New York 1115 Medicaid Redesign Team Waiver Amendment: Continuous Medicaid and Child Health Plus Eligibility for Children up to Age 6 Virtual Public Hearing and Annual Public Forum Transcript
February 28, 2024

Good afternoon, everyone. I think we'll give a minute or two for people to sign on in case others want to join and then we'll get started. Thank you.

Okay, looks like we have leveled off here. Welcome everyone and thank you for joining us for the 1115 Waiver Annual Public Forum and the Public Hearing for the Continuous Medicaid and Child Health Plus Eligibility for Children up to Age Six 1115 amendment. Before we begin, I will turn it over to my colleague, Georgia, to explain how to turn on the closed captioning feature and how to make the two ASL interpreters easier to see. Go ahead Georgia.

As Selena mentioned, close captions are available during today's webinar. To enable the close captions during the webinar, just look for the CC icon in the lower left-hand side of your screen and click on “show closed captions.” Additionally, we do have two ASL interpreters with us today on the webinar, Hannah and Carly. You may see Hannah now signing up top and if you'd like to move our ASL interpreters down into your dashboard next to the presentation, you can do so by right clicking on their video at the top of the screen and selecting “move to stage.” All right, I'll send it back to you, Selena.

Alright. Thank you very much Georgia and to our two ASL interpreters Carly and Hannah. 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. Thank you so much for joining us today again to walk through the agenda, first we'll provide some background on the public hearing format and the 1115 demonstration waiver generally, and then an overview of New York's 1115 Waiver and amendment updates more specifically. Then, we will move to an overview of the proposed 1115 amendment on Continuous Eligibility for Children Ages Zero to Six; we'll go over some projected milestones and we will end with time for public comments.

So, on the next slide we have information on the public hearing format. Today, as I mentioned, today's hearing is serving dual purposes for the 1115 annual public forum and for the proposed amendment, which is required by federal regulations and New York's 1115 Waiver Special Terms and Conditions. So, public forums provide the State with an opportunity to get feedback on demonstration projects and is a valuable opportunity for us to learn and hear from different perspectives. The recording and transcript of this hearing and forum will be available on the MRT Waiver website approximately seven to ten days after the hearing. Language translation is available upon request and the slides will be posted on the website.

So, on the next slide I will go over the 1115 waivers. Section 1115 demonstration waivers offer states 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, allow states to use Medicaid funds in ways that are not otherwise allowed under federal rules, i.e., making them eligible for federal match. These 1115 waivers are typically approved for three-to-five-year terms.

So, on the next slide we continue this overview. The State and CMS come to agreement on the Special Terms and Conditions for the 1115 waivers which outline the details of the waiver, including the waiver expenditure and waiver authorities. They also specify the timeline and

nature of state deliverables, such as the general and financial reporting. These reports include quarterly and annual reports that must be submitted to CMS and an independent evaluation that also has to be conducted at the conclusion of a demonstration program. Spending under 1115 waivers must be budget neutral, which means that the federal spending under the waiver cannot exceed the projected costs that would occur without the waiver.

On the next slide we have an overview of New York State's 1115 waiver. New York's 1115 demonstration waiver, which is called the Medicaid Redesign Team or MRT Waiver and was formerly known as the Partnership Plan, has been in effect since 1997. It was most recently renewed on April 1st, 2022, and will be effective through March 31st, 2027, and the proposed amendment that we will be discussing later on will be an amendment to this existing demonstration waiver. So, the goals of the MRT Waiver are to improve access to health care for the Medicaid population, improve the quality of health services delivered, expand coverage to additional low income New Yorkers with the resources generated through managed care efficiencies, and we have our new goal, which was added with the approval of the New York Health Equity Reform, or NYHER 1115 amendment, and this new goal is to advance health equity, reduce health disparities, and support the delivery of health related social need services.

On the next slide, we have an overview of the NYHER amendment. Sorry, we have one more slide before that slide. So, New York's 1115 MRT Waiver authorizes Medicaid Managed Care in New York. Managed Care is when a health insurance plan or health care system coordinates the services, quality, and cost of care for its enrolled members. The 1115 Managed Care program includes Mainstream Medicaid Managed Care, Managed Long Term Care, and Home and Community Based Services and a few other programs. Next slide, please.

