1115 Medicaid Redesign Team Waiver: Extension Request Public Forum and Public Hearing Webinar Transcript
January 21, 2021

Donna Frescatore and others, I have overseen the waiver management and submission process for the Medicaid program and we're here today for the first of two public forums and public hearings and we'll describe the difference between the two, but this meeting is serving a joint purpose in connection with the extension request for the 1115 Medicaid Redesign Team waiver. Before we begin, I'll hand over the mic over to our Medicaid Director, Donna Frescatore, who will give an introduction, and then hand it back over to me. So, Donna..

Thank you Brett and good afternoon everyone, this is Donna. Thank you for joining us this afternoon, and I'll be very brief because really the purpose of today's public forum and public hearing is to hear from all of you, so we thank you for your participation. We want today to just do a very brief overview of the 1115 waiver, both generally, and specific to the MRT waiver, formerly known as the Partnership Plan, which has had a couple different names overtime, and then talk a little bit about some of the current waiver and then set our with on the Centers for Medicare and Medicaid Services. The extension of the interesting waiver, which I think I should note, expires on March 31st of 21, and then talk just very briefly touch on kind of the future vision as we currently see it, for waivers, 1115 waivers, here in NY Medicaid Program. I'm joined today by Brett Friedman, who started us off and is the Director of Strategic Initiatives and Special Medicaid Counsel in the Office of Health Insurance Programs. Also joined by Amir Bassiri who is the Medicaid Chief of Staff and Greg Allen who is the Director of Program Development and Management, which supported today by many other OHIP colleagues, including our waiver management team, Phil and Simone, thank you for helping out, and Georgia, thank you as well from our communications area to help make things smooth for everyone. Brett, why don't you take it away and we'll move through the agenda and then look forward to hearing from all of today's participants. Thank you all.

Thank you, Donna. That's correct, we'll keep the presentation itself, short, and join you on the purpose of the forum and hearing, and then really, as Donna mentioned, the goal today is the hear comments from you. And we have a number of pre-registered commenters, but we'll also open up to those who are pending, who haven't pre-registered, so we can solicit and receive all the appropriate comments in connection with the renewal. As Donna mentioned, this both serves as a public forum and a public hearing. A public forum, and we'll again, we'll go on more, is a required federal regulation that every year during the duration of 1115 demonstration, we have to

hold a public forum, in which the public can provide feedback and comment on the waiver itself. And a public hearing is not this similar, but it is the only connection with the extension or renewal of an existing 1115 demonstration and it must occur at least twenty days prior to submission or the application itself, and so we were meeting our CMS, federal transparency requirements through holding two public hearings in connection with the submission of our labor. On the public forum side, we will discuss that this is a virtual hearing on past extensions, we'll give an overview on 1115 waiver authorities, our waiver itself and then some of the amendments that are pending under the current 1115 waiver. And then for purposes of the public hearing, we'll discuss the contents of this extension request specifically, the Pharmacy Carveout, the MLTC Transportation Carveout for non-emergency medical transportation services, where we think the future of the waiver is going because as described in a preview conference we had back in November, this waiver is simple by design, and we'll discuss why and how they relate to t-tractions, we'll talk about next steps in terms of the time frames and submissions for the waiver amendment and then we'll go into real public comments and provide you resources for questions should you want additional information on the waiver itself. So, can you turn to the next slide, please?
As I mentioned earlier, this is a special virtual public hearing. In non-pandemic times, we would hold these in person, and we would hold them in different parts of the state. And we would want you to see our faces and we would see your faces with appropriate accommodations, so that we could solicit the appropriate feedback and comments on the waiver. Given that we're in the amidst of a pandemic, and we do not want to congregate, we want to adhere to social distancing guidelines published by both the CDC and the state, and with the expressed authorization and approval of CMS, we are holding these hearings virtually via a synchronize visual or audio modality and with the ability to provide a forum through the WebEx platform to be able to give commenters the ability to provide comments through those channels. As I mentioned earlier, this is both a public forum which is going to flip the comments on the progress of the demonstration, so there's typically an annual public hearing process and you can tell us what you think about the nature of the way the current demonstration is going, as well as the public hearing, which will give you an opportunity to provide comments on the new aspects of the demonstration. For purposes of making your comments, it doesn't matter, you should just provide your comments to us, whether it's on big components of the waiver or what's being proposed as part of the amendment. There's no formality as to which is a forum or hearing, but we ask those requirements under the federal law, and so, you know, this qualifies as both. For accommodation purposes, we are recording this public hearing and public forum, so please be aware of that. If you ask questions and if you're not comfortable being recorded, you shouldn't ask questions. Given that it is recorded, we are going

to post the recording on our website, we will transcribe it and it will be available in multiple languages, should people request it. Next slide, please.

This slide provides a very brief overview of what is a 1115 Demonstration Waiver. Section 1115 refers to a provision of the federal Security Act that authorizes the Center's for Medicare and Medicaid Services to approve demonstrations and those demonstrations grant states, like New York, the flexibility for innovative projects that advance the objectives of the Medicaid program. And specifically, it gives the Secretary of HHS, who usually delegates to CMS, the authority to waive certain provisions and regulations for the Medicaid program. The typical things that are waived are things like state wideness, so we would do things in a state plan and then if it's going to apply statewide, or if it doesn't restrict beneficiary frame of choice. Those are core tenants of the Social Security Act, but overtime, we've wanted to do things say, that are regionally focused or regionally saved in, or that apply to specific populations. If we want to do it that way, we have to do it through a Section 1115 Waiver at the demonstration project, rather than as a state plan amendment or through another federal authority. It also is really important because it permits Medicaid funds to be used in ways that are not otherwise allowed or what people call, "matchable." So, if we want to pay for things that the Medicaid program is part of the federal Medicaid mandatory or optional benefit design would pay for, we can get federal match for things that we couldn't get under a state plan. Our DSRIP program was a very good example of that, in terms of paying for deliveries assisting transformations in services that wouldn't be possible through the existing Medicaid program, but were possible through a demonstration because they advanced the objectives of the Medicaid program. A waiver is not required to toggle services from 1115 through state plans or state plans through 1115, necessarily because services that are already existing or optional Medicaid benefits can be approved under our state plan authority. That is an important distinction as we navigate the parameters of the 1115 process. Typically waivers are approved for three to five years, although, those of you who follow waivers closely in the news have probably seen as these previous CMS administration has left Washington, they approve certain waivers in states that will pursue policy objectives that further the previous administrations goals as being ten years in duration. Those ten-year waivers are uncommon and although we thought that we'd ask CMS for a ten-year waiver here, waivers like ours were not ones CMS would approve for that specific period of duration. Next slide, please?

In terms of the components of an 1115, there are really two aspects that they are calling out. The first are the Special Terms and Conditions. These are the outlines of the agreement that we have with CMS as to the obligations and authorities under the waiver. Our waiver, given that it has been around, I'll mention, since 1997, has hundreds and hundreds of pages of STCs that govern in

different problematic aspects of the waiver, but when you talk about the STCs, you talk about the conditions that CMS places on our authority to claim federal match, or two waive the state wideness, or to bring a beneficiary of your choice or other aspects that are waived for purposes of what goes into our 1115. The FCC requires that we file quarterly, and annual reports and we conduct an independent evaluation at the end of the demonstration program, which we have done in connection with this demonstration renewal. The other critical aspect of the 1115 waiver is that we must be budget neutral to the federal government. So the demonstration of budget neutrality is the critical component of any waiver, in that, the amount of money you would spend under the authorities through the waiver are no more than what you would have spent absence the waiver. And so you have a trended baseline, or a trended base of Medicaid important expenditures and you have to predict what your expenditures will be under the waiver and you have to show CMS that they are less than the program would have spent without the waiver. One note here too, just to distinguish 1115 waivers from other waivers; 1115's are only one type of waiver we can seek from CMS to provide flexibilities under the Medicaid program. New York has a number of what are called "1915c" waivers. These a specific to authorizations of home and day services, and so all quote on quote waiver services that are provided for the OPWDD programs, those are not covered by this 1115 waiver. There may be aspects of this CMS authorization that touch on OPWDD services, but when you think of the OPWDD, the web-tab, the (inaudible), and the pseudo-services that OPWDD certifies and regulates as waiver services, those are not covered by the 1115. There are also other waivers that New York State does not use, like 1915b Managed Care waivers and it's important to understand that because it's a part of our negotiations with CMS over previous waiver amendments, the previous administrations guided us to use the 1115 waiver as quote on quote waiver of last resort, which means they would only seek an approved 1115 waiver authority if you couldn't do so on your state plan, if you couldn't do so on your 1915b or 1915c. Insuring that we still have this baseline of 1115 waiver demonstration authority to pursue real innovation in our Medicaid program is critical but it's not the only source of waiver authority that governs the Medicaid programs, including OPWDD services, our children's services and our traumatic brain injury and nursing home transitional diversion. Those are all 1915 waivers that are not covered by this renewal. Next slide, please?

