New York 1115 Waiver Amendment: Making Targeted, Evidence-Based Investments to Address the Health Disparities Exacerbated by the COVID-19 Pandemic
Virtual Public Hearing Transcript
May 3, 2022

Hello everyone and welcome. We are just waiting a few minutes to let people sign on and then we will begin. Thank you.

It looks like we're sort of leveling off here, so I think we'll get started.

Welcome everyone. And thank you for joining us for the first of two public hearings on our 1115 waiver amendment, Making Evidence-Based Investments to Address the Health Disparities Exacerbated by the COVID-19 Pandemic. Before we start the presentation, I'll turn it over to my colleague, Georgia, to tell you how to turn on the closed captioning feature and make the two ASL interpreters easier to see. Take it away, Georgia.

And Georgia, if you're speaking, I think you might be on mute.

Okay, I sure was. All right, thanks everybody, we'll start that again. So, in order to enable close captions today throughout the webinar, you should find the CC icon, which is shown here in the little gray oval in the lower left of your screen, and once you hover on that, or click on that, you should have the option to show closed caption throughout the webinar. For folks who have any issue with that, please feel free to type into the Q and A, and we will gladly assist you.

We also have 2 ASL interpreters with us today. Muffy Cave and Bruce Swartz. Bruce is signing right now; they are going to switch on and off throughout the webinar. So, in order to utilize those services and feature the ASL interpreters in in a more prominent way, you can move them down to what is called the stage in Webex and that is where you are viewing the presentation. So, if you'd like an ASL interpreter to be side by side with the presentation all you need to do is hover over the video of either Daniel or Muffy. For both, right click and select move to stage. You can also drag their video down on to the stage and you can have them both there at the same time so that when they do switch off, it'll be a seamless transition. Any questions about that, feel free to type into the Q and A as well and we'll be glad to assist, and I'll hand it back to Selena.

Georgia, excuse me.

Welcome again everyone, my name is Selena Hajiani, I am the Director of Strategic Operations and Planning here at the Office of Health Insurance Programs at the Department of Health. Just to walk through the agenda, first, we'll start by giving a little background on the virtual public hearing format and the 1115 waiver demonstration and then we will go through the proposed 1115 waiver amendment and the 4 goals of the waiver listed here. Then we will go over the estimate of annual amendment expenditures, next steps, guidelines for public comment, we will provide contact information and resources and then we will begin the public comment portion of the hearing and we'll also provide instructions at that time as well. Next slide, please.

In compliance with COVID-19 social distancing guidelines and approved CMS exceptions, we are conducting these 2 virtual public hearings virtually. Public hearings provide the public with the opportunity to comment on the state's amendment application. It is very important for you to provide comment because we can only change the amendment based on the public

comment that we receive. We look forward to receiving your comments. While we, at the state level, have worked very hard on this amendment application, it requires broad and meaningful partnership and our collective work has only just begun. Comments can be reiterated or supplemented through submissions sent by a mail or email and recordings and transcripts of this hearing will be available on the MRT website about three to five days after the hearing. Language translation is also available upon request and the slides will also be posted to the website. Next slide, please.

So now for some background on New York's 1115 Waiver Demonstration. Section 1115 Demonstration Waivers give states the flexibility to implement innovative projects that promote the objectives of the Medicaid program. Section 1115 of the Social Security Act authorizes the security, Secretary of Health and Human Services to waive certain Medicaid program provisions and regulations. They also allow the use of Medicaid funds in ways that are not otherwise allowed under federal rules, i.e., making them eligible for federal matching funds. Typically, 1115 waivers are approved for five, three-to-five-year terms. However, recently, CMS has been approving some for longer terms. Next slide, please.

New York's 1115 Demonstration Waiver is called the Medicaid Redesign Team Waiver or MRT Waiver and was formerly known as the Partnership Plan. It has been in effect since 1997. This waiver was last renewed on April 1, 2021 and will be effective through March 31, 2027. The goals of the larger MRT Waiver are to improve access to healthcare for the Medicaid population, improve the quality of health services delivered and expand coverage to additional low-income New Yorkers with resources generated through managed care efficiencies. Next slide, please.

And now for a special cameo from Mr. Brett Friedman to go over the status of waiver activities. Hi everyone, can you hear me? Yes. Great, thank you. Hello everyone, as your outgoing Medicaid Director, I wanted to provide the history of how we got to where we are today, to provide this waiver amendment in appropriate context. The timeline really goes back to November of 2019 and for those of you who remember, that's when New York submitted its formal DSRIP amendment and extension request. DSRIP was set to expire in March of 2020, and in November of 2019, we worked to renew that waiver. Subsequently, in February of 2020, right before the pandemic, CMS declined to negotiate a DSRIP waiver extension. That was part of the prior administration. They weren't in the business of extending DSRIP programs and so DSRIP then in March of 2020 was left to expire. We had worked with CMS through the pandemic to try and amend and extend our baseline waiver and to achieve certain pandemic efficiencies. So, you saw in May of 2020, CMS did not allow us to administratively extend our waiver request. And so, in June through March of 2021, we worked to do the baseline waiver amendment extension. That's just what Selena mentioned, which was just renewed, effective a few weeks ago, where we got a new 5-year waiver extension and that was the result of the work we did in June 2020 through March of 2021, we submitted that extension request in March of 2021, and we had really over this past year negotiated that waiver extension. Next slide, please.

While we were negotiating the baseline waiver extension that now takes us through 2027, we began a very elongated planning process for this new programmatic amendment that we're discussing today. In August of 2021, on our website, we released a concept paper that described what the state was thinking around new programmatic reforms that would be an amendment to that baseline MRT Waiver. We collected feedback on the concept paper, not just from many of you on this call today, but also from CMS, to see whether it really worked to address health equity in a way that the federal government would support as well as how

various stakeholders thought that we should be redesigning our Medicaid program, and then based on that feedback in this past March, we submitted to the State Register and now put out for a public notice of the programmatic waiver, which now corresponds with the formal 5-year extension request we received on the larger MRT Waiver. And so, what that means is now that we have that 5-year baseline extension that we worked for the better part of a year to get with CMS, we now have the ability to programmatically amend it through what we're submitting today. So, I want it to be very clear that this, we have the baseline extension that was approved, that's really great news because we have a waiver that we can now amend. And then this programmatic amendment, which was really work, you know we worked with everyone on for the last 8 or 9 months through the concept paper and otherwise is now the formal application to amend the MRT Waiver to do this new programmatic reform. You could call it the successor to DSRIP, which was similarly a program under the larger MRT Waiver. But this really goes above and beyond DSRIP, to a whole health equity design that Selena will discuss in the forthcoming slides. So, with that timeline, I'll kick it back to Selena. But I wanted to make sure everyone was aware of what's been happening over the last two and a half years, as we've worked to amend and extend our 1115 waiver application across multiple presidential administrations and changing needs for the state. So, with that, you can advance the slide and I'll hand it back to Selena. Thank you.

Here are links to the public notice in the State Register and the draft application. The public notice can be found on pages 75 to 80 of the State Register, linked at the bottom left of the slide and the draft amendment can be found on the DOH 1115 Medicaid Waiver webpage. Next slide, please.

And now for the overview of the 1115 waiver amendment. Next slide, please.

New York is seeking 13.52 billion dollars over 5 years for this 1115 waiver amendment that centers around advancing health equity and is designed to address health disparities and systemic healthcare delivery issues that have been both highlighted and intensified by the COVID-19 pandemic. These initiatives are intended to work together to foster greater collaboration across the health care delivery system, expand and expand access to services that address the physical and behavioral health and social care needs of our Medicaid members. The goals of this waiver amendment are 1. building a more resilient, flexible, and integrated delivery system that reduces health disparities, promotes health equity and supports the delivery of social care, 2. developing and strengthening supportive housing services and alternatives for the homeless and long-term institutional populations, 3. redesigning and strengthening system capabilities to improve quality, advance health equity and address workforce shortages, and 4. creating statewide digital health and telehealth infrastructure. Next slide, please.

So, Goal #1, Health Equity-Focused System Redesign really lays the foundation for the rest of the waiver. It is a regional approach to addressing health equity across New York State and increasing the focus on our vulnerable populations while ensuring that our delivery system is designed to provide whole person care, and also reflects the importance and interconnectedness of the continuum of physical and behavioral health and social care needs. Goal 1 is comprised of 4 components. The first is the Health Equity Regional Organizations or HEROs construct for which we are requesting 325 million dollars. HEROs are central to the entire waiver, as they are the regional mission-based entities that will serve as the central point of planning and will comprise a broad coalition of stakeholders in each region. Two critical roles of the HEROs are 1. the development of Annual Regional Plans that will map out the landscape between the fiscal and behavioral health and social care needs of vulnerable

populations in their respective regions. It will also outline methods for addressing those needs through VBP interventions that enable holistic, clinically integrated and value driven care. The Regional Plans will also identify, and address gaps related to housing and telehealth, which will be expanded upon in goals 2 and 4 respectively. And then number 2, HEROs will also serve as hubs for regional collaboration, coordination, decision making and data infrastructure. This work will include assessing regional data capabilities and providing technical support. Data sharing and collection is really important for measurement and success with the plan activities. And overall, this thoughtful planning coordination and execution is key to addressing health disparities in a way that will enhance existing efforts, minimize disruption and limit unintended consequences. Additionally, DOH will contract with one HERO per region for each of the 9 regions. If necessary, there could be sub stratification for densely populated areas. Our state is so diverse that it is important that all stakeholders that are most intimately familiar with the members and needs of their region, come together to chart the best path forward to meet the varying needs across the state. Next slide, please.

So, this map shows the nine regions that we are proposing. This is an expansion of the eight historical rate setting regions. The difference is that the North Country is separated out into a distinct region and also Rockland and Westchester Counties have been moved to the Hudson Valley Region or Region Number 3. For comparison, there were 25 PPSs under the DSRIP program with overlapping regions. We felt that it was important to have a single HERO per region to ensure a unified and comprehensive approach to meeting regional need. For those of you that are not familiar with the DSRIP program, it is the Delivery System Reform Incentive Program. It was a 5-year programmatic waiver amendment that invested 8 billion dollars with the goal of reducing avoidable hospital use by 25%. Next slide, please.

So now for the HERO goals. A first goal of HEROs is to guide the development of a delivery system made for well care that is focused on the needs of the whole person, that integrates physical and behavioral health and social care, meets patients where they are and improves outcomes for all patients, particularly the most vulnerable and underserved. A second goal of HEROs is to facilitate the movement to more advanced VBP or value based payment models, focused on health equity that provide cash flow stability during health crises. A third goal is to build on the success of the DSRIP program and while addressing challenges and lessons learned. And finally, to support the health care system to rebuild from the COVID-19 pandemic in a way that fosters flexibility and resilience. Next slide, please.

We've been getting a lot of questions about the role of HEROs, so we thought it was important to clarify what they are and what they are not. HEROs are intended to work with existing regional and local health systems. Hubs for regional planning, consensus building, collaboration and coordination and decision making. Composed of and governed by a broad range of providers, CBOs, MCOs and other stakeholders. And built to inform future advanced VBP arrangements targeted at social care needs and health equity. HEROs are not, they are not Performing Provider Systems or other forms of intermediary entity. They are not responsible for receiving or distributing waiver funds, which is one of the main differences from the way that PPSs functioned under DSRIP. They are not duplicating any existing public health activities. They are intended to build upon and help advance existing work. Nor are they controlled by any single entity or provider type. Next slide, please.

So, this is a list of entities that HERO membership could include, such as Local Health Departments, MCOs, health systems, healthcare providers, behavioral health providers, CBOs, consumer representatives, members of the workforce, qualified entities, among others.

And there will be requirements for HERO membership to ensure broad representation. Next slide, please.

So, this diagram outlines the HERO structure. Starting from the top left, DOH will contract with the HERO entity, which can be an LLC or a nonprofit and it will have a governance structure that meets the composition requirements for each provider class, and also has appropriate operating agreements or bylaws as indicated in the blue box to the right. The goal here is to establish a diverse governing body that is representative of each constituent group and has balanced stakeholder decision making authority. DOH will also provide limited planning grants to each HERO. The HERO would include the entities listed on the previous slide and down below in the purple and gray boxes. And the HERO would work to identify and develop collaborative activities, focused on health equity, social care, data sharing and integration of new and existing efforts, as indicated in the long gray arrow at the bottom. Next slide, please.

The second component of Goal #1 is Social Determinants of Health Networks, for which we are seeking 585 million dollars. The Social Determinants of Health Networks or SDHNs, they are coordinated networks of physical and behavioral health and social care CBOs that will organize a regional referral network. And this portion of the waiver amendment will also include a statewide IT social needs referral and data platform to support data collection, referral network and informed targeted interventions. This would also help to overcome data barriers, such as lack of data sharing standards and closed loop data systems that are not interoperable. This would also allow data connection between SDHNs, HEROs, and VBP arrangements in the state. And so, SDHNs are important for ensuring that all CBOs have the capacity to fully participate in the activities of the waiver and to build strong connections across the delivery system. Next slide, please.

