DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Amir Bassiri
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New York Department of Health
Empire State Plaza, Corning Tower, Room 1466
Albany, NY 12237

Dear Amir Bassiri:

The Centers for Medicare & Medicaid Services (CMS) is approving New York's request to amend to its Medicaid section 1115(a) demonstration entitled, "Medicaid Redesign Team" (MRT) (Project Number 11-W-00114/2). Approval of this demonstration amendment will allow the state to advance health equity, reduce health disparities, support the delivery of health-related social needs (HRSN) services, and promote workforce development. In addition, the amendment provides the state with Substance Use Disorder (SUD) demonstration authority. This amendment is effective as of the date of this approval and will remain in effect throughout the demonstration approval period, which is set to expire March 31, 2027.

Through the combination of a Medicaid Hospital Global Budget Initiative, HRSN services and activities, workforce initiatives, and the establishment of a Health Equity Regional Organization (HERO), the state is aiming to reduce health disparities across the state and improve health equity. The New York 1115 demonstration amendment supports the state's interest and preparation in pursuing two Center for Medicare and Medicaid Innovation (CMMI) models—the Making Care Primary model and the States Advancing All-Payer Health Equity Approaches and Development (AHEAD). By the end of this section 1115(a) demonstration, the state's goal is to have made significant movement towards value-based payment (VBP) strategies, multi-payor alignment, and population health accountability. The overall goals of this approval include:

1. Investments in HRSN via greater integration between primary care providers and community-based organizations (CBOs) with a goal of improved quality and health outcomes;
2. Goal of improving quality and outcomes of enrollees in geographic areas that have a longstanding history of health disparities and disengagement from the health system, including through an incentive program for safety net providers with exceptional exposure to enrollees with historically worse health outcomes and HRSN challenges;
3. Focus on integrated primary care, behavioral health (BH), and HRSN with a goal to improve population health and health equity outcomes for high-risk enrollees including kids/youth, pregnant and postpartum individuals, the chronically homeless, and individuals with SUD;

4. Workforce investments with a goal of equitable and sustainable access to care in Medicaid; and
5. Developing regionally focused approaches, including new VBP programs, with a goal of statewide accountability for improving health, outcomes, and equity.

CMS has determined that this amendment is likely to assist in promoting the objectives of the Medicaid statute by increasing access to high-quality medical assistance and coverage for Medicaid beneficiaries. With this amendment, New York is introducing new initiatives and investments to assist the state in improving health coverage, access, and consistent provision of high-quality services for Medicaid beneficiaries, while additionally making important gains in advancing health equity among its beneficiary populations.

As reflected in the statute, the primary objective of the Medicaid program is to furnish medical assistance. This demonstration is expected to promote the objective of furnishing medical assistance by strengthening access to high quality care for all those with Medicaid coverage.

CMS's approval is subject to the limitations specified in the attached waiver and expenditure authorities, special terms and conditions (STCs), and any supplemental attachments defining the nature, character, and extent of federal involvement in this project. The state may deviate from the Medicaid state plan requirements only to the extent those requirements have been specifically listed as waived or not applicable to expenditures under the demonstration.

Extent and Scope of the Demonstration Amendment

Approval of the New York amendment includes the following new initiatives: (1) HRSN, (2) HERO, (3) Medicaid Hospital Global Budget Initiative, and (4) Strengthen the Workforce. The initiatives below, in some cases, complement each other to further the demonstration goals. For example, SCNs and the HERO collaborate to ensure standard screening, referral, service delivery, stakeholder engagement, and data collection which is expected to ultimately lead to advanced VBP arrangements and options for incorporating HRSN into VBP methodologies.

(1) HRSN

HRSN Infrastructure

The demonstration amendment provides New York under the HRSN infrastructure authority the opportunity to create SCNs, which are contracted entities in each of the state's regions. The SCNs will provide HRSN screening and referral services to otherwise eligible Medicaid beneficiaries that are targeted populations for HRSN services.

CMS's authorization of limited infrastructure spending up to the amount of $500 million to support HRSN services, is expected to improve the availability and quality of the services delivered.

HRSN Services

CMS is authorizing up to $3.173 billion for the provision of increased coverage of certain services that address HRSN, as evidence indicates that these benefits are critical drivers of an individual's access to health services that keep them well.[1,2] The state has designed a two-tiered system of benefits based on screening. All Medicaid beneficiaries will receive Level 1 services which entails referring individuals to existing state, federal, and local programs that are separate from the newly authorized HRSN set of services. Level 2 HRSN services will be provided to targeted eligible beneficiaries enrolled in Medicaid managed care who meet certain criteria such as: 1) Medicaid high utilizers, 2) individuals enrolled in a New York state designated Health Home, 3) individuals with SUD, 4) individuals with serious mental illness, 5) individuals with intellectual and developmental disabilities, 6) individuals who meet the Department of Housing and Urban Development's definition of homeless, 7) pregnant persons, up to 12 months postpartum, 8) post-release criminal justice-involved population with serious chronic conditions, SUD, or chronic Hepatitis-C, 9) juvenile justice involved youth, foster care youth, and those under kinship care, 10) children under the age of 6, and, 11) children under the age of 18 with one or more chronic conditions. SCNs will work in conjunction with managed care plans to provide referrals for HRSN services.

HRSN services authorized in this demonstration must be evidence-based and medically appropriate for Medicaid eligible beneficiaries who meet predetermined and documented clinical and social risk factors. A comprehensive list of the populations that will be eligible to receive Level 1 and Level 2 HRSN services will be described in the post-approval Protocol(s) for HRSN Services and Infrastructure, subject to CMS review and approval. The specific HRSN services are described in the STCs.

CMS is approving as part of the amendment's HRSN package the potential for individuals with high-risk pregnancies to receive nutrition interventions (i.e., pantry stocking, food prescriptions or meal delivery) for up to the length of the pregnancy, and then up to two months postpartum, for a total of 11 months. These individuals must meet all other requirements to receive the service, including meeting clinical risk factors. This approval also authorizes additional nutritional support (i.e., meals, pantry stocking, food prescriptions) for the households of high-risk pregnant individuals or high-risk children is permitted, if the pregnant individual or child is screened as needing the service. Expanding the nutritional support service to include pantry stocking and food prescriptions in addition to meals treats them similarly and further supports the health needs of the beneficiaries related to social needs. We are defining the size of an eligible household for beneficiaries in alignment with the state's Supplemental Nutrition Assistance Program (SNAP) household definition. These nutritional interventions may be

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[1] As discussed in a letter to State Health Officials issued on January 7, 2021, https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf, addressing Social Determinants of Health can more effectively improve population health, reduce disability, and lower overall health care costs in the Medicaid program. While "social determinants of health" is a broad term that relates to the health of all people, HRSN relates more specifically to an individual's adverse conditions reflecting needs that are unmet and contribute to poor health. See also https://www.healthaffairs.org/do/10.1377/forefront.20191025.776011/full/

[2] Bachrach, D., Pfister, H., Wallis, K., Lipson, M. Addressing Patients' Social Needs: An Emerging Business Case for Provider Investment. The Commonwealth Fund; 2014; https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_fund_report_2014_may_1749_bachrach_addressing_patients_social_needs_v2.pdf.

renewed for additional 6-month periods if the state determines the beneficiary still meets the clinical and needs-based criteria. Medicaid-covered HRSN services and supports will not supplant the work or funding of another federal or state non-Medicaid agency. This should include making sure eligible individuals are enrolled in other food assistance programs such as SNAP/WIC as primary and assessment of services provided to make sure that Medicaid is wrapping around and appropriately adjusting Medicaid benefits and not displacing/duplicating these services.