So, New York's 1115 waiver, as Donna mentioned, is now called the Medicaid Redesign Team waiver. It was renamed about five or six years ago. When it was initially approved by CMS in 1997, it was called the Partnership Plan, and we renamed it because many of the programmatic reforms over the last eight or nine years were derivative of the first Medicaid Redesign Team process and were reflective of their recommendations, which helped redesign the Medicaid

program until now. The last time our MRT waiver was renewed was on December 6, 2016 and it was a five-year approval, ya know, a little less than a five-year approval (through March 31, 2021). That means that within about two months' time, our waiver would otherwise be set to expire, and we'd have to wind-down all of the waiver authorities or all of the programs that already 1115 waiver authorizes. This reveal was critical to preserving the things that are in our current MRT waiver. The goals of the waiver which are consistent with the Social Security Act and MRT authorization is to improve access to healthcare for our Medicaid population, improve quality of healthcare services delivered, to expand access to family planning services, and to expand coverage, although most of our coverage expansions are through the managed care efficiencies, but were not done through our waiver, they were caught up by through other authorities. For example, for family planning services program, it is the source of certain coverage categories, although it's not really, as I mentioned, the primary source of expanded coverage in New York State. Next slide, please?

Our current MRT waiver authorizes some very fundamental elements of our Medicaid program as it looks and feels today. The first is, it is the sole basis of authority by which we pursue Medicaid Managed Care. Mainstream, HARPs, HIV, SNPS, and MLTC are all authorized by virtue of the 1115 waiver. Without the 1115 waiver, we'd have to find other authorities and mechanisms through which to govern our agreement with CMS for purposes of putting a significant portion of our Medicaid population into Managed Care. The 1115 waiver was also the umbrella and the source of authority for the DSRIP Program, with which I expect many attendees on this call are intimately familiar, but for the five plus year in which DSRIP was in effect, it was governed by components of this massive 1115 document and as people know it provided incentives for providers to create and sustain integrated, high preforming delivery system. The DSRIP component of the MRT waiver expired on March 31, 2020, a year before the larger MRT waiver was due to set to expire. As folks know, and I'll discuss in a few other slides, we tried to renew the DSRIP component of the 1115 waiver back in November of 2019, and CMS did not act on that renewal application. Next slide, please?

When a waiver is in effect, CMS permits a state to amend the waiver, and this is a critical aspect. So, apart from the renewal of the larger term, which is what's happening here today, we can at any time seek programmatic amendments to the waiver itself – Add, take away, modify programs that impact and further the goals of 1115. And so we have, coming out of the MRT II process last year, three pending 1115 waiver amendments that are in front of CMS and being considered, even as the waiver is otherwise set to expire. These are the transition of behavioral health and community-based services, to behavioral health for adult rehabilitation, restricting the authorities

for certain behavioral health services. That was submitted on September 2, 2020. We have changes in the eligibility requirements for Managed Long-Term Care. That was submitted on November 10 and is currently under review by CMS. We are changing certain of the authorities to permit Medicaid Manage Care enrollees to being default enrolled and so that's consistent with our larger duals integration strategy, so if you are aging out of a mainstream plan and you enroll in the affiliated duals special needs plan, which is the Medicare Advantage Plan, out of the mainstream plan, it permits you to being default enrolled so that you can stay in both plans and have integrated coverage for both Medicare and Medicaid. That was also submitted on November 10. Those have been submitted and deemed complete, they are under review by CMS and they've undergone public comment and we incorporate public comment in those submissions. On the approval of these amendments, if not conditioned on approval of CMSs waiver, but we want to ensure there's a term to accommodate those programmatic changes. The next slide, please?
So, we're going to move on to talk about what's in this current extension request. The next slide, please?
Just to orientate you in terms of our efforts, I referenced them in a prior slide, but when DSRIP was set to expire on March 31, 2020, about four or five months before consistent with the CMS requirements for submitting applications for renewal, we saw a four-year DSRIP extension. We submitted a comp-granted waiver application in November 2019, right before Thanksgiving, for CMS to consider in connection with extending the DSRIP program for a year to align with the larger expiration of the MRT waiver and to have an agreement for another three-year expansion for a modification of the DSRIP Program in ways that were clearly delineated in that way for applications. We submitted to CMS and CMS in February 2020 declined to negotiate the DSRIP extension and renewal request. That aligned, we thought, with the federal priorities of that CMS administration. That they weren't interested in DSRIP or DSRIP-like programs anymore. They viewed the 1115 waiver as last resort, and it didn't align really with where the federal government thought our Medicaid Program should be headed. While they declined to negotiate, we were left to think through what our waiver would look like and shortly thereafter, as folks are aware, in March of 2020 the pandemic hit New York State very hard, and shortly thereafter, CMS gave states an opportunity under section 1115 to seek emergency 1115 authorities to help with the pandemic response. In connection with that, State Medicaid wrote a letter, New York State submitted an emergency 1115 waiver application that among other things, saw a one-year administrative extension of the MRT waiver, so instead of expiring on March 31 of 2021, they would expire in 2022, so that we could have sufficient time to think about the way the pandemic would impact the nature and design of our Medicaid Program and form a more comprehensive,

COVID-informed ask of CMS. CMS declined to provide a one-year administrative extension. They had the authority to do so, but didn't believe it was in their best interest, and so, in June of 2020, we were left to virtue of the normal process for extending a waiver which takes six months. By virtue, we had to meet all of the transparency requirements and federal regulation, we had to start doing a waiver for renewal to avoid the expiration of the waiver and losing all the authority for our Managed Care Program and everything the 1115 waiver authorizes. So, in conjunction with CMS we worked through to develop a three-year extension proposal, which was designed just to preserve, not to change, but to preserve the 1115 waiver authorities. So, we started that in June and since June, we've been working on the process that we're discussing today. Next slide, please?

In light of that message of preservation, the current extension proposal includes three components. First and most significantly, it's a three-year extension of the existing special terms and conditions and funding under the MRT waiver. We started this process in June before the election, before we knew if there would be a new administration and what it would look like and we couldn't risk expiration of an 1115, so first and foremost, we wanted to just make sure the term would continue and we wouldn't lose the authorities because again, once you extend you can always amend. The three-year extension was done at the recommendation of CMS because it is the most common period for a renewal, and they thought it would result in the most rapid approval of the extension request. We also use this opportunity to make subsequent changes to the 1115 waiver. Really designed to modify the STCs to reflect two recommendations of MRT II, which was to transition the pharmacy benefit from Mainstream Medicaid Managed Care back into fee-for-service where it existed historically and to transition the non-emergency medical transportation benefit that's within the current MLTC benefit package back into fee-for-service, which along with other MRT II recommendations, with regard to that risk transportation broker. Doing these carveouts within the larger MRT renewal allows us to achieve implementation around the dates that were proposed and recommended by the MRT approved in last year's budget. Next slide, please?

Just to reiterate once again, this approach merely extends the current programs and waiver authorities to preserve Medicaid Managed Care, MLTC, HARP, the limited components of the Children's HCBS that were approved under the 1115 just mentioned in 1915c and other programmatic features that exist in the 1115 MRT waiver. The reasons for what's a relatively, and I'll say this, uninteresting waiver extension is that it's designed to preserve the way of waiver programs and helped us lay out the changes in presidential administration and CMS leadership, with the belief that a Biden administration's Medicaid priorities would be similar to the historical

nature of our 1115 waiver program to use the 1115 waiver authority more flexibly then what's conveyed by the Trump administration. It provides us additional time to consider the longer-term impacts of COVID-19 on US healthcare delivery system. Some of the initial thinking there was reflecting on a 2020 submission, but the COVID-19 had laid there several gaps in our delivery system that would allow the 1115 waiver authority to be an effective tool to which to make meaningful Medicaid change on a three to five or greater your cycle to think through how to arm our providers, our plans and other more effectively for pandemic response and it allows the pending, which we discussed, and anticipated 1115 waiver amendments to be reviewed and approved constant with implementation goals and targets. And this is reflected because in the event that CMS didn't approve a 1115 waiver amendment or it expired, we wouldn't be able to make those, you know, many of those programmatic changes that we discussed on the previous slide. Next, please?

So, I'll hand it over to Amir who will go through and then I think Greg follows on the Pharmacy and Transportation Carveouts, respectively. So, Amir…

Thank you, Brett and good afternoon everyone, my name is Amir Bassiri, I'm Chief of Staff to the Medicaid Director, and I'll give a high-level overview of the Pharmacy Carveout. The Pharmacy Carveout was a recommendation that came out of the Medicaid Redesign Team II and was enacted in as part of the state fiscal year of 2020-2021 budget and among other things, this will actually provide the State with several benefits, including full-transparency and visibility into prescription drug costs, administrative efficiencies that are achievable under the fee-for-service system, optimization of federal rebates through a single, unified drug list; centralizing the Medicaid programs negotiating powers to leverage additional rebates from drug manufacturers; and addressing associated reductions in State rebate revenue from the growth in the 340B program. Next slide, please.

