

Medicaid

Medicaid Matters New York

Matters

Comments on NYS Department of Health 1115 Medicaid Demonstration Waiver Amendment Application | May 20, 2022

Medicaid Matters perspective:

Overall, Medicaid Matters supports the goal of infusing the Medicaid program with new funding with the intention of reaching greater health equity. As Medicaid consumer advocates, our interest is in:

- making sure the intended health equity outcomes are reached;
- seeing New Yorkers experience greater access to services and achieve better health and wellness; and
- ensuring that public Medicaid funds are not squandered or treated as payout to the managed care insurance industry and well-financed providers.

As Medicaid Matters' focus is on people served by Medicaid in New York, our primary interest in this waiver application is its impact on Medicaid enrollees. If the State seeks to improve individual health outcomes and meaningfully address unmet social needs, Medicaid consumers must experience engagement with health care providers, managed care organizations, and other organizations differently than they currently do. There must be tangible, structural change in this regard. The waiver amendment application does not currently describe how the patient experience and how access to health and other services will be different.

Many groups and organizations will provide comments from their own unique perspectives. Medicaid Matters urges the State to carefully consider their comments on the waiver, as they bring expertise and experience specific to certain aspects of the waiver (such as working with people who are or were incarcerated, older adults and people with disabilities with long-term needs, and more).

Issues Medicaid Matters urges New York State to consider:

Lessons learned from the Delivery System Reform Incentive Payment (DSRIP) program

- The Health Equity Regional Organizations (HEROs) described in the new waiver application would include a variety of stakeholders, including consumer representation. This should be written as a requirement and should specify consumers, consumer advocates and community members separately.
- The State must acknowledge community-based organizations (CBOs) have been doing the work to address social determinants of health, particularly in medically-underserved communities, for decades. CBOs must be at the table in decision-making capacities and built in to the governance structures of the HEROs and Social Determinant of Health Networks (SDHNs). They must be financially supported to enable and foster their participation and service provision under the new waiver.

CBOs should be compensated for staff time to participate in the work of the HEROs and SDHNs, in addition to funding for IT systems, consulting services, and infrastructure.

- Flow of funding must be as transparent as possible. The public must be able to track the funding the State receives all the way down to the entities that receive it.
- Independent oversight must be established as part of the new waiver. This function was fulfilled under DSRIP by the Project Approval and Oversight Panel (PAOP), on which the Medicaid Matters Coordinator served for over five years. Any independent oversight body should include robust and diverse consumer and community representation from across the state (more so than the PAOP), and it should convene regularly in public meetings with opportunities for public comment. It is critical that data reports be shared before they are too stale to make changes to the program.
- Performing Providers Systems in DSRIP were asked to construct elaborate sustainability plans and demonstrate how their structure and programs would continue beyond the life of DSRIP. This same focus on sustainability must be required in this new waiver initiative, and sustainability measures must be built into the evaluation of the program. The State should commit to an organized and transparent pursuit of the funding needed to guarantee the long-term existence of the HEROs without expecting them to rely on financial support from health providers or insurers who may seek to inappropriately influence HERO operations and outcomes.

Reaching greater health equity

- “Health equity” must be clearly defined; consumer representatives and community members must be included in reaching a shared, agreed upon definition. An agreed upon definition may draw from work already done in this area by groups such as [Unidos US](#). There are also a variety of resources in this area from the [American Medical Association](#), the [American Public Health Association](#), and the [Centers for Disease Control and Prevention](#). Everything about this waiver, whether it is the language used, outcome metrics, or specific goals, must be centered around the agreed upon definition of “health equity.”
- Medicaid Matters is concerned about the allocation of waiver funding. As described in the application, the funding New York is requesting will be distributed to SDHNs and toward workforce investment (such as for community health workers) on a regional basis. This would be done across the regions evenly with a small amount added to New York City. It is grossly inadequate to devote only \$15 million of the \$116 million for the SDHNs to the New York City region. New York City comprises more than 40 percent of the state population and has a significantly higher percentage of people of color than the state as a whole. The distribution of waiver funds, as described, will contribute to perpetuating structural barriers to addressing health disparities. For the waiver to reach its stated health equity goals, funding must be allocated on a population basis. Resources to address social determinants of health must be prioritized in the places where New Yorkers of color live, with attention to race, ethnicity and poverty, and where data shows prevalence of preventable chronic illness.