So, the third component of Goal #1 is the movement to advanced VBP arrangements for which we are seeking 7 billion dollars. A VBP or value-based payment ties provider payments to quality and incentive improvements and incentivizes improvements in care. It can be a powerful tool for advancing health equity and integrating physical and behavioral health and social care. It allows flexibility and can be tailored to address a variety of specific needs. So, based on the regional planning and data collection work of the HEROs and SDHNs, DOH will enter into advanced VBP arrangements with various stakeholders and MCOs, targeted at health equity measures. This could include global prepayment, bundled and episodic payment structures. And also, to incorporate the focus on health equity, DOH will update the VBP roadmap. And finally, the fourth component of Goal #1 is a targeted set of in-reach services for incarcerated individuals that will be provided 30 days prior to their release to support the successful transition to community life. And for this, we are seeking 745 million dollars. Connecting service providers and incarcerated individuals prior to release is integral for encouraging post release continuity of care. These services include care management and discharge planning, clinical consultant and peer services, and Medicaid management planning, and the delivery of certain high priority medication. This proposal will be phased in by population over two years. In the first year it'll be expanded to state facilities and in year two, it will be expanded to local jails. So, in combination, the four components of Goal #1 HEROs, SDHNs, advanced VBP models and targeted services for incarcerated individuals are intended to drive a coordinated and holistic approach to reducing health disparities across the state. Next slide, please.

Okay, so, Goal #2. We are seeking 1.57 billion dollars for an investment in Supportive Housing Services. These would provide individuals experiencing homelessness and those transitioning from long-term care institutional settings with support to find housing and to remain safely in

the community. This work will build on the work of the MRT housing programs and other ongoing efforts. It will also address known barriers, such as limited eligibility for housing programs and issues connecting individuals and institutions with appropriate and affordable housing as well as discharge planning. The Annual Regional Plans under Goal #1 will include an inventory of available housing resources and regional need to map out existing work and gaps in services. And the Enhanced Supportive Housing Initiative, which is designed to encourage coordinated, targeted efforts across the implementation spectrum will connect high Medicaid utilizers with housing and services and will be funded through VBP arrangements and matching 1115 waiver dollars. The services through the Enhanced Supportive Housing pool will include medical respite programs to provide a safe place for recovery for those recently discharged individuals that are at risk of imminent homelessness. Community transitional services that will support individuals through the process of finding and securing housing, such as housing navigation, help with the application process and other assistance. Tenancy supports to ensure that individuals can stay safely housed, such as planning, life skills, training and eviction prevention and referral to and coordination of related services, such as accessibility modifications and behavioral health and home and community-based services. Next slide, please. Excuse me.

Goal #3, System Redesign and Workforce Capacity focuses on providing support to those that directly serve our most vulnerable populations. Our workforce and financially distressed safety net hospitals and nursing homes who were on the front lines of the pandemic and faced significant hardship. These next two initiatives are intended to help them both rebuild and make advancements. We are seeking 1.5 billion dollars for the COVID unwind quality restoration pool, which is a VBP quality incentive pool for financially distressed hospitals and nursing homes. These VBP arrangements will be focused on helping these entities improve quality, participate in the advancement of health equity described in this amendment, and expand workforce capacity. Moving on to workforce, workforce shortages and other concerns have been a focal point for many years now. And have only been amplified by the pandemic. Our workforce is essential for the functioning and success of our entire delivery system. We are seeking 1.5 billion dollars to fund activities, including recruitment and retention activities, development, and strengthening of career pathways to enable more defined career trajectories, workforce training to support the health equity goals of this waiver, the expansion of a community health workforce and standardization of occupations and jobs training to ensure that training needs uniform standards and that credentials are transferable across the state. Next slide, please. All right, getting close now.

Goal #4, Creating Statewide Digital Health and Telehealth Infrastructure. For this, we are seeking 300 million dollars to expand access to these services. And we, this was intended to ensure that everyone from the provider to the patient level, has the tools that they need and the understanding necessary to fully take advantage of these technological advancements to improve access and delivery of care. These activities will include telehealth kiosks in homeless shelters to expand service access for individuals experiencing homelessness, community health worker training so that they can assist members to fully use and benefit from telehealth services and tablets for providers and enrollees that lacks access to the necessary technology. So, together the four goals of this amendment, and the associated initiatives and investments, support and reinforce the overarching goal, which is to reduce health disparities and better serve our Medicaid members. Next slide, please.

This slide is a little small. Okay, so starting in the right most column, we are seeking 8.7 billion dollars for Goal #1 Health Equity-Focused System Redesign, 325 million for HEROs, 585 million for SDHNs, 7 billion for Advanced VBP models and 745 million for Criminal Justice-

Involved Populations. For Goal #2 Supportive Housing, we are seeking 1.6 billion dollars, Goal #3 System Redesign and Workforce 3 billion, and Goal #4 Digital Health and Telehealth we are seeking 300 million dollars for a total of 13.52 billion. We are expecting the spending to ramp up over time. So, if you see in the second column for demonstration year 1, we're estimating spending 928 million dollars and ramping up to 3.8 billion dollars in demonstration year 5. Next slide, please.

So now, for the next steps. Well, I guess, a previous step, so our public notice was posted to the State Register and the public comment and tribal comment periods began on April 13. Our public hearings, the first of which is happening currently and the next one will be on May 10, which is next week. The public and tribal comment periods will end on May 20, which is a week extension from the previous deadline of May 13, so everyone has a little bit of extra time. Our target date to incorporate public comment and finalize the amendment is July 1. The target date for a formal submission of the amendment application to CMS is July 25, which would trigger a 30-day federal public comment, period, which could run from July 30 to August 29. And we could potentially begin negotiating terms of the amendment with CMS, starting in summer of 2022. And finally, our target implementation date is January 1, 2023. And now I will turn it over to my colleague, Phil, to MC the public comment and provide instructions. Thank you.

All right, next slide. Thank you, Selena. Okay, just some housekeeping details and guidelines for the public comment portion of this public hearing. A few bullet points here to go over with everyone. A list of the pre-registered commenters will indicate the order in which you will be called on to speak. So, there is a particular numerical order that we have for each speaker this afternoon and I will be introducing speakers shortly. A member of the DOH team will call your name, which will be myself and manually unmute your line to allow you to provide your comment. Comments will be timed, please limit your comment to five minutes to allow for everyone an opportunity to speak this afternoon. Written comments will be accepted through May 20 by email at 1115waivers@health.ny.gov or by mail at the address below on this slide Department of Health, Office of Health Insurance Programs, Waiver Management Unit, 99 Washington Avenue, 12th floor suite 1208, Albany, New York, 12210. Okay, next slide.

Any questions or comments, please use the email address just provided 1115waivers@health.ny.gov. Next slide.

And this is a great resource page. 1115 MRT Waiver resources. There's links to different sections of our website where you can find the amendment application, the public notice, the original concept paper, our quality strategy, and, of course, the first link, hyperlink is to our 1115 MRT waiver website. And this will be made, from what I understand, available, will be posted on our website so that folks can go back and go through these slides again. Next slide.

You'll see this one-minute remaining, just to make sure that we keep everybody on track in terms of time. And then the next slide, there'll be a time is up slide, just to let folks know that they hit their five-minute mark.

Okay, having said that I'm happy to introduce our first speaker and our second speaker, our first speaker is Kathy Preston followed by Lara Kassel. Kathy, please present your public comment and I believe you should be unmuted right, Georgia?

Yes, thank you. Can you hear me? Sure can. Okay, great, thank you. I'm Kathy Preston, with the New York Health Plan Association, representing nearly all of the plans participating in the

Medicaid program. Thanks, for the opportunity to offer comments on proposed 1115 waiver amendment today. Overall, we appreciate that health plans appear to play a pivotal role in many of the initiatives included in the proposed waiver amendment. Plans are already heavily engaged in their communities, working to address social care needs and investing in value-based arrangements, focused on improving equity and eliminating disparities. We are hopeful that the waiver initiatives will build on existing success without creating new barriers to progress and we stress the overarching need for flexibility in that regard. Successful evolution to an equitable and value-based delivery system requires alignment of incentives among providers and payers. Existing misalignment created barriers to progress in VBP under DSRIP. It's critical that waiver initiatives allow plans to build on existing infrastructure and investment in VBP arrangements and allow flexibility for plans, providers, and CBOs to pursue arrangements that meet the state's goals. But some that may not fall exactly into the VBP roadmap parameters, or the regionally developed priorities envisioned under the proposed waiver amendment. And we hope that those kinds of arrangements will also be able to receive waiver funds. We're very concerned that the HERO concept will require too much financial investment and time to establish, will create unnecessary bureaucracy, and could limit flexibility to pursue innovative partnerships and projects. We recommend that DOH reconsider the HERO, and instead suggest that the state convene regularly scheduled regional discussions and learning collaboratives throughout the phases of the waiver along with statewide gatherings to share successes and challenges in the development and execution of VBP arrangements. A statewide collaborative could also work to develop a common set of new evidence based measurable and outcome-oriented health equity measures, building on existing HEDIS and core metrics related to equity and disparities. Further, we do not believe that HEROs are needed to quote, retool service integration or quote, breeding of health, behavioral health, and social care. Plan, provider, and CBO networks already do this work, and those relationships can be enhanced to achieve new goals without creating new and duplicative infrastructure, which is unlikely to be sustainable at the end of the waiver period. While we support development of social determinants of health networks as one way to allow CBOs to coordinate a range of services and streamline contracting, we do not believe that SDHNs should be the only path to such arrangements for plans or that only such arrangements be eligible for waiver funding. Many plans have existing relationships with CBOs that may remain outside of an SDHN. Future partnerships with these CBOs that meet the state's goals should be eligible for waiver funding on the same basis as those arrangements with SDHNs. Finally, we have concerns with global prepayment models, including the possible scope, scale, and accountability of such models and we'd like to better understand the state's expectation in that regard. More detailed comments will be included in our written submission to DOH. Thank you very much. That's the end of my comments.

Oh, thank you. Next speaker Lara Kassel followed by Maria Cristalli.

Hi, this is Lara Kassel. Can you hear me? Sure. Great, thank you. I appreciate the opportunity to testify today. I am the coordinator of Medicaid Matters New York. Medicaid Matters is the statewide coalition representing the interest of people who are served by New York's Medicaid program. I bring comments today, and we will have comments that are more fully fleshed out in writing. I bring comments today from the perspective of staff to the coalition, having worked together as a coalition to bring the interests of people to the table in the last waiver amendment which, of course, was the DSRIP waiver. But I also bring the unique perspective as a member of the DSRIP oversight panel on which I sat on behalf of the coalition. Before I get into a few of my comments, I'd like to make note that many consumer advocates will provide comment from a variety of unique perspectives. So, Medicaid Matters will not be providing detail-oriented comments on very specific issue areas. By that I mean, there will be a

variety of comments that you receive from, from consumer advocates who work with children and families, consumer advocates who bring the needs of people who need long term services and supports. So, we will be providing more overarching comments and we urge you to pay close attention to the comments that are brought by other consumer advocates that will bring the very specific, more detail-oriented comments, about their, from their unique perspectives. As it relates to our experience, as a coalition, and my experience as a member of the DSRIP oversight panel, I want to start by bringing what we're sort of loosely referring to as DSRIP lessons learned. Having just lived through this over the past several years we, we have some, some very unique perspective and experience about how we, how we observed the DSRIP program and how it was going through the course of the program. And one of the areas that we refer to, with the two-word phrase, funds flow, is perhaps one of the most important things to reiterate about this coming waiver. We believe very strongly as consumer advocates that there must be transparency in how the DSRIP, and how the SHERPA funds will flow. And there must be accountability as far as, accountability and transparency as far as how the funds will flow, who will make the decisions about how they will flow and, and how we will see that the funds are getting to where they are intended to go. Another sort of DSRIP lesson learned is support for community-based organizations to participate in the, in the waiver program. It is really vitally important to make sure that community-based organizations and community groups and community members are supported and provided with opportunities that are meaningful. We are very pleased to see that, that there is community written into the design of the HEROs, but it's very important that community-based organizations and community groups be supported financially to participate because they will not automatically be able to get up and participate on their own without some additional support. And then lastly, from, in the sort of DSRIP lessons learned, the oversight panel on which I and others sat should be replicated, but also enhanced, to include more community members, more representation from within the Medicaid program and have a public oversight role similar to what we saw before, but with new opportunities for information, and, you know, public information and public input. I see that I'm running out of time so, I will quickly move to what I was going to wrap up with, which is, you know, we, we know that Medicaid is not perfect. This is why we have jobs as Medicaid consumer advocates, and we would urge the state to, in addition to all of the goals that are embedded into the waiver application think about what we vision for a more perfect Medicaid program. Yes, the goal of this of this waiver application is to, is to reach greater equity and there are some very interesting ideas and interesting commitments being made to on how we'll get there. But let's also consider how we, how we might reach a more perfect Medicaid program. A couple of examples that we could think of are investing in stronger managed care oversight and perhaps thinking about the people who live in New York who don't have access to coverage by Medicaid and figuring out ways to make sure that they have access to coverage and access to services as well. So, I see my time is up, we will be submitting written comments. Thank you.

Thank you. Next speaker is Maria Cristalli followed by Jaime Saunders.

