1115 Medicaid Redesign Team Waiver: Annual Public Forum
September 28, 2022

Hello everyone, sorry for the delay we're having some technical issues, but welcome and thank you for joining us for the 1115 Medicaid Redesign Team Waiver Annual Public Forum. Before we begin, I'm going to pass it over to my colleague, Georgia, to tell you how to turn on the closed captioning feature and how to make the two ASL interpreters easier to see. Go ahead, Georgia.

Hi, good afternoon, everybody. Thank you, Selena. As you'll see here on the screen there are directions for enabling the closed caption feature on today's webinar. You will need to look for the CC or closed caption icon in the lower left-hand side of the screen and then click on hover over that, and then click on show closed captions, which should enable the feature for you.

We also have two ASL interpreters with us today, Diane and Muffy. I might just ask Muffy to turn on her video for a second so folks can see how to bring their, okay there's Muffy. Okay. So, in order to have the ASL interpreters visible in your dashboard area, what you need to do is right click or grab the ASL interpreter video that you see at the top of the screen and drag them down next to the presentation, which will add them to your dashboard area, or what they call the stage. And then you can have them next to the presentation as we go through. It is recommended that you do add both of our interpreters today to the staging area, so, as they switch on and off, you won't have to look for them above, they'll just be right there. If anybody has any issues with either of these features, or has any additional questions, please submit them in the Q and A, and we will help you out. Thank you.

All right. Well, thank you, Georgia, and thank you to our two ASL interpreters Diane and Muffy.

My name is Selena Hajiani, I'm the Director of Strategic Operations and Planning here at the Office of Health Insurance Programs at the Department of Health. Today, I'm going to provide a brief overview of New York's 1115 Demonstration Waiver and then we'll have time for a public comment at the end. Sorry, next slide please.

So, to walk through the agenda. First, we'll provide some background on the virtual public hearing format and 1115 Demonstration Waivers generally. Then I'll provide an overview of New York's 1115 Waiver and two amendment applications that we have in progress: The New York Health Equity Reform Amendment, and the Institutions for Mental Disease Amendment. Next slide please.

So, in compliance with the COVID-19 guidelines and approved CMS exceptions, we are conducting this forum virtually today. Public forums provide the State an opportunity to get feedback on demonstration projects, and also as a valuable opportunity for us to learn and hear different perspectives. Recording and transcript of this forum will be provided on the MRT Waiver website about 5 to 7 days after this forum. Language translation is available upon request and the slides will also be posted to the website. 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 under Section 1115 of the Social Security Act. These waivers authorize the Secretary of Health and Human Services to waive certain Medicaid program provisions and regulations, and also allow the use of Medicaid funds in ways that are not otherwise allowed under federal rules i.e., making them

eligible for federal match. 1115 Waivers are typically approved for 3 to 5 years, although recently some have been approved for longer terms. Next slide please.

So, the State and CMS come to agreement on the Special Terms and Conditions for the 1115 Waivers or the STCs. The STCs outline the details of the waiver, including waiver expenditures and authorities and they also specify the timeline and the nature of state deliverables such as general and financial reporting. These reports include quarterly and annual reports that must be submitted to CMS and also an Independent Evaluation has to be conducted at the conclusion of the demonstration program. Spending under 1115 Waivers must be budget neutral, meaning that spending under the waiver cannot exceed projected costs without the waiver. Next slide please.

So, New York's 1115 Demonstration Waiver, The Medicaid Redesign Team Waiver, formerly known as the Partnership Plan, has been in effect since 1997. The MRT Waiver was most recently renewed on April 1st, 2022 and will be effective through March 31st, 2027. The goals of the MRT Waiver are to improve access to healthcare for the Medicaid population, to improve quality of health care services delivered, and expand coverage to additional low-income New Yorkers with the resources generated through managed care efficiencies. Next slide please.

So, New York's 1115 Waiver authorizes managed care in the State. Managed care is when a health plan or system coordinates the services quality and cost of care for its members. The 1115 managed care programs include Mainstream Managed Care, Medicaid Managed Care, Managed Long-Term Care, and Institutions to Community Long Term Services and Supports, Home and Community Based Services, Health and Recovery Plans and HIV Special Needs Plans. Next slide please.

