



Department
of Health

New York State Medicaid Redesign Team (MRT) Waiver

*Strategic Health Equity Reform Payment
Arrangements: Making Targeted, Evidence-Based
Investments to Address the Health Disparities
Exacerbated by the COVID-19 Pandemic*

1115 Research and Demonstration Waiver
#11-W-00114/2



Office of Health Insurance Programs
One Commerce Plaza, Albany, NY 12207

www.health.ny.gov/health_care/medicaid/redesign/mrt2/

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Introduction

New York State (NYS or the State) requests \$13.52 billion over five (5) years to fund a new amendment to its 1115 Waiver Demonstration 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. The COVID-19 pandemic devastated many vulnerable populations of Medicaid recipients, with a particularly detrimental impact to populations with historical structural racism and health disparities including persons living in poverty, Black and Latino/Latinx and other underserved communities of color, older adult populations, criminal justice-involved populations, high-risk mothers and children, persons with intellectual and developmental disabilities (I/DD), persons with physical disabilities, persons living with Severe Mental Illnesses (SMI), persons with Substance Use Disorders (SUD), and persons experiencing homelessness.¹ Understanding that health disparities differ by population, geography, and previous community investment, addressing these disparities calls for a tailored approach based on these factors.

Addressing health equity and achieving an equitable recovery from the COVID-19 pandemic, while advancing other long-standing delivery system reform goals of NYS, is a complex undertaking and requires a transformational, coordinated effort across all sectors of the health care delivery system and continuum of social services. Indeed, to address the full breadth of factors contributing to health disparities, NYS will not only pursue reforms and investment in the health care delivery system, but also in training, housing, job creation, and many other areas. Accordingly, if approved, this waiver amendment reflects that achieving an equitable recovery from COVID-19 is a process, not just an outcome, and would be just one part of NYS's intertwined Reimagine, Rebuild, Renew initiatives that collectively form a unified statewide strategy for equitable COVID-19 recovery.

At the same time, because health and healthcare are local and the social service offerings may differ by region, this statewide strategy must also tie back to local gaps and needs, particularly for the health care safety net. Accordingly, NYS proposes an ambitious partnership with the Federal government through this new 1115 Waiver amendment that creates a pathway to address and rectify these historic health disparities. This partnership is critical to addressing health disparities exacerbated by COVID-19, promoting health equity, and fulfilling the promise of the Medicaid program to provide comprehensive health benefits to those who need them.

If approved, this 1115 Waiver amendment would utilize an array of multi-faceted and linked initiatives to change the way the Medicaid program integrates and pays for social care and health care in NYS. It would also lay the groundwork for reducing long standing racial, disability-related, and socioeconomic health disparities; increase health equity through measurable improvement of clinical quality and outcomes; and keep overall Medicaid program expenditures budget neutral to the federal government. 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

¹ "Growing Data Underscore That Communities of Color Are Being Harder Hit by Covid-19." KFF, June 3, 2020. https://www.kff.org/policy-watch/growing-data-underscore-communities-color-harder-hit-covid-19/?utm_campaign=KFF-2020-Medicaid&utm_source=hs_email&utm_medium=email&utm_content=86645517&hsenc=p2ANqtz-qmJyXvzln0gTazLacRVMVAOc976Kgl_bUeT6xa4PytfG4EnMogmGXuBCXLpTz3NTM8UHzelGfzql2BUcB8p5nM_p-bw&hsmi=86645517.

only for pharmacy- and durable medical equipment-related costs. The initiatives enacted through this amendment will predominantly foster greater collaboration across the health care delivery system in New York State and expand access to services that address the physical and behavioral health and social needs of beneficiaries.

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 (SCN) 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 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.*

Background and Context: Lessons Learned from the COVID-19 Pandemic

Since the inception of New York's 1115 waiver in 1997, New York has invested in and fortified one of the most comprehensive Medicaid programs in the country and has frequently been among the first states to expand eligibility or incorporate enhanced benefits. The Medicaid program, combined with other state-supported health insurance options such as the Essential Plan and Child Health Plus offered through the NY State of Health Marketplace, provide comprehensive coverage to nearly all low-income New Yorkers.

The comprehensiveness, value and accessibility of the Medicaid program has never been more important than during the COVID-19 pandemic. As the Centers for Medicare and Medicaid Services (CMS) is aware, the COVID-19 crisis hit New York first and hardest. The first confirmed COVID-19 case in New York occurred on March 1, 2020. Six weeks later, there were 18,825 COVID patients in New York hospitals.² At the peak of the pandemic, epidemiological models indicated that the State required inpatient capacity of anywhere from 55,000 to 136,000 beds for COVID-19 alone. At the same time, public health authorities lacked extensive clinical and epidemiological knowledge about the treatment and spread of the disease, and health care workers faced rampant shortages of protective equipment. The State had to implement an emergency pause of the economy, enact immediate regulatory relief to facilitate care, and coordinate an operational response, all in real-time.

Responding to COVID-19 taught NYS critical lessons about coordinating an effective and massive response within the existing health care system, from ramping up the availability of testing to bringing hospital resources and staff to high-priority regions. During these efforts, losses in employer-sponsored coverage or changes in economic status resulted in the Medicaid program

² New York Forward, Daily Hospitalization Summary by Region, available at <https://forward.ny.gov/dailyhospitalization-summary-region>.

extending health coverage to more than 888,000 additional New Yorkers, growing from over six million enrollees in March 2020 to approximately 7.4 million in January 2022.

Notwithstanding these successes in the mobilization of New York's pandemic response and the ability of the State's Medicaid program to absorb a tremendous influx of new enrollees, the pandemic revealed that even an immediate, effective emergency response was insufficient to overcome a long history of structurally racist policies and practices in the U.S. that have contributed to inequity in health care and significant health disparities. This impact is reflected by the pandemic's disproportionate impacts to low-wage workers and people of color, putting them at higher risk of getting sick and dying from COVID-19.³ Additionally, as CMS is aware, Black and Latino/Latinx populations accounted for higher levels of COVID-19 related hospitalizations and mortality than white populations.⁴ Critically, these studies have found that structural determinants and socioeconomic factors resulted in an increased likelihood of out-of-hospital deaths and infections than with other populations and were a prime causal factor resulting in vastly higher mortality rates in these populations.⁵ The higher rates of COVID-19 cases, hospitalizations, and deaths among people of color—due to their higher prevalence of chronic illness, overrepresentation in frontline and essential jobs, increased likelihood of living in multifamily or multi-generational housing, and other factors—have illustrated how pervasive health inequities remain. Research also shows that there are a significant number of children in New York whose primary caregiver has died due to COVID-19, leading to the potential need for additional mental health resources, along with many children and adolescents who have been pushed into poverty as a result of the economic impact of the pandemic⁶. The U.S. Surgeon General has created an advisory for children and youth on mental health in the context of the COVID-19 pandemic, as this has contributed to the pre-existing challenges facing children and adolescents, such as in-person schooling, in-person social opportunities with peers and mentors, access to health care and social services, food, housing, and the health of their caregivers.⁷

Although the New York State Medicaid program has been actively working to improve health outcomes among Medicaid members, including through its groundbreaking and successful Delivery System Reform Incentive Payment (DSRIP) program, which began to develop and fund ways to address SCN and Value Based payment (VBP), COVID-19 is evidence that significant health disparities persist. To that end, this waiver seeks to build on the prior work and the State's learnings during COVID-19 in designing and evaluating practical, common-sense, and actionable ways to leverage New York's robust Medicaid infrastructure to promote health equity for New Yorkers.

Relationship with Larger 1115 Waiver and DSRIP

For the last decade, through its current 1115 waiver, NYS has engaged in efforts to redesign Medicaid using managed care and its recently ended the DSRIP program. The State's overall

³ Centers for Disease Control and Prevention, Health Equity Considerations and Racial and Ethnic Minority Groups, Updated April 19, 2021 and available at: <https://www.cdc.gov/coronavirus/2019-ncov/community/healthequity/race-ethnicity.html>

⁴ Gbenga Ogedegbe, M.D. et al., Assessment of Racial/Ethnic Disparities in Hospitalization and Mortality in Patients with COVID in New York City, JAMA (Dec. 4, 2020).

⁵ Benjamin D. Renelus et al., Racial Disparities in COVID-19 Hospitalization and In-Hospital Mortality at the Height of the New York City Pandemic, J. Racial and Ethnic Health Disparities (Sep. 18, 2020).

⁶ United Hospital Fund. "Covid-19 Ripple Effect: The Impact of Covid-19 on Children in New York State." United Hospital Fund. Accessed February 25, 2022. <https://uhfnyc.org/publications/publication/covid-19-ripple-effect-impact-covid-19-children-new-york-state/>.

⁷ "Protecting Youth Mental Health - Hhs.gov." Accessed February 25, 2022. <https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf>.

goals in implementing the Medicaid Redesign Team (MRT) Section 1115(a) demonstration have been to improve access to health services and outcomes for low-income New Yorkers by:

- Improving access to health care for the Medicaid population;
- Improving the quality of health services delivered; and
- Expanding coverage with resources generated through managed care efficiencies to additional low-income New Yorkers.

The DSRIP program had an overall goal of reducing avoidable hospitalizations by 25 percent and achieving savings while transforming the health system to utilize 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 percent of the value of all Medicaid managed care contracts in shared savings (Level 1) or higher VBP arrangements, and 35 percent of contract value in upside and downside risk (Levels 2 and 3) arrangements.⁸ 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 2011.⁹

Notwithstanding the successes of DSRIP, there were also several challenges and noted improvements in the way that this waiver program could have been structured to achieve more holistic and longer-lasting delivery system reform. In designing this amendment proposal, NYS has intentionally considered these needed improvements and incorporated lessons learned from its DSRIP experience. These lessons include reflecting the need for regional alignment on objectives; providing more direct investment in services rendered by Community Based Organizations (CBO) that address SCN; developing VBP arrangements that promote whole person care by involving behavioral health providers in governance and design of these arrangements; promoting regional coordination of workforce initiatives to address shortage areas in terms of employee types and overall supply; creating administrative simplification through avoiding the creation of new intermediary entities; leveraging the success of, and avoiding any duplication involving, public health planning activities conducted by local health departments or other public health authorities, such that there alignment with *Prevention Agenda 2019-2024: New York State's Health Improvement Plan* (the *Prevention Agenda*); and achieving even deeper alignment of provider and payer incentives—particularly the highest level of VBP, with symmetrical risk sharing and monthly prepayments (capitation and/or global budgets).¹⁰ The DSRIP experience has informed New York's approach to this amendment, such as lessons learned from the forming and collaboration of the Performing Provider Systems (PPS) and other community partners, the feedback received from stakeholders and the public throughout the demonstration, and insights uncovered during the subsequent DSRIP evaluation process, which will be outlined with more detail in the sections to which they apply. The State has identified

⁸ www.health.ny.gov. (2019, September). Retrieved March 3, 2022, from

https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/2019/docs/sept_redline2cms

⁹ Weller, Wendy, Ph.D. et al. "DSRIP: Final Summative Evaluation." State University of New York at Albany, August 2021. https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/2021/docs/2021-08-24_final_summative_rpt.pdf.

¹⁰ "Department of Health." *Prevention Agenda 2019-2024: New York State's Health Improvement Plan*. Accessed March 2, 2022. https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/.

several key practices that will be leveraged to accomplish the health equity and system transformation goals outlined in this amendment.

This waiver amendment request is intended to further advance the combination of the State's 1115(a) MRT waiver demonstration and previous DSRIP goals, with the more explicit prioritization of integrating social care and health care into the NYS Medicaid program to increase health equity across the needs of New York's vulnerable and underserved populations that were revealed by the COVID-19 pandemic. Building on the promise of DSRIP, the integration of social care through meaningful reward incentives and member risk adjustment will be the vehicle through which NYS can achieve and sustain the benefits of this amendment.

Proposed Goals, Initiatives & Investments

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.

As described above, the COVID-19 pandemic highlighted and, in some cases, exacerbated the impact of long-standing health disparities based on race, ethnicity, disability, age, and socioeconomic status. Specifically, the COVID-19 pandemic and its higher rates of cases, hospitalizations, and deaths among people of color and other minority populations and people with disabilities due to their higher burdens of disease, over-representation in low-wage essential jobs, increased likelihood of living in multi-family or multi-generational housing or institutions, and other factors demonstrated how pervasive health inequities are in NYS.¹¹ Additionally, based upon existing measurement sets and data collection efforts, including the biennial *New York State Health Equity Report*, the quality of and access to health care services in low-income communities and among racially and ethnically diverse population groups reflect a health care delivery system that is not designed to meet community needs and eradicate health disparities.¹²

One of the lessons from DSRIP identified in the DSRIP final summative evaluation report was the importance of embracing meaningful patient patient-centered care, especially for the hardest-to-reach populations. DSRIP allowed for meaningful progress toward patient-centered care, shifting the focus to preventative care and requiring primary care practices to work toward national quality standards for patient-centered care. However, there is more work to be done to identify and connect these populations with the health, behavioral health, and social care. As the evaluation highlights, "the goal should be bringing redesigned team-based care to patients and redesigning the care interface so that it's more patient-centric."¹³

These findings reflect a health care delivery system that has been historically structured to address illness and disease-burden with patients presenting in hospitals or clinics when care is needed. Through the DSRIP experience, NYS's provider community and Managed Care Organizations (MCOs) have learned new, more efficient ways to address individual and population health. In turn, these efforts have begun to create the collective recognition that the ability of MCOs, CBOs, and other providers to coordinate effectively to address SCN directly

¹¹ United Hospital Foundation, New York State Medicaid Health Equity Options, at 1 (March 2021).

¹² NYS Department of Health, New York State Health Equity Report (April 2019), available at https://health.ny.gov/community/minority/docs/health_equity_report_2019.pdf.

¹³ Weller et al, "DSRIP: Final Summative Evaluation."

influence how, and if, Medicaid members remain stable and healthy in community settings. Moreover, these interventions have the demonstrated potential to improve their health outcomes and prevent disease, which has only revealed the further limitations of delivery systems that are built for “sick care.” It is now widely acknowledged that SCN factors, rather than medical interventions and services, are the key driver for a large majority—up to 80 percent—of health outcomes.¹⁴ Moreover, SCN are often the direct reason for health inequities, such as differential rates of diabetes related to lack of access to healthy food. Nationally, there are an increasing number of successful attempts to scale proven SCN interventions; however, NYS believes that these interventions can scale further—from helping thousands to helping millions. The State believes CMS shares this vision, as demonstrated through its increasing willingness to use 1115 waiver authority to permit state Medicaid programs to address SCN interventions and funding gaps. For example, CMS approved North Carolina’s 1115 waiver in 2019, which seeks to use Medicaid to pay directly for some non-medical interventions targeting housing, food, transportation, and interpersonal violence/toxic stress supports.¹⁵

Building on these efforts, NYS recognizes that, in order to further our collective ability to improve health outcomes for all patients, particularly those who are vulnerable and underserved, the State must augment existing systems and develop a nimble delivery system built for “well care,” that includes the following features:

- Understands and accounts for all the physical and behavioral health and social factors impacting a patient, meeting them where they are and serving the whole-person;
- Extends the capabilities of clinicians beyond the four walls of health care settings to understand all of the factors impacting patient’s health outcomes;
- Scales an integrated approach to addressing the SCN that impact individual patients and their ability to stabilize and thrive in community settings, effectively integrating social care and health care; and
- Addresses patient and population level needs during normal times, while also capable of flex and surge capacity during pandemics, public health crises and natural disasters by ensuring that safety net facilities are well-positioned for future success and to support the waiver amendment’s objectives.

This waiver proposal is a catalyst to developing this new delivery system, and will require thoughtful planning, coordination, and execution to address and reduce health disparities, while minimizing disruption and limiting unintended consequences. Furthermore, NYS recognizes that any success will reflect the regional differences and needs of our diverse state, as populations may be impacted differently and experience varying levels and types of health disparities and SCN.

Past waiver experiences have shown how targeted investments in effective regional coordination can create stakeholder alignment around aggressive actions to implement policies and programs that achieve delivery system reform. This is evident not only in the tangible improvements in care and performance, but also in positive feedback from participants in both overall satisfaction and

¹⁴ Moody’s Analytics, Understanding Health Conditions Across the U.S. BlueCross BlueShield Association. December 2017, available at www.bcbs.com/sites/default/files/file-attachments/health-of-america-report/BCBS.HealthOfAmericaReport.Moody’s_02.pdf.

¹⁵ North Carolina’s Medicaid Reform Demonstration, approved October 19, 2018, see Attachment G a, available at <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nc/nc-medicaid-reform-ca.pdf>.

perceptions of the effectiveness of the program.¹⁶ These same strategies can be equally successful in addressing racial, ethnic, disability, age, and socioeconomic disparities in care, promoting a common framework for assessing and measuring improvements in health equity, and strengthening the entire NYS health care delivery system. The disparate impact of COVID-19 on disadvantaged populations demands a comprehensive response that addresses underlying SCN as an inherent part of addressing health disparities and achieving health equity. Building on longstanding investments and efforts, the Medicaid program is in an excellent position to bridge this gap based on the demographic composition and physical health, behavioral health, and social needs of its beneficiaries.

Although New York's DSRIP program included some projects addressing SCN, these early attempts need to be brought to scale across the state. Part of the State's strategy to expand access to SCN-related services was through VBP. The State furthered this through a VBP requirement for all upside and downside risk arrangements to include at least one SCN intervention and contract with at least one CBO. The State has approved approximately 200 SCN interventions through VBP. However, the utilization and comprehensiveness of these interventions varies significantly by contract.¹⁷ NYS has learned from these experiences and believes that a more structured approach, as highlighted below, will more successfully connect traditional health care services and SCN service systems, in order to take a more holistic approach to health care and address the health needs of the whole person.

