# 1115 Waiver Demonstration Conceptual Framework:

# A Federal-State Partnership to Address Racial Disparities Exacerbated by the COVID-19 Pandemic

*New York State Department of Health
Office of Health Insurance Programs*

New York State (NYS or the State) requests [$12] billion over five (5) years to fund an 1115 Waiver Demonstration to address the inextricably linked health disparities and systemic health care delivery issues that have been both highlighted and intensified by the COVID-19 pandemic. In NYS, the COVID-19 pandemic has been particularly detrimental to vulnerable populations with historical health equity disparities, including persons living in poverty, older populations, high-risk mothers and children, persons with intellectual and developmental disabilities, persons living with severe mental illnesses, persons with substance use disorders, and Black and Brown communities. Achieving an equitable recovery from the COVID-19 pandemic while advancing other long-standing delivery system reform goals of NYS requires a transformational, regionally focused effort across all sectors of the health care delivery system and, particularly, for the health care safety net.

In response, the State proposes its most ambitious partnership yet with the Federal government that has the potential to stabilize and transform New York’s safety net, promote community based and non-institutional care, better integrate health care and social care, leverage emerging technologies and care models, and ensure readiness for future health care emergencies. Through the multi-faceted efforts in this demonstration, NYS anticipates that it will be able to reduce long standing racial and socioeconomic health disparities, increase health equity through measurable improvement of clinical quality and outcomes, and keep overall Medicaid program expenditures budget neutral to the federal government.

This proposed waiver demonstration would include major investments in ***five*** core project areas:

1. **Direct Investments to Build a More Resilient, Flexible and Integrated Delivery System that Is Able to Reduce Racial Disparities and Promote Health Equity**: The COVID-19 pandemic highlighted and, in some cases, exacerbated the impact of long-standing health disparities based on race, ethnicity, and socioeconomic status. Specifically, the COVID-19 pandemic and its higher rates of cases, hospitalizations, and deaths among people of color and other minority populations due to their higher burdens of disease, over representation in low-wage essential jobs, increased likelihood of living in multi-family or multi-generational housing, and other factors demonstrated how pervasive health inequities are in NYS.[[1]](#footnote-1) Additionally, based upon existing measurement sets and data collection efforts, including the biennial *New York State Health Equity Report*, the quality of and access to health care services in low-income communities and among racially and ethnically diverse population groups reflects a health care delivery system that is not designed to meet community needs and eradicate health disparities.[[2]](#footnote-2) The COVID-19 pandemic also revealed that the hospital system throughout NYS needed to be better prepared to support a cohesive pandemic response, including the ability for stronger health care systems to assist safety net hospitals in ethnically diverse and medically underserved areas.

To achieve these goals, this waiver demonstration proposed three, upfront direct investments within demonstration year 1 for a total expenditure of $XX billion:

* 1. **Prepare for Health System Transformation in Underserved Areas:**The health care delivery system in underserved areas is frequently characterized by hospitals without the resources to provide the highest quality care. Specifically, there is often an overreliance on hospital-based care, while at the same time insufficient integration of physical health and behavioral health services, inadequate access to ambulatory care services, and a failure to address the underlying social determinants of health. As outlined below, to address these issues, this demonstration would authorize hospitals and health systems--in collaboration with other health and social care providers in newly constituted regional entities--to pursue All Payer Global Budget Pilots, implement advanced value-based payment (VBP) arrangements that support integration of downstream providers and community-based organizations (CBOs), deliver intensive care management for the highest cost/highest need patients, implement workforce training to provide hospital staff the skills they need to work effectively in an ambulatory care environment, and provide the information technology (IT) and business process infrastructure to coordinate these efforts across all health care and social care providers in the region. These strategies will enable the transformation away from hospital-centric delivery of care to distributed ambulatory networks that provide easier and more efficient access necessary to address acute and chronic health disparities that result in not only a lower quality of life in non-pandemic times but also higher morbidity and mortality during a pandemic. Accordingly, this funding pool would provide an upfront and direct investment to safety net health care systems to stabilize their operations and ensure appropriate patient care access post-COVID-19, such that these hospitals and health systems can then invest more aggressively in their transformation through other components of this waiver demonstration.
	2. **Strengthen the Capacity of the Hospitals and Health Systems to Respond to Future Pandemics:** Concurrent with the goals of this waiver demonstration to continue the transformation away from hospital-centric care and achieve an equitable pandemic recovery, the COVID-19 pandemic also revealed that NYS must have a ready-to-execute strategy to respond to a significant increase in hospitalizations attributable to a pandemic. This response must include access to a sufficient number of hospital beds, a trained workforce to manage increased hospitalizations, and the IT and business process infrastructure to make the system work effectively. Properly designing and building the necessary flexibility into the hospital system that provides for a coordinated and sufficient increase in staffed operating beds above what is needed in non-emergent times is critical for both a sufficient pandemic response as well as a sustainable health care delivery system. These initiatives include:
		1. *Training.* Most critically, ensuring an available and cross-trained workforce that is able to respond to a large influx of patients, which would include training of clinical staff (e.g., physicians, nurses) to maintain skills outside of core areas of expertise--including cross-coverage between inpatient and ambulatory care settings--but consistent with their scope of practice, training of non-clinical staff to do atypical and non-routine pandemic-related tasks, and developing a staffing plan that will remobilize this cross-trained staff among newly competent tasks.
		2. *Physical and IT Infrastructure Preparation and Planning.* Improving the capacity of distressed and safety net hospitals in medically underserved areas to update their oxygen, electrical and IT systems, as well as rapidly engage in planning and preparation for the rapid, technology-enabled conversion of non-typical, acute medical patient care space, such as cafeterias, psychiatric rooms and other spaces, and alternative care sites to offer acute and subacute patient care. This planning process would include any necessary regional coordination among systems and other partners.
		3. *Inventory Planning.* Enabling distressed and safety net hospitals that were on the front lines to engage in meaningful planning activities with regard to appropriate inventories of durable medical equipment and consumable supplies that are necessary for an effective pandemic response. This planning would determine what investments are needed in expansion of the consumable stockpiles and how such stockpiles may be appropriately funded to ensure regional capacity and access.
	3. **Develop a Strong, Representative and Well-Trained Workforce***.* Even prior to the COVID-19 pandemic, areas of NYS were experiencing shortages across the health care continuum. As NYS works to build back better post-pandemic and to make significant progress toward eliminating racial disparities and promoting health equity, having a strong and well-trained workforce that is both representative of the populations being served and free of implicit bias is imperative. Building on the work from the prior waiver demonstration that ended in March 2020, NYS proposes a substantial reinvestment in Workforce Investment Organizations (WIOs) to focus on the needs of their respective regions and coordinate with the other WIOs across NYS to facilitate a cohesive approach to workforce development and share best practices. Importantly, this investment would both expand capacity through a well-trained workforce and recognize that training investments themselves function to an important SDH, related to job insecurity or unemployment. Specifically, funds would support initiatives targeted at addressing workforce needs and the specific projects outlined for this waiver demonstration, and would include:
		1. Recruitment, retention, and training initiatives that would expand and enrich the workforce to address shortages across the healthcare continuum, recruit greater participation by people of color in medical professions, and improve quality of care and to provide workers with a greater range of opportunities for advancement; and
		2. Training initiatives that would support regional collaboration and the move to more advanced models of VBP that incorporate new health equity design, including training staff to do social care assessments that will form the hallmark of the VBP model design (as further described below), building out capacity to CBOs to address the social care needs, facilitating telehealth care delivery, ensuring a consistent workforce to assist in the reintegration into supportive and community-based housing, and incorporating principles of implicit bias and cultural sensitivity training for all member-facing staff.
1. **Promote Health Equity through the Development of Social Determinant of Health Networks (SDHNs) and Health Equity Regional Organizations (HEROs):** Targeted investments in effective regional coordination can create stakeholder alignment around aggressive actions to implement policies that address racial and socioeconomic disparities in care, promote a common framework for assessing and measuring improvements in health equity, and strengthen and better integrate the entire NYS health care delivery system. The disparate impact of COVID-19 on disadvantaged populations demands a comprehensive response that addresses underlying SDH as an inherent part of addressing health disparities and achieving health equity. Building on longstanding investments and efforts, the Medicaid program is in an excellent position to bridge this gap based on the demographic composition of its beneficiaries. NYS will integrate health equity as a fundamental standard for the investments listed below in advanced VBP arrangements, providing support through the development of SDHNs and HEROs. This approach will also allow for targeted new investments in social care and non-medical, community-based services that directly address SDH, as more fully described below.
	1. **Investments in SDHN Development and Performance**($X billion): Differences in SDH factors are a primary contributor to racial disparities in health outcomes. A growing number of innovative CBOs are employing interventions in SDH areas, such as community health worker support, healthy behaviors, nutrition, social isolation, education, transportation, and the organization of benefits and employment. NYS will catalyze this process through a separate investment in coordinated networks of CBOs—referred to as Social Determinant of Health Networks (SDHNs)—that take a comprehensive and outcomes-focused approach to addressing the full spectrum of social care needs offered by CBOs in a region, create a supportive IT and business processes infrastructure, and adopt interoperable standards for social care data exchange.
	2. **Investments in HERO Development and Performance**($X billion): This demonstration will pursue the development of Health Equity Regional Organizations (HEROs), which will be mission-based entities that build a coalition of managed care organizations (MCOs), hospitals, community-based providers, CBOs organized through SDHNs (as described above), Qualified Entities (QEs), and other stakeholders in regions. The HEROs would focus on collaboration, coordination, and facilitation of investments and activities that best address the needs of the communities they serve, with the goal of raising the overall health of these communities. The HEROs would (i) help assess community health and social care needs for its attributed populations through new assessment tools or refinements to existing tools; (ii) develop a common set of health equity improvement measures and interventions that go beyond traditional differentials in HEDIS and QARR; (iii) advance a retooled design for services integration, care management, and the more successful braiding of health, behavioral health, and social care that build on the Promising Practices from the Delivery System Reform Incentive Payment (DSRIP) program, leverage regional and coordinated response strategies from the pandemic, and promote use of these new and refined health equity improvement interventions and measures generally and for targeted populations (e.g., children, maternal health, SUD treatment, etc.), create accountability for quality and cost, and facilitate value; and (iv) coordinate these HERO investments to ensure they both meet the needs of the respective communities they serve and also deliver risk-adjusted outcomes on par with communities that are not disadvantaged.

