SOCIAL JUSTICE POLICY COLLECTIVE

Comments to the New York State Health Equity Medicaid Redesign 1115 Waiver Amendment application

Context

Total Medicaid spending in New York is $83.8 billion, with federal, State, and local shares of $48.0 billion, $27.8 billion, and $8.0 billion, respectively.

Why Medicaid reform is important.

- There are 7 million Medicaid enrollees of 19.5 million total population, or over 1/3 of New Yorkers use Medicaid as their primary insurance.
- Medicaid enrollees experience poor health outcomes related to long-standing health disparities based on race, ethnicity, disability, age, and socioeconomic status.
- There are higher rates of hospitalizations and deaths among people of color and other minority populations and people with disabilities
- The quality of, and access to, health care services in low-income and racially and ethnically diverse population groups does not meet community needs
- Current delivery systems that are built for "sick care."
- It is widely acknowledged that Social Determinants of Health (SDH) factors, rather than medical interventions and services, are the key driver for a large majority–up to 80 percent–of health outcomes

The Health Equity Medicaid Redesign Strategy

This waiver proposal is a catalyst to developing this new delivery system

- State will develop a nimble delivery system built for "well care"
- State will establish regional networks to implement policies and programs that achieve delivery system reform.
- Will create a fully integrated social care and health care program that features:
    - a more resilient, flexible, and integrated delivery system that reduces racial disparities, promotes health equity, and supports the delivery of “social care”;
    - supportive housing and alternatives to institutions for the long-term care population; and
    - a health and behavioral health system capable of responding to future pandemics and natural disasters.

Target groups

- persons living in poverty,
- Black and Latino/Latinx and other underserved communities of color,
- older adult populations,
- criminal justice-involved populations,

- high-risk mothers and children,
- persons with intellectual and developmental disabilities (I/DD),
- persons living with severe mental illnesses, persons with substance use disorders,
- and persons experiencing homelessness

New Planning and Delivery Model: Health Equity Regional Organizations (HEROs)

- create regional health networks to better coordinate the work of existing programs,
- more direct investment in and involvement of ***community-based organizations*** and ***behavioral health providers*** in governance,
- administrative simplification, and
- an alignment of provider and payer incentives.

HEROs would include:

- MCOs,
- hospitals and health systems,
- community-based providers (including primary care providers),
- accountable care organizations (ACOs) and independent provider associations (IPAs),
- behavioral health networks,
- providers of long-term services and supports, including those who serve individuals with I/DD,
- Qualified Entities (QEs) such as Health Information Exchanges (HIEs) and Regional Health Information Organizations (RHIOs),
- ***consumer representatives***, and
- other stakeholders.

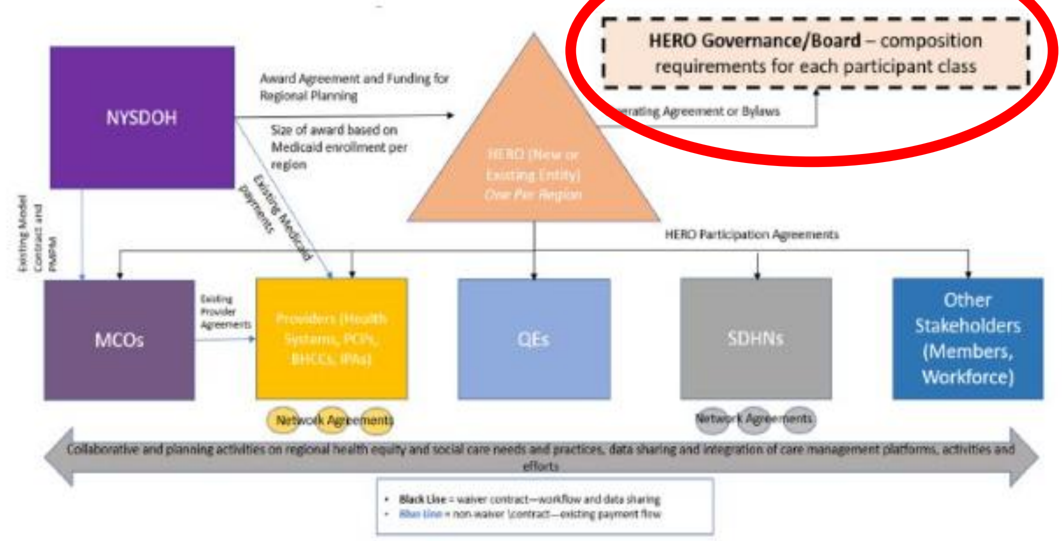
Exhibit 1: HERO Structural Diagram

Comments and Recommendations

The concept of a regional planning and service system is sound and has been used to varying degrees of success in other states and localities. The challenge for these arrangements, especially one that is striving to redirect existing Medicaid funds away from "sick care" to prevention and other forms of "social care" is deciding which entity or service is going to receive fewer resources and which services and supports will be enhanced.

Reorganizing a care system is a difficult and complex task that must be tackled by the regional governing body, indicated above in the red oval.

