Moving Ahead: Exploring New York's Forthcoming 1115 Waiver

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Introducing Our Speakers

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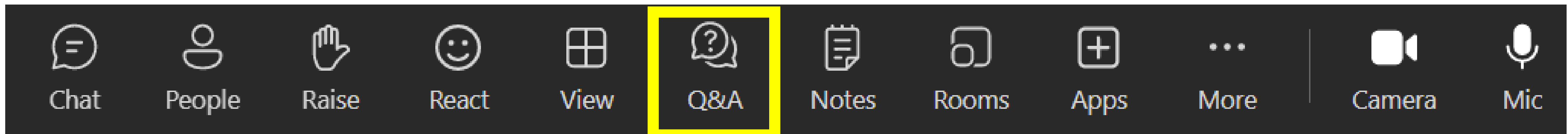
Housekeeping

- Please enter questions through the Q&A feature in Teams (screenshot below), and we will answer questions at the end
- You may also email questions directly to info@copehealthsolutions.com.



- Attendees will receive a PDF copy of the presentation, a link to the recording and a written Q&A

- After the presentation, COPE Health Solutions will send out a brief survey—we'd greatly appreciate you sharing any comments or feedback!

Agenda

1. **Introduction to forthcoming New York Health Equity Reform (NYHER) 1115 Waiver and Aligned CMS/CMMI Programs**
    a. High level CMS goals
    b. Overview of NYHER and New York State Medicaid Transformation roadmap/goals/objectives

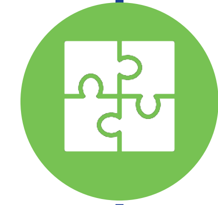
2. **Overview of aligned CMS/CMMI programs – what are they and what do they mean for you?**
    a. Overview of how NY State is regionally split between MCP and AHEAD
    b. What happens if I stay in MSSP or ACO REACH?

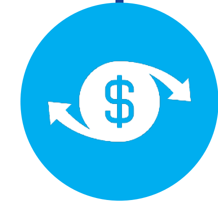
3. **Consistent Themes and Components from CMS and New York State (financial, quality reporting, health equity, etc.)**
    a. What types of programmatic and contracting changes are consistent across NYHER and the aligned CMS/CMMI programs?
    b. What is the timeline to participate in these models?

4. **Lessons Learned from California's Medicaid Waiver: CalAIM**

5. **What Can You Do Next?**

6. **Q&A**





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High Level CMS and New York State Medicaid Transformation Goals

1. **Value-Based Payment (VBP)**
    - Achieve a shift to care relationships with accountability for quality and total cost of care for all Medicare fee-for-service beneficiaries and the majority of Medicaid beneficiaries by 2030.

2. **Primary Care Development Focus**
    - *Incentives:* Financial incentives to support healthcare providers in the transition from expensive acute care to high quality primary care.
        - Primary care spending as a percentage of New York's total health care spending has been increasing but has not kept pace; and
        - Goal of recent rate increases and enhanced Patient Centered Medical (PCMH) investment to align with Medicare models and NY Waiver efforts.
    - *Investments:* Allocating resources for enhancing infrastructure and capabilities in primary care and for health system transformation and connected with health-related social needs (HRSN).
    - *Multi-Payor Alignment*. Focusing on multi-payor alignment strategies in primary care to complement efforts between and among Medicare, Medicaid and commercial.

3. **HRSN Integration:**
    - Emphasis on integrating HRSN considerations into the overall care model; employ screening tools for needs and demographic data collection, implement risk stratification to quality data measurement sets, and measure ROI on high-value HRSN.
    - *Gap Closure:* Strategies to identify and address gaps related to social determinants for improved health outcomes.

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What We Know About the NY 1115 Medicaid Waiver (Not Yet Approved)

Background

New York State's Medicaid Redesign team had requested $13.52 billion from the federal government over the balance of the waiver term. This amount will likely be reduced proportionally depending on the when the waiver is approved.

Five Major Components

Hospital	SDoH	Primary Care	Workforce	HERO
• Funding to for distressed safety net hospitals to participate in advanced VBP/CMMI models, integrate with primary care, and HRSN • Question: is waiver funding additive to current DPP, ICP, and NYS VAPAP funds to hospitals?	• Formation of Social Care Networks (SCNs) report to MCOs and report outcomes to the state; 1 SCN per region • Funding for SCN infrastructure • Utilize Health Related Social Needs (HRSN) screening tool • Directed payment-type funding to flow through health plans to SCNs, CBOs, IPAs for pay for HRSN.	• Specific allocation to primary care • Tool will impact health plan risk adjustment calculation • Build on PCMH investments • Move to advanced VBP and payor alignment	• New strategies on innovative workforce funding • Programs may include: training and recruitment pathways (WIOs), and training loan forgiveness (similar to MA)	• Data driven entity that will help inform where social care investment is awarded • Help with evaluation design • Data aggregation • Regional assessment of need

Timing

The amendment approval and draft STCs are expected soon!