To reinforce these efforts and address sustainability, NYS will integrate health equity as a fundamental standard for the investments in advanced VBP arrangements, providing support through the development of SCN networks of care and Health Equity Regional Organizations (HEROs). This approach will also allow for targeted new investments in social care and non-medical, community-based services that directly address SCN, as more fully described below.

1.1 Investments in Regional Planning through HEROs

This amendment will pursue the development of HEROs, which will be mission-based organizations that build a coalition of 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) including behavioral health IPAs, behavioral health networks, providers of long-term services and supports (LTSS) including those who serve individuals with I/DD or physical disabilities, community-based organizations (CBOs) organized through social determinants of health networks (SDHNs, as described below), Qualified Entities (QEs) (which in New York are Health Information Exchanges (HIEs) and Regional Health Information Organizations (RHIOs)), consumer representatives, and other stakeholders (See Exhibit 1). They will be regionally focused in order to align with the health equity needs that differ by community and future value-based payment contracting structures.

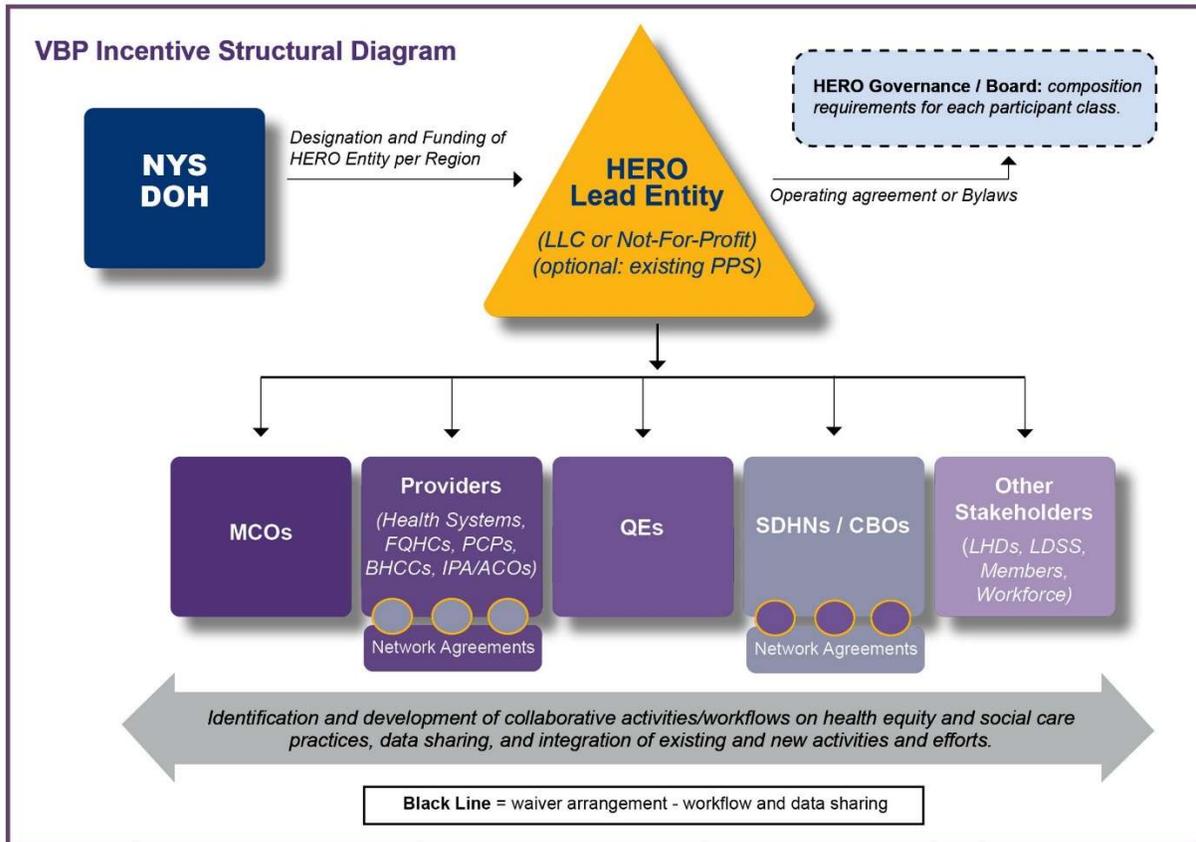
HEROs may be led by a variety of existing and new corporate entities (e.g., LLC, not-for profit) including but not limited to local departments of health or social services, behavioral health IPAs and other structures formed by regional participants. Similar to the Accountable Health Communities model in states such as Hawaii, or Washington's Accountable Communities of

¹⁶ Weller et al, "DSRIP: Final Summative Evaluation" pg. 422.

¹⁷ Department of Health. NYS DOH Approved VBP SDH Interventions. Accessed March 3, 2022. https://www.health.ny.gov/health_care/medicaid/redesign/sdh/sdh-vbp_library.htm

Health bodies, HEROs would focus on collaboration and coordination, and facilitation of activities that best address the needs of the communities they serve (with the goal of raising the overall health of these communities).

Exhibit 1: HERO Structural Diagram



HEROs will be structured to replicate the successes of DSRIP, while also incorporating changes informed by the challenges encountered and lessons learned throughout the program. The DSRIP program included the creation of 25 PPSs, which were local collaboratives of safety net provider partnerships that were awarded the ability to earn performance incentive payments to move the needle on reducing avoidable admissions and achieving clinical outcomes, which included moving PPS partners toward pay for performance VBP arrangements. The PPSs were regional entities across the State, and some had overlapping geographic coverage areas. To ensure a comprehensive and coordinated regional approach, New York seeks to authorize only a single HERO per region based on the nine historical regional divisions utilized by DOH for Medicaid Managed Care Organization rate setting, CMS Health Insurance Market Reforms,¹⁸ and to measure public health outcomes. However, DOH would consult with local health departments and other key stakeholders to sub-divide these regions based on compelling evidence that such further divisions would enhance the work of HEROs. To that end, the HERO would serve as a

¹⁸ CMS, New York Geographic Rating Areas: Including State Specific Geographic Divisions, available at <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/ny-gra>.

collaborative body bringing together key stakeholders, serving as the central point of regional planning and coordination around health equity improvement initiatives, and leveraging any existing public health planning activities that are ongoing within regions, including those initiatives spearheaded by local health departments.

The utilization of PPSs as drivers of coordination and collaboration outside of the structure of the delivery system ultimately proved to be a highly successful strategy for informing priorities, building infrastructure and capacity, improving clinical processes, integrating Primary Care and Behavioral Health Care, and aligning the efforts of stakeholders toward a common purpose. DSRIP succeeded in beginning a culture shift in the State's healthcare system, including by some of its biggest actors, with increased attention to population health and SCN and a shift from siloed providers and organizations to a more mutually supportive, data-driven, and adaptive network, and demonstrated that network's power to innovate in the face of complex challenges. HEROs will operate on a similar principle, this time transforming New York's healthcare system to be more responsive to, and inclusive of, the broad range of health, behavioral health, and SCN needs of underserved communities.

Moreover, PPSs formalized and connected regional networks of providers and CBOs that previously had more limited interaction, despite serving the same communities, resulting in better care coordination, and contributing to improved performance by the system overall. DSRIP demonstrated that broad systems change can be accomplished via the collective effects of smaller, regionally oriented organizations working to solve problems, as they are uniquely experienced within that region. Local health care providers and community-based organizations that deliver social and human services are most familiar with the needs of their local populations and are best equipped to identify gaps in service and propose interventions with the highest chance of success. The long-term implications and potential of such networks to improve the delivery system was evident in the closing months of DSRIP, which coincided with the early weeks of the COVID-19 pandemic in the State. As reported in the DSRIP Evaluation, "PPSs and their partners were able to mobilize and respond relatively quickly and effectively to the COVID-19 crisis; more quickly and effectively than would have been possible without the DSRIP program."¹⁹

Another lesson learned from DSRIP is that the early engagement and inclusion of MCOs in the regional structures will enable the development of strong and sustainable partnerships and increase opportunities for successful outcomes.²⁰ MCOs which serve 78% of NYS Medicaid enrollees and account for 60% of total Medicaid spending, are key partners in population health management that play an integral and influential role in the State's health infrastructure and are well-positioned to assist with community needs assessments, identify gaps in regional care infrastructure, and align the efforts of their provider networks. In addition, this partnership will allow for a mutually beneficial relationship with smaller entities and CBOs that will be able to develop the understanding, infrastructure, and capacity to assume the necessary risk to participate in VBP arrangements and thereby ensure the stability and sustainability of these efforts.

The broad array of participants that will be included in HERO networks and governance, as well as the planned structure and functions of SDHNs, (described below), reflect these lessons for system transformation learned from DSRIP – as the collective regional efforts will benefit from

¹⁹ Weller, Wendy, Ph.D. et al. "DSRIP: Final Summative Evaluation." State University of New York at Albany, August 2021. https://www.health.ny.gov/health_care/medicaid/redesign/dsrp/2021/docs/2021-08-24_final_summative_rpt.pdf.

²⁰ Weller et al, "DSRIP: Final Summative Evaluation" pg. 429.

local insight and smaller community organizations will receive benefits in the form of participation in broader care networks, granting access to information sharing, referrals, and resources that might otherwise be outside of their capacity to obtain.

Through more inclusive governance and network structures, smaller organizations with strong community experience and expertise will have the opportunity for more equitable participation and will have greater access to data and other tools.

a. HEROs Governance

In each region, the NYS Department of Health (DOH) will contract with a HERO entity, which may be an expansion of an existing entity, or a new corporate entity formed by regional participants, including MCOs, primary care and other clinical and community-based providers, IPAs including behavioral health IPAs, QEs, SDHNs and others. The HERO entity must establish a governing body representative of each constituent group, and with balanced stakeholder decision-making authority, along with appropriate sub-committees composed of participants, to collaborate on developing and coordinating the HERO's planning activities – for example, a sub-committee that focuses on care coordination, discharge planning requirements, and behavioral health-focused VBP arrangements for individuals with serious emotional disturbance (SED), SMI, and SUD. The HERO may also enter into downstream agreements with participants to govern participation requirements and data sharing. NYS will set aside a limited portion of waiver funds to be paid directly to HEROs for their own planning objectives, but not as an intermediary to fund ongoing waiver projects. Existing contracts for non-waiver funds remain unchanged.

With limited modifications to governance structure, some existing PPSs would be ideally situated to function as the HERO entity in a region. Moreover, local health departments could in some instances be well-equipped to serve as the regional HERO, as they already have some of the necessary data infrastructure in place, as well as relationships with other government entities participating in regional planning efforts around SCN needs, such as housing authorities.

b. Planning Responsibilities

The primary deliverable for HEROs is a regional plan, updated annually, that would enable a coordinated, holistic, clinically integrated, and value-driven approach to evaluating and addressing the needs of vulnerable populations in a financially stable and efficient manner through VBP. Any plans would have to consider the existing public health activities in that region and relate back to the broader goals and objectives of the State's *Prevention Agenda*. This plan is important as NYS works toward a strong and equitable recovery from the COVID-19 pandemic. They would develop a mission-driven framework, establishing goals, intended impacts, and a theory of change of how to accomplish the work.²¹

²¹ Similar to Rush University Medical Center's (RUMC) Anchor Mission Strategy. See Ubhayakar S, Capeless M, Owens R, Snorrason K, Zuckerman D., Anchor Mission Playbook, Rush University Medical Center and The Democracy Collaborative; August 2017, available at <https://www.rush.edu/sites/default/files/2020-09/rush-anchor-mission-playbook-091117%282%29.pdf>.

The regional plan would also identify specific actions and initiatives that facilitate assessment and data collection functions and that promote further coordination of care management for population health improvement. During DSRIP, in absence of a set of central standards, PPS data collection lacked the uniformity necessary for reliable, comprehensive, integrated data collection. With the end of the DSRIP demonstration, the State has recognized the need for data standardization and interoperability. Through parallel projects as well as through the structures included in this amendment, the State is taking steps to ensure the adoption of statewide standards for data collection and availability and to better identify data infrastructure gaps. Additionally, while hospitals and PPSs were generally held to certain collection and access standards to participate in DSRIP and were therefore able to access the data needed to inform their practices and interventions, CBOs, behavioral health providers, and other small practitioners did not have ready access to data resources, apart from publicly available sources.

For many smaller organizations, support will be needed to assist in interfacing with data collection infrastructure to ensure the multiple issues that influence providers' ability to obtain, analyze, use, and share data are addressed. As a part of their planning function, the State expects HEROs will play an important role in centralizing data collection and aggregation. This will include assessment of regional data collection capabilities, providing data collection technical support, and interpreting regional data to inform priorities and targeted interventions. Ultimately, HEROs will serve as the central hub of a data infrastructure that operates with continuous feedback and measure adjustment with additional dimensions of data collection and analysis emerging as necessary to address additional areas of need.

In certain cases, HEROs could also identify spending priorities for which NYS could seek federal approval for directed MCO payments or other mechanisms to allocate funding. Activities contained in a HERO's regional plan may include:

- Assessing and identifying local needs and health inequities by population, and service gaps;
- Establishing regional priorities based on local needs and specific populations including populations with SED, SMI, SUD, and criminal justice-involved backgrounds;
- Ensuring racial, ethnic and gender concordance between patients and providers, so that providers resemble the patient population to facilitate patients' desire to seek care;
- Developing other ways to address racial barriers that impact access to care;
- Ensuring that implicit bias training and awareness, as well as trauma-informed care is part of workforce training;
- Training on structural competence-based formulation, treatment planning, and the behavioral health system response to low-acuity crises;
- Centralized data collection and exchange among a variety of sources, including national, State, local and proprietary (e.g., criminal justice, foster care, census data, etc.);
- Regional facility and delivery system planning;
- Clinical integration of behavioral and physical health;
- Integration and connection of the full spectrum of behavioral health and SUD services to ensure seamless access to and navigation of these services;

- The relationship of regional efforts to those actions plans found in the State's *Prevention Agenda*;
- Identifying available local social services programming for the purposes of blending and braiding across funding streams and maximizing resources;
- Assessing existing housing inventory and identifying gaps where housing is needed; and
- Identifying housing solutions, including increasing the Supplemental Security Income (SSI) state supplement for high needs populations, addressing the supportive housing needs of individuals with SMI and other conditions requiring support to maintain housing, and other general housing solutions.

c. Other Responsibilities

Beyond the regional planning responsibilities, HEROs would be the catalyst for other critical components of achieving waiver goals, including:

- *Uniform Social Needs Assessment.* HEROs would develop a strategy and process for the implementation of a State-chosen standardized assessment tool that determines the community SCN for the Medicaid members in its region on an annual basis, such as the Accountable Health Communities (AHC) health-related social needs screening tool from CMS.²² This uniform social needs assessment tool, and the information derived from it, would be intended to address gaps in race and ethnicity data currently collected by NYS, which prevents meaningful stratification of clinical quality measurement sets; to inform the person-centered services planning process required by MCOs under 42 C.F.R. § 438.725; and to help inform the development of targeted interventions that can work to integrate and address the physical and behavioral health and social care needs of Medicaid members in a region;
- *Measure Selection and Development.* Each HERO would select from a statewide and regionally specific set of health equity-specific quality improvement measures or stratification approaches to existing measures to achieve regional priorities. The measures would be developed or informed by the Clinical Advisory Groups and interventions that address the regional health equity needs or use standards such as NCQA's Distinction in Multicultural Health Care as a way to distinguish plans that meet or exceed standards in collecting race/ethnicity data and language data and culturally appropriate care;²³ and
- *Targeted VBP Interventions.* HEROs would build regional consensus around a retooled VBP approach and design for services integration and care management with a focus on specific target populations (e.g., SMI, SUD, SED, I/DD), and the more successful braiding of health, behavioral health, and social care, including evidence-based approaches to collaborative care in primary care, that build on the Promising Practices from the DSRIP program. The entities would also leverage regional and coordinated response strategies from

²² The NYS Department of Health Office of Health Insurance Programs has found through its research and assessment of screening tools that the AHC social needs screening tool may be an appropriate tool to use statewide. NYS DOH OHIP, Social Determinants of Health Standardization Guidance (April 2020).

²³ National Committee for Quality Assurance, Distinction in Multicultural Health Care, available at: <https://www.ncqa.org/programs/health-plans/multicultural-health-care-mhc/>.

the pandemic, promote use of these new and refined health equity improvement interventions and measures generally and for targeted populations (e.g., children, maternal health, SUD treatment, adults with SMI, children with serious emotional disturbance, etc.), create accountability for quality and cost, and facilitate value.

The ultimate objective of the HEROs is to inform the continued movement to more advanced VBP models, including arrangements that utilize episodic and global prepayment structures to reward efficient operations focused on population health, behavioral health and social care integration, and health equity promotion strategies during normal times, and provide cash flow stability during health crises that create disruption in anticipated utilization, and more targeted VBP arrangements—whether focused on specific sub-populations, care transitions or episodes of care—that address specific health equity needs.

d. HERO Funding

The HEROs would not receive and distribute waiver funds as other intermediary entities had in other waiver demonstrations approved by CMS. Rather, the HEROs would receive limited planning grants under the waiver, be able to receive and ingest data from national, State, local and proprietary data sources, and assume a necessary regional planning focus in order to create collaborations, draw insights from different data sources and needs, and develop a range of VBP models or other targeted interventions suitable for the populations and needs of each region that would be funded through the mechanisms described in Section 1.3 below.

