1115 Waiver Amendment NY Health Equity Reform (NYHER)

Presented by
ACANY and LIFEPlan CCO

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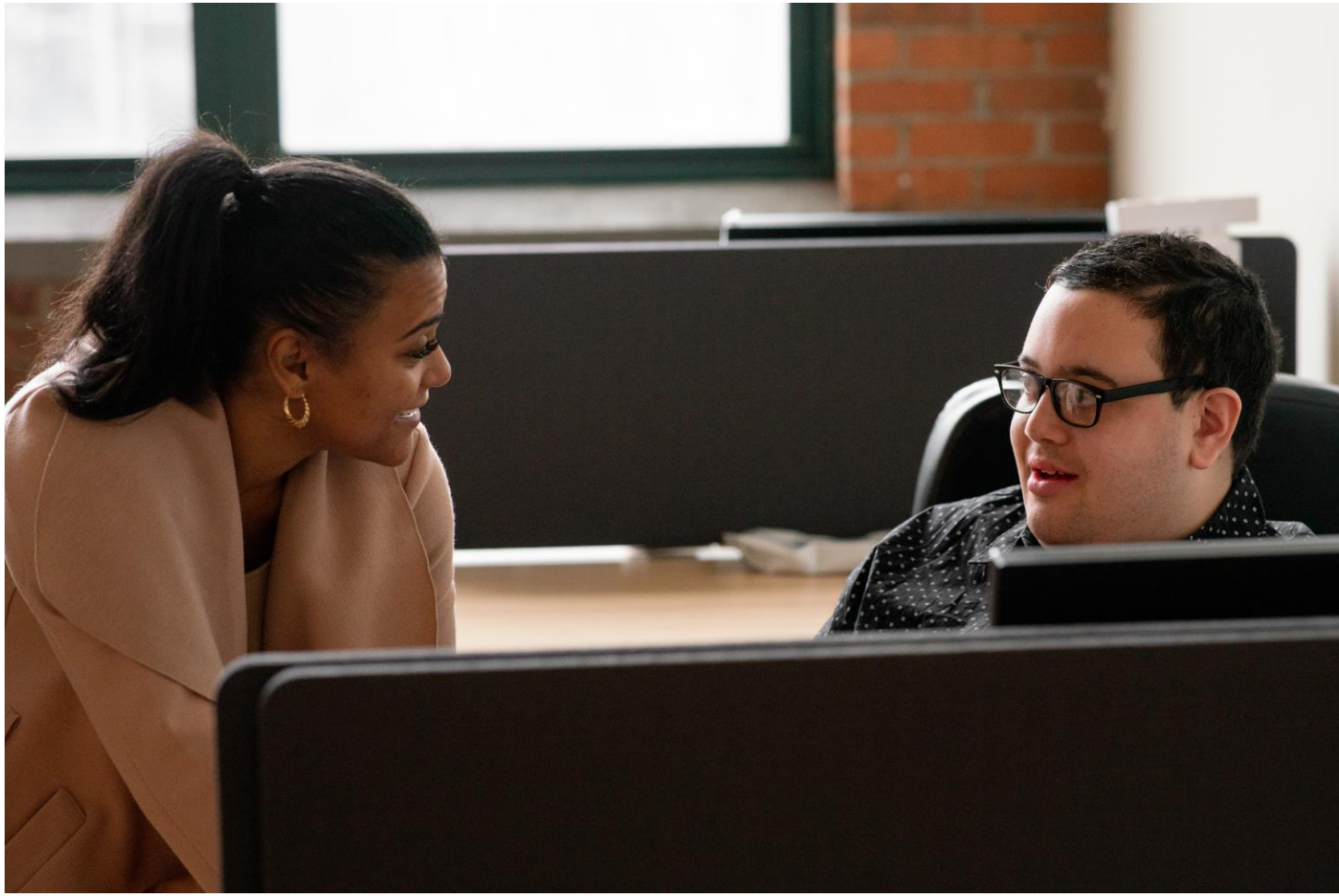


Introduction

Focus for today:

1115 Waiver Amendment – New York Health Equity Reform (NYHER) opportunities and concerns specific to Medicaid Members with an Intellectual and/or Developmental Disability (IDD) and IDD providers.

Agenda

- CCOs and TriaDD
- NYS 1115 Waiver
- 1115 NYHER Amendment
- Opportunities
- Timeline
- Next Steps

Participant Survey

What type of organization do you represent:

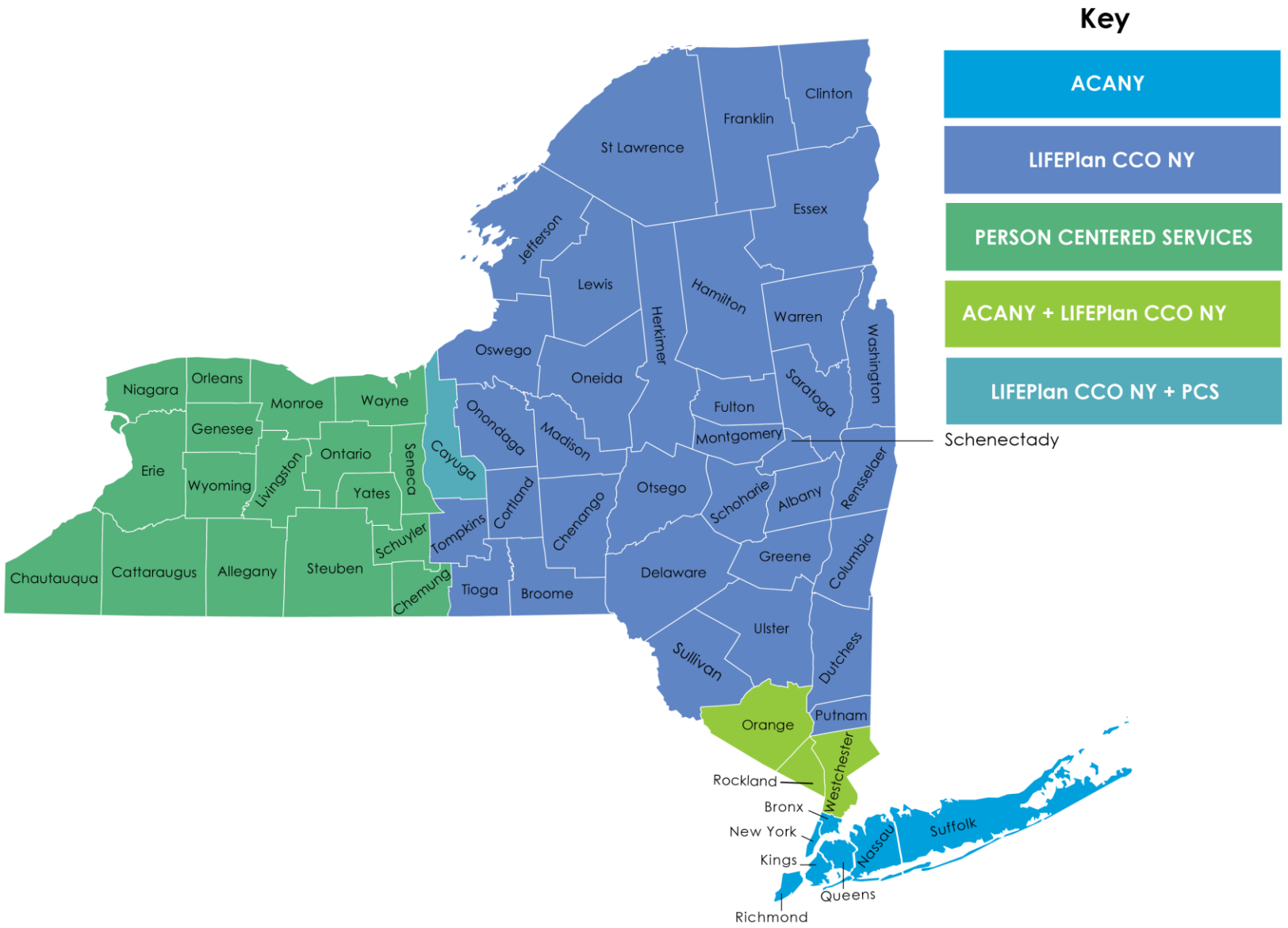
1. Developmental Disabilities Provider
2. Care Coordination Organization
3. Social Care Network
4. Medical/Behavioral Health Provider
5. Other

TriaDD

ACA/NY • LIFEPlan CCO • Person Centered Services

- Partnership between three CCOs
  - Advance Care Alliance NY (ACANY)
  - LIFEPlan CCO
  - Person Centered Services
- Governance – IDD Providers statewide
- 62,000 members statewide
- Formed in 2018 to explore integrated care options together - CCOs were meant to be Phase One of the transition to Specialized IDD Health Plans
- In response to OPWDD, created an IDD Provider led integrated care model.
- As of 2023, collaborate on 1115 NYHER initiatives.

TriaDD Service Area



ACANY + LIFEPLAN CCO NY + PERSON CENTERED SERVICES COVERAGE MAP

What is a CCO?

- Care Coordination Organizations (CCOs) are specialized Health Homes for people with an Intellectual and/or Developmental Disability (IDD) who qualify for Office for People with Developmental Disabilities (OPWDD) services
- Coordinate physical health, behavioral health, IDD services (long term services and supports) and health related social needs (HRSNs)
- 7 CCOs formed in 2018
- At least 2 CCOs in each county to offer choice
- 130,000+ members statewide

CCO Services

Every person should have the right to define the life they want to live!

- Enrollment
- Assessments
- The Life Plan
- Connection to services
- Consent
- Member & Provider Relations
- Clinical Team
- Community Resource Tool

1115 Waiver – Medicaid Managed Care

- 1115 Waivers give states flexibility for innovative projects that advance the objectives of Medicaid

- New York's 1115 Waiver - NYS Medicaid Redesign Team (MRT) Waiver and has been in place since 1997
  - Renewed in 5-year increments
  - Effective from 4/1/22 – 3/31/27
  - Transitioned many populations and benefits from FFS Medicaid to Managed Care
  - Currently very few Medicaid beneficiaries who are exempt or excluded from managed care (See NYS Medicaid Managed Care: Exclusions and Exemptions)

- Many amendments

New York Health Equity Reform (NYHER)

- 1115 Waiver Amendment
- Approved on 1/9/2024
- $7.5B
- Ends 3/31/2027
- Three investment areas with the goal “to advance health equity, reduce health disparities, and support the delivery of social care.”

1115 NYHER Initiatives

NYHER Initiative		IDD Provider Opportunity
Health Equity Regional Organizations (HERO) $125M	One Statewide organization will be designated to do planning, data aggregation, regional needs assessment and planning, stakeholder engagement in regions, VBP planning, and publish health equity data	Participate as an IDD expert on both statewide and regional forums/workgroups.
Social Care Network (SCN) Infrastructure $500M	9-13 Regional SCNs to be selected through a procurement process. Responsibilities: Screening and referral, contracting with MCOs, build network of CBOs, capacity building, pay for HRSN services based on NYS fee schedule	Contracted as CBOs in each SCN across the state and participate in the SCN referral platform to send/receive referrals
Health Related Social Need (HRSN) Services $3.173B	HRSN screening, case management, nutrition supports, housing supports, transitional housing for individuals transitioning out of institutions, transportation. Members must meet eligibility criteria. (Level 1 - Medicaid FFS and Level 2 - Medicaid MCO)	Perform HRSN screenings for people with IDD. Provide Level 1 navigation to existing services and Level 2 care management. IDD is included as an eligible criteria.
Strengthen the Workforce $694M	Student Loan Repayment (SLR) $48M – PCPs, dentists, child psychiatrists, NPs and ped nurses. 4-year commitment to 30% Medicaid. Career Pathways Training (CPT) $646M – build the allied health and other health care workforce through training. 3-year commitment	These funds will flow through the 7 existing regional Workforce Investment Organizations (WIOs). We will connect with the WIOs to determine opportunity for CCOs and/or IDD providers
Medicaid Hospital Global Budget Initiative $2.2B	Private non-profit hospitals in Bronx, Brooklyn, Queens or Westchester counties, 45% Medicaid, Operating margin for 2019-2022 <=0.	Once hospitals have been identified, determine IDD population and opportunity

