



**New York State Draft 1115 Waiver Amendment
Community Health Care Association of New York State Comments
May 18, 2022**

Background

The Community Health Care Association of New York State (CHCANYS) is grateful for the opportunity to comment on the draft 1115 waiver amendment, Making Targeted, Evidence-Based Investments to Address the Health Disparities Exacerbated by the COVID-19 Pandemic. CHCANYS is the primary care association of more than 70 NYS federally qualified health centers (FQHCs), also known as community health centers (CHCs), that serve approximately 2.1 million New Yorkers each year at over 800 sites in medically underserved communities. FQHCs are non-profit, community run clinics that provide high-quality, cost-effective primary care as well as behavioral health, dental care, and social support services to everyone, regardless of their insurance coverage, immigration status, or ability to pay.

The majority of FQHC patients are extremely low income; 90% live below 200% of the Federal poverty level. FQHCs serve populations that the traditional healthcare system has historically failed: 68% are Black, Indigenous, or People of Color (BIPOC), 28% speak limited or no English, 13% are uninsured, and 4% are unhoused. Nearly 60% of our FQHCs' patients are enrolled in Medicaid, CHIP, or are dually enrolled in Medicare and Medicaid. FQHCs are a crucial safety net for New York's residents of both rural and urban areas, working tirelessly to provide healthcare and social services for people who experience poverty, racism, and discrimination that inhibits their health and well-being. As safety-net providers who have built trust and relationships in medically underserved communities, FQHCs have long worked to address health disparities and advance health equity. The waiver must prioritize and invest in primary and preventive care to further the goals of improving health outcomes and advancing health equity.

FQHC Alternate Payment Methodology (APM)

CHCANYS is pleased to see reference in the draft waiver amendment to a FQHC-specific alternative payment methodology (APM) which we believe is necessary to align care delivery models with value-based payment goals. Federal law mandates that state Medicaid programs reimburse FQHCs using a visit-based bundled payment methodology, known as the prospective payment system (PPS), regardless of contractual agreements between FQHCs and Medicaid managed care plans. However, 42 U.S.C. §1396a (bb)(6) permits an FQHC to be paid under an Alternative Payment Methodology (APM) through a State Plan Amendment (SPA), with the following conditions:

- a) the APM reimbursement is not less than what the FQHC would have received under a "traditional" visit-based PPS methodology **and**
- b) each health center individually agrees to participate in the APM.

The traditional visit-based PPS methodology incentivizes volume over value. However, a FQHC APM allows State Medicaid programs to adopt a different methodology that can support integrated care, incentivize high-quality comprehensive primary care services, allow flexibility to address patients' social determinants of health, and promote increased access to care. Without the limitation of payment tied to a narrow billable visit, health centers can adopt innovative care delivery modalities such as telehealth, remote patient monitoring, same-day visits for primary care and behavioral health, and



team-based care designed to best suit a given patients' needs. Moreover, an APM will empower FQHCs to better coordinate with community partners to provide whole person care, including addressing patients' social needs, which are known to be the root causes of health disparities.

In alignment with Medicaid goals, more than 90% of health centers have achieved NYS-specific PCMH designation. The care management, care coordination and risk stratification elements of the PCMH program have prepared health centers for a capitated APM and other value-based arrangements. CHCANYS appreciates the inclusion of an FQHC capitated APM in the waiver amendment and welcomes the opportunity to work with DOH to submit a State Plan Amendment (SPA) for a capitated APM.

Capacity-Building Investments for FQHCs and FQHC-led IPAs

FQHCs are safety net providers located in the communities that have been most adversely impacted throughout the pandemic, and were at the forefront of public health efforts, including standing up mass testing sites and vaccination efforts statewide. To address the prevention and population health goals of the waiver, recognition and targeted investment are needed to expand interventions focused on health equity and population health improvement for the large proportion of the Medicaid population served by health centers. CHCANYS requests financial investment in community health centers to prepare to implement interventions focused on health equity and population health improvement goals, including through workforce development.