During budget negotiations last year, the state and the legislature recognized the importance of the 340B program, too many safety net providers in New York State. As part of the final legislation, several things were included related to the 340B program, which resulted in one; the establishment of the 340B Advisory Group, which was charged with providing non-binding recommendations regarding the reimbursement of 340B drugs, and the states goal in establishing the Advisory Group was to ensure representation from all provider types and geographic regions, and we included all types of 340B providers as well as health plans and pharmacies. It also established a recurring reinvestment of $102M to directly support safety net providers, to preserve critical services that are currently funded with 340B revenue. This funding stream is recurring, meaning that when the pharmacy benefit is transitioned on April 1, this spending is carried forward

in future years. When the benefit is transitioned to fee-for-service, many things will remain as they are today for 340B covered entities. For instance, covered entities will continue to purchase 340B medications and drugs at reduced prices. Covered entities will also continue to receive any margin they currently receive on 340B revenue with Medicaid-covered, physician administered drugs, as well as any 340B revenue they receive from other payors, that being Medicare or commercial insurers. Also, very important to note, that Medicaid members will continue to have access to their medications regardless of whether 340B drug stock is used or not. The tagging of the claim of 340B is not visible to the member and will not result in any disruption at the counter when members pick up their medication. That's a brief overview of the Pharmacy Carveout. I will hand it over to Greg Allen to talk about the Transportation Carveout.

Thank you very much, Amir, and thanks everybody for joining and dedicating this amount of time and big shout out to Brett and Amir, for I thought, very clear descriptions, especially Brett, probably the best, easy to understand description of the various complicated contours, of as you say, somewhat uninteresting territory on the waiver, but I thought that was just an excellent overview, so hopefully everyone enjoyed that as much as I did, or at least close to as much as I did. So, MLTC Transportation Carve-out, so, many of you that have been following the MRT know that we have been working on recommendations for a few years now, some of which was advanced by many of the Managed Long-Term Care Plans, to move the transportation benefit out from underneath those plans and into fee-for-service. There was a concern that the non-emergency transportation benefit has become more difficult to manage over the years. We have a very large, and I would say, successful stand-up of assuming that responsibility for the Mainstream Plans several years ago. Through our managers and that will be transitioning into a broker, which I will talk about, ya know, we have been able to do a statewide standup of a very robust Medicaid transportation management business, we've moved trip ordering online, we, you know, have a member satisfaction feature, we resolve problems very quickly, and some of the MLTCs were struggling because many of them are smaller and contracting this work was getting, ya know, more difficult. That said, I will say, there are some plans to build very critical features for transportation, weaving together day services, etc., transportation, we will work really hard to maintain those capacities as part of this transition, just as we did when we transitioned the much larger Mainstream benefit. You know, the benefits here, laid out in these boxes, we're able to then create sort of, a more consistent management of the benefit across Mainstream Managed Long-Term Care and fee-for-service, in one-book business and what Amir laid out is the strength from the Pharmacy side. We know we can greatly reduce costs, many of the plans were smaller, didn't have enough market leverage to, ya know, provide efficiency, so the fee-for-service rates and

those may be able to be negotiated by a broker will likely be lower and what we will not specifically lay out as part of this action, we are moving from a non-risk based arrangement with our transportation manager and the plan is to procure a transportation broker, which would have some very carefully articulated and monitored risk arrangements, so that the broker would be able to get some value a work by increasing payment where quality is increased and decreasing payment where there are quality issues, and also potentially building a more robust network. This definitely creates a larger pool of our available, you know, members here, meaning that we could begin to align public transit routes a little bit better, begin to do, you know, ride shares to shared locations and again, that allows us to, you know, become more efficient and lower costs and hopefully increasing a relatively high member satisfaction that we've been enjoying as we've been moving forward. There's a piece on the bottom here just reminding everybody, we're not changing the transportation benefits, or the eligibility for that benefit, the scope of the benefits. We'll still have public transit, taxi, ambulette, no changes on cost sharing, so this really is an assumption of the benefit by fee-for-service for Managed Long-Term Care. Our plan pushes us out a little deeper into the year to give us a little time to work on some of the axis issues with the plans, but just wanted to make you aware of that and I think I'm turning the microphone back to Brett here, so thanks everybody.
Great, thank you, Greg. Yeah, if we could into the next slide, we'll get to the more exciting elements of this. We've been receiving a lot of public comments already, since our waiver application was posted publicly, I think it was on or about December 10 with the state register, and it's available on our website and we'll have links at the end, but a lot of the comments have focused on the fact that we are merely extending our waiver for a three-year period, but we're not doing anything, other than the two elements we just discussed, we're not doing anything new programmatically. All our DSRIP, even other initiatives, like criminal justice reform, or other aspects we've introduced previously, and again, that's by design. The purpose of this renewal is simply to have worked with the prior CMS administration, to ensure that our waiver didn't expire, because that really would have been, for all the reasons we've discussed, a dreadful prospect for the nature and design for our Medicaid program. But once the waiver is renewed, we can then amend it and we do very much plan, and as those, you know, suggested, in recent press conferences is this week, we have, you know, we are in the planning process as to think through what our next, big ask will be of the Biden administration to align with federal and state priorities. And this slide, highlights what some of those things will be. Whether its developing longer-term COVID-19 pandemic responses, given the gaps that the pandemic has showed in connection with our delivery system, especially the impact that the pandemic has had on black and brown

communities and other historically communities with access or health equity issues. The ability to turbo charge or further sustain movement to VBP, including higher-level VBP arrangements and global payment arrangements within specific regions. The ability to make good on our commitment to fund the social determinants of health and to promote interconnectivity around CBO's and social determinants of health in the fabric of our delivery system, which has been critically important to the pandemic. All of those things will inform on the next new 1115 waiver amendment, so we will renew and then we will amend and we are in the process now of soliciting input and thinking about what that next waiver amendment will look like and we are also analyzing the statements coming out through the Biden administration and what's important to them in connection with the Medicaid program to make sure that we can submit a proposal that does what DSRIP did for our delivery system back in 2014. Next slide, please?

These are the next steps, just in terms of timing on where we stand with this renewal application. The public comment period began on December 16, 2020, we received many public comments already and we encourage written submissions so we can log them and them distribute them appropriately through when we go ahead and submit our waiver application. It's important to know our waiver application is not yet in front of CMS. CMS is aware it's coming, they've reviewed it for completeness and for technical accuracy, that it contains all of necessary component parts, but it's not a pending waiver application or renewal application right now. It first needs to go through public comment, which started on December 16, consistent with the federal authorities I said earlier. We have to hold two virtual public hearings, the first is today, the 21st, the next is next week, for the same sort of block of time. And we'll continue to go through public comments through these hearings. We then, once all of those public comments are collected and we assess them and incorporate them in the draft application that we published publicly, we will submit it to CMS in early March. I think our targets initiative's about March 5, and what that does is it gives CMS time to review the application and deem it complete, which takes about a week or two, before the waiver expires. We're hoping, given the simplicity of the waiver, that they can approve it relatively quickly on or before or around the date that our current waiver expires so we have continuity, but even if they don't approve it when our waiver period ends, we will go into something called a period of temporary extension, which is a familiar fate our waiver. We've been in temporary extension before. It's just means that CMS has not formally approved, but our waiver remains in effect because we've submitted an ongoing application. And then, incase CMS does approve it, that approval will be restored April 1, 2021, and we'll have until 2024 before we have to go through this whole rigmarole again and do a whole application and the intermate evaluations and the transparency. CMS makes these processes very sequenced and (inaudible), because these are

really special demonstrations that CMS grants, so we'll have to go about doing it six months before 2024. Next slide, please?

So, we are entering the public comment portion. I spent a long twenty minutes going through this, but I hope the background was helpful. I'll hand it over to my colleagues in Waiver Management Unit, but just a few notes here: This is a public comment period, it's not a question answer session. You can ask questions as part of your public comments, but we will take back and work to respond to through either, I think using the website or in the revised waiver application, itself, but distinct from the public sessions that Amir held with the Pharmacy Carveout, and that we've done on the Transportation Carveout, this forum today is not design to have a question and answer dialogue. It's really designed for different participants to use this forum as a way of telling us their beliefs and what they think and whether we're in the right direction or the wrong direction or any other aspects of the proposal itself that you think we should be mindful of as we work this into the final application. We know that, and consistent with what was in the state register, there was a registration process for comments, and I know many of you have used that registration mechanism. My colleagues will use that list in the order in which people registered to call in people and unmute them, and then you can make your comment. You'll have a maximum of five minutes and we'll give you a minute warning. Once we go through the list and get a vote of how many people were on the list, we will allow folks to either, in the Q and A box, or if you look down to the bottom right hand side of your WebEx platform, you'll see a little icon that looks like a hand and it you click that button, it will say you "Raised Your Hand" we can use that to find you and unmute you so you can make your public comment. And we are happy to hear from anyone that is in attendance on what public comments they have. They are critically important to us as we work with CMS in terms of achieving this waiver renewal, again, your feedback is important to us and we want to make sure it's heard and we're here to hear it. So, Phil, thank you for taking it over and let me know if I missed anything in terms of the orchestration here.

