NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

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Commissioner

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Acting Executive Deputy Commissioner

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Dear Colleague:

The New York State Department of Health (the State) requests $13.5 billion over five (5) years to fund a new 1115 Waiver amendment, "Strategic Health Equity Reform Payment Arrangements: Making Targeted, Evidence-Based Investments to Address the Health Disparities Exacerbated by the COVID-19 Pandemic" (SHERPA), that addresses the inextricably linked health disparities and systemic health care delivery issues that have been both highlighted and intensified by the COVID-19 pandemic. If approved, this 1115 Waiver amendment would utilize an array of multi-faceted and linked initiatives in order to change the way the Medicaid program integrates and pay for social care and health care in New York State (NYS). It would also lay the groundwork for reducing long standing racial, disability-related, and socioeconomic health disparities, increase health equity though measurable improvement of clinical quality and outcomes, and keep the overall Medicaid program expenditures budget neutral to the federal government.

To achieve this overall goal of fully integrating social care and health care into the fabric of the NYS Medicaid program, while recognizing the complexity of addressing varying levels of social care needs impacting the Medicaid population, this waiver proposal is structured around four subsidiary goals:

1. *Building a more resilient, flexible, and integrated delivery system that reduces health disparities, promotes health equity, and supports the delivery of social care;*
2. *Developing and strengthening supportive housing services and alternatives to institutions for the homeless and long-term institutional populations;*
3. *Redesigning and strengthening system capabilities to improve quality, advance health equity, and address workforce shortages; and*
4. *Creating statewide digital health and telehealth infrastructure.*

Anticipated Impact on Tribes

The anticipated impact of this amendment would have on Tribal members includes:

- Improving patient-centered care by further sustaining the integration across physical health, behavioral health, addiction treatment, and social services in communities and through sustained investment in health equity;
- Expanding and integrating supportive housing services to ensure alternatives to institutions for the long-term care population; and
- Improving access through workforce investments, aid to financially distressed hospitals and nursing homes, and increased availability of digital and telehealth services.

For the last decade, through its current 1115 waiver, NYS has engaged in efforts to redesign Medicaid using managed care and its recently ended DSRIP program. DSRIP had an overall goal of reducing avoidable hospitalizations by 25 percent and achieving savings while transforming the health system to use VBP. NYS achieved many of its goals with DSRIP, including a 26 percent reduction in Potentially Preventable Admissions (PPAs) and an 18 percent reduction in Potentially Preventable Readmissions (PPRs) through Measurement Year 5; facilitated a significant increase in Patient Centered Medical Home (PCMH) certification; made major progress in integrating physical and behavioral health care; and improved care transitions that directly reduced readmissions. The DSRIP program also incorporated a Value-Based Payment Roadmap, which achieved its goals of at least 80% of the value of all Medicaid managed care contracts in shared savings (Level 1) or higher VBP arrangements, and 35% of contract value in upside and downside risk (Levels 2 and 3) arrangements. As a result of all these initiatives and others in the State's current 1115 waiver, as well as other Medicaid redesign initiatives, NYS Medicaid spending per beneficiary in 2019 was less than in 2011.

With this waiver amendment proposal, NYS is incorporating lessons learned from its DSRIP experience, the experience of forming and collaborating with PPSs, the feedback received from stakeholders and the public throughout the amendment, and insights uncovered during the subsequent DSRIP evaluation process. The State has identified several key practices that will be again leveraged to accomplish the health equity and system transformation goals listed in this amendment with some adjustments in implementation in response to the challenges, nuance, and opportunities experienced during previous efforts, and that recognize addition need as highlighted by COVID-19.

The following chart outlines the specific goals NYS hopes to achieve through this waiver and the objectives of each goal.

Goal	Objective(s)
1. Building a more resilient, flexible and integrated delivery system that reduces health disparities, promotes health equity, and supports the delivery of social care	a. Investments in regional planning through Health Equity Regional Organizations (HEROs) b. Investments in Social Determinant of Health Networks (SDHNs) c. Investments in Advanced VBP Models that fund the coordination and delivery of social care via an equitable, integrated health and social care delivery system d. Capacity building and training to achieve health equity goals e. Ensuring access for criminal justice-involved populations
2. Developing and strengthening supportive housing services and alternatives for the homeless and long-term institutional populations	Investments in supportive housing services, with a focus on the homeless and long-term institutional populations

3. Redesigning and strengthening system capabilities to improve quality, advance health equity, and address workforce shortages	a. Creation of a COVID-19 Unwind Quality Restoration Pool for financially distressed hospitals and nursing homes b. Investments to expand workforce capacity and develop a strong, representative and well-trained workforce
4. Creating statewide digital health and telehealth infrastructure	Ensure that the consumer-driven wave is available equitably by building digital and telehealth infrastructure and care models to significantly expand access to care, both in underserved areas, such as rural and other communities without convenient access to primary or specialty care, and for underserved needs, such as behavioral health and the management of chronic diseases