1115 NYHER Funding

NYHER Funding By Demonstration Year

Strategy	DY 0 04/01/2023 to 03/31/2024	DY 1 04/01/2024 to 03/31/2025	DY 2 04/01/2025 to 03/31/2026	DY 3 04/01/2026 to 03/31/2027	Total ($ in Millions)
Health Equity Regional Organization (HERO)	**$0**	**$50**	**$40**	**$35**	**$125**
Social Care Networks (SCNs) and HRSN Infrastructure	**$0**	**$260**	**$190**	**$50**	**$500**
Health Related Social Needs Services	**$0**	**$695**	**$1,250**	**$1,420**	**$3,365**
Medicaid Hospital Global Budget Initiative	**$550**	**$550**	**$550**	**$550**	**$2,200**
Primary Care Delivery System Model	**$0**	**$147**	**$147**	**$197**	**$492**
Strengthen the Workforce	**$0**	**$188**	**$335**	**$172**	**$694**
Student Loan Repayment	$0	$12	$24	$12	$48
Career Pathways Training Program	$0	$176	$310	$160	$646
Continuous Eligibility for Children from 0 Up to Age 6	**$0**	**$23**	**$45**	**$45**	**$112**
Total	**$550**	**$1,913**	**$2,557**	**$2,468**	**$7,488**

Dollars in Millions

Strengthening the Workforce

Student Loan Repayment Program - $48M

- Must make a four-year commitment with an organization that is at least 30% Medicaid/Uninsured
- There will be award criteria
- Program will be administered by Workforce Investment Organizations (WIOs)
- Payments will be made to loan servicing orgs (not participants)

Eligible Healthcare Titles		
Psychiatrists, with a Priority on Child/Adolescent Psychiatrists	Primary Care Physicians and Dentists	Nurse Practitioners and Pediatric Clinical Nurse Specialists
• Up to $300,000, per provider • Estimate loan repayment for 50 psychiatrists	• Up to $100,000, per provider • Estimate loan repayment for 50 primary care physicians and 50 dentists	• Up to $50,000, per provider • Estimate loan repayment for 40 nurse practitioners and 40 pediatric clinical nurse specialists

Strengthening the Workforce

Career Pathways Training (CPT) Program - $646M

- Fund education and participant support services to provide holistic educational and professional placement supports for those newly entering the workforce and those seeking to advance in their careers.
- Must make a three-year commitment of service, in the new professional title, to Medicaid providers that serve at least 30 percent Medicaid members and/or uninsured individuals.
- Training will be organized to support • New Careers in Healthcare and Healthcare Career Advancement

Eligible Healthcare Titles		
Nursing	Professional Technical	Frontline Public Health Workers
• Licensed Practical Nurse (3,600 slots) • Associate Registered Nurse (1,500 slots) • Registered Nurse to Bachelor of Science in Nursing (1,500 slots) • Nurse Practitioner (250 slots)	• Physician Assistant (300 slots) • Licensed Mental Health Counselor (750 slots) • Master of Social Work (1,250 slots) • Credentialed Alcoholism and Substance Abuse Counselor (1,300 slots) • Certified Pharmacy Technician (500 slots) • Certified Medical Assistant (4,000 slots) • Respiratory Therapist (300 slots)	• Community Health Workers (3,000 slots) • Patient Care Managers (250 slots)

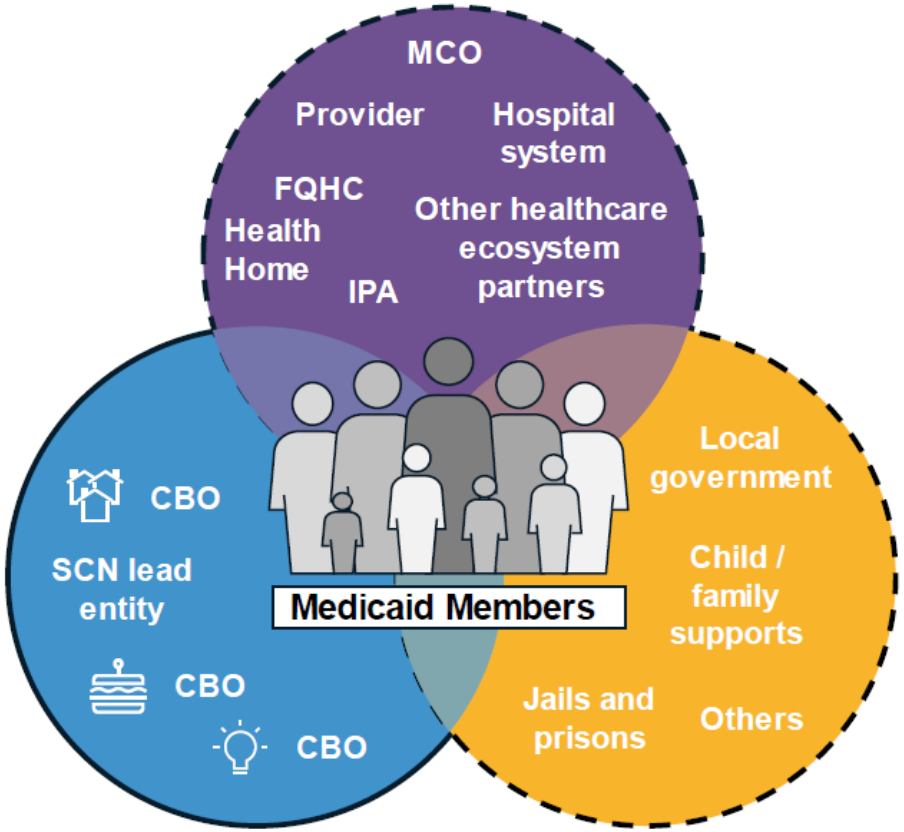
Social Care Network Role

DOH will award one Social Care Network (SCN) per region (with up to five awards in New York City), with up to 13 SCNs statewide. Each SCN will be a designated Medicaid provider and serve as the lead entity in their region for:

Organization	• Establish and maintain a governing body and executive leadership team that reflects and understands the unique needs of the region.
Contracting	• Contract with Managed Care Organizations in each region to facilitate payments and validate member eligibility.
Fiscal Administration	• Receive and manage monthly payments per Medicaid Managed Care Member. • Submit fee-for-service claims for members that are in fee-for-service. • Pay CBOs for services rendered in a timely manner.
IT Platform/Data and Reporting	• Contract with Social Care IT platform to manage referrals and ensure connectivity. • Enable HRSN data sharing through the Statewide Health Information Network for New York.
CBO Network and Capacity Building	• Formally organize and coordinate contracted network of CBOs to deliver social care services. • Ensure network adequacy and build CBO capacity to participate in the network.
Regional Partnerships	• Collaborate with partners within the regional ecosystem to screen members for HRSNs. • Validate eligibility, navigate to appropriate services, manage and close the loop on referrals.