With this approval, CMS will permit up to six months of short-term pre-procedure and post-hospitalization housing, which may be renewed per year (on a rolling 12-month basis) during the approved demonstration period limited to a clinically appropriate time period. Pre-procedure housing has been requested by New York and will focus around an episode of care and preventing use of inpatient or facility services. As indicated above, the totality of the combined services would be six months per 12-month period.

CMS is providing authority for cooking supplies outside of initial transitions into the community, brokerage fees for beneficiaries obtaining housing that requires those payments, as well as transportation costs for beneficiaries accessing covered HRSN and case management services. However, these services are outside of the HRSN capped hypothetical budget neutrality construct and will be paid for with budget neutrality savings by the state.

HRSN services will be provided through a combination of the fee-for-service and managed care delivery systems, with case management and referral services administered through SCNs in each region of the state. The state will initially operationalize the benefits through non-risk arrangements in managed care, effective April 2024, with the aim of integrating the benefits into full risk managed care by March 2027.

CMS also expects the state to maintain existing state funding and efforts for HRSN services, without this demonstration authority supplanting existing efforts, and to have in place partnerships with other state and local entities to coordinate possible pathways to permanency for services to be provided without demonstration authorities.

Coverage of targeted HRSN services and supports is likely to assist in promoting the objectives of Medicaid because it is expected to help beneficiaries stay connected to coverage and access to needed health care. The housing and nutritional support services authorized in the demonstration are expected to stabilize the housing and nutritional situations of eligible Medicaid beneficiaries and thus increase the likelihood that they will keep receiving and benefitting from the Medicaid-covered services to which they are entitled.

Coverage of targeted, clinically appropriate HRSN services will also provide a regular source of care to meet individuals' comprehensive health needs. This is likely to improve health outcomes directly, as well as improve the use of other clinical services. By providing the short-term services needed to stabilize housing, this demonstration will test whether the individual's health outcomes will improve in addition to their utilization of appropriate care.

Moreover, the Medicaid statute, including both sections 1905 and 1915 of the Social Security Act (the Act), already includes mechanisms that reflect the critical role of upstream services (i.e.,

those that help avert more intensive medical interventions) in meeting the medical assistance needs of certain Medicaid-eligible populations (e.g., individuals with disabilities).

Medical assistance made available under a state plan option authorized under section 1915(i) of the Act provides that same package of home and community-based services (HCBS) to individuals meeting needs-based criteria that are less stringent than criteria required for institutional placement. These services are also intended to avert a need for nursing facility care.

Available evidence[3] suggests there may be populations in addition to those eligible under 1915(c) or 1915(i) criteria that would benefit clinically from the section 1915(c) or 1915(i) services described above, as well as additional upstream HRSN services. Additional research is needed to better understand the effects of providing these types of services to a broader group of people. To that end, this demonstration will test whether expanding eligibility for these services to additional populations or providing additional services can improve the health outcomes of certain Medicaid beneficiaries. The demonstration will also test whether extending eligibility for a broader range of Medicaid beneficiaries or providing additional services will help to maintain coverage by preventing health-related incidents that could lead to enrollment churn.[4]

Moreover, access to these services for individuals with poorer health outcomes may help to reduce health disparities. Expanding who can receive these services is expected to help a broader range of Medicaid beneficiaries not only receive, and benefit from, the medical assistance to which they are entitled, but also, these services are expected to further reduce health disparities often rooted in socioeconomic factors.[5] Thus, broadening the availability of certain HRSN services is expected to promote coverage and access to care, improve health outcomes, reduce disparities, and create long-term, cost-effective alternatives or supplements to traditional medical services.

(2) HERO

CMS is authorizing up to $125 million (total computable) in expenditure authority for the HERO over the course of the remaining demonstration period. The HERO is a contracted statewide entity designed to develop regionally focused approaches to reduce health disparities, advance quality and health equity for overall populations, and support the delivery of HRSN services. In support of the demonstration amendment's aim of reducing health disparities, the HERO will conduct the following five activities: (1) data aggregation, analytics, and reporting; (2) conduct a regional needs assessment and planning; (3) convene regional stakeholder engagement sessions; (4) make recommendations to support advanced value-based arrangements and develop options for incorporating HRSN into VBP methodologies; and (5) conduct program analysis, such as publishing initial health equity plans and health factor baseline data on Medicaid populations.

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[3] September 23, 2021. ASPE Contractor Project Report: Building the Evidence Base for Social Determinants of Health Interventions. https://aspe.hhs.gov/reports/building-evidence-base-social-determinants-health-interventions

[4] April 12, 2021. Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic. https://aspe.hhs.gov/sites/default/files/private/pdf/265366/medicaid-churning-ib.pdf

[5] April 1, 2022. Addressing Social Determinants of Health: Examples of Successful Evidence-Based Strategies and Current Federal Effort. https://aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84aae8ff0fae7474af82/SDOH-Evidence-Review.pdf

The HERO will assist New York in developing and designing VBP goals to address HRSN and the most impactful health equity priorities.

(3) Medicaid Hospital Global Budget Initiative

CMS is approving this initiative in recognition that some financially distressed safety net hospitals in New York face substantial challenges in making additional, necessary investments for delivery system reform, as they are often already financially hard-pressed to maintain basic operations let alone develop new processes and infrastructure. This initiative will support investments that will lead to measurable improvements in outcomes and financial sustainability of these hospitals which have a high Medicaid and Uninsured Payor Mix. The Medicaid Hospital Global Budget Initiative will support financially distressed safety net hospitals transition to a global budget to incentivize and enable selected hospitals to focus on population health and health equity, improve quality of care, stabilize safety net hospital finances, and advance accountability through the adoption of a global budget alternative payment model.

