

# NEW YORK STATE MEDICAID REDESIGN TEAM (MRT) WAIVER

1115 Research and Demonstration Waiver  
#11-W-00114/2

## COVID-19 1115(a) Demonstration Request

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

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**Submitted on:**  
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## **COVID-19 Section 1115(a) Demonstration Application**

The New York State Department of Health (“DOH”), on behalf of the State of New York (the “State” or “New York”), proposes emergency relief as an affected state, through the use of section 1115(a) demonstration authority as outlined in the Social Security Act (the “Act”), to address the multi-faceted effects of the novel coronavirus (“COVID-19”) on the State’s Medicaid program. New York is committed to working with the Centers for Medicare & Medicaid Services (“CMS”) to ensure a thorough, timely, and appropriately comprehensive response to the COVID-19 pandemic.

### **I. DEMONSTRATION GOAL AND OBJECTIVES**

Effective retroactively to March 1, 2020, New York seeks section 1115(a) demonstration authority to operate its Medicaid program without regard to the specific statutory or regulatory provisions (or related policy guidance) described below, in order to furnish medical, social, and behavioral health (inclusive of mental health and substance use disorder) services and assistance, in a manner intended to protect, to the greatest extent possible, the health, safety, and welfare of individuals and providers who are being affected by COVID-19.

#### ***Background***

As CMS is aware, on March 7, 2020, Governor Andrew M. Cuomo signed Executive Order No. 202 declaring a Disaster State of Emergency for the entire State of New York due to the outbreak of COVID-19 in the State. Under the terms of the Executive Order, since amended to reflect the changing nature of the outbreak and the State’s rapid responses to these changes, certain State laws were suspended or waived, and State agencies have been instructed to take all reasonable efforts to assist in the response and recovery. These responses are informed by the fact that New York has had the highest number of confirmed cases in the country at 335,395. As of the date hereof, there have been 21,478 cases resulting in death. Given the extent to which the COVID-19 pandemic has affected New York, the State continues to need more than double the number of current approved hospital beds, for COVID-19-related hospitalizations. On a permanent basis, the State has only 53,000 inpatient beds, of which 80% are occupied in the normal course.

Despite the State’s decisive response to the COVID-19 outbreak by our providers, local districts, health plans, and communities—which has been extraordinary and involves taking swift action to approve private laboratories to test for the virus, standing up drive-through testing centers in outbreak hotspots to increase its testing capacity, and now rapidly building temporary hospital sites—the COVID-19 pandemic has demonstrated an immediate and fundamental need to rapidly pivot and reconfigure the State’s healthcare delivery system in response to public health emergencies. While the State’s five-year effort to transform its delivery system under its current 1115 waiver, called the Medicaid Redesign Team (“MRT”) Waiver, focused on reducing avoidable hospital use by 25 percent and the conversion of inpatient beds to build a robust and culturally informed ambulatory care environment, the COVID-19 pandemic instead calls for a different direction, requiring the State to drastically and immediately expand the number of available inpatient beds, support essential providers, preserve community based provider

capacity, and repurpose the infrastructure created through the MRT Waiver to better respond to the pandemic.

### ***Emergency Waiver Objective: Addressing Immediate Needs***

Based on these factors, New York has an **immediate need** as described in this emergency waiver request, to reinforce and sustain our delivery systems and providers now through the COVID-19 crisis, as a first step to a longer-term solution by building the capacity to scale up and scale down to meet the needs of its residents. To achieve this goal, the State must immediately **deploy a statewide system of flexible hospital, ambulatory provider and member in-reach capacity and fully mobilize this capacity now**. Enabling these efforts is the purpose of this 1115 emergency demonstration application.

**In the longer term, the State recognizes that the same capacity being supported by this application should be further built out to not only deploy during pandemic threats or other public health emergencies, but also continue to fuel the more permanent system shift to ambulatory, home and community-based services and preventive models that achieve our shared goals of value-based care.** COVID-19 will not be the last pandemic or public health emergency that New York and the country will face, and future diseases, catastrophic weather events, or acts of terrorism, among other potential causes of public health emergencies, may pose an even greater strain to the State's health care infrastructure. While addressing these longer-term needs are vitally important, they are distinct from the purpose and scope of the emergency 1115 waiver authority currently contemplated by CMS. Accordingly, New York intends to address these needs as part of a subsequent 1115 waiver request that aligns with the expiration of New York's MRT Waiver. To that end, this 1115 demonstration application limits its focuses to New York's immediate needs to address the current pandemic.

### ***Overview of System Investments and Funding Pools***

To address the immediate needs made apparent by the COVID-19 pandemic, the State requests this emergency waiver to make **three key initial investments** to preserve essential providers that serve as the safety net are developing emergency response capacity in the near term:

- 1. Emergency Capacity Assurance;**
- 2. Rapid Facility Conversion; and**
- 3. Regional Coordination and Workforce Deployment.**

To support targeted and appropriately prompt distribution of funds, these efforts will be funded through **two funding pools** using constructs from New York's existing MRT Waiver with which New York providers are familiar:

- **Emergency Capacity Assurance Fund (ECAAF) (\$1.85 billion):** This pool will provide direct funding to stabilize providers and ensure the ongoing availability of provider capacity during and after this public health emergency. Specifically, this funding would be directed to supporting initiatives #1: Preserving the Safety Net; and #2: Rapid Facility Conversion. These funds will be disbursed directly to providers, as identified below, through a precise and rapid application process where providers will describe and attest

to how they intend to spend the funds within pre-set priority areas and the specific timeframe over which the funds will be spent. Unspent funds identified in provider progress reports will be reallocated to emerging needs or other providers.

