STATE OF NEW YORK
EXECUTIVE CHAMBER
ALBANY 12224

KATHY HOCHUL
GOVERNOR

September 30, 2026

The Honorable Robert F. Kennedy Jr.
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Kennedy:

Pursuant to the terms of the New York State Medicaid Section 1115 Demonstration Medicaid Redesign Team (MRT) Waiver (11-W-00114/2), New York State ("New York" or the "State") submits the enclosed proposal requesting a five-year extension of the MRT demonstration to the Centers for Medicare & Medicaid Services (CMS) for its approval.

This extension builds on nearly three decades of successful demonstration experience, during which New York has used its Section 1115(a) authority to improve quality of care, and reduce overall healthcare costs. New York accomplished these goals by modernizing service delivery; integrating physical health, behavioral health, and long-term care services and supports; providing evidence-based services that address upstream drivers of health; and advancing system-wide program integrity and accountability controls. Since health-related social need (HRSN) services launched statewide in 2025, more than 1.5 million Medicaid members have been screened for unmet health-related social needs. New York has made significant progress toward achieving the expected waiver outcomes while maintaining federal budget neutrality. However, because the HRSN initiative is still in its early years, additional time is needed to see the full impact on health outcomes and long-term cost trends, which will continue to be evaluated over the life of this extension.

New York remains committed to and will continue working with CMS on its pending amendments for the Medicaid Buy-In Program for Working People with Disabilities (MBI-WPD) and Pre-Release Services for Incarcerated Individuals.

New York State has fully complied with federal transparency requirements in preparation for formally submitting this waiver extension proposal. The State transmitted tribal and public notices referencing the preliminary proposal draft (July 8, 2026), conducted an in-person public hearing with live webcast (July 31, 2026) and a virtual public hearing (August 11, 2026), and received over 190 comments. The State's engagement with stakeholders informed the structure

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and substance of this submission, and the comments received are addressed in the attached extension application.

Consistent with CMS's June 2026 State Medicaid Director Letter on budget neutrality methodology (SMD #26-003), New York will continue to work closely with CMS to ensure compliance as part of this submission.

The partnership between CMS and New York State continues to be important to the success of the 1115 MRT Waiver. We look forward to our continued collaboration. If you have any questions, please contact Amir Bassiri, New York's Medicaid Director, at (518) 474-3018.

Sincerely,

Kathy Hochul
Governor

Enclosures

cc: Mehmet Oz, M.D., Administrator, Centers for Medicare & Medicaid Services
Dan Brillman, Director, Center for Medicaid and CHIP Services and Deputy Administrator, Centers for Medicare & Medicaid Services
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James McDonald, M.D., Commissioner of Health, New York State
Amir Bassiri, Medicaid Director and Deputy Commissioner of Health, New York State

NEW YORK STATE MEDICAID REDESIGN TEAM (MRT) WAIVER

Project Number #11-W-00114/2

1115 Waiver Extension Request

New York State Department of Health
Office of Health Insurance Programs

One Commerce Plaza
Albany, NY 12207

September 2026

NEW YORK STATE | Department of Health

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Section 1: Introduction

The State of New York ("New York" or the "State") is requesting a five-year extension of the Medicaid Redesign Team (MRT) Section 1115(a) demonstration, currently authorized through March 31, 2027. This extension request is both a reflection of what New York has achieved and a roadmap for what comes next.

New York has been at the forefront of Medicaid innovation. Since first receiving its Section 1115(a) demonstration authority a quarter of a century ago, the State has expanded coverage while improving the quality and reducing the cost of care. In recent years, it has integrated physical, behavioral, and long-term services and treated upstream drivers of health that shape the lives of millions of New Yorkers.

Effective April 2022 and amended in 2024 to add a range of new programs, the current MRT demonstration marked a bold new chapter. Despite a limited timeframe for implementation, New York established seven programs that together represent a fundamental shift in how the State delivers care in just 22 months. At the foundation of that shift is a first-of-its-kind Social Care Network (SCN) infrastructure spanning nine regions, connecting members to more than a thousand providers that address housing instability, food insecurity, and other upstream drivers of health. Building on that infrastructure, the Health Equity Regional Organization (HERO) initiative brought cross-sector partners together to discuss population health priorities and drive regional dialogue around the communities these networks serve. Federal funding for residential and in-patient addiction treatment broadened the continuum of care for Substance Use Disorder (SUD), creating more evidence-based options for members with complex needs. To ensure progress would be durable, New York made investments in the healthcare workforce needed to sustain it: the Career Pathways Training (CPT) for entry-level workers and the Healthcare Access Loan Repayment (HEALR) programs both have expanded access to critical service providers and provided opportunities for economic advancement across the state. As its investments build momentum, the current demonstration already shows promising results: more than 1.5 million members have been screened, and half have an unmet social need – a signal of both the scale of the challenge and the substantial opportunity ahead to improve health outcomes and reduce costs for Medicaid members.

With this extension, New York seeks to maintain that momentum. The State proposes to renew certain authorities without modification, amend others to reflect lessons learned, and discontinue select authorities that no longer need 1115 authority. It also proposes to discontinue certain initiatives to align with recent federal guidance. Rooted in years of on-the-ground implementation experience and shaped by the needs of millions of New Yorkers, these proposals represent the State's next step toward a more coordinated, person-centered, and fiscally sustainable Medicaid program.

Section 2: Historical Context

New York's use of Section 1115(a) demonstration authority, and the lessons learned from its use, span nearly three decades. From the outset, New York pioneered an ambitious agenda: expanding Medicaid managed care, modernizing long-term services and supports, and integrating physical health, behavioral health, and targeted support services into a unified system. Across nearly three decades and four major extension periods, the demonstration has served as the platform on which New York has expanded coverage to millions of residents, restructured its care delivery system, and made upstream investments in population health, all while providing a model for Medicaid innovation that other states have looked to and built upon nationwide.

The following outlines those four major extension periods.

1997–2012 | The Partnership Plan to Build Managed Care

First approved in 1997, the Partnership Plan established managed care as the primary delivery system for Medicaid and authorized targeted coverage expansions to low-income adults. Through subsequent amendments, the State implemented initiatives that broadened access and improved care:

- Family Health Plus (2001) expanded coverage to low-income adults who did not otherwise qualify for Medicaid;
- The Family Planning Expansion (2002) extended family planning services to a wider population; and
- The Home and Community-Based Services (HCBS) Expansion Program (2010) provided alternatives for adults at risk of institutionalization.

2012–2016 | Delivery System Transformation and Behavioral Health Integration

The period from 2012 to 2016 marked a deliberate and incisive change in how New York organized and delivered care, as the aims of New York's demonstration shifted from coverage expansion toward care integration and system reform.

In 2012, New York launched the Managed Long-Term Care (MLTC) program, enrolling eligible Medicaid members who required more than 120 days of community-based long-term care into managed care plans that coordinated long-term services and supports alongside other services. Built on the foundation of the Long-Term Home Health Care Program (LTHHCP), this approach enabled more New Yorkers to remain in their communities rather than in institutional settings. In 2014, long-stay nursing facility services were extended to both MMMC and MLTC members, accompanied by an independent long-term care services and supports assessment process to ensure members received the right level of care.

In March 2014, the Federal-State Health Reform Partnership (F-SHRP), a concurrent Section 1115 demonstration that had carried managed care enrollment authority for aged and disabled populations since 2006, expired and its enrolled populations and authorities were consolidated into the Partnership Plan.

During this period, the State made significant strides toward the integration of behavioral health and primary care. Essential to this progress was the introduction of two new plan types – Health and Recovery Plans (HARPs) and HIV Special Needs Plans (HIV SNPs) – in 2015. Offering behavioral health home and community-based services, these plans brought mental health and substance use disorder services into the standard Medicaid care model.

The State's landmark Delivery System Reform Incentive Payment (DSRIP) program, approved in April 2014, committed $8 billion in federal investment to 25 Performing Provider Systems with the goal of reducing avoidable hospital use by 25 percent.

2016–Present | The Medicaid Redesign Team (MRT) Demonstration and Service Expansion

In December 2016, the Partnership Plan was renamed the New York Medicaid Redesign Team (MRT), as the State reinforced its commitment to system-wide reform. Along with sustained and expanded investment in established initiatives, this period also saw New York introduce and learn from new initiatives, including:

- Integrating Children's HCBS and the Section 1915(c) Children's Waiver populations into managed care (2019);
- Reforming MLTC partial-capitation to improve coordination and accountability (2019); and
- Launching CORE Services to streamline its behavioral health service offering and provide person-centered supports for adults with serious mental illness and substance use disorders (2021).

The State advanced its Value-Based Payment (VBP) Roadmap during this time, aligning managed care plan and provider contracts with quality and total-cost-of-care accountability – laying the operational groundwork for the system-wide reforms that would follow. DSRIP concluded on March 31, 2020, serving as the backbone of value-based payment infrastructure in New York and a national model for delivery system reform.

In March 2022, CMS approved a five-year extension of the MRT demonstration through March 2027, including continued alignment of dual-eligible members with MMMC plans offering Dual Eligible Special Needs Plans (D-SNPs).

Building on its track record of delivery system innovation, New York took a significant step in 2024 by redirecting the demonstration toward treating upstream drivers of health, thereby improving population health while reducing unnecessary costs. In January 2024, CMS approved New York's demonstration[1], a $7.5 billion package that reoriented the demonstration around this goal, establishing:

- Health-Related Social Needs (HRSN) Services to connect members to services that address housing instability, food insecurity, and other upstream drivers of health, services delivered through nine regional Social Care Networks (SCNs);
- The Health Equity Regional Organization (HERO) to facilitate regional dialogue on population health priorities;
- The Medicaid Hospital Global Budget Initiative (MHGBI) to support financially distressed safety-net hospitals in transitioning to a global budget;
- Workforce Initiatives, including the Career Pathways Training (CPT) and Healthcare Access Loan Repayment (HEALR) programs, to address healthcare workforce shortages;
- Institution for Mental Diseases (IMD) authority to fund expanded substance use disorder treatment, enable a full continuum of evidence-based residential and inpatient treatment, as well as expanded access to Medication-Assisted Treatment.

CMS also approved authority for New York to draw down up to $3.9 billion in Designated State Health Program (DSHP) funding to finance these initiatives.

Early results are encouraging and are expected to compound over time. The State has built an innovative network of community-based organizations (CBOs) and providers delivering HRSN services, developed robust data infrastructure to manage these programs efficiently, and generated strong stakeholder engagement across the state. Early evaluation findings – detailed further in this application – indicate meaningful progress toward the program's goals and a clear imperative for continued federal support.

[1] Centers for Medicare & Medicaid Services (2024, January 9). *MRT Special Terms and Conditions.* NYS DOH. https://www.health.ny.gov/health_care/managed_care/appextension/docs/2024-01-09_ny_stc.pdf

This extension request builds on that momentum. By reducing healthcare costs and improving outcomes for its Medicaid populations, New York seeks not only to serve its members through continuous innovation, but also to share the lessons learned from this work nationwide.

Section 3: Extending the Existing Demonstration

New York is requesting a five-year extension to continue a select set of waiver and expenditure authorities approved in the current Section 1115(a) MRT demonstration (see Section 4: Waiver and Expenditure Authorities). This request reflects the State's assessment that many key reforms authorized in recent amendments – particularly, those involving delivery system transformation, workforce development, substance use disorder treatment, and HRSN services – require more time to mature, demonstrate outcomes, and achieve sustainability. Certain requests, such as the discontinuation of continuous eligibility, reflect the State's effort to comply with recent CMS guidance.

The extension request continues and refines existing demonstration initiatives rather than expanding the demonstration's footprint. New York seeks to preserve core authorities that are essential to maintaining program stability, completing multi-year implementation efforts, and avoiding disruption to Medicaid beneficiaries, providers, and community-based partners.

Goals and Objectives of the Extension

The goals and objectives of this demonstration extension are intended to continue, maintain, and operationalize the goals and objectives approved under the current Section 1115(a) demonstration, including:

- Improving access to healthcare for the Medicaid population;
- Improving the quality of health services delivered;
- Expanding coverage with resources generated through managed care efficiencies to additional low-income New Yorkers; and
- Addressing upstream drivers of health, advancing population health and supporting the delivery of HRSN services.

Initiatives Continuing without Amendments

3.1 Mainstream Medicaid Managed Care (MMMC)

The State requests to extend waiver and expenditure authority for Mainstream Medicaid Managed Care (MMMC).

MMMC is New York's primary delivery system for Medicaid services, covering approximately 75 percent of all New York Medicaid members. Managed care plans are responsible for ensuring members have access to a comprehensive range of preventive, primary, specialty, ancillary and inpatient services through their provider networks. MMMC includes three plan types: Mainstream, HARP, and HIV SNP.

- Most Medicaid eligible individuals are required to enroll in an MMMC plan unless otherwise exempt or excluded.
- A HARP plan manages care for adults with significant behavioral health needs. It facilitates the integration of physical health, mental health, and substance use services for individuals requiring more specialized approaches, expertise, and protocols. In addition to the State Plan Medicaid services offered by Mainstream MCOs, qualified HARPs will offer access to an

enhanced benefit package comprised of Community Oriented Recovery and Empowerment (CORE) Services designed to provide the individual with a specialized scope of support services not currently covered under the State Plan
- An HIV SNP provides the same services as other Medicaid plans, as well as specialty services for individuals living with or at risk for HIV/AIDS.

This request preserves and strengthens a core component of New York's Medicaid program, supporting integrated and accountable care delivery for Medicaid members. New York, in collaboration with CMS, continually pursues new ways to improve care under the Medicaid program. During the current demonstration period, the State has:

- Introduced a coverage option in the MMMC and HARP products for individuals dually eligible for Medicaid and Medicare; and
- Shifted pharmacy benefits from the Medicaid managed care program to a fee-for-service option that provides the same benefits and a broader pharmacy network at a lower cost.

MMMC enrollment totaled more than 4 million members in May 2026, with more than 130,000 members enrolled in HARPs. Enrollment has grown from 3 million members in May 2012. Strong enrollment growth reflects New York's effort to expand access to healthcare.[2]

Performance on quality and member-experience measures in MMMC has improved on most measures in recent years. In the 2026 adult member survey, 84.7 percent of members reported it was usually or always easy to get the care, tests, or treatment they needed, and 76.1 percent rated their overall healthcare as an 8, 9, or 10 on a scale of 0 to 10, up from 73.5 percent in the 2024 survey; members' rating of their personal doctor rose significantly, from 79.6 to 83.8 percent.[3,4]Since 2021, these plans have also improved on several adult quality measures, including asthma medication ratio (ages 19-64), which increased from 51 percent to 77 percent and controlling high blood pressure, which improved from 65 percent to 70 percent.[5,6] In measurement year 2024, statewide rates exceeded national Medicaid averages on measures including controlling high blood pressure (70 vs. 67 percent), glycemic control for members with diabetes (64 vs. 59 percent), and postpartum care (87 vs. 81 percent) prenatal care, postpartum care, blood pressure control, and diabetes control.[5,6]

3.2 Managed Long-Term Care (MLTC)

The State requests to extend waiver and expenditure authority for MLTC.

The MLTC program was implemented to deliver community-based long-term services and support through managed care arrangements for individuals who are chronically ill or disabled. The purpose of this request is to maintain continuity of care, system oversight, and access to community-based alternatives to institutional care. New York contracts with three types of long-term care plans: MLTC Partial Capitation (MLTCP), Medicaid Advantage Plus (MAP), and Program of All-Inclusive Care for

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[2] *Medicaid Managed Care Enrollment Reports.* (2026, May). NY DOH. https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/

[3] DataStat, Inc (2026, March). *New York State Medicaid Managed Care Program CAHPS® 5.1H Adult Medicaid Survey Continuous Quality Improvement Report*. New York State Department of Health. https://www.health.ny.gov/health_care/managed_care/medicaid_satisfaction_report/2026/mmc/statewide.pdf

[4] DataStat, Inc (2024, March). *New York State Medicaid Managed Care Program CAHPS® 5.1H Adult Medicaid Survey Continuous Quality Improvement Report*. New York State Department of Health. https://www.health.ny.gov/health_care/managed_care/medicaid_satisfaction_report/2024/mmc/statewide.pdf

[5] *Quality Assurance Reporting Requirements (QARR) Reports.* (2024). NY DOH. https://www.health.ny.gov/health_care/managed_care/reports/eqarr/

[6] *Quality Assurance Reporting Requirements: Beginning 2008.* 2021 data. NY DOH. https://health.data.ny.gov/Health/Quality-Assurance-Reporting-Requirements-Beginning/vbkk-tipq/data_preview

the Elderly (PACE).

To be eligible for MAP or MLTCP, an individual must require more than 120 days of community-based long-term care services and, in line with New York's minimum needs requirement, must either:

1. Need at least limited assistance with physical maneuvering in more than two activities of daily living (ADL); or
2. Have a dementia or Alzheimer's diagnosis and need at least supervision with more than one ADL.

To qualify for PACE, individuals must be assessed as in need of community-based long-term care services for more than 120 days and assessed as eligible for nursing home level of care.