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CMS Model Overview

	MCP (Limited to Upstate NY)	MSSP ACO	ACO REACH	AHEAD (Limited to Downstate NY)
Target Providers	Physician Practice or FQHC	Risk Bearing Physician Networks		Providers Market Wide
Overview	• CMMI program targeted at individual primary care practices that are new to value-based care	• A progressive risk sharing program created as part of the ACA in 2010 • Enables physician networks to take risk against a budget and share in savings.	• A full risk program created by CMMI • Enables physician networks and other organizations to take full risk for total cost of care.	• Voluntary model limited to 8 states, including Downstate NY • Designed to align with State Medicaid alternative payment model
Target Populations	• Original Medicare beneficiaries	• Original Medicare beneficiaries	• Original Medicare beneficiaries	• All Populations for Institutions • Medicare & Medicaid for physicians
Entity Eligibility	• Individual primary care practices and FQHCs in 8 states, including upstate NY	• Physician networks interested in taking risk	• Physician networks interested in taking risk • “New Entrants”	• Hospitals • Primary care practices, FQHCs, RHCs in AHEAD state or sub-state area and participating in the state’s Medicaid Primary Care APM (Hospital owned PCP only eligible if hospital in global budget)
Application Status/Timeline	• 10.5-year contract (7/1/24 – 12/31/34)	• Open Annually in Q1	• Closed (last year PY26)	• 11-year contract (2024 – 2034)
Payment Model	• FFS moving to primary care capitation	• Shared savings against benchmark	• Shared savings/losses against benchmark	• Hospital Institutional global budget with care coordination incent first two years • Enhanced Primary Care Payment PMPM
Market Impact	• Low	• Moderate	• Moderate	• Very High

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Which CMS Models Apply To Your Organization?

All counties in **Upstate NY**, outside of the circled zone, are eligible to participate in **MCP.**

CMS has **excluded** the following **Downstate NY counties** from participating in MCP: Westchester, Bronx, New York, Richmond, Kings, Queens, Nassau.

Entities located in these counties ***are eligible*** to participate in **AHEAD.**

All of New York is eligible to participate in the **NY Waiver, MSSP** and **ACO REACH (no new applications being accepted for ACO REACH at this time).**

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Consistent Themes and Components from CMS and New York State

	NY Waiver	MCP	AHEAD	ACO REACH	MSSP
Collection of **SDoH member data** consistently and integration into **risk stratification**, as well as to inform network gaps	✓	✓	✓	✓	✓
Expansion of primary care access while engaging in transformation to **improve quality** and **financial performance** • Primary care investments and **enhanced payments**	✓	✓	✓	✓	
Putting dollars at risk, with different **performance benchmarks** and **risk-sharing methodologies**	✓	✓	✓	✓	✓
Measurement of **quality scores** to **track performance**	TBD	✓	✓	✓	✓
Submission of **Health Equity Plans (HEPs)** • Strategies to identify health outcome disparities in their populations of focus, implementing initiatives to measure and reduce disparities over time	TBD	✓	✓	✓	

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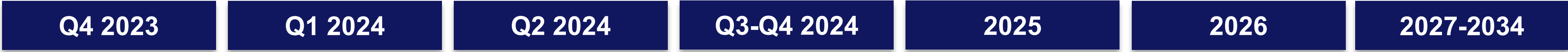
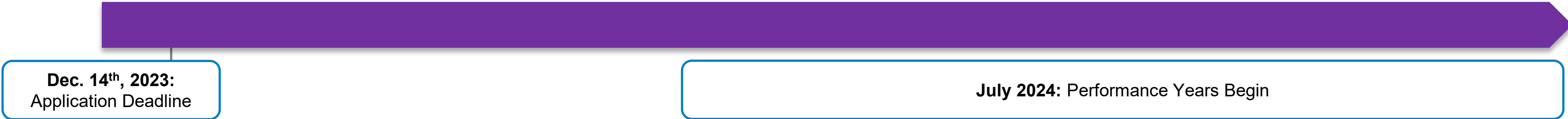
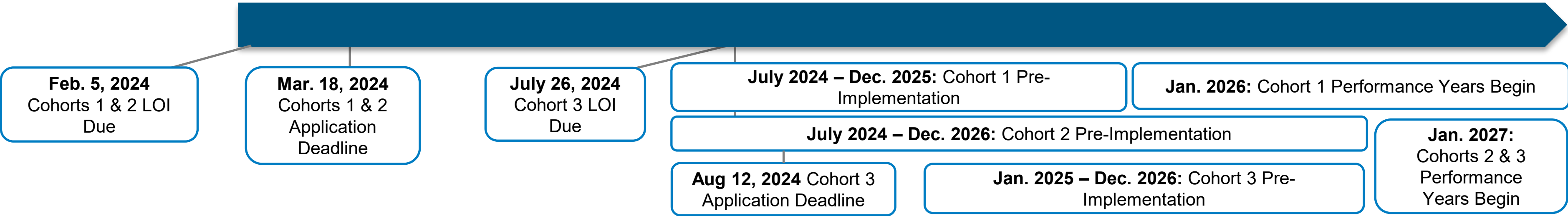
CMS Models & NY Waiver Timeline