Thank you, Brett. Ok, next slide? Once again, my name is Phi Alotta. I work with the Department of Health in the Waiver Management Unit. And I'm just gonna provide some housekeeping details to help guide the public comment portion of this hearing today. As Brett indicated, there is a list of pre-registered commenters in a particular order and you will be called on to speak. Currently, we have about eighteen commenters registered. A member of the DOH team will call your name and manually unmute your line to allow you to provide your comment. Please specify if this comment is regarding the current waiver for the Public Forum, as Brett mentioned earlier, or the waiver extension for the public hearing. Comments will be timed, please limit your comments to five minutes to ensure everyone has an opportunity to speak. Written comments will also be

accepted through February 6, by email and you can email 1115 waivers at 1115waivers@health.ny.gov or by mail at Department of Health, Office of Health Insurance Programs, Waiver Management Unit, 99 Washington Ave., 7th Floor (Suite 720), Albany NY. If we were in person, many of the commenters would leave their written testimony with us outside the room, but this is a little different this year, so we urge you to email or mail hardcopies of your public comment. Ok, next slide, please?

Questions or comments for further information, once again, please feel free to contact this 1115waivers@health.ny.gov. Next slide?

This is just a resource page of different links to the MRT waiver website: MRT II, Managed Care, Pharmacy Carveout and Quality Strategy. As mentioned earlier, the slides and transcript will be available we anticipate within the next three to five days and will be posted to the Department of Health's website. And we can notify folks via MRT LISTSERV that that has been done. So, follow-up and circle back with the slides. Next slide?

OK, so this is just a slide that we've inserted here just to remind folks that there's a minute remaining. For those of you who would have been in person, we would have someone actually hold up a sign that says you have one-minute remaining. And then finally, I think the final slide, 23, is just and indication to folks that your time is up, once again, limiting comments to five minutes to ensure that everyone has an opportunity to speak. As I mentioned earlier, we have about 18 speakers in chronological order here and happy to introduce the first speaker, and that is Amber Decker. Amber Deck, please provide your comment, you're the first speaker this afternoon.

I believe Amber may have left. She did make a note that she provided some comment in the chat.

OK, thank you Georgia. We will move onto our second speaker, Judy Westler. Is Judy Westler online, please comment. Yes, I am. Thank you.

Yup, I spent five years as a member of the payoff, the public over-sight body as the assembly rep, and also have been actively involved with communities together for health equity, so my statement comes out of that experience. There are some major issues I raise and continue to raise and that's equity, cultural, access issues and community contracts. Most of these were on the breach and focus on hospitals. There was some good that happened during DSRIP waiver, but not reach enough communities to make a difference for an over $8 billion expenditure. So, the recommendations, this is for the next iteration of the waiver, that money should go to communities, not to hospitals. The focus should be on the issue that I just said, and that there should be continuation of funding with general net worth. There has to be a focus on community health and prevention which has been poorly lacking. There's a need to address the current disparities and equity. I've been amazed at the lack of any attention to that or commenting on that

in this waiver and we hear statement about how necessary important particularly under this pandemic, but it hasn't happened. There needs to be a plan for equity. Another piece is major planning has been done at Northshore, and like NYU, Northshore couldn't even meet the minimum safety nets standards that were set by the state health department to become a PPS. So, leaving a major part of the planning in their hands is telling us that the concern about safety nets and about equity and the alike is just not getting the attention that they need. We need to go back to three regional networks that were funded and set up with a great opportunity to much to our surprise although, many of us push for it there is a good dollar amount that was attached to it, but unfortunately, clearly, it was maybe meant as a stop and unfortunately, was not continued even though that is the best way to have some planning coming from communities, rather than what seems to happen there, which is coming from the governor's office from the state health department, but more unfortunately from hospitalist associations and major hospital networks. As long as that continues and the community doesn't have and option and a say, an involvement, we will continue to have the kinds of problems I cited about and lack of attention, equity and other issues. I have a comment to myself, say the safety nets, which is not happening and also I understood that there is a completed evaluation, but even as a member of pay-off, I haven't seen it, so I am officially requesting a copy of the full-evaluation on the DSRIP experiment and I will submit these comments in writing. Thank you for the opportunity.

Thank you very much. We appreciate these comments. Yeah, I'm sure.

Thank you, Judy. Next commenter is Latisha Gibbs. Please provide comment, thank you.

Hello, I'm Latisha Gibbs. I work for Help People, we're a community representative health-based organization located in South Bronx. What I wanted to speak about is the current state that New York State is currently in, especially with New York State facing COVID-19 pandemic. You know, among the nation, is more, you know, now than ever, that it be more indiscreetly urgent for the 1115 waiver to include evidence-based taxes that have been proven to significantly prevent, reduce and control the alarming increasing rate of chronic diseases, especially among the black and brown and immigrant communities of color. I say this because it has been proven equities of health during this whole COVID-19 pandemic, the alarming rate of deaths among these communities, shows the high rates of inequality of healthcare given to these communities. I believe that the inclusion of self-evidence-based programs would be more so under control and we can really educate the way to take care of themselves and get to those vulnerable populations as we always do because we are the front liners. As mentioned, during the DSRIP process we did have a lot of success working with some of the programs; however, I urge that more of the funding go to community-based health organizations, because none of the DSRIP projects would

have been ever accomplished, without the help and inclusion of community-based organizations. I believe and strongly believe, coming form a Medicaid constituent, that with these type of programs, that are put into place and have been proven to work over and over again that the death that we face during this COVID-19 pandemic could have been subsided, especially among the vulnerable community. So, I urge that this 1115 waiver not only includes more funding to the community-based health organizations, also create more access to care and more evidence-based programs that the community-based organizations deliver. Thank you. Thank you very much.

Commenter number 4, Terry Junjulas, I apologize if I mispronounce anyone's name. Your line should be open.

No worries, you got it right. Thanks so much to have to opportunity to speak today. Are you hearing me OK?

Yes.

I think that was yes. So, my name is Terry Junjulas and I'm the Executive Director at the Albany Damien Center and I'm also a New York State resident who's been living with AIDS for the past 25 years. I am alive today because of the investment New York State has made to our HIV continuum of care and will be forever grateful for those investments. I owed my life to them. The Albany Damien Center that I run is a community-based organization that is a 340 BMC that provides non-medical services and uses the 340B savings to fund food and meals, housing and transportation, access to medication and medical appointments, for hundreds of persons struggling with HIV and AIDS in the Upstate Capital Region. These services are critical to keeping people with HIV and AIDS on their medications to reduce their viral load, because science has shown that when you reduce a person's viral load, it can prevent mortality from AIDS and prevent the transmission of HIV which creates new HIV infections, and that we can certainly not take our eye off of. I am strongly opposed of the 1115 waiver request, as this waiver is a deviation from federal law with respect to the New York State Medicaid program as it applies to the 340B drug discount program. As we heard, New York State is requesting in the waiver to carveout Medicaid claims from 340B entities in New York State starting on April 1. The carveout proposal contains the 1115 waiver request would have severe and harmful impact on the providers, such as the Albany Damien Center and the people we serve. I see the MRT proposal as not only a significant deviation from federal law, but worse. Undermining the benefits and purpose of the federal 340B program will underserve communities during this unprecedent COVID pandemic. It also decides the executive orders signed by President Biden, yesterday, on advancing racial equity and support for under-served communities to the federal government. As the overwhelming majority

of persons receiving services under the 340B program are from very low income black and brown communities. This is a time for equity, and this is also a racial justice issue. Any part of the 1115 waiver request that is in violation of this executive order, needs to be rejected. We're also alerting you to the fact that the state has notified us last week, that we will begin this transition next month, well before the waiver will be submitted to CMS for review. I will note that the state has offered a $102 and million to help our 340b agencies. Unfortunately, this amount does not come close to the estimated $250 million we are set to lose. Additionally, as of today, we still have no information about how this money will be disbursed and we are unable to adequately plan for an event that will happen on April 1, which is just a few short months away, or as I say in executive planning world, it essentially is tomorrow. The 340B Advisory Group referenced by Amir additionally did not finalize any recommendations because the agencies affected by the carveout walked out in the process as they were not being heard or respected throughout that process. I furthermore disagree, that people will still have access to their medications. If you do not have food, if you do not have housing, if you cannot have access to mental health/substance use services, you will not be able to get your medications. We are the agencies that provide this access to these medications. Take us of the picture and people will not be able to access healthcare. They will see increased Medicaid costs to avoid ER visits and hospitalization and we will have more deaths. In conclusion, I'm requesting the rejection of this 1115 waiver request to prevent the loss of life and the destruction of our 340B safety net systems that will result from the changes to 340B. Thank you again for the opportunity to speak today.

Thank you.

Alright, thank you. Speaker number five Anthony Randolph. Your line should be open.

