

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop S2-25-26  
Baltimore, Maryland 21244-1850



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## State Demonstrations Group

March 9, 2026

Amir Bassiri  
Medicaid Director, Deputy Commissioner  
New York Department of Health  
Empire State Plaza, Corning Tower, Room 1466  
Albany, NY 12237

Dear Director Amir Bassiri:

The Centers for Medicare & Medicaid Services (CMS) completed its review of New York's Evaluation Design, as required by the Special Terms and Conditions (STCs), specifically, STC #17.3, of the "Medicaid Redesign Team" (Project Number 11-W-00114/2), effective through March 31, 2027. CMS has determined that the Evaluation Design, which was submitted on June 7, 2024, and revised on May 23, 2025, and January 16, 2026, meets the requirements set forth in the STCs and CMS's Evaluation Design guidance, and therefore approves the Evaluation Design.

CMS has added the approved Evaluation Design to the demonstration's STCs as Attachment G. A copy of the STCs, which includes the new attachment, is enclosed with this letter. In accordance with 42 CFR 431.424, the approved Evaluation Designs may now be posted to the state's Medicaid website within 30 days. CMS will also post the approved Evaluation Designs as a standalone document, separate from the STCs, on Medicaid.gov.

Please note that an Interim Evaluation Report, consistent with the approved Evaluation Design, is due to CMS one year prior to the expiration of the demonstration, or at the time of the extension application, if the state chooses to extend the demonstration. Likewise, a Summative Evaluation Report, consistent with the approved designs, is due to CMS within 18 months of the end of the demonstration period. In accordance with 42 CFR 431.428 and the STCs, we look forward to receiving updates on evaluation activities in the demonstration monitoring reports.

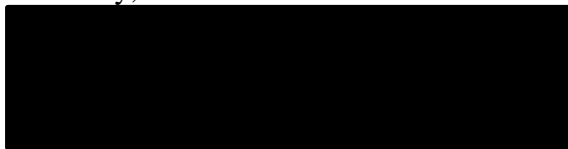
States are responsible for following all applicable federal law and regulations when they claim and use federal Medicaid and CHIP funds and must fully comply with all applicable Medicaid and CHIP statutes and regulations under a section 1115 demonstration, except where specific provisions have been expressly waived or identified as not applicable for that demonstration. This obligation includes all requirements in Title XIX and Title XXI of the Social Security Act and implementing regulations governing provider screening and enrollment activities, pre- and post-payment review claiming, payment methodologies and rate-setting,

utilization controls, and program integrity including processes to identify, investigate, and refer suspected fraud, and methods to receive complaints and identify questionable practices. States must maintain effective systems and safeguards to prevent, detect, and address any fraud, waste, or abuse (FWA) in the delivery of and payment for Medicaid and CHIP services, including referrals to law enforcement when appropriate.

States should have heightened monitoring and oversight mechanisms in place featuring robust internal controls to identify and remediate all vulnerabilities (including, but not limited to, FWA and beneficiary access issues) inherent in service areas approved as part of a demonstration. At any time, CMS may request that the state provide a plan detailing the state's systems and safeguards to prevent, detect, and address any FWA relative to this demonstration. Failure to meet program integrity obligations under federal statutes and regulations or under the terms and conditions of this demonstration approval may result in compliance actions or other enforcement measures that could include requirements to develop and implement corrective action plans, withholdings, deferrals, disallowances, and termination of demonstration authority.

We appreciate our continued partnership with New York on the section 1115 demonstration. If you have any questions, please contact your CMS demonstration team.

Sincerely,



Danielle Daly  
Director  
Division of Demonstration Monitoring and Evaluation

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

# New York Medicaid Redesign Team (MRT) Section 1115 Demonstration: Evaluation Design Document

Prepared by Public Consulting Group LLC

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Project No. 11-W-00114/2



**PUBLIC**  
CONSULTING GROUP

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## Glossary & Acronyms

**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.<sup>1</sup>

**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 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.<sup>2</sup>

**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.

**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 (MMMMC)** - A term used to refer to non-specialty managed care plans.

**Managed Care Organization (MCO)** - Integrated entities in the healthcare system, which endeavor to reduce healthcare expenditures costs.

**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.

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<sup>1</sup> 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.

<sup>2</sup> HIV Special Needs Plan (HIV-SNP). Available at: <https://www.health.ny.gov/diseases/aids/general/resources/snps/> Accessed on October 15, 2025.

**Medicaid Buy-In Program for Working People with Disabilities (MBI-WPD)** – A program to allow working individuals with disabilities the opportunity to maintain financial independence through employment while retaining their Medicaid coverage, despite earnings that may result in income in excess of regular Medicaid limits.

**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 Managed Care Organizations (MCOs) offering three types of plans: MMMC, HARPs and HIV-SNPs.

**New York State Department of Health (NYS DOH)** - Oversees the health, safety, and well-being of New York State residents.<sup>3</sup>

**Office of Addiction Services and Supports (OASAS)** - Oversees the substance use disorder systems of care for the residents of New York State.<sup>4</sup>

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

**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.

**Workforce Investment Organization (WIO)** - WIOs receive funding to implement the Career Pathways Training (CPT) Program, which will recruit and train thousands of new health, mental health, and social care workers across New York. This program will also provide new career advancement opportunities to many current health care workers throughout the State.

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<sup>3</sup> About the New York State Department of Health (NYS DOH). Available at: <https://www.health.ny.gov/about/> Accessed on October 15, 2025.

<sup>4</sup> About the Office of Addiction Services and Supports (OASAS). Available at: <https://oasas.ny.gov/about> Accessed on October 15, 2025.

## A. General Background Information

### 1. DEMONSTRATION NAME & TIMING

The 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 temporary extension period of the previous waiver and the current wavier 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 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<sup>5</sup>:

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,

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<sup>5</sup>Demonstration Approval. Available at: [ny-medicaid-rdsgn-team-appvl-01092024.pdf](https://www.ny.gov/files/document/2024/01/ny-medicaid-rdsgn-team-appvl-01092024.pdf). Accessed on July 10, 2025.

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 of improving access to care and quality of health services delivered, and align with the State Medicaid Director Letter<sup>6</sup>:

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 time period continue to operate under the 1115 authority, such as mandatory managed care; 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 approval, 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.

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<sup>6</sup> 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.

- 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.
- 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 or hospitals 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 Health Care Program (LTHCP) 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 and coordinated 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 a major delivery system reform: 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, behavioral health and BH HCBS for eligible Medicaid members with diagnosed SMI or SUD to receive services within their own 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 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. During this period of the demonstration the State implemented a value-based payment roadmap and sought to increase accountability for population health. The State also supported providers’ ability to increase efficiencies in the delivery of care and support population health.

