1115 Medicaid Redesign Team Waiver: Annual Public Forum Transcript
March 26, 2025

Good morning, everyone. Thank you so much for joining us today for our 1115 Medicaid Redesign Team Waiver Annual Public Forum. Before we get started, I will pass it over to my colleague, Georgia to walk through the accessibility features.

Good morning, everybody. Thanks. Good morning, everybody. Today's webinar session does have a few additional accessibility features for those who'd like to utilize them. Closed captions are available. You can activate the closed captions by finding the CC icon in the lower left-hand corner of your screen and click on show closed captions to enable this feature. Additionally, today we do have ASL interpreters available. At the top of your dashboard, you should see Sabrina signing along with us. There will also be another interpreter with us today, Rachel. So, if you'd like to have the interpreters right next to the presentation during today's session, you can move them to your stage. To move an ASL interpreter to the Webex presentation area or stage, you just right click on the interpreter's video icon and select move to stage. This will keep them right next to the presentation. With that, I'll pass it back to Selena to go over today's agenda.

Oh, thank you, Georgia. I will also, I'll pass it to Simone to go over the agenda.

Thank you, Georgia, and thanks Selena, and thank you to our two ASL interpreters Selena, Sabrina, and Rachel. My name is Simone Milos. I work in Strategic Operations and Planning in the Office of Health Insurance Programs at the Department of Health. Thank you again for joining us today. To walk through the agenda, first we'll provide some background information on the public forum format. We will provide an overview of 1115 waivers generally, and New York's 1115 waiver, then we will provide some information on Continuous Eligibility for Children Ages 0-6, New York Health Equity Reform programs, other 1115 programs and pending amendments, and at the end we will leave time for public comment. Next slide, please.

Public forums are required by federal regulations and are detailed in New York's Special Terms and Conditions, or STCs, which are the agreement between the State and the Centers for Medicare and Medicaid Services, or CMS. The purpose of today's public forum is to provide an overview of the 1115 waiver and afford the public an opportunity to provide comments. The recording, transcript, and slides from today's public forum will be available on the MRT waiver website in about seven to ten days. Language translation is also available upon request. Next slide, please.

Section 1115 demonstration waivers grant flexibility to states to implement innovative projects that advance the objectives of the Medicaid program. Under Section 1115 of the Social Security Act, these waivers authorize the Secretary of Health and Human Services to waive certain Medicaid program provisions and regulations and allow Medicaid funds to be used in ways that are not otherwise allowed under federal rules. For example, making certain investments eligible for federal match. Typically, 1115 waivers are approved for three-to-five-year terms. Next slide, please.

The State and CMS come to an agreement on the Special Terms and Conditions, or STCs. The STCs outline the details of the waiver, including waiver and expenditure authorities. STCs specify the State's obligation to CMS during the life of the demonstration, including general and financial reporting requirements and the timetable of state deliverables. The State is required to submit quarterly and annual reports to CMS, and an independent evaluation is completed at the end of the demonstration program. Spending under the 1115 waiver is required to be budget

neutral, and what this means is that spending under the waiver cannot exceed projected costs without the waiver. Next slide, please.

New York's 1115 waiver is called the Medicaid Redesign Team, or MRT waiver. The MRT waiver was formerly known as the Partnership Plan and has been in effect since 1997. The MRT waiver was most recently renewed on April 1st of 2022, and is effective through March 31st of 2027. The goals of the MRT waiver are to improve access to healthcare for the Medicaid population, improve the quality of health services delivered, expand coverage to additional low-income New Yorkers with resources generated through managed care efficiencies, and advance health equity, reduce health disparities, and support the delivery of health-related social need, or HRSN services. Next slide, please.

The MRT waiver authorizes Medicaid Managed Care in New York State. Managed care refers to when a health insurance plan or healthcare system coordinates the provision, quality, and cost of care for its enrolled members. 1115 managed care programs include Mainstream Medicaid Managed Care, Managed Long Term Care, and Institution to Community Long Term Services and Supports, Home and Community Based Services for adults and children, Health and Recovery Plans, and HIV Special Needs Plans. Next slide, please.

And here I will turn it over back to Selena Hajiani. Thank you.

Thank you, Simone. Hi, everyone. My name is Selena Hajiani. I am the Director of the Division of Strategic Operations and Planning, and also the 1115 Waiver Director for the New York Medicaid program. I oversee the implementation of the New York Health Equity 1115 amendment programs, which I will go over shortly. First, starting with continuous eligibility for children up to age six. This past November, CMS approved our 1115 amendment to expand continuous eligibility to allow for it from the time a child is born until their sixth birthday. This allows them to remain enrolled in Medicaid and Child Health Plus, even if there are changes in the family circumstances. It's intended to reduce the number of children that are disenrolled due to temporary fluctuations in family income at annual renewal, for example, and to help keep children connected to the care so that they are set up for improved health and social outcomes later in life. And this can be particularly important, for example, for medically fragile children who would suffer severe detriments if they were not able to continue services. And this continuous eligibility expansion has been in place since January of this year. Next slide, please.

So, in January of 2024, CMS approved our 1115 amendment for the New York Health Equity Reform programs. It will be effective through March of 2027, and will expire with the underlying 1115 waiver. Through this amendment, we have several initiatives working in alignment to achieve more equitable and integrated delivery system. These initiatives include the Social Care Networks, which are coordinating the delivery of health-related social needs services, population health initiatives to improve our understanding of health, behavioral health, social care, and workforce needs across the state through the Health Equity Regional Organization, and to support safety net hospital transformation and transition to global budgeting through the Medicaid Hospital Global Budget Initiative. And finally, initiatives to strengthen the health, behavioral health, and social care workforce, caring for our Medicaid population in New York through career advancement and student loan repayment. And I'll go through these programs more in depth in the following slides.