MLTC enrollment increased from 252,761 members in May 2022 to 289,540 members in May 2026. During the same period, MAP enrollment grew approximately 150 percent, from 33,296 to 83,114 members.[7] In a survey sponsored by the New York Department of Health, 82 percent of MLTC members rated their health plan as good or excellent and 85 percent rated their plan's helpfulness in managing illnesses as good or excellent.[8]

During the current demonstration period, the State has:

- Consolidated MLTCP plans from 25 in 2021 to 13 in 2026, facilitating more intensive oversight while ensuring members retain adequate choice;
- Increased the number of MAP plans from 3 in 2021 to 11 in 2026, expanding choice for fully integrated duals in need of long-term care; and
- Implemented a minimum needs eligibility standard for MLTC enrollment, with assessments conducted by a conflict-free assessment contractor.

3.3 Facilitated Enrollment Services

The State requests continued expenditure authority to provide facilitated enrollment services through managed care organizations (MCOs) using MCO staffed referred to as marketplace facilitated enrollers (MFEs).

The purpose of the initiative is to help eligible individuals enroll in coverage accurately and to ensure they continue to have access to enrollment assistance when needed.

Facilitated enrollment plays a pivotal role in connecting people to coverage. New York has an integrated online eligibility system, NY State of Health, where individuals can apply for health insurance coverage. Available plans include Medicaid, Child Health Plus, Essential Plan (New York's Basic Health Program [BHP]), and Qualified Heath Plans (QHP). Approximately 80 percent of individuals applying for or renewing their Medicaid coverage through New York State of Health use an application assistor. It is estimated that marketplace facilitated enrollers (MFEs) are responsible for approximately 60 percent of the Medicaid applications taken through NY State of Health. Facilitated enrollers provide one-on-one assistance to help people enroll in Medicaid and other insurance affordability programs.

At any time, there are approximately 5,500 application assistors helping consumers apply for and maintain their coverage. Enrollment assistance is provided by several types of trained organizations and staff, including navigators selected through a competitive grant process; Certified Application

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[7] *Medicaid managed care enrollment reports.* (2026, May). NY DOH. https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/

[8] *Managed long-term care report.* (2023). NY DOH. https://www.health.ny.gov/health_care/managed_care/mltc/pdf/mltc_report_2023.pdf

Counselors (CACs) at organizations such as hospitals, federally qualified health centers (FQHCs), and community-based organizations (CBOs); and MFEs employed by health plans.

All assistors perform the same duties and must adhere to the same set of standards. This includes completing comprehensive initial certification training and an annual recertification training program. The recertification series includes between three and six trainings per year on various topics.

3.4 Community Oriented Recovery and Empowerment (CORE) Services

The State requests to extend waiver and expenditure authority for this initiative.

CORE Services provide person-centered behavioral health services for eligible adult Medicaid beneficiaries with serious mental illness (SMI) and/or SUD. Services are mobile, delivered at home or in the community, and build practical skills for fostering community participation and independence. CORE Services comprises four services:

1. **Community Psychiatric Support and Treatment**: Goal-directed, solution-focused therapeutic interventions, including clinical counseling and therapy;
2. **Psychosocial Rehabilitation**: Skill building and psychoeducational interventions that improve the member's functional abilities, support person-centered recovery goals, and promote full community participation and independence;
3. **Family Support and Training**: Instruction, emotional support, and skill-building that facilitate family engagement and active participation in the member's recovery process; and
4. **Empowerment Services – Peer Supports**: Non-clinical, peer-delivered services that promote coping and management skills for behavioral health symptoms through the perspective of a shared personal experience of recovery.

The purpose of this request is to continue serving members' recovery-based behavioral health needs and continue refining the program based on implementation experience and outcome data.

The State first implemented CORE Services statewide on February 1, 2022, transitioning several Adult Behavioral Health Home and Community-Based Services (BH HCBS) rehabilitation services into a more streamlined and flexible set of offerings. Individuals receiving these four services through BH HCBS were fully transitioned to CORE Services by April 30, 2022. New York has supported implementation through multiple initiatives. These include extending Adult BH HCBS infrastructure funding through July 2024 to support provider transition; the CORE Peer Navigator Project (2023–2025), which connected approximately 250 HARP-eligible individuals to services; statewide provider networking events attended by more than 430 stakeholders; and annual CORE Summits designed to strengthen provider collaboration and care coordination. Since implementation, 119 providers have been fully designated to deliver CORE services. Utilization continues to grow, with 12,452unique individuals receiving CORE services since launch and 5,209 individuals receiving at least one CORE service in 2025.

Stakeholder feedback and early monitoring data suggest that CORE Services allows members to achieve their rehabilitation and recovery goals more effectively than previous models. Providers report positive outcomes associated with improved BH care integration, including collaboration between CORE Services providers and managed care plans. As of December 2025, members engaged in CORE Services were enrolled for an average of 6.6 months and made an average of 28 claims during their enrollment, indicating consistent engagement with services over a relatively short period.

3.5 Residential and Inpatient Treatment for Individuals with Substance Use Disorder (SUD)

The State requests continued waiver and expenditure authority to provide Medicaid-covered services in residential and inpatient treatment settings that qualify as Institutions for Mental Diseases (IMDs).

The IMD setting – a facility with more than 16 beds that specializes in psychiatric or SUD care – is a critical component of New York's comprehensive SUD continuum of care. It is essential to ensuring that individuals with high-acuity substance use disorders (including individuals with co-occurring mental health conditions, opioid use disorder, and complex medical and social need) receive timely access to clinically appropriate treatment. IMDs offer intensive, short-term treatment that supports stabilization and transitions to lower levels of care within the broader continuum of care. While changes in drug-related overdose deaths and other substance use disorder outcomes may be attributed to multiple factors, including broader statewide investments across the continuum of care, the State has observed encouraging improvements in several SUD-related outcomes during the period of IMD implementation. For example, from 2022 to 2024, drug-related fatal overdose rates decreased by 31 percent and drug-related non-fatal overdose discharges from the emergency department or inpatient hospitalization decreased by 15 percent. Statewide, the drug-related fatal overdose rate fell from 32.3 to 22.4 per 100,000 residents over this period, while drug-related non-fatal overdose discharges declined by 19 percent from emergency departments and by 7 percent from inpatient hospitalizations.[9,10]

Continued comprehensive 1115 IMD waiver authority ensures that residential programs may provide the medical, psychological, rehabilitative, and recovery-oriented supports necessary for sustained recovery. Continued authority is essential to maintaining statewide treatment capacity and preserving access to evidence-based residential services for Medicaid beneficiaries who might otherwise experience delays in care, avoidable emergency department utilization, inpatient admissions, homelessness, criminal justice involvement, or disengagement from treatment altogether.

During the period of New York's IMD initiative and the continued expansion of New York's residential and community-based treatment continuum, the State has observed encouraging trends across several key performance indicators related to access to care, continuity of treatment, and utilization of evidence-based services. Among Medicaid beneficiaries, follow-up after an emergency department visit for SUD improved by 7.3 percent within 7 days and 5.5 percent within 30 days between 2022 and 2024. Follow-up after high-intensity care improved by 6.6 percent within 7 days and 3.1 percent within 30 days, reflecting stronger care transitions and coordination across levels of care. During the same period, utilization of evidence-based medications also increased among Medicaid beneficiaries. Initiation of pharmacotherapy following a new episode of opioid use disorder improved by 14.7 percent, while use of pharmacotherapy for alcohol use disorder improved by 12.7 percent. Treatment engagement rates also increased across alcohol, opioid, and other drug categories. Specifically, treatment engagement increased by 3.5 percent for alcohol use disorder, 2.9 percent for opioid use disorder, and 1.6 percent for other drug use disorders.[11]

New York expanded statewide treatment capacity. Between 2022 and 2025, bedded treatment capacity increased by 6.4 percent (from 58.2 to 61.9 per 100,000 residents), ambulatory treatment capacity increased by 26.2 percent (from 184.5 to 232.7 per 100,000 residents), and total capacity across all program types increased by 21.4 percent (from 242.7 to 294.7 per 100,000 residents).

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[9] Centers for Disease Control and Prevention. (2026). *Mortality Data on CDC Wonder, 2018–2024*. National Center for Health Statistics. https://wonder.cdc.gov/mcd.html

[10] Centers for Disease Control and Prevention. (2026, May). *Nonfatal Drug Overdose Surveillance and Epidemiology (DOSE-SYS) System* [Interactive dashboard; filtered for the state of New York, January 2022 – December 2024]. https://www.cdc.gov/overdose-prevention/data-research/facts-stats/dose-dashboard-nonfatal-surveillance-data.html

[11] New York State Office of Addiction Services and Supports. *OASAS Analysis of Medicaid Claims and Encounter Data, 2022 – 2024.*

These measures reflect statewide treatment capacity and include both Medicaid and non-Medicaid populations. This sustained growth in both bedded and community-based capacity through the IMD initiative reflects the State's continued investment in a comprehensive continuum of care.[12]

New York's IMD initiative supports the State's behavioral health transformation efforts by ensuring that residential treatment is integrated into a person-centered continuum of care that includes withdrawal and stabilization services, outpatient treatment, medications for addiction treatment, crisis stabilization, peer and recovery supports, care management, reintegration services, and recovery-oriented community-based care consistent with the American Society of Addiction Medicine guidelines. The demonstration has also facilitated greater consistency in coverage, reimbursement, and care coordination across Medicaid fee-for-service and Medicaid managed care delivery systems.

The purpose of this request is to strengthen statewide treatment infrastructure, preserve residential treatment capacity, improve coordination across the continuum of SUD care, and support ongoing reductions in avoidable emergency department use, inpatient admissions, overdose deaths, and other adverse health outcomes. As an essential part of the broader continuum, IMDs ensure individuals receive care in the most appropriate setting.

Consistent with CMS guidelines, New York's IMD authority advances two evidence-based goals:

1. Increasing engagement in SUD care across the continuum; and
2. Improving the quality of care and health outcomes for individuals with SUD.

The demonstration aligns with CMS guidance encouraging states to improve access to clinically appropriate residential treatment while simultaneously strengthening community-based behavioral health infrastructure and promoting care in the least restrictive appropriate setting.

New York's 2024 SUD IMD waiver initiative, which allows for federal financial participation for services delivered in qualifying IMD settings, has expanded access to residential treatment, improved coordination across the continuum, and strengthened the overall SUD treatment system. Through the waiver, New York introduced a residential re-integration service that supports transition to independent living in an environment supportive of recovery.

Through the implementation of standardized clinical assessment tools, such as Level of Care for Alcohol and Drug Treatment Referral (LOCADTR), New York has strengthened its ability to ensure individuals are matched to the appropriate levels of care and can transition effectively across levels of treatment settings.

Additional innovations include expanded opioid prescriber education, enhanced integration of the Prescription Monitoring Program, strengthened protocol monitoring and reporting requirements, and enhanced coordination across physical health, mental health and substance use disorder treatment settings. Medicaid reimbursement methodologies, updated rate codes, utilization review process, reporting requirements, and extensive provider training further support consistent, high-quality implementation statewide across both fee-for-service and managed care delivery systems. These updates reflect the State's commitment to continuous improvement across its care continuum, including withdrawal and stabilization, rehabilitation, reintegration, and community-based recovery supports.

As part of these changes, the State transitioned legacy residential programs to the Part 820 model, establishing a single, recovery-oriented, standardized framework for SUD residential treatment across stabilization, rehabilitation, and re-integration levels of care. This redesign strengthens New York's ability to divert individuals from unnecessary inpatient hospitalization and emergency

[12] New York State Office of Addiction Services and Supports. (2026). *OASAS Provider and Program Search.* https://webapps.oasas.ny.gov/providerDirectory

department utilization while supporting transitions to lower levels of care and community-based recovery supports.

Part 820 Residential Programs are a cornerstone of New York's ability to expand access to community-based alternatives to higher levels of care while providing recovery-oriented step-down services. The Part 820 model enhanced the State's capacity to address gaps in crisis response and recovery support by allowing programs to provide short-term crisis, stabilization, respite, and reintegration services designed to reduce relapse risk and support sustained recovery in community settings.

Continued IMD authority is particularly important for members who struggle to access healthcare including individuals in rural communities, individuals experiencing homelessness, formerly incarcerated populations, and individuals with co-occurring behavioral health conditions who frequently encounter barriers to timely treatment access. Recent improvements have been observed across communities throughout the State, including those that have historically faced barriers to treatment access. Between 2022 and 2024, 79 percent of New York counties, including 72 percent of rural counties and 87 percent of urban counties, experienced reductions in total overdose fatalities. Further, 98 percent of counties, including 97 percent of rural counties and 100 percent of urban counties, saw reductions in non-fatal overdoses. At the same time, disparities persist within the State, underscoring the continued need for accessible, clinically appropriate residential and inpatient treatment for high-need populations across geographic areas.

The State continues to implement its IMD demonstration with a focus on measurable performance, quality improvement, and accountability. New York continues to monitor implementation and outcomes through demonstration reporting, quality oversight activities, managed care monitoring, and performance measurements aligned with CMS SUD demonstration expectations. Measures include indicators related to treatment access, continuity of care, transitions between levels of care, emergency department utilization, inpatient utilization, medication utilization, overdose-related outcomes, and engagement in treatment.

National evidence supports continuation of IMD expenditure authority as part of the comprehensive state SUD delivery system efforts. Research shows that federal financial participation for IMD services is associated with reduced inpatient and emergency department utilization, lower cost of care, improved quality of care, and increased access to integrated SUD and behavioral health services.[13, 14, 15]

In summary, continued IMD authority remains essential to maintain access to clinically appropriate residential and inpatient SUD treatment for Medicaid beneficiaries. As demonstrated through improvements in treatment engagement, follow-up care, medication utilization, overdose outcomes, and treatment capacity, the waiver has strengthened New York's ability to provide care across a comprehensive continuum of services. Extension of this authority will allow the State to preserve these gains while continuing to strengthen community-based services and support a comprehensive continuum of care for individuals with substance use disorders.

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[13] Baser, O., Waters, H. C., Yapar, N., Rodchenko, K., Isenman, L., Han, X., Freedman, D., & Patel, R. (2025). Impact of Medicaid Institution for Mental Diseases exclusion on serious mental illness outcomes. *The American Journal of Managed Care, 31(12), 364–370.* https://doi.org/10.37765/ajmc.2025.89841

[14] California Department of Health Care Services. (2022). *Drug Medi-Cal Organized Delivery System FY 2021 evaluation report*. https://www.uclaisap.org/dmc-ods-eval/assets/documents/20220422-DMC-ODS-FY-2021-Evaluation-Report-with-Appendices_V2.pdf

[15] Ge, Y., Romley, J. A., & Pacula, R. L. (2024). The impact of Medicaid Institution for Mental Disease exclusion waivers on the availability of substance abuse treatment services and the varying effect by ownership type. *The Milbank Quarterly, 102(3), 669–691.* https://doi.org/10.1111/1468-0009.12710

3.6 Designated State Health Programs (DSHP)

The State makes three requests concerning DSHP funding:

- To rollover already-drawn down DSHP funds that the State projects will remain unspent by the end of the demonstrations for continued use on the DSHP-funded initiatives approved in the current demonstration, including HRSN services, HERO and Workforce initiatives into the extension period;
- To continue expenditure authority to draw down FFP for unclaimed DSHP funds up to the already approved total $3.9 billion in total computable in the current demonstration[16] to be spent on the DSHP-funded initiatives; and
- For the Workforce initiatives, to exercise the time-limited close-out expenditure authority referenced in the current demonstration's STCs. STC 12.7.d permits the State to pay administrative costs and monitor remaining service obligations associated with the Student Loan Repayment for Qualified Providers (known as the Healthcare Access Loan Repayment [HEALR] program) and Career Pathways Training programs from April 1, 2027 until March 31, 2031, as the programs phase out.

The State received DSHP approval on January 9, 2024, and spent the following year rapidly standing up the necessary infrastructure for the five DSHP-funded initiatives.[17] As a result, HRSN services, the largest DSHP-funded initiative, became operational in January 2025. On April 10, 2025, CMS released an SMDL RE: Designated State Health Programs and Designated State Investment Programs stating it does not anticipate approving new state proposals for or renewing existing Section 1115 demonstration expenditure authority.[18] Because these services launched recently, an additional year to draw down FFP for unclaimed DSHP funds would support New York to fully realize the program's intended improvements in health outcomes and generate the associated cost savings. Accordingly, the State requests an additional five years – the full duration of the renewal demonstration period – to spend the remaining DSHP funds.

DSHP funding provided New York the opportunity to successfully scale up a first-of-its kind social care infrastructure that transforms care delivery, while also enabling investments to strengthen the state's healthcare workforce. However, ongoing economic uncertainty, medical cost pressures in public health insurance programs, and the potential for reduced federal assistance constrain the State's ability to sustain these initiatives without DSHP authority. Continued DSHP authority is needed to maintain these initiatives as designed and to ensure continuity of care for the thousands of members who have engaged in HRSN services to date.

Compliance with provider rate increase requirement: On November 24, 2025, CMS approved New York's Provider Payment Rate Increase Attestation Table, submitted per Section 7 of the STCs. New York sustained rates for the three service categories (primary care, obstetric, and behavioral health services) at the required levels for the remainder of the demonstration period and invested more than $199 million in rate increases for primary care.

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[16] DSHP preliminary financial projections summary – unclaimed DSHP funds – as of 08/26/26 with HRSN services projections as of 07/13/26.

[17] The five DSHP initiatives are HRSN infrastructure (i.e., Social Care Networks), HRSN services, CPT, HEALR, and HERO.