CMS is authorizing up to $2.2 billion (total computable) over approximately three and a half years (date of amendment approval through March 31, 2027) or $550 million (total computable) annually for the Medicaid Hospital Global Budget Initiative provided that the state meets certain requirements outlined in the STCs. This initiative will provide funding to certain private not-for-profit hospitals that are financially distressed;[6] located in in the Bronx, Kings, Queens, and Westchester Counties due to their significantly adverse health risk factors and health outcomes and Medicaid and Uninsured Payor Mix of at least 45 percent.[7]

In support of the state's delivery system transformation goals, the state will be required to submit a plan for a Medicaid Hospital Global Budget Model. If the state applies for and is chosen as a participant in the CMMI AHEAD model and satisfies criteria as part of its participation in the model, it will be deemed to have met the requirements for this initiative. Nothing binds CMS to approve any future proposal from the state. AHEAD is a voluntary, state-based alternative payment and service delivery model designed to curb health care cost growth, improve population health, and advance quality and health equity by reducing disparities in health outcomes. If the state is not chosen under the AHEAD model, it must submit its own Medicaid Hospital Global Budget Model that meets the requirements specified in the STCs.

(4) Strengthen the Workforce

CMS is authorizing up to $694 million (total computable) over three years to support workforce recruitment and retention to promote the increased availability of certain health care practitioners who serve Medicaid and demonstration beneficiaries. New York, like other states, continues to face health care provider shortages, as well as challenges in recruiting and retaining a diverse

[6] Private Not-For-Profit Hospitals with an average operating margin that is less than or equal to 0 percent over the past four years (Calendar Years 2019-2022) based on audited Hospital Institutional Cost Reports (excluding COVID relief funding and state-only subsidy); and Private Not-For-Profit Hospitals or their affiliates that received state-only subsidies due to financial distress in State Fiscal Years 2023 and/or 2024.

[7] These areas have measurably higher rates of obesity, diabetes, hypertension, congestive heart failure, infant mortality, and avoidable hospitalizations. The Bronx has consistently been ranked as the worst county in New York State with respect to health outcomes and social factors contributing to overall health.

workforce, and the COVID-19 public health emergency (PHE) magnified these issues. This approval continues and builds upon other demonstration workforce initiatives meant to improve access to care for Medicaid beneficiaries. New York will implement two workforce initiatives, Student Loan Repayment for Qualified Providers and Career Pathways Training (CPT), that will target workforce shortages in healthcare staffing, support the delivery of HRSN services, and increase access to culturally appropriate services. Demonstration funding for these initiatives does not supplant state and federal funding or duplicate existing workforce loan repayment and professional training programs.

The student loan repayment program will provide loan repayment for healthcare professionals working in certain healthcare workforce shortage professions,[8] who make a four-year full-time work commitment to a practice panel that includes at least 30 percent Medicaid and/or uninsured members.

The CPT Program is designed to build up the allied health and other healthcare workforce by funding training and education that focuses on career advancement and unemployed individuals in order to create a reliable healthcare workforce pipeline to address health workforce shortages throughout the state. The CPT program will be organized into no more than three regions to support statewide implementation. CPT participation is conditioned on a three-year commitment of service to healthcare providers enrolled in the Medicaid program that serve at least 30 percent Medicaid members and/or uninsured individuals. The state will contract with Workforce Investment Organizations (WIOs), to implement the CPT program. WIOs will provide participant recruitment, coordination of training, supportive services, and meaningful case management support of the individuals to assure successful completion of their programs and job placement.

Designated State Health Programs (DSHP)

In December 2017, CMS issued SMDL #17-005, titled "Phase-out of Expenditure Authority for Designated State Health Programs in Section 1115 Demonstrations," in which CMS announced it no longer would accept state proposals for new or extended section 1115 demonstrations that rely on federal matching funds for DSHP. The 2017 SMD Letter explained that CMS has approved section 1115 demonstrations that provided federal funding for DSHP that had previously been funded only with state funds, because (absent the section 1115 authority) state expenditures on these programs did not qualify for federal matching funds. These approvals enabled the state to use the "freed up" state dollars, that would otherwise have been spent on the DSHP, on demonstration expenditures. CMS has rescinded this previous guidance, effective December 23, 2022,[9] and is implementing an updated approach to DSHP as discussed below and as reflected in other recent section 1115 demonstration approvals.[10]

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[8] The loan repayment amount varies by healthcare professionals and is limited to psychiatrists (up to $300K), primary care physicians (up to $100K), dentists (up to $100K), nurse practitioners (up to $50K), and pediatric clinical nurse specialists (up to $50K).

[9] https://www.hhs.gov/guidance/document/phase-out-expenditure-authority-designated-state-health-programs-section-1115

[10] https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/or-health-plan-09282022-ca.pdf, and https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/az-hccc-ca-10142022.pdf.

Recently, states have proposed demonstrations that seek federal matching funds for a state-funded DSHP so that they can "free up" state funding for Medicaid coverage initiatives. CMS is approving section 1115 demonstrations that provide federal funding for DSHPs under defined criteria that limit both the size and scope of DSHP and apply additional parameters and guardrails. Federal expenditure authority for DSHP is provided only if the state uses the "freed up" state funding on a new demonstration initiative that CMS has determined is likely to assist in promoting the objectives of Medicaid, such as improving access to high-quality covered services. CMS expects that any new DSHP-funded initiative will add to the state's Medicaid program, not supplant existing services or programs.

CMS's revised approach to DSHP, and the approach being approved with this New York MRT amendment, demonstrates CMS's continuing commitment to the federal-state financial partnership as a hallmark of Medicaid. As described in the STCs, New York will be required to contribute state funds other than those freed up by the federal investment in DSHP for expenditures under the DSHP-supported demonstration initiative. DSHP authority will be time-limited, and the state will be required to submit a sustainability plan which describes the scope of DSHP-supported initiatives the state wants to maintain, and the strategy to secure resources to maintain these initiatives beyond the current demonstration approval period.

As described in the STCs, New York is contributing non-DSHP funds (e.g., general revenue) as the non-federal share of the DSHP-supported initiatives on an annual basis. With this New York demonstration amendment, CMS is authorizing up to $3.981 billion in DSHP expenditure authority to support DSHP-Funded Initiatives, which include the HERO, new HRSN services, HRSN infrastructure, and workforce initiatives. Any new DSHP-funded initiative requires approval from CMS via an amendment to the demonstration that meets the applicable transparency requirements.

As with other recent DSHP approvals, the state can seek federal matching funds up to the amount of the approved DSHP cap only if budget neutrality "savings" are available for that purpose. Because the state will be permitted to use the freed-up state funds that result from approval of the federal matching funds for its DSHP only on initiatives that improve access to covered services, approving the federal match for the state's DSHP is expected to result in an increase in overall service coverage of low-income individuals in the state, improve health outcomes for Medicaid beneficiaries and other low-income populations in the state, and increase efficiency and quality of care. Additionally, because the DSHP-funded HRSN demonstration initiative on which New York is permitted to spend its "freed up" state funds will be treated as "hypothetical" expenditures for purposes of budget neutrality, the state will not be able to generate increased "savings" from the DSHP funded-HRSN demonstration initiative. This will also help to ensure that approving these federal expenditures will not have a significant negative impact on Medicaid fiscal integrity.