So, on the next slide we have an overview of the Social Care Networks. So, what is a Social Care Network? They are essentially networks of community-based organizations, providers, and other partners that will deliver health-related social needs services, screening, navigation, to our

Medicaid members. The SCNs are regionally based, intended to meet the unique and diverse needs of our members across the state. The SCNs are run by nine SCN lead entities that are responsible for building the networks, supporting CBOs and providers to provide the HRSN screening and services, also standing up an IT infrastructure to support financial and other data reporting and performing administrative functions. Their job is essentially to make it easier to connect Medicaid members to the services that they need, and also for CBOs and providers to participate in this program. The SCNs were selected this past summer, and the HRSN services went live this past January, so we're in month three right now. There are a range of services covered by the Social Care Networks, screening using CMS' Accountable Healthy Communities Screening tool, navigation, which can include navigation to existing state, federal, and local programs. All members are eligible for screening and navigation to state, federal, and local programs. However, those that are eligible for enhanced services, which I'll go over the criteria in a minute, and are not already receiving nutrition, a duplicative nutrition and housing services through another program would be eligible to receive enhanced care management, nutrition services such as medically tailored meals, housing supports such as tenancy, sustaining services, and rental subsidies, transportation supports to HRSN-related appointments as well. It's important to note that these services are temporary. They serve as a bridge to permanent services, and while these services can't be duplicative of supports that members are receiving through other programs, they can wrap around those services to meet related needs that might not otherwise be able to be met under those existing programs. And you can find a lot more information on our website, which will be on the resource, the link will be on the resource slide at the end. Next slide, please.

So, who is eligible for services? Like I mentioned, all Medicaid members are eligible for screening and navigation to existing services such as SNAP, WIC, food banks, et cetera. However, there are four overall criteria to receive the enhanced HRSN services that are reimbursable through this program. First is a demonstrated social need, second is enrollment with a Medicaid Managed Care Plan, third criteria for one or more of the enhanced populations. Those are listed here on the right; individuals with substance use disorder or serious mental illness, pregnant and postpartum individuals, children under the age of 18 with chronic conditions as well. And finally, additional clinical criteria may be necessary for specific services. This applies to some HRSN services, not all of them, for example, as for asthma remediation, an individual would have to be diagnosed with asthma. Okay, next slide, please.

So, here's the map of the Social Care Networks. Like I mentioned, we have nine Social Care Network lead entities for eleven regions across the state. The Social Care Networks had to apply individually for each region, but some were awarded for multiple regions.

Ok, on the next slide, I will talk, we'll go into the Medicaid Hospital Global Budget Initiative. So, through NYHER, New York Health Equity Reform programs, we are working to enhance provider capacity to participate in new alternative payment models while improving quality of care and population health outcomes. So, this program, the Medicaid Hospital Global Budget Initiative, is designed to advance population health, support the transition to a global budget model, and deepen integration between health, behavioral health, and health-related social need services. Since NYHER began, we have been selected to participate in CMS' All Payer Health Equity Approaches and Development model, which is a total cost of care model, which is also focused on improving quality of care while lowering costs and promoting multi-payer alignment. This 1115 Hospital Global Budget Initiative is intended to help the participating hospitals prepare for the AHEAD model. For example, this year the hospitals have begun building out transformation roadmaps, which include activities and investments meant to support the population health goals, and the global budget transition.

So, on the next slide, we have an overview of the workforce initiatives. The first is the Student Loan Repayment program, which is focused on recruitment and retention for providers in high demand fields by offering loan repayment. This includes psychiatrists with a priority for child and adolescent psychiatrists, primary care physicians and dentists, nurse practitioners, and pediatric clinical nurse specialists. Individuals that receive this loan repayment, that are awarded, would have to make a four-year commitment to working at a Medicaid enrolled provider or serving a patient panel of 30 percent Medicaid and/or uninsured individuals. We're planning to release the applications for this program this summer. We will do outreach to let everyone know that it's coming, prior to the application release. We'll publicize this through our MRT Listserv, so please sign up for that through the Department of Health website, through the Department of Health social media accounts, as well as through partners and other stakeholders. Next, we have the Career Pathways Training program. Oops, sorry Georgia, if you don't mind going back, apologies. And that is also intended to address New York's health, behavioral health, and social care workforce shortage, and ensure that the needs of our Medicaid members are met across the state. The program includes two tracks, those who are seeking to advance in their careers and are already in the workforce, and those who are newly entering the workforce. A key component of this, similar to the Student Loan Repayment program, is that they will have to make a three-year commitment to serve at a Medicaid enrolled provider that serves at least 30 percent Medicaid and/or uninsured individuals. The CPT program launched in October of 2024, and very excited to say that we have more than 1,400 participants enrolled in the last five months. But much of school enrollment happens in the fall, so we're hoping for a big jump coming, in the coming months. In order, if you're interested in participating in the program, please go to our website for the Career Pathways Training program. We have links to all of the Workforce Investment Organization websites. The Workforce Investment Organizations are administering this program, and you can go to their websites to find the interest forms to start the enrollment process.

Okay, and on the next slide we have a map of the Workforce Investment Organization, or WIO regions. We have the Caring Gene Healthcare Career Pathways in North Country, Central New York, Capital Region and Southern Tier; Finger Lakes Performing Provider System in Western New York and the Finger Lakes; and 1199 SEIU Training and Employment Funds in the Hudson Valley, New York City, and Long Island.

Okay, and then on the next slide we have an overview of the Health Equity Regional Organization. We launched the Health Equity Regional Organization in January of this year. We have announced the United Hospital Fund to lead this initiative. They will be responsible for regional convenings, so that we can collect information and have a deeper understanding of the health, behavioral health, and social care needs across the state, data aggregation to serve the same purpose, regional needs assessment and planning to help inform our planning work. We will be developing a statewide health equity plan that will be informed by all of this regional information and finally, program evaluation, which is not the same as our formal 1115 program evaluation, but this is sort of ongoing implementation evaluation and support so that we continuously improve our NYHER programs as we implement them.

