1115 Medicaid Redesign Team Waiver: Extension Request Public Forum and Public Hearing

Webinar Transcript

January 27, 2021

Alright, I think we're going to get going. It looks like attendee entrances have leveled off around 82. So, with that, Donna, can I have you kick things off?

Good afternoon, everyone, this is Donna Frescatore, New York Medicaid Director. Thank you for joining us this afternoon. Today's agenda, we hope you will find helpful, but we're mostly here to hear from you. Today, Brett and our Waiver Management Team, with the support of our Communications Team, will take us through a short presentation that will include some background on the 1115 waivers, the history if this particular waiver, talk about some of the waiver amendments that have currently been submitted and our plans for extension of the current waiver. Sometimes called the Partnership Plan Waiver, more often call the MRT Waiver, as well as some thinking on future waivers. So, with that, I don't want to take a lot of time here. Again, thank you for joining us and we look very forward to hearing your comments. Brett? Thanks.

Yep, thank you Donna. Hi, this is Brett Friedman, I'm the Director of Strategic Initiatives and Special Medicaid Counsel in the Office of Health Insurance Programs. I will lead today's discussion, in walking through the contents of our current proposed waiver renewal that will be filed shortly with CMS, what it means, what it entails, but as Donna mentioned, this is both a public hearing and a public forum, so that we have a chance to hear from you, as to what your thinking is and what your thoughts are on the contents of this waiver renewal. This is the second of our two public hearings and public forums with regards to the waiver. And we look forward to any comments presented during these hearings or written comments, which we will tell you how to submit if you have not already. A note, this public forum and public hearing is being recorded. Please, if you can go to the next slide.

The agenda today has two parts. It's both a public forum, which is what we do every year during the course of a waiver to hear from the public, and we'll go through what we'll normally do during our public forum. We'll talk about what 1115 waiver demonstrations are, the contents of New York's 1115 waiver, as Donna mentioned called the Partnership Plan, now called the Medicaid Redesign Team or MRT Waiver, and we'll talk about some of the pending waiver amendments that we have in front of CMS currently, most of which are outgrowths from last year's Medicaid

Redesign Team II process. Today's agenda also includes a public hearing, which is a specific opportunity in connection with a renewal application, given the expiration of our waiver on March 31, of 2021, to hear from you about anything to do with the renewal of the waiver and to talk about our current extension request and the approach we're taking. Specific elements of that waiver request, including the Pharmacy Carve Out, the transition of the Pharmacy benefit from Managed Care back into fee-for-service. The Managed Long-Term Care Transportation Carve Out, which is the transition of the non-emergency medical transportation benefit from Managed Long-Term Care into fee-for-service. Potential future amendments, what we're thinking as to future of what we're not submitting to CMS today, but what we intend to submit in the near future. We'll discuss next steps in terms of the public comment process and when we expect the waiver to go in, and then we'll hear from you. Public comments, I think we have an upwards of 30 registered commenters today. We look forward to hearing from you on any aspects of this waiver request process and then anyone else who wants to join. And we'll talk about if you haven't pre-registered, what you can do to make a comment today. So, next slide, please?

This is a special virtual public hearing format, as you would imagine, in normal times, we would have done this in person, in different locations throughout the state to ensure everyone had the opportunity to make their comments in person, if the comments weren't submitted in writing. But with social distancing guidelines, federally and within the state, and due to the COVID-19 pandemic, and with the expressed permission of CMS, to satisfy the public hearing and public forum requirements in federal regulation, we are permitted to hold two virtual public hearing and format meetings using the WebEx platform, which is a real-time audio modality. Whereby, we can record and hear from you. We appreciate your willingness to participate in what is inevitably a different and strange process, which I think we're all becoming very accustomed to at this point. As mentioned earlier, public forums are what we do to solicit comments during the progress of the demonstration project. A demonstration project being the content of our 1115 demonstration waiver, and it affords you, as the public, an opportunity to provide comments on the onlooks of the demonstration, and then the public hearing is specific in connection with a renewal or an extension of a demonstration application and so, we are doing that as well. Serving us both doesn't in fact how you will make your comments, whether its on the existing waiver or the renewal, you should feel free to make any comment you want on the MRT waiver itself and what we're trying to do, which regards to the renewal. A recording and transcript from the hearing and forum will be available on the MRT II Waiver website at a link of which will be in this presentation. We will make it available three to five days after the hearing at it will be transcribed and we will provide language translation upon request for accessibility purposes. Next slide, please?

What is an 1115 waiver overview? Section 1115 refers to a provision in the federal Social Security Act which permits CMS to grant demonstration waivers to states that want to pursue innovative projects that advance the objectives of the Medicaid program. It is a very broad federal authority that New York State has used for more than 20 years to do innovative things in our Medicaid program, and it does that because it gives the Secretary of HHS usually acting through the CMS administrator, the authority to waive certain provisions or regulations, i.e. federal requirements, that apply to the Medicaid program. For example, one state Medicaid requirement is that anything that we do needs to be state-wide, so if we want to do a specific demonstration in a geographic area that's not state-wide, we would need a waiver, or if we want to focus on a specific population with special needs, we would do that through a waiver, as opposed to through our Medicaid state plan. So, in addition to waiving those basic requirements of the Medicaid program to do other things, it also allows Medicaid funds, the Medicaid match, if you will, with 50/50 normal times that's provided where CMS will provide us with federal match on state expenditures that are not otherwise matchable under federal rules. If we want to do things with like DSRIP, where we were paying for community-based organizations services that weren't traditionally matchable under federal authorities, the waiver programs would allow us to do that. Critically, we do not need a waiver to approve federal match on things that are already authorized in the state plan. So, benefits like, transportation or pharmacy, that already existed in state plan authority did not require a waiver amendment in state federal match, but other things like focuses on special populations or focuses on services, those would require a waiver as a pre-requisite implementation. CMS puts very strict parameters on 115 waivers. They typically are approved in three to five year increments, although some waivers approve very recently in are approved in three to five year increments, although some waivers approved very recently in the waited days of the previous presidential administration, approve waivers for upwards of ten years and that's a reflection of federal priorities that are not shared under our waiver. Next slide, please.

Our waiver, and like other waivers, contain special terms and conditions. If you think about a waiver as an agreement between the federal government and the state, the special terms and conditions are, the obligations of the parties under that agreement. They specify the states obligations to CMS during the life of a demonstration, including how we have to financially report or report quality data, and the timetables for those deliverables. It justifies that CMS has to provide us with federal financial participation on those initiatives and specifies any specific quarterly and annual reports that CMS requires, as well as independent evaluation as to whether our demonstration program is achieving the objectives. We've done independent evaluations under DSRIP, we've done it under each component of the waiver as it exists today to make sure and

track whether we're doing what we said we were going to do and it's doing it in the way we thought it would. The other requirement that's general in a 1115 demonstration is it must be budget neutral and so we make a demonstration of budget neutrality and what that means is the federal Medicaid expenditures that are made under the waiver cannot be greater than what the federal government would have paid without the waiver in place. So, if there's a course of a projected federal spend, and if we didn't do the labor, we have to show is part of the labor that the federal government in funding these otherwise, non-matchable services or initiatives, are not spending any more than they would have spent otherwise. Next slide, please?

The New York State 1115 waiver, as Donna mentioned, has been around in various forms, since 1997. It used to be called the Partnership Plan. It was last renewed on December 6th, 2016, towards the end of the Obama administration, and renewed through March 31st of 2021. We are going through this renewal process now because of that March 31st, 2021 expiration date. We are required to extend the labor and undertake this process today. The goals of our waiver are to improve access to healthcare for the Medicaid population, to improve the quality of health care services delivered, to expand access to family planning services, and to expand coverage and to provide coverage expansions, mainly in the family planning services space. Other population expansions are done through other authorities, not through the labor, with resources generated through managed care efficiencies. And we'll discuss it in a slide, but what makes our waiver so critical for the Medicaid program is it is the authorization for Medicaid Managed Care. The fact that a substantial portion of our Medicaid population receives their Medicaid benefits through Managed Care Plans, that is a function of our 1115 waiver. Next slide, please?

The MRT waiver program, as I just mentioned, it authorizes our entire Medicaid Managed Care program, so the fact that article 44 license manage for organizations author conference of health service coverage to low-income or non-attributing individuals, that is a function of an authorization granted through our Managed Care program. Those Managed Care programs include Mainstream for people without special needs, Health and Recovery Plans for people with behavioral health diagnoses, the ability to provide coverage for Home and Community Based Services through Managed Care, as well as our Managed Long Term Care program, that provides a benefit package inclusive of Long Term Supports and Services or Community Based Long Term Care Services. In the past, our waiver has authorized specific programs like the Delivery System Reform Incentive Payment Program or DSRIP. Many of you on this call are probably eminently familiar with DSRIP and how it provided incentives for Medicaid providers to create and sustain an integrated, high performance health care delivery system. We'll discuss DSRIP, but that

component of the waiver expired this past March. We saw to renew it, but that was not approved by CMS last February. DSRIP was a program as part of the larger 1115 waiver, so think of the 1115 waiver as the umbrella under which many of these programs fit. Next slide, please?

In addition to the renewal of the waiver, which is set to expire in the next eight weeks or so, there are a number of MRT II waiver amendments that are currently pending, so within the last six to eight months, we've, and in connection with recommendations made by the second Medicaid Redesign Team that were released last March, we've proceeded to see certain amendments to the waiver that will carry through with the amendment. There was a transition of Behavioral Health Home and Community Based Services to Behavioral Health Adult Rehabilitation Services option that was submitted on September 2, 2020. The Managed Long Term Care Plan Eligibility requirements to add any Dual eligibility requirements. That was submitted on November 10, 2020, and then, Voluntary Mainstream Enrollment for Certain Dual Eligible population, this relates to our integrated care for Dual Eligible initiative, and that was also submitted on November 10, 2020. These amendments are not part of today's discussion. They have already gone through public comment and transparency and have been submitted and are pending review and approval with CMS, but we wanted to let you know that even with the ongoing nature of the 1115 renewal, there are certain programmatic changes that we had in front of CMS that would be reviewed concurrently, with our request for waiver extension and renewal. Next slide, please?

So, what is in this specific extension request? If we could move to the next slide?

Context is helpful because we've done a lot over the last 15 months or so with our 1115 waiver, in hopes of working with the prior administration in making sure the waiver remains in place and keeps our Medicaid program serving the people who are most in need of it. Beginning in November of 2019, New York submitted a comprehensive waiver amendment request, which was both an extension of DSRIP and a renewal of the waiver. It saw to expand DSRIP and then improve upon DSRIP and its promising practices through a four-year extension request. We submitted with CMS, they deemed it complete and started to review it, but in February of 2020, they declined to negotiate the DSRIP extension renewal based on the fact that it did not align with their federal priorities and they didn't want to negotiate, while our waiver was so close to otherwise expiration. So, we hit a roadblock there, which regard to the extension of DSRIP as a significant component of our waiver, as well as to remove the waiver itself. So, we've really been trying what we do today for a very long time. In May 2020, after the COVID-19 pandemic hit and New York was heavily affected, pursing to special CMS authority, we submitted an administrative extension request. So, we said, in light of the pandemic and the fact that our waiver is expiring, we really

want you just to bump everything out by a year, no questions asked. And that was done, so we had more time to plan the waiver renewal in light of COVID and the challenges that everyone across the state was experiencing and to be able to assess the needs of the state, both during the pandemic and as we come out of the pandemic. Again, CMS declined to grant us that one-year administrative extension on our waiver renewal. So, once they told us that in June, we very quickly had to pivot to the current strategy, which was to preserve the waiver and preserve the waiver at all costs. Because if the waiver were to expire, we would have nothing to amend and nothing to think through and help programmatically in the future. So, we started with technical guidance's through CMS, a three-year extension proposal that is, again, simply designed to preserve the 1115 waiver authorizes in hopes we can later amend them for programmatic reasons. And that is what we're discussing here today. This is really the preservation option, which was a reflection of, I think, the prior administration's priorities and their support of what was in New York's 1115 waiver historically. There's not a lot in here, but it's part of a larger strategy in terms of ensuring that we have a waiver to amend in the future. Next slide, please.

With that in mind, we have three components of the current waiver extension request. It's a three-year extension of the Special Terms and Conditions in funding authorities under the current waiver. Nothing programmatic, just change the 21 to 2024. And that gives us more term in which we have to work with the new CMS administration to figure out how to meet the programmatic needs and objectives of Medicaid and for the future. We're also making to technical revisions to the Special Terms and Conditions, in light of MRT II recommendations from last year's budget, which was the transition of the Pharmacy benefit from Mainstream Managed Care to fee-for-service and transition of the non-emergency medical transportation benefit from Managed Long-Term Care to fee-for-service. Those were utilized in this opportunity now to make those technical conforming edits, in light of the MRT II recommendations, but the real purpose of this submission to CMS is really to extend the term. Next slide, please?