Social Care Network Ecosystem

Figure 1: Overview of SCNs in context of broader ecosystem and aspiration for impact on Medicaid members



1. Where entities above are not part of SCNs

Social care network (SCN)
Healthcare ecosystem partners[1]
Other ecosystem partners[1]

Impact of future state system on Medicaid members

- **Scaled delivery** of social care services and **improved access** for Medicaid members
- **Reliable and timely referral** of members to social care services
- **Seamless tracking** of members needs to streamline and close loop on referrals to social care services
- Improved and increased **collaboration between social care service providers and other partners in regional ecosystem** (e.g., healthcare providers, care management providers, MCOs, others)

Role of Community Based Organizations (CBOs)

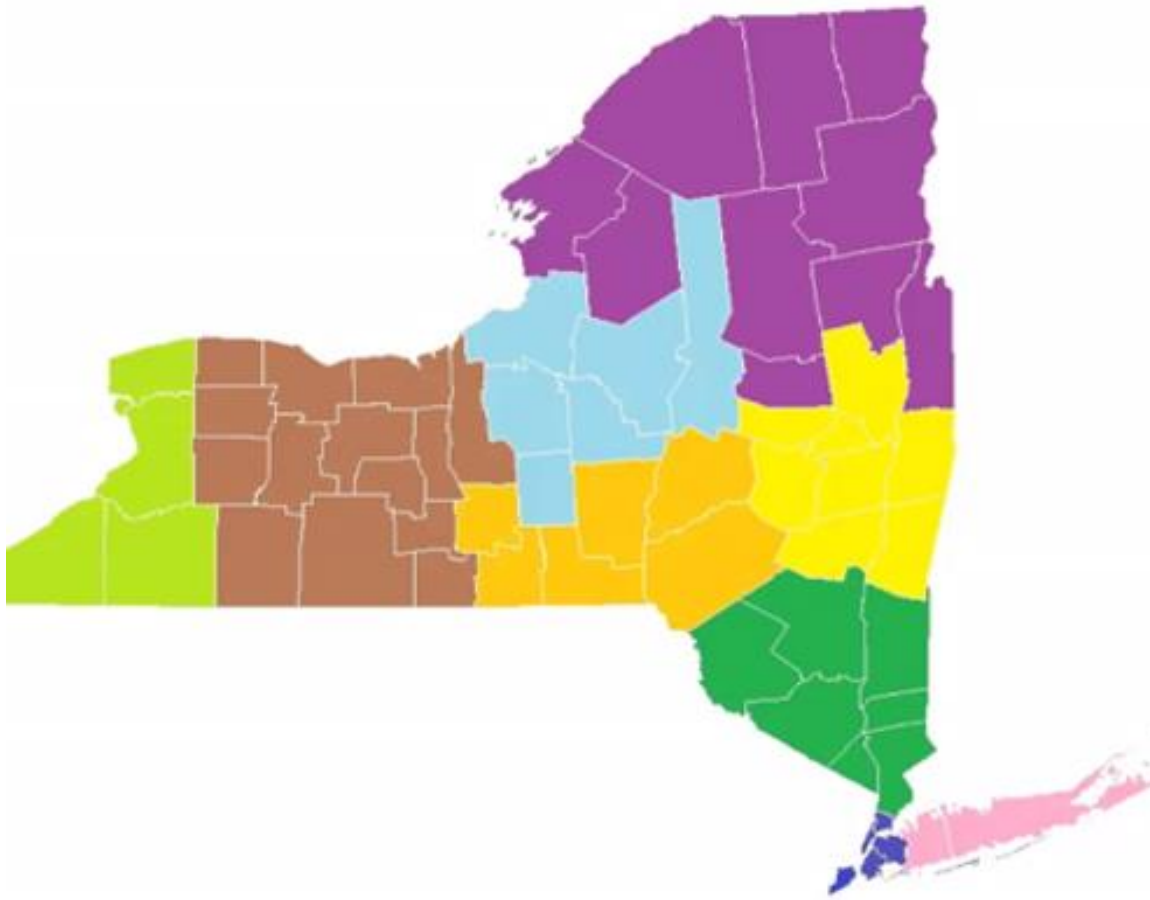
- CBOs are non-profits (unless exempt by NYS)
- Must be able to screen for HRSN needs, do social care navigation and provide HRSN services
- Must have at least one service location in the SCN region
- Employ Social Care Navigators who will screen members, validate their eligibility and perform closed-loop referrals in the SCN's closed loop referral platform
- Demonstrate cultural and linguistic competency
- Willingness to engage and be trained on the SCN's data and IT platform(s)
- Accept referrals, provide services and collaborate with the SCN

Social Care Network Regions

Table 2: SCN Regions and Funding

Social Care Network (SCN) Regions	Counties	Total Funding
Region 1: Capital Region	Albany, Columbia, Greene, Rensselaer, Montgomery, Saratoga, Schenectady, and Schoharie	$ 29,230,628
Region 2: Western NY	Cattaraugus, Chautauqua, Erie, Niagara	$ 36,859,552
Region 3: Hudson Valley	Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester	$ 44,886,771
Region 4: New York City	Bronx	$ 54,541,802
Region 4: New York City	Kings	$ 65,676,397
Region 4: New York City	Queens	$ 34,602,335
Region 4: New York City	New York	$ 52,080,677
Region 4: New York City	Richmond	$ 22,509,718
Region 5: Finger Lakes Region	Allegany, Cayuga, Chemung, Genesee, Livingston, Monroe, Ontario, Orleans, Schuyler, Seneca, Steuben, Wayne, Wyoming, Yates	$ 38,604,750
Region 6: Southern Tier	Broome, Chenango, Delaware, Otsego, Tioga, Tompkins	$ 22,639,240
Region 7: Central New York	Cortland, Herkimer, Madison, Oneida, Onondaga, and Oswego	$ 31,414,924
Region 8: Long Island	Nassau, Suffolk	$ 42,179,889
Region 9: North Country	Clinton, Essex, Franklin, Fulton, Hamilton, Jefferson, St. Lawrence, Lewis, Warren, and Washington	$ 24,773,317

An applicant can apply for multiple regions but must submit a separate application for each region.