The integrated HERO structure would enable a coordinated, holistic, and value-driven approach to evaluating and addressing the needs of vulnerable populations in a financially stable and efficient manner, which is especially important as the State works toward a strong and equitable recovery from the COVID-19 pandemic. Based on these activities, individual and regional performance will determine HERO funding, with the ultimate objective of the HEROs being the continued movement to more advanced VBP models, including arrangements that utilize global prepayment structures to reward efficient operations focused on population health during normal times, and provide cash flow stability during health crises that create disruption in anticipated utilization.

1. **Investments in Advanced VBP Models that Drive an Equitable, Integrated Health Care and Social Care Delivery System ($XX billion):** Additional targeted investments in more advanced VBP models will support the transformation and integration of the entire NYS health care and social care delivery system. Incentive awards will be made available to MCOs, and by extension CBOs and provider partners, through their VBP contracts or other acceptable structures aligned with this objective. The funds would encourage the evolution of their agreements into more sophisticated VBP contracting arrangements that incorporate health equity design, are risk adjusted to reflect both the health care and social care needs of their members, reward providers’ improvements in traditional health outcome measures, but also health equity measures, and use fully prepaid payment models that fortify against fluctuations in utilization based on pandemics. Additionally, this component of the waiver would seek specific authorities for NYS to utilize *global* prepayment payment models in selected regions, such that lead VBP entities, including hospitals and accountable care organizations (ACOs), are able to extend successes and performance across payor types, including Medicaid fee-for-service (FFS), Medicaid managed care, Medicare FFS, Medicare Advantage, and commercial plans.
2. **Creating Statewide Digital Health and Telehealth Infrastructure ($XX billion):** A silver lining of the COVID-19 pandemic has been the clear opportunity for—and accelerated realization of—widespread consumer and provider use of digital and telehealth care, including tools such as remote patient monitoring, innovative care management technologies, and predictive analytics. Consumers report high satisfaction with telehealth options, with prominent surveys showing satisfaction levels of 86-97%, often higher than for in-person visits. Preliminary data also suggests that telehealth has been a critical means at reaching hard-to-engage populations with historical access issues, especially for behavioral health services. With the State’s continued push towards advanced VBP models, digital tools and telehealth will be critical means by which the health care system can adjust the mechanisms for care delivery to become more focused on outcomes than billable events, with flexibility in the frequency and duration of virtual visits and other digital modalities of care. Telehealth can also increase access to high-demand specialties, and improve use of tools such as home monitoring to anticipate and prevent acute events.