Eligibility, Benefits, and Cost Sharing Changes

Beneficiaries would experience no reduction in available services, how they receive and access services, how services are delivered, or their expected cost sharing responsibilities. Under New York's current 1115 waiver demonstration, cost sharing is required only for pharmacy- and durable medical equipment-related costs. NYS seeks approval from CMS to provide a targeted set of Medicaid services for incarcerated individuals 30 days prior to release, including in-reach care management and discharge planning, clinical consultant services, peer services, medication management plan development and delivery of certain high priority medications to ensure active Medicaid status upon release and to assist with the successful transition to community life. While this work may be conducted post-release, the chances of finding and engaging a previously incarcerated individual is significantly more difficult post-release and greatly reduces the chance of stabilization. Early results from other pilots across the nation show significant improvements in stabilization and outcomes when a pre-release model is used. These changes paired with coordinated field-based services that SDHNs through new VBP funding models could stabilize and support this population and reduce recidivism and adverse health outcomes. Individuals eligible for this program are those who are incarcerated in state facilities with two or more chronic physical/behavioral health conditions, a serious mental illness, HIV, or an opioid use disorder.

Enrollment and Fiscal Projections

We anticipate no change in estimated annual enrollment to result from the programs detailed in this application with the exception of the provision for Criminal Justice-involved populations. This component of the amendment is estimated to result in an added enrollment of approximately 92,000 members annually based on DOCCS discharge information by condition for individuals with chronic conditions, SMI, or HIV/AIDS, compiled in 2019. Current average annual enrollment is 4.8 million.

The expected increase the annual average demonstration cost of $40 billion by $2.7 billion to $42.7 billion annually.

Hypotheses and Evaluation

The State will evaluate this amendment in alignment with all CMS requirements. An evaluation design will be developed that will evaluate the hypotheses identified below and will include the methodology, measures, and data sources that will be used to assess the impact of the amendment. This evaluation design will be in addition to the current approved evaluation design. Included in the chart below are the hypotheses by goal and examples of measures and data sources. These hypotheses, measures, and data sources are subject to change and may be further clarified based on input from CMS and stakeholders.

The goals of this amendment are as follows:

1. Building a more resilient, flexible, and integrated delivery system that reduces health disparities, promotes health equity, and supports the delivery of social care.
2. Developing and strengthening supportive housing services and alternatives for the homeless and long-term institutional populations.
3. Redesigning and strengthening system capabilities to improve quality, advance health equity, and address workforce shortages.
4. Creating statewide digital health and telehealth infrastructure.

The proposed hypotheses for these goals, as well as examples of measures and data sources, are as follows:

Hypothesis	Example Measures (Not Final)	Data Sources
Goal 1: Building a More Resilient, Flexible and Integrated Delivery System that Reduces Health Disparities, Promotes Health Equity, and Supports the Delivery of Social Care		
Establishment of the HEROs, SDHNs, and advanced targeted VBP arrangements will be associated with a decrease in health disparities across the demonstration.	HEDIS Quality Measure: Hemoglobin A1c Control for Patients with Diabetes	Claims data
Establishment of the HEROs, SDHNs, and advanced targeted VBP arrangements will promote greater integration between physical health, behavioral health, and social care needs.	HEDIS Quality Measure: Screening for Clinical Depression and Follow-up Plan	Claims data; Survey
Establishment of the HEROs, SDHNs, and advanced targeted VBP arrangement will result in the implementation of universal screening for social needs will result in increased referrals over the period of the amendment.	Number of referrals	Statewide social needs referral and data platform
The number of advanced targeted VBP arrangements, and the number of members and dollars covered in such arrangements will increase over the period of the amendment.	Number of advanced targeted VBP arrangements; Number of members in advanced targeted VBP arrangements; Number of dollars in advanced targeted VBP arrangements	Health Plan Data