Okay, and I think I will now pass it over to Simone to talk about other programs and pending amendments.

Thank you, Selena. In January of 2024, the State received approval for the Substance Use Disorder Institutions for Mental Diseases Transformation Demonstration Program. Historically, funding authorities did not provide coverage for residential treatment. Therefore, individuals were frequently served in higher levels of care than clinically appropriate and care coordination

was fragmented between physical and behavioral health services. Individuals experienced difficulty with transitioning from the hospital or inpatient setting to the residential level of care and often had readmissions to higher levels of care. The State received approval for the residential redesign initiative through this amendment approval. Residential redesign is a cornerstone to New York State's ability to respond to this need by strengthening community service access as an alternative to detoxification and providing recovery-oriented, supportive residential step downs. This demonstration program provides access to high quality, evidence-based opioid use disorder, and substance use disorder treatment services, ranging from residential and inpatient treatment to ongoing chronic care for these conditions in cost effective community-based settings. This includes services provided in residential and inpatient treatment settings that qualify as an IMD. Currently, the Office of Addiction Services and Supports, or OASAS, is supporting the transition from Part 819 residential or medically monitored model, to the Part 820 residential model. The goal is to complete this statewide conversion by February 2026. You also have information on this slide about the Medicaid Buy-In Program for Working People with Disabilities, or MBI-WPD, and Career Pathways Training program, or CPT, amendment. The MBI-WPD Demonstration Program aims to help more New Yorkers with disabilities find and maintain employment while obtaining critical services needed to live and work independently in the community. This demonstration program seeks to establish enhanced Medicaid financial eligibility rules for the program with favorable income and resource rules. The second component to this amendment request makes changes to the approved CPT program. Currently, Workforce Investment Organizations are authorized to provide up to two days of backfill payments to providers for employees attending education or training programs during work hours in order to preserve access to care. We are seeking to amend the current two day maximum to allow for up to five days. CPT participants may require up to five days of backfill coverage for more intensive periods of certain educational programs, while other titles may need fewer than two days of backfill coverage due to less extensive training and educational requirements. This variability highlights the need for a more flexible approach to backfill, based on the demands of the academic program. And we will work with CMS to move this amendment request through the appropriate process. Next slide, please.

This slide contains some resources that may be helpful. The first is New York's 1115 waiver website. Also, the current STCs, or Special Terms and Conditions, a link to New York's Social Care Networks website, a link to the CPT program website, and a direct link to subscribe to the MRT Listserv. If you have any questions or would like further information on the 1115 waiver, you can reach out to us at the email provided here, and that is 1115waivers@health.ny.gov. Next slide, please.

That brings us to the end of the presentation of today's public forum. Now we will move on to the public comment portion. Next slide, please.

I'll provide some guidelines for the public comment process. We have a list of pre-registered commenters. Those individuals will be called on today in the order in which they registered to speak. If you did not pre-register but would like to provide comment, you can either raise your hand or put a message in the chat and we will add you to the speaker list. We will call your name, and your line will be manually unmuted to allow you to provide your comment. We are timing comments. Please limit your comments to five minutes in order to keep the public forum moving smoothly. Written comments will be accepted through April 5th by email at 1115waivers@health.ny.gov or by mail at the address shown here, and that is Department of Health, Office of Health Insurance Programs, Waiver Management Unit, 99 Washington Avenue, 8th floor, Suite 826, Albany, New York 12210. Next slide, please.

As I mentioned, we are timing public comments today. If this slide shows up, it's just to alert the speaker that there's one minute remaining of their five-minute presentation time, and the last slide will just alert the speaker that their time is up. So, with all of that being said, we do have some speakers that have pre-registered, and our first speaker today is Kelly Kading. Georgia, can you please unmute Kelly's line?

Morning. Thank you. Can you hear me?

Yes.

Thank you. All right. Well, good morning, my name is Kelly Kading and thank you for the opportunity to comment today. I'm speaking on behalf of Nutrition4Good. We're a not-for-profit enhanced HRSN service provider, and we contract with several of the SCNs through the NYHER MRT. We provide all the nutrition services covered under the waiver, including all the healthy food provisions and nutrition counseling. First, just want to commend the DOH for the robust and thoughtful design of the waiver. It's clear that significant effort has gone into addressing the complex social drivers of health, and we appreciate the inclusion of nutrition services as a critical component. However, you know, while the waiver allows for nutrition counseling, it doesn't require it to be paired with the food assistance that's offered through enhanced HRSN. We definitely don't want to create barriers for people to access food. That's absolutely critical, but we also can't miss the opportunity to provide education and support needed to drive lasting health improvement. We, you know, we know research shows that access to food alone doesn't change behavior. So, we suggest pairing nutrition counseling with the food provisions instead of making them separate, because people struggle to make food choices that effectively manage chronic conditions like diabetes and hypertension over the long-term. So, as an organization delivering these services on the ground, we see firsthand how impactful it is when food and nutrition counseling go hand in hand. So, if Medicaid is investing in food programming, we want to ensure that investment leads to better long-term health outcomes, which is why we would urge DOH to consider requiring the service to be paired. So, not as a conditional to unlock a food service but offering them in tandem. So, in the immediate term, DOH could provide guidance to the SCNs in terms of referral workflows to make sure that members who are eligible for both services are getting referred in for both to ensure they receive food assistance and are seamlessly connected to nutrition counseling. So, when food and nutrition are, when food is paired with education, not as a barrier but as a supportive service, we see better health or healthcare costs and can impact health equity in our community. So, we would encourage the Department to take steps to maximize the impact of this important waiver. Thank you.

