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 10, 2022

So, we'll just give it 1 more minute Thank you.

Okay I guess we'll get started now. Welcome everyone, thank you for joining us for the second 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 begin, I'm going to turn it over to my colleague, Georgia. We'll explain how to turn on the closed captioning feature and how to make the two ASL interpreters easier to see taken away Georgia. Georgia, if you're speaking, I think you might be on mute.

Oh, apologies. Good afternoon, everybody. So, as you can see on this slide here, close captions are available today on the Webex and you can find and enable close captions by clicking on the CC icon and the lower left of the screen, and then by clicking on show closed captions. Participants who have questions about this feature, please feel free to type them into the Q & A, and we'll be happy to assist you. We also have 2 ASL interpreters with us today: Alanna and Chris Kelly. In order to have a better view of our interpreters it's advised that you move the interpreters down to the stage and the stage is the area where the presentation currently is. So, in order to move our interpreters to the stage, you would either pull their video from the top, or on the layout, or you would right click their name and select move to stage. You can add them both to the stage. They will be transferring between 1 another during the presentation. So, in order to have them both available and a seamless presentation we advise that you put them both on your stage. Again, any questions about this, please feel free to reach out to us via the Q & A box and we'll be happy to assist. Thank you.

Okay, thank you, Georgia. And thank you to our two ASL interpreters, Chris and Alanna for joining us today. My name is Selena Hajiani. I am the Director of Strategic Operations and Planning at the Office of Health Insurance Programs at the Department of Health. We are here today to give an overview of New York's waiver amendment application and to receive verbal public comments. We've extended the time of the hearing from initially was 1 to 4 PM, and we've extended it to 6 PM to accommodate all of the speakers. I believe we have 58 in total, so it may run a little longer. We'll do our best to move quickly through the presentation. One thing that I would like to note before we get started also is that we are no longer using the name Strategic Health Equity Reform Payment Arrangements. A new name will be forthcoming. Now, to walk through the agenda. First, we'll give some background on the virtual public hearing format and the 1115 demonstration waiver then we will move to the overview of the proposed 1115 waiver amendment, and we'll walk through the four goals listed here. Then we will move to the estimate of annual amendment expenditures, next steps, provide guidelines for public comment will also provide contact information and a list of resources and then we will begin the public comment portion of the hearing and provide, we'll provide instructions at that time. Next slide please.

In compliance with COVID-19 social distancing guidelines and approved CMS exceptions, we are conducting these two public hearings virtually. Public hearings provide the public with the opportunity to provide comments on the State's amendment application. It is very important that you provide comment because we can only change the amendment draft in response to public comments. We look forward to receiving your comments while we, at the state level, have worked very hard on this amendment application. This amendment will require broad and

meaningful partnership, and our collective work has only just begun. You can also reiterate or supplement your comments through submissions sent by a mail or email, which will provide a new addresses for at the end and recording and transcripts of the hearing will be available on the MRT waiver website about three to five days after the hearing. Language translation will also be available upon request, and we will also be posting the slides to the website as well. Next slide please.

So, section 1115 demonstration waivers, provide States with the flexibility to implement innovative projects that promote the objectives of the Medicaid program. Section 1115 of the Social Security Act authorizes the Secretary of Health and Human Services to wave certain Medicaid provisions and regulations, and also allows 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 3- to 5-year terms, but recently, CMS has approved some for longer terms. Next slide.

New York's 1115 demonstration waiver, the Medicaid Redesign Team or MRT waiver formerly known as the partnership plan has been in effect since 1997. It was most recently renewed on April 1st, 2022, and it will be effective through May 31st, 2027. The goals of the larger waiver are to improve access to health care 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. And so just so it's clear the amendment that we will be presenting today amends the larger MRT waiver. So, there are sort of 2 distinct concepts, but they are related in that this one will amend the larger waiver. Next slide please.

So now for the overview of the 1115 waiver amendment, next slide please.

New York is seeking $13.52 billion over five years for this 1115 waiver amendment that centers around advancing health equity and is designed to address health disparities and systemic health care delivery issues that have both been highlighted and intensified by the COVID-19 pandemic. The initiatives are intended to work together to foster greater collaboration across the health care delivery system and expand access to services that address physical and behavioral health and social care needs of our Medicaid members.

The goals of this waiver are, this waiver amendment are 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 support in 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 work for shortages; and 4. create statewide digital health and telehealth infrastructure. Next slide, please.

So, goal number 1, health equity-focused system redesign, really lays the foundation for the rest of the waiver. It is the regional approach to addressing health equity across New York State and increasing the focus on our vulnerable populations while also 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 number 1 is comprised of 4 main components, the first of which is the Health Equity Regional Organizations or HEROs construct for which we are seeking $325 million. HEROs are really central to the entire waiver. 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. development of the annual regional plans that will map out the landscape of physical and behavioral health and social care needs of vulnerable populations in their regions and also outline methods for addressing needs through VBP interventions that enable holistic, clinically integrated and value driven care. The regional plans will also identify, and address gaps and services related to housing and telehealth, which will go into more detail and goals 2 and 4, respectively. And second, HEROs will serve as hubs for regional collaboration, coordination, decision-making and data infrastructure. This work will include addressing data, regional data capabilities and providing technical support data collection and sharing is really important for the measurement and the success of plan activities. This thoughtful planning, coordination, and execution is really key to addressing health disparities in a way that enhance existing efforts, minimize disruption, and limit unintended consequences. DOH will also contract with one HERO per region for each of the nine regions. If necessary, there could be sub-stratification for densely populated areas. Our state is so diverse that it's important that stakeholders that are the most intimately familiar with the members and needs of their region come together to chart the best path forward to meeting the varying needs across the state. Next slide please.

So, this is the map of the nine regions. It is an expansion of the eight historical rate setting regions. The differences are that the North Country is separated out into a distinct region, region number 9, and Rockland in Westchester counties are 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 aren't familiar, the Delivery System Reform Incentive Payment, or DSRIP program was a 5-year programmatic waiver amendment that invested $8 billion with the goal of reducing avoidable hospital use by 25%. Next slide please.

Now for the goals of the HEROs. A first goal of the HEROs is to guide the development of a delivery system made for well-care that is focused on the needs of the whole person and 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 is to facilitate the movement to more advanced VBP models focused on health equity and provide cash flow stability during health crises. A third goal is to build on the successes of the DSRIP program while addressing challenges and lessons learned, and a fourth goal is to support the healthcare 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 and 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, 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 form of intermediary entity; they're not responsible for receiving or distributing waiver funds – this is one of the main differences from the way that PPS functioned under DSRIP; they are not duplicating any existing public health activities – they are intended to build upon and to help advance existing work; and 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 and MCO's, health systems, healthcare providers, behavioral health providers,

CBOs, consumer representatives, members of the workforce, qualified entities, among others. There will be requirements for HERO membership to ensure broad representation. Next slide please.
This is a, this diagram outlines the HERO structure starting at the top left. DOH will contract with the HERO entity, which can be an LLC or not-for-profit and 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 have balanced stakeholder decision-making authority. DOH will also provide limited planning grants to each HERO. And the HERO would include the entities listed on the previous slide and that are also listed here in the purple and gray boxes. And finally, the HERO will work to identify and develop collaborative activities, focused on health equity, social care, data sharing, and the integration of new and existing efforts as indicated in the long gray arrow at the bottom. Next slide, please.

So, the second component of goal number 1 is the social determinants of health networks, or SDHNs, for which we are seeking $585 million. SDHNs are coordinated networks of physical and behavioral health and social care CBOs that will organize a regional referral network. Under this goal, we will also procure a statewide IT social needs referral and data platform to support data collection, the referral network, and informed targeted interventions. This will also help to overcome data barriers, such as lack of data sharing standards and closed loop data systems that are not interoperable, and it will also allow data connection for SDHNs, HEROs, VBP arrangements and the state. So SDHNs are really 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 3rd component of goal number 1 is the movement to advanced VBP arrangements for which we are requesting $7 billion. VBP ties provider payments to quality and incentivizes improvements and care. It can be a powerful tool for advancing health equity and the integration of physical and behavioral health and social care. It allows for flexibility and can be tailored to address a variety of specific needs. Based on the regional planning and data collection work of the HEROs, and SDHNs, DOH will enter into advanced VBP arrangements with the various stakeholders and MCOs targeted at health equity measures including global prepayment bundled and episodic payment structures, and also to incorporate the focus on health equity DOH will update the VBP roadmap. And the 4th and component of goal number 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 for which we're requesting $745 million. Connecting service providers and incarcerated individuals prior to their release is integral for encouraging post-release continuity of care. These services include care management and discharge planning, clinical consultant and peer services and medication management planning and the delivery of certain high priority medications. In combination, the 4 goals, or the 4 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.

Goal number 2, we are requesting a $1.57 billion dollar investment in supportive housing services. They are intended to provide individuals experiencing homelessness and those transitioning from long term institutional care settings with the support that they need to find housing and remain safely in the community. This will build on the work of the MRT housing programs and other ongoing efforts. And will also address known barriers, such as limited eligibility for housing programs, connecting individuals and institutions with appropriate and affordable housing and discharge planning, excuse me, so the annual regional plans from goal

1 will include an inventory of available housing resources and regional need to map out existing work and gaps in service. The enhanced supporting housing initiative, which is designed to encourage coordinated and targeted efforts across the implementation spectrum will connect high Medicaid utilizers with housing and services. Funding through VBP, funding will be available through the VBP arrangements and matching 1115 waiver dollars. The services funded through the enhanced support of housing pool will include medical respite programs to provide a safe place for recovery for 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 the individual 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, behavioral health and home and community-based services. Next slide, please.

Goal number 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. They were on the front lines with a pandemic and faced significant hardship. These next 2 initiatives are intended to help them both rebuild and make advancements. We are seeking $1.5 billion for the COVID-19 unwind quality restoration pool, which is a VBP quality incentive pool for financially distressed hospitals and nursing homes. These VBP arrangements would be focused on helping these entities improve quality, participate in the advancement of health equity as described in this amendment, and also expand their workforce capacity. Moving on to workforce, workforce shortages and other concerns have been a focal point for many years 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 to fund activities, including recruitment and retention activities, development and strengthening of career pathways to enable more defined career trajectories, working on workforce training initiatives to support the health equity goals of the waiver, expansion of the community health workforce, and standardization of occupations and jobs training to ensure that training meets uniform standards and that credentials are transferable across the state. Next slide, please.

Goal number 4. We are seeking $300 million to expand access to digital health and telehealth services to ensure that everyone from the provider to the patient level has the tools and understanding necessary to fully take advantage of these technological advancements to improve access and delivery of care. These activities include telehealth kiosks and homeless shelters to expand services for individuals experiencing homelessness; community health worker trainings, so that they can assist members to fully use and benefit from telehealth services; and tablets for providers and enrollees that lack access to necessary technology. Taken together, the 4 goals of the amendments 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.

In the interest of time, I'm not going to walk through all of this, but in the right most columns are the totals for each goal that I walked through in the previous portions of the presentation. And here you see in each column, we have the spending estimates by year with the annual totals in the bottom row. We expect to spending to ramp up over time, starting with $928 million in year 1, growing to $3.8 billion in year 5. Next slide, please.

Okay now, for next steps. We posted the public notice in the state register on April 13th and this also commenced our public comment and tribal comment periods. Public hearings, we had one

last week on May 3rd, and the second of which is occurring currently. Our public comment period ends on May 20th which is a week extension from our previous May 13th deadline. We, our target date for incorporation of the public comments, and to finalize the amendment is July 1st and our target date for formal submission of the amendment application to CMS is July 25th, which would trigger a federal public comment, period of 30 days which could run from July 30th to August 29th. We could potentially begin negotiating the terms of the amendment with CMS, starting in the summer of 2022 and our target implementation date is January 1st. Next slide, please.

Okay. And now I will turn it over to my colleague Phil to MC the public comment portion of the hearing. Thank you all.

Okay. Oh, great. Thank you, Selena. So, this slide here is some housekeeping details as we move into the public speaker portion of the presentation or public hearing this afternoon. To some guidelines, there's a list of pre-registered speakers, and this will be indicated in the order in which you will be called to speak. However, if someone has either declined to speak at the last minute that may shift the order slightly, but we are going in in numerical order. I will call your name and manually your line will be unmuted so that you will be allowed to provide your comment. Comments will be timed. Please let me limit your comment to 5 minutes. And just a reminder that written comments will be accepted through May 20th by email, and at 1115waivers@health.ny.gov or by mail at. The Department of Health, Office of Health Insurance Programs, Waiver Management Unit, 99 Washington Avenue, 12th floor suite 1208, Albany, New York 12210. Next slide, please.

Questions or comments, please email us at our BML, which is 1115waivers@health.ny.gov. In real time, they'll be checking this mailbox you can also enter your questions in the Q & A box in the lower righthand side of your screen and we will respond in real time. Next slide please.

This is the resource page has a lot of helpful information here. The 1st link, we'll bring you to our 1115 MRT website. The 2nd link provides information on our MRT2 projects. And then the next link, we'll bring you to our 1115 amendment application. Public notice in the state register there is a copy also linked in here as well as the original concept paper there's a link for, and finally the quality of strategy is going to, at the bottom of this slide and these slides will be made available shortly following our presentation over the next few days and will be posted on our DOH website. Next slide.

Okay, this slide is just a reminder to folks that are presenting that there's 1 minute remaining before your 5-minute allotted time is is concludes. And next slide please and this is just a reminder that your time is up as mentioned earlier ae do have a pretty long list of public speakers presenters this afternoon and we're making every effort to get to everyone, this afternoon, so, and I think that is the last slide. Georgia, but if you could advance Yep. Okay, so without further ado, it's my pleasure to introduce the 1st speaker. Erica Coletti followed by Mark Ropiecki. Erica, please. Please go ahead and present and we'll we'll unmute your line.

Good afternoon. My name is Erica Coletti, and I am the CEO of Healthy Alliance, and I'm honored speaking today. The work we do evolved from our experiences operating as 1 of the 25 legacy PPS organizations Alliance for Better Health. We've grown and changed since DSRIP but have kept to our mission to improve health and empower the underserved. As 1 of the first, social care focused IPAs in the country, we've worked to build a collaborative and robust network of integrated social, medical, and behavioral providers across 22 counties in upstate New York. Our team and partners have connected and assisted over 19,000 community

members by bringing together organizations, big and small to coordinate and collaborate so that community members have reliable access to the resources they need. We appreciate the state's continued effort and attention on Medicaid redesign and their work to move this next phase forward. After reviewing the latest waiver draft, there are a couple of major points I'll be addressing. Firstly, we are encouraged and appreciate the States call out for a statewide referral platform based on our experiences with close to 600 partner organizations. We believe that this will significantly improve efficiency and reduce complexity relative to implementing and operating multiple technology platforms per interagency referrals. Most importantly, if implemented and managed well with clear program standards and accountability, using a single platform will ensure an improved and consistent experience for the community members who don't live work and play by regional and health system borders. In addition to this point, we suggest that the state focus investment, beyond the referral platform on technologies and processes needed to support a person-centered approach to improve health, the referral platform is only 1 piece of a complex technology environment where each health plan uses their own care management tools, health systems operate their own EHRs in community-based organizations and help homes, use other case management tools to support their in house activities and state reporting requirements. This is only scratching the surface of complexity not including the critical consideration of data privacy. We, as a state have invested heavily in acquiring an aggregating encounter data to support clinical quality measures analysis through the SHIN-NY. Our organization has learned through 4 years of building and managing a social care network that the call out for a data platform and the draft waiter waiver significantly underrepresents the level of management and investment needed to acquire aggregate and analyze social medical and behavioral data in a manner that will provide insight to help guide decision making. We suggest that the state encourage further collaboration and investment between qualified entities, such as HIXNY and SDHN building upon existing efforts, rather than expending resources to build this into the regional HERO concept. We further suggest that the state whole technology company is accountable for prioritizing and delivering on interoperability requirements within committed timelines. From my final point of feedback, our focus is on the VBP design. 52% of the funding is slated for VBP arrangements with a heavy, heavy focus on special populations. What's the impact on the community member, the community members, family, and the community as a whole when programs are specific to individual health plans and special populations? Fragmentation and care and under investment in upstream activities, I loop the impact on public health, especially in upstate communities where lower Medicaid membership will result in fewer VBP arrangements. When programs and funds are driven by the insurance card a person carries or the health system that provides their primary care deeper silos are created. Consider the difficulties a family will encounter managing social care services when household members are enrolled in different health plans with different social care benefits. We asked the state to design the programs and services to meet the needs of all community members. We propose that funding for social care needs is done in a holistic and consistent manner like the public utility for central services. We recommend the state provides the budget and mandates health plans to fund social care needs through regional SDHNs o address community needs for all of their members, not just their special populations. This approach would remove fragmentation and create a consistent infrastructure to truly operationalize health equity. I ask that all of those listening and commenting to put their fear of change aside and maintain, maintain focus on the community members. Seeking to understand their experience and their needs and engage their input and solutions. On behalf of Healthy Alliance, thank you for your consideration and the opportunity to speak.

Thank you. Next speaker, Mark Ropiecki. My apologies in advance if I mispronounce any one's name. Followed by Carol Tegas please go ahead.

Thanks Phil, appreciate it. Good afternoon and thank you for all your efforts to bring us to this point too. My name is Mark Ropiecki, pretty close and I'm the Executive Director for Care Compass network and was responsible for the rollout of the initial 1115 waiver the DSRIP waiver in the southern tier region of New York State. I along with 7 other legacy PPS entities, PPS successor entities and regional networks from across upstate New York have come together and prepared a joint comment regarding our collective experiences and implementing such waivers in upstate New York. Part of what has positioned us to provide these comments as the enhanced regional collaboration that was created as a result of the DSRIP waiver. The collective group has engaged a large region of upstate New York spanning the Capital, Leather Stocking, Southern Tier, Central New York, Finger Lakes, Tug Hill, Seaway and Adirondack regions. We've helped to convene over 950 partner organizations, engaged nearly 1 million, Medicaid members across 42 counties in New York, including both urban and rural settings. We have all seen the tremendous benefits of what the waiver is able to do in our respective communities and believe this new waiver has strong promise to both build on and help sustain previous waiver investments. To the highest extent possible, we encourage DOH to facilitate the waiver framework by leveraging existing infrastructure resources and relationships that are currently in place. With regards to the regions, there were 8 distinct regions in upstate New York during the initial waiver with most having some county overlap with the adjacent regions. The composition of these regions worked well, in terms of geography population centers and regions, specific health and wellness considerations. Throughout the initial 1115 DSRIP waiver period New York state invested significant resources in funding and developing infrastructure, workforce, and relationships to execute the waivers objectives, which resulted in substantial clinical improvements to the benefit of the Medicaid members in our regions. Together or today, the relationships that resulted from the DSRIP performance, period, constitute the dividend of extensive state investment in developing these regional networks. Our respective regions have continued to evolve with a focus on improving health and wellness in the support of advancement of value-based care. We support flexibility in the designation of the regions. In the waiver to the, to the fullest extent possible, so we can further leverage the health systems payers, and even the active value-based arrangements that have formed since our work began. This will also allow for the utilization of existing IT infrastructure like population health, closed loop, referral care, management, telehealth and other IT investments and regional collaborative work groups like workforce and health equity councils that have formed. The upstate organizations are collectively willing to collaborate and encourage DOH to consider the provider impact to regions and natural care pathways that exists today. MCO active participation, integration, collaboration, and accountability will be critical in the new waiver. The proposed waiver emphasizes the integration of SDHNs in the VBP environment, shared learnings, and coordination with MCOs, as well as MCO participation in the HEROs. However, there is limited language about the MCO role itself with an enhanced role MCO in this waiver, we recommend that DOH more clearly defined mandates or requirements for MCO participation, integration, collaboration and accountability with consideration for domains such as regulatory accountability or oversight, revenue, transparency, program measurement, methodologies, meaningful funds flow, data-sharing, timely VBP contract execution, including timely identification, and dissemination of the patient attribution rosters and collaboration with regional entities to achieve scale. Lastly, in the DSRIP 1115 waiver, a panel of projects was used to identify interventions and also determine attribution, evaluation, measure progress, and even measure funds flow. In our direct experience with the DSRIP projects, they achieve substantial changes with regards to interventions and and infrastructure, but limited at times, the ability for local communities to innovate. Fortunately, the PPSs were able to create innovation programs and other homegrown initiatives that led to the successes noted in the in the waiver. We recommend that DOH acknowledge the need for flexibility and promote innovation by again, permitting the local communities to innovate and solve local problems with local solutions. We suggest allowing for

innovation by freeing community-based social care providers to design and discover the evidence for evidence based social care by serving members through their diverse workforce and experiences. DOH should limit defined or approved panels of interventions so that the local region can retain flexibility and innovate to meet the specific and unique needs of the regional population. The upstate New York work group will be preparing a written comment for DOH by the public comment deadline. And in addition, myself and Care Compass Network will be providing a written comment as well. Thank you for your time.

Hey, thank you. Our next speaker is Carol Tegas followed by John Grant. Thank you go ahead.

Thank you. I appreciate the opportunity to speak today to provide insight and feedback on the new 1115 waiver proposal. My name is Carol Tegas, Executive Director of the Finger Lakes PPS, also known as FLPPS. FLPPS was the 2nd largest PPS in the state under the DSRIP program, with 13 counties, and over 300,000 lives. We organized our work by leveraging existing care patterns and relationships across the region through naturally occurring care networks. I would first, like to reinforce the comments that have already been provided from partners in the Rochester and Finger Lakes region all of whom had been critical to the work of Medicaid redesign, and all of whom continue to work, collaboratively to improve health care in our region. I also wholeheartedly support the public comment, just provided by Mark Ropiecki on behalf of the upstate and regional networks, and we will work collaboratively, collaboratively across the upstate region with those organizations. The following comments you have heard over the last few weeks, bear repeating waiver HERO regions should reflect existing care patterns, provider networks and supporting structures. The waiver should call for regions to leverage the resources and infrastructure that currently already partner and collaborate. The waiver should allow for flexibility and design in implementation that meets data driven, regional priorities without overly prescriptive approaches. The waiver should ensure concise plan for accountability for all HERO participants. Key to the successful work of FLPPS in achieving 99% of DSRIP milestones in significant clinical outcome improvement with redesigned workflows implementation of best practices and achievement of clinical outcome performance is the structure of the regional cross provider naturally current care network partnership, network, and clinical quality committee. We led the transitional housing and maternal child health projects under DSRIP both providing the foundation upon which sustainable models of care can be built. We ramped up several pilots, including an innovative housing pilot that took the DSRIP housing project to the next level by connecting hospitals and homeless shelters to create work flows that ensure discharged homeless individuals are safely settled in a shelter with appropriate wraparound services. Dr. Jeff Kaczorowski spoke last week. Our maternal child health project kicked off great work in our community to leverage community-based care providers and improving the health of moms and babies. We wholeheartedly support last week's comments from the children's agenda and the children's Institute to ensure greater focus on families and children in the waiver, especially the mental health of children and families. We have several other examples of pilot work that focused on community-based care, including CBO led community navigation pilots, cultural competency, health literacy CBO operations specialists, which leverage CBO expertise, and the CBO VBP readiness pilot in partnership with our local United Way. We managed over 85 system transformation projects that were focused on community integration initiatives implemented by over 60 community-based partners. This work was the beginning of a priority focus and our PPS and integrating community and clinical care, in a meaningful way, through our current system, transformation, community investment program we as a data driven approach to identify and focus on community and clinical integration initiatives to address social determinants of health and maternal child health, behavioral health and care management through a subsidiary health home, the greater Rochester health home network, we focused on supporting care management agencies in their

work with high risk populations. We endorsed the health home coalition comments from last week, and partnered with honey, the health home, upstate, New York, the other health homes in our region to provide written testimony. We also have direct care management services as well to supplement the critical access to care management services for health home. FLPPS continues to support partners with our infrastructure and team expertise for program and project management workflow, redesign data, analytics, workforce, development and reimbursement modeling and other strategic services. We've provided support to the finger lakes IPA FLIPA a growing, forward, thinking network of and behavioral health providers. We are also a designated New York state, workforce investment organization, a WIO, and we are ready to take on the States workforce development goals. We have already partnered with community colleges to develop a career pathway in social supports program for community-based workers. We have built a world class learning management system for the community to leverage as part of that work. We have partnered with community organizations across the region to support the finger lakes COVID-19 response. This work was an extraordinary example of the partners in our region, coming together, with a single purpose for immediate action and results. We, in the finger lakes region are collectively poised for the next generation of Medicaid reform truly addressing health disparities and inequities through addressing social determinants of health in a meaningful way in partnership with the human service sector. We support the state and advancing the integration of social care in a manner that creates a sustainable model sustainable model of holistic care for the Medicaid population. Thank you so much for the opportunity to comment.