Good afternoon. Can you hear me okay? Yes. Thank you, thank you to the DOH team for this opportunity to offer comments on the MRT Waiver. My name is Maria Cristalli, and I serve as the President/CEO of Hillside. Hillside is a not for profit organization that provides 10,000 children and families annually services in Central and Western New York and Prince George's County, Maryland. The COVID-19 pandemic has created transform, transformational waves in virtually every aspect of society. Our communities are stressed, there's been a significant uptick in youth violence nationally as well as locally. Far too many black and brown youth that we serve have been victims of this violence and are in need of additional support to stay safe and thrive. In the waiver amendment children are not sufficiently addressed. There is no

specific funding that is earmarked for children or children services. In the amendment, the children are conceived as a sub population that warrants special consideration. Please establish children subcommittees across all the regions as part of the HERO structure. In addition, I ask that you designate specific funding for children services, including subpopulations of children that are served in the child welfare system, mental health system, and the DD system. I recommend that HEROs must evaluate gaps in children's mental health services. Specific regional plans for youth with co-occurring needs, like I/DD and mental health, substance abuse and mental health and assess our current workforce in crisis resources. Please include guiding principles under which the HEROs must address youth services in the plan and coincide with the vision of families and providers as part of that process. Also, there are children with complex needs that span across the systems I mentioned. They've spent more time boarding in hospital emergency departments, due to behavior challenges and have long waiting periods for services. As a part of this process, please specifically address co-occurring youth with mental health and I/DD as a population that must be afforded the flexibility that can come with the 1115 authority and not restrict their care to the 1915(c) waivers. Thank you very much.

Thank you. Our next speaker is Jaime Saunders followed by Anna Lipton Galbraith.

Wonderful, good afternoon. You can hear me? Yes. Wonderful, thank you so much, really appreciate this opportunity. I am Jaime Saunders, President and CEO of United Way of Greater Rochester and the Finger Lakes, an organization dedicated, for over a century, to supporting our community through partnerships with human service agencies, government partners and the private sector. This multi sector partnership provides a unique vantage point to see both the barriers and opportunity before us as we seek to more effectively support our neighbors through equitable access and holistic care. Our collective response to COVID-19 demonstrated the power of what is possible when the private, public, and nonprofit sectors come together with a common goal and focus for the, for the public good. Human service community-based organizations, CBOs, were on the front lines alongside government and the health care sector and did not close their doors. Collectively we met the basic needs of food, housing, health, safety, and the call for mass vaccinations at scale in a dynamic and uncertain time. Before the pandemic, human service agencies served one in five of our neighbors to make ends meet and to provide essential care. Our nonprofit partners are now reporting double and triple the demand for services in the aftermath of COVID for basic needs, domestic violence supports, mental health, substance abuse, and housing, all key areas identified in the waiver or SHERPA. Yet the nonprofit sector has not been built, nor supported as a sector. The sector we know today developed organically over decades by passionate individuals coming together to meet local needs and grew to be key partners with government subcontracting for direct services. Today, human service providers rely on a smattering of unpredictable funding, functioning within restrictive policies and regulations that have ultimately held the sector back. The waiver presents a significant and long overdue opportunity to support the evolution of supports available to meet the community needs of today and the future. But this can only happen through the evolution of funding for the human service sector, providing these critical services. We know the overarching value-based payment fee structure will not be enough to transform the sector. Due to chronic underfunding few CBOs have the infrastructure to achieve these standards, yet their services are integral to the goal for overall health outcomes. One example includes the New York state cap of 15% on administrative costs, well below the average of 30% other sectors, which has left CBOs hollowed out and left behind without adequate technology, data analytics, and practices, making the sector ill prepared to deliver in this VBP world. It is essential that there is a targeted infusion of funds and capacity building supports to ready CBOs for active participation in the vision outlined in the waiver,

complimenting existing New York State contracted work with nonprofit partners. Despite these barriers, human service agencies have proven time and again that they are a vital part of the value chain of support for our neighbors. Imagine the impact when they are invested in and have the tools they need to do their best work to innovate and to meet the needs before them. United Way has been actively engaging and listening to our human service partners in the region and offer the following list of seven reoccurring themes for your consideration. Number one, human service CBOs need increased and early investment to be ready to support the waiver. Recognizing 80% of a person's health outcomes are outside the clinical setting, we request that New York State revisit the current 4% budget allocation for the social determinants of health network to include a larger infusion for capacity building grants for CBOs, not just potential VBP partners, to help ready the sector to deliver and support essential factors in social determinants. Number two, leverage the great work already happening in the regions to jump start the goals of the waiver from PPSs, to the 211-referral network, to the state's investment in Monroe County Systems Integration Project, which just went live last month. Build on the assets already in place, with shared learning statewide to move us collectively forward faster and with better outcomes. Number three, support regional flexibility of design and implementation. Community needs, technology, and programmatic solutions will perpetually evolve and change. Building a nimble structure to allow for this inevitable evolution is prudent and most effective for long term success. We ask the state to reconsider the requirement of a single statewide data, single statewide database and other prescriptive elements as outlined in the current waiver and rather, to focus on defining the overall goals and objectives and allowing communities to leverage elements already in place and focus on interoperability and future proofing and not a single solution set. Number four, equity is more than access and must be centered in the design and implementation of the waiver from the start by directional shared language between the health systems, CBO sector, and individuals impacted by the system must be established immediately. Reconsider the, number five, reconsider the requirement for evidence based services to include evidence informed and promising practices. Evidence based is a gold standard hurdle very few CBOs can overcome. It's costly, limits innovation, and is counter to the stated equity goals by narrowing the partner set to only the largest providers. Number six, in regards to workforce investment, we need to explicitly include human service and frontline CBO staff of the social determinants of health network, not just health care and nursing homes. It is critical that frontline workers for CBOs also be prioritized, as they experience the same pressures, trauma, workforce shortages and wage compression. And lastly, number seven, leverage the relationships and expertise of United Way and the 211 network in New York State. We are in every single county and change of this scale and scope will be best served by engaging local, trusted CBO ambassadors at the neighborhood level. We are positioned to translate the health care approaches and expectations to support this transformation. I want to close by thanking New York state for this opportunity. Please know we are excited and ready to be a key partner in this much needed transformation as we innovate and build toward a more equitable and healthy future for all. Thank you.

Thank you. Our next speaker is Anna Lipton Galbraith, if I mispronounced your name my apologies, followed by Kelly Dodd. Hi Phil, it's Georgia, I'm not finding Anna Lipton on our attendee list, so if they're there, they could message us. Georgia, John Grant is speaking on behalf of Anna. Okay. Okay, please, please go ahead, John.

Hi, can everyone hear me? Yes. Great, thank you so much for the flexibility. My colleague Anna had a quick conflict. I'll go ahead and get started. Thank you to New York State Department of Health and Medicaid Redesign Team for the opportunity to provide comments on New York States 1115 waiver amendment request. My name is John Grant and I represent

Findhelp, a public benefit corporation, formerly known as Aunt Bertha. To people and organizations that help others, Findhelp is a modern safety net that brings dignity and speed to the process of getting help because our open community organization network helps all people know what social services, they are eligible for and if an organization is able to pay for the service on their behalf, all while protecting the privacy of the individual. Our mission is to connect all people in need and the programs that serve them with dignity and ease. Further, we're supporting Medicaid plans to facilitate, facilitate claims and payments to the CBOs that provide SDoH services through our marketplace program navigators can send groceries or diapers, set up rides to healthcare appointments and much more. In New York, we're working with customers across the state, including hospital networks, health plans, community based organizations and health information exchanges among others. Our social care network continues to grow across New York with over 11,700 available programs to New Yorkers and over 1,600 of those programs are in network, participating in deeper navigation for people in need. Today, I'd like to address three concepts and share lessons we've learned from supporting waiver implementation in other states, promoting interoperability, emphasizing CBO choice, and consumer directed privacy and peripheral consent. On interoperability, we believe in a truly interoperable approach to social care data exchange. This is founded on agreed upon data standards and incentivizes vendors to support consistent data reporting. Given the uniqueness of New York, we support the proposed regional based approaches to SDHNs and encourage collaborations between entities while recognizing and leveraging existing social needs referral and data platforms through FHIR integration and care management systems. We encourage the state to utilize New York's existing robust statewide community networks in the creation of HEROs and SDHNs and further leverage shiny policy and governance frameworks to promote interoperability and standards development across the state. This is especially important as federal priorities have shifted to promoting interoperable data standards with the integration of USCDI version two SDoH data elements. In recent years, other states have adopted models that mandate healthcare plans and providers use, exclusively use a single vendor for social care referrals and requires CBOs to sign exclusivity contracts as a condition of funding. This type of single vendor approach is a shortcut around building interoperable technology solutions and has not been successful in practice. Rather than taking a single platform approach, we encourage New York State to employ an approach to developing statewide IT referral infrastructure that is built upon using a built upon interoperability standards, which will shape a more sustainable and equity driven path moving forward. For example, in California, CalAIM is a vendor agnostic model and we're actively engaged in supporting enhanced care managers to order community services for Medicaid members. On CBO choice, as New York State plans to continue exploring innovation approaches serving diverse regions of the state, we believe that maintaining an open network of CBOs should be at the forefront. An open network can also be focused and include preferred providers, meaning that health plans and providers have targeted and sometimes contractual relationships with specific CBOs to target specific member needs. Health equity advancement requires both an active and focused network of service providers to meet the needs of all communities in the state. Members should be empowered and afforded the opportunity to seek services through self-navigation without being required to have someone else to do it for them. This is especially important in more rural areas of the state where navigators may not be as readily available as they are in more urban areas. State led approaches that attempt to mandate use of a single technology platform have struggled with adoption for a number of reasons, including inadequate investment in interoperability and integrations with existing systems of record and insufficient incentive for CBOs to participate. By intentionally narrowing networks that CBS can engage in, the entire community is disadvantaged by limiting the number of services people can access. We look forward to a policy guidance that promotes a health equity driven model and prohibits exclusive networks

that limit individuals access to services. And finally on privacy, incorporating referrals to social care into our health care infrastructure relies on the collection, storing, and sharing of some of our most private and personal information. As New York prepares to bolster infrastructure for facilitating referrals beyond traditional healthcare entities, it's imperative that the protection of privacy is at the center of this conversation with individuals maintaining control over their personal information. In some cases, states are defaulting to the same all-in consent model used within the healthcare system, while we're sharing health information is needed to ensure continuity of care, the health care context participating entities are governed by HIPAA standards. Within these growing social care referral networks, many participating entities are not governed by HIPAA, using a one-time all-in consent in this context to allow a broad network of service providers to access information in a centralized database compromises the privacy of an individual's most personal information. We believe that best practices build upon a peripheral consent model, where individuals opt in to share their information with each, for each referral and network members access to referral history is permission based. While HIPAA dictates how health information is shared between HIPAA covered entities, in the social care context, data sharing must be driven by the individual and can only be shared with appropriate consent and permissions. States are developing best practices to ensure that individual data and privacy is protected. In New Hampshire legislation, the legislature recently passed SB 423, which requires peripheral consent on electronic referrals to social care, could possibly serve as model legislation for other states. We encourage New York State to examine this model legislation to inform the privacy approach. Thank you again for this opportunity and we look forward to the opportunity to be a thought partner with leaders in New York as you advance this work.

Thank you. Next speaker is Kelly Dodd followed by John Croce.

Hey, this is Kelly, can you hear me? Yes. Thank you. My name is Kelly Dodd. I'm with the United Way of New York State, serving as the 211 New York Director. Thank you for this opportunity to provide public comment on the waiver proposal. For over 15 years, 211 has been integral to connecting New Yorkers statewide to services in their community that address social determinants of health, especially those who are Medicaid recipients or low income. This has never been more evident than during the COVID-19 pandemic when 211 saw a 150% increase in calls and contacts from community members, seeking help. During the pandemic, 211's across the state partnered with local and county governments, health departments, LDSS' and LDSS' to ensure residents were connected to the resources available in response to the pandemic. Those basic needs supports that helped day to day. 211's also answered calls from New Yorkers referred by, to 211, by state resources, including the New York state COVID vaccine help hotline and ERAP help line. While we appreciate that the work that 211 is doing with the New York State eHealth Collaborative to establish a trust framework and exchange of community resource information is mentioned in the waiver draft, 211 is concerned about the lack of recognition of 211 as the most current and up to date index community resource directory and is further concerned about the proposal of a statewide IT social needs infrastructure data platform, data platform, a single source. Any solution developed or purchased should be done so with transparency, clarity of purpose, clarity of data ownership, and data maintenance, including the human resource data base, meet HSDS or human services data specification standards to maximize interoperability. 211 believes that rather than the state prescribing a statewide INR platform, which would supplant existing 211 infrastructure, as well as technology infrastructure and other social care networks, the state should look to create a community information exchange linked to, linked to 211, similar to what has been done in San Diego. Recognizing that interoperability across platforms should be the goal, rather than a single tool forced upon all. 211 has the experience, expertise, and

expertise in maintaining, standardizing, cure and curating live, constantly changing community resource database. As such 211's expertise should be thoughtfully leveraged and invested in through the 1115 waiver, not taken for granted, not undermined by decisions made through the waiver. The trust built between the state, NYeC, and any statewide vendor or vendors must recognize the intellectual property and curation services of 211, critical to connecting vulnerable New Yorkers to critical services. Further, 211 New York State recommends centering and supporting and compensating CBOs ensuring that small CBOs that work to support equitable care are not left behind in SDHN networks seeking advanced VBP arrangements. 211 has data, historical data, that can support the matching of needs and CBOs meeting those needs to ensure that networks are inclusive of CBOs, large and small, within regions. Finally, 211 commends the focus on workforce. We additionally recommend connecting workforce development to information and referral services through 211 to connect services and programs that address social determinants impacting their ability, the workforce's ability to be successful participants in healthcare workforce, recognizing that many are low income and at risk, despite working and supporting Medicaid beneficiaries. Again, please take advantage of the longstanding trusting resources that exist within our communities, including 211 and United Ways. Thank you.

Thank you. Our next speaker is John Croce followed by Debbian Fletcher- Blake.