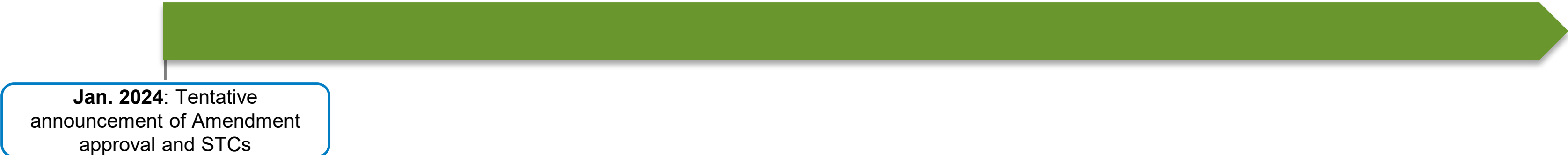
MCP



AHEAD



NY Waiver



ACO REACH & MSSP

State of California CalAIM Lessons Learned and Considerations

Areas	Opportunities for Improvement	Considerations and Updates from Lessons Learned
Awareness & outreach to providers	• CalAIM's extensive breadth of initiatives, benefits, range of participation criteria & rolling updates makes it difficult for providers to follow and to succeed • Independent provider groups & small/mid-size CBOs do not have the bandwidth to track & integrate these changes • Providers have struggled to link CalAIM benefits to core business & value-based payment (VBP) arrangements & all line of business strategies	• Encourage and support consistent guidelines for health plans to include CalAIM contractual and related activities and issues through JOC or other provider engagement forums • Work with plans to better incorporate CalAIM benefits into VBP arrangements & incentives (e.g., quality gap closure) • Require health plans to develop & maintain outreach campaigns • State issued clarified guidelines for all programs to clarify eligibility requirements to reduce plan-imposed changes
Cross-plan collaboration & standardization	• Varying health plan requirements for eligibility, authorizations & enrollment, requiring providers & CBOs to maintain multiple workflows & templates • Post-contracting, there is limited required coordination & standardization across health plans that translates to on the ground daily efforts	• Local/regional collaboratives proved vital to coordinating implementation & problem-solving at community level; collaboratives should be organized before implementation • State issued an "Action Plan" that details what is required vs optional/flexible to minimize variation in policy interpretation for outreach, eligibility, engagement, documentation & billing (effective 01/24)
Data access & sharing	• Providers/CBOs must maintain multiple portals & log-ins, even for the same vendor, across different health plans • Closed referral loops (inter-agency & plan-provider/CBO) remain rare	• State continues to implement state-wide data exchange; in parallel health plans and enabling vendors should be incentivized to achieve cross-plan data sharing & platform integration for purposes of care continuity & ease of use

State of California CalAIM Lessons Learned and Considerations

Areas	Opportunities	Considerations and Updates from Lessons Learned
Member engagement & retention	• Health plan developed chase lists for potentially eligible members generate low engagement rates	• Engaging & screening members in community or at point of care (not just telephonically/mail) is critical to improving enrollment rates • Some plans have piloted member incentives, expansion of may support providers in improving member engagement
Funds flows	• Low member retention rates place providers & CBOs at risk for monthly pre-payments if members are subsequently determined to be "disenrolled" 30-90 days post payment • Given the complexity of the target populations, many providers feel funding amounts for services are inadequate	• While PMPMs are preferable for cash flow, some health plans are evaluating fee-for-service models to reduce the risk of payment "clawbacks" • Given the populations of focus target the top 2-5% of high-risk members, risk-adjusted payment models should be deployed that account for varying clinical & SDOH factors
CBO & provider infrastructure & training	• Accessing certain infrastructure funds required providers & CBOs to already be contracted to services & commit to service levels (units of service, case loads)	• Providing planning grants well before go-live at the local level for prospective contracted providers will allow time for capacity building, training & collaboration
Payer & provider contracting	• Health plans frequently utilize standard contracts as CalAIM templates with non-applicable terms creating unintended complexities and requiring revisions that slow contracting • Variation in health plan requirements for contract approval make completing the process challenging & time-consuming	• Specific technical support, outreach, funding and incentives for CalAIM engagement should be tailored and provided to small/mid-size provider groups and CBOs, particularly in rural regions to achieve scale • Opportunity to improve eligibility process and data