[18] Drew Snyder. (2025, April 10). *RE: Designated state health programs and designated state investment programs*. CMS. https://www.medicaid.gov/resources-for-states/downloads/dshp-dsip.pdf

Initiatives Continuing with Amendments

3.7 Demonstration-Eligible Populations

The State requests to continue waiver and expenditure authorities for its demonstration-eligible populations, with one amendment. The State requests to continue:

- **Demonstration Population 9 (HCBS Expansion):** Individuals who are not otherwise eligible, who are receiving HCBS, and who are determined to be medically needy based on New York's medically needy income level, after application of community spouse and spousal impoverishment eligibility and post-eligibility rules consistent with Section 1924 of the Act;
- **Demonstration Population 10 (Institution to Community)**: Individuals moved from institutional nursing facility settings to community settings for long-term services and supports who would not otherwise be eligible based on income, but whose income does not exceed the income standard described in the existing demonstration's CMS-approved STC 4.4(c), and who receive services through the managed long-term care program under the demonstration; and
- **Demonstration Population 12 (Family of One [Fo1] Children):** Medically needy children Fo1 Demonstration children under age 21 with a waiver of 1902(a)(10)(C)(i)(III) who meet the targeting criteria, risk factors, and clinical eligibility standard for #NY.4125 waiver including intermediate care facilities (ICF), nursing facilities (NF), or Hospital Level of Care (LOC) who are not otherwise enrolled in the Children's 1915(c).

The State requests to discontinue authority for Demonstration Population 2 (TANF Adult). For a full description of the TANF Adult discontinuation, see the Discontinuing Initiatives section.

3.8 Health-Related Social Needs (HRSN) Services

The State requests to continue expenditure authority to provide the full scope of HRSN services to eligible populations, as approved during the prior demonstration period, with minor modifications described below.

New York's approach centers on Social Care Networks (SCNs), which are operated by regional SCN Lead Entities – hubs that connect members to HRSN services, coordinate care, and ensure Medicaid members get the support they need. This model deploys evidence-based practices to support proactive, patient-centered whole-person care focused on improving health and disease prevention, slowing disease progression, and reducing healthcare costs. HRSN services address key upstream drivers of chronic disease – including housing instability, food insecurity, and transportation barriers: each associated with poor health outcomes and increased healthcare utilization among Medicaid members.[19] Continuing this authority will maintain care continuity for the more than 1.5 million members who have already engaged with SCNs, sustain a statewide model that advances whole-person care, and improve population health while reducing avoidable utilization and costs.

Continued expenditure authority will allow New York to collect longer-term outcome data on this innovative program, supporting the State's transition to risk-based payment models. It also upholds ongoing efforts to deliver person-centered care, enhance program integrity, and ensure responsible fiscal stewardship. Sustained authority is critical to maintaining continuity of care for members, including the more than 1.5 million members who have engaged with the SCN program; identifying upstream drivers of health in the remaining unscreened population; and enabling long-term cost

[19] Deng, S., Hager, K., Wang, L., Cudhea, F. P., Wong, J. B., Kim, D. D., & Mozaffarian, D. (2025). *Estimated impact of medically tailored meals on health care use and expenditures in 50 US States*. Health Affairs. https://doi.org/10.1377/hlthaff.2024.01307

reduction – thereby advancing CMS and New York's shared goal of a more accountable, outcomes-driven Medicaid system.

3.8.1 Amendment Requests

Continue non-risk funding for HRSN services during transition to a risk-based funding structure: New York requests to maintain non-risk payments for HRSN services for one additional year, prior to transitioning to risk-based funding[20] in April 2028. This additional period will allow the State to collect sufficient encounter, utilization, and cost data to support actuarially sound rate development and ensure compliance with managed care rate setting requirements, while protecting the federal taxpayer through accurate and appropriate payment levels. DSHP has been critical in the establishment of these services and will be critical to the continued development of these new delivery models. The State will develop a plan to shift cost-effective, evidence-based HRSN services to a risk-based structure, using DSHP funding for the remainder of the demonstration period up to the spending cap. The State will work with CMS to support this structured transition to risk-based arrangements.

Use DSHP funds to continue HRSN services and shift to capitation: New York requests to rollover unspent and unclaimed DSHP funds, as described in the DSHP funding initiative section above, to be used for funding HRSN services. Regarding HRSN Services, New York will use these funds for two purposes:

1. To pay for non-risk HRSN services for one additional year, until moving to capitation in April 2028; and
2. To pay for the state share of Medicaid managed care plan capitation per-member-per-month (PMPM) rates for HRSN services, including any related value-based payment tied to HRSN services.

Authorize expenditures for HRSN services: New York proposes to remove Brokerage Fees from its HRSN service offerings as coverage is no longer necessary. New York City's Fairness in Apartment Rental Expenses (FARE) Act prohibits such fees from being charged to tenants. Although brokerage fees persist in one other region of the State, HRSN expenditures on these fees have been minimal to date.

With this change, New York requests to continue the following HRSN services:

HRSN services
i. Care Management • Level One Care Management (Navigation Services) • Level Two Care Management (Enhanced Population)
ii. Housing • Home Accessibility and Safety Modifications • Home Remediation Service • Asthma Remediation • Medical Respite (Recuperative Care) • Rent/Temporary Housing • Utility Setup/Assistance • Pre-Tenancy Services and Housing Navigation • Community Transitional Supports (CTS)

[20] Capitated payments are fixed, pre-paid, per-person payments for providing contracted services.

• Tenancy Sustaining Services
iii. Nutrition Supports • Nutrition Counseling and Education • Medically Tailored Meals or Clinically Appropriate Home Delivered Meals • Medically Tailored or Nutritionally Appropriate Food Prescriptions • Fresh Produce and Non-Perishable Groceries (Pantry Stocking) • Cooking Supplies
iv. HRSN Transportation Services

Authorize expenditures for HRSN eligible populations: New York recommends updating the enhanced HRSN populations by creating a new population category, "High-Risk Children under Age 18", which consolidates three existing child populations: (1) Juvenile Justice-Involved Youth, Foster Care Youth, and Those under Kinship Care, (2) Children under the Age of 6, and (3) Children under the Age of 18 with one or more chronic condition.

With this update, New York's enhanced HRSN populations would be defined as follows:

HRSN-eligible populations	
i.	High-Risk Children under Age 18 (grouped child populations)
ii.	Medicaid High Utilizers (defined by Emergency Department, Inpatient, or Medicaid spend; or transitioning from an institutional setting)
iii.	Individuals enrolled in a New York State designated Health Home which currently includes individuals with HIV/AIDS, Sickle Cell Disease, Serious Mental Illness, Substance Use Disorder, Serious Emotional Disturbance, Complex Trauma, or two or more chronic conditions (e.g., Diabetes and Chronic Obstructive Pulmonary Disease)
iv.	Individuals with Substance Use Disorder
v.	Individuals with Serious Mental Illness
vi.	Individuals with Intellectual and Developmental Disabilities
vii.	Pregnant persons, up to 12 months postpartum
viii.	Post-release criminal justice-involved population with serious chronic conditions, SUD, or chronic Hepatitis-C

3.8.2 Current Demonstration Progress

Continued authority to provide HRSN services advances New York's and CMS's long-standing goal of improving members' health outcomes while reducing costs from avoidable healthcare utilization. Central to this strategy is addressing upstream drivers of health – consistent with CMS's commitment to whole-person care models that address chronic disease management, preventive care, nutrition, and housing.[21] Evidence suggests that social and environmental factors may account for up to roughly half of the variation in county or population-level health outcomes, while clinical care makes a

[21] *Medicare and Medicaid Programs; CY 2026 payment policies under the physician fee schedule and other changes to Part B payment and coverage Policies; Medicare Shared Savings Program requirements; and Medicare Prescription Drug Inflation Rebate Program.* (2025, July 16). CMS. https://www.federalregister.gov/documents/2025/07/16/2025-13271/medicare-and-medicaid-programs-cy-2026-payment-policies-under-the-physician-fee-schedule-and-other#p-820

more limited contribution.[22] A growing body of research demonstrates that addressing these non-clinical upstream drivers of health is associated with better health outcomes, increased use of preventive care, improved medication adherence, and the potential for meaningful cost-savings.[23,24]

HRSN services increase access to care, transforming health in communities and addressing persistent drivers of chronic disease. New York's model is intentionally designed to reach individuals where they are and meet their unique needs. The program addresses challenges like food deserts, healthcare access gaps, and infrastructure limitations across diverse urban and rural communities with limited access to care.

Since CMS approved New York's HRSN services in January 2024, the State launched and scaled critical statewide infrastructure and moved quickly from foundational investments to statewide service delivery within one year. Since the January 2025 launch, the program has seen strong, sustainable growth in screenings, referrals, network development and service delivery for New Yorkers. HRSN service delivery has scaled, with more than 1.5 million members screened for unmet needs as of August 2026. Comparable programs in other states that have had a longer time to scale have shown significant results for members, the State, and taxpayers. Notably, North Carolina's HRSN program, Healthy Opportunities Pilots, has reduced Medicaid spending by $164 PMPM overall.[25]

3.8.2.1 Infrastructure to support service delivery

Established statewide infrastructure: Since the program launch in 2024, New York quickly built strong regional networks, IT infrastructure, and accountability systems to enable program and service delivery.

This infrastructure also aligns with key national priorities, including:

- Supporting person-centered care through coordinated networks, shared systems, and a trained navigator workforce;[26]
- Strengthening regional infrastructure that expands provider capacity and opens access points in underserved and rural areas;[27]
- Building interoperable, cross-sector data systems for real-time information sharing;[28] and

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[22] Whitman, A., De Lew, N., Chappel, A., Aysola, V., Zuckerman, R., & Sommers, B. D. (2022, April 1). *Addressing social determinants of health: Examples of successful evidence-based strategies and current federal efforts.* (HP-2022-12). Assistant Secretary for Planning and Evaluation, Office of Health Policy. https://aspe.hhs.gov/sites/default/files/documents/6ba4bbb2e9c9551355a6926f023f1585/SDOH-Evidence-Review.pdf

[23] Escobar, E. R., Pathak, S., & Blanchard, C. M. (2021, August 12). *Screening and referral care delivery services and unmet health-related social needs: A systematic review. Prev Chronic Dis 2021*;18:200569. Centers for Disease Control and Prevention. https://www.cdc.gov/pcd/issues/2021/20_0569.htm

[24] Honeycutt, A., Khavjou, O., Tayebali, Z., Dempsey, M., Glasgow, L., & Hacker, K. (2024, December). *Cost-effectiveness of social determinants of health interventions: Evaluating multisector community partnerships' efforts.* American Journal of Preventive Medicine. https://www.ajpmonline.org/article/S0749-3797(24)00256-3/fulltext

[25] *Healthy Opportunities Pilots Lead to Healthier Outcomes and Reduce NC Medicaid Costs.* (2026, June 2). North Carolina Department of Health and Human Services. https://www.ncdhhs.gov/news/press-releases/2026/06/02/healthy-opportunities-pilots-lead-healthier-outcomes-and-reduce-nc-medicaid-costs

[26] *CMS behavioral health strategy.* (2026, April 16). CMS. https://www.cms.gov/about-cms/what-we-do/cms-behavioral-health-strategy

[27] *Rural health.* (2026, March 13). CMS. https://www.cms.gov/priorities/health-equity/rural-health

[28] *Strategic direction.* (2026, March 16). CMS. https://www.cms.gov/priorities/innovation/about/strategic-direction

- Reinforcing fiscal accountability through performance-based funding, standardized reporting, and transparent payment and oversight systems.[29]

The program has scaled regional networks and built provider capacity. New York's HRSN infrastructure was established on a compressed timeline. In only 22 months, SCN Lead Entities built and scaled regional networks (including Community Based Organizations (CBOs), MCOs, healthcare providers, and others), engaged more than 1.5 million members in HRSN screening, and launched HRSN service delivery statewide. This rapid scaling has enabled the program to serve vulnerable populations with chronic conditions. SCN Lead Entities serve populations within each region that range from approximately 105,000 to 2.2 million Medicaid members, achieving considerable scale in a short timeframe.

New York's unique approach ensures "no wrong door" to accessing services by leveraging regional networks and non-traditional access points beyond traditional clinical settings (e.g., schools and places of worship). SCN Lead Entities have built new capacity in their communities through training, upskilling, and local investment to create statewide access for members and ensure a member-centric approach to care and service delivery. As of June2026, these networks include more than 1,400 contracted service providers (more than 800 CBOs and 600 healthcare partners) and more than 3,000 Social Care Navigators. Trainings in trauma-informed care, cultural and linguistic awareness, and care delivery have strengthened networks and ensured members receive high-quality care. Program infrastructure has been intentionally designed to deliver a member-centric experience (e.g., dedicated navigator workforce supporting members at each step, newly developed social care data systems to capture each member's unique needs). SCN Lead Entities have also established recurring trainings and office hours to ensure ongoing support for network partners.

The program has established a technology backbone that supports data flow and encounter-level insights across New York's care ecosystem. Since August 2024, the State has connected the nine SCN Lead Entities, three SCN IT Platform vendors, six Qualified Entities, approximately 25 MCOs, and more than 1,400 CBOs and provider partners. This infrastructure enables real-time data exchange and coordinated care for members with unmet HRSNs – spanning screening, eligibility, referral, service delivery, and outcomes. During program design and launch, the State and SCN Lead Entities worked together to refine technical guidance to enable accurate and member-focused workflows. Developing a novel, member-centric IT Platform for use across the state required focused effort for ongoing refinements during launch to enable a smooth member and provider experience. Through this work, SCN IT Platform vendors have strengthened their ability to integrate health care and targeted support services, including connections with electronic health records across all State platforms. This integrated model is made possible through the Statewide Health Information Network for New York (SHIN-NY), a cutting-edge statewide health information exchange that keeps member data uniform and accessible across stakeholders. Standardized data from each platform ensures reliable oversight, accountability and visibility across the full member journey. SCN Lead Entities receive regular member-level data updates, enabling them to identify high-risk individuals and respond to dynamically evolving member and regional needs. This infrastructure underpins a robust data ecosystem that supports high-quality program evaluation, accountability, and transparency.

SCN systems are built for accountability, performance, and fiscal oversight. The State has established a strong governance and performance management framework ensuring SCN Lead Entities can continually improve, troubleshoot issues, and exchange best practices, while maintaining fiscal accountability and responsible stewardship of Medicaid resources. This framework is built on three pillars: tying funding to performance benchmarks, requiring detailed standardized reporting, and conducting regular performance reviews.

[29] Ibid.

To receive infrastructure funding, SCN Lead Entities must meet defined reporting, quality, and operational benchmarks. For example, benchmarks include training a set number of Social Care Navigators to deliver Screening, Navigation, and Enhanced Care Management services to the region; distributing a threshold of capacity-building funds to network providers; and meeting quarterly targets across screenings, eligibility assessments, and service delivery.

The State requires detailed reporting on both program performance and infrastructure spending. SCN Lead Entities submit Quarterly Performance Reports tracking progress against more than 40 standardized metrics (e.g., network size, members referred to services) with supporting narrative and report on infrastructure spending across technology, workforce, and provider capacity – enabling close oversight of how funds are used. Complementing these formal reports, the State hosts quarterly performance dialogue meetings with each SCN Lead Entity to review progress in depth and collaboratively address challenges.

The State has a performance management strategy in place to monitor and incentivize SCNs to meet HRSN program targets. The State monitors progress in part by using a Weekly Performance Management Report (also known as the "Operational Indicator Survey") that was first implemented in February 2026. Each week, the SCNs report on HRSN screenings, eligibility assessments, referrals, and service delivery metrics. Several metrics are also included to measure network and operational efficiency.

3.8.2.2 Screening and HRSN service delivery

This foundational infrastructure has enabled coordinated HRSN screening and service delivery at scale across New York. HRSN services launched statewide in January 2025, less than one year after CMS approved the program.

Screenings scaled across the healthcare system. SCN Lead Entities have implemented a consistent, statewide process for identifying people's needs and connecting them to services, embedding HRSN screening into routine clinical and community touchpoints. All screenings are conducted using a standardized version of the Accountable Health Communities (AHC) HRSN Screening Tool, ensuring consistency across regions and reliable identification of unmet HRSNs.

Screening volumes have grown rapidly with broader provider participation, a maturing workforce, and stronger integration across care settings. As of August 2026, more than 1.5 million out of 5.4 million waiver eligible members (approximately 28 percent) have received an HRSN screening. Of the remaining approximately 3.9 million members who have not yet received a screening, the State estimates that approximately 2.3 million (approximately 60 percent) have an unmet HRSN, aligned with SCN program screening data to date. Ensuring that SCNs can continue to reach the potential 2 million plus members with unmet needs will improve health outcomes and reduce healthcare costs across the state.

Nearly 60 percent of members screened to date have at least one unmet social need, with nutrition being the most common (86 percent), followed by housing (53 percent) and transportation (34 percent). Of members identified as having an unmet HRSN, nearly 60 percent have two or more unmet needs. Moreover, these screenings connect members to pathways supporting employment and education, aligning HRSN investments with broader Medicaid commitments to increased workforce participation.

The program has achieved statewide access and delivery. SCNs report at least one contracted provider for every HRSN service in all 62 counties (except for medical respite, as the certification process was recently launched). On average, each county has approximately 20 HRSN service providers. Beyond this breadth, regional customization ensures members can access services and have their needs appropriately met. Proof points range from local synagogues in New York City coordinating kosher meal services for more than 1,000 members to rural CBOs that actively plan

around transportation constraints to connect residents with HRSN services. Historically, barriers such as provider shortages, transportation access, and limited care infrastructure have disproportionately affected populations with high medical needs and high medical costs.[30] The SCN program prioritizes regionally specific access to get ahead of those challenges upstream, enabling earlier identification of needs and more sustained engagement for members who might otherwise remain disconnected from care.