Good afternoon. Can you hear me? Yes. Thank you. My name is John Croce. I'm President of CPESN in New York, and I appreciate the opportunity to present today to the MRT committee. CPESN NY LLC-IPA is a 275 privately owned community pharmacy network that spans the whole state. We are part of CPESN USA, which currently has 44 such networks with over 3,300 member pharmacies. CPESN NY obtained both their LLC and IPA structure in 2019, allowing us to enter into both commercial and value-based payment arrangements. Our members are pharmacies providing enhanced services and support beyond just providing prescriptions cheap, accurate and fast. CPESN NY LLC's common goal is the delivery of enhanced services outside of the traditional pharmacy dispensing model to decrease overall health care costs and improve patient's outcome. We have been able to demonstrate this by collaborative efforts with the patient's health care team, care managers, social workers, a pilot program with Healthy Alliance under DSRIP for a behavioral health medication management program, and with many others in removing barriers to a patient's wellbeing. Community pharmacy has been a trusted member of a patient's care team. A big component of that service is the staff that performs the service. These are the owners, highly invested in the communities. Many times, the only pharmacy provider in that underserved or rural area are these privately owned community pharmacies, as many of the big box providers have left their market. It is this commitment to the community that helps support our goals. In whole, the pharmacy community rose to the challenge and needs of the COVID pandemic imposed upon all of us. Community pharmacies remained open with no interruption of service by providing same day home delivery, curbside consulting, and drive through services. Community pharmacy was a linchpin in our states and national approach to providing vaccinations. Specifically, CPESN's pharmacies being in outlying areas was able to not only have the vaccine available in those zip codes, but actually got the vaccines in the arms of their clients who have known and trusted them for many years. On some of the specific comments in the proposal, under the HERO governance, we request that community pharmacies be included in the composition of the governance boards of the HERO entity. Not including community pharmacies along with hospitals, behavioral health entities, CBOs, RHIOs, and others would be a missing piece in the developing regional plans and the impact that pharmacy care management could make on those plans. Under Goal 1.3, the value-based payment investments, there's a couple of comments. I would recommend that the data access and data

flow shown in the social determinants of health network exhibit two be readily accessible to all providers and participants with minimal barriers. I recommended a universal platform to address data collection across different healthcare systems, EMRs, and providers. I ask, how will the services and data collection be arranged for clients who are not members of the lead MCO in the social determinants of health regions? And then finally recommend that safety net provider status should not be a factor under this waiver amendment, including the social care components of value-based payment arrangements. As we draw on the lessons learned from DSRIP, there needs to be many considerations on how data is handled in achieving our goals with the incorporation of MCOs as drivers in these arrangements, there needs to be an efficient and secure method of access and promise of the access itself. Pharmacy has a strong method of data collection during the RX filling process and can be a resource for data as well as a productive user of the data outside of our set when assessing outcomes. With regards to capacity, billing, training, and work force strategies, I request that pharmacy staff such as clerks, drivers, and technicians be equally considered in this workforce environment enhancement. Community pharmacies were hit just as hard as hospitals and nursing homes but are not specifically mentioned in this proposal. Career ladder are mentioned for entry level workers with strong community ties, such as home health aides and dietary aides, but again, no mention of any pharmacy aides or personnel in this category. CPESN NY LLC-IPA is currently in a pilot with Healthy Alliance to provide pharmacy staff community health worker training. Combining the high level of trust and interactions that community pharmacies have with their patients, and with the effective screening and referral through the Unite New York platform, it has been shown to be a very powerful force in addressing social determinants of health needs in their communities, communities. Under Goal 2 of supportive housing services, I recommend a request that pharmacy and visiting nursing associations be mentioned highly in supporting aging in place programs. Having CPESN pharmacies provide medication management in a collaborative environment with visiting nurse's associations ensure patient adherence and allows a visiting nurse to be a nurse, to allow them to assess social determinants of health screening, asthma triggers, assessment of disease states, and have better care for the patient overall. Generally, there needs to be a plan for continuity of services for patients who cross into other regions and also a statewide social care referral network, including the technology and the human referral navigation, should be considered so that our patients and staff have a common experience across the state. This will be efficient for certain programs with common needs, goals, and services to be delivered consistently. In closing, I just like to state as much as the health and social disparities were exposed by the COVID pandemic. It also exposed the value of pharmacy beyond the traditional view of filling prescriptions. I hope the innovative nature of this waiver takes it full advantage of pharmacies, increase role in improving patient social and healthcare needs. Thank you.

Oh, thank you. Our next speaker is Debbian Fletcher-Blake, followed by Karen Lipson. Do we have Debbian Fletcher-Blake on? Debbian is on and unmuted but may be muted on her end as well. Debbian, if you're on, we cannot hear you. If you could please send an email to our BML that would be helpful, and we can add to you in on our list of speakers. Moving to our next speaker, Karen Lipson.

Are you on? Yes, I am. Can you hear me? Yes. Great. I'm Karen Lipson. I'm an Executive Vice President with LeadingAge New York. LeadingAge New York is an association of not for profit and public providers of long term and post-acute care services and aging services. We were pleased to see the sizeable investment that the state intends to make in addressing health equity and the stability of the health care delivery system through this waiver. However, we were sorely disappointed to see that the proposed waiver once again overlooks the older adults on Medicaid, and the long-term care and aging service system that serves them. 86% of

New Yorkers who died of COVID were over age 60, 48,000 people. It is undisputed that older adults were disproportionately hit by COVID, yet this waiver effectively casts them aside. We saw the same inequity and inattention to older adults and long-term care providers under the prior DSRIP waiver. Only 1.3% of DSRIP funds were allocated to long term care providers. One lesson from DSRIP is that we need specialized approaches to address the needs of dually eligible older adults and long-term care. Let's not make the same mistake again. Working towards health equity includes combating ageism in our health care system and ensuring access and quality care to individuals with age related functional limitations. The biggest problem with this waiver, from the perspective of dual eligibles and older adults who are overwhelmingly covered by Medicare and Medicaid, is its reliance on advanced VBP arrangements to drive the investment in the health care system. This approach ignores the bifurcation of funding between Medicare and Medicaid for older adults. It is very challenging to develop advanced VBP arrangements that involved, that involve the dually eligible population and incorporate the long-term care system and that's probably why the proposed waiver's discussion of value-based payment does not address dual eligibles or the long-term care beneficiary cohort. VBP will not drive meaningful investment into the long-term care system during the term of this waiver. I want to turn to the social determinants of health. We support the concept of integrating interventions addressing the social determinants of health and health equity into the deliver, delivery of health care, and we support regionally driven efforts to ensure that interventions are aligned with community needs. We're fortunate to have a broad away, broad array of social care interventions already embedded in our long-term care system, in MLTC and PACE programs and in the aging services system. The waiver should not duplicate those efforts. It should not create new layers of costly administration or force plans and providers to reconfigure their services and disrupt existing relationships. It's worth noting that the waiver's approach to social care assessments is inconsistent with the Department's current policy of implementing independent assessment for personal care and managed long-term care. We prefer the waiver's approach of allowing plans and providers to conduct assessments. So, what should New York State do for its dually eligible older adults? It should provide a targeted alternative mechanism, tailored for long-term care to drive investment in the long-term care system through the waiver in lieu of the advanced VBP arrangements that are currently proposed. It should address social determinants of health for older adults in part through investments in service coordination, in affordable senior housing. This is a proven model that saves Medicare and Medicaid dollars and helps older adults remain independent in the community. It is not technically supportive housing. That is a different model. For older adults who need 24/7 supervision and support, but do not need skilled nursing care and cannot access that 24/7 support in an independent living setting, we should invest in the Medicaid assisted living program. For Medicaid beneficiaries who require nursing home care and cannot access the skilled nursing they need in the community, we should provide operating support for small house and greenhouse facilities. We should support the reopening of adult day health care programs, and we should invest in social care for dually eligible older adults who don't need long term care services. They have a gap in access to social care services. The waiver presents an enormous opportunity for our health system, and our long-term care system and it would be a shame to once again overlook older adults and long-term care. Thank you.

Okay, thank you. We have Debbian Fletcher-Blake back on the line. Please go ahead.

Thank you, can you hear me now? Yes, I can, thank you. Thank you. Thank you for the opportunity to comment on the 1115 waiver. My name's Debbian Fletcher-Blake, I'm CEO of VIP Community Services. We are multi-service organization in the Bronx providing health and housing services. There's a lot of flexibility as to how final decisions will be made by HEROs, MCOs, the SDHNs. Flexibility is good. It will allow for innovation to address real needs and

waiver goals. However, there should be concerns that with great flexibility, along with historic dominance of health systems, such as MCOs, that funding mechanisms could disadvantage CBOs and the people they serve. The complexity of the 1115 waiver will also advantage these large organizations with significant resources. The state should consider structures and continuing oversight to ensure equitable and beneficial distribution of dollars to achieve the waiver goals and to ensure that the state does not repeat the errors of DSRIP, in which effective CBOs were largely left out. The goals of the waiver are comprehensive and offer significant opportunities for providers, communities, and also the Department of Health. To better understand how these goals will achieve the desired health equity, it is important that health equity is defined, and a health equity framework is developed to guide the process. As such, I recommend the DOH to define health equity and to develop a framework for providers. Further, I recommend the DOH defines social care. The waiver discusses involvement of many sectors and professionals. The HERO structure diagram calls for collaboration and coordination among many groups but falls short of naming Medicaid recipients. Equity can be achieved only when all are included and represented. I recommend that the DOH utilizes the federally qualified health centers 51% board requirement and require that governing boards established through the waiver have a 51% majority Medicaid recipients. While the waiver is clear on assuring language access, it does not go far enough to require health literacy as a key component. In light of the devastation, people of color with chronic illnesses faced during the pandemic, health literacy must be comprehensively addressed. I recommend health literacy being incorporated as one of the tools to accomplish health equity. Further, the waiver provides for differential attribution through behavioral health providers, health homes, care coordination organizations, as well as primary care providers. There are enormous complexities inherent in these methodologies. For example, there are patients who will receive article 31 and 32 services from different providers, sometimes in different boroughs. Attribution in such cases will be extremely difficult to manage, especially when patients fall in different networks. Also, the current methods used to attribute lives to providers is arbitrary. Sometimes providers are unaware of attributed lives, which is detrimental to both those providers as well as the patients themselves. In such cases where attribution will be a barrier to equity, I recommend the DOH considers other funding methodologies, such as per member per month reimbursement based on services provided and a degree of patient engagement. Such reimbursement methodologies will be more equitable for the patients, behavioral health providers, and CBOs. As the waiver asserts, HEROs will develop their own unique measures based on needs of the region. I am in agreement with this requirement. However, the issues of health and social inequity facing communities in New York State have a common thread. As such, some measures should be developed by the Department of Health uniformly for all regions. This will allow for comprehensive evaluation of outcomes at the state level while not hindering HEROs from addressing issues that are local. The DOH should have responsibility over these region planning measures. I recommend a state convened advisory board that evaluates outcomes to determine when equity is achieved. And finally, the DOH's resolve to redesign and strengthen system capabilities to improve quality and advance health equity is commendable. In addition to our hospitals and nursing homes, federally qualified health centers, behavioral health providers, and CBOs are pivotal as safety net providers during the travel waves of the pandemic. These providers serve the state's most vulnerable populations and were already experiencing declining operating margins even prior to the pandemic. These organizations must be strengthened to continue providing high quality and equitable services to New York State communities. I recommend the state includes FQHCs, behavioral health providers, and CBOs in the value-based pool that will be available to financially distressed safety net and critical access hospital and nursing homes. The rest of my comments will be provided in written form. Thank you for your time.

Thank you. Our next speaker is Zachariah Hennessey followed by Jeff Kaczorowski.

Good afternoon, my name is Zach Hennessey and I represent Public Health Solutions, New York City's largest public health nonprofit, serving over 100,000 New Yorkers per year. PHS currently coordinates a community resource network in New York City, which is similar to what the state describes as a social determinants of health network, where we partner with organizations along the continuum of care- health plans, healthcare providers, and our network of nearly 300 community-based organizations to connect New Yorkers to resources that resolve their unmet social needs. Through our experience, we have found that local planning and collaborative design among health and human services providers is essential to successful enrollment and engagement in community-based services and improving outcomes. We especially believe strongly in the importance of CBO engagement in network decision making. This was validated by our multi part symposium series, which brought together key stakeholders from government CBOs, providers, payors, technology companies, and philanthropy to develop a road map to advance health equity in New York City. This has been recently released and available on our web site. The learnings, along with our own experience, revealed the importance of local community engagement and participation in the planning, design, implementation, and evaluation of a network, including the intended beneficiaries of the proposed reforms. Because New York City has tremendous community diversity, the individuals and organizations who represent local priorities and understand these diverse needs must have a seat at the table. This is also where the role of a lead entity within a network is important. These organizations should be well connected to local communities and have already built trusted local relationships. They should have the capabilities to manage contracting and payments effectively, established community led planning groups to set local priorities, work with local health care providers to develop effective workflows, ensuring meaningful clinical integration, and engage local community members in quality and evaluation activities. If the social determinants of health network is to become a sustainable part of the public health infrastructure, it must be agnostic and sufficiently flexible to scale and serve the needs of those, beyond the scope of the Medicaid program. It must address the health-related social factors that drive population health outcomes and health equity for all New Yorkers, including the uninsured, those living with specific vulnerabilities, the undocumented and otherwise disconnected. It will also require a larger investment than the 15 million proposed for New York City where 60% of Medicaid members reside. With greater investment and autonomy, social determinants of health networks can develop a broad-based network that supports Medicaid and value-based payment methodologies. Health care partners would be able to purchase a unique suite of services from the social determinants of health networks, including value-based payments, in lieu of services, and direct grants based on their populations needs and priorities. But to ensure high uptake and usability for the CBOs, the system should be built to ensure that these networks can also fund services related to identified gaps that are not covered by VBP arrangements, or contracted providers. This will also help to ensure that access to essential services, such as housing, food, and transportation do not become overly dependent on membership to a specific health care provider or a plan. Continuing, the proposal leaves open the possibility for a region to be subdivided into multiple sub regions. I'm sorry, my screen froze. At PHS, we strongly believe there should be only one network infrastructure for the city. New York City is a unique, apologies, New York City is a unique environment, and many of the cities' CBOs provide services across multiple boroughs. Given the overlapping service footprints, if New York City is divided into multiple regions, these organizations would be forced to limit access. It also leads to a greater potential for different screening, measurement, evaluation tools, payment points, and value-based payment models across boroughs, further complicating collaboration within the network and the administration and evaluation of these networks. Finally, based on the current proposal, MCOs are

encouraged to contract with the social determinants of health network, but they are not clearly financially incentivized to engage in arrangements that utilize these networks. We encourage the state to expand your plans to create a structure under the waiver program that extends the current proposed incentive awards for MCO and provider participation in HEROs to network utilization. Based on our experience, if these organizations are not incentivized to use social, the social determinants of health network, the potential for substandard contracts between CBOs and managed care organizations is high. Additionally, alternative arrangements would result in variable payment points and alternative IT and infrastructure requirements within a given region. This leaves CBOs susceptible to inequitable contract terms, multiple technology platforms and payment models, and decreases access to their services. The States should consider policies that will support health and human Services integration into these networks with the goal of driving meaningful progress towards achieving health equity at scale. Thank you. PHS is ready to support the state's program to the best of our ability and welcome further engagement with the state as you finalize your plans.