Hello, can you hear me? Yes. Yes, Good afternoon, my name is Anthony Randolph, and I'm writing to provide comments on the State's MRT 1115 Waiver Extension request. As I said, my name is Anthony Randolph and I'm a member of Amida Care HIV Special Need Plan and I receive services from Harlem United, located in New York City. I'm concerned that the State is seeking approval to carve-out the medical pharmacy benefit from managed care to fee-for-services. This change will put the lives of Medicaid recipients like myself, and other community members, and health care centers like Harlem United, and my health care plan Amida Care work together. And umm, I'd like to say that, they work and make it easier for me to stay in good health by resolving problems when they arise without unnecessary delays. I had trouble filling a prescription, I got sick, and went to the pharmacy. I needed to have it filled immediately, and there was an issue. I called Harlem United to my case worker and while I was sitting there, Harlem United called Amida Care, who got in contact with my doctor, who got in contact with the pharmacist. When the

pharmacist approached me again I thought he was going to ask me to leave. He said, Mr. Randolph your medication will be ready within 15 minutes. Now under the carve-out plan, Harlem United and Amida Care would not have been able to help me to directly. Instead I would have had to call a 900 number, an 800 number, with thousands of other people. By the time the issue is resolved I wouldn't have needed anyone to help, it would've been too late. When I had, I'm sorry, I just can't understand why the State would make it harder for me and my community to access care. Especially during the middle of HIV and COVID pandemic that's effecting low-income black and brown communities like mine. The change will prevent health centers from benefitting from the 340B drug discount program, resulting in loss of funding for the very services that is critical. This will touch so many lives. Mental health, housing, people that need food. These programs like Harlem United and Amida Care are what we need in the community. So why take them out of the community? Why make it harder for them? I'm here today because of Amida Care. I'm here today because Harlem United cared enough to help me. When I was in the hospital with COVID, my health center was the ones that helped me back on my feet. I get housing through them, I get mental health through them. Amida Care my health plan steps in when there is issues. All of this will be lost. And I don't understand why. The Governor and the State Legislators have to know that, how much is my death worth to ya'll? How much I our death worth to ya'll? Because someone will die because of this. Why? Thank ya'll very much.
Thank you. Ok thank you, ah, speaker number six, Charles King. Your line should be open. Hello I just want to check, can you hear me? Yes, we can hear you. Yep, we can Charles. Ok thank you. So yes, Housing Works appreciated the opportunity to comment on New York State's draft request for the year extension of the 1115 Medicaid Redesign Team Waiver Demonstration, which we understand is set to expire at the end of March. While Housing Works is generally supportive of the intention of the existing waiver to improve the program while containing costs, we want to voice our strong opposition to the proposed amendment to the waiver to include the transition or carve-out of pharmacy benefits from Medicaid managed care to fee-for-service. Housing Works is a covered entity under the federal 340B drug discount program and if New York State implements this carve-out we estimate that Housing Works and its clients will serve to lose at least 10 million dollars annually in 340B savings that we currently rely on to deliver effective health care and provide a range of critical but otherwise unfunded or underfunded services to low income communities we care for. Housing Works is the nation's largest community based services organization founded in 1990 with the mission to end the dual crisis of homelessness and AIDS through advocacy and the provision of life saving services. We operate four community health centers and were planning to expand and open two additional in medically underserved New York

City communities providing an integrated model of care that seeks to provide emotional and physical health to the most vulnerable and underserved New Yorkers facing challenges of homelessness, mental health issues, substance use disorders, and incarceration. Like the 70 plus federally qualified health centers in New York State (inaudible) our centers are a critical component in the healthcare delivery system providing high-quality and patient centered and community based primary care to anyone who needs care, regardless of their ability to pay, as well as behavioral health services (inaudible) in a culturally and linguistically appropriate setting. Housing Works currently invests 340B savings that support otherwise unfunded or underfunded services necessary to improve access to quality care and to address barriers faced by the marginalized populations we serve. Our health centers provide comprehensive prevention and care to thousands of people annually, over 70% of them rely on Medicaid and a majority of whom face multiple barriers in healthcare access and effective care. Almost 90% of the patients we served in the last year live below the 150% of the federal poverty level, 41% are experiencing homelessness, and 17% are uninsured. Approximately 84% of the people served by Housing Works are either black or LatinX members of our community. Approximately 30% are cisgender women and over a third identify as lesbian, gay, bisexual, transgender, gender non-conformity or gender queer. 11% of all patients identify as people of trans experience. A loss of 10 million dollars in annual 340B savings would directly and significantly impact Housing Works ability to provide services that include HIV prevention, testing, and care for uninsured patients. Outreach to shelter residents and other people experiencing homelessness, HIV, and HCD, counseling and testing, case management, care coordination, access to transitional and permanent housing and access to other non-medical services required to engage and obtain marginalized people in our health and behavioral healthcare including syringe exchange and other low threshold harm reduction services. I want to note, as the person who testified just prior to me noted, we work very closely with our pharmacy and consider the pharmacist to be part of our care team which is exactly why whenever there is an issue around someone's prescription, around refills, around someone's lost meds, we can quickly solve those issues and help people stay as true to their treatment. Carving-out the pharmacy benefit will cause Housing Works, other FQHCs, HIV Ryan White providers, and a disproportionate share of hospitals to lose the intended benefits of the 340B program. The State's plan to carve-out the pharmacy benefit will eviscerate the health care safety net in the communities we serve and will increase cost to the State and will worsen health outcomes. And I know my time is almost up so I just want to underscore, in addition to my written testimony, as Perry Junjulas said, what has been offered to assist patients facing this cut of funding is grossly inadequate. There is not a clear mechanism for how it gets distributed, and in fact, we have no

security that this funding will continue in the out years. So for this reason, we request that this be removed from the waiver extension application. Thank you.

Thank you Charles. Ok, thank you. Speaker number 7, Matthew Bernardo, please, your line should be open.

Yes, thank you. I am Matthew Bernardo, I serve as the Executive Director of Housing Works Community Health Care. We are an FQHC and a covered entity under the 340B program. We serve approximately 9,000 patients yearly and over 65,000 visits. We serve a diverse population of homelessness, Black, Latino, LGBT community. I am speaking today in opposition of the waiver and the Pharmacy Carve-Out portion of the waiver. The original intent of the 340B program was to enable covered entities, such as Housing Works, to stretch scarce resources as far as able and reaching more eligible patients and providing more services. It is an important part of the safety net and the delivery service that New York City and New York State deliver today. We believe that the pharmacy carve-out proposal will harm our clients, the populations we serve, and the New York safety net. Some examples of how it would directly impact our client and populations; viral load detection services, such as the undetectable Prep and Hepatitis-C services would be, would not be funded. We would reverse the progress on the 'End the Epidemic' which we made so much progress in raising the viral load suppression rates around the State. Also would affect navigation programs, especially for people, homeless populations, that need navigation to and from services. Unpaid nursing visits that often aren't paid under our FQHC rates that allows us to operate small clinics with really specialty populations such as drug user help, those small clinics would would not be viable or sustainable without 340B funding. Transportation/nutrition, which we noted before, are also things we rely on 340B funding for. And even just recently, the vaccine and testing for COVID, is mostly funded currently through our 340B program and additional resources not presented at this point, and it enables Housing Works and other community organizations, to be first out of the gate to be helping these communities during the pandemic. This also has impacts on the organization as a whole also. Funding agreements, our line of credit, would be in jeopardy for renewal. It would cost jobs, and it would also cost jobs and businesses with our contracted pharmacies which are embedded in our clinics. So, we also believe that we have planned clinics that are about to open that would be in jeopardy because they would be no longer sustainable under this model. We also object to the process that was developed here, it was rushed, there is still no solutions or answers to the issues that we raised at this late date, only two months from implementation. And we believe that this is too big of a change that affects Ryan White providers, SNPs, community based organizations, populations, all those are just, it's too big of a change to be rushed through and not be thoroughly

have answers, also, the transparency of the stakeholder process was obviously not there, was not collaborative, people did walk out on it and were not really able to put their best efforts in trying to get a better solution here. So for these reasons we believe that this would devastate the safety net, it would devastate community based organizations, it would devastate Ryan White providers in our efforts for ending the epidemic. We do not believe that this should be, should go forward, and we believe in equity and that if the Governor is serious about providing it, why are you taking funds from all those who are actually doing the services. So thank you.

Thank you Matt.