Many FQHCs have formed or joined Independent Practice Associations (IPAs) in partnership with other FQHCs, primary care providers, behavioral health agencies, and Community-Based Organizations (CBOs). IPAs are the primary vehicle through which FQHCs can participate in advanced VBP arrangements while maintaining protections for Federally required FQHC rates. IPAs enable FQHCs to better address population health and coordinate with behavioral health organizations and social services agencies. IPAs are also best suited to identify high-risk FQHC patients and connect them to the appropriate level of care within the SDHN structure. However, FQHC-led IPAs remain self-funded and challenged to develop needed infrastructure. The State must make investments in FQHC-led IPAs to support the data analytic capabilities needed to effectively manage population health, drive improved outcomes, ensure connectivity with social care needs providers, and be high performers in value-based contracts. Specifically, CHCANYS requests a \$6M investment for capacity building at existing FQHC-led IPAs to strengthen FQHC engagement in VBP contracting.

Statewide Social Needs Referral Platform

CHCANYS supports the creation of a uniform statewide social needs referral platform and data warehouse. Many providers, including IPAs and health centers, have integrated referral platforms into their day-to-day operations. To ensure there is no duplication, the State must require that a statewide social needs platform leverages existing electronic workflows when feasible and is interoperable with existing popular platforms used by providers around the state. The platform must also connect with Electronic Health Record (EHR) platforms, the Statewide Health Information Network for New York (SHIN-NY), and the Medicaid Data Warehouse (MDW). Data from a statewide social care platform must be bidirectional, with referring providers and VBP networks enabled to access patient encounter details easily to ensure they can utilize the platform to inform their population health interventions in a timely manner. Social care data housed in the platform must be protected with the same security and patient



consent as medical data. To address these and other considerations, the State should convene a stakeholder group to advise the State during the procurement and/or development of a statewide platform. Additionally, upfront investments must be made to providers to support the adoption of a new social needs platform, and the platform must be a public utility; there should be no requirement for providers to purchase licenses for the platform in the post waiver period.

Data Sharing

It is widely acknowledged that timely, comprehensive patient utilization and cost data is necessary for successful VBP contracting. CHCANYS applauds the stated goal of the waiver to ensure ready access to data resources for providers. Recognizing that MCOs possess the most timely, accurate, and comprehensive data on encounters, utilization, and cost, CHCANYS requests that the State require and enforce data sharing standards from MCOs to providers for value-based contracting. Specifically, CHCANYS requests that the State update the model contract to define and enforce minimum intervals for “timely” sharing of data from MCOs to VBP contractors. Additionally, the model contract must establish minimum standards for types of data that are necessary to successfully manage value-based contracting including, but not limited to: costs at the claim level, care gap reports, and regularly updated patient attribution lists.

Standardized Assessment Tool

The waiver proposes a standardized assessment tool to determine community social care needs for Medicaid members. Many health centers have already selected and use their own social care needs screening tools, which have been integrated into their practices and electronic health records. For example, many health centers use the nationally recognized Protocol for Responding to and Assessing Patients’ Assets, Risks, and Experiences (PRAPARE) as a condition of Federal grants. A new social care screening tool disrupts and duplicates existing workflows and would be costly and time-intensive to implement. The State should standardize nationally recognized data elements, but not prescribe a single tool.

Contracting Requirements

Currently, the State sets minimum goals for dollars captured in arrangements by Level 1 and Level 2 or higher. However, these goals do not consider provider types in each Level of VBP contracting and leaves full discretion to MCOs on whether to enter into VBP arrangements with certain providers. This has restricted willing and capable community-based primary care providers from participating in VBP arrangements with certain MCOs. CHCANYS requests that the State set requirements for MCOs to enter into VBP arrangements, through a lead contractor such as a FQHC-led IPA, with health centers who meet a minimum percentage of the provider’s patients covered by the MCO.

Primary Care Attribution

Currently, the discrepancies between MCO attribution, consumer utilization, and VBP contractor rosters make it nearly impossible for health centers to effectively manage patient health outcomes. For example, a health center is currently held accountable for patients who are auto-assigned to the health center as their primary care provider, but receive primary care elsewhere, and for whom MCOs cannot provide current contact information. A primary care attribution methodology must include the ability to



add patients who receive most of their care at the FQHC and remove patients who receive the majority of care from other providers. Additionally, the attribution methodology should stipulate that patients with serious mental illness be attributed to behavioral health providers. CHCANYS requests the state to set minimum required standards for primary care-centered attribution, as opposed to the current non-binding guidelines. These required standards should include periodic (i.e., quarterly) reconciliation to actual utilization.

