New York Medicaid Redesign Team (MRT) Section 1115 Demonstration: Preliminary Interim Evaluation Report Draft

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Preliminary Draft IER Issue Date: July 2, 2026

Project No. 11-W-00114/2

PUBLIC CONSULTING GROUP

Contents

List of Exhibits

Glossary & Acronyms

Career Pathways Training (CPT) Program - The CPT program is one of two workforce initiatives designed to address critical workforce shortages across the healthcare, behavioral health, and social care sectors. CPT establishes a statewide framework to fund education and training programs that build a sustainable and diverse workforce pipeline to better serve Medicaid populations.

Community Based Organization (CBO) - 501(c)(3) or 501(c)(4) non-profit community focused organization that provides HRSN services directly to members.

Community Oriented Recovery and Empowerment (CORE) Services - Services that are person-centered, recovery-oriented, mobile behavioral health supports intended to build skills and self-efficacy that promote and facilitate community participation and independence.[1]

Health and Recovery Plans (HARPs) - Plans that manage care for adults with significant behavioral health needs. They facilitate the integration of physical health, mental health, and substance use services for individuals requiring specialized approaches, expertise and protocols which are not consistently found within most medical plans.

Health Care Access Loan Repayment (HEALR) Program - A workforce initiative that offers student loan repayment assistance to providers in the eligible titles who make a four-year commitment to maintain a personal practice panel or work at an organization where at least 30% of the patient panel are Medicaid enrollees and/or uninsured individuals.

Health Equity Regional Organization (HERO) - Contracted statewide entity designed to develop regionally-focused approaches to improve population health and support the delivery of HRSN services.

Health Related Social Needs (HRSN) - Social and economic needs that individuals experience that affect their ability to maintain their health and well-being.

HIV Special Needs Plan (HIV-SNP) - A health plan that covers all the same services as other Medicaid health plans and works in the same way. HIV-SNPs also provide additional specialty services important to people living with or at risk for HIV/AIDS.[2]

Home and Community Based Services (HCBS) - Services that provide opportunities for Medicaid members to receive services in their own home or community rather than institutions or other isolated settings.

Independent Evaluator (IE) - An entity that is contracted to conduct an annual evaluation of the performance outcome measures specified in the contract.

Interim Evaluation Report (IER) - A Centers for Medicare and Medicaid (CMS) required document produced by an independent evaluator that implements the CMS-approved 1115 waiver evaluation design. The report discusses evaluation progress and preliminary findings from the demonstration and is

[1] Community Oriented Recovery and Empowerment (CORE) Services. Available at: https://omh.ny.gov/omhweb/bho/core/core-services-operations-manual.pdf Accessed on October 15, 2025.
[2] HIV Special Needs Plan (HIV-SNP). Available at: https://www.health.ny.gov/diseases/aids/general/resources/snps/ Accessed on October 15, 2025.

due either one year prior to the end of the demonstration period or at the time of a waiver extension application.

Key Informant Interviews (KIIs) - Interviews to collect information from a wide range of people who have firsthand knowledge about a topic of interest.

Mainstream Medicaid Managed Care (MMMC) - A term used to refer to non-specialty managed care plans.

Managed Care Organization (MCO) - Integrated entities in the healthcare system that manage Medicaid benefits in an effort to control healthcare expenditures costs and improve quality of care.

Managed Long- Term Care (MLTC) - A system that streamlines the delivery of long-term services to people who are chronically ill or disabled and who wish to stay in their homes and communities.

Medicaid Advantage Plus (MAP) Program - A Managed Long-Term Care plan for people who have both Medicaid and Medicare. This plan helps people who need health and long-term care services like home care and personal care in order to stay in their homes and communities as long as possible.

Medicaid Data Warehouse (MDW) - The State's Medicaid Data Warehouse (MDW) houses enrollment and eligibility data, as well as claims and managed care encounters.

Medicaid Hospital Global Budget Initiative (MHGBI) - This initiative is expected to support the improvement in quality of care and promote adoption of alternative payment models that will stabilize finances of certain safety net hospitals, advance accountability and improve health outcomes.

Medicaid Managed Care (MMC) - Refers broadly to the managed care delivery system which provides Medicaid State Plan benefits to members through MCOs offering three types of plans: MMMC, HARPs and HIV-SNPs.

New York State Department of Health (NYSDOH) - Oversees the health, safety, and well-being of New York State residents.[3]

Office of Addiction Services and Supports (OASAS) - Oversees the substance use disorder systems of care for the residents of New York State.[4]

Office of Health Insurance Programs (OHIP) - Provides oversight and management to Medicaid and Child Health Plus programs for New York State.

[3] About the New York State Department of Health (NYSDOH). Available at: https://www.health.ny.gov/about/ Accessed on October 15, 2025.
[4] About the Office of Addiction Services and Supports (OASAS). Available at: https://oasas.ny.gov/about Accessed on October 15, 2025.

Qualified Entity (QE) - Qualified Entities (QE) are organizations certified by NY State to operate as regional health information exchanges, storing and sharing patient health information. The QEs and participate in the Statewide Health Information Network of New York (SHIN-NY).[5]

Statewide Health Information Network of New York (SHIN-NY) - The SHIN-NY is the State's health information exchange, connecting the QEs, and thus enabling statewide data sharing to support collaboration and coordination of care.

Social Care Network (SCN) - A network established to better coordinate regional social care service delivery, improve health outcomes and enhance integration with physical and behavioral health care.

Social Care Network (SCN) Lead Entity - the entity responsible for coordinating the network of HRSN service providers and health care providers; the entity that contracts with OHIP and the MCOs within their regional network.

Summative Evaluation Report (SER) - A CMS-required document produced by an independent evaluator that implements the CMS-approved 1115 waiver evaluation design. The document presents findings on the demonstration's policies and is due 18 months after the end of the demonstration period.

Workforce Investment Organization (WIO) - The WIOs are organizations that are contracted by the State to administer the Career Pathways Training (CPT) program.

[5] Qualified Entity Organizational Characteristics and Requirements. Available at: https://www.health.ny.gov/technology/regulations/shin-ny/docs/qualified_entity_organizational_characteristics_requirements.pdf. Accessed on May 28, 2026.

A. Executive Summary

1. INTRODUCTION

This Preliminary Interim Evaluation Report (IER), "this report", presents findings from the implementation evaluation of New York State's Medicaid Redesign Team (MRT) Section 1115 demonstration, most recently authorized for the period of April 1, 2022 through March 31, 2027. The interim evaluation targets the time from January 1, 2020, through December 31, 2025, which includes the last year of the prior demonstration period, the previous temporary extension period, and the first approximately three and a half years of the current demonstration period. Some additional information derived from administrative data on progress through the Spring of 2026 is also included.[6] This report focuses on implementation progress, since it is too early in the demonstration period to evaluate impact and longer-term outcomes. The summative evaluation will extend through the end of the waiver period, March 31, 2027.

New York State's overarching goals for the demonstration are the following:

1. Improve access to health care for the Medicaid population;
2. Improve the quality of health services delivered;
3. Expand coverage to eligible New Yorkers; and
4. Advance health equity, reduce health disparities, and support the delivery of Health Related Social Needs (HRSN) services.

On January 9, 2024, two years into the current demonstration period, CMS approved an amendment (hereafter, "the January 2024 amendment") which includes several programs that align with the overall goals. The CMS approved goals are[7]:

1. Investments in HRSN via greater integration between primary care providers (PCPs) and community-based organizations (CBOs) with a goal of improved quality and health outcomes;
2. Improving quality and outcomes of members in geographies that have a long-standing history of health disparities and disengagement from the health system;
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 members including kids/youth, pregnant and postpartum individuals, the chronically homeless, and individuals with serious mental illness (SMI) and substance use disorder (SUD);
4. Workforce investments with a goal of equitable and sustainable access to care in Medicaid; and
5. Developing regionally focused approaches, including new value-based payment (VBP) programs, with a goal of statewide accountability for improving health, outcomes, and equity.

[6] For the most recent Social Care Network Program implementation updates, visit the State's SCN Program website, available here: https://www.health.ny.gov/health_care/medicaid/redesign/sdh/scn/.
[7] Demonstration Approval. Available at: ny-medicaid-rdsgn-team-appvl-01092024.pdf. Accessed on July 10, 2025.

In alignment with the Evaluation Design Document, approved by CMS on March 9, 2026, this report focuses on the implementation evaluation of the following January 2024 amendment initiatives:[8]

- Social Care Network (SCN) Program – establishes (HRSN) infrastructure and provides HRSN screening and related services
- Career Pathways Training (CPT) Program – a workforce pipeline initiative administered by Workforce Investment Organizations (WIOs)
- Health Care Access Loan Repayment (HEALR) Program – a workforce development program with loan repayment to support provider retention and recruitment
- Medicaid Hospital Global Budget Initiative (MHGBI) – supports safety-net hospitals sustainability and alignment with population health goals
- Health Equity Regional Organization (HERO) – facilitates the development of regionally focused population health strategies and value-based payment approaches

2. KEY FINDINGS & CONCLUSIONS

Due to (1) the approval of the January 2024 amendment partway into the current waiver period, (2) the subsequent implementation dates for the amendment initiatives, and (3) the timing of this report, limited data was available upon which to base conclusions. The findings provided in this report were developed from the qualitative data gathered from key informant interviews (KIIs) early in the implementation period and administrative data where available. Specifically, KIIs were conducted between September and November 2025, with leadership and senior staff from the SCN Lead Entities, HRSN service providers, WIOs, and NYSDOH administrators. These interviews inform findings related to implementation progress, barriers, facilitators, and early perceptions of program effectiveness. Additional information was drawn from administrative data sources that included both quantitative data and narrative descriptions of progress. The administrative data sources, such as State issued ad hoc progress summaries, generally provide information as of April 2026.

Preliminary conclusions about progress on the January 2024 initiatives and related key findings are presented below, including progress and challenges encountered. Additional details, including strategies employed to address challenges, are provided in Section F. Results.

a. SCN Program

The establishment of nine regional SCNs in a short period of time represents significant progress.

- In one year, the HRSN program progressed from CMS approval (January 2024) to an operational statewide system of SCNs (January 2025).
- Rapid progress was made in building networks, hiring staff, and initiating services.

[8] At the interim reporting period, the independent evaluators focused first on the SCN program, then the workforce initiatives, and gathered relatively limited information on the MGHBI and HERO. The Summative Evaluation Report will contain more robust information on these programs.

- All nine SCNs are performing the full continuum of their core activities, including network development, HRSN screening, eligibility assessments, care navigation and referral, and service delivery.
- As of April 30, 2026:
    - SCNs Lead Entities have awarded >$80M in CBO capacity building funds.
    - There are over 1,300 unique individual HRSN service providers contracted with SCNs across 62 counties.
    - More than one million (1,006,015) Medicaid members were engaged in screening for unmet HRSNs.

The State, with the support of the New York eHealth Collaborative (NYeC)[9] and The Gravity Project,[10] achieved the complex under-taking of establishing a statewide social care technology ecosystem.

- 9 SCN Lead Entities, 3 SCN IT Platform vendors, 6 Qualified Entities, and approximately 25 MCOs are connected and capable of exchanging data in near real-time, supporting timely end-to-end support for members with unmet HRSNs.
- OHIP supported the development of a complex array of standards, tools, and workflows to support consistent documentation of screening, eligibility assessment, navigation, referrals, service delivery, claims, and reporting.
- OHIP supported the creation of a "social care encounter" that represents a first in the nation approach for capturing all aspects of HRSN service provision with standard terminology and code sets, implemented uniformly, statewide. Information captured in the social care encounter provides extensive data for program monitoring and evaluation and future policy development.
- The social care technology ecosystem provides flexible options for providers to participate and share data, such as the ability to integrate "off-platform" screenings.
- Workflows were designed to focus on the member experience to decrease the need for members to navigate multiple organizations or repeat steps in the process, supported by platform-based information sharing.

There is a shared understanding among stakeholders regarding the purpose and value of the SCN program and there is strong commitment to its goals.

- Key informants emphasized the link between HRSN services and improved health outcomes.
- Informants framed the SCN program as part of a broader system redesign, emphasizing incremental steps towards long-term transformational change.

[9] For more information about NYeC, visit: Connecting Healthcare Professionals Statewide | NY eHealth Collaborative
[10] For more information about The Gravity Project, visit: Gravity Project

- Despite the challenges encountered, informants expressed appreciation for the scale, flexibility, and intent of the investment.

Implementation challenges during the first year of the program were identified through KIIs.

- Given the January 2024 approval date of the amendment, little time remained in the demonstration period to implement the SCN program, resulting in a rapid start-up period that involved large-scale IT infrastructure development.
- Operational guidance required multiple updates which impacted workflows, necessitated SCN IT platform adjustments, and led to delays and confusion.
- HRSN service provider readiness varied; the SCN Lead Entities invested time and effort to support HRSN service providers to be ready to offer services, with some contracted HRSN service providers not actively providing services at the time the interviews were conducted.
- SCNs reported that the State's milestones for operational metrics related to screening, assessment, navigation, and referral were challenging.

b. CPT Program

The CPT program has meaningfully advanced its goal of building a workforce equipped to serve the Medicaid population while providing transformational opportunities for participants.

- The State contracted with three regional WIOs to administer the CPT program.
- The WIOs contracted with partner institutions, conducted outreach and engagement sessions, and have enrolled learners. The CPT program training pathways are fully operational.
- There is strong interest in the program; nearly 13,000 individuals are enrolled as of March 31, 2026, most in nursing and professional technical titles.

Implementation challenges during the first year of the program were identified through KIIs.

- WIOs were challenged by time constraints; limited time was available to recruit, enroll, and ensure degree completion by the end of the waiver period.
- Enrollment in the frontline public health worker category was relatively low, and there was some confusion about the role in the labor market.

c. HEALR Program

The State designed and launched the HEALR program.

- Eligible provider roles were defined, award thresholds were set, two application pathways (individual and employer-initiated) were put in place, and policies were established for service commitment, verification, leave, and recoupment.

- Application windows for both individuals and employers opened November 2025 and closed March 31, 2026 for employer-initiated applications and closed April 15, 2026 for individual applications.
- There were 899 applications representing 299 unique eligible employee organizations.
- Award notifications are anticipated in late summer 2026.

Implementation challenges during the first year of the program were identified through KIIs.

- Aligning a four-year service commitment with a waiver that concludes in 2027 has required careful communication through webinar and FAQ responses to ensure applicants understand that commitments extend beyond the demonstration period.

d. MHGBI

The MHGBI was launched and is in progress.

- The twelve participating safety-net hospitals submitted required deliverables, such as roadmaps and budgets.
- Early implementation efforts emphasized hospital specific planning for transformation initiatives related to financial sustainability, quality improvement, access to care, and integration with community based and HRSN services.
- On March 23, 2026, CMS approved the State's MHGBI Implementation Plan, demonstrating continued implementation progress.[11] The plan describes how the MHGBI is aligned with related initiatives and articulates goals for the program. The plan also establishes the participating hospital's metrics and reporting requirements, and the pay-for-performance methodology.

e. HERO

The HERO initiative was launched and is in progress.

- The State contracted with the United Hospital Fund (UHF) to serve as the HERO facilitator. UHF is an independent, nonprofit organization that provides analysis, convening, and thought leadership on health policy in New York.
- UHF established agreements and partnerships with the State and academic partners to enable access to a variety of data sources and data analytic capabilities to support their work which includes producing regional and statewide needs assessments.
- UHF facilitated two rounds of regional convenings, one in fall of 2025 and one in the spring of 2026, enabling multi-sector dialogue and planning around population health priorities.

The State has, and continues to, work closely with contractors, partners, and stakeholders, to put in place strategies to address challenges, and to collaboratively develop operational and programmatic

[11]MHGBI Approved Implementation Plan. Available at: https://www.health.ny.gov/health_care/medicaid/redesign/1115_waiver/nyher/mhgbi/attachment_l.htm Accessed on May 27,2026.

enhancements. The programs and initiatives authorized in January 2024 have evolved significantly since the KIIs took place in the Fall of 2025. A second wave of interviews is planned which will engage an even broader group of stakeholders, including Medicaid members. The next iteration of this report will include information on the State's lessons learned and actions taken to continually monitor and improve these initiatives.

3. NEXT STEPS FOR THE INDEPENDENT EVALUATION

This preliminary IER will be updated and included as an attachment to the State's 1115 waiver extension application upon submission to CMS. Planned updates include:

- The addition of HRSN eligibility assessment, referral and service delivery data.
- Population demographics and baseline statistics for each demonstration target group and planned measures.
- Addition of G. Conclusions and H. Lessons Learned and Policy Implications, and related updates to the Executive Summary.

The Summative Evaluation Report, representing the entirety of the independent evaluation of this demonstration period, is due to CMS 18 months after the end of the demonstration period. Upon CMS approval, the report will be posted on the State's website.

B. General Background Information

1. DEMONSTRATION NAME & TIMING

New York's Medicaid Redesign Team (MRT) Section 1115 demonstration (formerly called New York State's Partnership Plan Medicaid Section 1115 demonstration) was originally approved by the Centers for Medicare and Medicaid Services (CMS) in July of 1997. The demonstration has since been extended, amended, and renewed several times. In 2021, CMS approved the State's request for a temporary extension in light of the COVID-19 pandemic, allowing the State to submit an updated demonstration proposal. The current waiver was approved from April 1, 2022, through March 31, 2027. The independent evaluation covers the last year of the prior demonstration period, the temporary extension period, and the current waiver period: January 1, 2020, to March 31, 2027.

2. DEMONSTRATION GOALS

New York State's overarching goals for the implementation of the current MRT Section 1115 demonstration are the following:

1. Improve access to health care for the Medicaid population;
2. Improve the quality of health services delivered;
3. Expand coverage to eligible New Yorkers; and
4. Advance health equity, reduce health disparities, and support the delivery of (HRSN) services.

On January 9, 2024, two years into the current demonstration period, CMS approved an amendment (hereafter, "the January 2024 amendment") which includes several programs that align with the overall goals. The CMS approved goals are[12]:

1. Investments in HRSN via greater integration between primary care providers (PCPs) and community-based organizations (CBOs) with a goal of improved quality and health outcomes;
2. Improving quality and outcomes of members in geographies that have a long-standing history of health disparities and disengagement from the health system;
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 members including kids/youth, pregnant and postpartum individuals, the chronically homeless, and individuals with serious mental illness (SMI) and substance use disorder (SUD);
4. Workforce investments with a goal of equitable and sustainable access to care in Medicaid; and
5. Developing regionally focused approaches, including new value-based payment (VBP) programs, with a goal of statewide accountability for improving health, outcomes, and equity.

With the January 2024 amendment approval, CMS jointly approved New York State's Section 1115 IMD SUD demonstration, which provides NY with the authority to maintain and expand SUD-related services, and to continue delivery system improvements to provide more coordinated and comprehensive treatment for members with SUD. The goals of the IMD SUD demonstration align with the broader goals

[12]Demonstration Approval. Available at: ny-medicaid-rdsgn-team-appvl-01092024.pdf. Accessed on July 10, 2025.

of improving access to care and quality of health services delivered, and align with the state Medicaid Director Letter[13]:

1. Increased rates of identification, initiation, and engagement in treatment;
2. Increased adherence to and retention in treatment;
3. Reductions in overdose deaths, particularly those due to opioids;
4. Reduced utilization of emergency departments (EDs) and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services;
5. Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate; and
6. Improved access to care for physical health conditions among members with SUD.

3. HISTORY OF THE DEMONSTRATION

New York's 1115 demonstration has evolved over the nearly 30 years since its inception in July 1997. The history of the demonstration is organized into two time periods: (1) The Partnership Plan and (2) The NY MRT, which includes the current demonstration period. A description of both periods, including changes as a result of extension, renewal, or amendments, is provided below.

a. The Partnership Plan: 1997 - 2016

New York State first received CMS approval for a five-year Section 1115 demonstration in July 1997, called the Partnership Plan. The demonstration's focus was to transition the State's Medicaid program from a fee-for-service (FFS) system to a managed care system and to expand coverage to individuals in need of long-term services and supports (LTSS). Several policies implemented during this period continue to operate under the 1115 authority, such as mandatory managed care while others expired without renewal or transitioned to State Plan authority.

The demonstration extensions, renewals, and amendments during the Partnership Plan period include:

- 1997: Original demonstration approved, permitting NY to enroll most Medicaid members in managed care and extend coverage to certain individuals in need of LTSS.
- 2001: Implemented the Family Health Plus (FHPlus) program which provided comprehensive health coverage to low-income uninsured adults who had an income greater than Medicaid State Plan eligibility standards. FHPlus expired in December 2013 and became a state-only program in 2014.
- 2002: Incorporated a family planning benefit providing services to women losing Medicaid eligibility and to certain other adults of childbearing age. The family planning benefit expired in December 2013 and became a State Plan benefit in 2014.

[13] State Medicaid Director Letter, SMD #17-003, November 1, 2017. Available at: https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd17003.pdf. Accessed on July 10, 2025.

- 2006: Demonstration renewed and the authority to require some disabled and aged population to enroll in mandatory managed care was transferred to a new demonstration, the Federal State Health Reform Partnership (F-SHRP), which was later phased out, and this authority was restored to this demonstration in April 2014.
- 2010: Added the Home and Community Based Service (HCBS) expansion program covering cost-effective HCBS to certain adults with significant medical needs as an alternative to institutional care in a nursing facility.
- 2011: Demonstration was extended, and two new initiatives were authorized, each designed to improve the quality of care rendered to Partnership Plan members.
    - The Hospital-Medical Home project provided funding and performance incentives to teaching hospitals focused on improving primary care quality in hospital outpatient settings; this initiative ended in December 2014; and
    - An initiative which provided funding, on a competitive basis, to hospitals or collaborations and other providers for developing/implementing strategies to reduce the rate of potentially preventable readmissions for the Medicaid population (this initiative was never implemented).
- 2011: In collaboration with CMS, NY addressed uncompensated care clinic through the State's Indigent Care Pool (ICP) that expired in December 2014.
- 2012: CMS granted NY authority to mandate managed care enrollment for eligible individuals in need of more than 120 days of community-based long-term care. Mandatory Managed Long-Term Care (MLTC) enrollment was implemented in New York City (NYC) in 2012 and was phased-in throughout the rest of the State from 2013 to 2015. The MLTC provided LTSS as well as other ancillary services.
- April 2013:
    - Long-Term Home Health Care Program (LTHHCP) members began transitioning from the State's 1915(c) waiver into the 1115 demonstration and into managed care;
    - Eliminated the exclusion from Mainstream Medicaid Managed Care (MMMC) program of foster care children placed by local social service agencies and individuals participating in the Medicaid buy-in program for the working disabled; and
    - Provided expenditure authority for New York to claim Federal Financial Participation (FFP) for expenditures made for certain Designated State Health Programs (DSHP).
- December 2013: Ensured the demonstration was aligned with Medicaid Expansion and other changes made under the Affordable Care Act (ACA). Implementation began in January 2014.
- March 2014:
    - Authorized 12-month continuous eligibility for the new Medicaid population of adults determined eligible using the Modified Adjusted Gross Income (MAGI) methodology.
    - Phased out the F-SHRP demonstration by moving members into the 1115 demonstration.