New York operates a person-centered, integrated care approach to improve outcomes for high-need populations. New York's HRSN services take a person-centered integrated approach – conducting screenings and providing targeted support services to ensure members receive coordinated support across providers and settings. SCN Lead Entities are responsible for identifying and addressing members' HRSNs, reducing administrative burden on clinical providers and ensuring every Medicaid member can access a dedicated support network. An example of this is SCNs embedding social care navigators into clinical practices. Social Care Navigators work to provide referrals, follow-up, and ongoing support – ensuring timely access to services and continuity of care.

HRSN services are reaching younger, higher-need members with greater healthcare utilization and costs. Over a 12-month period (December 2024 through November 2025), SCN program evaluation data shows that non-dual Medicaid members receiving enhanced HRSN services have significant clinical needs and healthcare utilization compared to the statewide non-dual Medicaid population. Members receiving services were two to three times more likely to have certain chronic conditions than the statewide comparison population. Healthcare spending among members receiving services was approximately 2.25 times higher than the statewide comparison population, averaging $1,766 PMPM compared to $782 PMPM.

Targeted, data-driven initiatives are being rolled out across the state to improve outcomes for high-need populations. In one diabetes-focused initiative, providers identify eligible members who are then connected to Social Care Navigators who deliver nutrition and care management supports, and track outcome measures including cost, ED utilization, and clinical indicators such as hemoglobin A1C. Similar initiatives are underway for members with asthma and for pregnant and postpartum members. By tailoring interventions to the specific needs of high-risk populations, these initiatives aim to drive measurable improvements in health outcomes while reducing high-cost utilization that falls disproportionately on these members.

Members benefit from services across four HRSN domains. Members are accessing a comprehensive, integrated set of HRSN services structured across four core domains – housing, nutrition, care management, and transportation – each targeting critical upstream drivers of health. Together, these services help members better manage chronic conditions, engage in care, and reduce avoidable high-cost utilization.

- **Housing:** Housing services help members find, maintain, and live safely in stable housing. These services prevent adverse health outcomes for vulnerable populations through services ranging from Home Modifications (e.g., handrails and grab bars for medically frail members) to Medical Respite (Recuperative Care) for homeless members after their surgery.

  Evidence from similar programs demonstrates significant reductions in acute care utilization and costs related to hospitalization.[31] Maryland's Section 1115 housing program reported a

[30] Douthit, N., Kiv, S., Dwolatzky, T., & Biswas, S. (2015, June). *Exposing some important barriers to health care access in the rural USA.* Elsevier Public Health. https://www.meddean.luc.edu/lumen/meded/pathology/homepage/small%20groups/ay2017/ruralhealthcaredisparities.pdf

[31] Deng, S., Hager, K., Wang, L., Cudhea, F. P., Wong, J. B., Kim, D. D., & Mozaffarian, D. (2025, April 7). *Estimated impact of medically tailored meals on health care use and expenditures in 50 US States*. Health Affairs. https://doi.org/10.1377/hlthaff.2024.01307

48 percent reduction in overall hospital visits and a 51 percent reduction in emergency department visits following placement in supportive housing.[32] California saw a 29 percent net cost reduction from its recuperative care supports for people at risk of homelessness[33] and a 14.5 percent net medical cost reduction associated with home accessibility and safety modifications.[34] A U.S. Department of Health and Human Services evidence review similarly found that supportive housing improves health outcomes and reduces inpatient, emergency department, and long-term care costs.[35]

These outcomes are reflected in the experiences of New York members. One SCN Lead Entity helped a Staten Island member, who had been homeless for three years while living with lupus, secure stable housing for herself and her children. With safe housing in place, she now consistently attends medical appointments and better manages her health. Another SCN Lead Entity assisted a member in the rural Finger Lakes region with asthma who had been visiting the emergency department multiple times per week for nebulizer treatments due to lack of electricity at home. By addressing her overdue rent and utility needs, she was able to use the nebulizer reliably in her house and stopped visiting the emergency department while better managing her condition.

- **Nutrition:** Nutrition supports help members put fresh food on the table. Services range from medically tailored meals designed for people with chronic conditions, to pantry stocking fresh produce for pregnant members and high-risk children under age 18, improving nutrition and preventing adverse health outcomes.

  Evidence shows that nutrition services reduce hospitalizations and overall healthcare costs. A study of California's Medi-Cal Community Supports program found that services like medically tailored meals were associated with reductions in emergency department use and hospitalizations.[36] Medically tailored meal provisions specifically were associated with a 47 percent reduction in annual hospitalizations and 19.7 percent reduction in annual healthcare expenditures.[37]

  For high-risk members navigating difficult transitions, these supports can be transformative.

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[32] Miller, R. G., Wright, R. S., Hatton, C. R., Lepley, D., & Lindamood, K. (2024). *Preliminary impact of supportive housing on hospital utilization for individuals experiencing homelessness.* Transactions of the American Clinical and Climatological Association, 134, 123–132. https://pmc.ncbi.nlm.nih.gov/articles/PMC11316863/

[33] *Medi-Cal community supports are delivering on their promise: Cost-effectiveness of California Medi-Cal community supports fact sheet*. (2026, May). California Department of Health Care Services. https://www.dhcs.ca.gov/wp-content/uploads/2026/05/Cost-Effectiveness-of-California-Medi-Cal-Community-Supports-Fact-Sheet.pdf

[34] *Community supports, or in lieu of services (ILOS), annual report*. (2025, April). California Department of Health Care Services. https://www.dhcs.ca.gov/wp-content/uploads/2025/10/DHCS-1915b-Annual-Report-on-ILOS-STC-B20-2025.pdf

[35] Whitman, A., De Lew, N., Chappel, A., Aysola, V., Zuckerman, R., & Sommers, B. D. (2022, April 1). *Addressing social determinants of health: Examples of successful evidence-based strategies and current federal efforts.* Assistant Secretary for Planning and Evaluation, Office of Health Policyhttps://aspe.hhs.gov/sites/default/files/documents/6ba4bbb2e9c9551355a6926f023f1585/SDOH-Evidence-Review.pdf

[36] Medi-Cal community supports are delivering on their promise: Cost-effectiveness of California Medi-Cal community supports fact sheet. (2026, May). California Department of Health Care Services. https://www.dhcs.ca.gov/wp-content/uploads/2026/05/Cost-Effectiveness-of-California-Medi-Cal-Community-Supports-Fact-Sheet.pdf

[37] Hager, K., Cudhea, F. P., Wong, J. B., Berkowitz, S. A., Downer, S., Lauren, B. N., & Mozaffarian, D. (2022). *Association of national expansion of insurance coverage of medically tailored meals with estimated hospitalizations and health care expenditures in the US*. JAMA Network Open. https://doi.org/10.1001/jamanetworkopen.2022.36898

One SCN Lead Entity supported a member with brittle diabetes transitioning from incarceration. The man had experienced multiple hospitalizations due to malnutrition while living in a hotel with no access to groceries. The member's Social Care Navigator connected him to nutrition services, and he was able to better manage his chronic condition while successfully navigating the transition back into the community.

- **Care Management:** Enhanced Care Management connects members to a coordinated network of services, including CBOs, healthcare providers, MCOs, crisis services, and behavioral health services. Care managers work across providers, schools, and community programs to build unified care coordination and ensure timely service delivery.

  In the Bronx, one SCN Lead Entity has partnered with approximately 15 schools to engage high-risk children and their families, connecting them quickly to relevant services such as case management for asthma remediation. By meeting families in a trusted, familiar setting, this approach reduces barriers to care and enables earlier intervention, helping children stay healthy, in school, and on track.

- **HRSN Transportation:** Reliable transportation to HRSN services helps members access non-clinical supports – such as housing services and nutrition programs – that address upstream drivers of health. For low-income and high-risk populations, lack of transportation is a well-documented barrier to engaging with these services and its effects fall disproportionately on members in areas with limited access to care. By removing this barrier, transportation services ensure those most affected by upstream drivers of health can access the supports they need.

Service delivery is accelerating. With more than a year of operational experience and robust data confirming the prevalence of unmet social needs, New York is now focused on HRSN service delivery for members with identified needs. Analogous to screenings which grew sevenfold from the period Q1 2025 to Q1 2026 and reached more than 1.5 million members as of August 2026, service delivery has rapidly accelerated. As SCNs have achieved full-scale operations over recent months, the number of members who began receiving services quadrupled between January and May 2026. This growth reflects increased operational capacity, more precise targeting of members with unmet needs, growing provider confidence, and positive member experiences with the SCN model.

Future payment model ties funding to results and accountability. The SCN program is building toward a transition to value-based payment (VBP). SCN Lead Entities function as Medicaid-billing entities that manage HRSN infrastructure and service delivery, receiving PMPM payments and fee-for-service reimbursements while contracting with downstream providers. This structure makes SCN Lead Entities responsible for outcomes, service quality, data accuracy, and fiscal stewardship. The model applies managed care-style payment, reconciliation, and oversight mechanisms to HRSN services at statewide scale.

Central to this oversight is an annual PMPM reconciliation process in which New York compares encounter data submitted by MCOs against actual HRSN spending to verify that payments were consistent with Medicaid enrollment, demonstration eligibility, and the established HRSN fee schedule. Overpayments are recouped and underpayments are reconciled. As SCN Lead Entities complete their annual reconciliation, the State will be positioned to assess performance, validate expenditures, and increasingly tie payments to outcomes – aligning with CMS's initiatives on value-based payment and performance-driven models.[38, 39]

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[38] *MAHA ELEVATE (Make America Healthy Again: Enhancing Lifestyle and Evaluating Value-based Approaches Through Evidence) model.* (2026, May 18). CMS. https://www.cms.gov/priorities/innovation/innovation-models/maha-elevate

[39] Centers for Medicare & Medicaid Services. (2026, March 16). *Strategic direction.* https://www.cms.gov/priorities/innovation/about/strategic-direction

Continued authority is essential to sustain this model, maintain members' continuity of care, address upstream drivers of health, and reduce long-term costs – delivering on CMS and New York's goal of a more accountable, outcomes-driven Medicaid system.

3.9 Workforce Initiatives

Under the Section 1115(a) demonstration, New York developed workforce initiatives to address critical shortages in high-need health, behavioral health, and social care professions.

On July 17, 2025, CMS issued guidance indicating that the agency does not anticipate approving proposals for new workforce authority or extensions of existing workforce authority. The guidance notes that the agency would "allow currently approved initiatives to run their course."[40] Consistent with the planned phase-out of these initiatives, the State requests to rollover and exercise unused expenditure authority for Workforce funds from the current demonstration period into the extension period solely for service commitment monitoring and close-out purposes. This request is limited to the time-limited expenditure authority authorized by STC 12.7.d. As the program phases out, the State will pay close-out administrative costs and monitor remaining service obligations associated with the Student Loan Repayment for Qualified Providers and Career Pathways Training programs from April 1, 2027 through March 31, 2031.

These initiatives are aimed at addressing one of the most acute challenges facing New York's healthcare system; the State projects a significant healthcare workforce shortage by 2030, with an additional 33,420 registered nurses; 9,010 licensed practical nurses; and 9,360 nurse practitioners needed to keep pace with demand.[41] Taken together, these programs are valuable tools for addressing the workforce shortage while maintaining and expanding access to care for Medicaid members across New York. Given CMS's guidance advising that the agency does not anticipate approving expenditure authority for new or existing Workforce initiatives, the State therefore requests the close-out expenditure authority specified in the current demonstration's STCs.[42]

The purpose of these requests is to support the monitoring and close-out of two Workforce initiatives implemented under the current demonstration: (1) CPT and (2) HEALR programs. Both programs were designed to address shortages in high-demand physical and behavioral healthcare roles, thereby increasing the availability of critical staff across New York's healthcare workforce.

The CPT program provides tuition support, academic support services, career guidance and job placement support, and other supports for individuals entering or advancing in health-related fields who commit to three years of full-time work with Medicaid-serving providers. The program was designed to fill critical gaps in provider access for Medicaid members, provide holistic support to trainees, and create economic opportunities for future healthcare workers, while maintaining strong fiscal discipline and program oversight. The program is regionally administered and covers tuition, program fees, textbooks and supplies, and backfill reimbursement for participants.

In New York, where some regions have faced acute shortages in specialized provider care, the CPT program is essential to expanding services for Medicaid members. For example, the CPT program has enrolled 2,648 in behavioral health training and education programs, addressing a critical need across the state and advancing New York's commitment to expanding behavioral health capacity. Notably, by enrolling more than 9,4610 participants in nursing programs, CPT's targeted focus on the

[40] Drew Snyder. (2025, July 17). *Section 1115 demonstration authority for workforce initiatives*. CMS. https://www.medicaid.gov/resources-for-states/downloads/workforc-ltr-to-states.pdf

[41] Represents growth from 2020. 2024 Health Care Workforce in New York State (Center for Health Workforce Studies): https://www.chwsny.org/wp-content/uploads/2024/05/Health-Care-Workforce-in-NYS-Tracking-Final.pdf

[42] Drew Snyder. (2025, July 17). *Section 1115 demonstration authority for workforce initiatives*. CMS. https://www.medicaid.gov/resources-for-states/downloads/workforc-ltr-to-states.pdf

nursing shortage represents a significant contribution toward closing statewide workforce gaps. This intentional approach helps direct investments precisely where they are most needed to improve access to care for Medicaid members.

Beyond tuition assistance, the CPT program's impact extends to wraparound support services that drive student success. Three Workforce Investment Organizations (WIOs), designed to administer the CPT program, facilitate partnerships and connect students with case management, tutoring, and other academic supports, including books, fees, and backfill. These services are intended to remove or reduce common barriers that prevent students from succeeding in their courses, completing their programs, obtaining professional licensure (if required), and securing job placement. In one example, a WIO helped facilitate tutoring services for students struggling academically, resulting in the students' average grades increasing from 69 percent to 91 percent in four months.[43]

The CPT program has established a dual-pipeline workforce development model that simultaneously advances the careers of existing healthcare workers while recruiting new entrants into the Medicaid workforce. This approach fills immediate entry-level gaps while creating clear pathways for career progression, which is crucial to long-term workforce retention. To date, the program has enrolled more than 8,544 new individuals and upskilled more than 5,688 incumbent workers.

The program also promises substantial economic benefits for New York's healthcare ecosystem. Of the nearly 14,232 participants enrolled to date, 11,805 (82 percent) fell below 80 percent of the Area Median Income, and 1,295 were unemployed at the time of enrollment. By reaching workers and moving them into stable healthcare careers, the program offers a genuine pathway to economic mobility while contributing to a meaningful reduction in the State's healthcare workforce shortage.

Grounded in a robust, data-driven performance management framework, the CPT program actively tracks key metrics including the number of enrolled students, number of trainees who have completed training, and, most critically, the number of students meeting their three-year service commitment. This focus on measurable outcomes supports accountability and provides clear visibility into the program's success in addressing regional workforce vacancy rates.

The HEALR program offers student loan repayment to eligible providers who make a four-year commitment to full-time service caring for at least 30 percent Medicaid or uninsured patients. Targeted providers include psychiatrists, primary care physicians, dentists, nurse practitioners, and pediatric clinical nurse specialists. By removing or reducing the educational debt for an essential pool of healthcare workers, the HEALR program attracts and retains workers in high-need specialties and aims to improve member access to care. To date, the State has received 890 applications for the HEALR program. The program has helped bridge the gap between the State's supply of and demand for child psychiatrists and has expanded access to dental providers specializing in the treatment of Medicaid members with intellectual and developmental disabilities.

One of the clearest lessons from the current MRT demonstration is that targeted investment in a robust healthcare workforce is essential to a strong Medicaid program. As one participant in the program reported, CPT program "has given me access to quality education and training without the overwhelming financial burden. I can focus fully on developing the skills necessary to become a competent, compassionate healthcare provider. This program means greater financial stability, a faster path to graduation, and the ability to enter the workforce sooner with less debt. It also reinforces my confidence and commitment to making a meaningful impact in the lives of those I will care for." While the State acknowledges CMS's decision not to continue granting expenditure authority for workforce initiatives, the experience of the current demonstration makes clear that investments in workforce development are among the most effective tools available to strengthen

[43] Data from September 2025 to December 2025, provided by the Finger Lakes Performing Provider System WIO

Medicaid delivery, expand access to care, and meet the evolving needs of New York's communities.

3.10 Health Equity Regional Organization (HERO)

The State requests to continue the remaining $78 million in expenditure authority for the HERO initiative. The HERO has been a third-party research entity responsible for collecting data and making recommendations for data-driven, tailored strategies to advance population health.

The purpose of this request is to build upon existing infrastructure and information gathered during the initial demonstration period and transition to an advanced analytics platform to better support program operations and integrity. During the current demonstration, the HERO integrated Medicaid claims, HRSN data, vital statistics, and stakeholder input from regional convenings to identify gaps in access, quality and outcomes across physical health, behavioral health, and HRSN services. The HERO also conducted landscape research in support of initial ideas for future VBP arrangements. This included multi-state literature review of relevant CMMI models and landscape analyses to identify how other state Medicaid programs have integrated HRSN into managed care and provider payment models. As the HERO continues to advance its data aggregation efforts and stakeholder engagement, the State is encouraged by the progress made and looks forward to leveraging these insights to shape future VBP arrangements for the delivery of HRSN services as part of the broader demonstration goals.

