COMMUNITY CARE OF BROOKLYN

May 19, 2022

Submitted Electronically

New York State Department of Health
Office of Health Insurance Programs
Waiver Management Unit
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RE: New York State 1115 Waiver Amendment Public Comments on behalf of the CCB Collaborative

To Whom It May Concern:

The **CCB Planning Collaborative** is pleased to provide these public comments to the State regarding the 1115 Waiver Amendment entitled, "Strategic Health Equity Reform Payment Arrangements: Making Targeted, Evidence-Based Investments to Address the Health Disparities Exacerbated by the COVID-19 Pandemic." The Waiver's focus on social determinants, community engagement and equity demonstrate appreciation for the need for structural change, and a disruption to the status quo; however, the current constructs and investments need to be pragmatically structured to achieve desired outcomes.

The **CCB Planning Collaborative** ("CCB Collaborative") was founded from the successful and sustained work of the **Community Care of Brooklyn (CCB) Performing Provider System (PPS)** which was funded under New York's prior Delivery System Reform Incentive Program **(DSRIP)** Waiver and has been in operation since April of 2015 (see Appendix A for full description of the CCB Collaborative entities). The CCB Collaborative is looking to further the known and effective community driven change of CCB, which **consists of over 1,000 organizations in Brooklyn representing the largest and broadest array of Brooklyn stakeholders** that span various communities, specialties, functions, and care settings. These stakeholders have committed to work together on a plan to improve the health and well-being of Brooklyn residents through implementation of transformative clinical and business initiatives**. Other than NYC itself, CCB covers more targeted citizens than any other NYS county or region.**

A key component of CCB is **Brooklyn Communities Collaborative (BCC)** (founded in 2019) which continues to operate as a convenor of and capacity building entity for community-based organizations. BCC distinguishes itself from other planning entities by including patient and community participatory action research (PAR) to help define its planning efforts. The CCB Collaborative also builds on the **Brooklyn Community Action and Advocacy Workgroup (CAAW)** which serves as a model for cross sector collaboration representing over 125 community stakeholders with a majority of its membership residing in the neighborhoods served by the Collaborative. Project work completed by CCB includes but is not limited to integrating behavioral health and primary care, meaningfully moving the needle on effective transitions in care, with programs developed with community input solicited through a PAR approach. Investments in projects such as care management connections, hydroponic farms at local schools, workforce programs, and other initiatives were driven by community engagement, and addressed specific needs in a measurable way.

The CCB Collaborative is comprised of a select group of members of CCB that includes Chief Executive Officers, Executive Directors and assignees, and has expanded to include **Downstate Health Sciences University**, the Borough's only academic medical center, as a clinical and research partner, and **Healthfirst**, one of the largest non-profit managed care organizations covering the region, and one of the only State-approved MCOs headquartered in NYC, that is already engaged in advanced level VBP arrangements with nearly all the hospitals and many of the providers involved with the CCB Collaborative.

The **CCB Collaborative has already initiated regional planning efforts in Brooklyn** centered on the Waiver principles by completing a current state assessment and aligning Brooklyn-based health system providers, FQHCs, CBOs, and payors to identify and explore **innovative projects that aim to expand and improve access to primary care and integrate social supports into clinical settings, advance telemedicine capabilities and redesign the currently fragmented delivery system into a coordinated and integrated Brooklyn-based system of care, focusing first on maternal and perinatal health, behavioral health, cardiovascular and cancer services** (see plan in Appendix B).

We are writing because we believe the status quo of health care disparities and health inequity in Brooklyn is not acceptable and health care delivery models must be changed to address this public health crisis. New York City, representing 56%[1] of Medicaid enrollment, has an extraordinary opportunity under this Waiver to **improve the health and extend the life expectancy of Brooklyn residents and deliver care in a more culturally competent, patient centric and efficient manner. Brooklyn is an area with the highest concentration (18%)[2] of Medicaid enrollees in the State and a population with the most documented health disparities.** Obesity and hypertension, which increase the risk of cardiovascular diseases, are prevalent in Brooklyn. Flatlands and Canarsie neighborhoods have obesity and hypertension rates that are significantly higher than the rest of NYC (30 vs. 24 percent adult population with obesity, and 37 vs. 28 percent adult population with hypertension).[3]

We believe the **State should focus the Waiver investment in the successful regional collaborations that formed under DSRIP and have been sustained—such as the CCB Collaborative—rather than create new entities**. The Waiver Amendment speaks to the ongoing sustainability of planning entities which will be difficult to achieve for new organizations without existing infrastructure and administrative capabilities. The State should also learn from the shortcomings of DSRIP, including **shifting funding away from siloed prescriptive transactional projects to investment in comprehensive transformation plans that aim to coordinate and integrate care delivery for the region, such as the plan proposed by the CCB Collaborative described in more detail in Appendix B.**

The CCB Collaborative believes that to continue to advance its work on transformation in Brooklyn, the Waiver Amendment should be modified to accomplish the following:

1. **Recognize Brooklyn as a key geography for addressing health disparities by selecting CCB as the HERO for Brooklyn and investing more significantly in supporting community-driven approaches to change**.