There would be one HERO per region and nine regions, with New York City potentially being subdivided into multiple sub-regions. Based on the historical spending of successful regional planning entities that grew out of DSRIP, the State requests \$325M over five years for HEROs, with annual spending of \$65M. The State examined the annual operating budgets of these entities and estimated the cost of the activities required over the waiver period. This funding would support the HEROs' regional planning, data collection, reporting, and coordination activities.

e. Sustainability

The original intent for PPSs established under the DSRIP demonstration would have seen them renewed with scaled-back operations as the organizations worked to better incorporate MCOs and CBO, eventually transforming into Value Management Organizations (VMO)s – entities meant to continue the transition to more sophisticated VBP arrangements²⁴. When CMS declined to approve the DSRIP extension amendment proposed by the State in November 2019, most PPSs ceased operations. Several participants in the final summative evaluation of the DSRIP program noted that the five-year demonstration period was not sufficient time to make a difference in health care delivery because of the number of system-level changes that needed to take place.

²⁴ “Department of Health.” NEW YORK STATE MEDICAID REDESIGN TEAM (MRT) WAIVER. Accessed February 25, 2022. https://www.health.ny.gov/health_care/medicaid/redesign/dsrp/2019/docs/formal_amendment_req.pdf.

To avoid these issues in this amendment, the State anticipates HEROs would extend beyond the period of the waiver and become self-sustaining entities that continue to act as coordinating bodies, engaging in stakeholder convening activities and research and data analytics on regional health equity issues. One example of a sustainable model exists already in Common Ground Health, a not-for-profit research and planning organization based in Rochester, New York that provides ongoing value to the community by bringing together local stakeholders on area health issues.²⁵

NYS expects the value of HEROs as a regional planning and coordinating body across health and social service programming, similar to Common Ground Health, will be demonstrated over time and supported through contributions by its members, grants, and other external funding sources. For example, as the volume of SCN interventions grows, coordination across funding streams and data sources, such as that needed to engage and address housing needs through public assistance housing programs, will be a growing and ongoing need. Assuming proven value during the waiver period, the HERO participants, consisting of MCOs, providers, and others, could contribute funding to HEROs after the waiver period in order to further shared health equity goals, thus granting more time for system-wide changes to materialize from these efforts.

1.2 Investments in Social Determinant of Health Networks (SDHNs) Development and Performance

Differences in SCN factors are a primary contributor to racial and disability disparities in health outcomes.²⁶ A growing number of innovative CBOs are employing interventions in SCN areas, such as community health worker support, healthy behaviors, nutrition, social isolation, education, transportation, and the organization of benefits and employment. While planning and coordination needs will be addressed by HEROs, there is an urgent need to organize CBOs and social service providers and develop the programming and workflows necessary for them to coordinate and work with health care delivery systems. NYS will catalyze this process through a separate investment in coordinated networks of CBOs referred to as Social Determinant of Health Networks (SDHNs) — that take a comprehensive and outcomes-focused approach to addressing the full spectrum of SCN offered by CBOs in a region, help CBOs create supportive IT and business processes infrastructure, and adopt interoperable standards for a social care data exchange.

Critically, this type of CBO network development began to catalyze as a logical outgrowth of DSRIP, with several Performing Provider Systems (PPS) or providers within a PPS, electing to form network entities that are capable of participating meaningfully in VBP arrangements. Examples of these developing SDHNs include the Healthy Alliance Independent Practice Association, which described itself as “the first IPA in the nation entirely devoted to addressing social determinants of health;”²⁷ the EngageWell IPA, which “was created by New York City not-for-profit organizations working together to offer coordinated, integrated treatment options that

²⁵ Common Ground Health, About Us, available at <https://www.commongroundhealth.org/about>.

²⁶ Singh, G. K., Daus, G. P., Allender, M., Ramey, C. T., Martin, E. K., Perry, C., Reyes, A., & Vedamuthu, I. P. (2017). Social Determinants of Health in the United States: Addressing Major Health Inequality Trends for the Nation, 1935-2016. *International journal of MCH and AIDS*, 6(2), 139–164. <https://doi.org/10.21106/ijma.236>

²⁷ Alliance for Better Health, Healthy Alliance Independent Practice Association, Innovative Health Alliance of New York, and Fidelis Care Join Forces to Improve Health by Addressing Social Determinants of Health CISION PR Newswire, (Sept. 23, 2019), available at <https://www.prnewswire.com/news-releases/healthy-alliance-independent-practice-association-innovative-health-alliance-of-new-york-and-fidelis-care-join-forces-to-improve-health-by-addressing-social-determinants-of-health-300923094.html>.

include addressing social determinants of health — housing, nutrition, economic security;²⁸ and SOMOS Innovation “a full implementation of the holistic care model” and “the next step on the path to culturally competent Value-Based [H]ealthcare.”²⁹ DSRIP also funded four CBO Planning Grants to support the strategic planning activities and engagement in DSRIP and VBP. From the planning grants, three of the awarded organizations have created CBO consortiums, Health Equity Alliance of Long Island, CBO Consortium of Upstate New York, and the Hudson Valley Collective for Community Wellness. These CBO led groups have not only been sustainable but have hundreds of members that meet on a regular basis to strategize the integration of health and human services in their communities.

As mentioned previously, under VBP, NYS required all upside and downside risk VBP arrangements to include at least one social determinant of health intervention and contract with at least one community-based provider. From this requirement, the State has approved approximately 200 SCN intervention contracts³⁰. The main interventions selected include home-delivered medically tailored meals, food pharmacies, housing navigation, eviction prevention, social isolation intervention, high-risk maternity engagement, and pediatric asthma education and removal of triggers. Examples of preliminary results from the individual contracts include:

- *Pediatric Asthma*: The data from a three-month pre- to post-intervention period show a 46.2 percent decrease in inpatient admissions and a 42.9 percent decrease in ED visits. Primary care utilization increased by 16.7 percent over the same three-month period. Asthma medication ratio (AMR) adherence increased by 32.5 percent for 2018 and 2019.
- *Medically Tailored Meals*: 15,900 meals served to date. ED decreased from 160 visits to 60, urgent care decreased from 30 visit to 10 visits, and acute inpatient utilization decreased from 200 stays to 110 stays.
- *Chronic Condition and Social Isolation*: 76 percent of participants had pain controlled from pre- to post-intervention, 79 percent were consistently not lonely from pre to post, 14 percent had a reduction in hospitalizations and 62 percent consistently had no admissions from pre to post.

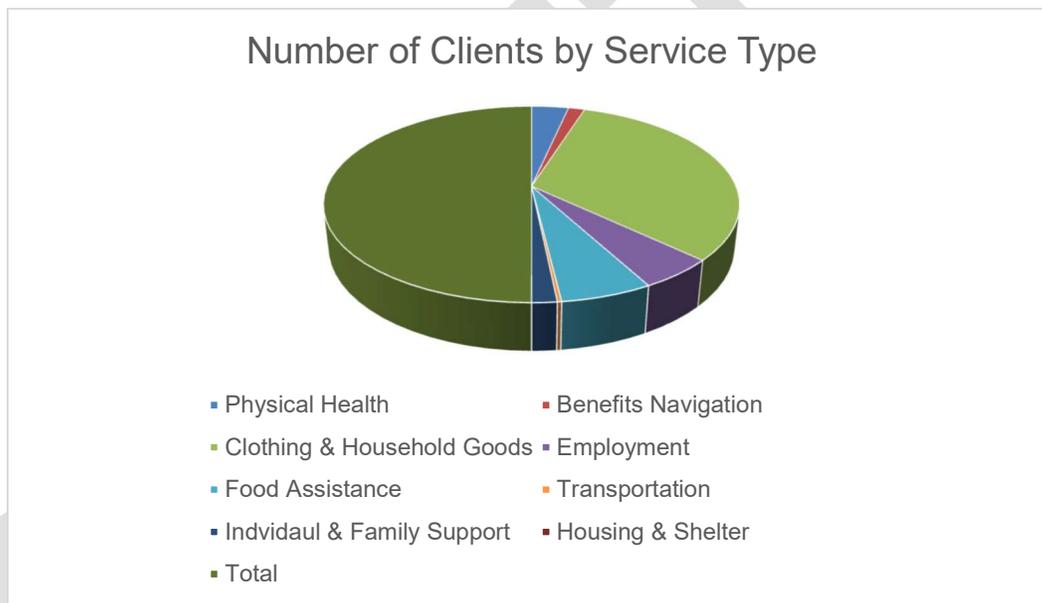
²⁸ EngageWell IPA, About Us, available at <https://engagewellipa.com/about-us/> (accessed on July 6, 2021).

²⁹ SOMOS, About SOMOS Innovation, available at <https://somoscommunitycare.org/about-somos-innovation/> (accessed on July 12, 2021).

³⁰ *Department of Health*. Value Based Payment (VBP) Resource Library. (n.d.). Retrieved March 4, 2022, from https://www.health.ny.gov/health_care/medicaid/redesign/sdh/sdh-vbp_library.htm

A VBP Example: Social Needs Screening and Referral

Under a VBP Contract with a MCO, a CBO conducted outreach to Medicaid Members within one county. The CBO used a social needs screening tool and identified areas of need. Using an IT referral platform, the CBO connected the member to medical and social services. Services included, housing, physical health, food assistance, clothing and household goods, benefits navigation, individual and family support, transportation, and employment. There was a total of 365 individuals screened from 4/1/2020-3/31/2021.



While the successes are promising, the State has been unable to scale these interventions. Despite the encouragement of screening and addressing multiple social risk factors, most interventions submitted were only for one social risk factor for the entire arrangement. Interventions did not take into consideration the multiple social risk factors that could be at play in someone's health. Contracts were also relatively small and contracted with only one CBO.³¹ MCOs and CBOs cited difficulties with contracting and creating a uniform referral system. This led to low utilization of some interventions that could have been extremely impactful during the COVID-19 pandemic and beyond. The primary feedback from many stakeholders involved in these contracts was that efforts need to be coordinated on a larger and more comprehensive level and that additional funding beyond plan premium to ensure adequate investment and support from MCOs. This component of the proposed amendment would rectify these issues in the following ways.

³¹ Department of Health. New York State Approved Value Based Payment Interventions. (n.d.). Retrieved March 4, 2022, from https://www.health.ny.gov/health_care/medicaid/redesign/sdh/2019-09-24_app_interventions.htm

a. SDHN Network Development

Similar to the developing collaboratives, each SDHN would consist of a network of CBOs within each region of the State (which should overlap with the regions and sub-regions that align with HERO development) to provide evidence-based interventions that address a range of SCN. The State would designate nine regions and select a lead applicant within each region, which may be a CBO itself or a network entity (e.g., an IPA, DSRIP-funded CBO Planning Grant Entity) composed of CBOs. As mentioned above, a SDHN could also be a PPS (or a component of a PPS) that seeks to convert, or have already begun to transition, into a network entity focused on SCN.

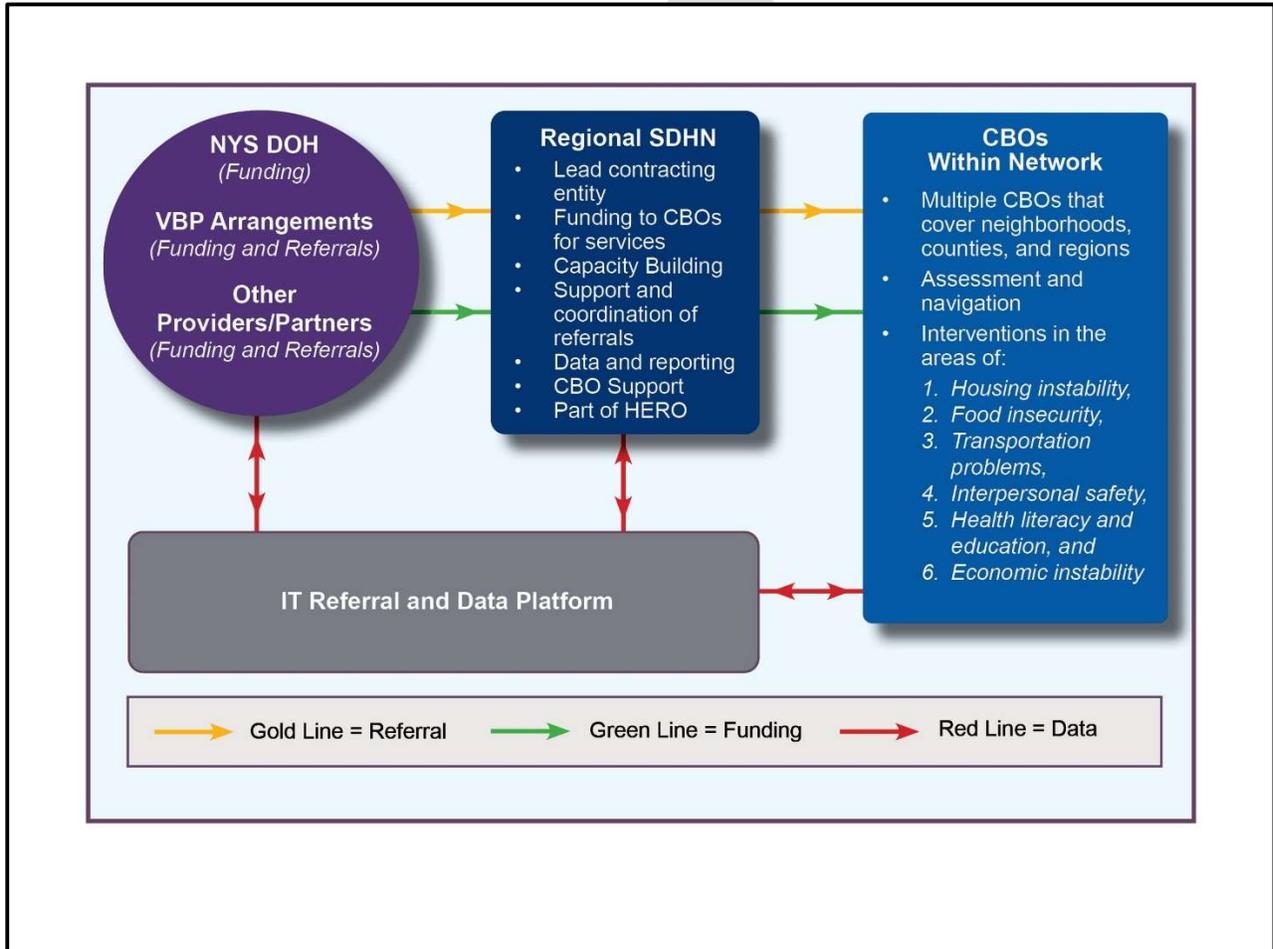
Each lead entity would create a network of CBOs that will collectively use evidence-based interventions to coordinate and deliver services to address a range of SCN that will improve health outcomes, such as housing instability, food insecurity, transportation, and interpersonal safety. Networks will be composed of small neighborhood or zip code level organizations as well as larger county- or regionally focused organizations. SDHNs will ensure at least a subset of network CBOs are trained to work with special populations, including individuals with SMI, SED, addiction disorder, and/or criminal justice involved backgrounds, including a focus on assisting these populations with employment, eviction prevention assistance, early intervention, preventive care, and prevention of adverse childhood events (ACEs). The SDHN in each region would be responsible for:

1. Formally organizing CBOs to perform SCN interventions;
2. Coordinating a regional uniform referral system and network with multiple CBOs, with partners such as health systems, community and specialty behavioral health providers, care managers, other health care providers, and local government agencies, including but not limited to health departments, departments of social services, and the criminal justice system;
3. Creating a single point of contracting for SCN interventions in VBP arrangements or with other providers; and
4. Advising on the best structure for screening Medicaid members for the key SCN social care issues and make appropriate referrals based on need by the entities designated by the State or MCOs to perform the standardized social needs assessment which could be performed by the MCO, SDHN, Health Home, or other entity best-positioned in the region to engage in these activities.

The SDHNs will also provide support to CBOs around building capacity, adopting, and utilizing technology, service delivery integration, creating and adapting workflows, and other business practices, including billing and payment. These SDHNs will coordinate and work with providers in MCO networks to serve Medicaid patients more holistically, particularly those from marginalized communities, effectively wrapping a social services provider network with existing MCO clinical provider networks.

As evidenced by Exhibit 2, SDHNs will receive direct investments to develop the infrastructure necessary to support this network of care, including to develop the IT and business processes and other capabilities necessary. CBOs in these networks will also receive funding necessary to integrate into this network and provide services. VBP arrangements, and other partnered contracts will pay CBOs per service using a fee schedule.

Exhibit 2: SDHN Structural and Funding Diagrams



b. Social Care Data Interoperability Exchange

The New York eHealth Collaborative (NYeC) and 2-1-1 New York have received funding from the HHS Administration for Community Living to establish a trust framework and statewide governance structure to support collaboration and exchange of community information across existing networks and users.³² Another, similar system is also under development in Rochester, NY. The Systems Integration Project is a collaborative, community-based effort to create a secure data hub for information-sharing and care coordination meant to connect individuals and families to needed SCN services. The

³² NYeC and United Way's 2-1-1 NY won HHS competition for Innovative Partnership to Advance Health Equity. New York eHealth Collaborative. (2021, October 29). Retrieved March 4, 2022, from <https://www.nyehealth.org/nyec-and-united-ways-2-1-1-ny-won-hhs-competition-for-innovative-partnership-to-advance-health-equity/>

project will feature personalized digital dashboards giving individuals and their care teams a complete view of each member's needs while compiling community data that can be utilized to drive better, data-informed future interventions.³³ The pandemic highlighted the growing need for social data sharing, which was stymied by a lack of commonly used data sharing standards and many CBOs utilizing bespoke or "closed loop" data systems that are not widely interoperable. Without these efforts at the NYeC and SDHN levels, the interoperability problems that plagued the introduction of electronic medical records will similarly inhibit the integration of CBOs and SCN interventions into traditional health providers.