As I've relayed many times, the approach extends the current programs and waiver authorities, so Mainstream Managed Care, MLTC, HARP, the Children's Home and Community Based Services that are authorized that aren't under the 1915c waiver, and other programmatic features like self-direction that are authorized under the current 1115 waiver. Other reasons why we chose this approach is it preserves these waiver programs during the change in presential administration. By virtue of the CMS process for waiver extension, we had to start this process dating back all the way to June of last year and with all of the election, being an election year and uncertainty doing a non-programmatic renewal us a chance to do what we had to do, while figuring

out where CMS would be to do other things and more programmatic things. It also provides us just more time to consider longer-term impacts of COVID-19 on the healthcare delivery system. As discussed above, the 1115 waiver is a very broad authority, to achieve many different Medicaid program objectives and thinking through how COVID-19 tested the healthcare delivery landscape, not just hospital providers, but the entire continuum. It gives us a chance to use this authority to think through ways that we can test innovative models to be more pandemic ready in the future. And it also allows pending and anticipated 1115 waiver amendments, like the three I mentioned earlier, which regards to the Duals and eligibility change and the transition of the behavioral health benefits to be reviewed and approved consistent with MRT II recommendations. Next slide, please?

At this point, as we get into the specifics of the Pharmacy Carve Out and the Transportation Carve Out, I'll hand it over to Amir Bassiri, the Chief of Staff for the Medicaid program, and then Greg Allen, to discuss the specific programmatic changes. So, Amir?

Thank you, thank you Brett, and good afternoon, everyone, my name is Amir Bassiri, I'm Chief of Staff to the Medicaid Director. And I will be giving high-level overview of the Pharmacy Carve Out and as Brett mentioned earlier, the Pharmacy Carve Out was a MRT II recommendation and was enacted of April of last year as part of the state fiscal year of 2020-21 budget, with the intent and goal of among other things, providing the state with full-transparency and visibility into prescription drug costs administrative; efficiencies that are available under the fee-for-service system; optimizing of federal rebates through the use of a single-unified preferred drug list; centralizing our negotiating power and leveraging better manufacturer discount; and addressing associated reductions in State rebate revenue due to the growth of the 340B program. Next slide, please?

During budget negotiation in March of 2020, both the state and the legislature recognized the importance of the 340B program for many safety net providers in the state. And as part of those negotiations, there were a few resulting actions. One of which, was to establish a 340B advisory group, which had representation from several different provider groups and geographic regions, and they were charged with providing non-binding recommendations regarding a reinvestment of 340B drugs. That reinvestment was established at $102 million beginning when the benefit was transitioned on April 1 and those dollars are intended to directly support the safety net providers that are in the 340B program and preserve the critical services that they're currently providing to Medicaid members with their 340B revenue. A couple of small points as to the 340B program once pharmacy benefit is transitioned from Managed Care to fee-for-service, many things relating to the 340B program remain as they are today. A few of those things are the fact that covered

entities that participate in the program continue to access and purchase 340B drugs at a reduced 340B price. Any covered entities that have 340B physician administered drugs will continue to receive their margin as physical administered drugs will remain under the guides of Managed Care Plans and they will allow continue to receive any 340B margin they currently obtain from other payors, such as Medicare and commercial insurance. Most importantly, Medicaid members will continue to access their medications, regardless of whether 340B drug stock is used. The tagging of a claim is 340B versus non-340B is not visible to the member and will not result in disruption at the counter when members pick up their medications. I look forward to hearing your comments later in the presentation, and with that, I'm going to turn it over to my colleague, Greg Allen, to talk about the MLTC Transportation Carveout.

Thank you very much, Amir. Appreciate that, and thank you Brett, for a very excellent overview of the complicated waiver topic. I think you both made two very complicated topics, simple. Next slide, please?

This Transportation Carveout really is the culmination of many years of transitioning and working to improve the management of the non-emergency transportation benefit. So, most of you know, Medicaid pays for lives to Medicaid covered services through public transportation, through wheelchair vans or ambulettes and also by taxi-livery. And for several years now, we've been approached by many Managed Long Term Care Plans asking to move the benefit out of the Managed Long Term Care benefit package because for several of them it was smaller and harder for them to maintain a network. Some of their members were transitioning from fee-for-service and have been enjoying that benefit. We have two transportation managers who arrange rides from members consistent with our state regulation across the state. This would basically align the benefit for those members who are Managed Long Term Care to the rest of the Medicaid population. We very successfully, I think, transitioned the transportation benefit out of Mainstream Managed Care, which was much larger several years ago as part of an earlier MRT activity. We've been working to continue to improve that service. We've seeing higher scores in number satisfaction. Tidiness of rides and appointments, better satisfaction with call center. So, we're now moving our MLTC members carefully during the next fiscal year in a phase process into a very well developed, robust, and more consumer-centric system. We are also during this period, not directly related to the MLTC Carveout, but moving from our manager to a broker arrangement. That broker arrangement will allow us to attach quality through our vendor, so the higher quality vendors can be assigned preference, or quality vendors will receive less money and be moved out of network. Again, continuing the promote higher quality and efficiency. This also allows us to

begin to establish more transportation efficiencies as we're moving Long Term Care members, many of whom go frequently to day services, we may have may plans transferring folks to the exact same day services, so we can create efficiencies, create more member comfort also create some savings for the program as well. Just an important reminder here at the bottom, we're not changing the scope of benefits for the transportation program, we're not changing the eligibility for that program. We're not implementing any cost-sharing for members as a result in this. This is just actually changing the overlay and the means by which members would get access to that transportation service. It's online, it's easy to order, it allows us to have a lot more eyes on it. With that, go to the next slide and pass the baton back to my friend and colleague, Brett.

Great. Thanks Greg, thank you Amir. The number one question we've gotten through this process is, what about all of the other stuff that you would want to be doing through the 1115 waiver process? Things like the extension of DSRIP, which I mentioned earlier, was not considered by CMS back in February. Other potential waiver amendments and proposals that have been discussed and circulated in the past. The, as I mentioned earlier, I really can't reiterate it enough, is that this waiver renewal is not to the exclusion of any future programmatic changes. What this waiver does is it is the predicate step to larger programmatic changes that we would want to make. With the diagram on this slide is intended to show is we are going to be developing our longer-term COVID-19 pandemic responses and how those responses inter-lay with the intensive purposes of a 1115 waiver demonstration. We're going to think about ways in which we can achieve further movement to value-based payment, value-based care and global payment pilots that remains consistent with the VBP road map and DSRIP. A long-term strategic goal of the Medicaid program, which hasn't changed, as well as our investment and support of providers and community-based organizations that address the Social Determinants of Health and all of those things are going to get wrapped up in one of more future 1115 waiver proposals that get submitted to CMS once the waiver is renewed. As we think through the future, we wanted to make sure this slide was featured prominently because this renewal process, which is again, an extension and continuation of the authorities authorized under our waiver is not to the exclusion of these longer-term things that still aren't critically important. What makes New York State's Medicaid program an efficient service delivery model for people who are eligible. Next slide, please.

This just takes us to where we are in the extension process. We had published the waiver renewal application and the public noticed in the state register on December 16, 2020. That started the public comment period. By virtue of the federal regulations discussed earlier are two public hearings. We held one last week on January 21 and then today on January 27. We will continue

to collect comments until February 5 or so. February 5 is really the end date. If a comment or two comes in after, we will read it and we will respond to it. And then we will be unmasking all of those comments. We will be thinking about the ways those comments can impact and change any features of the application published on December 16, and then in early March, on or about March 5, we intend to send the completed package that has now gone through the public comment process to CMS. That gives us time before the waiver expires on March 31 to CMS to receive the waiver, deem it complete and allow our waiver to continue. Once the waiver is approved, we will have another three years of term in order to amend and any future amendments can also then further increase that term in the event of the alliance with the larger demonstration project we choose to pursue. Next slide, please.

This is where I will turn the mic over to our waiver management fellow, who will help rate the public comment section. I'll have Phil go through the details, but just to highlight the critical components, I believe, folks registered through the link and those individuals will get priority. We will call on you in the order in which you are registered, but once we go through that list, we will open up the ability for others to make public comments and you can do so through one of two mechanisms on the WebEx platform. The first is, if you look on your WebEx window, you will see a little hand, in the bottom right-hand screen. It looks like a very strange version of a hand. If you click on that, that will highlight your name and we can then call on you in the order in which the hand is raised. Alternatively, if you want to type a question in the Q and A box or indicate in the Q and A box that you have a question. We can use that as a means to call on you as well. And the Q and A box will be downloaded in the WebEx platform so that can also be a written record of the comments you make during this public process. So, with that, I will hand it over to Phil, to walk through any other logistical details before we start running through the registration list. Thank you so much.

OK, alright. Well, thank you Brett. Good afternoon, everyone. Thank you for joining us. If you could advance to the next slide, please?

So, I'm just going to go over a couple of housekeeping details to help guide the public comment portion of our program today. As Brett mentioned, there is a list of pre-registered commenters in the order in which they registered, and we'll be going through that list very shortly. A member of the DOH team will call your name and manually unmute your line to allow you to provide your comment. Please specify if this comment is regarding the current waiver for the Public Forum or the waiver extension for the Public Hearing. Comments will be timed and please limit your comment to ensure everyone has the opportunity to speak. If you did not pre-register, as Brett

mentioned, you can raise your hand of provide a comment in the chat and we will identify you and make sure that you get on the list to speak this afternoon. Written comments will be accepted through February 6 by email at 1115waivers@health.ny.gov or by mail and the mailing address is there on the slide. Next slide, please?

Questions or comments for further information, once again, please feel free to email us at 1115waivers@health.ny.gov. Next slide, please.

This slide is a resource slide and provides some useful links to the MRT waiver website, our MRT II website, Managed Care website, also our Pharmacy Carveout website and our Quality Strategy website. So, feel free to use that as a resource. Next slide, please?

So this slide is just to let folks know that they have one minute remaining on their five minutes, when they're providing their public comment. And we'll be tracking time just to kind of keep everybody on track. Next slide, please.

And then finally, just a time is up slide to let everybody know that their five minutes was exhausted. Okay? Next slide, please. That might be our final slide. Yep.

OK, thank you Georgia. So we have, looks like about 35 pre-registered speakers, and we're just going to start in order of the registration. And I apologize in advance if I mispronounce anybody's name. Your line will be unmuted, and your name is announced. So, with that being said, we'll jump right into public comment and the first commenter is Dan Lowenstein, your mic should be unmuted.

Alright, Dan Lowenstein. Great I'm first in line, that's great. Thank you very much, Donna, Greg and Phil, and the rest of the DOH team. I am Dan Lowenstein, I am Vice President of Government Affairs for the Visiting Nurse Service of New York. We have provided written comments, which will be the basis of my remarks today. Most people know the VNS, we are the largest home and community-based healthcare provider in New York, providing a wide range of services and programs. Homecare, hospice, palliative care, community-based behavioral health, the largest not for profit MLTC plan, the large MAP plan for Dual-affiliated integrated plan for Dual-eligible intermittent eligible individuals and a Medicaid special needs plan for those who are living with or at risk with HIV/AIDS. Over the course of the pandemic, we served well over 4,300 people who lived with COVID since then. I'm going to be brief in my comments. I'm going to comment briefly on the current waiver and then talk about some recommendations for the future. So, first of all, we recognized the DOH has submitted the waiver extension and we support that with the

exception of we do not recommend that DOH move forward with the Pharmacy Carveout for HIV/special needs plans. These plans have developed highly effective care management models that have resulted in higher drug adherence and lower treatment advancement rates, again rates for people living with HIV/AIDS. Removing the billing management Pharmacy benefit will inhibit our ability to integrate pharmacy and medical benefits and this will have implications on our ability to reduce unnecessary hospitalizations, control costs and really affect our ability to evaluate the HIV/AIDS epidemic. Now, as for future waiver amendments, there's a few different recommendations we have. First of all, value-based call and investment quality. We do realize that VBP's matured since where it was a dozen years ago. Patients and providers, it really should be incentive advice to improve quality, but be given the flexibility to develop even models that work and achieve quality and cost objectives that make sense for the populations they are serving. We also think that misuse of the last roadmap was a meaningful input from the home-base and community-based providers and given that more care is taking place in the home and the demonstrated impact on the board of all yard visits and admissions, we think that this is a valuable inclusion that should be in future amendments. And finally, with the expiration of the VBP roadmap, combined with the proposed elimination of the quality payments, the reduction of measures through fewer AIS assessments, there's a real uncertainty about where quality is moving and we need some certainty about how to quality in the Long-Term Care space, to really make this a valuable moving forward. Secondly, advancing Medicare and Medicaid integration. We are very much supportive of where the State wants to go with this. We do think that we can move faster on populations or complex in costs to Medicaid and Medicare, those are Dually eligible long-term care needs, and we think that this existential opportunities through the waiver process to encourage more non-integrated dual eligible MLTC members to join integrated care plans. We also think that DOH should post share in Medicare savings because that is where these benefits are accruing to and maybe pursing an increase where beneficiaries would enroll in integrated care. Third, prioritize and invest in home-base care. As you've seen during the pandemic, more care in the home. That is the theme. More complex care in the home. We know that the CMS hospital without walls program is really gearing up some providers here that are leveraging that. More of a nursing facility level of care in the home would make sense and we know that is going to be an important element going forward. Fourth, investing in the home health work force and industrial technology and IT, the MLTC work force investment program was great. We think it could be streamlined somewhat, but it allowed us to train more than a six thousand home health aids in the core elements of delivering value. Finally, hospice, and we think we established this with you last time, hospice is both compassionate care and saves a lot of money.