Evolving those functions of the HERO would enable New York to be at the forefront of Medicaid data analytics and program administration, including enabling real-time feedback to inform decision-making. In addition to supporting evidence-based policy decisions based on observed metrics of success, it would leverage predictive modeling, machine learning, and anomaly detection to help serve as an early warning system for outlier programmatic, billing, or referral patterns before they become material, enabling reforms and referrals to be implemented quickly as issues arise. By improving the speed and quality of data analysis and decision-making, this new team will help improve program design and operations, while ensuring continued access to care for those who need it most.

Throughout the next demonstration period, the HERO can work to refer identified instances of potential fraud, waste, and abuse to the Office of the Medicaid Inspector General (OMIG) for investigation and action as appropriate, continuing to safeguard the Medicaid program. OMIG is an independent entity created within the New York State Department of Health to promote and protect the integrity of the Medicaid program in New York.

Continued authority and rollover of unspent funds are necessary to build on the foundation set forth during the current demonstration period and to support New York's data-driven approach to evidence-based policymaking and program integrity.

3.11 Medicaid Hospital Global Budget Initiative (MHGBI)

Under the Section 1115(a) demonstration, New York launched the MHGBI to support financially distressed hospital transformation to prepare for the transition toward advanced VBP models. The State is requesting Medicaid authority for hospital global budgets in accordance with the Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model requirements.

New York continues to prioritize hospital transformation efforts and readiness for the AHEAD model by working across the AHEAD project team and the Section 1115(a) demonstration team, coordinating closely with stakeholders, and making strides developing the Medicaid hospital global budget methodology. The State's AHEAD project team conducts regular meetings with the Center for Medicare and Medicaid Innovation (CMMI) to assess the model policy and timeline changes initiated in 2025. In terms of authority pathways for Medicaid hospital global budgets, New York submitted a

preliminary list of questions related to federal authority for global budgets to the Centers for Medicaid & CHIP Services (CMCS) in April of 2025 and awaits guidance on those questions. To continue preparing for Medicaid hospital global budget implementation, the State plans to initiate group and one-on-one engagement with hospitals to evaluate the current status of hospital readiness in more depth, assess the potential financial impacts of transitioning to a global budget methodology, and support modifications to existing contract agreements with payors. These activities will support hospital readiness for a global budget arrangement and prepare for the commitment to CMMI's AHEAD hospital participation milestone by at least 90 days prior to the beginning of the model's performance period.

In terms of overall methodological approaches to Medicaid hospital global budget, New York has conformed to the AHEAD Notice of Funding Opportunity's (NOFO's) Medicaid alignment criteria. The NOFO stipulates that the Medicaid hospital global budget must be paid on a regular, periodic basis. In particular, the NOFO specifies that the Medicaid hospital global budget considers incentives for hospital recruitment; covers inpatient and outpatient services; accounts for inflation, population growth, and demographic changes; and is adjusted for social and medical risk and performance on quality metrics. It must also account for changes in service line and unplanned volume shifts. In developing the methodology, New York is using this guidance and the Medicare methodology as a reference point, deviating from the Medicare methodology where appropriate for Medicaid-specific concerns and goals. High-level points of deviation include (non-exhaustive and preliminary):

- A risk adjustment approach that is aligned with State Medicaid methodologies and goals, including the use of ZIP code-level 3M Clinical Risk Group (CRG) risk adjustment. This adjustment will be applied annually to reflect changes in beneficiary enrollment and risk scores;
- Developing criteria for assessing and approving service line adjustment requests, forecasted revenue estimates for service line additions/expansions will be added prospectively to the global budget calculation for the first two years (with mid-year reconciliations);
- Alignment of quality metrics with Section 1115(a) demonstration metrics relevant to the Medicaid population, including demographic data completeness, screening for upstream drivers of health, potentially preventable readmissions, and care coordination. The quality adjustment will begin as pay-for-reporting in model performance year 3 and eventually ramp up to pay for performance. Measurement of quality performance will be against hospitals in the relevant region of the state (rather than national benchmarks); and
- A total cost of care (TCOC) adjustment that is calculated, excluding social risk and quality adjustments, will start in performance year 4 as upside only and become two-sided in performance year 7. The TCOC adjustment will also use 3M CRG and take into account the state TCOC accountability target for AHEAD.

New York continues to work with CMS and to hone the details of each Medicaid hospital global budget adjustment and baseline inclusion rules to ensure alignment with CMS criteria and the overall needs of the participating hospitals and Medicaid population impacted. New York will work to develop the HGB baseline through discussions with CMS, but the request is that the MHGBI funding will be maintained in the HGB baseline calculation for eligible hospitals.

Discontinuing Initiatives

The State proposes to discontinue the following initiatives where federal demonstration authority is no longer necessary or aligned with current CMS policy, while taking steps to ensure continuity of services and orderly transitions for impacted individuals.

3.12 Health-Related Social Needs (HRSN) Infrastructure

The State does not request to continue expenditure authority for the HRSN infrastructure funds initiative. The State projects it will reach its $500 million expenditure cap by the end of the current demonstration[44]. In January 2024, CMS approved the launch of the Social Care Networks program. Since the launch, the State developed robust provider networks, IT infrastructure, and accountability systems to enable program delivery. Now established statewide, this HRSN infrastructure is poised to continue to mature and deliver strong outcomes in the next demonstration period. Because ending this authority will not impact members, a transition plan is not necessary.

3.13 Demonstration Services for Behavioral Health Provided under MMMC (Demonstration Services 9: Residential Addiction Services, Crisis Intervention Services, and Licensed BH Practitioner Services)

The State requests to discontinue this authority upon extension (March 31, 2027).

New York originally used the Section 1115(a) demonstration to implement residential addiction services, crisis intervention services, and licensed behavioral health practitioner services for Medicaid Managed Care members. Since implementation, all services authorized under this initiative have transitioned to New York's Medicaid State Plan and have been operationalized as standard components of the Medicaid benefit package.

Because these services have been fully incorporated into the State Plan and are available through the Medicaid program, continued demonstration authority is no longer necessary. Discontinuation of this authority reflects the successful integration and sustainability of these behavioral health services within New York's Medicaid program rather than a reduction in covered benefits, provider participation, or member access to care. Because ending this authority will not impact Medicaid members or the availability of these services, a transition plan is not necessary.

3.14 Self-Direction Pilot

The State requests to discontinue this initiative upon extension (March 31, 2027).

Neither the Adult Self-Direction Pilot nor the Child Self-Direction Pilot has drawn down Medicaid federal financial participation under the Section 1115(a) demonstration. The Adult Self-Direction Pilot will continue to operate under state authority where appropriate. It has been funded exclusively with state funds and does not require extension of federal demonstration approval. The Child Self-Direction Pilot authorized under the current 1115 demonstration was never implemented, and the State does not anticipate implementing the pilot at this time.[45] Since ending this authority will not impact services delivered, the State does not intend to develop a transition plan.

3.15 Behavioral Health Home and Community-Based Services (BH HCBS)

The State requests to end expenditure authority for BH HCBS that have not transitioned to CORE – i.e., Education Support Services, Pre-Vocational Services, Transitional Employment, Intensive Supported Employment, Ongoing Supported Employment, Habilitation, and Non-Medical Transportation.

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[44] DSHP preliminary financial projections summary–HRSN infrastructure spend versus cap–as of 08/26/26 with HRSN services projections as of 07/13/26.

[45] Separate from New York's 1115 authority for the Child Self-Direction Pilot, the State's 1915(c) authority to provide Financial Management Services to assist members in purchasing Adaptive and Assistive Technology (ATT), Environmental Modifications (E-Mods), and Vehicle Modifications (V-Mods) will continue under the Children's Waiver. These services are authorized through the 1915(c) waiver and therefore do not depend on the Section 1115(a) demonstration authority that New York is requesting to discontinue.

Prior to the transition to CORE Services, the utilization of BH HCBS was low. Utilization began to decrease further each month following the CORE Services implementation on February 1, 2022, with claims data showing a substantial shift away from BH HCBS toward CORE Services. Utilization for the remaining seven BH HCBS have continued to decline significantly with approximately 31 individuals enrolled in these BH HCBS.

Final timing for the BH HCBS phase-out will be coordinated with the 1115 waiver extension timeline and public notice process to allow sufficient stakeholder engagement and implementation planning. In coordination with CMS, the State is implementing a structured phase-out process. In parallel, the State will issue formal notification to Health Homes (HHs), Care Management Authorities (CMAs), and BH HCBS providers as well as to HARP and HIV SNP plans with a member notification template.

By the end of the current demonstration period, the State will issue formal notifications to members eligible for or receiving BH HCBS via Mainstream Managed Care Plans. Every individual currently receiving BH HCBS will receive an individualized transition plan and will be connected to appropriate alternative services, including CORE Services and other State Plan behavioral health services. The transition will be complete by the end of the current demonstration and will ensure continuity of care and no service interruption.

New York will monitor the transition process and service use to support a coordinated phase-out aligned with the demonstration extension timeline. In parallel, New York will work with existing BH HCBS providers to support transitions to CORE Service designations or other appropriate service models where providers are interested and eligible.

3.16 Demonstration Population 2 (Temporary Assistance for Needy Families [TANF] Adult)

The State requests to discontinue authority for Demonstration Population 2: Temporary Assistance for Needy Families (TANF) Adult upon extension (March 31, 2027).

Since 2015, adults applying for both TANF and Medicaid no longer need a separate Medicaid eligibility determination – even when their income isn't calculated under Modified Adjusted Gross Income (MAGI) rules. The population was defined as follows:

- **"Demonstration Population 2 (Temporary Assistance for Needy Families [TANF] Adult).** TANF Recipients. Expenditures for healthcare related costs for low-income adults enrolled in TANF. These individuals are exempt from receiving a MAGI determination in accordance with 1902(e)(14)(D)(i)(I) of the Act."

New York is actively planning a structural change to how Medicaid eligibility is authorized for individuals receiving Temporary Assistance benefits. Medicaid eligibility will no longer be derived from the Temporary Assistance determination. The State will work to transition members by January 1, 2027.

3.17 Continuous Eligibility for Children up to Age Six

To comply with the July 2025 CMS guidance, Section 1115(a) Demonstration Authority for Continuous Eligibility Initiatives,[46] specifying that CMS does not anticipate extending existing Section 1115(a) demonstration authority for expanded continuous eligibility initiatives, the State has discontinued continuous eligibility for children up to age six.

New York has phased out continuous eligibility for children up to age six. The necessary system updates have been communicated to stakeholders, and internal coordination continues through the State's customer service call center and appeals units.

[46] Drew Snyder. (2025, July 17). *Section 1115 demonstration authority for continuous eligibility initiatives*. CMS. https://www.medicaid.gov/resources-for-states/downloads/contin-elig-ltr-to-states.pdf

Starting in May 2026, activities began to initiate renewals for children whose current coverage depends on this Section 1115(a) demonstration authority. Some children may no longer be eligible for Medicaid and may need to transition to other forms of coverage. New York's MAGI eligibility system is an integrated eligibility system and considers both Medicaid and Child Health Plus eligibility for children over the income limit for Medicaid. At the time of redetermination, if the member was ineligible for Medicaid, they were reviewed for other insurance affordability programs and given timely notice. By July 2026, all individuals have either been re-enrolled in Medicaid if they remain eligible or transitioned to another program if they no longer qualify. New York will not require expenditure authority for this initiative past the end of the current demonstration period.

3.18 Twelve-Month Continuous Eligibility

To comply with the July 2025 CMS guidance, Section 1115(a) Demonstration Authority for Continuous Eligibility Initiatives, specifying that CMS does not anticipate extending existing Section 1115(a) demonstration authority for expanded continuous eligibility, the State has discontinued 12-month continuous eligibility.[47]

New York's 12-month continuous eligibility program extended coverage for full 12-month periods regardless of changes in income or circumstance to select populations.[48] Pregnant individuals and those up to 12 months postpartum will still be eligible for 12-month continuous eligibility. To comply with CMS guidance, New York developed policy frameworks and configured systems to end 12-month continuous eligibility for adults. The necessary system updates have been communicated to stakeholders, and internal coordination continues through the State's customer service call center and appeals units.

System action was taken beginning May 2026 to initiate the renewal process for cases only eligible due to this initiative. Adults aged 19 through 64 who have reported changes in income over the Medicaid limit will also be subject to renewal, instead of remaining enrolled through their initial 12-month eligibility period. New York's MAGI eligibility system is an integrated eligibility system and considers Medicaid eligibility as well as Essential Plan and tax credits available for adults. At the time of redetermination, if the member was ineligible for Medicaid, they have been reviewed for other insurance affordability programs and given timely notice. By July 1, 2026, all individuals have either been re-enrolled in Medicaid if they remain eligible or transitioned to another program if they no longer qualify. New York will not require expenditure authority for this initiative past the end of the current demonstration period.

Changes to Eligibility Requirements, Benefits, Cost Sharing, and Delivery System

As indicated above, in the detailed discussion of each initiative, the requested extension of this Section 1115(a) demonstration primarily continues New York's existing demonstration eligibility rules, benefits, and cost sharing requirements. This extension reflects a limited set of changes to criteria for eligibility, benefits, cost sharing, and delivery system. These changes are indicated by the summary table below.

In addition to the initiative-level impacts to eligibility, benefits, cost sharing, and delivery system identified in the table below, New York is actively preparing for the operational updates needed to comply with State Medicaid Director Letter (SMD) # 25-003 (RE: Medicaid Managed Care Payments

[47] Ibid.

[48] States are required to provide twelve months of continuous eligibility for children under the age of 19 enrolled in Medicaid or CHIP: *Continuous Eligibility for Medicaid and CHIP Coverage.* (2025). CMS. https://www.medicaid.gov/medicaid/enrollment-strategies/continuous-eligibility-medicaid-and-chip-coverage.

and Emergency Medical Condition Coverage for Aliens Ineligible for Full Medicaid Benefits).[49] The State will continue to work with CMS to evaluate whether modifications to existing authorities are required, including as they relate to Section 1115(a) demonstration managed care authorities.

Impact on Eligibility Requirements, Benefits, Cost Sharing, or Delivery System

Initiative	Changes to Eligibility, Benefits, or Cost Sharing	Changes to Delivery System
Initiatives requested to continue without amendment		
MMMC	No change	No change
MLTC	No change	No change
Facilitated Enrollment Services	No change	No change
CORE Services	No change	No change
Residential and Inpatient Treatment for Individuals with Substance Use Disorder (SUD)	No change	No change
DSHP	No change	No change
Initiatives requested to continue with amendment		
Demonstration-Eligible Populations	*Changes to eligibility:* • Continuing expenditure and waiver authority for HCBS Expansion, Institution to Community, and Family of One Children • Discontinuing expenditure and waiver authority for TANF Adult	No change
HRSN Services	*Changes to benefits: discontinuing Brokerage Fees as coverage is no longer necessary* *Changes to eligibility terminology: replacing three population categories – Juvenile Justice-Involved Youth, Foster Care Youth, and those under Kinship Care; children under the age of six; and children under the age of 18 with one or more chronic condition – with a new category "High-Risk Children under Age 18"*	Moving from non-risk to risk-based arrangement in 2028
Workforce Initiatives	No change	No change
HERO	No change	No change
MHGBI	Per New York's request in Section 3, the State will continue	

[49] Caprice Knapp. (2025, September 30). *RE: Medicaid Managed Care Payments and Emergency Medical Condition Coverage for Aliens Ineligible for Full Medicaid Benefits.* CMS. https://www.medicaid.gov/federal-policy-guidance/downloads/smd25003.pdf

Initiative	Changes to Eligibility, Benefits, or Cost Sharing	Changes to Delivery System
	to work with CMS and to hone the details of the waiver authority and expenditure authority requests for this initiative.	
Initiatives requested to discontinue		
HRSN Infrastructure	No change	No change
Demonstration Services for Behavioral Health Provided under MMMC	*Changes to benefits:* discontinuing expenditure authority for Demonstration Services 9 (Residential addiction, crisis intervention, and licensed behavioral health practitioner services), which have entirely transitioned to the State Plan	No change
Self-Direction Pilot	*Changes to benefits:* discontinuing expenditure authority for children and adult self-direction	No change
BH HCBS	*Changes to benefits:* discontinuing a set of BH HCBS (Education Support Services, Pre-Vocational Services, Transitional Employment, Intensive Supported Employment, Ongoing Supported Employment, Habilitation, and Non-Medical Transportation) that have not transitioned to CORE Services	No change
Demonstration Population 2 (TANF Adult)	*Changes to eligibility:* discontinuing waiver and expenditure authority for TANF Adult	
Continuous Eligibility for Children up to Age Six	*Changes to eligibility:* discontinuing in accordance with CMS guidance[50]	No change
Twelve-Month Continuous Eligibility	*Changes to eligibility:* discontinuing in accordance with CMS guidance[51]	No change
Non-drug benefit cost sharing	*Changes to benefits and cost-sharing:* Discontinuing authority to comply with H.R.1 (Pub. L. No. 119-21, § 71120)	No change

Section 4: Waiver and Expenditure Authorities

The State requests to continue the relevant waiver and expenditure authorities. Continuation of these authorities is necessary to sustain programs and complete implementation of recently approved initiatives.

