New York State Medicaid Redesign Team 1115 Research & Demonstration Waiver Delivery System Reform Incentive Payment (DSRIP) Amendment Request

Public Comment

The NYS Association for Rural Health (NYSARH) appreciates the opportunity to comment on the proposed Waiver Amendment.

Introduction

The New York State Association for Rural Health suggests that the 1115 Research & Demonstration Waiver include a 'Rural Lens'. Promising Practices that work well in an urban environment may not translate to the 45 of 62 Counties (73%) that are rural. New York State defines a county as being rural if it has a population of less than 200,000. The scope of NYSARH includes the all rural counties in New York State.

- Fewer than 50,000 residents: Allegany, Cortland, Delaware, Essex, Greene, Hamilton, Lewis, Orleans, Schoharie, Schuyler, Seneca, Wyoming, Yates
- 50,000 – 100,000 residents: Cattaraugus, Cayuga, Chemung, Chenango, Clinton, Columbia, Franklin, Fulton, Genesee, Herkimer, Livingston, Madison, Montgomery, Otsego, Putnam, Steuben, Sullivan, Tioga, Warren, Washington, Wayne
- 100,000 – 200,000 residents: Chautauqua, Jefferson, Ontario, Oswego, Rensselaer, St. Lawrence, Schenectady, Tompkins, Ulster
- Portions of Dutchess and Orange Counties are federally designated as rural also.

DSRIP 2.0 will be both finite in funding and in time. With that understanding NYSARH recommends that these funds be invested in promising practices and new approaches that can build sustainable solutions for New York's rural communities that integrate primary care, behavioral health and social determinant of health solutions. The mechanism for launching new sustainable solutions should be robust investment in innovative pilot and demonstration projects that are sustainable overtime through savings realized under VBP contractual arrangements.

Rural communities can develop rurally appropriate solutions. NYSARH recommends that a portion of the DSRIP 2.0 funds, no less than $45 million, be designated for Rural Health Pilot Projects.

- NYSARH suggests a 36-month Pilot funding RFP specific to rural priorities. The States 30+ Rural Health Networks should be encouraged to sponsor projects.

NYSARH understands that the 1115 Waiver is for Medicaid only, but we encourage the Department of Health to develop Pilot Projects that address All Payers. New York State initiatives such as Health Across All Policies and the NYS Prevention Agenda address health disparities for ALL New Yorkers. We encourage the DOH to broaden its vision for the possible impact of DSRIP 2.0.

NYSARH supports the proposed Waiver's alignment with Federal priorities, behavioral health, prevention services, long-term care and maternal/newborn health.

NYSARH supports solution-oriented Demonstration Projects to prove improved outcomes and/or lower costs that may become sustainable via Value Based Payment arrangements with insurance companies. We note that health insurance companies need to agree to these ideas in order for DSRIP 2.0 to be successful. The State must incentivize MCOs to engage with the CBO community in pilot project development and investment.

NYSARH asks DOH to consider revising the CBO Designations to recognize that there are Tier 2 CBOs whose primary business in **not** Medicaid-funded. It is important to ensure rural CBOs that do a limited amount of Medicaid-funded work, but mostly provide non-Medicaid services, are not disadvantaged, thus disadvantaging the rural populations they serve. [examples: Tioga Opportunities, Healthcare Consortium of Columbia County]

In the DSRIP 2.0 concept paper that was distributed by DOH 9/17/19, funds flow was not articulated. NYSARH recommends that the methodology that DOH will propose needs to be more clearly articulated.

Funding should be included in DSRIP 2.0 to support the three CBO Consortiums created during the original DSRIP. NYSARH suggests $1 million each per year for four years = $12 million.

As New York State privatizes Medicaid services to Managed Care insurance companies it is important to preserve recipient Due Process rights. DSRIP 2.0 needs to include a Patient Bill of Rights that the MCOs are contractually required to uphold.

Rural communities typically experience shortages of health, behavioral health, long-term care and dental providers. Residents experience challenges with access to transportation and long distances to appropriate care providers. Rural residents experience significant health disparities compared to urban residents. On average, rural residents die two years earlier than urban residents of New York.

https://www.ruralhealthinfo.org/topics/rural-health-disparities

Please see the Rural Health Strategy recommendations links below:

https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Rural-Strategy-2018.pdf

https://www.arc.gov/assets/research_reports/BrightSpotsCaseStudiesJuly2018.pdf

https://www.rd.usda.gov/files/RuralResourceGuide.pdf

https://www.qualityforum.org/Publications/2018/08/MAP_Rural_Health_Final_Report_-_2018.aspx

Section I: Historical Summary

- No comment

Section II: Changes Requested

NYSARH supports the overarching goals of the proposed Amendment to continue the transition from fee-for-service to alternative payment mechanisms, align with federal goals and to fully develop 'promising practices' developed during the first four years of the DSRIP Waiver.