Goal 2: Developing and Strengthening Supportive Housing Services and Alternatives for the Homeless and Long-Term Institutional Population		
Establishment of a regional network of SDHNs will increase referrals to Enhanced Supportive Housing Initiative services.	Number of referrals	Statewide social needs referral and data platform
The regional approach by the SDHNs of referring members to Enhanced Supportive Housing Initiative services for the homeless and long-term institutional population will result in permanent housing.	Rate of formerly homeless in permanent housing	Statewide social needs referral and data platform
Goal 3: Redesigning and Strengthening System Capabilities to Improve Quality, Advance Health Equity, and Address Workforce Shortages		
Investments in financially-distressed hospitals and nursing homes will increase quality improvement initiatives, workforce training, pandemic-related needs, and health equity-related work over the life of the amendment.	Number of quality improvement initiatives; Number of workforce trainings	Survey
Investment in Workforce Investment Organizations (WIOs) to retain existing healthcare staff and recruit new staff will reduce workforce shortages and turnover.	Number of new staff; Staff turnover rate	Survey
Investment in healthcare workforce training will result in an increased number of community health workers, care navigators, and peer support workers.	Number of community health workers; Number of care navigators; Number of peer support workers	Survey
Goal 4: Creating Statewide Digital Health and Telehealth Infrastructure		
Targeted investments in digital/telehealth infrastructure will increase telehealth utilization for underserved areas (e.g., rural, other communities without convenient access to primary or specialty care).	Rate of telehealth visits	Claims data
Targeted investments in digital/telehealth infrastructure will increase telehealth utilization in populations with underserved needs (e.g., behavioral health, management of chronic disease).	Rate of behavioral health telehealth visits	Claims data
Targeted investments in digital/telehealth infrastructure increase telehealth utilization across communities of color.	Rate of telehealth visits stratified by race and ethnicity	Claims data
Targeted investments in digital/telehealth infrastructure will be associated with improved outcomes	HEDIS Measures: Follow-up after Hospitalization for Mental Illness Hemoglobin A1c Control for Patients with Diabetes	Claims data

Waiver and Expenditure Authorities

In addition to the waiver authorities already granted in the current 1115 waiver demonstration, the State is requesting the following waiver authorities necessary to implement the initiatives aimed at addressing health disparities and the social determinants of health as detailed in this amendment.

#	Authority	Waived
1	To permit New York to geographically phase in the Managed Long Term Care (MLTC) program and the Health and Recovery Plans (HARP) and to phase in Behavioral Health (BH) Home and Community Based Services (HCBS) into HIV Special Needs Plans (HIV SNP).	Statewideness Section 1902(a)(1)
2	a. To enable New York to apply a more liberal income standard for individuals who are deinstitutionalized and receive HCBS through the managed long term care program than for other individuals receiving community-based long term care. b. To the extent necessary to permit New York to waive cost sharing for non-drug benefit cost sharing imposed under the Medicaid state plan for beneficiaries enrolled in the Mainstream Medicaid Managed Care Plan (MMMC) – including Health and Recovery Plans (HARP) and HIV SNPs – and who are not otherwise exempt from cost sharing in §447.56(a)(1). c. Family of One Non-1915 Children, or "Fo1 Children" – To allow the state to target eligibility to, and impose a participation capacity limit on, medically needy children under age 21 who are otherwise described in 42 CFR §435.308 of the regulations who: 1) receive Health Home Comprehensive Care Management under the state plan in replacement of the case management services such individuals formerly received through participation in New York's NY #.4125 1915(c) waiver and who no longer participate in such waiver due to the elimination of the case management services, but who continue to meet the targeting criteria, risk factors, and clinical eligibility standard for such waiver; and 2) receive HCBS 1915(c) services who meet the risk factors, targeting criteria, and clinical eligibility standard for the above-identified 1915(c) waiver. Individuals who meet either targeting classification will have excluded from their financial eligibility determination the income and resources of third parties whose income and resources could otherwise be deemed available under 42 CFR §435.602(a)(2)(i). Such individuals will also have their income and resources compared to the medically needy income level (MNIL) and resource standard for a single individual, as described in New York's state Medicaid plan.	Comparability Section 1902(a)(10) Section 1902(a)(17)

#	Authority	Waived
	d. To provide targeted services to individuals who are incarcerated up to 30 days prior to their release into the community, to the extent that such individuals are eligible to enroll in MMMC, HARP or HIV SNPs. .	
3	To enable New York to provide behavioral health (BH) HCBS services and the Adult Rehabilitation Services named Community Oriented Recovery and Empowerment (CORE) Services, whether furnished as a state plan benefit or as a demonstration benefit to targeted populations that may not be consistent with the targeting authorized under the approved state plan, in amount, duration and scope that exceeds those available to eligible individuals not in those targeted populations.	Amount, Duration & Scope Section 1902(a)(10)(B)
4	To the extent necessary to enable New York to require beneficiaries, including those individuals who are incarcerated up to 30 days prior to their release, to enroll in managed care plans, including the Mainstream Medicaid Managed Care (MMMC), and MLTC (excluding individuals designated as "Long-Term Nursing Home Stays") and HARPs programs in order to obtain benefits offered by those plans. Beneficiaries shall retain freedom of choice of family planning providers.	Freedom of Choice Section 1902(a)(23)(A)
5	To enable the state to limit the number of medically needy Fo1 Children not otherwise enrolled in the Children's 1915(c) waiver.	Reasonable Promptness Section 1902(a)(8)

Expenditure Authority: New York is requesting expenditure authorities under Section 1115 to disburse funds for the initiatives detailed in this amendment. These include the authority to disburse funds for the creation and initial planning operations of HEROs and SDHNs; to utilize VBP funds in service of this amendment's health equity goals; the expansion of supportive housing services; programming targeted at quality improvement, workforce, and health equity in financially distressed hospitals and nursing homes and workforce investments; digital health and telehealth infrastructure.

