Inclusive Alliance

1115 Waiver Updates:

Inclusive Alliance's Approach to Preparing for the Social Care Network RFP

Monthly Webinar Series

September 20, 2023

Lauren Wetterhahn, Executive Director

Heidi Arthur, HMA

Logistics & Learning Objectives

- Logistics:
  - Please send your questions in by using the Q&A box in Zoom
  - Slides & recording will be shared with registrants by Friday
- Learning Objectives:
  - Identify aspects of NY's original fall 2022 NYHER proposal that are still in the running to be part of the approved waiver
  - Anticipate the likely timeframe of upcoming waiver & social care network RFP action steps
  - Contribute suggestions regarding Inclusive Alliance's planned community engagement structure to guide its SCN application

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ABOUT US

Our Mission

To advance the growth and quality of cost effective and inclusive individual services for children and adults through innovation, collaboration and coordination.

Our Purpose

Prepare members for managed care and the transition to value-based payment (VBP)

Our Funders

CENTRAL NEW YORK COMMUNITY FOUNDATION

HRI HEALTH RESEARCH INCORPORATED

Health Foundation for Western & Central New York

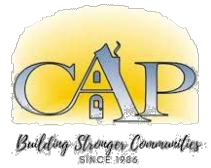
NY HEALTH FOUNDATION

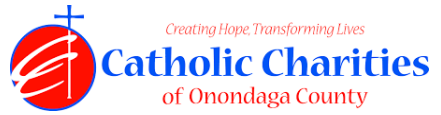
CNY CARE COLLABORATIVE

Independent Practice Association (IPA) of community-based organizations of varying sizes and scopes of services.

2016	501c3	7	40
Year Founded	Nonprofit	Counties	Members (& Growing!)

Meet Our Inclusive Alliance Members – Sept.





Meet Our Staff

Nicole Hall
Network Development Manager

Michael Rock
Network Development Manager

Lauren Wetterhahn
Executive Director

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Central New York's Guide To New York Health Equity Reform (NYHER)

Lead Partners: Inclusive Alliance · ican IPA Independent Pratice Association · Omnes IPA All in for better health · healtheconnections

Visit our 1115 Waiver Resource Center

inclusivealliance.org/1115

- Information about the waiver amendment request
- Recordings of our 1115 waiver monthly webinar series
- Link to sign up for our waiver resource newsletter
- Additional waiver-related resources based on community interest
- 1115 Medicaid waiver acronym & definitions list – COMING SOON

Supporting Partner: Excellus

A nonprofit independent licensee of the Blue Cross Blue Shield Association

Medicaid 1115 NYER Waiver Amendment Status Check

- Amir Bassiri keynote presentation at United Hospital Fund (UHF) Medicaid conference on July 20
- 1st substantive updates regarding what aspects of the initial waiver proposal are likely to be included in the approved waiver
- Timeline of negotiations will likely continue “later into the fall” (rumor mill now indicating late October)
- Given that the underlying 1115 waiver ends in Spring 2027, timeframe to implement waiver activities is shortening
- Rumor mill suggesting the RFP for social care networks may be released BEFORE the waiver amendment is approved (?)

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1115 Waiver Update

Waiver Recap

New York is in the final stages of negotiating it's New York Health Equity Reform (NYHER) 1115 Waiver Amendment Update with CMS.

Overall Goal: *"To advance health equity, reduce health disparities, and support the delivery of social care."*

- New York seeks to build on the investments, achievements, and lessons learned from the DSRIP to scale delivery system transformation, improve population health and quality, deepen integration across the delivery system, and advance health-related social need (HRSN) services.
- Importantly, the amendment will allow for the standardization and collection of data that will allow the state to stratify measures to evaluate impacts on underserved communities, enhance Medicaid services to best serve all populations, and implement social risk adjustment.
- This would be achieved through targeted and interconnected investments that will augment each other, be directionally aligned, and be tied to accountability. These investments focus on:

Population Health

Social Care Networks

Strengthening the Workforce

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Waiver Negotiations

DOH is still in negotiations with CMS on the final waiver components included in the amendment.

- Social Care Networks (SCN) and Health Related Social Needs Services (HRSN)
- Strengthening the Workforce
- Primary Care Delivery System Model
- Stabilizing the Safety Net & Advancing Accountability
- 
- Health Equity Regional Organizations (HEROs)
- Targeted In-Reach Services for Criminal Justice-Involved Population
- Digital Health and Telehealth Infrastructure

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1115 Waiver Update

Health Equity Regional Organization (HEROs)

- A single statewide independent HERO entity is intended to bring a diverse and comprehensive range of stakeholders together to collaboratively support:

Data Aggregation

- Bring together and distribute information on health outcomes, health care utilization and social care needs to support population health improvement activities under the waiver

Regional Needs Assessment & Planning

- Work with partners in each region to identify regional health equity goals/priorities, service delivery and workforce related gaps contributing to health disparities, and target health and social needs-related interventions that address regional needs and priorities