Value-Driving Entities

- There are 25 PPSs in the State. It is important that the state clarify the numbers of VDEs envisioned. While 25 VDEs may be too many, NYSARH is very concerned that a "mashing together" of the PPS regions could have a significant negative impact of New York's rural communities. Far too often areas in the Catskills, Finger Lakes and Southern Tier have their voices drowned out by their upstate urban neighbors.
    - Proposed regions must be open to public comment prior to implementation.
    - When considering VDE regions, please give thought to aligning the counties included in the DSRIP region/market not only with existing PPSs, but also with MCO service areas and QE service areas. Some counties are shared and split into several regions/markets.
    - Support 'additional flexibility to align the best future management structure for the given region/market'

- We are not sure how to integrate multiple competing MCOs [some for-profit, some not] in governance leadership and collaborative structure. As mentioned above, DSRIP 2.0 needs to include incentives for MCOs to engage directly with CBOs and the Behavioral Health Care Collaboratives that have established IPAs. To date many overtures from these newly engaged entities have been rebuffed by the MCOs.

- Strongly support inclusion of Qualified Entities. There was much overlap/duplication in the first roll-out of PPSs with work already done to develop the RHIOs.

- Applaud the requirement to have 'representation from community-based providers, including primary care, behavioral health and long-term care'
    - Recommend requiring the addition of health home and children's health home care coordination agencies
    - The inclusion of CBO's is referenced on page 7 'an inclusive governance structure that includes a range of providers, MCOs and CBOs in executive steerage'
        - We wish to emphasize that this makes CBO's an equal partner with the MCOs, hospitals, community-based providers, behavioral health and long-term care agencies.
    - NYSARH recommends requiring inclusion of Rural Health Networks on the VDE governance boards for those VDEs that are serving New York's rural counties.
    - Suggest that additional representation on VDE governance include pre-hospital care providers such as County 911 and regional EMS organizations.

- Support building on progress already being made by ACOs, IPAs, BHCCs etc.

Section III: Additional Priority Areas

- Support reducing maternal mortality and low birth weight.
    - Build on existing County-based public health initiatives
    - Build on the existing pre-natal/peri-natal coalitions that exist throughout the State
    - One project could be expanding access to doula services for women with high-risk pregnancies.
    - Bring a 'rural lens' to any proposed 'maternity bundle'. Many rural women do not have timely access to full-service obstetrical care.

- Support more effective interventions for high need children.
    - Engage with Schools, Police and Counties from the beginning – they have been working to develop mental health systems of care, foster care prevention, support for children with special needs and early intervention for decades.
    - In rural settings the Mobile Crisis Team is likely to be a more effective model than a Mental Health Urgent Care center.
    - For children with significant disabilities or illness [CP, MD, cancer, HIV etc.] utilize best practices learned from previous waivers such as the Care at Home Waiver to provide more flexible and family-oriented supports & services.

- Support training and cross-system collaboration to enhance trauma informed care and address the impacts of Adverse Childhood Experiences (ACE).
    - Support Demonstration Programs that address mental health, substance use, stigma and suicide among children and teens including LGBTQ teens.
    - NYSARH suggests that the DSRIP 2.0 funding may provide a unique opportunity to drive mental and behavioral health resources into rural K-12 schools for a multi-year Demonstration Project that will provide 'proof of concept' to justify long term funding. Examples include
        - The school mental health training center at MHANYS,
        - School-based clinics sponsored by community health centers,
        - System of Care programs.
    - This funding might also be used to explore an expanded role for School Nurses.

- Long-Term Care Reform
    - No amount of reform will work without additional resources. Medicaid funding for all levels of long-term care needs to be <u>significantly</u> increased for the system to provide even the uneven level of quality that is currently available.
    - Systematic cost savings may be achieved by investing more in pre- and inter-institutional supports such as Telehealth, Community Paramedicine, Community Health Workers, Health Navigators, Peer Advocates, Visiting Nurses and Personal Assistance.
    - Support for Social Determinants of Health such as safe, accessible and affordable housing and nutritious, accessible and affordable food may also reduce expensive institutional placements.
    - Support INTERACT collaboration between hospitals and skilled nursing facilities.
    - Support leveraging Qualified Entities to crosswalk Medicaid and Medicare data.
    - NYSARH recommends seeking out projects that creatively and effectively address the needs of family caregivers such as information, referral, peer support, emergency and planned respite and expansion of the Consumer Directed Personal Assistance Program.
    - Include recommendations of the DOH 'Long Term Care Planning Project'.
        - Pilot Projects involving older adults should demonstrate meaningful coordination with their Area Agency on Aging and NY Connects program.
        - More indicators are needed to address services for older adults.