In addition, the State is requesting expenditure authority similar to that allowed for Designated State Health Program (DSHP) funding so that certain state and local health program expenditures are counted toward the State's share of funding for this amendment.

#	Program	Authority
1	Demonstration-Eligible Populations	Expenditures for healthcare related costs for the following populations that are not otherwise eligible under the Medicaid state plan. a. Demonstration Population 2 (TANF Adult). Temporary Assistance for Needy Families (TANF) Recipients. Expenditures for health care related costs for low- income adults enrolled in TANF. These individuals are exempt from receiving a MAGI determination in accordance with §1902(e)(14)(D)(i)(I) of the Act. b. Demonstration Population 9 (HCBS Expansion). Individuals who are not otherwise eligible, are

#	Program	Authority
		receiving HCBS, and who are determined to be medically needy based on New York's medically needy income level, after application of community spouse and spousal impoverishment eligibility and post-eligibility rules consistent with section 1924 of the Act. c. Demonstration Population 10 (Institution to Community). Expenditures for health care related costs for individuals moved from institutional nursing facility settings to community settings for long term services and supports who would not otherwise be eligible based on income, but whose income does not exceed the income standard described in STC 4(c) of section IV, and who receive services through the managed long term care program under the demonstration. d. Included in Demonstration Population 12 [Family of One (Fo1) Children]- Medically needy children Fo1 Demonstration children under age 21 with a waiver of 1902(a)(10)(C)(i)(III) who meet the targeting criteria, risk factors, and clinical eligibility standard for #NY.4125 waiver including intermediate care facilities (ICF), nursing facilities (NF), or Hospital Level of Care (LOC) who are not otherwise enrolled in the Children's 1915(c).
2	Twelve-Month Continuous Eligibility Period	Expenditures for health care related costs for individuals who have been determined eligible under groups specified in Table 1 of STC 3 in Section IV for continued benefits during any periods within a twelve month eligibility period when these individuals would be found ineligible if subject to redetermination. This authority includes providing continuous coverage for the Adult Group determined financially eligible using Modified Adjusted Gross Income (MAGI) based eligibility methods. For expenditures related to the Adult Group, specifically, the state shall make a downward adjustment of 2.6 percent in claimed expenditures for federal matching at the enhanced federal matching rate and will instead claim those expenditures at the regular matching rate.
3	Facilitated Enrollment Services	Expenditures for enrollment assistance services provided by managed care organizations (MCO), the costs for which are included in the claimed MCO capitation rates.
4	Demonstration Services for Behavioral Health Provided under Mainstream Medicaid Managed Care (MMMC)	Expenditures for provision of residential addiction services, crisis intervention and licensed behavioral health practitioner services to MMMC enrollees only and are not provided under the state plan [Demonstration Services 9].

#	Program	Authority
5	Targeted Behavioral Health (BH) HCBS and CORE Services	Expenditures for the provision of BH HCBS and CORE Services under Health and Recovery Plans (HARP) and HIV Special Needs Plans (SNP) that are not otherwise available under the approved state plan [Demonstration Services 8].
	Designated State Health Programs Funding	Expenditures for designated state health program. Program specifications and total funding amount to be negotiated with CMS.
	Health Equity Regional Organizations (HEROs), Social Determinants of Health Networks (SDHN), and Value Based Payment Incentive Pools	Expenditures for incentive payments and planning grant payments for the HERO, SDHN, and VBP programs

Submission and Review of Public Comments

A draft of the proposed amendment request is available for review under the "MRT 1115 Waiver Amendments" tab at: https://www.health.ny.gov/health_care/medicaid/redesign/medicaid_waiver_1115.htm For individuals with limited online access and require special accommodation to access paper copies, please call (518) 473-0868.

Prior to finalizing the proposed amendment application, the Department of Health will consider all written and verbal comments received. These comments will be summarized in the final submitted version. The Department will post a transcript of the public hearings on the following website: https://www.health.ny.gov/health_care/medicaid/redesign/medicaid_waiver_1115.htm.

Please direct all questions to 1115waivers@health.ny.gov.

Written comments will be accepted by email at 1115waivers@health.ny.gov **or** by mail at:

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Office of Health Insurance Programs
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All comments must be postmarked or emailed by May 20, 2022.

We look forward to our continued collaboration.

Sincerely,

[redacted]

Brett R. Friedman
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