Most of the folks who are in need of hospice in Medicaid are dually eligible and we think that there's a good deal of things that could happen if there's some kind of way or program that will allow us to better use hospice for the dual-eligible population and one of those ways and maybe if we can't figure out a way outside the waiver to allow hospice in Medicaid assisted living facilities for those residents who need it. That is the extent to my comments, and I have less than a minute left. Thank you.

Ok, thank you. Next speaker is Cathy Preston. Your line should be open.

Next speaker is Kathy Preston your line should be open. Next Speaker Kathy Preston your line should be open. Are you on? I'm here. OK. Can you hear me? Yeah yup can hear you. Ok thank you very much. Thank you for the opportunity to provide comment regarding the waiver extension today. I am Kathy Preston for the NY Health Plan Association. HPA is comprised of 28 health plans that provide comprehensive services to more than 8 million fully insured New Yorkers including more than 4 million Medicaid managed care enrollees. Our member plans have long partnered with the state in achieving its health care goals. We strongly support the extension of existing 1115 MRT waiver program including the continuation of mandatory enrollment in Medicaid managed care for the vast majority of those eligible for Medicaid the 12 month lock in and facilitated enrollment program. HPA has however serious concerns with the proposed programmatic amendment to carve out for pharmacy benefit for Medicaid managed care in fee-for-servicey service and carve out the non-emergency medical transportation benefit from the managed long term care program. We oppose these changes and believe they undermine the foundation of managed care for all upon which the states 1115 mrt waiver is built and the state goals to deliver comprehensive integrated whole person care. On pharmacy carveout HPA strongly believes the state projections for financial statements are flawed and the carveout actually result in substantial cost increases. Equally critical HPA believes that the carveout will undermine managed care management and impede progress towards value based delivery system. It's also likely to devastate 340B providers who participate in the program. We're particularly concerned about the carveout taking place during a pandemic. The carveout threatens care management. We believe disconnecting the pharmacy benefits from the rest of the Medicaid enrollee's care undermines the states goal to deliver comprehensive integrative whole person care. The carveout creates impediments to value based payments or VBP arrangements. Under VBP the funding for at risk for shared savings is based on total plan premium revenue. The pharmacy revenue is between 27 and 30 percent total premium removing it from the benefit would substantially diminish the pools and funds that could be put at risk lessening the impact of VBP

arrangements and undermining the ability of providers in VBP to ensure the most effective use of the pharmacy benefit. On the financial impact, we disagree with the State's projection savings analysis with the regards to the carveout. We don't believe it appears to fully account for lost premium tax revenue, (inaudible) and we also believe it has over estimated administrative savings. To the extent of the savings doesn't accrue we believe that could create substantial losses for funding for 340B providers. On the MLTC transportation carveout HPA is concern that the transition of this benefit to fee-for-service is an important part of the MLTC plan to coordinate a member's overall care by ensuring that appointments are not missed. HPA requests that the state require the transportation brokers to contract with experience upstate health plan transport networks to utilize cost effective services that are already in place and that concludes my comment. Thank you very much.

Okay thank um next speaker is Amber Decker, your link should be open. Hi Phil, I don't have that speaker on the line at this time. Ok um moving to the next speaker um Doug iorth. Thank you for this opportunity to provide comments on the 1115 MRT waiver extension proposal. I'm Doug Wirth, president and CEO of Amida Care. Amida care is the largest of three Medicaid special needs programs in NY. We serve over 8,300 members who are either HIV positive or transgendered person and homeless New Yorkers both who are placed as higher risk for HIV. Our plan is specifically designed to help people living with HIV access life extending therapy and reduce hospital use associated with unmanaged HIV disease. Over the past 17 years we have developed a strong care management model that integrates pharmacy benefits management into whole person care. Amida Care supports the extension of all whole current programs and authorities in the state's current waiver. But we urge New York State to maintain the pharmacy benefit within managed care. Returning the management of the pharmacy to fee-for-service service threatens the viability of care management in the Medicaid program and the quality of member care. It disrupts progress towards ending the HIV epidemic in New York. It disrupts SNP provider networks and impedes VBP arrangement within NYS Medicaid providers and poses serious concerns for Medicaid spending and budget neutrality. Accordingly DOH should withdraw the programmatic amendment to carve out the pharmacy benefit from the Medicaid management care into fee-for-service in New York State's Medicaid program. Integrated whole person care is the hallmark of New York State's Medicaid reform effort and a critical driver of both efficiency and advocacy. And integrative pharmacy benefit is an essential component of whole person care. Pharmaceutical breakthroughs have not only extended life but have resulted in reduction in hospitalizations and length of stay. Suppression of the HIV virus through early and persistent HIV therapy not only improves individual health outcomes but eliminates viral transmission. HIV-SNP

expert pharmacy staff serve as a single point of contact for physicians and members. Direct management of the pharmacy drug benefit results in critical real time insights into members health. Prescription drug claims are processed at the point of service virtually eliminating any lag in data compared to other services. Barriers to access can be quickly resolved and often in real time reducing the possibility of disruptions in treatment and initiation adherence and persistence. Removing the pharmacy benefit at myriad vary points at plans per view will erode our ability to manage members health care efficiency and effectively and harm our members. In a fee-for-service service environment members and providers will call a general call center oriented towards the needs of the general population with the risk of delayed responses and or multistep processes to reach an informed resolution. Delays and missteps in processes risk disruptions and care treatment interruptions ultimately viral transmission. Especially in populations struggling with mental illness and multiple chronic conditions. This disruption will be compounded by the destabilization of the SNP provider network that largely consists of community health centers and disproportionate shared hospitals. These providers would no longer be able to leverage the 340B drug discount program and tap into pharmaceutical companies' discounts to fund uncompensated care and care expansion and impoverished community. Unintended consequences of loss of these critical resources have not been factored into the State's analysis of the cost and savings associated with fee-for-service service management of the pharmacy benefit providers stand to lose $250 million annually and frontline workers and recipients will bear the burden of lower staffing and fewer services. The carveout is also contrary to the value based payment roadmap which DOH committed. Removing this benefit from managed care will inevitably shrink the pool funds that can be put into VBP arrangements with providers lessening the breathe and impact with VBP arrangements in NYS Medicaid program that were committed to under the special terms and conditions of the 1115 waiver with CMS. Providers in VBP arrangements is often focused on ensuring efficient use of the pharmacy benefit and rely on pharmacy claims data just like plans managed care. Our deepest concerns, the full cost to these disruptions have not been fully factored. In addition to not factoring into the cost of the limiting critical safety net services the State is not fully considered the finding of several studies demonstrating the carveout approaches result in higher drug cost. In conclusion, we recommend DOH halt its effort to carveout the pharmacy benefit for pharmacy Medicaid plans. We make this recommendation with the profound desire to strengthen the Medicaid program which is allowed Amida care and the SNPs to contribute towards the ending the HIV epidemic in New York.

Ok, thank you. Next speaker is Lyndel Urbano your line should be open. Good afternoon my name is Lyndel Urbano. I'm the Director of public policy at Amida Care. Thank you for the opportunity

to provide comments. Amida Care supports expansion of as Doug said a moment ago he supports the extension of services and programs under the existing waiver. But we urge New York State to maintain the pharmacy benefits within managed care. This policy change was adapted during a hurried Medicaid redesign process that severely impacted by New York shutdown and response to COVID-19 and without adequate stakeholder input. Changes to the carveout carve in administration of the pharmacy benefits should not be pushed through in a hurried manner and in the face of broad cross specter opposition. Rather the proposal should be withdrawn and postponed for consideration, if at all, along with the plans of the 1115 demonstration package. This is especially critical given the unintended inevitable of the carveout loss of $250 million in 340B program savings that are necessary to support access retention and persistence in care. These beneficiary services have no alternative needs support and the departments effort provided time limited partial decision of fund which resulted in stalemate providers and others experts who remain united in opposition. Carving management out of the pharmacy benefits out of managed care disrupts the whole person care and puts at risk headway made in ending the HIV epidemic, weakens healthcare delivery systems, and erodes readiness to respond to COVID-19 and future health public emergencies. It also disrupts performances such as value based payment arrangements and proven methods to reduce fraud, waste, and abuse. We are concerned at the full cost related to these disruptions that have not been fully factored. In addition to not factoring the cost of eliminating the critical safety net services provided by 340B, the State has not fully considered the findings of several studies that demonstrates the carveout approaches result, that result in higher Medicaid drug cost. This failure to accurately to the savings is especially concerning in light of the overarching requirements of the 1115 waivers to demonstrate that Medicaid spending be budget neutral. According to survey conducted by PHP and HVA the Mendes group found that 2019 for example NYS saved 21.4% relative to the rest of the country for plan paid prescription. The analysis also found that the carveout the pharmacy benefit in fee-for-service is estimated to cost New York's Medicaid program $285 Million during the first year of implementation. This amount grows to about $1.7 Billion of the cost, uh, over time, over five years. Justifications for carving the benefit out include both greater transparency into the drug supply chain and greater bargaining power for centralized drug purchasing. New York State and it's Medicaid Managed Care Plans have already succeeded in enhancing transparency to the elimination of PBM price spreading, spread-pricing. Despite the (inaudible) appeal of greater bargaining power resulting in greater drug discounts the State is predicting only 1% increase in the supplemental rebates that can result from such greater bar purchasing power. In addition, New York State already has tools such as the pharmacy spread-tax pricing cap and (inaudible)

the process that enhances power to secure supplemental rebates. The vast majority of the increase in the State's rebate revenues is actually coming from a transfer of the 340B drug discounts from community health centers, hospitals, and other safety net providers to the State. With this new policy drug manufacturers would simply redirect the benefit so the discounts they currently give to hospitals and community health centers to the State. The savings are not at the expense of manufacturers. But rather our front line workers and health centers and hospitals. We urge the State to engage with stakeholders in a more ah, we urge the State to engage with stakeholders in a more open and less time constrained process to develop other policy measures and tools that are, that are possible in the carved-in environment. The MRT process was constrained by time and the epidemic. The 340B advisory group process was constrained by a refusal by the State to consider alternate savings mechanisms. The group has been unable to reach an agreement with the State. Certain disruption to these savings is not a condemnation of the benefits of the Medicaid program overall, nor its beneficiaries. Accordingly, DOH should halt this effort to carve-out the pharmacy benefit from managed plans. The pharmacy carve-out in New York State threatens the viability of care management in the Medicaid program and the quality of member care, impedes VBP arrangements for New York Medicaid program providers and poses serious concerns for Medicaid spending and budget neutrality. Thank you for this opportunity to provide comment.