- April 2014:
    - Authorized NY to begin steps on the Delivery System Reform Incentive Payment (DSRIP) program.
    - Granted expenditure authority to establish an Interim Access Assurance Fund (IAAF) and for the DSRIP design and planning phase.
- December 2014:
    - Extended long-term nursing facility services to members of New York's MMMC and MLTC populations, instituted an independent LTSS assessment process, and implemented the Independent Consumer Support Program.
- August 2015:
    - Authorized NY to implement the Health and Recovery Plans (HARPs) to integrate physical, BH and BH HCBS for eligible Medicaid members with diagnosed SMI or SUD to receive services within their homes and communities.
    - HIV Special Needs Plans (HIV-SNPs) will also offer BH HCBS to eligible members.
    - Expanded BH benefits; all Medicaid Managed Care (MMC) plan will offer BH benefits in integrated plans including four new demonstration services.
    - Eligibility flexibilities were effectuated:
        - Allows adults enrolled in Temporary Assistance for Needy Families (TANF) to be enrolled as a demonstration population without a MAGI determination;
        - Extends continuous eligibility for members of the Adult Group who turn 65 during their continuous eligibility period; and
        - Temporary coverage for Adult Group members who are determined to be eligible to receive coverage through the Marketplace.

b. The NY MRT: 2016 - 2027

The Partnership Plan was renamed to the New York MRT Section 1115 demonstration effective with the CMS approved extension in December 2016. The extension provided NY with authority to continue the DSRIP program and move from the early planning and implementation phase to the pay for performance period. The State also implemented a value-based payment roadmap and sought to increase accountability for population health.

The current demonstration period represents the last five years of the NY MRT period. The State is focusing on supporting providers' ability to increase efficiencies in the delivery of care and to improve population health.

The policies approved during or just before the current demonstration period are the focus of this independent evaluation, with some exceptions for policies that are either very narrow in scope or policies that were the subject of previous independent evaluation reports, as noted.

- December 2016: Demonstration extension approved.

- Partnership Plan was renamed to the New York MRT.
- Provided time-limited authorization of the DSRIP program and the DSHP expenditure authority through March 2020; *this DSRIP program was the subject of a previous independent evaluation report.*[14]
- Authorized the Behavioral Health Self-Direction pilot which made self-direction services available to HARP and HIV-SNP members receiving BH HCBS to be in effect from January 2017 through March 2027; *the Self-Direction pilot was the subject of a previous independent evaluation report.*[15]

- April 2019:
  - MMC members charged drug copays approved in the Medicaid State Plan and not subject to any non-drug copays that are described in the Medicaid State Plan; *this policy change is relatively narrow in scope and is not a specific focus of the independent evaluation.*
- August 2019: *CMS approved concurrent amendments to the 1115 MRT waiver and the 1915(c) Children's waiver; these policies were the subject of a previous independent evaluation report*[16] *and the current evaluation builds on the previous findings.*
  - Mandated managed care enrollment for children receiving HCBS under the State's consolidated 1915(c) Children's waiver
  - Continued Medicaid eligibility for "Family of One" (Fo1) non-1915(c) children who would have been eligible for Medicaid under the Children's waiver criteria of receiving at least one 1915(c) service had case management not been moved under the State Plan as a Health Home (HH) service or who were in a non-SSI category and receive HCBS or HH comprehensive case management.
  - Included Children's waiver HCBS and State Plan behavioral health services in the Medicaid managed care package.
  - Included children receiving HCBS under the Children's waiver in the Self Direction Pilot for Individual Directed Goods and Services
- December 2019*: A relatively narrow set of policy changes were approved; they are not a specific focus of the independent evaluation.*
  - Implemented a lock-in policy for partially capitated MLTC plans, pursuant to which members of partially capitated MLTC plans could transfer to another partially capitated plan without cause during the first 90 days of a 12-month period.

[14]New York State DSRIP Final Summative Report. Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ny/Partnership-Plan/ny-medicaid-rdsgn-team-dsrip-final-summative-eval-report-20211214.pdf Accessed on April 14, 2026.
[15] New York State SDC Pilot Interim Evaluation Report. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ny-medicaid-rdsgn-team-cms-appr-inter-eval-rpt-HARP-SDC-pilot.pdf. Accessed on April 14, 2026.
[16] New York State 1115 MRT and 1915(c) Children's Design Interim Evaluation Report. Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ny/Partnership-Plan/ny-medicaid-cms-apprvd-intrm-eval-rpt-07272021.pdf Accessed on April 14, 2026.

- Limited the nursing home benefit in the partially capitated MLTC plan to three months for those members who had been designated as Long-Term Nursing Home Stays (LTNHS) in a skilled nursing or residential health care facility, at which time the individual was to be involuntarily disenrolled from the partially capitated MLTC plan and payment for nursing home services will be covered by Medicaid FFS for individuals that qualify for institutional Medicaid coverage.

- October 2021: Added a set of rehabilitative services called Community-Oriented Recovery and Empowerment (CORE); substituting for and improving upon four BH HCBS within HARP and HIV SNP; *this amendment was approved during the prior demonstration period and implemented during the current demonstration period and is included in the independent evaluation.*

- January 2022: Managed Care Risk Mitigation COVID-19 Public Health Emergency amendment was approved; *this policy* was *the subject of separate, CMS-approved, independent evaluation report.*[17]

- March 2022: Five-year non-programmatic extension granted, and approval of a previously submitted amendment allowing dual eligibles to stay in MMMC Plans that offer Dual Special Needs Plans (D-SNPs) once they become eligible for Medicare; *this amendment is narrow in scope and not a specific focus of the independent evaluation.*

- November 2022: Reasonable Opportunity Period (ROP) Extension COVID-19 Public Health Emergency (PHE) Section 1115 demonstration was approved; *this policy was the subject of separate, CMS-approved, independent evaluation report.*[18]

- January 2024*, these policies are* the *primary focus of the independent evaluation:*

  - Institution for Mental Disease (IMD) Transformation demonstration program; which authorized the State to receive federal Medicaid matching funds for services delivered to members residing in an IMD with a SUD diagnosis and authorized a new service "residential re-integration".

  - Authorized the State to make targeted, evidence-based investments in HRSN infrastructure, including Social Care Networks (SCNs), and HRSN Services, the Medicaid Hospital Global Budget Initiative (MHGBI), the Health Equity Regional Organization (HERO), the Career Pathways Training (CPT) Program, and the student loan repayment program now known as the Health Care Access Loan Repayment (HEALR) Program.[19] With the exception of the MHGBI, these initiatives are supported by DSHP funds, and are described in greater detail in Section B.5. Designated State Health Program (DSHP)-Funded Initiatives

[17] New York State COVID-10 PHE Amendment Final Evaluation Report. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ny-medicaid-rdsgn-team-phe-cov19-finl-rpt-apprvl-ltr.pdf Accessed on April 14, 2026.

[18] Reasonable Opportunity Period Extension COVID-19 Public Health Emergency Amendment Evaluation Report. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ny-medicaid-rdsgn-team-rop-covid19-phe-amendment-evaluation-report-final.pdf Accessed on April 14, 2026

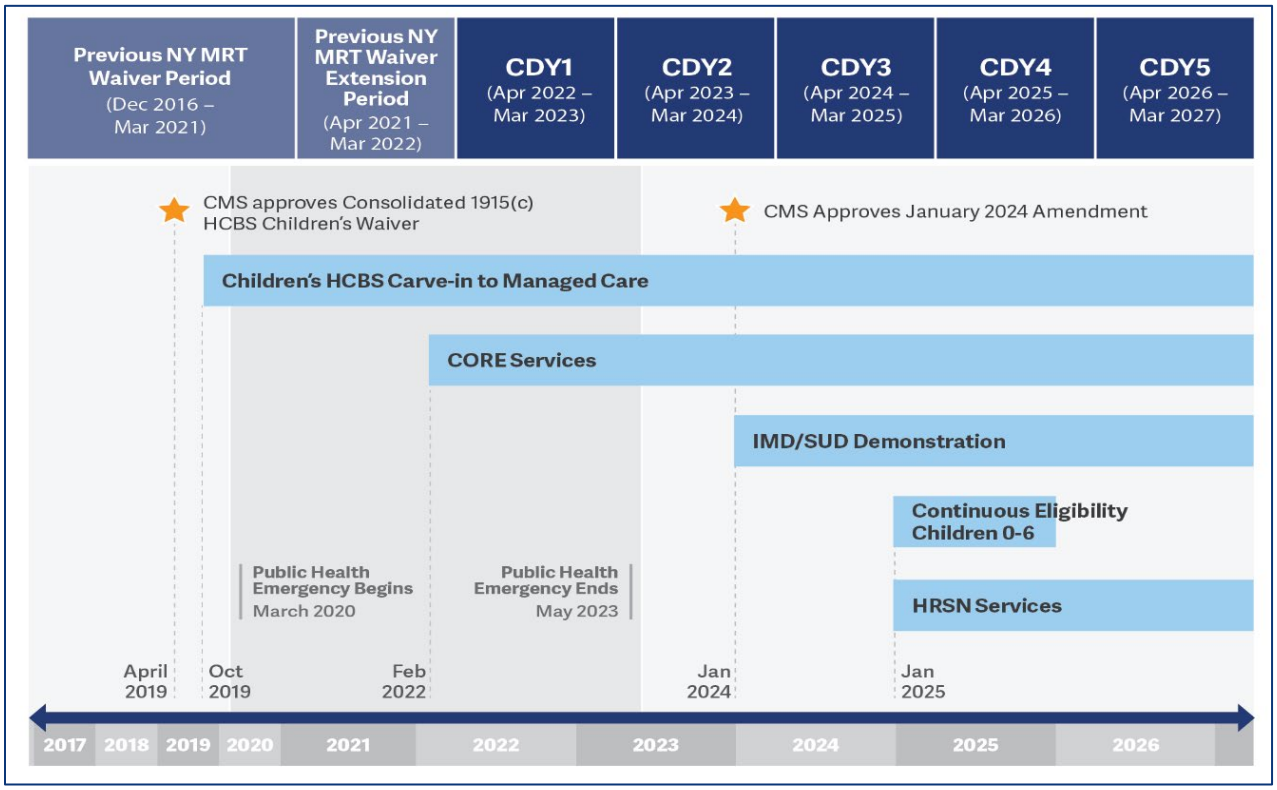
[19] About the HEALR Program. Available at: Health Care Access Loan Repayment (HEALR) Program. Accessed on January 9, 2026.

- November 2024: Continuous Medicaid and Child Health Plus Eligibility for Children up to Age Six; *this policy is included in the independent evaluation.*

4. POPULATIONS IMPACTED BY THE DEMONSTRATION

The policies and initiatives put in place prior to 2020 have impacted specific groups of Medicaid eligible children and adults over time and have been the subject of previous independent evaluations. The current evaluation focuses on the populations most impacted by policies that were enacted during, or just before, the current demonstration years (CDY), shown in Exhibit 1: Major Demonstration Amendments. Note that the January 2024 amendment includes the HRSN services depicted in the Exhibit, as well as Strengthening the Workforce, HERO, and the MHGBI which are not shown but are included in the evaluation design.

Exhibit 1: Major Demonstration Amendments



Each policy targets a specific population which receives benefits through one of the State's managed care plans, specifically: MMMC, HARP, HIV-SNP, or MLTC, as shown in Exhibit 2: Target Populations. The evaluation focuses on the relevant policy changes and the impacted populations; results will be stratified by plan type where applicable. Exhibit 2 provides the estimated annual population sizes.

Exhibit 2: Target Populations

Policy	Impacted Population	Estimated Annual Population Size	Plan Types
Children's HCBS Carve-in to Managed Care	Youth Eligible for HCBS	8,000[20]	MMMC
CORE Services	Behavioral Health High-Risk Adults	165,000[21]	HARP, HIV-SNP, MMMC
IMD SUD Demonstration	Individuals with SUD Service Needs	IMD/ Reintegration: 8,000 – 9,000[22]	HARP, HIV-SNP, MMMC
Continuous Eligibility Children up to Age Six	Children up to Age Six	800K	MMMC
HRSN Services[23]	All Medicaid Managed Care Members	5.5M	HARP, HIV-SNP, MMMC, MLTC
January 2024 Amendment Initiatives[24]	All Medicaid Managed Care Members	6.6M	HARP, HIV-SNP, MMMC, MLTC

In the following sections, each of the sub-populations (the five populations in the table above) is described briefly, key findings from previous reports are summarized, and a description of how the current evaluation approaches the population is provided. Note that populations may overlap. For example, a member may be included in the individuals with SUD service needs population and the behavioral health high-risk adult population.

a. Youth Eligible for HCBS

The 1115 demonstration continues to impact children under the age of 21 who are eligible for HCBS under the consolidated 1915(c) Children's waiver, which authorizes HCBS necessary to prevent the need for institutional care (i.e., psychiatric hospitalization, residential treatment, nursing home admission) or to assist the member to return to their home and community after discharge from an institutional level of care. To be eligible for Children's waiver HCBS, members must have a medical condition, developmental disability, or serious mental health disorder that impacts their daily functioning and that places them at imminent risk of hospitalization or institutionalization. Children in foster care with a developmental disability, or who are medically fragile, are included.

The 1115 waiver amendment allowed the State to move the services covered by the consolidated 1915(c) Children's waiver from FFS to MMC. Mandatory enrollment in managed care for youth eligible for HCBS began in October 2019, except for children and youth in foster care, for whom mandatory MMC enrollment started in July 2021.

[20] Estimate based on preliminary data analysis conducted by the IE.
[21] Estimate based on information contained in the Managed Care Program Annual Report (MCPAR) for New York: 2023-24 Health and Recovery Program (HARP). Accessed on November 15, 2025.
[22] Estimates based on information contained in the New York Health Equity SUD amendment Approval letter ny-medicaid-rdsgn-team-appvl-01092024.pdf ("Summary of All OASAS Services" Table; page 174 out of 217). Accessed on October 15, 2025.
[23] The HRSN infrastructure and services target all Medicaid managed care members and are evaluated under hypothesis 5.
[24] The January 2024 amendment initiatives seek to advance health outcomes and population health; the impact of the amendment as a whole is evaluated under hypothesis 6.

The 1115 waiver also provides continued Medicaid eligibility for medically needy Fo1 children who meet the target criteria, risk factors, and clinical eligibility standard for placement in intermediate care facilities (ICF), nursing facilities (NF), or hospital level of care (LOC), but are not otherwise enrolled in the Children's 1915(c) waiver. This group receives Health Home Comprehensive Care Management, a State Plan service, but no HCBS, and would have lost coverage if not for the continued Medicaid eligibility provision in the waiver; this group is not a focus of the evaluation.

The Children's Design was the subject of a previous interim evaluation which focused on the implementation process and identification of pre-implementation trends in outcomes of interest.[25] The authors were unable to draw definitive conclusions regarding the effect of the Children's Design on care coordination, care access, and quality of care due to limited data for the post-implementation period. The current evaluation builds on previous findings by examining access and quality indicators for this population.

b. Behavioral Health High-Risk Adults (HARP and non-HARP members)

The State began to systematically transform the behavioral health system for high-risk individuals from an inpatient-focused system to a recovery-focused system approximately 10 years ago. Since then, several demonstration components have targeted the behavioral health high-risk adult population, including the introduction of the HARP specialty managed care plan and a wider array of BH services. NY uses BH high-risk eligibility criteria to identify members eligible to enroll in HARP and to identify non-HARP members eligible for specialty BH services including CORE and BH HCBS.[26]

- CORE consists of four services: Community Psychiatric Support and Treatment (CPST), Psychosocial Rehabilitation (PSR), Family Support and Training (FST), and Empowerment Services - Peer Support.[27]
- The adult BH HCBS are Habilitation (i.e., Residential Support Services), Education Support Services, Pre-vocational Services, Transitional Employment, Intensive Supported Employment, and Ongoing Supported Employment.

The HARPs, specialized managed care products that cover physical health, mental health, and substance use services for adults with significant behavioral health care needs, were phased in from 2015 to 2016. The HARPs were the subject of a previous interim evaluation which reported increasing, but low, rates of BH HCBS utilization among plan members over time.[28]

The CORE services launched in February 2022. In January 2023, the BH HCBS were carved into MLTC Medicaid Advantage Plan (MAP) which allows individuals enrolled in a MMMC, HARP, or HIV SNP product

[25] Independent Evaluation of the New York State 1115 Waiver amendment: The Children's Design. Available at: NY MRT Interim Approval Letter_Signed.pdf. Accessed on November 5, 2025.
[26] Behavioral Health (BH) High-Risk Eligibility Criteria. Available at: Behavioral Health (BH) High-Risk Eligibility Criteria. Accessed on October 31, 2025.
[27] NYS Office of Mental Health, Community Oriented Recovery and Empowerment Overview. Available at: https://omh.ny.gov/omhweb/bho/core/ Accessed on October 15, 2025.
[28] New York State HARP Interim Evaluation Report. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ny-medicaid-rdsgn-team-cms-appr-inter-eval-rpt-HARP-SDC-pilot.pdf Accessed on April 14, 2026.

who then become eligible for Medicare and are in need of LTSS to continue accessing BH HCBS services without disruption when moving to a MAP product.[29]

The current evaluation builds on previous findings by assessing BH HCBS and CORE utilization and related outcomes among all eligible adult members.

c. Individuals with SUD Service Needs

Individuals with SUD service needs, a subgroup of those with high BH needs, are impacted by the approval of the IMD SUD demonstration in January 2024, which authorizes the State to receive federal Medicaid matching funds for services delivered to members residing in an IMD with a SUD diagnosis, and authorizes a new service "residential re-integration". All other levels of ambulatory care for SUD treatment, as well as medication-assisted treatment (MAT), residential and inpatient services and withdrawal management, are covered under the State Plan.[30]

Individuals with SUD are defined based on prior SUD service utilization. The evaluation design assesses utilization of SUD services, including in the IMD setting, and related outcomes among the SUD population.

d. Children up to Age Six

New York's Medicaid State Plan provides 12-month continuous eligibility for children under the age of 19 in Medicaid and the State's Children's Health Insurance Program (CHIP), Child Health Plus. Historically, the 1115 waiver authorized the State to provide a 12-month continuous eligibility period for individuals in the following Medicaid eligibility groups, regardless of the delivery system through which they receive Medicaid benefits:

- Pregnant Group
- Adult Group
- Parents or Other Caretaker Relatives
- Low-Income Families, Except for Children

The State's continuous eligibility policies were recently expanded:

- In June 2023, CMS approved the State Plan amendment which extended postpartum health coverage from 60 days to 12 months following pregnancy. *The postpartum year coverage is a State Plan policy and thus not in the scope of the independent evaluation.*
- In November 2024, CMS approved the continuous eligibility policy to include children, including the State's Children's Health Insurance Program (CHIP), Child Health Plus, from birth through the end of the month in which their sixth birthday falls; *note that this policy was in effect during 2025 only.*

[29] NYS Office of Mental Health; Office of Addition Services and Support; Department of Health. "Behavioral Health Guidance for Managed Care Organizations Carving Behavioral Health into Medicaid Advantage Plus." Available at: https://omh.ny.gov/omhweb/bho/docs/guidance-for-mcos-carving-bh-medicaid-advantage-plus.pdf Accessed on October 15, 2025.

[30] Attachment H: SUD Implementation Plan, Approved January 9, 2024. Available at: https://www.health.ny.gov/health_care/medicaid/redesign/med_waiver_1115/2024-01-09_app_sud_impl_plan.htm. Accessed on October 28, 2025.

The evaluation examines the impact of the continuous eligibility policy for children up to age six on continuity of coverage, utilization, cost, and access to routine care during 2025, the only year in which the policy was fully in effect.[31] Given the short duration of the policy, its potential to impact the population and produce measurable results is extremely limited.

e. All Medicaid Managed Care Members

The January 2024 amendment includes investments in HRSN infrastructure and services that target *all* Medicaid members. HRSN services are primarily delivered through the managed care delivery system, which is the focus of the independent evaluation. FFS members are eligible for HRSN screening and HRSN 1115 Level One Case Management services, however, *FFS members are not included in the independent evaluation target population*. Broadly, the amendment seeks to advance population health and support the delivery of HRSN services. The evaluation design focuses on understanding the severity and prevalence of HRSN *among Medicaid managed care members* and the effectiveness of the HRSN component at mitigating these needs. The design also examines the impact of the amendment on quality of care and health outcomes, and disparities in outcomes and how these change over time.

The January 2024 amendment also authorizes the HERO, MHGBI, and Strengthening the Workforce initiatives; each of which broadly seeks to impact all Medicaid managed care members in alignment with the Medicaid statute, see Exhibit 3: DSHP Initiatives and Objectives.

5. DESIGNATED STATE HEALTH PROGRAM (DSHP)-FUNDED INITIATIVES

Under the demonstration, the State has expenditure authority to invest in the following DSHP-funded initiatives: HRSN Infrastructure and Services, HERO, and two workforce initiatives (the CPT program and the HEALR program). The goals of the DSHP-funded initiatives align with the objectives of the Medicaid statute to expand coverage, improve access to covered services, improve quality by reducing health disparities, or increase the efficiency and quality of care. A summary is provided in Exhibit 3: DSHP Initiatives and Objectives.

Exhibit 3: DSHP Initiatives and Objectives

DSHP-Funded Initiative	Alignment with Objectives
HRSN Infrastructure and Services	Investments made in HRSN infrastructure will advance integration between providers and community-based organizations with a goal of improved care quality and health outcomes. Investments in HRSN services will support member engagement in social care and will effectively mitigate HRSN with goals of improved access to care and improved quality of care by reducing health disparities.
HERO	Investments in the HERO are made to develop regionally-focused approaches, with a goal of statewide accountability for improving health outcomes and population health.

[31] In July 2025, CMS notified state Medicaid directors that CMS does not anticipate extending existing section 1115 demonstration authority for expanded continuous eligibility, beyond what is required or available under the Medicaid or CHIP statutes. NY subsequently began winding-down the continuous eligibility policy for children from birth through age six, resulting in approximately one year of implementation (2025). Available at: https://www.medicaid.gov/resources-for-states/downloads/contin-elig-ltr-to-states.pdf Accessed on April 15, 2026.

Workforce Initiatives: CPT and HEALR Programs	Workforce investments aim to increase the adequacy of the workforce with a goal of equitable and sustainable access to care.

Each of the DSHP funded initiatives is described in more detail in the program overview subsections found in Section F. Results.

A significant contextual factor is the COVID-19 PHE, which took place during the extension of the previous demonstration period and thus overlaps with proposed baseline periods. During the PHE, states were required to maintain continuous enrollment of Medicaid members in an effort to preserve coverage and prevent loss of benefits. The continuous enrollment mandate, and the subsequent unwinding process, had impacts on enrollment which must be considered in the evaluation. While there are no specific hypotheses related to enrollment, the evaluation design includes an assessment of enrollment over time and by demographics. This information will provide context for findings and will be considered in statistical modeling as appropriate in the Summative Evaluation Report (SER).