[1] New York Department of Health. NYS Medicaid Enrollment by County, April 2022. NYS Medicaid Enrollment Databook. https://www.health.ny.gov/health_care/medicaid/enrollment/

[2] New York Department of Health. NYS Medicaid Enrollment by County, April 2022. NYS Medicaid Enrollment Databook. https://www.health.ny.gov/health_care/medicaid/enrollment/

[3] City of New York. Community Health Profiles 2018, Brooklyn Community District. https://www1.nyc.gov/assets/doh/downloads/pdf/data/2018chp-bk18.pdf

The Waiver Amendment states that the DOH would designate nine HEROs across the State, aligned with the nine rate setting regions for Medicaid managed care. **The State should consider Brooklyn a distinct planning region within NYC, and designate CCB as the Brooklyn HERO**. If the State selects only one NYC HERO, there should be dedicated funding for regional planning in Brooklyn in order to build upon previous work accomplished by CCB.

To accomplish the objectives of the HERO outlined in the Waiver, CCB alone would require a budget of $5 million annually to secure the required people, systems (IT platform, data and analytical capabilities), and other resources. The proposed financing in the Waiver for HEROs of 2% or $65 million annually is insufficient to accomplish the goal of driving community-based planning.

Brooklyn is the most highly populated borough in NYC with an **estimated 2.6 million people**, and is home to the state's largest portion of Medicaid enrollees, **with 1.4 million Medicaid enrollees representing 18% of total statewide Medicaid enrollees and a third (33%) of the total NYC Medicaid enrollee**s.[4] The social, medical and behavioral care needs of Brooklyn residents are different than those in Queens, the Bronx and Manhattan. We believe there is tremendous opportunity to drive great value to key stakeholders, including patients, payors, businesses, and the health care workforce, with a focused planning effort in Brooklyn.

Many of the social determinants of health, such as access to healthy food, a living wage, and adequate housing have long been neglected in Brooklyn's most under-resourced neighborhoods. These inequities affect total cost of care, providing a significant opportunity to enable transformation and generate value to the State Medicaid system.

Moreover, the COVID-19 pandemic highlighted the years of disinvestment in Brooklyn's communities and shined light on the racial health disparities that have existed for some time, as many communities that experienced significantly higher rates of COVID-19 hospitalizations and deaths were formerly redlined neighborhoods. The following figures illustrate some of the socioeconomic and health outcome disparities in Brooklyn.

a. The proportion of Black residents in Brooklyn is 36% compared to 16% in Manhattan,[5] and Black residents comprise greater than 60% of some Brooklyn neighborhoods such as East Flatbush (88%), Brownsville (76%), South Crown Heights/Lefferts Gardens (69%), and Bedford-Stuyvesant (64%);[6]
b. Poverty rates in Brooklyn are more than 26% higher than those in the rest of NYS, with approximately 18% of Brooklyn residents living below the poverty line in 2019;[7]

[4] New York Department of Health. NYS Medicaid enrollment by County, April 2022. NYS Medicaid Enrollment Databook. https://www.health.ny.gov/health_care/medicaid/enrollment/
[5] World Population Review, Brooklyn and Manhattan Population. https://worldpopulationreview.com/boroughs/brooklyn-population and https://worldpopulationreview.com/boroughs/manhattan-population
[6] NYC Community Health Profiles, 2018. https://www1.nyc.gov/site/doh/data/data-publications/profiles.page#bk
[7] City Data Brooklyn, 2019. https://www.city-data.com/poverty/poverty-Brooklyn-New-York.html

c. Fetal-infant mortality rates in Brooklyn neighborhoods such as Brownsville and East Flatbush are almost double that of NYC average (rate of 12.1 and 11.2 deaths per 1,000 births, compared to 6.6, from 2015-2019);[8]
d. Lung and bronchus cancer was the leading cause of cancer deaths across Brooklyn, with an incidence of 44.7 and mortality of 23.3 per 100,000. Asian and Pacific Islanders have the highest incidence of lung cancer;[9]
e. Black men have the highest incidence rate of prostate cancer in Brooklyn (196.4 per 100,000).[10]

2. **Prioritize investing in entities that were successful under DSRIP and that continue to sustain programming that addresses health equity, access, and workforce challenges (i.e., housing, transportation, training, etc.) in alignment with stated 1115 Waiver goals.**

The CCB Collaborative members have built a strong and comprehensive foundation to enable transformation and improve health outcomes in Brooklyn. Together, the CCB Collaborative members represent a substantial footprint within the overall Brooklyn health care market, with a **combined network of over 3,000 clinicians (including 1,100 primary care providers)**, and accounting for over 2,000 staffed beds (41%), nearly 64,000 total discharges (34%), 328,000 emergency room visits, 13,000 FTEs (38%), and over $2 billion in net patient revenues as of 2019.[11]

CCB demonstrated success under DSRIP and developed strong relationships and engagement capabilities that are difficult to replicate.