Thank you. Our next speaker, Jeff Kaczorowski followed by Sarah Ravenhall.

Hi, I'm Jeff Kaczorowski. I'm a pediatrician and I work at the Children's Agenda in Rochester, New York. I'm also professor and vice chair of pediatrics at the University of Rochester Golisano Children's hospital and I'm the volunteer Co-chair of the New York State First 1000 Days on Medicaid initiative and Co-chair of the Child Health Value Based Payment Clinical Advisory Group. Thank you, Selena. Thank you, Brett, and Amir. I'm here to talk about children in the waiver and really lack of children and families in the waiver. We're excited about this waiver focused on equity. That's a very important distinction. It's an unprecedented opportunity to improve the health of many New Yorkers in its implementation over 5 years, but then structurally into the future, to improve health outcomes and cost effectiveness. And given that, it's really disappointing and it seems almost unconscionable that the waiver does not explicitly focus on children's health, especially their mental health and it does not focus on the tremendous disparities in maternal morbidity and maternal mortality and early childhood health. This is in spite of the fact that with this proposed waiver focused again on equity, children are the poorest and most diverse segment of our population and the largest proportion of New Yorkers to be covered by Medicaid. New York State Medicaid and Child Health Plus provide coverage for 41% of the states' children 0 to 18. 60%, 60% of children under the age of 3 and 50% of pregnant women in New York are on Medicaid. In the last significant Medicaid waiver ending in 2020, children were also not a priority. It's time to change that. I want to focus my comments on two areas, children and youth mental health and maternal and early childhood health. By everyone's account, the mental health for children in our country is a crisis. One that has been more revealed and exacerbated by the pandemic. Every major medical entity, including the surgeon general has stated that children's mental health is a crisis. There are weekly stories in the New York Times about the children's mental health crisis, including this past Sunday front page headline, "It's Life or Death". U.S. teens are facing a mental health crisis. 50% of parents in New York say that their children's mental health is a crisis. More for children living in poverty and who are black or brown. This is an equity and pandemic issue. We argue that this is the premier pandemic equity issue. yet the New York State proposed Medicaid waiver does not address it with any planned implementation or investment. There is a lot that can be done to address this issue. Including partnerships with schools, CBOs, and primary care practices. And primary care and mental health child, mental health care clinics should be expanded to schools. We asked that the Medicaid waiver explicitly and specifically indicate that children of all ages with mental health concerns are a priority population that must be addressed with this funding innovation just as it has for the criminal justice involved in the homeless and the long-term institutionalized populations in the

current proposal. There are nearly two million children on Medicaid and New York state, and half of them are experiencing significant mental health problems. We would ask that the minimum investment should be 1.5 billion dollars similar to the investment that's designated to homeless and long-term institutionalized populations. For maternal and child health outcomes, New York has some of the worst outcomes in the country. Our maternal morbidity and mortality statistics in the United States are among the worst in the world. Black women are five times more likely to die than white women during pregnancy in New York state. And black infants are twice as likely to die compared to white infants. There's a lot that we can do about this, too. We recommend four specific additional strategies. One, continuous coverage on Medicaid for children and their mothers from birth to child aged 3. Maternity post-partum care coverage was just extended in New York state from 60 days the 1 year after birth. Thank you. Washington state has just guaranteed continuous coverage for children on Medicaid from 0 to 6 years, 0 to 6 years of age. Two, support for parents of all newborns, universal home visitation to reduce infant mortality and morbidity and maternal mortality and morbidity for all new parents and their babies, has been passed as legislation in both Oregon and New Jersey. The New York State First 1000 Days initiative that we are involved with is supporting initial implementation of home visitation and telehealth visits focused on all newborns and parents. This pilot needs to be expanded, expanded statewide. And at the end of 5 years, we should have a plan for universal parent supports for all children in New York. We could afford that. Three, there are significant and clear value in two generation, family-oriented approaches to address parent's mental health concerns, parents and families' social needs and the development of children. And four, for telehealth connections mentioned in the fourth part of the waiver, both providers and families need to have stable and universal access to the Internet, necessary equipment and training. This has to be available to families too. And that's a significant problem for families with young children, the poorest demographic in New York state. In our region in our FLPSS region, in our PPS region, in the last waiver, we chose to have a focus on maternal and child health, and it resulted in decreased teen pregnancies, increased children developmentally on track and ready for school, and improved maternal and infant morbidity. This can be done, but it needs to be done in a structured way, statewide. There are resources that I want to point you to that can help. Specifically the recommendations of New York State's First 1000 Days Committee on Medicaid, and also the New York State First 1000 Days Preventive Pediatric Clinical Advisory Group report. Thank you.

Thank you. Our next speaker is Sarah Ravenhall followed by Jim Sinkoff.

Hi, good afternoon. Can you hear me? Yes. Thank you. On behalf of the 58 local health departments in New York state represented by their association in New York State Association of County Health Officials, or NYSACHO, we're grateful for the opportunity to provide testimony during today's hearing. I would first like to thank Commissioner Mary Basset, Mr. Amir, Bassiri, and others at the State Department of Health for including our recommendations regarding the local health departments' unparalleled role in health equity, emergency preparedness, and the Medicaid 1115 waiver plan. Since we issued our recommendations, we've seen broader recognition of the strengths local health departments will bring to enhance this program and included eligibility to apply as regional HEROS. Local health departments are diverse entities, in that they serve unique populations, provide varied services, have access to different resources. They're governed differently, staffed differently, managed differently and beyond. So, it should therefore be no surprise that these departments will also vary in the way in, which they envision their role as leaders in the States plan for the 1115 waiver program. While vastly different in many ways, there are commonalities make it so that, despite final agreement on how each department ends up participating, they should and must be involved in local planning to ensure the success of the program. All local health

departments have a statutory obligation to assess the health of their communities and to address the root causes and inequities that impact health outcomes. Unlike the healthcare sector and community-based organizations, local health departments are also unique in that they are public servants whose work is to protect the health of their community, rather than a specific patient, or client base. As such local health departments are uniquely situated to serve as convenors bringing together a broad range of stakeholders. Over the past decade, the State Department of health has purposely aligned the community health assessment process with hospitals, IRS community service plan requirements and using the state's prevention agenda to help guide priority health needs, these local partnerships have identified the statewide and local priority, health areas of greatest need and impact in their communities. This alignment assures a comprehensive community health assessment, and the development and implementation of community health improvement plans that engages many sectors in population-based health interventions. Through previous DSRIP MRT efforts, the department focused on public population health outcomes by engaging clinical providers through payment driven incentives with limited recognition and utilization of the expertise of the local public health system. At the local level, these linkages are largely dependent on the willingness of the provider community to work with the local health departments. So, NYSACHO recommends the state focus on the following during the next phase of the 1115 waiver plan. Formally require local health departments be included in the waiver development going forward, prioritize local health departments that wish to serve as the Health Equity Regional Organizations, or HEROs in their region, and includes language that allows alternatives to a separate governance form in recognition of local health departments governance structure as well as their statutory role as local government agencies. While departments that wish to apply and service HEROs should be given this priority, it doesn't mean that every local health department will participate as such. Assure that the HEROs and Social Determinants of Health Networks identify, compliment, and enhance existing population health initiatives and programs that are run by local health departments and that waiver related funding mechanisms support these efforts to the extent possible within federal limitations. Please identify and share information with local health departments about program development for example, what data and formula was used to develop the Medicaid rate setting regions? When the local health officials have access to data and an understanding of state programs, they're better position to help support and communicate to the public. We appreciate the opportunity to provide input today and urge that local health departments continue to be integrated into the population health and health equity initiatives proposed in this waiver application and look forward to working with you. Thank you so much.

Thank you. Our next speaker is Jim Sinkoff, followed by Joanna Loomis. Hi Phil, it's Georgia. I'm unable to find Jim in our attendee list. Okay, thank you Georgia.

How about is Joanna Loomis on the line? Yes, I am. Can you hear me? Yes, I can. Please go right ahead. Alright. Good afternoon. North Country Initiative, NCI, and Fort Drum Regional Health Planning Organization, FDRHPO, appreciate the opportunity to provide feedback regarding the proposed waiver amendment. As a former PPS that manages multiple value based arrangements and a health planning organization that served as the population health improvement program within Jefferson, Lewis and Saint Lawrence counties, NCI and FDRHPO support the waiver request to CMS to promote health equity and facilitate VBP maturation. We strongly support the following components. First, HEROs funded directly by New York state and incorporating input from appropriate stakeholders and SDHNs integrating the spectrum of health partners to collaboratively, identify address and track social care needs. We also support that HEROs and SDHNs may be pre-existing entities. Second, support for maturation, including funding to support the transition into risk, socially risk adjusted payment and per

service funding to CBOs. We applaud incorporation of risk mitigation funding, especially for rural, critical access and/or financially distressed providers for whom the transition into risk is not possible without such supports. Third, incorporation of behavioral health attribution methodologies and the VBP roadmap. Fourth, workforce support for traditional and nontraditional rules, innovative strategies for recruitment and retention, and training to support culturally competent care teams. Fifth, Funding to promulgate innovative and effective telehealth best practices and special supports for individuals with mental illness and/or substance use disorder, those in need of supportive housing, and criminal justice populations. We urge that additional considerations should be made to address the following: First, regions. To meaningfully advance the waiver's goals, there will need to be more than the nine proposed regions. We disagree with combining rural and urban areas that are geographically contiguous, but do not have similar populations, a history of collaboration, or share existing IPA/ACO structures or VBP arrangements. NCI and FDRHPO's proposed region is disparate and includes partial footprints of 5 former PPS. We strongly advocate for our region to consist solely of Jefferson, Lewis, and St. Lawrence counties, to leverage our ability to meaningfully impact our populations. Second, a region's HERO and SDHN should be allowed to be the same entity where appropriate. Third, the role of MCOs. We advocate for clearly defined parameters to transparently guide the contracting process, given MCO's historical leverage in negotiations. Any funds flow through, or by should be clearly governed, including a requirement for approval by the VBP provider network. Changes to MCO premiums and allowable medical costs should be evaluated for the impact on VBP performance as contracts are often measured according to medical expense ratios, which consider premiums received and healthcare expenditures for attributed populations. MCOs must be required to provide robust and timely data. Currently, data provided to ACOs and IPAs is inconsistent across payors in terms of content, format, and timeliness. Fourth, VBP maturation. While we support the inclusion of specialized arrangements and global capitated models, we caution the not every region's population supports adoption of such models, which especially in rural areas, may result in low population and denominator sizes, leading to statistical noise and unreliable results. It is therefore important to value the role that total cost for general population as well as non-capitated arrangements play in the value based care landscape. Fifth, the role of primary care. We strongly advocate for the continuance and enhancement of per enrollee per month supports to PCMH practices. Primary care should continue to serve as the hub for patients care management. We also note that chronic care management and transitional care management are not Medicaid billable and advocate for these services to be billable to Medicaid as part of this waiver or otherwise. And finally, community health workers and peer services. To maximize the impact of these uniquely positioned roles and ensure their sustainability, these services should be universally billable. That is, available to all Medicaid members and at rates commensurate with their impact and with a significant hiring and training investments they require. On behalf of NCI and FDRHPO, we appreciate your consideration. Thank you.

Thank you. Our next speaker is Rolanda Ward followed by Charles King. Please go ahead.