Thank you. Our next speaker is John Grant followed by Laura Gustin. John, please go ahead.

Thank you very much. Thank you to the New York State Department of Health for the opportunity to present comments on the 1115 waiver amendment request. My name is John Grant and I represent FindHelp, a public benefit corporation, formerly known as Aunt Bertha. To people in organizations that help others FindHelp is the 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're 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 that the programs that serve them with dignity and ease. Our social care network continues to grow across, and you work 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, we'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 was 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 and encourage collaboration 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 communicable networks in the creation of HEROs and SDHNs and further leverage SHIN-NY policy and governance frameworks to promote interoperability in 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 to SDOH data elements. In recent years, other states have adopted models that mandate healthcare plans and providers exclusively use a single vendor for social care referrals and require to sign exclusivity contracts as a condition of funding. This type of single vendor approaches, a shortcut around building, interoperable technology solutions, and has not been successful in practice. Rather

than taking a single platform approach, we, we urged New York State to employ an approach to developing statewide IT referral infrastructure that has built upon interoperability standards, which will ship a more sustainable and equity driven path, moving forward. For example, in California, CALAIM is a vendor agnostic model 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 innovative approaches serving diverse regions of the state we believe that maintaining an open network of CBS 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 at the state. Members should be empowered and afforded the opportunity to seek services through self-navigation without being required to have someone do it for them. This is, especially important in more rural areas in a 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 has 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 can engage in the entire community is disadvantaged by limiting the number of services people can access. We look forward to policy guidance that promotes health equity driven model and prohibits exclusive networks that limit individual's access services. On privacy, incorporating referrals to social care, and our healthcare infrastructure relies on the collection storing and sharing of some of the 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 where sharing Health information is needed to ensure continuity of car. In the healthcare context participating entities are governed by HIPAA standards. But 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 service providers to access information in a centralized database compromises the privacy of an individual's most personal information. We believe that the best practices build upon a peripheral consent model where individuals opt in to share their information for each referral and network members access to referral history is permission based. While HIPAA dictates how health information is shared between the 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. Thank you again, for this opportunity and we welcome the opportunity to be a thought partner with leaders in New York as you advance this innovative work.

Thank you. Our next speaker is Laura Gustin followed by Dan Lowenstein.

Great. Thank you. Good afternoon. My name is Laura Gustin, and I am the Executive Director of the Monroe County Systems Integration Project, or SIP. I want to begin by thanking New York State for recognizing SIP in the 1115 waiver proposal. We are excited by the many ways the hard work might support and inform how we build a more resilient, equitable and integrated system at scale. In 2019, $15 million from New York State to implement an integrated person-centered system that connects Monroe County's health, human service, education, and public sectors over the last 3 years and in collaboration with over 300 partners we have designed and implemented innovative solutions that will jumpstart waiver objectives. For example, SIP is implementing an integrated service delivery model that transforms how people access services. Key areas of focus include police, space, neighborhood, navigation centers, common front door

protocols that normalize the experience of entering the system shared processes for referral management and service pathways the standardized how a person navigates the system as they transition from crisis to stable to thriving. SIP has also implemented a data ecosystem to facilitate integrated service delivery, including a data hub, data integration, infrastructure and my way finder, a user interface that provides both people and providers digital tools to access, manage and monitor system interactions. As part of this effort SIP has fully integrated with 2 in one's community resource directory and established a legal framework for cross sector data, sharing a data governance model that fosters interoperability and a shared language protocol and associated algorithms for measuring both risk and well-being. This data ecosystem, also power SIPs measurement model, which monitors the inputs outputs outcomes and returns on investment in an integrated system. In addition, SIP centers the needs and desires of community. We practice human centered design and every aspect of our work maintain a standing community voices network, have embedded diversity, equity and inclusion practices, and an equity review board that reviews and improves project workflows, pilots, and strategies through an equity lens. Based on this experience, we asked that the State address the following 4 considerations when finalizing the 1115 later waiver proposal. First, through nearly 5,000 touch points with community, we know that many individuals want information and tools to self-navigate the system. Community members do not want to tell their story again and again; they want control over who sees their data, who is on their care team, and whether a referral is made. In response, we ask that New York State, consider issues of equity, empowerment, and data sovereignty when designing and deploying digital solutions. Second, we are discussed whether we are discussing the practice of integrated service delivery, or the data systems that facilitate it, we are working at the precipice of innovation. As such New York State must adopt standards the ensure communities meet waiver defined objectives while concurrently incenting the design and implementation of next generation solutions that move us beyond today's evidence base. Third, our communities work on SIP as well as our collective response to the COVID COVID-19 pandemic has reinforced the notion that meaningful transformative solutions must be designed and realized at the local level. Deep trusting relationships are the foundation of integration and business requirements, service pathways and overall system performance are locally influenced. To do this work the data and business intelligence that drives systems transformation must be locally held. There is an opportunity for New York State to define the required building blocks of transport transformation without obligating universal solutions. We ask that the state instead focus on the development of standards, integration of state, health data sets and interoperability. Finally, we have come to understand that the social determinants of health are the same as a social determinants of education. School shoulders, similar responsibilities for connecting students and families to social care and our current currently seeking similar, integrated solutions. In response, a nibble approach that extends beyond the health sector requirements is essential. With each silo we flatten the system becomes more accessible navigable and aligned. As with each of these examples, we hope the state will consider moving away from instituting overly prescriptive approaches that limit our ability to maintain significant and transformative change at scale. On behalf of those participating and SIP if we thank you for your time consideration and the opportunity to speak with you this afternoon. Please know, that the solutions and resources developed by SIP remain available to New York City throughout the waiver process.

Thank you thank you. Our next speaker is Dan Lowenstein followed by Roberta Todd.

I am Dan Lowenstein, Vice President of Government Affairs for the Visiting Nurse Service of New York. We are also going to be providing a written comments and we appreciate the opportunity today. We are one of the oldest and largest, not-for-profit homing community, based health care organizations in the United States and since our founding 130 years ago and

continuing today, we provide an innovative quality and compassionate care to the most vulnerable and marginalized populations in our communities in New York. We're the largest certified home health agency, the largest hospital hospice, and we provide an extensive community behavioral health services as well as health plans, including HIV Special Needs Plans, and Fully Integrated Medicaid Advantage Plus Plans. Now, our primary focus is on ensuring that vulnerable New Yorkers, those who are aging, or living with disabilities, have multiple comorbidities, or otherwise impacted by social determinants of health and get the care they need to live safely in their homes and the vast majority of these individuals are eligible for both Medicaid and Medicare. They are dually eligible and some facts about this population in New York. They are 15% of New York medicated enrollees in 25% of our Medicare enrolled. But 42% of the Medicaid spending, and two thirds of that spending is on long-term care. And that doesn't even include the medical care Most of which is paid for by Medicare. And that's really the challenge. Because this is a Medicaid waiver, designed to be mitigated funded care, more efficient and effective. It does not really do what we think fully consider the needs of dual eligible individuals and we see an important opportunity to partner with CMS on a shared Medicaid, Medicare savings plan. That can help New York reinvest critical resources in the Medicaid program. Enormous opportunity is also to achieve the goals of this waiver by focusing more on duals. Readmissions are 10 to 31% higher for duals. They were 3 times more likely to be hospitalized with COVID, COVID complications then Medicare only beneficiaries and and dual dual. Dual eligibility is the most powerful predictor of poor health outcomes in performance of all social risk factors. Related to this is care in the home. Now, the draft, the waiver amendment rightly invest in supportive housing and telehealth and there are additional opportunities to prioritize home as a health care setting because care in the home is proving to be an effective effective and less costly is critical to serving hard to serve populations, is a growing preference, preference for consumers and personal care to telehealth post-acute care, primary care, behavioral health hospice and even hospital in the home, home is really where care is gravitating to and it's also a critical tool. And addressing the health disparities, because by design caring, the home lowers the cultural and racial barriers to care and meets people where they are in their homes in their communities, and thereby reduces institutional barriers to care. And this was true when our nurses went rooftop to rooftop on the lower side, and the beginning of the 20th century to serve marginalized minority population and shut out of health care institutions and it remains true today. We're focusing on really 4 areas, the dual eligible beneficiaries, leveraging social determinants of health, learnings, sustainable and meaningful VBP models, and investing in a home health and behavioral health workforce in telehealth again. We have written comments and I'm going to talk until I run out of time, but on the dual eligible beneficiaries within the HERO. We really recommend that a specific population be dually eligible individuals, particularly those with long term care needs and that we align the federal estate initiatives to fully prioritize integrated programs, like the MAP plans and programs that offer enhance coordination. And DOH should also propose, as we said to share in Medicare savings that can be attributed to this Medicaid spend set the leveraging social determinants of health. We, there's been a lot of energy think, and an investment in coordinating the services. And they, but they still appear to be fragmented. We recommend to focus on a meaningful uniform tool that will allow plans providers and CBS to partner. More effectively, and the state to work on, an improved data collection, particularly in enrollment within Medicaid, and MCO could be incentivized to screen for additional SDOH and be incentivized to increase the uptake of Z codes. I'm going to just stop now given the time and give it back to the host, submit the rest of the written comments. Thank you.

Thank you our, our next speaker is Roberta Todd, followed by Steve Moore. Please go ahead.

Alright, good afternoon. I'm Roberta Todd, a Health Justice Organizer for Northwest Bronx Community and Clergy Coalition. I thank all that have arranged this hearing and your willingness to listen to comments before finalizing the program. Northwest Bronx Community and Clergy Coalition has been conducting grassroots community, organizing in the Bronx since 1974. The organization supports racial justice, systemic change, intergenerational relationships, economic democracy, gender justice and environmental sustainability, our membership of 5,000 throughout the bronze have been engaged and campaigns to address the disparity of healthcare in the Bronx since 2013. I am commenting along with other coalition members of the Communities Together for Equity on the program's approach for addressing social determinants of health as Bronx is and has been running for many years as number 62 out of all counties in New York state and health outcomes. Health equity has been an important initiative of our organization. COVID 19 has had significant impact on bronze communities and action is needed to prevent a recurrence. And this action can best be designed by including the voices of the community. A fundamental principle of our organization is to allow those who are impacted to be at the table when designing solutions. I want to share the Bronx healthy buildings program, which existed from 2006 to 2020, because it demonstrates what can happen when work as leaders or equal partners with medical and government institutions to address improving social determinants of health. There was strong concern that when a governance structure is created, that allows a power imbalance with being dominated by clinically focused entities versus being at the table, in a leading or equal role, some community requirements may be miss are closer to the community and can effectively communicate and lead programs that will generate results that can address solutions to improve social determinants of health. The healthy buildings program was a cross sector initiative to promote holistic community health by addressing the upstream causes of asthma related emergency department, visits, hospitalizations and miss school or workdays. Its purpose was to address data indicating that Bronx residents visited the emergency department for asthma at nearly twice the New York state rate and triple the state rate brock's residents also die from asthma and twice the city-wide rate and nearly 4 times the state rate. It addressed the top 2 health issues raised by the community number 1 was violence and housing was number 2. The solution for violence was alternative employment for the underground economy this was met by in this program through the development of an integrated pest management training program with hospice community college, pest-infested infestation is a key trigger for asthma, and the newly trained individuals would be employed as part of addressing improved housing conditions. This exemplifies how collaboration beyond the medical community is required and important for most solutions to improve components of social determinants of health in a community. The program was a collaborative partnership led by my organization, other members of the partnerships were private and city hospitals in the community as well as the other CBOs and academic institutions, and elected officials. All partners wanted to make sure that marginalized improvement in marginalized Bronx communities. One of the reasons that Northwest Bronx had a leadership role is a funder building community health challenge organization. When they convened it the grant, they said that a community had to be the lead. It also stipulated that work had to have 3 partners, a community-based organization, a local hospital, and the local health department. We suggest considering having similar stipulations in the 1115 waiver program, for aspects of programs, addressing social determinants of health we considered this program successful, because we looked at 1 building that we had 233 units. We got the involvement of 200 tenants. 60% completed the survey. We were able to get funding of $3 million for a much-needed roof and we had 74 residents engaged. In the writeup, we'll have more details about that and more reasons. But we wanted to give an example of why it's important to have community-based organizations and equal or leadership role when we're trying to address social determinants of health and the community. Thank you for your time.

Thank you. Our next speaker is Steve Moore followed by Rose Duhan. Please go ahead.

Hello. My name is Steve Moore, and I appreciate the time today. I'm a community pharmacist at Condo Pharmacy up in Plattsburgh, New York. I'm also a past president of PSNY the Pharmacist Society, the State of New York, and the current Vice President and CPA, the National Community Pharmacist Association while I will start with a disclaimer that you have heard and we'll certainly hear from others with a much greater technical understanding of this process, I will say that I'm excited for the opportunity speak today, given the waivers overall goal of fully integrating social care and healthcare into the fabric of the New York State Medicaid program. I truly believe that community pharmacy is uniquely positioned to help meet this goal and in many cases is already doing. So, I'll start by specifically referencing John Croce's remarks about the work done by its network of pharmacies here in New York and the practice transformation as well as well as reinforced his specific requests in regards to some of the goals. In regards to goal 1.1a, and HERO governance, community pharmacy should be included as part of the governance boards are the HERO entities. In regards to goal 1.3 and the VBP investment community pharmacy should be considered both a user and supplier of real time data simple things such as including patient blood pressures, and test results in electronic prescription data goes a long way to ensuring quality care. Goal 1.4, capacity, building and training and workforce strategies, community, pharmacies, staff, such as clerks, drivers and community health care workers and technicians are incredibly dedicated personnel and community pharmacies are a source of not only these these resources for our community patients. We're also a sort of a source of jobs. These are great careers for patients and residents in New York State, so we'd encourage New York State to consider these people as part of the workforce investment. Goal to supportive housing, pharmacy service, supportive housing services excuse me, pharmacy should be mentioned in regards to supporting aging in place programs it dovetails very well with what we do in regards to delivery services and we've had some great partnerships throughout the state throughout the 56 page waiver proposal pharmacy is mentioned twice once in regards to cost sharing practice, I would encourage the state to discontinue. And again, in regards to incarcerated individuals and I'm excited to see that there's an effort to manage any patient population, but this patient population proactively as well. With that of being said, I would make 3 big picture recommendations of my own while. The first, seemingly may not be directly related to this 1115 waiver, I would encourage the state of New York to continue to work started during the pandemic and advanced the professional pharmacy forward here in New York. Pharmacists, unregistered pharmacy technicians must be allowed and encouraged to practice at the top of their licenses as our current scope of practices. Antiquated and outdated relative to that of other states I'll reference COVID testing immunizations and pharmacies during the pandemic is 2 services that we're not necessarily providing prior to the pandemic by the end of the pandemic pharmacists and are trained technicians, certified, registered pharmacy, technicians were providing 85% of the COVID shots that were done throughout the country, and that was only done, because our scope was advanced so we would encourage you to continue with the good work that has been done. I would encourage the state as well as other stakeholders to consider how any community pharmacy partnership, or ever any community partnership or initiative born by this. 1115 waiver amendment may be affected by the decisions and practices of large corporations, such as pharmacy benefit managers. Corporate entities cannot be allowed to destroy a network of providers, or a significant portion of a network of providers supporting the 1115 waiver amendment for their own financial interest. Finally, I would strongly encourage the state to remove the board of pharmacy along with the boards of the other medical professions from oversight and place it under the purview of the Department of Health. Who better to determine what how the healthcare providers in New York can should be doing to support new initiatives such as this 1115 waiver will require then DOH. The additional services performed by my

pharmacy colleagues, throughout the state, during the covert pandemic, demonstrate that pharmacy is willing and able to do more than counting for. We have tools that are available and sufficiently staff, pharmacies and properly supported. Pharmacists remain an untapped resource already located in the community New York is trying to reach through this way for amendment. We stand ready and willing to collaborate and participate. I, thank you for your time. It will be submitted written comments.

Thank you. Our next speaker is Rose Duhan followed by Lauren Wetterhahn. Please go ahead.

My name is Rose Duhan. I'm the president and CEO of the Community Health Care Association of New York State also known as CHCANYS, New York, Primary Care Association for Community Health Centers, also known as federally qualified health centers, or FQHCs. In New York State, more than 70 community health center organizations, provide a central primary care and preventative services at over 800 sites. These services include traditional primary care, and also behavioral healthcare, substance use disorder services, dental care, school-based health centers and social supports. Community health centers are care for more than 2 million New Yorkers annually, 60% of whom are covered by Medicaid. Health centers operate in medically underserved communities, many of, which are communities of color. Health centers were founded to specifically address health disparities for providing care to populations that face historic, systemic discrimination. Participation of health centers in any significant Medicaid initiatives are is key to ensuring the success of the waiver goals to align health and social services while advancing health equity. In alignment with Medicaid goals more than 90% of health centers have achieved New York state specific PCMH designation, the care coordination and risk stratification elements of the PCMH program have prepared health centers for advanced value-based payment arrangements. We are pleased to see reference in the waiver to an FQHC specific alternative payment methodology, or APM, which we believe is necessary to align care delivery models with value-based payment goals. CHCANYS welcome to the opportunity to work with DOH to submit the required state plan amendment state plan amendment for capitated APM. FQHCs have formed or joined independent practice associations for purposes of value-based contracting. IPAs enable community health centers to better address population health and coordinate with behavioral health organizations and social service agencies. Investments to build health center led IPA capacity and infrastructure are necessary to advance contracting arrangements in short productivity with social care needs providers. In addition to CHCANYS requests that the state enforce requirements for managed care plans to enter value-based payment arrangements with that are advancing HERO-determined goals. Community health centers are safety net providers located in the communities that have been most adversely impacted throughout the pandemic and health centers were at the forefront of public health efforts, including standing us standing up mass testing sites and vaccination efforts statewide. To address the prevention and population health goals with the waiver, recognition and targeted investment are needed to expand interventions focused on health equity and population health improvement for the large proportion of the Medicaid population served by health centers. Given their patient attribution and ability to advance primary care and prevention, we're pleased to see that will be meaningful partners in hero governance and have representation on clinical advisory groups. CHCANYS supports and interoperable, statewide social needs referral platform and data warehouse, many providers, including, and health centers have integrated referral platforms into their day-to-day operations to ensure there's no duplication. The state must require that a social needs platform is interoperable with existing platforms used by providers around the state. Data from a statewide social care platform must be easily accessed by providers to ensure that they can utilize the platform to inform their population health interventions in a timely manner. As comprehensive patient data must be timely to be functional for, for value-based contracting to CHCANYS

applauds the state of goal of the waiver to ensure ready access to data resources for providers recognizing that managed care organizations possess timely and comprehensive data on encounters utilization and cost, CHCANYS request that the state require and enforce data sharing for managed care organizations to providers for value-based contracting. The waiver proposes a standardized assessment tool to determine community social care needs for Medicaid members. CHCANYS notes that many health centers have already selected and use a social care needs screening tool, which has been integrated into their electronic health records. The requirement to change, the tool used would disrupt existing workflows and be costly and time intensive to implement the state should define standardized data elements, but not prescribe a single tool. CHCANYS also supports the following initiatives in the proposed waiver: enrolling justice involved populations into the manage into the Medicaid program 30 days prior to release; expanding and incentivizing the use of telehealth through payment parody, including health center, employed behavioral health providers, who may be working off site; expanding the scope of workforce initiatives to provide a wide range of training recruitment and retention initiatives across the care continuum; and establishing a long-term funding sustainability mechanism for community health workers after the waiver period ends. Thank you for the opportunity to comment today.

Thank you. Our next speaker is Lauren Wetterhahn followed by James Sinkoff. Please, go ahead.

Thank you, Phil. I'm Lauren Wetterhahn, Executive Director of Inclusive Alliance. We are a CBO network and IPA founded in 2017 comprising nearly 50 diverse health care and non-billing social care providers serving Central New York counties in region 7 of the proposed HERO region map released by the department at last week's public comment. Our members include organizations that serve individuals with disabilities, mental health and substance use challenges and unmet social care needs. We echo the collective public comment that was delivered earlier by Mark Ropiecki of Care Compass network, and we look forward to continuing collaboration with the network entities across state of New York. Inclusive alliance is supportive of the draft waiver amendment, and we'll focus our comment upon the proposed social determinants of health network. Health equity, regional organization entities and advanced VBP model funding pool. We believe both SDHNs and HEROs are necessary to achieving the waiver's goals and should be strengthened in the final waiver amendment request to ensure they will be successful in their respective roles. The proposed work of the social determinants of health networks will require significantly greater investment than the $585 million currently allocated for SDHNs statewide over 5 years if they and their constituent CBOs are to achieve their stated goals. Some specialty CBOs may participate in activities funded by the supportive housing and services for criminal justice involved populations pools, the SDHN pool will have the broadest CBO participation, and yet is allocated less funding. During DSRIP, non-billing CBOs were categorized as non-safety net providers, limited to 5% of direct funding, widely recognized barrier to meaningful CBO participation. The current funding proposal for SDHNs represents only 4% of the total and even lesser share. SDHNs share of the total funding request should be increased substantially. The initial allocations in the Office of Health Insurance Programs presentation for the public health planning Council on October 10th, 2021, hold for 10% of the total request to support SDHNs. Likewise, the proposed work of health equity regional organizations will likely require a greater investment than the $325 million currently allocated for HEROs statewide over 5 years if they are to see succeed in supporting the waiver goals. Regional planning, data aggregation and analytics, facilitating collaboration, and prioritizing regional goals that will directly impact VBP arrangements are important activities that will require very specialized skill sets and infrastructure. Additional detail is needed regarding the way that the $7 billion allocated for the advanced VBP model pool will be distributed via the

managed care organizations to participants and advanced the VBP arrangement and flexibility may be required to ensure providers at varying levels of VBP readiness are able to participate in this pool to achieve the overall goal integration of physical health, behavioral health, and social care. Not all providers are equally prepared to participate in VBP arrangements and the healthcare providers still requires significant upfront investments in value-based care infrastructure before they can benefit from incentive payments tied to VBP participation. This is doubly true of social care providers that historically received less investment. Additionally, there has not been a clear path to value-based contracting for all providers, which has limited their ability to move in the direction of VBP readiness. The advanced model pool should allow for upfront investments in value-based care infrastructure for providers at earlier stages in readiness as well as incentives for population health activities aligned with regional goals are articulated by the HEROs that necessarily occur outside of the arrangements. Inclusive Alliance looks forward to the release of the final proposed waiver amendment and to engaging CBOs in Central New York community planning and capacity building activities between now and next year's hopeful waiver amendment approval. Thank you.