Through an 1115 demonstration, NYS can ensure that this consumer-driven wave is available equitably by building digital and telehealth infrastructure and care models to significantly expand access to care, both in underserved areas, such as rural and other communities without convenient access to primary or specialty care, and for underserved needs, such as behavioral health and the management of chronic diseases. Telehealth capabilities for safety net providers need to expand beyond simple, siloed solutions thrown into service during an emergency into thoughtfully designed platforms integrated with EHRs, care management programs, social care services, the statewide health information exchange, and professionals and non-professionals trained to maximize the use of such technology.

1. **Developing Supportive Housing and Alternatives to Institutions for the Long-Term Care Population ($XX billion):** Transitioning individuals to community-based settings from institutional care and connecting people to stable housing have long been priorities of New York State, and the COVID-19 pandemic has exacerbated this concern. The exacerbation of these needs has manifested in two ways:
	1. During the pandemic, individuals and families experiencing homelessness are at significant risk of infection in congregate settings, such as homeless shelters, and also may have lost access to other supports, such as services and food provided through schools. Individuals experiencing homelessness are also more likely to have underlying conditions, behavioral health issues, substance use disorders, and limited access to health services. During and outside of the pandemic, access to housing, both permanent and transitional, and supports are indispensable aspects of a viable safety net and of health equity. Supportive housing was a major initiative of the Medicaid Redesign Team (MRT) in 2011. Since that time, the MRT has made significant financial commitments for rental subsidies and supportive housing services. New York State also committed to a $20 billion, five-year capital plan in 2017 to build or preserve more than 100,000 affordable and 6,000 supportive housing units, and funds supportive housing programs directed at specific populations as well, including for individuals with disabilities, those with serious behavioral health needs, and older adults. In particular, the MRT supportive housing program has been shown to reduce Medicaid spending, largely through fewer emergency room visits and lower costs for inpatient hospital stays. On an annualized basis, the 2,071 MRT participants who received supportive housing subsidies saw their Medicaid expenses fall by 15%.[[3]](#footnote-3)
	2. Individuals who reside in long-term care institutions, such as psychiatric facilities, nursing homes or Intermediate Care Facilities for people with intellectual and developmental disabilities (I/DD), were also disproportionately impacted by the pandemic through increased rates of infection or disruption of available habilitative or rehabilitative services. This initiative would allow for new investment—both in upfront capital and in ongoing operations—to slim down expensive institutional capacity of all kinds that align with existing efforts and legal requirements for community-based care and integration, including individuals in nursing homes and congregate facilities for people with I/DD; the frail and elderly; people with severe mental illness; people with substance use disorders; and others with long-term care needs.[[4]](#footnote-4)

The downstream effects of COVID-19 and service disruption on these populations, including the erosion of public trust, will likely persist for years. Accordingly, New York will redouble its focus on supporting community-based options for supportive housing and medical respite programs to maximize independence, decrease spending, and improve quality of life for these individuals, especially those who are eligible for long-term services and supports and with behavioral health needs. In large part, this initiative is also the best preparation for the next pandemic or similar large scale health care event. With the proposed funding from this waiver, the NYS Medicaid program will create a coordinated approach to housing supports, including a unified array of supportive service offerings across multiple settings and population silos, and furthering patient-centered care by focusing the locus of services on the patient’s home. This would allow NYS to align and expand existing programs in regard to quality, services, and funding; improve potential health outcomes for every population served by supportive housing programs in New York; and reduce overall health care spending for these populations.