Q&A

Appendix

ACO REACH Overview

ACO model with health equity requirements and capitated downside risk-sharing arrangements covering a Medicare Fee-For-Service (FFS) population

Timing & Eligibility

- **Applications are currently closed**. Program term continuing through PY26
- REACH ACOs must meet beneficiary minimum requirements that include:
  - Standard ACO: 5k Medicare FFS beneficiaries across plan years
  - New Entrant ACO: 3k in PY24, 4k in PY25, 5k in PY26
  - High Needs ACO: 750 in PY24, 1k in PY25, 1.25k in PY26

Key Components

- **2 downside risk-sharing levels** with risk corridors and optional stop-loss
  - **Professional:** 50% shared savings/losses rate with monthly capitation based on primary care services
  - **Global:** 100% shared savings/losses rate; REACH ACOs may receive capitation based on primary care services or all services
- **Health Equity Plan** addressing targeted health disparities in underserved communities required from each REACH ACO
  - REACH ACOs also receive a Health Equity Benchmark Adjustment based on the social needs of the aligned beneficiary population and must meet Health Equity Data Reporting requirements
- **Up to 12** Benefit Enhancements (BE) & Beneficiary Engagement Incentives (BEI) to tailor beneficiary care
  - BE & BEIs include the 3 Day SNF Rule Waiver and Nurse Practitioner and Physician Assistant Service Expansion

Quality Measures

Measure	REACH ACO Type		
	Standard	New Entrant	High Needs
Risk-Standardized All-Condition Readmission (ACR)	P4P	P4P	P4P
All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions (UAMCC)	P4P	P4P	P4P
Timely Follow-Up After Acute Exacerbations of Chronic Conditions (TFU)	P4P	P4P	
Days at Home for Patients with Complex, Chronic Conditions (DAH)			P4P
CAHPS	P4P	P4P	P4P*

High Needs ACOs will be held to pay-for-reporting (P4R) in PY23 and pay-for-performance (P4P) in PY24-PY26

- **2%** of the PY benchmark is withheld from REACH ACOs and may be earned back through performance against quality measures

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MSSP ACO Overview

ACO model with progressive upside and downside risk-sharing arrangements covering a Medicare FFS population with recent health equity changes impacting shared savings/losses amounts

Timing & Eligibility

- **Applications open annually** with agreement period term of five years
- SSP ACOs must have 5k+ assigned Medicare FFS beneficiaries in each of the three benchmark years prior to the agreement period and during each performance year

Key Components

- **Two participation tracks** with varying savings/losses rates applied after an ACO-specific minimum savings rate (MSR) & MLR are met or exceeded
  - CMS calculates the MSR/MLR rates for ACOs in Basic A & B; ACOs choose from MSR/MLR rate options in all other tracks
- ACOs may waive the **3 Day SNF Rule**

Quality Measures

1. Advanced Payment Model (APM) Performance Pathway (APP)
   - PY23-24: 10 CMS Web-Interface Measures; or 3 MIPS (CQM) measures
   - PY25+: 3 MIPS CQM or electronic (eCQM) measures
2. Health Equity Adjusted Quality Score
   - CMS applies underserved multiplier to the ACO's quality score

Track	MSSP Savings/Loss Rate by Track					
	Savings			Losses		
	If Quality Standard (QS) Met:	If QS Not Met:	NTE:	If QS Met:	If QS Not Met:	NTE:
Basic: A & B	40%	40% * ACO's health equity adjusted quality score (HEA)	10% of benchmark	N/A; upside only	N/A; upside only	N/A; upside only
Basic: C	50%	50% * HEA	10% of benchmark	30%	30%	2% of ACO participant revenue capped at 1% of benchmark
Basic: D	50%	50% * HEA	10% of benchmark	30%	30%	4% of ACO participant revenue capped at 2% of benchmark
Basic: E	50%	50% * HEA	10% of benchmark	30%	30%	8% of ACO participant revenue capped at 4% of benchmark*
Enhanced	75%	75% * HEA	20% of benchmark	40-75%*	75%	15% of benchmark