The demonstration extensions, renewals, and amendments during the NY MRT Phase include:

- 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.
  - 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.
- 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.
- August 2019:
  - 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:
  - 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.
  - 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.
  - *These policies are narrow in scope and not a specific focus of the independent evaluation.*

The amendments approved during or just before the current demonstration period are the primary focus of the independent evaluation:

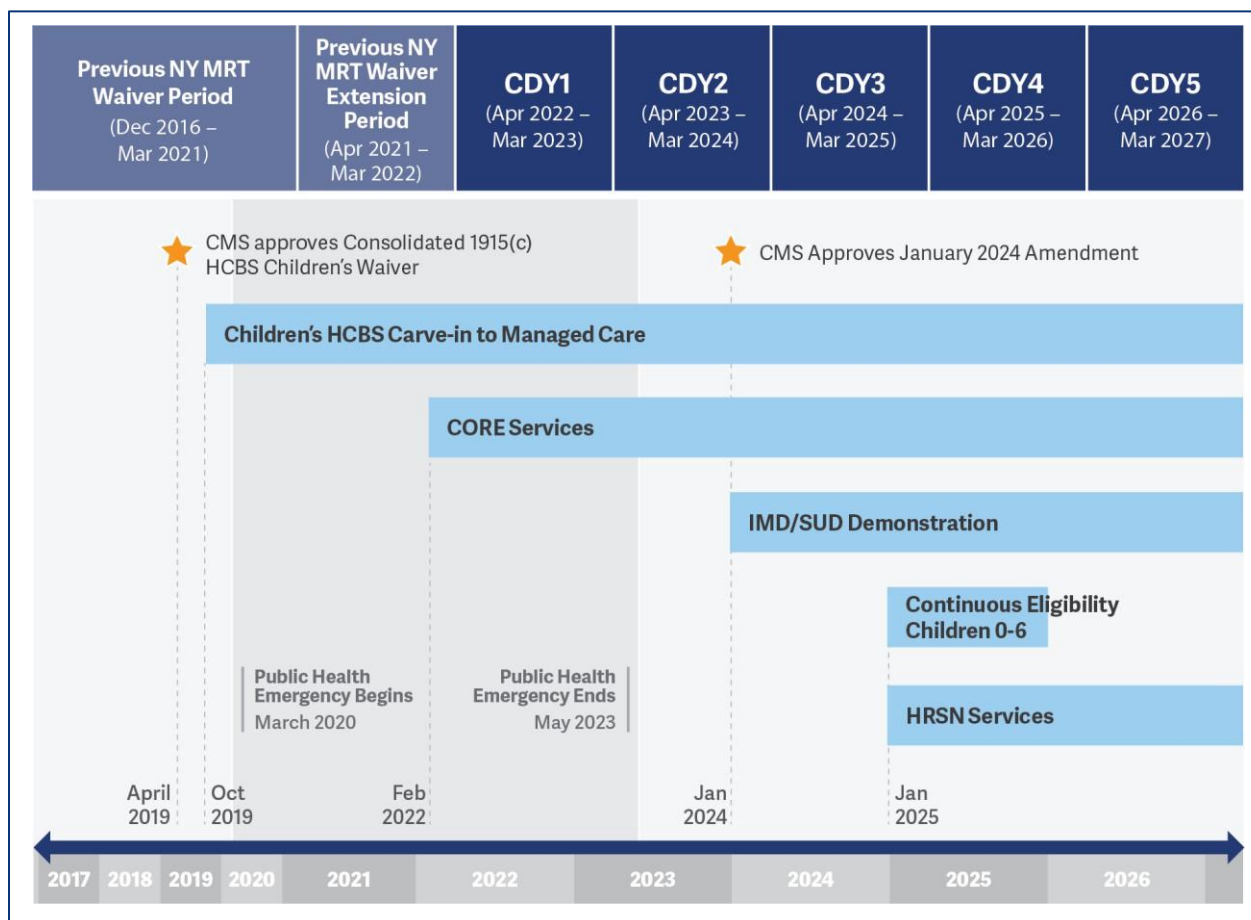
- October 2021: Added a set of rehabilitative services called Community-Oriented Recovery and Empowerment (CORE); substituting for and improving upon four BH HCBS within HARP and HIV SNP; *this amendment was approved during the prior demonstration period and implemented during the current demonstration period and is a focus of the independent evaluation.*
- January 2022: Managed Care Risk Mitigation COVID-19 Public Health Emergency amendment was approved; *not in the scope of the independent evaluation within this report.*
- 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; *not in the scope of the independent evaluation within this report.*
- January 2024:
  - 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 (SLR) Program.<sup>7</sup>
    - With the exception of the MHGBI, these initiatives are supported by DSHP funds, and are described in greater detail in Section A.5 Designated State Health Program (DSHP)-Funded Initiatives
    - *These policies are the primary focus of the independent evaluation.*
- November 2024: Continuous Medicaid and Child Health Plus Eligibility for Children up to Age Six; *this policy is a focus of 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 period, shown in Exhibit 1. 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.

<sup>7</sup> About the HEALR Program. Available at: [Health Care Access Loan Repayment \(HEALR\) Program](#). Accessed on January 9, 2026.

Exhibit 2 Major Recent 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. The evaluation focuses on the relevant policy changes and the impacted populations; results will be stratified by plan type where applicable.

## Exhibit 2 Target Population

Policy	Impacted Population	Estimated Annual Population Size	Plan Types
<b>Children’s HCBS Carve-in to Managed Care</b>	Youth Eligible for HCBS	8,000 <sup>8</sup>	MMMC
<b>CORE Services</b>	Behavioral Health High-Risk Adults	165,000 <sup>9</sup>	HARP, HIV-SNP, MMMC
<b>IMD SUD Demonstration</b>	Individuals with SUD Service Needs	IMD/ Reintegration: 8,000 – 9,000 <sup>10</sup>	HARP, HIV-SNP, MMMC
<b>Continuous Eligibility Children up to Age Six</b>	Children up to Age Six	66,000 <sup>11</sup>	MMMC
<b>HRSN Services<sup>12</sup></b>	All Medicaid Managed Care Members	6.6M	HARP, HIV-SNP, MMMC, MLTC
<b>January 2024 Amendment Initiatives<sup>13</sup></b>	All Medicaid Managed Care Members	6.6M	HARP, HIV-SNP, MMMC, MLTC

Next, 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

<sup>8</sup> Estimate based on preliminary data analysis conducted by the IE.

<sup>9</sup> 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.

<sup>10</sup> 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.

<sup>11</sup> New York State Medicaid Redesign Team (MRT) Waiver Continuous Eligibility Waiver amendment. Available at: [https://www.health.ny.gov/health\\_care/medicaid/redesign/med\\_waiver\\_1115/docs/draft\\_amend\\_request.pdf](https://www.health.ny.gov/health_care/medicaid/redesign/med_waiver_1115/docs/draft_amend_request.pdf) Accessed on October 15, 2025.

<sup>12</sup> The HRSN infrastructure and services target all Medicaid managed care members and are evaluated under hypothesis 5.

<sup>13</sup> 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.

began in October 2019, except for children and youth in foster care, for whom mandatory MMC enrollment started in July 2021.

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 report which focused on the implementation process and identification of pre-implementation trends in outcomes of interest.<sup>14</sup> 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 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.<sup>15</sup>

- CORE consists of four services: Community Psychiatric Support and Treatment (CPST), Psychosocial Rehabilitation (PSR), Family Support and Training (FST), and Empowerment Services— Peer Support.<sup>16</sup>
- 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 report which reported increasing, but low, rates of BH HCBS utilization among plan members over time.

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

<sup>14</sup> 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.

<sup>15</sup> Behavioral Health (BH) High-Risk Eligibility Criteria. Available at: [Behavioral Health \(BH\) High-Risk Eligibility Criteria](#). Accessed on October 31, 2025.

<sup>16</sup> 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.

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.<sup>17</sup>

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.<sup>18</sup>

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

### d. Children up to Age Six

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 continuous eligibility policy 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.

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

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<sup>17</sup> 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.

<sup>18</sup> 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](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.

policy was fully in effect. 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 managed care members. Broadly, the amendment seeks to advance population health, reduce health disparities, and support the delivery of HRSN services. The evaluation design focuses on understanding the severity and prevalence of HRSN among 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.

Given the timing of the January 2024 amendment approval and the subsequent implementation timeline for the HRSN infrastructure and services, there will be little, if any, quantitative data available for the interim evaluation report. Qualitative data on the implementation of the HRSN infrastructure and services will be included in both the interim and summative reports. In addition, the evaluation includes implementation questions for the HERO, MHGBI, and Strengthen the Workforce components of the amendment.