Thank you. Next speaker is Rose Duhan. Your line should be open. Thank you, good afternoon, I'm Rose Duhan, CEO of the Community Health Care Association of New York State. I want to thank my colleagues that have commented already, Dan, Kathy, Doug, and Lyndel and echo their concerns with an opposition to the pharmacy carve-out. On behalf of the 70 health center members of the Community Health Care Association of New York State thank you for the opportunity to testify on the State's MRT 1115 Waiver Extetension Request. The Community Health Care Association is generally supportive of the intent of the waiver to improve the Medicaid program and ensure access to healthcare for those who need it most. But we have grave concerns about the Medicaid Pharmacy Carve-Out from managed care to fee-for-service. The 340B program allows covered safety net providers, including community health centers, to purchase pharmacy drugs at reduced costs. Community health centers reinvest the savings into initiatives that expand access to care, particularly for the uninsured. New York State community health centers. provide care to about one third of all uninsured individuals in New York State. Services supported by 340B include free or extremely low cost drugs, transportation vouchers, non-medical services such as food pantries and intensive outreach which is particularly critical during the pandemic to those that have been isolated, such as follow-up needed for chronic disease

management and ensuring children do not fall behind in their regular vaccines. 340B reinvestments directly support the State's robust COVID-19 vaccination program currently underway. Our health centers use 340B savings to support unfunded costs such as conducting vaccine related outreach and education, vaccinating behavioral (inaudible) organizational staff and standing up large-scale community vaccination events. Without 340B people most adversely impacted by the pandemic would not have access to vaccines in their community. The proposed change will result in enormous financial losses, programmatic reductions and staff cuts for impacted providers in the middle of this pandemic. Perhaps what is most devastating is that the carve-out will have the biggest negative impact on the health outcomes of the States sickest and poorest communities. The very patients hit hardest by COVID-19. Community health centers have been working non-stop to test and vaccinate patients in their communities regarless of the fact that much of the work is not reimbursed. Community health centers are stepping up to meet the demand of county, city, State, and federal governments all the while continuing to provide high quality primary and preventive care and dealing with the physical and emotional toll of the pandemic. This carve-out will have devastating and lasting effects on the health care safety net at a time when black, brown, and poor community members and providers can least afford it. Based on last years data, community health centers alone stand to lose a collective $100 Million dollars per year. The State has proposed a one time investment of $102 Million dollars, an amount insufficient to replace all the funding lost by 340B providers. Now and into the future we have seen as this economic crisis growth rose in Medicaid enrollment and uninsured populations that benefit from this program. This one-time funding is woefully inadequate given the losses to safety net providers at a time when they can least afford it, and does not provide a long-term solution for sustainability. The 340B program is a well established mechanism created by Congress to ensure safety net providers have the necessary resources to expand uncompensated care programs and adequately care for their patients health and health related social needs. It is not contingent on State budget fluctuations and cuts. It is unacceptable that New York would include this carve-out in its waiver extension request during the most significant public health crisis in modern history. Including the pharmacy benefit carve-out will undermine the overall success and goals of the State's 1115 waiver and undermine the State's response to the novel Coronavirus pandemic. The State's overarching goals of the 1115 waiver extension are to reform access and quality in the Medicaid program. But the Medicaid pharmacy benefit carve-out will not achieve these goals. We respectfully urge the Department to remove the pharmacy benefit carve-out from the 1115 waiver extension request. Thank you.

Alright thank you. Nest speaker is Letisha Gibbs. Your line should be open. Hi Phil, we don't currently have that speaker on the line. Ok, thank you. Next speaker would be Brooke Brailey. Hello, thank you. My name is Brooke Brailey and I'm the Director of Administration at the Alliance for Positive Change in New York City. Thank you all and New York State Department of Health for the opportunity today to deliver remarks about the 1115 Waiver Extension Request. My organization, the Alliance for Positive Change, has been on the front lines of the HIV-AIDS epidemic for thirty years. We have decades of experience providing services to individuals living with multiple chronic and complex health conditions such as HIV, Hepatitis, substance use, mental illness and other behavioral health challenges. And we remove barriers to accessing testing treatment and care. The Alliance is generally supportive of the Waiver's extension request. However, we are very concerned about the pharmacy benefit carve-out from Medicaid managed care to fee-for-service. The inclusion of the carve-out would be devastating to the health care safety net including Ryan White providers like Alliance who benefit from the federal 340B program. Alliance ensures that over 800 New Yorkers living with HIV-AIDS have consistent access to life-saving medications and treatment adherence support. All made possible by using 340B savings. Alliance reinvests 340B savings to expand access to counseling, support groups, direct observational therapy, incentives. food and nutrition programs, transportation assistance, peer navigation to medical care, and support services for Alliance's 6,000 registered clients. The augmentation of 340B savings ensures New Yorkers adhere to medication and achieve improved health. As the director of Alliance's dedicated Treatment Adherence Program, I am proud of our 95% durable viral load suppression rate among participants. Because of peer counseling and case management and support services made possible through 340B savings, we are able to help New Yorkers adhere to HIV medications and directly contribute to New York State's efforts to end the HIV-AIDS epidemic. I recently spoke to one of our clients who told me how thankful he was to have Alliance's treatment adherence services. As a young Latino who feels more comfortable speaking Spanish he reached out to thank our bi-lingual team saying, "Thank you for taking such good care of me, especially in these hard, hard times." He told me how attentive, kind, caring, and accommodating our team is. And said, "without a doubt they are saving my life. Of all the conditions I deal with, it makes such a difference and it doesn't go unnoticed." He's talking about the phone calls to check in during the pandemic, the added support to help our clients keep up with their medications during these stressful times, and the tailored, non-judgmental support he receives because of 340B. The people we serve come from communities of color, and communities hardest hit by the COVID-19 pandemic. If the carve-out were to move forward, these services our clients have come to rely on would be eliminated and our ability to respond to COVID-

19 threatened. As we have heard today, what the Department of Health has stated the carve-out will achieve, $87 Million State savings in fiscal year 2022, but will likely result in approximately a $245 Million annual loss to the most vulnerable health care providers in the State. The Mendes Group has also refuted the State's projected savings, largely due to the increases in avoidable emergency and inpatient costs. If savings aren't the point, what's the point other than to make it impossible to preserve the health care safety net. Respectfully I urge you to reconsider this plan and remove the pharmacy carve-out from the State's 1115 waiver extension request. Thank you for this opportunity. Respectfully, thank you.

Ok, thank you. Next speaker, Christine Tarnowski, your line should be opened. Good afternoon. Thank you for the opportunity to speak today regarding the 1116 waiver request. My name is Christine Tarnowski and I'm the Associate Executive Director with the Albany Damien Center. The Albany Damien Center is a community based 340B entity that provides non-medical services and uses the 340B savings to provide meals, housing, and transportation and access to medication and medical appointments for hundreds of individuals with HIV and AIDS living in the upstate Capital Region. These services are critical for keeping people with HIV and AIDS on their medication to reduce their HIV viral load, which reduces their mortality from AIDS and prevent the transmission of new HIV infections. We are strongly opposed to the 1115 waiver request and this waiver is a deviation from federal law with respect to the New York State Medicaid program as it applies to the 340B drug discount program. The State is requesting to carve-out Medicaid claims for 340B entities starting on April 1st, as you know. This carve-out proposal contained in the State's waiver request would have substantial and harmful impacts on numerous providers like the Albany Damien Center. But more importantly, for the people we serve. This MRT proposal is not only a deviation from federal law but worse, it undermines the benefits and purpose of the federal 340B program for underserved communities during an unprecedented pandemic. It also denies the Executive Order just signed by President Biden on January, 20th on advancing racial equity in support for underserved communities through the federal government. As an overwhelming majority of the people we serve under our 340B program are from very low-income, black, and brown communities. The MRT waiver request degrades equity within our healthcare delivery system and it's certainly a racial justice issue. Any part of the 1115 waiver that is in violation of this executive order, should be rejected. As stated before the State has offered $102 Million dollars to help all of our 340B agencies. However. this amount does not even come close to the estimated $250 we are set to lose. And additionally, as of today, we still have no real information about when or how this funding will be dispersed which greatly impacts our ability to adequately plan for an event that will happen just a matter of weeks away. We also disagree that people will

still have adequate access to their medication. We are the agencies that help those people with multiple barriers get and take their medications. If someone does not have food or housing or mental health support or substance abuse treatment they will never obtain access or take their medication. If you take agencies like ours out of the picture, as the carve-out will ultimately do, you will actually see higher Medicaid costs due to increases in avoidable ER visits and hospitalization. In conclusion, we are requesting the rejection of the 1115 waiver in order to prevent the loss of life and destruction of our State safety-net that will result from these changes to the 340B. Thank you again for the opportunity to speak today.

Ok, thank you. Our next speaker, Elizabeth Perez. Next speaker, Elizabeth Perez, your line should be open. Ok, we will move to the next speaker, Anthony Randolph. your line should be open. Hello, can you hear me? Yes, good afternoon, my name is Anthony Randolph and I want to make a comment on the State's MRT 1115 Waiver Extension Request. I'm a member of Amida Care HIV Special Needs Program, and I receive services from Harlem United, located in New York. I'm concerned that the State is seeking approval to carve-out the Medicaid Pharmacy Benefit from managed care to fee-for-service. This change will put live of Medicaid recipients like myself, and thousands of others, at risk. Community health centers like Harlem United and my health plan, Amida Care work together to make it easier for me to stay in care by resolving problems when they come up. Without any unnecessary delays. I was sick and I was having trouble filling a prescription that the doctor gave me. And I needed it immediately. I didn't have anywhere to turn, the pharmacy wasn't going to fill it. I called Harlem United to my caseworker. And while I was sitting in the pharmacy they called Amida Care who got in touch with my doctor, who got in touch with the pharmacist. They had experience with this. They've seen it before. When the pharmacist approached me again I thought he was going to ask me to leave. Instead he said my prescription would be filled in about fifteen minutes. Under the carve-out, Harlem United and Amida Care would not have been able to help me directly. Instead I would have had to call an 800 number with thousands, and thousands of other people. And by the time they got to my issue, I probably wouldn't have needed medication, it would have been too late. I can't understand why the State would make a change that would make it harder for me, and my community, to access care. Especially in the middle of HIV epidemic and Corona 19 pandemic that's affecting low-income black and brown communities like mine. The change will prevent health care centers from benefitting from the federal 340B drug discount program, resulting in loss of funding for the very services we need in the community. If this plan goes through, I worry that Medicaid recipients like me will get sicker and have to use the emergency room more often because lost access to coordinated care from the special needs program and community health centers like Harlem

United. So I ask the people in power, how much is my life worth to you? I also challenge you to save lives instead of saving dollars. Talk to the people that's on the ground that knows what is going on. Talk to Doug Wirth, Patrick McGovern from Amida Care. Talk to Jackie Kilmer, to (inaudible) McPherson from Harlem United. These people are on the ground everyday saving lives. Give them the tools that they need to help us live better. I thank you very much.

Ok, alright thank you. Ah, the next speaker, Charles King. Hi Phil, I do not have that speaker on the line but Elizabeth Perez did reach out, she was having some audio issues so we can try unmuting her again if you'd like to circle back. Sure thank you. Okay, she is unmuted. Ok, Elizabeth Perez, your line is open. Elizabeth Perez, are you on? Your line should be open. Ok, maybe we can circle back with Elizabeth. Hello? We can try to circle back with her, I'll connect with her offline. Ok. Next speaker then would be Charles King. Charles King is not on the line. Ok, how about Matthew Bernardo? Is Matthew on? I do not see Matthew on the line either. Moving to William Smith-Rivera. Is William on? Give me just one second on that one Phil, I'm looking for William right now. I do not see William on the line. Ok, moving on to Sean Philpott-Jones. You're the next speaker, your line should be open. Sean, are you on? Hi, can you hear me? Hi, can you guys hear me now? We can, thank you. Hi, good afternoon, my name is Dr. Sean Philpott-Jones. I'm the Vice President for Government Relations and Grants Management at Hudson Healthwaters Health Network. On behalf of Hudson Healthwaters, I am grateful for the opportunity to provide public comment on the State's 1115 MRT Waiver Extension Request. We are supportive of the waiver's intent and its extension. However, we oppose the inclusion of the pharmacy benefit carve-out because of the negative impact on safety net providers across the State. This change will hit federally qualified health centers or FQHCs, Ryan White clinics, disproportionate share hospitals, and sole community hospitals particularly hard. Hudson Headwaters has served the Adirondack and North Country regions of upstate New York as an FQHC since 1981. Like all FQHCs, Hudson Healthwaters mission is to ensure high-quality healthcare to all regardless of an individual's insurance status or their ability to pay. Our service area is roughly the size of Connecticut, approximately 7200 square miles and mostly rural. We provide care to nearly 100,000 unique patients at health centers offering primary and select specialty service, as well as dental and behavioral health visits. We are the largest primary care provider in this region and we are recognized locally and nationally as a leader in primary care. In many towns Hudson Headwaters is the sole medical provider. Health disparities in our region are mainly a matter of economic means, education, and age. The area is challenged economically with a significant reliance on seasonal employment. And we have chronically high jobless rates. The area also has a large elderly population. It is second only to southwest Florida in terms of the

number of residents 65 and older. Finally, the region has been hit hard by the opioid abuse epidemic. Our patient population, not surprisingly, has very high health care needs. To support the services we provide to these patients we rely on various public and private funding sources. Like many FQHCs, one of our most important funding sources is the 340B drug discount program. The savings generated from that program account for nearly a third of our direct patient care expenses. FQHCs like Hudson Headwaters are good examples of the difference that 340B makes in patient's lives. Besides providing medication discounts and other financial assistance programs for uninsured or low-income patients, 340B revenues support core programs and services consistent with the FQHC mission including dental care, home-based care, obstetrics and gynecology, and palliative care. The revenues also offset the costs of COVID-19 testing and vaccination clinics. And finally, at Hudson Headwaters, we use our 340B savings to improve infrastructure, renovate facilities, and expand services into areas with limited or no local access to care. Many FQHCs around the State do the same. Providing medical care to underserved communities that would otherwise go without. New York's proposal to carve-out the pharmacy benefit will cause many health care organizations, particularly those that serve a large number of Medicaid eligible patients, unable to profit from the 340B program fully. As a result, 340B covered entities statewide will be forced to cut back or eliminate essential patient services and programs. Likely cutbacks include: provider, nursing, and care management staffing; eliminating assistance programs that ensure access care and prescription drugs for low-incomes patients; reducing home-based health services; restricting access to vital specialty services; and slowing expansion into underserved communities. As already mentioned, we support the State's goal of reforming and improving the Medicaid program while containing costs. However, the pharmacy carve-out benefit. or benefit carve-out, will not achieve these goals. The Department of health has stated that the carve-out will achieve about $87 Million in savings in FY-2022, or less that 1% if the current projected budget deficit. However independent analysis suggests that this will result in an approximately $245 Million dollar annual loss to safety net providers. New York's FQHCs alone stand to lose a collective $100 Million dollars a year. Admittedly, the waiver extension does include an investment of $102 Million to support entities that currently benefit from the 340B savings, recognizing the negative impact of the carve-out on safety-net providers. That's enough to cover the anticipated losses of New York's FQHCs in the first year. However, the waiver does not include distribution methodology and this funding is to be shared by all covered entities, not just FQHCs. Thus, this funding commitment is inadequate given the enormity of the safety-net providers potential losses. The carve-out is not a long-term solution for sustainability and certainly not now. Doing so denies 340B eligible health care providers like FQHCs, Ryan White clinics,

disproportionate share hospitals, and sole community hospitals, access to crucial savings during the worst pandemic in over a century. We thus respectively request that the Department remove the pharmacy carve-out from the MRT 1115 Waiver Extension Request. Thank you for your consideration.

