The 2023 Medicaid Conference

Charting a Path to Equitable Integration

July 20, 2023

United Hospital Fund

Improving Health Care for Every New Yorker
The 2023 Medicaid Conference Agenda

8:30am    Networking Coffee Hour, sponsored by Acentra Health
9:30am    Welcome
9:45am    State of the State of New York Medicaid Keynote
11:00am   Break
11:15am   Strategies for Providing Substance Use Disorder Treatment and Care to Medicaid Members Panel
12:30pm   Lunch
1:30pm    Challenges in Providing Primary Care to Medicaid Members Panel
2:45pm    An Equitable Model to Integrate Care Keynote
3:30pm    Closing

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The 2023 Medicaid Conference Welcome & Keynote

State of the State of New York Medicaid

9:30-11:00am

• Oxiris Barbot, MD, President and CEO, United Hospital Fund
• Melinda Abrams, MS, Executive Vice President for Programs, The Commonwealth Fund
• Amir Bassiri, MSW, Medicaid Director, New York State Department of Health

#UHFMedicaid2023
Medicaid in New York 2023 Conference
United Hospital Fund

Amir Bassiri
Medicaid Director, Office of Health Insurance Programs
New York State Department of Health
Today’s Agenda

Public Health Emergency (PHE) Unwind
- Recap/Timeline
- Unwind Metrics
- E14 Waivers and Other Member Resources

1115 Update
- Status of Waiver Negotiations
- Update on Waiver Components/Framework

2023-2024 Medicaid Budget
- Budget Highlights and Alignment with 1115
- Budget Spotlights: Primary/Preventive Care and Behavioral Health Investments

07/20/2023
## Acronyms to Know

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
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<tbody>
<tr>
<td>AVS</td>
<td>Asset Verification System</td>
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<tr>
<td>CBOs</td>
<td>Community Based Organizations</td>
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<tr>
<td>CHP</td>
<td>Child Health Plus</td>
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<td>CMS</td>
<td>Centers for Medicare and Medicaid Services</td>
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<tr>
<td>CSEU</td>
<td>Child Support Enforcement Unit</td>
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<tr>
<td>DOH</td>
<td>Department of Health</td>
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<tr>
<td>HRA</td>
<td>Human Resource Administration</td>
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<tr>
<td>LDSS</td>
<td>Local Department of Social Services</td>
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<tr>
<td>MAGI</td>
<td>Modified Adjusted Gross Income</td>
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<tr>
<td>MBI-WPD</td>
<td>Medicaid Buy in for Working People with Disabilities</td>
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<tr>
<td>MCO</td>
<td>Managed Care Organization</td>
</tr>
<tr>
<td>MMC</td>
<td>Medicaid Managed Care or Mainstream Managed Care</td>
</tr>
<tr>
<td>MOE</td>
<td>Maintenance of Effort Period</td>
</tr>
<tr>
<td>non-MAGI</td>
<td>Non-Modified Adjusted Gross Income</td>
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<tr>
<td>NYSoH</td>
<td>NY State of Health</td>
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<tr>
<td>PHE</td>
<td>Public Health Emergency</td>
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<tr>
<td>RFI</td>
<td>Request for Information</td>
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<tr>
<td>SHO</td>
<td>State Health Officer</td>
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<tr>
<td>SPA</td>
<td>State Plan Amendment</td>
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<tr>
<td>TPHI</td>
<td>Third Party Health Insurance</td>
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<tr>
<td>WMS</td>
<td>Welfare Management System</td>
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PHE Unwind Update
As the Public Health Emergency comes to an end, New York is required to begin redetermining Medicaid eligibility. The below outlines the key dates New York is working toward:

<table>
<thead>
<tr>
<th>Month</th>
<th>Event</th>
</tr>
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<tbody>
<tr>
<td>Mar 2023</td>
<td>Renewal packets sent for 6/30/23</td>
</tr>
<tr>
<td>Apr 2023</td>
<td>HRA new apps return to normal rules*</td>
</tr>
<tr>
<td>May 2023</td>
<td>First discontinuances are effective*</td>
</tr>
<tr>
<td>Jun 2023</td>
<td>Last unwind renewal packets for 5/31/24</td>
</tr>
<tr>
<td>Jul 2023</td>
<td>Last renewals processed</td>
</tr>
<tr>
<td>Aug 2023</td>
<td>Last renewals effective</td>
</tr>
<tr>
<td>Sep 2023</td>
<td>Rest of State LDSS new apps return to normal rules*</td>
</tr>
<tr>
<td>Oct 2023</td>
<td>First discontinuances are effective*</td>
</tr>
<tr>
<td>Nov 2023</td>
<td>Last unwind renewal packets for 5/31/24</td>
</tr>
<tr>
<td>Dec 2023</td>
<td>Last renewals processed</td>
</tr>
<tr>
<td>Jan 2024</td>
<td>Last renewals effective</td>
</tr>
<tr>
<td>Feb 2024</td>
<td>NYSOH new apps return to normal rules*</td>
</tr>
<tr>
<td>Mar 2024</td>
<td>First discontinuances are effective*</td>
</tr>
<tr>
<td>Apr 2024</td>
<td>Last unwind renewal packets for 5/31/24</td>
</tr>
<tr>
<td>May 2024</td>
<td>Last renewals processed</td>
</tr>
<tr>
<td>Jun 2024</td>
<td>Last renewals effective</td>
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</table>

*New applications returning to normal rules and discontinuances started July 2023 and continue throughout

07/20/2023
DOH is working with CMS to monitor the monthly cohorts going through the unwind. As of June 30, 2023, 72.05% (402,708) of the 558,923 individuals included in the June 2023 cohort have renewed their coverage in NYSOH and at the LDSS. This includes CHP, MA, and EP with June 30th renewal dates.

DOH continues to use strategies to ensure that members keep Medicaid eligibility where possible and provide alternative options for members who do not retain Medicaid eligibility

- Utilizing ex parte for MAGI members
- Minimizing the information beneficiaries must complete
- Accepting beneficiary images of completed paperwork
- Collaborating with the United States Digital Services (USDS) to reduce likelihood of procedural disenrollments
- Utilizing various E14 Waivers

**DOH is utilizing E14 Waivers throughout the Unwind**

New York has submitted a series of E14 Waivers to:
- Reduce churn during the unwind (reducing the chance of eligible members losing Medicaid for procedural reasons)
- Allow NY to return to normal operations more seamlessly
- Allow NY to more efficiently enroll eligible individuals
- Make keeping Medicaid easier on many members

These E14 Waivers are approved by CMS, and DOH will be holding a webinar.

07/20/2023
DOH is tracking member renewals across various metrics, including age, race/ethnicity, preferred written language, and county/region.

This map represents the percentage of enrollees in each region who have completed renewal by program for the most recent renewal cohort.

https://info.nystateofhealth.ny.gov/PHE-unwind-dashboard

07/20/2023
Helping members through the unwind:

NYS utilizes assistors who are trained to educate and provide enrollment assistance to individuals and families through NY State of Health. There are three kinds of assistors:

- **Certified Application Counselors (CACs)**
- **Marketplace Facilitated Enrollers (MFEs)**
- **Navigators**

77% of the individuals enrolled through the marketplace had the help of an assistor.

In addition to assistors for NY State of Health, there are resources to support the aged, blind, and disabled population with the submission of applications and renewals to Local Departments of Social Services.

Assistor data as of 6/30/23
Out-of-Home Ad Samples
New York has also created materials for members to use during the unwind, such as brochures and FAQs. Additionally, a member webinar will be scheduled soon.

How can you help?

- Remind members to update their information, especially their address.
- Direct members to resources, like the below FAQs:
  - **NYSOH** - [https://info.nystateofhealth.ny.gov/frequently-asked-questions-about-renewals](https://info.nystateofhealth.ny.gov/frequently-asked-questions-about-renewals)
  - **NYC HRA** - [https://info.nystateofhealth.ny.gov/sites/default/files/PHE%20Tool%20Kit%20-%20FAQs%20for%20LDSS-HRA%20enrollees.pdf](https://info.nystateofhealth.ny.gov/sites/default/files/PHE%20Tool%20Kit%20-%20FAQs%20for%20LDSS-HRA%20enrollees.pdf)
  - **LDSS** - [https://info.nystateofhealth.ny.gov/sites/default/files/PHE%20Tool%20Kit%20-%20FAQs%20for%20LDSS-HRA%20enrollees.pdf](https://info.nystateofhealth.ny.gov/sites/default/files/PHE%20Tool%20Kit%20-%20FAQs%20for%20LDSS-HRA%20enrollees.pdf)
1115 Update
New York is in the final stages of negotiating its New York Health Equity Reform (NYHER) 1115 Waiver Amendment Update with CMS.