### 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 SLR 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.

#### Exhibit 3 DSHP-Funded Initiatives and Objectives

<b>DSHP-Funded Initiative</b>	<b>Alignment with Objectives</b>
<b>HRSN Infrastructure and Services</b>	Investments made in HRSN infrastructure will advance integration between primary care 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 mediate HRSN with goals of improved access to care and improved quality of care by reducing health disparities.
<b>HERO</b>	Investments in the HERO are made to develop regionally-focused approaches, with a goal of statewide accountability for improving health outcomes and population health.
<b>Workforce Initiatives: CPT and SLR Programs</b>	Workforce investments aim to increase the adequacy of the workforce with a goal of equitable and sustainable access to care.

## 6. OTHER CONTEXTUAL FACTORS

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 will include 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.

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.<sup>19</sup> 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 interim and summative evaluation reports will include a description of the PCMH program and other related initiatives and consider them when interpreting demonstration findings.

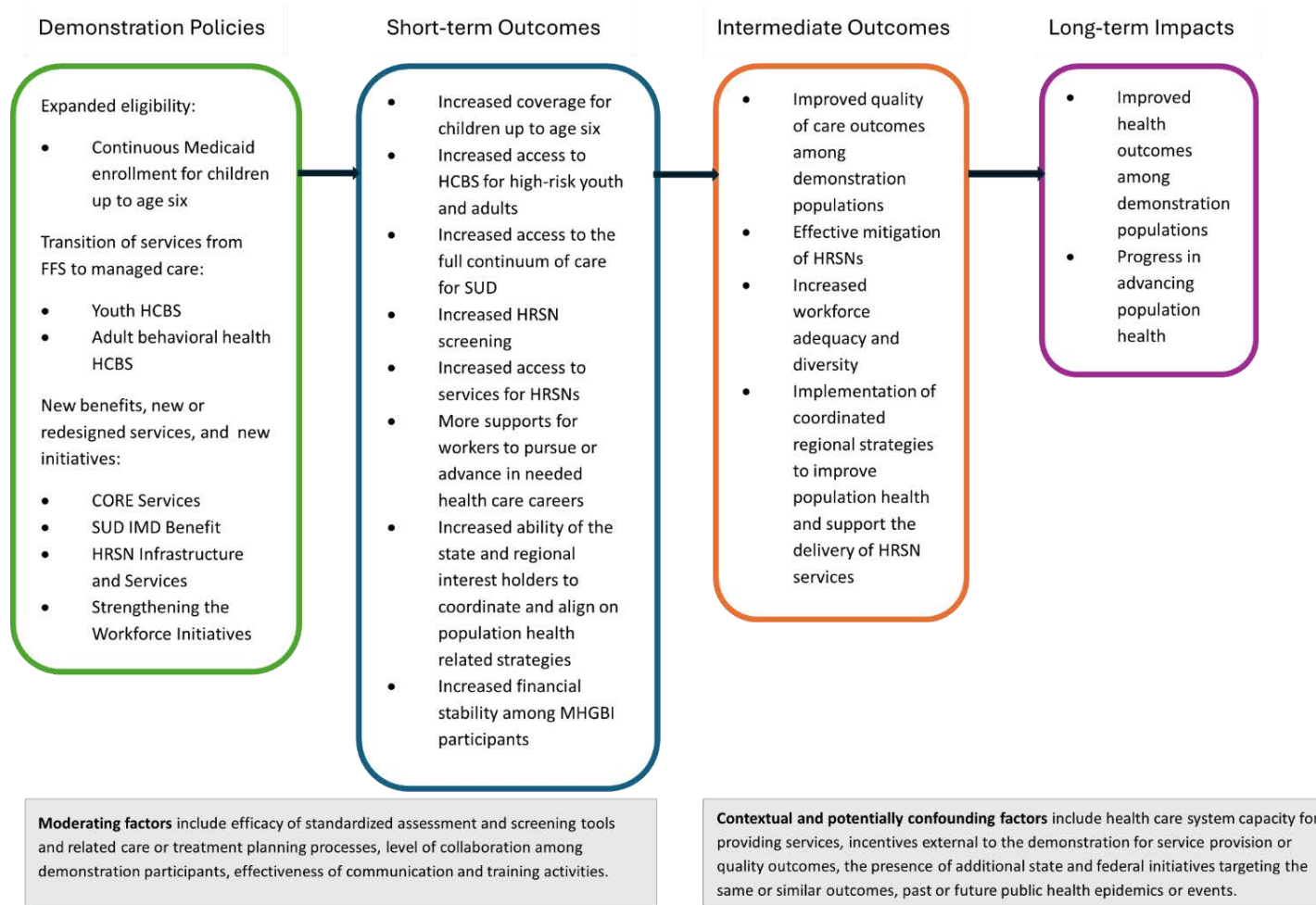
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<sup>19</sup> New York State Patient Centered Medical Home information. Available at: [New York State Patient-Centered Medical Home \(NYS PCMH\)](#). Accessed on January 9, 2026.

## B. 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, amendments implemented in previous demonstration periods and/or narrow in scope are not the focus of the implementation evaluation.

#### *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 SLR program? What are the barriers to implementation, what strategies have been used to address these barriers? What factors have contributed to successful progress?
- 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?
- 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?

## 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. The corresponding research questions, measures, data sources, and analytic approaches are provided in Exhibit 6, the Evaluation Design Table, in Section C. Methodology.

### Exhibit 5 Policies and Hypotheses

Policy	Hypothesis
<b>Children's HCBS Carve-in to Managed Care</b>	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.
<b>CORE Services</b>	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.
<b>IMD SUD Demonstration</b>	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.
<b>Continuous Eligibility Children up to Age Six</b>	4. The continuous eligibility policy for children up to age six will increase enrollment duration and increase access to routine care for this population.
<b>HRSN Services</b>	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 children, pregnant and postpartum individuals, the chronically homeless, and individuals with SUD.

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**January 2024  
Amendment  
Initiatives**

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6. The January 2024 amendment initiatives will lead to reductions in health disparities.

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## C. Methodology

### 1. OVERVIEW OF ANALYTIC METHODS

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

The implementation questions will be evaluated primarily by using new qualitative data gathered in key informant interviews or focus groups specifically for purposes of the independent evaluation. In addition, administrative data will be included where available and relevant to the implementation questions. For example, for the January 2024 amendment *Implementation Question 5: “What progress has been made in implementing the Career Pathways Training program?”* the evaluation will include the number of individuals recruited, enrolled in, and placed, through each type of CPT program. This data will be extracted from the required Workforce Investment Organization (WIO) progress reports. Similarly, the number of individuals awarded student loan repayment via the SLR program will be reported to inform the January 2024 *Implementation Question 6: “What progress has been made in implementing the Student Loan Repayment program?”*. At the time of writing, the CPT and SLR administrative data represent the only quantitative data known to be available that is relevant to the implementation questions. The evaluators will continue to engage with the State to identify any additional administrative data or program reports that could serve as secondary data sources to lend additional context to the implementation evaluation.

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 6. 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 re-considered based on the data available and the significance of the trending break.