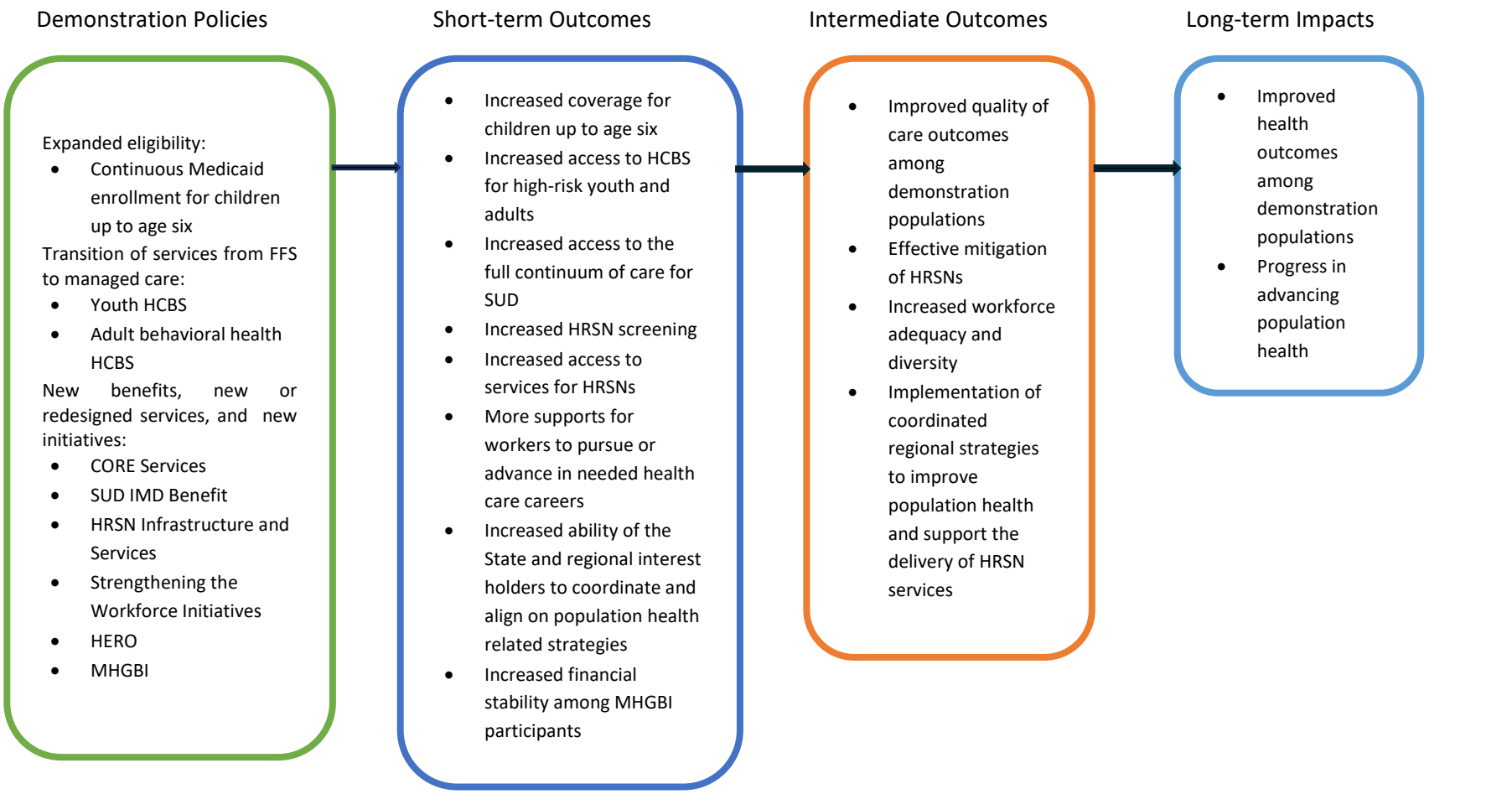
Additional contextual factors include several State and local health care delivery and payment reform efforts underway in NYS that are designed to impact outcomes that are the same as, or are aligned with, the demonstration outcomes under evaluation. For example, the State's Patient-Centered Medical Home (PCMH) program launched in April 2018 is an evidence-based approach to promote better health, lower costs and better patient experience.[32] The PCMH program is not under evaluation, but PCMH expansion over the past several years is important context to consider alongside findings from the evaluation. The IER and SER will include a description of the PCMH program and other related initiatives and consider them when interpreting demonstration findings.

[32] New York State Patient Centered Medical Home information. Available at: New York State Patient-Centered Medical Home (NYS PCMH). Accessed on January 9, 2026.

C. Evaluation Questions and Hypotheses

1. CONCEPTUAL FRAMEWORK: THE LOGIC MODEL

Exhibit 4: The Logic Model



2. EVALUATION QUESTIONS

The evaluation design includes (1) implementation questions and (2) hypotheses, research questions, and subsidiary research questions. The implementation questions examine how the IMD SUD demonstration and the January 2024 amendment initiatives were put in place, how they proceeded over time, what factors supported effective implementation, what barriers were encountered, and what strategies were put in place to address or resolve barriers. The hypotheses and research questions examine the short- and long-term impacts of each policy on outcomes and policy-specific goals.

a. Implementation Questions

This component of the evaluation examines the implementation process for the amendments approved in January of 2024: the IMD SUD demonstration and additional amendment initiatives. As previously stated, the implementation evaluation does not focus on amendments implemented in earlier demonstration periods or those with a narrow scope.

Implementation Evaluation: IMD SUD Demonstration

- Question 1: Which key entities are collaborating to implement and operationalize the demonstration, and what are their main roles? How and why have the roles or participation of those key entities changed during the demonstration?
- Question 2: What strategies implemented during the demonstration do key program staff identify as most effective for achieving the goals of the demonstration?
- Question 3: What are barriers for key program staff implementing the demonstration, and what strategies have they used to overcome barriers? What are facilitators for key program staff implementing the demonstration, and what suggestions do they have for improving the demonstration?
- Question 4: What challenges have providers experienced in providing services as part of the demonstration, and what strategies have they used to overcome challenges? What aspects of the demonstration have worked well for providers, and what suggestions do they have for improving the demonstration?

The evaluators considered gathering new primary data on member experience related to the IMD SUD demonstration. Given the challenges involved with outreach and engagement to this population, the level of effort to obtain participation and adequate sample sizes in surveys or focus groups was deemed prohibitive. Therefore, the implementation questions do not capture member perspective.

Implementation Evaluation: Additional January 2024 Amendment Initiatives

- Question 1: What progress has been made in implementing the SCN program, including network development and HRSN screening, eligibility assessments, care navigation, and delivery of Enhanced HRSN Services? What are the barriers to implementation, and what strategies have been used to address these barriers? What factors have contributed to successful implementation progress?
- Question 2: How have investments in infrastructure and technology supported the implementation of SCNs?

- Question 3: How have SCN partners and interest holders experienced the implementation of the SCN program?
- Question 4: What are members' experiences with screening, eligibility assessment, and navigation through the SCN program? What are eligible members' experiences with utilizing Enhanced HRSN Services? How effective are these services at meeting the needs they are designed to address?
- Question 5: What progress has been made in implementing the CPT program? What are the barriers to implementation, and what strategies have been used to address these barriers? What factors have contributed to successful implementation progress?
- Question 6: What progress has been made in implementing the HEALR program? What are the barriers to implementation, and what strategies have been used to address these barriers? What factors have contributed to successful implementation progress?
- Question 7: What progress has been made in implementing the MHGBI? What are the barriers to implementation, and what strategies have been used to address these barriers? What factors have contributed to successful implementation progress?
- Question 8: What progress has been made in implementing the HERO initiative? What are the barriers to implementation, and what strategies have been used to address these barriers? What factors have contributed to successful implementation progress?

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b. Hypotheses and Research Questions

An overarching hypothesis was developed for each policy under evaluation. Each hypothesis states what is expected to happen to the target population as a result of the policy as indicated in Exhibit 5: Policies and Hypotheses The corresponding research questions, measures, data sources, and analytic approaches are provided in Exhibit 7: Evaluation Design Table, in Section D.2. Overview of Analytic Methods.

Exhibit 5: Policies and Hypotheses

Policy	Hypothesis
Children's HCBS Carve-in to Managed Care	1. The Children's HCBS carve-in to managed care will increase access to HCBS, leading to improved quality of care outcomes and to decreases in the percentage of children in this population being referred to and diverted to more costly institutional levels of care.
CORE Services	2. The transition to CORE services will improve access to rehabilitation and recovery services for Behavioral Health High-Risk Adults, leading to improved quality of care and health outcomes for this population.
IMD SUD Demonstration	3. The IMD SUD demonstration will improve access to SUD services across the care continuum, leading to increased engagement in care, and improved quality of care and health outcomes for this population.
Continuous Eligibility Children up to Age Six	4. The continuous eligibility policy for children up to age six will increase enrollment duration and increase access to routine care for this population.
HRSN Services	5. The HRSN component of the January 2024 amendment will support the delivery of social care through SCNs and improve overall quality and health outcomes for high-risk members including high utilizers of Medicaid, individuals enrolled in a NYS Health Home, high-risk children under age 18, pregnant and postpartum individuals, individuals post-release from the criminal justice system with a chronic condition, individuals with an intellectual or developmental disability, individuals with SMI, and individuals with SUD.
January 2024 Amendment Initiatives	6. The January 2024 amendment initiatives will lead to reductions in health disparities.

D. Methodology

This section presents the entirety of the independent evaluation methodology, as per the CMS-approved Evaluation Design Document; note that due to the limited scope of the IER, some of the methods described below were not applicable at the time of this report.

1. OVERVIEW OF EVALUATION REPORTS

Due to the timing of demonstration amendments and related implementation plan approvals, and claims-based data lags, not all planned analyses are included in the IER. Specifically:

- Results for the IMD SUD Implementation Questions will be included in the SER only, due to the start date of the demonstration and the planned timeline for conducting KIIs (summer 2026).
- Preliminary results for the January 2024 amendment Implementation Questions are included in the IER, based on wave one of KIIs conducted between September and November 2025. An additional wave of interviews will be conducted approximately one year later, just prior to the end of the demonstration period. Findings from wave two will be included in the SER.
- Cost analyses will be included in the SER only.
- Planned regression models will be provided in the SER only, due to there not being enough data points to model post-demonstration trends in time for the IER.

Additional details on the approach to the interim evaluation are provided in Exhibit 6: Interim Evaluation Analyses.

Exhibit 6: Interim Evaluation Analyses

Hypothesis	Interim Evaluation Report
1. The Children's HCBS carve-in to managed care will increase access to HCBS, leading to improved quality of care outcomes and to decreases in the percentage of children in this population being referred to and diverted to more costly institutional levels of care.	Descriptive statistics; t-tests
2. The transition to CORE services will improve access to rehabilitation and recovery services for Behavioral Health High-Risk Adults, leading to improved quality of care and health outcomes for this population.	Descriptive statistics; t-tests
3. The IMD SUD demonstration will improve access to SUD services across the care continuum, leading to increased engagement in care, and improved quality of care and health outcomes for this population.	Descriptive statistics; t-tests
4. The continuous eligibility policy for children up to age six will increase enrollment duration and improve access to care for this population.	Not included due to the January 2025 implementation date of the policy
5. The HRSN component of the January 2024 amendment will support the delivery of social care through SCNs and improve overall quality and health outcomes for high-risk members	Qualitative findings from wave one of KIIs Process measures from year one of the HRSN program, if available

including children, pregnant and postpartum individuals, the chronically homeless, and individuals with SUD.	
6. The January 2024 amendment initiatives will advance population health and reduce health disparities.	Not included; this hypothesis is about the long-term impact of the amendment; results will be included in the SER only

2. OVERVIEW OF ANALYTIC METHODS

A summative evaluation will be a mixed-methods evaluation conducted including quantitative and qualitative data sources to assess implementation process and evaluate short and long-term outcomes.

The implementation questions are addressed primarily by using new qualitative data gathered in KIIs specifically for purposes of the independent evaluation. In addition, administrative data is included where available and relevant to the implementation questions. The evaluators continue to engage with the State to identify additional administrative data or program reports that could serve as secondary data sources to lend additional context to the implementation evaluation for future evaluation reports.

The hypothesized short and long-term impacts of the demonstration will be evaluated using a variety of data sources and analytic methods, as summarized in Exhibit 7: Evaluation Design Table. At the time of writing, the evaluators are confident there will be adequate data points to perform the analyses described below. There may be instances in which some analyses are not feasible due to unforeseen trending breaks in specific measures. In these cases, the analytic approach will be reconsidered based on the data available and the significance of the trending break.

Exhibit 7: Evaluation Design Table

Research Question	Outcome Measures	Data Sources	Analytic Approach and Comparison Strategy
Hypothesis 1: The Children's HCBS carve-in to managed care will increase access to HCBS, leading to improved quality of care outcomes and to decreases in the percentage of children in this population being referred to and diverted to more costly institutional levels of care.			
Primary research question 1.1: Did the transition of Children's HCBS from FFS to managed care improve access to HCBS for the eligible population?	• HCBS Service Utilization Rates by service type, year, clinical characteristics, and demographics	MDW and Related Datasets	Interrupted time series with members in the pre-demonstration period as the baseline
Subsidiary research question 1.1a: What are the distributions of: individuals meeting the Youth Eligible for HCBS criteria, individuals engaged in youth HCBS?	• Distributions of individuals by year, clinical characteristics, and demographics	MDW and Related Datasets	Descriptive statistics
Primary research question 1.2: Did quality of care outcomes among Youth Eligible for HCBS improve	• Child and Adolescent Well-Care Visits • Oral Evaluation, Dental Services • Inpatient Utilization • ED Visits (Total, BH, non-BH)	MDW and Related Datasets	Interrupted time series with members in the pre-demonstration

Research Question	Outcome Measures	Data Sources	Analytic Approach and Comparison Strategy
after the transition of HCBS from FFS to managed care?	• Plan All-Cause Readmission by year, clinical characteristics, and demographics		period as the baseline
Primary research question 1.3: Were there decreases in utilization of institutional levels of care among Youth Eligible for HCBS following the transition of youth HCBS from FFS to managed care?	Rates of utilizing facility level care among Youth Eligible for HCBS: • Hospital Facility • Nursing Facility • Intermediate Care Facility by year, clinical characteristics, and demographics	MDW and Related Datasets	Interrupted time series with members in the pre-demonstration period as the baseline
Hypothesis 2: The transition to CORE services will improve access to rehabilitation and recovery services for Behavioral Health High-Risk Adults, leading to improved quality of care and health outcomes for this population.			
Primary research question 2.1: Did the transition to CORE services improve access to rehabilitation and recovery services for BH High-Risk Adults?	• CORE Service Utilization Rates • Adult BH HCBS Service Utilization Rates • Utilization of Recovery Oriented Services for Mental Health • Engagement in Community-based Mental Health Care by service type, plan type, year, clinical characteristics, and demographics	MDW and Related Datasets	Interrupted time series with members in the pre-demonstration period as the baseline
Subsidiary research question 2.1a: What are the distributions of: individuals meeting the BH High-Risk Adult criteria, individuals engaged in CORE services, individuals engaged in BH HCBS?	• Distributions of individuals by plan type, year, clinical characteristics, and demographics	MDW and Related Datasets	Descriptive statistics
Primary research question 2.2: Did quality of care outcomes among BH High-Risk Adults improve after the transition to CORE services?	• Adherence to Anti-psychotic Medication for People with Schizophrenia • Adult Access to Preventive/Ambulatory Health Services • Colorectal Cancer Screening • Dental Service Utilization • ED Visits (Total, BH, non-BH) • Follow-Up • After Hospitalization for Mental Illness • Inpatient Utilization • Plan All-Cause Readmission • Potentially Preventable Mental Health Related Readmission Rate by plan type, year, clinical characteristics, and demographics	MDW and Related Datasets	Interrupted time series with members in the pre-demonstration period as the baseline

Research Question	Outcome Measures	Data Sources	Analytic Approach and Comparison Strategy
Hypothesis 3: The IMD SUD demonstration will improve access to SUD services across the care continuum, leading to increased engagement in care, and improved quality of care and health outcomes for this population.			
Primary research question 3.1: Did the IMD SUD demonstration improve access to, and engagement in, SUD services across the care continuum for this population?	• Non-acute SUD Service Utilization Rate • Residential Care Utilization at each of 3 Levels • Residential Care Average Length of Stay at each of 3 Levels • Initiation and Engagement of SUD Treatment • Follow-up After High-Intensity Care for SUD • Pharmacotherapy for Opioid Use Disorder (OUD) by plan type, year, clinical characteristics, and demographics	MDW and Related Datasets	Interrupted time series with members in the pre-demonstration period as the baseline
Subsidiary research question 3.1a: What are the distributions of: individuals in need of SUD services, engaged in each level of care for SUD?	• Distributions of individuals by plan type, year, clinical characteristics, and demographics	MDW and Related Datasets	Descriptive statistics
Subsidiary research question 3.1b: What factors may be barriers to, or facilitators of, access and engagement in SUD treatment?	Not applicable	Program documents and reports, if available KIIs or focus groups	Document review Qualitative analysis
Primary research question 3.2: Did quality of care outcomes among individuals in need of SUD services improve following the implementation of the IMD SUD demonstration?	• ED Visits for SUD, for OUD • Inpatient Utilization for SUD, for OUD • Adult Access to Preventive/Ambulatory Health Services • Colorectal Cancer Screening • Plan All-Cause Readmission by plan type, year, clinical characteristics, and demographics	MDW and Related Datasets	Interrupted time series with members in the pre-demonstration period as the baseline
Primary research question 3.3: Did health outcomes among individuals in need of SUD services improve following the implementation of the IMD SUD demonstration?	• Rate of overdose deaths among adult Medicaid members living in a geographic area covered by the demonstration by plan type, year, clinical characteristics, and demographics	MDW and Related Datasets Vital Statistics	Interrupted time series with members in the pre-demonstration period as the baseline

Research Question	Outcome Measures	Data Sources	Analytic Approach and Comparison Strategy
Primary research question 3.4: Did the IMD SUD demonstration stabilize or reduce costs of care for the SUD population?	• Total cost of care per member per month	MDW and Related Datasets	Interrupted time series with members in the pre-demonstration period as the baseline
Subsidiary research question 3.4a: What types of care were the primary drivers of the total cost of care for the SUD population?	• Source of care cost drivers (inpatient, non-ED outpatient, ED outpatient, pharmacy, long-term care)		Interrupted time series with members in the pre-demonstration period as the baseline
Hypothesis 4: The continuous eligibility policy for children up to age six will increase enrollment duration and increase access to routine care for this population.			
Primary research question 4.1: How did the continuous eligibility policy for children up to age six impact enrollment duration among eligible members?	• Average months of enrollment by demographics	MDW and Related Datasets	Pre-post comparison
Primary research question 4.2: How did the continuous eligibility policy for children up to age six impact health care utilization and cost?	• Service Utilization by type (outpatient, inpatient, ED, pharmacy) • PMPM Cost of Care (total, and by type) by demographics	MDW and Related Datasets	Pre-post comparison
Primary research question 4.3: Did quality of care indicators improve following the implementation of the continuous enrollment policy for this population?	• Child and Adolescent Well-Care Visits • Oral Evaluation, Dental Services by year and demographics	MDW and Related Datasets	Pre-post comparison

Research Question	Outcome Measures	Data Sources	Analytic Approach and Comparison Strategy
Hypothesis 5: The HRSN component of the January 2024 amendment will support the delivery of social care through SCNs and improve overall quality and health outcomes for high-risk members[33] including children, pregnant and postpartum individuals, the chronically homeless, and individuals with SUD.			
Primary research question 5.1: Did the HRSN initiative effectively mitigate members' identified HRSNs?	• Proportion of survey respondents who agreed that services received fully met their needs by year, HRSN service type, and demographics	SCN Member Survey KIIs or focus groups	Descriptive statistics Qualitative analyses
Subsidiary research question 5.1a: Did the prevalence of HRSN screening increase over the course of the implementation?	• Number of persons screened by year, plan type, and clinical characteristics and demographics	MDW and Related Datasets Health Plan Reported Data	Trend over time (anticipate 1 year of pre-demonstration baseline data)
Subsidiary research question 5.1b: What was the prevalence of HRSN needs over the course of the implementation?	• Number of unique individuals with 1 or more HRSNs • Number of identified needs by year, HRSN type, and clinical characteristics and demographics	MDW and Related Datasets	Descriptive statistics
Subsidiary research question 5.1c: Did eligible members engage in the services made available to them under the HRSN initiative?	• HRSN Service Engagement: of those individuals screened, proportions: • Eligible for navigation • Utilized navigation • Eligible for Enhanced HRSN • Utilized Enhanced HRSN by year, HRSN type, clinical characteristics and demographics	MDW and Related Datasets	Descriptive statistics
Primary research question 5.2: What were the experiences of members with HRSN screening and services?	Proportion of survey respondents who reported good to excellent experience with: • Screening process • Social Care Navigator • Nutrition Service Provider • Housing Service Provider • Transportation Service Provider Proportion of survey respondents who were happy with the quality of services received: • Nutrition Service Provider • Housing Service Provider • Transportation Service Provider By year and demographics	SCN Member Experience Survey	Descriptive statistics

[33] The State indicates that the term "high-risk members" includes "children, pregnant and postpartum individuals, the chronically homeless, and individuals with SUD" in the Stated goals of the demonstration. For purposes of evaluation, "high-risk members" is defined as individuals who meet the eligibility criteria for Enhanced HRSN Services.