VBP Design & Development

- Work with newly aggregated data and feedback from regional partners to identify VBP goals and models that address the health and social needs of the region and address the most impactful health equity priorities

Program Evaluation

- Perform an ongoing review of waiver programs and access to new services to support continuous improvement in program design and implementation and quantify the impact on underlying regional health equity priorities

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Population Health & Health Equity Improvement Overview

Proposed Goals:

- Build on the achievements, such as PCMH, of the Delivery System Reform Incentive Program (DSRIP);
- Improve population health and health equity, with a particular focus on reducing health disparities for children, pregnant and postpartum individuals, and high-risk adults;
- Further care coordination and the integration of behavioral health, specialty care, and HRSN services; and
- Move toward advanced payment models that leverage multi-payor alignment

Proposed Components:

- Primary Care Delivery System Model
- Stabilizing Safety Net Providers & Advancing Accountability

Primary care forms the foundation of a high-performing health care system and population health

At a time when Medicare and Medicaid beneficiaries most need accessible, affordable, high-quality primary care to meet their rising needs and coordinate their care journey through increasingly fragmented expensive systems, primary care faces existential challenges to its core functions and modes of operation (NASEM 2021).

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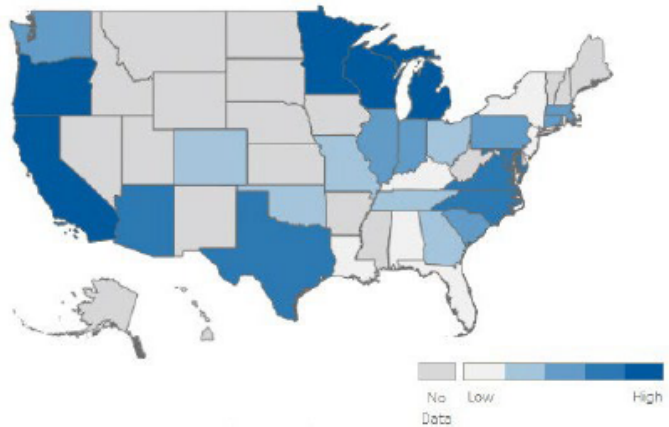
Importance of Primary Care

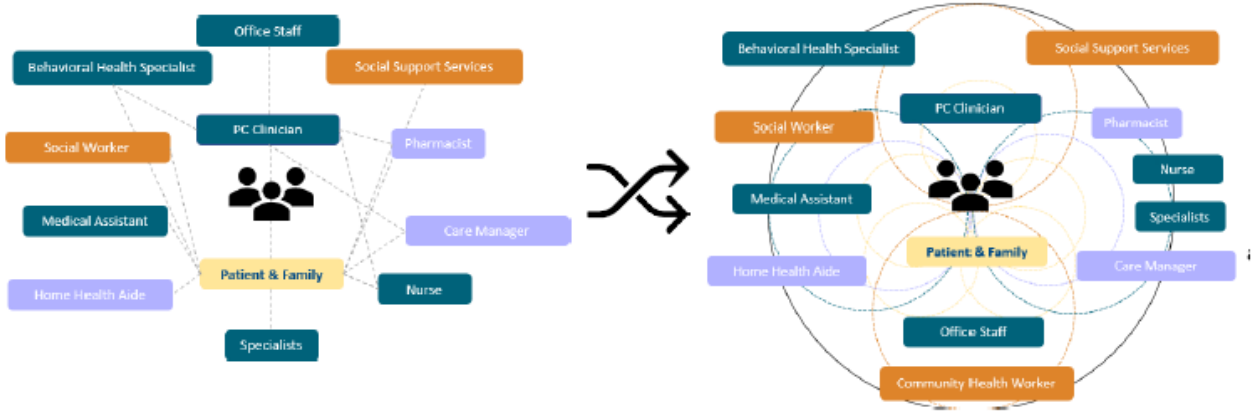
In 2020, the national average of spending on primary care was 12.1%. New York had one of the lowest percentages of spending on primary care where data was available at 8.2%.

Multi-payor models that align payment and quality will contribute to NYS having a more successful primary care system and Making Care Primary (MCP) is one of them.

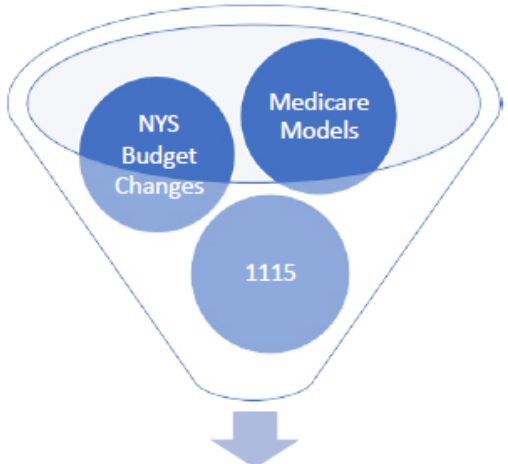
Over the next two sections, you will notice that the waiver and budget will both play roles in improving NYS' primary care system.