Thank you. Thank you. Our next speaker is James Sinkoff followed by Mark McKinney. Please go ahead.

Hello. My name is James Sinkoff. I'm delighted to be able to comment. I'm the Deputy Executive Officer and Chief Financial Officer of Sun River Health. Allow me to contextualize my comments reflecting upon the waiver. Sun River Health, one of the largest FQHCs, is a network of 45 clinical sites and affiliated CBOs, such as the Peekskill Preservation Company and Affordable Housing Company, the Caribbean Women's Health Association, the Community Health Alliance of Staten Island, and the Warwick Area Farm Workers Organization, whose work is essential to address the social determinants of health. For example, the 2.6 million meals served in 2021. We served nearly 220,000 patients in 18 counties, most of whom live at or below the federal poverty level, reside in both densely populated urban and suburban neighborhoods, as well as sparsely populated rural areas. Our population is diverse, like all FQHCs in all respects, that diversity implies our patients present with complex medical, dental, mental health and substance abuse morbidities, combined with substandard access to affordable housing, transportation, nutritious food and inequitable access to specialist and tertiary care services. Sun Rive Health collaborating with sister organizations have advanced the primary care model to include managing Medicare and dually eligible patients under the MSSP program, managing TANF and SMI populations, and the jointly governed primary care behavioral health CBH Care IPA, and managing nearly 100,000 Medicaid members under the FQHC governed and operated Community Health IPA. This work is directly related and influenced by the state's roadmap to value. We commend the for continuing to accelerate healthcare transformation, putting social care and equity at the center of population health management. While the waiver rightly identifies the intersection between social determinants, health equity, and value based care, the waiver as currently construes, falls short and making direct significant investment needed to defragment the healthcare delivery system and drive care at the community and neighborhood level. Specifically, the waiver articulates an overreliance on incentives to drive transformation the system, which may unintentionally perpetuate a system of winners and losers, which might undermine the august and moral imperative, providing equitable care. The funds flow methodology while, using incentives to encourage transformation does not assure a success by making direct investment needed in the infrastructure of the largest and strongest statewide primary care safety net system represented by FQHCs. Notably, is an inconsistency between the overarching goal of addressing health inequity and disparities without the concomitant direct investment in FQHC primary care infrastructure and staff to drive and derive fundamental change in the health and wellness of the targeted population. Value based primary care

payment is a piece of this puzzle and we were pleased to see an FQHC alternative payment is a qualifying health equity informed arrangement. However, infrastructure investment is essential to existing networks of CHCs to augment and accelerate population whole person care. Excuse me. The investment will result in achieving the States' and our shared goals. Comprehensive primary care inclusive of social care clearly makes a difference. Numerous studies show a causal relationship between advanced primary care and reduced illness and death. But primary care remains woefully underfunded. The U.S. spends 5 to 7% on primary care as a percentage of total healthcare spending, compared with OECD countries, which spend 14% on services. Therefore, we strongly urge the state to increase the percent of premium going to primary care services within alternative payment models. Ensure quality payments are not adjunct to service reimbursement, but fundamentally embedded in the models of care associated with payments. We commend the state's reference to North Carolina model, but also recommend enhanced outreach, technical, regulatory, and contractual fixes within the VBP context, to guide plans and providers in aligning shared accountabilities to engage patients that may be hard to engage due to all of the social determinant factors described in the waiver. Community health centers are best positions in suited to deliver care and to meet the needs of our patients and communities with respect and dignity and achieve the goals of the state. Thank you so much for your time and consideration today.

Thank you. Our next speaker is Mark McKinney followed by Wade Norwood. Mark, please go ahead.

Thank you. I'm the CEO of Hixny, in the SHIN-NY qualified entity serving the Adirondack Leatherstocking, Mid-Hudson Valley and Capital Region. We are a model of a functional and fully integrated clinical and social care system today. In partnership with the Healthy Alliance, the social determinants of health network, we enable clinical providers in our community to review social determinants of health history side by side with clinical data for their patients and make closed loop referrals to social care networks without leaving their existing HER workflow. Through this partnership providers have new, faster, and easier ways to make referrals for critical social care services and all clinical and social care data is seamlessly integrated into a single analytical environment that supports quality measurement, clinical and social gaps in care identification as well as ad hoc analysis that supports outcome and program evaluation. Hixny's pleased to provide the following comments. Firstly, we appreciate the recognition that the state has made and acknowledging the role that the SHIN-NY can play. We encourage the state to more fully leverage it significant prior investments in both the SHIN-NY and DSRIP to accelerate proposal goals and eliminate duplicative efforts. The SHIN-NY and its QEs should be viewed as the data integration and measurement platform. QEs should not be viewed as a source for feeding or otherwise supporting reporting applications with clinical data, but rather as the aggregator of claims, clinical, and SDHOH data. This reduces duplicate efforts, increases speed to implementation and addresses the critical, critical challenges encounter during DSRIP. QEs have proven their ability to successfully integrate with many different systems and will be able to connect to and aggregate data from a statewide referral platform with existing social determinants and claims data. Allocating additional waiver funding to support these access activities is essential to success and reduces the potential for duplicative efforts. The state should encourage, encourage the use of a single consolidated resource directory that spans all regions, networks, and other boundaries, that is available to any provider using any system. This will offer flexibility, eliminate duplication and improve consistency of regional efforts. During the past year through the SHIN-NY innovation and interoperability funding, New York State has invested in developing and releasing a social referral directory using the open referral standards that is fully capable of serving this need today. Interoperability is essential to future success. The waiver is a great opportunity for New York State to continue to demonstrate national

leadership on interoperability and statewide data exchange and should require mandatory participation in the SHIN-NY by all parties as a condition of participation. Furthermore, all participating parties, including MCOs, physician practices, hospitals, SDHNs, CBOs, and OASAS and OMH providers should be required to submit clinical and/or claims data to the SHIN-NY. As part of this effort, New York state should further commit to the sharing of Medicaid claims data with the SHIN-NY QEs and require interoperability using common standards, such as the Gravity Project, open referral or FHIR among its providers and statewide platforms. Finally, the highest quality social care referrals begins when patient needs are correctly matched to their provider specialties. Technol, technology alone is insufficient to support the needs of medical providers who do not yet have the experience with the capabilities offered by individual social care providers. Through our partnership with the Healthy Alliance, 97% of all referrals have requested assistance in identifying the most appropriate social resource for the patients. This support is easily provided to partnerships between SDHNs and QEs and will increase the volume of, of quality referrals made to social care providers benefitting Medicaid patients and overall program goals. Success will require many doors leading to the same place. The collaboration between Hixny and the Healthy Alliance is a model that can easily and successfully be replicated throughout the state. We recommend to state fund these types of partnerships as well as leverage existing investments in the SHIN-NY to ensure that a single comprehensive patient record is available to all clinical and social care providers that supports all data and information needs. Thank you for the opportunity to comment.

Thank you. Our next speaker is Wade Norwood, followed by Alissa Wassung. Please go ahead.

Thank you, Phil. My name is Wade Norwood, and I am the CEO of Common Ground Health. Throughout the course of the last two years and three months, like many others, we found that the nature of our health planning work evolved dramatically. The global pandemic required our regional partnerships to focus on supporting community health during a window in which schools were closed, when access to non-urgent medical services was, were curtailed, and when the traditional community venues for health education, promotion and outreach; places like barber shop, beauty, salons and churches; were no longer spots for community gathering. As a result, we had to learn how to do business differently. And we had to use our planning tools, resources, and partnerships to meet the fierce urgency of COVID-19. And that focused our region on a deeper understanding of the way in which socioeconomic inequities, the health impacts caused by the type of job one holds, one's housing units' construction and floor layout, access to outdoor recreation and trust in credible sources of health information, all of these were the things Du Bois wrote about a century ago in his 1st, definitive study of health equity. And as a result, Common Ground Health's mantra became, "A crisis is a terrible thing to waste." And that's why I'm here today to thank you and your colleagues for not wasting this crisis. Let me also say, thank you for recognizing the work of common ground health, and developing the proposed health equity regional organizations, the HEROs. As, you know, key to our health planning work is the fact that Common Ground Health convenes and support more than 700 individuals representing more than 230 organizations at the 24 coalitions and committees that we in the Finger Lakes convene to engage in regional health improvement. This grass tops and grass roots level of network partners is what powers our data and analysis to support region-wide needs assessment and county level prevention agenda work. So, please know that I've been alarmed to see that these two partnerships within the nine county Finger Lakes region along interstate 390, from Lake Ontario to the Pennsylvania border, are not proposed as our HERO region. Please fix this. And as the State's waiver program evolves and advances, please draw map lines that reflect the natural care networks and patterns that support local collaboration. Please protect the integrity of our Finger Lakes region. I make this request while sharing with you that I'm excited about the proposed social determinants of health networks but

hope that waiver implementation will similarly allow the structure as such a networks to leverage the knowledge, relationship, and capacities of, and within, the state's various regions. I appreciate how criminal justice involve persons are specifically called out in the waiver. But as a New York State region, it be remiss for me not to note that the waiver application does miss the opportunity to follow up on the First 1000 Days. To deepen the partnerships between health care providers and schools, partnerships, which were key to our pandemic journey, and will be key to the present stage of our pandemic journey, and that is attending to children's mental health. At present, we're exploring new convenings with such communities as new Americans and refugee populations and indigenous peoples, and the states should be encouraging, since health equity requires focus on regional subpopulations, that their concerns are more appropriately left that by regional responses to the waiver. I close with no illusion that enactment of the waiver and its approval by the federal government will be a magic cure all that solves all of our health systems challenges. But I do hope to leave behind as the takeaway of my remarks the wisdom that is Common Ground Health's agency model. It's an African proverb that hangs in our office. It says "If you want to go fast, go alone. If you want to go far, go together." We at Common Ground Health are proud to be your partner in going together. Thank you for your kind attention.

Thank you. Our next speaker is Alissa Wassung followed by Chloe Cheng. Please go ahead.

Thank you so much for the opportunity to comment on the State's 1115 waiver application. My name is Alissa Wassung and I'm the Senior Director of Policy and Planning at God's Love We Deliver the non-sectarian, nonprofit provider of medically tailored home delivered meals. For almost 20 years, God's Love has been serving enrollees in the New York State Medicaid program as an active participant in MLTC PACE and MAP plans, the state's DSRIP program, participating as a Tier 1 CBO for multiple VBP contracts and more recently, as part of the lieu of services provision. Through these and other initiatives, we have been able to bring our life savings services to Medicaid enrollees and the communities we serve improving their health and lowering their healthcare costs. Were grateful to New York State Department of health for being a partner in innovation. The waiver application is a bold reimagining of the complex systems that need help. We applaud the team for recognizing the vital role social service providers in creating health equity. Our comments below are offer through this lens, and from the perspective of a long-time provider in New York State Medicaid. We'll address three areas here and more in our written comments. First, I'd like to start with the end of a project with outcomes and measure selection. We believe that the waiver's an opportunity to define a new set of clinical and community equity improvement measures that will give us the data we need to build a more resilient and equitable health care system. Because DOH only can coordinate data of this magnitude, we encourage the waiver to more robustly define the quantitative and qualitative outcomes, measures, and detail how regional definitions will roll up into the aggregate whole. Further, the process of defining success should include consumers and communities, to lift up the voices of beneficiaries and avoid the pitfalls of designing a system without all the information. Second, assessment data systems and interoperability. For the uniform social care assessment, we applaud the recognition of health care's primary role and care coordination inside and outside the hospital walls. Much has been written on how assessments for social needs can be burdensome to enrollees. We believe that is CMS' Accountable Help Communities was a step in the right direction. We do you need to make sure the assessment that New York State chooses is nuanced enough so enrollees can get to the right services. Several New York City pilot projects have created solutions in this space. Most notably the food and nutrition services bundle in New York City. We suggest that a workgroup be established with clinical and community based providers that offers best practices for assessments and incorporates the wisdom of communities. For social care interoperability

exchange, an absence of the statewide system that's allowed others have to build projects with multiple tech systems that solve the referral barriers between clinical and community data systems. These numerous systems encouraged innovation, but I've also been a capacity burden on CBOs participating in multiple partnerships both favor a uniform system and also want to preserve the innovation achieved through interoperability. Similarly, the state's platform must be able to integrate with existing government level systems in such a way as to mitigate duplication, reduce administrative burden for CBOs and most importantly eliminate access barriers for enrollees. For example, in just the food space Departments of Education, Agriculture Markets, Aging and more all offer food programs for patients. These systems must talk to one another. Interoperability and integration are something that CMS is focused on and as DOH considers examples, we lift up the CHORDS CoHID project in Colorado and of course, the previously mentioned Gravity work. We also request that DOH provide further clarity on how SDH information will flow up to the QEs and back to the SDHNs, and ultimately CBOs for care coordination. God's Love endeavor to participate in the RHIOs, QEs and has been an active partner in NYeC, yet, there is still no clear path to preserve privacy and facilitate data sharing. For VBP God's Love currently has 20+relationshipsd and extensive history with the VBP program. We found that novel relationships of this kind require more guidance and resources than what is shown in the VBP incentives diagram to achieve the impact they envision. It is imperative the delivery and reimbursement of social determinants of health services be closely tracked and truly incentivized in this model. We strongly encourage the state to release guidance that specifies that SDH related payments can be counted in the numerator of plans MLRs, given that they would fall within the federal Government's definition for quality improvement activities. Thank you so much for this opportunity to address here and the opportunity to comment on this waiver. We look forward to submitting our written comments at a later date.

Thank you. Our next speaker is Chloe Cheng followed by Al Cardillo. Please go ahead.

Hello. My name is Chloe Cheng, and I'm the Vice President of Strategy and Compliance at SOMOS. SOMOS is a federation of over 2,500 diverse community based physicians that deliver culturally competent healthcare to predominantly low income, immigrant, and minority communities in New York City. SOMOS's patient population comprises close to 20% of the New York City Medicaid population. A population that faces significant challenges accessing care, including language barriers, and social determinants of health. SOMOS is honored to once again partner with New York State, as it continues its march towards transforming its health care delivery system. As with our last 1115 waiver, SOMOS stands ready to promote health equity, stabilize and transform New York's safety net system, promote community based care, integrate health care and social care, and leverage emerging technologies and care models to ensure readiness for future health care needs. SOMOS sees the States plan to invest in advanced VBP models that drive an equitable integrated health and social care delivery system as a critical aspect of the overall approach of achieving the goals of this waiver proposal. As the first, and probably still the only organization to have implemented full risk level 3 VBP contracts for the Medicaid population in the state of New York overall, SOMOS is this highly supportive of this important and potentially historic effort. SOMOS does, however, oppose one element of the waiver proposal, regional global pre-payment models. While investments in the adoption of higher level of VBP models is important, SOMOS has strong reservations with regard to this specific pilot proposal. SOMOS understands the state's intent, but we acknowledge that there could be many adverse impacts of global pre-payment pilot program based on, based upon the location, scope, scale, and structure chosen by the state and federal governments. While there could be benefits in integrating providers and community based organizations on a large scale, much of the effectiveness will depend on how the pilot is structured and governed. SOMOS

sees a contradiction between a waiver focused on, on health equity and a proposal for a global payment system that has the potential to disenfranchise community providers and consolidate power in large, institutional healthcare entities. History has shown us that extreme consolidation in healthcare markets leads to higher costs and poorer quality outcomes. It should be noted that the Stats still retains its ability to explore all alternative payment proposals throughout the life of this waiver and may choose in the future to proceed on any particular path after appropriate dialogue and design consultation with stakeholders from the effected communities. Simply said, this proposal could have monumental consequences on the health care delivery, financing, and access for an area or population. Therefore, and more thought in conversation should occur before proceeding with this proposal. However, should the state choose to move forward with this pilot, SOMOS recommends this pilot occur outside the New York City area, due to the density of health care providers and patients, and the overall level of complexity in the nation's largest urban healthcare market. Thank you for your time and consideration.

Thank you. Our next speaker is Al Cardillo followed by Mitch Gruber.

Thank you very much, and again, our appreciation to the Department for conducting this hearing and allowing the opportunity. I'm Al Cardillo, I'm the President and CEO of the Home Care Association of New York State. We have within our membership all levels of homecare, managed long term care and PACE, hospice models, waiver programs and ancillary community support services that support the entire infrastructure. Homecare is a core of the entire system, unlike the experiences of 1115 Waiver, please include us in this new waiver, build upon us and leverage the comprehensive and unique position and resource that homecare brings to the healthcare system and to the health equity goals of this waiver and ultimately to society. And please consider avoiding the irony of a multi-billion dollar funded initiative to address equity that in itself, and in its design, perpetuates inequity. We appreciate and strongly endorse the focus of this effort on equity and addressing disparities and we stand in unison to advance this cause and we stand ready to work with the administration, the legislature, and all the collaborating partners in this effort. Homecare lives and provides services in the spaces where people live and need those services and that's the home and community. The roots of homecare are public health and that includes health, social, and environmental needs of individuals, communities, and populations. HCA has long been committed to addressing disparities and advancing equity. We have for the last 8 to 9 years been working to advance a bill for collaborative models to approach and address health disparities. We have conducted studies in health disparities, aligning the data and, and the position of homecare agencies with other partners to respond to the array of disparities and equity needs in the system. And we are currently implementing a statewide project that has multiple layers to address disparities, diversity, and equity. That includes training and education. It includes translation services. It includes population health. It includes a statewide assessment of disparities with that homecare can potentially reach and support, and so on. We also appreciate the collaboration focus and structure of this initiative. Home care is a core collaborating partner in the system and collaborates across the continuum. HCA is currently the, is currently leading a Hospital-Homecare Statewide Collaborative working in conjunction with the state and regional hospital associations where we have been promoting of both front end and far end collaboration to strengthen the system. The same, we are, we are working with and leading workforce collaboratives, a, a statewide partnership program and infection control, addressing sepsis across the continuum, a new initiative in community medicine, and we just, I had a very, I think very innovative discussion in relation to the collaboration of home health and community health centers and what that may bring. So, we're very, we're positive to see the collaboration part of this program. But we also, thus far on the material see, very scarce roles for home, health, and hospice and perhaps it's just a matter of terminology. But we also think it's very significant that it'd be very clear, and on the map, and not

in, in other category, as was in the DSRIP waiver. A significant parts of the home care system are are often overlooked in key programs and policies when they are really core and/or specialty parts of the system. We, we also, feel very positive, that, that there was a distinct effort to not duplicate or replace, but to build in this waiver. And we urge that that be a real part of this system. But that will only work to the extent to which leaders, partners, and decision makers are listening and understanding. We are also positive to see the focus on workforce. Certainly, the workforce needs are plenty across the system, but in the home care situation, it's really quite urgent. And we, we, urge that that in this waiver, we really seek structural solutions because if we're really going to serve the population needs workforce needs to be covered. Also, very positive to see the focus on support of housing. It's a key to long term care reform and to the quality of life and the future of the system. We urge you to make sure that home care and hospice are part of that. On value based payment again, we are strong proponents and we walk with the department in this effort, but we also urged the department to support the ability for homecare and health plans and partners and physicians, behavioral health and hospitals, pharmacies, others, to be able to engage in a truly effective program and I know I'm done. I'll, I'll, I'll, I'll sum up, so, you know, while the waiver, while the waiver, a framework considers, regional planning entities, we really urge you to consider beyond a top-down approach and the regional approach, an organic approach. Things that are occurring right now across the state, organically are truly transformative. Listen to what's happening at the bottom level look and be open to that. We look forward to working with you, working with the administration, and really making this a very significant initiative for the state of New York. Thank you.

Oh, thank you. Our next speaker is Mitch Gruber followed by Jim Karpe. Please go ahead.

Thank you very much. Thank you for the opportunity today. My name is Mitch Gruber. I am Chief Partnerships Officer at Foodlink Regional Food Bank in Rochester, New York. I'm thrilled to be able to deliver these remarks stemming from bunch of other people from the Rochester area, Carol Tegas, Laura Gustin, Wade Norwood. All of them done incredible job to really organize the CBO network to be thoughtful about what is in this draft paper. And before I launch it, my, I do just want to thank everyone who's spent so much time on this. The amount of work on, a document and a project like this is, that is certainly not lost on us, we appreciate the efforts here. I want to just start by giving a brief overview of Foodlink, and I'll be very brief. The core of our work for 43 years has been food banking, but we've deliberately transformed in recent years to one of our region's leading public health organizations. In addition to distributing over 20 million pounds of food per year, we operate a kitchen which has more than 10,000 healthy meals and snacks per day for children in our community and we have a suite of community help, to increase the accessibility of healthy local foods anchored by the curbside market, one of the most effective mobile markets in the nation. The curbside market proves to be one of the bright spots for DSRIP in our region. As you worked with our PPS, MCOs, and payors to create new programs that deliver healthy foods to the most vulnerable in our community. We have executed three fee-for-service campaigns with Excellus Blue Cross Blue Shield, providing regular access to boxes of healthy produce via the curbside market. The percentage of participants who reported that that quote, never worried about running out of food end quote, increased by nearly 15 points thanks to this unique partnership and intervention. We are now engaging Excellus once again for a new healthy food box program, aimed at improving the health and food security of pregnant individuals who receive a box of food via the curbside market on a weekly basis, on a bi-weekly basis, pardon me. With all of that context on examining the state of 1115 waiver, we have a few focus areas that excite us and the few areas of concern. We applaud the draft for promising to invest in CBOs. We look forward to engaging HEROs and SDHNs to ensure that CBOs get the requisite support for personnel, infrastructure, IT. We also applaud the focus on workforce development in the health care sector and hope

there is an opportunity for us to collectively develop a pipeline for careers in the CBO sector as well. CBOs are chronically understaffed, and we need to build workforce development opportunities for us to be effective at the work outlined in the draft. We are concerned, however that there is too narrow focus on quote evidence-based interventions for CBOs. The reality is that healthy food is one of the greatest needs in our, but food base intervention do not necessarily lead to specific improvements and health outcomes that could be described as evidence based. The link between a nutritious diet and access to healthy foods to healthcare costs is widely documented. Food and insecurity poor diet compromise our region's health and burden the healthcare system. In a survey of more than 60,000 households who visited emergency food programs, 66% reported making a difficult choice between paying for food and paying for medical bills. Over 150,000 people in Foodlink', 10 county regions struggle with food, food insecurity every year. So, please, let's not overcomplicate this. Let's not make every food-based intervention frame itself as medically tailored meals or a food pharmacy. Let's not allow specific and frankly, problematic language to get in the way of critical work. For example, terms like food insecurity and food deserts may suggest that someone who lives a few blocks from the grocery store may not need a food-based intervention but that person's lived experience may very well tell a different story. Let's not make this waiver so rigid that food banks, meal programs and food pantries have to jump through unnecessary hoops to provide food and nourishment to those who need it most. Finally, let's make sure there's opportunity for regional customization and innovation. After all a success story in New York City, or in North Carolina does not always translate to success in Rochester. Regional success stories should serve as the foundation for how we identify and scale projects. Thank you for allowing us to come and talk publicly. It is our hope that the successes we found from our health care partnerships can be supported, scaled up, and serve as a model for other nonprofits and health care systems across the state.

Thank you. Our next speaker is Jim Karpe followed by John Coppola. Please go ahead.