Social Care Network Applicants

Name	NYS SCN Region
Adirondack Health Institute (AHI)	North Country - Region 9
Healthy Alliance	Capital Region - Region 1, Central NY - Region 7, North Country - Region 9
Forward Leading IPA/Inclusive Alliance	Central NY - Region 7
Forward Leading IPA - Finger Lakes	Finger Lakes - Region 5
Hudson Valley Care Collaborative	Hudson Valley - Region 3
Public Health Solutions/WholeYouNYC	NYC - Region 4 (All)
FLPPS/TogetherNow	Finger Lakes - Region 5
Staten Island PPS	NYC - Region 4 (Staten Island)
Health & Welfare Council of Long Island/HEALI	Long Island - Region 8
Western NY Integrated Care Collaborative, Inc.	Western NY - Region 2
SNAPCAP & Value Network	Western NY - Region 2
Care Compass	Southern Tier - Region 6
Community Care of Brooklyn (CCB)	NYC - Region 4 (Brooklyn)
Southern Tier Health Equity Partners	Southern Tier - Region 6
Brightpoint Care (CHIPA/Sun River)	Hudson Valley - Region 3
SOMOS/Montefiore	NYC - Region 4 (Bronx, Manhattan, Queens)

Participant Survey

Is your organization currently participating/engaged with one of the Social Care Networks?

1. Yes
2. No
3. N/A

Social Care Networks – please put your SCN's contact information in the chat for interested providers!

1115 for People with IDD

130,000 People with IDD – receiving OPWDD waivered services

- 30,000 in Medicaid Managed Care
- 100,000 in FFS Medicaid
  - Medicaid FFS enrollees not eligible for 1115 initiatives (NYHER, Value Based Payment innovations, in-lieu of services, etc.)

230,000 People with IDD in Medicaid Managed Care

- 30,000 – receive OPWDD waivered services
- 200,000 – no OPWDD services
  - How many people might be eligible for OPWDD services?
  - Can the system handle more people?

People with IDD in Medicaid Managed Care

Attachment O: NYS Medicaid New York Health Equity Reform (NYHER)

Social Care Network (SCN) Medicaid Member Populations by Region - Table of Contents

	Population	Mainstream	MLTC	Total	BH % within Population
Reg 1 - Capital	Individuals with Intellectual or Developmental Disabilities (IDD)	9,611	251	9,862	45%
Reg 2 - Western NY	Individuals with Intellectual or Developmental Disabilities (IDD)	15,738	459	16,197	34%
Reg 3 - Hudson Valley	Individuals with Intellectual or Developmental Disabilities (IDD)	21,822	1,056	22,878	33%
Reg 4 Bronx	Individuals with Intellectual or Developmental Disabilities (IDD)	31,345	2,165	33,510	28%
Reg 4 Kings	Individuals with Intellectual or Developmental Disabilities (IDD)	35,400	3,080	38,480	25%
Reg 4 NY	Individuals with Intellectual or Developmental Disabilities (IDD)	12,853	1,635	14,488	31%
Reg 4 Queens	Individuals with Intellectual or Developmental Disabilities (IDD)	29,576	2,364	31,940	26%
Reg 4 Richmond	Individuals with Intellectual or Developmental Disabilities (IDD)	6,230	370	6,600	27%
Reg 5 Finger Lakes	Individuals with Intellectual or Developmental Disabilities (IDD)	13,725	574	14,299	44%
Reg 6 - Southern Tier	Individuals with Intellectual or Developmental Disabilities (IDD)	4,121	82	4,203	41%
Reg 7 - Central NY	Individuals with Intellectual or Developmental Disabilities (IDD)	10,978	311	11,289	39%
Reg 8 - Long Island	Individuals with Intellectual or Developmental Disabilities (IDD)	19,117	1,374	20,491	30%
Reg 9 - North Country	Individuals with Intellectual or Developmental Disabilities (IDD)	5,516	111	5,627	47%
TOTALS		216,032	13,832	229,864	

The Coalition for Whole Person Supports
Integrated Care Matters

A Statement of Critical Importance for the Field Supporting Persons with IDD and Their Families In New York

6/14/24

Statement of Purpose: We are a group of experienced current and former leaders from voluntary agencies and government who believe the time has come for significant and permanent change in the way services in our system are designed, delivered, and financed for the almost 140,000 individuals with I/DD who are eligible for Medicaid or dually eligible for Medicare and Medicaid.

History and the Case for Change: Many of us were instrumental in the development of the current system, which grew out of the court-ordered reforms of the 1970s, during which NYS decided not only to close Willowbrook, but all twenty Developmental Centers. Prior, a smattering of group homes in the seventies were developed via state contracts. With this new direction and policy, a massive undertaking involving a partnership of Federal, State and Local Governments and willing community partners got underway. When the dust settled, we had ICFS, Day Treatment and thousands of people living in the community.

Whole Person Supports Paper

For questions or a copy of this paper, contact Kristen.Scholl@ccany.org

1115 NYHER HRSN Services

Level 1

All Medicaid members (FFS and managed care) are eligible to receive HRSN screenings and navigation to pre-existing state, federal and local programs to address their HRSN.

Level 2

Enhanced services are available if a member enrolled in Medicaid Managed Care screens positive for an unmet HRSN and meets one of the Level 2 criteria. Must be evidence based and medically appropriate.