Okay, so now we have a summary of the NYHER amendment. It was approved by CMS on January 9th, which was last month, and will be effective until 3/31/27 and it has the goal that I mentioned a few slides ago to advance health equity, reduce health disparities, and support the delivery of social care. With this amendment we are building on the investments, achievements, and lessons learned from the Delivery System Reform Incentive Payment, or DSRIP, program which was a prior 1115 amendment, and it focused on scaling delivery system transformation improving population health quality and excuse me, enhancing integration across the delivery system and, and now we will be advancing health related social need services. So, we would achieve these goals through targeted and interconnected investments that will augment each other, be directionally aligned, and be tied to accountability. These different components are the Social Care Networks and services, population health, and workforce initiatives.

So, on the next slide, we have an overview of the Social Care Networks, or SCNs, for which CMS approved $500 million. The SCNs will be regional networks of HRSN focused CBOs. There will be a single SCN per region with up to 13 SCNs, depending on the number of awards made for the New York City region, there could be up to one SCN per county in New York City. The SCNs will be responsible for managing the fiscal and administrative duties on behalf of the CBOs, to allow the CBOs to focus on what is really important, on providing the services to our Medicaid members. So, now to move on to the services, all Medicaid. Oh, sorry not done with it, that last slide yet. All Medicaid members will be screened and will be eligible for navigation to existing programs. The targeted high need populations listed here will be eligible for enhanced housing, nutrition, and HRSN transportation services as well as HRSN case management. These populations include Medicaid high utilizers, pregnant persons, children aged zero to six, and those children under 18 with chronic conditions.

So, on the next slide we have listed out the HRSN services for which CMS has approved $3.4 billion. This is, this is a full list, I won't read it all to you, but it's a range of screening, housing, HRSN, excuse me, transportation and case management and nutrition services of varying levels of intensity, which will allow for care planning based on the members level of need.

So, on the next slide we have an overview of the workforce initiatives, which are intended to address high demand workforce shortages and improve access to and quality of services. The first is the Career Pathways Training Program, or CPT program, for which we have $646 million. The intent of this program is to fund comprehensive educational programming and support services to support recruitment and retention of high quality, diverse workforce that is dedicated to working in high need communities. The participants will have to make a three-year commitment to work for Medicaid providers that serve at least 30% Medicaid and/or uninsured individuals. The program will be managed by three high performing WIOs that will recruit students and providers coordinate educational programs and provide educational and job placement support to the participants. The educational programs will be for the nursing, professional technical, and frontline public health workers, titles listed here which includes LPNs, Nurse Practitioners, Physician Assistants, Social Workers, and Community Health Workers. Those trained will help to build capacity for both more traditional health and behavioral health services and the HRSN services that will be provided through the Social Care Networks. The second program is the Student Loan Repayment Program, for which we have $48 million. This program is again intended to attract high demand practitioners to serve Medicaid members. Similar to the CPT Program, awardees will make a four-year full-time commitment to maintaining a personal practice panel, or working at an organization with a panel that includes at least 30% Medicaid and/or uninsured individuals. The awards will be made based on criteria including geographic distribution of applicants, regional need, a commitment to working in underserved communities, and linguistic and cultural competency. The titles that are eligible for the loan repayment are listed here. They are Psychiatrists, with a priority for Child and Adolescent Psychiatrists, Primary Care Physicians, Dentists, Nurse Practitioners, and Pediatric Nurse Specialists.

On the next slide, we have an overview of two of the population health and health equity initiatives. The first is the Medicaid Hospital Global Budget Initiative, for which we have up to $2.2 billion. The goal is to stabilize and transform targeted, financially distressed voluntary hospitals to advance health equity and improve population health in communities with the most evidence for health disparities. This program was designed to align with the CMMI AHEAD model, which is a total cost of care model that is intended to drive, excuse me, state and regional health care transformation and multi-payer alignment with the goal of improving population health and lowering costs. So, the Medicaid component, the Medicaid Hospital Global Budget will be structured as incentive funding to stabilize Medicaid-dependent, financially distressed, safety net hospitals, and to, the goal will be to develop capabilities to advance health equity, participate in advanced VBP arrangements and enhance integration with primary care, behavioral health, and HRSN services. Incentive payments would be linked to transformational activities and quality improvement measures, including those related to health equity. The second program is the Primary Care Delivery System Model, which will increase investments in primary care with a focus on children and support providers in the movement to advanced VBP arrangements, which will complement the CMMI Making Care Primary Model, which is a Medicare model. MCP is a voluntary model that aims to increase access to high quality, whole person care. And so, this Primary Care Delivery System Model on the Medicaid side will be authorized outside of the 1115 waiver but is tied to the rest of the work of the NYHER amendment. All PCMH practices or Patient Centered Medical Home