Research Question	Outcome Measures	Data Sources	Analytic Approach and Comparison Strategy
Primary research question 5.3: Did quality of care and health outcomes among persons eligible for Enhanced HRSN Service improve following receipt of Enhanced HRSN Services?	• Adult Access to Preventive/Ambulatory Health Services • Colorectal Cancer Screening • Inpatient Utilization • ED Visits (Total, BH, non-BH) • Plan All-Cause Readmission by year, clinical characteristics and demographics	MDW and Related Datasets	Individual-level interrupted time series regression for comparisons within the target population, before and after utilizing Enhanced HRSN Services.
Primary research question 5.4: How did renewals of recurring nutrition services affect care utilization and member physical and mental health outcomes?	• Adult Access to Preventive/Ambulatory Health Services • Colorectal Cancer Screening • Inpatient Utilization • ED Visits (Total, BH, non-BH) • Plan All-Cause Readmission • Potentially Preventable Mental Health Readmission Rates by year, clinical characteristics and demographics	MDW and Related Datasets KIIs or focus groups	Individual-level interrupted time series regression for comparisons within the target population, before and after utilizing Enhanced HRSN Services. Qualitative analyses
Subsidiary research question 5.4.a: What costs were associated with renewals of recurring nutrition services?	• Total cost of renewals of recurring nutrition services • Average per member cost of recurring nutrition services by year	MDW and Related Datasets	Descriptive statistics
Primary research question 5.5: Did local investments in housing supports and nutrition services change over time, and if so, how?	• Number of HRSN type programs by year	Annual Monitoring Reports: Maintenance of Effort section	Descriptive statistics
Primary research question 5.6: What costs were associated with the HRSN services?	• Estimates of total cost for each service type, including: Direct costs (personnel, supplies, service delivery), Indirect costs (administrative, IT), and Overhead costs (facility costs) by year, HRSN service and region	MDW and Related Datasets SCN Annual Reports	Descriptive statistics
Hypothesis 6: The January 2024 amendment initiatives will lead to reductions in health disparities.			
Primary research question 6.1: Were there disparities in indicators of health care access and quality among high-risk members prior to the amendment?	• Adult Access to Preventive/Ambulatory Health Services • Colorectal Cancer Screening • Inpatient Utilization • ED Visits (Total, BH, non-BH)	MDW and Related Datasets National benchmarks, state-specific standards and	Descriptive statistics

Research Question	Outcome Measures	Data Sources	Analytic Approach and Comparison Strategy
	• Plan All-Cause Readmission • Potentially Preventable Mental Health Readmission Rates by year, clinical characteristics and demographics	targets	
Primary research question 6.2: Did disparities identified under research question 6.1 improve following implementation of the amendment initiatives?	• Adult Access to Preventive/Ambulatory Health Services • Colorectal Cancer Screening • Inpatient Utilization • ED Visits (Total, BH, non-BH) • Plan All-Cause Readmission • Potentially Preventable Mental Health Readmission Rates by year, clinical characteristics and demographics	MDW and Related Datasets National benchmarks, state-specific standards and targets	Interrupted time series with members in the pre-demonstration period as the baseline

3. DEMONSTRATION AND COMPARISON POPULATIONS

The populations[34] impacted by the demonstration are identified and described in Section B.4. Populations Impacted by the Demonstration. The approach to comparison for each research question is provided in Section D.2. Overview of Analytic Methods. Most of the analyses are interrupted time series with a pre-demonstration within-group comparison, consisting of individuals who met the same criteria as the demonstration population in the period preceding the implementation. The pre-demonstration period for each population is provided in Exhibit 8: Demonstration and Comparison Periods. In some instances, the pre-demonstration period overlaps with the COVID-19 PHE. In these cases, a sensitivity analysis will be conducted to examine the impact on outcomes of including, versus excluding, the years most impacted by the PHE (2020 and 2021).

Exhibit 8: Demonstration and Comparison Periods

Demonstration Population	Pre-demonstration Period	Demonstration Period
Youth Eligible for HCBS	January 2017 – September 2019	October 2019 – March 2027
Behavioral Health High-Risk Adults	January 2018 – January 2022	February 2022 – March 2027
Individuals with SUD Service Needs	January 2021 – December 2023	January 2024 – March 2027
Children up to Age Six	January 2024 – December 2024	January 2025 – December 2025[35]
All Medicaid Managed Care Members	January 2022 – December 2024	January 2025 – March 2027

[34] Throughout this document, the term "Medicaid members" is used to represent "waiver-eligible Medicaid members". To streamline the document for the reader, the "waiver-eligible" qualifier is not used. For example, when presenting findings for the SCN program, "Medicaid Managed Care members" refers to "HRSN waiver-eligible Medicaid Managed Care members".

[35] The continuous eligibility policy for children up to age six was in effect for calendar year 2025. A wind-down of the policy began in 2026. Since the policy was in effect for 1 year, the evaluation will include comparisons to the prior year for a limited number of research questions.

4. EVALUATION PERIOD

The full time period under independent evaluation is January 1, 2020, through March 31, 2027; this represents the final year of the prior demonstration period which has not previously been evaluated, the temporary extension period, and the current five-year waiver period. The interim evaluation focuses on the time period from January 1, 2020, through December 31, 2025. Some additional information derived from administrative data on progress through the Spring of 2026 is also included. The summative evaluation will extend through the end of the waiver period, March 31, 2027.

5. EVALUATION MEASURES

The evaluation measures are summarized in Exhibit 9: Evaluation Measures Summary.

Exhibit 9: Evaluation Measures Summary

Measure (Acronym) Steward	Description
Adult Behavioral Health Home and Community-based Service (BH HCBS) Utilization **Homegrown**	The number of unique individuals who received each adult BH HCBS service during the measurement year. The number of claims submitted for each adult BH HCBS service during the measurement year.
Adults Access to Preventative/ Ambulatory Health Services (AAP) **NCQA/HEDIS**	The percentage of members 20 years of age and older who had an ambulatory or preventive care visit during the measurement year.
Adherence to Anti-psychotic Medication for People with Schizophrenia (SAA) **NCQA/HEDIS**	The percentage of members aged 18 years and older with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period during the measurement year.
Child and Adolescent Well-Care Visits (WCV) **NCQA/HEDIS**	The percentage of members aged 3-21 who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.
Colorectal Cancer Screening (COL-E) **NCQA/HEDIS**	The percentage of members aged 45-75 who had appropriate screening for colorectal cancer.
CORE Service Utilization **Homegrown**	The number of unique individuals who received each CORE service during the measurement year The number of claims submitted for each CORE service during the measurement year
Dental Service Utilization **Homegrown**	The percentage of members aged 21 and over who received a comprehensive or periodic oral evaluation with a dental provider during the measurement year.
Emergency Department Utilization (EDU); Total, BH, non-BH, SUD, OUD **NCQA/HEDIS**	The rate per 1,000 of members aged 19–64 who had ED visits during the measurement year. Five rates are reported: total, for a behavioral health need, for a non-behavioral health need, for SUD, and for OUD.

Measure (Acronym) Steward	Description
Engagement in Community Based Mental Health Care After Hospitalization (ENG-CBMH) **Homegrown**	The percentage of Medicaid members aged 6-64 hospitalized with a primary mental health diagnosis having ≥ two outpatient visits, intensive outpatient sessions, or partial hospitalization events within 30 days of discharge
Follow-up After High-Intensity Care for SUD (FUI) **NCQA/HEDIS**	The percentage of acute inpatient hospitalizations, residential treatment or withdrawal management visits for a diagnosis of SUD among members aged 13 and older that result in a follow-up visit or service for SUD. Two rates are reported: 1. The percentage of visits or discharges for which the member received follow-up for SUD within the 30 days after the visit or discharge. 2. The percentage of visits or discharges for which the member received follow-up for SUD within the seven days after the visit or discharge.
Follow Up After Hospitalization for Mental Illness (FUH) **NCQA/HEDIS**	The percentage of discharges for patients aged 19-64 who were hospitalized for treatment of selected mental health disorders or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Two rates are reported: 1. The percentage of discharges for which the member received follow-up within seven days after discharge. 2. The percentage of discharges for which the member received follow-up within 30 days after discharge
HCBS Utilization **Homegrown**	The number of unique individuals who received a youth HCBS service during the measurement year. The number of claims submitted for youth HCBS services during the measurement year.
HRSN Screening Rate **Homegrown**	Proportion of Medicaid eligible members screened for HRSNs at least once in the measurement year.
HRSN Prevalence **Homegrown**	Number of individuals with one or more HRSNs. Number of identified HRSN needs by HRSN type.
HRSN Service Engagement **Homegrown**	HRSN Service Engagement: of those individuals screened, proportions: • Eligible for navigation • Utilized navigation • Eligible for Enhanced HRSN Services • Utilized Enhanced HRSN Services
HRSN Member Experience **Homegrown**	Proportion of survey respondents who reported good to excellent experience with: • Screening process • Social Care Navigator • Nutrition Service Provider • Housing Service Provider

Measure (Acronym) Steward	Description
	• Transportation Service Provider
HRSN Member Satisfaction **Homegrown**	Proportion of survey respondents who were happy with the quality of services received: • Nutrition Service Provider • Housing Service Provider • Transportation Service Provider
Initiation and Engagement of SUD Treatment (IET) **NCQA HEDIS**	The rate of members aged 19–64 with a new episode of SUD who received the following. • *Initiation of SUD Treatment.* The percentage of members who initiated treatment through an inpatient SUD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication treatment within 14 days of the diagnosis. • *Engagement of SUD Treatment.* The percentage of members who initiated treatment and who were engaged in ongoing SUD treatment within 34 days of the initiation visit.
Initiation of Pharmacotherapy upon New Episode of Opioid Dependence **Homegrown**	The percentage of individuals who initiate pharmacotherapy with at least one prescription or visit for opioid treatment medication within 30 days following an index visit with a diagnosis of opioid dependence.
Inpatient Utilization (IPU) **Homegrown**	The rate per 1,000 of members aged 19–64 who had an inpatient stay during the measurement year. Three rates are reported: total, for SUD, for OUD.
Non-acute SUD Service Utilization Rate **Homegrown**	The number of claims submitted for non-acute SUD services in the measurement year.
Oral Evaluation, Dental Services (OED) **NCQA/HEDIS**	The percentage of members under age 21 who received a comprehensive or periodic oral evaluation with a dental provider during the measurement year.
Overdose Deaths **Homegrown**	Rates of overdose deaths among adult Medicaid members living in a geographic area covered by the IMD SUD demonstration.
Pharmacotherapy for Opioid Use (POD) Disorder **NCQA/HEDIS**	The percentage of OUD pharmacotherapy events that lasted at least 180 days among members age 16 and older with a diagnosis of OUD and a new OUD pharmacotherapy event.
Plan All-Cause Readmission (PCR) **AHRQ**	For members aged 18-64, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.

Measure (Acronym) Steward	Description
Potentially Preventable Mental Health Related Readmission **AHRQ**	The proportion of individuals readmitted within 30 days for a clinical condition that is the same as, or related to, an eligible initial mental health discharge.
Residential Care Utilization at each of three Levels **Homegrown**	The number of unique individuals utilizing each of three levels of residential care for SUD.
Residential Care Average Length of Stay at each of three Levels **Homegrown**	The average length of stay for each of three levels of residential care for SUD.
Use of Pharmacotherapy for OUD **Homegrown**	The percentage of OUD pharmacotherapy events that lasted at least 180 days among members age 16 and older with a diagnosis of OUD and a new OUD pharmacotherapy event.
Utilization of Recovery Oriented Services for Mental Health **Homegrown**	The percentage of HARP enrolled members age 21 and older who received any of the following mental health recovery-oriented services for at least three months during the measurement year: Personalized Recovery Oriented Services (PROS), HCBS, Certified Community Behavioral Health Clinic (CCBHC) Rehabilitation/Peer Services.

6. DATA SOURCES

This section provides a summary of the data sources used for the evaluation, including Medicaid administrative data (e.g., claims and encounters, eligibility and enrollment), program-specific administrative data, and KIIs. Each source and its main purpose for the evaluation is listed in Exhibit 10: Data Sources. In most cases, the Independent Evaluator (IE) accessed data housed in curated datasets maintained by NY and described in further detail below.

Exhibit 10: Data Sources

Primary Source	Main Purpose for Evaluation
MDW and Related Datasets	Enrollment, claims-based quality measures, service utilization. Accessed via State-curated datasets: CDM, NYHERBOOK, OHIP Databooks, OMH Dataset
HRSN Member Experience Survey	Member experience with HRSN screening and services; de-identified data set.
WIO Reports	CPT program data, reported by the WIOs, will be used for applicable implementation questions.
KIIs	Qualitative data on program implementation and member experience.
SCN Operations Manual	Contextual knowledge of program operations.
SCN Network Composition Reports	SCN reported quantitative data on SCN network development.

SCN Quarterly Performance Reports	SCN reported progress, including work plan performance measures, and progress on objectives.
Annual Monitoring Reports	State reported progress on the demonstration implementation, as reported to CMS
Ad hoc Progress Summaries	State reported progress on the demonstration implementation supplied directly to the IE[36]

a. Medicaid Data Warehouse and Related Datasets

The State's Medicaid Data Warehouse (MDW) houses enrollment and eligibility data, as well as claims and managed care encounters. The MDW incorporates several 3M products to identify members' clinical risk groups (CRG) and to model potentially preventable events. The MDW is the primary source for four curated datasets which were accessed by the IE: the Clinical DataMart (CDM), the NY Health Equity Reform Databook (NYHERBOOK), the Office of Health Insurance Programs (OHIP) Databooks, and the Office of Mental Health (OMH) dataset. The Office of Health Services Quality and Analytics (OHSQA) established the CDM as a single source of truth for population-based metrics. It is leveraged by the State for a wide range of program administration and reporting purposes. The CDM is the main source for the majority of the claims-based metrics in the evaluation. The NYHERBOOK houses the HRSN-waiver related information, such as HRSN-waiver eligibility, screening, referral, and service information. The OHIP Databooks are the main source for eligibility and enrollment information; some OHIP Databooks are publicly available.[37] The OMH dataset is the source for OMH-derived metrics that are not available in the CDM.

b. HRSN Member Experience Surveys

OHIP will administer a member experience survey in 2026, designed to measure the impact of the SCN program along three dimensions:

- Effectiveness of the SCN in improving members' physical health, behavioral health, and quality of life
- Effectiveness of the SCN in addressing members' HRSNs
- Effectiveness of the SCN in creating a positive experience for members accessing HRSN services

Additional details on the survey, including the target population and survey methodologies, and the results, will be provided in the SER. Survey results are not available for this IER.

The SCN Lead Entities conduct a "pulse" survey, a brief, targeted survey to gauge member sentiment in real time. The results provide the SCN Lead Entities with information that may help identify areas for process improvement or other program enhancements. The SCN Lead Entity-administered survey is not a data source for the independent evaluation.

[36] The IE does not independently verify the information contained in the ad hoc progress summaries.
[37] Monthly New York State Medicaid Enrollment Trends. Available at: NYS Medicaid Enrollment Databook. Accessed on November 6, 2025

c. Workforce Investment Organization Reports

The WIOs are required to submit reports including individual and program level data on the CPT program, and narrative updates, to the State. The reports include information on recruitment, participation, completion, credentialing, and service commitments. The WIOs also provide updates on participating partners, including educational institutions, training partners, and eligible employers for participants fulfilling their service commitments. The data are collected throughout the life cycle of the CPT program.

d. KIIs

The IE conducted a series of KIIs with a range of stakeholders to collect qualitative data to inform the evaluation of the implementation and impact of key waiver provisions. The first wave of KIIs was conducted between September and November 2025. The findings are included in the IER. Wave one prioritized generating qualitative data on two components of the January 2024 amendment: the SCN program and the CPT program. The wave one KIIs included:

- 9 SCN Lead Entities
- 7 HRSN service providers in total; working across all 9 SCN Lead Entities[38]
- 1 NYSDOH administrator involved in the SCN program
- 3 WIOs
- 3 WIO partners or internal wraparound service providers
- 1 NYSDOH administrator involved in the CPT program

Interviews included one to three representatives per conversation. In collaboration with NYSDOH, the IE developed and utilized tailored interview guides for different stakeholder types. Semi-structured KIIs lasted 30-60 minutes, were conducted by video conference or phone call, and maintained privacy protections in accordance with CMS guidelines. Interviews were recorded and transcribed with participant consent for qualitative analysis.

The IE also reviewed the State's monitoring reports submitted to CMS and conducted a structured conversation with NYSDOH administrators to provide up-to-date information on the implementation progress of the additional January 2024 waiver amendment programs: the HEALR program, MHGBI, and HERO.

The IE will conduct a second wave of KIIs to inform the SER. The wave two interviews will continue to focus on the SCN and CPT programs, by following-up on first-round interviews with SCN Lead Entities, HRSN service providers, and WIOs, while also expanding the interviews to additional stakeholders in the SCN and CPT programs, including: providers, MCOs, Medicaid members receiving HRSN services, and CPT program participants. The wave two interviews will also include a deeper dive into the implementation of the following components: HEALR program, MHGBI, and HERO.

[38] Seven HRSN service providers were interviewed. Since some providers were contracted with more than one SCN, all SCNs were represented.

Additionally, wave two KIIs will be conducted to gather qualitative data to inform the evaluation of the IMD SUD demonstration. These interviews will include SUD service providers and NYSDOH administrators with knowledge of the design and implementation of the IMD SUD demonstration.

The wave two planned KIIs include approximately:

- 9 SCN Lead Entities
- 9 HRSN service providers
- 1 NYSDOH administrator involved in the SCN program
- Up to 9 MCOs involved in the SCN program
- Up to 9 providers involved in the SCN program
- 20-30 Medicaid members who received Enhanced HRSN Services
- 3 WIOs
- 1 NYSDOH administrator involved in the CPT program
- Up to 10 CPT program graduates/participants
- Up to 6 CPT program placement sites
- 1 NYSDOH administrator involved in the HEALR program
- 1 NYSDOH administrator involved in the HERO
- 1 HERO Facilitator
- 2-4 HERO partner or collaborator organizations
- 1 NYSDOH administrator involved in the MHGBI
- 12 hospitals participating in the MHGBI (all participating hospitals)
- 5-10 SUD service providers
- 1 NYSDOH administrator involved in the IMD SUD demonstration

The actual number of interviews may vary from the planned number as interviews are discontinued once saturation is reached for a specific segment of interviews, as described in Section 6.7.b. Qualitative Analysis

In the event the evaluators identify opportunities to convene focus groups during naturally occurring events, such as provider meetings, some KIIs may be replaced with focus groups. The evaluators will weigh the benefits of efficiency in data collection against concerns that social desirability could influence responses in group settings.

Exhibits 11 and 12 include KII sample topics, organized by policy and stakeholder group.

Exhibit 11: Key Informant Interview Topics: January 2024 Amendment Initiatives

Stakeholder Group	KII Topics
HRSN Infrastructure & Services: The Social Care Network Program	
SCN Lead Entities	• Perceptions of the January 2024 1115 waiver amendment purpose and goals • Region-specific contextual factors for SCN implementation • Implementation barriers, successes, and progress • Partnership development and network building • HRSN service delivery • Infrastructure and technology • Measuring progress and success • Workforce considerations • Long-term role of SCNs
HRSN service providers	• Perceptions of the January 2024 1115 waiver amendment purpose and goals • Region-specific contextual factors for HRSN service provider activities • Implementation barriers, successes, and progress • Barriers or facilitators of member engagement • Infrastructure and technology • Measuring progress and success • Workforce considerations
SCN NYSDOH Administrators	• Perceptions of the January 2024 1115 waiver amendment purpose, goals, contextual factors, and alignment with other state initiatives • Implementation barriers, successes, and progress • Infrastructure and technology • Measuring progress and success • Workforce considerations • Long-term role of SCNs
MCOs	• Implementation experience • Sustainability and integration of the HRSN services in VBP arrangements
Providers (hospitals, primary care, etc.)	• Implementation experience of screening, eligibility assessments, navigation and referrals • Implementation experience with infrastructure and technology
Medicaid members receiving Enhanced HRSN Services	• Member experience and satisfaction with screening, navigation, and receipt of HRSN services
Career Pathways Training Program	
WIOs	• Perceptions of the January 2024 1115 waiver amendment purpose and goals • WIO structure and staffing • Implementation barriers, successes, and progress • Measuring progress and success • Coordination with other WIOs and SCNs • Workforce considerations and regional context • Perceptions of the long-term impact of the CPT program

Stakeholder Group	KII Topics
WIO Partners	• Perceptions of the January 2024 1115 waiver amendment purpose and goals • Partnership role with the WIO • Implementation barriers, successes, and progress • Support service implementation • Measuring progress and success • Workforce considerations and regional context
CPT NYSDOH Administrators	• Perceptions of the January 2024 1115 waiver amendment purpose, goals, contextual factors, and alignment with other state initiatives • The CPT program's role in addressing workforce needs • Implementation barriers, successes, and progress • Measuring progress and success • Infrastructure and technology • Perceptions of the long-term impact of the CPT program
CPT Participants	• Experience completing training and service commitment program requirements • Impact of the CPT program on career trajectory
CPT Service Commitment Sites	• Experience engaging with the CPT program and integrating CPT participants into their workforce • Impact of the CPT program on the State's workforce
Health Care Access Loan Repayment Program	
NYSDOH Administrator	• Barriers and facilitators to implementation progress • Perceptions of HEALR program impact
Health Equity Regional Organization Initiative	
HERO Facilitator	• Strategies for identifying regional and statewide priorities, needs, and solutions around population health and health related social needs • Experience facilitating regional approaches to population health and health related social needs
HERO Partners	• Experience engaging with the HERO facilitator directly or through facilitator supported events or initiatives
NYSDOH Administrator	• Barriers and facilitators to implementation progress
Medicaid Hospital Global Budget Initiative	
NYSDOH Administrator	• Barriers and facilitators to implementation progress
Participating Hospitals	• Experience with the global budget initiative • Perceptions of the effectiveness of the initiative

Exhibit 12: Key Informant Interview Topics: IMD SUD Demonstration

Stakeholder Group	KII Topics
SUD Providers	• Enrollment/participation in the waiver • Perceptions of the impact of residential reintegration services and the waiver overall • Perceptions of SUD provider capacity in the State
NYSDOH Administrators	• Perception of most significant changes authorized under the waiver

e. SCN Operations Manual

The OHIP issues the "Social Care Network: Program, Billing, and Data Governance Operations Manual" (SCN Operations Manual); it is a living document most recently updated May 1, 2026. The manual provides OHIP's requirements governing the delivery of HRSNs services, as well as operation instructions including SCN reporting requirements. The SCN Lead Entities are the primary audience, but it is also helpful to network members and to the IE as a resource for understanding SCN operations.

f. SCN Network Composition Plan and Report

SCNs initially reported planned network composition prior to implementation and report actual contracted network composition on a quarterly basis. The report enables the State to monitor network adequacy. The report contains information on contracted organizations including HRSN service providers, health care providers, and other organizations supporting SCNs with delivery of screening, navigation, and HRSN service delivery.

g. SCN Quarterly Performance Report

SCNs submit a performance report on a quarterly basis. The report includes the SCNs work plan performance measures and a narrative response to a series of questions related to the program objectives.

h. Annual Monitoring Reports

States operating CMS approved 1115 demonstrations are required to submit periodic reports to CMS on implementation progress, known as the Monitoring Reports.[39] Historically, states were required to submit the reports on a quarterly basis. In June 2025, the cadence shifted from quarterly to annually and a new monitoring report template was issued. The Monitoring Report is now an excel workbook containing several worksheets:

- Overview
- Executive Summary
- Implementation Updates
- Base Metrics
- Policy-specific Metrics
- State-specific Metrics
- Metrics Context

The IE reviews the CMS approved Monitoring Reports to gain information on implementation progress.

i. Ad hoc Progress Reports

To include the timeliest information possible on implementation progress in the evaluation reports, the State may issue ad hoc progress summaries and supply them directly to the IE. The summaries may contain administrative data and narrative descriptions of progress. The IE does not independently verify the

[39] More information on the CMS-required Monitoring Reports can be found at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation/1115-demonstration-state-monitoring-evaluation-resources.

information contained in the summaries, rather, the source is cited in the evaluation report as "State reported" information.

7. ANALYTIC METHODS

a. Quantitative Analysis

The objective of the quantitative analyses is to describe any changes in hypothesized demonstration outcomes over time, and to attribute changes in outcomes to the demonstration policies when appropriate based on the available analytic methods.