**Relationship with Larger 1115 Waiver**

For the last decade, through its current 1115 waiver, NYS has engaged in efforts to redesign Medicaid using managed care and its recently-ended DSRIP program. DSRIP had an overall goal of reducing avoidable hospitalizations by 25 percent and achieving savings while transforming the health system to use VBP. NYS achieved many of its goals with DSRIP, including a 26 percent reduction in Potentially Preventable Admissions (PPAs) and an 18 percent reduction in Potentially Preventable Readmissions (PPRs) through Measurement Year 5; facilitated a significant increase in Patient Centered Medical Home (PCMH) certification; made major progress in integrating physical and behavioral health care; and improved care transitions that directly reduced readmissions. The DSRIP program also incorporated a Value-Based Payment Roadmap, which achieved its goals of at least 80% of the value of all Medicaid managed care contracts in shared savings (Level 1) or higher VBP arrangements, and 35% of contract value in upside and downside risk (Levels 2 and 3) arrangements. As a result of all these initiatives and others in the State’s current 1115 waiver, as well as other Medicaid redesign initiatives, NYS Medicaid spending per beneficiary in 2019 was less than in 2011.

With this waiver demonstration proposal, NYS is learning from its DSRIP experience, such as the need for regional accountability, governance involvement of CBOs, more direct investments in SDH, administrative simplification, and an even deeper alignment of provider and payer incentives, particularly the highest level of VBP with symmetrical risk sharing and monthly prepayments (capitation and/or global budgets). The current demonstration waiver request is intended to further advance the combination of the State’s previous DSRIP goals with the more explicit prioritization of health equity across vulnerable and underserved populations, as revealed by the COVID-19 pandemic. Specifically, building on the promise of DSRIP, completing the State’s journey to value based care will be the vehicle through which NYS can achieve and sustain the benefits of this demonstration.

**Budget Neutrality and Sources of Financing**

Strengthening the safety net is a top priority for the State, but NYS’s own fiscal position has been undermined by the pandemic and it could not afford such funding on its own. In fact, absent federal support, the State would be forced to reduce safety net expenditures. As required for a 1115 waiver, New York will meet budget neutrality requirements, post rebasing.

In addition to financing the non-federal share of this 1115 demonstration through transfers from units of local government and state general revenue commitments that are compliant with section 1903(w) of the Social Security Act, New York seeks flexibility with the Centers for Medicare and Medicaid Services (CMS) to identify other sources of matching funding. Specifically, given the focus of this larger demonstration on the long-term effects of COVID-19, it would be appropriate to recognize that local governments, public benefit hospitals, and the State have been required to make substantial commitments of capital and resources to combat COVID-19 prior to availability of any federal funding through Family First Coronavirus Response Act (FFCRA), the CARES Act, or other sources of federal funding that will be made available to states that are experiencing the impacts of the COVID-19 pandemic. To the extent CMS and New York are able to identify state and local financial commitments, similar to State Designated Health Programs, that have been used to fund health care services and have replaced traditional Medicaid-covered services or programmatic administrative activities, NYS asks to revisit prior administrative guidance issued by CMS and allow these expenditures to be counted towards New York’s non-federal share under this 1115 waiver.

1. United Hospital Foundation, New York State Medicaid Health Equity Options, at 1 (March 2021). [↑](#footnote-ref-1)
2. NYS Department of Health, *New York State Health Equity Report* (April 2019), available at <https://health.ny.gov/community/minority/docs/health_equity_report_2019.pdf>. [↑](#footnote-ref-2)
3. Sandra McGinnis et al., Medicaid Redesign Team Supportive Housing Evaluation: Overall Summary Report (June 2020), available at (<https://www.health.ny.gov/health_care/medicaid/redesign/supportive_housing_initiatives.htm>. [↑](#footnote-ref-3)
4. CMS recently approved New York’s State Plan Amendment for Community Integration and Tenancy Stabilization Services, which is an important component of a larger supportive housing strategy. [↑](#footnote-ref-4)