Alright, thank you. Next speaker would be Kenneth Desa. Your line should be unmuted. We don't have Kenneth on the line. Ok, moving on to Andrea DeMeo. (inaudible) (screeching sound). Is Andrea on? (screeching noise) Georgia, do you have Andrea DeMeo in your queue? I do but there is some audio issues with her connection, she's got some feedback. (screeching) Ok, perhaps we should circle back to Andrea. Ok, next speaker Aarathi Nagaraja, your line should be unmuted. Do we have Aarathi on? I am looking for her right now, one second. I do not see that speaker on our list. Ok, moving on to the next speaker, Giselle Hearne. She does not appear to be registered but she is on our list. Are you on? And Georgia... I do not see her on the list. Ok, moving on to our next speaker, Jacqueline Chiofalo. Is Jacqueline on? Jacqueline is on, I'm just having an issue with this. Ok, she should be unmuted. Hello. Is Jacqueline on? (inaudible)

My name is Jacqueline Chiofalo. I am speaking to you on behalf of the Institute for Family Health, a network of 32 secondary qualified health insurers in New York City and the mid-Hudson Valley. The Institute co-founded in 1984 by Dr. Neil Calman, President and CEO, provides primary care, oral health care and behavioral health services to approximately 116,000 patients in low income, urban and rural communities. Most of our patients are publicly insured through Medicaid or Medicare, about 30% are privately insured and roughly 15% lack insurance of any kind.

The institute responded quickly to the COVID-19 pandemic providing both telehealth and in person services as well as aiding our hospital partners to care for hospitalized patients.

Now we are actively vaccinating our patients and other eligible community members as quickly as the vaccine supplies permit.

Thank you for inviting me to testify on the 11/15 Medicaid redesign team Waiver extension.

We are extremely concerned with the inclusion of the pharmacy benefit carveout from Medicaid managed care to fee for service model. Should this proceed, the institute will not be able to provide medications to our patients who lack insurance and we will have to scale back outreach programs and other care coordination activities made possible by the savings accrued from the 340B program. The 340 B program is crucial for our mission to providing high quality care and accessible care for our patients. In addition to providing medication to patients who lack

insurance, savings achieved are ultimately used to provide essential care coordination, community outreach and other specialized services to our patients and communities. Simply put the 340B program has allowed us to reach out and care for our most vulnerable patients including those who are experiencing homeless and those affected by HIV and AIDS. To our knowledge, the State has not provided any assurance that our vulnerable communities will still be able to access these services. The Governor's proposed allocation one-time investment safety net and __will not substantially cover the breadth of services we provide as a result of the 340B program. Nor will this carve out save the State any money. A report from the Mendes Group calculated the loss of over $1.5 Billion to the state for over five years.

Furthermore, there are no plans from the state to provide low-cost medication to our patients who are under or uninsured. We also remain deeply concerned about the impact that the carveout will have on the greater healthcare ecosystem in our communities. Should the proposal pass, many safety net facilities already operating on razor thin margins already compromised by the Coronavirus pandemic, may not survive leaving gaps in care in highly vulnerable communities and populations. How will the safety net facilities that do survive care for these patients after the state has now removed essential resources? We believe the destruction caused by having patients switch from Medicaid managed care formulary that currently covers their medications to the New York State formulary as a process of having them having to get their new prescriptions for many of their drugs will generate an average of one doctor's visit for the every one of the 4.9 million Medicaid managed care enrollees at a cost of $150 per medical visit. There will be an excess cost of $735 Million, far more than any projected savings from the carve out. The carve out fee for service will also mean that patients who now carry a Medicaid managed care card will also have to carry a State Medicaid card every time they fill a prescription. We are concerned that this will increase the potential for stigma in obtaining medications successfully already mitigated by our Medicaid managed models. For these reasons, we strongly oppose the inclusion of the pharmacy benefit carve out and we urge you to withdraw it from consideration. Thank you again.

Ok, thank you. Next public speaker is Eric Bartley. Is Eric on? Yes, hello. Hello, your line is open. Thank you. Good afternoon Department of Health team. Thank you for this opportunity to speak regarding the waiver extension. My name is Eric Bartley and I am a patient at Callen-Lorde Community Center. Callen Lorde is a friendly, qualified health center with clinics in Chelsea, the South Bronx and Brooklyn. I am one of merely 18,000 patients who are served every year with quality, affirming healthcare. I'm here today because I am very concerned that the State is requesting approval to put out the Medicaid Pharmacy Benefit Managed Care to Fee for Service.

I understand that this carve out would prevent Callen-Lorde from benefitting from the federal 340B drug d program resulting in a loss of 340B savings that are used to support of very important patient care services that are otherwise unfunded or underfunded.

This change would directly affect me. I've been a patient at Callen-Lorde since 2007 and Callen-Lorde has saved my life. At 58 years old, I've been living with HIV for almost 40 years. My doctor has recommended that I see several specialists. I didn't have time nor patience necessary to schedule multiple and important appointments. My referrals would expire before I could ever make these appointments. Years literally had passed. My doctors suggested reaching out to our care coordinators. The care coordinators were amazing. They were able to finally schedule these appointments. Two appointments led to having surgery to areas that I thought were just fine. It was alarming, but life- saving. The same care coordinators were able to assist me with a digital blood pressure machine because a manual device was too difficult for me to use properly. Now my blood pressure is monitored daily and I've gained a sense of control and apartment back again. Because of their dedication to my unique circumstances, the care coordinators saw how frustrated I was and desperate for someone to help. Care coordination is one of the many services supported in part by 340B funding. Without revenues of 340B, the services I was able to take advantage of may disappear. I do not understand why NY State would take an action that would result in financial hardship for clinics like Callen-Lorde causing them to reduce services that people in my community rely on especially when we are dealing with public health crisis' like HIV, and Covid-19 that hits hardest in communities that are low income and black and brown. For example, the state claims that everyone will have equal access to Covid-19 vaccine while at the same time asking for permission for a pharmacy carve out that would threaten the survival of and capacity of safety net help providers need to deliver the vaccine to medically underserved communities. Please understand that how important it is right now, and in the future, to protect trusted safety net providers and the crucial health and social services they provide every day for me and for people like me. Thank you so much.

Ok thank you. Our next speaker is Tom Duane. Thank you very much, can you hear me? Yes. Ok. I haven't been very involved in political issues since I left office, but this is too important not to be involved in. By the way, this is my first time on Webex, I hope this isn't taking away from my time. I did put on a tie today because I thought we would be seeing each other like on other meetings like hearings etc. I'm wearing a tie and a buttoned-down shirt. Just so you know, I do have a face made for radio. I want to urge everyone to read my Op Ad in the Albany Times Union from January 11th. It regards the struggle to end the Aids epidemic which is really one of the

Governor's signature – it's really one of greatest things he's done and his battle to stop Covid-19 in our state. It's really the same fight. And if you go to my twitte@TKDuane. I'm not really Mr. social media, but it took me hours and hours to do it. But take a look at it because it took a lot. I'm here to speak out against the pharmacy carveout. By the way, I was on the original Medicaid Redesign Task Force. I was fortunate to be a supporter of them and I believe a friend of both governor Cuomo's' when they were in office.

Mario Cuomo was the first person to say words like "lesbian and gay". He instituted domestic partnership. He was there when Brashi – it was his court of appeals, state court of appeals that ruled in favor of Brashi so that people would stop losing their homes and then he codified it, and the regulations and then the other thing he did was that he raised the reimbursement for services provided for people who were dying at that time with Aids and it at the time actually helped to keep Catholic hospitals, among other hospitals in business that increased reimbursement for taking care of people that no one wanted to touch. I could tell you stories, but you know what but watch me on YouTube to see what it was like in those days. There were senators who would not shake my hand and stigma has not really changed too much since then. To me it's just ridiculous that $80 million dollars will go back into the state's general fund and then the safety net providers, the FQHCs are going to lose $250 Million dollars provide services to the chorus. You've heard this from other people so I'm not going to go through it again, but you know. By the way, do you know how hard it is for people to testify like this? People are struggling just to get by. The exact same people who are going to get hit hardest by what's being discussed today. Getting rid of this – What benefit of $250 million dollars? These are women who are out working, taking care of kids, trying to protect themselves from Covid-19. Some of them with HIV. You know, safety net providers losing this kind money is just a horrendous thing to do. You know this is taking money away helping them to get; gay, straight, black, brown, young, old to get access to the vaccine. To get access to testing right now. I know one-minute remaining – I know. Although I've seen some people go on as long as they want to. The republicans on the show, they would let me with hearings. I'm going to turn 66. I have HIV for almost 40 years and I have mental health issues. I This is part of my show and tell. take more medicine then my mother did. I have a health problem, imagine if I didn't. Not just to treat HIV but to be able to find out whether or not they can get the test for Covid-19. It's the same struggle. It's the same fight. The same people who. Do you know how many people I know who have HIV, gay, straight, black, white brown, API, Asian? I'm the keeper of the secret of so many people living with HIV - it will go to my grave because there is such stigma. And the only other people who know are their health care providers. They told me only because I was open about my HIV status when I was in office. And I know the certain things

people go through and the fear they live with that they may not be able to get - Your going to make it harder for them to get access their HIV medicine and their mental health drugs let alone to be tested for Covid-19? And to get the vaccine – it's going to be incredibly difficult for them. Ok – I know so you're going to cut me off. So let me just say this – everybody whose hearing this because you can't see me – go to my twitter page and just tweet out my Times Union OpEd to everyone you know – please and tell them to tweet it out. Because I don't really think the Governor's – he can't mean this. The ending of Aids epidemic – this was like a great thing he did. The Cuomo's have done really good things for the HIV and LGBT community through the years. I cannot believe that he would be willing to do this. This is not the Cuomo family that I know. This is not something that they would do. So please – let's remind him how heroic that family has been. And how good they have been to the queer community. How good they have been with people living with HIV and those at risk of getting HIV. This is totally unacceptable. A stupid little savings of health care – during this time, to make it more difficult for people to actually stay alive. Thank you for letting me testify.