practices, those designated as PCMH practices, will be eligible for the Medicaid model. In the first two years of the model, all PCMH practices will receive enhanced payments, monthly payments for their managed care members. In the third year, the enhanced payments will transition to a bonus structure linked to quality and efficiency measures and after year three, these payments will be transitioned to an advanced payment model. Next slide, please.

So here we have the last two programs. The first is the Health Equity Regional Organization, or HERO, for which CMS authorized $125 million. This would be an independent statewide entity that will help to inform the states plan to advance the goals of the NYHER amendment and of OHIP generally. They will convene and collaborate with stakeholders across the state on data aggregation, regional needs assessment and planning, VBP design and development, and they will also perform program evaluation for the waiver programs. Finally, in addition to the components of the NYHER amendment, CMS also approved increased federal funding for substance use and opioid use disorder treatment services. These are community based residential and inpatient services, including those provided in Institutions for Mental Disease, or IMDs, and we anticipate that this will drive $22 million in annual state savings.

So, now we'll move on to the overview of the proposed 1115 amendment for Continuous Eligibility for Children Ages Zero to Six in Medicaid and Child Health Plus. Next slide, please.

So, the goal of this amendment is to prevent gaps in coverage, improve continuity of care, and promote health equity for children in important developmental stages. We would be the fourth state to have this policy in place. CMS or the Centers for Medicare and Medicaid Services, has already approved this for Oregon, Washington, and New Mexico with a number of other states also with active applications. Additionally, we received strong support for continuous eligibility for children during our public comment period for the NYHER amendment as well. Next slide, please.

So, here we briefly describe some of New York's current continuous eligibility. We currently have a twelve-month continuous eligibility policy which has been in place since 1999. This policy has allowed members to maintain coverage for the twelve months between redeterminations, however, coverage losses that occur at the time of redetermination have been an issue for children in the Medicaid and CHP programs, with some children moving in and out of coverage. So, this can cause disruptions in care and can prevent long term care planning again, for children at these critical developmental stages. This chart here shows the current income eligibility for children up to age six. The income limit for children up to age one is 223% of the federal poverty level, or FPL for children ages one to six it's 154% of FPL and for children ages zero to six in CHP, it's 400% of FPL. The changes proposed in this amendment will not change the eligibility limits for the Medicaid or CHP program for the initial eligibility determination and the 12-month continuous eligibility would also apply to them at the point at which they are close to turning six. Next slide, please.

So, as I mentioned earlier, this amendment would authorize continuous eligibility for children up to age six, which would allow a child to remain enrolled in Medicaid or CHP until their sixth birthday, regardless of changes in household information. Under this amendment, the State would continue to do annual eligibility redeterminations, however, children under age six would continue to be eligible for Medicaid or CHP despite any changes to household information, such as income. There are certain expectations, exceptions, excuse me which would result in disenrollment, such as, if the child moves out of state, or was enrolled in the program in error. Despite the changes to the continuous eligibility policy, it is still important to keep household information up to date. So, we believe that this policy change could have significant benefits for

our members under age six. This includes making it easier to develop long term care plans for focused on a child's health, behavioral health, and health related needs; could also avoid costly and disruptive coverage changes; and would improve short- and long-term health outcomes.

So, on the next slide, we have an overview of projected milestones for both the NYHER and Zero to Six amendment. Last month, as I mentioned, the NYHER amendment was approved. This month, we are holding the two public hearings for the Continuous Eligibility amendment, one of which is happening right now. In April, we expect the PCMH payments related to the Primary Care Delivery System Model to begin. The HERO health equity planning work will begin in June. In August, we expect the CPT program to begin and in September, we are hopeful that the Continuous Eligibility for Children Ages Zero to Six amendment will begin but this will depend on the timing of CMS approval. In October, we anticipate that the HRSN services will begin. Finally, we expect the student loan repayment applications to be released toward the end of 2024 or early next year.