Thank you for the opportunity to testify today. I will be focusing on people with I/DD, intellectual and developmental disabilities. The, the system of care for this population is coordinated by the Office for People with Developmental Disabilities, OPWDD. I'm Jim Karpe, the father of two young adults with developmental disabilities. I'm a volunteer advocate who participates in multiple organizations, including Medicaid Matters New York, The Queen's Council on Developmental Disabilities and self-organized family groups, including SWAN and the Self-Direction Round Table, I'm actively involved in those groups, however, my testimony today is my own views. I'll be brief. I'm gratified and I'm deeply worried. I'm gratified that people with I/DD are specifically mentioned in the opening paragraph of the draft, of the draft waiver. It's exciting to think about the good that could be done over the next five years, if we had the funding and flexibility to test new approaches to services. And if it's done on the right scale HEROs and SDHNs will serve a valuable role, bringing together the many stakeholders to learn from each other and to work together to find solutions. And I'm worried. This draft waiver speaks of a tailored approach, but it's clear that the people who wrote the document have only a sketchy understanding of the I/DD system. If we are to have tailored solutions, then first, the tailor has to take measurements. I'm deeply worried about the harm done by imposing a set of poorly fitting changes. I'm worried that the waiver, as currently written will pull us backward. The existing system of care for people with I/DD attempts to focus on the whole person. New York state already aims, imperfectly, to provide for people with I/DD lifelong supports for housing, employment, and social engagement. These things that are now recognized as the social determinants of health are built into the system of care for people with I/DD. We can see this in OPWDD's stated goal, help people with developmental disabilities live richer lives. This is a glorious vision. It's imperfectly realized, but beautiful in its intent. So, we and do not need to start from square one when it comes to creating a system of social determinants of health. We

already have such a system, a flawed one, and what we desperately need is the flexibility to make improvements to it. So, I'm worried that this waiver as currently written, will pull backward. And I believe we can avoid that backwardness by creating programs within this 1115 waiver that are informed by knowledge of the system of care and that are specially tailored to the unmet needs of people with I/DD. Here's the heart of my suggestion, create programs for I/DD designed to meet two criteria. Alignment with the long-term goal of supporting people to live richer lives. And structure to produce lasting change in the system of I/DD services. I'll be putting together detailed suggestions and will submit my written remarks. The quick version is focused on identifying and spreading successful efforts. Build on what's already been proven to be successful in past pilots. I'll give three quick I/DD examples. First, several BIP grant funded programs, successfully moved individuals with into less I/DD restrictive environments. When the BIP funding ended, most of those programs ended. Second example, there was a self-funded project by advocates ink, which provided enhanced self-direction supports to individuals who no longer had family to support them. And last the intentional community model as practiced by Camphill, routinely achieves amazing results. Each of these examples, help people with I/DD live richer lives and each of them face funding challenges under the current New York state rules. Jim Karpe, father of two young adults with I/DD. And I, thank you for your attention today.

Thank you. Our next speaker is a John Coppola followed by Heidi Siegfried. Please go ahead, John.

Good afternoon. I want to begin by saying thank you to all the people who've done such a good job of presenting during these hearings fantastic ideas and thank you to the state agencies for providing this opportunity. My name is John Coppola. I represent the Alcoholism and Substance Abuse Providers from throughout New York State, prevention, treatment, harm reduction and recovery workers. I want to begin by sort of emphasizing two points, one which was made earlier by Al Cardillo, and that is that we not miss the opportunity to make a meaningful impact on the equity and health disparities goals, which are articulated in the, in in the waiver proposal. And we need to make sure that that that is that that actually happens. I'll talk about that in a second, and the second thing is that we not miss the opportunity to learn from the failures that occurred during DSRIP and to learn from the successes. And that would be the suggestion that we rely much more heavily on community based organizations and again, I think the 1115, a waiver proposal does go in that direction. So, let's make sure that both of those things happen. To begin on the equity, theme, first it's important that in any revision done that we more clearly define exactly what we mean by equity and what exactly what we mean when we say we're going to reduce health disparities, and we include some method of accountability, some infrastructure to measure the degree to which equity and health disparities are actually being impacted. And we're recommending the creation of an independent body to conduct ongoing monitoring of the process and the activities, and the distribution of funding and asking the question, and are we meeting our equity and health disparity goals and are we maximizing the use of these resources? So, we think that's an extraordinarily important thing to do. The, the program itself, the initiative itself should reflect equity in all of its dimensions. So, when we look at a distribution of resources across the various systems, is there equity across systems and within systems, and making sure that when we dispense funding with the COVID relief funding pool, that equity is involved there, that community based organizations in addition to hospitals and long term care facilities have access to those funds because they're experiencing the same kinds of, of, of, of economic and financial distress. Relative to governance, ensuring that the HEROs include substance use service providers, mental health service providers and consumers on the HEROs boards and any decision making bodies, that that's a requirements, not, not an option. Not something that people are encouraged to do. And that social determinant

of health networks, every single one of them includes a substance use disorder, a service provider leadership person and, and also a successful CCBHC and successful CCBHCs, that we look at the leadership of those organizations and make sure that they are integrated into the governance structure and infrastructure, you know, for this initiative. And looking at, you know, equity across service systems, relative to the infrastructure so, to the degree that community based organizations and substance use disorder programs were neglected in the past when it came to billing, quality assurance, utilization review, and increasingly as, as data and analytics become more and more important to decision making, that they be included in those, and and in those, that that that infrastructure, be, we apply an equity lens there as we all prepare for value based payment. And looking at funding attribution is is, is kind of a new concept for a lot of community based organizations that we should really consider that in addition to attribution, or, as an alternative to attribution, that we make funding decisions based on quality and the degree to which programs are actually meeting the equity and disparity metrics that we're laying out and addressing structural racism, structural barriers to access to care and retention in services and and looking at the outcomes specifically the black, indigenous, people of color, and and underserved communities. We're recommending that all rates be examined to ensure that the Medicaid rates that people receive meet the cost of providing services. We really support the idea of housing and supportive housing, you know, being an integral part of the, of the of the service delivery system and, and also recommend that we include recovery housing, transitional housing and residential treatment. We support integration of behavioral health services, addiction, mental health and primary care, and make sure that we address underserved populations, like people who are for formally, formally incarcerated, women with children, LGTBQ pop, population so we do equity, equity, equity. And then finally, telehealth. It's social determinants of health networks should all have access to distributing tablets and smartphones and other communication tools as well as ensuring that infrastructure includes broadband access and interoperability so that underserved and under resourced communities can have more equity in terms of access to services.
Thank you very much and I really appreciate the hard work that's going into this process and to the proposal.

Thank you. Our next speaker is Heidi Siegfried followed by Faven Araya.

Please go ahead. Ah, yeah. Hi, I'm Heidi Siegfried. I'm the Health Policy Director at Center for Independence of the Disabled in New York, and we’re, we're a nonprofit organization whose goal is to ensure full integration of independence and equity, equal opportunity for all people with disabilities by removing barriers to full participation in the community. So, our mission is to help people access the care and services they need to live independently and not in institutions like nursing facilities, psychiatric centers, prisons, and other congregate settings. Our open doors program specifically works with people to transition out of nursing facilities and we also help people get employment, food access, healthcare, housing, subsidies, transportation, heating, all the social determinants of health, or has termed in this new waiver application, social care. And we also help people with disabilities learn about their rights to accommodations, so they can advocate for themselves. CIDNY whole heartedly supports the waiver's most important goal of building a delivery system that reduces health disparities, promotes health equity, and supports the delivery of social care. But this goal needs to be fleshed out with strong definitions of health disparities and health equity. People with disabilities are recognized as a health disparity population, and HHS developed data collection standards for disability as well as race, ethnicity, sex, primary language, as required by the Affordable Care Act. Health equity should also be understood to include medically underserved individuals as defined in our new health equity assessment law, which really recognizes all, it understands it's understood to be intersectional and includes all aspects of a person's identity. Key to the

success of this waiver will be the HEROs, which must have a membership that represents the populations that are to be served. A term that has been gaining traction in various research communities is co-production of knowledge. Co-production refers to a way of working where service providers and users work together to reach a collective outcome. It's built on the principle that those who are affected by a service, are best placed to help design it. The structure of the HEROs is currently envisioned to give too much weight to manage care organizations and providers. HEROs should be required to specifically include consumers, consumer advocates, and community members, and their participation should not be tokenized and should be valued in order to produce regional plans that are successful and to inform quality measures that are relevant. The Disability Rights movement adopted a slogan in the 90's, nothing about us without us, which is appropriate here. CIDNY also supports the social determinants of health concept and hopes to participate given our expertise and connecting people with disabilities with their social care needs. CIDNY is concerned about the focus on managed care organizations, which is where the bulk of the funding, and the waiver will be going. Medicaid Managed Care plans do not universally have a good track record for providing the services people are entitled to and have been seen by people with disabilities as a barrier to getting the adequate care, which allows them to live independently in the community. Market-based systems, whether they are hospital systems or health plans, are not the ideal, ideal way to develop equitable health care. When health plans try addressing social determinants of health, there is always the nagging thought that they will not get a return on their investment, because the patient might choose to go elsewhere, which, of course, would be their right. This is why CIDNY has long supported universal, single payer health care. The health plans may also be, and have articulated at the last hearing, that they are reluctant to meaningful part, meaningfully participate in HEROs. So, the state needs to have better, invest and better oversight of the managed care plans to restore trust and ensure greater access to services. Independent consumer advocacy services will also need to be expanded and adequately supported to provide assistance to people who need help navigating this new environment of value based care. CIDNY supports investing in supportive housing services and alternatives for the homeless and long-term institutionalized populations. Callers to CIDNY are most frequently seeking affordable, accessible housing and the lack of affordable accessible housing has been a barrier for those looking to get out of nursing facilities. The housing barrier has recently been surpassed by the workforce shortage barrier. People who have a home to return to our languishing in nursing homes because after fighting with the health plan to get adequate hours authorized, there simply are no home care workers available to staff those hours. Therefore, we also support the goal of developing a strong representative and well, trained workforce. This goal must include fair pay for homecare. We do not expect that the wage increases we won this year will make the home care workforce crisis disappear. We again, we do support telehealth it's been it's been our surveys shown that people with disabilities have really benefited from telehealth. It must be a choice. It needs to be a situation where, if you prefer telehealth, that's fine. If you prefer in person visit, it can't be a situation where there isn't the kind of network adequately to get access to a provider in, in, in in person. So, anyway, we look forward to the success of this waiver and supporting it in whatever can, way we can. Thank you.

Okay, thank you. Our next speaker is Faven Araya followed by Humberto Brown.

Hi, are you able to hear me? Yes. Okay, great, thank you. Good afternoon. Thank you for providing a space for us to provide a public comment. My name is Faven Araya and I'm here representing the Arthur Ash Institute for Urban Health, a local community based organization that serves the diverse communities of central Brooklyn through, through a social justice and health equity lens. As the lead agency, I'm also here representing Communities Together for Health Equity, also known as CTHE. We are a diverse and representative group of over 70 New

York City CBOs working to ensure comprehensive services for underserved communities. We were established in 2014 and through our persistent advocacy efforts, we served as a catalyst for the state's first CBO planning grant and was the first of three regional CBO led consortium, funded to ensure community engagement was meaningfully integrated into the healthcare transformation process. Since that time, CTHE has sustained and expanded its infrastructure and reach, responded to urgent community needs throughout the pandemic, and organized to establish a model of community engagement that set precedence for the state's proposed Social Determinants of Health Networks. During the last DSRIP period, the state invested in strategies to restructure and transform New York's health care system in hopes of achieving a 25% reduction in avoidable hospital use. While progress was made, transformation was not achieved, nor responsive to community needs, which was later demonstrated by the pandemic. The waiver did not adequately invest in a public health infrastructure and was further exposed by the lack of effort to confront or meaningfully address health disparities, social determinants of health, racial inequality, segregated care, all of which disproportionately impact low-income workers and people of color who often represent Medicaid beneficiaries, which are the target population the state's program is designed to support, but did not sufficiently do so in the midst of a crisis. So, how do we avoid the pitfalls of the previous waivers, those that are demonstrated during the pandemic and those that are structurally weaved into our health care system? Well, the state's new proposal heavily emphasizes working towards health equity, which we support, but it does not define or address approaches to measuring equity. This also applies to the integration of community engagement and the social determinants of health. Measures of success that reflect and appropriately assess the impact of addressing social determinants of health and the contributions of CBOS in the health care transformation process is critical to evaluate process, course correct, and create opportunities for sustainability. This will require the active engagement and involvement of CBOs to help identify and define metrics beyond clinical, clinical outcomes that align with community based work. The other infrastructure that's proposed is the Health Equity Regional Organizations, the HEROs, which proposes a more inclusive governance structure, but still leaves a lot of room for power imbalances that CBOs, that CBOs being dominated by clinically focused entities, who offer a valuable, but limited understanding of the, on the ground community experiences. Therefore, a diverse and equitable representation is needed to ensure planning efforts are reflective of the community served and responsive to specific regional needs. Additionally, the proposal should, in terms of health networks, offer a unique and holistic approach to addressing social care needs, but they must be led by CBOs and CBO networks like CTHE, who already do this work. CBOs have a long history of addressing social determinants of health. They provide culturally and linguistically tailored interventions and are able to access and have trusted relationships with hard-to-reach populations. But they haven't been adequately funded to scale, expand, and enhance their program's services in a coordinated fashion. A key to the success of the Social Determinants of Health Network will be establishing payment models that appropriately compensate CBOs for their work. This includes providing funding upfront and investing in social determinants of health interventions that are evidence based, emerging in promising practices. CBOs have a range of programs, services and approaches to addressing diverse community needs all of which should be considered. When determining payment models, historically, VBP arrangements with CBOs were limited in quantity, scope, and funded and funding, diminishing any real opportunities to fully integrate social determinants of health in a comprehensive and meaningful way. We hope that this is not the case and this new iteration of the waiver. And while we acknowledge the elements of these principals are included in the state's proposal, how it actually translates into practice will determine the state's true commitment to health equity. Thanks for the opportunity to provide comments and we look forward to the changes moving forward.

Thank you. Our next speaker is Humberto Brown followed by Andrea Wanat. Please go ahead.

Hi, good evening. Humberto Brown, I'm also part of the committee, the group for Together for Health Equity that Faven Araya spoke about, so she really described it. My comment is going to be very brief, but I want to call first, the attention that we were first network to be supported by the previous iteration of the waiver, and as I look to the report that was prepared, we were excluded, we were not even mentioned on page 17 as one of the main networks, and the only network that was supported for New York City, meaning the five boroughs. And most of this organization address social determinants, as was mentioned before, we were one of the networks that really pushed the system to address social determinants and wanted to just focus and addressing illness and sickness from a clinical perspective. So, that's my first, concern, because all concern, if this is an organization, a network that participated, got funded, for, for three, four, five years, and we are not even mentioned in the report, but I see that the content of the report reflect all our suggestion, our critique. So, people write up this stuff that we said, we did, we, we, we submitted a strategic plan at the end of the process indicating what we thought were priority the issue of social determinants, the need to change the way we structure the participation of CBOs and we participated in many of the initiative as the board for social determinants, we were the driving force with the, with the Department of health, trying to define how we participate with these different sectors. So that's my first observation that to be clear that we're going to do something, but we even exclude from the beginning. The sectors that did most of the work really raise a concern that is our work really valued, or we get invited to this process just to meet the pre-requirement to make the to do the proposal or the proposal to have legitimacy. That's my first, observation about exclusion. The second comment I support what is said by most of the other CBO organizations, that we need to look at each of the pathology of power. How do you put people to collaborate with hospital with and the power dynamic, retained in their hands, they define what we do how we do it, what get address and that's what we end up having that the MCO only did 1 social determinant and 1 CBO collaboration ,when we spoke about the intersectionality of social determinant from the beginning, that the person is not just homeless and have good transportation or living good, or have good healthcare. Those things are interconnected. And that was a false way of design in this type of work. I also want to support that if you the, HERO and the Social Determinants Network, that it requires what we did at the beginning of the previous iteration that you have to give a space for, for, for CBOs in the variety of work that we do, and the complexity of it to have a planning space to understand the complexity of multiple initiatives for housing or transportation, or how we link people to the network of hospital, we need a space to do that to bring them under one umbrella, where the hospital and the MCO has already a strategy and what they do normally is unfair. So, if we want to bring, we do a new initiative, and we tried to incorporate social determinants, we have to get time and resources. The last time we got this grant, because we demanded that the state find the CBOs like they find the PPSs and give them a whole year, and they have participated without any structure and the planning strategy we had to go to CMS was to get this approved. We hope that my suggestion, as we incorporate some specific spaces for CBOs to able to do strategic planning and also, the CBOs, that there's equitable power as we create these structures that we not just collaborating in system that invisiblize us. That we find new mechanism to amplify the voice of community based organization and the community itself. So, those are some of my, my basic suggestions. I also agree with the people who emphasize that we need to define equity. We need to define what we're talking about, addressing social inequality and I think we need also some metric of what we mean, by transformation because we talk about transformation like, it's something natural. We need to have metric and goals that include also the community. So, somebody who said a transform something, but if the process of that transform, and we still retain those segregated care and into those system, we miss a great opportunity to use these dollars to really transform the system and transform the quality of care for the majority of people of color and community who are historically marginalized. Thank

you for the opportunity and we hope that this is not the last conversation you have with CBOs, that we get built in, in the process of defining how we're implemented if we got if we get the 13.5, the money we get that we can help co-design it and not just been forced in it from a subordinate position. Thank you, again.

Thank you. Our next speaker is Andrea Wanat followed by Hannah Diamond.

Good afternoon. Are you able to hear me? Yes. Okay, great. Thank you. So, my name is Andrea Wanat and I'm the Chief Operating Officer for Value Network, which is an IPA and behavioral health care collaborative located in Western, New York, and I just wanted to touch on a couple of things. So, I'll start off with just talking about the goal of the 1115 waiver is to build an integrated network of social care that can reduce health disparities, promote equity, and improve the delivery of care for patients. Foundational to these objectives is the task of designing a value based payment model to support three things, the people, the processes and the technology needed by providers to achieve these 1115 waiver objectives. Healthcare disparities arise from three factors, including environmental factors, individual's patient's health care literacy, and their access to clinical effectiveness of the health care system that they utilize. The measurement of social determinants is still at its infancy. We currently lack social determinants of health data demonstrating the additional health care costs for patients who are homeless, who lack of regular food source, and for those who require regular transportation to access medical care, including their preventative visits to the primary care physician or to pick up prescribed medications. So, in order to build a payment model to support social care, accurate and up to date social determinants of health data and paid claims data will be needed to quantify the cost associated with these patients gaps in in their quality of care as well as their total cost of care. So, it will be important to stratify this data with outcome measures by patient cohort, including infants and children, and adolescents and adults, middle age and elderly patients. HEDIS data will provide the key metrics across the age and gender continuum. Most important will be to determine what the return on investment is for partners who are successful in reducing health disparities and promoting equity. Without a clear return on investment, building a value based payment support for social care is highly unlikely. So, currently, the managed care organizations have value based payment contacts with a variety of entities, including health systems, IPAs, ACOs, private equity firms, and private practices. Under these arrangements, the risk is placed on the provider group to improve quality and lower the overall patient costs. In other words, the thought is, better care, lower costs. Currently these arrangements lack any source of funding for social care or any social care risk adjustment for practices with higher rates of social determinants of health within their population. So, in addition to building a payment stream, supporting social care. The waiver does focus on the behavioral health population. So, in Western New York, Value Network is a Behavioral Health Care Collaborative IPA that has built a clinical and a business model so, to support level 1 and 2 risk arrangements, Value Network has identified that behavioral health patients have between two and three and a half times the overall total cost of care then non behavioral health patients. And that key clinical metrics, such as hypertension, diabetes, management control, and their annual visit to the primary care physician can show significant disparities. The most interesting fact is that the higher the cost for behavioral health patients does not come from behavioral health related costs yet, they come from hospital, hospital outpatient and professional costs for their non behavioral health medical care. In addition, value network is aware of the impact that social determinants of health can have all these overall health care costs and needs. Therefore, Value Network is working to build the infrastructure to better manage the non-behavioral health care costs. This data that we have highlights the care, the health care disparities that exists between behavioral health and non-behavioral health health patients. However, the success of our Behavioral Health Care Collaborative has been limited by our inability to access a full range

of claims data from the MCOs. Currently the MCOs have a variety of methods to provide their downstream risk providers with data, but they do not provide actual claims data to Value Network or other Behavioral Health Care Collaboratives. Accessing this claims data is key to our success and it will enable our network, and others throughout the state, to understand the quality of care, and the total cost of care for our population to reduce health care disparities. This data will enable Value Network to design and customize intermediate interventions to address avoidable health care services in quality gaps and address social, social care needs. There is a simple solution that would support the 1115 waiver and all providers to engage in value based payment contracting, and that solution lies within our Regional Health Information Organization, Organizations. In Western New York, the HEALTHeLink RHIO has been a data aggregator for the CMS CPC Plus program and is in the process of continuing that work for Primary Care First. Under this program, CMS provides paid claims data to HEALTHeLink, helping to support better quality care at lower costs. HEALTHeLink also using the population health system to support their value based payment initiatives their tool has all the components of a high performing population health tool, including attribution, gaps in care, HEDIS scoring, risk adjustment registries, ADT alerts, et cetera. So, Value Network currently you utilize the helping link system to access medical data on our attributed patients. However, not all Medicaid MCOs are currently providing their data to HEALTHeLink. This limits the ability for our IPA to access complete information. Therefore, my recommendations to this committee are, as follows New York State must actively participate in the Western New York Data Aggregation Initiative by providing our RHIO, HEALTHeLink, with a full file of paid claims data for the Western New York Medicaid population. By doing this, this will enable the Western New York providers, Value Network and other key stakeholders to measure their quality cost across the Medicaid population and therefore, we'll be able to develop the coding for social determinants of health to support sustainability and a payment model for social care. And lastly, New York State should not require that a single social determinants of health tool, or vendor be used as the exclusive tool for SDOH partners statewide. Instead, New York State needs to utilize the existing investments that have been made across the state in various tools, because given the uniqueness of New York State, there should be regional based approaches to the Social Determinants of Health Networks. And thank you for your time, I appreciate it. Have a great day.

Hey, thank you. Our next speaker is Hannah Diamond followed by Courtney David, please go ahead. Is Hannah Diamond on? Okay, I'm not hearing Hannah Diamond. Perhaps we can move to Courtney David? Hi, good afternoon, can you hear me? Oh, this is Hannah Diamond, are you able to hear me now? Oh, yes, I can. Okay. Yeah. I'm sorry about that. No, no problem. Please go ahead. Okay. And then the next speaker will be Courtney.