Descriptive Analysis

The evaluation includes several process measures and some outcomes measures for which there is no comparison group available. In these instances, descriptive statistics are provided, such as the measure range, median, and mean. Tests for statistical significance are provided. The evaluation also includes descriptive summaries of the size and demographic characteristics of target populations, including frequencies and proportions, which will help to identify characteristics that will be included as covariates in regression modeling.

Interrupted Time Series

An interrupted time series (ITS) model is the most robust choice available for most of the research questions, due to the lack of comparison groups. The ITS model provides estimates of the outcome trends in the demonstration population relative to the trends in the pre-demonstration period for the population. The IE anticipates three to five pre-demonstration period data points and three or more post-demonstration data points, depending on the implementation date of the specific policy under evaluation, making the ITS approach a feasible option for the summative evaluation. Since the pre-demonstration period overlaps with the COVID-19 PHE, sensitivity analyses will be examining ITS results with the years 2020 and 2021 in the model, and not in the model.

Covariates and Subpopulation Analyses

Covariates in regression models include member clinical characteristics and demographics: age, sex, race/ethnicity, and region (NYC versus rest of state). Where applicable, health plan type (MMMC, HARP, HIV-SNP) is also included as a covariate. Outcome differences across subpopulations are explored where there is sufficient subgroup sample size. Subpopulation outcomes are compared to national or state-specific standards or benchmarks.

b. Qualitative Analysis

The IE utilized a comprehensive and in-depth approach to analyze the qualitative data gathered through KIIs to identify salient themes and findings. First, the IE reviewed KII transcripts for accuracy and completeness. Interview transcripts were imported into a secure, qualitative analysis software for coding and analysis. The IE first conducted "in-vivo" coding, the practice of abstracting a word or short phrase directly from the interview transcript, to retain the authenticity of informant statements (Strauss, 1987).[40] In-vivo codes were grouped into first order categories, and a codebook was developed through several

[40] Strauss A. (1987). *Qualitative Analysis for Social Scientists*. Cambridge University Press.

rounds of iteration between the qualitative research team. An independent qualitative research team member, who did not engage in the in-vivo coding process, validated the coding, codebook, and first-order categories. After establishing inter-coder reliability across several transcripts, the codebook was applied to all transcripts. The IE assessed transcripts for saturation as defined by the point where few or no new learnings for a given topic were offered by key informants.

Finally, thematic analysis was applied to the qualitative data grouped through first-order codes. The qualitative research team iterated to extract findings. Exemplary quotations are used to support findings where appropriate.

c. Integration of Findings

The quantitative and qualitative data collection and analysis activities took place in parallel leading up to the evaluation report. The IE synthesized quantitative and qualitative findings to identify and explore areas of convergence and divergence and identify potential explanations for divergence in the evaluation reports. The evaluation reports present findings for each implementation and research question in an integrated fashion, including both quantitative and qualitative findings.

E. Methodological Limitations

The evaluation design methodology is subject to the following limitations.

1. TIMING OF AMENDMENT APPROVALS AND IMPLEMENTATION

The evaluation includes initiatives and policies that were approved and implemented later in the demonstration period, including those in the January 2024 amendment, the IMD SUD demonstration, and the continuous eligibility for children up to age six policy. These initiatives and policies may not generate detectable changes in outcomes within the demonstration period, particularly at the time of the interim evaluation.

In addition, the timing of the approval and implementation of these initiatives results in limited quantitative data available for the evaluation, especially at the interim. Since the interim evaluation was conducted early in the implementation of the January 2024 amendment initiatives, there was limited quantitative data available, as systems for collecting and validating data were not all fully mature. For example, the IER includes rates of HRSN screening, but does not include information on HRSN assessments, referrals and service engagement, or HRSN member experience. The lack of quantitative data is a limitation in that little information is available to contextualize the qualitative findings.

2. TIMING OF QUALITATIVE DATA COLLECTION

The evaluation design includes two waves of KIIs. Wave one took place in advance of the IER, from September to November 2025, while wave two has not yet been conducted. The findings in the IER are thus limited to the perspectives of the stakeholders interviewed in wave one, primarily individuals in organizational leadership positions. Additional stakeholder groups, including members, will be interviewed in wave two. The methodology section provides additional details on the two waves, including stakeholder types.

3. SNOWBALL SAMPLING METHOD

A snowball sampling approach was utilized to identify HRSN service providers in SCN networks, and to identify WIO partners, to take part in KIIs. This approach involves Lead Entities identifying network providers or organizational partners to refer to the IE, and in some cases, facilitating the connection. This technique was effective in identifying a responsive sample but may introduce bias and limit the representativeness or generalizability of the findings.

4. LACK OF A COMPARISON GROUP FOR SEVERAL TARGET POPULATIONS

Four of the five demonstration target populations lack a robust comparison group: Youth Eligible for HCBS, Behavioral Health High-Risk Adults, Individuals with SUD Service Needs, and Individuals with HRSNs. These groups are defined based on clinical criteria and needs-based criteria: people who meet the criteria are significantly different from those who do not meet the criteria. In addition, because the policies are typically implemented statewide and are not phased-in over time, comparison groups of eligible individuals not exposed to the demonstration are not available. An interrupted time-series approach to estimating changes during the post-demonstration period is planned for research questions associated with these populations, which is limited in that it does not support causal inference.

5. SUBPOPULATION SIZES

The MRT demonstration targets many individuals that can be divided into multiple subpopulations based on demographic and other characteristics, such as health plan type. Subgroups may not be of sufficient size to support statistical analysis on all subgroups of interest. The IE will explore disparities in outcomes by race/ethnicity within the groups where numbers are sufficient.

6. HISTORIC EFFECTS

The impacts of the COVID-19 pandemic/PHE include increased Medicaid enrollment due to deferred redeterminations, as well as changes in health care access and utilization. These impacts took place prior to the start of this demonstration period and thus overlap with pre-demonstration baseline periods. Sensitivity analyses will be conducted to examine if outcomes vary when the years most impacted by COVID-19 are included, or excluded, from regression models in the SER. Another relevant historical factor is the adoption of naloxone to reverse opioid overdose, which is likely to have a large impact on the rate of lethal overdose. Due to this expected confounding, the evaluation will assess rates of ED Visits (Total, BH, non-BH) for SUD in addition to overdose death rates and will consider the historical trajectory of naloxone uptake in evaluating the results.

7. OVERLAP WITH OTHER STATE AND FEDERAL INITIATIVES

The demonstration period overlaps with several state and federal initiatives designed to impact the same or similar outcomes. The most significant of these will be described in the summative evaluation reports to provide context. That said, when policies or initiatives target the same outcomes, are implemented statewide without a control group, and the timing overlaps completely, it is generally not possible to isolate the impact of an individual policy.

F. Results

This section presents the preliminary results of the implementation evaluation of the following January 2024 amendment initiatives: SCN program, CPT program, HEALR program, MHGBI, and HERO initiative. Due to the approval of the January 2024 amendment partway into the current waiver period, the implementation period for these initiatives does not span the full five-year waiver period. The implementation dates for the amendment initiatives varied due to the need to complete pre-implementation planning activities specific to each initiative. The SER will expand on these implementation findings.

These preliminary findings were developed from (1) the qualitative data gathered from KIIs early in the implementation period (September to November 2025), as described in d. KIIs , and (2) administrative data sources that included both quantitative data and narrative descriptions of progress. The administrative data sources, such as State issued ad hoc progress summaries, generally provide information as of April 2026. A description of each program or initiative precedes the findings.

1. SOCIAL CARE NETWORK PROGRAM

a. SCN Program Overview[41]

In January 2024, CMS approved an amendment to New York's 1115 waiver that authorized the creation of the Social Care Network (SCN) program, with the goal of improved quality and health outcomes for all Medicaid members through investments in HRSN infrastructure and services. The SCN program is intended to strengthen collaboration across the healthcare and social service ecosystem and support New York's broader transition toward integrated, value-based care. CMS authorized the State to invest up to $500 million in infrastructure to support HRSN services and up to $3.173 billion for increased coverage for specific evidence-based HRSN services that are critical drivers of an individual's access to care.

The HRSN infrastructure funding flows directly from OHIP to the SCN Lead Entities. The infrastructure funding is *partially* tied to performance on key operational metrics: screening, assessment, timely outreach, referrals, and closed-loop referral rates, with no performance-based payments in Year 1 and increasing accountability in later years (10% in Year 2 and 15% in Year 3). This phased approach is intended to support baseline data collection and support SCNs in building capacity for future value-based payment models while maintaining a focus on measurable effectiveness across the Medicaid beneficiary journey. A portion of the infrastructure funding awarded to SCN Lead Entities may in turn be awarded to CBOs in the form of capacity building funds.[42] HRSN infrastructure investments are allowed in four areas to support the SCN program:

- Technology – wide range of technology to support coordinated and member-centric provision of HRSN screening, eligibility, assessment, referral, and service delivery. Examples include electronic

[41] The information in this section is based in part on the "Social Care Network: Program, Billing, and Data Governance Operations Manual". Available at: https://www.health.ny.gov/health_care/medicaid/redesign/sdh/scn/docs/operations_manual.pdf. Accessed on May 27, 2026. Additional information is drawn from the Demonstration Approval. Available at: ny-medicaid-rdsgn-team-appvl-01092024.pdf. Accessed on July 10, 2025.

[42] CBOs are non-profits and are eligible for capacity building funds. For-profit HRSN service providers are not eligible.

referral systems, shared data platforms, and interoperability with the State Health Information Network for New York (SHIN-NY). The overarching social care technology ecosystem is designed to provide end-to-end visibility into the member journey throughout the health and social care systems.

- Business/Operational Development – development of SCN administrative capabilities, including those of the SCN Lead Entities and contracted CBOs. Examples include developing policies and workflows for all SCN activities (screening, referral, referral management, member navigation, etc.).
- Workforce Development – worker certification and training, including training on new policies and procedures.
- Outreach and Education – investments to educate stakeholders, including outreach and education materials and costs associated with stakeholder convenings.

The HRSN services are administered by regional SCNs, entities that are newly established under the amendment. The SCN Lead Entity is the organization that contracts with OHIP and the MCOs in their region and thus plays a critical role in managing regional networks, facilitating data sharing, reimbursing providers, and ensuring accountability for outcomes. The SCN Lead Entities coordinate Medicaid member screening, eligibility assessment, navigation, referral, and HRSN service delivery, and are accountable for network performance.

SCN Lead Entities are funded through two primary sources under the 1115 waiver: the HRSN infrastructure funding described previously, and PMPM (per-member-per-month) payments, which flow from OHIP to the MCO, then to the SCN. The State developed PMPM rates to account for regional costs to conduct screening, navigation, and Enhanced HRSN Services. The SCNs submit claims to the MCOs for HRSN services provided. The PMPM amount is informed by the weighted average of navigation and Enhanced HRSN Services for the attributed Medicaid managed care members. The PMPM rate is provided to the SCN for all attributed Medicaid members, including unengaged members, within the SCN region. Members are attributed to the SCN designated for the county in which the member resides. A PMPM reconciliation process is conducted annually to assess payment accuracy, ensure alignment with rate schedules, and make any necessary adjustments. The SCN Lead Entities are responsible for establishing a process for reimbursing their contracted HRSN service providers for services rendered.

The State aims to screen all Medicaid members for HRSNs annually, and as needed based on changes in circumstances, and connect or "navigate" individuals to services to address *unmet* needs. If the member has access to services to meet their needs through an existing program or their health plan, coordination is provided to support the member in accessing those services. All SCNs use a standardized screening tool, the Accountable Health Communities (AHC) HRSN Screening Tool.

The HRSN benefit design is a two-tiered system. All Medicaid members are eligible for Level 1 HRSN services: screening and subsequent navigation to existing state, federal, and local programs for any unmet HRSNs, such as Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF); services that are not reimbursable by Medicaid. Medicaid *managed care members* are eligible for Level 2 HRSN services, known as the "Enhanced HRSN Services", if they meet specific eligibility

criteria. The Enhanced HRSN Services are provided through contracted HRSN service providers and are reimbursed using Medicaid funds; they are:

Housing Supports

- Housing transition and navigation services
- Community transitional services
- Rent/utilities
- Pre-tenancy and tenancy sustaining services
- Home remediation
- Asthma remediation
- Home accessibility and safety modifications
- Medical respite

- **Nutrition**
  - Nutritional counseling and classes
  - Medically tailored or clinically appropriate home-delivered meals
  - Food prescriptions
  - Fresh produce and nonperishables (i.e. pantry stocking)
  - Cooking supplies (kitchenware, microwave, refrigerator)
- **Transportation**
  - Reimbursement for public and private transportation to connect to HRSN services and HRSN case management activities
- **Care Management**
  - Care management, outreach, referral, and education, including linkages to other state and federal programs
  - Connection to clinical case management
  - Connection to childcare, employment, education, and interpersonal violence resources

Eligibility for Enhanced HRSN Services is determined through a combination of HRSN screening and eligibility assessments. Members must meet all four components of the following eligibility criteria to receive Enhanced HRSN Services:

- **Unmet HRSNs:** Member must have an identified unmet HRSN per the AHC HRSN Screening Tool. Member must be assessed to meet related Social Risk Factor descriptions.
- **Enhanced Population:** Member must belong to one or more covered populations, as assessed by criteria.
- **Clinical Criteria/Social Risk Factors:** Member must demonstrate medical necessity for individual Enhanced Services, as assessed by clinical criteria/Social Risk Factors.
- **Enrolled in Medicaid Managed Care**

Additional detail on the eligibility criteria and descriptions of the Enhanced Populations can be found in the "Social Care Network: Program, Billing, and Data Governance Operations Manual".[43] At a high level, the Enhanced Populations include:

- Medicaid High Utilizer (adults and children)
- Enrolled in a NYS Health Home (adults and children)
- Individuals with SUD
- Individuals with SMI
- Individuals with Intellectual and Developmental Disabilities (adults and children)
- Pregnant and Postpartum Persons
- Post-Release Criminal Justice-Involved Population with chronic conditions, SUD, or chronic Hepatitis-C
- High Risk Children under the age of 18

b. SCN Program Implementation Findings

The findings presented here were developed from (1) the qualitative data gathered from KIIs early in the implementation period and (2) administrative data sources that included both quantitative data and narrative descriptions of progress through April 2026. For more recent implementation updates, visit the State's SCN Program website[44].

The IE conducted KIIs with organizational leadership and senior staff across the SCN Lead Entities (9), HRSN service providers (7), and a NYSDOH administrator (1) between September and November 2025, approximately 8-10 months after SCN program implementation began in January 2025. The administrative data sources, such as State issued ad hoc progress summaries, generally provide information as of April 2026. At the time of report writing, data on HRSN eligibility assessments, referrals and services are not available as the processes for capturing and integrating these data elements are currently being refined to ensure quality, consistency, and accuracy. This data will be included in the SER.

Implementation Question 1: What progress has been made in implementing the SCN program, including network development and HRSN screening, eligibility assessments, care navigation, and delivery of Enhanced HRSN Services? What are the barriers to implementation, and what strategies have been used to address these barriers? What factors have contributed to successful implementation progress?

Social Care Network Implementation Progress

Immediately following the January 2024 amendment approval, the State moved quickly to implement the SCN program. NYSDOH released a competitive Request for Application (RFA) on January 16, 2024 for SCN Lead Entities. The State defined 13 HRSN regions and invited organizations to apply for the SCN Lead Entity

[43] Social Care Network: Program, Billing, and Data Governance Operations Manual. Available at: https://www.health.ny.gov/health_care/medicaid/redesign/sdh/scn/docs/operations_manual.pdf. Accessed on May 27, 2026.
[44] For the most recent Social Care Network Program implementation updates, visit the State's SCN Program website, available here: https://www.health.ny.gov/health_care/medicaid/redesign/sdh/scn/.

role for one or more regions. The State received 32 qualified applications for SCN Lead Entities and awarded nine. Awardees and their corresponding regions are shown in Exhibits 13 and 14.

Exhibit 13: SCN Lead Entity Map

Exhibit 14: SCN Lead Entity, Region, and County

Social Care Network Lead Entity	
NYS Region	**NYS Counties (NYC borough where applicable)**
Care Compass Collaborative	
Southern Tier	Broome, Chenango, Delaware, Otsego, Tioga, Tompkins
Forward Leading IPA	
Finger Lakes Region	Allegany, Cayuga, Chemung, Genesee, Livingston, Monroe, Ontario, Orleans, Schuyler, Seneca, Steuben, Wayne, Wyoming, Yates
Health Equity Alliance of Long Island	
Long Island	Nassau, Suffolk
Healthy Alliance Foundation Inc.	
Capital Region	Albany, Columbia, Greene, Rensselaer, Montgomery, Saratoga, Schenectady, Schoharie;

Central New York	Cortland, Herkimer, Madison, Oneida, Onondaga, Oswego
North Country	Clinton, Essex, Franklin, Fulton, Hamilton, Jefferson, Lewis, St. Lawrence, Warren, Washington
Hudson Valley Care Coalition, Inc.	
Hudson Valley	Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester
Public Health Solutions	
Queens	Queens
Kings	Kings (Brooklyn)
New York City	New York (Manhattan)
Staten Island Performing Provider System	
Richmond	Richmond (Staten Island), and select zip codes within Kings and Queens counties
Somos Healthcare Providers, Inc.	
Bronx	Bronx
Western New York Integrated Care Collaborative	
Western NY	Cattaraugus, Chautauqua, Erie, Niagara

Key Informant Understanding of Waiver Context and Perceptions of Program Purpose

Key informants expressed a clear understanding of the SCN program's purpose and key elements. They frequently described the January 2024 amendment as focused on addressing HRSNs, with many interviewees explicitly linking HRSN services to improvements in health outcomes and reductions in acute care utilization, consistent with demonstration goals. Some framed the SCN program as part of a broader system redesign, emphasizing incremental steps towards long-term transformational change. Interviewees also highlighted the SCN's role in building critical data infrastructure to support HRSN identification and service delivery statewide. Additionally, key informants with prior experience implementing New York's Delivery System Reform Incentive Payment (DSRIP) program noted that their familiarity with DSRIP helped them understand the waiver's emphasis on structural change.

When asked to share their understanding of the SCN component of the January 2024 waiver amendment, a key informant shared*:*

> *"It's a coordinated way to address people's basic needs around food, housing and transportation…we've done it in pockets over the years. …To be able to do it in a really coordinated, systemic fashion is really the overall purpose" (SCN KII, Fall 2025).*

While informants identified a range of implementation challenges typical of large, multi-sector initiatives early on in program roll-out, consistent support for the SCN program's vision and success emerged as a common theme. Across regions and stakeholder groups, interviewees described the SCN program as a meaningful statewide effort to structurally integrate social services with the clinical health care system. Informants expressed appreciation for the scale, flexibility, and intent of the investment, emphasizing that

it enabled rapid progress in building networks, hiring staff, and initiating services. Many articulated a shared belief that addressing HRSNs through coordinated systems can improve outcomes, strengthen communities, and support return on investment.

SCN Implementation Progress and Challenges: Overview

The SCN program is being fully implemented across all regions in the State. SCNs are engaging in the full continuum of core activities, including network development, HRSN screening, eligibility assessments, care navigation and referral, and service delivery.

Exhibit 15: SCN Program Core Implementation Activities

SCN Lead Entities made substantial progress standing up the program's core infrastructure and operational capacity. They established administrative and governance structures, developed contracting processes with HRSN and other providers, and implemented financial systems to manage and distribute capacity-building funds across their regions and reimburse HRSN service providers for services. Infrastructure funds supported the recruitment and onboarding of HRSN service providers, expansion of staffing models, and strengthening of internal operational systems. Lead Entities have actively worked to recruit diverse partners—spanning housing, nutrition, transportation, and other domains—into their networks, formalizing participation agreements and building referral relationships. Workforce development has also been central to implementation progress, with SCNs hiring Navigators and other frontline staff responsible for outreach, screening, eligibility determination, and care coordination.

Operationally, SCNs have moved beyond network formation to service administration and delivery. All regions are implementing member outreach and engagement strategies, conducting HRSN screenings and eligibility assessments, navigating members to existing resources, initiating referrals to contracted HRSN service providers for Enhanced HRSN Services, and delivering HRSN services. Lead Entities have focused on developing workflows to connect clinical and community partners, while simultaneously refining data systems and reporting processes to support program oversight. Although implementation has varied across regions in pace and scale, the overall trajectory reflects meaningful advancement from infrastructure development to active service provision.

SCN Implementation Progress and Challenges: Network Development

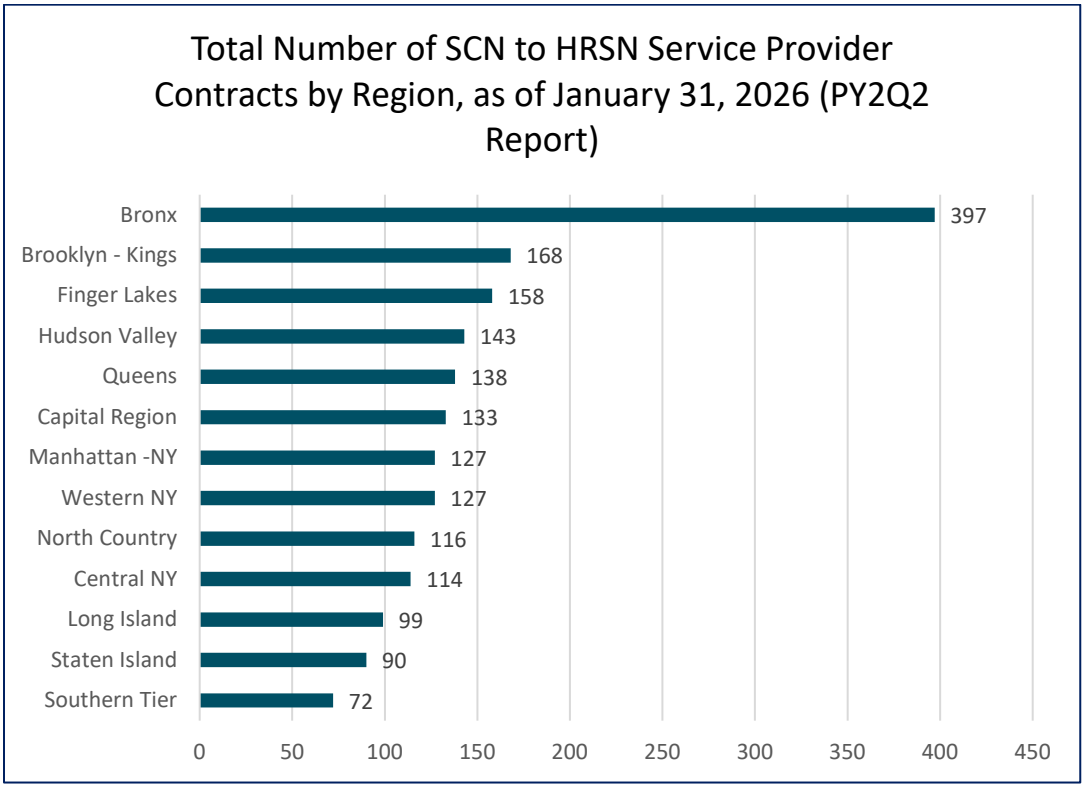
Lead Entities are responsible for developing a regional network of HRSN service providers that has sufficient capacity to meet the HRSN screening and service delivery needs of the SCN's eligible Medicaid members. Key informants reported that they invested significant time into developing relationships with HRSN service providers to garner partner buy-in to support the growth of their networks. The IE reviewed SCN Network Composition Reports submitted by Lead Entities to the State for the PY2Q2 quarter (November 2025—January 2026); these reports were the data source for Exhibits 16 to 18 and the information in the narrative on network composition.