Exhibit 6 Evaluation Design Table

Research Question	Outcome Measures	Data Sources	Analytic Approach and Comparison Strategy
<b>Hypothesis 1:</b> 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.			
<b>Primary research question 1.1:</b> Did the transition of Children’s HCBS from FFS to managed care improve access to HCBS for the eligible population?	<ul style="list-style-type: none"> <li>• HCBS Service Utilization Rates by service type, year, clinical characteristics, and demographics</li> </ul>	MDW and Related Datasets	Interrupted time series with members in the pre-demonstration period as the baseline
<b>Subsidiary research question 1.1a:</b> What are the distributions of: individuals meeting the Youth Eligible	<ul style="list-style-type: none"> <li>• Distributions of individuals by year, clinical characteristics, and demographics</li> </ul>	MDW and Related Datasets	Descriptive statistics

Research Question	Outcome Measures	Data Sources	Analytic Approach and Comparison Strategy
for HCBS criteria, individuals engaged in youth HCBS?			
<b>Primary research question 1.2:</b> Did quality of care outcomes among Youth Eligible for HCBS improve after the transition of HCBS from FFS to managed care?	<ul style="list-style-type: none"> <li>• Child and Adolescent Well-Care Visits</li> <li>• Oral Evaluation, Dental Services</li> <li>• Inpatient Utilization</li> <li>• ED Visits (Total, BH, non-BH)</li> <li>• Plan All-Cause Readmission</li> </ul> by year, clinical characteristics, and demographics	MDW and Related Datasets	Interrupted time series with members in the pre-demonstration period as the baseline
<b>Primary research question 1.3:</b> 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: <ul style="list-style-type: none"> <li>• Hospital Facility</li> <li>• Nursing Facility</li> <li>• Intermediate Care Facility</li> </ul> by year, clinical characteristics, and demographics	MDW and Related Datasets	Interrupted time series with members in the pre-demonstration period as the baseline
<b>Hypothesis 2:</b> 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.			
<b>Primary research question 2.1:</b> Did the transition to CORE services improve access to rehabilitation and recovery services for BH High-Risk Adults?	<ul style="list-style-type: none"> <li>• CORE Service Utilization Rates</li> <li>• Adult BH HCBS Service Utilization Rates</li> <li>• Utilization of Recovery Oriented Services for Mental Health</li> <li>• Engagement in Community-based Mental Health Care</li> </ul> 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
<b>Subsidiary research question 2.1a:</b> What are the distributions of: individuals meeting the BH High-Risk Adult criteria, individuals engaged in CORE services, individuals engaged in BH HCBS?	<ul style="list-style-type: none"> <li>• Distributions of individuals by plan type, year, clinical characteristics, and demographics</li> </ul>	MDW and Related Datasets	Descriptive statistics
<b>Primary research question 2.2:</b> Did quality of care outcomes among BH High-Risk Adults improve after the transition to CORE services?	<ul style="list-style-type: none"> <li>• Adherence to Anti-psychotic Medication for People with Schizophrenia</li> <li>• Adult Access to Preventive/Ambulatory Health Services</li> <li>• Colorectal Cancer Screening</li> <li>• Dental Service Utilization</li> <li>• ED Visits (Total, BH, non-BH)</li> </ul>	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
	<ul style="list-style-type: none"> <li>• Follow-Up</li> <li>• After Hospitalization for Mental Illness</li> <li>• Inpatient Utilization</li> <li>• Plan All-Cause Readmission</li> <li>• Potentially Preventable Mental Health Related Readmission Rate</li> </ul> by plan type, year, clinical characteristics, and demographics		
<b>Hypothesis 3:</b> 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.			
<b>Primary research question 3.1:</b> Did the IMD SUD demonstration improve access to, and engagement in, SUD services across the care continuum for this population?	<ul style="list-style-type: none"> <li>• Non-acute SUD Service Utilization Rate</li> <li>• Residential Care Utilization at each of 3 Levels</li> <li>• Residential Care Average Length of Stay at each of 3 Levels</li> <li>• Initiation and Engagement of SUD Treatment</li> <li>• Follow-up After High-Intensity Care for SUD</li> <li>• Pharmacotherapy for Opioid Use Disorder (OUD)</li> </ul> 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
<b>Subsidiary research question 3.1a:</b> What are the distributions of: individuals in need of SUD services, engaged in each level of care for SUD?	<ul style="list-style-type: none"> <li>• Distributions of individuals</li> </ul> by plan type, year, clinical characteristics, and demographics	MDW and Related Datasets	Descriptive statistics
<b>Subsidiary research question 3.1b:</b> What factors may be barriers to, or facilitators of, access and engagement in SUD treatment?	Not applicable	Program documents and reports, if available Key informant interviews or focus groups	Document review Qualitative analysis
<b>Primary research question 3.2:</b> Did quality of care outcomes among individuals in need of SUD services improve following the implementation of the IMD SUD demonstration?	<ul style="list-style-type: none"> <li>• ED Visits for SUD, for OUD</li> <li>• Inpatient Utilization for SUD, for OUD</li> <li>• Adult Access to Preventive/Ambulatory Health Services</li> <li>• Colorectal Cancer Screening</li> <li>• Plan All-Cause Readmission</li> </ul> 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
<b>Primary research question 3.3:</b> Did health outcomes among individuals in need of SUD services improve following the implementation of the IMD SUD demonstration?	<ul style="list-style-type: none"> <li>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</li> </ul>	MDW and Related Datasets Vital Statistics	Interrupted time series with members in the pre-demonstration period as the baseline
<b>Primary research question 3.4:</b> Did the IMD SUD demonstration stabilize or reduce costs of care for the SUD population?	<ul style="list-style-type: none"> <li>Total cost of care per member per month</li> </ul>	MDW and Related Datasets	Interrupted time series with members in the pre-demonstration period as the baseline
<b>Subsidiary research question 3.4a:</b> What types of care were the primary drivers of the total cost of care for the SUD population?	<ul style="list-style-type: none"> <li>Source of care cost drivers (inpatient, non-ED outpatient, ED outpatient, pharmacy, long-term care)</li> </ul>		Interrupted time series with members in the pre-demonstration period as the baseline
<b>Hypothesis 4:</b> The continuous eligibility policy for children up to age six will increase enrollment duration and increase access to routine care for this population.			
<b>Primary research question 4.1:</b> How did the continuous eligibility policy for children up to age six impact enrollment duration among eligible members?	<ul style="list-style-type: none"> <li>Average months of enrollment by demographics</li> </ul>	MDW and Related Datasets	Pre-post comparison
<b>Primary research question 4.2:</b> How did the continuous eligibility policy for children up to age six impact health care utilization and cost?	<ul style="list-style-type: none"> <li>Service Utilization by type (outpatient, inpatient, ED, pharmacy)</li> <li>PMPM Cost of Care (total, and by type) by demographics</li> </ul>	MDW and Related Datasets	Pre-post comparison
<b>Primary research question 4.3:</b> Did quality of care indicators improve following the implementation of the continuous enrollment policy for this population?	<ul style="list-style-type: none"> <li>Child and Adolescent Well-Care Visits</li> <li>Oral Evaluation, Dental Services</li> </ul> by year and demographics	MDW and Related Datasets	Pre-post comparison

<b>Hypothesis 5:</b> 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 <sup>20</sup> including children, pregnant and postpartum individuals, the chronically homeless, and individuals with SUD.			
<b>Primary research question 5.1:</b> Did the HRSN initiative effectively mitigate members' identified HRSNs?	<ul style="list-style-type: none"> <li>Proportion of survey respondents who agreed that services received fully met their needs</li> </ul> by year, HRSN service type, and demographics	SCN Member Survey KII's or focus groups	Descriptive statistics Qualitative analyses
<b>Subsidiary research question 5.1a:</b> Did the prevalence of HRSN screening increase over the course of the implementation?	<ul style="list-style-type: none"> <li>Number of persons screened</li> </ul> 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)
<b>Subsidiary research question 5.1b:</b> What was the prevalence of HRSN needs over the course of the implementation?	<ul style="list-style-type: none"> <li>Number of unique individuals with 1 or more HRSNs</li> <li>Number of identified needs</li> </ul> by year, HRSN type, and clinical characteristics and demographics	MDW and Related Datasets	Descriptive statistics
<b>Subsidiary research question 5.1c:</b> Did eligible members engage in the services made available to them under the HRSN initiative?	<ul style="list-style-type: none"> <li>HRSN Service Engagement: of those individuals screened, proportions:</li> <li>Eligible for navigation</li> <li>Utilized navigation</li> <li>Eligible for Enhanced HRSN</li> <li>Utilized Enhanced HRSN</li> </ul> by year, HRSN type, clinical characteristics and demographics	MDW and Related Datasets	Descriptive statistics
<b>Primary research question 5.3:</b> What were the experiences of members with HRSN screening and services?	Proportion of survey respondents who reported good to excellent experience with: <ul style="list-style-type: none"> <li>Screening process</li> <li>Social Care Navigator</li> <li>Nutrition Service Provider</li> <li>Housing Service Provider</li> <li>Transportation Service Provider</li> </ul> Proportion of survey respondents who were happy with the quality of services received: <ul style="list-style-type: none"> <li>Nutrition Service Provider</li> <li>Housing Service Provider</li> <li>Transportation Service Provider</li> </ul> By year and demographics	SCN Member Experience Survey	Descriptive statistics
<b>Primary research question 5.2:</b> Did quality of care and health outcomes among persons eligible for enhanced	<ul style="list-style-type: none"> <li>Adult Access to Preventive/Ambulatory Health Services</li> <li>Colorectal Cancer Screening</li> </ul>	MDW and Related Datasets	Individual-level interrupted time series regression for comparisons

<sup>20</sup> 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.