https://www.milbank.org/primary-care-scorecard/



https://innovation.cms.gov/innovation-models/making-care-primary



The Future of Primary Care

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1115 Waiver Update

Population Health & Health Equity Improvement

Primary Care Delivery System Model

Multi-Payor Alignment to Advance Primary Care

- New York will implement a statewide approach to advancing primary care that invests in primary care and enables Medicaid primary care providers to move forward advanced VBP arrangements, complementary to those found in upcoming CMMI models
    - This will have a special focus on care for children and moving further towards VBP
- **Eligibility:** All Patient Centered Medical Home (PCMH) primary care practices
- **Structure:**
    - *Years 1-2:* All PCMH practices would receive enhanced PMPMs for their Medicaid Managed Care members
    - *Year 3:* Transition enhanced payments to a bonus payment structure, linking payments to quality and efficiency
- After the current 1115 demonstration period, this funding would be transitioned to an advanced value-based payment model

Making Care Primary (MCP) is a new, voluntary **Medicare** primary care model for which CMS is starting to accept applications. Through MCP, investments in primary care are increased so patients can access more seamless, high-quality, whole-person care.

The 1115 will complement MCP through PCMH investments and aligned quality measures to enable primary care organizations to support multi-payor alignment and provide Medicare and Medicaid beneficiaries with integrated, coordinated, person-centered care that improves population health outcomes.

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1115 Waiver Update

Population Health & Health Equity Improvement

Stabilizing Safety Net Providers & Advancing Accountability

Goal: Stabilize and Transform Targeted Voluntary Financially Distressed Hospitals to Advance Health Equity and Improve Population Health in communities with the most evidence of health disparities[1]

Potential Structure: Provide incentive funding to stabilize financially distressed safety net hospitals and develop necessary capabilities to participate in advanced VBP arrangements, integration with primary care, behavioral health, and HRSN services

Incentive payments would be tied to transformational activities and quality improvement measures, including those related to health equity

1) https://www.countyhealthrankings.org/explore-health-rankings/new-york/data-and-resources

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Social Care Networks

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

Fiscal Administration Contracting Data Collection Referral Management CBO Capacity Building

Next, well look at:

- Scope of HRSN Services
- Screening and Referral Process Flow
- SCN Flow

What lessons learned from DSRIP by stakeholders will help form successful SCNs?

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Social Care Networks HRSN Services

Standardized HRSN Screening	Housing	Nutrition	Transportation	Case Management
• Screening Medicaid Members using questions from the CMS Accountable Health Communities HRSN Screening Tool and key demographic data	• Navigation • Community transitional services • Rent/utilities • Pre-tenancy and tenancy sustaining services • Home remediation and education • Home accessibility and safety modifications • Medical respite	• Nutritional counseling and classes • Home-delivered meals • Medically tailored meals • Fruit and vegetable prescription • Pantry stocking	• Reimbursement for public and private transportation to connect to HRSN services and HRSN case management activities	• 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

AHC HRSN Screening Tool Core Questions

If someone chooses the underlined answers, they might have an unmet health-related social need.

Living Situation

1. **What is your living situation today?**[3]
   - ☐ I have a steady place to live
   - ☐ I have a place to live today, but **I am worried** about losing it in the future
   - ☐ I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

2. **Think about the place you live. Do you have problems with any of the following?**[4]
   CHOOSE ALL THAT APPLY
   - ☐ Pests such as bugs, ants, or mice
   - ☐ Mold
   - ☐ Lead paint or pipes
   - ☐ Lack of heat
   - ☐ Oven or stove not working
   - ☐ Smoke detectors missing or not working
   - ☐ Water leaks
   - ☐ None of the above

Food

Some people have made the following statements about their food situation. Please answer whether the statements were OFTEN, SOMETIMES, or NEVER true for you and your household in the last 12 months. [5]

3. **Within the past 12 months, you worried that your food would run out before you got money to buy more.**
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

4. **Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.**
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

Transportation

5. **In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?**[6]
   - ☐ Yes
   - ☐ No

Utilities

6. **In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?**[7]
   - ☐ Yes
   - ☐ No
   - ☐ Already shut off

+ 4 more core questions regarding interpersonal safety/ domestic violence (do not map to HRSN enhanced services)

+16 supplemental questions regarding financial strain, employment, family & community support, education, physical activity, substance use, mental health, & disabilities

https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf
https://innovation.cms.gov/media/document/ahcm-screening-tool-citation.pdf