So, one of the waiver amendment applications that we have in progress is the New York Health Equity Reform, or NYHER Amendment. We are seeking 13.52 billion dollars over 5 years with an overarching goal to reduce health disparities, advance health equity, and support the delivery of social care. We propose to achieve this through the following strategies: 1. build a delivery system that will support the overall goal, 2. strengthen transitional housing, 3. strengthen system capabilities to improve quality, advance health equity and address workforce shortages and 4. create statewide digital health and telehealth infrastructure. Next slide please.

So, this is the timeline for the amendment. We have a lot of green check marks, which is very exciting. The noticing, public hearings and comment period ended in the spring.
We had a very robust and thoughtful public comment period with a lot of feedback in nearly 1800 individual comments. We submitted the application to CMS on September 2nd and the application was deemed complete on September 15th. The federal public comment period began on September 19th, and will run until October 19th, after which we will begin negotiating the terms of the amendment with CMS and our target implementation date is January 1st. Next slide please.

So, another 1115 amendment application that we are proposing is the Institutions for Mental Disease, or IMD waiver amendment. An IMD is a hospital, nursing facility, or other institution with more than 16 beds that is primarily engaged in providing care to individuals with behavioral health needs including serious mental illness and substance use disorder. Under this application New York is seeking federal funds for short term IMD inpatient, residential and other services for adults with behavioral health diagnoses. This application also includes a request for in-reach services for 30 days prior to discharge for individuals that have had long

term stays in state psychiatric centers. These services include care management, clinical consultation, peer services and pharmaceutical management and the goals of this amendment are to reduce length of stay for inpatient and transitional services, to help individuals integrate into and remain safely in the community with a focus on recovery and to reduce the overall cost of care. There will be two public hearings; one on October 26th and one on October 31st, where there will be a more in-depth summary of this amendment, and there will be opportunity for a public comment and written comments may also be submitted until November 4th. Next slide please.

So now I'm going to pass it over to my colleague, Phil, for the public comment portion of the forum. Thank you.

Oh, thank you. Selena and good afternoon, everyone. Can you advance the next slide please?

I'm just going to take a few minutes to review the guidelines for public comment. A list of the pre-registered commenters will indicate the order in which you will be called on to speak. If you haven't pre-registered, you may raise your hand or put a note in the Q and A box, and we will add you to our list of speakers this afternoon. A member of the DOH team will call your name and manually unmute your line to allow you to provide your comments. Comments will be timed. Please limit your comments to 5 minutes. Written comments will be accepted through October 10th by email at 1115waivers@health.ny.gov or by mail and the address there is below at 99 Washington Avenue, Albany, New York 12210. Okay, next slide.

Any other questions or comments for any additional information, please contact us at our 1115waivers@health.ny.gov email and we will respond, promptly. Next slide please.

This is a resource page for the 1115 Waiver. The there's a link to our 1115 Waiver website. Also, the NYHER Amendment application that we mentioned earlier, you can click on that and that'll take the right to our application. And then the IMD Amendment public hearing and pre-registration information is listed. As mentioned earlier, our first public hearing for that amendment application is October 26th and our second public hearing is on Monday, October 31st. Okay, next slide.

This is just a slide that will let speakers know and there's one minute left remaining of the five minutes for their presentation. And I think the next slide is just the slide to let speakers know that their time is up.

Okay, having said that I am happy to introduce the first speaker, Kathy Preston followed by Kayleigh Zaloga. Kathy, please go ahead. We'll, unmute your line.

Okay, can you hear me? Yes. Okay, great. Thank you. Thank you.

I am Kathy Preston with the New York Health Plan Association, representing 26 health plans that partner with the State to serve nearly 6 million Medicaid members. New York's Medicaid managed care program is now more than 30 years old. The program has served enrollees, providers, and the State well with improved access for Medicaid members to more coordinated, higher quality and more cost-effective care than the predecessor fee for service structure. The system has undergone much change in the more than 30 years since it was first authorized with an especially accelerated pace of change over the last decade. New York's Medicaid managed care program is arguably the most expensive in the country with a longstanding emphasis on prioritizing access and choice for Medicaid members. The Medicaid