So, I believe this brings us to the end of our overview of the amendment and the annual public forum information so I will now pass it over to my colleague, Phil Alotta, for the public hearing portion of the hearing. Thank you.

Thank you, Selena and good afternoon, everyone. Once again, my name is Phil Alotta, with the Department of Health. I'm going to just take a few minutes of your time to go over some of the housekeeping details for the public comment portion of this forum. If I could have the next slide, please.

There's a list of pre-registered commenters, which will indicate the order in which you will be called on to speak. However, if you would like to present and haven't registered yet, raise your hand or send a message in the chat box and we'll add you to our list. I will call on your name and we will manually unmute your line to allow you to provide your public comment this afternoon. Comments will be timed, so please limit your comment to five minutes. Written comments will be accepted through March 8, 2024, by email at 1115waivers@health.ny.gov or by mail at the Department of Health, Office of Health Insurance Programs, Waiver Management Unit, 99 Washington Avenue and that's the 8th floor, suite 826, Albany, New York, 12210. Okay, next slide.

If you have any questions or comments, or would like any additional information, you can contact us at as I mentioned, 1115waivers@health.ny.gov and we'll be happy to respond. We review all the emails that come into our BML. Next slide, please.

This is just a handy reference page. These are some links that you can explore. There's a lot of information here on the New York 1115 waiver website and then the current Special Terms and Conditions and of course, the Continuous Eligibility for Children Ages Zero Through Six, and the 1115 amendment application. Again, if you have any questions, please feel free to email us at the address listed here. Next slide, please.

This is just a helpful, will help us keep on track this afternoon. It will just let the presenter know that there's one minute remaining. Everyone's allotted five minutes to present their public comment this afternoon and the next slide will indicate that your time is up for your public comment period so just please be mindful, there's about five minutes per presenter, and we want to keep everything on track this afternoon. Having said that I am pleased to present the

first presenter this afternoon and that's Kathy Preston. Georgia if you could please unmute Kathy's line and please go ahead and present.

Is Kathy on?

She is on and unmuted.

Please go ahead.

Thank you. So, this is Kathy Preston from the New York Health Plan Association. On behalf of our plan members participating in the Medicaid program, we want to express our continued support for the state's underlying 1115 MRT waiver, which utilizes a managed care program as the care delivery system for the Medicaid population and has enabled New York State to achieve nation leading results in access to care, quality of care and cost effectiveness for the Medicaid population; including the integration of behavioral health and medical health care, and care for frail, elderly and disabled New Yorkers through the MLTC program. We are also excited about the opportunities to address health equity and health disparities through the recent 1115 waiver amendment, and we fully support the proposal to provide continuous coverage for children up to age six. Thank you very much.

Okay, thank you Kathy for your comment. Our next presenter is Karen Lipson. Georgia, if you can please unmute Karen's line.

All right, Karen should now be unmuted.

Thank you. I am an Executive Vice President with LeadingAge New York. We are an association of not-for-profit and government sponsored providers of long-term care, post-acute care and aging services. Our members include senior housing, home care, adult day health care, hospice, assisted living, nursing homes, managed long-term care and PACE programs. Thank you for allowing me to present today. I would like to focus my remarks on the fastest growing demographic in New York State and that is older adults. Specifically, I'd like to highlight the lack of attention to the needs of our growing population of older adults in this waiver, and in particular, the most vulnerable cohort, older adults who require long-term care services. The Governor herself has pointed out that by 2035, just 11 years from now, one quarter of New York State's population will be over age 65 and experts project that two thirds of those who reach the age of 65 will need long term care services at some point in their lives. Medicaid is the predominant payer for long-term care in New York State and across the nation. Unfortunately, we are experiencing a crisis in long-term care in New York State, especially for low-income individuals. There are widespread workforce shortages that are preventing individuals from accessing the care they need, whether it's skilled home healthcare, personal care, adult day health care or residential care. Medicaid assisted living programs are closing their doors due to inadequate rates, leaving residents with no alternative but to seek nursing home care. Only 24 counties have an operational adult day health care program. Mission driven nursing homes are closing beds and closing entirely at alarming rates due to inadequate reimbursement and the inability to get the needed staff. Despite waiting lists for nursing home care in most markets, 11 nursing homes closed in the last four years, nine of those were not-for-profit homes. As a result, individuals in need of nursing home care often have to choose a facility, a facility far from their loved ones and far from their home communities because there are no available beds nearby. This reduction in capacity is affecting not only consumers who need long term care, it's also creating ripple effects across the healthcare continuum. Patients are backed up in hospitals and hospital emergency departments are going on diversion