Thank you for the opportunity to comment on the New York State Medicaid Redesign Team Waiver application. My name is Hannah Diamond, and I am the State Policy Advocacy Specialist at PHI, a New York based national organization committed to strengthening the direct care workforce by producing robust research and analysis, leading federal and state advocacy initiatives, and designing groundbreaking workforce interventions and models. My testimony today focuses on the over 550,000 personal care aides, home health aides, and certified nurse aides in New York that assist older adults and people with disabilities to maintain their optimal health, wellbeing, and independence across long term care and other care settings. The direct care workforce represents the largest and fastest growing occupation in the state. Between 2018 in 2028, PHI projects that New York State will have 1.1 million job openings in direct care, including jobs, new jobs and job openings caused by turnover. PHI celebrates The Department of Health's use of the 1115 waiver to support the direct care workforce. Because direct care workers provide the majority of paid hands-on care to Medicaid clients, they are best positioned to understand their client's needs, recognize changes in their clients' conditions and achieve

value based payment goals. These investments also advance the health equity goals of med, of the Medicaid program as most of the direct care workforce is comprised of women, of people of color, and immigrants, and nearly 40% are themselves Medicaid recipients. My comments today on behalf of PHI will reiterate the importance of using this waiver to invest in the direct care workforce. While our written comments will provide recommendations to ensure the successful implementation of all four goals outlined in this waiver, our oral comments today focus specifically on goal number three, which is to redesign and strengthen system capabilities to improve quality, advance health equity, and address workforce shortages. First, we offer suggestions for strengthening workforce investment organizations, or WIOs, to achieve value based payment goals. Our recommendations are based upon our own experience as a WIO and additional analysis from qualitative interviews with providers and WIOs in New York City. Based upon lessons learned, PHI suggests developing methodology to ensure equitable distribution of funds, especially given the expanded scope of this renewed program, maintaining the foundational elements of the previous workforce investment program, including offering training for all long term care roles and across long term care delivery settings, requiring stricter engagement from managed long term care plans and identifying, implementing, and sustaining training programs, introducing increased flexibility in the design and implementation of training programs, implementing more robust data gathering to better quantify the impact of training on client and workforce outcomes, and introducing incentives to ensure sustainability beyond the scope of the funding period. The remainder of our comments today focus on the recruitment and retention training and career pathways initiatives outlined in section 3.2 of the waiver application. The recruitment and retention investments outlined in this waiver will support pilot programs designed to enhance job satisfaction, stabilize the workforce, and amplify workers contributions. We suggest that the recruitment and retention funds include an independent evaluation to measure their impact and to identify opportunities for replication and scale up. Additionally, adequate training and advancement opportunities are critical for job satisfaction, workforce retention, and high-quality care. Current training standards and programs do not, for the most part, sufficiently prepare direct care workers for their positions and direct care workers have limited opportunities for advancement. Specific to this waiver, we urge the state to incorporate a plan to analyze the current training landscape and to understand its strengths and identify opportunities for improvement. This analysis should integrate input from a range of stakeholders and could draw on examples from other states. While PHI supports all advancement opportunities for workers, we especially want to underscore the importance of offering advancement opportunities within direct care. By offering career ladders and lattices for direct care workers, New York's long term care industry would be able to compete more effectively with other sectors, improve workforce retention, and maximize workers contributions to care quality and outcomes. Thank you for the opportunity to offer oral testimony today. Our written comments will provide more detailed recommendations regarding the remainder of the waiver application. We look forward to working with The Department of Health to strengthen the infrastructures surrounding the direct care workforce to accomplish the state's health equity goals. Thank you.

Hey, thank you. Our next speaker is Courtney David, followed by Harvey Rosenthal. Please go ahead, Courtney.

Thank you. Good afternoon. My name is Courtney David, and I am the Executive Director of the New York State Conference of Local Mental Hygiene Directors. The Conference represents the Directors of Community Services, Commissioners of Mental Health for each of the counties in the state, also referred to as a local governmental unit. The DCS' are county officials and has specific responsibilities and authority under the local services provisions of Article 41 of the Mental Hygiene Law for planning, development, implementation, and oversight of services to

adults and children in their counties affected by mental illness, substance use disorder, and intellectual developmental disabilities. LGU oversight of the local behavioral health network for persons of all ages allows for community interfacing with not-for-profit providers and serves as a bridge between health care and social care. The role of the LGU in the community is critical and unique. As government partners, the DCS' work collaboratively with state agency officials in all department levels within the county. The DCS' work, day in and day out to develop comprehensive, integrated, and cost-effective systems for the cross-system coordination of multiple local services. The people they serve never just need one service. Their needs are complex and extend beyond the scope of behavioral health care and into other distinct areas such as housing, public benefits, the criminal justice system, and the county jail. Several DCS' also provide direct services, which is especially critical in many rural areas of the state. The LGU planning function is a key component of responsibility. By legal statute, the DCS' had been conducting local planning since the 1970s, whereby they develop and annually submit a local services plan to each of the state's mental hygiene agencies. These plans establish local priorities, needs, and outcomes for the LGU in the coming year and the metrics used to measure the outcomes. The local plans are approved by the LGU's community services boards, which is comprised of local service providers, consumers, and other community members, and are subsequently submitted approved, and certified by state agencies. DCS' are expert convenors, which has been evidenced at the macro level working closely with state partners on projects, such as the regional planning consortiums, at the meso level through county level care networks, and on the micro level for individual client care. While we are pleased to see our local partners such as public health and social services departments be directly identified as stakeholders as part of the HEROs, we ask the Department to require the inclusion of the DCS' as part of planning activities. The County Commissioners of Mental Health, DCS' should be recognized as beneficial resources to the state for determining gaps in services, as they already work together regionally with local providers to ensure effective service delivery for these high needs' populations. The Conference will be submitting more comprehensive written comments, outlining other recommendations for your consideration. And I thank you for the opportunity to comment at this time.

Thank you. Our next speaker is Harvey Rosenthal followed by Nikki Kmicinski.

Thank you for the opportunity and all the work and new round of visioning that is reflected here in this plan. I'm Harvey Rosenthal a person of long-term mental health recovery and CEO of the New York Association of Psych Rehab Services, a 40-year-old statewide partnership of bounds of New Yorkers who receive and or provide community based mental health services dedicated to the massive health, wellness, rights, recovery, and community inclusion people with mental health, substance use, and trauma related challenges. Medicaid redesign and performance been a long, long priority in front of APRS and accordingly, I've served on the original MRT and continue to serve as a member of the state's value based payment work group and behavioral health clinical advisory group. I'd like to emphasize several points on behalf of our members. There must be a central decision-making role for beneficiaries in service design, strong visible roles and seats at every table, work group, advisory board, and other decision-making bodies or beneficiaries in the formation, operations of both the HERO and the Social Determinants of Health Networks. The waiver design must strongly promote beneficiaries' self-determination, informed choice, and privacy protections, requiring clear educational materials in a variety of languages and formats. We must not go further down the road of blaming people for system failure. We must take full responsibility for doing all that is necessary to properly engage and support people, especially those in states of crisis and great need. Current reimbursement systems and expectations, I'm sorry, I do not cover that. We must, there is no place for coercion in the healthcare system. We must expand, incentivize a broad array of voluntary engagement

services. As regarding privacy protections, we continue to advocate for the opt in approach. Social determinants of health, major focus of the waiver is to increase outcomes related to housing, food, financial stability, access to culturally appropriate social support systems. Yet our current behavioral health measures continue to rely on HEDIS measures that are focused more on getting people to the doctor or taking medication. We are however, greatly encouraged by NCQA's readiness to run a new HEDIS measures that will look at improvements to access to housing, employment, transportation, and strengthen culturally appropriate social support systems. We are looking for the state to adopt these measures as soon as they become finalized and to hold our system accountable for addressing these social determinants of health for the folks we serve by attaching pay for performance incentives, rather than the current pay for reporting system. Excuse me. Advancing access to a central office for community providers. Everyone here knows that the money in DSRIP went to the hospitals after – I have to rush here – and not the community providers, especially behavioral health providers. There's a lot of concern in our community this will happen once again either with the hospitals, or now, at this point, with the managed care plans. We are counting on the state to ensure that contracts in this environment include, mandatorily include, community based mental health providers and that these contracts, or what plans do, is monitored and held to account. Critically important, we must improve hospital discharge planning. We read about it in the papers all the time. We must have transitional peer bridges supports to specialized low threshold housing. We have to. Okay. Community behavioral tendencies. Nope. NYAPRS lauds the waiver's focus on workforce expansion, training, and compensation, more details are needed here. There must be strong and visible roles for providers, as I said, also beneficiaries at every table, workgroup, advisory board, and decision-making body. We should enhance the role of peer run agencies. We've heard about community health workers. We need to have peer services properly and sustainably funded and playing an appropriate role, peers are not here just to get people to the doctor Think of us as coaches and not, and not case managers. Medicaid restoration, we applaud the, the restarted Medicaid 30 days before leaving. It's a critical sort of component in re-entry. We need to do more about diversion and see that people are treated in prisons and not subjected to the torture of solitary confinement. But we really think this is a really essential sort of a measure. We also support the transition of Medicaid's, of individuals who are poised to be discharged from state PCs with that Medicaid. Racial equity, the preponderance of black and brown individuals with mental health conditions who are confined in our criminal justice systems or are placed in involuntary treatment orders, underscore our abject failure to effectively engage and serve people of color. It is essential that we create incentives to ensure that health and behavioral healthcare systems employ and deploy people of color in key roles across the spectrum from administration to frontline engagement and support roles. Thank you.

Hey, thank you. Our next speaker is Nikki Kmicinski followed by Tracie Gardner.

Can you hear me? Yes. Hello, my name is Nikki Kmicinski. I'm the Executive Director of Western New York Integrated Care Collaborative. Thank you for the opportunity to make comments today. We support New York State's innovative goals found in the 1115 waiver amendment. Western New York Integrated Care Collaborative is the network lead entity for community integrated health network of over 30 local, trusted nonprofit community based organizations, serving 15 counties. Our network has been supported for over 10 years by federal, state, and New York based philanthropic organization funding to develop, to develop this essential community hub infrastructure. We have executed over 20 contracts with various health plans to address social care needs of their members. We appreciate the state's dedicated funding to the further development of the regional social determinants of health networks or SDHNs. SDHNs such as ours are integral to assuring, ensuring the complete care of our community members. Network lead entities at these networks provide resource savings

from using intermediary as the contractor and closing gaps in care by triaging work out to a network of providers. By centralizing our IT solutions, revenue cycle management activities and quality assurance, we realized economies of scale that lowers the cost of entry for CBOs and our [inaudible] produces a lower cost, high quality CBO delivery system for health plan purchasers. We encourage the state to consider existing networks who have already begun this complex work to build upon existing infrastructure. Past experience serving the region should be a factor in selecting a social determinants of health network awardee and should weigh heavily in the evaluation scoring. We ask that the state require eligible SDHNs to have a minimum core set of essential CBO partners with signed letters of commitment to work with that SDHN. The minimum core set of CBOs should include the following committed partners with the SDHNs, food banks, faith based, educational and youth serving organizations, housing providers, community organizing groups, adult protective services and aging and disability networks. CBOs are an asset to New York State. Our western New York regional hub ensures health equity with a focus on engaging a broad range of CBOs. Particular expertise in serving high risk groups including racial and ethnic minorities, LGBTQ populations, rural markets, refugee populations, and persons negatively impacted by poverty. We encourage New York State to ensure the funding and decision making, to ensure, include CBOs as equal and participatory partners from the beginning in all aspects of this Medicaid project, including the proposed referral system, value based payment project planning, and with a point to include CBOs from rural, urban, and suburban areas. CBOs provide essential services such as food, housing, transportation, and programs addressing health and equity of New Yorkers. CBOs dutifully responded to serve our community during the part, pandemic. However, CBOs also have extreme staffing shortages. Thus, CBOs should be included in workforce training and capacity building earmarked in goal 3 of the amendment. We also advocate, advocate for individual CBOs to be allowed to contract with more than one SDHN, as many serve communities crossing the proposed regional bound, boundaries. In regards to value based payments, we recognize that addressing health related social needs is a critical factor in improving health outcomes for the target population. As a result, MCOs should be required to contract with SDHNs in the same manner that they have to contract with a minimum number of healthcare providers to meet Medicaid network adequacy requirements. As a result, MCOs should not achieve network adequacy unless they show proof of contracting with designated SDHNs in their defined service area. In regard to a statewide referral platform, fortunately, the State of New York has already invested heavily in a statewide system to provide assistance to residents using the 211 and New York Connect systems. Since there's already sunk investment in these systems, the state could have a greater impact with their investment if they use this funding to bolster the existing systems and address the biggest need, which is for the support of a community information exchange between systems, such as 211. The Regional Health Information Organizations, such as Healthy Link in western New York, already exist to ensure closing loop on referrals, HIPAA considerations, and adequate data sharing, including claims and outcome data between all parties. Funding and project should also align with New York State's age friendly initiative. The state needs to ensure there's a focus on older adults and dual eligible beneficiaries built in symmetry, existing infrastructure. On behalf of the entire Western New York Integrated Care Collaborative, we are excited for this unprecedented opportunity and eager to support the state in our regional community and partners through this project. I will expand on these points through our written comments. Thank you for the opportunity.

Hey, thank you. Our next speaker is Tracie Gardner, followed by Marc Natale. Please go ahead.

Thanks. I will definitely be submitting written comments. Thank you for the opportunity, long awaited. My name is Tracie Gardner, Senior Vice President for Policy Advocacy at Legal Action Center. We use legal and policy strategies to fight discrimination, build health equity and restore

opportunity for people with arrest conviction records, substance use disorders, HIV and AIDS. We collaborate with Punishment to Public Health Initiative at John Jay College of Criminal Justice over the last 5 years to facilitate the New York City Health and Justice Working Group. Since, since 1973, Legal Action Center has always understood the link between correctional and community health. We've worked more than 20 years with New York State on strategies to capitalize on Medicaid opportunities, to address the health and support needs of the reentry population through coverage, coverage, and employment. During my employment with the Governor's Office, and then with The Office of Health Insurance Programs, I worked with a wide variety of stakeholders in New York State government, and in the community of provider advocates and people with lived experience to advance the previous 2016 waiver application, waiver amendment submission. 30-day prerelease component of the waiver is critical for care coordination, peer engagement, and medication management and if authorized, will have New York State still be the first in the country to allow billing behind the walls. We know, for mental health services and AIDS Institute programs that the best practices in transition care from any facility require building a relationship with individuals inside prior to their transition outside. In the healthcare realm, we know this, the value of discharge planning, and we need to similarly invest in a strong and well resourced, transitional, transitional infrastructure for people coming out of incarceration of any length of time of any length of time. Reentry begins upon admission since 80% of people from state prison come home to their communities and the jail stay can be as short as 3 to 5 days. So, there should be an emphasis on jail realities by ensuring coverage and billing capacity upon admission to jail. In the section focused on those with criminal legal system involvement, the application speaks to a critical need to provide services to those suffering from mental health and substance use disorder. Although on page 31, it seems to limit these services under the waiver to those with chronic diseases, serious mental illness, and opioid use disorder, and this is really should be expanded to include all substance use disorder based on the amount of people impacted by substance use disorder, not just OUD. The expansion is happening, would happen at a great time that we are about to implement a correctional, substance use disorder treatment law, which will be an effect in October and this new law provides these correctional facilities provide treatment and transitional services that supports the initiation, operation, and enhancement of substance use treatment and transitional services. Expanding the waiver application to include SUD would allow for a seamless continuum of care for those suffering with SUD, as they will receive services behind the wall and then transition to services to an outside provider. For this new policy framework to provide, and this is critical, New York must continue to improve collaboration between the Department of Health and the Department of Corrections and Committee Supervision. Despite legislation already mandating agencies to ensure that clients that individuals leave state correctional facilities with active Medicaid coverage. It still takes 24 to 48 hours for that coverage to be activated. This is already law since 2016 and it is still not working, and this is widely known. We need to, in order to take advantage of this opportunity of the waiver, be able to ensure that those mechanisms are actively working. Finally, or not finally, given the logistical challenges that persist at the state level, we ask the state to include New York City in phase 1 of the proposed timeline for in-reach Medicaid services. They already have the infrastructure to do this and there's no better place to pilot this initiative than New York City jails, where the health care provider is a division of the local Medicaid hospital system and has electronic health records on the same platform as community based counterparts. Finally, we need to have criminal legal system, we need the state to require that each HERO submit a detailed plan to improve health access and health outcomes for criminal legal system impacted individuals and their families. It's not enough to include as a, as an option, and we saw under DSRIP, very few PPSs chose to focus on this highly vulnerable population and barely anyone so far in this public meeting is talking about the criminal justice population. See, I have my own timer. It's clear from the testimony that we need to be partners, and collaborate with the state on the inequities, inherent in both the corrections

and health system, or we will be perpetuating the very problems that we're trying to combat with this waiver. Thank you.

Hey, thank you. Our next speaker is Marc Natale followed by Bonita Gibb. Please go ahead.

Thank you very much, Phil. Again, my name is Marc Natale and I'm the New York State Network Director for Unite Us. Thank you for the opportunity to provide comments on behalf of Unite Us on the New York State Medicaid Redesign Team's 1115 Research and Demonstration Waiver proposal. Unite Us has identified core mission alignment between our company's drive to improve outcomes for all and the waiver proposal. Therefore, we are excited to share our support for the proposal's mission and design structure. We would also like to express our strong support for the proposal's plan to utilize a single statewide social care platform as the foundational infrastructure that will power secured, cross sector communication and collaboration, and support the social determinants of health networks, HEROs, and value based payment arrangements. Unite Us also agrees that now is the time to plan and implement systems transformation to confront the inequities laid bare by the COVID-19 pandemic. It's at the time to build and sustain communities as they recover and strengthen and support them into the future with a well-funded, integrated, and comprehensive public health infrastructure. Founded in 2013, in New York City, Unite Us is a technology company that provides an end-to-end solution to connect health and social care. Our goal is to ensure every individual, no matter who they are, or where they live, can access the critical services they need to live happy and healthy lives. Our coordinated social care networks in more than 45 states, including an existing and well-established asset across all of New York State, demonstrates that a robust, collaborative, and holistic community-wide approach to identifying and addressing unmet social needs not only improves individual health and quality of life, but also improves community health, reduces healthcare costs, and promotes health equity. Our work also demonstrates that social care providers can be empowered to securely share limited information about the clients they serve. Based on our experience, we know that the proposals design to integrate health and social care to address unmet social care needs provides a clear path to keep people healthy, well, and economically resilient. Our model, which is consistent with the proposals design approach, combines health technology, such as our high trust and HIPAA certified platform with an informed community engagement strategy that drives provider adoption and offers network optimization support. This proven and scaled approach supports meaningful outcomes focused collaboration, ultimately leading to healthcare communities and cost savings. Our approach also prioritizes client privacy and confidentiality for all seeking social services, including enhanced privacy protections for those seeking sensitive services in order to develop trust within the communities we serve. We also know that state support for a single social care platform is the best proven approach to ensure the end-to-end integration of health and social care, as has been pioneered by North Carolina's Department of Health and Human Services, and adopted by several other states, such as Rhode Island and Virginia. There are many benefits to deploying a single statewide platform as our formal written comment letter will show in more detail, including the ability to standardize the social care taxonomy, to empower providers to manage connections to care, making the sector less fragmented and easier to navigate. A single platform can also provide the structured intervention and outcome data necessary to successfully integrate social care into value based payment arrangements and broader value based care strategies. So, on behalf of Unite Us, thank you again for the opportunity to comment on this proposal.

Okay, thank you. Our next speaker is Bonita Gibb followed by Lori Andrade. Please go ahead.

Good afternoon, everyone and thank you so much for this opportunity to speak. My name is Bonita Gibb, and I am the Strategic Planning Coordinator for Herkimer County representing Herkimer County Public Health, Mental Health, Social Services, and the Youth Bureau. We speak today to shine a light on rural health disparities. Rural health disparities are often bandied about in discussion, but rarely do we people see meaningful action to address disparities unique to, or exacerbated by, rural living. When interventions, policies, or funding are put forward, the size of the population and not the size of the need is all too often the determining factor in who benefits and who gets left behind. This is antithetical to the very idea of addressing health disparities. The current proposal seeks to expand telehealth services. While this is a huge step in the right direction for addressing disparities for many, it does not explicitly take into account the underlying service disparity for rural populations. As many of my urban counterparts understand all too well, broadband, and cellular service access is truly a zip code level disparity. In Herkimer County, approximately 20% of our population lacks broadband access and 12% of our households don't even own a computer. This disparity only widens when you take into account income levels. Of those Herkimer County residents who make less than 20,000 per year, which is about one fifth of our population, 42% lack Internet access. Approximately 40% of our county households make 25 to 75,000 per year. Of these households, 21% lack broadband access. Without support for equitable broadband infrastructure, expanded telehealth services cannot address health disparities and may even widen the gap. This is only one piece of a larger issue in disparate access. Rural areas are, and have been for decades, desperately in need of health care providers and direct care staff. From EMS to home health aides, to primary and specialty conditions, rural areas are continuously operating at a deficit. Our workforce shortages are not unique to the pandemic. Herkimer County's ratio of population to primary care physicians is 3,090 to 1. When we account for primary care clinicians, such as nurse practitioners, that ratio is 1,800 to 1, with Herkimer County still ranking 58th out of 62 counties. While increasing reimbursement rates and wages is a necessary step towards addressing the workforce shortages, this is not the only reason rural areas have difficulty attracting and retaining providers and agencies. Herkimer County has one small critical access hospital in the southeastern corner of county, and a handful of satellite clinics hailing from larger hospitals outside of our county. The majority of these clinics are located in the southern portion of the longest county in the state. This leaves our northern and mid county residents with an hour or more drive to access basic services. Operating these clinics on a volume-based reimbursement budget is nearly impossible. Without attention to our current volume-based payment structure, simply increasing reimbursements for either wages or services does not address rural disparities. Finally, but certainly not last, we want to recognize that the inequitable distribution of funds that places population over need. For example, Herkimer County is in the fourth quartile for children less than 72 months with an instance of confirmed high blood lead levels at both 5 and 10 micrograms per deciliter in New York State. Despite being in the top 10 worst counties for high blood lead levels in children, our funding to prevent exposure and address long term health outcomes has been cut again. This systemic disregard for the breadth of need, callously downplays the impacts of lead exposure on children, increases barriers to prevention efforts, and knowingly places the burden of inequity on lower income children and families. This is not how health disparities should be addressed. These are just three examples of the health disparities rural people face. We are often overlooked because we lack the population, not the need. The flow of interventions, funding, and policy changes should be, and must be, proportionate to the size of the need. That is health equity. Herkimer County Public Health, Integrated County Planning, Mental Health, and Social Services stand together, ready, and able to ensure that the realities of rural disparities and the disparities of implementation are meaningfully recognized going forward. I thank you for your time and consideration.

Thank you. Our next speaker is Mary, excuse me, Lori Andrade, followed by Mary Zelazny.