The state must contribute $351 million in original, non-freed up DSHP funds, for the remaining demonstration period ending on March 31, 2027, towards its initiatives. Additional requirements for DSHP are defined in the STCs – as are program types excluded from eligibility for DSHP funding – and the state may not claim federal financial participation (FFP) for DSHP until the specific state programs are approved by CMS. CMS has generally not approved DSHP requests for expenditures that are already eligible for federal Medicaid matching funds or other sources of

federal funding, that are generally part of normal operating costs that would be included in provider payment rates, or that are not likely to promote the objectives of Medicaid (e.g., bricks and mortar, animal shelters and vaccines, and revolving capital funds). The specific state programs will be limited to programs that are population- or public health-focused, aligned with the objectives of the Medicaid program with no likelihood that the program will frustrate or impede the primary objective of Medicaid, which is to provide coverage of services for low-income and vulnerable populations, and serve a community largely made up of low-income individuals.

Provider Rate Increase

CMS is committed to improving access to quality care for all Medicaid beneficiaries and is engaged in an "all of Medicaid" approach to improve coverage, access to, and quality of care, as well as to improve health outcomes for all beneficiaries consistent with Medicaid's statutory objectives. Further, we expect that such policies will also have the effect of mitigating health disparities. Research shows that increasing Medicaid payments to providers improves beneficiaries' access to health care services and the quality of care received. To that end, as a condition of approval for expenditure authority for DSHP, quality and health equity initiatives such as the Medicaid Hospital Global Budget Initiative, HRSN services, related infrastructure, Workforce Initiatives, and the HERO, the state will be required to increase and (at least) sustain Medicaid fee-for-service provider base payment rates and Medicaid managed care payment rates in primary care, behavioral health, and obstetrics care, should the state's Medicaid-to-Medicare provider rate ratio dip below 80 percent in any of these categories.

At least a two-percentage point payment rate increase will be applied to each of the services in each service category in each of Medicaid managed care and fee-for-service delivery systems that the state operates. The state must attest that the rate increases will be implemented according to the STCs, and that it will not decrease provider payment rates for other Medicaid or demonstration-covered services for the purpose of making state funds available to finance these required provider rate increases (i.e., cost-shifting). The state must also sustain the increase for the remaining years of the demonstration.

New York is also required to invest approximately $199 million (total computable) in rate increases as part of the demonstration amendment, which must be sustained by the state once implemented. This requirement is applicable even if no Medicaid rates are below 80 percent of Medicare rates. The state may make the rate increases in any demonstration year, but the net provider rate increases must amount to $199,072,125 by the end of the demonstration period. CMS expects the state to prioritize the three core service domains listed above, but the state may invest into specialty rates such as dental services if the three service domains already have rates close to Medicare.

SUD Amendment

On December 21, 2022, New York submitted an amendment application to its section 1115(a) demonstration. With this approval, the state is authorized to receive federal Medicaid matching funds for services delivered to beneficiaries residing in an institution for mental diseases (IMD) with a SUD diagnosis. New York submitted its SUD Implementation Plan and SUD Health

Information Technology (HIT) Plan as required by the STCs. The SUD Implementation Plan describes the strategic approach and detailed project implementation plan, with timetables, programmatic content, and the key goals and objectives of the SUD demonstration. The SUD Implementation Plan also includes a HIT Plan that details the necessary health information technology (IT) capabilities in place to support beneficiary health outcomes to address the SUD goals of the demonstration. CMS has completed its review of the SUD Implementation Plan and SUD HIT Plan and has determined that both are consistent with the applicable requirements set forth in the STCs. The agency is, therefore, concurrently approving the SUD Implementation Plan and SUD HIT Plan. These documents will be incorporated as Attachment H of the STCs.

The goal of the SUD demonstration amendment is for the state to maintain and enhance access to SUD services, and to continue delivery system improvements to provide more coordinated and comprehensive treatment for beneficiaries with SUD. With this approval, beneficiaries will have access to a continuum of services at new settings that, absent this approval, would be ineligible for payment for most Medicaid enrollees. Specifically, the SUD demonstration amendment, in alignment with the demonstration goals outlined in SMDL #17-003, "Strategies to Address the Opioid Epidemic,"[11] published on November 1, 2017, is expected to:

- Increase rates of identification, initiation, and engagement in treatment for SUD;
- Increase adherence to and retention in treatment;
- Reduce overdose deaths, particularly those due to opioids;
- Reduce utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services;
- Reduce readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate; and
- Improve access to care for physical health conditions among beneficiaries with SUD.

Continuous Eligibility for Children

In support of additional coverage expansion across the state, New York has indicated to CMS that it intends to submit an amendment to its demonstration in early 2024 to provide continuous Medicaid eligibility to children up to age six. This policy aims to support consistent coverage and continuity of care by keeping beneficiaries enrolled until they reach age six, regardless of income fluctuations or other changes that otherwise would affect eligibility (except for death or ceasing to be a resident of the state). CMS looks forward to receiving the official amendment request from New York.

Budget Neutrality

Under section 1115(a) demonstrations, states can test innovative approaches to operating their Medicaid programs if CMS determines that the demonstration is likely to assist in promoting the objectives of the Medicaid statute. CMS has long required, as a condition of demonstration approval, that demonstrations be "budget neutral," meaning the federal costs of the state's Medicaid program with the demonstration cannot exceed what the federal government's Medicaid costs in that state likely would have been without the demonstration. In requiring

[11] https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd17003.pdf.

demonstrations to be budget neutral, CMS is constantly striving to achieve a balance between its interest in preserving the fiscal integrity of the Medicaid program and its interest in facilitating state innovation through section 1115 approvals. In practice, budget neutrality generally means that the total computable (i.e., both state and federal) costs for approved demonstration expenditures are limited to a certain amount for the demonstration approval period. This limit is called the budget neutrality expenditure limit, and is based on a projection of the Medicaid expenditures that could have occurred absent the demonstration (the "without waiver" [WOW] costs). Historically, if a state's "with waiver" (WW) costs for a demonstration approval period were less than the expenditure limit for that period, the unspent funds or "savings" rolled over into the next approval period, which meant that the state could incur higher WW costs during the new approval period.

CMS and states have generally been applying an approach to calculating budget neutrality that CMS described in a 2018 SMDL.[12] Under this approval, projected demonstration expenditures associated with each new Medicaid Eligibility Group in the WOW baseline have been trended forward using the President's Budget trend rate to determine the maximum expenditure authority for the approval period. In contrast, under the approach described in the 2018 SMDL, CMS would use the *lower of* the state's historical trend or the President's Budget trend rate. Using the President's Budget trend rate instead aligns the demonstration trend rate with federal budgeting principles and assumptions.