because the hospitals cannot find places to discharge patients who are stable and ready to leave. We were disappointed to see that this waiver, like the DSRIP waiver, does little or nothing to address the needs of our most vulnerable older adults who need long-term care services. Health equity must include equity for older adults. The waiver's commitment to health equity falls short when it comes to older adults. It invests in safety net hospitals and primary care, but it fails to invest in long term services and supports. Like safety net hospitals, long term care services are funded predominantly by Medicaid and like safety net hospitals, long term care providers are depleted by decades of under-funding. The Career Pathways Program invests $646 million in the development of health care personnel in 14 job titles, but it does not appear to allow a cent to be invested in the development of home health aides, or certified nurse aides, titles that are in extraordinarily high demand in New York State. The waiver seeks to address health related social needs, in part through housing related supports, but it does not appear to create a path to expand a program that has been tested and works to connect residents of affordable senior housing with services, combat social isolation, and prevent declining health; and that is the Resident Assistant Program in affordable senior housing. So, we are left with a pressing question; What is New York State's strategy to address the needs of our growing population of older adults? Is there a coherent plan? The waiver presents an opportunity to support such a plan for older adults and long-term care and perhaps there are still some opportunities through implementation of the waiver to target programming and funding at the needs of older adults in need of long-term care services and the workforce that supports them. If so, if there are those opportunities, we would welcome the opportunity to work with the department to help develop them. Thank you.

Okay, thank you, Karen. Our next speaker is Shetal Shah.

Georgia, if we could unmute Shetal's line and, oh, please go ahead.

Okay, I'm just trying to see, can, is the video working or does it matter, I guess? So, my name is Dr. Shetal Shah, and I am a pediatrician neonatologist and obviously resident of Long Island. From 2019 to 2021, I served as the Volunteer President of New York Chapter Two of the American Academy of Pediatrics, during which time I represented 1,500 pediatricians from Long Island, Brooklyn and Queens. Currently, I serve as the New York State delegate of the American Academy of Pediatrics section on neonatal, perinatal medicine, which includes over 400 neonatologists statewide. As neonatologists, we specialize in the care of critically ill and often premature newborns, and we are in full support of this amendment for the health benefits it will provide our patients across the state. Prematurity in New York is incredibly common. 1 in 11 babies in our state will be born premature. In 2022, that included almost 20,000 babies. While Medicaid is by far the single largest insurer of children in our state, premature infants are disproportionately enrolled. Overall, 45% of children in New York are covered by Medicaid and CHP. However, 50% of newborns are born in the program, but for extremely premature infants, that number increases to almost 55%. Ensuring the optimal health of the majority of our critically ill newborns thus relies on building a seamless system for these infants to access care. Infants born extremely premature have ongoing health needs related to their underdeveloped organ systems. These infants often require multiple pediatric subspecialty appointments with ophthalmologists, pulmonologists, cardiologists, endocrinologists, GI physicians, and rehabilitation specialists throughout the first years of early childhood. Reviewing over 500 medically complex newborns from across the region, data from Westchester Medical Center showed infants were discharged with an average of four follow up appointments and up to 9% of the babies required supplemental oxygen at discharge. Enhancement, such as continuous enrollment, will have an outsized impact on the ability for my patients to access care, allowing for optimal health outcomes. Infancy in childhood, provide