My name is Rolanda Ward and I'm an Associate Professor of Social Work, and the Endowed Faculty Director of the Rose Bente Lee Ostapenko Center for Race, Equity and Mission at Niagara University. Thank you for the opportunity to share insights with you about the impact of the COVID-19 pandemic in our area. Over the last two years, I have served as a facilitator of our Niagara Falls Health Equity task force, and during this time our task force has worked to identify the barriers community members face as a result of this pandemic. Our understanding about how to meet the needs of community members, in order to meet the needs of community members, we need to build a health equity network that includes the major systems

found in most social determinants of health models. We found that when we brought together CBOs and key leaders from school districts, family support nonprofits, workforce development nonprofits, food insecurity organizations, and healthcare institutions, we found significant success. We found out with a common goal, members of the task force were willing to attend our weekly, at first, meetings, and now biweekly meetings, in order to identify current regional gaps as well as solutions that could be driven from our collective resources. Our task force used key data indicators to increase health equity for targeted zip codes and racialized populations. We found success and increased health equity for individuals who are unable to navigate the healthcare system as well as government systems developed during the pandemic. We object, sorry, we support the objective of the waiver and we support the concept of Health Equity Regional Organizations. We do urge you to consider how informal conditions and task forces are creating outcomes that sit outside of government. Our task force saw firsthand how intentional activities that identify vulnerable populations could be met from a local level. As a region that sits at 59 out of 72 regarding health outcomes, we decided to invest human capital to transform historical outcomes. We urge you to consider how local organizations are supported with resources, financial resources, technical assistance in order to do what is identified as a community goal. In addition, we urge you to consider how real time data is distributed to local organizations that are working to address health disparities. The pandemic revealed how data can be made more transparent in order to target specific populations. Finally, I would like to encourage you to consider the role of the local physician. We found that local physicians were less likely to take an important role during the pandemic because of the barriers they experience on the provider side. Health disparities are addressed when collaborations exist with CBOS, healthcare organizations, government and information distributing organizations. We recognize, lastly, we recognize that counties have different needs and that urban area have significantly more resources than rural areas or first wing counties. We urge you to consider how the voices of rural counties will be received when developing regional plans that are heavily, heavily concentrated on urban needs. I thank you for this opportunity for input and I welcome follow up.

Oh, thank you. Our, our next speaker is Charles King followed by Laurie Lanphear. Please go ahead.

Thank you for the opportunity to provide comment on the New York State Department of Health draft 1115 waiver amendment. Housing Works, I'm the CEO of Housing Works and our comprehensive prevention and care services include four Federally Qualified Health Centers in medically underserved, New York City communities, over 700 units of supportive housing, mental health and substance use services and a range of supportive services from care coordination to job training, all delivered using a low threshold, harm reduction approach. Housing works welcomes and strongly supports themes of the draft application for 13.52 billion dollars in federal funding over five years for a new 1115 waiver demonstration, explicitly targeted to address things such as, social determinants of health and lack of community driven planning to continue to drive persistence and unacceptable health disparities experienced by many Medicaid beneficiaries. While it is true that New York state health inequities are highlighted a new by the COVID-19 pandemic, they have long characterized the disparate impact of HIV, Hepatitis C and other public health crises in our state. Housing Works is pleased to see that the waiver application sets out new planning and implementation structures that adopt a potentially more in utilitarian and effective approach than previous MRT efforts. Experience has demonstrated that the initial MRT process was largely window dressing to give the appearance of community engagement while the outcomes were being negotiated by powerful interest groups behind the scenes. That said, there were a number of solid community developed recommendations, many of which were adopted, including harm

reduction as a treatment modality within OASAS licensed facilities, the waiver that allows syringe exchanges, to bill Medicaid for counseling services and various MRT housing pilots. But other important ideas such as respite care for people experiencing homelessness or housing insecurity notably included in the current waiver application were killed by bureaucrats most significantly former Governor Cuomo and his Department of Budget broke the fundamental promise to reinvest savings realized through Medicaid Redesign to improve individual and community health. Savings realized through Medicaid Redesign where to be invested in housing and other interventions to address social and structural barriers to effective prevention and care. After only two years, however, DOB instead began raiding the Medicaid program savings for the general fund to balance the New York State budget. Housing Works has long understood the importance of addressing social drivers with the HIV epidemic. We formed housing works in 1990 in direct response to the inability low-income New Yorkers with HIV experiencing homelessness to gain access to safe and stable housing. There is a large body of consistent, empirical evidence that safe, stable housing is essential to support effective anti-viral treatment and sustain optimal health for people with HIV and makes it impossible to transmit HIV, including New York state data, showing that unstable housing is the single strongest predictor of poor HIV health outcomes accounting in large part for HIV related racial disparities. From our beginning Housing Works has understood that housing is healthcare and has been committed to low threshold harm reduction approaches to housing assistance where admission and retention in housing is based on behaviors rather than status as a drug user, person with mental health issues, or other conditions. While we support the regional planning by HERO to gather information available on housing resources, the truth is that existing and planned supportive and low-income housing resources are still far short of need. Although housing works welcomes the inclusion of enhance of the enhanced supportive housing pool outlined in the waiver application, we noticed, we note that the use of funding provided appears quite limited. It must be recognized that housing is a powerful health maintenance and prevention tool, especially for persons experiencing homelessness who are highly vulnerable to violence and our acquisition of HIV, HCV, or other infectious disease, such as people have trans experience, homeless and runaway youth and young black, and Latino MSM. Housing Works long experience also demonstrates the importance of integrated community focused responses that include a range of non-medical interventions that work to overcome barriers to effective care by providing wraparound services, designed to target social determinants of health outcomes. The proposed waiver application, likewise, underscores the importance of such initiatives therefore, we are deeply concerned that current plans to carve out the pharmacy benefit from Medicaid Managed Care to fee-for-service, which would eliminate an estimated 8 million dollars for Housing Works alone annually in 340B program savings is directly at odds with and will undermine the stated goals of the proposed 1115 demonstration project. Housing works four health centers, provide comprehensive prevention and care services over 8,000 individual's annually over 70% of whom rely on Medicaid and the majority of whom face multiple barriers to healthcare access and effective care. Savings realized 340B, federal drug discount program are reinvested by housing works to support integrated services that include HIV, testing, prevention, and care. It is impossible reconcile current plans to eliminate access by New York safety net providers 340B savings with the stated goals of the draft 1115 waiver application to advance health equity. Housing works urges New York State Department of Health to reverse the planned carve out of Medicaid Managed Care pharmacy benefit in the interest of rallying every resource at our disposal to promote health equity and end the public health crises of HIV, HCV, overdose and related conditions, thank you.

Good, thank you. Our next speaker. Is Laurie Lanphear followed by Anne-Elizabeth Straub. Please go ahead.

Good afternoon, thank you for the opportunity to provide verbal comment on the 1115 waiver amendment for this committee. My name is Laurie Lanphear and I'm the Executive Director of the Coalition of New York State Health Homes. The Coalition of New York State Health Homes represents 26 health homes across every region of New York State with member Health Home and enrollees totaling over 155,000 adults, children, youth, and families, including those with the highest medical, behavioral health and social care needs in the state. Health Homes and their associated care management agency networks have repeatedly risen to the challenge, adapted, improved, become more efficient, demonstrated significant positive health outcomes for members, and continued to do so, despite the enormous challenges they have faced over the past years. We feel the infrastructure and model of health homes is uniquely positioned to play an integral role in supporting the goals outlined in the 1115 waiver. This community based support of meeting members where they're at with a boots on the ground approach was particularly valuable during the COVID-19 pandemic, and will continue to be necessary post pandemic. We appreciate all the effort time and energy. The state has put into developing a concrete, comprehensive roadmap to post pandemic recovery that is outlined in the 1115 amendment draft. We're excited and ready for the opportunity to support the state and the efforts outlined. I would like to take some time to provide verbal comments on why Health Homes will be integral in the success of the 1115 waiver amendment. The coalition of New York State Health Homes has submitted comprehensive written comments in addition to what I would like to review today and it's happy to answer any questions or clarify. The Health Home Coalition would like to present four main points for consideration and updating the 1115 waiver amendment draft. These include number one, to ensure that Health Homes are not in afterthought in the VBP program, we strongly advocate that the state require qualifying contracts to use established Health Homes as the Medicaid care management partner, where applicable, for eligible populations. In addition, we ask that the state require or strongly encourage networks in the VBP entities to leverage Health Home care management more broadly to ensure efficiency and reduce the, the risk of redundant layers of care management for eligible Medicaid members. It would be wasteful and inefficient to discard the infrastructure that has been built in Health Homes, rather than to continue to improve and enhance them. Health Homes have proven models, population health outcomes, and are an essential component of future advanced VBP arrangements in the Medicaid environment. Health Homes are at risk of operating on the fringe, unless they are already established as a core vehicle within a larger health system or population health focused organization. A second request is that we request DOH position Health Homes formally within the structure of and SDHNs and HEROs as a required component of governance as the care management entity in the region. We request language in the waiver, specifically listing Health Homes with a defined and formal role, which could be either as a lead or a participant in the HEROs and SDHNs. And. Thirdly, we asked that state, we asked at the state, add care managers and Health Homes to the list of entities and professionals that would be the target of workforce investment through the WIOs. Health Homes are the fabric that has continued to knit together a fragmented health care delivery system while at the same time, experiencing a workforce crisis like never before. Without investment and our most valuable resource, our workforce, Health Homes remain at risk of providing this critical care management service. Lastly, we strongly encouraged the 1115 waiver amendment add Health Homes and care managers to the planning and inventory effort into the list of providers who can assess and determine to connect individuals with housing services. This would also include a requirement that HEROs and SDHNs to collaborate with Health Homes on their housing related deliverables. Health Homes have proven that community level care management interventions are successful and addressing social care needs such as housing with numerous positive outcomes that speak for themselves. In conclusion, the Coalition for New York State Health Homes is optimistic about the opportunities the 1115 waiver document outlines to address health disparities and equity

from the lessons learned during the COVID-19 pandemic. Health Homes, and their associated care management agencies were on the front lines, addressing these disparities and ensuring members received the care that was, and continues to be, desperately needed. We stand ready to support you, our State partners, in the 1115 waiver initiatives, in serving the most vulnerable New York State Medicaid members. Thank you for your time.

Thank you. Our next speaker is Anne-Elizabeth Straub, followed by Jordan Goldberg. Anne please go ahead.

Yes, can everybody hear me? Yes. Thank you. My name is Anne-Elizabeth Straub. Thank you for the opportunity to speak today on the 1115 waiver. I am a member of the Civics League for Disability Rights, an advocacy group with members living in Brooklyn, Manhattan, Queens, and the Bronx. My remarks differ slightly from what I submitted in writing, because I'm responding in part to issues that have been raised during this meeting. I am here today because it is our experience as adults with physical disabilities that we are frequently left out of the planning process with the health care planning. As we've heard in this meeting, this is also the experience of other consumer groups. The Civics League suggests the following. To address the needs of adults with physical disabilities living in the community, New York state needs to come up with a plan to count people with physical disabilities and to know where we are. During the pandemic, this was number one barrier for people getting help. It was lack of information about where, where our members, what our numbers were and the locations. In other words, how many of us there are, and where we were. We would like, we urge, that we use some of the funding in this waiver to make disability a demographic identifier, so we're counted with attention to maintaining privacy. The issue of counting people has also been identified, not only for our state, but in general, and was mentioned by the CDC in one of the recent webinars. We think that there should be a requirement that participation by people with lived experience in the development of the Health Equity Regional Organizations. We know that there is not sufficient data, excuse me, to represent our experiences. With no representation, we feel we will be left out again. We would like that there be a requirement that any programs include specific measurable quality goals that speak to the specific needs of people, people with physical disabilities, or any other consumer group. Use, how can this be accomplished? Use the waiver to create a specialized program for people with disabilities that focuses on the health outcomes of our community and have us included in its development. If we are at the table during planning, we can make sure that we're not left out. Our needs are different from the I/DD community, from the HIV community, and the behavioral health community. Well, even though individual members of all those communities might also have a physical disability. The version, the first version of the draft document actually didn't even have physical disabilities people mentioned and it was the only due to advocacy that people with physical disabilities were added. Why should that have been necessary? As a New Yorker with a physical disability I, along with others, have been left out of conversation after conversation about health care. Many of the populations that we talked about before overlap but are treated differently. For example, a person incurring a spinal cord injury at 19 has access to the full complement of services of the I/DD community and a different person with the same injury at at 25 has none. During COVID, we encountered discussions of health care rationing and members of my community died in high numbers, during the pandemic. I feel compelled to point out that at the same time, this planning, about the next several years is taking place we are still attempting to deal with the revision of Medicaid eligibility standards and a cap in the last budget even more and more people are being added to the roles. While we are thankful that our community was added into the waiver, it is disheartening that we had to tell you that people with disabilities were impacted, have significant health disparities, and need to be included. Beyond that I wanted to express general agreement with the Health Homes remarks,

just prior to ours because our experience is analogous. Thank you for this opportunity. That's the end of my remarks.

Thank you, our next speaker is Jordan Goldberg followed by Gloria Kim. Jordan, please go ahead.