HRSN services improve following receipt of enhanced HRSN services?	<ul style="list-style-type: none"> <li>• Inpatient Utilization</li> <li>• ED Visits (Total, BH, non-BH)</li> <li>• Plan All-Cause Readmission</li> </ul> by year, clinical characteristics and demographics		within the target population, before and after utilizing enhanced HRSN services.
<b>Primary research question 5.3</b> : How did renewals of recurring nutrition services affect care utilization and member physical and mental health outcomes?	<ul style="list-style-type: none"> <li>• Adult Access to Preventive/Ambulatory Health Services</li> <li>• Colorectal Cancer Screening</li> <li>• Inpatient Utilization</li> <li>• ED Visits (Total, BH, non-BH)</li> <li>• Plan All-Cause Readmission</li> <li>• Potentially Preventable Mental Health Readmission Rates</li> </ul> by year, clinical characteristics and demographics	MDW and Related Datasets KIs or focus groups	Individual-level interrupted time series regression for comparisons within the target population, before and after utilizing enhanced HRSN services. Qualitative analyses
<b>Subsidiary research question 5.3.a</b> : What costs were associated with renewals of recurring nutrition services?	<ul style="list-style-type: none"> <li>• Total cost of renewals of recurring nutrition services</li> <li>• Average per member cost of recurring nutrition services</li> </ul> by year	MDW and Related Datasets	Descriptive statistics
<b>Primary research question 5.4</b> : Did local investments in housing supports and nutrition services change over time, and if so, how?	<ul style="list-style-type: none"> <li>• Number of HRSN type programs</li> </ul> by year	Annual Monitoring Reports: Maintenance of Effort section	Descriptive statistics
<b>Primary research question 5.5</b> : What costs were associated with the HRSN services?	<ul style="list-style-type: none"> <li>• Estimates of total cost for each service type, including: Direct costs (personnel, supplies, service delivery), Indirect costs (administrative, IT), and Overhead costs (facility costs)</li> </ul> by year, HRSN service and region	MDW and Related Datasets SCN Annual Reports	Descriptive statistics
<b>Hypothesis 6</b> : The January 2024 amendment initiatives will lead to reductions in health disparities.			
<b>Primary research question 6.1</b> : Were there disparities in indicators of health care access and quality among high-risk members prior to the amendment?	<ul style="list-style-type: none"> <li>• Adult Access to Preventive/Ambulatory Health Services</li> <li>• Colorectal Cancer Screening</li> <li>• Inpatient Utilization</li> <li>• ED Visits (Total, BH, non-BH)</li> <li>• Plan All-Cause Readmission</li> <li>• Potentially Preventable Mental Health Readmission Rates</li> </ul> by year, clinical characteristics and demographics	MDW and Related Datasets National benchmarks, state-specific standards and targets	Descriptive statistics

<p><b>Primary research question 6.2</b>: Did disparities identified under research question 7.1 improve following implementation of the amendment initiatives?</p>	<ul style="list-style-type: none"> <li>• Adult Access to Preventive/Ambulatory Health Services</li> <li>• Colorectal Cancer Screening</li> <li>• Inpatient Utilization</li> <li>• ED Visits (Total, BH, non-BH)</li> <li>• Plan All-Cause Readmission</li> <li>• Potentially Preventable Mental Health Readmission Rates</li> </ul> <p>by year, clinical characteristics and demographics</p>	<p>MDW and Related Datasets</p> <p>National benchmarks, state-specific standards and targets</p>	<p>Interrupted time series with members in the pre-demonstration period as the baseline</p>
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## 2. DEMONSTRATION AND COMPARISON POPULATIONS

The populations impacted by the demonstration are identified and described in Section B.4. The approach to comparison for each research question is provided in Section C. 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 7. 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 7 Demonstration Populations 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 <sup>21</sup>
All Medicaid Managed Care Members	January 2022 – December 2024	January 2025 – March 2027

## 3. EVALUATION PERIOD

The period under evaluation is January 1, 2020, through March 31, 2027; this represents the previous temporary extension period and the current five-year waiver renewal period. The interim evaluation targets the time from January 1, 2020, through March 31, 2025; this represents the temporary extension period and the first three years of the waiver renewal period. The summative evaluation will extend through the end of the waiver renewal period, March 31, 2027.

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

<sup>21</sup> 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.

- Results for the IMD/SUD Implementation Questions will be included in the summative report only, due to the start date of the demonstration and the planned timeline for conducting key informant interviews.
- Preliminary results for the January 2024 amendment Implementation Questions will be included in the Interim Report, based on wave one of key informant interviews scheduled to take place in late 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 Summative Report.
- Cost analyses will be included in the Summative Report only.
- Planned regression models will be provided in the Summative Report only, due to there not being enough data points to model post-demonstration trends in time for the Interim Report.

Additional details on the approach to the interim report are provided in Exhibit 8. The Summative Report will include the results for all hypotheses and research questions as represented in this evaluation design document.

#### Exhibit 8 Interim Report 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 including children, pregnant and postpartum individuals, the chronically homeless, and individuals with SUD.	Qualitative findings from wave one of Key Informant Interviews Process measures from year one of the HRSN program, if available
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 Summative Report only

## 4. EVALUATION MEASURES

The evaluation measures are summarized in Exhibit 9.

### Exhibit 9 Evaluation Measures Summary

Measure (Acronym) Steward	Description
<b>Adult Behavioral Health Home and Community-based Service (BH HCBS) Utilization</b> Homegrown	The number of unique individuals who received each BH HCBS adult service during the measurement year  The number of claims submitted for each BH HCBS adults service during the measurement year
<b>Adults Access to Preventative/ Ambulatory Health Services (AAP)</b> NCQA/HEDIS	The percentage of members 20 years of age and older who had an ambulatory or preventive care visit during the measurement year.
<b>Adherence to Anti-psychotic Medication for People with Schizophrenia (SAA)</b> NCQA/HEDIS	The percentage of members 18 years of age and older during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period.
<b>Child and Adolescent Well-Care Visits (WCV)</b> NCQA/HEDIS	The percentage of members 3-21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.
<b>Colorectal Cancer Screening (COL-E)</b> NCQA/HEDIS	The percentage of members 45-75 years of age who had appropriate screening for colorectal cancer.
<b>CORE Service Utilization</b> 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
<b>Dental Service Utilization</b> Homegrown	The percentage of members 21 years of age and over who received a comprehensive or periodic oral evaluation with a dental provider during the measurement year.
<b>Emergency Department Utilization (EDU); Total, BH, non-BH, SUD, OUD</b> NCQA/HEDIS	The rate per 1,000 of members 19–64 years of age 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
<b>Engagement in Community Based Mental Health Care After Hospitalization (ENG-CBMH)</b> 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
<b>Follow-up After High-Intensity Care for Substance Use Disorder (FUI)</b> NCQA/HEDIS	The percentage of acute inpatient hospitalizations, residential treatment or withdrawal management visits for a diagnosis of substance use disorder among members 13 years of age and older that