1. Reimaging the HERO Governance Board – A sample "health equity" approach

The stated goal of the Demonstration Project is to create a new mental health service system built on the principles of health equity, social determinants of health and "social care." Such a radically new system requires an entirely different approach to planning, implementing, and evaluating services.

Those most impacted by the service system are the people using services (service users/peers) and the entities responsible for designing and delivering the services (CBOs and other providers).

MCOs, QEs, and related network organizations are responsible for administrative tasks that can either enhance or detract from the quality of services, but they do not have a direct role in delivering services on a day-to-day basis. Furthermore, profit oriented MCOs (and many health systems) have business interests that (under current incentives) oftentimes do not align with those of service recipients and providers.

Therefore, leadership of the new regional delivery systems must actively engage and integrate service users and providers as equal partners. To do so will require not just membership on the governing board, but special provisions so their unique concerns will be incorporated into the final decisions related to strategy and the allocation of resources.

The first step would be the makeup of the board membership itself, which would include more than token representation by a "peer" and a CBO member. In the example below, seven of the thirteen members would be peers and providers and only those members who directly provide services or represent provider networks would be allowed to vote on resource allocation issues.

Health Equity Regional Organization Governance Board

- Peer Representatives (3)
- CBO Representatives (2)
- LTSS & I/DD Representatives (2)
- MCO (1)*
- Health System (1)
- Network Representatives (1)
- Qualified Entities (1)*
- Other stakeholders (2)*

*non-voting members

Rules: All decisions require six affirmative votes of the nine voting members, including at least one affirmative vote from a peer and CBO representative. The board composition must be diverse and inclusive, including at least five members from historically underrepresented groups, including people of color, women, and people who use the public mental health system.

2. Technical Support for the HERO board

In addition to affirmative and inclusive board membership, the board's work will be supported by a regional HERO coordinator hired by the board and technical staff, who are independent from any of the individual stakeholder groups and are funded by NYSDOH at a level sufficient to provide:

- research and analysis informed by national and international best practices;
- quarterly outcome metrics (as defined by NYSDOH and the board) on the performance of the HERO network, and
- manage open-ended requests for information (RFIs) and requests for proposals (RFQs) from all interested parties for programs and projects that advance the SDH and equity goals of the HERO.

3. Independent and Transparent Evaluation

Evaluating the performance of each HERO needs to happen in real time, e.g., monthly and quarterly, to quickly discern what approaches show promising results as measured against key health outcomes, and which strategies need to be improved or abandoned and replaced with a different approach. And by routinely comparing results across all of the HEROs simultaneously, state officials will be able to analyze how and why there are disparate outcomes and require low performing HEROs to adopt operating procedures shown to produce better outcomes.

Performance evaluation should be undertaken by an independent entity that has the skills and resources commensurate with the task. Ideally, such an entity would model the same inclusion and equity principles that underpin the demonstration waiver itself, i.e., both field-based researchers and project managers would have diverse backgrounds as well as technical expertise.

The overarching goal of the evaluation process would be to identify strategies that significantly improve health and behavioral health outcomes and incorporate those "social care" services and supports into the mainstream Medicaid program as soon as possible and on a continuous basis.

4. Developing Peer Leadership

Providing peers with a genuine opportunity for meaningful participation as members of planning and decision-making bodies requires an ongoing investment in recruitment and training of "non-professional" service users who, traditionally, have been excluded from these activities.

As part of the 1115 Demonstration Project, the state should invest in regional leadership academies and training programs to enhance the skills and knowledge of peers who are interested in sharing their lived experience through participation on boards, committees, and related task forces and commissions.

The topics and curriculum for these training programs could build off of several current models that train peers to access professional roles.

Sample topics could include:

- Board membership guidelines
- Roberts Rules of Order
- Conflict resolution
- How to set up and run a meeting
- How government works – local, state, federal
- Government funding and budgeting
- Medicaid insurance
- Health delivery systems

Conclusion

Committing to structural healthcare reform requires committing to reforms in what services and supports are given priority, who delivers these services, and how they are paid for. If those with the greatest vested interest in preserving the current system are allowed to assume leadership positions in the new regional planning bodies, little genuine reform will occur. The difficult task for the state is to affirmatively engage with those that have the most at stake in a quality health and behavioral system—service users and their families. Incorporating their ideas and advice will present challenges that can only be overcome through a sustained effort that allows individuals to gain sufficient knowledge and experience to assume roles on planning and decision-making bodies from which they have historically been excluded.

Submitted by Steve Coe (steve@stevecoe.us) on behalf of the Social Justice Policy Collective.

The Collective is an advocacy forum that advances programs and policies that address the needs of people living with mental health conditions and experience poverty, racism, substance use/misuse, and trauma, and who rely on public supports to meet their basic needs.

The Collective supports solutions that: are developed with the active engagement of community members and mental health service users; promote racial equity and human rights; emphasize social determinants of health, including safe affordable housing, preventive services, and community-based natural supports; are shown to be cost-effective and are highly regarded by service users; and can be replicated on a scale commensurate with the need.