- **Regional Coordination and Emergency Deployment Fund (RCEDF) (\$900 million):** This pool will fund Performing Provider Systems (“PPSs”) to support #3: Regional Coordination and Workforce Redeployment efforts. This fund will be allocated based on attribution of Medicaid lives adjusted to account for concentrations of COVID-19 cases in the region and other factors pertinent to the emergency response, as applicable.

These two funding pools will fund the **three key investments** further detailed below:

1. **Preserving the Safety Net - Developing an Emergency Capacity Assurance Fund: \$1.2 Billion**

To protect against degradation of access to key health care services, limit unproductive disruption, and avoid gaps in the health delivery system that are arising from the current public health emergency, New York seeks authorization to make payments for the financial support of selected Medicaid providers affected the public health emergency. Under this waiver, these payments would be made through the ECAF.

***Limit on Federal Financial Participation (FFP).*** New York may expend up to \$1.2 billion in federal financial participation for direct to provider ECAF payments for the period from the date of approval of the ECAF expenditure authority until the earlier of (i) 60 days from the date that the public health emergency period ends, or (ii) March 31, 2021. To the extent available funds are not expended in this time-limited ECAF, they are available through the RCEDF funded program.

***Funding.*** In addition to financing the non-federal share of ECAF payments through transfers from units of local government and state general revenue commitments that are compliant with section 1903(w) of the Act, New York seeks flexibility with CMS to identify other sources of matching funding for the ECAF. Specifically, local governments, public benefit hospitals, and the State have been required to make substantial commitments of capital and resources to combat COVID-19 prior any 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 after New York. To the extent CMS and New York are able to identify state and local financial commitments, similar to certified public expenditures, that have been used to fund health care services and have replaced tradition Medicaid-covered services or programmatic administrative activities, we ask that these expenditures also be counted towards New York’s non-federal share under this 1115 waiver.

***Eligible Providers:*** These funds are available to essential providers involved or impacted by the emergency response to the COVID-19 public health emergency, including: (1) providers of care in the community, such as primary care providers, dental providers, behavioral health home and community based services providers (e.g., habilitation,

respite services), ambulance and non-emergency transportation, and other community based practitioners, which is reflected by CMS's guidance on use of this emergency 1115 waiver application to permit retainer payments to certain community based providers, such as those providers offering habilitation services and home care services providers licensed under Article 36 of the Public Health Law<sup>1</sup>; (2) health care facilities (hospitals and diagnostic and treatment centers licensed under Article 28 of the Public Health Law and mental health and substance use disorder facilities licensed, certified or designated under Article 16, 31 and 32 of the New York Mental Hygiene Law) and nursing facilities.

***Application Requirements.*** The State will make all decisions regarding the distribution of ECAF payments to ensure that sufficient numbers and types of providers are available to Medicaid beneficiaries in the geographic area to provide access to care for Medicaid and uninsured individuals while the State is facing the public health emergency caused by the COVID-19 pandemic. The ECAF payments shall be limited to eligible providers that the State determines to offer necessary capacity for Medicaid and uninsured individuals and face sustainability challenges due to the impacts from the public health emergency.

In determining the qualifications of a provider for this program and the level of funding to be made available, the State will take into consideration whether the funding is necessary (based on current financial and other available information regarding community need and services) to provide essential services access to Medicaid and uninsured individuals, as well as the appropriate payment mechanism, such as modified billing standards (such as to promote telehealth encounters), to sustain existing provider capacity and state plan and demonstration services to vulnerable populations, account for disruptions in workflows, redeployment of staff and other changes necessary during this time to shift approaches to emergency operations. The regulatory waivers sought through this emergency 1115 demonstration application will facilitate these funding mechanisms, but with appropriate controls and process checks. As described below in the section on "Regulatory Waivers," certain regulatory flexibilities and abeyances to State Plan and demonstration services requirements will be necessary to make this funding available expeditiously to providers for these purposes. Before issuing any payments to providers, the State must post on its Website a list of qualifications or requirements that providers must meet to receive payments under this section. The State will initiate an open application period of at least 10 days duration for providers to submit applications.

***ECAF Payments.*** ECAF payments are not direct reimbursement for expenditures or payments for services. Payments from the ECAF are not considered patient care revenue and shall not be offset against disproportionate share hospital expenditures or other Medicaid expenditures that are related to the cost of patient care.

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<sup>1</sup> See CMS, COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies § IV.B.2 (last updated May 5, 2020). As reflected in the CMS guidance, certain eligible providers may overlap with provider types or services eligible for retention payments authorized under Appendix K to New York's Section 1915(c) Waivers, as determined by the State to be in financial hardship as a result of the public health emergency, but the State will account for and ensure that any funding made available to these eligible providers under this 1115 waiver authorization will not duplicate, and account for, funds received through other waiver authorities.