**Overall Goal:** “To advance health equity, reduce health disparities, and support the delivery of social care.”

- New York seeks to build on the investments, achievements, and lessons learned from the DSRIP to scale delivery system transformation, improve population health and quality, deepen integration across the delivery system, and advance health-related social need (HRSN) services.
- Importantly, the amendment will allow for the standardization and collection of data that will allow the state to stratify measures to evaluate impacts on underserved communities, enhance Medicaid services to best serve all populations, and implement social risk adjustment.
- This would be achieved through targeted and interconnected investments that will augment each other, be directionally aligned, and be tied to accountability. These investments focus on:
  - Population Health
  - Social Care Networks
  - Strengthening the Workforce

*Draft: Subject to CMS Negotiations*
DOH is still in negotiations with CMS on the final waiver components included in the amendment.

1115 Waiver Update

Waiver Negotiations

Social Care Networks (SCN) and Health Related Social Needs Services (HRSN)

Strengthening the Workforce

Primary Care Delivery System Model

Stabilizing the Safety Net & Advancing Accountability

Health Equity Regional Organizations (HEROs)

Targeted In-Reach Services for Criminal Justice-Involved Population

Digital Health and Telehealth Infrastructure

Draft: Subject to CMS Negotiations

07/20/2023
Health Equity Regional Organization (HEROs)

A single statewide independent HERO entity is intended to bring a diverse and comprehensive range of stakeholders together to collaboratively support:

1. **1115 Waiver Update**
   - Work with partners in each region to identify regional health equity goals/priorities, service delivery and workforce related gaps contributing to health disparities, and target health and social needs-related interventions that address regional needs and priorities.

2. **Regional Needs Assessment & Planning**
   - Work with newly aggregated data and feedback from regional partners to identify VBP goals and models that address the health and social needs of the region and address the most impactful health equity priorities.

3. **VBP Design & Development**
   - Perform an ongoing review of waiver programs and access to new services to support continuous improvement in program design and implementation and quantify the impact on underlying regional health equity priorities.

4. **Program Evaluation**
   - Bring together and distribute information on health outcomes, health care utilization and social care needs to support population health improvement activities under the waiver.
Population Health & Health Equity Improvement Overview

Proposed Goals:
- Build on the achievements, such as PCMH, of the Delivery System Reform Incentive Program (DSRIP);
- Improve population health and health equity, with a particular focus on reducing health disparities for children, pregnant and postpartum individuals, and high-risk adults;
- Further care coordination and the integration of behavioral health, specialty care, and HRSN services; and
- Move toward advanced payment models that leverage multi-payer alignment.

Proposed Components:
- Primary Care Delivery System Model
- Stabilizing Safety Net Providers & Advancing Accountability

Primary care forms the foundation of a high-performing health care system and population health.

At a time when Medicare and Medicaid beneficiaries most need accessible, affordable, high-quality primary care to meet their rising needs and coordinate their care journey through increasingly fragmented expensive systems, primary care faces existential challenges to its core functions and modes of operation (NASEM 2021).
In 2020, the national average of spending on primary care was 12.1%. New York had one of the lowest percentages of spending on primary care where data was available at 8.2%.

Multi-payor models that align payment and quality will contribute to NYS having a more successful primary care system and Making Care Primary (MCP) is one of them.

Over the next two sections, you will notice that the waiver and budget will both play roles in improving NYS’ primary care system.
Primary Care Delivery System Model

Multi-Payor Alignment to Advance Primary Care

- New York will implement a statewide approach to advancing primary care that invests in primary care and enables Medicaid primary care providers to move forward advanced VBP arrangements, complementary to those found in upcoming CMMI models
  - This will have a special focus on care for children and moving further towards VBP
- **Eligibility:** All Patient Centered Medical Home (PCMH) primary care practices
- **Structure:**
  - **Years 1-2:** All PCMH practices would receive enhanced PMPMs for their Medicaid Managed Care members
  - **Year 3:** Transition enhanced payments to a bonus payment structure, linking payments to quality and efficiency
- After the current 1115 demonstration period, this funding would be transitioned to an advanced value-based payment model

Making Care Primary (MCP) is a new, voluntary Medicare primary care model for which CMS is starting to accept applications. Through MCP, investments in primary care are increased so patients can access more seamless, high-quality, whole-person care.

The 1115 will complement MCP through PCMH investments and aligned quality measures to enable primary care organizations to support multi-payor alignment and provide Medicare and Medicaid beneficiaries with integrated, coordinated, person-centered care that improves population health outcomes.
Goal: Stabilize and Transform Targeted Voluntary Financially Distressed Hospitals to Advance Health Equity and Improve Population Health in communities with the most evidence of health disparities

Potential Structure: Provide incentive funding to stabilize financially distressed safety net hospitals and develop necessary capabilities to participate in advanced VBP arrangements, integration with primary care, behavioral health, and HRSN services. Incentive payments would be tied to transformational activities and quality improvement measures, including those related to health equity.