Hi, can you hear me. Hello? Yes, yes. Thank you. Thank you for the opportunity to provide comments regarding New York state's current 1115 waiver proposal. My name is Jordan Goldberg, and I am the Director of Policy at the Primary Care Development Corporation. PCDC is a New York based national nonprofit and U.S. Treasury certified community development financial institution. Our mission is to create healthier and more equitable communities by building expanding and strengthening primary care. The new 1115 proposal rightly focuses on healthcare disparities and systemic healthcare delivery issues that have been exacerbated, exacerbated by the pandemic. PCDC appreciates that the Department of Health has recognized the critical role that addressing social determinants of health can play in improving individual and community health as well as for focusing on behavioral health and underserved populations. We also support the proposals regional focus, which recognizes that community tailored care is best suited to address the needs of those in the community. And we appreciate the emphasis on the role of CBOs, and we support the continued focus on value based payment. However, we strongly urge the department to reconsider the minimal investment in and support for primary care in this proposal. It is clear that community based person center primary care must play a central role in order to achieve the goals of the waiver, including those related to social determinants of health, yet, primary care is not adequately knowledge or funded in this proposal. As described in a recent landmark report by the National Academies of Science, Engineering and Medicine, primary care is the provision of integrated accessible healthcare services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Because of those ongoing relationships with patient's community based context and integrated role, primary care saves lives, improves individual and community health and is central to health equity. In fact, primary care is the only part of the health system that's been proven to lengthen lives and reduce health disparities while reducing costs. However, primary care remains overburdened and under invested. The role of primary care and public health planning and emergency preparedness has been seriously undervalued and the failure to prioritize primary care, particularly during the pandemic, continues to be felt most acutely by marginalized populations, the very communities this waiver seeks to support. I'm going to focus the rest of my comments today on three key recommendations for the proposal, investing more directly in primary care, ensuring that primary care providers can participate in value based arrangements and setting up the right infrastructure to allow primary care to meet community's needs. First, we encourage the department to make a dedicated investment in primary care, including for FQHCs and independent providers, similar to the proposed dedicated 1.5 billion dollars set aside for critical access hospitals. As I mentioned already, primary care saves lives and reduces inequity. But despite its proven impact, primary care just continues to be under-funded. In the U.S., primary care accounts for about 35% of all health care visits each year and only about 5% of healthcare expenditures are for primary care services. The lack of sufficient funding for primary care impacts both patients and providers leading to inadequate access, low quality, care, worse outcomes, and a burdened and burnt out workforce that loses experience professionals and has trouble attracting new ones. Many parts of New York state already locked adequate members of primary care providers and the workforce continues to struggle to bring new providers in. Infusing primary care with adequate funding will increase access and quality as well increase utilization of preventative services, improve healthcare outcomes, and move

towards health equity for all and the most underserved populations. Second, we really urge the department to ensure that the payment programs in the proposal are available for and appropriately tailored to primary care providers. While we support DOH's continued move towards value based payment, assuming that the risk is not disproportionately put on already burdened primary care practices, investments in primary care shouldn't be limited to performance based investment. Moreover, the value based payment plans in the proposal aren't sufficient to address primary care need. DOH should not limit investing in primary care to Patient Centered Medical Homes incentive payments. While PCMH is an effective and important model, and should be continued to be supported through its existing incentive mechanisms, many Medicaid providers are not PCMHs because of the challenges involved in becoming and maintaining recognition when overburdened with day to day requirements of patient care, compliance and revenue cycle management. On that note, and finally, to move primary care towards Patients Centered Medical type delivery models as well as value based payments and arrangements, DOH should invest more to support primary care practices. We urge the department to put the same emphasis on infrastructure for primary care as on setting up and supporting SDHNs and HEROs. Specifically, based on our experience, providing technical assistants and support to providers, we recommend investing in three specific areas for primary care, capacity, building, infrastructure, and workforce development. PCDC has tried and trained many small practices and community health centers to adapt their practices to the ever-evolving needs of patients and constantly changing insurance and regulatory landscape. We believe primary care practices of all types have the potential to meet the needs targeted by this proposal with the right support. An accessible and high functioning primary care system leads to a healthier and more equitable New York. We will provide more extensive written comments with these proposals, and I thank you for your time.

Okay, great. Thank you. Our next speaker is Gloria Kim, followed by Tammy Holmes. Please go ahead.

Good afternoon. My name is Gloria Kim, and I'm the Senior Policy Analyst at the Human Services Council. Through advocacy and collaboration, HSC supports over 170 human services organizations and their leaders in addressing their concerns of public policy, economic trends and the regulatory environment. HSC appreciates the New York State Department of Health's recognition of the important role community based organizations have on the overall health and wellness of the communities they serve through an integrated delivery system that promotes health equity. There's great potential achieving the goals of this waiver demonstration by leveraging the work and expertise of CBOs as equal partners in improving population health. By bringing human services into the community and moving away from traditional institutional care, we will be better able to meet the goals of integrating health and Human services. Therefore, CBOs should have the opportunity to define their value and roles in the health care delivery system. Human Services CBOs address health related needs, social care needs and social determinants of health daily with services such as emergency food assistance, housing assistance, health coaching, and countless others. As healthcare organizations, such as hospitals, health systems, and managed care organizations have increased recognition of the importance of integrating human and health services the, the demand for CBO services has increased and CBOs are being asked to modify operations and capabilities to meet the needs of the health care system and its patients. Despite the demands being placed the CBO sector, contracts to support and sustain CBO services have been limited. Also, since are funded, largely through government contracts, and due to inadequate funding, they experience a high risk of insolvency and financial distress. Improved funding would better equip to provide sustainable services and respond to public health crises, such as COVID-19. Additionally, the state should develop more innovative funding streams, such as

investments in initiatives that integrate health factors into government policy making across all sectors such as education, housing, the environment, urban planning and transportation. However, to overcome the institutional barriers to cross sector collaboration, this requires adequate investment by the state into these sectors. The state should invest in CBO infrastructure or incentivize health care organizations to invest in CBO infrastructure. This would allow CBOs to meet the operational requirements for hiring new staff training, managing reporting and data, procuring technology, infrastructure and adhering to compliance activities as funds to these items are still lacking, which are all essential to managing an effective program. The state should also consider the value of the services CBOs can provide not traditionally covered by Medicaid to their members for better community health. They are at the front lines of communities and can be valuable partners to health care organizations, aiming to address patient's holistic needs. CBOs connect with hard to reach population and members who are lost the healthcare follow up. They also understand the barriers individuals and families face in accessing health care as well as the other issues, such as language access, housing, transportation, that make follow up difficult. CBO services can increase health efficacy by ensuring people have access to nutritious food and safe housing and can help reinforce health instructions and the importance of health care in general, with the people with whom they work. The services provided by CBOs have critical connections to health care outcomes. Moreover, CBOs provide many niche services to small populations that are often not reached by other means. This is especially the case with CBOs that serve specific neighborhoods, people who speak a particular language people with specific conditions and other defined populations. However, individuals served by these CBOs are often the hardest to reach and though the scale of a potential intervention is small, it could have a higher impact, or be combined with other services for a higher impact. Of note, small CBOs or CBOs that serve a niche population have much less contracting leverage in an already uneven playing field where health care organizations have increased power. So, in contracting with the CBO, it's important to consider how there can be more equitable terms that cover the CBOs program or intervention costs. HSC appreciates DOH’s recognition of the important role CBS play in population health, and support the investments made through DSRIP, but more needs to be done to counter the lack of investment made by the state and the work of CBOs. So, for it to come to the table in a meaningful way, the state must reimagine the approach taking to develop shared goals and understand strengths and limitations, which would also promote better facilitation in the contracting process, which would support human services contributions to communities. Thank you.

Okay, thank you. Our next speaker is Marcus Johnson followed by Al Kinel. Marcus please go ahead, if you're on the line.

Good afternoon can you hear me? Yes, yes. Good afternoon again, My name is Marcus Johnson. Thank you for the opportunity to speak on the 1115 waiver today. I'm a member of the Civics League for Disability Rights of which I'm Co-leader. We’re an advocacy group with members living in Brooklyn, Manhattan, Queens, and the Bronx. We are here today say enough. Enough leaving people with disabilities out of your thinking. Our community counts, we matter. Use this waiver to pay attention to our needs. The original version of this document left people with physical disabilities out of the proposed solutions to address health disparities. While we are thankful our community was added into the waiver, it is disheartening that we have to tell you that people with disabilities were impacted by COVID-19, have significant health disparities and need to be included. In saying that, the Civics League for Disability Rights suggest the following. To address the needs of adults with physical disability living in the community, New York state needs to come up with a plan to count people with physical disabilities and to know where we are. During the pandemic, one barrier to people with

physical disabilities getting help was no one knows where, or how many of us there are. Use this waiver to make disability a demographic identifier so we are counted. Two, require participation of people with lived experience in the HERO. We know that is not sufficient data to represent our experiences. With no representation, we fear we will be left out, yet again. Require that any programs create and include specific measurable quality goals, that speak specifically to the needs of people with physical disabilities. And that makes us think, or question that if disability were a color would we then be counted? Now, how could this be accomplished? Take this moment, and listen to the narrative of the live experience, create a specialized program for people with physical disabilities. Our needs are different from the I/DD, HIV, behavioral health community. With this waiver the Department of Health can finally answer the question of why people with the physical disabilities are not counted. Use the waiver to create a specialized program for people with disabilities that focuses on the health outcomes of our community. We are clearly too easily forgotten in having a place at the table for people with the lived experience with, with physical disabilities is the only way for positive change of now and future health is very that impacts people with physical disabilities as well, meaning the other marginalized disparities and those with disabilities in general. I appreciate this opportunity to speak today. Thank you.

Thank you. Our next speaker is Al Kinel and followed by Ralph Warren Jr. Please go ahead Al. Do we have Al Kinel on the line? Perhaps you're on mute? I have unmuted Al, he should be able to speak. Thank you. Al, please go ahead if your line is unmuted.

Great, thank you. My name is Al Kinel, and I'm President of Strategic Interests, a 12 year old base, Rochester consulting firm that helps make communities healthier. We offer advisory and implementation services to providers, payors, collaborators, and more to address the quadruple aim. We have served the Medicaid population through engagements with health systems, practices, ACOs, SNFs, CCOs, CBOs, QEs, and more. We've been a transformation agent advancing VBP in New York for NYSE, Department of Health and CMS, for many practices and physicians in four programs, MU, behavioral health, PCMH and CMS transforming clinical practice. For years we supported two PPSs, FLPPS and CCN, and we helped our community fight COVID by rapidly and successfully creating and deploying remote monitoring solutions. We're active supporters and volunteers within New York and we prioritize impact over profits. New York has accomplished a great deal with regards to Medicaid redesign, however, gaps still exist. The goals outlined in the 1115 conceptual framework delivered to CMS are a great start and can effectively close many of them. The 1115 waiver initiative for the Finger Lakes community is led by Common Ground, United Way and FLPPS. We applaud their efforts and support comments made by leaders from those entities. Our comments are offered as systemic change recommendations to be considered state wid,e based on our broad and deep experiences, understanding of the strategic interest of all types of providers, our ability to bring them together to benefit communities and our desire to help New York. Comment one, sectors such as SNPs, CBOs and I/DD providers are critical to the Medicaid population and will be critical for HEROs and SDHNs. Providers within these sectors were fragile prior to COVID and devastated by the pandemic. While many healthcare sectors receive significant federal and state funding with MU, these three did not. New York can and should provide significant funding to SNPs, I/DD providers and CBOs, and perhaps others, to stabilize, enhance, integrate, optimize and utilize their systems and processes, so they can effectively participate in the 1115 programs. New York can and should also consider transformation agent services to help these providers obtain funds and establish a solid IT foundation, as they did for hospitals and ambulatory practices. Of course, they should also be included in the design, execution, and rewards from the VBP programs that emerge. If so the HEROs and SDHNs in the communities will have a better chance and accomplishing stated

goals. Comment two, the concept of creating HEROs and SDHNs is spot on to cover each region. To be unified and comprehensive as desired, they must be aligned around the natural referral patterns among providers and CBOs within their geography and they must have efficient communications with relevant oversight entities, DOH, and OMH. Unfortunately, New York healthcare is a labyrinth of providers, coordinators, utilities, and oversight entities that lack synchronous alignment around geographies. Entities such as CCOs in OPWDD, Health Homes, BHCCs, and RPCs, FQHCs and more were all initiated and rolled out across New York at different times with different territories. Adding a new layer of HEROs and SDHNs, without better aligning some of the layers that are misaligned of different sectors, we'll add to the complexity and will result in excess time, costs, and pain in capturing, tracking, sharing, and reporting. New York State DOH and OMH should consider reorganizing reorganizing as many as possible of the entities supporting different types of providers within the geographical regions and attempt to align the HEROs and SDHNs to them. I know each hero and SDHN will attempt to do the best they can within those territories, but the misalignment is beyond their control. Doing so will help synchronize incentives, programs, results, and funds flow. The QEs will then be able to share and report data to support these needs statewide. Comment three, New York should consider including a framework of possible approaches and initiatives that HEROs and SDHNs can include to establish new capabilities for targeted VBP interventions. For DSRIP, New York asked each PPS to select projects to address the unique needs of the geography. that worked very well. Some of the aspects we should consider in addition to that include committees, funding, or initiatives like social determinants centric initiatives in addition to supportive housing. Perhaps transportation, food and literacy. Environment centric initiatives, such as hospital in the home, SNF in the home and rural health are leveraging the power of PCMH. A framework for sector and or population centric initiatives, linking all who care for, for example, the aging, I/DD, refugee, children, maternal child disease, specific, mental health, ethnic, or criminal justice populations and for each, there should be a way to help them come up with tools and approaches to understand and sharer clinical and social needs, transitions of care and closed loop, referrals, pop health techniques with effective outreach and care coordination, interventions and ways to stay connected between encounters and, of course, establish the capabilities to share best practices and apply state wide as good ideas emerge. Thank you very much.

Thank you, our next speaker is Ralph Warren, followed by Judy Wessler. Please, please go ahead, Ralph. Hi Phil, I don't have a Ralph in the attendee list, so we can move on to Judith. Okay, our next speaker then would be Judy Wessler. Please, please, go ahead.