- Hot Spot Areas
    - DOH should use this opportunity to revisit the status of healthcare in 'hotspot' areas to learn if progress has been made and if so, spread information about best practices.

Section IV: Continued Investment/Improvements

- **Workforce Flexibility & Investment**
    - Support non-traditional workforce initiatives such as Community Health Workers, Health Navigators, Community Paramedicine & Peer Advocates
    - Support NYS covering the training and continuing education costs for these para-professional staff. Also providing remote, webinar and multi-site training opportunities accessible to people in rural communities.
    - Partner with the existing Area Health Education Centers, which are located in each region, to leverage existing infrastructure.
    - Engage the paraprofessional workforce in developing benchmarks and realistic outcomes for Value Based and/or Bundled Payment options.
    - Provide at least 'living wage' salaries for these types of positions. Too often, people in these positions are part-time, 'gig' contractors, volunteers or minimum wage employees.
    - Develop criteria, regulations and funding for EMS Paramedicine.
    - Innovative models are needed to support Home Health Aide, Certified Nurse Assistant, Personal Assistant and informal caregiver workforce needs.
    - Include projects that incorporate diversity and cultural sensitivity initiatives.
    - Encourage partnerships with existing workforce development programs with Department of Labor, ACCES-VR, VISTA and AmeriCorps.
    - NYSARH supports the use of peer support and peer mentors but cautions that these personnel are not a replacement for clinical services.

- **The Professional Workforce Needs Investment as well**
    - There is a significant shortage of behavioral health providers
        - NYSARH recommends funding a Pilot sustainable infrastructure Value Based Payment project that includes incentives for paid preceptorships to provide supervision time for disciplines that require a period of supervised work.
        - Another Value Based Payment Pilot project should be designed to look at behavioral health caseloads, burnout, job changing and opportunities to work at 'top of license'.
    - NYSARH recommends more funds for Rural Workforce recruitment, development, training, preceptors, residencies, internships and support.
    - NYSARH recommends some reform to immigration and licensure regulations.
        - There seems to be some need to address federal immigration policies.

        - NYS should be more flexible in allowing licensure for providers trained in other countries. Current licensure standards limit access to providers.
    - NYSARH supports adding rights for a wider variety of academically prepared mental health practitioners to bill Medicaid and be included in Medicaid VBP arrangements. These disciplines should include Licensed Certified Social Workers (LCSW) with or without the 'R' designation, Marriage and Family Therapists, Rehabilitation Counselors, Art Therapists and Music Therapists.
    - NYSARH encourages DSRIP 2.0 to fund Demonstration Projects that foster connectivity and coordination between medical universities, nursing schools and affiliated health professional training programs with rural internships and residencies, preceptors, immersion experiences and other programs to enhance the success of professional recruitment to rural areas.
        - Explore designating a portion of Doctors Across NY funding specifically for providers practicing in rural areas
    - Include projects that incorporate diversity and cultural sensitivity initiatives that address disparities in health outcomes.
        - While racial and ethnic disparities are undoubtedly important, please consider rural disparities in this part of the design.

- **Coordinated Population Health Improvement**
    - Support incorporation of Prevention Agenda Goals
    - Build on existing County-based public health initiatives
    - Build on best practices from the Population Health Improvement Program (PHIP) contracts now wrapping up
    - Support Medicaid, Medicare and a 'multi-payer lens' to promote '360° population health' [page 10]
    - The State should encourage MCOs that offer Medicare Advantage Plans to pay for evidence-based population health programs.
        - Pay for chronic disease self-management programs.
        - Support Social Determinants of Health services [transportation, nutrition, utilities etc.]
        - Expand the use of Special Supplemental Benefits for Chronically Ill to coordinate better with Medicaid-funded services.
    - Incentives should be provided for care transition, care management and care transition programs using patient navigators and community health workers to support better health outcomes for people with chronic conditions.

- **Social Determinant of Health Networks (SDHN)**
    - NYSARH recommends that the three CBO Consortia developed as part of the original DSRIP be engaged in the development of the SDHN and that they receive continued funding under DSRIP 2.0 to do this work.

The State should leverage the investment and relationships already developed through the Consortia as the foundation for the SDHN.