a period of rapid growth and development, creating a sensitive window to capitalize on the benefits of early treatment, and in many cases actually forestalling medical issues that can persist into adulthood. Gaps in insurance coverage for medically complex children are associated with a seven times higher risk of having an unmet health care need. For premature infants, the infants that I care for, an inability to obtain a crucial physician appointment or refill a medication could result in an unnecessary emergency room use rehospitalization or an even worse medical outcome. Further, continuous Medicaid coverage helps the overall child health care system by minimizing the paperwork and staff time required to assist eligible infants with reenrollment. Often overlooked in the discussion of a longer coverage period for children is the unacknowledged but ever-present role that pediatric offices, including administrative and nursing staff, play in assisting parents with reapplying for coverage. Typically, parents are not aware that coverage has lapsed until they make an appointment for well-childcare, and offices realize that the insurance coverage is no longer active. This typically occurs at the 15-month well child visit, after 12-months of automatic enrollment. Pediatric staff must then coach the parent through the reenrollment process. One pediatrician estimated that her staff spends between two and four hours per week assisting parents of young children with reenrollment. Time that is better utilized by nursing and social work staff, providing immunization, counseling parents of children with chronic conditions, triaging parental phone calls, or working with schools. Sadly, since reenrollment can take two to three months, the child is potentially already immunization delayed by the time they present for well-childcare and further, they've already missed critical developmental health screenings. For sick children, we usually air on the side of seeing the patient and reenrolling them afterwards, forcing our teams to navigate a bureaucracy to receive payment, which can take up to 18 months. In this context, the benefits of continuous coverage on health, on the health of children, and babies is clear. The process will result in decreased bureaucracy, less interrupted care, and more staff time to address actual health issues for patients. Finally, it's essential that should this waiver be adopted, that it just begins as soon as possible and cover all eligible children under six years. Given the known and expected benefits of this policy, New York's children should not wait to be continuously enrolled. Adopting the model of some other states, in which only children born after a certain implementation date are eligible, should be avoided at all costs. As we noted it during the introduction of this call, this waiver is part of an increasing realization that streamlined continuous Medicaid eligibility for children is the best means to meet the needs of our kids. Several other states, Oregon, New Mexico, and Washington already have this provision and New York State should join them. Thank you.

Thank you. Our next presenter is Jeff Kaczorowski. You know, please unmute Jeff's line. Okay, please go ahead.

Hi, I'm Jeff Kaczorowski. I'm speaking today on behalf of the New York State American Academy of Pediatrics. I'm currently the Chair of the New York State American Academy of Pediatrics, and I want to say, thank you for the opportunity to comment specifically on the issue of zero to six continuous coverage in this waiver. I also work as a senior health advisor to the children's agenda at Upstate New York Policy and Advocacy Organization. The New York State AAP is an organization that represents about forty-five hundred, 4,500 pediatricians across New York State, and we're dedicated to the health of all children. We are committed to working with New York State to advance and implement policies that support all children to ensure that they can thrive. And I have two comments and two recommendations around the zero to six continuous coverage waiver. The two comments are first, children are the poorest and most diverse segment of our population, children are the poorest and most diverse segment of our population and so it is very heartening to see that the 1115 waiver supports this addition of continuous eligibility for children zero to six as part of a next waiver. Health equity begins with

children. The second comment is, I really want to echo Dr Shah's comments a minute ago and say, thank you to Deputy Commissioner Bassiri and his team for putting forth forward zero to six continuous coverage. As pediatricians, we see kids every day and we know the research data about what happens when kids lose access to insurance. The consequences that gaps in coverage for children have are immense. They can include children losing essential care. They can include parents avoiding care, and they can even include children getting so sick that they end up in the emergency room, or they end up hospitalized or worse than that because parents are afraid that accessing care without insurance will not be financially manageable. This zero to six continuous coverage goes so far to help that, and we are very grateful. Zero to six is exactly the time that we would choose to first have this coverage take place because, as you all know, it's such a critical time for brain maturity and also, because it is a time where families, many families, are not connected with other systems. Kids haven't started school yet. We need this interaction between families and children and the health system to really be robust to benefit our kids' health and wellbeing. My two recommendations are these; The first recommendation we have is for the waiver to specifically state continuous coverage will be for all children less than six years old, covered by Medicaid or Child Health Plus. We strongly discourage a system as been as has been implemented in other states, which is slowly phased in coverage after a certain date for only newborns at birth, leaving out existing children under six years of age would benefit from continuous coverage. So, in other words, we don't want this to just start at birth. We want for kids who are one years old this year, and might be turning two, or one years old, and who might be turning two in September of 2024 to be able to be eligible for continuous coverage. The second recommendation we have is for the New York State Department of Health to work closely with CMS to track important and mutually agreed upon data to demonstrate the success of this continuous coverage in order to ensure that the benefit will be permanent in New York and maybe even might be expanded upon beyond age six. Wouldn't it be great if we could one day make it to age 10, and have all kids covered through elementary school? Thank you and the New York State AAP stands with you and is excited to work with you to implement this exciting new continuous coverage for kids zero to six.