Accordingly, this framework will develop an aggregated, interoperable, and comprehensive statewide resource repository of CBOs and services that will support healthcare providers' ability to make appropriate referrals, facilitate the exchange of SCN data, and ultimately ensure increased access to critical housing, food, and other social support services. Informed by state and federal contribution recommendations in an Assistant Secretary for Evaluation and Planning report, *Social Determinants of Health Data Sharing at the Community Level*,³⁴ this work will feed into the creation of a single statewide social needs referral and data platform. NYS envisions that this platform would serve as the basis for the social care data exchange that regionally based SDHNs will use across the state and would be aligned with national standards as they develop. DOH will procure a statewide IT social needs referral and data platform infrastructure for the SDHNs, HEROs, and VBP arrangements to connect the social needs of Medicaid members. This platform will also coordinate and report up social need assessment data and referral and service outcomes. Referrals will flow through the lead entity using the state-wide IT platform. The IT platform will not only report back critical data but will also connect to existing state systems like the Statewide Health Information Network for New York (SHIN-NY).³⁵

c. SDHN Funding

Funding will be distributed to the awarded lead SDHN entities in each designated region. Funding will total \$116M per year, with each region receiving \$12M per year (\$15M NYC). The cost of the SDHN per region includes the initial infrastructure, staffing, coordination of CBOs, capacity building of CBOs, and contracting. Once functional the SDHN will have ongoing staffing needs, connection to community and health system partners, continued growth, capacity building and coordination of regional CBOs, data reporting through the statewide network, management of contracts, and payment to CBOs for services through contracted VBP arrangements or other provider contracts. SDHNs may also fund services related to identified gaps that are not covered by VBP arrangements or contracted providers. There will also be capacity and coordination funding needs for the ongoing participation in the HERO and Enhanced Housing Initiative. DOH will also release a competitive procurement for a statewide IT platform. Up to \$30M for a five-year period will be dedicated to the creation, training and maintenance of the statewide social needs platform.

³³ "Systems Integration Project." United Way of Greater Rochester and the Finger Lakes. Accessed March 2, 2022. <https://unitedwayrocfly.org/landing-pages/systems-integration-project/>.

³⁴ "Social Determinants of Health Data Sharing at the Community Level." ASPE. (2021, March). Retrieved March 7, 2022, from <https://aspe.hhs.gov/sites/default/files/private/pdf/198636/MarketplaceRate.pdf>

³⁵ [Statewide Health Information Network for New York \(SHIN-NY\)](https://www.nyhealth.org/Statewide-Health-Information-Network-for-New-York). Accessed March 4, 2022. [nyhealth.org](https://www.nyhealth.org)

d. Shared Learning and Sustainability

The State will leverage the learnings from the SDHNs to support the integration of high-value services into managed care contracts and VBP arrangements on an ongoing basis that extend beyond the life of the waiver. While there is ample evidence around the potential for SCN interventions to improve health, advance health equity and better manage health care costs,³⁶ the research around the effectiveness of scaling the interventions to a regional and statewide basis has not been measured. NYS anticipates that the amendment evaluation would examine this question to leverage findings for long term policy changes in NYS, as well as other states.

1.3 Investments in Advanced VBP Models that Fund the Coordination and Delivery of Social Care via an Equitable, Integrated Health and Social Care Delivery System

With the HERO and SDHN infrastructure established, advanced VBP arrangements will support the mid- to long-term transformation and integration of the entire NYS health care and social care delivery system by funding the services needed to address SCN at scale. Under this structure, incentive awards would be made available to MCOs (that have participated meaningfully in HEROs) providers and organizations in qualifying VBP contracts approved by DOH. MCOs would be required to engage in VBP contracts with an appropriately constructed network of providers for the population specific VBP arrangement. For example, behavioral health IPAs and/or other behavioral health provider networks would be included along with primary care providers for VBP arrangements targeting the SMI, SUD, and dually diagnosed populations. In these instances, DOH would award the pertinent waiver funding based on differential attribution methodologies utilizing a member's primary behavioral health provider (e.g., Article 31, 32, 36, or integrated clinic) or Health Home focusing on individuals with behavioral health diagnoses, rather than a primary care only attribution methodology. Similarly, for VBP arrangements involving people with I/DD, attribution may occur based on the individual's Care Coordination Organization (CCO).³⁷ For adults with physical disabilities attribution may occur based on the individual belonging to a specialized Health Home.

The VBP funds through this waiver proposal would encourage the evolution of the MCO-network entity agreements into more sophisticated VBP contracting arrangements that incorporate health equity design, fund the integration with social care, adjust risk to reflect the continuum of physical and behavioral health and social care needs of their members, reward providers' improvements in traditional health outcome measures as well as advanced or stratified health equity measures informed by the HERO, and/or use fully prepaid payment models that fortify against fluctuations in utilization based on pandemics. In particular, using socially risk adjusted payment—whether through accurate use of z-codes or the data collected from the uniform social needs assessment tool described above—can incentivize and appropriately reward plans and providers for caring

³⁶ The Commonwealth Fund, Review of Evidence for Health-Related Social Needs Interventions, July 2019, available at <https://www.commonwealthfund.org/sites/default/files/2019-07/COMBINED-ROI-EVIDENCE-REVIEW-7-1-19.pdf>; Pruitt, Z et al. Expenditure Reductions Associated with a Social Service Referral Program, Population Health Management, Vol. 21, No. 6, Nov. 28, 2018, available at <https://www.liebertpub.com/doi/10.1089/pop.2017.0199>.

³⁷ Care Coordination Organization Health Home Care Management profile. Office for People With Developmental Disabilities. (n.d.). Retrieved March 7, 2022, from <https://opwdd.ny.gov/data/care-coordination-organization-health-home-care-management-profile>

more holistically for these vulnerable populations.³⁸ Prepayment approaches would also be available to providers who are not the lead VBP contractor, such as behavioral health providers, but are providing care to the lead contractor's attributed members through a downstream targeted or bundled arrangement.

The State recognizes that there have been successes under DSRIP, especially with VBP readiness and transition, that should continue under this new waiver amendment. PPSs that have shown deep experience and success with New York's current VBP arrangements, including through designation as "Innovators" under current, CMS-approved version of A Path toward Value-Based Payment: New York State Roadmap for Medicaid Payment Reform (VBP Roadmap),³⁹ with the necessary infrastructure and experience serving their communities and specific populations, may be eligible for upfront VBP incentive funding to facilitate the transition to these new health equity-driven VBP arrangements.

Additionally, this component of the waiver would seek specific authorities for NYS to utilize global prepayment payment models in selected regions where these arrangements logically apply; that is, where there is a lead or dominant health system or financially integrated provider-based organizations with demonstrated ability to manage the physical and behavioral health care of targeted populations in that region. In a global model, the lead health system VBP entity—whether part of an integrated delivery system or clinically and financially integrated IPA or ACO—would extend successes and performance across payor types, including Medicaid fee-for-service (FFS), Medicaid managed care, Medicare FFS, Medicare Advantage, and/or commercial plans.

The global model would further support New York State's efforts to reduce costs and improve quality of care in the selected regions, with a focus on achieving health equity and lasting health system transformation, especially in regions with significant health disparities. The lead VBP entity would bring together providers across the continuum of care and health plans across all payors to improve population health in the target region. The lead VBP entity would be responsible for managing the total cost of care, establishing provider-payor relationships, negotiating and effectuating contracts, and providing data and analytics for performance measurement and continuous improvement around established quality measures.

The global model would function similar to existing directed payment models in that the State would convert global budget dollars into a minimum fee schedule paid to the lead VBP entity by MCOs, which would be reconciled quarterly to align with the fixed annual budget. Payments would be made to downstream provider entities through fee schedules or sub-capitated arrangements that are negotiated with the lead VBP entity. As a fixed budget, the model would incentivize delivery systems to keep patients in the appropriate care setting and shift care to the community. Quality measures focused on hospital performance, population health and equity

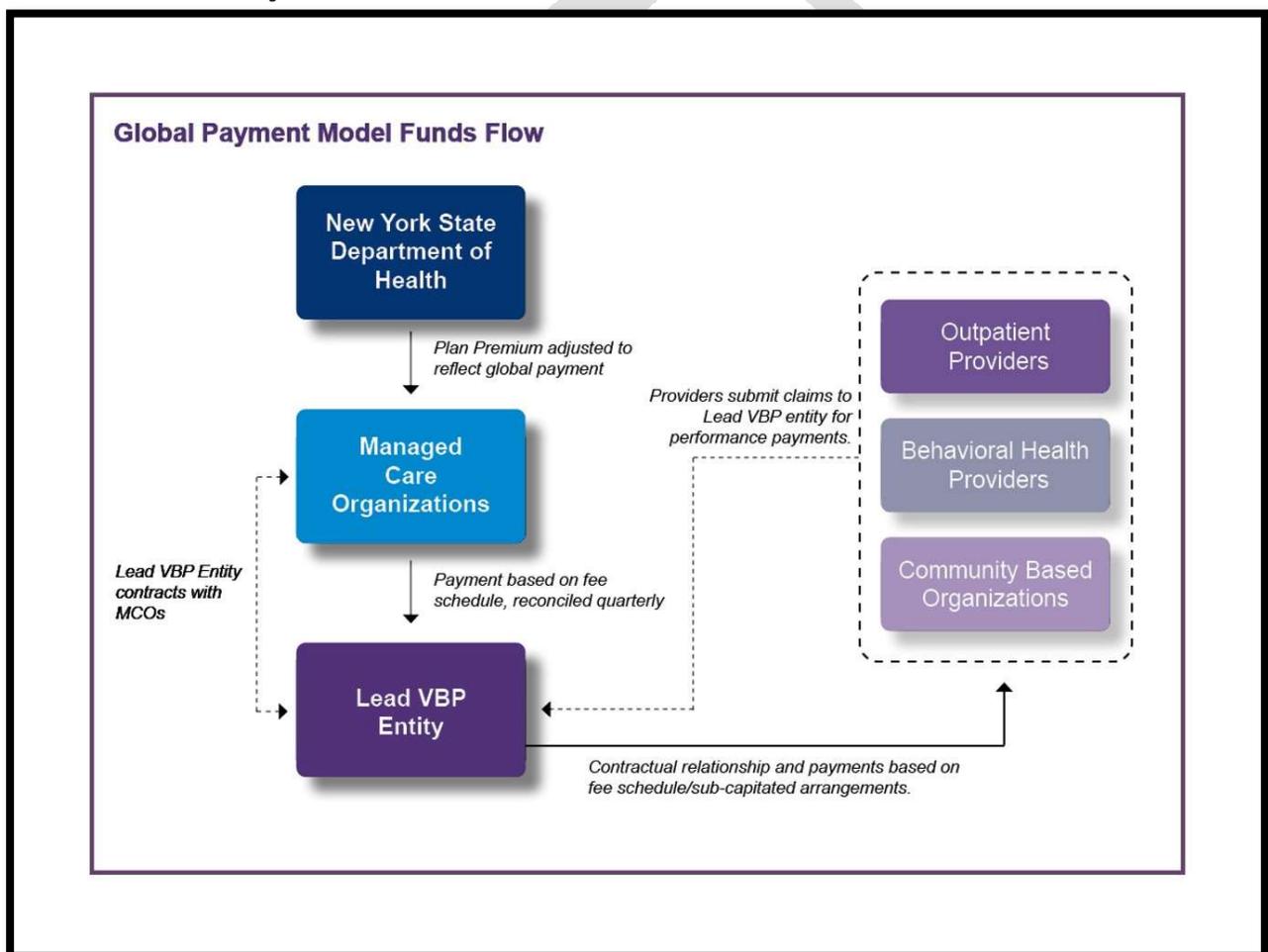
³⁸ Jaffrey, J. and Safran, D., Addressing Social Risk Factors in Value-Based Payment: Adjusting Payment Not Performance to Optimize Outcomes and Fairness, Health Affairs, April 19, 2021, available at <https://www.healthaffairs.org/doi/10.1377/hblog20210414.379479/full/>. National Quality Forum, A Roadmap for Promoting Health Equity and Eliminating Disparities: the Four I's for Health Equity, September 2017, available at https://www.qualityforum.org/Publications/2017/09/A_Roadmap_for_Promoting_Health_Equity_and_Eliminating_Disparities_The_Four_I_s_for_Health_Equity.aspx.

³⁹ The VBP Innovator Program provided special designation for experienced VBP contractors as a mechanism to allow experienced providers to continue to chart their path into VBP. The Innovator Program is a voluntary program for VBP contractors prepared for participation in Level 2 (full risk or near full risk) and Level 3 value-based arrangements. These providers enter Total Care for General Population and/or Subpopulation arrangements and are eligible for up to 95 percent of the total dollars that have been traditionally paid from the State to the MCO. NYS DOH, VBP Roadmap 56 (September 2019), available at https://www.health.ny.gov/health_care/medicaid/redesign/dsrrip/vbp_library/2019/docs/sept_redline2cms.pdf.

would further advance value-based care goals. Through an all-payor model, a global budget would also encourage cooperation along business lines for clinical integration and population health goals.

A global prepayment payment model would allow for the necessary upfront investments in the care delivery model to improve population health and provide value-based care. Global budgets would include expenditures beyond utilization of services to account for needed investments to improve health outcomes, including strengthening or developing new outpatient and community-based services, providing integrating the full spectrum of behavioral health and SUD services in settings traditionally focused on physical health in a financially sustainable manner, providing non-medical SCN services that improve health outcomes and are not traditionally covered by Medicaid, and investing in a sustainable workforce for new care models.

Exhibit 3: Global Payment Model Funds Flow



a. Redesign the VBP Roadmap to Address Health Equity and Regional Social Care Needs

NYS will develop a comprehensive range of VBP arrangements for the HEROs, SDHNs, and MCOs to consider adopting based on the specific populations and needs within each region. As NYS developed for its DSRIP waiver, NYS would develop a menu of options

within a new VBP Roadmap, with services that will be included in each VBP model, the members eligible for attribution for each model, selection and specifications of quality and outcome measures for each model, and methods to calculate the risk-adjusted cost of care and benchmarks.⁴⁰

In order to reaffirm NYS's commitment to VBP post-DSRIP, the State updated the VBP Roadmap to condense and clarify the previous iteration in January 2022. The State also held a public webinar and public comment period for the updated VBP Roadmap. While the focus of the public comment period was for the streamlined VBP Roadmap, more than half of the comments pertained to this 1115 waiver application and future iterations of the VBP Roadmap. The comments expressed broad support for more expansive and flexible SCN-related VBP arrangements and included thoughts on potential improvements, such as global and episodic payment arrangements, adjustments to support smaller CBOs in VBP arrangements, and improved data access. The State is thoughtfully considering all this feedback, has incorporated pertinent feedback into this 1115 waiver application and will incorporate relevant feedback into the next iteration of the VBP Roadmap.

Examples of qualifying health equity-informed VBP arrangements might include episodic or bundled-payment arrangements involving Medication-Assisted Treatment (MAT), maternal health, Alternative Payment Models with Federally Qualified Health Centers (FQHC) that involve a per member per month wrap payment for members to allow for flexibility in pursuing integrated care, and individuals experiencing significant episodic BH needs (e.g., transitioning to the community from a long-term or short-term stay in an inpatient psychiatric facility due to SMI, SUD detoxification and rehabilitation, or high use of outpatient services and psychiatric medications). Examples of qualifying subpopulation arrangements may include individuals experiencing chronic homelessness, whether sheltered-based or on the street; children in foster care; individuals with I/DD or with physical disabilities who are in managed care; individuals who have previously been incarcerated; individuals experiencing first episode psychosis; and persons living with HIV/AIDS or at high-risk of contracting HIV/AIDS.

b. Advanced VBP Contract Requirements and Funds Flow

The provider agreement entered by the MCO and VBP network entity would need to implement or build on HERO programs with a specific emphasis on prepaid or global payment models, and address local needs based on priorities identified by the HERO. It would also include an appropriately constructed network of providers based on the needs of the target populations, data sharing requirements, and specific quality measures and health equity measures informed by the HERO. MCOs would be encouraged to contract with safety net hospitals, clinics, community-based behavioral health providers, provider entities, or SDHNs for care management, referrals, or potentially other management/administrative capabilities that build on the regional health equity activities as identified by the HERO. NYS envisions that not every VBP arrangement will utilize SDHNs as the vehicle for CBO contracting, especially in areas where there is a strong cohort of existing CBOs or IPAs that are already successfully managing the needs of specific populations. However, under the waiver, NYS would give funding preference to arrangements that utilize SDHNs. Moreover, in order to effectively reimburse directly for SCN services, the VBP incentive pool will use an established fee schedule to pay CBOs

⁴⁰ See VBP Roadmap, at 4.

for interventions on a per service basis or similar methodology, rather than rely solely on funding CBO services exclusively through the potential for upside shared savings at the end of a measurement period. The fee schedule will be similar to North Carolina's (NC) Healthy Opportunities Pilot Program, that includes a standardized service name, rate and service definition for each evidence-based intervention.⁴¹The statewide IT referral platform will allow for streamlined service payments with a built-in fee schedule. VBP arrangements will have a portion of funding dedicated to the provision of uniform screening and social care services.