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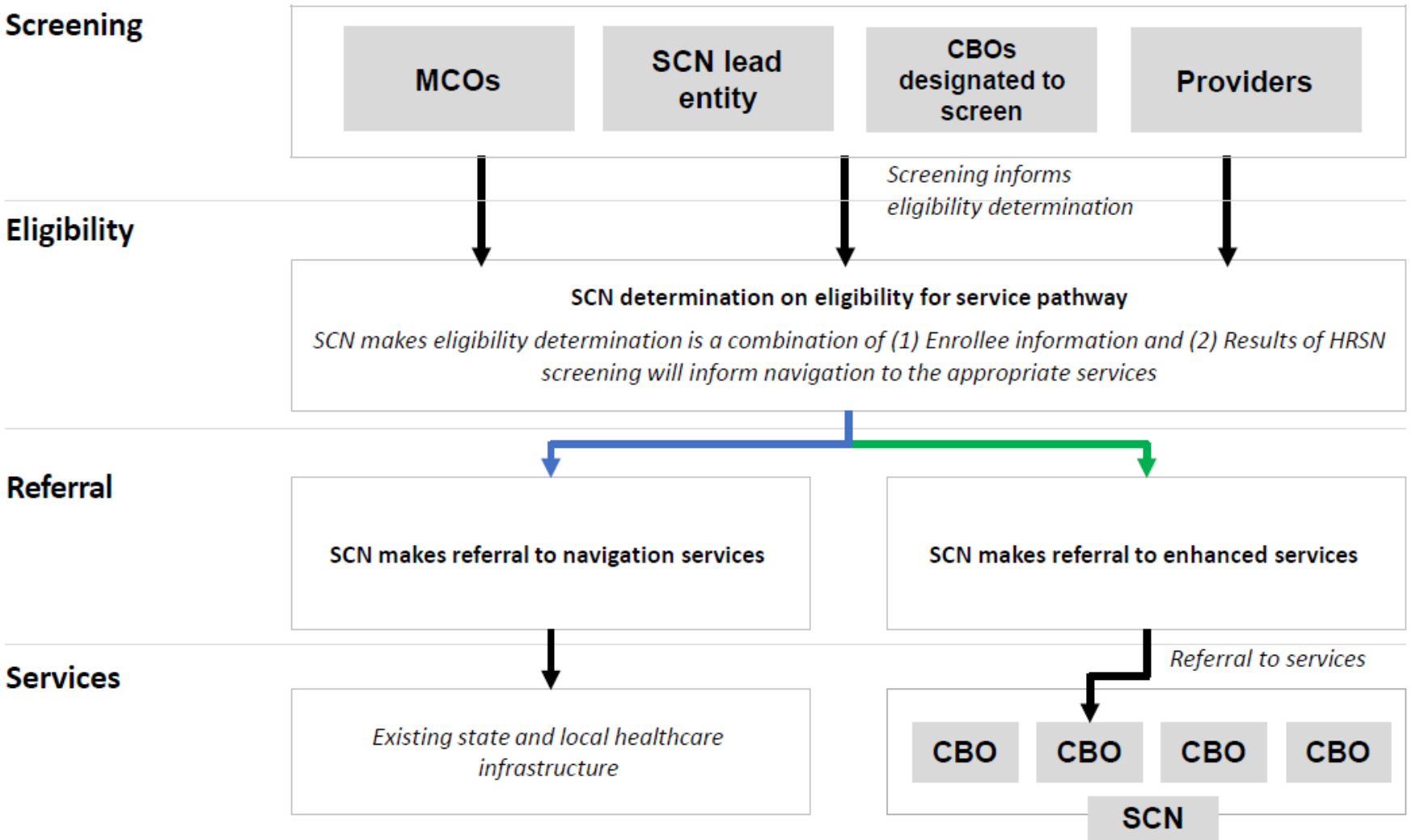
Screening & Referral for HRSN Services