In a key change from the approach described in the 2018 SMDL, CMS is treating certain HRSN expenditures as "hypothetical" for purposes of New York's budget neutrality calculation. As described in the 2018 SMD Letter, when calculating budget neutrality CMS effectively treats a hypothetical expenditure like an expenditure the state could have made absent the demonstration. As a result, hypothetical expenditures are included in both the without waiver (WOW) baseline and the estimate of the with waiver (WW) expenditures under the demonstration, and states do not have to find demonstration "savings" to offset hypothetical expenditures. However, when evaluating budget neutrality, CMS does not offset non-hypothetical expenditures with projected or accrued "savings" from hypothetical expenditures. That is, "savings" are not generated from a hypothetical population or service if the state does not spend up to the hypothetical expenditure limit. To allow for hypothetical expenditures, while preventing them from resulting in "savings," CMS applies a separate, independent budget neutrality "supplemental test" for hypothetical expenditures. These supplemental budget neutrality tests subject the hypothetical expenditures to predetermined limits to which the state and CMS agree, and that CMS approves, during negotiations. If the state's WW hypothetical spending exceeds the supplemental test's expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending by finding "savings" elsewhere in the demonstration or to refund the federal matching funds to CMS.

In the 2018 SMD Letter, CMS explained that it historically considered demonstration expenditures to be "hypothetical" in the following circumstances: (1) when they are for populations or services that the state could otherwise have covered under its Medicaid state plan or other title XIX authority, such as a waiver under section 1915 of the Act; or (2) when a WOW spending baseline is difficult to estimate due to variable and volatile cost data resulting in

[12] August 22, 2018. SMD#18-009 Re: Budget Neutrality Policies for Section 1115(a) Demonstration Projects. https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd18009.pdf

anomalous trend rates (e.g., CMS has treated demonstration expenditures on the "adult group" described in section 1902(a)(10)(A)(i)(VIII) of the Act as hypothetical for this reason).

Under this approval, certain HRSN expenditures are considered "hypothetical" expenditures and are included in the budget neutrality WOW baseline. Some of these expenditures, as discussed above, are expenditures for services that the state could otherwise cover under other title XIX authority, such as tenancy and nutrition supports for beneficiaries. Treating those expenditures as hypothetical is consistent with how CMS has historically treated similar expenditures. While other approved HRSN expenditures could not otherwise be covered under title XIX authority, such as expenditures on section 1915(c) and 1915(i) services for beneficiaries who would not otherwise be eligible for them under section 1915, there are insufficient or inconsistent data to calculate a WOW baseline for at least some of these expenditures. Treating those expenditures as hypothetical also is consistent with how CMS has historically treated similar expenditures.

As discussed above, based on robust academic-level research, it appears likely that these state expenditures could improve the quality and effectiveness of downstream services that can be provided under state plan authority.[13] Additionally, as discussed below, covering HRSN services
might improve beneficiary health, reducing the future downstream costs of medical care for these beneficiaries. At the same time, predicting these downstream effects on overall Medicaid program costs of covering certain evidence-based HRSN services is extremely difficult, making it hard for CMS to pinpoint the estimated fiscal impact of these expenditures on demonstration budget neutrality or on the state's overall Medicaid program. Treating demonstration HRSN expenditures as hypothetical will give the state the flexibility to test these worthy innovations, especially as CMS anticipates that they might result in overall reductions in future Medicaid program costs.

Historically, CMS has often authorized expenditures through section 1115 demonstrations subject to expenditure limits. In this case, to ensure that treating certain HRSN expenditures as hypothetical will not have a significant negative impact on Medicaid fiscal program integrity, CMS is applying a budget neutrality spending cap to HRSN services expenditures and an additional sub-cap to HRSN infrastructure expenditures, and is referring to these expenditures as "capped hypothetical expenditures" in the STCs.

The caps on expenditures for these HRSN services and related infrastructure activities differ from the usual limits CMS places on hypothetical expenditures under the "supplemental test" discussed above in several respects. First, ordinarily, if a state exceeds the hypothetical expenditure limit, it can offset the additional costs with savings from the rest of the demonstration. That will not be permitted with the HRSN expenditures. However, unspent expenditure authority allocated for HRSN infrastructure in a given demonstration year can be

[13] Lipson, D. J. *Medicaid's Role in Improving the Social Determinants of Health: Opportunities for States*. National Academy of Social Insurance; 2017; https://www nasi.org/wp-content/uploads/2017/06/Opportunities-for-States web.pdf; Whitman, A., De Lew, N., Chappel, A., et al. *Addressing Social Determinants of Health: Examples of Successful Evidence-Based Strategies and Current Federal Efforts*. Assistant Secretary for Planning and Evaluation; 2022;
https://aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84aae8ff0fae7474af82/SDOHEvidence-Review.pdf.

applied to HRSN services in the same demonstration year. Any unspent HRSN services expenditure authority may not be used to fund HRSN infrastructure. Second, the expenditures subject to the cap are narrowly defined to reflect only expenditures associated with services that research indicates are likely to have certain positive downstream effects, as discussed above. Third, the upper limit on the cap is based on a range of estimates of the likely cost of these expenditures over the course of the 3.5 year amendment period and set at a mid-point in that range. While this cap deviates from the traditional approach to hypothetical expenditures, it is consistent with CMS' historical approach to maintaining budget neutrality in Medicaid demonstrations, and it does not alter the underlying financing structure of the Medicaid program. This cap will ensure that the state maintains its investment in the state plan benefits to which beneficiaries are entitled while testing the benefit of the HRSN services described above. This cap will not apply to any other benefits or services.

CMS is also revising the approach to adjusting the budget neutrality calculation in the middle of a demonstration approval period. Historically, CMS has limited its review of state requests for "mid-course" budget neutrality adjustments to situations that necessitate a corrective action plan, in which projected expenditure data indicate a state is likely to exceed its budget neutrality expenditure limit. CMS has updated its approach to mid-course corrections in this demonstration approval to provide flexibility and stability for the state over the life of a demonstration. This update identifies, in the STCs, a list of circumstances under which a state's baseline may be adjusted based on actual expenditure data to accommodate circumstances that are either out of the state's control (e.g., expensive new drugs that the state is required to cover enter the market); and/or the effect is not a condition or consequence of the demonstration (e.g., unexpected costs due to a public health emergency); or the new expenditure (while not a new demonstration-covered service or population that would require the state to propose an amendment to the demonstration) is likely to further strengthen access to care (e.g., a legislated increase in provider rates). CMS also explains in the STCs what data and other information the state should submit to support a potentially approvable request for an adjustment. CMS considers this a more rational, transparent, and standardized approach to permitting budget neutrality modifications during the course of a demonstration.

Element of the Request that the State will Pursue via Managed Care Authority

During the course of the negotiations, the state requested to direct its managed care plans to make Medicaid Patient Centered Medical Home (PCMH) payments to align with PCMH payments available to Medicare providers under the Making Care Primary Model. CMCS informed the state that no section 1115 authority was needed for the state to direct its managed care plans to make these payments since primary care is a Medicaid state plan benefit. CMCS apprised the state of alternative options for establishing this model, including a state-directed payment (SDP). CMCS noted other states have established PCMH payments under SDP authority. New York has indicated that it intends to pursue SDP authority for these payments. Nothing binds CMS to approve any future SDP proposal from the state.

