Written Response to the 1115 Research and Demonstration Waiver Draft

Provided by the Coalition of NYS Health Homes

Laurie Lanphear, Executive Director

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The Coalition of New York State Health Homes (CNYSHH) represents 26 Health Homes across every region of New York State with CNYSHH member Health Home enrollees totaling over 155,000 adults and children/youth including those with the highest medical, behavioral health, and social care needs in the state. The CNYSHH seeks to improve the health and lives of all individuals served in the Health Homes by enabling providers to deliver the highest quality, most cost-effective Complex Care Management to all.

The CNYSHH is pleased to see the draft "1115 Research and Demonstration Waiver: Strategic Health Equity Reform Payment Arrangements: Making Targeted, Evidence-Based Investments to Address the Health Disparities Exacerbated by the COVID-19 Pandemic" investment in addressing health disparities, health and racial equity, social determinants of health, IT and infrastructure, workforce, advanced VBP models, and support of specialized populations. Health Homes, and their associated Care Management Agency (CMA) networks, have repeatedly risen to the challenge, adapted, improved, become more efficient, demonstrated significant positive health outcomes for members and continue to do so despite the enormous challenges that they have faced over the past years. We feel the infrastructure and model of Health Homes is uniquely positioned to play an integral role in supporting the goals outlined in the 1115 Research and Demonstration Waiver.

We respectfully submit the following four key points for your consideration during the 1115 Waiver public comment period and have included additional data and information to support each point throughout this letter. We are happy to provide any additional detail or clarification on the below positions.

1. To ensure that Health Homes are not an afterthought in the VBP-IPP program, and included as the care management vehicle for VBP arrangements, we strongly advocate that the State:
    - Require qualifying contracts to use established Health Homes as the Medicaid care management partner, where applicable for eligible populations.
    - Require networks and lead VBP entities to leverage Health Home Care Management more broadly to ensure efficiency and reduce the risk of redundant layers of care management for eligible Medicaid enrolled adults, children, and youth.

2. We request that DOH position Health Homes formally within the structure of SDHNs and HEROs as a required component of governance as the Care Management (CM) entity/entities in the region. We request language in the waiver, specifically listing Health Homes with a defined and formal role, which could be either as a lead or a participant in the HEROs/SDHNs.
3. We ask that the State in addition to specifically listing community health workers (CHWs), care navigators and peers, add care managers and Health Homes to the list of entities and professionals that would be the target of workforce investment through the WIOs and other waiver-funded workforce investment streams.
4. We strongly encourage that the 1115 Waiver Amendment add Health Homes and care managers to the planning and inventory effort to invest in Supportive Housing Services and Alternatives for the Homeless and Long-Term Institutional Populations and to the list of providers who can do assessment and determination to connect individuals with housing services.

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

1. **<u>Health Homes Have Developed a Network Structure that Aligns with the Goals of the 1115 Research and Demonstration Waiver Amendment</u>**

    - The CNYSHH strongly recommends that any investment of future funding be made into enhancing what is currently in place and successful instead of trying to duplicate a model without proven outcomes. Health Homes play a critical role in improving population health management across NYS by being the primary provider of Medicaid Complex Care Management. This includes Health Homes as critical partners with ACOs, IPAs, and other accountable networks. Health Homes have spent the last 10 years developing robust network partner connections with hospital and healthcare systems, behavioral healthcare providers, MCOs, CBOs, RHIOs, ACOs, IPAs, LDSS, LGU's, DSRIP PPS', housing providers, and other social care community providers. Health Homes include a network of over 400 Care Management Agencies statewide many of which provide a full array of community-based services. ***It would be wasteful and inefficient to discard the infrastructure that has been built in Health Homes rather than to continue to improve and enhance them through targeted waiver investment and inclusion in waiver initiatives, like the HEROs and SDHNs.***
    - Health Homes have positioned themselves to act as either a HERO or SDHN while also being the Complex Care Management provider of choice for NYS Medicaid enrolled adults, children, and youth, most at risk therefore Health Homes must be listed formally in the governance structure of both the HEROS and SDHNs. Health Homes should be allowed to build upon the already existing capacity they have developed, ***including revenue cycle management and support, quality oversight, training and technical assistance, workforce development, complex care management expertise, data analytic support, community level support with home-based interventions,*** and much more. These competencies and

existing infrastructure have application to the HERO and SDHN and Health Homes serving in the governance and potentially lead role in regions across the State seems like a natural fit.