Ok the next speaker is Chris Quinones. Good afternoon everyone, my name is Chris Quinones, I am the Chief Administrative Officer over at Sunriver Health. Sunriver health is a community health system that encompasses 64 sites throughout a ten county region of New York including the Hudson Valley, New York City, and Long Island. We provide primary, preventative, behavioral, and oral healthcare services to more than 245,000 patients served annually. So we've been participating in the 340B program since 1992 and currently fill over 15,000 prescriptions per month. I personally have been in this non-profit and the FQHC arena for the past 23 years and have through my hands have also implemented this program at a couple other organizations and I think that similar to what has been discussed by some of the others, we are walking down a path of tremendous risk. This is one of the few programs that when you look at its effectiveness, it's just that, it's effective, it's working. So we are on the path of risk when we talk about change. And so, one always says, why change something that is working? In our case outside of the 15,000 prescriptions per month, we take the respective what others see as revenue, we actually have reinvested that in providing affordable medications, leveraging 340B program to support a critical array of services for our patients, including, certified Diabetes educators, nutritionists, harm reduction activities, mobile health services, and so many more. One would say that as we are reinvesting in these critical services that really not only provide access to care but the necessary follow-up as well, we put that at risk if we don't have those dollars available to continue to reinvest. As an organization we understand the position the State is in, or we are trying to understand the position the State is in, and we want to find ourselves to be supportive of the over-arching goals of the 1115 waiver to reform and improve the Medicaid program while containing costs. But we are concerned. And we are concerned about the Pharmacy Carve-Out. We appreciate that the waiver includes a one-time investment of 102 Million to support covered entities that would experience a disruption with this policy change, but before moving forward we do request that the State and CMS increase the amount of dollars included in this pool given size of the estimated losses. Share also the methodology, be transparent about the methodology for distribution and

indicate how these resources will be made available on an ongoing basis. I think a one-time shot is just not going to be sufficient and similar to what others stated before, we run the risk without these funds of losing critical positions that provide the follow-up care, and levels of access for care for so many communities that we serve. For black and brown communities to migrant communities, homeless communities across the board. All of New York State, all communities that are truly underserved. This has been one of the most effective programs to serve those communities. And I think that we as non-profits, FQHCs and the like have done a good job of implementing it. And so, we look forward to seeing more information with regards to how we are going to continue to reinvest in these programs, but better put, if there is a way to maintain the program the way it is and not have the carve-out that would be ideal. Thank you all for your time. Ok thank you. Speaker number nine, William Smith-Rivera your line should be open. Hi Phil, I'm not seeing William on the list. Ok, we will move to speaker number 10, Henry Bartlett.

Hello can you hear me? Yes. Ok. My name is Henry Bartlett. I'm the vice president for government and community relations for Damien Family Care Centers. We are based in Queens. We are a network of 14 Federally Qualified Health Centers in the greater New York metro area, reaching as far north as the lower Hudson Valley and as far east as Long Island. We serve 12,000 a year approximately. And we have a very strong emphasis on serving patients linked to substance abuse treatment programs. So in some cases we are actually co-located with OASAS substance abuse treatment programs, and in other cases we have community based health centers, but we have a very high percentage of the population of folks who are in treatment and in recovery. We are a minority majority network of health centers in that the majority of folks we do serve are black and brown, they are largely impoverished, well over half of them on any given day are homeless. We want to support the 1115 Waiver but strongly oppose the idea of the pharmacy carve-out. Because we think it will be devastating for the population we serve and we think it's going to blow a huge hole in the safety net. Already in 2020, community health centers lost around 212 Million dollars in revenue because of the impact of COVID 19. We can scarcely afford to lose more associated with the 340B program. I want to look back on when this recommendation was first drafted and be sensitive to the fact that it was done in a time before the COVID epidemic, but to continue to push it in the wake of the COVID epidemic seems pretty tone-deaf to me. What would the impact be at Damien? Well, of our 12,000 patients, at any time about 1,000 of them are uninsured. We provide them with a full array of services and medications without regard to ability to pay. We believe we would lose around a Million dollars in funding, which the only way we can manage that is to stop providing free medications, to the uninsured people that we serve. So that means that this population would not be getting their HIV meds, they would not be getting their

Hepatitis-C meds, they would not be getting their psych meds, they wouldn't be getting their substance use disorder meds and a whole variety of other things. We think that that's a strikingly bad idea but we don't know another way to manage this cut. I watched over the weekend Dr. Celine Gounder, who is from NYU and who is a senior advisor to the Biden administration on the roll-out of the COVID vaccine program. And she talked about how difficuly it is to reach into the urban poor community, to the black and brown community and to get them vaccinated, and to find providers who are trusted in that community to give them the vaccinations. She specifically mentioned how much the Biden administration plans to rely on the FQHC world in order to get that done. We have those relationships but if our financial future is jeopardized by the carve-out and by barring us from participating in the 340B program in any meaningful way, that just seems like a really bad idea. I would also add to what my friend Perry Junjulas said which is that this is really a social justice issue as well as a health care issue. We know that the population that did poorest thus far in COVID are underserved black and brown folks. And we believe that this only exacerbates that. I would urge the health department to remove this particular provision and I would urge them to strongly consider supporting what Assemblyman Godfried and Senator Rivera are recommending which is that we take a three year breather on this and figure out a way to do this in a way that makes sense and not to do it in a rush while we are in the middle of a global pandemic. Thank you.

Ok, thank you. Speaker number 11, Christine Tarnowski, your line should be open. (38:14)

Hi Phil, I do not see Christine Tarnowski on our attendee list.

Ok thank you, we'll move to speaker number 12, Charyna Vega. Your line should be open.

Hi good afternoon everyone, my name is Charyna Vega and I'm the Treatment Adherence Manager at the Alliance for Positive Change. I thank the New York State Department of Health for the opportunity to deliver remarks today about the 1115 Waiver Extension Request. My organization, the Alliance for Positive Change, has been on the front lines of the HIV AIDS epidemic for thirty years. We have decades of experience providing services to individuals living with multiple chronic and complex health conditions such as HIV, Hepatitis, substance use, mental illness, and other behavioral health challenges. At Alliance, we offer the full continuum of services to treat the whole person, mind body and spirit. We meet people where they are and remove barriers to access testing, treatment, and care. Like Alliance, I'm generally supportive of the waiver's intent to improve the Medicaid program while containing costs. However, I am very concerned about the inclusion of the Pharmacy Benefit Carve-Out from Medicaid managed care to fee-for-service. The inclusion of the carve-out will surely be devastating to the healthcare safety net, including community health centers, disproportionate share hospitals, and Ryan White

providers like Alliance. The carve-out will cut out safety net providers across the State from the benefits of the federal 340B program, which are used to fund otherwise uncompensated care and care extension in impoverished communities. Alliance ensures that over 800 low-income New Yorkers living with HIV-AIDS have consistent access to life saving medications and treatment adherence support. All made possible by using 340B savings. In fact, over 95% of those enrolled in Alliance's treatment adherence program have a durable, undetectable viral load. Alliance reinvests 340B savings to expand access to counseling, support groups, direct observational therapy, incentives, food and nutritional programs, transportation assistance, peer navigation for medical care and more for Alliance's 6,000 registered clients. The augmentation of the 340B savings ensures New Yorkers adhere to medication and achieve improved health. As Alliance's Treatment Adherence Manager I see first-hand how the supportive services funded through 340B savings help New Yorkers adhere to HIV medication and lead healthier lives. The clients we serve need the services we offer them. Many live very isolated lives with little to no support. Alliance's Treatment Adhearance program makes sure people have easy access to their medication, are supported on their journey to become undetectable, can receive direct observational therapy on-site and virtually, and guarantee referrals for basic needs that help them stay adherent. It's a matter of life and death and many of our clients need these supportive services to survive. Alliance is proud of our 95% viral load suppression rate and contributions to the New York State effort to end the AIDS epidemic, also which are possible because of the 340B program. I recently spoke with about their treatment adherence services and they told me how thankful they were to have Alliance services in their lives. They appreciate the phone calls to check in during the pandemic and the added support to keep up with their medication in these stressful times. The people we serve come from communities of color and communities hardest hit by the COVID-19 pandemic. The State has acknowledged that public health crisis such as HIV and COVID-19 disproportionately impact poor, black, indigenous, and people of color. The State also claims to be working toward equitable distribution of the COVID-19 vaccine. There is a glaring disconnect between these two assertations and the stark reality that 340B carve-out will end the survival of the very safety-net providers that have the power to remedy these issues every day. Respectfully I urge you to reconsider this plan remove the 340B carve out from the (inaudible) 1115 Waiver Extension Request. Thank you for this opportunity to highlight the work that organizations like the Alliance for Positive Change are doing to combat HIV-AIDS, Hepatitis, and other chronic illnesses in New York State. We have made great strides but we must continue our work collectively and preserve the health care safety net to ensure that New Yorkers have the opportunity to live full,

healthy, productive lives. I appreciate your time today. Thank you. Ok, thank you. Speaker number 13, Richard Fowler, your line should be open.