## **2. Rapid Facility Conversion: \$650 Million**

Beyond ensuring that provider capacity exists to serve patients during this emergency, New York State and its providers, must build facility capacity to meet demand in a public health emergency, both to quarantine and treat patients. To do so, providers need support to identify and prepare suitable types of facilities to allow fast conversion for triage and other emergency health management. We anticipate \$650 million of ECAF funding will fund rapid conversion of facilities to meet new demands made on New York State's delivery systems due to COVID-19.

*Use of Funds:* For Rapid Facility Conversion, funds will be used for identifying and conducting essential preparation for convertible outpatient/ambulatory surgery centers, nursing homes, and residential facilities, as well as minimal features of such facilities and changes that can be made during an emergency, identifying additional infrastructure that can be converted (e.g., hotels, convention centers, schools, etc.) and a plan to achieve such conversion rapidly; and creating flexible discharge networks with other facilities. The State will work with local counties, other public health oversight authorities and facilities to monitor trends and projections for additional inpatient capacity to be made available and viable sites for conversion. Funding will be used by facilities for conversion costs, staffing and for admission/discharge administrative operations.

## **3. Regional Coordination and Workforce Redeployment: \$900 Million**

One of the greatest challenges in this health care crisis is that resources have become necessarily refocused almost exclusively on addressing patients directly impacted by the crisis, leaving other patient with fewer resources. This challenge has been especially acute in the COVID-19 crisis with patients practicing social distancing and not able to reach place-based health care. Leveraging the existing infrastructure built with the funding provided as part of the MRT Waiver, this effort repurposes significant components of existing PPSs, of which there are 25 throughout the State, into regional coordination hubs for COVID-19 response.

In this new capacity, PPSs will coordinate efforts across a continuum of care with existing PPS providers and community-based organizations ("CBOs") leveraging existing contractual relationships and infrastructure to fill gaps in care needed to support emergency response, as well as serve COVID-19 patients discharged into the community through new service delivery channels (e.g., video and telephonic visits, electronic consults with specialty care, behavioral health and other provider types). By utilizing the existing PPS infrastructure already developed through 1115 waiver funding, the State will be able to reuse existing capacity not already overburdened by crisis response and service provision demands to meet emerging needs more rapidly. This will greatly increase flexibility and will allow for scaled-up COVID-focused operations and leveraged workforce to meet localized service gaps created by the pandemic.

As recent events with COVID-19 unfold, it is revealing a notable gap in the delivery system as providers cannot reach effectively into homes and community settings to care for patients during emergencies, and to connect health care and behavioral health care practitioners to patients in different locations. The technology exists but significant additional planning and investment is critical to a robust infrastructure for telehealth and telephonic care. PPSs will form a statewide

collaborative group to identify current gaps, identify local strategies/solutions for mutual assistance and to also inform statewide standardization of technical requirements, workflows, as well as training and technical assistance to further build the necessary infrastructure to meet the immediate demands under the current crisis.

*Use of Funds:* Utilizing the existing infrastructure of the PPSs as designated regional coordination hubs, PPSs, their downstream providers and CBOs will be able to implement rapid capacity transformations under the following **four domains**:

1. **Domain 1: Serve as regional coordination point** for administrative action, planning and services coordination for their affiliated performance network of providers, CBOs and social services partners. The health care system had to pivot resources to meet the immediate crisis of COVID-19. By shifting this focus, providers create a new risk where other vulnerable populations with chronic medical, mental health and SUD needs could become untethered from important provider connections and impact health outcomes. In a regional coordination role, PPSs can organize services, infrastructure and workforce redeployment to address community needs related to the COVID-19 crisis in a culturally informed and flexible manner, coordinating risk stratification and resource efforts to address high-risk patients. For example, PPSs may work with affiliated providers and CBOs in their networks to (a) identify patients who no longer have supports in place (e.g., day programs are closed, loss of aides or personal care assistants rendering personal care services, lack of access to needed specialty care, etc.) who need to be linked to other network supports (e.g., Health Home, telehealth support, replacement personal care services support, etc.), (b) track service capacity across the continuum of care, (c) work with clinical leadership across the PPS and its network providers to standardize guidelines on treatment and criteria for telehealth vs. in-person care, and (d) coordinate and reconfigure workflows between PPS providers and critical CBOs and social care providers to shift monitoring of, and services to, vulnerable populations to ensure access to food, shelter and other services that reduce the need for in-person visits.
2. **Domain 2: Deploy telehealth and other technologies** across the continuum of care to reduce barriers, increase access to critical services, and enhance care coordination. Innovative adaptations are necessary to support services that have depended on in-person interactions, such as SUD therapies that have long relied on group counseling. Emergencies like COVID-19 require the expansion of tele-practice and telephonic services to maintain engagement of patients who may be even more vulnerable due to the stressors of social isolation or are unable to access care as their providers have been redirected from day-to-day in-person chronic disease management to focus on virus response. PPSs will ensure that across their network of organizations, telehealth technologies and workflows are deployed to increase coordination and support of remote services and patient monitoring including those recovering from COVID-19 and need services delivered in the home and community to reduce the burden on overwhelmed hospitals. During the emergency period, funding and technical assistance through the PPSs will bolster the ability of their network of organizations to provide telehealth through various modalities such as, but not limited to (a)