Thank you. I want to thank Brett Friedman and the staff that work with him to highlight equity issues and health planning, two concepts that were almost like, verboten in former years of health and in this state. So that's really important. But defining what equity is and how we get to it is equally as important and hopefully something that will be discussed as this planning goes forward and before the funding comes through. Some recommendations, the HERO structure is great as a local health planning mechanism, but the membership is way too diverse and to me almost resembles the PPSs of DSRIP, which were not very well working organizations. I was, this is my fourth Medicaid waiver that I've been commenting on and involved in, and I was a member with Lara of the PAOP in DSRIP, and I can tell you that the PPS structure worked lovely for some hospitals, which got most of the funding, but did not work for many communities and certainly not for community based organizations. So, the structure and membership of the HEROs has got to be better defined and should have a majority of consumers and community members defining this. One, the social determinants of health are a good, very good proposal and hopefully the leadership of the networks will be local will be culturally and linguistically and racially and and, and disability rights, relevant to

the populations. And the, the fear is that, once again, the leadership will be divorced from the population and for those of us, like myself, who worked so many years with community organizations, and worked on health planning and health access, and all sorts of things like that, that unless the leadership is really committed and is a part of the communities that are going to be served it doesn't work. It works maybe for the leadership, but not for the communities. A serious, and I was upset when I saw this in this draft, it mentions three of the four regional funded planning, consortiums funded under DSRIP. I am part of the Communities Together for Health Equity, network and steering committee, and we were the group that fought for this funding and finally got agreement from the health department. To fund these networks and then come to find out that three of the four networks are mentioned in this draft, but they left out Communities Together for Health Equity, which is just stunning to me. So, I would like to be able to talk with and I'm sure other members will be talking about this as well, with why this happened and why after funding the regional plans that these came up with, they're not even acknowledged or mentioned in any way in this draft and could have been a good basis for proposals to work on. So, those kinds of things kind of have to be worked out. And there, I'm just reading some portions. I will submit written testimony and I just I want to talk about the VBP that value based payment. As somebody who watched the development of this within this under DSRIP, the politics and the, excuse me, the games that got played in developing the VBP Roadmap and who was involved, and how the issues were identified and how they were defined and and all those other words was very painful. And how communities were left, really left out of those discussions so that the basis, the background, and the, the bag for doing more with VBP is totally missing and so, in order to use value based payments and have questions about that, it's got to be redone. It's gotta be done in a way that that matters and MCOs were told that they could choose one social determinants of health that they wanted to do, and they could choose one CBO to work with them on it. And, you know, there was no discussion about it or anything. So if that's the kind of things that are to continue to happen then we will get nowhere and get nothing and 7 billion dollars is, I'll clean my language, a lot to spend on nowhere and nothing. The other thing that I want to say about it is and I've tried to ask people this. Is there someplace or somewhere or some study that we can point to that shows that value based payment actually works and who it works for and how it works before we jump in with 7 billion dollars of this waiver to advance it and move it? So, if we are going to use VBP, we need to start again on how it's defined and who's defining it and what it looks like. Using academic medical people to define what social determinant need is this doesn't really work for communities. So that's got to be started all over again. And the. I'm sorry, I'm taking longer, but there were a couple of people that went on and on, so I just want to finish my thoughts on this. So, I think it's really, really important and that some of that 7 billion dollars could be used better on things like the HEROs and the social determinants of health networks, and some of the other pieces of this waiver, the housing piece, which, I don't know, enough about, to to really comment on. But I know how important housing is. As somebody who decided on her own to sign up for a Medicare advantage plan, I can tell you that MCOs, HMOs, whatever we're going to call them, including the nonprofit ones, don't necessarily work for the people that they're supposed to be covering. So just handing over things. And I know there's a lot of politics behind it, and who gets to decide what and how is, you know, not necessarily in always in the public interest. So, I have lots more and I will submit this in writing. I'm very happy to have discussions with the people in the department that are working on this. And I would hope that they would also reach out more to, to communities and community based organizations to get a better feeling of, you know, what health equity means, how you address it, what you do and and and what, you know, how we can achieve what goals we say we have. So thank you for this time. And I'm sorry, I went over, but I really have a lot more to say.

Thank you for your comments. Our next speaker is Manyon Lyons. Followed by Milenka Berengolc. Manyon please go. Please go ahead. Your line should be open. I don't have that attendee on the list, so we can move on. Okay. Our next speaker then would be Milenka. Are are you on the line? I also don't see Milenka. Okay, all right moving on to the next speaker. Rahel Araya hope pronounce your name. Rahel, are you on the line? Give me one second, so I'm going to look. Sure. I do not see that attendee either. Okay, and our last speaker on the list is Ann Marie White. Are you on the line? Ann Marie is unmuted now. Please go ahead.

Okay, thank you so very much. Hello, my name is Ann Marie White and I'm Executive Director of Children's Institute here in Rochester, New York. We are a 60 year nonprofit serving school age and young children and providers and families throughout New York State and we joined together to raise every child's complete wellbeing with a special emphasis on social, emotional development and health. I really appreciate this opportunity to speak and to, we are excited and ready to be a key partner in work that's promoting equity. Our first point is that children really need a special focus in the planning. Children comprise a vulnerable population in need of protection from inequities and health conditions and services. One in five of all 20 million New York State residents are under the age of 18 and nearly over 100, excuse me, 1,000,119, or 5% of the total population of New York residents are under the age of 5 alone. We know from recent US Census reports, we know that behavioral and physical health risks do reach children inequitably. For instance, we can see that in the CDC's recent report this month, that shows that U.S. children now have COVID antibodies at the rate of 75% compared to more than half of the U.S. population. So, we see their risks are much greater. We also know children carry burdens and social determinants of health and children under the age of 18 are the age group with the highest rates of poverty. For instance, we see four out of every ten children live below the 200% federal poverty level in New York State. We also know that social determinants of health take root early in a person's life and childhood and the effects of health inequities transmits intergenerationally. So a focus on children and on prevention is essential. And we would like to share that the prevention of health inequities are rising, due to adverse, social conditions. That work takes many forms in community life and in the work of community based organizations. In the early years of life, we see that this work comes in the form of services, for instance, to provide families with high quality, early learning and childcare, including out of school time. We see this comes in the form of supportive activities that help families maintain nurturing and stable home environments. And also, we see it in the work that creates healthy and safe schools and communities. There are already many existing networks of evidence based quote social care efforts that have long existed outside of the system of healthcare. For instance, the work of providing childcare or human service or family services leads to, we know for decades now, longterm savings in health education and human service needs. Child Care, for instance, is a social determinants of health provider and they have a place within the prevention and population health waiver. So it's really recognizing that many community based organizations are working in this space, but they do not yet see themselves working with healthcare entities or really being sustained by the operations and decisions of those within the health care system. So, it's really imperative for the waiver to establish principles or of engagement so managed care organizations are required to approach CBO partners with equity and CBO agencies and workforces really must feel that there is a really equitable partnership, and they have an equal stake at the table where their expertise and decision making is on equal footing, having done this work for generations. Decisions also need to be made locally, that local flexibility is so essential again, because this work has been going on and many networks exist. The regional boundaries that are drawn do not reflect where in our region for instance, these existing networks are working, and so building or bounding a new system of social care without reference to what's already present can duplicate or weaken what's already there or really fundamentally delay rather than catapult the

existing capacity in CBOs towards the elimination of health inequities across New York State as the waiver seeks to catalyze. I'd like to share that regions such as the Finger Lakes, for instance, have existing strengths in serving children an exemplar that is listed as, as an evidence based practice is Get Ready to Grow, which is providing comprehensive health development and social determinants screening and linkage support for services to children under the age of 5 and their parents. This existing network of providers, which is providing this integrated work and addressing the social determinants of health, is working beyond the boundaries of, of one of the regions as proposed. So we really asked for also when considering children's mental health to really look at the work of prevention and evidence based preventative practices, such as behavioral consultation, play based targeted intervention, greater knowledge and practice and developmentally appropriate play and interaction, infant and early childhood mental health practices and learning as well as social, emotional learning that's focused on both adults and children. This prevention piece is essential to be stumming the tsunami of the mental health crisis, and ensuring that problems don't get worse and the need for more mental health providers can be diminished at the same time, we're addressing the current crisis. And so we really hope, in in summary, that the waiver will continue to support community based organizations, include financial resources, really to support participation in the system and that capacity building as well as we've heard other speakers reflect upon. Thank you so much for this time, this opportunity, and we look forward to ongoing dialogue.

Well, thank you for your comment that concludes our list of speakers, unless anyone has come in while we were going through this process. Georgia do we have anyone else in the queue? Nobody in the queue, but if they, if we miss them, they can comment in the Q and A, and I will find them in the attendee list. Okay, perhaps we can pause for one minute just to see if any Q and A comes in. So it looks like we don't have any more of the scheduled speakers. So, if anyone would like to comment at this time, it looks like we can accommodate 2 more speakers. If you'd like to raise your hand, or put a comment in the chat that you would like to speak. So, I do see one comment of a speaker Catherine Macpherson. We can go ahead and unmute Catherine. Okay.

Hi, thank you so much for the opportunity to bring some comments today. I'm Catherine Macpherson, Senior Vice President of Healthcare Strategy and Development and Chief Nutrition Officer for Moms Meals. I'm a registered dietician as well. Moms Meals is a leading provider of fully prepared refrigerated meals delivered direct to the homes of Medicare and Medicaid beneficiaries and others in New York state and nationwide. We offer a broad selection of medically tailored meals to support common health conditions, including those with heart disease, diabetes, renal disease, cancer and other conditions. Addressing food, insecurity and other social determinants of health has been compelling for some time. However, the need to do so now is even more urgent in the midst of the COVID-19 crisis, which brought to light long standing health disparities, especially among vulnerable Medicaid enrollees. We were excited to see that within the 1115 amendment, the Department of Health recognizes the success of medically tailored meals as a social determinants of health intervention, resulting in reduced emergency department and urgent care visits and a reduction in acute inpatient days. A major contributing factor to keeping people in good health in their homes and out of the hospital is proper nutrition. And access to home deliver and healthy food is particularly important for those who have been diagnosed with nutrition sensitive conditions like diabetes, heart failure, cancer and others. As you, as you currently know New York state is conducting, an in lieu of services medically tailored meals pilot program. However, there have been some challenges with that program and there is a lack of dedicated financial resources to the program. In California, a similar MTM pilot program, well, actually, it's no longer a pilot, but

it's a broad program also launched on January 1st, 2022. As part of that program under CalAim, managed care plans have the ability to apply and receive funding under the CalAim incentive payment program that allows for planning and infrastructure building and it incentivizes managed care plans to participate in the pilot program. And so, as of the January 1st launch date, 17 managed care plans are participating three more will launch within the next 12 months. In the New York program to date, only one managed care plan has committed to participating in the in lieu of services pilot program. And so we encourage the department look closely at the payment structures and incentives, which will encourage participation and buy in from all parties in important programs, like the pilot, and then going forward, in the waiver. I did see some payment for infrastructure building in some of the goals, but we believe that value based payment programs can be successful when they're addressing social determinants of health. And, you know, that these new models and Medicaid should be preventative and holistic, to permit the downstream costs, but that the financial incentives need to be there to drive participation. So, by establishing a formal and permanent, medically tailored meals program, to to provide meals to those Medicaid recipients who are in the greatest need of assistance, New York state can realize all of those benefits. So, committing state resources now will support the adoption and success of the current pilot program, and also, including medically tailored meals as part of the go forward Medicaid program with this waiver and beyond, will provide predictable support for Medicaid recipients while signaling to managed care plans and others, the States commitment to supporting the social determinants of health. Another area I want to speak to briefly is that, you know, as the state looks at building out resources or partners in delivering community, delivering community services, or social determinants of health services, Moms Meals delivers to every address in this state. You know, community based organizations are vital to communities and do critical work. However, due to limitations in geographic delivery areas, you know, availability of medically tailored menu types, volunteer and staffing shortages, potential waitlists for services and our experience scaling an MTM program with community based organizations alone can prevent, present challenges. This was our experience in California, and even in New York where the nursing home diversion program waiver, found that there were no CBO meals providers in several counties and Moms Meals now works collaboratively with the state and with community based organizations to serve those members. And so, we would respectfully request that the language to describe the category of providers allowed to participate in the SDOH related services include, be broad enough to include, organizations like Moms Meals and other mission driven social determinants of health focused business organizations. We'd like to ensure that we're able to continue to serve vulnerable populations in New York under the 1115 waiver amendment and that participation in life enhancing services for beneficiaries is not limited to community based organizations alone, which may be defined as nonprofit and volunteer based organizations. Moms Meals is a mission driven organization. Our mission is improving life through better nutrition at home and we've been in business for 22 years and have served New Yorkers for most of our history and we truly believe that in partnership with the Department of Health, we can help the state, achieve its goals and objectives in the 1115 waiver. Thank you for your time. And we look forward to working with you in the coming months.

Okay, great. Thank you. Appreciate the comment. I'm going to pass this over to my colleague, Selena for any closing remarks.

Thank you, Phil. I just want to say, thank you all so much for attending this hearing today and for all of your thoughtful public comments. If you, sorry, I forgot to turn on my video. Okay, so if you enjoyed this enough, you can join us again next week, at the same time. We will be sending out a reminder towards the end of the week, that will include the registration link if

you've not already registered. You may provide additional public comment at that hearing or through the 1115 waiver email, or through the mail as listed out on the slide that we provided, which will be posted onto the website. And with that, you know, thank you all so much and I hope everyone has a great rest of your day. Take care.