Thank you, thank you for your comment. Our next presenter is Marie Mongeon. Hope I didn't mispronounce your name, apologies.

Good afternoon. Thank you for the opportunity to comment today. My name is Marie Mongeon and I'm the Vice President of Policy at CHCANYS, the statewide association representing New York's Federally Qualified Health Centers. Health centers are New York's primary care safety net. They serve 2.3 million New Yorkers, nearly 60% of whom are Medicaid beneficiaries. Health centers serve those most affected by poverty, racism, discrimination and instability and food and housing, which adversely impact their health and their wellbeing. This waiver presents a chance to revamp the health care landscape with a renewed emphasis on addressing the whole person. Something health centers are incredibly supportive of and have implemented into their work since their inception during the Civil Rights Movement. However, this opportunity risks falling short of its transformative potential, if not implemented with careful consideration of its collaboration with health centers. As such, we recommend the following changes to the waiver. First, as the State is selecting Social Care Networks, we ask the State to consider the proposed engagement between SCNs and health centers. We recommend that the State view favorably any applications that actively engage health centers in the SCN activities. SCNs can leverage health centers extensive experience and screening and providing for health-related social needs. Health centers are established in their communities and have built trust with partner organizations, including large and small CBOs, IPAs, managed care organizations and hospital systems to better serve their patient populations.

Infrastructure developed by health centers and health center-led IPAs can support SCNs, especially as they work to maintain waiver activities in the long term through value-based payment. We ask that the State require health center placement on SCN governing boards and ensure that any willing health center can work in partnership with any given SCN. The latter is especially important given enhanced Patient Centered Medical Home payments will be contingent on participation with an SCN but health centers will have no ability to compel SCNs to work with them. Second, we asked the State to ensure that in addition to screening for health-related social needs, every Medicaid member be screened for engagement with primary care. In instances where an individual has no primary care home, they must be referred to services and health centers will be ready to take those referrals. To truly address a whole person's needs, every Medicaid member should have the opportunity to engage with a primary care home. Funding for health centers through the waiver is paramount. While health centers are not considered CBOs for purposes of the waiver per the Q&A that was released last night, health centers must be eligible to receive reimbursement for screening for social needs and for providing social need services for which they currently receive no funding. Although health centers are paid a bundled rate, this rate does not adequately address the additional infrastructure and activities required under this waiver. In fact, it doesn't even cover current costs according to recent analysis by the Urban Institute. Unfortunately, health centers are excluded from the proposed 2% increases in primary care, behavioral health, and obstetrics because of that unique reimbursement rate. We ask the State to correct for this oversight by investing in health center reimbursement as well as the 2% increases in other areas. We're very appreciative and supportive of the State's commitment to workforce investments under the waiver. Given health centers crucial role in treating Medicaid and uninsured patients, it's essential that trainees within the Career Pathways Training Program are placed within health centers to fulfill their service commitments. We request that Workforce Investment Organizations work to prioritize the unique needs of health centers and their development of strategies and programs, and that they rely on health center partners to help them develop those programs. Last, CHCANYs endorses the State's Continuous Eligibility amendment that will provide uninterrupted care for children zero to six. We're really grateful for the State’s commitment to ensuring healthcare access to children and looking forward to the proposal's implementation. Thank you.

Okay, thank you. Our next presenter is James Sinkoff. Please, please go ahead.

So, Georgia, do we see James Sinkoff?

Yeah, I sent out a request to unmute, but I think James has to accept it. I think we're just pending that. Maybe we can come back.

Okay, our last pre-registered speaker is Meghann Hardesty.

You want to unmute her line and we can come back to James?

All right. Meghann is unmuted and should be able to speak.

Thank you.