Thank you for your comment. Our next speaker today is Jillian Cohen.

Simone, I’m not seeing Jillian. If they are on the line maybe they could raise their hand, they might be using a cell phone. Otherwise, maybe we can come back if they can pop a note. Thanks.

Sounds good. Thanks, Georgia. Our next speaker is Glenn Liebman.

My name is Glenn Liebman. Hey Selena. I'm the Director of the Mental Health Association in New York State, MHANYS. I've been director for over 20 years. Our organization is comprised of 26 affiliates and 52 counties throughout New York State, and we largely provide community-based mental health services, but we're also very engaged in the community around advocacy, education, and training. There were a few things I want to comment on. First of all, I really, in

terms of what the first speaker said, I agree a hundred percent. We know there's been so much effort and time, and work put into this, and I know you also have to be incredibly flexible with everything that’s going on with the federal government and, you know, it's very much appreciated that you are consistently talking about behavioral health, so that's very much appreciated. So, a few things I want to talk about. I'm largely just going to focus on the workforce piece. That's a huge component of the work that we do. Matter of fact, we're fighting every day now in the budget for a 7.8 percent investment in our sector because we are falling apart. There are crises in the mental health field. It's very interesting, in a world where nobody can agree on anything, 90 percent of people, according to the Washington Post, believe there's a mental health crisis in New York State. So, I think that speaks, across the country rather, I think that speaks volumes to where we are in terms of our understanding of mental health, and also the fact that we don't have the resources. We have a governor who has been very committed to mental health, thankfully. She's been a great advocate for us, but the reality is the workforce has become such an issue for us that we are unable to retain and recruit quality staff. So, with the onset of the 1115, we were optimistic that maybe a part of that could be specifically for behavioral health. And I know it is, and I know certainly we, you know what we're talking about with, you know the things around tuition reimbursement and things like that, it certainly is very relevant, but we were hoping to see a full-scale investment in behavioral health. Of the 646 million dollars for the Career Pathway Training, we were advocating that at least a third of that be used specifically for behavioral health, for mental health and substance abuse because we are in that level of crisis. So, that's one thing we've certainly advocated for. The other thing is, and it gets into the weeds a little bit, but I think it's really important, is specifically, and we've written to Commissioner McDonald about it, is around the 12.5 CPT professional education program, around the career pathway trainings. So again, we were appreciative that, you know, social workers are included, mental health counselors are included, CASACs are included, we think that's laudable and certainly we appreciate it, but there are two categories that are not included in this and those two categories are really vital in our field, and I think that would really help with some of our resource issues. And those two programs are peers. Peers are an incredibly important part of the mental health system and we, they should be recognized as part of the CPT funding because peers are such a dramatic part of the work that’s done. The idea that someone themselves has gone through a lot of the same issues that people are going through now, is incredibly powerful. We know the importance of the peer movement, certainly the New York State Office of Mental Health has really been emphasizing it, and the governor has recognized it as well, so we’re really hoping to see that peers be part of CPT because they’re losing out as, in not being part of it. And the other part of it, this, is the paraprofessionals. You know, we talk about the CASACs and it’s great that CASACs are a part of this, but there is a paraprofessional part of the Office of Mental Health as well. And I know there are ongoing work around this, creating this certification, and I think it’s really important that these folks also be part of this. We need to make sure that paraprofessionals, young people who graduate from high school, don’t know where their career path might go, they do want to be in our field and yet they don’t have the resources to be in our field. They’re not cognizant of the opportunities that are out there for them. And the idea, much like a CASAC idea, is that we get them engaged in our field at a young age, graduating from high school, community college, even four year school, and they have to have those opportunities that will exist for them to be able to transition into our, into careers in mental health, and then have career ladders and they can move up the ladder and then become certified or credentialed as mental health professionals. And that’s really what we were hoping for with you know, with what’s going on in terms of the CPT training. So, we really, we know that time is running out, but we really continue to advocate strongly that those two categories be part of the eligibility for workforce. Thank you very much for your time.

Thank you for your comment. Our next speaker today is Scott Emery.

Morning. Thanks for the opportunity to comment. My name is Scott Emery, I'm the Chief Strategy Officer of Healthy Alliance, a network focused on giving people in our communities opportunities to achieve the best possible health before serious and costly medical problems evolve. We are doing this across 24 counties here in New York State, which includes the three most rural counties, and the only 100 percent rural county in the state, according to the most recent US census. Over the past decade, Healthy Alliance has worked with its historical 450 plus partners to create network of providers that represents the entire healthcare ecosystem, ranging from regional health systems to organizations that render community-based interventions and everything in between, who are connecting communities with high needs and poverty, many of those in rural counties, to resources based on those needs. First and foremost, we fully support the MRT 1115 waiver amendment because it has provided Healthy Alliance, among others, the opportunity to operationalize these kinds of networks. These demonstration periods allow providers who are in the throes and know exactly what needs to be done at the local levels, to show the impact of this work on both a statewide and at a national level, which is more needed today than ever. The counterpart 1115 waiver demonstrations in Arizona and North Carolina, as well as similar models and programs focused on community-based interventions, have proven to produce fiscal savings and upward economic stability, reducing total expenditures and PMPM costs by several points and in lots of cases, millions of dollars. In addition to bending Medicaid cost curves, community-based interventions have also shown reductions in ED visits, inpatient admissions, crisis utilizations, and much more, all of which are traditionally at peak usage in communities with high needs, often leading to overworked providers. Lastly, we're very excited for the opportunity ahead that the MRT 1115 waiver brings, from contracting with partners and screening Medicaid members, to early collaboration with our WIO, to our Social Care Network Council comprised of representation from all HRSN service lines, counties, and provider types to our weekly communication with over 800 organizations. We've already seen signs of success across the three regions that we are responsible for. As we continue to connect historically disparate silos, the innovation of this initiative and investment from the State will improve medical coverage, acquisition and provision, and advancement of quality services, inclusive of non-medical drivers of health services from Medicaid beneficiaries. New York State and OHIP's valiant work to make connecting people and communities to support, based on individual needs via screening and navigation, is a priority and is something to admire for the growth of both our economic, physical, and social care needs. Healthy Alliance is eager to see the anticipated outcomes and benefits here in New York like greater efficiency across the healthcare ecosystem. It generates cost reduction, and better health outcomes, and we are ready to continuously continue the shift to both bending the cost curve and improve health for many years to come. Thank you for the opportunity to speak this morning.