deploying technologies supporting new models of therapy services, care coordination and patient monitoring such as care management platforms and closed loop referral systems for social services, (b) use of alternative service delivery channels, such as video and phone, and (c) deploy technologies that increase document sharing capability and reduce barriers, such as e-signature programs and cloud based document repositories while (d) adapting CBO and social service provision models to tele-work and integrating efforts with other providers, and (e) work together to create a statewide telehealth support infrastructure that is assurance easy access and crisis-ready telehealth for New York.

3. **Domain 3: Bring to scale what works: Promising Practices that Enhance Care Coordination, Care Management and Care Transitions.** The COVID-19 emergency has demonstrated the need for the State, its providers and managed care plans to continue to embrace a flexible approach to service delivery and payment during times of crisis, particularly as some essential service providers have had to pivot almost exclusively to virus response, creating the potential for patients with complex, chronic and behavioral health needs to decompensate. Building on the “Care Coordination, Care Management and Care Transitions” Promising Practices from the current waiver, PPSs will leverage these proven approaches to deliver care at scale that maximize emergency room diversion models and support mobile-based health centers, which frees up emergency and inpatient capacity for treatment of COVID-19 patients. Examples of such Promising Practices include: (a) *Population Targeting: Managing Care Transitions for At-Risk Patients* by deploying new transitional care nurses (TCNs) and managers organized into transitional care teams (TCTs), which provide safe and effective transitions of care for patients at particular risk for readmission, (b) *Extending Care Management’s Reach: Delivering Community Based Telemedicine to Special Populations*, achieved through a telemedicine program for triaging, treating, and monitoring non-urgent illnesses and injuries in patients’ homes, (c) CMS’s *Emergency Triage, Treat, and Transport (ET3) Model* that permits beneficiaries to receive treatment from alternative destinations from the emergency room and which CMS has recognized as playing an important role in the COVID-19 emergency response<sup>2</sup>; and (d) *Regional Care Management: Tracking High Utilizers Across Multiple Settings to Bridge Gaps in Coordination*, addressing patients who rapidly cycle out of and back into care settings and are served by multiple providers by bridging gaps in coordination across these providers. By deploying these Promising Practices during the current crisis, with limited to no necessary modification to these proven care models, PPSs will help provide relief to hospitals to focus on addressing the public health crisis and direct patients to the most appropriate care setting; while also supporting increased testing and administration of treatments, and monitor outbreaks in hot-spot communities to prevent further viral spread. Without this emergency waiver amendment, the loss of PPS support will cause these Promising Practices to end at perhaps the most critical juncture to scale their efficacy through the response to the COVID-19 pandemic.

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<sup>2</sup> CMS, ET3 Model Description, available at <https://innovation.cms.gov/innovation-models/et3>.



4. **Domain 4: Workforce redeployment and training to rapidly transform capacities in response to a public health emergency.** The COVID-19 epidemic has required the workforce to rapidly adapt how services can be delivered such as shifting SUD recovery peers to telephonic engagement and redeploying home-visiting Community Health Workers to do telephonic outreach to conduct broader social risk assessments. Refresher courses and centralized resources become a critical support for the volunteer healthcare professionals coming out of retirement. Other workforce training needs will surface as staff are redeployed to meet the crisis surge demands. PPSs will identify workforce capacity and training needs among their community partners to determine which providers to immediately mobilize, as well as identify and deliver strategic training programs that are available through remote learning to redeploy current community and healthcare workers to take on new roles during an emergency period.

Importantly, SUD providers that deliver medication assisted treatment such as opioid treatment providers (“OTPs”) have had to modify practices consistent with social distancing requirements. This need has led to innovative strategies that have never before been used by these providers, such as use of alternate locations for administering methadone, dispensing take-home medications in significantly greater volume, and use of telehealth and telephonic interventions to ensure stability and minimize risk for diversion of controlled substances. For example, Certified Peer Recovery Advocates (“CPRAs”), a valuable provider type in SUD treatment, work in a variety of settings where patients, struggling with SUD, often leave treatment with no linkage to on-going treatment. To provide ongoing service to these patients, PPSs must support modifications of existing procedures, workflows, and infrastructure to deploy these and other types of workers to provide treatment and services in the home and community. If redeployed, these CRPAs can, where appropriate, provide services through video and telephonic visits. They may also need to be deployed to meet certain clients in-person (e.g., homeless). We need to maintain and grow these practitioners and facilitate services that help meet the goals of social distancing by serving patients where they are at.