DOH will award one Social Care Network (SCN) per region (with up to five awards in New York City). Each SCN will be a designated Medicaid provider and serve as the lead entity in their region for:

Next, well look at:

- **Scope of HRSN Services**
- **Screening and Referral Process Flow**
- **SCN Flow**

What lessons learned from DSRIP by stakeholders will help form successful SCNs?
### Standardized HRSN Screening
- Screening Medicaid Members using questions from the CMS Accountable Health Communities HRSN Screening Tool and key demographic data

### Housing
- Navigation
- Community transitional services
- Rent/utilities
- Pre-tenancy and tenancy sustaining services
- Home remediation and education
- Home accessibility and safety modifications
- Medical respite

### Nutrition
- Nutritional counseling and classes
- Home-delivered meals
- Medically tailored meals
- Fruit and vegetable prescription
- Pantry stocking

### Transportation
- Reimbursement for public and private transportation to connect to HRSN services and HRSN case management activities

### Case Management
- Case management, outreach, referral management, and education, including linkages to other state and federal benefit programs, benefit program application assistance, and benefit program application fees
- Connection to clinical case management
- Connection to employment, education, childcare, and interpersonal violence resources
- Follow-up after services and linkages

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**1115 Waiver Update**

**Social Care Networks HRSN Services**

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**Draft: Subject to CMS Negotiations**

07/20/2023
Screening & Referral for HRSN Services

Screening
- MCOs
- SCN lead entity
- CBOs designated to screen
- Providers

Screening informs eligibility determination

Eligibility
SCN determination on eligibility for service pathway
SCN makes eligibility determination is a combination of (1) Enrollee information and (2) Results of HRSN screening will inform navigation to the appropriate services

Referral
- SCN makes referral to navigation services
- SCN makes referral to enhanced services

Services
- Existing state and local healthcare infrastructure

Key
- Navigation to existing services
- Enhanced Services

07/20/2023
Initial HRSN Funds Flow

CBOs that are part of the network will be paid based on a fee schedule for services delivered to members.

0 State Directed Payments to MCOs

1 Infrastructure Funding

2 SCN Payments

3 Payments per delivered service to CBOs for screening + delivery of HRSN services

- NYS
  - Submit social care encounters to NYS

- MCO
  - SCN Data & IT platform
    - Submit social care claim
    - Generate social care claim

- SCN

- CBO

Draft: Subject to CMS Negotiations
Strengthen the Workforce

The NYHER amendment will invest in workforce initiatives to support advancing health equity and addressing high demand workforce shortages to improve access to and quality of services.

Elements:

- **Career Pathways Training Programs**
  - Development of training programs to support recruitment and career pathways for new and existing health care workers.

- **Loan Forgiveness**
  - Loan forgiveness for primary care physicians, psychiatrists, nurse practitioners, pediatric clinical nurse specialists, and dentists who commit to work for Medicaid-enrolled providers in specified healthcare shortage areas.

- **Workforce Investment Organizations (WIOs)**
  - High-performing Workforce Investment Organizations (WIOs) will manage training programs for incumbent workers and workers newly entering the workforce, with a focus on high-demand direct care titles that provide health, behavioral health, and social care.
2023-2024 Budget Update
2023-2024 Budget Update

Overview of Medicaid Spending under the Enacted Budget

- CY 2023 began with approximately 7.8 million individuals enrolled in Medicaid.
- Enrollment is projected to decline in FY 2024 to 6.9 million individuals.
- This is due to the redetermination of eligibility for all Medicaid enrollees (unwind) starting in April 2023 and ending in May 2024.

### Summary of Medicaid Spending All Funding Sources

<table>
<thead>
<tr>
<th>Medicaid Spending ($ in Millions)</th>
<th>FY 2023</th>
<th>FY 2024</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Medicaid</strong>*</td>
<td>$98,965</td>
<td>$108,672</td>
<td>$9,707</td>
</tr>
<tr>
<td><strong>DOH Global Spending Cap</strong></td>
<td>$26,161</td>
<td>$28,110</td>
<td>$1,949</td>
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</tbody>
</table>

*Includes the Essential Plan.