Thank you for your comment. Our next speaker today is JoAnne Ryan.

Hi Simone, I see the JoAnne here. I’m trying to send the request to unmute.

Thanks, Georgia.

JoAnne, you may have to accept it.

Okay, we may have to go on to the next speaker and come back to JoAnne, if that's okay.

No problem. We can come back to JoAnne. Next speaker is Meghan Young.

Good morning. My name is Meghan Young and I'm a SNAP-Ed nutritionist with our SNAP-Ed New York Hudson Valley team. On behalf of SNAP-Ed, I thank you for the opportunity to speak

today. As you may already know, SNAP nutrition education coordinated by OTDA is administered by a network of state and local providers, including the following: local Cornell Cooperative Extension offices, New York State Department of Health, New York State Office for the Aging, Food Bank of New York City, New York Common Pantry, Children's Aid Society, City Harvest, Bronx Works, and Common Threads. Working together, these organizations deliver a variety of important programs to SNAP eligible individuals and qualifying communities to improve the likelihood that persons eligible for SNAP will make nutritious food choices within a limited budget and choose physically active lifestyle. Direct education is our foundation, driving the work we do. Using evidence-based curricula we teach a variety of topics, healthy eating on a budget, smart shopping for vegetables and fruit, healthy meal planning, basic cooking, and food safety skills, and physical activity. We meet our audience where they are at through the creation and strengthening of our SNAP-Ed New York website, social media platforms, over 300 low-cost recipes, food demos, educational videos, and virtual educational opportunities. Some quotes from our participants participating in our direct education: “These classes have been a big encouragement to keep going, find new ways of doing things and improve my health. Eating healthier has actually saved me money at the store. I have been eating popcorn now instead of potato chips and I've been using the dietary guidelines to make healthier choices. I am learning a lot.” Then through our policy systems and environmental change approaches, we go beyond programming to influence community level health promotion in our communities. These efforts include, but are not limited to, our fruit and vegetable prescription programs, farm to work site or community site, and rescued eats. Around the state, there are phenomenal examples of these projects enhancing the communities and lives of the people who live in them. Efforts like these are not done alone, and through our collective and collaborative practices with schools, local DSS agencies, medical providers, emergency feeding programs, farms, farmers markets, and community support agencies, we are able to enhance opportunities for our communities to lead a healthier lifestyle. SNAP-Ed is proud of our ability to bring these partners to the table to strengthen, support, and facilitate change. So, we at SNAP-Ed were very excited about the New York Health Equity Reform amendment, recognizing how HRSNs impact one's health. We hoped it would also offer opportunities to enhance and support some SNAP-Ed PSE efforts where SNAP-Ed funds are not able to do so, like providing vouchers for the purchase of fresh produce in our fruit and veg prescription programs or providing produce for our farm to work community sites. Our community partners were also excited at the potential to enhance and further support the work they do to provide in their communities. We engaged with our SCN from the start and shared near and far with our partners. That was the easy part. To say it was an undertaking is an understatement. The Medicaid world is not one that we are well versed in, nor live in. We are out in our community educating. The same goes for our community partners. Many of our SNAP-Ed implementing agencies and community partners have decided to take a wait and see approach, as they currently do not have the capacity for such an undertaking. With the support of our implementing agency in the Hudson Valley, we completed the onboarding to participate in our SCN’s wave one launch to receive referrals for our FVRx program. However, we have since opted not to participate in the level two referrals for a few reasons. We offer a fruit and vegetable prescription program, not a food prescription program. This terminology seemed to change somewhere along the way. Though we are happy that people are being fed, right? That is very important, and we don't want to take that away from people. We also, it was also cost prohibitive for our implementing agency to provide a food prescription, being weekly vouchers for up to three meals a day, seven days a week, over six months. The reimbursement rate, the weekly reimbursement rate for providing a food prescription for one individual in our region would be $96 a week, equaling $2,496 total over six months of eligibility. If you multiply that by the potential number of participants, that is a big ask for a small community-based organization or agency to pay out weekly while waiting for reimbursement. It's a lot more than the $120 we provide over six months where we provide vouchers after one of each ten

workshops to our participants. At SNAP-Ed, education is our foundation and our FVRx program is no different and we found it very challenging to kind of see a way for the both to mesh well. There was also no clear guidance on what backup documentation would be required to seek reimbursement. Concerns from our partners were: it's a heavy lift, it's not the world they live in, the upfront costs provide the services. There's concern that for-profit groups are waiting in the wings to jump in and provide their services where our community-based organizations cannot. What happens after a person is no longer able to receive these enhanced services? Where do our food rescue partners fall? They are integral part of our feeding communities, but they can't participate to receive reimbursement for food that they provide. People want, our partners want to be involved, but they want someone else to handle the reimbursement piece. That seems overly complicated and too much for them. We are still hopeful to receive HRSN level one referrals to our SNAP-Ed programs through our SCN, we hope that there can be a continued conversations on how we better mesh the two worlds of our medical world and our, you know, community-based organizations to really make these services more impactful and have a positive change within our communities cause, they are really important. Thank you.

Thank you for your comment, and it looks like JoAnne Ryan now has her hand raised. Perhaps we could circle back there.

Can you hear me now?

Yes, thank you.