Using the PPS infrastructure, each respective network of organizations will quickly identify types of workers appropriate to retrain and deploy strategically to meet the needs of their patients. We anticipate these types of strategic workforce redeployment programs to need technologies that support workers in the field, such as cloud-based document and care plan sharing tools on laptops and tablets, and ability to retrain the workforce efficiently, such as remote learning management systems. Examples of such activities include redeploying existing workforce to (a) Testing and administration of vaccines and other treatments during response phase, including promoting compliance with federal and state public health measures; (b) deploy home health aides to support monitoring and evaluation of individuals in the community during recovery phase; and (c) deploy community health workers to reduce barriers and support connectivity to social services to bridge social barriers impacting patient health outcomes (i.e., transportation, meal deliveries, etc.).

***Eligible Providers:*** Existing PPSs (applicant) with their affiliated provider network are eligible; however, PPSs with a demonstrated ability to partner with CBOs and have an inclusive provider network will be given special consideration and weighted appropriately in the application process based on the domains included in this funding pool.

***Application Requirements and Payment Triggers:*** PPSs will be asked to submit a brief and succinct regional coordination plan with attestation to identified activities and dollars spent in the four domains: (1) regional coordination and administrative activities; (2) telehealth infrastructure; (3) the Promising Practice interventions that are being scaled and tied to crisis response; and (4) workforce redeployment, including a description of how redeployment works, how long it lasts, payment for those services, and other features). The State will provide a streamlined, but structured application template with a fast-tracked approval process to ensure funding is timely to meet the State's emergency needs and that gives preference to PPSs that have a demonstrated ability and history of CBO inclusion and funding, especially in markets with multiple PPSs approved.

In order to receive funds to disburse among their networks, PPSs must first receive approval from the State for their regional coordination plan, noting that due to the intersecting nature of PPSs in some regions of the state, overlapping coordination will be allowed in the interest of providing the most connected and appropriate care in response to community needs. We request approval to distribute funds to PPSs in the following manner:

1. Distribute 50% of allocated funds to PPSs upon initial approval of the fast-tracked regional coordination plan;
2. Distribute remaining funds based on achieving progress and reporting milestones that are unique to each PPS and identified in their approved regional coordination plan. PPSs are expected to report progress 45 days after receipt of initial funds, and again in 90 days. Should funds be expended within the first 45 days, PPSs can request in their report up to an additional 25% of allocated funds until the totality of their allocation is spent.
3. Unused funds will be reallocated to other PPSs based on availability and identified and emerging needs across the domains. We anticipate this fund will be fully liquidated within the waiver period given the high level of need.

New York believes this waiver will be achieved in a budget-neutral manner, by seeking to achieve the same population health objectives as previous waiver investments, with the added goal of establishing a pivot towards a more flexible, strategic, community-focused health care system that responds dramatically more effectively in times of a national or state health emergency.

## ***Regulatory Flexibility***

Concurrent with these efforts, New York requires certain regulatory and waiver flexibilities, as referenced in this request, for the duration of the COVID-19 public health emergency to enable providers, managed care plans, and CBOs to implement emergency interventions and respond to capacity demands related to the COVID-19. To achieve these objectives, the State has identified and requests the following regulatory flexibilities:

- **Authority to Suspend Contract and Program Standards**. Under the MRT Waiver, the State requires Medicaid managed care plans to pay for Medicaid State Plan services, including long-term care, mental health and substance use disorder services and supports, and other demonstration services, including home and community-based services and other services, pursuant to the terms of the MRT Waiver. As reflected herein, such State Plan and demonstration services cannot be delivered consistent with applicable requirements due to the disaster emergency. Accordingly, the State requests general authority to modify or suspend contract standards, program standards, cost sharing, and reimbursement methodologies for State Plan services, 1915(c) waiver services (if not waivable under an Appendix K to those waivers, as instructed by CMS), and demonstration services, whether paid through fee-for-service or through Medicaid managed care plans, in connection with the activities and funding objectives set forth in this application and without SPA submission and approval processes and public notice rules (42 C.F.R. §§ 447.205 & 447.57) .
- **Temporary Hospital Facilities**. As part of the immediate need to respond to the COVID-19 pandemic, New York has rapidly developed and established new hospital facilities that are capable of treating both patients diagnosed with COVID-19 as well as patients experiencing the need for inpatient hospitalization or emergency department services for conditions other than COVID-19. As part of this waiver application, New York seeks regulatory flexibility to establish these facilities and claim federal financial participation on the inpatient and outpatient emergency department services furnished therein, notwithstanding the requirements of the State Plan and CMS regulatory requirements.
- **Institutions for Mental Disease Bed Capacity and Ancillary Services**. More specifically, New York proposes to utilize waiver funding to reimburse expenditures on behalf of demonstration populations under 65 years of age who are patients in Institutions for Mental Disease (“IMD”) during the COVID-19 emergency, notwithstanding the 16-bed limitation and prohibition on federal financial participation. This proposal is intended to facilitate a temporary increase in bed capacity for affected beneficiaries and to allow facilities that are IMDs (or that become IMDs by temporarily increasing capacity above 16 beds) to claim for covered services provided to IMD residents during the emergency period. Consistent with Rapid Facility Conversion goals, as set forth above, New York also proposes this flexibility to extend to situations where a hospital repurposes psychiatric beds in response to COVID-19 and temporarily delivers IMD care in appropriate alternative settings (that may exceed 16 beds). Coverage would include the IMD stay and any other medically necessary, State plan covered services (ancillary services) provided to the IMD resident.