- The waiver application proposes statewide standards for data collection and availability and statewide and regionally-specific sets of health equity-specific quality improvement measures. It does not, however, identify the entities that will determine what those measures are or how they would be prioritized. Specificity must be built in, and consumers and consumer advocates must be part of that process.
- Non-clinical outcomes should be weighed as heavily as clinical outcomes. Examples of non-clinical outcomes include: vaccination rates; timely prenatal care visits; accessibility of consumer-facing materials; reversal rates of plans' adverse determinations in fair hearings and external appeals; and timely processing of requests for new or increased services (to name a few).
- It is critical to collect and report disaggregated data. [California](#), [Massachusetts](#), [New Jersey](#), and [Oregon](#) have recently submitted 1115 waiver applications calling for disaggregation of data by race and ethnicity and in some areas by other subgroups as well. A [new Florida law](#) requires managed care plans to stratify and publicly report performance data by age, race, ethnicity, primary language, sex, and disability (beginning in 2026). Part of newly collecting disaggregated data will be asking people to self-report their demographics. People must be informed in understandable, clear language why they are being asked for this information, what it will be used for, and how it may result in better health and access to services.
- The call for improved Medicaid data collection and reporting on health disparities is not new. There may be potential in CMS' new data reporting system, T-MSIS, for improving the quality, frequency, and transparency of health disparities data in Medicaid, [along with other approaches](#) (from the National Health Law Program, May 2021).
- The waiver should include incentives for avoiding nursing home placements (like the incentives in DSRIP for avoiding hospitalization). Metrics should be incorporated related to compliance with the *Olmstead* decision, which entitles people to services in the most-integrated setting in the community.
- The waiver amendment discusses the disproportionate impact of COVID-19 on Black, Latinx and other people of color, and refers to New York's pandemic responses that included "bringing hospital resources and staff to high-priority regions." There is, however, no discussion of how hospital resources could be re-distributed going forward so as to ensure ongoing capacity to meet the health care needs of communities of color.
- While referencing "a long history of structurally racist policies and practices in the U.S. that have contributed to inequity in health care and health disparities," the application includes no mention of how New York's own policies have contributed to inequities in the way our health delivery system is organized. The lack of health planning and reliance on a market-driven health system have over the years enabled the movement of key hospital resources to white suburban areas with commercially-insured residents, while draining resources from communities of color and rural areas with

many uninsured residents and people covered by Medicaid. The State must specifically acknowledge the inequities created by these state policies and commit to a comprehensive program of advancing equity in all health policies. This work could start with this waiver amendment and grow to encompass a wholesale review of state policies and processes that have perpetuated disparities and poor health for people of color, people with disabilities, and other underserved and marginalized communities. Examples of structural changes that must be reviewed and changed include distribution of the Indigent Care Pool and instilling the Certificate of Need process with a more intentional focus on community impact.

Managed care as the focus

- Value-based payment lead entities should be required to demonstrate how they are incorporating the work of the HEROs into their goals and anticipated outcomes. If HEROs are successfully including community members and CBOs in their structures, completing comprehensive assessments of the needs of their regions, and reporting what the region's needs are, there should be a clear connection to what the value-based payment arrangements are aiming to achieve and they should be required to demonstrate this. Funding to be directed through managed care organizations must reflect the priorities and plans developed by the HEROs, and come with requirements to demonstrate progress in achieving those priorities.
- Under the State's new waiver design, community-based organizations and providers would be providing a variety of services that managed care plans currently get paid for in their capitation, like care coordination. Managed care plans must be held accountable for the delivery of meaningful care coordination and other functions they are paid to carry out. The State should match compensation to the entities actually doing the work; CBOs should get paid more and upfront, and regular managed care capitation rates should be decreased for plans no longer doing the work they are paid to do under their capitation.
- The new waiver design has the potential for creating care management siloes, with some care management continuing at the plan level and some being carried out by CBOs providing social care. People must understand who is ultimately responsible for their services and who to turn to when they need help.
- Independent consumer advocacy services should be expanded and adequately supported to assist people who need help navigating a new environment of value-based care.
- It is unclear how people who are covered by Medicaid but not enrolled in managed care will benefit from value-based payment arrangements. The State must articulate how health equity will be reached for these groups of people.
- Medicaid managed care plans do not universally have a good track record for providing the services people are entitled to. Plans are often seen by consumers as a barrier. The State must invest in better oversight of managed care plans to restore trust and ensure greater access to services.