Good afternoon and thank you for this opportunity to provide comment. I'm Richard Fowler my pronouns are he or him and my comments are specific to the carve-out proposed in the 1115 waiver extension request. I'm the consumer relations coordinator, as well as a patient living with HIV for over two decades, at Trillium Health located in Rochester, New York. Where we serve 7400 patients in the greater Rochester and Finger Lakes region. Founded to provide clinical and supportive services for persons living with HIV and AIDS over 30 years ago, Trillium Health is a federally qualified community health center look-a-like that provides extraordinary care to --- from all backgrounds regardless of income, sexual orientation, gender identity, race, or ethnicity. As we are all well aware the 340B program was established by the federal government in 1992 to help safety net providers serve people who would otherwise fall through the cracks. Last year the New York State budget included a little known provision that would carve the pharmacy benefit out of Medicaid managed care and replace it with a fee-for-service model as a cost saving measure, leading to the MRT 1115 waiver request that we are discussing which, if approved, will have a devastating impact on Trillium Health and many other health care providers across the State. Without the 340B savings, Trillium Health will lose more than 5 Million dollars annually, forcing us to reduce or eliminate many of our basic services including food, housing, transportation, and care coordination. It's a fact that a someone who doesn't have food or a place to live, is not necessarily worried about taking their anti-retroviral therapy. And people who can't afford a bus ticket aren't able to make it to their medical appointments. Trillium Health depends on the ability to buy prescription medicine at a reduced price through the 340B federal discount program in order to provide comprehensive wrap-around health care services at little to no cost to our patients. As chair of the Rochester area task force on AIDS, and a member of the leadership team for Monroe county partnering to end the epidemic, I can assure you that without these services, HIV rates will rise thwarting the strides we have made towards ending the epidemic in New York. Our patients will be the ones who lose. Communities of color will be disproportionately impacted exacerbating health inequities and leading to poorer health outcomes, specifically for our low income families. The bottom line is that the reduction of 340B savings will have a devastating impact across New York State. It will threaten our patients living with HIV and it will undermine our success in addressing health disparities particularly within communities of color within the midst of a global pandemic. Thank you for your time.
Ok, thank you. Speaker number 14 Ismael Ruiz, your line should be open.

Yes, good afternoon. Thank you for this opportunity. My name is Ismael Ruiz and I am a consumer and a peer for the Alliance For Positive Change. I thank the New York State Department of Health for the opportunity to deliver remarks about the 11115 Waiver Extension. The Alliance For Positive Change has been on the front line of the HIV-AIDS epidemic for thirty years. Alliance is a health care safety net provider with decades of experience providing services to individuals such as myself, New Yorkers living with multiple, chronic, and complex health conditions such as HIV, Hepatitis, substance use, mental illness and other behavioral challenges. Alliance has helped me create positive change in my life. As a Medicaid recipient, and like Alliance, I am generally supportive of the waiver's intent to improve the Medicaid program while containing costs. However, I am very concerned the inclusion of the Pharmacy Benefit Carve-Out from Medicaid Managed Care to fee-for-service. Inclusion of the carve-out will hurt the health care safety net including community health centers and Ryan White providers like Alliance. The carve-out will cut off all safety net providers across New York State from benefits of federal 340B programs. Alliance ensures that over 800 low-income New Yorkers living with HIV-AIDS have consistent access to life saving medication and adherence support all made possible by using 340B savings. In fact, over 95% of those enrolled in Alliance treatment adherence programs have a durable undetectable viral load. We reinvests 340B savings to expand access to counseling, supportive groups, direct observation therapy, incentives, food and nutrition programs, transportation assistance, peer navigation to medical care and more for Alliance's 6,000 registered clients. I am personally a part of Alliance's dedicated treatment adherence program and count on the services I receive to help me adhere to my HIV medication. I have been receiving services for 15 years at the Alliance and I can attest that if these services were to be cut out it would negatively impact my health. I receive direct observation therapy services to help me adhere to my medication every day. Additionally I receive job training, supportive services, and peer support and encouragement from people who share my life experiences. Alliance's support has been especially helpful during the stressful times of the pandemic. Thank you for the opportunity to highlight how Alliance has helped me and the work that organizations like the Alliance for Positive Change are doing to fight fight HIV-AIDS, Hepatitis, and other chronic illnesses in New York State. All New Yorkers deserve the opportunity to live full, healthy, productive lives. Respectfully I urge you to reconsider this plan and remove the 340B carve-out from the State's 1115 Waiver Extension Request. I appreciate your time today. Thank you all.

Ok, thank you. Speaker number 15, Peter Meacher, your line should be open.

Hi everyone, my name is Peter Meacher I'm the Chief Medical Officer at Callen-Lorde Community Health Center in New York City. On behalf of Callen-Lorde, its staff, board of directors, and

patients I thank you for this opportunity to testify. Callen-Lorde is a federally qualified health center who has been serving LGBT New Yorkers for over 50 years. We have sites in three boroughs. A third of our patients are HIV positive, a third are transgender and non-binary. A half of the people are of color, a third are uninsured, and a third have public insurance. Today I am here to really build on what's been said but to comment specifically on the State's waiver extension request. As Callen-Lorde is supportive generally of the waiver's intent to improve the Medicaid problem whilst containing costs. However, as Chief Medical Officer and a medical provider for eight years at Callen-Lorde, I'm extremely concerned with the inclusion of the Pharmacy Benefit Carve-Out from Medicaid managed care to fee-for-service. This inclusion will eviscerate the health care safety net including community health centers and Ryan White providers and others. Um, I want to describe a patient I saw just recently. I'll call him Jay. Jay is a thirty year old Hispanic man. Been HIV positive for seven years. Been on drug (inaudible) for seven years. A gay man. He has always been very wary of health care and in fact got his HIV test at an outreach event we'd organized. But he trusted us and so with the of our benefits navigators, our nurses, he came in to a visit and got benefits sorted, understood what was involved in taking anti-retrovirals and has been virally suppressed now for seven years. He's also Hepatitis C positive and more recently that was addressed and treated and that was a lot to do with the careful education our nurses were able to do, as well the pharmacy support that we've heard about to ensure that he stayed on track with the Hep-C treatment. So at the beginning of this year Jay was housed, stable health wise, working three jobs, one in a bodega another delivering foods, and another in a third delivery job. With COVID he lost all three jobs, has now been made homeless. We've been able to help him with legal services, have him on-track to get housed, and have been able to connect him with food support. Now everyone I described who helped Jay in this process is, we are, possibly going to have to let them go. The outreach, the people working the outreach event, the benefits navigator, the nurses who coached him into starting anti-retrovirals and then later Hep-C treatment. They may have to go because this is how we fund them with 340B savings. The pharmacy support person, they'll probably have to go cause they're funded by 340B savings. The case managers who connected him with legal help and working on his housing, also may have to go. This you know, this is just, um, you know we've really struggled in this pandemic to take care of the very people in the very communities we're being told we should be reaching. We have those connections we have that trust and at this time, more than ever, to be eviscerating and decimating how we're able to do that work it makes absolutely no sense. It's short-sided, it's a false economy and it's going to wreak havoc in the very communities that we serve, the very communities we're being told that we should be focusing on getting better health care to and COVID vaccinations to.

So we really strongly strongly oppose the inclusion of the 340B carve-out. This is a really toxic move. Thank you for your time.
Ok thank you. Commenter number 16 Jonathan Bustamante, your line should be open. Hello, can you hear me? Yes. Hi, it is weird to talk and see no faces. So, hi everybody, my name is Jonathan Bustamante, I'm a photographer, I'm a patient navigator, I'm an immigrant, I'm a gay HIV person of color. But momre important, I'm someone's son, and someone's cousin, someone's brother, someone's coworker, someone's lover. I understand that this carve-out would prevent my provider from benefitting from the federal 340B drug discount program. (inaudible) of savings that are used to support important services (inaudible) . These changes will impact my life significantly because I will no longer be able to have the quality of life that I have developed since becoming involved in Housing Works Services. I really value the care, treatment, and support Housing Works provides to me. As an immigrant, as a gay HIV person of color, I find important information on developing skills, to counseling (inaudible) essentials to have a decent and healthy life. And now I have the opportunity to pay it forward because I am a peer worker. I feel safe and taken care of in this organization and I want others in need to have the same opportunities that I have. I cannot imagine the harm that this carve-out will cause to members of my community. If my (inaudible) has to reduce hours of operation for example or cut services as a result of this carve-out. It is important that me and people like me have a place to go to continue to receive these types of services. I really find these intentions to be inhuman. And it is hard for me to find a reason why the State will take action that will result in financial hardship at these organizations forcing them to reduce services that are required by me and people like me in my community. Especially when we are dealing with public health crisis like the HIV crisis and also now with the Coronoavirus that is harder more (inaudible). For example the State claims that everyone will have equal access to the COVID-19 vaccine while at the same time is asking for federal permission for a pharmacy carve-out that will threaten the survival and capacity for safety net health providers needed to deliver the vaccine in medically underserviced communities. Please understand how important it is right now and in the future to protect health safety net providers and the critical health and social services they provide today and every day for me and people like me. So many times we hear before there isn't money, there isn't money, but with the COVID crisis we just saw the biggest (inaudible) of money from taxpayers and members to the corporations and the people who already have the money. 5 Trillions were passed in a matter of a week I believe. So, so many times I wonder, there is no money or there is no will. So, my message is for the Phil, Bret, Amir, Donna, Greg, John and Simone. I'm someone's son, I'm someone's cousin, I'm someone's brother, I'm someone's neighbor, coworker. And this someone could be your brother, your sister, could be

your cousin, your father, I'm like someone else. So this is an invitation for you guys to practice compassion and I urge you to remove the 340B carve-out from the State and you know make, we can make this work better. There is a reason why I came to this country and I'm one of the lucky persons who received an improved life because of the greatness of this country. And I don't think it's the time for us to go back, I believe we shouldn't have to have this conversation on cutting services. We should have this conversation on providing more services. Thank you, that's it.