**Department of Health (DOH) Medicaid spending not subject to the Global Cap Index includes certain Medicaid spending in other agencies, administrative costs, such as the takeover of local administrative responsibilities, costs related to a portion of the takeover of local government expenses, and costs related to State mandated increases in the minimum wage and other wage enhancements.
The budget demonstrates New York’s commitment to enhancing and expanding access to mental health services to ensure people receive the support they need in the most appropriate and effective setting.

And continues to support agencies’ responses to the pandemic, combat the opioid epidemic through harm reduction and innovations in treatment and recovery programs, and fund initiatives to ensure access to care and supportive services.
The 2023-2024 enacted budget also has wide-ranging investments to promote Primary and Preventive Health that complement the goals of the 1115 Waiver.

- Benchmarking primary care reimbursement to 80% of Medicare
- Statewide Expansion and Higher Reimbursement for Doula Services
- Universal Hepatitis C (HCV) Screening
- Increased vaccine administration fees to expand access to children
- Coverage for Adverse Childhood Exposures (ACEs) Screening
- Increased reimbursement for School Based Health Centers
- Investments in Supportive Housing
- Updated Integrated Licensure Standards
- Community Health Workers (CHW) Expansion to serve more populations (including high-risk populations, maternity, children under 21, etc.)
- Expanded Coverage for Nutritionist Services
Questions
The 2023 Medicaid Conference Morning Panel

Strategies for Providing Substance Use Disorder Treatment and Care to Medicaid Members

11:15am-12:30pm

- Ken Shatzkes, PhD, Program Director, Foundation for Opioid Response Efforts (FORE)
- Shonny Capodilupo, LCSW, Senior Director of Behavioral Health Services, Open Door Family Medical Center
- David Collymore, MD, MBA, Chief Medical Officer, Acacia Network
- Daniel Schatz, MD, Medical Director for Substance Use Services, NYC Health + Hospitals

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The 2023 Medicaid Conference Afternoon Panel

Challenges in Providing Primary Care to Medicaid Members

1:30pm-2:45pm

• Alex Brandes, JD, MPH, Director of Medicaid Institute, United Hospital Fund
• Adam Aponte, MD, MS, FAAP, Chief Medical Officer, Boriken Neighborhood Health Center
• Paulo Pina, MD, MPH, FAAP, Network Pediatric Medical Director, Family Health Centers at NYU Langone Health
• Stephanie Wang, MD, FACP, Senior Medical Director of Care Transitions & Population Health, Mount Sinai Morningside and West Hospitals
The 2023 Medicaid Conference Keynote & Closing

An Equitable Model to Integrate Care

2:45pm-3:45pm

• Kathleen Noonan, JD, President and CEO, Camden Coalition
• Oxiris Barbot, MD, President and CEO, United Hospital Fund
• Dan Brillman, MBA, Co-Founder and CEO, Unite Us

#UHFMedicaid2023
Strengthening ecosystems and helping people with complex health and social needs

Kathleen Noonan
President & CEO, Camden Coalition

July 20, 2023
Through trial and error, we have learned:

1. Short-term care management alone cannot remedy lifetimes of complexity and embedded inequities

2. It really does take an ecosystem (teaming and collaboration is key)

3. To truly move the needle, we need to work simultaneously toward individual-level outcomes and ecosystem change metrics
We started in Camden City focused on people who accounted for a disproportionate amount of healthcare.

- 10% of patients = 74% of receipts
- 1% of patients = 30% of receipts

Number of patients
Bedside engagement

Care team & community visits

Measuring readmissions & connection to care

Addressing health & social needs
The people we help are like Charlie…
We wanted to address the fragmentation leading to poor outcomes.
The research question we asked: At 180 days after a hospital discharge, do patients enrolled in the Camden Core Model experience a lower rate of hospital readmissions?
The answer: Lifetimes of complexity and embedded inequities cannot be remedied by short-term care management. We need broader ecosystem change and multi-faceted measures of success.
As we reflected on the results, we asked our Community Advisory Committee what they valued.

We were obviously asking the wrong question. We need to ask better questions.

Nothing works overnight; everything is a process. Building people up who have mental health issues, health issues, spiritual issues is a process.

Think you measure how much people are involved with their community or their family.