So sorry about that. Switching between different speakers. Good morning, my name is JoAnne Ryan. I'm the president and CEO of Ronald McDonald House Charities of Rochester. The Rochester chapter was the 128th chapter to open in the world in 1990. We support families receiving care at the University of Rochester Medical Center Golisano Children's Hospital and Rochester Regional Health. There are over 400 chapters located in 65 countries. And while every chapter serves the same mission, they do so with full autonomy, and they can design programs and services that will meet the unique needs of their region. Each has its own governing board and operates as its own 501c3. There are 176 chapters in the US and there are 9 in New York State. The Ronald McDonald House Charities of Rochester offers its full support of the 1115 Medicaid waiver and urges the New York State Department of Health and others here today to continue their support in this commitment to New Yorkers and the nation as a whole. The New York State 1115 Medicaid waiver is transforming how we support families facing Medicaid crises, and the Ronald McDonald House Charities of Rochester is uniquely positioned to advance its goals. This waiver prioritizes improving health care access, reducing disparities, and supporting the delivery of health-related social needs services. Exactly what Ronald McDonald House has been doing for the past 35 years. RMHC supports not only services through the supportive services that we provide, but all CBOs are contributors to the quintuple aim. We are helping to decrease costs, increase quality, enhancing family experiences. We are also helping to support our clinicians, which is decreasing clinician burnout. We are also clearing barriers so that we are helping to provide access to care. These are key contributors to health care outcomes. At Ronald McDonald, we provide services to our 24-bedroom Westmoreland house, and a 7-bedroom house within the hospital, ensuring that families have a safe place to stay which is close to their children while they are in care. This reduces financial and logistical barriers to care while improving outcomes and positively shortening lengths of stay. Our house within the hospital was the fourth to open in the Ronald McDonald world in over 400 chapters located in 65 countries. And now, to this day, is still 1 of 19 throughout the world. This allows families to be with their children who are most critically ill or injured, and to stay only steps away while their children are receiving care. This waiver focuses

on expanding social care services which aligns directly with our transportation supports, meal supports, and also connecting individuals to services, which helps families remain close to their children, which impacts not only the outcomes, but also impacts the family as a whole. Keeping them together as a unit provides for a safe and usually timely discharge, which helps the family to rebound quicker. In 2024, Ronald McDonald provided almost 10,000 family nights at no cost to the family. Our chapter is 85 percent philanthropically funded, and we recognize that recovery doesn't end with discharge. We are newly launching our house to home initiative which is a unique mobile unit that will bring specialized telehealth care, including durable medical equipment, directly into the homes of children who are discharged. These children are medically complex. This aligns beautifully with the eligible child 0 to 6 who are medically fragile. These children historically have had a 20 percent no-show rate post-discharge. The result of that 20 percent has also meant that they are usually high users of both ED and also resulting in high utilization of readmission rates. Those readmission rates result in higher costs and lengthier stays, which also have contributed to more health outcome disparities. By bringing enhanced telehealth through title care and social support directly to families, we are also helping families again to maintain wellness longer. We are also helping to maintain the relationship with their primary physician through title care. These innovative ways of providing services to families are innovation and technology blended to help families to achieve better outcomes. These opportunities also are a way to help New Yorkers to stay healthy. The 1115 waiver presents an opportunity for sustainable and long-term opportunities for families to maintain their best outcomes for their children. Thank you for your commitment to care in New York and our opportunity to partner with you. We are proud to be part of your vision for a better New York and we are proud to be conduits to care. We know that community-based organizations have always been the strong part of wellness, and now it's wonderful to see New York State recognize that in partnership. Thank you for the opportunity to speak today.

Thank you for your comment. Our next speaker today is Beth Richardson.

Hello?

We can hear you.

Okay, perfect. Hi, so my name is Beth Richardson. I am the manager of the New York State Food as Medicine Coalition. We're a group of stakeholders from across the food as medicine landscape, including: research and academia, agriculture, community-based organizations, private companies, as well as policy makers and nutrition people in the government setting. The New York State Food as Medicine Coalition is focused on improving nutrition security as an intervention for improving the health of New Yorkers. We promote communication and collaboration between all areas of food as medicine, all areas of the food as medicine landscape within the state, as well as nationally. The Medicaid 1115 waiver provides such a great opportunity to weave food as medicine initiatives into healthcare and state policy. Our coalition was able to provide recommendations to New York State on the waiver before its implementation. As these guideline, as the waiver guidelines came out, it became apparent that this demonstration waiver reaches a very small subset of the population that would benefit from food as medicine interventions. The increased screening and care navigation will provide a huge help to Medicaid members in addressing their social determinants of health. And with increased screenings and referrals in a narrow population that's eligible for the enhanced services, it's reasonable to expect that there will be increased referrals to existing services such as SNAP, WIC, and food pantries. These services are not receiving increased funding commiserate with the projected increase in referrals and usage. We understand the importance of starting with the most vulnerable community members to make a large impact. However, this

method leaves a large area of opportunity to expand programming to other Medicaid recipients. Any person with chronic diseases such as diabetes or heart disease, will benefit from food as medicine intervention. We already know from Tuft's True Cost of Food, the impact that food as medicine interventions have on both health outcomes and budget outcomes for the health care at large. Nutrition services offered within the waiver have the possibility of having a positive impact on both the New York budget, as well as the health of our community members. So, when thinking of infrastructure around the 1115 waiver implementation, all impacts should be considered to best help the community. Programs such as SNAP, WIC, and food pantries exist outside of the enhanced services of the waiver but will also need increased resources to provide for the new influx of referrals resulting from the waiver screenings and assessment.
So, the question becomes, how is long-term successful nutrition security being formed? Additionally, New York is often at the forefront of healthcare reform, especially in the areas of delivery and accessibility. With proper data and analysis, this demonstration waiver offers the opportunity to highlight an innovative whole person approach to long-term health. And so, are health measures being documented and analyzed? Are we going to show the impact of this demonstration waiver on the health of individuals outside of utilization rates? Thank you so much for your time.