References to the Special Terms and Conditions (STCs) in the tables below denote the most recently approved STCs for the current demonstration.

[50] Drew Snyder. (2025, July 17). *Section 1115 demonstration authority for continuous eligibility initiatives*. CMS. https://www.medicaid.gov/resources-for-states/downloads/contin-elig-ltr-to-states.pdf
[51] Ibid.

Requested Waiver Authorities to Continue

#	Waiver Authority	Reason for and Use of Waiver Authority
1.	**Statewideness Section 1902(a)(1)**	To permit New York to geographically phase in the HIV SNP
2.	**Comparability Section 1902(a)(10), Section 1902(a)(17)**	a. HCBS Expansion: To enable New York to apply a more liberal income standard for individuals who are deinstitutionalized and receive HCBS through the managed long-term care program than for other individuals receiving community-based long-term care. b. Family of One Non-1915 Children, or "Fo1 Children": To allow the State to target eligibility to, and impose a participation capacity limit on, medically needy children under age 21 who are otherwise described in 42 CFR §435.308 of the regulations who: 1) receive Health Home Comprehensive Care Management under the State Plan in replacement of the case management services such individuals formerly received through participation in New York's #NY .4125 1915(c) waiver and who no longer participate in such waiver due to the elimination of the case management services, but who continue to meet the targeting criteria, risk factors, and clinical eligibility standard for such waiver; and 2) receive HCBS 1915(c) services who meet the risk factors, targeting criteria, and clinical eligibility standard for the above-identified 1915(c) waiver. Individuals who meet either targeting classification will have excluded from their financial eligibility determination the income and resources of third parties whose income and resources could otherwise be deemed available under 42 CFR § 435.602(a)(2)(i). Such individuals will also have their income and resources compared to the medically needy income level (MNIL) and resource standard for a single individual, as described in New York's State Medicaid Plan.
3.	**Amount, Duration & Scope Section 1902(a)(10)(B)**	To enable New York to provide Community Oriented Recovery and Empowerment (CORE) Services, whether furnished as a state plan benefit or as a demonstration benefit to targeted populations that may not be consistent with the targeting authorized under the approved state plan, in amount, duration and scope that exceeds those available to eligible individuals not in those targeted populations
4.	**Freedom of Choice Section 1902(a)(23)(A)**	To the extent necessary to enable New York to require members to enroll in MCOs, including the MMMC, and MLTC (excluding individuals designated as "Long-Term Nursing Home Stays") and HARPs programs in order to obtain benefits offered by those

#	Waiver Authority	Reason for and Use of Waiver Authority
		plans. Members shall retain freedom of choice of family planning providers.
5.	**Reasonable Promptness Section 1902(a)(8)**	To enable the State to limit the number of medically needy Fo1 Children not otherwise enrolled in the Children's 1915(c) waiver.

Requested Waiver Authorities to Discontinue

#	Waiver Authority	Reason for and Use of Waiver Authority
1.	**Statewideness Section 1902(a)(1)**	To permit New York to geographically phase in the MLTC and HARP
2.	**Comparability Section 1902(a)(10), Section 1902(a)(17)**	To the extent necessary to permit New York to waive cost sharing for non-drug benefit cost sharing imposed under the Medicaid state plan for beneficiaries enrolled in the Mainstream Medicaid Managed Care Plan (MMMC) – including HARP and HIV SNPs – and who are not otherwise exempt from cost sharing in 447.56(a)(1).
3.	**Direct Payment to Providers Section 1902(a)(32)**	To the extent necessary to permit the State to make payments to individuals enrolled in the Self-Direction Pilot Program to the extent that such funds are used to obtain self-directed HCBS LTC services and supports.

Requested Expenditure Authorities to Continue

#	Expenditure Authority	Reason for and Use of Expenditure Authority
1.	**Demonstration-Eligible Populations**	Expenditures for healthcare related costs for the following populations that are not otherwise eligible under the Medicaid state plan. a. Demonstration Population 9 (HCBS Expansion). Individuals who are not otherwise eligible, are receiving HCBS, and who are determined to be medically needy based on New York's medically needy income level, after application of community spouse and spousal impoverishment eligibility and post-eligibility rules consistent with section 1924 of the Act b. Demonstration Population 10 (Institution to Community). Expenditures for healthcare related costs for individuals moved from institutional nursing facility settings to community settings for long term services and supports who would not otherwise be eligible based on income, but whose income does not exceed the income standard described in STC 4.4(c), and who receive services through the

#	Expenditure Authority	Reason for and Use of Expenditure Authority
		managed long-term care program under the demonstration. c. Included in Demonstration Population 12 [Family of One (Fo1) Children]. Medically needy children Fo1 Demonstration children under age 21 with a waiver of 1902(a)(10)(C)(i)(III) who meet the targeting criteria, risk factors, and clinical eligibility standard for #NY.4125 waiver including intermediate care facilities (ICF), nursing facilities (NF), or Hospital Level of Care (LOC) who are not otherwise enrolled in the Children's 1915(c).
2.	**Facilitated Enrollment Services**	Expenditures for enrollment assistance services provided by managed care organizations (MCOs), the costs for which are included in the claimed MCO capitation rates.
3.	**CORE Services**	Expenditures for the provision of CORE Services under HARP, HIV SNP, and MAP that are not otherwise available under the approved state plan [Demonstration Services 8].
4.	**Residential and Inpatient Treatment for Individuals with Substance Use Disorder (SUD)**	Expenditures for Medicaid state plan services furnished to otherwise eligible individuals who are primarily receiving treatment and/or withdrawal management services for substance use disorder (SUD) who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD).
5.	**Health-Related Social Needs (HRSN) Services**	Expenditures for health-related social needs services not otherwise covered that are furnished to individuals who meet the qualifying criteria as described in Section 6 of the STCs. This expenditure authority is contingent on compliance with Section 7, as well as all other applicable STCs.
6.	**Medicaid Hospital Global Budget (MHGBI)**	Per New York's request in Section 3, the State will continue to work with CMS and to hone the details of the waiver authority and expenditure authority requests for this initiative.
7.	**Designated State Health Programs (DSHP)**	Authorization to rollover and use unused expenditure authority from the current demonstration into the extension period for continued use on the DSHP-funded initiatives approved in the current demonstration, including HRSN services, HERO and Workforce initiatives, described in Section 11 of the STCs, which are otherwise state-funded, and not otherwise eligible for Medicaid payment. These expenditures are

#	Expenditure Authority	Reason for and Use of Expenditure Authority
		subject to the terms and limitations and not to exceed specified amounts as set forth in these STCs. These expenditures are specifically contingent on compliance with Section 7, as well as all other applicable STCs. Authorization to draw down FFP for unclaimed DSHP funds up to the already approved total $3.9 billion in total computable in the current demonstration to be spent on the DSHP-funded initiatives.
8.	**Health Equity Regional Organization (HERO)**	Expenditures for an independent contracted statewide entity to operate an advanced analytics integrity program, designed to identify fraud, waste, and abuse billing and referral patterns.
9.	**Workforce Initiatives**	Expenditures for provider student loan repayment and Career Pathway Training programs that meet the criteria as specified in Section 12 of the STCs. Time-limited expenditure authority is granted until four years following the demonstration (April 1, 2027 until March 31, 2031), to allow the state to pay close-out administrative costs and monitor remaining service commitments.

Title XIX Requirements Not Applicable to the HRSN Expenditure Authorities	
Comparability; Amount, Duration, and Scope	**Section 1902(a)(10)(B), Section 1902(a)(17)**
To the extent necessary to enable the state to provide a varying amount, duration, and scope of HRSN services to a subset of beneficiaries, depending on beneficiary needs	
Comparability; Provision of Medical Assistance and Reasonable Promptness	**Sections 1902(a)(10)(B), 1902(a)(17), 1902(a)(8)**
To the extent necessary to allow the State to offer HRSN services to an individual who meets the qualifying criteria for HRSN services, including delivery system enrollment, as described in Section 6 of the STCs.	

Requested Expenditure Authorities to Discontinue

#	Expenditure Authority	Reason for and Use of Expenditure Authority
1.	**Demonstration Services for Behavioral Health Provided under Mainstream Medicaid Managed Care (MMMC)**	Expenditures for provision of residential addiction services, crisis intervention and licensed behavioral health practitioner services to MMMC members only [Demonstration Services 9].
2.	**Self-Direction Pilot**	Expenditures to allow the state to make self-direction services available to HARP and HIV SNP members receiving BH HCBS or children meeting targeting criteria for the Children's 1915(c) Waiver and in MMMC receiving HCBS under the Children's Waiver. The program will be in effect from January 1, 2017, through March 31, 2027 [Demonstration Services 8].
3.	**Behavioral Health (BH) HCBS**	Expenditures for the provision of select BH HCBS under HARP and HIV SNP that are not otherwise available via CORE Services or under the approved state plan: Education Support Services, Pre-Vocational Services, Transitional Employment, Intensive Supported Employment, Ongoing Supported Employment, Habilitation, and Non-Medical Transportation.
4.	**Demonstration Population 2 (TANF Adult)**	Expenditures for healthcare related costs for the following population when not otherwise eligible under the Medicaid state plan: a. Demonstration Population 2 (Temporary Assistance for Needy Families [TANF] Adult). TANF Recipients. Expenditures for healthcare related costs for low-income adults enrolled in TANF. These individuals are exempt from receiving a Modified Adjusted Gross Income (MAGI) determination in accordance with 1902(e)(14)(D)(i)(I) of the Act.
5.	**HRSN Infrastructure**	Expenditures for payments for allowable administrative costs and infrastructure not otherwise eligible for Medicaid payment, to the extent such activities are authorized in Section 6 of the STCs. This expenditure authority is contingent on compliance with Section 7 of the STCs, as well as all other applicable STCs.
6.	**Twelve-Month Continuous Eligibility Period**	Expenditures for healthcare related costs for individuals who have been determined eligible under groups specified in Table 6 of STC 4.4(e) for continued benefits during any periods within a 12-month eligibility period when these individuals would be found ineligible if subject to redetermination. This authority includes providing continuous coverage for the Adult Group determined financially eligible using MAGI based eligibility methods. For expenditures related to the Adult Group, specifically, the State shall make a downward adjustment of 2.6 percent in claimed expenditures for federal matching at the enhanced federal matching rate and will instead claim those expenditures at the regular matching rate.
7.	**Continuous Eligibility for**	**Title XIX Expenditure Authority**

#	Expenditure Authority	Reason for and Use of Expenditure Authority
	Children up to Age Six	Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by New York for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period of this demonstration, be regarded as expenditures under the state's title XIX plan. The following expenditure authority must only be implemented consistent with the approved Special Terms and Conditions (STCs) and shall enable New York to implement the section 1115 demonstration amendment. All other requirements of the Medicaid program, including current and future CMS guidance for continuous eligibility, as expressed in law, regulation, and policy statements must apply to these expenditures, unless identified as not applicable below. **Continuous Eligibility.** Expenditures for continued state plan benefits for individuals who have been determined eligible as specified in Table 1 of STC 1.2, who are not otherwise excluded under STC 1.3 for the applicable continuous eligibility period, and who would otherwise lose coverage during an eligibility redetermination, except as noted in STC 1.4. **Title XXI Expenditure Authority** Under the authority of section 1115(a)(2) of the Act as incorporated into title XXI by section 2107(e)(2)(A), state expenditures described below, shall, for the period of this demonstration, and to the extent of the state's available allotment under section 2104 of the Act, be regarded as matchable expenditures under the state's title XXI plan. The following expenditure authority must only be implemented consistent with the approved STCs and shall enable New York to implement the section 1115 demonstration amendment. All other requirements of the CHIP program, including current and future guidance for continuous eligibility, as expressed in law, regulation, and policy statements must apply to these expenditures, unless identified as not applicable below. **Continuous Eligibility**. Expenditures for continued state plan benefits for individuals who have been determined eligible under groups specified in Table 1 of STC 1.2, who are not otherwise excluded under STC 1.3 for the applicable continuous eligibility period who would otherwise lose coverage during an eligibility redetermination, except as noted in STC 1.4.

Section 5: Budget Neutrality

The State is seeking CMS approval to extend the majority of its programs authorized under its existing Section 1115(a) MRT demonstration for an additional five-year period.

As required for all Section 1115(a) demonstration extension applications, the State has prepared the necessary budget neutrality documentation to demonstrate that the proposed extension remains budget neutral to the federal government. In light of CMS guidance *RE: Budget Neutrality and Certification by the Chief Actuary of CMS for Section 1115 Medicaid Demonstration Projects (SMD #*

26-003) released on June 11, 2026, New York will work closely with CMS to ensure compliance.[52]

Based on available budget neutrality reporting data previously submitted to CMS, New York's Section 1115(a) MRT demonstration has met the requirements for budget neutrality as detailed in Section 15 (General Financial Requirements) of the CMS approved STCs. Projected waiver expenditures for the extension period were developed in accordance with CMS budget neutrality guidance, including State Medicaid Director Letter (SMD) # 24-003, issued August 22, 2024.

Considerations Impacting Caseloads and Costs

The purpose of this extension request is to maintain and continue existing demonstration programs with limited, targeted modifications. As such, the State does not expect caseloads or aggregate costs to materially change as a result of this extension request.

Consistent with the extension approach described in Section 3 (Extending the Existing Demonstration), the extension reflects continuation of the current demonstration structure, alongside a discrete set of initiative level changes that are incorporated into the State's budget neutrality assumptions.

There will also be changes due to requests to discontinue or phase out select demonstration authorities, including:

- Demonstration Services for Behavioral Health provided under MMMC;
- Self-Direction Pilot;
- BH HCBS;
- Demonstration Population 2 (TANF Adult);
- Continuous Eligibility for Children up to Age Six; and
- Twelve-Month Continuous Eligibility.

These phaseouts are not expected to result in increases in overall enrollment or expenditures. The phaseouts reflect authorities that either must be phased out to comply with federal guidance, that are no longer needed as separate demonstration components, or that have transitioned or are transitioning to State Plan authority.

Anticipated Waiver Cost and Caseloads

This extension proposal is budget neutral and does not request any additional federal funding. The request seeks to extend existing waiver authorities and programs. It does not introduce new initiatives with material fiscal impact and is therefore expected to have no more than a nominal impact on overall enrollment and cost relative to the current demonstration.

The State anticipates a total caseload across the extension proposal to be 5.1 million members for Demonstration Year (DY) 29, with aggregate projected waiver expenditures of approximately $85.0 billion. These numbers are subject to change depending on the demonstration year used. These projections reflect baseline utilization trends and continuation of currently approved initiatives.

Estimated "Without Waiver" baseline costs are derived from historical claims and utilization

[52] Dan Brillman. (2026, June 11). Budget Neutrality and Certification by the Chief Actuary of CMS for Section 1115 Medicaid Demonstration Projects (SMD 26-003). CMS. https://www.medicaid.gov/federal-policy-guidance/downloads/smd26003.pdf

experience over the applicable base period April 1, 2020 to March 31, 2024 and are trended forward in accordance with CMS approved methodologies. Detailed historical caseloads and costs for the current demonstration period are presented in Exhibit 1 (Historical Caseloads and Costs) and Exhibit 2 (Projected Caseloads and Costs).

Exhibit 1: Historical Caseloads and Costs (in total computable dollars) *

Demonstration Year (DY)	DY 22	DY 23	DY 24	DY 25
Historical Caseload*	5,159,262	5,584,088	5,902,978	5,767,071
Historical Cost ($ in Millions)*	$58,112.8	$63,568.2	$68,230.3	$80,239.8

*Total historical cost figures and caseloads are extracted from the MDW as of March 2026.