Lead Entities have made substantial progress in network development. As of April 30, 2026:

- Statewide, over 1,300 unique individual HRSN service providers across 62 counties are under contract with an SCN and enrolled to deliver services for nutrition, transportation, housing, and care management.
- Contracted HRSN service providers are a mix of CBOs (~700) and healthcare providers (~600).
- Most (70%) of the contracted entities are non-profits, and the majority (62%) have an estimated annual budget under $5M.

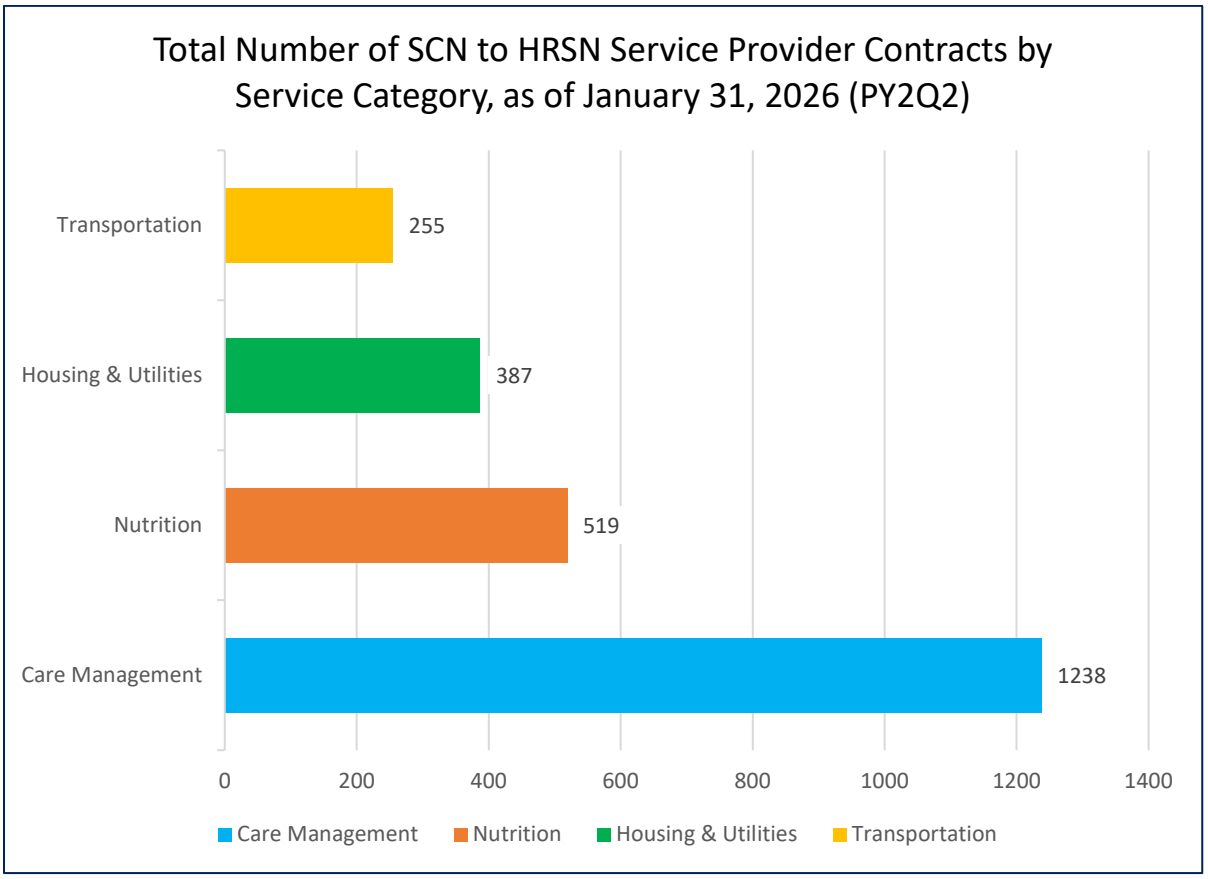
The number of HRSN service providers contracted in each HRSN region as of January 31, 2026 is shown in Exhibit 16: Total Number of SCN to HRSN Service Provider Contracts by Region; note that individual HRSN service providers may have contracts in multiple regions.

Exhibit 16: Total Number of SCN to HRSN Service Provider Contracts by Region



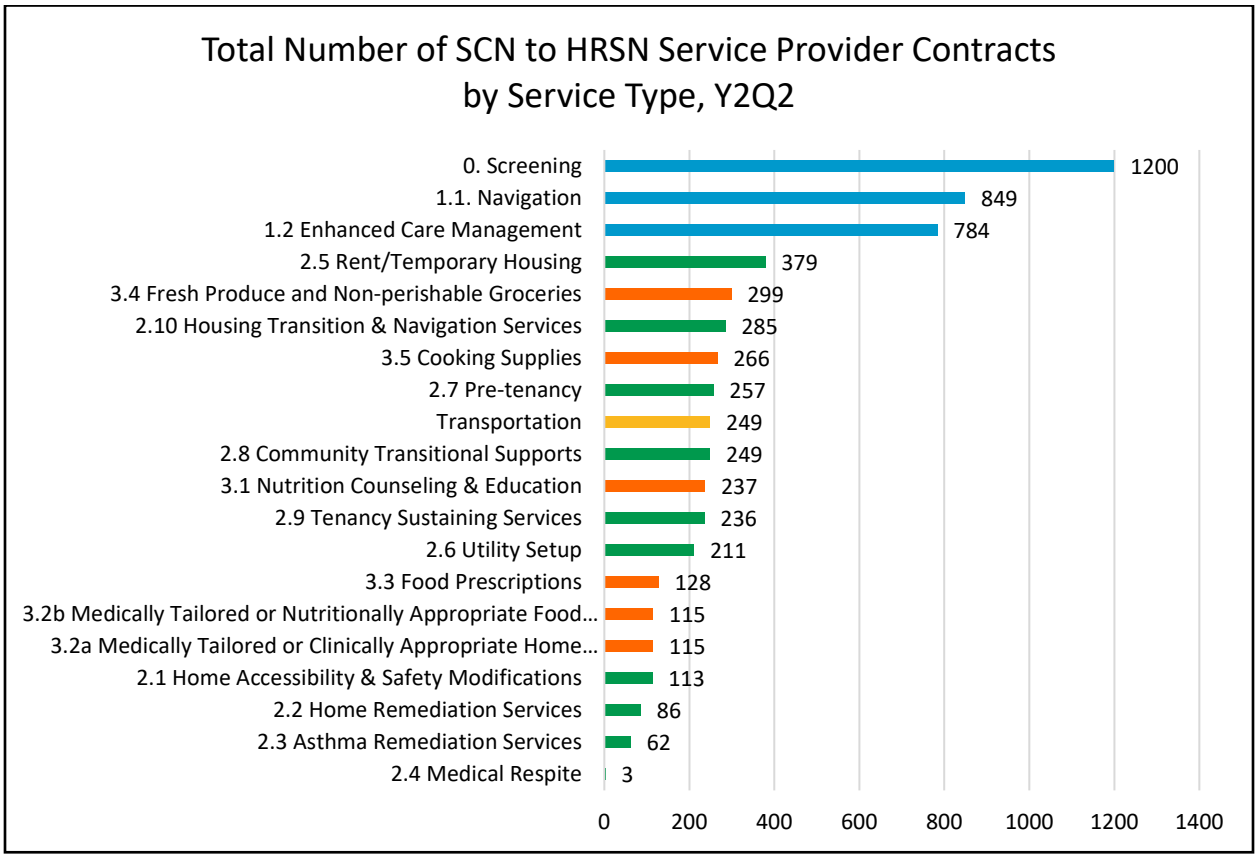
Exhibits 17 and 18 provide information on the categories of service and types of services that HRSN service providers offer or intend to offer; individual HRSN service providers may offer multiple services. The number of unique individual HRSN service providers contracted for each category of HRSN service as of January 31, 2026, is shown in Exhibit 17: Total Number of SCN to HRSN Service Provider Contracts by Service Category. Most HRSN service providers (1,238 of the ~1,300 HRSN service providers) offer care management.

Exhibit 17: Total Number of SCN to HRSN Service Provider Contracts by Service Category



There are multiple types of HRSN services within each service category. The number of unique individual HRSN service providers contracted for each detailed service type as of January 2026 is shown in Exhibit 18: Total Number of SCN to HRSN Service Provider Contracts by Service Type The color of the bars corresponds to the color of the service category in Exhibit 17: Total Number of SCN to HRSN Service Provider Contracts by Service Category. There are a relatively small number of providers for home modification and remediation services (services 2.1, 2.2, and 2.3), and for medical respite (2.4) which *may* indicate a gap in capacity for these services.

Exhibit 18: Total Number of SCN to HRSN Service Provider Contracts by Service Type



Note that Medical Respite providers must be certified by NYSDOH. The state reported 3 certified providers as of January 2026.

The data represents contracted HRSN service providers, as reported by the SCNs, but does not indicate whether a contracted provider is actively delivering HRSN services, and does not include information on the number of members a given provider is able to serve. In Fall 2025, key informants shared that following contracting, some HRSN service providers took time to begin accepting referrals and delivering services, for a variety of reasons. It is also likely that there is substantial variation in individual HRSN service provider capacity; each contracted provider does not represent the same capacity to process referrals and delivery services to members. Additional data is needed to understand network capacity in relation to member needs.

Key informants from Lead Entities repeatedly cited time constraints as a primary challenge to developing the relationships and trust required to build adequate networks of HRSN service providers. They highlighted the extremely limited pre-implementation planning period for contracting, onboarding, training, and relationship building with HRSN service providers. Lead Entities aimed to recruit HRSN service providers that met the cultural, linguistic, and other needs of their region's members. Rural and suburban regions described broad workforce and provider shortages, underscored by transportation barriers. Urban regions experienced local variation, where provider availability could differ dramatically by neighborhood.

SCN Implementation Progress and Challenges: HRSN Screening

SCNs utilize the AHC HRSN Screening Tool to assess needs across HRSN domains including housing and utilities, food security, transportation, employment, education, and interpersonal safety. Lead Entities are responsible for ensuring their networks have adequate capacity to conduct HRSN screenings to meet the screening milestones set by the State. HRSN service providers, health care providers, MCOs, and other network partners can screen Medicaid members (although MCOs will not be reimbursed). HRSN service providers are expected to utilize the SCN IT Platform (discussed in further detail in Implementation Question 2) to conduct and capture results of HRSN screenings. Other providers may complete screening off-platform; a process is in place to capture off-platform screenings in the data system.

The State has set HRSN screening targets, which include:

- 25% of Medicaid members screened by 3/31/2026
- 50% of Medicaid members screened by 3/31/2027

Statewide, as of April 30, 2026, more than one million (1,006,015) Medicaid members were engaged in screening for unmet HRSNs, representing approximately 18% of the 5,696,119 Medicaid members; ~7 percentage points below the 25% target.

Each SCN is charged with meeting these same screening targets for the Medicaid members in their region. As of the end of April 2026, most regional screening rates were between 14% to 22%. Two regions exhibited lower rates and one region, at 39% members screened, exceeded the 25% target.

The State has a performance management strategy in place to monitor and incentivize SCNs to meet the HRSN screening targets. The State monitors progress in part by using a Weekly Performance Management Report (also known as the "Operational Indicator Survey") that was first implemented in February 2026. Each week, the SCNs report metrics on HRSN screenings, eligibility assessments, referrals, and service delivery metrics. A limited number of metrics are also included for network and operational efficiency.

Key informants expressed a range of challenges when implementing the HRSN screening processes. Changes to operational guidance from the State required corresponding workflow adjustments in the SCN IT platform, leading to delays, poor platform performance, or confusion. These workflow changes were underscored by general challenges with adoption of new technology. The IE did not interview healthcare providers in wave 1 of KIIs, but Lead Entities mentioned mixed experience with hospital implementation of HRSN screening, citing challenges integrating the screening tool into existing workflows, leading to "off-platform" screens.

Interviewees also noted that lack of trust between SCNs/HRSN service providers and Medicaid members could affect screening uptake. Without an established relationship in place, Medicaid members could be wary of outreach attempts that felt unfamiliar or transactional.

Finally, key informants reiterated the importance of HRSN service provider readiness. Ensuring HRSN service providers were onboarded and ready to screen members took time. Some HRSN service provider key informants noted early concerns over conducting screenings that were not promptly reimbursed. SCNs serving rural regions reported lack of access points for HRSN screening as a barrier, while urban

areas faced volume-related workflow challenges, with too many individuals to screen that overwhelmed available staff.

SCN Implementation Progress and Challenges: Eligibility Assessment

To determine eligibility for receiving Enhanced HRSN Services, SCNs conduct standardized eligibility assessments for members with an unmet HRSN identified upon screening. As of April 2026, 49% of the members screened had an unmet HRSN need. SCN Lead Entities are responsible for ensuring that appropriate SCN staff, typically Navigators, conduct an eligibility assessment for Medicaid members who screened positive for an identified HRSN in a timely way.

Key informants described frustration or disappointment when Medicaid members had an unmet need identified upon screening and were not eligible for Enhanced HRSN Services due to not meeting the specific eligibility criteria. In these cases, SCNs/HRSN service providers aimed to navigate members to other existing local, state, or federal resources, but worried about damaging the trust and relationship they had cultivated with the member.

SCN Implementation Progress and Challenges: Care Navigation and Referral

Care navigation is a critical component of the SCN program model to ensure that members successfully receive HRSN services to meet their identified needs. Care Navigators can be employed by the Lead Entities, or network members such as healthcare providers or HRSN service providers.

Some key informants shared that they felt the screening, eligibility assessment, and care navigation goals or milestones set by the State were challenging or too ambitious. They also cited changing and late communication of milestones as a challenge to meeting them successfully.

Although the SCN Program, Billing, and Data Governance Operations Manual includes explanations of the allowable care navigation services for reimbursement under the waiver, interviewees expressed uncertainties or confusion related to operational and financial aspects of the care navigation services and workforce. Key informants reported that care Navigators/managers perform a significant amount of work outside of member encounters, for example, reaching out to a landlord on a member's behalf, but expressed uncertainty over which care navigation services were billable under the waiver. This led to further uncertainty over how to best staff care navigation services, and a range of different staffing models. One key informant shared:

> *"I think one of the challenges that we've had is in rolling out the social care network process. It's very clear what's required to get the check cut to pay the rent. It's not very clear how to receive reimbursement to pay the staff to do the coordination that it takes to get that check cut." (SCN KII, Fall 2025)*

SCN Implementation Progress and Challenges: Service Delivery

HRSN service providers reported positive experiences implementing a program perceived as focused on serving their communities. They emphasized the speed with which they could serve members and meet their most pressing needs effectively and quickly. An HRSN service provider commented:

"I think one of the major benefits is if I receive a referral in the morning, I may more than likely be able to pay that back rent by the end of the day, you know the funding is attached to it. There is expertise attached to it and the support and the guidance to fulfill that unmet need locally is there, which I think speaks volumes to…how we've been able to implement." (SCN KII, Fall 2025)

Key informants from Lead Entities shared that referral workflows can be difficult to operationalize when HRSN service providers contract with SCNs and join the network but are not yet ready to activate service delivery due to concerns over increased demand overwhelming their capacity.

Scaling up the delivery of certain elements of the enhanced housing supports emerged as a challenge. In particular, medically necessary home modifications or home remediation services appeared to be a more specialized service with a limited number of specially trained or certified providers available, leading to delays. While there was not a shortage of HRSN service providers able to provide tenancy and eviction supports, lack of available housing options in some regions and challenging communication between care Navigators and landlords presented barriers to service delivery.

Strategies to Address SCN Implementation Barriers

SCNs adopted a range of intentional, tailored strategies to overcome the barriers that key informants identified as they implemented core program activities related to network development, HRSN screening, eligibility assessments, care navigation, and delivery of HRSN services.

A central approach has been hiring staff from within the regions served by SCNs. Lead Entities recruited regional directors, Navigators, and other key roles who live and work in their communities and understand local cultures, provider landscapes, and community dynamics. Embedding Navigators in pediatric ambulatory practices or schools, particularly for targeted "hot spotting" initiatives such as in asthma care, strengthened referral pathways and engagement. The strategy of embedding Navigators often led to connection with additional family members who were also eligible for services.

Several SCNs also invested heavily in relationship-building early on, hiring staff dedicated to partnership development and launching regular meetings with state partners to troubleshoot issues and align expectations.

To address outreach, engagement, and network development challenges, SCNs supplemented state communications materials with their own. They translated waiver terminology into language that resonated with providers and members. Some established Medicaid Member Advisory Councils to guide communications and quality improvement. Provider-facing strategies, such as dedicated provider relations managers, hosting office hours and training sessions, strengthened operational uptake. At least one HRSN service provider hosted internal intensive "days of learning" that focused on educating SCN staff and their partners as to "what is the SCN, what is the purpose of it, what can this do for our clients and why we needed to buy into it." This helped build staff buy-in, understanding, and also helped identify champions for this work. Investments in multilingual communication tools, such as language lines and text platforms also helped address linguistic barriers to improve member engagement.

Factors for Successful SCN Implementation Progress

Several intersectional factors emerged as critical drivers of successful SCN implementation progress. Interviewees consistently emphasized that prior experience in the NY DSRIP program was beneficial. Leaders with historical knowledge of DSRIP leveraged their familiarity with state processes and reporting expectations to reduce the learning curve and facilitate efficiency. This experience also allowed some regions to leverage existing infrastructure, data systems, and community partnerships rather than building entirely from scratch.

Strong community partnerships were another critical success factor. HRSN service provider participation, and their willingness to adapt to a new reimbursement structure, enabled faster activation of services when the program required rapid scaling. Regions that established clear communication mechanisms, whether through formal meetings or structured feedback loops, were better able to stay on track, identify barriers early, and problem-solve collaboratively. Hiring individuals who could serve as "brokers" to bridge gaps between clinical providers, HRSN service providers, and Lead Entities strengthened coordination, while creating local champions helped build broader buy-in and momentum. Relationships with landlords were particularly critical in advancing housing-related services.

Finally, interviewees described the importance of organizational agility. SCNs that found early wins spoke about operating with a "start-up mindset," and quickly corrected poor hiring decisions, adjusted workflows, and refined strategies in real time. Hiring from within the community ensured cultural competence, local credibility, and practical knowledge of regional dynamics. Together, prior waiver experience, strong partnerships, intentional communication, and adaptive leadership created conditions that supported steady implementation progress.

Implementation Question 2: How have investments in infrastructure and technology supported the implementation of SCNs?

Infrastructure Investments and SCN Implementation

SCN Lead Entities receive infrastructure funds to support development of the network and they in turn award capacity building funds to CBOs. As of April 2026, >$80M has been awarded to CBOs in SCN networks.

Key informants primarily discussed how they leveraged capacity building funds to support implementation. Capacity building funds meaningfully supported CBOs ability to participate in the SCN program. Interviewees reported that the funds were primarily utilized for workforce capacity and staffing infrastructure, with many initially prioritizing hiring key personnel to establish operational capacity and coordination functions. Over time, spending shifted from foundational hiring to performance-related activities, reflecting maturation of network operations.

Availability of flexible, up-front investments accelerated readiness and implementation. Key informants emphasized the importance of this, sharing:

> *"…in the beginning capacity dollars, and still to say, are really important because what we saw…during you know [DSRIP] and value-based payment is community-based organizations*

can't just jump into something like this. Right, that's impossible. They need those start-up funds to really be able to have an active participation." (SCN KII, Fall 2025)

Key informants further emphasized the value of capacity building funds to community-based organizations for whom participation in the SCN model reflected a significant shift in their typical operations:

"CBOs are used to grant funding where they're getting a lump sum. You have your $50,000, you provide your services. So, the CBO capacity funding is really essential because it allows…actually that startup and more comfort level. So, there's been a lot of education and assistance there too with the onboarding process. It did take some time." (SCN KII, Fall 2025)

Technology Investments and SCN Implementation

Key to the success of the SCN program is the development of a statewide social care technology ecosystem capable of exchanging data in near real-time and supporting timely, end-to-end support for members with unmet HRSN. The State reports the following key accomplishments:

- In one year, OHIP, with the support of NYeC and The Gravity Project, helped build the Statewide social care technology ecosystem that is now connecting the 9 SCN Lead Entities, 3 SCN IT Platform vendors, 6 Qualified Entities (QEs)[45], and approximately 25 MCOs.
    - The new technology ecosystem leveraged existing statewide health information exchange architecture, the SHIN-NY platform.
    - SCN Lead Entities were allowed to select the SCN IT Platform that best fits their region's needs, as long as it met specific requirements set forth by the State to ensure it enabled the SCNs to fulfill core responsibilities. Across the State, Lead Entities are utilizing three SCN IT Platforms.
- Operationalizing a cohesive statewide social care system involved establishing a very large number of inter-related data requirements and data flows, including a social care Enhanced Services Member File (ESMF) and a "social care encounter".
    - The social care coding foundation was established, including approximately 55 Screening LOINC codes, 20 ICD-10 Z-codes, 200 SNOMED CT codes, 120 HCPCS code/modifier combinations, and 130 MVD data elements — to support consistent documentation of screening, eligibility assessment, navigation, referrals, service delivery, claims, and reporting.
    - The ESMF was purpose-built for the SCN program to consolidate and share social care data for members in the program.
    - OHIP supported the creation of a "social care encounter" that represents a first in the nation approach for capturing all aspects of HRSN service provision with standard terminology and code sets, implemented uniformly, statewide. Information captured in

[45] Qualified Entities (QE) are organizations certified by NY State to operate as regional health information exchanges and participate in the Statewide Health Information Network of New York (SHIN-NY). The QE requirements can be found here: qualified_entity_organizational_characteristics_requirements. Accessed on May 28, 2026.

the social care encounter provides extensive data for program monitoring and evaluation and future policy development.

As of late 2025, key informants reported that deployment of HRSN screening and referral platforms has been uneven, and at times, disruptive to SCN operations. Key informants reported challenges with slow platform rollout and the burden of frequent technical and workflow revisions. While SCNs appreciated the responsiveness of the State to feedback, operational manual changes prompted frequent and disruptive changes to platform workflows. Variation in technology rollout across regions was driven by differing levels of prior SCN experience with IT platforms. Several key informants expressed that an initial planning period may have helped to avoid these challenges.