- We understand the SDHN to be a collaborative entity similar to an IPA or ACO for CBOs. An existing example may be the WNY Integrated Care Collaborative.
- The SDHN will require a Community Information Exchange (CIE) to effectively deliver, monitor and evaluate service delivery. What is the DOH plan for an information system (or systems) for non-clinical data sharing?
  - Please connect with the CIE Planning Project, currently in process, funded by the Health Foundation for Western & Central New York.
- Align the counties included in the SDHN region/market not only with existing PPSs, but also with MCO service areas and QE service areas.
  - Recognize and build upon existing SDH CBO delivery systems and naturally occurring networks. PLEASE do not create a new artificial construct. Let each Region select its members and leadership.
- Support extra attention for Medicaid members with complex health and social needs and children/families at risk of adverse childhood experiences.
- There is still a need for transportation solutions in rural areas that address non-medical needs such as trips to the pharmacy or grocery store. Current Medicaid transportation regulations do not permit rides for Social Determinants of Health and other needs such as employment support, probation/parole/child welfare and housing searches. We believe DSRIP 2.0 may provide an opportunity to reform Medicaid transportation regulations to permit more flexible uses of existing services, open opportunities for more public transit and support hybrid models that combine transportation methods, including volunteers.

- **Addressing the Opioid Epidemic**
  - Support for the proposed Opioid interventions
    - Expansion of Medication Assisted Recovery is positive
    - One project suggested is to explore the challenges of integrating medically assisted recovery in with the work of primary care providers with a view towards more carefully researching what the barriers are, seeking opportunities for commonalities and working toward capacity development.
  - Recommend broadening this Investment/Improvement to include a range of addiction issues that have a significant impact on rural health morbidity and mortality such as Methamphetamine, Alcohol and Tobacco.
    - Vaping (electronic cigarettes) is a relatively new area of health concern that may also need to be included.

Section V: Performance Measurement

- It is not clear in the Draft document (9/17/19) how people will be attributed to the VDEs. Please provide greater clarity about attribution in the next version of the Waiver application.
- The quality indicators chosen will greatly impact the financial benefits for VDEs, MCOs, SDHNs and their partners. An inclusive and broad-based input process should be developed during the next few months to pin down the quality indicators that will be used to calculate bonuses in VBP arrangements within DSRIP 2.0.
- NYSARH recommends that the revised Waiver application specify the role of the Project Approval and Oversight Panel to monitor projects selected for funding, actual funds flow, as well as project milestones and outcomes.
- NYSARH understands that documentation is essential, but our members' experience with previous initiatives has been that required documentation has been burdensome, expensive and led to some people leaving the healthcare field. We encourage a more balanced approach.

Section VI: Interim Access Assurance Fund

- NYSARH supports additional funding for financially distressed safety net hospitals.
- Please note that the reason many of these hospitals are financially distressed is their high percentage of patients with Medicaid insurance. While one-time funding is appreciated, the real solution is for Medicaid rates to cover the true cost of care.
- There needs to be a significant investment in subsidized Rural Residencies and Rotations to encourage new MDs, NPs, DOs and PAs to practice in rural communities.

Section VII: Evaluation

- NYSARH believes that the voices of people served are an essential component to an effective evaluation process. We recommend that the evaluation include an assertive in-person outreach component to a diverse range of Medicaid members who are high users of healthcare. "Nothing about us without us."

Section VIII: Budget

- Rural communities can develop rurally appropriate solutions. NYSARH recommends that a portion of the DSRIP 2.0 funds, no less than $45 million, be designated for Rural Health Pilot Projects.
- Funding should be included in DSRIP 2.0 to support the three CBO Consortiums created during the original DSRIP. NYSARH suggests $1 million each per year for four years = $12 million.
- As New York State privatizes Medicaid services to Managed Care insurance companies it is important to preserve recipient Due Process rights. DSRIP 2.0 needs to include a Patient Bill of Rights that the MCOs are contractually required to uphold.

- In the DSRIP 2.0 concept paper that was distributed by DOH 9/17/19, funds flow was not articulated. NYSARH recommends that the methodology that DOH will propose, needs to be clearly articulated and open to public comment.

Section IX: Summary

- No comment

About NYSARH

The Mission of NYSARH is to improve the health and well-being of rural New Yorkers and their communities. NYSARH is a not-for-profit, non-partisan, grassroots organization working to preserve and improve the health of the citizens in rural New York State. NYSARH was founded in July 2001. The organization is affiliated with the National Rural Health Association.

NYSARH is a membership organization. NYSARH membership includes representatives of all facets of the rural health care industry, as well as individuals and students. On many different levels, NYSARH serves individuals, consumers, non-profit organizations, government agencies and officials, health care facilities, emergency medical service providers, long-term care organizations, businesses, universities, foundations, associations, and other stakeholders in rural health. NYSARH members include rural hospitals and federally qualified health centers located in rural communities.

Federal approval is not guaranteed. How can NYSARH help?

Submitted 11/4/19