Good afternoon, thank you for the opportunity to provide comments. I'm Lori Andrade, the COO of the Health and Welfare Council of Long Island. I am speaking on behalf of the Steering Committee of the Health Equity Alliance of Long Island, or HEALI, a coalition formed from the CBO planning grant. HEALI engages more than 85 health and human service agencies to ensure equitable health and life outcomes for all Long Islanders through cross sector partnerships. Thank you for recognizing HEALI in the waiver document. Social determinant of health networks coordinate community based organizations to provide integrated social determinants of health. It is critical that wherever possible these networks be led by community based organization. We are very concerned about the reduction and funding for the social determinant of health networks. There must be a significant upfront investment in the networks to build the technological and human resource capacity, systems, and workflows since the success of the waiver's intent is highly dependent on the network's capacity and viability. The investment in these networks cannot be short changed or undervalued. Additionally, we encourage incentive awards for managed care organizations and provider utilization of social determinant of health networks. Payment structures should provide MCOs and providers that work within the SDH networks access to any subsidies flowing from waiver funds. The SDH network inherently promotes the information sharing and collaboration that the waiver identifies as key to improving health outcomes. The standardization of a statewide IT system across health systems, plans, and SDH networks is key to improving health equity statewide. The development of the SDH network led coordination in each of the regions is critical to align workforce development interagency work agreements, workflows, and outcomes assessments within a region. This will create a cohesive system within each region and between regions. We are unclear on how this statewide IT system will integrate with current data collection and reporting required by various contracts between CBOs and New York State departments. This is a moment in time for the state to integrate department level data collection and reporting, as well as integrate client level applications for state administrator programs. This will improve access and the experience for clients and streamline the administrative and programmatic work for CBOs. The HEROs charged with critical regional planning, the lead entity for the HERO should be outside the structure of the delivery system in order to play a neutral and unbiased role in working with the governing body to develop the regional plan and ensuring equity. The lead equity, the lead entity for the HERO should be neutral without the potential for financial gain from the plan. With a neutral, unbiased lead entity, the HEROs work in building a regional plan is equity based and client centric and not disproportionately to the benefit of the MCOs or the health systems, or CBOs. We applaud the state's priority of CHW workforce development and want to emphasize that the need for this to be adequately funded for long term sustainability. While a universal threshold for training is necessary, ongoing training is also necessary for long term success for community health workers. We applaud the state's inclusion of statewide digital health and telehealth infrastructure and the recognition of community health workers to improve access to technology and services. We ask that the state to include social care services in the development of this infrastructure to further integrate health and social care, integrate telehealth in the social determinants of health network infrastructure development, and expand access to care to individuals. The HEALI Steering Committee and Coalition look forward to working with the state on the waiver program. Thank you for your consideration and this opportunity.

Thank you. Our next speaker is Mary Zelazny followed by Lori VanAuken. Please go ahead, Mary.

Thank you. My name is Mary Zelazny. I'm the CEO of Finger Lakes Community Health and the Board Chair of FLIPA, the Finger Lakes Independent Provider Association. FLIPA includes 11

Federally Qualified Health Centers, or lookalikes, 6 behavioral health providers, and a rural health network that spans 23 counties across Upstate New York, and we are actively working to expand our network with other social determinants of health partners. The current network includes 75 community health center sites, 97 school based health centers, 20 behavioral health, mental health and substance use disorder, clinical, and treatment centers, and 40 housing facilities, serving total, over 225,000 patients annually. FLIPA's mission is built on the foundation that the integration of behavioral health, social care, and primary care is essential to improve the health and wellness of patients and that failing to meet the needs of any one of these areas leads to greater challenges in the other two. FLIPA recently consolidated with the Upstate Community Health Collaborative, UCHC IPA, bringing together our collective experience and expertise. UCHC's first year of value based payment contracting was 2018 and FLIPA began value based contracting in 2019. Given each organization's expertise, our comments today focus on the value based payment portion of the waiver proposal and segments of the waiver document that relate to VBP. We will later be submitting comprehensive written comments. It is the opinion of FLIPA that the waiver goals of clinical integration of behavioral and physical health, including SUD services, are better planned, and coordinated through an IPA, rather than the HERO. IPA's have consistently promoted and evidenced their members seamless access to and navigation through these services. Targeted VBP intervention and informing VBP models should also be under the responsibility of the IPA's because they have significant experience and success in doing this work. IPA's will be able to provide meaningful contributions to these conversations, while not requiring an intermediary. Many HERO entities will be starting from square one, with developing relationships, understanding VBP models, and appreciating the nuances of a varied network of population, patient populations. IPA's have already learned a great deal in this arena and would be a loss of momentum and duplication of resources to engage a HERO as an intermediary. VBP is the largest portion of allocated funding, however, there are limited details included in the waiver proposal. VBP must include guardrails that protect providers and set them up to be successful, while also ensuring accountability for Managed Care Organizations. For instance, VBP metrics need to be tied to comprehensive and meaningful outcomes for people, not only minimally necessary process metrics. Also, when MCO's benchmark providers against state rates, it generalizes community and regional differences and distorts the data to the detriment of providers. In many cases making it impossible for providers to affect substantial improvements or substantial impact in a one-year period. A stark example of why this is so important is that during UCHC's first year of value based payment contracting, they saved an MCO 9 million dollars, however, because they had just missed the quality metric by 1 point, they received no shared savings dollars. Gap to goal benchmarks are more equitable, allowing providers to prioritize local needs and offering a better opportunity to meet quality goals and VBP arrangements that return dollars to the providers who do the hard work of improving quality. Alignment of metrics and VBP arrangements across MCOs would allow providers to implement initiatives that have significant impacts on the health of those served regardless of payer. Providers do not view patients in terms of insurance, however, the current VBP structure establishes silos based on payer that is in congress to those providing care. Upfront investments for providers to provide, to improve work flows and outreach efforts is essential for providers to meet and exceed VBP metrics. Currently, providers are not receiving VBP shared savings distributions until 12 months after the end of the contract period. This funds flow process, restrict, restricts providers and optimally performing on contracts due to the lack of upfront financial resources. Upfront investments for providers should not be deducted from future savings, earnings. Many efforts to outreach and engage individuals who have not engaged in services in over a year, have missed key prevention screenings, or who have significant behavioral health and social care needs, requiring staff and infrastructure that is not always billable in the traditional models. Up front investments can help providers build capacity

for these critical activities that will result in improved VBP success later. Ensuring these funds to be dedicated to the providers of care, including SDoH services, rather than accruing to the MCO bottom line will be key. We are an integrated network, but we are not allowed to collocate services, due to independent state bureaucracies and code requirements among primary care, behavioral health, and SUD services. Updating and aligning the regulations would enable us to fully reach our potential and benefit our mutual patients with both behavioral health and physical health services being provided in a coordinate, highly coordinated fashion. We will submit more extensive comments in writing. Thank you so much for allowing us to say our piece.

Okay, thank you. Our next speaker is Lori VanAuken followed by Briana West.

Thank you so much for this opportunity to comment and special thanks to the panelists who are listening to many hours of testimony with I suppose more to go, and to my colleagues throughout the state who have already provided their insight. I'm Lori VanAuken, President and CEO of Catholic Charities Family and Community Services in Rochester, New York. Along with our four affiliates, Catholic Charities of the Diocese of Rochester serves approximately 250,000 clients from all faiths and backgrounds annually throughout 12 counties in the Finger Lakes region. With this waiver, our service network will bridge two of the nine areas. We employ close to 1,500 staff members who provide an enormous range of multifaceted human services that address social care needs and the services from cradle to grave. These include access to food, housing, employment preparation, substance use disorder and behavioral health treatments and we meet some of the most vulnerable populations, meet the needs of some of the most vulnerable populations in the region, including folks who are living with developmental disabilities. We continue to partner with the Finger Lakes Performing Provider System, and the Systems Integration Project, and we are a founding member of your health partners, Behavioral Health Care Collaborative, an IPA, along with members of FLIPA and the include, Inclusive Alliance. We're truly grateful that the waiver amendment will bring better integrated primary health care and social care while addressing health equity and we hope the following comments will be helpful in informing New York State's work in this endeavor. Consider a strategy focused on New York's children. Medicaid covers 50% of births each year, 60% of children ages 0 to 3 and 40% of children ages 0 to 18, but the waiver fails to address the racial and ethnic disparities in maternal and infant morbidity and mortality. There are glaring disparities in early childhood health and a great need for youth mental health services. There needs to be a focused strategy on just, on addressing the disparities in the health of our children. The waiver calls out the use of evidence-based interventions. Such interventions are effective when implemented with fidelity into the model and when used with the populations for whom the intervention yields results. To implement programs that are evidence-based requires training, credentials, monitoring, and so expansion of these programs will require additional investments and appropriate deployment. Further, not all evidence-based programs are culturally appropriate. For example, DBT, Dialectic Behavior Therapy has become the treatment of choice for clinical, complex, clinical disorders. However, there is a lack of evidence supporting this approach with culturally diverse groups and its availability in community mental health settings is scarce. Evidence-based programs must be culturally appropriate, well-resourced, and the human services field needs to be well prepared to implement these approaches. It is unclear from reading the waiver that these factors are truly considered and resourced appropriately. From the behavioral health perspective, several years ago, New York State invested well over 60 million dollars in behavioral health care collaboratives and now with more FMAP money coming in the near future. Many of the behavioral health care collaboratives also operate IPA's and these entities have developed their expertise and are working on value based payment arrangements. Their work in the state and investment in expertise and learnings has to be leveraged in this waiver and should, they should be, Behavioral Health IPAs should be a required partner in each Social

Determinants of Health Network. From the CBO perspective, the fee for service model must be effective and efficient with prompt payment and ease of billing, upfront investments, and an administrative burden to be minimized. In establishing metrics, we ask New York State to consider access, quality, and efficiency metrics, in addition to volume metrics. The waiver cites the number of referrals for social needs, this is a volume metric. Consider the percentage of accepted referrals by a CBO or result, or a resolved referral which provides more comprehensive pictures of success. And finally, as a provider of services to people with intellectual and developmental disabilities, we are so pleased that this population is included in the waiver, and we look forward to working with our local HERO and Social Determinants of Health Network to address disparate access to community-based support for those who are black and brown and living with I/DD. There's much work to be done in this area. Again, thank you for the opportunity to share these comments and we will be submitting a written statement as well. Thank you.

Okay, thank you. Our next speaker is Briana West followed by Ashley Restaino. Please go ahead, Briana.

Hello, and thank you for the opportunity to share my comments on the 1115 waiver today. My name is Briana West. I'm a current, I'm currently an unpaid graduate candidate and intern for Communities Together for Health Equity, or CTHE. CTHE is made up of a collective network of over 70 CBOs and stakeholders working to ensure comprehensive services for diverse and underserved communities. Over time, CTHE has sustained and expanded its infrastructure and reach, responded to urgent community needs throughout pandemic, and organize CBOs to establish a model of community engagement, and set precedence for the States proposed Social Determinant of Health Networks. I also feel it is important that I bring to this comment period my unique perspective as a student in the space of health policy and the process of health care transformation. My time and work with CTHE has allowed me to make connections between my relation to the health care system as well as that of my family and fellow community members. Most of all, my experience with CTHE has made clear the significance of CBO community engagement and the need for the state to allocate sufficient funding and support to networks, like CTHE, to increase CBO capacity. During my time with CTHE, I have been able to listen to the individual voices of community members, especially those in underrepresented groups such as the disabled community, youth, undocumented individuals, as well as other culturally diverse groups. We work with these communities to gain insights on their struggles, frustrations, and needs in relation to the health care system. Using CTHE's model for community engagement, we collected survey data on social determinants of health and used this data to create visual representations of communities by need, by borough, and by current access to care. This data was shared with CBO partners to give them the means to pivot, expand, or change their efforts if needed, with the ultimate goal of providing appropriate linkages to care. Community members feel safe and trust CBOs and they are comfortable sharing the obstacles that they face with them. With CTHE, they shared their reluctance to see a healthcare professional out of the fear of not understanding their health insurance plan and acquiring large medical bills. They expressed their frustration with the healthcare providers and when going to an appointment and all that, and all their doctor could see was their disability. When speaking to youth groups, they requested access to mental health services as well as, as well as, expressed a genuine concern for the future of health care, and also the hope for a more inclusive and equitable system in the future. For these reasons, I hope to see more CBO representation and decision-making power going forward since they represent and advocate for the ideas, needs, and values of the communities that they serve. I hope to see communities grow and thrive with the transformations to the healthcare system, mainly in respect to some of the current pressing issues of housing, employment, access to food, and mental health. The

networks, the network of CBOs that make up the CTHE Collective are passionate, hardworking, resourceful, and trusted community leaders, of which communities rely on for information, connections to services, and support. Which is also why CTHE is perfectly positioned to be a regional leader to support this change in health care framework. However, as a valuable part of this process, we are looking for clear measures of equity from the implementations of this waiver as well as equal CBO engagement. I share this testimony in hopes to emphasize what we already know that CBOs know how to reach out to and support the needs of their communities and that they play a critical role in addressing social determinants of health. With this knowledge, with this knowledge, it is appropriate that we request equitable, equitable, and sustain inclusion in the healthcare transformation process and we look forward to being a part of this change. Thank you again for the opportunity to speak today.

Thank you. Our next speaker is Ashley Restaino followed by Camila Figueroa-Restrepo. Please go ahead, Ashley.

Thank you for the opportunity and space to provide public comment today. My name is Ashley Restaino, the Managing Director of Strategic Initiatives and Operations at the Staten Island PPS, one of the twenty-five PPSs founded through the original DSRIP program. We appreciate the efforts New York State has made in developing this proposal to extend the waiver amendment, but must address significant gaps in meaningfully transforming care for vulnerable residents. Being one of the top performing networks and distributing over 90% of DSRIP funds earned directly to community partners, we feel well positioned to provide comment. Over the last 7 years, we've collaborated closely with the continuum of providers in our community, have learned lessons from vulnerable communities during DSRIP, and while responding to the COVID-19 pandemic and we continue to contract with community partners on social determinants of health and population health improvement programs, distributing dollars post DSRIP earned from the DSRIP high performance fund. This proposal is about programming for underserved people who experience health inequities and health disparities due to structural barriers inherent in our healthcare system and society. It's not about funding profitable corporations, companies, and systems. If the goal of this proposed program is to improve health equity and reduce health disparities through Social Determinants of Health Networks, the allocation of funding to those networks should endorse that goal. Commitment is made not by words, but by resources, and this proposal shows a lack of commitment to the community-based organizations that are doing this work, who've been serving higher volumes of people, yet struggling to survive due to impacts of the pandemic. During the height of the COVID-19 pandemic, people from marginalized and underserved communities including veterans, children, people with disabilities, LGBTQIA+ people, justice involved individuals, people with co-occurring behavioral health conditions, and especially black and brown communities who intersect with the populations just stated, suffered disproportionately in all ways. Data shows they had a higher rate of death from COVID-19, suicide, job loss, and experienced greater social needs between 2020 and 2022 than in previous years. The allocation of funds to the Social Determinant of Health Networks that directly serve these people is inadequate to achieve the proposed goals and outcomes. An unprecedented and historic event occurred when the CDC announced that overdose deaths surpassed COVID-19 deaths in 2021. Multiple overdose victims and people with addiction are also disproportionately impacted by social determinants of health needs and those disparities starkly increase for people if they are also a member of one or more of the populations I previously stated. More resources are needed to support this highly complex and fragile population, including opportunities to expand billable services provided by certified peer workers and a stigma free clinical workforce. Significant investments must also be made in desperately needed resources, including temporary and emergency shelter, transitional housing, and crisis response. In addition, the DSRIP experience with Medicaid managed care

plans and value based contracts would suggest that a proposal to allocate over 50% of the proposed funding to the plans to achieve value based contracting goals is misdirected. Equitable distribution of value based contracts with community providers and/or Social Determinant of Health Networks should be a requirement for all health plans. During DSRIP, the managed care plans did not demonstrate a willingness to do that. In echoing previous comments, we strongly suggest that requirements such as timely and accessible downstream data sharing, contracts with community based organizations, and cost transparency are mandated or required for plan participation. If the plans are the proposed drivers of outcomes and transformation, they must develop real relationships with community based organizations with real investments, creating real opportunities for outcomes and sustainability. To conclude, serving people when they are already in crisis does little to address the upstream factors and root causes of health disparities and equities. We, as an interconnected and cross sector system of government officials, leaders, and healthcare providers must also do more to include the voice of the community to address structural barriers, to better health and upward social mobility. Thank you again for the opportunity to provide comment.

Thank you. Our next speaker is Camila Figueroa-Restrepo and followed by Jeff Coots.

Good afternoon. Please go ahead. Can you hear me? Yes. Okay. So, my name is Camila Figueroa-Restrepo, I'm a psychologist and community based researcher and from the intersection of my identities, I will tell the story of how policies led me to seek redemption. I came to the U.S. in 2018 to work as a family reunification specialist of unaccompanied children. Many of you may remember what happened that summer, where every single child crossing the U.S. border was separated from their families. No words are enough to describe the impact of racist, punitive, and discriminatory policies until your own physical and mental health are compromised. Still, as a result of this experience, I was able to understand that the emotional trauma caused by forced separation was not quickly restored after reunification. There is no one size fits all solution, but people who have experienced the burden, understand the complexity of the problem and know how best to address it. Today I welcome the state's proposal on addressing health disparities and SDoHs. We can't deny the reality that was aggregate, aggravated by the pandemic. Long standing health disparities and systemic healthcare delivery issues, governed by powering balances that affect communities who have been historically underserved. However, often lacking equitable community engagement, solutions to such problems originate from health sectors resulting in policies and practices that fail to meet community needs. For equitable solutions, we have to shift to bottom-up approaches that consider the experience of marginalized and vulnerable populations. Why is this important? I'll share the premise of the work I do now. The closer to a community you are, the closer to a solution you are. Led by the Arthur Ashe Institute for Urban Health, I now serve as a Senior Program Coordinator of Communities Together for Health Equity, CTHE, a demographically and linguistically diverse group of over seventy CBOs and stakeholders, working to ensure comprehensive services for over 350,000 individuals across New York City. Through my work with CTHE, I have witnessed how CBOs have come together to plan, design, implement activities to assess the needs of underserved New York City residents, provide education in six different languages on SDoH, facilitate linkages to care, and position community members to identify solutions to overcome health disparities. Collectively, these efforts have reached over 1,200 so called, hard to reach individuals, including people with disabilities BIPOCs, youth, undocumented, and LGBTQIA+. Assessment findings highlighted an overwhelming percentage, over 73%, of individuals who were unable to satisfy their basic needs as a result of the pandemic. More specifically, employment, access to food, mental health, and housing were identified to be priority community needs. Overall, 51% reported they could use more help to access basic necessities and 57% would like to be contacted to receive help. Our most recent

efforts are focused on building an equitable and sustainable infrastructure to connect those in need with comprehensive care as well as advocating on behalf of users for policy changes that include their voices, sentiments, and recommendations. I couldn't continue this testimony without including some of them. Healthcare is viewed by almost all participants as frustrating, biased, expensive, time consuming, and confusing. Misunderstanding can serve as a deterrent for communities accessing healthcare. We recognize education and access to information is crucial. Despite recognizing the importance of primary care participants raised, it has historically offered segregated and limited care and called for a holistic approach that incorporates mental, emotional, and spiritual practices. Community members also highlighted the need to strengthen social support and urged campaigns that address reducing the stigma associated with seeking help. Communities echoing a lot, echoes, aligned systems and delivering quality care requires capacity build, but the goal is not just for clinical staff to work more effectively, but also to work more compassion. Our collective efforts provide nuance and culturally informed recommendations to the local health care planning process. Incorporating CBOs in the governance structure, allowing them to share their expertise, and to reach community voices will help create a more appropriate, equitable, inclusive, and diverse response to community needs. We need to ensure that upfront funding mechanisms compensate CBOs appropriately for what they do best, which include not only evidence-based, but also emerging and promising strategies. Without it, the same issues rooted in inequities will remain pervasive as demonstrated by the pandemic. While we acknowledge the elements of these principles are included in the state's proposal, how it's translated into practice will determine the true commitment to see thriving and healthy communities. Thank you for this opportunity to provide comments.

Thank you. Our next speaker is Jeff Coots followed by Kelsey Antle. Thank you. Please go ahead.

Good afternoon and thank you for the opportunity to provide these comments. My name is Jeff Coots, and I direct the From Punishment to Public Health Initiative at John Jay College of Criminal Justice Senior College within the City University of New York. As part of our work to improve cross sector collaborations at the intersections of public health and public safety, we have joined with Legal Action Center over the past 5 years to facilitate the New York City Health and Justice Working Group. The members of this group are drawn from the fields of healthcare delivery, care management, addiction and mental health services, managed care, housing and shelter, education, alternative to incarceration and reentry, as well as staff members from City, County, and State Public Safety and Public Health Agencies. As you can imagine, our members are particularly excited to see the criminal justice priorities in the current waiver amendment language and I'd like to focus my comments in this area. The state's request to allow for 30 days pre-release Medicaid services for care coordination, peer engagement, and medication management will significantly improve outcomes for some of the most vulnerable members of our community. As you know, best practices and the transitions of care from any facility requires building relationships with clients prior to their transition, thereby helping them to prioritize their health and wellness amiss a whirlwind of lifestyle changes and logistical challenges. Far too often we see individuals returning from jail and prison to live on the streets, bouncing in and out of emergency departments, psych units, and detox beds. As we've heard from earlier speakers, we also need to prioritize SUD services in all forms, not just for those with SUD, or with opioid use disorder, especially given the rise of fentanyl in recent years. And for this new policy framework to thrive, New York must continue to improve collaboration between the Department of Health and Departments of Corrections. As we noted earlier, despite legislation already mandating these agencies to ensure clients leaves state correctional facilities with active Medicaid coverage, it still takes up to 24 to 48 hours for the coverage to be activated and clients

continue to leave state facilities without proper documentation that will enable them to access care in community-based settings. During COVID, our members reported that this lag time in Medicaid activation stretched as long as 10 days for some clients. Given these logistical challenges that persist at the state level, we ask the state to include New York City in Phase 1 of the proposed timeline for Medicaid in-reach services. There's perhaps no better place to pilot this initiative than in the New York City jails, where the healthcare provider is a division of the local Medicaid hospital system, running electronic health records on the same platform as their community based counterparts. We also encourage the state to acknowledge the development of the Medicaid Re-entry Act at the federal level, which would open the door for all states to pursue this type of in-reach with Medicaid resources. If approved, New York would be positioned as a leader among early adopter states, having the resources and policy frameworks in place to take full advantage of the new regulations that will be promulgated by the Center for Medicare and Medicaid Services. I also want to return again to the need to consider justice impacted clients in each phase of these reform efforts. In this vein, we encourage the state to require that each HERO submit a detailed plan to improve health access and health outcomes for individuals and families impacted by the criminal legal system. It is not enough to simply include this as an option, as we saw under DSRIP that very few PPSs chose to focus on this highly vulnerable population. Although I'll say, a recent speaker Ms. Restaino from the Staten Island PPS were leaders in the precinct response efforts to engage SUD clients in the aftermath of an arrest, showing that these types of resources can have a significant impact on cross systems reform efforts. We're also excited to see housing access prioritized within the waiver amendment. However, the use of the term supportive housing appears misleading here, as the waiver language requests short term housing and services, rather than permanent housing and permanent onsite services that make up the supportive housing model. The section would better be termed as targeted transitional housing, with a focus on specific vulnerable populations such as those leaving state hospitals, long-term residential, and in carceral settings. These services can follow the critical time intervention evidence-based practice that provides a high dosage of treatment and services in the early months of transition, followed by a step down of dosage over time as the individual stabilizes in the community. This targeted transitional housing framework should also incorporate the addiction recovery housing facilities that were recently signed into law in New York State. Despite the vital role that recovery housing plays in building a foundation for long term recovery, it has been chronically underfunded and has historically received little attention in our state. Allowing Medicaid coverage for recovery housing would ultimately reduce Medicaid spending as studies have shown that recovery housing improves outcomes, leading to fewer Medicaid covered detox and inpatient treatment stays. On the whole, we are excited at the opportunities presented in this waiver amendment and upon approval, we look forward to supporting the state throughout its implementation. I will submit the remainder of my comments in written form and thank you for the opportunity to speak here today.

Thank you. Our next speaker is Kelsey Antle followed by Sumeet Sharma. Please go ahead, Kelsey.