- Health Homes represent significant investment in regional infrastructure. This includes care management platforms that have been enhanced to meet the needs of the program and regional population health efforts, connectivity to RHIO's, connectivity and use of regional social care platforms, telehealth platforms, and Data Use Agreements (DUA's) through the SSP with NYS DOH. DOH should ensure that this investment is carried forward to the waiver to ensure efficiency and avoid any duplication of resources under new waiver initiatives.

2. <u>Health Homes Are Positioned to Play an Integral Role in VBP Arrangements</u>

- The CNYSHH fully supports the 1115 Waiver Amendment outline of a redesigned VBP roadmap that expands advanced Value Based Contracting beyond the traditional total cost of care (TCOC) model to include attribution by a member's behavioral health provider and/or Health Home and addresses health equity and regional SDH needs.
- The CNYSHH was very pleased to see that MCO's would be required to "engage in VBP contracts with an appropriately constructed network of providers for the population-specific VBP arrangements". However, we do believe the 1115 waiver Amendment language that suggest MCO's "would be strongly encouraged to contract" with SDHN should be updated to reflect this is a requirement of the new VBP Roadmap, including eligible contracts including Health Homes formally as a network partner. With the significant investment being made into SDHNs the only way to ensure long-term sustainability and success is with these formalized MCO relationships.
- Health Homes, and their network of Care Management Agencies (CMAs), are already successfully serving the targeted populations outlined in the 1115 Waiver Amendment draft for advanced VBP arrangement opportunities. These populations include SMI, SUD, homeless and housing insecure, SED, and I/DD with a successful model of "meeting members where they are at" with community level engagement resulting in positive health outcomes and Medicaid savings. We ask that the State formally identify Health Homes as an eligible entity to form a network and enter into eligible contracts for the VBP-IPP program.
- ***We request that the State position Health Homes as the established/preferred Complex Care Management entity in advanced VBP arrangements by directing enhanced funds (or withholding funds) to entities that align (or don't align) with the State's expectations for leveraging HHCM for eligible populations. New York State has already invested in HH infrastructure for the past 10 years and capabilities; limiting the Health Home role in VBP will result in a less coordinated and/or duplicative Care Management in advanced VBP arrangements. Health Homes have proven models, population health outcomes, and are an essential component of future advanced VBP arrangements in the Medicaid environment. Health Homes are at risk of operating on the fringe unless they are already***

established as a core vehicle within a larger health system or population health focused organization.

3. **Health Homes are the Statewide Social Determinants Provider of Medicaid Complex Care Management with Proven Outcomes that would Support VBP/IPP-Global Payment Model Outcomes**

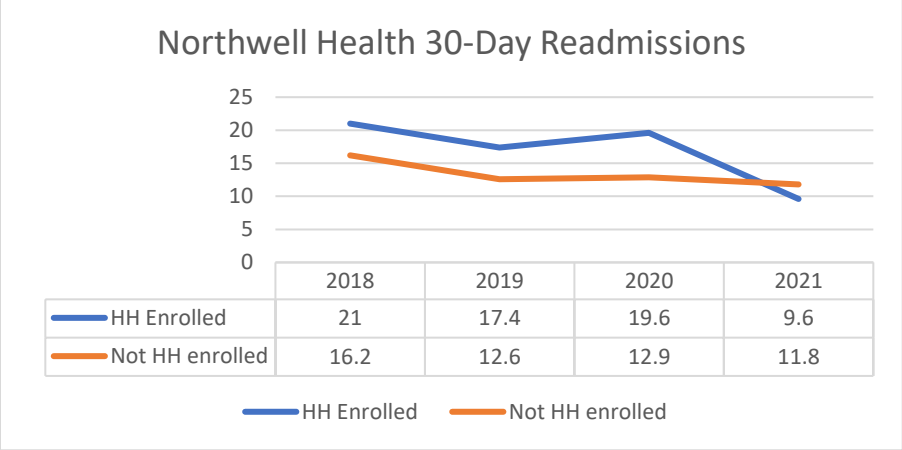
- Health Homes have proven outcomes to support that the Medicaid Complex Care Management model is effective in addressing social determinants of health leading to positive health outcomes and reducing avoidable health spending. According to a NYSOMH HARP Focused Clinical Study - Performance Opportunity Program presented October 21, 2021, members with a Health Home Care Manager were 5.0 times more likely than those with an MCO Care Manager to receive follow-up at 7 days and 14.4 times more likely to receive follow-up within 30 days for after discharge for a behavioral health stay.[1]