Unknowns:

- The fee schedule
- HRSN service definitions
- Definition of IDD
- Clinical criteria

HRSN Level 2 Eligibility Criteria for Medicaid Managed Care members:

- High Utilizer (Inpatient, ED, Medicaid spend)
- Health Home enrollee
- Pregnant up to 12 months postpartum
- Post-release criminal justice
- Juvenile justice, foster care and kinship care
- Children under age 6
- Children under 18 with chronic conditions
- Substance Use Disorder
- Intellectual or Developmental Disability
- Serious Mental Illness

1115 NYHER HRSN Services

TriaDD

IDD Providers

TriaDD

Standardized HRSN Screening

- Screening Medicaid Members using questions from the CMS Accountable Health Communities HRSN Screening Tool and collecting key demographic data

Housing Supports

- Navigation
- Community transitional services
- Rent/utilities
- Pre-tenancy and tenancy sustaining services
- Home remediation
- Home accessibility and safety modifications
- Medical respite

Nutrition

- Nutritional counseling and classes
- Medically tailored or clinically appropriate home-delivered meals
- Food prescriptions
- Fresh produce and nonperishable groceries
- Cooking supplies, such as pots, pans, utensils, microwaves, etc.

Transportation

- Reimbursement for HRSN public and private transportation to connect to HRSN services and HRSN case management activities

Case Management

- Case management, outreach, referral management, and education, including linkages to other state and federal benefit programs, benefit program application assistance, and benefit program application fees
- Connection to clinical case management
- Connection to employment, education, childcare, and interpersonal violence resources
- Follow-up after services and linkages

1115 NYHER HRSN Services

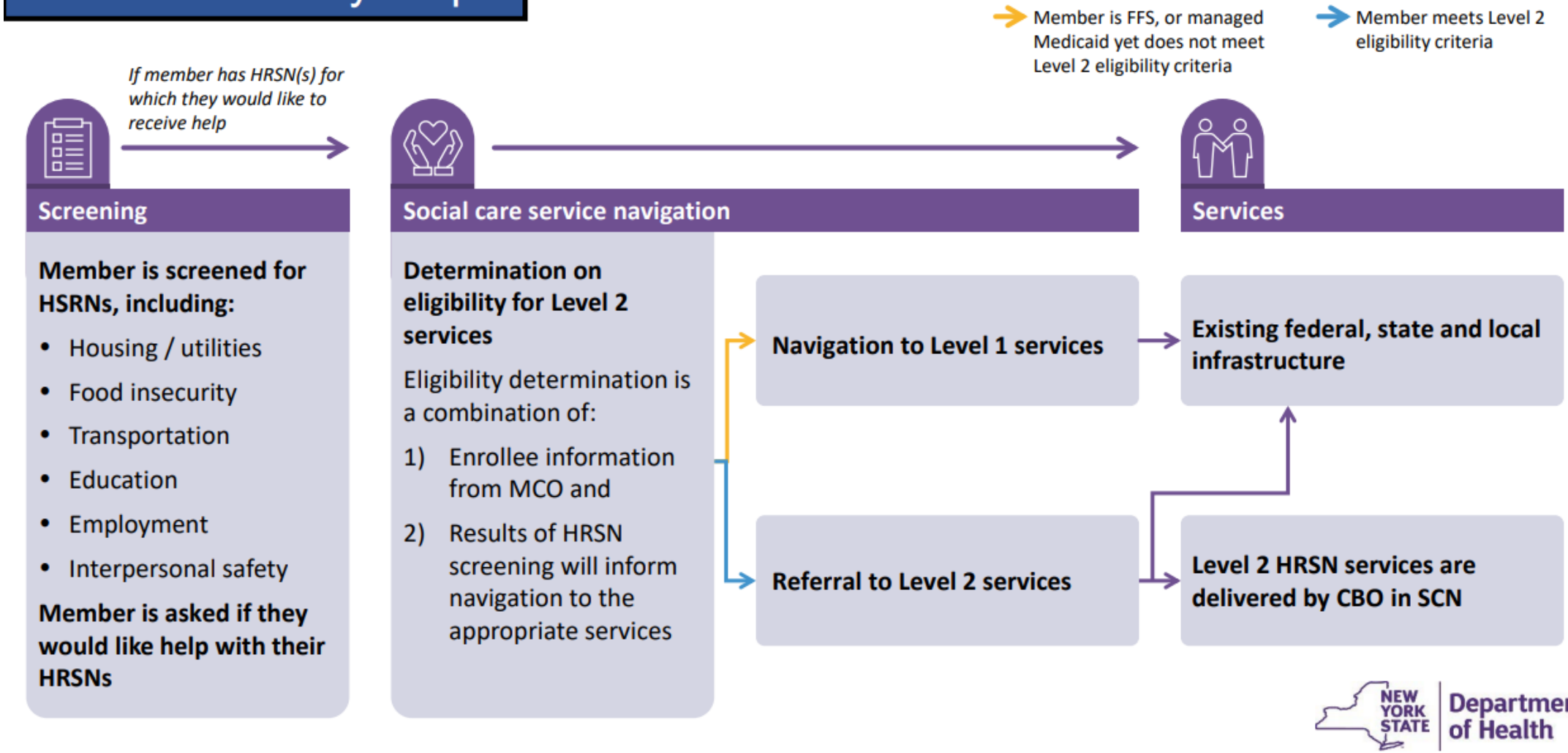
Category	Service Name	Description
Screening	Screening	Social needs screening of Medicaid member using the CMS AHC HRSN screening tool
Multi Domain	Navigation Case Management	Linkages to other local, state, and federal benefits and programs
Multi Domain	HRSN Case Management	Case management, outreach, referral management and education, including linkages to other state and federal benefit programs, benefit program application assistance, and benefit program application fees. Connection to clinical case management. Connection to employment, education, childcare, and interpersonal violence resources. Follow up after services and linkages.
Housing	Navigation	Housing navigation services.
Housing	Community Transitional Supports	One-time transition and moving costs (e.g., security deposit, first month's rent, brokers fees, utility activation fees, movers, relocation expenses, pest eradication, inspection fees, pantry stocking, and the purchase of household goods and furniture).
Housing	Utility Set up / Assistance	Utility costs including activation expenses and back payments to secure/keep utilities. Service is limited to individuals receiving rent/temporary housing.
Housing	Rent/temporary housing for up to 6 months	Rent/temporary housing (+/-utilities) for up to 6 months. Limited to individuals transitioning out of institutional care/congregate settings or individuals who are homeless, such as nursing facilities, large group homes, congregate residential settings, IMDs, correctional facilities, and acute care hospitals; individuals who are Medicaid high utilizers who are homeless as defined by 24 CFR 91.5; and youth transitioning out of the child welfare system including foster care.
Housing	Pre-tenancy and tenancy sustaining services	Pre-tenancy and tenancy sustaining services, including tenant rights education and eviction prevention.