### *Scope of the Current and Future 1115 Waiver Requests*

Consistent with the purpose of 1115 research and demonstration waivers, this scope of this application seeks federal share payments and associated regulatory flexibility for services, activities, and expenditures related to the State Medicaid program's response to the COVID-19 pandemic that **are not otherwise available** under state plan amendments, Section 1915(c) Appendix K waivers, and Section 1135 emergency waivers. Moreover, New York recognizes that FFCRA and the CARES Act both offer available sources of funding to States, local governments, and eligible providers to assist in activities related to the public health emergency and the economic impact of the pandemic. This application serves an entirely separate function that is not intended to duplicate any funding streams made available to providers under Medicare or enhanced Federal Medical Assistance Percentage ("FMAP") for State Plan services or other economic relief dollars that may be paid to providers, such as hospitals and members of the workforce, that are on the front-lines of the COVID-19 response. As described above, the purpose of this 1115 emergency demonstration application is to make specific and targeted investments in the Medicaid delivery system, sustain provider capacity, promote capacity expansion targeted to public health emergencies in areas not already capable of receiving enhanced FMAP or other federal support funding, but that are nonetheless essential to New York's comprehensive emergency response and mobilization efforts as well as preserving beneficiary access to essential health care services.

The scope and purpose of this waiver is borne out by the longer-term vision of this request. Specifically, while New York has worked to evolve its delivery systems for value-based care, COVID-19 has laid bare the necessity for New York's hospital system to be fundamentally reconfigured for scalability and flexibility, not just for the short-term as contemplated in this waiver, but for the long term to maximize our shared investment. As indicated above, COVID-19 will not be the last pandemic or public health emergency that New York and the country will face. Future diseases, threats, or emergencies may pose an even greater strain to the State's health care infrastructure and we must learn from this event. At the same time, New York must avoid unnecessary permanent inpatient capacity increases. New York State intends, as part of a renewal of our broader MRT Waiver expiring April 2021, to build upon current learnings from addressing COVID-19 to further build the delivery system of the future that has flex capacity, while meeting our shared goals of value-based care. To that end, New York plans to submit a concept paper to CMS further describing the contours of these long-term needs that would comprise a renewal of its larger MRT Waiver.

Consistent with CMS guidance issued in response to the unprecedented emergency circumstances associated with the COVID-19 pandemic, CMS is not requiring that states submit budget neutrality calculations for Section 1115 emergency demonstration projects designed to combat and respond to the spread of COVID-19. As New York embarks on the broader renewal of its MRT Waiver to allow the State to pivot towards a more flexible, strategic, community-focused health care system that responds dramatically more effectively in times of a national or state health emergency, we ask CMS to recognize that this waiver can still be achieved in a budget-neutral manner. The fact that this country faces an unprecedented public health crisis does not absolve the State from the need to meet budget neutrality requirements for a federal waiver; but as part of this waiver submission, New York requests additional flexibility in the

calculation of budget neutrality—as contemplated already by CMS—to ensure a thorough, timely, and appropriately comprehensive response to the COVID-19 pandemic and future public health emergencies. To this end, New York requests an extension of up to twelve-months of the current terms and conditions in the MRT Waiver to allow the State time to review all programs authorized under the MRT Waiver in light of the pandemic and conduct the appropriate budget neutrality review.

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**II. DEMONSTRATION PROJECT FEATURES**

**A. Eligible Individuals:** The following populations will be eligible under this demonstration. To the extent coverage of a particular service is available for a particular beneficiary under the State plan, such coverage will be provided under the State plan and not under demonstration authority.

Check to Apply	Population
X	Current title XIX State plan beneficiaries
X	Current section 1115(a)(2) expenditure population(s) eligible for/enrolled in the following existing section 1115 demonstrations:  All eligible populations identified under the New York Medicaid Redesign Team Waiver (formerly called Partnership Plan)

**B. Benefits:** The state will provide the following benefits and services to individuals eligible under this demonstration. To the extent coverage of a particular service is available for a particular beneficiary under the State plan, such coverage will be provided under the State plan and not under demonstration authority.

Check to Apply	Services
X	Current title XIX State plan benefits
X	Others as described here: <ul style="list-style-type: none"> <li>• Existing demonstration services to identified demonstration populations under the New York Medicaid Redesign Team Waiver (formerly called Partnership Plan).</li> <li>• 1915(c) waiver services, if not waivable by through an Appendix K to those waivers, as instructed by CMS.</li> </ul>

**C. Cost-sharing**

<b>Check to Apply</b>	<b>Cost-Sharing Description</b>
<b>X</b>	There will be no premium, enrollment fee, or similar charge, or cost-sharing (including copayments and deductibles) required of individuals who will be enrolled in this demonstration that varies from the State’s current state plan.