Measure (Acronym) Steward	Description
	<p>result in a follow-up visit or service for substance use disorder. Two rates are reported:</p> <ol style="list-style-type: none"> <li>1. The percentage of visits or discharges for which the member received follow-up for substance use disorder within the 30 days after the visit or discharge.</li> <li>2. The percentage of visits or discharges for which the member received follow-up for substance use disorder within the seven days after the visit or discharge.</li> </ol>
<b>Follow Up After Hospitalization for Mental Illness (FUH)</b> <b>NCQA/HEDIS</b>	<p>The percentage of discharges for patients 19-64 years of age 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:</p> <ol style="list-style-type: none"> <li>1. The percentage of discharges for which the member received follow-up within seven days after discharge.</li> <li>2. The percentage of discharges for which the member received follow-up within 30 days after discharge</li> </ol>
<b>Home and Community Based Service (HCBS) Utilization</b> <b>Homegrown</b>	<p>The number of unique individuals who received a youth HCBS service during the measurement year</p> <p>The number of claims submitted for youth HCBS services during the measurement year</p>
<b>HRSN Screening Rate</b> <b>Homegrown</b>	<p>Proportion of Medicaid eligible members screened for HRSNs at least once in the measurement year</p>
<b>HRSN Prevalence</b> <b>Homegrown</b>	<p>Number of individuals with one or more HRSNs</p> <p>Number of identified HRSN needs by HRSN type</p>
<b>HRSN Service Engagement</b> <b>Homegrown</b>	<p>HRSN Service Engagement: of those individuals screened, proportions:</p> <ul style="list-style-type: none"> <li>• Eligible for navigation</li> <li>• Utilized navigation</li> <li>• Eligible for Enhanced HRSN</li> <li>• Utilized Enhanced HRSN</li> </ul>
<b>HRSN Member Experience</b> <b>Homegrown</b>	<p>Proportion of survey respondents who reported good to excellent experience with:</p> <ul style="list-style-type: none"> <li>• Screening process</li> <li>• Social Care Navigator</li> <li>• Nutrition Service Provider</li> <li>• Housing Service Provider</li> <li>• Transportation Service Provider</li> </ul>
<b>HRSN Member Satisfaction</b> <b>Homegrown</b>	<p>Proportion of survey respondents who were happy with the quality of services received:</p> <ul style="list-style-type: none"> <li>• Nutrition Service Provider</li> <li>• Housing Service Provider</li> <li>• Transportation Service Provider</li> </ul>

Measure (Acronym) Steward	Description
<b>Initiation and Engagement of Substance Use Disorder Treatment (IET)</b> NCQA HEDIS	<p>The rate of members 19–64 years of age with a new episode of SUD who received the following.</p> <ul style="list-style-type: none"> <li>• <i>Initiation of SUD Treatment.</i> The percentage of members who initiate treatment through an inpatient SUD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication treatment within 14 days of the diagnosis.</li> <li>• <i>Engagement of SUD Treatment.</i> The percentage of members who initiated treatment and who were engaged in ongoing SUD treatment within 34 days of the initiation visit.</li> </ul>
<b>Initiation of Pharmacotherapy upon New Episode of Opioid Dependence</b> Homegrown	<p>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.</p>
<b>Inpatient Utilization (IPU)</b> Homegrown	<p>The rate per 1,000 of members 19–64 years of age who had an inpatient stay during the measurement year.</p> <p>Three rates are reported: total, for SUD, for OUD</p>
<b>Non-acute SUD Service Utilization Rate</b> Homegrown	<p>The number of claims submitted for non-acute SUD services in the measurement year.</p>
<b>Oral Evaluation, Dental Services (OED)</b> NCQA/HEDIS	<p>The percentage of members under 21 years of age who received a comprehensive or periodic oral evaluation with a dental provider during the measurement year.</p>
<b>Overdose Deaths</b> Homegrown	<p>Rates of overdose deaths among adult Medicaid members living in a geographic area covered by the IMD SUD demonstration</p>
<b>Pharmacotherapy for Opioid Use (POD) Disorder</b> NCQA/HEDIS	<p>The percentage of OUD pharmacotherapy events that lasted at least 180 days among members 16 years of age and older with a diagnosis of OUD and a new OUD pharmacotherapy event.</p>
<b>Plan All-Cause Readmission (PCR)</b> AHRQ	<p>For members 18-64 years of age, 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.</p>
<b>Potentially Preventable Mental Health Related Readmission</b> AHRQ	<p>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.</p>
<b>Residential Care Utilization at each of 3 Levels</b> Homegrown	<p>The number of unique individuals utilizing each of 3 levels of residential care for SUD</p>

Measure (Acronym)	Description
<b>Steward</b>	
<b>Residential Care Average Length of Stay at each of 3 Levels</b>	The average length of stay for each of three levels of residential care for SUD
<b>Homegrown</b>	
<b>Use of Pharmacotherapy for Opioid Use Disorder (OUD)</b>	The percentage of OUD pharmacotherapy events that lasted at least 180 days among members 16 years of age and older with a diagnosis of OUD and a new OUD pharmacotherapy event.
<b>Homegrown</b>	
<b>Utilization of Recovery Oriented Services for Mental Health</b>	The percentage of HARP enrolled members 21 and up 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.
<b>Homegrown</b>	

## 5. DATA SOURCES

This section provides a summary of the data sources used for the evaluation, including traditional Medicaid administrative data (e.g., claims and encounters, eligibility and enrollment), program-specific data, publicly available data (e.g., national survey datasets), and key informant interviews. Each source and its main purpose for the evaluation is listed in Exhibit 10. 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	Curated Datasets or Reports	Main Purpose for Evaluation
<b>MDW and Related Datasets</b>	CDM OHIP Databooks OMH Dataset	Enrollment, claims-based quality measures, service utilization
<b>SCN Member Experience Survey</b>	De-identified Survey Response Files	Member experience with HRSN screening and services
<b>PCMH Reports</b>	n/a	PCMH related measures may be included in the “related state initiatives” section of the evaluation reports to provide context for findings. These measures are not evaluation outcome measures.
<b>WIO Reports</b>	n/a	Strengthening the Workforce program data, reported by the WIOs, will be used for applicable implementation questions
<b>KIIs</b>	n/a	Qualitative data on program implementation and member experience

### a. Medicaid Data Warehouse and Related Datasets

The State's Medicaid Data Warehouse (MDW) houses enrollment and eligibility data and 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 three curated datasets which were accessed by the IE: the Clinical DataMart (CDM), the Office of Health Insurance Program (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 OHIP Databooks are the main source for eligibility and enrollment information; some OHIP Databooks are publicly available.<sup>22</sup> The OMH dataset is the source for OMH-derived metrics that are not available in the CDM.

### b. Health Plan Reported Data

Health plans in NY are required to report health care data through an annual public reporting system called the Quality Assurance Reporting Requirements (QARR). The QARR is largely based on measures of quality established by the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®) with NY State-specific measures added to address public health issues of particular importance in NY. In cases where the evaluation design included a quality metric that is not available in the CDM but is available in the QARR dataset, the IE accessed the QARR metric results via the Health Data NY portal.

New York provides free public access to curated datasets from New York State Department of Health (NYS DOH) and other State agencies via Health Data NY.<sup>23</sup> The State's data use policy requires that the following disclaimer is included: NYS DOH makes no representation, warranty or guarantee relating to the data or analyses derived from these data.<sup>24</sup> The IE utilized the Health Data NY portal to access the QARR dataset.<sup>25</sup>

### c. Social Care Network Member Experience Survey

The SCN lead entities are required to administer a member experience survey using a template provided by the State. Surveys are sent to each member within 30 days of the conclusion of their services. The SCNs de-identify and aggregate survey responses before submitting the results to the State. The survey questions include ratings of satisfaction with the screening process, the social care navigator, and the services received. Members are also asked to rate the quality of the services they received and to indicate if they agree that the services fully met their needs.