1115 NYHER HRSN Services

Category	Service Name	Description
Housing	Home remediation	Repairs or remediation for issues such as mold or pest infestation if repair or remediation provides a cost- effective method of addressing occupant's health condition, as documented by a health care professional, and remediation is not covered under any other provision such as tenancy law.
Housing	Home accessibility and safety modifications	Medically necessary air conditioners, humidifiers, air filtration devices, and refrigeration units as needed for medical treatment and prevention. Minor medically necessary home accessibility modifications.
Housing	Medical respite	Medical respite is a temporary setting for homeless individuals that will provide lower-intensity care setting for individuals who would otherwise lack a safe option for discharge and recovery or would require a hospital stay.
Nutrition	Nutritional counseling and classes	Nutrition counseling and education, including on healthy meal preparation.
Nutrition	Medically Tailored Meal (MTM)	Medically Tailored or Clinically Appropriate meals delivered to an individual's home or private residence for up to 6 months.
Nutrition	Fruit and vegetable prescription	Medically tailored or nutritionally-appropriate food prescriptions (e.g., fruit and vegetable prescriptions, protein box), delivered in various forms such as nutrition vouchers and food boxes, for up to 6 months.
Nutrition	Pantry Stocking	Pantry stocking, fresh produce and nonperishable groceries for up to 6 months. For children and Pre/Postpartum populations.
Nutrition	Cooking supplies	Cooking supplies that are necessary for meal preparation and nutritional welfare of a beneficiary when not available through other programs (e.g., pots and pans, utensils, microwave, refrigerator).
Transportation	HRSN Public and Private Transportation	Reimbursement for HRSN Public and Private Transportation to connect to HRSN services and HRSN case management activities listed above.