a. The CCB Collaborative includes a forum **for active engagement with Brooklyn community residents to listen to their voices on how to improve their health and well-being**, building on the work of the CCB **CAAW**.
b. The CCB Collaborative is also unique in that it is **already actively engaged with a payer (Healthfirst),** and has VBP arrangements already in place that likely meet the requirements of "Advanced VBP models" including Global Prepayment models as articulated in the Waiver Amendment that can be expanded and built upon for specific populations with health and social care needs.
c. CCB has continued to sustain and further develop population health programming since DSRIP, including **development of the CCB IPA which includes over 105 entities**, and the **Brooklyn Health Home (BHH), which currently provides care management services** to patients with complex care needs and is currently providing capacity and administrative support services to a network of 17 Brooklyn-based CBOs.
d. **CCB has already initiated regional planning efforts in Brooklyn,** aligning Brooklyn-based providers, FQHCs and CBOs, **and expanding the Collaborative to include Downstate Health Sciences University as an academic, clinical and research partner**.
e. **Brooklyn Communities Collaborative (BCC)** has developed strong relationships at the CBO and community level that are difficult to replicate and has experience in evaluating community needs and translating into programmatic implementation using proven tools, including participatory action research (PAR). In the post-DSRIP period, CCB provided

[8] NYC Summary of Vital Statistics 2019. https://www1.nyc.gov/assets/doh/downloads/pdf/vs/2019sum.pdf
[9] NYS Department of Health. Cancer Incidence and Mortality for Kings County (Brooklyn), 2015-2019. https://www.health.ny.gov/statistics/cancer/registry/vol1/v1ckings.htm
[10] New York State Department of Health, New York State Cancer Registry Cancer Incidence and Mortality by Gender and Race, 2015-2019. https://www.health.ny.gov/statistics/cancer/registry/pdf/table4.pdf
[11] American Hospital Directory Database. 2019 Medicare Cost Reports. https://www.ahd.com/

financial support to its partners and was able to quickly mobilize its community-based partners and clinical practices to reach deeply into Brooklyn communities to increase COVID-19 testing and vaccination. BCC invested $4 million into a Strong Communities Fund Grant program to support CBOs providing vital services including food, housing support, behavioral health and social services to Brooklyn residents.

The State's limited resources should be invested in entities with such existing partnerships, rather than unnecessarily replicating a foundation already built in Brooklyn.

3. **Provide upfront direct investment to CBOs and safety net and State-run healthcare providers to support development of needed infrastructure and capacity.**

Distressed and underfunded institutions do not have working capital to initiate new programs. The Waiver must recognize the need for funding to support start-up operational expenses to expand services (e.g., hiring clinicians and other staff for primary care, mental health and maternal/child health).

The State could accomplish this goal by shifting a portion of the current Waiver allocation under Goal 1.3: Health-Equity Focused System Redesign, Advanced VBP Models, currently funded at $7 billion (or 52% of total funding) to Goal 3: System Redesign for Financially Distressed Providers, and clarifying that these funds in the VBP Incentive Pool can be paid by the State directly to CBOs, safety net and State-run hospitals, and primary care providers and used to build capacity in the following areas:

a. **IT Infrastructure to Achieve a Common Shared EHR Platform**. The Waiver Amendment and/or a newly authorized state capital program to support the Waiver should explicitly provide for fundamental investment in a common shared EHR platform for providers. Without this investment upfront, there will be no ability to measure performance and target resources appropriately. **A shared EHR platform is essential to effectively integrate care and drive value long term, as it enables efficient data sharing and common governance practices critical to effective care management and population health at scale.** A common EHR provides foundational infrastructure to enable future state care models in alignment with Waiver goals (i.e., telehealth, patient navigation, medication reconciliation, risk stratification). The CCB Collaborative members are on disparate platforms that limit interoperability and do not have the capital to independently implement a common EHR, and estimate the investment required to be close to $500 million.

b. **Workforce Capacity and Training Initiatives**. The Waiver Amendment allocates up to 11% or $1.5 billion over five years for workforce capacity and training, which is **not sufficient to achieve the workforce enhancements outlined below, nor is it achievable without front loading necessary funding.** Given the lessons from the pandemic experience on the critical role of the health care workforce and current shortages from the Great Resignation, **the State should increase funding for regional Workforce Investment Organizations (WIOs) and other entities that develop new career pathways and pipelines for community health workers, peers, care managers, etc. that build on current workforce activities with our labor partners.**

CCB recognizes the need for a change in care team composition to adequately meet the

needs of the complex Medicaid population in Brooklyn. Building on significant workforce development efforts during DSRIP, during which CCB provided more than 50,000 hours of training to over 1,500 staff from 156 organizations, BCC continues this work today. BCC, through its Brooklyn Health Enterprise Hub, in partnership with healthcare employer partners, academic and training institutions, including CUNY and Downstate Health Sciences University, and 1199SEIU, are working to build career pipelines and create workforce equity opportunities for people from underserved communities, develop curricula, and recruit and train individuals for careers in healthcare that meet employers' needs. This not only provides opportunity for employment and career advancement within the healthcare sector but also builds a healthcare workforce that reflects the communities they serve, providing the linguistic and cultural support that has been shown to improve health outcomes.