Where do we go from here because they said it is not making a difference, but it is making a difference to us.
We realized we couldn’t do it alone. It took stronger partnerships and collaboration.
Ecosystem of care - a local network of organizations, sectors, fields, and/or professions working collectively to address the root causes of poor health among individuals with complex health and social needs.
Charged with marching orders from our CAC, we started to envision an equitable ecosystem of care.
We also created a new organizational goal for ourselves. By 2025, confront inequities and system failures by strengthening the ecosystems of care for 500 communities in Camden, across New Jersey and around the country.
The Coalition’s six domains of a strong ecosystem is now a focus of our measurement along with individual metrics.
A well-prepared, diverse, interprofessional workforce that is supported to deliver high quality, person-centered care.

- **Workforce**
  - **Teaming and collaboration**: Care team members are collaborating and coordinating internally and externally (across organizations and sectors).
  - **Training in core competencies**: Staff are trained in complex care competencies, including principles and approaches described by the Camden Coalition here: [https://camdenhealth.org/work/complex-care-core-competencies/](https://camdenhealth.org/work/complex-care-core-competencies/)
  - **Community Representation**: Workforce is reflective of the communities being served and includes people with lived experiences, and/or community health workers in clinical and non-clinical roles.
Services for participating population(s) that are accessible and effective.

- **Whole-person care management**: Services to address the needs of participants are coordinated among different providers and across medical, behavioral health, and social care systems to ensure a person's goals and care plan are met.
- **Screening and Referrals**: Ecosystem partners screen participants for multiple social needs, provide relevant and effective referrals, and are able to track and respond to referral outcomes.
- **Performance monitoring**: Ecosystem partners continuously monitor the continuum of services needed by participants, routinely evaluate the quality, equity and outcomes of provided services, and engage in quality improvement activities to improve services.
- **Best practices and innovation**: Commitment to best practices in care delivery through use of culturally appropriate, evidence-based programs and innovation through piloting promising practices to inform the development, scale, and spread of effective programs. Ecosystem partners routinely disseminate learning.
Quantitative and qualitative data to identify and understand participating populations, continuously measure and improve the delivery of care and support.

- Community data sharing infrastructure
- Participant engagement in data sharing
- Analytics and workflows
- Shared quality metrics

**Limited Level 1**
Data is consistently shared across ecosystem partners for joint purposes.

**Promising Level 2**
Participants receiving services within the ecosystem are aware of and have consented to their data being shared by ecosystem partners, have input into how their data are being used by partners, and are able to review their own data.

**Strong Level 3**
Ecosystem partners have access to sufficient cross-sector, population-level data sets that are used to understand the populations served, inform program design and workflows, and to assess outcomes.

**Advanced Level 4**
Acknowledging the value of shared metrics, ecosystem partners consistently track agreed-upon metrics to measure the quality and effectiveness of their joint efforts. Service participants in the ecosystem have meaningful input into the metrics used.
For example, our Pledge to Connect initiative attempts to strengthen three domains, as well as increase participant’s connection to mental health services.
Our Safer Cities work is focused on other ecosystem domains in addition to pre-natal care initiation rate.
We are starting to share this framework with others in communities across the country.
We are also creating a new online curriculum to create a shared framework for complex care.

*The report "Core Competencies for Complex Care Providers" can be found at: camdenhealth.org/core-competencies/*
1. Lifetimes of complexity and embedded inequities cannot be remedied by short-term care management.

2. It really does take an ecosystem (teaming and collaboration is key).

3. To truly move the needle, we need to work simultaneously toward individual-level outcomes and ecosystem change metrics.
Join your colleagues in complex care at
Putting Care at the Center 2023
Nov. 1-3, 2023 in Boston, MA

Register now for our annual conference for the complex care field and learn more about:

• Sponsorship opportunities
• Interprofessional CEUs
• Discounts
• Virtual access for those unable to travel

camdenhealth.org/annual-conference | #CenteringCare23
Thank you

Kathleen Noonan
knoonan@camdenhealth.org
Thank you for attending the 2023 Medicaid Conference!
The 2023 Medicaid Conference Acknowledgements

This conference was supported by funding from the Commonwealth Fund, Unite Us, Acentra Health, findhelp, NYSTEC, Public Health Solutions, Big Apple Event AV, and the New York Academy of Medicine. All speakers, moderators, and panelists were generous with their time and insights. Many UHF staff persons contributed to the success of the conference, including James Andrews, Catherine Arnst, Emily Arsen, Denise Arzola, Oxiris Barbot, Giovanna Braganza, Alex Brandes, Hillary Brown, Adam Fifield, Joan Guzik, Hollis Holmes, Amy Lin, Susan Olivera, Anna Quinn, Emily Regas, Joey Rodriguez, Sally Rogers, Chad Shearer, Amanda Williams, and Sarah Wylie.
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