Key

- Navigation to existing services
- Enhanced Services

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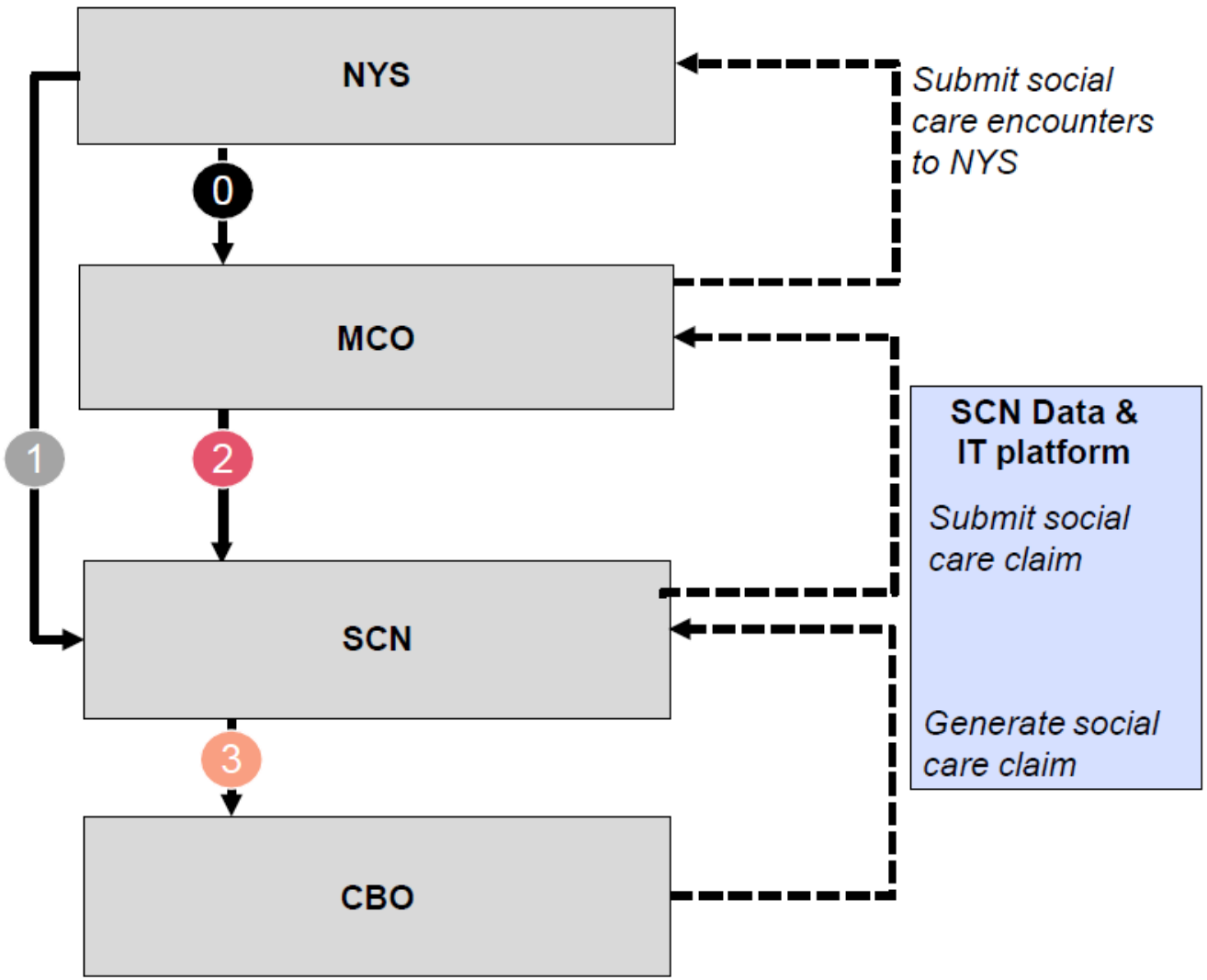
Initial HRSN Funds Flow

CBOs that are part of the network will be paid based on a fee schedule for services delivered to members



0 State Directed Payments to MCOs

1 Infrastructure Funding

2 SCN Payments

3 Payments per delivered service to CBOs for screening + delivery of HRSN services

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Strengthen the Workforce

The NYHER amendment will invest in workforce initiatives to support advancing health equity and addressing high demand workforce shortages to improve access to and quality of services

Elements:

Career Pathways Training Programs

Development of training programs to support recruitment and career pathways for new and existing health care workers

Loan Forgiveness

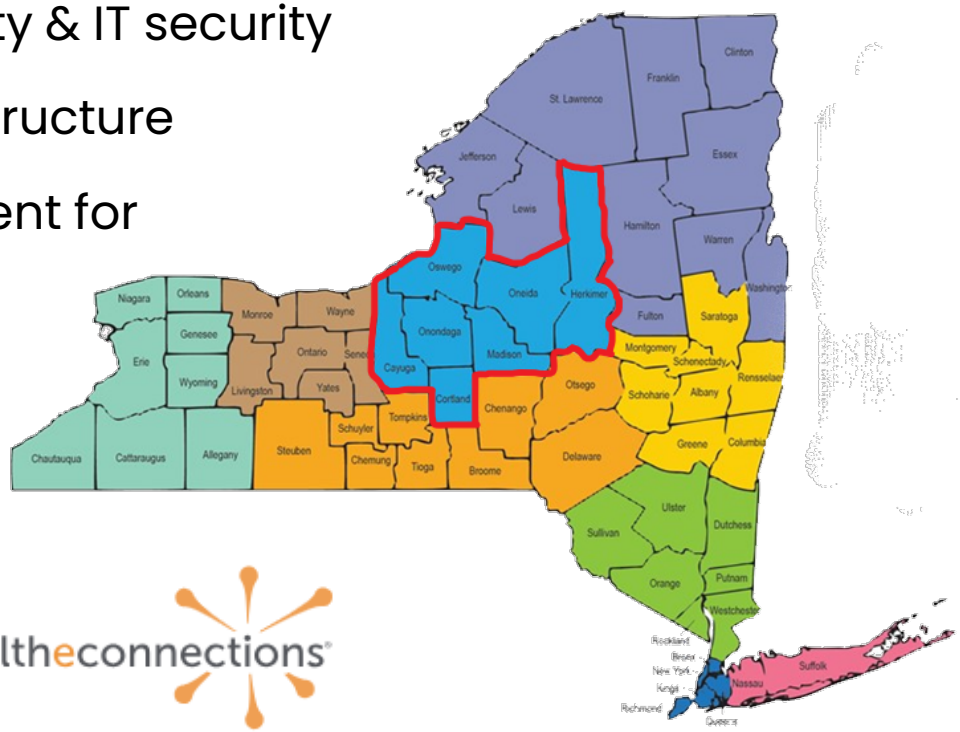
Loan forgiveness for primary care physicians, psychiatrists, nurse practitioners, pediatric clinical nurse specialists, and dentists who commit to work for Medicaid-enrolled providers in specified healthcare shortage areas