Requests Not Being Approved at This Time

New York asked CMS to defer consideration of the serious mental illness (SMI) component of its SUD/SMI amendment until a later time to provide additional time to consider meeting

required milestones under the SMI framework, and to continue discussions with CMS about providing services to individuals who reside in a state mental health hospital or IMD for more than 60 days. Under the 2018 SMI SMDL, the IMD expenditure authority is only available for short-term stays.

New York and CMS continue to review the state's request for limited coverage of certain services furnished to certain incarcerated individuals for up to 90 days immediately prior to the beneficiary's expected date of release. New York is working to align its request with the April 17, 2023 SMDL #23-003, entitled "Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who Are Incarcerated."[14] CMS looks forward to continuing to work with the state on this component of the amendment request.

Monitoring and Evaluation

Consistent with CMS's requirements for section 1115 demonstrations, and as outlined in the demonstration's STCs, the state is required to continue conducting systematic monitoring and robust evaluation of the demonstration, including the policies and initiatives approved through this amendment, per applicable CMS guidance and technical assistance. The demonstration's monitoring activities must support tracking the state's progress toward meeting the goals—including relative to their projected timelines and applicable milestones—of the demonstration's program and policy implementation, and infrastructure investments. The state must report on metrics that relate to the demonstration's key policy components.

The demonstration's metrics reporting must cover categories including, but not limited to, enrollment and renewal, including enrollment duration, access to providers, utilization of services, and quality of care and health outcomes. The state is required to do robust reporting of outcomes of care, cost and quality of care, and access to care aligned with the demonstration's policies and objectives, to be reported for all demonstration populations. Such reporting must also be stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, English language proficiency, primary language, disability status, and geography), and by demonstration components, to the extent feasible. Subpopulation reporting will support identifying any existing shortcomings or disparities in quality of care and health outcomes and help track whether the demonstration's initiatives help improve outcomes for the state's Medicaid population, including the narrowing of any identified disparities.

To that end, CMS underscores the importance of the state's reporting of quality of care and health outcomes metrics known to be important for closing key equity gaps in Medicaid/ Children's Health Insurance Program (CHIP) (e.g., the National Quality Forum (NQF) "disparities-sensitive" measures) and prioritizing key outcome measures and their clinical and non-clinical (i.e., social) drivers of health. In coordination with CMS, the state is expected to select such measures for reporting in alignment with a critical set of equity-focused measures CMS is finalizing as part of its upcoming guidance on the Disparities-Sensitive Measure Set.

[14] https://www.medicaid.gov/sites/default/files/2023-04/smd23003.pdf

For the HRSN components, in addition to reporting on the metrics described above, the state must track beneficiary HRSN eligibility levels, participation, screening, rescreening, receipt of referrals, recurring nutrition services, and social services over time, as well as narratively report on the adoption of information technology infrastructure to support data sharing between the state or partner entities assisting in the administration of the demonstration and social services organizations, and the contracted providers of applicable services (e.g., managed care plans and their contracted HRSN providers). The state must additionally monitor and provide narrative updates on its progress in building and sustaining its partnership with existing housing and nutrition agencies. Furthermore, the state's enrollment and renewal metrics must also capture baseline data and track progress via Monitoring Reports for the percent of Medicaid renewals completed ex-parte (administratively), as well as the percent of Medicaid beneficiaries enrolled in other public benefit programs (such as the SNAP or Women, Infants and Children) for which they are eligible. The Monitoring Reports must also provide status updates in accordance with the Monitoring Protocol on the implementation of infrastructure investments tied to the HRSN initiatives.

For the Workforce Initiatives, the state must report on student loan repayment and CPT activities, in addition to providing details on statewide and regional program targets, vacancy rates, CPT program completion rates, and corrective actions. The state must also include narrative information on the operations of the WIOs. For the HERO component, the state must report on data aggregation, regional needs assessments and planning, stakeholder engagement, development of future VBP arrangements, health equity plans, and health factor baseline data. For the Medicaid Hospital Global Budget Initiative, the state must report on the required data and reports outlined in the STCs for each of the demonstration years, as well as data on relevant quality measures and progress toward meeting program targets.

Monitoring Reports should include required financial information (e.g., hospital uncompensated care costs, state-only subsidies received, payor-mix calculations, and operating margin calculations). The state will also be required to provide narrative annually on which hospitals have applied for the CMMI AHEAD model. For the SUD component, the state's monitoring must cover metrics in alignment with the respective milestones as outlined in the SMDL #17-003.

Furthermore, under the STCs and consistent with current CMS guidance, the state must develop a rigorous Evaluation Design using robust data sources and sound analytic approaches that support a comprehensive and meaningful evaluation of the demonstration to assess whether the demonstration components, including components added to the demonstration through this amendment, are effective in producing the desired outcomes for its beneficiaries and providers, as well as the state's overall Medicaid program. In compliance with the STCs, New York submitted to CMS a draft Evaluation Design for the policies effective as of April 2022, which is currently under CMS review. With this amendment approval, the state can choose either to amend its existing draft Evaluation Design or submit a separate Evaluation Design. The demonstration evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components—including those that were authorized in the initial approval of the New York MRT demonstration—that support understanding of the demonstration's impact on beneficiary coverage, access to and quality of care, and health outcomes, as well as its effectiveness in achieving the policy goals and objectives.

In addition to evaluation hypotheses for New York MRT policies that were previously approved, hypotheses for the HRSN components of the demonstration must focus on areas such as beneficiary utilization of HRSN services, severity of beneficiaries' social needs, utilization of preventive and routine care, utilization of and costs associated with potentially avoidable, high-acuity health care, utilization of hospital and institutional care, and beneficiary physical and mental health outcomes. In addition, the state must coordinate with its managed care plans to secure necessary data—for a representative beneficiary population eligible for the HRSN services—to conduct a robust evaluation of the effectiveness of the HRSN services in mitigating identified needs of beneficiaries. Hypotheses must be designed to help understand the impact of housing supports, case management, nutritional services, and transportation support toward accessing covered HRSN services and case management activities on beneficiary health outcomes and experience.

In alignment with the demonstration's objectives to improve outcomes for the state's overall beneficiary populations eligible for the HRSN initiatives, the state must also include research questions and hypotheses focused on understanding the impact of the HRSN initiatives on advancing health quality, including through the reduction of health disparities, for example, by assessing the effects of the initiatives in reducing disparities in health care access, quality of care, or health outcomes at the individual, population, and/or community level. The state must also include research questions and hypotheses focused on how renewals of recurring nutrition services affect care utilization and beneficiary physical and mental health outcomes, as well as the cost of providing such services.

The evaluation must also assess the effectiveness of the infrastructure investments authorized through the demonstration to support the development and implementation of the HRSN initiatives. The state must also examine whether and how local investments in housing, nutrition, and any other type of allowable HRSN services change over time in concert with new Medicaid funding toward those services. In addition, considering how the demonstration's HRSN expenditures are being treated for purposes of budget neutrality, the evaluation of the HRSN initiative must include a cost analysis to support developing comprehensive and accurate cost estimates of providing such services. The state is also required to include a robust assessment of potential improvements in the quality and effectiveness of downstream services that can be provided under the state plan authority, and associated cost implications.