- Huther Doyle Health Home, part of the HHUNY network demonstrated a positive correlation with using the Health Home infrastructure, with the additional support of Health Home embedded navigators and peer's, in closing 4 specific gaps in care. This study "2019-2020: Gaps in Care: Connecting the Dots Through Health Home Care Management" was through a Finger Lakes Performing Provider System (FLPPS) funded grant of Health Home enrollees in a 10-county region of NYS.
    - [2]**7-Day follow-up after Mental Health Inpatient Hospitalization**: there was an improvement from 44% to 92% of individuals making their 7-day follow-up appointment.
    - **30-Day follow-up after a Mental Health inpatient stay** – measured improvement from 39% to 87%.
    - **Diabetes Screening for members using antipsychotic medications**: screening improved from 8% of members being screened in February 2019 to 85% in December 2020.
    - **Diabetes Monitoring for members with diabetes & schizophrenia:** 13% of members with gap monitored in February, 82% monitored in December.
- Community Care Management Partners (CCMP) Health Home has observed that 79% of CCMP's Health Home members with major depressive behavior were significantly less depressed after one year of Health Home enrollment[3]. Also, of note, CCMP measured a 66% reduction in alcohol use score after one year of Health Home enrollment for members with

[1] IPRO focus study results of 197 POP-eligible members. Results presented in the October 21, 2021 Statewide Managed Care Behavioral Health Medical Directors Meeting.
[2] Huther Doyle Health Home study included 44 care management agencies and 600 care managers
[3] Using CCMP's PHQ-9 scores* show 202 members with moderately severe and severe depression at the time of their initial assessment in 2019. Upon a reassessment, 161 of these members moved to a lower depression severity group.

severe alcohol abuse[4] and a 58% reduction in drug use amongst members with severe drug abuse[5].

- Northwell Health has seen Health Home enrolled members have 30-day readmission rates that are trending down.[6]



- Health Homes are the only statewide program that has consistently assessed all members for social determinants of health (SDoH) using the Accountable Health Communities (AHC) health-related social needs screening tool from CMS. As the HERO's develop a strategy and process for the implementation of a standardized assessment tool the Health Homes are uniquely positioned to use their experience to be the statewide assessor of needs. We request that the State adopt the current modified version of the CMS approved Accountable Health Communities Health-Related Social Needs Screening Tool that is being utilized by DOH and Health Homes across NYS as the tool to assess health related social needs.

4. <u>Health Homes are necessary in ensuring Access for Criminal Justice-Involved Individuals.</u>

- We are encouraged to see Health Home listed in the financial projection for the impact of the correctional in-reach model. We request the language in the 1115 Waiver Amendment go a step further and explicitly identify Health Homes as the Care Management entity for the Medicaid correctional in-reach model.
- The eligibility for the correctional in-reach model mirrors that of Health Home eligibility. Health Homes have over a decade of proven outcomes serving the targeted populations

[4] Using AUDIT scores to calculate first and second weighted average score for groups risky to severe/high risk.
[5] Using DAST scores to calculate weighted average of scores for severe level groups to determine the percentage decrease from first to second score.
[6] Northwell Health claims data analysis. Available upon request.

identified in the in-reach model, including behavioral health, substance use disorder, complex health needs, and social care needs. In addition, Health Homes and their associated CMAs have spent significant time and energy in establishing relationships with the county jails and NYS correctional facilities and expanded relationships, network competencies, and training to effectively serve the justice-involved individuals as they re-enter their communities.