c. Leverage Ongoing Primary Care Investments

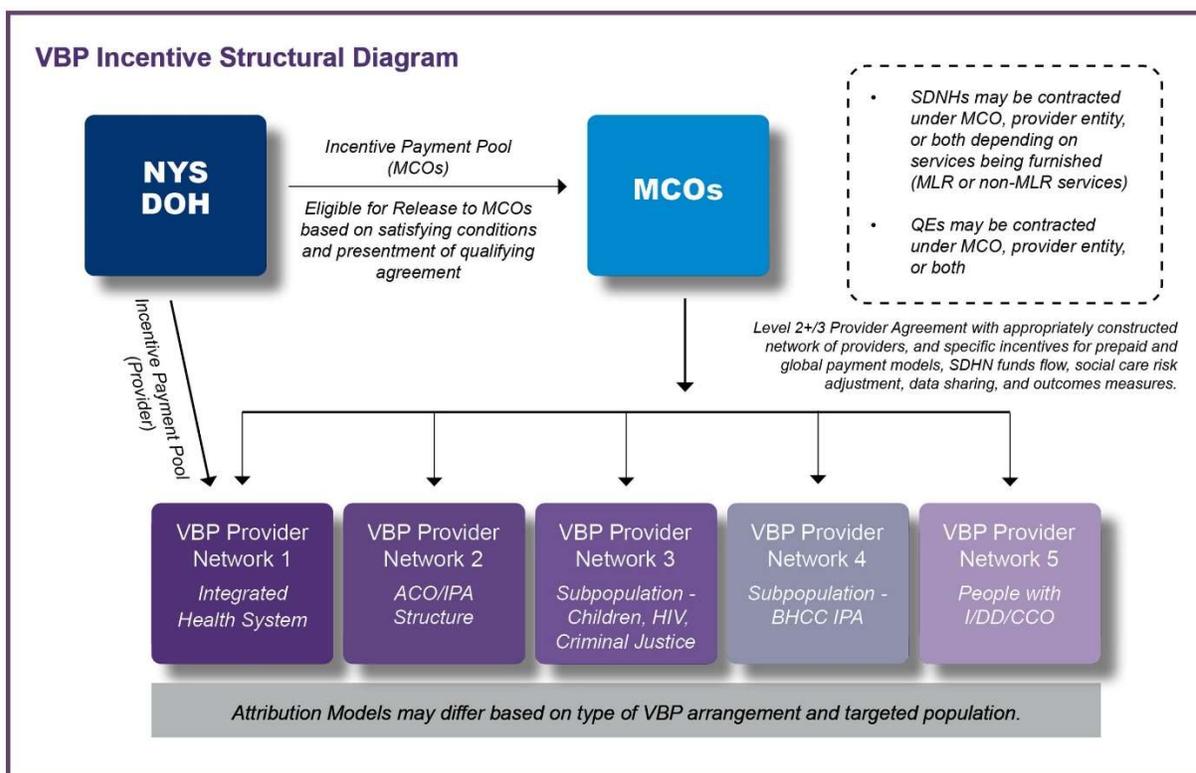
While moving to health equity focused and advanced VBP contracts, these models will continue to recognize the important role primary care plays in care management and service coordination. The role of primary care is evidenced by the significant investments that have been and are continuing to be made through the NYS PCMH program. In order to become a PCMH practice, primary care providers must meet several different standards to address the critical needs driven by SCN, which have been demonstrated to result in higher-quality and more effective care for these patients.⁴² Any transition to more targeted and health equity oriented VBP arrangements will necessarily leverage the State's past investments in PCMH and ensure that they continue to play a care coordination and service planning role in the VBP arrangements that work to improve the health of specific populations.

VBP incentive funds under this structure would be made available to MCOs and participating providers upon presentation and approval of qualifying VBP contracts, which specify network composition, the assumption of financial risk, minimum data sharing requirements, risk mitigation strategies offered by the MCO, and other requirements to be specified by NYS. To this end, incentive funds would both be loaded into the MCO premium to reflect additional plan administrative costs associated with implementation of these programs and funded directly to the participating providers as part of qualifying arrangements (See [Exhibit 4](#) for a depiction of the VBP incentive structure).

⁴¹ Manatt [NC-Pilot-Service-Fee-Schedule_Final-for-Webpage.pdf \(manatt.com\)](#). Accessed March 7, 2022.

⁴² K.S. Chen, T. Robertson, M. Wu, et al., The Impact of the PCMH Model on Poststroke Follow-up Visits and Hospital Readmissions, Health Services Research, 2020.

Exhibit 4: VBP Incentive Structural Diagram



1.4 Capacity Building and Training to Achieve Health Equity Goals

Workforce and training are critical foundations to achieving the health equity goals under this proposal and to developing delivery systems of “well care” capable of serving the whole person. To provide the SCN interventions through the SDHNs, NYS will need to expand the number of community health workers, care navigators and peer support workers, particularly drawing from low-income and underserved communities to ensure the workforce reflects the community they serve. Workforce training will also support regional collaboration under the HEROs, the SDHNs, and the move to advanced VBP models, including:

- Training staff to do social need assessments that will form the hallmark of the VBP model design, including plan social care risk adjustment and enhanced data collection;
- Building out capacity to CBOs to address behavioral health needs and SCN, including for populations with severe SMI and SUD needs and those that were criminal justice-involved;
- Facilitating telehealth care delivery;
- Ensuring a consistent workforce to assist in the reintegration into supportive and community-based housing;
- Integrating CBO and caregiving staff into the care team; and
- Incorporating principles of implicit bias and cultural sensitivity training for all member facing staff.

This waiver component also expands workforce investments, including creating additional career ladders and pathways for these community health occupations so that entry level workers such as home health aides and dietary aides with strong community ties can advance in their career, and expanding on current apprenticeship programs and cohort training programs for community health occupations. These programs will provide opportunities to increase the economic mobility of individuals in the community, which in turn, plays a role in achieving health equity through addressing economic stability and job creation. Further detail on workforce investments is described in Goal #3 below.

1.5 Ensuring Access for Criminal Justice-Involved Populations

Based on historical data in New York, approximately 83 percent of incarcerated individuals are in need of substance use disorder treatment upon release, according to the New York Department of Corrections and Community Supervision (DOCCS).⁴³ Meanwhile, the share of individuals in New York City's jails who have mental illnesses has reached nearly 40 percent in recent years, even as the total number of incarcerated individuals has decreased.⁴⁴ Incarcerated individuals with serious health and behavioral conditions use costly Medicaid services, such as inpatient hospital stays, psychiatric admissions, and emergency department visits for drug overdoses at a high rate in the weeks and months immediately after release. Even under the best of circumstances, when a person is discharged without prior contact with a future care manager or provider or without long-acting depot medications or other addiction/mental health medications as indicated, there is a high likelihood they will not engage with critical service providers when they re-enter the community. Contact between service providers and the incarcerated individual needs to occur prior to release to facilitate the continuity of care after discharge and the use of medications appropriate for community-based (rather than jail or prison) settings.

To achieve its health equity goals, NYS recognizes this is a particularly vulnerable population, especially individuals with co-occurring conditions, who must maintain connectivity and access to critical services and medications as they transition back to community settings. NYS has identified that expanding Medicaid services for the criminal justice-involved population prior to re-entry is critical to achieving the waiver's health equity goals; therefore, the State is seeking to build and strengthen the relationship between the care provided inside its prisons and the care offered by Medicaid providers upon release, ensuring appropriate transition and supports prior to re-entry to ensure particularly vulnerable patients with comorbidities have the housing and other supports they need to stabilize in a community setting. This population can then be more effectively served as part of the health equity informed VBP arrangements described above. With this purpose in mind, NYS seeks approval for the following eligibility changes:

Provision of Targeted Medicaid Services to Incarcerated Individuals 30 Days Prior to Release: NYS seeks approval from CMS to provide a targeted set of in-reach Medicaid services for incarcerated individuals 30 days prior to release, including care management and discharge planning, clinical consultant services, peer services, and medication management plan development and delivery of certain high priority medications to ensure active engagement in services upon release and to assist with the successful transition to community life. Coverage for these services is suggested to be phased in, beginning with individuals incarcerated in State facilities, followed by local jails.

⁴³ Identified Substance Abuse, State of New York Department of Correctional Services (Dec. 2007).

⁴⁴ City of New York, Mayor's Task Force on Behavioral Health and the Criminal Justice System: Action Plan (Dec. 2014), available at https://a860-gpp.nyc.gov/concern/parent/5t34sk09n/file_sets/pz50gw62x.

The State will be able to bridge relationships between community-based Medicaid providers and justice-involved populations prior to release, thereby improving the chances individuals with a history of substance use, serious mental illness and/or chronic diseases receive stable and continuous care. By working to ensure justice-involved populations have a stable network of health care services and supports upon discharge, New York believes it will be able to demonstrate a reduction in emergency department use, hospitalizations and other medical expenses associated with relapse, as well as improvements in health outcomes, including a reduction in overdose rates and deaths.

There is ample documentation from across the country that the criminal justice-involved population contains a disproportionate number of persons with behavioral health conditions (i.e., substance use disorders and mental health disorders), as well as HIV and other chronic diseases. Nationally, an estimated 80 percent of individuals released from prison in the United States each year have a substance use disorder or chronic medical or psychiatric condition.⁴⁵ Incarcerated individuals have four times the rate of active tuberculosis compared to the general population, nine to ten times the rate of hepatitis C, and eight to nine times the rate of HIV infection.⁴⁶

In New York, a staggering 83 percent of New York's incarcerated individuals are in need of substance use disorder treatment upon release, according to the New York Department of Corrections and Community Supervision (DOCCS).⁴⁷ Meanwhile, the share of individuals in New York City's jails who have mental illnesses has reached nearly 40 percent in recent years, even as the total number of incarcerated individuals has decreased.⁴⁸ Of the 29,391 individuals who were discharged from jail in New York City during the 2018 calendar year, 26 percent had mental health needs; 11 percent suffered a severe mental illness; and 63 percent struggled with substance use.⁴⁹ These issues are not confined to New York City -- in the 19 counties participating in the New York State County Re-Entry Task Force Program, 26 percent of eligible individuals required mental health treatment, 79 percent required substance use disorder treatment, while 82 percent required social services.⁵⁰

National data indicates that incarcerated individuals with serious health and behavioral conditions use costly Medicaid services, such as inpatient hospital stays, psychiatric admissions, and Emergency Department (ED) visits for drug overdoses at a high rate in the weeks and months immediately after release.

New York-specific data, also highlights that there is a major gap in continuity of care for people cycling in and out of jail and that stronger outreach and engagement efforts could improve

⁴⁵ Shira Shavit et al., "Transitions Clinic Network: Challenges and Lessons in Primary Care for People Released from Prison," *Health Affairs* 36, no. 6 (June 2017): 1006–15.

⁴⁶ Jhamirah Howard et al., *The Importance of Medicaid Coverage for Criminal Justice Involved Individuals Reentering Their Communities* (U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Apr. 2016); Doris J. James and Lauren E. Glaze, *Mental Health Problems of Prison and Jail Inmates* (U.S. Department of Justice, Bureau of Justice Statistics, revised Dec. 14, 2006); *Behind Bars II: Substance Abuse and America's Prison Population* (National Center on Addiction and Substance Abuse at Columbia University, Feb. 2010); Lois M. Davis and Sharon Pacchiana, *Prisoner Reentry: What Are the Public Health Challenges?* (RAND, May 2003); Henry J. Steadman et al., "Prevalence of Serious Mental Illness Among Jail Inmates," *Psychiatric Services* 60, no. 6 (June 2009): 761–65; and Jennifer C. Karberg and Doris J. James, *Substance Dependence, Abuse, and Treatment of Jail Inmates, 2002* (U.S. Department of Justice, Bureau of Justice Statistics, July 2005).

⁴⁷ *Identified Substance Abuse*, State of New York Department of Correctional Services (Dec. 2007).

⁴⁸ *Mayor's Task Force on Behavioral Health and the Criminal Justice System: Action Plan* (Dec. 2014).

⁴⁹ *Correctional Health Services*, April 3, 2019.

⁵⁰ *County Re-entry Task Force Program Activity Report: July 2013 – June 2014*.

outcomes and prevent unnecessary utilization of expensive services. For example, in a study of 1,427 Medicaid recipients residing in Brooklyn, New York, with SMI who had also been released from prison within the past five years, 1,009 (71 percent) met criteria (based on Medicaid claims) suggesting inadequate behavioral health care in the prior year. The project team attempted to contact behavioral health providers who had served these individuals and were able to complete detailed treatment histories for 556 individuals. Of these 556 completed case reviews, 406 (73 percent) were confirmed to be disengaged from care and considered at high-risk for adverse events or poor outcomes. Among these 406 disengaged individuals, 176 (43 percent) were found to be re-incarcerated (prison or jail) at the time of review and another 161 (40 percent) were completely lost to care with no provider able to initiate outreach. Outreach was successfully initiated for only 64 (16 percent) of these individuals. This very high-risk population has very high rates of inadequate care.⁵¹ A follow-up study to the one above analyzed the population of individuals identified as disengaged from care. The study showed that if a provider was able to initiate outreach, approximately 65 percent of the group of disengaged individuals successfully re-engaged in care within 12 months. However, if no provider connected, or if the individual was incarcerated when reviewed, re-engagement rates remained very low (30 percent re-engaged within one year).⁵²

State and local correctional facilities (i.e., prisons and jails, respectively) provide medical services, including medications for medical and mental health conditions. Individuals also re-enter the community with a limited supply of medications. However, medication management for substance use disorders is generally not provided with an eye toward release back into the community. The provision of medication for specific conditions occurs within the controlled setting run by the facility, this stability disappears when a person is released into the community. Even under the best of circumstances, when a person is discharged without prior contact with a future care manager/provider or without long-acting depot medications or other addiction/mental health medications as indicated, there is a high risk they will establish other priorities and will not engage with critical service providers when they re-enter the community. Contact between service providers and the incarcerated individual needs to occur prior to release to facilitate the continuity of care after discharge and the use of medications appropriate for community-based (rather than jail or prison) settings. The use of depot, long acting and other addiction and mental health medications for treatment of schizophrenia and opioid addiction can support a smoother transition into the community and facilitate the successful linkage to other services that in turn, further maintain stability.⁵³ The ability to begin the use of depot and /long-acting medications prior to release will ensure these medications are clinically appropriate, well tolerated and more likely to remain in use when the individual re-enters the community. For patients for which longer acting medications are less appropriate, other mental health and addiction medications would be indicated.

⁵¹ Smith TE, Appel A, Donahue SA, Essock SM, Thomann-Howe D, Karpati A, Marsik T, Myers RW, Sorbero MJ, Stein BD: Determining engagement in services for high-need individuals with serious mental illness. *Administration and Policy in Mental Health* 2014; 41:588–597; doi: 10.1007/s10488-013-0497-1.

⁵² Smith TE, Stein BD, Donahue SA, Sorbero M, Karpati A, Marsik T, Myers RW, Thomann-Howe D, Appel A, Essock SM: Reengagement of high-need individuals with serious mental illness following discontinuation of services. *Psychiatric Services* 2014; 65:1378-1380; doi:10.1176/appi.ps.201300549 (This was before NYS had Health Homes, DSRIP, Medicaid Managed Care for behavioral health, and the other resources that now support community-based outreach for these individuals).

⁵³ The role of long-acting injectable antipsychotics in schizophrenia: a critical appraisal, S. Brissos et al., *Ther. Adv. Psychopharmacol* 2014 Oct. 4(5): 198-219

New York is seeking to build and strengthen the relationship between the care provided inside its prisons and jails and the care offered by Medicaid providers upon release. To facilitate the arrangement of critical services prior to release, the NYS Council on Community Re-Entry and Reintegration was formed to address obstacles faced by individuals transitioning to the community. Their recommendation was that NYS reinstate Medicaid benefits 30 days prior to release, without allowing the billing of services, and issue a Medicaid benefit card prior to release. In 2017, the DOH Office of Health Insurance Programs began reinstating Medicaid benefits prior to release across all systems. Further, as part of the State Fiscal Year 2016/-17 Budget, enacted state legislation that directs the state to “seek federal authority to provide medical assistance for transitional services including but not limited to medical, prescription, and care coordination services for high needs inmates in state and local correctional facilities thirty days prior to release.”⁵⁴

Because of NYS’s progress in suspending coverage and initiating re-activation upon release, the State is well-positioned to identify individuals who would benefit from pre-release in-reach and discharge planning.

Individuals eligible for this program are those Medicaid enrolled members who have two or more qualifying chronic diseases (such as Hepatitis C and diabetes), or one single qualifying condition of either HIV, a serious mental illness, or an opioid use disorder, and who are scheduled to be discharged from a jail or prison within 30 days. The State also suggests that providers be allowed to engage individuals in county jails within the first 30 days of incarceration, as long as there is reasonable expectation of discharge within that period. The average length of stay in a county jail is often brief, less than two weeks. Allowing care managers to provide service in the first 30 days would encourage community-based providers to collaborate with county jails; support the best practice of including discharge planning as part of jails’ medical intake sessions; and ensure individuals maintain their medication-assisted treatment (MAT) without tapering or discontinuation, with linkage to all forms of MAT medication. The State is further exploring continuity of benefits in the pre-sentencing period.

In 2019, there were 22,276 annual discharges from prisons, and 185,069 annual discharges from jails (42,033 located in New York City, and 128,650 in rest-of-State jails). The State estimates that approximately 48 percent of this population would meet the high-risk eligibility criteria (18 percent serious mental illness; 5 percent with HIV; 25 percent with chronic conditions, which include a SUD or HCV diagnosis) to receive services pre-discharge.

The targeted scope of benefits for this well-defined group of criminal justice-involved individuals will improve health outcomes, and consistent with current delivery transformation goals, reduce avoidable hospitalizations and Medicaid spending. It is anticipated that the overall costs will be offset by a reduction in Emergency Room visits, inpatient hospitalizations and other unnecessary services that are avoided as a result of providing a limited scope of Medicaid benefits during the 30-day pre-release period (e.g., a reduction of at least one ER visit at an average cost of about \$280 for every member served during the 30-day, pre-release period).

The services that are being requested for coverage during the 30 days prior to release from State and county correctional facilities are currently covered for Medicaid members who are not incarcerated and who are in fee for service or Medicaid Managed Care plans. Services are covered with non-federal and federal matching funds in accordance with the individual’s category

⁵⁴ Chapter 59 of the New York State Laws of 2016, Part B, § 21-a.

of eligibility. The State expects savings from drug rebates and from the decrease in unnecessary services.