Workforce Investment Organizations (WIOs)

High-performing Workforce Investment Organizations (WIOs) will manage training programs for incumbent workers and workers newly entering the workforce, with a focus on high-demand direct care titles that provide health, behavioral health, and social care

Inclusive Alliance's Qualifications to lead a Social Care Network

- Non-profit IPA network covering all Region 7 counties & HRSNs (food, housing, & transportation)
- 2.5 years' experience co-managing a regional referral network (Unite Us)
- Data warehouse & experience assessing CBO data capacity & IT security
- Local CBO-lead, representative, democratic governance structure
- Central administrative hub for contracting, billing, & payment for evidence-based interventions delivered by CBOs
  - National Diabetes Prevention Program Umbrella Hub
  - Pathways Community HUB
- Key Partners:



Independent Pratice Association

All in for better health

Human Services Leadership Council of Central New York

healtheconnections

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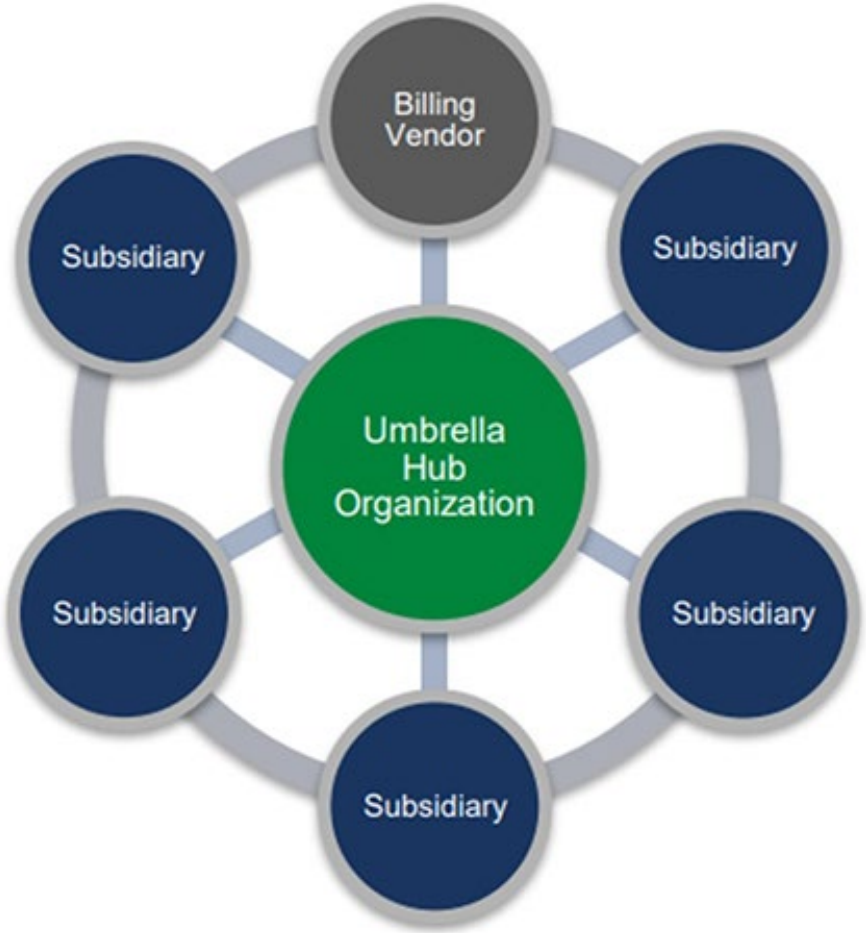
What Is a National Diabetes Prevention Program Umbrella Hub?

Evidence-based lifestyle change program for individuals with prediabetes and at-risk for type 2 diabetes. Decreases risk of type 2 diabetes by 58% and by 71% for those over age 60.



Umbrella HUB Functions:

- Serve as the sponsoring hub for a group of community-based organizations (subsidiaries) that have CDC pending, preliminary, or full DPRP recognition
- Provides administrative services, coordinates stakeholders, and holds CDC recognition
- Mission driven organizations with reach and resources to convene Community Based Organizations (CBO) while assuming fiscal responsibility