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

1. **Health Homes can assist the State in Developing and Strengthening Housing Services and Alternatives for the Homeless and Long-Term Institutional Populations**
    - We request that Health Homes be listed as the care management provider to complete housing assessment, referrals and coordination of related services and benefits under the Enhanced Supportive Housing Initiative. This would include a requirement that HEROs and SDNHs collaborate with Health Homes on their housing related deliverables.
    - Health Homes have proven that community level care management interventions are successful in addressing social care needs such as housing. Based on a representative sample of Health Home enrolled members completing the Accountable Health Communities (AHC) health-related social needs screening tool in Foothold Care Manager (FCM) at intake and reassessment, there was a 47% reduction in members who identified as being housing insecure after 1 year of continuous Health Home enrollment and a 52.6% reduction in Health Home enrolled members that identified as food insecure. Additionally, transportation access for Health Home enrolled members increased by 48%. [7]

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

1. **Developing a Strong, Representative and Well-Trained Workforce Including Health Home Care Management as Professions Where Workforce Investment is Directed**

    - The CNYSHH adamantly agrees with the 1115 Waiver Amendment outline on the need for recruitment and retention initiatives, strengthening career pathways, training initiatives, and expansion of the CHW and related workforce. We feel that Health Homes are uniquely

[7] Coalition of NYS Health Home analysis of 5603 Health Home enrolled members in Foothold Care Manager (FCM) that had an initial Accountable Health Communities (AHC) health-related social needs screening tool and a reassessment using the same tool in 2020-2021. All Health Home members had at least one year of continuous Health Home enrollment.

positioned to partner on these initiates and should be formally acknowledged in the 1115 Waiver Amendment for opportunities.

- Health Homes have spent the last decade building a robust training system to help support their Complex Care Management networks. This includes purchasing and implementing Learning Management Systems (LMS) that offer an array of training opportunities on many different related areas. These trainings include specialty populations, behavioral health, substance use, care transitions, cultural competency, trauma-informed care, addressing health disparities, and many more. In many regions of NYS Health Homes' training expertise has expanded beyond the Health Home network to include several of the integrated care providers including, social care community providers, home care agencies, home health aides, CHW's, peer navigators, and more.
- Health Homes, and their associated Care Management Agencies (CMAs) have a diverse, experienced, and educated workforce.
    - 45% of Health Home Care Managers are BIPOC.
    - 46% of Health Home Care Managers have 10 plus years of health and human service experience.
    - 95% of Health Home Care Managers hold an advanced college degree.[8]
- Health Homes and their associated CMAs are experiencing a workforce crisis like never before.
    - During the past three years over 85% of HHCM staff left community care management agencies compared to those that joined during that same time.
    - 1 in 4 HHCM positions are currently open, on average, statewide.[9]
- **Failure to invest in Health Home Care Management, sure up the career pipeline, and workforce recruitment and retention efforts will lead to devastating effects on the healthcare system and the highest risk, highest need members served**.

2. **<u>Safety Net</u>**

    - We support the inclusion of specific dollars for safety net hospitals on behalf of the Health Homes that are part of a Safety Net/High Medicaid volume hospital.

Goal 4: Creating Sitewide Digital Health and Telehealth Infrastructure

[8] HHCM information taken from a Coalition of NYS Health Home Workforce Survey results of 1584 HHCM staff members statewide.

[9] 2021 CNYSHH/NYS Care Management Coalition HHCM workforce survey. 1584 individual HHCM staff and 164 individual Health Home Care Management Agencies, covering every region of the state, responded to the Workforce surveys

- The significant financial investment that Health Homes have made into the IT infrastructure to support community level population health should not go unnoticed. Health Homes are grateful for the Health Home Development Funds that were available to help support this but for many these funds have run out. We request that as NYS looks to *Create Digital Health and Telehealth Infrastructure* Health Homes be included with financial support to assist in better integration of care management platforms, data and outcomes access, telehealth platforms and regional provider connectivity.

The Coalition for NYS Health Homes is optimistic about the opportunities the 1115 Research and Demonstration Waiver draft outlines to address health disparities and equity from the lessons learned during the COVID-19 pandemic. Health Homes, and their associated Care Management Agencies (CMA's), were on the front lines addressing these disparities and ensuring members received the care that was, and continues to be, desperately needed. We welcome the opportunity to discuss further how Health Homes should be represented in the 1115 Waiver moving forward. We stand ready to support you, our state partners and the 1115 Waiver initiatives in serving the most vulnerable NYS Medicaid members.