New York is requesting \$745M to provide these additional in-reach Medicaid services. As mentioned above, services would be phased-in over two years, with services being provided in State facilities in the first year and adding services in local jails in the second year. The estimate is based on average costs associated with Health Home care management, clinical consultation, and pharmacy for individuals with chronic conditions, SMI, HCV, and HIV in each of the correctional settings.

Taken together, this series of investments would enable a statewide strategy to address SCN at scale, while maintaining the flexibility to direct resources based on specific local challenges and needs, tied to health equity goals. The components of this overall framework are firmly rooted in the recommendations from the National Quality Forum in how states should promote health equity and eliminate health disparities:

- a. Evaluating health equity needs (Sections 1.1 and 1.2);
- b. Collecting and assessing data (Sections 1.1 and 1.2);
- c. Measuring improvements (Sections 1.2 and 1.3); and
- d. Redesigning payment models to support health equity (Sections 1.3, 1.4 and 1.5).⁵⁵

Goal #2: Developing and Strengthening Supportive Housing Services and Alternatives for the Homeless and Long-Term Institutional Populations

Transitioning individuals to community-based settings from institutional care and connecting people to stable housing have long been priorities of New York State, and the COVID-19 pandemic has exacerbated this concern. During the pandemic, individuals and families experiencing homelessness are at significant risk of infection in congregate settings, such as homeless shelters, and may have also lost access to other supports, such as services and food provided through schools. Individuals experiencing homelessness are also more likely to have underlying conditions, behavioral health issues, substance use disorders, and limited access to health services. Individuals who reside in long-term care institutions (such as psychiatric facilities, nursing homes, congregate care facilities, and Intermediate Care Facilities for people with I/DD) and correctional facilities were also disproportionately impacted by the pandemic, experiencing increased rates of infection and the disruption of necessary habilitative or rehabilitative services. The housing needs of these individuals are likely to be ongoing and escalate as the public health emergency order is lifted and the end of eviction moratoria results in greater housing instability and homelessness. Given this experience and ongoing need, NYS proposes to build on its existing and innovative work in supportive housing and community integration.

Building on NYS Supporting Housing Programs: Supportive housing was a major initiative under the Medicaid Redesign Team (MRT) in 2011. The MRT supportive housing initiative is composed of a diverse set of programs that target high utilizers of Medicaid and use a variety of

⁵⁵ National Quality Forum, A Roadmap for Promoting Health Equity and Eliminating Disparities: the Four I's for Health Equity (September 2017), available at https://www.qualityforum.org/Publications/2017/09/A_Roadmap_for_Promoting_Health_Equity_and_Eliminating_Disparities_The_Four_I_s_for_Health_Equity.aspx.

approaches to provide permanent supportive housing and tenancy-based services to different populations statewide. Since 2011, the MRT has made \$837M in financial investments using state-only dollars for rental subsidies and supportive housing services, serving approximately 15,000 Medicaid members. These programs include 54 capital projects, 13 rental subsidy and supportive services programs and one accessibility modification program. The programs serve homeless vulnerable individuals with HIV/AIDS, serious mental illness, I/DD and other developmental disabilities, or chronic conditions and individuals that often have high rate of comorbidities (exhibit 3). The initiative also targets those individuals living in institutional settings who can live safely in community-based settings⁵⁶.

In addition to investments in MRT Supportive Housing, New York State committed to a \$20 billion, five-year capital plan in 2017, to build more than 100,000 affordable and 6,000 supportive housing units under the Empire State Supportive Housing Initiative (ESSHI)⁵⁷. ESSHI funds supportive housing programs directed at specific populations, including individuals with I/DD or physical disabilities, those individuals with serious behavioral health and addiction needs, and older adults. Both the MRT and ESSHI housing initiatives are coordinated by an inter-agency workgroup involving Medicaid Program, DOH's AIDS Institute, Office of Mental Health (OMH), Office of Addiction Services (OASAS), Office for People with Developmental Disabilities (OPWDD), Office of Temporary Disability Assistance (OTDA), and New York State Homes and Community Renewal (HCR). HCR is the State's affordable housing agency, with a mission to build, preserve, and protect affordable housing and increase homeownership throughout New York State.

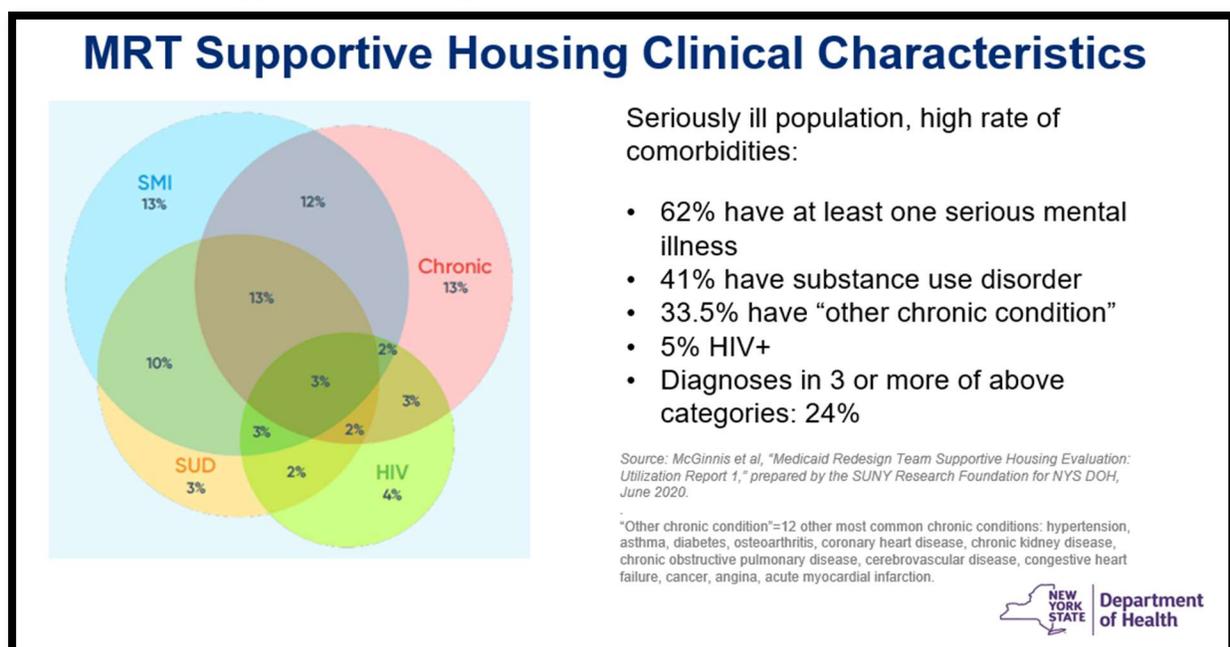
Through expansive data collection, evaluation and strong partnerships with housing providers, the initiative has created a high utilizer menu to prioritize those who are the most vulnerable and costly to the Medicaid system. In 2019, the Department received technical assistance from the National Academy for State Health Policy to create a housing model that partners MCOs and housing providers to effectively coordinate and link Medicaid members to available housing units. MCOs in this partnership use their data to identify their top homeless high utilizers who are eligible for a new housing program. The MCO then refers eligible individuals to the housing provider for further screening and appropriateness for the housing program. The MCO's care manager and housing provider work closely together to get individuals into the new housing units; and remain in contact care coordinator and avoid unnecessary emergency department (ED) visits.

The MRT Initiative has since built upon this work and added the connection of MCOs and other health system partners as key referral sources to other existing MRT programs. The results from the first project yielded a 46 percent reduction on ER visits and an overall 47 percent reduction in Medicaid costs.

⁵⁶ Medicaid Redesign Team Supportive Housing Initiative, https://www.health.ny.gov/health_care/medicaid/redesign/supportive_housing_initiatives.htm

⁵⁷ Governor Hochul Announces \$35 Million for at Least 1,400 Supportive Housing Units across New York State, December 20, 2021. <https://www.governor.ny.gov/news/governor-hochul-announces-35-million-least-1400-supportive-housing-units-across-new-york-state>

Exhibit 5 MRT Supportive Housing Clinical Characteristics



The MRT supportive housing initiative has undergone a rigorous five-year evaluation. Overall, the initiative has shown a reduction in the number of ED visits and inpatient hospital stays. On average, Medicaid claim costs declined by about \$6,800 per person with high utilizers of the programs having an average savings of \$45,600. Programs that transitioned individuals from nursing home settings saved an average of \$67,255 the first year and \$90,239 the second year in housing. Clients enrolled in MRT Supportive Housing also showed lower overall mortality (eight percent) than the comparison group clients of the evaluation (15 percent).⁵⁸

Despite these successes, the evaluation found barriers to accessing supportive housing. Some of the qualitative findings on under-served groups and barriers to supportive housing access include:

- Findings from the qualitative analysis highlighted individuals with significant or complex medical needs as an underserved population.
- Other groups identified as under-served included individuals who do not have the specific diagnosis required for the program, individuals with physical disabilities who require accessible housing, individuals disconnected from the service system, individuals with cognitive or developmental disabilities who require help with medication administration, and individuals with a chronic condition who do not have a secondary support (e.g., a family member) identified.
- In many cases, the providers described having an insufficient number of slots in the program, given the number of eligible individuals within their catchment area.

Providers in some regions, particularly rural areas, noted that lack of awareness about the program is a barrier to helping those who may benefit.⁵⁹

⁵⁸ Source: SUNY Research Foundation, McGinnis et al, “Medicaid Redesign Team Supportive Housing Evaluation: Cost Report 2”

⁵⁹ Source: SUNY Research Foundation, Lauren Polvere, Ph.D., Sandra McGinnis, Ph.D., Margaret Gullick, Ph.D., Kelly Gross, MSW, Gabriela Melillo, MSW, Veena Ravishankar, MS, “Access Report 1”

As mentioned above, the MRT Supportive Housing Initiative also assists those who are in institutional settings, such as Skilled Nursing Facilities, transition into the community. MRT funds two programs that are specifically targeted to this population, the Olmstead Housing Subsidy program and the Nursing Home Transition and Diversion Program. Both programs target those who are identified by the Open Doors Program and other referral sources, which assists individuals in institutional settings to return safely to their communities. The Open Doors Program refers individuals that are able to live safely in the community to the Olmstead Housing Subsidy Program or the Nursing Home Transition and Diversion Program⁶⁰. The Olmstead Housing Subsidy program was established in 2015 and currently serves 345 individuals as well as assisting with one-time transition needs⁶¹.

According to the States Minimum Data Set (MDS) a total of 19,094 individuals living in a SNF identified that they wanted to transition to the community in 2021. As exhibited by the cost savings, these transition programs are impactful. However, they face barriers of finding appropriate and affordable housing. Other barriers include discharge planning; the initial costs and coordination of transitioning into the community such as security deposit, brokers fees, first month's rent, start-up supplies; and coordination of care/services.⁶²

Continued Demand for Supportive Housing Programs Exacerbated by the COVID-19 Pandemic: During and outside of the pandemic, access to transitional and permanent housing and supports are indispensable aspects of a viable safety net and of health equity, as demonstrated by the success of the MRT investments described above and NYS's experience during the pandemic. From March 1, 2020 – June 24, 2021, there were 3,607 confirmed COVID-19 cases in shelters and 81 deaths. Of those 1,947 of the cases and 61 of the death's race/ethnicity was identified as black.⁶³ People who are homeless with complex medical problems are one of the highest cost groups of individuals enrolled in New York Medicaid, driving a large portion of avoidable hospital costs through lack of access to care outside the emergency department. They are disproportionately affected by behavioral health conditions, including substance use disorder. Housing investments, if supported by innovative services and VBP, can produce a great return on investment, as reflected by the MRT Supportive Housing Initiative and the findings from its five-year evaluation.⁶⁴

Across the nation, the COVID-19 mortality rate has been highest in nursing homes and among the long-term care (LTC) population (the frail elderly and people with complex chronic conditions, including people with I/DD). According to the CDC, as of November 2020, despite representing less than 0.5 percent of the US population, nearly 30 percent of COVID-related deaths nationwide

⁶⁰ Department of Health. NYS Money Follows the Person Demonstration (MFP). (n.d.). Retrieved March 4, 2022, from [https://www.health.ny.gov/health_care/medicaid/redesign/nys_money_follows_person_demonstration.htm#:~:text=Money%20Follows%20the%20Person%20\(MFP\)%20is%20a%20Medicaid%20program%20sponsored,funds%20the%20Open%20Doors%20program.](https://www.health.ny.gov/health_care/medicaid/redesign/nys_money_follows_person_demonstration.htm#:~:text=Money%20Follows%20the%20Person%20(MFP)%20is%20a%20Medicaid%20program%20sponsored,funds%20the%20Open%20Doors%20program.)

⁶¹ Department of Health. Supportive Housing Programs. (n.d.). Retrieved March 4, 2022, from https://www.health.ny.gov/health_care/medicaid/redesign/supportive_housing/programs.htm

⁶² Carol V. Irvin, Noelle Denny-Brown, Eric Morris, and Claire Postman. PATHWAYS TO INDEPENDENCE: TRANSITIONING ADULTS UNDER AGE 65 FROM NURSING HOMES TO COMMUNITY LIVING. December 12, 2016. Accessed March 4, 2022. [Pathways to Independence: Transitioning Adults Under Age 65 from Nursing Homes to Community Living \(mathematica.org\).](https://www.mathematica.org/publications/pathways-to-independence-transitioning-adults-under-age-65-from-nursing-homes-to-community-living)

⁶³ COVID-19 Homeless Population Pandemic Report | OTDA (ny.gov). Accessed March 4, 2022.

⁶⁴ Department of Health. Housing is Healthcare: Supportive Housing Evaluation. (n.d.). Retrieved March 4, 2022, from https://www.health.ny.gov/health_care/medicaid/redesign/supportive_housing/evaluation.htm

were residents of nursing homes.⁶⁵ Despite its extensive network of home and community-based services, NYS still has high numbers of people living in institutional settings. Individuals who reside in institutional settings (such as psychiatric facilities, nursing homes, congregate care facilities, and Intermediate Care Facilities for People with I/DD) or correctional facilities experienced disruption of necessary habilitative or rehabilitative services. NYS must continue and expand efforts to facilitate access to alternative environments for individuals requiring long-term care. This initiative would make new investments that align with existing efforts (such as the State's *Olmstead* plan to transition people to the least restrictive possible environment) to reduce institutionalization and institutional capacity of all kinds and to promote integration of currently institutionalized populations.

Investing in Supportive Housing Services and Alternatives for the Homeless and Long-Term Institutional Populations

Building off the MRT Supportive Housing Initiative and learning from the identified barriers from the evaluation of these past efforts, NYS seeks to address and expand its leading work through targeted investments in complementary supportive housing programming. Programming that will be necessary to address downstream effects of the COVID-19 pandemic. These investments will target instability in housing for Medicaid-eligible individuals and families, as well as address the urgent need for supportive housing for people experiencing homelessness. NYS seeks the following investments to support Medicaid patients who are particularly vulnerable, as they are experiencing homeless or living in institutional settings despite their potential ability to live in the community.

a. Local & Statewide Planning & Coordination through HEROs

This coordinated approach to housing will utilize HEROs outlined in the earlier section, as we anticipate housing to be a universal need. HEROs would conduct an inventory of supportive housing programs in each region and identify the gaps that exist, mapping existing efforts and any gaps by area and vulnerable population. Local Continuum of Care (COC) planning bodies have historically worked to organize local housing opportunities, but the HEROs would build on this work by working to understand the gaps that exist for the Medicaid population that is not engaged in current housing but are experiencing homelessness or living in institutional settings. The HEROs would then work on identifying housing solutions for the areas and populations where gaps exist, coordinating between MCOs, SDHNs, COCs, public housing authorities, federal programs administered by the U.S. Department of Housing and Urban Development, and local government entities overseeing local housing programs. This effort will be vitally important for the populations living in institutional settings that are not always eligible for many housing programs that require homelessness or those that are street homeless and not in shelter settings. This effort will be coordinated with the other NYS agencies through the existing MRT Supportive Housing Workgroup. Once complete, regional HEROs will then identify disengaged high utilizers of Medicaid that have high rates of ED, inpatient service usage, are within the top 20 percent of the counties Medicaid spend or have been living in an institutional setting for over 90 days.

This effort will match Medicaid and homeless data in order to identify eligible high utilizers that need enhanced engagement. To target the institutional population, the HEROs will

⁶⁵Characterization of COVID-19 in Assisted Living Facilities — 39 States, October 2020 (November 20, 2020): <https://www.cdc.gov/mmwr/volumes/69/wr/mm6946a3.htm>

leverage the Money Follows the Person and other data sources and programs to identify individuals for community-based living. Funds would be available for these entities to undertake this assessment and planning effort incorporating meaningful behavioral health measures to support clinical integration with physical health as a guiding principle. Measures for success will include rehabilitation and recovery goals. The regional HEROs would also engage in planning efforts in order to develop alternatives to remain in community-based settings.

Additionally, recognizing New York's aging population, the State will undertake a comprehensive planning effort to create a master plan for assuring the availability of sufficient long-term services and supports and accessible health care capacity to enable aging in place. Local planning efforts by HEROs and identified needs will be elevated statewide. This waiver initiative takes the first step in supporting investments in community-based care for those who rely on Medicaid and are unstably housed.