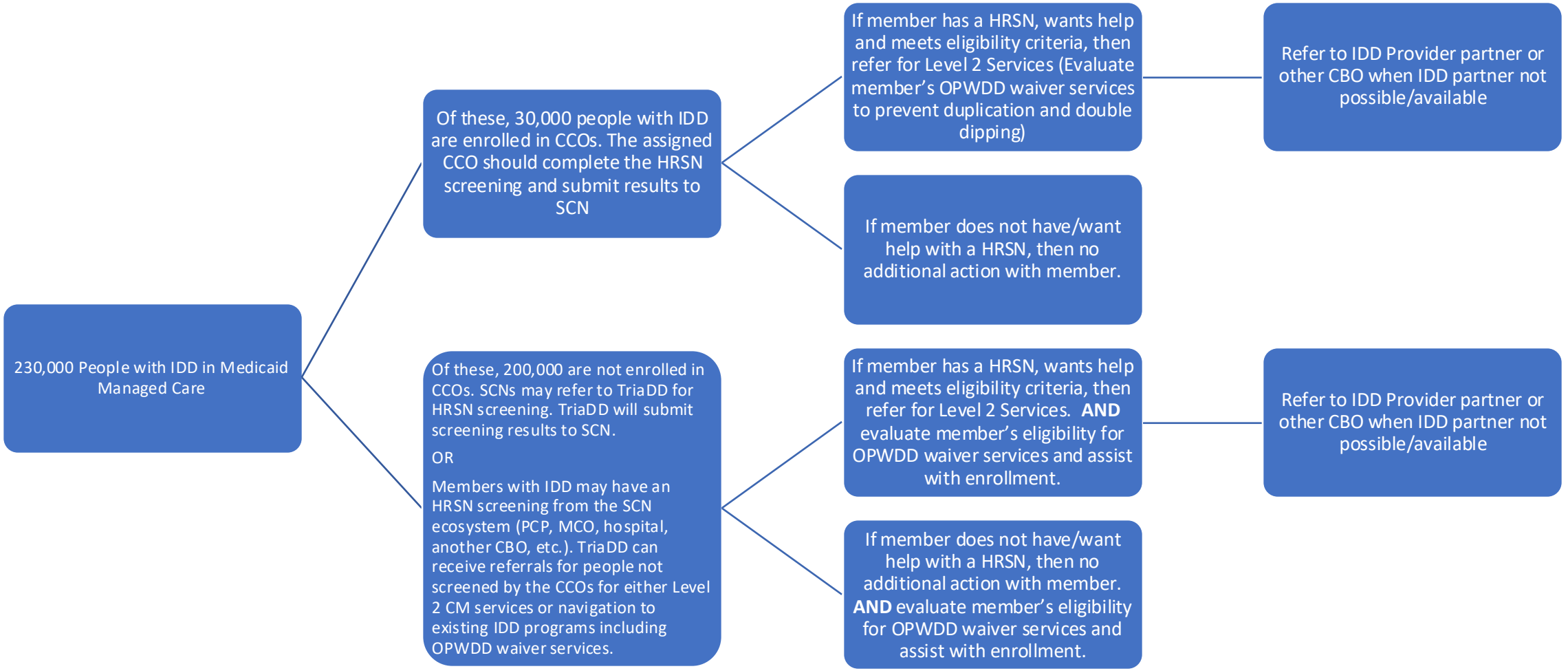
NYHER – DOH Member Journey

Member Journey Map

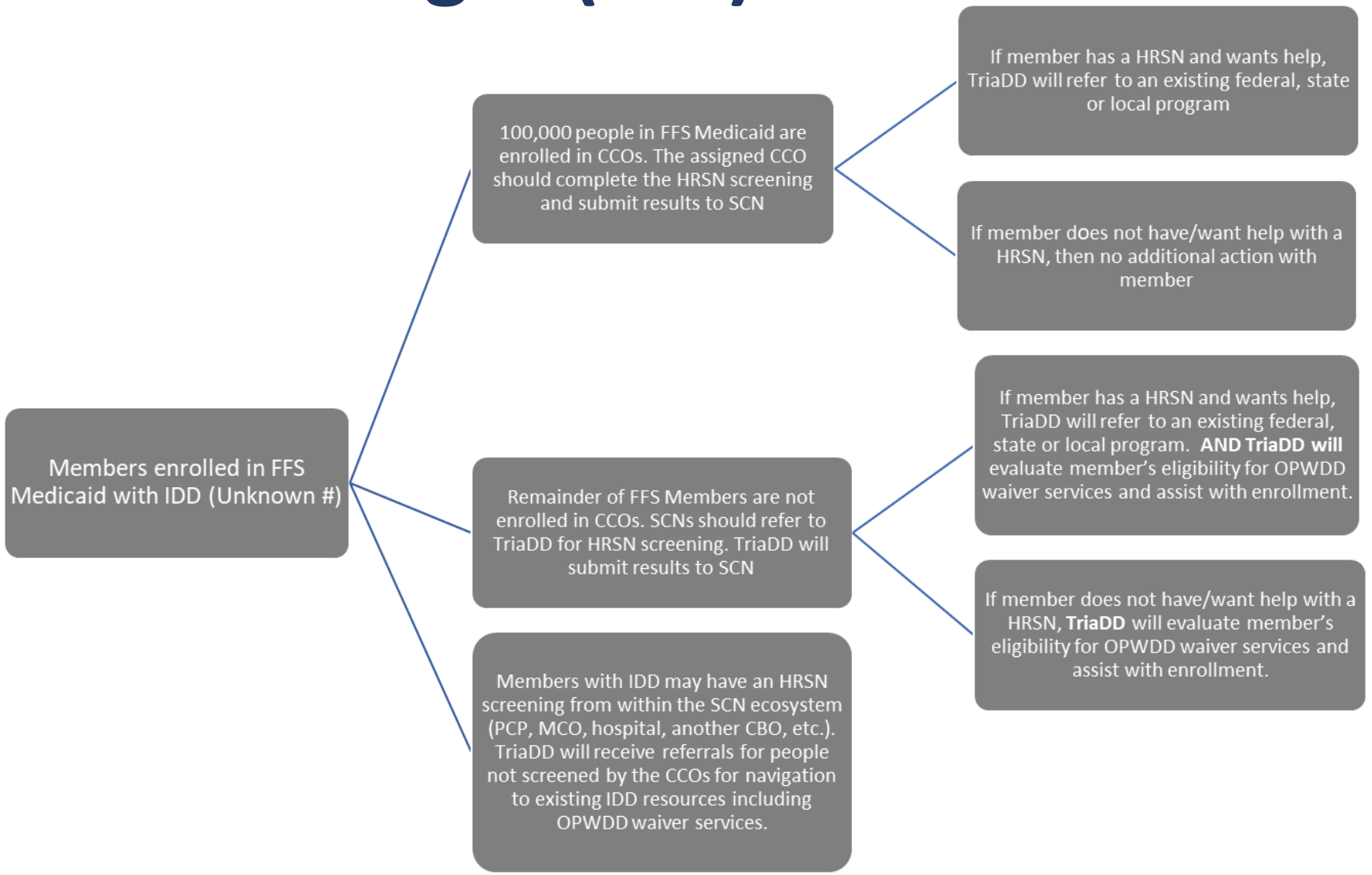


NEW YORK STATE | Department of Health

Workflow – Medicaid Managed Care

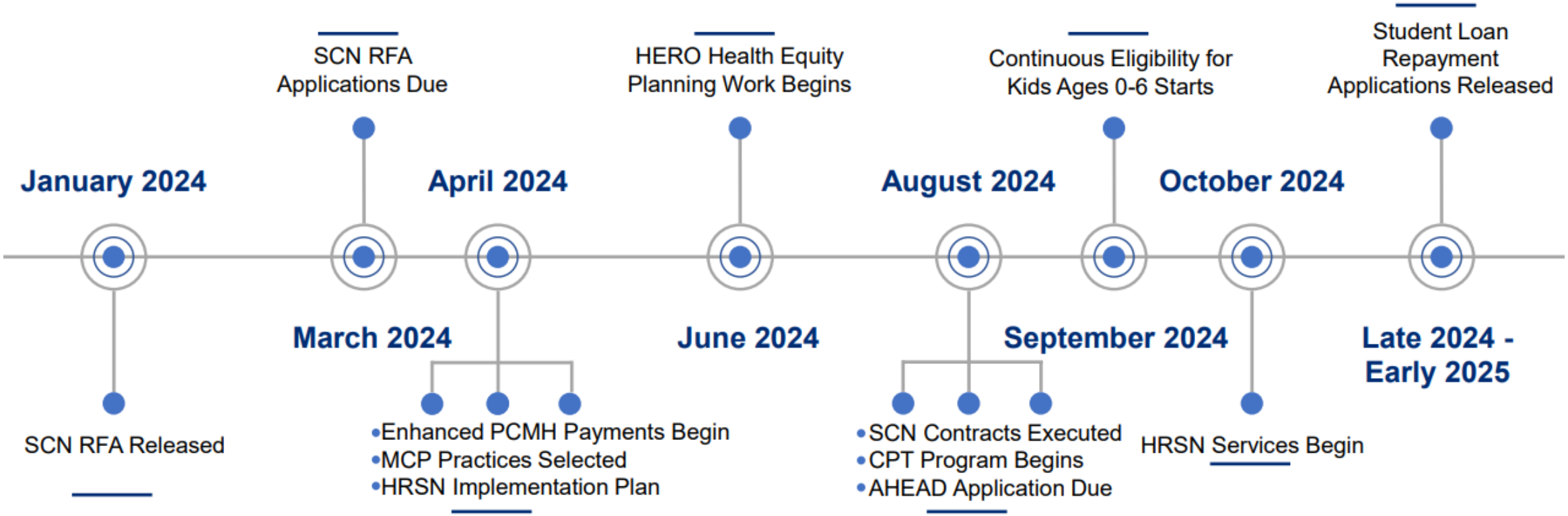


Workflow – Straight (FFS) Medicaid



NYHER Timeline

Projected Milestones for 2024



Next Steps

- Contact your regional Social Care Network
- Compare your service offerings to the Health Related Social Need (HRSN) services
- Evaluate workforce investment opportunities
- Stay connected
- Contact me with questions: Kristen.Scholl@ccany.org