Additionally, Lead Entities and HRSN service providers reported that, from their view, data does not *always* flow accurately or completely to the State, resulting in an underrepresentation of progress or decision-making based on partial or delayed information. Key informants, particularly HRSN service providers, described a lack of visibility in their own screening, referral, and service delivery data, prompting many partners to develop parallel internal tracking systems as a workaround.

The State reports that monthly SCN-led virtual demos and quarterly guidance releases helped ensure platforms were up to date and progress was tracked on key functionality improvements used directly by Navigators, including eligibility assessment conditional logic with automated workflows, prompts, and safeguards. The State reports that OHIP observed a reduction in average eligibility assessment completion times from approximately 45-60 minutes at the beginning of the program to 10-20 minutes on average as of May 2026, indicating increased efficiency in the workflows supported by SCN technology.

Implementation Question 3: How have SCN partners and interest holders experienced the implementation of the SCN program?

Implementation Challenges: HRSN service provider Experience

Despite experiencing numerous program benefits and successes, implementation has been uneven and, at times, challenging for HRSN service providers. HRSN service providers, particularly CBOs with less familiarity with Medicaid or managed care environments, experienced a slower start. The shift from grant-based funding to a new reimbursement-based payment model has been challenging, with some organizations struggling to adapt to new documentation and compliance requirements. Concerns about sustainably staffing this model were expressed by HRSN service providers learning how to navigate supporting FTE roles, particularly for care Navigators.

Frequent operations manual updates following program launch provided needed clarifications and adjustments but were experienced as burdensome for partners adapting to evolving administrative nuances. For HRSN service providers participating in multiple SCNs, differences in workflows and requirements were difficult and time-consuming to accommodate.

Data sharing and visibility remains limited and fragmented for HRSN service providers, as described above. They shared a frustration with their inability to easily monitor and track progress generally, and against performance milestones.

Implementation Successes: HRSN service provider Experience

The vast majority of HRSN service providers who were interviewed described positive experiences with implementation, as well as an investment in and dedication to the SCN model's goals. Partners described meaningful progress in building more coordinated, community-centered networks. A central strength of implementation has been the deliberate effort to bring together HRSN service providers, MCOs, healthcare providers, and other partners under more aligned incentives. Rather than creating entirely new systems, many SCNs connected existing pieces—leveraging established programs, trusted community relationships, and pre-existing referral pathways. SCN and HRSN service provider leaders that were already embedded in their communities, for example, through service on local boards or initiatives, reported that this helped build early trust and reduce barriers to buy-in. Key informants also described how in-person outreach and frequent site visits further strengthened relationships during the early stages of implementation.

Partnerships have extended beyond traditional health care providers. Collaborations with schools, federally-qualified health centers (FQHCs), utility partners, food delivery programs, and even landlords have broadened the program's reach. Key informants noted this was particularly important when they discussed housing-related efforts.

SCN and HRSN service provider leaders employed creative staffing approaches, such as leasing employees or embedding staff within partner organizations, to address workforce gaps and foster integration. Where Lead Entities offered robust and practical training (e.g., technical assistance), HRSN service providers expressed appreciation, noting that this support eased onboarding and other operational challenges.

Implementation Question 4: What are members' experiences with screening, eligibility assessment, and navigation through the SCN program? What are eligible members' experiences with utilizing Enhanced HRSN Services? How effective are these services at meeting the needs they are designed to address?

This question addresses member experience with the SCN program and will be addressed in the SER, following KIIs with Medicaid members.

2. CAREER PATHWAYS TRAINING PROGRAM

a. CPT Program Overview

The CPT program is one of two workforce initiatives designed to address critical workforce shortages across the healthcare, behavioral health, and social care sectors. CPT establishes a statewide framework to fund education and training programs that build a sustainable and diverse workforce pipeline to better serve Medicaid populations. By reducing barriers to career entry and advancement while aligning workforce development with health care system needs, the CPT program aims to strengthen provider capacity and support long-term transformation of the Medicaid delivery system.

The CPT program is divided into two career pipelines: the Healthcare Career Advancement Pipeline for individuals currently working in the health, behavioral health, or social care fields and the New Careers in

Healthcare Pipeline for individuals entering the workforce who are unemployed or not currently working for a health, behavioral health, or social care providers in New York State.

The program supports 13 occupational titles across three professional tracks including nursing, professional technical roles, and frontline public health workers. The educational requirements for these titles range from graduate and undergraduate degree-based programs to certificate-based programs of varying length and requirements. The full list of eligible titles is provided in Exhibit 19: Professional Tracks and Titles in CPT Program. Participants receive support to complete training and are required to commit to working full-time for at least three years with a New York Medicaid-enrolled provider that serves at least 30 percent Medicaid members and/or uninsured individuals.

Exhibit 19: Professional Tracks and Titles in CPT Program

Professional Track	Professional Titles
Professional Technical	• Physician Assistant • Licensed Mental Health Counselor • Master of Social Work • Credential Alcoholism and Substance Abuse Counselor • Certified Pharmacy Technician • Certified Medical Assistant • Respiratory Therapist
Nursing	• Licensed Practical Nurse • Associate Registered Nurse • Registered Nurse to Bachelor of Science in Nursing • Nurse Practitioner
Frontline Public Health Worker	• Community Health Worker • Patient Care Manager/Coordinator

The CPT program is administered by three regional Workforce Investment Organizations (WIOs) that recruit, enroll, and support participants. The WIOs coordinate training and monitor participants during their service commitments.

WIOs contract with academic institutions, career development centers, CBOs, local workforce development boards, county and state agencies, and educational coaching organizations across their respective regions to develop tailored educational pathways and support participants throughout the program. These partnerships enable the delivery of wraparound services, such as career counseling, and case management, which help participants overcome non-academic barriers and successfully complete the program. The WIOs recruit, enroll, and support participants and service commitment providers.

To support program operations, WIOs utilize robust technological systems, including Learning Management Systems, through which participants can access supplemental and customized training, and advanced tracking platforms through which the WIOS track and report participant progress, the provision and outcome of support services, and through which the WIOs can record, track, process and report program expenditures.

The CPT program implementation began in July 2024.

b. CPT Program Implementation Findings

The findings presented here were developed from (1) the qualitative data gathered from KIIs early in the implementation period and (2) administrative data sources that included both quantitative data and narrative descriptions of progress.

The IE conducted KIIs with organizational leadership and senior staff across the CPT WIOs (3), a partner academic institution (1) wraparound service providers both internal and external to the WIOs (2), and a NYSDOH administrator (1) between September and November 2025, approximately 14-16 months after CPT program implementation began in July 2024. The administrative data sources include WIO reports from the first year of the CPT program (July 2024—June 2025) and more recent updates provided by the State.

Implementation Question 5: What progress has been made in implementing the CPT program? What are the barriers to implementation, and what strategies have been used to address these barriers? What factors have contributed to successful implementation progress?

CPT Implementation Progress and Successes

In August 2024, as a result of a competitive RFA and procurement process, the State awarded contracts to three organizations to serve as WIOs. One WIO was able to enroll a small number of participants in the Fall 2024 semester. All three WIOs were actively enrolling participants by January 2025. As of March 31, 2026, there is strong interest in the CPT program, with nearly 13,000 individuals enrolled, most in nursing and professional technical titles.

Each WIO administers the CPT program in a defined region, as shown below.

Exhibit 20: Workforce Investment Organizations by Region

Workforce Investment Organizations (WIOs) and Regions Served	
NYS Region	**NYS Counties (NYC borough where applicable)**
1199 SEIU Training and Employment Funds (TEF)	
Region 1 Hudson Valley, New York City, Long Island	Bronx, Dutchess, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, Sullivan, Ulster, Westchester
Caring Gene Healthcare Career Pathways	
Region 2 Capital Region, Central New York, North Country, Southern Tier	Albany, Broome, Chenango, Clinton, Columbia, Cortland, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Jefferson, Lewis, Madison, Montgomery, Oneida, Onondaga, Oswego, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, St. Lawrence, Tioga, Tompkins, Warren, Washington
Finger Lakes Performing Provider System (FLPPS)	
Region 3	Allegany, Cayuga, Chemung, Genesee, Livingston, Monroe, Ontario, Orleans, Schuyler, Seneca, Steuben,

Finger Lakes, Western New York	Wayne, Wyoming, Yates, Cattaraugus, Chautauqua, Erie, Niagara

The CPT program has meaningfully advanced its goal of building a workforce equipped to serve the Medicaid population, while providing transformational opportunities for participants. Across regions, WIOs have operationalized education and training pathways aligned with high-demand health care roles and have begun developing a pipeline of individuals intended to strengthen workforce capacity in underserved communities.

At the time KIIs were conducted (September to November 2025), the CPT program had moved from early planning to implementation, actively enrolling participants across a range of approved academic and workforce training pathways. WIOs reported steady enrollment growth and strong interest from eligible participants, particularly for nursing degrees, which aligns with regional workforce needs. At the time key informants were interviewed, no CPT participants had yet graduated from their training programs or begun their three-year service commitment placements. WIOs were increasingly mindful of enrollment timelines to ensure students had sufficient time to complete their academic or credentialing programs before the end of the waiver period.

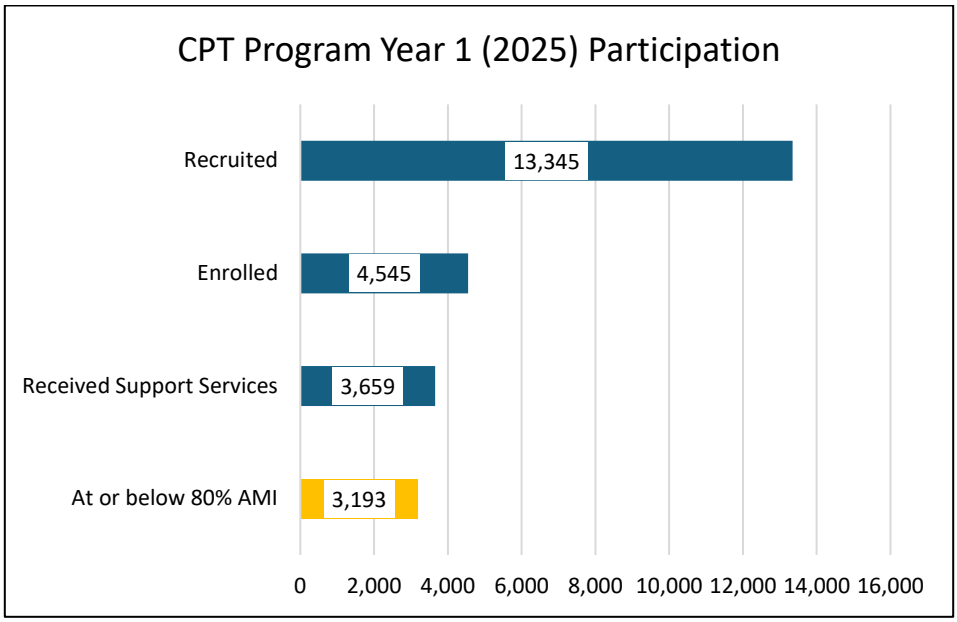
The IE reviewed the WIO reports for year one of the CPT program: July 1, 2024 – June 30, 2025, to gain more information on program participation. The year one WIO reports are the data source for the figures provided in Exhibits 20 to 23.

Exhibit 21: CPT Program Year 1 Participation provides a high-level snapshot of CPT program participation in year one, as of June 2025. The WIOs "recruited"[46] over 13,000 individuals, and of those, approximately one-third (N=4,545) were subsequently enrolled. Notably, the State reports that as of March 2026, the CPT program has enrolled a total of 12,837 individuals, a dramatic increase in enrollment in the first three-quarters of year two (July 1, 2025 to March 31, 2026).

In year one, the vast majority (81%) of participants utilized support services. Most enrolled participants (70%) were at or below 80% of the area median income (AMI). Nearly all enrollees remained engaged in the program during year one; fewer than 2% of the participants left the program (26 individuals "dropped out" and 62 were reported to be "on leave" (not shown in Exhibit 21).

[46] "Recruited" is defined as having formally expressed interest in the CPT program (e.g., completed a CPT program interest form).

Exhibit 21: CPT Program Year 1 Participation



During year one, the CPT program enrolled 2,335 individuals in training for a new career in healthcare, as shown in Exhibit 22: CPT Program Year 1 Enrollment by Career Category and Pipeline. Nursing enrollment (3,360 total) was nearly triple the enrollment in professional technical titles (1,176 total). Very few frontline public health workers were enrolled (9).

Among nursing titles, enrollment in the career advancement pipeline (1,979) was greater than the new career pipeline (1,381). The opposite pattern was observed among those in professional technical titles where enrollment in the new careers pipeline (820) is nearly double that of enrollment in the career advancement pipeline (356).

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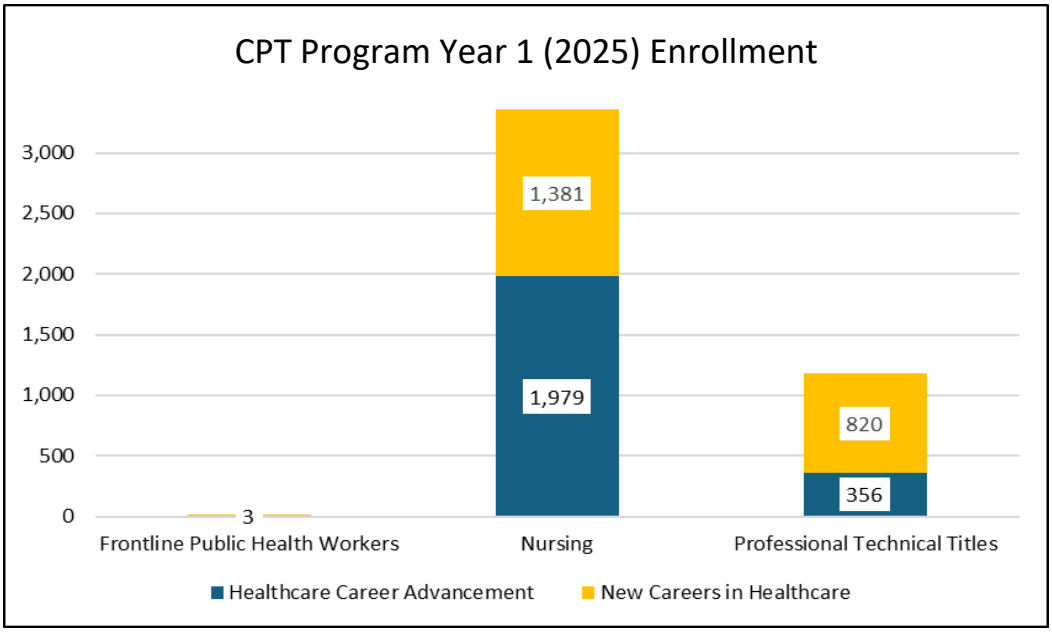
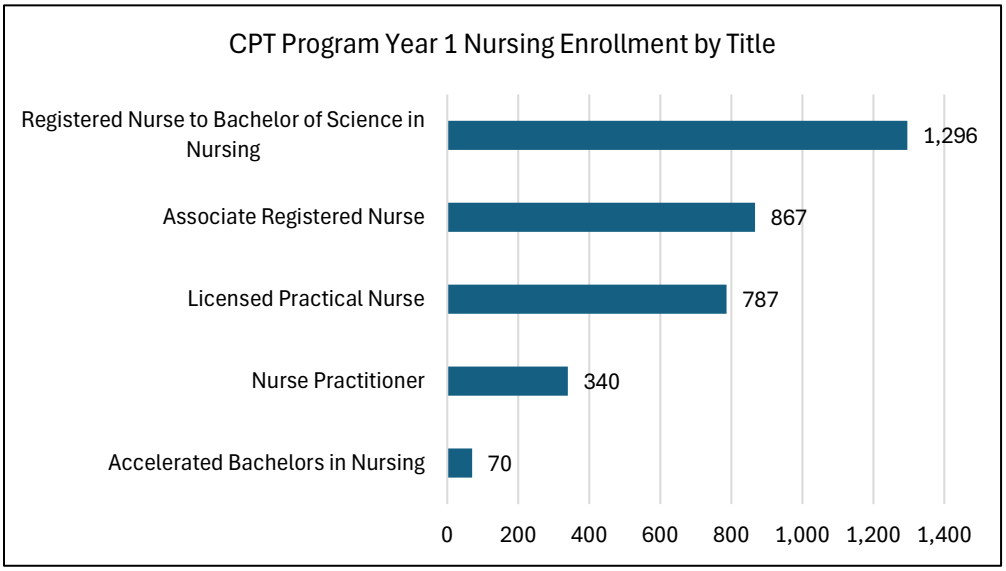
Exhibit 22: CPT Program Year 1 Enrollment by Career Category and Pipeline



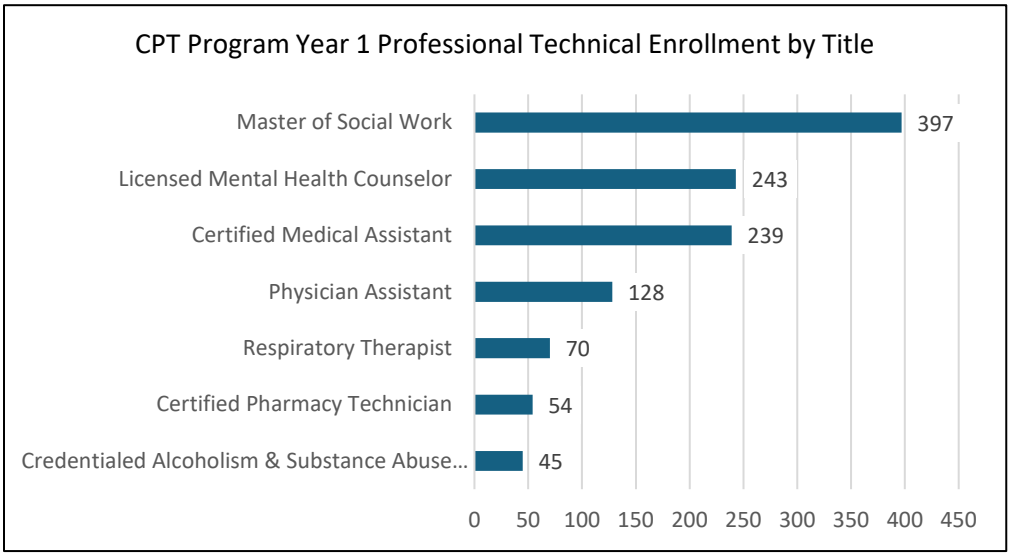
The highest enrollment among nursing titles was in the Registered Nurse to Bachelor of Science in Nursing title (1,296), followed by Associate Registered Nurse (867), and Licensed Practical Nurse (787), as shown in Exhibit 23: CPT Program Year 1 Nursing Enrollment.

Exhibit 23: CPT Program Year 1 Nursing Enrollment



Among professional technical titles, the highest enrollment was in the Master of Social Work title (397), followed by Licensed Mental Health Counselor (243), and Certified Medical Assistant (239), as shown in Exhibit 24: CPT Program Year 1 Professional Technical Enrollment. A total of 685 individuals were enrolled in behavioral health related titles (Master of Social Work, Licensed Mental Health Counselor, and Certified Alcoholism & Substance Abuse Counselor).

Exhibit 24: CPT Program Year 1 Professional Technical Enrollment



Key informants highlighted the significance of the opportunities afforded by the CPT program for participants, sharing:

> *"We're providing opportunities for people who might not otherwise have them to move into health professions into really good paying jobs." (CPT KII, Fall 2025)*

Another interviewee echoed this sentiment, commenting:

> *"We are providing entrance for thousands of individuals into the labor market…for occupations where it's severely needed. So, thinking about that from a longitudinal perspective is also really important…We definitely don't lose focus of that because this is a really transformational program." (CPT KII, Fall 2025)*

In addition to recruiting and enrolling students, WIOs coordinate wraparound services designed to support degree completion, including academic advising and tutoring (n=1,104), case management, benefits navigation, and language services (n=2,405), and coordination with potential future employers (n=150).

WIOs formalized partnerships with academic institutions and organizations offering wraparound supports and are developing relationships with employers/service commitment sites. A local college has committed

significant resources to aligning with the WIO in their region. They grew multiple programs rapidly, expanding internal capacity to take on more students (hiring more faculty, expanding enrollment options) and maintained frequent and close communication with WIO leadership.

CPT Implementation Barriers and Challenges

Time constraints were repeatedly cited as the largest barrier to implementation of the CPT program. For degrees with longer educational or training requirements, such as Physician Assistants, WIOs only had a very limited time to recruit and enroll students to ensure their degree completion by the end of the waiver period. Key informants noted that more strategic planning around program or waiver duration, length of education and training programs for approved titles, and sequencing of cohorts would have allowed more individuals to enroll and complete training. One key informant shared:

> *"We had some students who were planning to… [enroll in the CPT program]… and when they heard they wouldn't… finish in time…they decided not to [enroll]…" (CPT KII, Fall 2025)*

The CPT program also generated significant interest among potential participants, demonstrating both the need for such a program and the effectiveness of outreach strategies. WIOs had a very compressed planning period and moved as quickly as possible to process applications and stand up the program so as not to miss enrollment windows for students.

Key informants noted some concerns and confusion over Frontline Public Health Worker titles, specifically the potentially overlapping roles of Community Health Workers (CHWs) and care coordinators. Unlike more clearly defined roles such as RNs or LPNs, these titles are less clearly understood in the labor market, creating some uncertainty for prospective students and employers, and impacting recruitment and enrollment efforts. Only nine Frontline Public Health Workers were enrolled in year one. Some key informants expressed concern over the three-year service commitment requirement for individuals enrolled in the Frontline Public Health Worker titles. These roles typically have shorter and less costly training requirements paired with entry-level salaries and limited career growth trajectories, raising questions over the appropriateness of a three-year service commitment. The State has allowed some flexibility to address this concern; CPT participants may remain at a service commitment site in another role to fulfill the service commitment requirement.

Strategies to Address Implementation Barriers and Factors Contributing to Successful Implementation

Interviewees shared that robust outreach and marketing efforts increased awareness and enrollment in the CPT program. The State supported outreach campaigns, created informational materials, and engaged with the media and with provider organizations to create awareness of the CPT program. The three WIOs also launched their own targeted marketing initiatives.

Wraparound services and supports for CPT participants were repeatedly cited as critical to participant success. WIOs developed systems to proactively track students at risk of falling out of program compliance or who were struggling academically, allowing for early identification and targeted intervention. Case management, tutoring, and mentoring services were described as critical supports that helped students navigate rigorous coursework while often balancing work commitments, family and children, and the

challenges (for some participants) of returning to school later in life. A key informant familiar with providing CPT wraparound services shared:

> *"So, it's really about evaluating the needs of the student, looking at the student as an individual who wants to be successful, who is saying I know I have to work. I know I'm a single mom. I know I'm a single dad. I know I need to be at school. And…the only time I might have is 5:00 AM. …[O]ne of my mentors, she started at 5:00 AM…. They are tutoring 10, 11 PM. …[W]hen we do that, it really caters to the students" (CPT KII, Fall 2025)*

3. HEALTH CARE ACCESS LOAN REPAYMENT PROGRAM

a. HEALR Program Overview

The Health Care Access Loan Repayment (HEALR) Program is one of two workforce initiatives aimed at addressing shortages in high-demand healthcare roles and improving access to care for Medicaid members. The HEALR program provides student loan repayment assistance to providers in eligible titles (Exhibit 25: Maximum Awards by Eligible Positions) who commit to four years of service at a New York Medicaid-enrolled provider serving at least 30 percent Medicaid members and/or uninsured individuals. The HEALR program is intended to improve access to critical services for Medicaid members, attract providers dedicated to delivering high-quality services to Medicaid members, strengthen the availability and capacity of the health care workforce, and reduce awardee's educational debt to boost provider recruitment and retention.