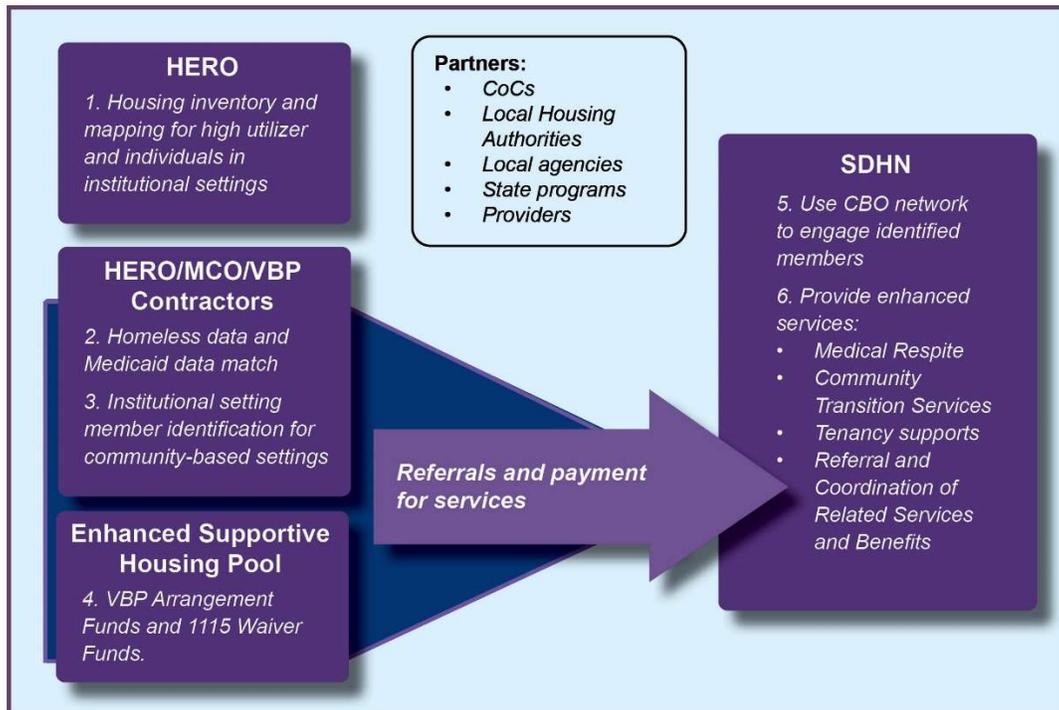
In order to truly reduce health disparities and promote health equity as stated in Goal #1, NYS has to target the housing gap. By implementing the five core tasks below, NYS can close gaps and create better health outcomes, care, and quality of life for Medicaid members.

1. Identify accessible and affordable housing options in each region for homeless and transitional populations.
2. Identify high utilizer members and those who can transition safely to the community.
3. Provide enhanced housing services and coordination of all needed services to identified members.
4. Ensure the availability of sufficient long-term services and supports and accessible health care capacity to enable aging in place.
5. Measure costs savings and health outcomes.

b. Enhanced Supportive Housing Initiative

Through this waiver, the State will establish an Enhanced Supportive Housing Pool which will be informed by a comprehensive and unified supportive housing and respite services menu for Medicaid members developed by HEROs and include MCO and VBP arrangement funding with matching 1115 waiver dollars. The enhanced housing services will be targeted to identified high utilizers or for those living in an institutional setting for 90 days or more using the regional data match mentioned above. The Enhanced Supportive Housing Initiative will utilize the HERO's housing inventory and mapping to find appropriate housing. The pooled funds will then be paid to the SDHN for CBOs to engage Medicaid members and provide medical respite, housing navigation, community transitional services, and coordinate care and services and tenancy supports. A diagram and funds flow for these investments are depicted in Exhibit 6.

Exhibit 6: Enhanced Supportive Housing Initiative Model and Funds Flow



As mentioned above, the MRT Supportive Housing evaluation results have shown a high costs savings of \$45,600 (homeless) - \$90,239 (transitional) per person and better health outcomes for these two vulnerable populations. The Enhanced Supportive Housing initiative will encourage a targeted effort in housing and will also create collaboration between MCOs, VBP contractors, SDHNs, and CBOs that offer and navigate housing options. The Enhanced Supportive Housing Initiative services include:

1. **Medical Respite:** Creation of new or expanding medical respite models of care for post-hospitalization discharges. Medical respite programs provide care to homeless individuals and individuals who are at imminent risk of homelessness and who are too sick to be on the streets or in a traditional shelter, but not sick enough to warrant inpatient hospitalization. They provide short-term care that allows individuals experiencing homelessness the opportunity to rest in a safe environment while accessing on-site medical care and other supportive services. There's strong evidence for return on investment (ROI) for medical respite programs. In addition to reducing the length of hospitalization, studies have shown patients discharged to medical respite programs have subsequent reduction in emergency department usage by 1.8 visits, and reduction in hospital inpatient readmissions by 0.6 admissions per year. Under MRTII, NYS is working to change State regulations and create a path for certification to allow more comprehensive medical respite model. Funding would be targeted

to the expansion of medical respite programs in geographic areas that have a high rate of homeless individuals using inpatient services. Including the provisions of capacity building and service dollars. The medical respite providers will be part of the respective regional SDHN.

2. **Community Transitional Services:** Transitional housing services for individuals living in institutional settings and those who are experiencing homelessness, including: housing navigation to support finding appropriate housing using HERO mapping, assistance with application process and interviews, case management and care coordination, short-term rental assistance (up to 6 months), security deposit, first month's rent, brokers fees, unit start-up needs. This would include Critical Time Intervention models to help people, particularly focusing on individuals with SMI and SUD-related needs that are leaving correctional facilities and other institutional settings, transition across levels of care, which is a time-limited evidence-based practice that facilitates community integration and continuity of care by ensuring a person has a support system and strong ties to their community during times of transition.
3. **Tenancy Supports:** Supports to ensure that individuals are able to stay safely housed in the community. This funding will be provided only if the housing program that the individual is connected to does not provide tenancy support services. Services include tenancy support planning, life skills training, eviction prevention, landlord tenant mediation, crisis planning, crisis intervention, individualized service plan, tenant check in and assistance, ongoing advocacy, and coordination.
4. **Referral and Coordination of Related Services and Benefits:** SDHNs working with their CBO network would utilize this supportive housing investment to coordinate related services and benefits that complement the provision of supportive housing. These services include:
 - Behavioral health supports, including substance use disorder services;
 - Home and Community Based Services, including those being expanded under Section 9817 of the American Rescue Plan Act and NYS's approved spending plan from CMS;
 - Environmental supports and accessibility modifications;
 - Employment and vocational services;
 - Additional SSI state supplemental funding for high needs populations; and
 - Other needed services and benefits.

To evaluate the efficacy of any new supportive housing investments, NYS will undergo an evaluation of the initiative, examining metrics such as retention in permanent housing.

c. Funding for the Enhanced Supportive Housing Initiative

New York requests \$1.57B over five years to fund the supportive housing initiatives described above, including community transitional services, tenancy supports, and

medical respite programs. The State estimates serving approximately 30,000 individuals over the five years and estimates the cost of \$1.56B for community transitional supports and tenancy services, based on an estimated annual cost of \$20,000 per individual, and \$5 million for medical respite capacity and services. Services will be ramped up over the five-year period, with an anticipated cost of \$60M in Year One.

Goal #3: Redesign and Strengthen System Capabilities to Improve Quality, Advance Health Equity, and Address Workforce Shortages

As described in the introduction, the COVID-19 pandemic has New York's taken a toll on New York's hospital and nursing home systems, as well as the healthcare workforce; workers that bore the primary responsibility of addressing surges in COVID-19 cases while experiencing, the strain of tragic losses of life first-hand. This burden has had a wide reach, with individual and system-level impacts. New York's financially distressed safety net and critical access hospitals and nursing homes felt this acutely, as they serve the State's most vulnerable populations and were already experiencing declining operating margins even prior to the pandemic. The pandemic has also had a tremendous, negative impact on the healthcare workforce, causing many to work long hours in difficult conditions leading to burnout, with some individuals leaving the healthcare workforce entirely. The capacity of our safety net hospitals, nursing homes, and healthcare workforce to provide high quality services to Medicaid members and support the furtherance of health equity and reduce racial disparities is an integral component of the State's work to rebuild and recover from the public health emergency. Post-pandemic, there is a need to rebuild the acute and chronic healthcare services disrupted by the public health emergency. Redesigning the healthcare delivery system to efficiently achieve better outcomes in underserved areas during non-emergency times must incorporate the need to support rapid mobilization of the workforce for pandemic response, continuation of essential healthcare services, effective care coordination, and quality care during a crisis and the subsequent period of recovery.

3.1 COVID-19 Unwind Quality Restoration Pool for Financially Distressed Hospitals and Nursing Homes

New York proposes to create a VBP pool that would be available to financially distressed safety net and critical access hospitals and nursing homes that have a high Medicaid payor mix to engage in VBP arrangements and facilitate post-pandemic quality improvement and meaningful contribution to the health equity goals of this waiver. These entities would engage with MCOs, HEROs, and SDHNs to coordinate these efforts with regional plans and strategies. Funds will be available to these entities to do the following:

- Further move toward VBP with a focus on quality improvement and promoting health equity, consistent with the goals of this proposed amendment;
- Develop workforce training, in collaboration with Workforce Investment Organizations (WIOs), to support quality improvement initiatives, pandemic-related needs such as cross training of staff to enable cross-coverage between inpatient and ambulatory care settings (but consistent with their scope of practice), and health equity-related work; and
- Implement interventions focused on health equity and population health improvement goals and work of HEROs described in Goal #1.

The State is requesting \$1.5B for these initiatives, with \$1B dedicated toward quality improvement and health equity-related interventions. These estimates are extrapolated from costs associated with previous VBP quality improvement initiatives.

3.2 Develop a Strong, Representative and Well-Trained Workforce

Even prior to the COVID-19 pandemic, areas of NYS were experiencing workforce shortages across the health care continuum. As NYS works to build back better post-pandemic and to make significant progress toward eliminating health disparities and promoting health equity, it is imperative to have a strong and well-trained workforce that is both representative of the populations being served and free of implicit bias. Building on the work from the prior waiver demonstration that ended in March 2020, NYS proposes a substantial reinvestment in WIOs to focus on the needs of their respective regions and coordinate with the other WIOs across NYS to facilitate a cohesive approach to workforce development and share best practices. As part of DSRIP, WIOs were tasked with providing training opportunities for the long-term care workforce. Under this waiver, New York would expand the investment in WIOs to expand workforce initiatives beyond the initial charge and focus on long-term care to provide a wider range of training, recruitment, and retention initiatives that would address the workforce shortage crisis across the care continuum, facilitate implementation of the health equity work of this waiver, and create opportunities for individuals advance in their careers. Planning efforts will involve a variety of stakeholders, including local government entities, labor organizations, provider organizations (inclusive of former PPSs with proven workforce strategies), and CBOs. Importantly, this investment would both expand capacity through a well-trained and culturally informed workforce and recognize that training investments themselves function as an important SCN, related to job insecurity and unemployment.

New York is requesting \$1.5B to fund these workforce initiatives. This estimate is based on WIO funding through the DSRIP program adjusted for the expanded responsibilities outlined below and the increase in severity of the workforce crisis that has been exacerbated by the pandemic.

Specifically, funds would support initiatives targeted at addressing workforce needs and the specific projects outlined for this waiver amendment, and would include:

- a. *Recruitment and Retention Initiatives:*** Expand and enrich the workforce to address shortages across the healthcare continuum (including behavioral health providers and long-term care and post-acute care professionals and paraprofessionals in a variety of long-term care settings including nursing homes), recruit greater participation by people of color in medical professions, and provide workers with a greater range of opportunities for advancement;
- b. *Develop and Strengthen Career Pathways:*** Support career pathways of frontline healthcare workers in entry level positions across the continuum of care where there are occupational shortages, thereby retaining talent and rewarding the workforce who served our communities during the pandemic;
- c. *Training Initiatives:*** Support regional collaboration and the move to more advanced models of VBP that incorporate new health equity design highlighted under Goal #1.

- d. Expanding the Community Health Worker and Related Workforce:** Expand CHWs, care navigators and peer support workers would assist in the addressing structural inequities and achieving the health equity goals of this initiative. Expansion efforts will include career pathways for these community health occupations, so that entry level workers such as home health aides, dietary aides, housekeeping staff with strong community ties can advance in their career. By building a career pipeline with opportunities for advancement, this approach coupled with hiring individuals with lived experience also addresses upward mobility and economic instability often impacting low-income and marginalized communities. Other efforts include providing cohort training programs for community health occupations and building and expanding registered apprenticeship programs.
- e. Standardize Occupations and Job Training:** Support a move towards standardizing new and emerging occupations and job training, bringing them to scale in the state.

In sum, these investments will strengthen delivery systems in New York to enable a more nimble response to future pandemics and natural disasters, while leveraging available resources to build the workforce needed for a 21st century delivery system that is reflective of the populations it serves and creating an economic jobs engine that develops the workforce needed to support patients in community settings and deliver SCN services at scale.

Goal #4: Creating Statewide Digital Health and Telehealth Infrastructure

A silver lining of the COVID-19 pandemic has been the opportunity for—and accelerated realization of—widespread consumer and provider use of digital and telehealth care, including tools such as remote patient monitoring, innovative care management technologies, and predictive analytics. Consumers report high satisfaction with telehealth options, with prominent surveys showing satisfaction levels of 86-97 percent, often higher than for in-person visits.⁶⁶ Preliminary data also suggests that telehealth has been a critical means at reaching hard-to-engage populations with historical access issues, especially for behavioral health services.⁶⁷ Over two million NYS Medicaid members used telehealth in SFY 2021, with behavioral health services accounting for approximately 50 percent of telehealth services. Telehealth was used throughout the State, but counties with the greatest proportion of telehealth utilizers per enrollees tended to be upstate. However, rural counties in New York’s North Country region tended to have a smaller proportion of telehealth utilizers. With the State’s continued push towards advanced VBP models, digital tools and telehealth will be critical means by which the health care system can adjust the mechanisms for care delivery to become more focused on outcomes than billable events, with flexibility in the frequency and duration of virtual visits and other digital modalities of care. Telehealth can also increase access to high demand specialties and improve use of tools such as home monitoring to anticipate and prevent acute events by extending the eyes and ears of providers into home and community settings. In a provider survey conducted by the NYS Department of Health in 2020, 70 percent of responding providers indicated they often used

⁶⁶ Ramaswamy, A, Yu, M., et al. Patient Satisfaction with Telemedicine During the COVID-19 Pandemic: Retrospective Cohort Study, *Journal of Medical Internet Research* 2020; 22(9) and J.D. Power, 2020 U.S. Telehealth Satisfaction Study, October 2020.

⁶⁷ Lau, J., Knudsen, J., et al. Staying Connected in the COVID-19 Pandemic: Telehealth at the Largest Safety-Net System in the United States, *Health Affairs*, June 11, 2020, available at <https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.00903>.

audio-visual telehealth in the past 3 months. When asked about patient barriers to telehealth, lack of internet connectivity (identified by 87 percent of respondents) and lack of hardware or devices needed for audio-visual telehealth (87 percent) were most often identified. Lack of provider training (47 percent), internet connectivity (40 percent), and lack of staff needed to facilitate telehealth (48 percent) were identified as additional provider-driven barriers, and the cost of equipment was the leading structural barrier (56 percent).

Through an 1115 amendment, NYS can ensure that this 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. NYS will promote the elimination of health disparities, in part, by ensuring equitable use and availability of telehealth, including telephonic-only service delivery where appropriate, across communities of color and other marginalized areas. To date, the largest segment of telehealth users are white non-Hispanic enrollees, consistent with NYS Medicaid population demographics. Digital health and telehealth capabilities for safety net providers need to expand beyond simple, siloed solutions thrown into service during an emergency into thoughtfully designed platforms integrated with Electronic Health Records (EHR), language access, care management programs, social care services, the statewide health information exchange, and professionals and non-professionals trained to maximize the use of such technology. In New York, 100 percent of hospitals, 81 percent of clinics, and 58 percent of physicians connect to the SHIN-NY which allows for the electronic exchange of clinical information between providers and regional networks. Providers have demonstrated ability to use a digitally connected infrastructure, though a statewide approach to integrating telehealth with EHRs and the SHIN-NY has not yet been developed.

Reimbursement levels in Medicaid populations served by safety net providers are not sufficient to make these investments on their own, as they sometimes are in the commercial market. Currently, some successful telehealth innovations in Medicaid have been achieved through small grants and regionally or population-focused pilot programs, without which device and infrastructure costs can be prohibitive for providers. The State will therefore use waiver funding to create an Equitable Virtual Care Access Fund to assist such providers with these human capital investments, resources, and support. Greater use of telehealth, virtual care and other digital health tools has many other potential benefits, including expanded access to specialists and better use of statewide system capacity, improved ability to engage in follow-up care, better ability to care for patients in a comfortable home setting, and a reduction in barriers such as childcare and transportation. Studies have shown significantly reduced rates of cancelled appointments when telehealth was utilized, compared to in-person visits only.⁶⁸ In approving plans and distributing funds for flexibility in health system capacity, the State will take into consideration appropriate payment mechanisms to promote virtual encounters to improve services to vulnerable populations and to address ongoing workflow disruptions and/or staffing shifts due to the COVID-19 public health emergency. Additionally, the State will ensure that State Medicaid payments for telehealth services are the same as in person services and ensure individuals dually eligible for Medicare and Medicaid enrolled in an integrated plan can receive telehealth services aligned with Medicaid telehealth policies.

⁶⁸ S. Jeganathan, L. Prassannan, et al. Adherence and acceptability of telehealth appointments for high-risk obstetrical patients during the coronavirus disease 2019 pandemic, *American Journal of Obstetrics and Gynecology*, September 22, 2020, available at <https://pubmed.ncbi.nlm.nih.gov/32984803/>.

Significant additional planning and investment is critical to create a robust infrastructure for telehealth, telephonic, virtual, and digital healthcare. Through a statewide collaborative group, the State will identify local strategies/solutions for mutual assistance and to also inform statewide standardization of technical requirements, workflows, as well as training and technical assistance to further build the necessary infrastructure to meet the immediate and long-term needs.