For the SUD program, the state must include an assessment of the objectives of these components of the demonstration. Hypotheses may include compliance with treatment, utilization of health services (emergency department and inpatient hospital settings), and a reduction in key outcomes, such as deaths due to overdose.

The state's evaluation efforts must also develop robust hypotheses and research questions to assess the effectiveness of the state's DSHP-funded initiatives in meeting the desired goals of such programs in advancing and complementing its broader HRSN and other applicable initiatives for its Medicaid beneficiaries and other low-income populations. The analysis must be designed to help demonstrate how these programs support, for example, expanding coverage, improving access, reducing health disparities, and/or enhancing home-and-community-based services or services to address HRSN or behavioral health.

For the Workforce Initiatives, the state must develop hypotheses and research questions to evaluate the effects of the initiatives on beneficiary access to care, as compared to what may be achieved through direct interventions such as rate increases. The state should also evaluate how close estimated costs and positions awarded to each CPT were to actual costs and awards, how effective backfill costs were at retaining work levels while the backfilled individual left for CPT, improvements in overall staffing levels, the rationale for any dropout or incomplete training programs, the quality of the WIO workforce training performance measures, and long-term effects of the workforce programs on retention. The Evaluation Design must outline hypotheses and research questions to assess whether these initiatives sustainably reduce workforce shortages and increase provider retention, especially in the concentration areas such as primary care, behavioral health, and family practice.

The state's evaluation efforts must also include developing hypotheses and research questions to assess the effectiveness of the Medicaid Hospital Global Budget Initiative in ensuring provision of consistent high-quality care to all beneficiaries, as well as progress toward adopting global payment methodologies. Evaluation hypotheses should focus on the effects of the Medicaid Hospital Global Budget Initiative payments toward improving hospital operating margins and an analysis of hospital financial health. For the HERO component of the demonstration, the evaluation should assess the effectiveness of the five main activities: data aggregation, regional needs assessment, stakeholder engagement, designing VBP, and program analysis.

As part of its evaluation efforts, the state must conduct a demonstration cost assessment to include, but not be limited to, administrative costs of demonstration implementation and operation, Medicaid health services expenditures, and provider uncompensated care costs. The state must analyze the budgetary effects of the HRSN services, and the overall medical assistance service expenditures and uncompensated care and associated costs for populations eligible for continuous eligibility, including in comparison to populations not eligible for such policies. In addition, the state must use findings from hypothesis tests aligned with other demonstration goals and cost analyses to assess the demonstration's effects on the fiscal sustainability of the state's Medicaid program.

The state is strongly encouraged to evaluate the implementation of the demonstration programs to better understand whether implementation of certain key demonstration policies happened as envisioned during the demonstration design process and whether specific factors acted as facilitators of—or barriers to—successful implementation. The implementation evaluation can inform the state's crafting and selection of testable hypotheses and research questions for the demonstration's outcome and impact evaluations and provide context for interpreting the findings. In addition, CMS underscores the importance of the state undertaking a well-designed beneficiary survey and/or interviews to assess, for instance, beneficiary understanding of the various demonstration policy components, and beneficiary experiences with access to and quality of care.

Finally, to the extent feasible, the state must collect data to support analyses stratified by key subpopulations of interest (e.g., by sex, age, race/ethnicity, English language proficiency, primary language, disability status, and geography). Such stratified data analyses will provide a fuller understanding of existing disparities in access to and quality of care and health outcomes

and help inform how the demonstration's various policies might support reducing such disparities.

Consideration of Public Comments

Health Equity Amendment Public Comments

To increase the transparency of demonstration projects, section 1115(d)(1) and (2) of the Act directs the Secretary to issue regulations providing for two periods of public comment on a state's application for a section 1115 demonstration that would result in an impact on eligibility, enrollment, benefits, cost-sharing, or financing. The first comment period occurs at the state level before submission of the section 1115 application, and the second comment period occurs at the federal level after the application is received by the Secretary. New York completed its state level public comment period, holding two virtual public hearings, as required, from April 13, 2022, to May 20, 2022.

Section 1115(d)(2)(A) and (C) of the Act further specifies that comment periods should be "sufficient to ensure a meaningful level of public input," but the statute imposes no additional requirement on the states or the Secretary to address those comments, as might otherwise be required under a general rulemaking. Accordingly, the implementing regulations issued in 2012 provide that CMS will review and consider all comments received by the deadline but will not necessarily provide written responses to all public comments (42 Code of Federal Regulations (CFR) 431.416(d)(2)).

The federal comment period opened on September 19, 2022, and closed on October 19, 2022. There were 303 public comments received during the federal comment period; however, nine of these comments were duplicative, unclear, or blank, and, therefore, were not considered. Out of the remaining 294 comments,[15] only one comment expressed opposition to the health equity amendment. Implementation of HRSN services was widely supported within the public comments. The most prevalent common themes in the comments supporting the demonstration were that it promotes equity, addresses social needs, and expands workforce capability. There were 17 comments in support and 276 comments that supported the demonstration but also offered suggestions for improvement.

A single commenter, the nonprofit statewide coalition Health Care For All New York,[16] expressed opposition to the health equity amendment, citing two primary concerns. The first concern was that the demonstration amendment request did not concretely identify the populations targeted or the specific health outcome metrics that would be used to define the demonstration amendment's success. The second concern was that the demonstration's equal allocation of funding across all regions of the state would perpetuate and potentially exacerbate existing racial disparities in New York. The commenter suggested that the funding should be allocated based on the regions with the greatest need.

[15] Out of the 294 relevant comments, 205 were an identical form letter from pediatric providers.

[16] Health Care for All New York (HCFANY) was the only commenter that overtly opposed the demonstration. HCFANY is a nonprofit that is a statewide coalition of 170 organizations dedicated to achieving quality, affordable health coverage for all New Yorkers.

Regarding the commenter's concern that the state's application did not concretely identify the populations targeted or identify specific health metrics/ outcomes that would be used to identify the demonstration's success, the demonstration's STCs provide this specificity. For example, the STCs specifically identify the HRSN eligibility criteria for the populations that will receive Level 1 and Level 2 HRSN services. The STCs require the state to monitor and evaluate all components of the demonstration amendment. The monitoring STCs require the state to report on specific metrics for each component of the demonstration amendment. The evaluation STCs require that the state to develop hypotheses and research questions to address every component of the demonstration amendment.

Regarding the comment that the allocation of funding would perpetuate and potentially exacerbate existing racial disparities, the STCs clarify that the amount of HRSN funding is on a statewide basis. Therefore, the areas of the state with the most beneficiaries who qualify for HRSN services will receive the most amount of funding. The stated goal of the amendment is to advance health equity, reduce health disparities, and support the delivery of HRSN services. In addition, the commenter notes that funding should be allocated based on the regions with the greatest need. The Medicaid Hospital Global Budget Initiative is targeted in the areas of the state with the greatest need.