managed care structure has made it possible for the State to expand Medicaid to include additional benefits and populations while lowering the per member cost of care versus the fee for service system. While health plans recognize that there are challenges with the system, we're committed to continuously working to improve the quality and efficiency of the Medicaid program for members and providers. The State has several important priorities for the program over the next several years, which will require a renewed partnership between the State and plans, including efforts to re certify eligibility for more than 7 million Medicaid members as the public health emergency ends, while assuring continued coverage; expand coverage to new populations to achieve universal coverage in New York; implement better care for Medicare and Medicaid dual members; move towards more integrated behavioral and physical healthcare; expand innovative value-based payment structures and implement a new 1115 Medicaid Redesign Waiver, focused on long standing issues with health equity and addressing social barriers to health, like housing and food insecurity. Each of these priorities is a massive undertaking on its own, requiring the full attention of the State, health plans, and stakeholders to be implemented effectively. Under DOH's next 1115 waiver application, health plans are expected to have a critical role in advancing delivery system reforms. This includes efforts to improve equity and eliminate disparities in the system through expanded work to address social care needs and enhanced efforts to progress towards value-based arrangements. Plans are already working on these priorities and look forward to intensifying those efforts. Plans have faced challenges, especially in times when the State faces its own budget shortfalls, plan premiums are delayed and or retroactive and plans spent several years with rates at the bottom of the actuarily sound rate range. Further, at a time when the State has been working to transform the system away from a volume-based structure to one that's based on value, quality incentive funding plans has been nearly eliminated. Such challenges can make annual or longer-term financial planning and investment decisions difficult for plans. HPA and our member plans have been consistent, reliable partners with the State in the implementation of Medicaid reforms and redesign, have worked collaboratively during challenges presented by COVID-19, and look forward to continuing the work to improve the program. Thank you for the opportunity to offer comments on the 1115 Waiver today.

Thank you. Our, our next speaker is Kayleigh Zaloga followed by Marie Mongeon. I apologize in advance if I mispronounce anybody's name but please Kayleigh go ahead. We'll unmute your line.

Thank you and great job. I'm Kayleigh Zaloga, President and CEO of the New York State Coalition for Children's Behavioral Health. I first want to thank the Department for really responding to our comments on the previous version of the waiver by adding children to this application and specifically including children of behavioral health needs and intellectual developmental disabilities and their families and providers throughout the application. We're happy to see the explicit inclusion of children's behavioral health providers on the governance boards of the HEROs, to be involved in the Social Determinants of Health Networks as well, especially specifically referencing the behavioral health IPAs and other behavior health provider networks and the advanced VBP models and other efforts to build capacity for community-based organizations to address behavioral health needs, the recruitment and retention of behavioral health providers. We all know that we're in a workforce crisis. We all talk about it a lot and we're happy to see that there's specific mention that crisis. Recruitment and retention efforts specifically aimed at attracting a diverse workforce to the behavioral health provider system and expanding access to services in underserved areas, whether that's via telehealth infrastructure, digital and other network extending and capacity increasing devices. We are concerned though, because we know that it takes a lot more than just adding certain list of providers to a group who might be invited to a meeting. We were invited to a lot

of meetings during DSRIP, but we weren't really at the table. The PPSs really didn't focus much of the funding on community-based organizations and especially not on children and children's behavioral health. So, we're really hoping that the 1115 Waiver is an opportunity for true cross system collaboration, there's a lot of work that needs to be done and we appreciate that it was acknowledged in this application to address children who have dual diagnosis of severe mental illness and other behavioral health issues as well as I/DD. Those kids currently, especially if they're also involved in the child welfare system are really falling through the cracks in a lot of ways and we think the waiver is an opportunity to bring agencies together, to bring providers who provide services to the different populations together. It's going to take a commitment, from the Department, from all the service providers, and from each agency to make this a meaningful change. We also appreciate that family and youth peers are a possibility to be included in the HEROs governance and planning processes, but we believe they need to be a mandated part of that. Similar to our past experience with DSRIP, being an option does not necessarily mean that we're an integral part of the process. And if we're going to create a system through this waiver that truly serves the needs of families and youth with behavioral health needs, then we need to really include them and make sure that their voices have to be listened to. When we're talking about the planning entities and the Social Determinants of Health Networks. We'll put a lot more details in our written comments, but I think our main takeaway here is that we are very glad to see the changes that were made. We want to be an integral part of making the 1115 Waiver truly serve children and families, and we're going to need a commitment from all folks who are involved to make sure that we're designing this system with the children and families who are most impacted and the providers who serve them as we create it, and not just as an afterthought or a possible inclusion in meetings and value-based payment arrangements. Thank you.