Ok, thank you. Speaker number 17, Chris Norwood, your line should be open. Ah, yes. It looks open, thank you.

I'm Chris Norwood, Executive Director of Health People Community of Health Institute. New York State has been devastated by an epidemic which has been fueled by chronic disease like no other in history. Yet a year later, still making more waivers the State has no plan to properly implement the many well known and evidence based practices to significantly prevent and control chronic disease. The omission of chronic disease from this federal waiver is not just disturbing it's an abandonment of public health which everyone involved at the New York State Department of Health has to know will only lead to more death and disability both from COVID and from chronic disease already being so out of control in the State. This State has the worst COVID outcomes for death and disability in the nation. In the first surge in the Spring death associated with chronic disease were staggering and included a 356% increase in diabetes deaths in New York City. 356%. While the State outside the city had the largest State increase in diabetes deaths. This appalling reality confirms the real price of the State's absolute studied refusal to confront chronic disease with evidence based strategies that could significantly improve self-care and prevention. This waiver is supposed to be revenue neutral. But the many proven self-cares courses for people with chronic disease are beyond revenue neutral. They absolutely save money. There is some twenty validated self-care courses and strategies for Type-2 diabetes alone shown to reduce blood sugar and complications. One of the best known is the Diabetes Self-Management Program or DSMP, saves an average of $2,200 per participant in medical costs in just the first year. Yet, once again, despite community pleas for years, even in planning this waiver, the State has refused to include the Statewide program of self-management education, especially education delivered accessibly to high-risk communities through their own local community groups, which is an imperative program. Let's review. I mean just really look at what this neglect systematic bias will continue to cost us. As the pandemic approached New York it was already clear that people with diabetes, especially low-income and minority populations, would incredibly vulnerable to COVID-19. The State had already had 40% increase in lower limb amputations since 2009, a sure sign of how sick this population had become. The State has 2 Million residents with diabetes, 600,000

on Medicaid. During the onrush of COVID it was terrible to know that if the State had even supported a cohearent effort to bring self-care education to high-risk communities a lot of people would not become sick or die and international studies have now made clear that this staggering cost that we experienced was not necessary. Studies show that it was not precisely diabetes itself driving deaths but excess blood sugar. When people with diabetes have good blood sugar control their risk for death or complications when they contracted COVID were not significantly worse that people without diabetes. But deaths and complications including ventilation, septic shock, acute respiratory disease, and acute heat disease rose steeply with blood sugar levels. So important was decreasing blood sugar, something that people can do within weeks with education and support, that in a detailed study of complications 7% of Type-2 diabetes patients in good control developed acute respiratory disease compared with 21% of those in poor blood sugar control. And just 1.4% in good control developed acute heart injury, but 9.9% in poor control developed acute heart injury. These are our long hauler populations whose lives possibly may have been destroyed forever and that shows how unnecessary it was. Based on available but incomplete date, we can project that 50% of State Medicaid recipients with Type-2 diabetes have blood sugar levels that would place them at higher risk for COVID death and disability. I know from experience how feasible it is to have community groups implement these programs themselves. We had a peer program where the peers from the South Bronx engaged almost 2,000 people with diabetes on Medicaid in the Diabetes Self-Management Program. Programs like this could be all over the State but once again the State refuses to include that in the waiver. I think this waiver should be entirely rejected because it rejects health for New York State. And I have to point out, it was not the Trump administration, it was New York State Department of Health by seizing the high-performance DSRIP funds which were supposed to continue effective programs for a year that collapsed the only community diabetes education in the South Bronx just as diabetes deaths were tripling. I would like to know what happened to that money. Thank you.

Ok, thank you. Speaker number 18 Jomil Luna, your line should be open. (9:36)

Ok, hello everyone my name is Jomil Luna, I work at AIDS Healthcare Foundation in the South Bronx. I come to you as an employee but also as an HIV positive consumer and I know first hand how these Medicaid carve-outs will be harmful. These carve-outs put patients at risk. Patients have so many competing factors as mentioned earlier such as food and housing insecurities, and when you take these live-saving programs away you put patients at risk of becoming overwhelmed in knowing how to navigate the system and ultimately falling through the cracks, worsening their health outcomes. I was looking at the latest New York City surveillance data for 2018 and 2019 and although overall HIV numbers are going down there was a little bit of a spike

in diagnosis in 2018 and 2019 in the Bronx. In 2020 so many people lost so much including not knowing, where they were going to get, ya know, their next meal. So paying for their HIV medications is one less thing patients want to worry about. And I'm curious to see, ya know, given the fact that, ya know, the sexual health clinics were closed in 2020 due to the pandemic, I wonder if HIV rates could potentially go up. When we look at what has happened with this pandemic we need patient safety nets more than ever. The system can be so cumbersome that there is no way the patient is going to understand all the fine detail. I myself have tried navigating the system as an HIV positive consumer when I had nothing and it was so hard an confusing. I finally got on my feet when I became a patient actually at AHS and covered entities like AHS will do what's best for the patient. I think patient choice is necessary and community based organizations like ours do what's best for the community and our patients. Covered entities invest back into the community and we do. We do have the best interest of the patients at heart. I'm very happy to report that, ya know, 340B savings have allowed many patients like myself and hundreds of others that I've been able to help throughout the years to reach a status of being undetectable and staying in care and staying healthy. And I want to thank everyone for your time. Thank you very much.

Ok, well thank you. That concludes the list of pre-registered speakers. If you didn't have an opportunity to comment and you would like to do so, Georgia can folks let us know in the Chat box? Sure they can use the raise their hand feature as Bret noted earlier or they can type in, and we just got one, Amber Decker, I believe we missed her in the original list so I will go ahead and unmute her now. Sure okay. Good afternoon Amber your line should be open for comment.

Hi, hi good afternoon. This is Amber Decker, I'm a family care advocate here. I have a parent who is a HARP member and a child who is in the OPWDD waiver and so I am pretty familiar with the special terms and conditions population. And just wanted to reiterate a bit of what was said earlier in terms of there needs to be more discussion about an increase in the support and services that was promised under the 1115 waiver for the special terms and conditions population. I was very disappointed to see that many of the reports on the health.ny.gov MRT 1115 waiver extension request website were incomplete. I didn't see any mentioning of the special needs plan HIV plan, which to be clear I feel have really not received any of the home and community based services that were promised under the 1115 waiver since 2014. And that also goes to the Children's CTFSS services as well as the HARP behavioral health home and community based services. And I hope that the Department of Health does in fact try to reach all of the individuals that are classified as special terms and conditions populations by asking more questions such as the ones that I saw in the Rand Corporation's interim report the date November 13, 2020. There was an

interim independent evaluation of the New York State Health and Recovery Plan at the very last page, which I believe is page thirty, actually pages 29-39. I'm dying to kind of know if this is actually going to be used with individuals or not or if this is just a guide that is going to be sort of ignored. As well as with providers. I think there needs to be a real engagement of consumers and providers. I'm also very concerned about the Pharmacy Carve-Out simply because there is so many questions that have gone unanswered. For example I have no idea if consumers are still going to be subject to co-pays. Um, how plans, if anything, will be involved in connecting individuals who have traditionally called them up when there is an issue. What if anything, how are issues on the consumers end going to be trouble shooted prior to this approval process going through? That should be happening maybe with a small group and seeing how it goes, versus changing everything into a pharmacy benefit carve-out immediately. There's lots of ideas out there and I'm not sure why there isn't more discussion and Q&A opportunities to talk about these things with the Department of Health and the Office of Health Insurance Programs. But obviously there is a huge need for that and I look forward to continuing a dialogue and working with the State on that end. Thank you.
Ok, thank you. Is there anyone else that would like to provide comment this afternoon. Please raise your hand and we can open the line for you. Yeah I see Henry Bartlett has a hand up Phil. Ok, Henry, would you like to, Henry was on our list earlier and provided comment. You got to me already thanks, you got to me already thank. Ok. Anyone else? Ok, um, Bret do you want to provide any closing remarks. I think so. Yeah, no thank you for that opportunity Phil. Just want to thank everyone for today's public hearing and public forum. And we appreciate the eighteen comments we received through the public hearing process and we look forward to considering them strongly, incorporating them in the waiver application draft through the end of the public comment period. We encourage people to continue submitting public comments through the end of the public comment period which Phil had mentioned will run through February 6, 2021. And they can be submitted at the address or through the website. And these slides will be available along with a recording of this presentation and a transcript on the website specific to this MRT waiver. And so these comments are tremendously helpful to us as we refine and submit the waiver application to CMS, as well as when we design our next waiver amendment with CMS. So I really can't thank you enough for taking the time to provide feedback and join this discussion. Until then I hope you have a good afternoon and I'm sure we'll hopefully see a few of you next week for the public hearing and please encourage others to attend. Thank you so much. Thank you.