BCC has raised private funding to support workforce development, including training health coaches at CUNY Kingsborough Community College and curriculum development and training for care management supervisors in the Medicaid Health Home program with the Brooklyn Health Home. BCC continues to work with healthcare providers to meet current workforce shortages, and to collectively plan for future workforce needs. These include positions critical to the integration of social support into the physical and behavioral health environment for licensed and non-degree professionals. Consideration to para-professionals and development of curriculum and training programs is required to accomplish meaningful gains in addressing social determinants related to the following areas:

i. Primary, behavioral and women's health practices in particular require an infusion of licensed clinical social workers, doulas, peer counselors, behavioral health associates and community health workers. Outlining career pathways starting at the high school level is necessary to address the demand for these positions in the envisioned future.
ii. Pipelines for licensed professionals, such as behavioral health nurse practitioners, psychiatrists and general obstetricians/gynecologists must be contemplated to address the growing needs of the Brooklyn communities represented by the Collaborative. A current landscape assessment reveals these positions being in critical shortage in the next three-five years.
iii. The current reimbursement system needs to be enhanced in order to enable safety net and State-run providers to offer market rate salaries, competitive benefits and professional development to retain these professionals. These administrative dimensions require investment that financially distressed institutions simply cannot afford.

The following statistics and the aforementioned operational challenges underscore the rationale for enhanced allocation to this aspect of the Waiver Amendment.

i. The unemployment rate in Brooklyn is 6.3% compared to 4.8% in the NY metropolitan area;[12]
ii. 30% of the NYC population resides in federally designated mental health

[12] New York State Department of Labor. State Labor Department Releases Preliminary March 2022 Area Unemployment Rates. April 2022. https://dol.ny.gov/system/files/documents/2022/04/press-release-2-march-2022.pdf

professional shortage areas (HPSA),[13] many of which are in Brooklyn; Brooklyn has one mental health provider for every 390 people compared to a better ratio of one mental health provider for every 100 people in Manhattan.[14]

Additionally, the CCB Collaborative recognizes as a core value the importance of racial and ethnic concordance between patients and physicians in order to build confidence in the care delivery system, engage patients in care, and offset years of deep mistrust.[15,16] For example, research has indicated a reduction in infant mortality with racially/ethnically concordant physician-patient relationships.[17] In responding to the critical shortage of clinicians, the **CCB Collaborative members led by Downstate Health Sciences University is uniquely poised and ready to intentionally focus efforts to increase the pipeline of diverse clinicians of color to meet the growing demands of the Brooklyn patient population**.

Downstate Health Sciences University is the sole academic medical center for a borough of 2.6 million people and is essential to training the future physicians and other professionals required to serve Brooklyn and NYC. Downstate Health Sciences University and CUNY have the academic platform to evolve curriculum to support innovative practice models and the infrastructure, community relationships and committed support from the CCB Collaborative provider, FQHC and CBO network for workforce training and support for essential School of Medicine training sites.

The State should consider the collective strength of Downstate Health Sciences University, including its School of Public Health, and the aforementioned workforce development programs though BCC, CUNY and various labor partners to form a WIO for Brooklyn and/or provide incentives for linkages with existing designated NYC WIOs through the Brooklyn Health Enterprise Hub which focuses on non-degree training programs. New York should provide more detail on how, specifically, Waiver funds will be used to support curriculum design, programmatic implementation and operating subsidy, and student incentives (i.e., tuition assistance), and consider looking beyond the WIOs to make meaningful investments in the workforce including direct care workers, CHWs, social workers, navigators.

c. **Virtual Care Capacity Including Telehealth Capabilities.** The State should invest more significantly in allowing the CCB Collaborative and others to create robust telemedicine platforms that will enhance access to care for historically marginalized communities. These

[13] NYC Mayor's Office of Community Mental Health. Mental Health Data Dashboard. https://mentalhealth.cityofnewyork.us/dashboard/

[14] County Health Rankings & Roadmaps. New York 2022 County Health Rankings. https://www.countyhealthrankings.org/app/new-york/2022/measure/factors/62/data?sort=sc-0

[15] PubMed. Race/Ethnicity Concordance Between Patients and Physicians. February 2017. https://pubmed.ncbi.nlm.nih.gov/28259218/

[16] The Commonwealth Fund. Disparities In Patient Experiences, Health Care Processes, And Outcomes: The Role Of Patient–Provider Racial, Ethnic, And Language Concordance. July 2004. https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_fund_report_2004_jul_disparities_in_patient_experiences__health_care_processes__and_outcomes__the_role_of_patient_provide_cooper_disparities_in_patient_experiences_753_pdf.pdf