So much. Hello, thank you so much for this opportunity. As, as you mentioned, my name is Kelsey Antle and I'm the Pretrial Services Evaluation Director at CASES. CASES full name is the Center for Alternative Sentencing and Employment Services, and we are one of New York City's leading providers of direct services for people involved in the criminal legal system, including people living with serious mental illnesses. So, I'm so grateful to speak to this panel as every year in CASES serves people with behavioral health conditions via intensive case management, forensic assertive, assertive community treatment teams, our outpatient Nathaniel Clinic, which provides mental health services, as well as our alternative to incarceration and pretrial services. Many of our clients also experience chronic health conditions and require

continuity of services and healthcare as well as earlier access to treatment and coordinated services when leaving a correctional setting. So, all of this is to say that I, you know, echo points made by so many others on this call, that the state's request to allow for 30 days pre-release Medicaid services is incredibly important. We believe at CASES that this will save money, ensuring our clients don't have to attend hospitals and emergency rooms to access care when they return to the community. This can be expensive for clients and, of course, is also expensive for the state. Further, the waiver will give our treatment staff an opportunity to really build relationships and engage clients before release, supporting retention and community-based treatment services in that critical first few weeks. To respect the panel's time, I know it's been such a long day, I just want to add that I wholeheartedly support points made by Tracie Gardner and Jeff Coots, that in order for this new policy framework to really thrive the way it's intended, I feel that New York must continue to improve coordination between the Department of Health and DOCCS, or the Department of Corrections and Community Services, as well as include New York City in phase 1 of the proposed timeline for in-reach. I also want to encourage the state to acknowledge the development of the Medicaid Re-entry Act at the federal level, as I think this really aligns with the values outlined here today. I also want to echo Jeff's point, encouraging the state to require the HEROs applicants submit a detailed plan for justice impacted individuals. This is really critical, for CASES participants in particular, as over one fifth of our pretrial participants are over the age of 50 and we know that because of incarceration history this actually puts them at a risk of chronic health conditions that mirrors conditions for people 65 and older in the community who do not have that justice history. Further, while our staff make every effort to connect clients to services and address, you know, potential mistrust that may have evolved in governmental systems, there's only so much we can do if the HERO does not include a concrete plan for serving people with a recent and maybe extensive history of incarceration as well as behavioral health conditions. And finally, I just want to circle back to the point that again, Jeff so eloquently made around the supportive housing elements of this plan. Whether we use the term supportive housing, or, you know, what I think to be more appropriate, the term targeted transitional housing, it is critical to explicitly outline plans to reserve these beds for justice impacted individuals. Many pretrial participants at my organization would benefit greatly from supportive housing. They really struggle with the shelter system with its rigid rules, they struggle to balance caring for sort of symptomatic mental health and substance use conditions, and unfortunately, they are often excluded from supportive housing due to a history of prior convictions. That 50 and older group that I mentioned, that has that really high risk for chronic health conditions, participants in that age group have an average of 17 prior convictions upon enrolling with us and so that extensive rap sheet really works against them with regard to many housing services, including supportive services. I'll just end with sharing a story from a participant who I recently interviewed, who is in his sixties, thank you for time, who is in his sixties, and came to us with over 80 prior convictions. And when he came to us, he was having an incredibly difficult time finding safe private housing. While CASES staff were able to connect him to a group home that he felt safe in for the moment, he repeatedly emphasized to me that in order for him to turn his life around and obtain secure employment that could result in him sort of exiting the criminal legal system, it was critical for him to have a place to call his own and it just did not feel like that was possible when I talked to him, which is incredibly disappointing. And so, I want to end with thanking everyone again for this time, I greatly appreciate your thoughts, and I will be submitting comments in written form as well. Thank you.

Okay, thank you. I'm told our next speaker Sumeet Sharma is not on the line so we will move to Jenny Chulee followed by Natasha Pernicka. Please go ahead.

Hello. Can you hear me? Yeah. Okay, thank you. Hi everyone. My name is Jenny Chulee. I am a student passionate about urban studies, anthropology, and philosophy, because it addresses the complexity of humanity and inequity. I've worked with the Commission on Public Health Systems, CPHS, during the summer of 2021, and I'm working with Communities Together with Health Equity, CTHE, as an intern for the past year along to the present. As an intern, I have assisted in reviewing data and analyzing Medicaid waivers across the country. With CTHE, I have facilitated community listening sessions to better understand community needs and to solicit input and suggestions from community members to overcome health barriers. For the 1115 Medicaid Waiver I hope to provide some recommendations and my own unique lived experience. As a community member, I've received help and support from CBOs. However, there's evidently a disconnect between different sectors in which access to healthcare government programs, and needed resources become incredibly limited. Trying to navigate the health care support system, I was often met with a roadblock of continuous referrals that led me out to no outcome and a loss of time. This was exacerbated during the pandemic. Even when I use the government provided posters with contact information, I was left on hold for hours because of the shortage of short of staff due to COVID. This experience was incredibly frustrating noting knowing I was not the only one who wasn't receiving the help they need. It was evident that with the amount of people that needed help a single phone number and a few staff would not in any circumstance be enough. Furthermore, the CBOs, while well adapted to providing community members with resources did not have enough funding, nor staff to be sustainable to take care of the community members best sought to find them. They further experienced difficulty in navigating and helping helping community members and navigating and accessing government resources. According to the research we conducted with the community members within the 5 boroughs, CBOs are the most trusted institutions that community members refer to. They are the most accessible and engaged with community members. CBOs hosting events, workshops and resources are essential to educating and informing the public. By hosting events, CBOs help strengthen social support and interaction among the community. By hosting workshops, CBOs help educate community members on social determinants of health, health-related disease, preventative health measures, mental health, and self-care. By providing community members with listening sessions, oh, sorry, my bad, with resources community members are linked to care and other services. Through our community listening sessions, we were able to better understand what community members need and how CBOs address these needs. We also reaffirm that communities trust CBOs and know exactly what they want from CBOs. CBOs need more resources and funding programs in order to fulfill these needs from community members, to optimize education and preventative care and workshop activities to keep community members, engaged, supported and represented. Therefore, this is why I recommend further funding towards CBOs, an integrated system where addressing health disparities, is distributed equitably between MCO, hospitals, CBOs and other sectors. It will be more profitable, sustainable and efficient if the burden is not only concentrated in medical institutions but distributed among CBOs who are already equipped with the knowledge and skills to address the community needs. In order for this to be sustainable and effective, it would be important to develop coordinated communication systems within and throughout the sectors. By having stronger communication, the system can function efficiently and reduce unnecessary spending and program that don't address core needs. This is also why it is important for CBOs to be given a leadership role in healthcare decisions, statewide programs, and projects. This bottom-up structure is the most cost effective and efficient way to insure community help. Thank you for the opportunity to provide comments.

Okay, thank you. Our next speaker is Natasha Pernicka and followed by Chris Norwood.

So, thank you so much for the opportunity to speak today. I'm Natasha Pernicka, I'm the Executive Director of the Food Pantries for the Capital District and one of the founders of the New York State Community Food Assistance Network. Working together to feed the hungry in our community for more than 40 years, the Food Pantries for the Capital District is a coalition of nearly 70 food pantries in New York's Capital Region. Collectively, our coalition provided groceries to approximately 52,000 people for more than 2.4 million meals last year in 2021. Year to date, here in 2022, we are already seeing a 10% increase in food pantry service levels compared to last year. And in addition, demand for Our Food as Medicine network of provider services continues since our launch in 2020. Our Food as Medicine network was developed through the 1115 Waiver known as DSRIP. More than 10 providers of medically tailored groceries, food pharmacies and pantries and prepared meals, including nutrition education services served 417 households in 2021. 90% of participant participating households in our Food as Medicine programming required home delivered services as transportation were barriers to accessing bricks and mortar organizations. We are still in the process of collecting clinical data. We have received overwhelmingly positive feedback from program participants through focus groups. In fact, one woman, I'd like to share her story quickly, spoke openly about her experience. Tammy, as a 52-year-old grandmother, raising her 2 grandchildren, she shares: You don't know hunger until you are panhandling on the street to pay for food for your children. She suffers from hypertension and diabetes, is obese, in a wheelchair and legally blind from her diabetes. She lives on disability. She has, she had given up hope of a better life before she started our Food as Medicine program. Within a year, she no longer had hypertension, had lost more than 40 pounds, reduced her insulin need by half. Food as Medicine gave her hope that she can be healthy again. It is clear from research and data shared across the U.S. that Food as Medicine interventions work. We believe the following items are critical for success for the proposed waiver. The fee for service schedule for CBOs providing services needs to include additional funding to support CBOs work to provide the services, including their ability to scale, integrate into the system and administrative. These include technology, training, and infrastructure costs. They're desperately needed for the nonprofit sector, to integrate into the medical system. As well, consistent transportation and other access to services must be included in the fee for service options so that people who lack transportation or other access, issues can still receive the needed services. While Medicaid serves an individual patient, social care needs to be provided for the whole household or it defeats the attempts to improve the one person's health outcomes. Ability to serve and funding to serve the whole household must be included in the food security programs. It is absolutely essential for all positions funded under the waiver to be paid at living wages. If positions are not paid at living wages it is contradictory to supporting social determinants and then employees are also users of the same CBOs that are participating in this process. Funding needs to be provided to ensure all positions are paid at living wages. You can use the New York Alice report for more information on that. Missing in the waiver are statewide associations, or networks of specific social risk factors, such as food, housing and transportation. This is essential for coming up with successful evidence, research-based continuum of care models that can be scaled and funded at appropriate rates. The waiver has plans for use of a statewide social care program referral platform. One of the challenges with resource referral systems is ongoing updates of correct information. Funding needs to be included to invest in social risk factor-based organizations maintaining up to date resource listings that can be shared among the social care system platforms. Thank you so much on behalf of the millions of New Yorkers who experience food insecurity, the New York state community food assistance network, and the Food Pantries for the Capital District. We are grateful for this opportunity to comment. Thank you.

Thank you. Our next speaker is Chris Norwood. Followed by Milenka Berengolc. Please go ahead, Chris.

Oh, hi, I asked, thank you. I asked to have my camera turned on. Okay. I'm a little confused by a public meeting where you can't see people. Hi, Chris. We temporarily made you a panelist, so there should be a video option at the bottom of the screen. Oh, okay. I can take advantage of that. Can I vote on anything? Are you able to see the video option at the bottom of the screen? Ah start video yes. Okay. It's still crossed out though. It may not be…do you have video capability on your screen? Now I go on the red line went out. I'm not going to hold things up now, but I really think as as a standard procedure in a public hearing, I can't see people, neither can anyone else and also the names of the people aren't up when they're talking so, you know, I mean, even though they're introduced, you may not hear it or something. So, you know, you don't always know who's talking. And I hope we will have a better procedure next time. Hello? Well, we are able to see you now so if you'd like to. Oh, you can see me? Okay. I'll take your word for it. Yes, we can see. Please go ahead. Okay, I'm Chris Norwood, Executive Director of Health People, co-founder of Community's Driving Recovery and also a proud member of CTHE. I want to say, I find this waiver a very troubling document. Even now with New York facing unprecedented mass illness from an unprecedented crisis of chronic disease, fueling infectious epidemic while an infectious epidemic fuels chronic disease, New York state is seeking more than 13 billion dollars without, in any way, addressing the fundamental drivers of ill health. I'll just mention New York's staggering increase in diabetes deaths in the first COVID surge, where the city had a 356% increase in diabetes deaths. The largest of any place in the nation and the state had the largest state increase. But now we've recently also learned that even after people have recovered from COVID, they have a measurable risk, 13 more cases per 1,000 post-COVID patients, of developing diabetes. That may be a small individual risk, but for the state with more than 5 million COVID survivors, that is a huge new reservoir of diabetes patients. Nothing in this waiver mentions, much less addresses, that. In the four major goals of the waiver, chronic disease, the singular driver of ill health in New York, is not mentioned once. First then chronic disease prevention and control must be prominently addressed in the major goals of this waiver. Second, CBOs must be allowed to actually function as CBOs, something this waiver does not permit, even with the plans for HEROs and SDoH networks. One major problem is that virtually every CBO service must be connected to an MCO from the start.
But because MCO's requires CBOs to have a level of compliance and IT upgrades that match compliance for medical entities, it now costs a CBO thousands and thousands of dollars upfront to become a direct service provider for patients at an MCO. I don't see that mentioned anywhere but that basic unmentioned fact will bar most CBOs from participating in this waiver from the start. Equally, the overall design, presumably, including CBOs is exclusionary because it does not permit them to act on the strength and special capacities of CBOs. Those strengths are especially their trust in the community and ability to engage high risk and so-called disconnected populations. We've most recently seen the value of that during COVID, when New York City's groundbreaking T2 program, which contracted with CBOs throughout the city to promote COVID prevention testing, and then vaccinated vaccination resulted in the city's having the highest COVID testing rate in the nation and now an, 82% of at least 1st vaccinations. Similarly, fighting chronic disease is going to require a major CBO approach. During DSRIP, for example, Health People was able to get to engage more than 2,000 Medicaid patients with type 2 diabetes in the diabetes self-management program. A six-session group course was well evaluated to reduce blood sugar costs and complications for people with type 2 diabetes. A special program with innovation funding we did right in homeless shelters was evaluated by the New York City Department of Health to have reduced emergency room visits of homeless participants by 45% in 6 months. That kind of education, both self-care and prevention, is key to controlling chronic disease, but we could never implement a program like this under this waiver. We engage so many people by our peer educators going to the places they were by going to shelters, churches, mental health day programs, right in the community. If the waiver is not

going to enable community groups to fight chronic disease and other conditions this way and clearly it does not enable that, we are basically nowhere in advancing the wellness our communities need desperately. A so-called reform program that depends only, or even largely, on referrals for enrollment, bypasses the outreach and neighborhood networks and that will hugely fail to engage those most in need. Also excellent is community health workers are by combining training and IT integration to community health workers. You have bypassed many workers, peer educators, navigators, outreach workers, facilitators who are key to engaging many populations in the same way that the state finally conceded to innovation funding in DSRIP, something the CBOs had to relentlessly push themselves, that is funding that stakeholders from CBOs and other people could apply for with their ideas of what would work best. For us to finally move toward wellness requires that this waiver have an innovation fund and a substantial one for CBOs and I guess practices and smaller clinics. DSRIP innovation funding was extraordinarily successful and effective. Why do we have to fight for this yet again? It says at the beginning of this waiver, it's based on lessons learned from DSRIP. But this was one of the major lessons, and it's clearly not included. At a minimum, 2 billion of the 7 billion for advancing VBP models should be applied to the best practice innovation and implementation fund for CBOs and other smaller entities. This fund would enable them to bring forward their own best ideas and approaches based on deep experience of needs and community wellness and will also enable new evaluation to which CBOs currently don't have real access, which is to say with permitted access to patient medical records, they can follow and document the progress of those they have engaged through the outstanding ability of CBOs. Without this, without enabling CBOs with their strength and community knowledge to function, we are actually back in the same place, making up new systems on the surface for old problems that haven't been solved and thank you everyone for being here.

Thank you. Our next speaker is Milenka Berengolc followed by Adria, Adria Cruz. Please go ahead Milenka.

To speak and give my comments I'm Milenka Berengolc, it's not always easy to figure out how to say it. Okay. So, I'm the Community Health Worker Director, and I oversee special projects at the Brooklyn Center For Independence of the Disabled, or BCID. BCID is a nonprofit, grassroots organization, and a community-based organization operated by a majority of people with disabilities for people with disabilities since 1956. And our mission, for more than these 60 years has been to empower disabled people by improving the quality of our lives and fostering our integration into mainstream society. So, we work together to ensure and protect our civil rights. And this is citywide. BCID seeks to remove physical, attitudinal and communication barriers for disabled people. We work to keep people with disabilities independent in the community and out of institutions. Based on a person-centered model, our primary services include peer support, disability rights advocacy, resource information and referral, housing and benefits counseling, Access-a-Ride advocacy, and also independent living skills consultation. Because our staff members, board members and volunteers have disabilities themselves, they are vital role models for the people we serve. Accessibility and health inequities are a critical issue for the disabled population. There's a preponderance of disability in and so we can talk about intersectionality and the BIPOC (Black, Indigenous, People of Color) communities Included in the people we serve are also the older population. We serve people who also have chronic conditions, sometimes multiple chronic conditions, which become disabilities as they age. The pandemic had an enormous impact on the disabled community. Already isolated, disabled people experience further isolation. Anxiety and fear about going out and becoming infected and not being able to get basic care. Home health aides became few and far between and in great part also due to lack of fair pay. When I came on board to run the community health worker program, BCID had just signed a contract with this, I'm going to say one-time MCO for a 1-year

pilot program, the community health worker program. The contract was renewed for the next 2 years. After that we were fortunate to obtain two grants, which combined allowed us to keep the program running. BCID's primarily dependent on government contracts and foundation grants. MCO data and confidentiality protocol requirements make it difficult to obtain contracts. Our program with a diversified team, including bilingual CHW's in Spanish, in Creole and in Arabic, is now coming to an end despite its great need and success according to exit surveys. It has been a continual struggle to find the funds for this vital program, which offers peer support and provides links to resources in the community and help disabled people navigate the health care system, including finding accessible doctor's offices and clinics, which may be fewer and far between. Our peers provided assistance including with food insecurity, benefits, vocational training and employment, durable equipment, and, of course, as I was saying, accessible doctor's offices and clinics, among many others. Our community was severely impacted by the pandemic. Disabled people became even more isolated. Anxious and fearful about going out. I think I already mentioned this. BCID is a part of the CTHE, The Communities Together for Health Equity coalition, and we are 1 of over 70 CBOs city-wide. CTHE has proposed strategies to restructure and transform the New York State health care and including the model of SDHN or social determinants of health networks. Clearly has been a lack of equitable inclusion of CBOs. CBOs need to be at the table. And not only part of the social determinants of health networks but at its head. We welcome that New York State's proposal emphasizes working toward health equity. It will be important though, to define equity and the approaches to measuring equity. Over two decades of research indicates that social determinants of health have up to a 6-fold greater impact on health than clinical care. Addressing social determinants of health requires collaboration across multiple sectors including, but not limited to, medical care, public health and social service providers. Thank you very much. I appreciate the opportunity.

Thank you. Our next speaker is Adria Cruz, followed by Danise Wilson. Please go ahead.

Thank you. Thank you to the New York State Department of Health for the opportunity to provide comments on the States proposed 1115 waiver amendment request to the federal government. I am Adria Cruz, deputy director for health programs, and integration at children's state. A multi service Human Services agency, based in New York City. We employ a holistic strategy serving nearly 50,000 children, youth, and their families at every stage of development in every key setting. The 1115 waiver presents an opportunity for the state to prioritize investments in children's health through the states to 167 school-based health centers, which are one of the most effective ways to keep kids healthy through access to high quality physical, mental and dental healthcare. We offer the following recommendations and urge the state to consider the solutions offered below to strengthen this health delivery system of school-based health centers for children, youth and their families. First, require SDHN's to include school-based health centers of ratings in schools, as part of their networks. The state has invested in the community school strategy over the past 7 years to address reducing the barriers to learning with school districts and community-based partners like Children's Aid, working together to provide wrap up, wrap around supports for children and families. Second, include school-based health centers as part of the HEROs. As the safety net, school-based health centers currently serve over 200,000 children statewide, who are primarily minorities. Third, utilize school-based health centers as a pathway or workforce development center to address the workforce shortages in hard to staff health professions. School-based health centers can afford opportunities for individuals in the early stages of their careers to continue with their training while working full time at this community-based safety net site. Fourth, guarantee Medicaid coverage for any uninsured child or adolescent that accesses the school-based health centers. This would build on New York State Department of Health stated goal to improve the safety net

health care delivery system that has been proven to reduce health disparities and promote health equity in marginalized and underserved communities. Fifth, define digital health and telehealth infrastructure and virtual care models to prioritize serving children and youth with accessibility barriers. As we continue to weather the Covid-19 pandemic, supporting healthcare services in community-based settings is critical to ensuring children and youth remain healthy and connected to primary and preventive health care services. The 1115 waiver presents an opportunity for the state to expand and strengthen health services and address equity and access issues for New Yorkers across the state. We strongly urge the state to include the needs of children in the school-based health center infrastructure, as part of the proposed new system. We hope that the state recognizes that whatever investments are made for children now, will help reduce Medicaid expenditures when they become adults in the future. Thank you.

Thank you. Our next speaker is Danise Wilson followed by Laura Jean Shipley. Please go ahead.

Good afternoon or evening. I'm not sure. My name is Danise Wilson. I am the Executive Director of Erie Niagara AHEC (Area Health Education Center). I'm here before you today and thank you for allowing the New York State AHEC system to speak so I'm here to represent the New York State AHEC system. We understand that New York State's overarching goal of incorporating fully integrated social care and health care into the fabric of the New York State Medicaid program will require achievement of four subsidiary goals. One of these redesigning and strengthening health and behavioral health system capabilities to provide optimal responses to future pandemic and natural disasters is perhaps the most critical to the success of the proposed project. Although each of the four goals require significant labor, this goal focuses specifically and substantially on the healthcare workforce. Indeed, without an adequate supply of well-trained health care workers and a nurturing system and culture within which they can operate, achievement of all related project goals may well be compromised. The New York State AHEC system requests that the New York State DOH SHERPA project leadership, and also the HEROs, the social determinants of health networks, and any other entity with which the HEROs may have participating agreements to consider strongly using the existing New York State AHEC system to help achieve workforce related components of the proposed project. New York State AHEC system currently covers every county with our 9 centers and 3 regional offices from Buffalo to Brooklyn. Specifically, the New York State AHEC system is poised to directly and immediately address the following components identified in the proposal. Goal 3, pandemic response redesign, focus area training in order to respond to needs and minimize disruption, delivery needs and healthcare services. Also 3.2 develop a strong representative and well-trained workforce. Focus area 2 develop and strengthen career pathways. Focus area 3, training initiatives, focus area 4, expanding community health workers, and related workforce, inclusive of all 4 components. Focus area 5, standardized occupations and job trainings. Since 2000 the New York State AHEC system has supported healthcare exposures to more than 272,000 middle and high school students, insured training for more than for more than 38,000 medical and health, professional students to receive over 3,700,000 hours of training in medically underserved communities. And provide a training and professional development to more than 400,000 health care workers to better support the diverse patient populations of New York State. New York State AHEC system is your health care workforce education organization. The structure of the New York State AHEC system is designed to understand and meet the unique healthcare workforce needs at both the regional and local community levels across the state. Many of the New York State AHEC centers participated with the PPS's during DSRIP initiative. As examples Northern AHEC and Central New York AHEC, in partnership with health workforce New York, contracted to work with 13 of 25 PPSs to provide workforce consulting and strategy, custom-built comprehensive online and in person training, delivery, tracking and

reporting systems, develop a digital application for district workforce spin and data collection. Similarly, Erie Niagara AHEC contracted with 2 PPSs to train over 600, excuse me 6,000 health care professionals in Erie and Niagara Counties. Western New York rural AHEC partnered with several PPS's as well to include participating in committee work groups in creating a comprehensive compensation and benefit analysis. Hudson Mohawk AHEC also contracted with 3 PPSs to convene workforce stakeholders, developing initial workforce plans and PPS. The New York AHEC system has over 20 years of partnering, engagement, fostering the development and support of New York state healthcare workforce, the New York State AHEC system, leverage the participants or partnerships such as with the health workforce collaborative to ensure collective capability in depth, flex, flexibility. Thank you.

Okay, Thank you. Our next speaker is, excuse me, Laura Jean Shipley followed by Arlette Cepeda. Please go ahead, Laura.