Ok. thank you. Hi Phil. We have Andrea on a separate line if we can circle back to Andrea. Sure, Andrea. Go ahead Andrea. Thank you. And thank you for the invitation to provide comments regarding the three-year extension of the Medicaid Redesign Waiver. My name is Andrea DeMeo and I am the President and CEO of Trillium Health. We are duly designated as a federally qualified center look alike and a Ryan White HIV clinic located in the heart of downtown Rochester New York and we have served our community for more than 30 years. While we are supportive of the intention of the waiver, and the goals of DSRIP, we are extremely concerned about the Pharmacy carveout and do not agree with this recommendation. This move will be financially devastating to safety net providers like Trillium Health and cause significant disruption in services and further confusion for patients all in the midst of navigating and responding to Covid-19. The Governor himself just recently highlighted that 1. 6 million New Yorkers are now insured under Medicaid. It is these very people who will be hurt by the carveout of the Pharmacy benefits which will eliminate the discounts from the safety net providers resulting in the cutting of services to those who need it the most. As a Ryan White clinic participating in the 340B drug discount program, we provide services to low-income individuals living with HIV. This benefit allows us to provide wrap-around services that engage and retain people into care, support medication adherence and often reduce viral load and thereby transmission of infection. These expanded services are critical to people living with HIV Aids as well as the goal of ending the epidemic in New York State. This move will take a giant step backwards. As a federally qualified community health center, we also receive discounts on prescriptions that allow us to provide the same expanded services with people and

families with low income or living in poverty. With this carveout, absence of prescription as well as other critical health services will be at significant risk. Food, housing and other services will be closed. And people will lose their jobs. In the Governor's budget proposal, he highlighted the importance of housing and food security programs which would be impossible for us to continue without the 340B program. And he spoke to reinvesting in a hiring program that would get people back to work from the Coronavirus. With this carveout of Pharmacy benefits, Trillium alone will be forced to cut more than 25% of our workforce, the very people that we have depended upon to risk their lives to respond to Covid-19. Although the Governor has allocated some funding in his budget for safety net providers, in lieu of keeping the benefits budget intact, it is simply nowhere near enough to cover this deficit or the impact of services and jobs as a result of this carve out. There will never be a time when this proposal makes sense. But especially now, as Covid-19 continues to ravage our community and disproportionately affect communities of color. This proposal is plainly non-sensical and dangerous for the safety of every New Yorker. We have been called upon to provide COVID testing and vaccinations for priority populations with no additional help or resources while simultaneously meeting all of existing programs, clinics and services. To address testing and vaccine equity we have established testing at vaccine sites, worked with community centers, public housing sites and nursing homes. We're participating in helping to educate our communities on the safety and efficacy of the vaccine and we stand ready to re-deploy our mobile clinic to further address the inequities existing in communities of color and receiving their vaccine. We have administered every single vaccine in accordance with the guidelines with no waste and have had vaccines redistributed to us because of our effectiveness in getting vaccines into arms and we are now called upon to help with community pop-up vaccination sites. Our patients and our community (inaudible) Without the 340B discount program, we will not have the resources we need to continue down this path. On behalf of our patients who are some of the most vulnerable New Yorkers, we propose that the Governor approves two votes; one in the Assembly A1617 and one in the Senate as 2520 which will allow us to pause for three years to allow time for a meaningful solution. You yourself had indicated that the purpose of this extension is to preserve the waiver which can be amended in the future. We need this time to consider the immediate, short and long-term of this change and make the decision for all of us in the name of public health. Thank you.

Thank you. Ok, moving back to the next speaker on the list. Damon Grandison your line should be open. Hi Phil, we don't have Damon on the line at this time. Ok. Our next speaker should be Satish Gunda. Are you on? I am here. Can you hear me? Yes. Yes hi.

Good afternoon. I appreciate you giving me an opportunity to comment on the 1115 waiver proposal. I am a pharmacist working in a small community pharmacy for the past 20 years. We are a small business that caters to a range of underprivileged patients who are suffering HIV, psychiatry, and are part of the LGBT community. We respond to the needs of these patients usually according to their requirements and involve ourselves to specialty packaging that requires a significant amount of time depending on the number of medications these patients take. We package accordingly whether it might be monthly, weekly, biweekly coordinating with their physician and their care team to accomplish the care for these patients.

If we don't respond to the right coordination of our patients, there is a high chance that our patients will become non-compliant which will probably go further their conditions. We have the tremendous results in patients their (inaudible) and additionally have seen a number of patients who are undetectable HIV. A major accomplishment of our program and moving to towards eliminating the HIV pandemic. That being said, managing and coordinating care with the HIV community takes a great deal of work, effort and time. Since the number of patients who don't have the proper communications capability to lead to, to understand their care and make sure they take their medication accordingly. All of these services are only possible due to the funding we receive from the 340B program. In other words, our business has to what we are doing has to have that 340B funding. Small businesses and the small community pharmacies without the funding, we are unable to fill that ample amount of prescriptions that a regular pharmacy fills. We cannot do that. We have to fill a small number prescription as a result of individualized care of these plans and will tell the pharmacies we will have to close our business which will cause a huge impact on the community that relies on our care as well as the government. With the respect to the impact, carveout pharmacy benefits from the Medicare, it will increase the number of hospitalizations and emergency room visits affecting the well-being of the patient. Trust is important to the business of the local community and highlight the role we play in our patients lives as they need pharmacies like us and the clinic where we normally do coordinated care, combining the medical and the pharmacy together. We urge the New York State to remove the carveout Pharmacy benefits from the 1115 Medicaid Waiver program. And I appreciate you give me an opportunity to speak on this floor. Thank you. Have a good day.

Ok thank you. Our next speaker is Gloria Kim. Are you on? Yes. Thank you. Good afternoon. My name is Gloria Kim and I am the Senior Policy Analyst of Senior Services Council and appreciate the opportunity to speak today on the waiver extension. So, there is great potential of achieving the goals with this intention by leveraging the work and expertise of community-based

organizations as equal partners in improving the population health. By bringing health care services into the community and by moving away from traditional care we will be better able to focus on the social determinants of health and the impact that CBOs have on the community especially during the pandemic.

And while we support the intentions of this waiver, it's crucial that the state invest in CBOs for the essential recovery of New York especially with the social and economic impacts of Covid-19. New York State is dependent on CBOs to deliver human services that address social determinants of health. CBOs enhance overall well-being by empowering individuals to reach their full potential and enable their communities to thrive. All this we know impacts health outcomes and its important to acknowledge that CBO's have been on this frontline of the pandemic, putting their selves in danger to ensure that communities are safe. As hospitals are inundated with Covid-19 infected patients, CBO's are crucial in keeping families out of the hospital so members of families can be treated with a broad range of social and economic factors especially in low-income communities are disproportionately impacted by the pandemic. At the same time, New York's vast network of CBOs are in distress, State and local governments rely heavily on these organizations to deliver services that directly contribute to health and wellbeing.

But longstanding policies, practices and funding practices have undermined the fiscal health of this sector, severely reducing the operating margins necessary to take on risk. A significant number are CBO's are insolvent and many have little to no reserve. Addressing the challenges of financial uncertainty will enable CBOs to perform the necessary work in communities on governments behalf and come to that table in meaningful ways to collaborate more effectively with the health care system. So, we appreciate DOH's effort so far, but it's not enough to counter the damaging policies like the Pharmacy benefit carveout and lack of investment made by the state in the work of the CBOs. If we are to are to come to the table in a meaningful way, the State must reimagine this much more broadly and take into the account the support and contributions CBO's have made to the community. Thank you.

Ok thank you. Looks like we have a previous speaker that was scheduled to speak now on, Elizabeth Perez. Yes, I am just, she disappeared on me. She should be unmuted now. Go ahead Elizabeth. Hi, I'm still not unmuted, it's still not working. We can hear you. Elizabeth we can hear you. Ok, let's ah, Elizabeth are you able to join? Hi, can you hear me? Yes, we can hear you. Ok.

Good afternoon and thank you for the opportunity to hear my concerns about the waiver application. I am the Compliance Officer and Counsel of East (inaudible) Public Services and I

am speaking today on behalf of our federally qualified health insurer and weekend neighbor health insurer and in addition to our (inaudible) status. We can also operate Ryan White program and assistance providing services to our HIV population.

As I mentioned before the subject of my concern is the Pharmacy Carveout. I recognize that the State is facing drastic budgetary healthcare challenges, but I need to express my extreme dismay that the State's solution to the budgetary constraints is removing resources from underserved black and brown communities like East Harlem. Almost 70% of our patients are enrolled in Medicaid or Medicaid Advantage Care, that's over 8,000 patients. This means the proposed changes of the 340B program would have a very serious impact on our ability to employ qualified staff to meet the unique and challenging needs of our community. We use the 340B revenue to employ staff, and intern managers that can meet necessary investments to getting to know our patients, understanding their barriers to health and working toward a healthier path for them. We can use the 340B dollars to benefit our patients and we have the track record to demonstrate that including recent HRSA health quality awards for quality leads, health clinic awards, and patient centered medical homes designation. As is, the State of state proposed solution, $102,000 million to set aside for affected designees, is neither an adequate nor a long-term solution.

I'm asking you to reconsider the plan changes in the 340B programs as documented in the 1115 Waiver because I know that we have a shared commitment to improve the lives of New York's most vulnerable residents. Thank you for the opportunity to speak.

Ok, thank you. So it looks like our next speaker is Opal Dunstan. Opal Dunstan? Hi good evening. Good afternoon. So, I'm giving testimony on behalf of VIP Community Services. And I'd like to thank you for allowing me to speak on such a crucial issue, the 1115 Waiver Extension Pharmacy Carveout. I'm the Chief Operating Officer and throughout my career in health care, I've had first-hand experience of the tremendous benefits that underserved communities get from the 340B Program. VIP provides an integrated menu of healthcare services of the patients in the Bronx and surrounding communities. The services including primary and specialty care, behavioral health, mental health, substance abuse, housing, shelter, care management and educational service. Through its health center, VIP provides medications for patients who are underserved or uninsured thereby preventing them from seeking care and emergency rooms for chronic and severe conditions. Consistent with FQHC, FQHC regulations treat our patients regardless of their ability to pay. Greater than 70% of VIP's patients report incomes at or below the 100% federal poverty level guideline. The majority of the patients represent racial and ethnic minority groups with over 75% identified as blacks or Latin. A large percentage of the patients are diagnosed with

substance use disorders and many chronic physical conditions such as hypertension, heart disease, diabetes, hepatitis, HIV, Aids, and opioid use disorders among the list of others. VIP's catchment area is in the South Central Bronx that was severely affected by the Covid-19. We do not yet truly know the true impact of Covid-19 on people or infected. You will depend on the 340B program to subsidize your care. Carving out Pharmacy benefits will prevent FQHCs from fully benefitting from the federal 340B Drug discount program. By reinvesting the savings that we obtain through the 340B program, VIP's able to provide an income that is used to offset the unreimbursed costs of caring for a very fragile patient population. The majority of whom have comorbid mental health, substance abuse and HIV, Hepatitis C and other chronic conditions. 340B revenue allows VIP to provide necessary service for unreimbursed care including but not limited to transportation, case management, care navigation, housing assistance and job training. If New York State prevents us from achieving savings from the 340B program, our patients will lose access to lifesaving medications and other critical support services. Given the demographics of the patient populations that receive services from VIP, it is critical that care is subsidized. Absence of 340B, patients would be forced to choose alternatives to the services for much needed care including delay of care. We would ask that you please stop the carveout and save the 340B program to ensure we can provide these much-needed services for our patients. And thank you again for allowing me to speak.

Ok thank you. Valerie Reyes-Jimenez is going to provide testimony on behalf of Vladislav Molchanov. Sorry if I mispronounced that name. Is Valerie Reyes on? Valerie is unmuted. Ok, please go ahead Valerie. Your line is unmuted Valerie, please go ahead. We may have some technical difficulties there Georgia. Hello, can you hear me? Yes, go ahead Valerie.

My name is Valerie Reyes Jimenez and I am delivering testimony on behalf of and as witness by Vladislav Molchanov. I write to comment on the State MRT 1115 Waiver extension request. My name is Vladislav Molchanov from (inaudible) and I receive services from housing located in daily house. I'm very concerned that the State is requesting approval about Medicaid Pharmacy benefits from managed care to Fee for service. I'm very concerned that this carveout will prevent my provider from benefitting from the 340B program resulting in loss of 340B savings that are used to support important services that are otherwise unfunded or underfunded. This change will directly affect me and my health. I am an immigrant and 24 years old. The funding from 340B by the Department of Health would be crucial for people like me. Since 2016, I was diagnosed with HIV, and had my relationship with the medical office and institute of family Health and Daily

Health. As a runaway youth, homeless and HIV positive as was followed around by substance abuse problems which I still struggle with nowadays. As an immigrant person who has multiple childhood problems and traumatic family relationships, highly sexual behavior and anxiety and not able to pay attention for a long time and tremendous frustration finally to put resources and a human professional who have been actively working on fixing for us and my life has been hard. I got housing from Daily House as of January 2016 that saved me from being homeless at 20 years old. In August 2020, I received my permanent residency and it opened some doors to education, to access to health and (inaudible) my records angelica. To successfully achieve and go on to college to continue my education. This process takes time and Daily House helped cover me where it would not be possible for me to do that by myself at this stage in my life. My worker helped to stay on track with important things like the right way to fill out documents to work with social institutions. She was just there when I needed her. (inaudible) on my watch. One of the directors at Daily House – she was like my Godmother. She can help me with everything. Despite my trust issue, I always know that she will be there to take care of me when things go wrong. Last in my letter is her ability to understand what I'm going through. Her ability to show that she cares and she wouldn't destroy the things that she's done, but at the same time she makes me process things for myself, for saying the right words and being kind. My physician has keeping her hands on my pulse points and taking care of my health issues along with the nurses and the rest of the medical staff throughout the last four years. She has been a great coordinator for her team members. Either way they have been interacting with me for four years. Four years ago, I didn't even speak English. The entire health care system is not easy to understand. Working with doctors is another complicated thing. Me as a client at Institute of Family health, medical office, and housing at Daily House have given me easy access to all of the health care that I need, starting with education, insurance, appointments. With these particular interactions with the Health Department, I've been provided with my own assistance to always help me to process my own with losing time and most important without all of the stress. I am not un-detestable. My mental health support, social work connections with larger organizations, keeping track of my health responsibilities, educational moments about my health and just support some people who I know and do not feel uncomfortable to talk about anything because they are holding my hand there and lift people close.