[17] Proceedings of the National Academy of Science (PNAS) USA. Physician–patient racial concordance and disparities in birthing mortality for newborns. August 2020. https://www.pnas.org/doi/10.1073/pnas.1913405117

platforms must be coupled with strategies to ensure individuals have access to devices and broadband for telehealth services to be optimally effective. The State includes as one of its Waiver core investment areas the creation of a **statewide Equitable Virtual Care Access Fund** and allocates 2% of total funding ($300M over five years) for safety net providers for human capital investment and resources to deliver telehealth through various modalities. **We support New York's focus in this area and recommend that the State increase this funding allocation, and provide more detail on how, specifically, it intends to use Waiver funds to advance digital health and telehealth in ways that meaningfully address health disparities.** For example, the State could specify use of Waiver funds to develop and support the following:

i. At scale remote patient monitoring programs for high-prevalence chronic conditions, such as hypertension, diabetes, COPD, and heart failure, tailored for communities identified as being high-priority;
ii. Regional specialty e-consult programs so that patients at safety net and State-run facilities can access specialty consult services (e.g., in neurology, psychiatry, pediatrics) from remote specialists, creating efficiencies and expanding access to specialty services;
iii. Telehealth platforms that connect patients to health providers for virtual visits, virtual consults and remote monitoring;
iv. School-based telehealth and school-based care coordination programs with a focus on expanding access to preventive services, primary care and behavioral health;
v. Universal broadband accessibility and affordability, including developing community Wi-Fi hot spots so that every New Yorker has access to the internet;
vi. Expanded funding for cell phones, tablets and remote monitoring devices where it is clinically and financially effective to do so; and
vii. Programs that enable safety net and State-run providers to hire CHWs and others to help bridge the digital divide and address barriers to participation (e.g., digital literacy, technology support, internet and device access and usability).

d. **Physician Recruitment and Start-up Capital for Network Development**. The Waiver Amendment does not explicitly include investments to hospitals, primary care providers and CBOs to efficiently resource the development of shared infrastructure for participating entities' capacity to succeed in VBP arrangements, including the following:
   i. Start-up operational expenses to expand services (primary care, mental health and maternal/child health), and supporting reimbursement models that incentivize this expansion, as current Medicaid outpatient rates do not cover cost to deliver services.
      1. Federally Qualified Health Centers (FQHCs) represent a significant component of the healthcare delivery system. FQHCs, which by their mission serve a significant population of Medicaid enrollees, face significant challenges in meeting the primary and specialty care needs of their communities, including the inability to suitably invest in the appropriate number of providers to manage chronic diseases and to perform specialty interventions. This includes full-time cardiologists, maternal fetal medicine specialists, oncologists and licensed therapists. The opportunity for a Brooklyn-based provider network in maternal/child health, heart and vascular services, cancer care and behavioral health afford scalable recruitment, credentialing and coverage opportunities for

member organizations that they would not be able to otherwise fund or administer.

ii. Funds to recruit and retain adequate and integrated provider networks capable of generating value. Brooklyn has a shortfall of primary care physicians (PCPs), averaging 5.7 PCPs per 10,000 people compared to the NYC average of 9.2; the problem is especially acute in North, Central, and East Brooklyn with seven out of nine council districts in the area reporting three or less PCPs per 10,000 people;[18]

iii. Funds to recruit and retain non-licensed front-line workers (e.g., CHWs, social workers, health coaches).

4. **The State should exhibit greater flexibility than in the prior DSRIP Waiver to accept existing, proven VBP arrangements available in the marketplace today, such as off-menu Level 3 Total Cost of Care arrangements, as Advanced VBP models**.

5. **We have significant concerns based on review of the Waiver Amendment that the current design, including the new role of SDHNs, may disrupt progress already made by CCB in developing and operationalizing integrated care models. Further discussion and stakeholder input is required and should address the following:**
   a. As the system is designed, the primary goal should be to support new integrated care models;
   b. Sufficient funding should be provided to invest in building CBO capacity and to incentivize integrated care models that deliver both social care supports and medical and behavioral health care services. How will regional SDHNs and health care provider networks be incentivized to work together and with MCOs on design of new integrated care models?
   c. To avoid creation of new siloed entities as SDHNs, the State should select experienced organizations with roots in the community that have earned the trust of CBOs to be SDHNs, such as BCC.

The State should leverage the significant investment already made in the SHIN-NY as it procures a statewide IT social needs platform, and the data structure should be designed to allow integration of data at the care team level. The State should consider allowing NYeC and the QEs to lead the selection of the statewide social care IT platform, and the criteria for selection should require that this data platform be in the public domain and shared with the State, versus considered proprietary.

The Waiver also indicates that SDHNs will advise on the best structure for completing social care need (SCN) screenings and referrals. **A statewide approach to screening will be helpful to ensure that all members are being asked the same questions, and to determine rules for data access and transfer; these determinations should be developed as part of a statewide collaborative process**. **However, to ensure widespread participation, there should be flexibility in the assessment tool that is allowed to do the screenings, rather than requiring adoption of a standard tool.**

In summary, we recommend that the State modify the Waiver Amendment prior to submission to CMS to:

[18] Primary Care Development Corporation. NYC Council District Primary Care Access Profiles. August 2019. https://www.pcdc.org/resources/nyc-council-district-primary-care-access-profiles/

1. **Allow CCB to serve as the HERO for Brooklyn. Provide for implementation funding to be directed by the Brooklyn HERO in support of value-based programs; subsequent operations would be funded through the MCOs;**

2. **Prioritize investing in entities and partnerships such as CCB that were successful under DSRIP and continue to sustain programming in alignment with stated 1115 Waiver goals;**

3. **Provide upfront direct investment to CBOs and healthcare providers to support start-up operational costs for IT infrastructure, workforce capacity and training initiatives, virtual care capacity, and network development;**

4. **Accept existing, proven VBP arrangements (e.g., off-menu Level 3 Total Cost of Care arrangements) as Advanced VBP models; and**

5. **Pursue further discussion and stakeholder input regarding the Waiver design to ensure it supports and does not interfere with the development of new integrated care models. The State should leverage the significant investment in the SHIN-NY as it procures a statewide IT social care platform and ensure the data structure is designed to allow integration of data at the care team level.**

Thank you for the opportunity to provide comments during the public stakeholder process. For questions or clarifications, please contact David Cohen (DCohen@maimonidesmed.org). We look forward to continued collaboration to advance health equity and improve the health and wellbeing of the communities we serve in Brooklyn.