**D. Delivery System:**

<b>Check to Apply</b>	<b>Delivery System Description</b>
<b>X</b>	The health care delivery system for the provision of services under this demonstration will be implemented in the same manner as under the State’s current state plan.
<b>X</b>	Other as described here: <ul style="list-style-type: none"><li>• Delivery system changes include rapid conversion of facilities, development of regional coordination hubs and redeployment of workforce and technologies needed to address patient needs occurring due to COVID-19, as described above.</li><li>• Existing service system for 1915(c) waiver services.</li></ul>

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**III. EXPENDITURE AND ENROLLMENT PROJECTIONS**

**A. Enrollment and Enrollment Impact.**

The State projects that approximately 100% of individuals as described in section II will be eligible for the period of the demonstration. The overall impact of this section 1115 demonstration is that these individuals, for the period of the demonstration, will continue to receive HCBS or coverage through this demonstration to address the COVID-19 public health emergency.

**B. Expenditure Projection.**

The State projects that the total aggregate expenditures under this section 1115 demonstration is \$2.75 billion to fund the mission-critical activities between March 1, 2020 and March 31, 2021.

In light of the unprecedented emergency circumstances associated with the COVID-19 pandemic and consistent with the President’s proclamation that the COVID-19 outbreak constitutes a national emergency consistent with section 1135 of the Act, and the time-limited nature of demonstrations that would be approved under this opportunity, the Department will not require States to submit budget neutrality calculations for section 1115 demonstration

projects designed to combat and respond to the spread of COVID-19. In general, CMS has determined that the costs to the Federal Government are likely to have otherwise been incurred and allowable. States will still be required to track expenditures and should evaluate the connection between and cost effectiveness of those expenditures and the State’s response to the public health emergency in their evaluations of demonstrations approved under this opportunity.

#### IV. APPLICABLE TITLE XIX AUTHORITIES

The State is proposing to apply the flexibilities granted under this demonstration opportunity to the populations identified in section II.A above.

Check to Apply	Program
X	Medicaid state plan
X	Section 1915(c) of the Social Security Act (“HCBS waiver”). Provide applicable waiver numbers below: <ul style="list-style-type: none"> <li>● NY CAH III (40163.R04.00)</li> <li>● NY CAH VI (40200.R02.00)</li> <li>● NY Children’s Waiver (4125.R05.00)</li> <li>● NY Long Term Home Health Care Program (0034.R06.00)</li> <li>● NY Nursing Home Transition and Diversion Medicaid Waiver (0444.R02.00)</li> <li>● NY Traumatic Brain Injury Waiver (0269.R04.00)</li> <li>● NYS OPWDD Comprehensive Waiver (0238.R06.00 and 0238.R06.01)</li> <li>● OMH SED (NY-11)</li> </ul>
X	Section 1115(a) of the Social Security Act (i.e., existing, approved state demonstration projects). Provide applicable demonstration name/population name below: <ul style="list-style-type: none"> <li>● New York Medicaid Redesign Team (formerly called Partnership Plan)</li> </ul>

#### V. WAIVERS AND EXPENDITURE AUTHORITIES

A non-exhaustive list of waiver and expenditure authorities available under this section 1115 demonstration opportunity has been provided below. States have the flexibility to request additional waivers and expenditure authorities as necessary to operate their programs to address COVID-19. If additional waivers or expenditure authorities are desired, please identify the authority needed where indicated below and include a justification for how the authority is needed to assist the State in meeting its goals and objectives for this demonstration. States may include attachments as necessary. Note: while we will endeavor to review all state requests for demonstrations to combat COVID-19 on an expedited timeframe, dispositions will be made on

a state-by-state basis, and requests for waivers or expenditure authorities in addition to those identified on this template may delay our consideration of the State’s request.

**A. Section 1115(a)(1) Waivers and Provisions Not Otherwise Applicable under 1115(a)(2)**

The State is requesting the below waivers pursuant to section 1115(a)(1) of the Act, applicable for beneficiaries under the demonstration who derive their coverage from the relevant State plan. With respect to beneficiaries under the demonstration who derive their coverage from an expenditure authority under section 1115(a)(2) of the Act, the below requirements are identified as not applicable. Please check all that apply.

Check to Waive	Provision(s) to be Waived	Description/Purpose of Waiver
X	Section 1902(a)(1)	To permit the State to target services on a geographic basis that is less than statewide.
X	Section 1902(a)(8), (a)(10)(B), and/or (a)(17)	To permit the State to vary the amount, duration, and scope of services based on population needs; to provide different services to different beneficiaries in the same eligibility group, or different services to beneficiaries in the categorically needy and medically needy groups; and to allow states to triage access to long-term services and supports based on highest need.
X	Section 1902(f)	Ability to submit SPAs after April 1 to be effective with the start of the emergency (to effect rate changes for services and programs funded under the MRT Waiver and State Plan.

**B. Expenditure Authority**

Pursuant to section 1115(a)(2) of the Act, the State is requesting that the expenditures listed below be regarded as expenditures under the State Plan.

Note: Checking the appropriate box(es) will allow the State to claim federal financial participation for expenditures that otherwise would be ineligible for federal match.

Check to Request Expenditure	Description/Purpose of Expenditure Authority
X	Allow for self-attestation or alternative verification of individuals’ eligibility (income/assets) and/or level of care to qualify for LTSS.
X	LTSS for impacted individuals even if services are not timely updated in the plan of care, or are delivered in alternative settings.