Thank you. Next speaker is Marie Mongeon and followed by Karen Lipson. Marie, please go ahead.

Thank you and hello, my name is Marie Mongeon, and I'm the Senior Director of Policy with the Community Health Care Association of New York State. CHCANYS as we're also known, represents over 70 community health centers that serve more than 1.3 million Medicaid beneficiaries each year. We're generally supportive of the State's efforts through the 1115 Waiver and more specifically through the pending waiver amendment. But today we'd like to share some comments to improve value-based payment arrangements between managed care organizations and safety net primary care providers. First, we ask the State to ensure timely data sharing between plans and providers. Providers often don't receive timely information around patient attribution and patient utilization that occurs outside of the health center. For a provider to ensure their own success in value-based payment, they must have monthly access to the full range of plan data, including claims, risk score calculation, timely care gap data, and patient rosters. Secondly, the Department must create and enforce minimum required standards for primary care centered attribution, including a requirement for periodic reconciliation to actual utilization. The discrepancies between MCO attribution, consumer utilization and value-based payment contractor rosters, make it nearly impossible for health centers to effectively manage patient health outcomes. A primary care attribution methodology must include the ability to add patients who have billable encounters at health centers and remove patients who have billable encounters at other primary care providers. Third, we request that the State define requirements for MCOs to enter into value-based payment arrangements with health center led IPAs, or independent practice associations, to promote primary care integration into value-based payment. Currently, MCOs have full discretion on whether or not to enter VBP arrangements with IPAs and may choose not to contract with health center led IPAs if they feel they've sufficiently met value-based payment

contracting targets by contracting with a hospital or other large healthcare entity. This is inequitable and leaves health centers occasionally unable to participate in VBP arrangements, even when they are willing and capable to do so. Fourth, the Department should consider incentivizing improvement-based targets to address health disparities. Improvement based targets require that a provider show improvement from a population's baseline over time. Improvement-based targets avoid penalizing providers who treat individuals with greater social needs or those who experience wider disparities, as is often the case for many within the health center patient population. In cases where measures are stratified by relevant characteristics like race, ethnicity and language, incentivizing improvement-based targets rewards the achievement of equity related goals without penalizing safety net providers for serving populations with the greatest health disparities. When significant improvements are made, and benchmarks are reached, contracts must reward those gains rather than offering all or nothing incentives that require providers to hurdle every benchmark to receive any incentive payment at all. Last, the State must provide upfront investments in community health centers and community health center led IPAs to advance equity based, value-based payment arrangements. The health center model of care, when properly resourced, is well suited to improve health equity and achieve the goals of value-based care. However, upfront investments in infrastructure, analytics, integrated care, workforce, and more are needed for health centers to be successful under advanced value-based payment arrangements. In cases where providers have made large unfunded investments to address social needs, improved health outcomes and achieve savings but fallen short on one or two metrics, they may not receive any financial benefit from the plan, depending on each health centers contracts terms. As such, we ask the State to ensure that safety net providers receive upfront investments to do the work needed to succeed under their value-based payment contracts. Thank you all for having me here today and we look forward to submitting more information in our written comments.

Thank you. Our next speaker is Karen Lipson followed by Keisha Barr. Please go ahead.

Hello. Can you hear me? Yes.

Great. Good morning, my name is Karen Lipson. I am an Executive Vice President from LeadingAge New York. We represent approximately 400 not-for-profit and public providers of long term and post-acute care services, senior housing, and managed long term care plans. I'd like to offer a few comments on the impact of the MRT Waiver and DSRIP on older adults, and the providers and plans that serve them. And I'd like to talk a little bit about the lessons that we have learned that can be applied as we move forward into the new waiver amendment and planning for the needs of our rising population of older adults. There are 860,000 adults aged 65 and over enrolled in the State’s Medicaid program. The vast majority are dually eligible, they’re covered by both Medicaid and Medicare. More than 300,000 of those Medicaid enrollees are receiving long term care services. And of those receiving long term care services, the vast majority, approximately 250,000 people are enrolled in partially capitated managed long term care plans that do not cover the benefits that are covered by Medicare. They primarily cover long term care services. These numbers of older adults in New York are growing. We're facing a major demographic shift in our state’s population. The number and percentage of individuals aged 65 and older is growing rapidly and at the same time, the percentage of working age adults is shrinking. We need to take immediate, concrete and carefully conceived actions to address the long-term care needs of our aging population. For too long, our state’s policies have been focused on how to cut long term care spending, not how to build a better system. We cannot continue to squeeze money out of the system and pile on layers of administrative requirements and expect to be able to continue to provide