Thank you for your comment. Our next speaker today is Aileen Martin.

Can you hear me?

Yes, we can.

Thank you. Thank you very much. Hi, my name is Aileen Martin. I am the Executive Director at Northern Regional Center for Independent Living. We serve Jefferson, Lewis and St. Lawrence counties, and I'm commenting, thank you first. Thank you for the opportunity to comment. Thank you for the work around developing Social Care Networks. In the North Country, out of necessity, we've kind of been using this model for many years. We have to partner as a community-based organization, partner with our clinical care organizations. We serve any person with any disability of any age as an independent living center, so we're not just focused on behavioral health issues, although we certainly do serve a lot of people who have behavioral health diagnoses, and we work with behavioral health providers for the past 37 years. As excited as we were about the SCN's intent to improve health equity and empower community-based organizations, our excitement has been dramatically tempered because our unique region is participating now in a huge region led by Healthy Alliance, which is a capital-based entity and in charge of a very large swath of New York in terms of the services and the region that it's in charge of. Our concerns fall into a couple of categories and one of them was addressed earlier, that community-based organizations are not prepared to respond in the amount of time that's being offered for the tight deadlines, turnaround times. They're not able to ramp up to services or sustain services while waiting for reimbursement. There just isn't the cash flow, and in terms of running a business, for instance, many small CBOs don't own their own building. They're renting a space which means they don't have capital to use for a line of credit. I mean it's very difficult to expect them to be able to sustain operations while waiting for some reimbursement. Expecting also, in terms of sustainability, that all the CBOs, even most of the CBOs, will be able to maintain sustainability by becoming Medicaid providers I don't think is reasonable. Our organization was a Medicaid provider for about five years and the work that it takes to be a Medicaid provider was not worth the return on investment. In fact, we lost money, and as a mostly grant funded organization, that was very dangerous for us. You don't always get paid what you bill for. Managed care organizations are very good at guarding their resources, and so, your reimbursement could be very late, it could be not at all. It depends on a lot of

administrative work to go into billing something for $17.50. It just doesn't make sense, even if you're looking at it when it becomes, you know a $60 bill at a full hour, and I have to pay three people to bill, chase the bill down, find out why it wasn't paid. It's just, expecting CBOs to do that, it is not reasonable. I don't see the sustainability in it. I also have problems, and I don't know if this is with Healthy Alliance, they're very careful at explaining to how they got to the things that they, the thresholds that they get to, and saying that they're under state guidelines, but, for instance, Healthy Alliance had a ceiling of $3,500 for infrastructure funds per CBO to become engaged. That amount is not high enough to get ramped up. It's just not. We have not, we did the con, you know, we did the, we have a credentialing letter, we submitted our application, we got to this contract, part of the contract and said we can't commit to that because it's not enough to get us up and going. And now there is some momentum funds that could be available, but again, that's an RFP process with a tight turnaround, and it's a reimbursement structure, so if you want me to ramp up to do these other things, it just doesn't make sense. And it represents like three percent of the total North Country infrastructure funds. The other problem really with having a region this large is the lack of representation of North Country in the decision-making body, of the organization of Healthy Alliance. So, I think that it just doesn't work well and needs to be rethought. As the State allocated this, I'm kind of asking the State to look again at how that allocation came down and to reconsider how that came down. Again, Medicaid beneficiaries are the people who will suffer from this if we don't ramp up in a healthy way, so we're nervous about that as well. As I mentioned, North Country community-based organizations are pretty good at creating our own networks and doing the work we need to do because these are our friends and our neighbors and our family. You know, the population here, you know, we know most of the people, so again if the State could reconsider how the network is. Thank you.

Thank you, Aileen. It sounds like maybe there might be some confusion here in terms of the requirement to be a Medicaid enrolled provider. That is not a requirement, that is a requirement of the Social Care Network lead entity, for example. So, if you wouldn't mind reaching out to us through the 1115 waiver email box with questions and maybe we can provide some clarity there. Thank you.

Thank you, and our next registered speaker is Erica Coletti.

It looks like we're having another issue getting Erica unmuted. The request has been sent, but we can try again in a minute. Was there somebody we had to go back to?

It looks like Erica just mentioned in the chat that Scott will be speaking.

Okay.

Or Scott already, the Scott who already spoke? Or a different Scott, if you could just confirm.

Scott already spoke; we can move to the next speaker, Simone.

That brings us to the end of our list of registered speakers. Wanted to check if Jillian Cohen was able to join the line?

I still don't see Jillian, but again, if Jillian is on the line and wants to speak, they could either raise their hand, maybe they're under a different number.

While we wait to see if anybody else would like to speak today who has not pre-registered, please either send a message in the chat or raise your hand, and we can give you the opportunity to speak.

It looks like we have somebody raising their hand, Georgia. And I would just ask when people speak, if you can try to slow down a little bit just to make it easier for the interpreters to follow along, we would appreciate it. Thank you. And Ngozi, it looks like your line may be unmuted.

Okay, now it should work.

I'm unable to unmute myself. I don't see anybody responding.

We can hear you now. You can go ahead.