Check to Request Expenditure	Description/Purpose of Expenditure Authority
X	Ability to pay higher rates for HCBS and other eligible providers performing similar State Plan services in order to maintain capacity.
X	The ability to make retainer payments to certain habilitation and personal care providers to maintain capacity during the emergency. For example, adult day sites have closed in many states due to isolation orders, and may go out of business and not be available to provide necessary services and supports post-pandemic
	Allow states to modify eligibility criteria for long-term services and supports.
X	The ability to reduce or delay the need for states to conduct functional assessments to determine level of care for beneficiaries needing LTSS and self-direction.
X	<p>Other: The ability to make certain changes in billing requirements to eligible providers to maintain capacity during the emergency.</p> <p>Eligible providers for these types of provider capacity payments are defined above and vary by funding pools:</p> <ol style="list-style-type: none"> <li><b>1. Preserving the Safety Net through an Emergency Capacity Assurance Fund;</b></li> <li><b>2. Rapid Facility Conversion; and</b></li> <li><b>3. Regional Coordination and Workforce Deployment</b></li> </ol>
X	Other: Ensuring that safety net providers—both those that operate facilities, provide care in the home or operate programs—have the capacity and resources to treat those affected directly by public health emergencies as well as those with unrelated needs who are impacted by resource limitations and are at risk of contagion.
X	Other: Support ambulatory and community-based providers weather the initial decrease in visits and associated revenue so that patients exiting hospitals have a system of care to support their needs, relieving hospitals from higher rates of readmissions.
X	Other: Identifying and conducting essential preparation to convert outpatient/ambulatory surgery centers, nursing homes and residential facilities (identify minimal features of such facilities and changes to be made in emergency); identifying other infrastructure to be converted (hotels, schools, stadiums, etc.) and a plan to achieve such conversions rapidly; and create flexible discharge networks with other facilities.
X	Other: Utilize the State’s existing PPS infrastructure and support funding to these entities to build out capacities and develop regional management strategies based on specific care delivery models to address COVID-19 (or a subsequent public health emergency) and improve care delivery post-pandemic or public health emergency.

Check to Request Expenditure	Description/Purpose of Expenditure Authority
X	Other: Develop and implement rapid deployment and training for health care and behavioral health workers to take on new roles during a public health emergency, modify procedures for existing roles during public health emergency (e.g., home care workers, clinicians engaged in testing, administrative staffing to report and track testing results, etc.).
X	Other: Extend all timeframes and deliverables of the Self-Directed Care pilot, including those of the external evaluator, for at least the number of quarters in which the emergency declaration was effective.
X	Other: Extend timeframes and deliverables of the New York Behavioral Health demonstration, including those of the independent evaluator, for at least the number of quarters in which the emergency declaration was effective.
X	Other: Permit providers to offer continuity of care for individuals in Institutions for Mental Disease, as demands from COVID-19 may make transfers more difficult or less timely. As part of this request, allow for expenditures/costs not otherwise matchable for increased bed capacity State plan covered services (including the stay and ancillary services) for Medicaid beneficiaries under 65 years of age that are patients in Institutions for Mental Disease, notwithstanding the prohibition on federal financial participation at Section 1905(a)(30)(B).

**VI. Public Notice**

Pursuant to 42 CFR 431.416(g), the State is exempt from conducting a state public notice and input process as set forth in 42 CFR 431.408 to expedite a decision on this section 1115 demonstration that addresses the COVID-19 public health emergency.

**VII. Evaluation Indicators and Additional Application Requirements**

- A. Evaluation Hypothesis.** The demonstration will test whether and how the waivers and expenditure authorities affected the State’s response to the public health emergency, and how they affected coverage and expenditures.
- B. Final Report. This report will consolidate demonstration monitoring and evaluation requirements.** No later than one year after the end of this demonstration addressing the COVID-19 public health emergency, the State will be required to submit a consolidated monitoring and evaluation report to CMS to describe the effectiveness of this program in addressing the COVID-19 public health emergency. States will be required to track expenditures, and should evaluate the connection between and cost effectiveness of those expenditures and the State’s response to the public health emergency in their evaluations of demonstrations approved under this opportunity. Furthermore, states will be required to comply with reporting requirements set forth in 42 CFR 431.420 and 431.428, such as information on demonstration implementation,


progress made, lessons learned, and best practices for similar situations. States will be required to track separately all expenditures associated with this demonstration, including but not limited to administrative costs and program expenditures, in accordance with instructions provided by CMS. CMS will provide additional guidance on the evaluation design, as well as on the requirements, content, structure, and submittal of the report.

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## VIII. STATE CONTACT AND SIGNATURE

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Authorizing Official (Typed): Donna Frescatore  
Authorizing Official (Signature):   
Date: May 11, 2020

### PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (Expires 03/31/2021). The time required to complete this information collection is estimated to average 1 to 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Your response is required to receive a waiver under Section 1115 of the Social Security Act. All responses are public and will be made available on the CMS web site. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. \*\*\*CMS Disclosure\*\*\* Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact Judith Cash at 410-786-9686.