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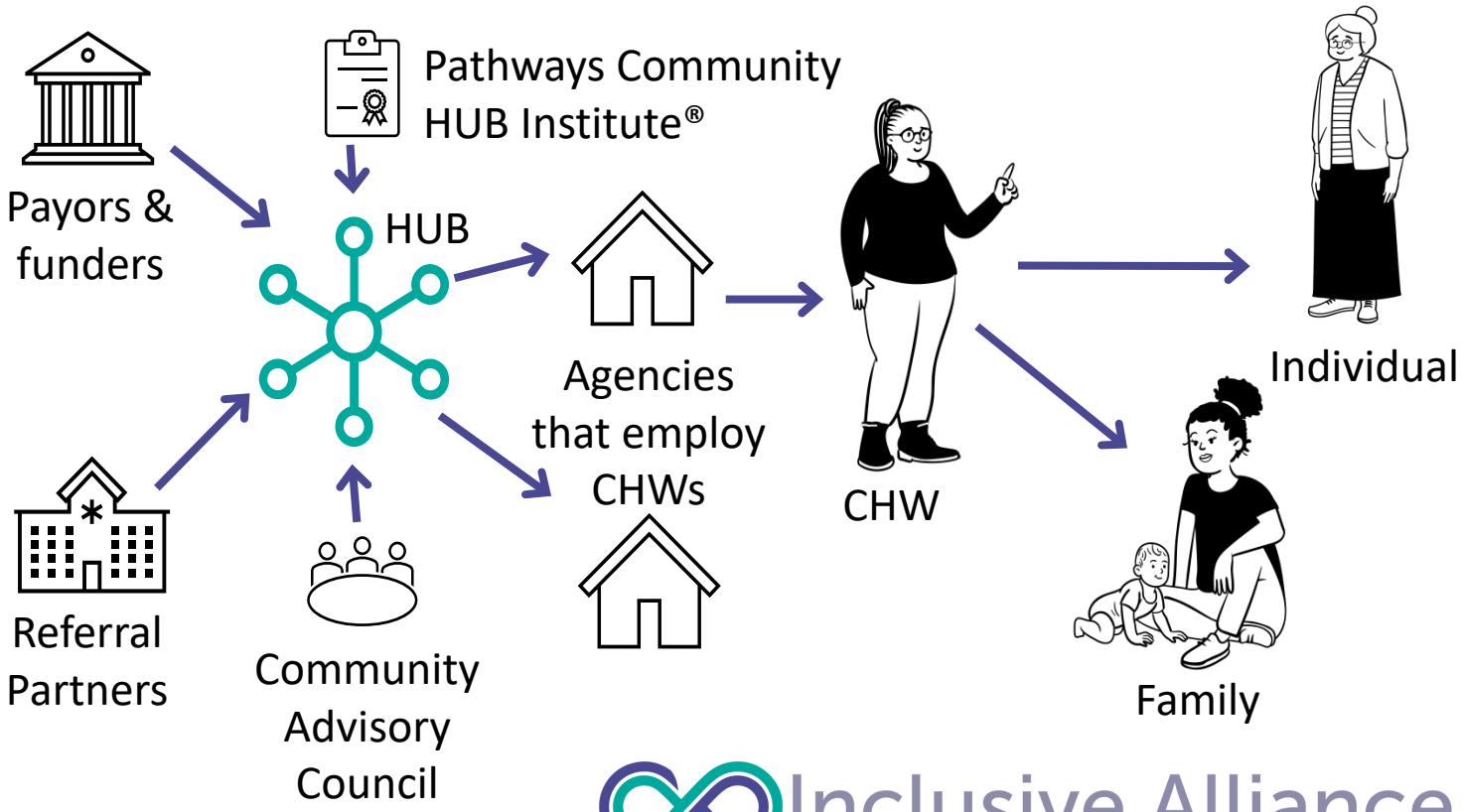
What Is a Pathways Community HUB (PCH)?

Both a standardized, evidence-based approach to community health work (pathways) AND the central administrative infrastructure (HUB) that supports CHWs to ensure services have measurable impact, are financially sustainable, & respond to community need

HUB Functions:

- Based in the community served
- Develops a care coordination agency & referral partner network
- Does NOT employ community health workers (neutral & accountable)
- Uses outcome-based contracting with funders and providers
- Facilitates the Community Advisory Council
- Uses PCHI® Model data collection tools, Pathways, data model
- Becomes PCHI Certified to ensure it follows PCHI Model to fidelity



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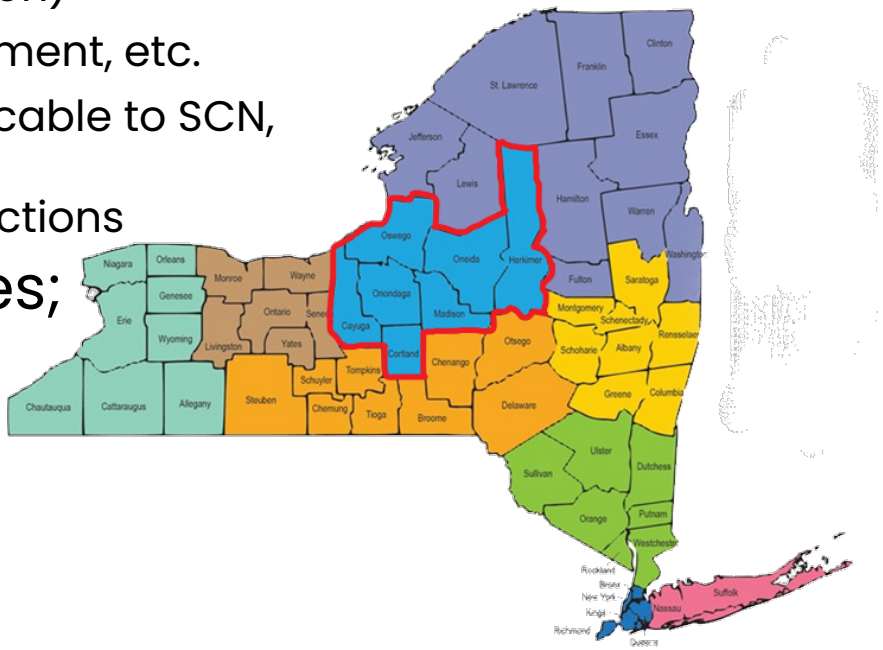
Inclusive Alliance's Approach to Preparing for the SCN RFP