Thank you. I commend the opportunity to have this public comment, and I heard and agree with several of my colleagues who indicated the challenge that community-based organizations, particularly small ones, are experiencing and trying to engage with this Social Care Network initiative. There are two particular things that I wanted to mention. One, the billing. The billing units was mentioned before, so I wouldn't spend time on that. But we want to acknowledge that the amount of time from our experience in serving clients, screening and getting clients to respond to accept care is significantly underrepresented in the amount of time identified by the 17.5 dollars for that interaction and even the ability to do two screenings with the care navigation is simply, in our experience of the work we've been doing for over 40 years, not a viable and sustainable option for organizations who do not have the resources to supplement this work. The other thing, and I'd like to ask the State to look at that again, and particularly in the times in which we are working now, which was before the 1115 waiver was done, before the new challenges. We're asking the State to consider the implication of the new environment that we're working in where clients who are eligible and need the services that the waiver can provide are rapidly going on the ground, because of the fear of what's happening in our public sector now with the method of operations of the new federal government. It will be harder, and it will take more time to really get clients to respond, even if you've been engaging with them already, and for new clients to trust, to engage and to provide information in the ways that we do it. So, I see a major challenge coming up with the implementation and the targets that those of us who have already identified prior to this time. To me, this is unlikely that small CBOs with low capacity may be able to continue to reach those targets and it needs some consideration by the State and the lead agency for how to address that barrier. And the last thing I want to say is that community-based organizations, particularly the smaller ones that don't have a lot of resources, need to understand how we can move forward in this environment; protecting our staff who will be encouraging, continue to encouraging and serving clients and may also be targeted for questions by law enforcement to give up clients' information that we, maybe not conducive to properly serving the clients or of gaining their trust and we are asking our staff not to give up information on clients without justification, and we are anticipating not just for us, but for the entire industry, that, you know, there are some risks. And so, if the State would give attention to this and, you know, advise the lead agencies or the community, you know, what might be available, it would be greatly appreciated. I'm complete with my statement.

Thank you. Our next speaker is Valerie Bogart.

Valerie is unmuted and should be able to go ahead.

Oh, it looks like she got re-muted again, Georgia. Oh, nope. Never mind.

Yeah, please go ahead, Valerie.

Can you hear me?

Yes, we can.

Okay, alright, took off the headphones that were a problem. Hi, my name is Valerie Bogart. I'm an attorney with the New York Legal Assistance Group. We're a downstate, nonprofit legal services organization. In part, what we do is help consumers access Medicaid and long-term care through MLTC and other waivers. We're very concerned about the CDPAP transition, and I know that's not only in the waiver, it's a state plan service, but 95 percent of CDPAP participants are in MLTC or mainstream plans, so it's very much a waiver issue. It's going to make the workforce crisis, a staffing shortage, much worse. The Department, it has blamed the CDPAP growth for, you know, many things but the fact is we have seen MLTC plans tell their members you have to switch to CDPAP, we do not have staffing in the traditional home care program. And that's what we've seen for the last many years, certainly throughout COVID. So it's going to, it's, and the Department approved PPL with, that is offering very, very poor home, health insurance benefits to its workers and not only are they poor, but they actually prevent a worker from qualifying for the essential plan, which New York is very proud that it expanded the income limit for, except these low income workers won't qualify for it because of technicalities with the Affordable Care Act They're excluded from it because PPL is offering rock bottom, minimal, terrible insurance. So, this is going to exacerbate the workforce crisis more, because CDPAP users won't be able to recruit and retain workers. Now, where does this come into the waiver? New York State has never implemented metrics for MLTC plans or managed care plans to track staffing capacity and timely access. In our written comments, we cite CMS has issued toolkits for states, with recommended evidence-based measures on how managed care plans should be tracking. How long does it take to implement services? What are the gaps in staffing? And other states are doing it, even Texas does it, but not New York. So, it's, that's something that has to be done. In our written comments, we have a lot more recommendations about data transparency. The Step Two Policy Project just cited NYLAG's work. We have an MLTC data transparency project and in agreeing with us that the MMCOR data filed by plans should be made public, not only through a FOIL request, but should be among the data that the state posts on the state, the Open Data website in a way that users can compare plans and understand it. And our report, and in our comments, we cite examples of it, shows ways that this can be done. The public is entitled to know, are some plans not giving any care over eight hours a day? Well, we are, when we looked at the MMCOR data, we found that's true, of not giving 24-hour care, and the State should be looking at that too. Data should be, much better data is needed about rebalancing, from nursing home care to community-based care. And that means reporting how many plans are disenrolling members because of a long-term nursing home stay. We, this has been going on since 2020, but there's no public data on which plans might be discharging more people from their plans because of a nursing home stay and the Department should be looking at that because that might mean they're not approving enough home care. We have a lot of other recommendations. We firmly believe that the OPWDD waiver, TBI, and Nursing Home Transitions waiver should be kept as 1915c waivers and should not be rolled into this 1115 waiver. We think behavioral health services that were carved into mainstream, that didn't, has not worked out well, and those should be carved out again. We think the Department should really examine the entire MLTC model for conversion to a managed fee-for-service model because of the perverse incentives that plans have to enroll more members with low hours. And that's really why costs have gone up. Not because of any fraud by CDPAP. It's really because of the capitation model that has incentivized plans to bring in more and more members

who need little service. They're still eligible, but there are much more cost-effective ways for the state to deliver that care. We also recommend in our written comments, transition rights. When someone has good cause to change MLTC plans, they should have transition rights. They should not be punished, because when they go to another plan, because their first plan has not provided services or because their aide had to be dropped because of the plan's contracting limitations. So, in our written comments we go through a number of places where transition rates need to be protected. Thank you.

Thank you for your comment. Again, if anybody else would like to speak today, please either raise your hand or send a message in the chat and we can unmute your line.

Again, if you'd like to speak, please feel free to either raise your hand or send a message in the chat and we would be happy to unmute your line.

Okay, I guess it looks like we don't have any takers but thank you all so much for joining us today for our 1115 public forum, and for the very thoughtful comments and feedback. You know, it really helps us to think about the programs and how we're implementing them. If you have further comments, please reach out to us through 1115waivers@health.ny.gov, or by mail at the address here on the screen. We will be posting this recording of the session, as well as the slides on our website. So, thank you so much and have a great day.