Exhibit 1a: Historical Caseload by MEG

Demonstration Year (DY)	DY22	DY23	DY24	DY25
Demonstration Group 1 – TANF Children under age 1 through 20	1,989,891	2,120,068	2,181,085	2,101,252
Demonstration Group 2 – TANF Adults 21-64	-	-	-	-
Demonstration Group 3 – SSI 0-64	368,941	363,512	375,030	377,792
Demonstration Group 4 – SSI 65+	37,379	44,279	84,364	108,075
Demonstration Group 5 – Non Duals 18-64	17,143	18,526	20,696	24,132
Demonstration Group 6 – Non Duals 65+	6,257	7,619	8,569	10,254
Demonstration Group 7 – MLTC Adult 18-64 Duals	44,121	43,997	43,086	44,416
Demonstration Group 8 – MLTC age 65+ Duals	211,505	214,824	225,961	246,952
Demonstration Group 9 – HCBS Expansion	10	7	5	9
Demonstration Group 10 – Institution to Community	416	397	364	430
Demonstration Group 11 – New Adult Group	1,932,330	2,144,995	2,182,741	2,088,231
Demonstration Group 12 – Family of One Non-1915c Children	719	746	847	693
Total	**4,608,712**	**4,958,971**	**5,122,747**	**5,002,235**

Exhibit 1b: Historical Cost by Program ($ in Millions)

Demonstration Year (DY)	DY22	DY23	DY24	DY25
Demonstration Group 1 – TANF Children under age 1 through 20	$6,197.7	$7,918.2	$8,460.1	$9,111.7
Demonstration Group 2 – TANF Adults 21-64	$0.0	$0.0	$0.0	$0.0
Demonstration Group 3 – SSI 0-64	$14,595.7	$14,770.8	$15,336.9	$18,221.9
Demonstration Group 4 – SSI 65+	$2,236.8	$2,545.5	$3,634.1	$4,831.1
Demonstration Group 5 – Non Duals 18-64	$1,410.1	$1,480.9	$1,694.3	$2,260.5
Demonstration Group 6 – Non Duals 65+	$469.4	$545.8	$654.7	$894.0
Demonstration Group 7 – MLTC Adult 18-64 Duals	$2,038.6	$1,993.5	$2,074.2	$2,505.5
Demonstration Group 8 – MLTC age 65+ Duals	$12,175.6	$11,808.1	$12,883.5	$16,198.6
Demonstration Group 9 – HCBS Expansion	$0.9	$0.6	$0.4	$0.7
Demonstration Group 10 – Institution to Community	$34.8	$31.8	$32.9	$45.2
Demonstration Group 11 – New Adult Group	$14,352.6	$17,021.1	$17,062.1	$18,519.2
Demonstration Group 12 – Family of One Non-1915c Children	$38.6	$42.8	$44.9	$46.8
BH HCBS**	-	-	-	-
Demonstration Only Services in MMMC**	-	-	-	-
Transportation**	-	-	-	-
Cooking Supplies**	-	-	-	-
Brokerage Fees**	-	-	-	-
DSHP	$0.0	$0.0	$0.0	$470.9
HERO**	-	-	-	-
Medicaid Hospital Global Budget Initiative	$0.0	$0.0	$0.0	$550.0
Student Loan Repayment**	-	-	-	-
CPT**	-	-	-	-
SUD IMD TANF Children 1-20**	-	-	-	-

SUD IMD TANF Adults 21-64**	-	-	-	-
SUD IMD SSI 0-64**	-	-	-	-
SUD IMD New Adult Group**	-	-	-	-
SUD IMD FFS**	-	-	-	-
HRSN Infrastructure**	-	-	-	-
HRSN Services**	-	-	-	-
Total	**$53,550.7**	**$58,159.0**	**$61,877.9**	**$73,656.0**

****Historical data presented for DY22-DY25 represents the most current complete data available. Most programs and services authorized under the NYHER amendment were not implemented until after this period, and therefore, there is no spending or utilization data to report for this time period for these programs unless otherwise noted.**

Exhibit 2: Projected Caseloads and Costs (in total computable dollars)

Demonstration Year (DY)	DY 29	DY 30	DY 31	DY 32	DY 33
Projected Caseload of the Demonstration	5,142,331	5,178,642	5,215,489	5,252,879	5,290,825
Projected Cost ($ in Millions)	$85,020.0	$88,369.4	$91,884.8	$95,551.1	$99,369.5

Section 6: Demonstration Evaluations to Date

This section contains two subsections. The first subsection summarizes the Annual Technical Reports done so far under New York's MRT Section 1115(a) demonstration. The State has worked with its external quality review organization (EQRO) to produce these reports.

The second subsection summarizes the State's evaluation plan and interim evaluation report produced by the State's independent evaluator (IE) for the demonstration. The following summaries present the findings from each entity and outline the corresponding next steps.

Summary of EQR Annual Technical Reports

New York is committed to ensuring Medicaid and Child Health Plus members receive high quality care. The State works with managed care organizations (MCOs, also referred to as Managed Care Plans – or MCPs – in EQRO's Annual Technical Reports [ATRs]) to track and improve care every year. Federal regulations require the State to contract with an EQRO to independently evaluate the quality, timeliness and accessibility of care that MCOs provide.

The EQRO produces an External Quality Review ATR each year. For Reporting Year 2024, IPRO, the State's EQRO, prepared two ATRs: [53]

- **Mainstream Medicaid Managed Care, Child Health Plus, HIV Special Needs Plan, and Health and Recovery Plan ATR; and**
- **Managed Long-Term Care (MLTC) ATR,** covering MAP and MLTCP.

[53] IPRO is the name of the EQRO conducting the evaluation

Each ATR summarizes the required and optional EQR activities, including:

- Validation of Performance Improvement Projects (PIPs);
- Validation of Performance Measures;
- Review of Compliance with Medicaid and Children's Health Insurance Program Standards;
- Validation of Network Adequacy;
- Administration of Quality-of-Care Surveys.

Each ATR also includes a plan-specific section with IPRO's assessment of each MCO's strengths and areas for improvement. The following year's ATR tracks how well each plan acted on those recommendations, creating an ongoing cycle of accountability and improvement.

ATRs are posted on the Department of Health's website.[54] The "Reporting Year" refers to the calendar year in which the review activities took place – for example, reports listed under "Reporting Year 2023" cover activities conducted during calendar year 2023. This differs from the CMS Reporting Cycle.

For the current demonstration period, the State submitted ATRs to CMS for Reporting Years 2019 through 2024. The State met every CMS deadline and posted each report online on time.

IPRO's Assessment of the Medicaid and Child Health Plus Quality Strategy

New York's Medicaid and Child Health Plus Quality Strategy runs from January 2023 through December 2025 and lines up with federal rules at 42 CFR 438.340. The strategy guides MCOs to expand access, raise the quality of care, and better serve low-income New Yorkers. It is built around eight goals, supported by focus studies, performance improvement projects, quality incentives, performance reports, and direct plan technical assistance.

From the baseline year (2021) through 2024, 15 measures in the strategy met or exceeded their 2025 targets. Areas of notable strength included care coordination, integrated care, safer member environments, behavioral health, dental care, maternal care, HCBS, care for infants and children, chronic disease management, and promoting data-driven Medicaid oversight

11 measures declined from the baseline or remained unchanged. These include the number of Medicaid-enrolled dentists, the share of members in a patient-centered medical home, follow-up after emergency room visits or hospital stays for mental illness (at 7 and 30 days), use of primary care, colorectal cancer screening, childhood immunizations (Combination 10), pharmacotherapy for opioid use disorder.

IPRO's main recommendations for consideration to the New York State Department of Health are:

- Update 2025 targets for measures that have already been met or exceeded;
- Continue outreach to members, providers, and MCOs to increase use of preventive care (particularly colorectal cancer screening and childhood immunizations);
- Expand the number of Medicaid-enrolled dentists to reach the target for 2025 and consider strategies to increase membership's utilization of primary care;

[54] New York State Department of Health. (2026, April). *External quality review annual technical report - New York State Department of Health.* https://www.health.ny.gov/statistics/health_care/managed_care/plans/reports/

- Continue outreach to members, providers, and MCOs to improve access to and quality of behavioral healthcare, with a focus on reducing avoidable emergency room visits and hospital stays for mental illness;
- Continue to use both quantitative data and qualitative data to identify successes, best practices, barriers, challenges and opportunities across quality improvement focus areas;
- Increase transparency and overall understanding in how compliance reviews are conducted by considering revising related policies and procedures, and technical methods of data collection and analysis; and
- Consider incorporating the Department's Consumer Guide Star Rating into future ATRs.

Summary of Performance Improvement Project (PIP) Performance

In 2024, results across all plan types were positive, with most plans demonstrating measurable improvement.

IPRO assessed that all Mainstream Medicaid, Child Health Plus, HIV Special Needs Plan, and Health and Recovery Plan (HARP) PIPs had no validation findings that indicated that the credibility of the PIP results was at risk. The 2024 PIP topic for Mainstream Medicaid, Child Health Plus, and HIV Special Needs Plans was Cancer Screening and Prevention. For HARPs, the topic was Continuous Engagement in Care and Treatment.

Among the 12 Mainstream Medicaid and Child Health Plans plus one HARP that completed the cancer screening PIP:

- 10 plans increased the share of members who received a breast cancer screening;
- Eight increased the share who received a cervical cancer screening;
- 13 increased the share who received a colorectal cancer screening; and
- Three increased the share who received an HPV vaccination.

Among the three HIV Special Needs Plans:

- One plan increased breast cancer screening rates;
- One increased cervical cancer screening rates; and
- All three increased colorectal cancer screening rates.

Among the eleven HARPs:

- Eight plans increased rates of community-based mental health follow-up after a mental health hospitalization; and
- Two increased continuous engagement in care for members with Substance Use Disorder.

For Managed Long-Term Care (MLTC), the 2024 PIP focused on improving depression screening rates for the general MLTC membership. All MLTC PIPs were assessed to have no validation findings that indicated that the credibility of the PIP results was at risk. By the end of the interim period, every MLTC plan had a standardized depression screening tool in place and had submitted the required interim data. This is a meaningful step toward earlier identification and treatment of depression in this population.

Summary of Performance on Measures Included in the Reports

In 2024, IPRO reviewed performance measures for every MCO. IPRO determined that each Mainstream Medicaid, Child Health Plus, HIV Special Needs Plan, and HARP MCO successfully calculated and reported rates to the Department of Health according to contractual requirements. For MLTC, IPRO determined that the Department of Health successfully calculated and reported MCO rates.

The Mainstream Medicaid, Child Health Plus, HIV Special Needs Plan, and HARP ATR use Quality Assurance Reporting Requirements (QARR), which draw on Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures. The table below shows the percentage of measure results across plans that were significantly better, significantly worse, or not significantly different than the statewide average of the specific plan type.

Plan Type	Significantly Better	Significantly Worse	No Significant Difference
Mainstream Medicaid & Child Health Plus	28%	30%	42%
HIV Special Needs Plans	23%	24%	53%
Health and Recovery Plans	17%	20%	63%

The MLTC ATR uses measures from the Uniform Assessment System for New York Community Health Assessment. The table below shows the percentage of measured results across plans that were significantly better, significantly worse, or not significantly different than the MLTC statewide average.

Plan Type	Significantly Better	Significantly Worse	No Significant Difference
Medicaid Advantage Plus	35%	18%	47%
Partial Capitation	49%	38%	13%
PACE	21%	38%	41%

Compliance Reviews, 2022–2024

Federal regulations require managed care plans to meet baseline standards covering member services, provider networks, grievances and appeals, and oversight of subcontractors. IPRO reviews the results of Department of Health compliance surveys. A survey may be a full check (Comprehensive) or a review of specific areas (Targeted or Focused).

For Mainstream Medicaid, Child Health Plus, HIV Special Needs, and HARP plans, most plans met most standards across all three years. The two areas where plans most often fell short were the handling of member grievances and appeals, and the oversight of subcontractors. Any plan with an identified deficiency was required to submit a Plan of Correction describing how it would resolve the issue, ensuring accountability for every deficiency. Child Health Plus plans were also reviewed for compliance with member disenrollment rules; a few plans missed the mark in one or more years.

For Medicaid Advantage Plus, Partial Capitation, and PACE plans, the State used a combination of

comprehensive and focused reviews, with focused reviews making up the majority. In 2024, focused reviews primarily examined the strength of provider networks. The standard plans most often missed related to making services available to members. Any plan with a gap was required to submit a Plan of Correction. [55] [56]

Summary of Network Adequacy

The State sets specific rules for provider availability – defining which provider types must be accessible and how many are required per county. These standards meet or exceed federal requirements. Each year, the EQRO conducts a validation of network adequacy using the results of the state's analysis of network data submitted by the MCOs.

In 2024, IPRO checked the analysis of every MCO. All plans were found to have no gap in their network or a Statement of Agreement established with the Department of Health allowing members to receive services from out-of-network providers. While every plan had at least one gap relative to New York's stricter county-level standards, the State has a protection in place for affected members: each plan is required to sign a Statement of Agreement allowing members in counties with network gaps to access out-of-network providers at no additional cost.

Summary of the Preliminary Interim Evaluation Report

To ensure the demonstration is achieving its goals for New York's Medicaid population, federal regulations under 42 CFR 431.420 require an independent, outside review. The State engaged Public Consulting Group (PCG) as its independent evaluator (IE). PCG leads all aspects of the evaluation, from research design through final reporting, and is responsible for producing the Evaluation Design Document (EDD) and evaluation reports that CMS requires.

CMS requires the State to submit an EDD within 180 days of a waiver approval, and a revised EDD within 180 days of any approved waiver amendment. CMS reviews each filing and provides feedback before granting approval. CMS approved the EDD on March 9, 2026, clearing the way for full evaluation work to move forward.

Evaluation Activities and Findings to Date

Even as the EDD awaited CMS approval, the State and PCG moved forward with early evaluation activities, focusing on five programs introduced under the January 2024 amendment. These programs are:

- Social Care Network (SCN) Program
- Career Pathways Training Program
- Healthcare Access Loan Repayment (HEALR) Program
- Medicaid Hospital Global Budget Initiative (MHGBI)
- Health Equity Regional Organization (HERO)

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[55] IPRO, *New York State Medicaid Managed Care, Child Health Plus, HIV Special Needs Plan, and Health and Recovery Plan: 2024 External Quality Review Annual Technical Report*, prepared for the New York State Department of Health (April 2026), Table 36 (pp. 88–91) and Table 37 (p. 92).

[56] IPRO, *New York State Medicaid Managed Long-Term Care: 2024 External Quality Review Annual Technical Report – Medicaid Advantage Plus Plans, Partial Capitation Plans, Program of All-Inclusive Care for the Elderly Plans*, prepared for the New York State Department of Health (April 2026), Table 23 (pp. 75–77), Table 24 (pp. 78–81), and Table 25 (pp. 82–83).

Most early evaluations focused on the SCN rollout, with the CPT program receiving the next greatest attention. Findings draw on document review, program data, and key informant interviews (KIIs) - structured conversations with program leaders and senior staff. Interviews were conducted from September through November 2025 with leaders and senior staff at the nine SCN Lead Entities, HRSN providers, Workforce Investment Organizations (WIOs), and the New York State Department of Health. Where available, a limited amount of administrative data was also reviewed. The full report is available at:
https://www.health.ny.gov/health_care/medicaid/redesign/1115_waiver/docs/interim_eval_rpt.pdf

Social Care Network (SCN) Program

Stakeholders broadly support the SCN program's goals and see connections to HRSN services as a meaningful pathway to better health outcomes. Interview participants framed the SCN program as part of a larger, long-term redesign of how New York delivers care, with many interviewees explicitly linking HRSN services to improvements in health outcomes and reductions in acute care utilization, consistent with demonstration goals.

Progress and program accomplishments have been significant:

- Launched nine regional HRSN networks: All nine SCNs have established governance structures and program operations, delivering across the full continuum of core activities, including network development, HRSN screening, eligibility assessments, care navigation and referral, and service delivery across regions and stakeholder groups, interviewees acknowledge the scale and complexity of investment, emphasizing how time-intensive efforts enabled rapid progress in building networks, hiring staff and initiating services.
- Onboarded HRSN providers: As of July 2026, across all of New York's 62 counties, more than 1,400 unique HRSN providers were under contract and enrolled to deliver services for nutrition, transportation, housing and care management. SCNs invested time to establish trust with their network of providers to garner buy-in to support community growth. Providers are actively assessing, referring, and serving members.
- Developed robust IT infrastructure: Novel IT and data systems have been developed to enable the program, linking nine SCNs, MCOs across the state, the State and HRSN providers, all within the first year of the program.
- Delivered capacity building support: Infrastructure funds were deployed to CBOs in the network to support recruitment of navigators and support staff, and to strengthen operations.

There is a shared understanding among stakeholders regarding the purpose and value of the SCN program and there is a strong commitment to its goals, including:

- Emphasizing the link between HRSN services and improved health outcomes;
- Framing the SCN program as part of a broader system redesign, with incremental steps seen as building towards long-term transformational change; and
- Appreciating the scale, flexibility and intent of the investment, despite challenges encountered.

Key challenges have also emerged during launch of the statewide program, which SCNs are working to address through onboarding of staff in the regions, investing in network relationships, and partnering with the State to troubleshoot:

- Compressed timeline. The amendment was approved in January 2024, leaving limited time within the waiver period for large-scale IT buildout and program implementation. Request for

Application awards for SCN LEs were made on August 1, 2024, and the program launched on January 1, 2025.

- Workflow mapping. Updates to program guidance to adjust for on the ground experience of networks required workflow and system adjustments, causing some delays and uncertainty for lead entities and providers.
- Variable provider readiness. HRSN providers onboarded at different times throughout the start of the program. Some contracted HRSN providers were not yet actively delivering services at the time of the interviews.
- Milestone pacing. SCN LEs had to establish networks and IT infrastructure while simultaneously try to meet escalating State milestones, which have been difficult to meet on the current timeline.

Career Pathways Training (CPT) Program

The CPT program is showing meaningful early results. Workforce Investment Organizations (WIOs) have established training pathways tied to in-demand healthcare roles. Most participants are pursuing nursing and professional technical roles in high-dem and healthcare fields. Notably, 81 percent of trainees used wraparound supports such as case management and tutoring, underscoring the importance of removing practical barriers to workforce participation.

There are areas that require continued attention. The compressed waiver timeline made it harder to recruit participants, complete enrollment, and allow adequate time to finish multi-year degree programs. Enrollment in the frontline public health worker track has been limited, in part because the role is less recognized in the broader job market. Increased outreach and employer engagement may help raise awareness.

Healthcare Access Loan Repayment (HEALR) Program

The HEALR program is on track and moving through its implementation phases. Eligible provider roles, award levels, and two application pathways – individual and employer-initiated – are in place. Program rules covering the service term, documentation requirements, leave policies, and repayment obligations have been established.

Award notices are expected in late summer 2026. Because the program's four-year service term extends beyond the current waiver end date of 2027, the State has proactively communicated with applicants through webinars and a detailed FAQ to ensure they understand that the service commitment continues after the demonstration period concludes.