Sincerely,

David I. Cohen, MD, MSc
Chair, CCB Executive Committee

APPENDIX A: BACKGROUND ON THE CCB PLANNING COLLABORATIVE

Who We Are

The **CCB Planning Collaborative** ("CCB Collaborative") originated from the foundational work of the **Community Care of Brooklyn (CCB) Performing Provider System**, the PPS funded under New York's prior **DSRIP** Waiver. **The CCB Collaborative** consists of over 1,000 organizations in Brooklyn comprised of a broad array of specialties, functions, and care settings, and is currently governed by an **Executive Committee** comprised of its member Chief Executive officers, Executive Directors and assignees. Anchor members include **Arthur Ashe Institute, Brownsville Multiservice Center (FQHC), Downstate University Health Sciences Center, Healthfirst, Maimonides Medical Center**, **One Brooklyn Health System (OBH), other Brooklyn health systems, other FQHCs and CBOs. Membership is open** and expanding to other Brooklyn providers.

The CCB Collaborative members have built a strong and comprehensive foundation to enable transformation and improve health outcomes in Brooklyn. Together, the CCB Collaborative members represent a substantial footprint within the overall Brooklyn health care market, with a **combined network of over 3,000 clinicians (including 1,100 primary care providers)**, and accounting for over 2,000 staffed beds (41%), nearly 64,000 total discharges (34%), 328,000 emergency room visits, 13,000 FTEs (38%), and over $2 billion in net patient revenues as of 2019.[19]

Objectives

Driven by the overarching objective to meet community needs and improve health in Brooklyn, the CCB Collaborative seeks to:

- Improve access to a more coordinated, cohesive and comprehensive Brooklyn-based system of care that results in the majority of Brooklyn residents receiving their care in Brooklyn;
- Improve the health and well-being of Brooklyn residents through active outreach and engagement by leveraging the work of BCC and its coordinated network of community-based partners providing supportive community resources and services to address issues of unemployment, housing and homelessness, food insecurity, lifestyle choices, and gun and domestic violence;
- Reduce disparities in health outcomes among the Black and Latinx populations in Brooklyn, particularly for diabetes, asthma, behavioral health, cancer, and maternal and infant mortality;
- Optimize resource allocation through continued clinical service line integration among the Collaborative hospital partners and coordinated capital planning and investment with a focus on early wins in neurology, cardiology, cancer care, women's and children's services and behavioral health services;
- Strengthen the academic training programs, including the education and training of medical students, through further program integration among partners to stabilize and expand the local healthcare workforce, recruit, develop and retain talent, and support research programs across specialties;
- Expand the Brooklyn Health Home network and activities that manage the behavioral health, physical health and social service needs of Medicaid patients in Brooklyn through integrated care practices; and
- Develop expanded network of accessible primary care providers throughout Brooklyn in partnership with existing FQHCs and physician practices that agree to exchange health data and coordinate care with the Collaborative hospitals, CCB IPA, and other partners.

[19] American Hospital Directory Database. 2019 Medicare Cost Reports. https://www.ahd.com/

CCB Sustainable Entities Post DSRIP

Significant progress has been made over the past five years through coordinated planning and investment under CCB to foster clinical relationships among Brooklyn healthcare organizations and build strong linkages to community-based organizations. Post DSRIP, these efforts have been sustained, continued and expanded through the development and ongoing work of the following Brooklyn entities and initiatives:

- **Brooklyn Communities Collaborative (BCC**), a not-for-profit 501c-3 organization which brings together over 100 health care organizations and CBOs to work on improving housing, employment, workforce issues and other socio-economic issues. BCC launched in 2019 as a community-led, anchor institution-supported effort to improve health and wealth in Brooklyn.
- **The CCB IPA** is a non-profit organization established in 2018 as an integrated network of health and social services partners committed to improving the health and well-being of diverse communities across Brooklyn. The network consists of 105 entities (208 unique TINS) including six acute care hospital sites (from three health systems Maimonides, One Brooklyn Health and Wyckoff), eight FQHCs, 500 primary care physicians working at 75 PCMH certified sites, 16 OASAS programs (11 sites) and 27 OMH programs, specialty physician practices, and community-based organizations. CCB IPA negotiates value-based contracts with Medicaid managed care organizations (72,000 covered lives) and participates as an ACO in the Medicare Shared Savings Program and Bundled Payments for Care Improvement – Advanced initiative.
- **The Brooklyn Health Home (BHH)** coordinates comprehensive, community-based care management services for chronically ill Medicaid patients by connecting them with a dedicated care manager, physical and behavioral health providers, social services, community programs and more.
- **Brooklyn's Community Action and Advocacy Workgroup (CAAW)** was started by CCB and is a model for cross-sector collaboration that identifies community needs through direct community input and develops strategies and interventions that address those needs. The group developed a series of participatory action research (PAR) projects that included community residents, high school and college students, as well as local organizations and elected officials, in the research, design, implementation, and report development. The group is currently developing programs in property management and built environment training which will improve the living conditions of countless individuals and families in Brooklyn. The CAAW has been meeting approximately every two months to provide participants with updates on ongoing PAR work and the resulting initiatives, which have continued and evolved since the group's inception.
- **Regional clinical and academic collaboration particularly among One Brooklyn Health, Maimonides Medical Center and Downstate Health Sciences University** has emerged from the pandemic and includes the appointment of common Clinical Board Chairs, including neurology and pathology, and plans for other regional clinical and academic programs in hematology/oncology. Maimonides and OBH are major training sites for Downstate Health Sciences University and essential for student tertiary services experience.

APPENDIX B: CCB Collaborative Regional Transformation Plan

See attached project plan graphic.

While CCB has succeeded across many dimensions, the CCB Collaborative members recognize that sustaining and modernizing Brooklyn's healthcare infrastructure most effectively requires further regional collaboration and **development of a regional transformation plan** with a long-term vision of creating an **integrated Brooklyn Academic Health Care System.**

The CCB Collaborative has completed significant planning to understand the current environment, the social, medical and behavioral health needs of Brooklyn residents, and identify service gaps. Members have participated in a series of meetings to discuss and identify the barriers to effective care within the current Brooklyn health system design that need to be solved in order to move the needle on improving the health equity of Brooklyn residents.

The Collaborative has identified the following transformative projects as having the greatest potential impact to improve the health and extend the life expectancy of Brooklyn residents, enabled by a mechanism for joint planning and investment. Detailed descriptions of these projects are below.

1. **Brooklyn Collaborative Digital Health Initiatives.** Literature review has shown that investment in appropriate virtual care, also known as telemedicine or telehealth, has significant potential to improve access to care, make care more equitable, reduce health care spending and improve quality by 15 to 20%.[20] The Collaborative members are each in preliminary stages of designing various digital health products and believe they could leverage these efforts and have greater impact for patients. The Collaborative would launch and manage the following:
    a. Center for Innovation (R&D) and Training
    b. Center for Digital Medicine and Telehealth Delivery
    c. Digital Front Door and Patient Access Center

2. **Brooklyn Shared Research Platform including Joint Clinical Trials Network.** A joint venture or collaborative agreement for shared research infrastructure management and investment that would have potential to reduce overhead expenditures and accelerate research. This would include the launch of a Brooklyn "Clinical Trials Network" that provides enhanced access to people in Central and East Brooklyn to clinical studies, and shared program development in health services and health equity research.

3. **Integrated Service Line Development.** The Collaborative identified preliminary candidates for accelerated integration based on its review of market data and interviews with clinical leadership in **maternal and perinatal health, behavioral health, cardiovascular care, and cancer care.** Within each area, the Collaborative would accelerate and expand integration of clinical service line departments by bringing clinical and academic assets together, and develop plans to expand access to services, improve population health, and create stronger clinical protocol and referral patterns to keep care within Brooklyn.

[20] Harvard Busines Review. The Telehealth Era Is Just Beginning. May 2022. https://hbr.org/2022/05/the-telehealth-era-is-just-beginning

a. **Maternal and Perinatal Health**. **Create a Brooklyn Center for Maternal Health** with the goal of reducing maternal and fetal deaths for Black women, as well as maternal morbidity arising from SUD and hemorrhage. The Center will require investment to build a coordinated Hub, Spoke and Node model, with Regional Birthing Centers and a new low risk (midwife) birth center option serving as the HUB, and three new comprehensive Women's Centers of Excellence serving as Nodes – two in Central Brooklyn and one in East Brooklyn, providing primary and specialty women's health with diagnostics, other ancillaries and access to MFM specialists and addressing co-morbid conditions such as SUD, mental health needs, diabetes and hypertension. The Spokes consist of existing and expanded hospital, FQHC and community-based primary care and obstetric practices providing prenatal care with embedded CHWs or social workers to screen for and provide social care (e.g., transportation, nutrition, housing assistance and substance use disorder referral).

b. **Behavioral Health. Expand previous DSRIP models that integrated behavioral health and primary care services and add digital telehealth capabilities** through partnership with digital behavioral health entities (e.g., Eleanor Health, Spring Health) to expand access and reduce disparities. The goal would be to achieve co-location (in-person or virtual) of behavioral services at every PCP site of Collaborative partners and supplement these practices with team-based models of care including psychiatric NPs, psychologists, health coaches, and other care team members who provide warm handoffs at point of care.