accessible high-quality care for our grandparents, our parents, and our future selves. One of the key successes of the MRT Waiver is that the MLTC program has helped to improve access to home and community-based services in upstate counties where it was once scarce under fee for service. However, access to community-based care statewide is threatened by an unprecedented work force shortage in long term care. It's threatened by flawed rate setting policies for manage long term care premiums and it's threatened by the recently created independent assessment process for managed long-term care, personal care and consumer directed personal assistant services. As we move forward into the waiver amendment and planning for our future long term care needs, we need to learn not just from the successes of the MRT Waiver and DSRIP, but also from their shortcomings. DSRIP did very little for older adults and the long-term care system. Only 1.4% of DSRIP funds were invested in long term care. In fact, the summative report, the final report, on DSRIP acknowledged that long term care was outside of the DSRIP program focus. We cannot continue to treat long term care as being outside of our focus. Our LeadingAge New York members spent thousands of hours and dedicated both personnel and funds to working on DSRIP committees and projects, but they received precious little benefit for the people they served through DSRIP. The primary obstacle was that DSRIP was designed for non-dually eligible populations. They were designed for people who receive Medicaid only and not Medicare. The proposed amendment to the 1115 Waiver released earlier this month appears poised to repeat the mistake of DSRIP. It does this by flowing funds predominantly through advanced value-based payment arrangements. These models appear to be infeasible for partially capitated plans and the providers that they contract with. DOH itself has stopped supporting value-based payment arrangements for partially capitated plans that serve 250,000 long term care beneficiaries. As a result, while the State is investing 13 billion dollars in an ambitious effort to build a more integrated health care delivery system, older adults and the providers that serve them are at risk of being left behind and ignored again. We would like to work with the Department of Health on developing value-based payment models tailored for long term care and older adults that will ensure the ongoing viability and accessibility of high-quality, long-term care in New York State. We'd like to work with you on senior housing with services that will enable older adults to remain healthy in their communities. Our grandparents, our parents and our future selves are counting on us to make long term care a program focus. I hope we can work together on developing real solutions. Thank you.

Thank you. Our next speaker is Keisha Barr, followed by Nadia Chait. Keisha, please go ahead.

Thank you. Good afternoon. My name is Keisha Barr. I represent Public Health Solutions, New York City's largest public health nonprofit, serving over 100,000 New Yorkers every year. PHS currently manages a Social Determinants of Health Network, which we call WholeYouNYC, where we partner with organizations along the continuum of care, health plans, health providers and our network of CBOs to connect New Yorkers to resources that resolve their unmet social needs. First and foremost, we'd like to applaud the State's recent increased investment in Social Determinants of Health Networks and CBO capacity building to meaningfully participate in these networks. The funding allotted to SDHNs, and CBOs will be important towards ensuring that these organizations have the capacity to scale and build the infrastructure, business processes, and human resource capacity required for sustained health care and human services integration. In addition though, to building the capacity of CBOs to advanced contracting arrangements, we also want to reemphasize the importance of community engagement in both HERO and SDHN planning and decision-making, including CBOs in the governance of the program will help to ensure planning efforts are not only grounded in the communities' lived experiences but also as essential to the successful