Exhibit 25: Maximum Awards by Eligible Positions

Eligible Positions	Qualifying Degrees	Maximum Award
Psychiatrists	Doctor of Medicine Doctor of Osteopathic Medicine	Up to $300,000 per awardee
Primary Care Physicians	Doctor of Medicine Doctor of Osteopathic Medicine	Up to $100,000 per awardee
Dentists	Doctor of Dental Surgery Doctor of Dental Medicine	Up to $100,000 per awardee
Nurse Practitioners	Master of Science in Nursing Doctor of Nursing Practice	Up to $50,000 per awardee
Pediatric Clinical Nurse Specialists	Master of Science in Nursing Doctor of Nursing Practice	Up to $50,000 per awardee

Loan payments are made directly to loan servicers to support retention and workforce stability statewide. Since launching, HEALR has established core operations, finalized eligibility criteria, initiated outreach, and accepted applications from employers and individual applicants.

HEALR program applications launched on November 21, 2025.

b. HEALR Program Implementation Findings

The findings presented here were developed from (1) the qualitative data gathered from KIIs early in the implementation period and (2) administrative data sources that included both quantitative data and narrative descriptions of progress.

The IE conducted one stakeholder conversation with NYSDOH administrators familiar with the HEALR program in November 2025. The administrative data sources, such as the State issued ad hoc progress summaries, generally provide information as of April 2026.

Implementation Question 6: What progress has been made in implementing the HEALR program? What are the barriers to implementation, what strategies have been used to address these barriers? What factors have contributed to successful progress?

HEALR Program Implementation Progress

HEALR program implementation has progressed through program launch and the establishment of core administrative, eligibility, and application infrastructure, with program activities focused on outreach, applicant education, and intake. At the time of this IER, awards have not yet been disbursed by the State. The State has finalized and publicly released comprehensive program materials, including a detailed Program Guide, Frequently Asked Questions, application portals, and webinar-based technical assistance to support both individual applicants and employers.

Key elements of the program design have been operationalized, including:

- Clear definition of eligible provider roles (psychiatrists, primary care physicians, dentists, nurse practitioners, and pediatric clinical nurse specialists) and corresponding maximum award thresholds;
- Establishment of service commitment site eligibility, linking participation to Medicaid-serving providers;
- Development of two application pathways, individual and employer-initiated, to support both provider-driven participation and employer-based recruitment and retention strategies; and
- Creation of formal service commitment, verification, leave, and recoupment policies to ensure accountability and program integrity over the four-year commitment period.

Application windows for both employers and individuals opened November 21, 2025. Employer applications closed on March 31, 2026 and individual applications closed on April 15, 2026. The HEALR program received 899 applications representing 299 unique eligible organizations. Most potential awardees were Nurse Practitioners, followed by Psychiatrists, Primary Care Physicians, and Dentists. Award notifications are anticipated in late summer 2026. As such, implementation to date reflects early-stage program operations focused on readiness, awareness, and intake rather than downstream workforce impacts.

Barriers to Implementation

Aligning a four-year service commitment with a waiver that concludes in 2027 has required careful communication through webinar and FAQ responses to ensure applicants understand that commitments extend beyond the demonstration period.

Strategies to Address Barriers

Detailed guidance materials, FAQs, and webinars have been used to clarify eligibility, application requirements, and service commitment expectations. The State has also extended application deadlines to promote broader participation and allow additional time for employer attestation and applicant preparation.

Factors Contributing to Progress

The HEALR program is strongly aligned with well-documented workforce shortages in settings that predominantly serve Medicaid members and is embedded within a broader demonstration workforce strategy that includes the CPT program and SCNs. By explicitly tying HEALR program eligibility to a commitment to serving the Medicaid population, the program reinforces system-level goals related to access and integration of social and clinical care. The State reported making an effort to align the HEALR program with existing state systems and prior programs, drawing on their successful administration of similar programs before achieving a timely program design and launch.

4. MEDICAID HOSPITAL GLOBAL BUDGET INITIATIVE

a. MHGBI Overview

The MHGBI Program Overview section provides a description of the program as it was conceived at the time of approval. During the first years of MHGBI Program implementation, program design details were further developed. The MHGBI Program Implementation Findings section provides a description of program design elements that were established during the implementation period.

The MHGBI provides payments to financially distressed hospitals for transformation activities to prepare them for the transition toward advanced VBP models, including global budgets. The movement to a global budget methodology prioritizes population health over volume-based reimbursement and promotes partnerships with community-based organizations and SCNs to connect Medicaid members with services such as housing, nutrition, and transportation.

Hospital participation in the MHGBI supports their transition to a global budget model in alignment with the State and the hospital's participation in the Center for Medicare and Medicaid Innovation (CMMI) Achieving Healthcare Efficiency through Accountable Design (AHEAD) model. The AHEAD model is a multi-payer, total cost of care model planned for implementation in five counties in the downstate region: Bronx, Kings, Queens, Richmond, and Westchester. Participation is voluntary and any hospital in the downstate region can participate. CMS recently revised the AHEAD model timeline; NY is in cohort 3 scheduled for a January 1, 2028 launch date.[47] In contrast, the MHGBI is open only to financially distressed safety net hospitals that met specific criteria and submitted a Letter of Intent to participate in the Bronx, Kings, Queens, and Westchester areas.

MHGBI participating hospitals are required to implement transformation initiatives aligned with the following CMS priorities: data, interoperability, analytics, and reporting, financial modeling, care coordination and management, quality improvement, compliance and business operations, network and

[47] Source: CMS Announces Major Changes to AHEAD Model Design. Accessed on April 14, 2026.

physician engagement, patient experience and engagement, opportunities for service line rationalization based on community need, and leadership, governance, and talent change management.

DOH will design a Medicaid hospital global budget methodology that reflects the unique needs of the Medicaid population. The global budget will provide stable payments to hospitals, enabling more flexibility to meet population health improvement goals while controlling cost growth. Participating safety net hospitals will receive incentive payments based on meeting milestones, including, but not limited to:

- Establishing a roadmap of key activities required to transition to a global budget model
- Developing a population health plan
- Undertaking quality improvement activities to address community-specific disparities
- Collecting and reporting standardized patient demographic data
- Collaborating across diverse AHEAD stakeholders and partners

The initiative leverages lessons from other global budget models and standardized planning templates to support hospitals in managing operational and financial challenges while maintaining high-quality care.

Over the life of the waiver, MHGBI is expected to strengthen the financial sustainability of safety net hospitals, improve coordination of care, and expand access to essential services for Medicaid populations through the end of the waiver period in 2027.

b. MHGBI Implementation Findings

The findings presented here were developed from (1) the qualitative data gathered from KIIs early in the implementation period and (2) administrative data sources that included both quantitative data and narrative descriptions of progress.

The IE conducted one stakeholder conversation with NYSDOH administrators familiar with the MHGBI program in November 2025. The administrative data sources, such as the State issued ad hoc progress summaries, generally provide information as of April 2026.

Implementation Question 7: What progress has been made in implementing the MHGBI? What are the barriers to implementation, what strategies have been used to address these barriers? What factors have contributed to successful progress?

Implementation Progress

At the time of this evaluation, MHGBI implementation is well underway. Twelve hospitals are participating in MHGBI: (1) Brookdale University Hospital and Medical Center, (2) The Brooklyn Hospital Medical Center, (3) Flushing Hospital Medical Center, (4) Jamaica Hospital Medical Center, (5) Maimonides Medical Center, (6) Montefiore Medical Center, (7) Montefiore Mount Vernon, (8) St. Barnabas Hospital, (9) St. John's Episcopal Hospital, (10) St. John's Riverside Hospital, (11) St. Joseph's Medical Center, and (12) Wyckoff Heights Medical Center.

State administrators reported that eligible hospitals have submitted required roadmaps and budgets, and that the State has engaged in iterative review and refinement of these submissions. This process has

involved back and forth discussions to clarify hospital proposals, align plans with program goals, and prepare for future global budget implementation.

Early implementation efforts emphasized hospital-specific planning for transformational activities related to financial sustainability, quality improvement, access to care, and integration with community-based and HRSN services. State administrators described hospitals' plans as increasingly focused on activities such as improved care transitions, follow-up care, and stronger connections to social supports, reflecting a more holistic approach to patient care.

The hospitals are currently implementing their transformational activities and are reporting progress to the State through measures represented by the following categories:

- Quality measures (for example, hospital-acquired infections, Leapfrog ratings, CMS Star ratings);
- Patient experience measures (for example, HCAHPS)
- Operational metrics (for example, FTEs hired, contracts executed)
- Financial measures (for example, return on investment, spending on CMS transformational categories vs. operating expenses, spending on salaries, technology).

On March 23, 2026, CMS approved the State's MHGBI Implementation Plan (the plan), demonstrating continued implementation progress.[48] The plan describes the State's strategy for developing a Population Health and Accountability Plan which will inform strategies for hospital transformation across the State's Medicaid population in alignment with the demonstration. The plan explains that the HERO's regional needs assessments and related research will support the State in identifying promising models from other states and markets and will enable coordination among all entities, including hospitals. The State will draw on the regional information to develop the Statewide Population Health and Accountability that focuses on gaps in access to care and improving population health outcomes. This planning will align with the population health-focused planning work under the MGHBI and the AHEAD model.

The plan articulates the following *goals for healthcare transformation* under the MHGBI:

- Use population demographics to evaluate the sub-state region's opportunities for population health improvement and care delivery efficiencies;
- Build a common agenda of initiatives with actionable, evidence-based strategies for increased healthcare access and improvement in population health outcomes across specific domains;
- Specify metrics and data sources for measurement of progress toward defined quality improvement targets;
- Establish a strategy for continuous communication with model participants and other stakeholders; and

[48]MHGBI Approved Implementation Plan. Available at: https://www.health.ny.gov/health_care/medicaid/redesign/1115_waiver/nyher/mhgbi/attachment_l.htm Accessed on May 27,2026.

- Memorialize these goals and document the State's commitments to improved health outcomes and population health strategies to ensure the maximum collective impact of the work of dedicated partners.

And two additional *goals for alignment with the AHEAD model*:

- Construct a Population Health and Accountability Plan for the 1115 demonstration that aligns with the AHEAD model requirements; and
- Ensure coordination across stakeholders by facilitating workflows across the SCNs, HERO, and AHEAD Model Governance Structure.

Goals of the MHGBI program are also articulated in the plan:

- Stabilizing financially distressed voluntary hospitals;
- Improving population health in communities with the most evidence of health disparities;
- Improving quality of care through hospital transformation towards advanced alternative payment models; and
- Deepening integration with primary care, behavioral health, and Social Determinants of Health (SDOH) services.

The plan establishes the metrics and reporting requirements for the participating hospitals, which include the completion of a baseline assessment, demographic data completeness for a variety of demographic variables, screening for HRSNs, and quality metrics. Most metrics are pay-for-reporting through March 2026. Demographic data completeness for core variables transitions to pay-for-performance in DY27 (4/1/2025 – 3/31/2026), some additional metrics transition to pay-for-performance the following year: screening for HRNS and a quality measure related to maternal health care.

The plan formalizes the approved performance payment methodology which includes a points system yielding a maximum of 100 points. Hospitals earning 76-100 points will receive 100% of their performance dollars; hospitals earning 51-75 points will receive 75% of their performance dollars, hospitals earning 26-50 points will receive 50% of their performance dollars, hospitals earning 0-25 points will receive 25% of their performance dollars.

Barriers to Implementation

The primary barriers to MHGBI implementation relate to the financial condition and capacity constraints of participating hospitals, as well as external uncertainty related to broader payment reform timelines. The State described many eligible hospitals as experiencing significant financial distress and workforce limitations, which can constrain their ability to engage fully in planning and transformation activities while maintaining day to day operations.

In addition, the State discussed uncertainty regarding the evolving timeline and requirements of the federal AHEAD Model. Recent shifts in the AHEAD implementation timeline have required the State to

consider how MHGBI activities align with a delayed federal start date and how to manage the resulting gap period within the waiver timeframe.

Strategies to Address Barriers

To address these challenges, state administrators described working closely with hospitals to review budgets, clarify expectations, and support realistic planning. During the State's review of hospital implementation and financial reporting, key areas requiring clarification emerged. The State reported that follow-up discussions and iterative reporting improved transparency, strengthened alignment with CMS requirements, and clarified long-term sustainability approaches. Areas for improvement and iteration strategies included:[49]

- **Performance metrics reporting:** Hospitals demonstrated inconsistency in reporting against identified initiative metrics, limiting the ability to assess progress and implementation. After requesting clarification, most hospitals provided enough detail to fully illustrate how initiative implementation was progressing.
- **Incomplete financial reporting:** Multiple hospitals submitted financial reports that were incomplete, contained edits to sections that were supposed to remain unchanged or did not fully reflect the totality of waiver funds received. In several cases, it was also unclear how funds were allocated between specific initiatives and general operating expenses. By asking follow-up questions, each subsequent quarterly report was more complete, providing a fuller picture of how funds were being allocated.
- **Alignment with CMS program guidelines:** Some hospitals expressed interest in using funds for infrastructure-related projects that fell outside the nine CMS-approved categories, requiring additional alignment and clarification on what funds could be used for. Ultimately, all funded initiatives were aligned with the nine CMS transformation categories.
- **Sustainability:** Ensuring that initiatives were sustainable or appropriately sunsetting at the expiration of MHGBI funding was a key priority and required extensive clarification with hospitals. In particular, several hospitals hired new FTEs to support initiative implementation, without providing clear plans for sustaining these roles beyond the demonstration period. After requesting clarification, hospitals explained how they planned to sustain or end initiatives, noting that many new FTEs would be self-sustaining after the initial start-up funds were used. To address this, the State will explicitly request that hospitals address sustainability plans in their next progress report.

The State has encouraged hospitals to be intentional about how they define and measure progress, including articulating expected return on investment, staffing strategies, and sustainability pathways.

[49] Common themes reflecting challenges and iterations in hospital roadmaps and financial reports were identified and described by the State. The IE did not independently review hospital roadmaps and financial reports for the IER.

The State has also drawn on experience from other global budget and hospital transformation models, including those in Maryland and Pennsylvania, and has coordinated internally across NYSDOH teams to streamline guidance, templates, and reporting expectations.

Factors Contributing to Progress

The State's ongoing engagement with hospitals, standardized planning templates, and cross-agency collaboration within the State have supported implementation progress.

5. HEALTH EQUITY REGIONAL ORGANIZATION

a. HERO Initiative Overview

The HERO initiative establishes a single statewide entity, the "HERO facilitator" to develop regionally focused approaches to advance population health and support the delivery of HRSN services.[50] The overarching function of the HERO facilitator is to assist the State in developing and designing VBP goals to improve population health. The HERO facilitator performs five main activities:

1. Data aggregation, analytics, and reporting
2. Conduct regional needs assessments
3. Convene regional stakeholder engagement sessions
4. Make recommendations to support advanced value-based arrangements and develop options for incorporating HRSN into VBP methodologies
5. Conduct program analysis, such as publishing initial population health plans and health factor baseline data on Medicaid populations

New York began planning the HERO initiative upon waiver approval.

b. HERO Initiative Implementation Findings

The findings presented here were developed from (1) the qualitative data gathered from KIIs early in the implementation period and (2) administrative data sources that included both quantitative data and narrative descriptions of progress.

The IE conducted one stakeholder conversation with a NYSDOH administrator familiar with the HERO initiative in November 2025. The administrative data sources, such as the State issued ad hoc progress summaries, generally provide information as of April 2026.

Implementation Question 8: What progress has been made in implementing the HERO initiative? What are the barriers to implementation, what strategies have been used to address these barriers? What factors have contributed to successful implementation progress?

Implementation Progress

The HERO initiative is a core component of New York's January 2024 amendment and is intended to support regionally informed strategies to advance population health. The state contracted with the United

[50] The state initially proposed nine regional organizations, or "HEROs" responsible for a variety of activities aimed towards improving the health of the communities in their respective regions. The approved amendment diverges from the initial concept in that it authorizes a single statewide entity to facilitate this work.

Hospital Fund (UHF) to serve as the HERO facilitator. UHF is an independent, nonprofit organization that provides analysis, convening, and thought leadership on health policy in New York. In the role of HERO facilitator, UHF convenes stakeholders across health care, public health, social services, and community organizations in New York to identify gaps in access, share best practices, and inform policy and program design.

At the time of this evaluation, HERO implementation is focused on holding regional convenings, establishing partnerships, and initiating data-informed learning activities. As of May 2026, two rounds of regional convenings were completed and a third, statewide convening is in the planning stage.

The first round of convenings consisted of 13 regional sessions (Finger Lakes, Western, Southern Tier, Central, Capital, Glens Falls, Plattsburgh, Watertown, Long Island, Bronx, New York City, Hudson Valley, and Staten Island) in September and October 2025. A total of 765 individuals, representing over 500 organizations, attended the first round of convenings (with an average of 59 attendees per session). These convenings brought together a wide range of stakeholders to examine regional needs and discuss implementation experiences. Attendees included SCN Lead Entities, CBOs (both participating in SCNs and not), providers (hospitals, PCPs, behavioral health providers, FQHCs, Certified Community Behavioral Health Clinics (CCBHCs), etc.), local public health departments, MCOs, and workforce partners (WIOs). SCN Lead Entities, CBOs, and providers represented the majority of attendees.

The initial round of regional convenings focused on identifying gaps in access to health and social are needs, surfacing barriers and enablers to waiver implementation, and aligning on physical and behavioral health, and health-related social needs. UHF and the State viewed convenings as an opportunity to lay the groundwork for collaboration, data-informed action, and to amplify voices from a variety of regional stakeholders. Session agendas opened with convening goals and objectives, overview of regional demographic and health data, findings from local Community Health Needs Assessments (CHNAs), and review of regional SCN screening progress. Meeting leaders facilitated exercises for attendees to identify top physical and behavioral health needs and priorities, as well as high-priority HRSNs. Sessions closed with a discussion of opportunities to sustain waiver efforts.

UHF facilitated a second round of regional convenings, which concluded in May 2026. This round of meetings focused on strategies to address barriers to HRSN screening. This focus, a shift from the originally planned focus on identifying resources to address regional needs informed by HRSN, Medicaid, and workforce data, was made in response to the real-time emerging priority of improving screening rates.

In parallel, HERO partners have begun working with state data teams, academic collaborators, and CBOs to assess available Medicaid and program data and to inform the development of metrics and analytic approaches that can support future convenings and policy discussions. The HERO facilitator's work on producing regional and statewide needs assessments is underway and will inform future work on development of a population health plan.

Barriers to Implementation

Barriers to HERO implementation primarily relate to timing, data maturity, and the broader policy environment. The accelerated waiver timeline has required HERO convenings to occur earlier than initially

planned, limiting the availability of mature implementation data from other January 2024 amendment initiatives. Data aggregation and analytic efforts have therefore been constrained by the evolving nature of SCN and workforce program reporting systems. Technology challenges and the need to bring on technical experts to build analytic capacity contributed to the limitations of using data at early convenings.

State administrators also noted challenges related to stakeholder engagement, including ensuring participation from the right mix of regional actors and sustaining engagement in the context of a rapidly shifting and uncertain political climate broadly.

Strategies to Address Barriers and Factors Contributing to Progress

The State commented that UHF's experience as a trusted convener under the DSRIP program and its longstanding credibility within communities makes UHF well positioned to facilitate productive discussions and adapt engagement strategies across regions. The State is pleased with UHF's regional collaborative model to appropriately engage the right stakeholders at convenings.

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G. Conclusions

This section of the IER will be included in an updated version of the report that will be attached to the State's 1115 waiver extension application when it is submitted to CMS. The updated version will contain additional quantitative data upon which to base conclusions.

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H. Lessons Learned and Policy Implications

This section of the IER will be included in an updated version of the report that will be attached to the State's 1115 waiver extension application when it is submitted to CMS. The updated version will contain additional quantitative data upon which to provide lessons learned and policy implications.

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I. Attachments

1. Evaluation Budget

The 1115 waiver evaluation deliverables and corresponding budget are provided in Exhibit 26: 1115 Waiver Evaluation Deliverables below.

Exhibit 26: 1115 Waiver Evaluation Deliverables

1115 Waiver Evaluation Deliverables	Amount	Year 1 (FY25)	Year 2 (FY26)	Year 3 (FY27)	Year 4 (FY28)	Year 5 (FY29)	Year 6 (FY30)
Revised Evaluation Design Document (EDD)	$90,398		$90,398				
Development of Analytic Plan & Data Infrastructure	$867,813	$433,906	$433,906				
Qualitative Data Collection & Analysis	$2,090,640			$1,301,719	$788,921		
Quantitative Data Collection & Analysis	$3,076,790			1,775,071	$1,301,719		
Final Interim Evaluation Report	$1,065,043			$1,065,043			
Final Summative Evaluation Report	$958,211					$867,813	$90,398
Totals	***$8,148,894***	***$433,906***	***$524,304***	***$4,141,833***	***$2,090,640***	***$867,813***	***$90,398***

2. TIMELINE AND MAJOR MILESTONES

The dates for submission of the Evaluation Design and Evaluation Reports are specified in the demonstration STCs. To ensure dissemination of evaluation findings, lessons learned, and recommendations, the State will post the Interim and Summative Evaluation Reports to the State's website within 30 calendar days of CMS approval, as per 42 CFR 431.424(d). Exhibit 27: Major Milestones Timeline depicts the major milestones timeline for the independent evaluation.

Exhibit 27: Major Milestones Timeline

Milestone	Target Dates	DY24 Apr 2022-Mar 2023	DY25 Apr 2023-Mar 2024	DY26 Apr 2024-Mar 2025	DY27 Apr 2025-Mar 2026	DY28 Apr 2026-Mar 2027	Post Y1 Apr 2027-Mar 2028	Post Y2 Apr 2028-Mar 2029
Evaluation Design Document Initial Submission & Revisions	12/14/2022 6/30/2023 7/5/2024 1/9/2026	X	X	X	X			
Procurement of Independent Evaluator	1/1/2025			X				
Data Access, Collection, and Analysis	4/1/2025 to 3/31/2028				X	X	X	
KIIs	9/1/2025 to 3/31/2027				X	X		
SUD Mid-point Assessment[51]	11/29/2026					X		
Interim Evaluation Report	Due with the Waiver Extension Application					X		
Summative Evaluation Report	9/30/2028							X

[51] SUD Mid-point assessment is a separate report; not included in this design.