Good afternoon and thank you. My name is Dr. Laura Jean Shipley. I'm a pediatrician and vice chair in the Department of Pediatrics at the University of Rochester, and the Associate Medical Director for Maternal Child Health and Accountable Health Partners, an integrated provider network that serves over 360,000 patients and extends across 17 counties in the Finger Lakes region. My testimony today comes from the perspective of ACO's and integrated provider networks and focuses most importantly on two high priority areas that appear to unfortunately have been excluded from this waiver draft. First, the child and adolescent mental health crisis. And second, the need for transformative payment strategies to support maternal and early child health. Speaking from the ACO and integrated provider network perspective, we really appreciate that this waiver addendum recognizes our organizations as key partners with expertise in value based contracting, relationships with managed care organizations, and the ability to advance VBP models. In support and elevation of my colleague, Mary Zelazny's comments earlier, we would like to call out that it will be very important that the waiver requirements around value-based payment models, preserves sufficient flexibility, such that providers and payers can work together to determine how best to align incentives to provide high-quality cost-effective care and equally important that contract contracting requirements are not established that create excessive financial risk for providers in either healthcare or CBOs. We also look forward to shared leadership and enhanced collaboration with our community-based organizations and our community as a whole. Our experience during the first Medicaid waiver proved that effective partnerships between our network, our Finger Lakes region PPS, community-based organizations, and our healthcare teams can lead to successful transformative models of care for our patients across the lifespan. We're proud to be one of the few regions in New York State that focused on maternal, infant and child health and projects that have led to decreases in unintended pregnancy, decreases and maternal morbidity related to tobacco use and maternal depression and increases in comprehensive screening for thousands of young children, screening that includes navigation and closed loop referral to services and is provided in community and healthcare settings. Of note, some of these strategies resulted in immediate, short-term savings. It's because of both this short-term cost savings, and even greater long-term value that we must emphasize our concern that maternal child health is not prioritized in this draft waiver addendum, particularly at a time when the mental and behavioral health crisis among pregnant women, children and teens is crushing to our communities. And when young children are experiencing dramatic developmental losses, all related to the COVID-19 pandemic, the crisis in child and adolescent mental health, which is highlighted weekly in national, state, and local news, and described on page 5 of the waiver amendment is like nothing any of us in pediatrics education or behavioral health have ever seen. In our region, more than 70% of primary care visits are related to anxiety, depression, suicide, and self-harm. Both pediatricians and school professionals named child and youth

behavioral health as their number one concern, impacting health and education and despite efforts to increase access, the waitlist for behavioral health care can last for several months. More than 50% of parents identify their child's mental health as a crisis in our region. We specifically asked that this waiver addendum prioritize child and adolescent mental health with a budget line item equal to that being targeted for other special populations identified in the waiver. This focus and funding is essential to support innovative cross sector and community partnered approaches that address child and teen mental health prevention, early treatment and crisis services and expanded training and workforce development. And schools and child-care programs must be recognized as critical partners in these efforts. We also specifically request that pregnant women, babies, and young children receive priority status in this waiver addendum. Children and pregnant women represent the largest portion of the New York population on Medicaid. 41% of the state's children 0 to 18 years old and nearly 60% of children under 3 are covered by Medicaid and Child Health Plus. In addition, 50% of pregnant women in New York are on Medicaid. The COVID pandemic significantly worsened existing inequities for New York's women and children. Without specific prioritization and allocated dollars to address inequity and health disparities for pregnant women and children, New York state will fall even further behind other states who are committing to transformative approaches in Medicaid redesign that prioritize maternal and child health. In this area, we specifically support the recommendations of the children's agenda, including continuous coverage on Medicaid for children and their mothers from birth to age each 3, support for parents of all newborns through universal newborn home visitation programs and expansion of the New York State 1st 1000 days pilots for implementation of these programs. We also support two-generational family-oriented approaches to address parents, mental health concerns, social needs and the development of children. New York state cannot miss a critical opportunity to reduce morbidity and mortality among pregnant women, infants, children, and future adults. And ensure better trajectories for years to come. Thank you so much for your time and for your consideration.

Thank you. Our next speaker is Arlette Cepeda, followed by John Croce. Please go ahead.

Hello. Can you hear me? Hello? Yes. Okay, great. Thank you for the opportunity to provide comments on the recent amendment New York State 1115 waiver demonstration. My name is Arlette Cepeda and I am the Deputy Director of La Colmena, a community based organization in Staten Island, working to empower day laborers, domestic workers, and other low wage, immigrant workers in Staten Island. La Colmena supports immigrant workers, LatinX, LGBTQIA+ and youth through organizing education, culture and economic development. We are committed to providing immigrants with the tools they need to become leaders who can speak and advocate for themselves and their communities. La Colmena offers supports in finding fair pay jobs, provides occupational health and safety training sessions and legal assistance and other essential service referrals, such as health insurance, wage theft and workers compensation. La Colmena advocates for immigrants and civil rights and sustain ongoing organizations and involvement in the local community while promoting and celebrating their culture. I want to take this opportunity to make sure that the immigrant communities are not excluded in this waiver, especially those who are undocumented. Community based organizations play a crucial role in removing barriers for immigrants, people of color, economically disenfranchised people and other historically, marginalized New Yorkers. The arrival of the COVID-19 global pandemic, put our work and commitment to the test and La Colmena staff and community leaders delivered. La Colmena was the only immigrant organization in Staten Island that kept its doors open to the community at the height of the pandemic, continue to provide uninterrupted services and it still does. La Colmena provided access to COVID-19 vaccines and tests when they first became available, and, in, to essential workers in Staten Island, bringing equitable access to these and other resources. CBOs like La

Colmena provide referrals to essential services that immigrant New Yorkers have difficulty accessing due to language, economic or technological barriers. As part of Communities Together for Health Equity we work hard to make sure that we work collaboratively to achieve health equity to our, for our community members and we know that we fulfill the critical role in addressing social determinants of health. CBOs have always addressed them and provide culturally, and linguistically relevant interventions have access to hard hard to reach populations but have always been inadequately funded to effectively sustain their programs and services. We request that the efforts within the amendment be led by CBOs who are already doing the work and have strong relationships with the communities they serve. The cities and state have always relied on to deliver goods and services, and we request that funding is distributed equitably among CBOs and that the support provided is sustainable and timely in addressing the needs of the community. We also request that the execution of the amendment goals are inclusive of historically marginalized or excluded people, that CBOs have a leading voice in the decision-making process of the implementation, and that it is done in a collaborative way with health institutions. Finally, a suggestion for centralized data collection for social determinants health network could be the IDNYC, which does not exclude immigrant workers. Thank you for the opportunity to provide comments on this waiver on behalf of La Colmena.

Thank you. Our next speaker, John Croce is not online, so we're going to go to our next speaker. Lowell Feldman. Please, go ahead.

Hello. I'm assuming you can hear me. Like, everybody else, thank you for this opportunity to speak. I've been in the healthcare industry in the state in New York since 1973 as a skilled nursing facility administrator and then skilled nursing facility operator across the entire state, just about every region that's been represented on this call. I no longer operate nursing homes. Actually, I think that's a blessing since I retired from that industry prior to COVID, but still remain very active in consulting in long term care and also in the substance use/abuse industry. I do sit on the board of directors of the New Horizons Counseling Centers, one of the largest outpatient behavioral health organizations Downstate New York, Queens, Nassau and Suffolk. And also, very active in a very rural area, in Sullivan County, which unfortunately has the highest per capita overdose rate of any county in the state. And since it's number 61, out of 62 counties, for the worst health in the state of New York. Recently, after a lot of a diligent effort I was able to secure a, a grant through OASAS for a private sector behavioral health and substance use provider Bridge Back to Life Center. And graciously launched a mobile treatment medication assistance treatment unit in the county and had the pleasure of having the Attorney General and some assembly and senate speakers at the ribbon cutting and hopefully through that effort OASAS will start saving some lives up there. I have to ditto just about every speaker that presented tonight. I've dealt with every population and know the shortfalls and comings of all the all the previous speakers, both in urban and rural areas, especially the speaker from Herkimer County and the rural disparities. I see that everyday up in Sullivan County. I would like to add, especially on the topic of telehealth. Telehealth, when I sat on the 1st 1000 days initiative, we proposed telehealth as a program, which unfortunately got shot down back on the 1st 1000 days initiative. We even offered to include it in all the other programs that were approved at that time. Telehealth was not accepted and was going nowhere. I did have the pleasure of meeting with former Medicaid Director Jason Helgerson on telehealth in the school systems and after presenting this Rochester report, the University of Rochester report to him, at that time schools were accepted as a site for telehealth, although to this day it has not been widely implemented. During the 1st 1000 days initiatives in our previous communications with New York state legislators, we have recommended that New York state introduce a New York state telehealth network. Not a broken telehealth network in different silos, where there's no connectivity and no interoperability and no other features other than visual communications. But a true telehealth

network, which has the capability of tracking data, which is essential, especially for value-based payments. I just attended a value-based payment conference in behavioral health in Washington and, yes, the data is essential to be able to dissect costs and services and positive or negative outcomes. And there's a severe need for the telehealth program in this state to launch, which, I believe is a major factor of this and in communication with many telehealth providers since I've been doing telehealth, since the 1980's, there is capability in fact zoom health has that capability. I see I have a minute left. In addition to that, I think we need some alternative residential treatment centers for substance abuse and behavioral health. To include the workforce, I've been working with programs in West Virginia and Kentucky, where the residential treatment programs, upon exiting from there have trained the recipients of the benefit of getting out of recovery but have jobs they can go to which continues the continuity of care and keeping them back from relapsing and repeatedly go into recovery. So, again, I appreciate this time. I'm no longer affiliated with any huge organization of those I meant, but as a private citizen in New York state, I ditto everything that's been said today and hope especially that the state looks at telehealth as an essential component to meet all these needs and launches a statewide telehealth network that has been prose for many years. Thank you very much for your time.

Thank you. Our next speaker is Matthew Kaufman. Followed by Carole Deyoe. Please go ahead.

Hello? Yes. Can you hear me? Yes, I can. Hi there. I'm Matt Kaufman. I'm an ER doctor and CEO of Station MD, which is a telemedicine or telehealth provider for vulnerable populations, and particularly people with intellectual and developmental disabilities. We serve people in in their home care settings, residing in community and congregate settings. And, and, we, we are pleased to speak at this public hearing. While we appreciate the thoughtfulness of the waiver proposal, and how it focuses on improving quality and advancing health equity for the Medicaid population, it's not clear whether the largest part of funding, the 7 billion dollars to continue to expand the Medicaid program, of value-based payment transformation will directly support people with intellectual and developmental disabilities. And that's a, that's a very vulnerable sub-population in the Medicaid program. In fact, people with IDD or intellectual and developmental disabilities have higher rates of, of ER visits, higher rates of hospitalizations, higher rates of hospital complications, and higher rates of chronic diseases. In fact, during the COVID crisis, what we found out, in an early study from New England Journal found that the big the, the independent risk factor after age for accounting for the highest risk of death, or disability, was IDD. So, it really, the COVID crisis really highlighted just what an importantly vulnerable population this is and just how the healthcare system as it as it currently stands is, is not meeting the needs. Specifically in terms of the model here that's proposing the 1115 waiver, given that they, that the IDD population is the last sub-population that has really not transitioned to managed care, we recommend that the waiver proposal be amended to make it clear that the 7 billion dollars in funding support Medicaid's value-based payment transformation be used for the following or includes the following supporting the transition to managed care for the IDD population through development of specialized IDD plans, such as provider led CPL plans that supports an integrated and person-centered approach. In addition, we support, we would hope that it would support the development of value-based payments and other formats as well and support IDD services, providers to identify and develop standards for quality and outcome metrics relevant for the IDD population to be used in future and value-based payment models. We also would urge supporting the development of pilots, demonstrations and other mechanisms to engage in value-based payments like, arrangements with New York state Medicaid program and current fee for service environment. Given that the IDD population was mostly overlooked in the DSRIP program developed under the previous Medicaid 1115 waiver,

we feel that highlighting this in the new waiver proposal will specifically support people with intellectual and developmental disabilities and help to improve the quality and health outcomes for this important, vulnerable population. Thank you very much.

Thank you. Our next speaker Carole Deyoe and followed by David Appel. Carole, are you on?

Hi, yes, I am. Can you hear me? Yes, I can. Please go ahead. Okay, thank you. On behalf of the New York State Association of Health Care Providers, Inc representing the home care industry, HCP thanks you for this opportunity to testify on the New York State 1115 waiver amendment. I'm Carole Deyoe, HCP Senior Associate of Public Policy. A central waiver theme is the state's desire to integrate social care and health care for those who are most vulnerable and who have endured long lasting health inequities. As service to this population, home care providers are perfectly positioned to be a partner in accomplishing this goal. Utilizing this waiver opportunity, the state must invest in the home care sector, which has empowered New Yorkers to remain safe in their communities throughout the pandemic, despite a worsening financial outlook for the industry. First and foremost, the home care sector must be part of the conversation. This waiver expands upon the successes of the past and the state recognizes, the DSRIP challenges, acknowledging that improvements are needed to achieve a quote, “more holistic and longer lasting delivery system.” The home care sector was excluded from DSRIP innovations, and we respectfully demand that we be included in the new waiver program. Where else is care more holistic than in the home? And yet I can count on one hand the number of times home care is referenced in this waiver proposal. Regional care is right for New York as the state is uniquely diverse in expanse and its Medicaid beneficiaries certainly have differing medical and cultural needs linked to where they live. We fully support the development of meaningful regional measures and goals. Social drivers of health are overwhelmingly local and the state's investment in non-medical community-based services must include home care. Home care is local care and by combining regional patient data collection with regional metrics, home care providers can contribute to public health from the ground up, by serving the unique needs of each community's individuals. Therefore, we agree with regional planning through the HEROs and insist that home care providers be included in the HERO governance structure. Home care providers must also be endorsed to partner with the social determinant of health networks in their communities. VBP initiatives must include home care services to the greatest extent possible. Aides spend more time with patients than most other providers and are best suited to observe and report on social drivers of health. Data sharing is paramount to integrated coordinated care. Regional metrics and goals will better indicate population health and improvements then the current system of paired developed measures. The state must ensure that managed care organizations follow the states course for these regional indices by requiring data sharing with providers. This data feedback loop to providers must be consistent and timely in order that strategic efficient investments can optimally impact key areas. Supplementing VBP contracts with payment for data collection by the home care team is a worthwhile investment of waiver funding as it would allow the HEROs together meaningful, local, social, racial, ethnic and health information to guide long term care supports and services by region. Including home care providers in data collection, and two-way data sharing will better inform all sectors, leading to a more efficient response to the needs of those in their homes and communities. About 10% of the waiver’s proposed expenditures are targeted for workforce initiatives and provider engagement is critical for their success. Providers are best suited to inform the state regarding existing disparities and local workforce needs in their sector. Home care in particular can benefit, as its workforce is primarily comprised of women of color living at, or near poverty level. Thus, strengthening the home care profession reduces economic disparities, increases fiscal stability, and improves access to services. These initiatives must be undertaken statewide, with regional lines of focus, and not limited to a select pool of providers. Advancing career pathways

for entry-level healthcare positions can raise the status of home care workers, making these jobs more desirable. As we ease out of the pandemic, the state has ambitions through this waiver to integrate social care and health care while transitioning New Yorkers to community-based settings from institutional care, correctional facilities, and unstable living conditions. Yet, this proposal ignores home care providers who keep vulnerable, aging, and disabled beneficiaries safe and healthy in their homes. Home care is a proven efficient partner within the healthcare system. Home care must be integrated into this waiver for systemic reforms to be effective. We underline VNS's comments earlier today regarding the dual Medicare/ Medicaid eligible beneficiaries as well as the workforce recommendations provided earlier today by PHI. Our written comments will be submitted to the department. Thank you.

Thank you. Our next speaker is David Appel followed by Alice Bufkin. David please. Go ahead.

Thank you very much. My name is David Appel. I'm a pediatrician and worked for many years as Director of Montefiore School Health program and I will be speaking for myself in support of school-based health centers being part of the 1115 waiver. There are over 250 school-based health centers statewide in some of the poorest neighborhoods in New York State. And for years I've integrated physical and behavioral health and taken care of social needs of the kids. School-based health centers are uniquely where children are at and have demonstrated improved outcomes for children in the area of asthma by reducing hospitalization rates by 50% and ER visits by 50% with adolescents, providing great access for reproductive health care and access for all kids, serving over 200,000 children a year. Looking at the goals for the 1115 waiver to build a more resistant, flexible, integrated delivery system that reduces disparities, promotes health equity and supports delivery of social care. That's exactly what school-based health centers do. New York State has the largest school, based health network in the country and yet it's in a very small percent of schools. It's a small part of the Medicaid budget and provide a wonderful opportunity to really look at what the impact of services are by bringing them directly in the community. So, I, I come with a number of recommendations. One is for shoring up the financial stability of school-based health and extending services to the very needy population, recommending that, that part of the 1115 waiver would grant Medicaid insurance coverage for the approximately 25 to 30% of children that attend schools with school-based health centers, but are uninsured will create a much greater financial base for school-based health centers, and encourage sponsoring agencies to open more. Second recommendation is with workforce development. At my time as director of the school-based health center, there were over 100 Licensed Practical Nurses that worked with us that were able to go on to get their RN's, working as RN's, within the healthcare system. Most of the LPN's that we had working with us were women and single mothers. Because they could do most of their class work very much within the same workday it was easy for them to be done, a day a week after 2 o'clock and with summers can be their clinical work was an excellent pathway. And it's a great investment for part of 1115 waiver to ship shore up their financial security. They also are cost effective. The asthma services were shown to save money by reducing hospitalizations and has also shown that children who received mental health services in schools also actually reduces their Medicaid costs over the year, so it keeps them mainstream and keeps them coming to school and active. So, recommendation is for that. Finally with the advent of telehealth it has the opportunity for far more, far more services to be available in schools that really don't have the capacity to house a school-based health center. To recommend that part of this 1115 waiver is that school-based health centers are allowed to be, be the site for the provision of telehealth. Kids can come into the nursing office. And if the nurse determines that they need to be seen, they can have a telehealth visit with the primary care provider or the school-based health center. Thank you very much for the time. And I'll be submitting supporting documents. Thank you.

Ok, thank you. And our next speaker is Alice Bufkin and I believe that is our last speaker for the afternoon, but we will, we will definitely check that. Alice, please go ahead.

Thank you. Good evening. Thank you for holding this hearing on the New York State Medicaid 1115 waiver application, and for listening to so many hours of testimony. This is certainly an exciting opportunity to expand access to healthcare and social services. My name is Alice Bufkin. I'm the Associate Executive Director of Policy and Advocacy at Citizens Committee for Children. We are able to issue children's advocacy organization dedicated to ensuring every New York child is healthy, housed, educated and safe. We also help coordinate The Healthy Minds, Healthy Kids campaign, a statewide campaign with the goal of ensuring every New York child receives the behavioral health services they need. I will be submitting written comments, but in the time I have today, I want to focus on a few key areas related to children and the waiver. First, I want to reiterate an issue that's been raised by a number of others in this process and that's the urgent need for the 1115 waiver to invest in children and families. About half of the Medicaid population is comprised of children and young people under age 20, yet the state's application references children only a handful of times, and certainly doesn't recognize them as a critical, distinct sub-population that should receive a proportionate amount of the proposed $13.5 billion healthcare investment in the state. One of the purposes of the waiver is to promote health equity and reduce health disparities. It is challenging to fundamentally address health disparities if almost all of our interventions are focused on adults after they've already been failed repeatedly by the state systems. We must intervene earlier whether in children's behavioral health, maternal health, social supports, or family services if we ever want to achieve an equitable future for New Yorkers. At a minimum we urge the state to fund child and family services in the waiver in a way that is more proportionate to the child population and Medicaid with a particular focus on child and adolescent behavioral health. In addition, we support the establishment of children's subcommittees within the HERO structure in recognition that we cannot continue to design programs for adults and translate them for children. We need to have a concerted focus on where we are falling short for children and families and what interventions will have a significant impact on their health and well-being. In terms of some of the specific focus areas for children I wanted to touch on a few areas of behavioral health. I think I know everyone in here would agree that it is difficult to overstate the deep and long-lasting impact that the pandemic is having on the mental health of children and adolescents. The American Academy of Pediatrics, research in general of other national groups, have all declared a national state of emergency on child and adolescent health. I think that partners on the ground can speak, and families in particular can speak deeply about the impact that this is having on their kids, their well-being and the way that they are viewing the world. But we know the foundation for these challenges were laid well before COVID-19, excuse me, really driven by chronic under-investment in the children's behavioral health system, deeply inadequate reimbursement rates and a focus on crisis rather than prevention. Then, of course, the pandemic has really had long term and profound impacts on loss, economic stability, housing, food insecurity, educational disruptions. So, we really feel that 1115 waiver offers an unprecedented opportunity to invest in children's behavioral health. I want to touch on a few key areas of investments, but we'll provide more details in my written comments. First, we urge to the state to use the waiver as an opportunity to invest in two generational models and in particular in pediatric primary care models that allow specialists to address the mental health needs of both parents and young children as well as connect them to social services. These models are enormously effective but our current reimbursement systems are not remotely set up to fully fund them. The waiver offers an important opportunity to expand these models and make them sustainable. We also cannot address the children's behavioral health system without addressing the chronic provider shortage. We urge the state to invest approximately a third of

the proposed workforce funding into the behavioral health system and invest in recruitment and retention strategies specifically designed to foster our workforce that is representative of the population its serving both in terms of linguistics access, in terms of race, in terms of LGBTQ status really looking at what we can do to promote access to a population of providers that really represents the young people and the families they are serving. Youth and family peers are particularly a central part of this workforce but are simply not compensated at the level necessary to ensure access. Next, we urge the state to ensure the waiver addresses cross systems populations with complex needs in particular children with co-occurring substance use disorders and/or intellectual and developmental disabilities. And finally, we join others in urging that HEROs play a role in evaluating gaps in children's behavioral health services across the continuum, from prevention to crisis to co-occurring needs to workforce shortages more broadly. Briefly wanted to touch on community engagement as others have pointed out and intent to engage existing communities but we feel there should be stronger requirements around engaging consumers, whether we're talking consumers, consumer advocates, community members, and we also want to make sure that those participating are adequately compensated. We also believe stakeholders representing children's needs should be required within the HEROs. We think that community engagement is particularly important in the state's goals around digital health and telehealth. We know that the waiver has already been laid out as a really important way to approach telehealth devices and telehealth access for all families and children under 18. The impact of that will be felt across systems and how families live. However, determining how families aren't counting barriers is requires a lot of constant community access to understand the specific needs of different communities, different families. This kind of feedback loop and infrastructure should be built into the HEROs and as others have stated, we also have to make sure that services are delivered through the modality that families need and prefer, whether in person or telehealth and we have adequate networks for both modalities. And again, I just want to thank you for the time today. The thought put into the waiver application itself really look forward to fighting with additional details and continuing the conversation with the great advocates who've been on this call so far. So, thank you.

Thank you. Georgia, do you see anyone else that is waiting to speak? I do not Phil. I think that's the end of the list. Okay, I think that concludes our public, our public speakers for the afternoon. And happy to turn it over to Selena for any closing remarks. Thank you so much.

Thank you, Phil. And thank you all so much for joining us today and for all of your thoughtful comments, it's very exciting and heartening to see how invested many of you already are in the work that we have ahead of us. Just a reminder to please submit any written comment that you have via mail or email by May 20th and a very special thank you to our ASL interpreters, Chris and Alana. I know this must have been a marathon for you. So, thank you for taking the time. And I believe that's all I have so thank you all so much and have a great rest of your evening. Take care.