enrollment and engagement in these services for overall improved health outcomes. As stated back in May, New York City has tremendous community diversity and those who represent local priorities and understand these diverse needs must have a seat at the table. Secondly, while we appreciate the revisions the State has made over the past few months to accommodate public feedback, the application continues to leave open the possibility for New York City to be subdivided into multiple regions. PHS believes strongly there should only be one network infrastructure for the city. Many of the city CBOs provide services across multiple boroughs and given this overlapping service footprint, if the city is divided into multiple regions, these organizations may be forced to limit access to their services to participate in one or a select few of the city's network. Given that effective regional coordination will be important both towards ensuring stakeholder alliance and effectively and efficiently implementing integrated delivery system reform, a multi-regional concept in New York City leads to a greater potential for different programmatic tools, payment points, and value-based payment models across boroughs especially for CBOs. This will further complicate collaboration within the network, and the administration and evaluation of these networks. It's also important to note these administrative complexities brought on by a multi-regional network approach in the city will not be limited to CBOs, but also experienced by managed care organizations and health care providers, many of whom also provide services city wide. Finally, while the State has communicated recently that MCOs will be incentivized to engage in value-based payment arrangements that utilize the SDHNs, the current language in the final application, which states that MCOs will be encouraged to contract with the network and will be given funding preferences to arrangements that utilize SDHNs remains subject to interpretation. As you finalize your plans over the upcoming months, we encourage the State to create a structure under the program that clearly defines incentive awards and minimum standards for MCO and provider participation in these networks. One that will promote network utilization since their participation will be key to long term sustainability of the SDHNs. Based on our experience, if these organizations are not incentivized to use the network, the potential for substandard contracts that leaves CBOs susceptible to inequitable contract terms, multiple payment models, and restricts access to these needed services is high. Additionally, we must also ensure funding mechanisms through the program compensate CBOs adequately and appropriately for services, and values the true cost of the work that they do. This includes both low and high intensity outreach, engagement and interventions, especially for those hard-to-reach Medicare populations, which are vital to the work of CBOs. Without adequate compensation for their time and effort, CBOs will be challenged in scaling their program services in a coordinated manner to meet the needs of program beneficiaries. We urge the State and CMS to consider these recommendations and PHS is ready to support the program to the best of our ability and welcome further engagement with the State as you finalize your plans. Thank you.

Thank you. Our next speaker is Nadia Chait, followed by Al Cardillo. Nadia, please go ahead. Is…Hi Phil, it's Georgia. I'm not seeing Nadia in our attendee list. Okay. Our next speaker then would be Al Cardillo followed by Matt Bishop. Is Al on?

Leaving one meeting, I'm being called into the hearing, one second. Al, I think you're unmuted and please go ahead.

Yes, I again apologize. I'm in multiple meetings at the same time, but I appreciate it. So, yeah, I'm happy to go. So first, I want to thank you for holding the hearing today and inviting us to provide some feedback. Just a little bit about HCA, we're an association that is statewide. We have over 300 members. Our members include all the components of the home and community-based system, certified agencies, licensed agencies, hospices, manage long term

care plans, FI's and an array of allied community support services. I think one point I would really like to stress is that these services are really a core of the entire system. And unlike the experience of the DSRIP waiver, we really urge the Department to include us, to build upon us and leverage the very comprehensive and unique position and resource that home care and home community-based services bring to the system. If one reads through the current waiver application, you don't see the words homecare materialized too many times. I think it's important that the role, the very robust role that home care plays in this system be recognized and reflected within the waiver. I think we should avoid the irony that a multibillion dollar funded waiver to address equity that in itself isn't designed to perpetuate the inequity of those who received these services. But overall, again, positively, we appreciate, we strongly endorse the focus of this waiver on equity and addressing disparities and we stand with you in this cause and ready to work with the administration, legislature, and all collaborating partners in the effort. A very important aspect about home care, distinguished from other parts of the system is that home care lives and provide services in the spaces where people live and where they get those services, which is their homes and communities. The roots of home care are in public health and home care provides unique opportunities to align the service staff and the navigators of service with the cultural and linguistic attributes of the population that we serve. In its roots in public health, home care is also very much a population health, community health, and a really holistic type of model in the servicing of the population. HCA is an association we've long been committed and been working on this issue of equity and disparities for many, many years. Some of the current things that we are doing we are implementing a statewide grant, which we've been doing over the course of the year to train and orient staff across the community continuum in disparities, equity, diversity, and in cultural competence. One of our programs offers a menu of over 40 courses that individuals can enroll in and take, and it's all funded by virtue of the Cabrini Grant Fund that we have to offer the program. There are other elements of this and population health and training and mental health comorbidity, and translation services. All of that are things that we have rolled out and are continuing to build in the initiative. I think one thing that's very critical in the waiver, it talks about workforce. I think we can all agree that workforce is a huge issue, impacting access to services, impacting the correct alignment between staff and services and it's really important that workforce initiatives that are part of the waiver really be aligned to try to support the entire system in terms of the workforce needs. I think one thing that's also really, very important in this and it was mentioned earlier is access to data. We really need to have access to data, whether it's for a value-based arrangements with plans or broader community responses in terms of addressing health disparity and health equity issues. Currently data like the UHS data, other data that are being made available aren't available directly to the home health and community-based services community. So, with that both the providers and often the plans are sort of operating semi blind and trying to create these value-based initiatives and I think data will be a big part of that. I will speak to the technology portion as well. That's also very critical. Not only does it support the workforce aspects, but it's really the new window into how we really need to overcome barriers in services. The technology enables the integration of information, enables services to be provided and accessible when patients are remote, especially when you're talking about rural communities or access issues are significant. Technological availability is really important. I will point out that home care has really not been included in most of the recent budget initiatives that relate to telehealth and it will be very important to include that in a waiver of this sort. I also want to speak to the again, the notion of how one approaches these community services. In DSRIP, most of what occurred is that the dollars were received, but they were used to duplicate what specialized providers in the community were already doing, an expert at doing and have longevity in doing. We really encourage, as the funds flow in this initiative, to really bring all parties to the table to discuss the allocation of the funds, to be considered for the allocation of the funds, and also to avoid