c. **Cardiovascular Care. Create a Brooklyn Heart and Cardiovascular Institute** with the goals of reduction in the number of Brooklyn residents with uncontrolled hypertension, reduced heart failure readmissions particularly among Black residents, and improved access measured by reducing the number of cardiac services out-migrating from Brooklyn from its current level of 21% of total cardiac discharges (outmigration rates are 55% for cardiac surgery and 39% for interventional cardiology). This program seeks to coordinate services across CCB Collaborative members under a common clinical quality committee and includes investments to increase primary care in the communities and engage residents in basic heart disease management programs and refer to cardiac specialists in a timely manner; develop a new Heart Failure Center in Central/East Brooklyn; and build remote patient monitoring services which can be scaled borough wide.

d. **Cancer Care. Create a single Brooklyn Hematology/Oncology service** with the goals of increased cancer screening especially for lung, colorectal, and breast cancer and improved early detection of cancer disease; decreased wait times between presentation, diagnosis and treatment; increased cancer clinical trials for Black and Brown residents of Central/East Brooklyn; and reduction in out-migrating cancer cases from current level of 40% of total cancer discharges. This would be accomplished by exploring different structures to achieve shared infrastructure including common clinical leadership and clinical protocols, regional tumor boards, clinical trials infrastructure, screening protocols (lung, breast, prostate, colorectal), and wrap around patient supports. Investments would be needed to expand the workforce by increasing primary care providers and building support workers (CHWs, social workers, navigators) to ensure patient follow-up to care and address SDOH such as transportation.

4. **Strengthen Network for Whole Person Care (Health Promotion) and Develop VBP Arrangements.**

Under this project, the Collaborative would design and build clinical and social support **network products** with VBP arrangements based on payer input for **s**pecific patient populations including Brooklyn residents with the following health needs: **maternal and perinatal care, substance use disorder (SUD), cancer, and cardiovascular care.** For each, the Collaborative would develop clinical pathways and capabilities to optimize patient care management and the ability to address the social determinants of health.

5. **IT and Analytics Infrastructure Alignment.** Joint investment to transition Collaborative provider partners to a common EHR (e.g., Epic) and data analytics platform**.** The CCB Collaborative estimates an investment needed of up to $500 million to implement Epic as a common EMR platform for its members. Among the health system members in the CCB Collaborative, OBH currently has an Epic platform including its acute and ambulatory sites, and Maimonides and Downstate Health Sciences University would need a full conversion from their current Allscripts platform to Epic.

6. **Brooklyn Healthcare Workforce Training Institute and GME Consortium.** Leveraging the expertise of Downstate Health Sciences University's School of Public Health, the CCB Collaborative would develop new, non-degree educational and training programs (certificates, badges) in priority workforce areas in primary care, maternal health, and behavioral health. In addition, the Collaborative could evolve to a GME consortium model to selectively align, improve, and grow residency and fellowship programs.

COMMUNITY CARE OF BROOKLYN

(1)

CCB Planning Collaborative to enable coordinated strategic planning and project development.

- Build on successful DSRIP collaboration
- Engage community members on ways to improve health in Brooklyn
- Establish collaborative pathways addressing primary care shortages, SDOH, and health disparities
- Vehicle for implementing transformative clinical and business initiatives

Continue assessment of opportunities for clinical collaboration in maternal and child health, behavioral health, cardiovascular medicine and cancer while evaluating and pursuing below project set and Waiver alignment opportunities

Initial Project Set

Brooklyn Collaborative Digital Health Initiatives

(2)

Develop a coordinated set of digital health initiatives that would launch and manage the following:

- Center for Innovation (R&D) and Training
- Center for Digital Medicine and Tele-health Delivery
- Digital front door and Patient Access Center

Brooklyn Shared Research Platform including Joint Clinical Trials Network

(3)

- Joint venture or collaborative agreement for shared research infrastructure management and investment
- Brooklyn "Clinical Trials Network" that provides enhanced access to clinical studies and shared infrastructure and supports
- Shared program development in health services and health equity research

Integrated Service Line Development

(4)

- Accelerate and expand integration of clinical service line departments by bringing clinical and academic assets together
- Develop plans to expand access to services, advance population health, reduce disparities, and create stronger clinical protocol and referral patterns
- Preliminary candidates for accelerated integration – CV, cancer, pathology, maternal and child health, behavioral health, urology

Strengthen Network for Whole Person Care and Develop VBP Arrangements

(5)

- Develop network products that could be part of VBP arrangements for specific patient populations (preliminary candidates: SUD, maternal and child)
- Evaluate for which populations can we create clinical and social support networks and programs to support products
- Develop clinical pathways and capabilities to optimize patient care management and the ability to address the social determinants of health
- Enhance primary care access and capacity including redesigning care models to support interdisciplinary teams and facilitate a whole person care approach

IT and Analytics Infrastructure Alignment

(6)

Transition Collaborative partners to a common EHR (e.g., Epic) and data analytics platform

Brooklyn GME Consortium and Healthcare Workforce Training Institute

(7)

- Collaborative agreement for selective shared research infrastructure management and investment
- Collaborative to develop new, non-degree educational/training programs (certificates, badges) in priority workforce areas in primary care, maternal health, and behavioral health
- Institute or Center for Health Services and Health Equity Research
- Alignment of research and clinical programs in key program areas