand transitional~~supportive~~ housing and related services to address the needs of two significant Medicaid populations:

- Individuals and families at risk of homelessness; and
- Individuals with long-term care needs in institutionalized settings, including people with I/DD in managed care.~~.~~

Comprehensive Housing Planning through HEROs

The regional HEROs will work with local Continuum of Care (COC) planning bodies and others to identify housing gaps and potential housing solutions for the two priority populations mentioned above. The HEROs will also use data to identify specific cohorts within these populations. Specifically, HEROs will use Medicaid and homeless data to identify individuals who are high utilizers of Medicaid that need additional engagement with the system. They will also use Money Follows the Person (MFP) and other programs that serve the institutional population to identify individuals who need further assistance to return to community-based housing.

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Enhanced Transitional~~Supportive~~ Housing Initiative

DOH will establish an Enhanced Transitional~~Supportive~~ Housing Initiative~~Pool~~ that will fund enhanced housing services, targeted to at-risk high utilizers and institutionalized individuals (as identified above). The Pool's funding will be supplemented with MCO and VBP arrangement funding as appropriate.

Funds will be used to reimburse SDHNs for engaging with these members and helping them to find and stay in housing through transitional~~supportive~~ housing services. These services would include:

- Medical Respite: Programs for homeless individuals to help avoid inpatient hospitalizations.
- Community Transitional Services: Services including housing navigation, application assistance, case management, short-term rental assistance (up to 6 months), and transitional housing costs (e.g., security deposits).
- Tenancy Supports: Supports to help individuals stay safely housed in the community, such as landlord mediation and crisis interventions.
- Referral and Coordination of Related Services: Care coordination provided by SDHNs or their affiliated CBOs to connect individuals with other services, which might include:
  - BH supports;
  - Home and community-based services (HCBS);
  - Environmental supports;
  - Employment supports; or
  - Additional SSI state supplemental funding for high needs populations.

SYSTEM CAPACITY AND WORKFORCE

Covid-19 Unwind Quality Restoration Pool

DOH requests $300 million per year ($1.5 billion total) for a VBP pool available specifically to financially distressed safety net hospitals and nursing homes, defined as those with a high Medicaid payer mix. Funds would be available for:

- Quality improvement and health equity activities;
- Workforce training efforts to support the above initiatives and pandemic-related needs; and
- Supporting safety net institutions' capacity to engage in other waiver initiatives, including VBP and HERO initiatives.

Organizations receiving funding will be required to align their activities with the goals of the regional plan established by the HERO in their region.

Of this~~Of the~~ total funding amount, DOH would direct $1 billion towards quality and health equity-related interventions and $500 million towards workforce training investments.

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Workforce Investments

DOH requests $1.5 billion to fund expanded Workforce Investment Organizations (WIO) initiatives. This proposal would expand WIO initiatives from their DSRIP-era focus on long-term care to include health care workers from across the care continuum. Funds would go to initiatives that:

- Expand and enrich the workforce to address shortages across the health care continuum, recruit people of color in medical professions, and provide workers with a greater range of opportunities for advancement;
- Support the career pathways of frontline health care workers in entry-level positions where there are occupational shortages;
- Support regional collaboration and training initiatives;
- Expand the community health worker and related workforce, including care navigators and peer support workers; and
- Standardize occupations and job training.
- WIOs will be required to collaborate with HEROs on identifying regional workforce needs, and with each other on ensuring goals are systematically consistent statewide.

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DIGITAL HEALTH AND TELEHEALTH

DOH proposes to use $300 million of waiver funds to invest in digital and telehealth infrastructure that expands access to care in underserved areas (e.g., rural areas and communities of color) and for underserved needs (e.g., behavioral health and chronic disease management). Using this funding, DOH would establish an Equitable Virtual Care Access Fund to help Medicaid providers receive the capital investments, resources, and support they need to employ telehealth more broadly and effectively.

DOH has identified a preliminary set of investments for this fund, which include:

- Care management and check-in services for Medicaid enrollees who are high utilizers of hospital services;
- Providing telehealth equipment to skilled nursing facilities (SNFs);
- Providing telehealth equipment and virtual care subscriptions to Medicaid enrollees who are homebound or in a residential facility;
- Funding community health workers (CHWs) in every county and providing them with telehealth equipment;
- Funding community dental health coordinators and providing them with telehealth equipment;
- Establishing telehealth kiosks in homeless shelters;
- Provider and member training in telehealth literacy; and
- Providing tablets to providers and enrollees who lack access to telehealth technology.

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DOH intends for this fund to support the delivery of telehealth or virtual care through a wide range of modalities and may consider funding other population health activities that are supported by virtual care, including technology addressing the needs of children served in multiple systems and electronic platforms that connect with Medicaid recipients in real time.

BUDGET NEUTRALITY

The proposed initiatives would increase the current annual demonstration cost from $40 billion to $42.7 billion. The waiver amendment proposal does not include a budget neutrality calculation. Instead, NYS seeks to work with CMS to identify an appropriate, wider basis to calculate the budget-neutral effects of this waiver. DOH hopes to revisit prior administrative guidance issued by CMS under the previous administration to count other local and State financial commitments, similar to Designated State Health Programs (DSHPs) as used in the DSRIP waiver and previous waivers. Additionally, the State would seek to identify federal savings that accrue outside the Medicaid program, with the recognition that the effects of Covid-19 and the downstream effects of health disparities are likely to have significantly budgetary impacts outside of Medicaid.