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MCP Overview

Primary care model facilitating transition from fee-for-service (FFS) to prospective, population-based payments supporting health equity and specialty care integration for practices with limited VBP experience

Timing & Eligibility

- Medicare-enrolled solo primary care practices, group practices, health systems, FQHCs & Indian Health Programs (IHP) with 125+ Medicare FFS beneficiaries in an MCP state (CO, MA, MN, NC, NJ, NM, upstate NY, WA)
- Applications **due November 30, 2023**
- **10.5-year model** term from July 1, 2024 through December 31, 2034

Key Components

- **3 distinct tracks** for varying levels of value-based experience:

MCP FINANCIAL OVERVIEW					
Tracks	Primary Care & Performance Payments			Investments	
	Primary Care Payments		Performance Incentive Payment Opportunity ↑	Enhanced Services Payment Amount ↓	Upfront Infrastructure Payment Amount ↓
	Fee-For-Service	Prospective Payment Percent ↑			
1	100%	0%	3%	$15 PBPM	$145k
2	50%	50%	45%	$10 PBPM	$0k
3	0%	100%	60%	$8 PBPM	$0k

[1] CMS projects the ESP amounts referenced in the table to be the average ESP amounts per track for MCP participants

- CMS to work with **state Medicaid departments** and **payers across lines of business** to **align** primary care incentives
- Additional model requirements include specialty care integrationt, a Health Equity Plan, and care delivery transformation development across tracks

Quality Measures

1. Controlling High Blood Pressure
2. Diabetes Hba1C Poor Control
3. Colorectal Cancer Screening
4. Person-Centered Primary Care Measures (PCPCM)
5. Screening for Depression with Follow Up
6. Depression Remission at 12 months
7. Screening for Social Drivers of Health
8. Total Per Capita Cost (TPCC)
9. Emergency Department Utilization (EDU)
10. TPCC Continuous Improvement (CI)*
11. EDU CI**

*Non-FQHCs only
**FQHCs only

- **Track 1** MCP Participants are only held to measures 1-4
- **Track 2 & 3 MCP Participants** are held to all measures
- Measures 1-7 are assessed on the MCP Participant's patient population across payors

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AHEAD Model Overview

Investment opportunity for up to 8 state agencies to receive up to $12 million to curb total cost of care growth, achieve health equity, set hospital global budgets and invest in primary care

Timing & Eligibility

State agencies in non-MCP states or substate regions with at least 10k Medicare FFS Part A and B beneficiaries are eligible to apply based on three Cohort classifications:

Cohort	Readiness	Application Due Date	Pre-Implementation Period	Performance Year Term
1	Ready to apply & implement ASAP	LOI: 2/5/24 Application: 3/18/24	July 2024 – Dec 2025	Jan 2026 – Dec 2034
2	Ready to apply but needs additional time to prepare for implementation	LOI: 2/5/24 Application: 3/18/24	July 2024 – Dec 2026	Jan 2027 – Dec 2034
3	Need additional time to apply	LOI: 7/26/24 Application: 8/12/24	Jan 2025 – Dec 2026	Jan 2027 – Dec 2034

*__LOI:__ Letter of Intent to Apply | **Application:** Cooperative Agreement Application
**Approximately 90 days from application due date to notice of award issuance

Key Components

- States will establish **investment and total cost-of-care targets**, an HEP, a model governance structure and align payors from across lines of business (LOB)
- Hospitals may voluntarily participate in global budgets across LOB
  - States must align Medicaid to global budgets by PY1 and at least one commercial or Medicare Advantage payor by PY2
- Primary care practices will receive ~$17 PBPM in **enhanced primary care payments** (supplemental to the maximum $12 million that each state could receive) and meet care transformation requirements aligned with existing Medicaid initiatives
  - Care Transformation domains include Behavioral health integration, Care coordination, Health-Related Social Needs (HRSN) screening

Quality Measures

Statewide Quality Measures: States will select a set of quality and population health measures from a menu of CMS-provided options and set targets, subject to CMS approval

Hospital Quality: Current CMS hospital quality programs will provide measures for acute care hospitals. Critical Access Hospitals (CAHs) will have a P4P program with upward adjustment for rural-relevant measures. All hospitals are eligible for a health equity improvement bonus

Primary Care Quality Measures: Five CMS-selected quality measures; states may propose alternative primary care measures that align with one of these domains.

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