On an ongoing basis, the State may choose to engage in other population health activities that are supported by virtual care, including:

- Identifying patients who no longer have supports in place (e.g., day programs are closed, loss of aides or personal care assistants rendering personal care services, lack of access to needed specialty care, etc.) who need to be linked to other network supports (e.g., Health Home, telehealth support, replacement personal care services support, etc.);
- Tracking service capacity across the continuum of care; and/or
- Working with clinical leadership across the HERO's network of providers to standardize criteria for virtual vs. in-person care.

Funding and technical assistance through the Equitable Virtual Care Access Fund will bolster the ability of safety net providers to provide telehealth through various modalities. These may include:

- 'At scale' remote patient monitoring programs and other advanced care management and coordination solutions for high-prevalence chronic conditions, such as hypertension, diabetes, COPD, and heart failure, tailored for communities identified as high-priority;
- Predictive analytics and other data platforms—including establishing data system interoperability—to support the delivery of comprehensive and integrated physical and virtual care;
- Patient-facing tools and devices to support the delivery of comprehensive and integrated physical and virtual care;
- Regional specialty e-consult programs so that patients at safety net facilities can access specialty consult services (e.g., in neurology, psychiatry, pediatrics) from remote specialists, creating efficiencies and expanding access to specialty services;
- Virtual platforms that connect nursing homes, skilled nursing facilities and other long-term care facilities to health system partners for virtual visits, virtual consults and remote monitoring;
- School-based telehealth and school-based care coordination programs with a focus on expanding access to preventive services, primary care and behavioral health;
- Payments for tablets and remote monitoring devices where it is clinically and financially effective to do so;
- Programs that enable safety net providers to hire community health workers and others to help bridge the digital divide and address barriers to participation (e.g., digital literacy, technology support, internet and device access and usability);
- Specialty virtual care models expressly designed to serve people who face accessibility barriers, such as people with long-term care needs and/or people with I/DD, and prevent avoidable hospitalizations;

- Remote or digital-only day habilitation or social day care services for individuals with long-term care needs;
- Infrastructure and virtual care models that increase access to novel treatments and/or clinical trials for underserved populations; and
- Pilots and/or reimbursement models for digital therapeutics, diagnostics, screenings (including, where appropriate, genetic testing), and other innovative products that can deliver effective interventions directly with a reduced need for clinical staff.

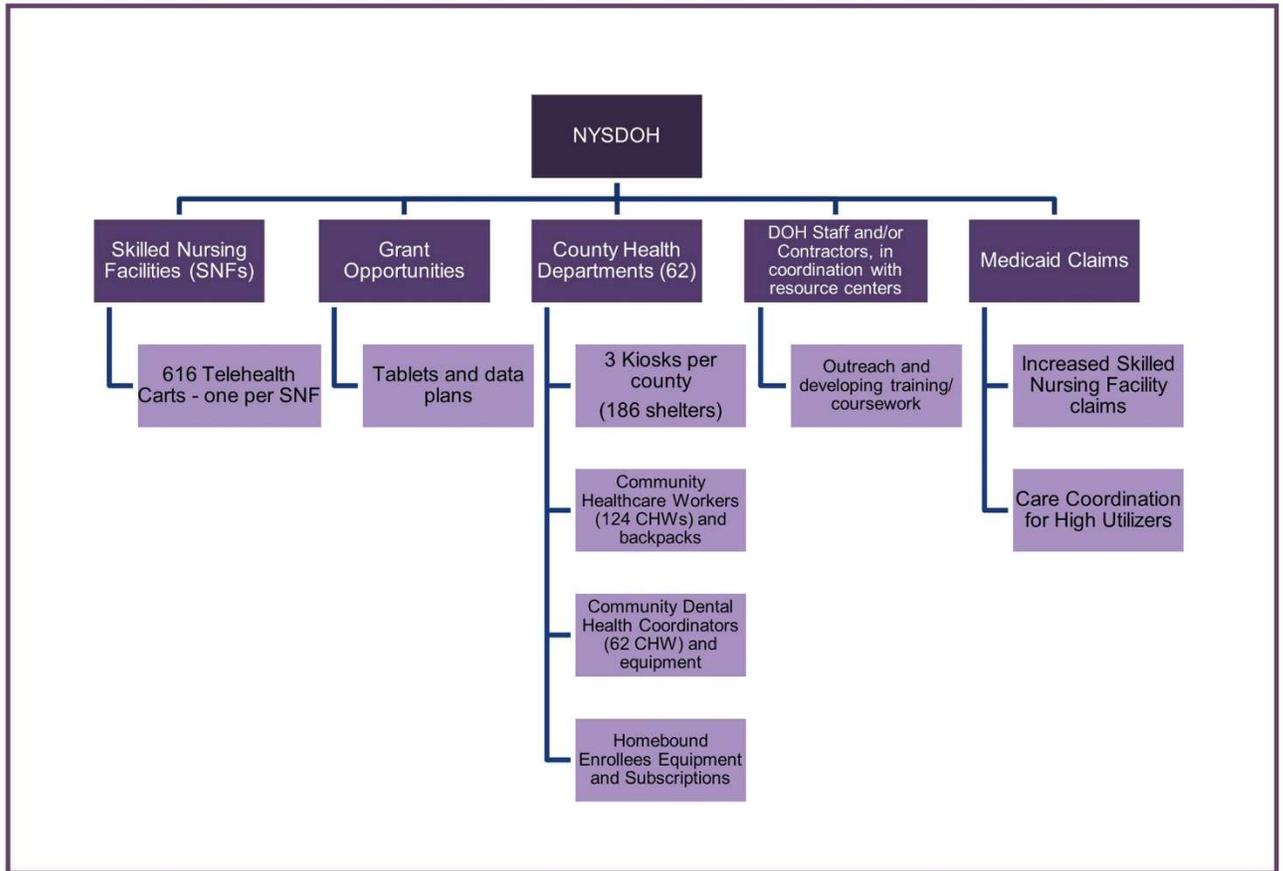
Each of these goals and their associated initiatives and investments address key challenges identified during the pandemic, as well as health disparities and racial inequities that hamper the State, MCOs and providers to collectively meet the needs of some of the most at-risk and underserved populations within our Medicaid population. Taken together, these initiatives create synergies that reinforce and support the overarching goals of this waiver proposal and our collective ability to stabilize and better serve all of our Medicaid population, particularly those most impacted due to longstanding racial and health disparities.

Statewide Digital Health and Telehealth Infrastructure Funding

Costs associated with telehealth initiatives are estimated at \$300M over five years. There are up-front costs associated with many devices needed to expand use of telehealth, as well as costs associated with training and infrastructure changes. The estimated cost breakdown of the various components of this initiative are:

- \$15M for care management and check-in services to reduce avoidable hospitalizations for 25 percent of the approximately 200,000 Medicaid enrollees utilize inpatient and emergency room services multiple times a year. Cost savings are expected to be realized once hospitalizations and emergency room use decreases;
- \$9M to equip approximately 600 Skilled Nursing Facilities (SNF) who are not dually enrolled in Medicare with telehealth equipment for their residents, which includes an estimated \$370,000 estimated for claim costs, based on 50 percent of the 200,000 Medicaid enrollees in SNF and a \$37 per visit cost;
- \$9M per year to connect approximately 19,000 homebound enrollees and those living in residential facilities with equipment and virtual care subscriptions, based on costs for similar previously grant-funded projects;
- \$7.5M for 124 Medicaid Community Health Workers (CHW) (two per county) at an expected cost of expected to cost \$45,000-\$60,000 per year per CHW, including \$279,000 annually (\$4,500 each) to outfit CHWs with a backpack needed to facilitate telehealth in the community;
- \$3.7M for 62 Medicaid Community Dental Health Coordinators (CDHC) at \$45,000-\$60,000 per year per CDHC, one per county. Includes \$235,600 annually (\$3,800 each) for a backpack containing tele-dental equipment, including high-resolution tele-dental cameras;
- \$3.7M to provide telehealth kiosks to at least three homeless shelters in each county at approximately \$20,000 each;
- \$5M for to develop and deliver provider and member training to promote telehealth and digital literacy; and
- \$7M to supply 10,000 tablets (\$700 each) to providers and enrollees who lack access to technology necessary for telehealth services.

Exhibit 7: Telehealth Funding Flow Diagram (Annual)



Delivery System Implications

One of the overall goals of this amendment is to facilitate the integration of New York State’s healthcare and social care systems and to support local healthcare networks in moving to a structure that is more responsive to and supportive of social care needs. The primary vehicles for this change will be HEROs and SDHNs, which will fill vital regional planning and coordination roles and inform new advanced, health equity targeted VBP arrangements.

This amendment also provides support for interventions with demonstrated impact to SCN measures with clear implications for more equitable healthcare delivery and health outcomes. These include supportive housing and telehealth services, as well as the further integration and coordination of behavioral health services and substance use disorder supports into the health and social care infrastructure through VBP, HERO, and SDHN participation.

Finally, with this amendment, New York hopes to stabilize and reinforce the healthcare system to ensure the necessary infrastructure is in place to weather any future system-wide emergencies to ensure more equitable outcomes following pandemics or similar disasters. This includes investments in quality and population health improvement and health equity, as well as workforce investments to provide for more representative, patient-centered healthcare experience and to enhance workforce recruitment, retention, and training to ensure that employment in New York’s healthcare system remains competitive and attractive to workers and provides opportunities for advancement.

Overall, the initiatives detailed in this amendment provide for a more equitable, integrated, and resilient delivery system with the means to support future evolutions and to be more responsive, adaptive, and patient-centered in the near term.

Implementation Timeline

Most provisions of the waiver amendment will begin immediately on January 1, 2023, except for HEROs and SDHNs, which will require additional time for procurement and set up, and the VBP arrangements informed by these entities. The State is exploring the procurement options available through state and federal regulations and will provide a detailed procurement and implementation timeline HEROs and SDHNs with the amendment submission.

Waiver and Expenditure Authorities

Waiver Authority: In addition to the waiver authorities already granted in the current 1115 waiver demonstration, the State is requesting the following waiver authority necessary to implement the initiatives aimed at addressing health disparities and the SCNs 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)

#	Authority	Waived
2	<p>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.</p> <p>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).</p> <p>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.</p> <p>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.</p>	<p>Comparability Section 1902(a)(10) Section 1902(a)(17)</p>
3	<p>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.</p>	<p>Amount, Duration & Scope Section 1902(a)(10)(B)</p>
4	<p>To the extent necessary to enable New York to require beneficiaries, including those individuals who are incarcerated up</p>	<p>Freedom of Choice</p>

#	Authority	Waived
	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.	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	<p>Expenditures for healthcare related costs for the following populations that are not otherwise eligible under the Medicaid state plan.</p> <ul style="list-style-type: none"> 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 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

#	Program	Authority
		<p>income standard described in STC 4(c) of section IV, and who receive services through the managed long term care program under the demonstration.</p> <p>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).</p>
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 (MMMMC)	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].
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	Expenditures for incentive payments and planning grant payments for the HERO, SDHN, and VBP programs

#	Program	Authority
	Networks (SDHN), and Value Based Payment Incentive Pools	

Budget Neutrality

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 \$42.704 billion annually. A more detailed cost breakdown by demonstration year is included below.

Strengthening the safety net is a top priority for the State, but NYS's own fiscal position has been undermined by the pandemic and it could not afford such funding on its own. In fact, absent federal support in the American Rescue Plan Act of 2021 (ARPA), the State would have been forced to reduce safety net expenditures immediately, as originally proposed in the State Fiscal Year 2021-22 Executive Budget. As required for a 1115 waiver, New York will meet budget neutrality requirements, post rebasing, but seeks additional flexibilities to support this proposal.

In addition to financing the non-federal share of this 1115 amendment through transfers from units of local government and state general revenue commitments that are compliant with section 1903(w) of the Social Security Act, New York seeks flexibility from CMS to identify other sources of matching funding. Specifically, given the focus of this larger amendment on the 32 long-term effects of COVID-19, it would be appropriate to recognize that local governments, public benefit hospitals, and the State have been required to make substantial commitments of capital and resources to combat COVID-19 prior to availability of any federal funding through the Family First Coronavirus Response Act (FFCRA); the Coronavirus Aid, Relief, and Economic Security (CARES) Act; ARPA; or other sources of federal funding that will be made available to states that are experiencing the impacts of the COVID-19 pandemic.

To the extent CMS and the State are able to identify state and local financial commitments, similar to the Designated State Health Programs that have been used to fund health care services and have replaced traditional Medicaid-covered services or programmatic administrative activities, NYS asks to revisit prior administrative guidance issued by CMS and allow these expenditures to be counted towards New York's non-federal share under this 1115 waiver. DSHPs were existing state-funded health programs that had not previously qualified for federal funding, including Medicaid-related funding. DSHPs existed in the state prior to the section 1115 demonstration. As part of previous 1115 demonstrations, CMS historically allowed states to count certain expenditures for the program as expenditures under the demonstration that qualify for federal matching funds, allowing the state to use these state dollars towards its Medicaid demonstration.

NYS and CMS could also work to identify federal savings that would accrue outside the Medicaid program, such as savings to the Medicare program due to reduced spending on the dual eligible population.

1115 Waiver Amendment Projected Enrollment

Proposal	DY1	DY2	DY3	DY4	DY5
Projected Enrollment	4,709,605	4,720,694	4,732,039	4,743,646	4,755,524
Goal #1: Health Equity-Focused System Redesign	4,318	36,864	36,864	36,864	36,864
HEROs	-	-	-	-	-
SDHNs	-	-	-	-	-
Advanced VBP Models	-	-	-	-	-
Criminal Justice-involved Populations	4,318	36,864	36,864	36,864	36,864
Goal #2: Supportive Housing	0	0	0	0	0
Goal #3: System Redesign & Workforce	0	0	0	0	0
System Redesign	-	-	-	-	-
Workforce Training	-	-	-	-	-
Goal #4: Digital & Telehealth	0	0	0	0	0
Total Projected Enrollment:	4,713,923	4,757,558	4,768,903	4,780,510	4,792,388

1115 Waiver Amendment Estimated Funding Schedule (in \$Millions)

Proposal	DY1	DY2	DY3	DY4	DY5	Total	Percent of Total
Goal #1: Health Equity-Focused System Redesign	\$205	\$852	\$2,526	\$2,533	\$2,540	\$8,655	64%
HEROs	\$65	\$65	\$65	\$65	\$65	\$325	2%
SDHNs	\$121	\$116	\$116	\$116	\$116	\$585	4%
Advanced VBP Models	\$0	\$500	\$2,167	\$2,167	\$2,167	\$7,000	52%
Criminal Justice-involved Populations	\$19	\$171	\$178	\$185	\$192	\$745	6%
Goal #2: Supportive Housing	\$63	\$101	\$301	\$501	\$601	\$1,565	12%
Goal #3: System Redesign & Workforce	\$600	\$600	\$600	\$600	\$600	\$3,000	22%
System Redesign	\$300	\$300	\$300	\$300	\$300	\$1,500	11%
Workforce Training	\$300	\$300	\$300	\$300	\$300	\$1,500	11%
Goal #4: Digital & Telehealth	\$60	\$60	\$60	\$60	\$60	\$300	2%
Total Ask:	\$928	\$1,613	\$3,486	\$3,693	\$3,800	\$13,520	100%

Amendment Evaluation and Hypotheses

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.

As stated previously, 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 demonstration.	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 demonstration.	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

Hypothesis	Example Measures (Not Final)	Data Sources
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 demonstration.	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

Abbreviations and Acronyms

ACO	Accountable Care Organization
AHC	Accountable Health Communities
AMR	Asthma Medication Ratio
ARPA	American Rescue Plan Act of 2021
CARES	Coronavirus Aid, Relief, and Economic Security Act
CBO	Community Based Organization
CCBHC	Certified Community Behavioral Health Clinic
CCO	Coordinated Care Organizations
CDHC	Community Dental Health Coordinators
CHW	Community Health Worker
CMS	Centers for Medicare & Medicaid Services
COC	Continuum of Care
DOCCS	Department of Corrections and Community Supervision
DOH	Department of Health
DSRIP	Delivery System Reform Incentive Payment
EHR	Electronic Health Records
ESSHI	Empire State Supportive Housing Initiative
FFCRA	Family First Coronavirus Response Act
FFS	Fee for Service
FQHC	Federally Qualified Health Center
HCR	Homes and Community Renewal (HCR)
HEROs	Health Equity Regional Organizations
HIE	Health Information Exchange
I/DD	Intellectual/Developmental Disabilities
IPA	Independent Provider Associations
LTC	Long-Term Care
LTSS	Long-Term Services and Supports
MAT	Medication- Assisted Treatment
MCO	Managed Care Organizations
MDS	Minimum Data Set
MRT	Medicaid Redesign Team
NYeC	New York e-Health Collaborative
NYC	New York City
NYS	New York State
OASAS	Office of Addiction Services and Supports
OMH	Office of Mental Health
OPWDD	Office for People with Developmental Disabilities
OTDA	Office of Temporary Disability Assistance

PCMH	Patient Centered Medical Home
PPA	Potentially Preventable Admission
PPR	Potentially Preventable Readmission
PPS	Performing Provider System
QE	Qualified Entities
RHIO	Regional Health Information Organization
ROI	Return on Investment
SCN	Social Care Needs
SDHN	Social Determinants of Health Networks
SED	Serious Emotional Disturbance
SHIN-NY	Statewide Health Information Network for New York
SMI	Severe Mental Illness
SNF	Skilled Nursing Facility
SSI	Supplemental Security Income
SUD	Substance Use Disorder
VBP	Value Based Payment
VBP Roadmap	<i>A Path toward Value-Based Payment: New York State Roadmap for Medicaid Payment Reform</i>
VMO	Value Management Organization
WIO	Workforce Investment Organization