the expenditure for the recreation of services and models, which already exist in the system and to which investment has been made. I want to just check, I see I have one minute remaining, but I don't know if I already exceeded my minute. And you're telling me my time is up. I just want to thank you for this opportunity. We look forward to working with the Department. We're totally committed to the issue and the direction and look forward to making home care a very robust part of the solutions that the State is exploring. And I, thank you.

Thank you we have another speaker, Matt Bishop. I'm getting a note that he's not available. Georgia, do you see him, see him in our list? I don't see him. I'm looking. I do not see him; I believe he signed off for a bit.

Perhaps we keep the lines open here until two, does that work?

Maybe at this time, we can see if anyone wants to raise their hand and provide comment. If you're interested, please raise your hand.

Okay seems like we are not seeing any volunteers. Is that right Georgia and Phil? Yep. I don't see anyone else. Okay. Okay, Georgia do you see anyone else raising their hand or any request in the Q and A to present? I do not see any at this time.

Okay. As mentioned earlier, folks have an opportunity to email 1115waivers@health.ny.gov So. Oh, we do have one. Okay. We convinced somebody, Skip. All right, I'll go ahead and unmute Skip at this time. Okay. Okay, Skip please go ahead.

Thank you very much. I'm really delighted to be heard. I think I was going to, wanted to do that, but I didn't properly enroll. I represent the Virtual Specialists, and we've been working tirelessly for nearly a decade to implement a statewide telehealth network and along comes the 1115 Waiver and goal four to me is like the have to have before you even think about goals one, two, and three. And I believe the network is there, I think it's fragmented of course, it's in every medical group, social services group. And what we are very passionate about doing is creating, you know, that unified network that we all envision reliable, obviously secure, backed by you know, the top innovative technologies in the, let's call it the visual space and video communication, education, et cetera, et cetera. So, we wanted to participate, we submitted our comments at the initial hearing, and lo and behold, here we are again and the need for what I'm referring to is on everybody's mind. And I just want the group to understand that that's what we would be a fundamental partner architecting that solution by unifying these disparate systems into a referring, what I would call experience center. So, whether you're looking for housing, healthcare, or mental care, you're able to quickly be connected with those who are offering those services within the state system. Yesterday we had a very productive conversation in Staten Island about this very thing and we're looking to create a HERO that will be the model that others can adopt, kind of to give them a pathway going forward. So, I could go on and on about this, but I just wanted you to know who I was and since you're kind of passing the hand for speakers I thought I'd throw mine in the ring. Thank you.

Thank you. I'm not seeing any other speakers, Georgia. Do you see anyone else? Nope, I don't see any other requests.

Okay that concludes our list of speakers for this afternoon. Selena, I'll turn it back over to you.

Okay, thank you Phil and thank you everyone who provided comments today. We really appreciate hearing your feedback. And with that, thank you and have a great afternoon.