- Assumptions based on staff involvement in the DSRIP PPS application submission & lessons learned
  - If the SCN RFP is released in the fall, anticipate tentative application deadline in late December
  - DOH will likely make numerous changes to the RFP/application
  - Lead applicants will likely need to provide:
    - A **network list** of CBOs and other HRSN providers that have agreed to participate in their SCN if awarded (maintaining documentation proving permission)
    - **Letters of support** from key stakeholders in healthcare, government, etc.
    - Qualifications of the lead applicant based on experience applicable to SCN, including governance
    - Explanation of how the lead applicant will address key SCN functions
  - We will NOT to be able to pick & choose counties; the regions will be defined by DOH, assuming:
  - Leverage existing infrastructure & build with the end in mind (sustainability)



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Inclusive Alliance's Approach to Preparing for the SCN RFP

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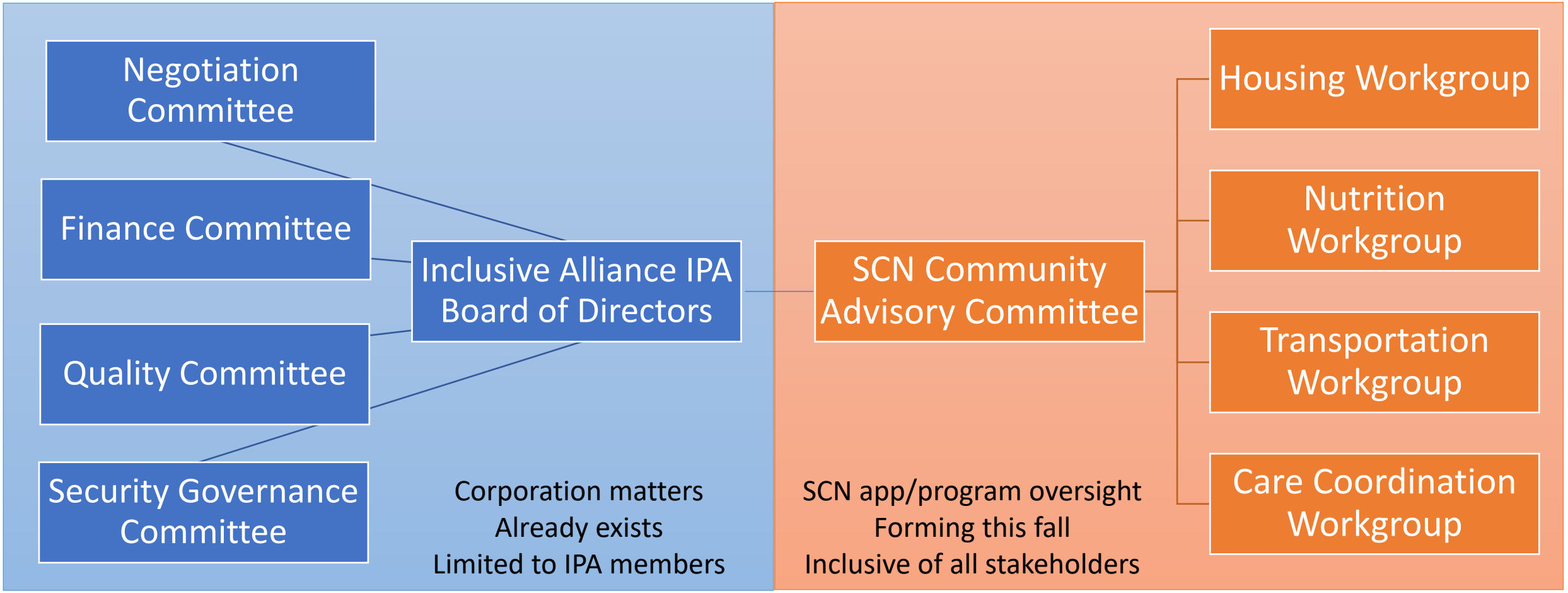
Proposed SCN governance model



Coming Attractions – Upcoming Inclusive Alliance

Subject to change:

- **October 18, 12-1:** CNY National Diabetes Prevention Program Umbrella HUB – How Can Your Organization & Clients Benefit

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Stay Involved & Get in Touch!

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