Workforce

CHCANYS is supportive of the waiver's expanded scope of workforce initiatives to provide a wide range of training, recruitment, and retention initiatives across the care continuum. In addition to investments through Workforce Investment Organizations (WIOs), the waiver should invest in other workforce development partners, such as Area Health Education Centers (AHECs) and community colleges, who have existing capacity to train in expertise specific to primary care.

CHCANYS is supportive of the waiver's initiative to expand the Community Health Worker workforce. To bolster these efforts, CHCANYS recommends that the State empower a governing body to standardize certification, training standards, and core competencies for CHWs. The State must also establish a long-term funding sustainability mechanism for Community Health Workers after the waiver period ends. While this initiative will improve care and expand career pathways, the waiver should also invest in development of career pathways and care delivery improvement through other health care titles as well, such as dental support staff, nationally certified Medical Assistants, health educators, and care managers.

The ability to provide visits remotely has enhanced FQHCs' ability to attract behavioral health providers, as well as other needed health professionals. However, telehealth reimbursement disparity for FQHCs remains a barrier. FQHCs continue to incur fixed personnel costs along with operation and maintenance of their physical sites and telehealth infrastructure regardless of provider and patient locations. A recent survey of CHCANYS members found that among all telehealth (audio only and audio visual) visits, about 17% occur with both the patient and the provider offsite. That same survey of CHCANYS members found that nearly 60% of behavioral health visits are occurring remotely, and 16% of those are occurring with both the patient and the provider located offsite. Given the increased need for behavioral health services since the beginning of the pandemic, recruitment for behavioral health providers is extremely competitive and nearly impossible when searching for multi-lingual providers. Full telehealth payment parity is needed regardless of provider and patient location to ensure that FQHCs have the most flexibility to recruit and retain providers and to meet the care needs of patients.

In addition to the workforce challenges listed above, New York is experiencing a workforce shortage of dental providers, including dentists, dental assistants, and dental support staff. FQHCs have built robust oral health programs. However, improving oral health outcomes will require that many kinds of providers offer oral health services and that effective approaches embed oral health services across community institutions. Benefits already accrue from initiatives to provide oral health services in the places where people already gather or go: Head Start programs, schools, pediatricians' offices, and community health centers. Additional investment and attention are needed to expand the dental health workforce and increase access to high quality dental care.



Governance

Given their patient attribution and ability to advance primary care and prevention, FQHCs must be represented in HERO governance and must be meaningful partners in HERO and SDHN networks and have representation on Clinical Advisory Groups. FQHC-led IPAs, who serve as the VBP contractor for many health centers, and School Based Health Centers (SBHCs), who provide medical, mental health and social services to meet the needs of their students and families, must also be incorporated into HERO and SDHN governance to leverage their existing work and avoid duplication of resources and effort.

Special Populations

CHCANYS supports enrolling justice-involved populations into the Medicaid program 30 days prior to release in alignment with the State's and FQHCs' shared goal to advance health equity. Doing so will ensure critical supports are in place to ensure continuity of care and address social determinants of health when justice-involved individuals transition back to their communities.

CHCANYS also urges the State to include children as a subpopulation of focus in the waiver, specifically Early Childhood 0-3 years. Current primary care models inadequately fund comprehensive child and family needs including caregiver-child relationships, universal screening, social-emotional development, social care needs, and maternal mental health. CHCANYS supports the overall goals of the First 1,000 Days Preventative Pediatric CAG, as outlined in their [October 2019 Final Report](#). These goals can be furthered through the waiver by developing advanced Early Childhood primary care VBP models that incentivize and enable FQHCs to operationalize the outlined NYS Model of Pediatric Population Health.

Health Equity Measures and Interventions

CHCANYS is supportive of the establishment of a statewide measure set through Clinical Advisory Groups (CAGs). A statewide menu of quality metrics will allow HEROs to adopt measures best suited for their region's population, will standardize measures across plans, and will enable contractors to better meet quality targets. Additionally, the state should set and enforce a maximum total number of quality measures that can be included in a VBP contract.

The standard for "evidence-based" interventions referenced in the waiver may be prohibitive in areas where there is not sufficient literature to meet this standard. Instead, the Health Equity interventions should be based on national standards, such as those under development by the National Committee for Quality Assurance (NCQA).

Contact

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