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<sup>22</sup> Monthly New York State Medicaid Enrollment Trends. Available at: [NYS Medicaid Enrollment Databook](#). Accessed on November 6, 2025

<sup>23</sup> New York State Open Data Health. Available at: [State of New York | Open Data Health | State of New York](#). Accessed on November 5, 2025.

<sup>24</sup> New York State Department of Health Data Use Policy Statement. Available at: [New York State Department of Health Data Use Policy Statement](#). Accessed on November 5, 2025.

<sup>25</sup> New York State Quality Assurance Reporting Requirements. Available at: [Quality Assurance Reporting Requirements: Beginning 2008 | State of New York](#). Accessed on September 24, 2025.

#### d. Patient Centered Medical Home Reports

The NYS PCMH program was established by the State in collaboration with NCQA, to further innovation and excellence in primary care. The publicly available NYS PCMH program reports are the data source for the PCMH related measures that may be included in the “related state initiatives” section of the evaluation reports.<sup>26</sup> These measures are not outcome measures in the evaluation design but may provide context for findings. The IE does not currently have access to the primary data source used to generate the reports.

#### e. Workforce Investment Organization Reports

The WIOs are required to submit quarterly reports including individual and program level data on the CPT program, and a narrative update, to the State. The reports include details on recruitment, participation, completion, credentialing, and status and location of service commitments. The WIOs also provide quarterly updates on participating partners, including educational institutions, training partners, and eligible employers for participants fulfilling their service commitments. The data are collected at the time of program enrollment, during ongoing monitoring, and job placement.

#### f. Key Informant Interviews

The IE will conduct a series of key informant interviews (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 will be conducted in the fall and early winter of 2025 and the findings will be included in the Interim Evaluation Report (IER). Wave one will prioritize generating qualitative data on two components of the January 2024 amendment: the HRSN Infrastructure and Services policy which establishes the SCN program and the Strengthening the Workforce policy which establishes the CPT program. The wave one planned KIIs include:

- 9 SCN Lead Entities
- 9 Community Based Organizations (CBO) (1 CBO from each SCN)
- 1 NYS DOH administrator involved in the SCN program
- 3 WIOs
- 3 WIO wraparound service providers or WIO partners
- 1 NYS DOH administrator involved in the CPT program

Additionally, the IE will review the State’s monitoring reports submitted to CMS and conduct structured conversations with NYS DOH administrators to provide up-to-date information on the implementation progress of the additional January 2024 waiver amendment programs: the MHGBI, the HERO, and the SLR program.

The IE will conduct a second wave of KIIs to inform the Summative Evaluation Report (SER). The wave two interviews continue to focus on the HRSN Infrastructure and Services policy, by following-up on first-round interviews with SCN Lead Entities, CBOs, and WIOs and expanding the interviews to additional interest holders in the SCN and CPT programs, including: providers, Managed Care Organizations (MCOs),

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<sup>26</sup> New York State Patient Centered Medical Home information. Available at: [New York State Patient-Centered Medical Home \(NYS PCMH\)](#). Accessed on November 6, 2025.

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: SLR, HERO, and MHGBI.

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 NYS DOH 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 CBOs
- 1 NYS DOH 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 NYS DOH administrator involved in the CPT program
- Up to 10 CPT program graduates/participants
- Up to 6 CPT program placement sites
- 1 NYS DOH administrator involved in the SLR program
- 1 NYS DOH administrator involved in the HERO
- 1 HERO Facilitator
- 2-4 HERO partner or collaborator organizations
- 1 NYS DOH administrator involved in the MHGBI
- 12 hospitals participating in the MHGBI (all participating hospitals)
- 5-10 SUD service providers
- 1 NYS DOH 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.b. Qualitative Analysis.

In collaboration with NYS DOH, the IE will develop and utilize tailored interview guides for different stakeholder types. Semi-structured KIIs last 30-60 minutes, are conducted by video conference or phone call, and maintain privacy protections in accordance with CMS guidelines. Interviews are recorded and transcribed with participant consent for 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 sample topics that will be covered in the KIIs, organized by policy and stakeholder group.

Exhibit 11 Key Informant Interview Topics: January 2024 Amendment Initiatives

Stakeholder Group	KII Topics
<b>HRSN Infrastructure &amp; Services: The Social Care Network Program</b>	
SCN Lead Entities	<ul style="list-style-type: none"> <li>• Perceptions of the January 2024 1115 waiver amendment purpose and goals</li> <li>• Region-specific contextual factors for SCN implementation</li> <li>• Implementation barriers, successes, and progress</li> <li>• Partnership development and network building</li> <li>• HRSN service delivery</li> <li>• Infrastructure and technology</li> <li>• Measuring progress and success</li> <li>• Workforce considerations</li> <li>• Long-term role of SCNs</li> </ul>
SCN CBOs	<ul style="list-style-type: none"> <li>• Perceptions of the January 2024 1115 waiver amendment purpose and goals</li> <li>• Region-specific contextual factors for CBO activities</li> <li>• Implementation barriers, successes, and progress</li> <li>• Barriers or facilitators of member engagement</li> <li>• Infrastructure and technology</li> <li>• Measuring progress and success</li> <li>• Workforce considerations</li> </ul>
SCN NYS DOH Administrators	<ul style="list-style-type: none"> <li>• Perceptions of the January 2024 1115 waiver amendment purpose, goals, contextual factors, and alignment with other state initiatives</li> <li>• Implementation barriers, successes, and progress</li> <li>• Infrastructure and technology</li> <li>• Measuring progress and success</li> <li>• Workforce considerations</li> <li>• Long-term role of SCNs</li> </ul>
MCOs	<ul style="list-style-type: none"> <li>• Implementation experience</li> <li>• Sustainability and integration of the HRSN services in VBP arrangements</li> </ul>
Providers (hospitals, primary care, etc.)	<ul style="list-style-type: none"> <li>• Implementation experience of screening, eligibility assessments, navigation and referrals</li> <li>• Implementation experience with infrastructure and technology</li> </ul>
Medicaid members receiving enhanced HRSN services	<ul style="list-style-type: none"> <li>• Member experience and satisfaction with screening, navigation, and receipt of HRSN services</li> </ul>
<b>Career Pathways Training Program</b>	
WIOs	<ul style="list-style-type: none"> <li>• Perceptions of the January 2024 1115 waiver amendment purpose and goals</li> <li>• WIO structure and staffing</li> <li>• Implementation barriers, successes, and progress</li> <li>• Measuring progress and success</li> <li>• Coordination with other WIO and SCNs</li> <li>• Workforce considerations and regional context</li> <li>• Perceptions of the long-term impact of the CPT program</li> </ul>

Stakeholder Group	KII Topics
WIO Partners	<ul style="list-style-type: none"> <li>• Perceptions of the January 2024 1115 waiver amendment purpose and goals</li> <li>• Partnership role with the WIO</li> <li>• Implementation barriers, successes, and progress</li> <li>• Support service implementation</li> <li>• Measuring progress and success</li> <li>• Workforce considerations and regional context</li> </ul>
CPT NYS DOH Administrators	<ul style="list-style-type: none"> <li>• Perceptions of the January 2024 1115 waiver amendment purpose, goals, contextual factors, and alignment with other State initiatives</li> <li>• The CPT program's role in addressing workforce needs</li> <li>• Implementation barriers, successes, and progress</li> <li>• Measuring progress and success</li> <li>• Infrastructure and technology</li> <li>• Perceptions of the long-term impact of the CPT program</li> </ul>
CPT Participants	<ul style="list-style-type: none"> <li>• Experience completing training and service commitment program components</li> <li>• Impact of the CPT program on career trajectory</li> </ul>
CPT Service Commitment Sites	<ul style="list-style-type: none"> <li>• Experience engaging with the CPT program and integrating CPT participants into their workforce</li> <li>• Impact of the CPT program on the State's workforce</li> </ul>
<b>Student Loan Repayment</b>	
NYS DOH Administrator	<ul style="list-style-type: none"> <li>• Barriers to and facilitators of implementation progress</li> <li>• Perceptions of SLR impact</li> </ul>
<b>HERO</b>	
HERO Facilitator	<ul style="list-style-type: none"> <li>• Strategies for identifying regional and statewide priorities, needs, and solutions around population health and health related social needs</li> <li>• Experience facilitating regional approaches to population health and health related social needs</li> </ul>
HERO Partners	<ul style="list-style-type: none"> <li>• Experience engaging with the HERO facilitator directly or through facilitator supported events or initiatives</li> </ul>
NYS DOH Administrator	<ul style="list-style-type: none"> <li>• Barriers to and facilitators of implementation progress</li> </ul>
<b>Medicaid Hospital Global Budget Initiative</b>	
NYS DOH Administrator	<ul style="list-style-type: none"> <li>• Barriers to and facilitators of implementation progress</li> </ul>
Participating Hospitals	<ul style="list-style-type: none"> <li>• Experience with the global budget initiative</li> <li>• Perceptions of effectiveness of the initiative</li> </ul>