Good afternoon. My name is Meghann Hardesty. I'm the Executive Director for Community Health IPA, which is also known as CHIPA. I want to, first, thank the Department for convening this vital session on the recently approved 1115 waiver amendment. However, we were profoundly disappointed in the Q&A that was released yesterday that indicated that FQHCs will

not be considered as CBOs in the formation of SCNs and we believe this creates a risk that the waiver will fall short of its goals of integrating primary care and social care, which is cited on the first page of the waiver approval as a primary goal of the waiver. Founded in 2015, CHIPA is New York's oldest and largest Independent Practice Association that is comprised solely of FQHCs. We represent 12 Federally Qualified Health Centers across 200 brick and mortar locations. CHIPA members provide care to approximately 600,000 New Yorkers annually, including around 400,000 Medicaid beneficiaries. Our member's efforts in managing value-based contracts have yielded substantial fiscal benefits, saving the Medicaid program over $14 million in five years and these funds get reinvested directly back into our member health centers, and in the communities they serve and not with investors or third parties. Today, I wish to underscore the critical role of Federally Qualified Health Centers in addressing health equities and bridging the gap between community based social service needs and health care. CHIPA believes that FQHCs are platforms for collaborations between health providers and Community Based Organizations that address unmet social needs and have a valuable role to play in the Social Care Networks that will be established under the new waiver amendment. FQHCs are the vanguard of social care, nurturing health equity since their establishment over 50 years ago. They play a critical role in serving historically marginalized communities, low-income individuals, Medicaid beneficiaries and people of color. On the clinical side, CHIPA's members are leaders in providing integrated care and comprehensive services to our patients. This includes primary care dental, mental health services, substance abuse, and screening for health-related social needs. These indicate in, excuse me integrated care models, facilitate early identification of health issues, timely intervention, and continuous monitoring, but beyond this comprehensive spectrum of clinical services. FQHCs address social needs that often go unattended by addressing each patient's socioeconomic, educational, employment, housing, food, and environmental challenges. As community-based providers, FQHCs have long recognized the profound impact of social determinants of health on well, and well-being and have fostered relationships with CBOs to optimize outcomes on behalf of their patients. As an example, Urban Health Plan in the Bronx, a member of CHIPA, has run a long-standing grassroots CBO collaborative called the Hunt's Point Longwood coalition that seeks to bridge services among providers of health, social, and community services. Another CHIPA member, Sun River Health, launched an organization as far back as 1987, which has provided access to affordable housing, housing navigation services, and emergency supports to families in securing stable housing, and has worked in close collaboration with Sun River since its founding. And finally, one of our members Community Health Network, CHN, operates a food pantry right within the walls of the health center. These are just a few examples among many. These innovative partnerships led by CHIPA members, and others across New York reflect the true spirit of Social Care Network provisions in the 1115 waiver. They demonstrate the commitment to integrated wellness that defines the FQHC model and there are some reasons, these are just some of the reasons, why CHIPA firmly believes that FQHCs should be crucial connectors within the Social Care Network. FQHCs are the medical and social lifeline for 2.3 million New Yorkers, over 60% of whom rely on Medicaid and the vast majority of them, nearly three quarters, live at or below the federal poverty level and 5% of them are unhoused. FQHCs have already developed significant capacity for screening their patients for unmet social needs and they have existing infrastructure for both delivering social care directly and for connecting our members, our patients, to external partners when needed. CHIPA's members stand as a testament to the foundational role FQHCs can play in Social Care Networks, our history of dedication, our scale of our impact on Medicaid recipients, and the tangible outcomes in primary and social care integration position us to significantly enhance healthcare delivery outcomes. Thank you for your consideration of this opportunity and your consideration on this matter.

Thank you. I'd like to reach back out to James Sinkoff. Are you available to present? We have you listed as a presenter.

James did send a note stating that they would submit their comment via writing.

Okay. Thank you, Georgia. That concludes the list of pre-registered presenters this afternoon. If there's anyone else that would like to present, please raise your hand, or indicate so in the chat box and be happy to unmute your line. Give folks a couple of minutes to respond.

Once again, if anybody else would like to present this afternoon please raise your hand or indicate in the chat box.

Okay, Georgia, I'm not seeing anyone on my end. Are you seeing anyone on your end?

No one on my end either.

Okay, well, with that being said, I'm happy to turn it back over to Selena to close out the public forum, public hearing this afternoon. Thank you, everybody.

Okay, well, thank you, Phil and Georgia, and thanks again to everyone for joining us today and for your very thoughtful comments and hope you have a great rest of your afternoon, take care.