Department of Health, would you consider the idea of cutting funding from places that I have considered above? Then think about from who exactly you would be taking this money from. When you get done with the first advice - start thinking about the consequences you would get for making that kind of decision in the city like New York. Think about where I could end up and

others like me if those places that could not be funded. I do not understand why the state would take an action that will result in financial hardship for community based providers forcing them to have to reduce health care services that are relied on by me and other people in my community especially when we are dealing with a public health crisis like HIV and Covid-19 that hit harder in communities that are low income, black and brown. For example, the State claims that everyone will have equal access to the Covid-19 vaccine, but at the same time, is asking for a federal commission for a pharmacy carveout that will threaten the survival and capacity of safety net health providers needed to deliver the vaccine in medically underserved communities. Please understand how important it is right now, and in the future to protect public safety net providers and the critical health and social services they provide every day for me and for people like me. Respectfully I urge you to remove the 340B carveout from the State's MRT Waiver extension request. Sincerely, Vladislav Molchanov. Thank you.

Ok, thank you. Our next speaker is Michael Redman. Hello, can you hear me? Yes we can. Ok excellent. Good afternoon everyone, my name is Michael Redman and I am a peer and a consumer of the Alliance for Positive Change. I thank the New York State Department of Health for the opportunity to deliver remarks today about the 1115 Waiver Extension Request. The Alliance for Positive Change has been on the front lines of the HIV-AIDS epidemic for thirty years. Alliance is a health care safety net provider with decades of experience providing services to individuals like myself, New Yorkers living with multiple chronic and complex health conditions such as HIV, Hepatitis, substance use, mental illness, and other behavioral health challenges. Alliance has helped me create positive change in mu life. As a Medicaid participant, and like Alliance, I am generally supportive of the waiver's intent to improve the Medicaid program while containing costs. However, I am concerned about the Pharmacy Benefit Carve-Out from Medicaid Managed Care to fee-for-service. The inclusion of the carve-out will hurt the health care safety net, including community based health centers and Ryan White providers like Alliance. The carve-out will cut off safety net providers across New York State from the benefits of the 340B program. Alliance ensures that over 800 low-income New Yorkers living with HIV-AIDS have consistent access to life saving medications and treatments and adherence support. All made possible by using the 340B savings. Over 95% of those enrolled in Alliance's Treatment Adherence Program have a durable, undetectable viral load. Alliance reinvests 340B savings to expand counseling to support groups, direct observational therapy, incentives, food and nutritional programs and transportation assistance, peer navigation to medical appointments and more to Alliance's 6,000 clients. I am a person of color living with multiple chronic conditions. As a part of Alliance's dedicated Treatment Adherence Program, I count on the services I receive to help me adhere to

my medication. I have been receiving these services at Alliance for 15 years. And I can attest that if these services were cut it would negatively impact my health. I receive direct observational therapy which helps me to adhere to my medications. I also receive timely information about COVID-19 and linkage to testing and the vaccine. Perhaps most importantly, I receive the support I need to fight HIV stigma in a non-judgmental environment surrounded by people who truly care about my health. If the carve-out were to move forward, these services I have come to rely on will be eliminated. Thank you for this opportunity to highlight how Alliance has helped me and the work that organizations like Alliance are doing to combat HIV-AIDS, Hepatitis and other chronic illnesses in New York State. All New Yorkers deserve the opportunity to live full, healthy, productive lives. Respectfully I urge you to reconsider this plan and remove the 340B carve-out from the State's 1115 Waiver Extension Request. And I want to conclude by saying, if anyone is curious of this carve-out and who it will affect, it will me, and my ability to give back to the community and the clients I serve. I appreciate you time, thank you very much.

Ok, thank you. Our next speaker is Faven Araya, are you on? (inaudible chatter) I'm sorry Georgia is Faven on? Is she in our list? Yup, I had her unmuted but I think we will have to circle back with her. Ok, our next speaker is Brian McIndoe. Is Brian on. I do not have Brian on the line. Ok, our next speaker is Colby Walsh. Is Colby on. We also do not have Colby on the line. Ok, our next speaker is Daniel Pichinson. Is Daniel on? Daniel should be unmuted. Hello? Yep hello we can hear you. Thank you.

Good afternoon Deputy Commissioner Frescatore. I am Daniel Pichinson, Executive Director of Ryan Chelsea Clinton. We are an independent health community center affiliated with Ryan Health serving the Hell's Kitchen and West Side communities of Manhattan since 2001. We are vehemently opposed to the transition of the Medicaid pharmacy benefit from Managed Care to fee-for-service and its inclusion in the States MRT 1115 Extension Request. Each year, here at Ryan Chelsea Clinton, we care for over 11,000 patients regardless of their ability to pay. Nearly 15% of our patients are uninsured, considerably higher than the Statewide average of just over 5%. Almost two thirds of our patients are enrolled in Medicaid or Medicare. We offer exceptional primary and pediatric care as well as specialty services such as behavioral health integration, women's health, dental care, chronic disease management and HIV prevention. Including community outreach options that make Prep and Pep more readily available in the community. We are also the provider of health services in one of our neighborhood schools, Park West High School. We oppose the carve-out and its inclusion in the waiver extension due to its negative effects on the 340B program and the services we provide with its savings. If New York State

implements the carve-out Ryan Chelsea Clinton could lose up to 2.5 Million in revenue. Our center could not sustain those cuts and would need to eliminate or cut approximately 25 staff positions, both management and members 1199, care management for individuals with chronic conditions including HIV and diabetes, medication assisted treatment for opioid addiction, community outreach to vulnerable populations providing access to health care addressing racial disparities and assistance, and we would likely close our school based health services in park West High School. In short, we would need to seriously evaluate and programs or services we provide to patients and communities that is non-reimbursable and is currently funded by our 340B savings. Each of those programs and staff members connect patients to care, improves their health, saves the health care system limited dollars, including Medicaid, in costly emergency room visits and hospital admissions and it saves lives. I invite you to come to Hell's Kitchen to my center, our center, on any given day and I introduce you to one of those patients to see the impact we have had. As we meet here today, over 1.3 Million New Yorkers have been diagnosed with COVID-19 and sadly nearly 34,000 have died. In the midst of the worst pandemic and public health crisis in a century, it seems counter intuitive that New York would implement this carve-out now, harming the health care safety net when it is needed the most. Almost three weeks ago, on Saturday, January 9th, our health center opened our doors, on a day that we are not usually open, to give COVID-19 vaccines to members of the public in priority group 1a. We vaccinated dozens of health providers in the community that don't work for a hospital or a community health center, yet are at risk of contracting and spreading the virus. We vaccinated another 92 individuals who are residents of a congregate care setting for people with serious mental illness. The administrative fee that we may capture for those individuals who are insured does not even scratch the surface of the cost to open and staff the center that day, schedule the appointments, and have the supplies ready to administer the vaccine. This is yet another example of our mission-critical work that is subsidized by our 340B savings. It pains me, but as much as my staff would want to be on the front lines to do our small part to defeat COVID-19, we need to face the cold reality of not having the financial resources to do this life-saving work. In light of the harm this policy would cause, we are even more deeply concerned that the State may not achieve the savings it projects. According to the Mendes Group report, instead of saving the State money, it will actually cost $154 Million in the first year of the carve-out and a total of $1.5 Billion over five years. This is compounded by the estimated 245 Million lost annually in 340B savings by safety net providers, including FQHCs, Ryan White providers, and hospitals that serve a disproportionate number of Medicaid and uninsured patients. In closing, I implore you to reconsider this policy given the devastating impacts on providers and the patients that we jointly serve, and to not include this in the waiver extension

request. Now is certainly not the time to irreparably harm New York's health care safety net. Our patients and communities deserve better. Thank you for the opportunity to present testimony today.

Ok, thank you. Georgia did you say Brian was back on or... Yep. I have unmuted him. Yes hi, can you hear me? Yes. Yes, hi, good afternoon. My name is Brian McIndoe, I'm the President and CEO of Ryan Health. I'm here to testify in opposition to the inclusion of the Pharmacy Benefit Carve-Out from Medicaid Managed Care to fee-for-service in the State's MRT 1115 Waiver Extension Request. I'm here today on behalf of the over 50,000 patients that Ryan Health serves every year. Ryan Health is a mission-driven federally qualified health center with 19 locations throughout Manhattan ranging from the Lower East Side to our newest site in Washington Heights. We have over 50 years' of experience providing health care in vulnerable communities to diverse populations who are most in need of our care. Over 85% of our patients are low-income, living at or below over 200% of poverty. 70% of them are enrolled in Medicaid and/or Medicare. And another 11% are uninsured. At least three fourths are people of color. Our opposition to the pharmacy benefit carve-out is rooted in the devastation it would cause to the savings that Ryan Health achieves under the federal 340B program. As a federal grantee, we have participated in this program for the past twenty years. We have worked diligently to make the program benefit our vulnerable patients and to fulfill the congressional intent of the statue which is to stretch scarce federal resources as far as possible, reaching more eligible patients and providing more comprehensive services. At Ryan Health we reinvest our 340B savings into efforts to achieve that intent in our own ways: we do subsidize low-cost or free medication to low-income patients; we finance our sliding fee scale for uninsured patients; supporting mission driven programs that operate at a loss; offering enhanced care coordination for those who are chronically ill including patients with diabetes and HIV; creating and implementing nutrition and diabetes education programs; and continuing outreach to local community members to bring them into care addressing racial disparities and inequalities in health care access. At this time I just would like to share a story of just one such patient, and you can just multiply this by the hundreds, who benefits by our diabetes education program. This individual is a patient Ryan Health (inaudible) site on the Lower East Side, is 78 years old, and is a very complex patient living with multiple co-morbidities including diabetes, HIV, high blood pressure, COPD, kidney disease, and cognitive impairment. His care team includes a medical case manager, certified diabetes educator, registered dieticians, and a primary care provider. For years, before entering our diabetes management and education program, he was not properly taking his medication and he was easily confused. In 2019 he became more engaged in his care when his certified diabetes educator implemented twice

monthly visits or calls with him. While his A1C was as high as 12.6% it has been at goal, less than 8% since engaging with our educator more regularly. He is a clear example that patients who live with complicated medical histories are manageable with long-term and very frequent follow-ups. Importantly, also know that it is the hands on intervention and care with a patient that keeps them out of the emergency room and from avoidable hospital admissions. The data for this patient shows that his ER visits and inpatient admissions reduced 50% in 2019 in comparison to 2018. I testify before you this afternoon with the somber knowledge that if the pharmacy carve-out is implemented it will have a devastating impact on the health care safety nets in New York State. The threats to the 340B program mean Ryan Health could lose up to $3.5 Million on an annual basis. We could not sustain that loss in funding and we would have to eliminate or cut the programs that I just talked about. And we would also have an impact on our workforce. The proposed funding pool of 102 Million to support covered entities that currently benefit from 340B savings is woefully inadequate. New York City FQHCs alone would lose an estimated $61 Million annually. Collectively, safety net providers across New York State would incur approximately $245 Million in annual losses. So for the reasons stated above and on behalf of our 50,000 patients and nearly 500 staff members, we are firmly opposed to the inclusion of the pharmacy benefit carve-out in the State's MRT 1115 Waiver Extension. Thank you allowing me to have my testimony today.