There were 205 identical public comments that were received from a letter writing campaign that supported the amendment, but advocated for additional, dedicated investments in maternal and child health with a focus on improving developmental, behavioral, and mental health. These commenters advocated for the need for the state to meet the federal Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) (child behavior and development) requirements through dedicated funding. In addition, the letter proposed that each region in New York should be required to identify a portfolio of effective behavioral and mental health approaches for children and youth, as outlined in the August 18, 2022, CMCS Informational Bulletin (CIB), that it should implement in demonstration years 2 through 5 of the amendment. Finally, these commenters advocated for continuous enrollment in Medicaid for children up to age six. The state has expressed interest in submitting an additional amendment to pursue continuous enrollment in Medicaid for children up to age six. The state expects to submit this amendment to CMS in early 2024.

Regarding the commenters' recommendation that the state meet EPSDT requirements through dedicated funding, nothing in the New York MRT demonstration overrides any EPSDT requirements. Regarding the commenters' recommendation that New York should be required to identify a portfolio of effective behavioral and mental health approaches for children and youth, the approval of the HRSN services for all children under age 6 and children under the age of 18 with one or more chronic conditions is expected to improve health outcomes for children with behavioral health needs. The August 18, 2022 CIB recommends that states expand provider capacity. The workforce initiatives approved under the demonstration amendment are expected to expand provider capacity in the state.

In addition to the 205 comments received from the letter writing campaign, 14 additional commenters, expressed concern that the amendment would be making insufficient investments in maternal and child health. During the course of the negotiations, the state expressed a desire to increase investments in maternal and child health. As a result, the state broadened the original

HRSN eligibility criteria to include pregnant persons, up to 12 months postpartum, children under age 6, and children under the age of 18 with one or more chronic conditions.

Other commenters recommended that the amendment include more data interoperability and social determinants of health (SDOH) data collection. The STCs require that the HERO conduct data aggregation, analytics, and reporting.

Some commenters shared that there was an insufficient emphasis on nutritional services and housing related services and supports. The HRSN STCs include several nutritional supports such as nutrition counseling, home-delivered meals, medically-tailored or nutritionally-appropriate food prescriptions, and fresh-produce and nonperishable groceries. The HRSN STCs also include several housing related services and supports for specific populations such as recuperative care and short-term pre-procedure and post-hospitalization housing, rent and/or temporary housing, pre-tenancy services, and tenancy-sustaining services.

After carefully reviewing the public comments submitted during the federal comment period and information received from the state public comment period, CMS has concluded that the health equity demonstration amendment is likely to assist in promoting the objectives of Medicaid.

SUD Public Comments

New York completed its state level public comment period for its SUD amendment, holding two virtual public hearings, as required, between October 5, 2022, to November 4, 2022. The federal comment period opened on January 5, 2023, and closed on February 4, 2023. CMS received seven comments during this federal comment period. Two were blank. Of the remaining five comments, two were from the same commenter. Overall, there were four separate commenters. One of the commenters supported the demonstration amendment for furthering efforts to improve behavioral health services and treatment. The other three commenters expressed opposition to the amendment.

One commenter raised concerns about the length of stay in IMDs. Any state with a section 1115 SUD demonstration is expected to meet a statewide average length of stay (ALOS) of 30 days or less in residential treatment settings over the duration of the demonstration approval period. Per the STCs, the state is required to monitor the ALOS in IMDs throughout the course of the demonstration approval period, and in the event the metric trend indicates any risks for the state to not meet the ALOS target over the approval period, it is required to develop careful mitigation strategies in its mid-point assessment.

The three commenters who opposed the demonstration amendment shared concerns that authorizing FFP for services provided in IMDs could risk diverting resources away from community-based services and would undermine community integration efforts for beneficiaries with SUD. Nothing in this demonstration requires that services be provided to any individual in any particular setting, nor does it limit the availability of community-based settings. Further, CMS requires states as part of the SUD demonstration to provide access to care across the continuum of care, including outpatient settings. CMS also requires a utilization review process to ensure beneficiaries receive treatment in the appropriate level of care.

One commenter recommended that CMS and the state ensure that Medication Assisted Treatment (MAT) is available, and that CMS and the state track increased MAT intake among IMD residents with SUD. It is a SUD demonstration milestone that MAT be available in residential treatment settings, and CMS will be tracking MAT availability as part of its demonstration monitoring.

Some of the commenters opined that the state has not explained why obtaining FFP for services in an IMD is a valid experiment under section 1115 of the Act and that CMS lacks authority to approve this amendment. CMS has determined that New York's request serves a research and demonstration purpose, as outlined in SMDL #17-003. Proposed hypotheses outlined in the state's application to be tested through evaluation include that, "Researchers will assess the impact of providing the full continuum of SUD treatment services, particularly residential treatment, on hospital emergency department utilization, inpatient hospital utilization, and readmission rates." CMS will work with the state to further detail evaluation plans as part of the evaluation design process outlined in the STCs.

We note that the demonstration includes both robust monitoring and evaluation requirements, and we expect the demonstration to yield data and analysis useful to Congress, the state, CMS, researchers, and other stakeholders. Furthermore, CMS does not lack the authority to approve the state's request for IMD expenditure authority. Section 1115(a)(2) of the Act grants the Secretary the authority, in the context of a demonstration project under section 1115(a), to provide federal matching for state expenditures that would not otherwise be federally matchable under the terms of section 1903. This "expenditure authority" has been exercised by the Secretary for decades to conduct demonstration projects that provide expanded coverage for individuals or services that could not otherwise be covered under a State's Medicaid State plan. This interpretation has been upheld in Court as a valid exercise of the Secretary's demonstration authority under section 1115. For example, Federal Courts have upheld demonstration projects that covered individuals under section 1115(a)(2) who would not otherwise be eligible for coverage. *See Spry v. Thompson*, 487 F.3d 1272 (9th Cir. 2007); *Wood v. Betlach*, No. CV-12-08098, 2013 WL 3871414 (D. Ariz. July 26, 2013).

After careful review of the public comments submitted during the federal comment period and the information received from the state, including information about comments the state received during the state-level public comment period, CMS has concluded that the SUD demonstration amendment is likely to advance the objectives of Medicaid.

Other Information

The award is subject to CMS receiving written acceptance within 30 days of the date of this approval letter. Your project officer is Jonathan Morancy and he is available to answer any questions concerning this amendment and his contact information is as follows:

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We appreciate the state's commitment to improving the health of its Medicaid beneficiaries, and we look forward to our continued partnership on the New York MRT section 1115(a) demonstration. If you have any questions regarding this approval, please contact Jacey Cooper, Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at (410) 786-9686.

Sincerely,

[redacted]

Daniel Tsai
Deputy Administrator and Director

Enclosure

cc: Melvina Harrison, State Monitoring Lead, Medicaid and CHIP Operations Group