#### Exhibit 12 Key Informant Interview Topics: IMD SUD Demonstration

Stakeholder Group	KII Topics
SUD Providers	<ul style="list-style-type: none"> <li>• Enrollment/participation in the waiver</li> <li>• Perceptions of the impact of residential reintegration services and the waiver overall</li> <li>• Perceptions of SUD provider capacity in the State</li> </ul>
NYS DOH Administrators	<ul style="list-style-type: none"> <li>• Perception of most significant changes authorized under the waiver</li> </ul>

## 6. 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 will be provided such as the measure range, median, and mean. Tests for statistical significance will be provided. The evaluation will also include 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. 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 will include member clinical characteristics and demographics: age, sex, race/ethnicity, and region (NYC versus rest of State). Where applicable, health plan type (MMMM, HARP, HIV-SNP) will also be included as a covariate. Outcome differences across subpopulations will be explored where there is sufficient subgroup sample size. Subpopulation outcomes will be compared to national or state-specific standards or benchmarks.

### b. Qualitative Analysis

The IE will utilize a comprehensive and in-depth approach to analyze the qualitative data gathered through KIIs to ensure the most salient themes and findings are identified. The qualitative analysis process will begin with a review of each KII transcript for accuracy and completeness. Interview transcripts will be imported into a secure, qualitative analysis software for coding and analysis. Open coding, “the interpretive process by which data are broken down analytically,” (Strauss & Corbin, 1990, p. 423)<sup>27</sup> will be initially performed. In vivo coding, the practice of abstracting a word or short phrase directly from the interview transcript, will be used during this process to retain the authenticity of informant statements (Strauss, 1987).<sup>28</sup> Using a grounded approach to analysis, the IE will continually assess transcripts for

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<sup>27</sup> Strauss, A., & Corbin, J. M. (1990). *Basics of Qualitative Research: Grounded theory procedures and techniques*. Sage Publications, Inc.

<sup>28</sup> Strauss A. (1987). *Qualitative Analysis for Social Scientists*. Cambridge University Press.

saturation as defined by the point where few or no new learnings for a given topic were offered by key informants.

Similar codes will then be grouped into first-order categories, and a codebook will be developed through several rounds of iteration between the qualitative coding team. An independent qualitative analysis team member, who will not have previously participated in the coding process, will validate the coding, codebook, and first-order categories. Coders will apply the codebook to the transcripts after establishing inter-coder reliability across several transcripts.

The final phase of the analysis will include organizing the first order categories into similar groups and applying thematic analysis to the codes. Iterating with the extant literature, second-order themes will emerge from the data. Exemplary quotations will be used to support the themes where appropriate. Finally, the IE will use the qualitative findings to contextualize the findings from quantitative analyses where appropriate.

### c. Integration of Findings

The quantitative and qualitative data collection and analysis activities will take place in parallel leading up to each evaluation report. The qualitative and quantitative evaluation teams will review all evaluation findings as a group, to identify and explore areas of convergence and divergence, and identify potential explanations for divergence in the evaluation reports. The evaluation reports will present findings for each research question in an integrated fashion, including both quantitative and qualitative findings.

## D. Methodological Limitations

### 1. TIMING OF AMENDMENTS

The demonstration includes amendments approved during the demonstration period and implemented later in the period, including the January 2024 amendment, IMD SUD demonstration, and continuous eligibility for children up to age six. These initiatives may not generate detectable changes in outcomes within the demonstration period. The IE recommends these amendments, if renewed, be included in the independent evaluation of the any demonstration renewal period as “continuing policies.”

### 2. 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: persons who meet the criteria are significantly different from those who do not meet the criteria. In addition, the policies affecting these groups apply statewide and will not be implemented in a phased-in manner, therefore, comparison groups of individuals eligible for, but not impacted by, the demonstration are not available. An interrupted time-series approach to estimating changes during the post-demonstration is proposed for research questions associated with these populations, which is limited in that it does not support causal inference.

### 3. 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.

### 4. HISTORIC EFFECTS

The impacts of the COVID-19 pandemic/PHE include increased Medicaid enrollment due to deferred redetermination and also affected health care access and utilization. These impacts took place prior to the start of this demonstration period and thus overlap with planned 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. Another relevant historical factor is the adoption of Narcan 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.

### 5. 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 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.

## E. Attachments

### 1. INDEPENDENT EVALUATOR

Consistent with the requirements of 42 CFR § 431.420, New York selected Public Consulting Group (PCG) as an independent evaluator to complete the independent evaluation of the demonstration required under 42 CFR § 431.424. As part of the independent evaluation, PCG is responsible for final measure selection, related evaluation design decisions, gathering new primary data specified in the evaluation design, performing data analysis, and preparing evaluation reports in accordance with CMS requirements. The New York State procurement staff worked with PCG to identify and address concerns that might arise during the administration of the contract. By requiring initial satisfaction of these standards by the contracting party to be awarded the contract, as well as ongoing maintenance of the requirements during the term of service, New York State is in a position to receive an objective evaluation report that is the product of a fair, impartial, and conflict-free evaluation.

As required by CMS and the Section 1115 demonstration's Special Terms and Conditions (STCs), New York conducted an open solicitation process to secure a third-party evaluator to conduct an evaluation of the State's Section 1115 demonstration. The State issued one contract for all evaluation activities and the production of required CMS reports. As the successful bidder, PCG demonstrated the following qualifications:

- Experience conducting program evaluations for programs administered by the federal department of Health and Human Services (HHS);
- Ability to provide at least two examples of program evaluations conducted meeting the above criterion;
- Experience with Medicaid claims data;
- Experience complying with human subjects' protection and data confidentiality laws (state and federal); and
- Experience with quantitative and qualitative evaluation design, implementation, analysis, and reporting.

## 2. EVALUATION BUDGET

The 1115 Waiver evaluation deliverables and corresponding budget are provided in Exhibit 13 below.

Exhibit 13 1115 Waiver Evaluation Deliverables

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

### 3. 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 14 depicts the major milestones timeline for the independent evaluation.

Exhibit 14 Major Milestones Timeline

Milestone	Target Dates	DY24	DY25	DY26	DY27	DY28	Post Y1	Post Y2
		Apr 2022- Mar 2023	Apr 2023- Mar 2024	Apr 2024- Mar 2025	Apr 2025- Mar 2026	Apr 2026- Mar 2027	Apr 2027- Mar 2028	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	
Key Informant Interviews	9/1/2025 to 3/31/2027				X	X		
SUD Mid-point Assessment <sup>29</sup>	11/29/2026					X		
Interim Evaluation Report	Due with the Waiver Renewal Application					X		
Summative Evaluation Report	9/30/2028							X

<sup>29</sup> SUD Mid-point assessment is a separate report; not included in this design.