Ok, alright thank you. Next speaker on our list is Michael Lee. is Michael Lee on? Yes hi, I'm here can you hear me? Yes I can. Perfect. Hi, my name is Michael Lee, I'm the Chief Operating Officer at Evergreen Health in Buffalo, New York. We have, I'm speaking about the MRT 1115 Waiver Extension Request specifically as it relates to Medicaid Managed Care Carve-Out, and I'd like to speak in opposition of that carve-out. Just a little bit about Evergreen. We have three legs into the 340B Program. One of them is a FQHC look a like designation, another is a Ryan White grantee, and a third one is an STI testing and treatment center. We serve about 15,000 patients annually. We have thousands of HIV positive patients, a lot of PREP patients, over 800 patient's on Prep, then many LGTB and other traditionally marginalized communities that we serve. I'd like to start out by just talking about the impact on the covered entities across the State. I know many, many folks have already talked about the financial implications of losing this benefit. As it relates to us I think it's most important to talk about viral suppression. And this has been brought up before. Viral suppression means that folks are, ah, their HIV is viral suppressed and that they're living essentially happy, healthy, and normal lives and that most importantly there is no onward transmission of the HIV virus. At Evergreen Health, much like the other folks that have spoke at this hearing, we have about 91% of our HIV patients virally suppressed, which is a huge deal in

that there is again no onward transmission and that they are living happy and healthy lives. This does not happen without all the ancillary services that we've heard about to prop up patients, HIV patients and safety net patient populations. Those things like transportation, housing, mental health services, substance use services, nutrition, pharmacy benefits. All of those ancillary services are funded in part by 340B savings and allow us to achieve that viral suppression. I think there is a disconnect in some of the States mentality that there will be no impact on patient benefits with carve-out to fee-for-service. And that simply isn't true. Because, you cannot tell somebody with HIV or another illness that it is as simple as taking a pill and they'll be fine. You have to continually engage them, you have to make sure that they have the support they need, you need to do that in an ongoing fashion. We just instituted dental services for our HIV positive population which has been absolutely ground-breaking for them. It's been one of the services that they've asked for many years, and we just were able to do that, thank you, in the last couple years due to 340B. I'd also like to talk about COVID a little bit. In about, just like other organizations, Evergreen has been asked by our county health department to take on their SCI testing and treatment services so they could focus on COVID. We have been leaned on to setup a mobile COVID testing site. We have been asked to do vaccination clinics. All of those things in which we have done, there has been no additional funding. And those things do not happen without the 340B savings that covered entities are allowed to use to extend and support their services. I will say also as a member of the 340B advisory committee that the Governor convened, that we originally went, I went into that group as a way that I thought we could make recommendations for this carve-out and come up with alternative funding, and that was not the case. Our purview was quickly cut into developing a mechanism to distribute this $102 Million dollars, which is again woefully inadequate to the $250 Million dollars that it would take in estimation to bring these covered entities whole. And that was not the case. We were, our charge was to figure out how to distribute this money and we were not allowed to have any input into or bring research or discussion about any other funding options. So to hear that this group is continually referenced as a source of information is disheartening. Because the truth is that without this 340B program there will be significant impacts on programs like Prep, on like HIV viral suppression, on like COVID testing and vaccination. All these things that we use the 340B program to prop up and to continue to achieve great health outcomes are at risk. And for folks that don't believe that's a reality. I can guarantee you all of our organizations are having conversations about what programs and services to downsize as a result of this carve-out. It's the reality we have to, we cannot operate and provide the level of services that we have, and have for years, to achieve these outcomes without 340B. And the $102 Million dollars is in no way able to make us whole. There

is no way to distribute the $102 Million dollars. And we absolutely need more time to figure this out. So I would respectfully advise the State and request that you remove the pharmacy benefit carve-out from the 1115 Waiver and thank you very much for letting me speak.

Ok, thank you. Our next speaker Jacob Ryder. Hi Phil, we do not have Jacob on the line. Ok. How about doctor, is it, Marcus Burchell? That speaker is also not on the line at this time. OK, is there anyone else that would like to speak that hasn't had the opportunity? Are you seeing anyone, Georgia, on your end? I'm going to take a look through the Q and A right now. Looks like Sarah Elinger is raising her hand. Yes, and we also have Carol Tegas, so I have Carol right here. I'm going to unmute her. OK. Is Carol unmuted?

Hi, it's Carol Tegas. Hello. Can you hear me OK? Yes we can. OK, great. Thank you. Thanks so much for the opportunity to speak today. Again, my name is Carol Tegas, I'm the Executive Director of the Finger Lakes Performing Providers System. We are one of the twenty-five organizations created by the state across the region to implement the (DSRIP) Delivery System Incentive Payment Program. From 2015 to 2020, I'm getting a little feedback from music, I hope that's not me. I hope that wasn't me, that's not my style of music. I don't hear it anymore. Our region, the Finger Lakes Region, and our PPS covers 13 counties we cover over 350,000 Medicaid lives through the services of hundreds of clinical and community-based partners. We're one of the few PPS organizations remaining, I would have loved to hear Dr. Jacob Riger, who turned his Albany Med PPS into a CBOIPA, so I'd love to read his comments if he was able to submit that. We, too, have reengineered. We have remained a PPS, but we are reengineering how we're serving our partners. We are going to be able to redesign Medicaid in our region with further investments using our DSRIP dollars that remain to reduce cost, improve outcomes and approve the patient and provider experience under the triple aid, under the goals of DSRIP. I wanted to thank you for the approach you're taking the preserve the authority of the 1115 waiver and really protecting the great aspects of our states unique programming under the waiver and the strategy that you are using the submit future amendments. I applaud the state for that. I do, however, want to join my partner, Andrea DeMeo, from Trillium, and I was really pleased to hear her speak. I'm sure I speak for our other F2HC's in the Finger Lakes Region in expressing feedback on the devastating impact of the proposed change for the 340B program. I'm not going to elaborate on any of that further, since the providers and patients, themselves, across the state had so eloquently and passionately spoken about the major concerns that they have. So, I'm not going to go into that. I did want to go back in history, just a little bit. I'm only going to take a minute here. I wanted to congratulate DOH and my college PPS's, and all the partners across the state

who participated in DSRIP for the successes under the DSRIP program. It's unfortunate, we did not really have an opportunity to celebrate the importance of the March 31, 2020 date. That was a huge milestone for our partners and for our state. Celebrating the end of DSRIP. Unfortunately, because the pandemic, we couldn't do it in person and really, because of COVID, we really didn't have the energy or the focus to be able to do that, but, what is interesting is that very set of goals and all the work that was done under DSRIP really positioned our region, anyway, and I'm sure other regions, really uniquely to continue to support partners and responding quickly to the pandemic. And not just from an organizational perspective, but from a relationship and collaboration perspective, the trust that was built across the partnership under the DSRIP program. We responded to the call for support and project management to stand-up testing sites and provided communication via across the 13 counties for our partners. We now have responded to the call for supporting the Finger Lakes vaccination hub work and helping to coordinate the vaccination roll-out. We're continuing to collaborate with partners post DSRIP and system transformation efforts outside of the COVID pandemic with large scale initiative to pursue innovation and behavioral health, maternal child health, social determinants of health and care management, as well as support regional population health efforts. We had the unique ability to bring together hospital systems, IPA's, ACOs, BHCC's, health homes, community-based organizations and community stakeholders across the region and continue to do so. In partnership with common-ground health, our regional health planning organization, our RIO, United Way, and other stakeholders, we provided feedback last year or maybe it was even the previous year, late previous year, to DOH on the DSRIP 2.0 proposal for something as the cohesive partnership from the Finger Lakes. We have maintained this region-wide partnership in the Finger Lakes region and have continued to apply the principals of the partnership to our COVID-19 crisis work and we'll continue to work better, towards a better health care system in our community. We hope you return to that feedback when it's time to dust of the proposal to CMS and we agree with the state that the key is to moving forward and improving healthcare is toward more aggressively to EVP, with better partnerships in Managed Care organizations and incorporating social determinates of health with CBO partnership. We support the 1115 waiver, except for that 340B piece, and we look forward to picking up where we left off. The Finger Lakes region stands ready to work with the state and MRT II and continue to redesign healthcare. Thank you.

OK, thank you. It looks like we have another speaker raising their hand. Georgia, it looks like Faven Araya. It looks like you're unmuted, Faven. Hi, are you guys able to hear me? Yes.

OK, great. Hi, my name is Faven Araya. I'm the Pharmacy for Urban Health, but also here to represent Communities Together for Health Equity, which is a diverse and representative group for over 70 New York City training-based organizations and stakeholders working to ensure comprehensive services for underserved communities. CTHE's demographically and linguistically diverse, providing social services addressing a spectrum of social determinants of health for over 350,000 communities city-wide and has collectively served as essential organizations responding in real time to the pressing social and economic community needs during COVID-19 pandemic. I'm here to express our collective concerns with the persistent exclusion of community voices and limited rights of communities to participate and provide leadership in planning and decision-making process, of which is in full-display today for the lack of communication and transparency for future hosts (inaudible). Over the five-year period of DSRIP, it has worked towards healthcare transformation with the primary goal of a 25 percent reduction in avoidable hospital use, a statistic that largely stands in the social determinates of health and requires the active participation and inclusion of CBOs to achieve sustainable health care transformations. While some progress has been made to bridge the gap between the community and the health system, the lack of systemic inclusion of community voices have been apparent and even more so today as we battle the COVID-19 pandemic. The fragmented health system failed policies and practices that further perpetuate health varies have recently contributed to the havoc unleased by the COVID-19 pandemic, as thousands of New Yorkers have lost their lives, their homes, and right to basic needs. The healthcare system was unprepared and unforgiving to communities of color, immigrants and those who reside in underserved and underenforced communities, the same communities that DSRIP aimed to target to achieve their goals, yet we remain confronted with the same reality. Our message remains the same – establish an equitable approach to health care transformation that values and is inclusive of community voices. In addition to seriously consider the water social implications of this impact. This will require three things: Structural changes to the existing system to allow for the inclusion of CBO's and states organizations and stakeholders engaged in the healthcare planning process, two, fair and equitable investments in CBO's. CBO's are mission-driven organizations that exist to meet community needs that have a long history of addressing social determinates of health. While the important role of CBO's is recognized now under the pandemic, the demand for their support and services will continue to persist. The state investment of CBO's is needed to meet the existing and future community needs. Three, coordinated population and health improvement. Community wellness and population health priorities have historically been determined by clinical standards and have lacked community perspective. The inclusion of CBO's is actively engaging stakeholders in the design planning,

budgeting, implementation process ensure the comprehensive and culturally linguistic competent approach to identify priority issues that reflect the on-the-ground community experiences. Without the implementation of practice of fundamental principles, the same issues routed in inequities will remain pervasive, as we've witnessed with COVID-19. The missed opportunity for systemic inclusion of CBOs during DSRIP have resulted in disparities and COVID-related cut cases and that's proper management of chronic and preventable diseases that increase the risk of COVID-related complications in death. And then the trust in COVID testing, treatments and now, vaccinations. As you plan for the future, the limited the state department of health and state government becoming informed and making decisions without mediation, our frontline community groups and community residents will further impeach community participation and for achievements to become sustainable. This implies that local knowledge and experiences will not inform health policy and minimize mistakes and gaps. We need the state to work with us to explicitly operationalize a commitment to providing CBOs in everyday New Yorker's, the opportunity to play more policy making role in planning delivery and evaluating the healthcare services for which they are in greatest need. With the challenges proposed to the addressed DSRIP five years ago, now exacerbated by COVID, we must shift gears establish a shared agenda, work collaboratively and transparently. We strongly urge you to take these comments under serious consideration and work to translate values into practice. Thank you for providing the opportunity to provide comment. Thanks.

Ok, thank you. Looks like we have another presenter in the queue here. Georgia, can you confirm Sarah Bellinger. Hello, this is Sarah Bellinger. Can you hear me? Yes. Hi, my name is Sarah Well-Bellinger. I'm with the New York State Association for Rural Health. I appreciate the information presented earlier in this segment and the awareness that there was a need to mitigate the negative impact of the Pharmacy Carveout, but I do not believe this is going to be enough. New York State Association for Rural Health is a not for profit, non-partisan, grassroots organization working to preserve and improve the health of residents of New York State. On many different levels NYSARH serves individuals, consumers, non-profit organizations, government agencies and officials, health care facilities, emergency medical service providers, long-term care organizations, businesses, university students, foundations, associations, and other stakeholders in rural health. I feel that we have a similar association to the previous speaker only that we are all upstate and rural instead of being downstate and urban. And we also cared greatly about the social determinants of health and feel that that is an area that the additional waiver as you work toward the future, after we preserve this one, should be focused on. But my comments today, like everyone else, are about the 340B program. It's a well established and existing mechanism

created by Congress to ensure safety net providers have the necessary resources to expand uncompensated care programs and to adequately care for their patient's health and health related social needs. It is unfathomable for New York to include the carve-out in an MRT Waiver Extension Request, thereby denying otherwise eligible health care providers access to these savings during the most significant public health crisis in modern history. This change would also threaten the strong public health response to the novel Coronavirus pandemic and will compromise the State's progress in ending the HIV epidemic. We respectfully request the Department to remove the pharmacy benefit carve-out from the MRT 1115 Waiver Extension Request and appreciate this opportunity to provide testimony.

Thank you. Georgia do we have anyone else wishing to speak that hasn't spoken. I'm not seeing anyone new at this time but I'm trying to go through the Chat and Q&A right now. If anyone else sees anyone. I do not see any other hands raised at this time. Ok thank you Georgia. That concludes the list of speakers for this afternoon. Bret do you have any closing remarks. I do not Phil. I just want to thank everyone for coming out and making such meaningful comments that will help inform the submission of the waiver process. And just a reminder that public comments, written public comments are due on February 6th, and so to the extent that you could not make a comment today, and all comments today were recorded, we look forward to receiving your comments in writing. Each of which will be logged and included in our communications with CMS. So thank you very much again and we look forward to hearing from you as we complete this process. Take care. Thanks bye.