Medicaid Hospital Global Budget Initiative (MHGBI)

All 12 safety-net hospitals participating in the MHGBI have submitted required deliverables, such as roadmaps and budgets. The State has worked collaboratively with hospitals through an iterative review process to refine submissions, clarify proposals, and align plans with program goals as part of broader efforts to prepare hospitals for future global budget implementation. Early efforts have prioritized hospital-specific planning across financial sustainability, quality improvement, access to care, and integration with community-based and HRSN services. Hospitals are increasingly adopting holistic approaches to patient care, including improved care transitions, follow-up care, and stronger connections to social supports.

Health Equity Regional Organization (HERO)

The State has selected the United Hospital Fund (UHF) – an independent, nonprofit organization focused on health policy in New York – to serve as the HERO facilitator. HERO meetings have begun, creating an early forum for regional dialogue on population health priorities. This work is foundational to the program's long-term goal of improving population health across communities.

Plans for Evaluation Activities During the Extension Period

With the EDD now approved, PCG will conduct a comprehensive mixed-methods evaluation encompassing both implementation analyses and outcome analyses.

Quantitative methods – using Medicaid claims and encounter data, administrative data, and HRSN service data – will measure whether the programs are achieving their intended effects, including comparisons of outcomes before and after program launch, long-term trend analyses, and quasi-experimental comparison group designs where appropriate.

Qualitative methods – including partner interviews and document review – will provide essential context on how programs were implemented, what barriers arose, and what conditions supported success.

The evaluation will examine access to care, quality of care, service utilization, and health outcomes across demonstration populations. Planned updates to the preliminary report include HRSN referral and service delivery data, baseline statistics for each target population, and new sections on Conclusions and on Lessons Learned and Policy Implications.

The Summative Evaluation Report – covering the full demonstration period and its impact on members – is due to CMS 18 months after the demonstration ends. Once approved, the State will post the report publicly on its website, ensuring transparency and accountability to New Yorkers.

Evaluation of Proposed Changes: Hypotheses, Research Questions, and Approach

For the extension period, the evaluation will follow a structured framework with defined hypotheses, research questions, measures, and data sources for each program. Every program is linked to a hypothesis about its expected effect on access to care, quality of care, service utilization, and health outcomes for its target population.

The State will incorporate the changes approved as part of this demonstration renewal into the Evaluation Design submitted to CMS within 180 calendar days following acceptance of the renewal approval. The revised Evaluation Design will identify, as applicable, research questions and hypotheses associated with the approved changes and describe the evaluation approach, measures, data sources, analytic methods, and comparison strategies that will be used to assess whether the changes achieve their intended outcomes. This will include evaluation of the modifications to HRSN services and financing, including the transition from non-risk to risk-based funding and changes to eligible populations and covered services; demonstration-eligible populations; and the phase-out or discontinuation of select authorities, including expanded continuous eligibility, workforce initiatives, HRSN infrastructure, and certain behavioral health authorities. The State and its independent evaluator will refine these elements based on the authorities ultimately approved by CMS and CMS feedback.

The evaluation will use rigorous mixed methods to test these hypotheses. Quantitative approaches may include pre/post comparisons, long-term trend analyses, and quasi-experimental designs where data and program structure allow. For example, a pre/post comparison is well suited to evaluating the hypothesis that the Residential and Inpatient Treatment for Individuals with Substance Use Disorder (SUD) program improves access to treatment. Qualitative methods will add depth by capturing how

programs were experienced on the ground including what worked, what did not, and why.

Extension Initiatives and Example Main Hypotheses

Initiative	Hypothesis
CORE Services	The transition to CORE Services will improve access to rehabilitation and recovery services for Behavioral Health High-Risk Adults, leading to improved quality of care and health outcomes for this population.
IMD SUD Demonstration	The IMD SUD demonstration will improve access to SUD services across the care continuum, leading to increased engagement in care, and improved quality of care and health outcomes for this population.
Health Equity Regional Organization (HERO)	The HERO initiative will increase volume and/or quality of referrals of fraud, waste and abuse investigation based on an advanced analytics platform.
HRSN Services	The HRSN initiative of the amendment will support the delivery of targeted support services through Social Care Networks (SCNs) and improve overall quality and health outcomes for high-risk members including children, pregnant and postpartum individuals, the chronically homeless, and individuals with SUD.

The table below shows example research questions, measures, and data sources that may be used to evaluate the next demonstration period and to assess progress toward the demonstration goals listed in Section 3 of this application. Final hypotheses, measures, and data sources may change based on CMS feedback during the approval process.

Example Research Questions and Measures

Research Question	Example Measures
Hypothesis 1: The transition to CORE Services will improve access to rehabilitation and recovery services for Behavioral Health High-Risk Adults, leading to improved quality of care and health outcomes for this population.	
Did the transition to CORE Services improve access to rehabilitation and recovery services for BH High-Risk Adults?	• CORE Service Utilization Rates • Adult BH HCBS Utilization Rates • Utilization of Recovery Oriented Services for Mental Health • Engagement in Community-based Mental Health Care by service type, plan type, year, clinical characteristics, and demographics
Hypothesis 2: The IMD SUD demonstration will improve access to SUD services across the care continuum, leading to increased engagement in care, and improved quality of care and health outcomes for this population.	
Did the IMD SUD demonstration improve access to, and engagement in, SUD services across the care continuum for this population?	• Non-acute SUD Service Utilization Rate • Residential Care Utilization at each of 3 Levels • Residential Care Average Length of Stay at each of 3 Levels • Initiation and Engagement of SUD Treatment • Follow-up After High-Intensity Care for SUD • Pharmacotherapy for Opioid Use Disorder (OUD) by plan type, year, clinical characteristics, and demographics

Research Question	Example Measures
Did quality of care outcomes among individuals in need of SUD services improve following the implementation of the IMD SUD demonstration?	• ED Visits for SUD, for OUD • Inpatient Utilization for SUD, for OUD • Adult Access to Preventive/Ambulatory Health Services • Colorectal Cancer Screening • Plan All-Cause Readmission by plan type, year, clinical characteristics, and demographics
Did health outcomes among individuals in need of SUD services improve following the implementation of the IMD SUD demonstration?	• Rate of overdose deaths among adult Medicaid members living in a geographic area covered by the demonstration by plan type, year, clinical characteristics, and demographics
Hypothesis 3: The HRSN component of the January 2024 amendment will support the delivery of social care through SCNs and improve overall quality and health outcomes for high-risk members[57] including children, pregnant and postpartum individuals, the chronically homeless, and individuals with SUD.	
Did the HRSN initiative effectively mitigate members' identified HRSNs?	• Proportion of survey respondents who agreed that services received fully met their needs by year, HRSN service type, and demographics
What were the experiences of members with HRSN screening and services?	Proportion of survey respondents who reported good to excellent experience with: • Screening process • Social Care Navigator • Nutrition Service Provider • Housing Service Provider • Transportation Service Provider Proportion of survey respondents who were happy with the quality of services received: • Nutrition Service Provider • Housing Service Provider • Transportation Service Provider by year and demographics
Did quality of care and health outcomes among persons eligible for enhanced HRSN services improve following receipt of enhanced HRSN	• Adult Access to Preventive/Ambulatory Health Services • Colorectal Cancer Screening • Inpatient Utilization • ED Visits (Total, BH, non-BH) • Plan All-Cause Readmission by year, clinical characteristics and demographics

[57] The State indicates that the term "high-risk members" includes "children, pregnant and postpartum individuals, the chronically homeless, and individuals with SUD" in the stated goals of the demonstration. For purposes of evaluation, "high-risk members" is defined as individuals who meet the eligibility criteria for enhanced HRSN services.

Research Question	Example Measures
services?	
How did renewals of recurring nutrition services affect care utilization and member physical and mental health outcomes?	• Adult Access to Preventive/Ambulatory Health Services • Colorectal Cancer Screening • Inpatient Utilization • ED Visits (Total, BH, non-BH) • Plan All-Cause Readmission • Potentially Preventable Mental Health Readmission Rates by year, clinical characteristics and demographics
Hypothesis 4: The HERO initiative will increase volume and/or quality of referrals of fraud, waste and abuse investigation based on an advanced analytics platform	
Did the integration of an analytics platform increase the volume and quality of referrals for Medicaid fraud and abuse?	• Referrals of investigations • Corrective action plans

The evaluation questions, hypotheses, measures, and data sources are subject to change. The State and its independent evaluator will refine them based on CMS feedback during the approval process.

Section 7: Public Notice Compliance and Documentation

The State views transparency and meaningful public input as critical to shaping the demonstration and informing its ongoing implementation. Throughout the most recent demonstration period, the State provided regular opportunities for stakeholders and members of the public to receive updates, provide feedback, and engage directly with the State.

Throughout the demonstration period, the State conducted Annual Public Forums that were open to the public. The State notified the public about these forums through various channels, including the New York State Register, the MRT Listserv, and publishing the relevant information, including date, time, and location, on the State's 1115 waiver website at least 30 days prior to the date of the planned forum. The dates of these forums were as follows:

- September 28, 2022
- February 28, 2024 (this public forum also served as a public hearing for the Continuous Eligibility for Children up to Age Six amendment)
- March 26, 2025

In addition, the State conducted public hearings related to proposed 1115 waiver amendments to afford the public an opportunity to learn more about each amendment and share feedback. The dates of these hearings were as follows:

January 2024 amendment (HRSN, HERO, MHGBI, Workforce Initiatives)

- May 3, 2022
- May 10, 2022

January 2024 amendment (SUD)

- October 26, 2022
- October 31, 2022

Continuous Eligibility for Children up to Age Six amendment

- February 21, 2024
- February 28, 2024 (this public hearing also served as the annual public forum)

Medicaid Buy-In for Working People with Disabilities (MBI-WPD) Demonstration Program and Career Pathways Training (CPT) Program amendment

- November 25, 2024
- December 4, 2024

The State also provided recurring opportunities for public engagement through the New York State Public Health and Health Planning Council (PHHPC). The council convenes regularly throughout the year, alternating locations in Albany and New York City, with meetings conducted through standing committees. Most recently, the Council's Committee on Codes, Regulations and Legislation held a meeting on September 17, 2026, followed by PHHPC's Annual full council meeting thereafter. All PHHPC meetings are subject to New York's open meetings law and are therefore available for public access.

The State further supports ongoing stakeholder engagement through the Medicaid Redesign Team Listserv (MRT Listserv). The MRT Listserv provides interested parties with timely information on Medicaid updates, meeting announcements, webcasts, meeting materials, updated timelines, and other opportunities for engagement.

In compliance with 42 CFR § 431.408, the State certifies that the abbreviated and full public notices for the waiver extension request were published in the New York State Register on July 8, 2026, with written comments accepted by electronic or written mail through August 21, 2026. In compliance with 42 CFR § 431.408(a)(3), the State conducted two public hearings on July 31, 2026, and August 11, 2026. The first public hearing was held in person at Empire State Plaza, Concourse, Meeting Room 2, Albany, NY 12242. This hearing was webcast live. The second public hearing was held virtually, via WebEx, and also served as the 1115 Annual Public Forum. American Sign Language (ASL) interpretation was available during both hearings. Notification and reminders of the extension request and public hearings were also shared via the MRT Listserv. The State's 1115 waiver website was updated on July 8, 2026 to post the draft waiver extension, preliminary interim evaluation report, public and tribal notice documents, and notify the public of the upcoming hearings and Annual Public Forum, including dates, time, and location. A copy of the New York State Register with the abbreviated and full public notices, as well as the MRT Listserv announcement are attached.

Both comment sessions were open to the public and included an overview of current waiver initiatives as well as a summary on New York's 1115 waiver extension request. After the presentation by NYS DOH staff, commenters, both registered and unregistered, were afforded the opportunity to share oral comments.

Public Comment Overview

The State received 165 written comments regarding the extension application, as well as an additional 32 comments received verbally from the hearings from individuals, advocacy groups, community providers, and other stakeholders. The written letters and emails, as well as verbal testimony during the public hearings, contained suggestions, questions and comments of support.

The total number of perspectives raised on issues is greater than the 165 written and 32 verbal public comments, since most contained multiple suggestions, questions, and support covering many different aspects of the 1115 waiver extension. While all comments have been considered, no changes were made to the extension request. NY appreciates all of the comments and feedback shared by its stakeholders regarding this waiver extension application. These comments help inform the content and approach of the waiver extension request and will be taken under advisement as the State implements the demonstration and considers future programmatic initiatives beyond the scope of this extension request. The current application reflects the importance of stakeholder public comment and the responsiveness of NY to these suggestions.

Public Comment Themes and State Responses

General Waiver Extension Comments

There has been a clear consensus among commenters around strong, enthusiastic support for the continuation of the waiver, with particular praise directed at the Social Care Network (SCN) infrastructure and the integration of Health-Related Social Needs (HRSN) services. Stakeholders validated that the waiver has successfully initiated a paradigm shift in New York's Medicaid program from a reactive, illness-based model to a proactive, preventive, and whole-person system of care. Key public comment themes include:

Commenters provided robust qualitative and quantitative evidence demonstrating that SCN-coordinated services have significantly improved member outcomes.

Stakeholders emphasized that Medicaid members rarely present with isolated social barriers. The SCN model's ability to simultaneously address housing instability, food insecurity, and transportation challenges through a single, coordinated entry point was cited as a critical driver of improved clinical compliance and an effective means to address access gaps.

A dominant theme across submissions was the need to sustain infrastructure and capacity-building funding for Community-Based Organization (CBO) partners. Commenters noted that smaller, grassroots, and rural organizations require a longer operational runway to achieve financial sustainability.

Multiple stakeholders and SCN lead entities recommended a one-year "non-risk" funding bridge for HRSN services. This transition period is deemed essential to allow encounter data to mature into a reliable actuarial basis before shifting to capitated, risk-based contracting models by April 2028.

Advocacy groups urged the State to ensure the waiver structurally accommodates high-acuity and historically marginalized groups. Specific recommendations were submitted to embed targeted protections and care coordination pathways for individuals with intellectual and developmental disabilities (I/DD), foster children, and individuals with a history of substance use disorders.

Stakeholders supported continued investment in shared, interoperable social care data platforms to facilitate seamless communication and data sharing between Managed Care Organizations (MCOs), clinical providers, and CBOs.

Suggestions were also made to expand use of data and analytics through HERO, strengthen enrollment and coverage-transition supports, provide additional workforce development opportunities, and strengthen hospital, long-term care, and other Medicaid service delivery.

The State appreciates these recommendations and will appropriately consider them in the continued implementation of the demonstration. Comments that were not germane to or were outside of the scope of this waiver extension were not included in this summary.

Continuation of HRSN and SCN Comments

Of the 197 comments received, 184 (93%) pertained to HRSN, with a vast majority expressing support for continuation of the program to maintain critical health-related supports and provide additional time to demonstrate impact over the extension period. Commenters highlighted the HRSN/SCN model's role in addressing housing, nutrition, transportation, and other barriers that affect health, as well as in improving coordination among Medicaid members, healthcare providers, and CBOs. Commenters expressed particularly strong support for continuation of nutrition and Food as Medicine services, including medically tailored meals and other nutrition supports. Commenters also emphasized the importance of housing supports, citing examples of rental and utility assistance, eviction prevention, housing navigation, home remediation, and accessibility modifications that helped members obtain or maintain stable housing. Many emphasized that the initiative remains relatively early in implementation and that additional time is needed for SCNs, provider networks, referral pathways, and partnerships to mature and demonstrate longer-term health and cost outcomes.

Commenters also highlighted early evidence of positive member impact, particularly among individuals with chronic conditions and high healthcare utilization. Two SCNs reported reductions in acute healthcare utilization. Finger Lakes Independent Provider Association (FLIPA) reported a 69 percent reduction in emergency department visits among engaged members, while Staten Island Performing Provider System (SIPPS) reported a 25 percent reduction in emergency department and hospital visits associated with SCN food services, including reductions of 36 percent among pregnant and postpartum members and 35 percent among high utilizers.

Numerous commenters requested continued infrastructure and capacity-building funding for SCNs and participating CBOs, including continuation of HRSN Infrastructure funding beyond the current demonstration period, emphasizing the need to preserve and build on investments already made in staffing, technology, administrative processes, and service-delivery capacity. They expressed concern that discontinuing infrastructure funding could affect the sustainability of the HRSN service delivery network, particularly for smaller and rural CBOs.

Commenters also supported the proposed one-year extension of non-risk HRSN funding through March 2028, which would provide additional time before the planned transition to risk-based funding in April 2028. In anticipation of this transition, some recommended ongoing CBO capacity support, transparent rate development, and proactive provider engagement to help prevent service disruptions and loss of provider participation. Multiple commenters also supported the State's request to use remaining DSHP funding to continue HRSN services during the extension period and maintain continuity during the transition to risk-based funding.

Regarding these comments, the State acknowledges the importance of continued CBO capacity and financial sustainability, as well as a stable transition to risk-based funding. The State maintains its proposal to discontinue HRSN Infrastructure authority while continuing non-risk HRSN payments through March 2028 to support the transition. Additional recommendations regarding HRSN program operations, reimbursement, service delivery, and implementation will be considered as part of the State's ongoing administration of the demonstration.

Other Demonstration Initiatives Comments

Commenters also addressed the discontinuation of expanded Continuous Eligibility authorities, generally opposing the change due to concerns regarding coverage churn and disruptions in access to care, particularly for young children and individuals with ongoing healthcare needs. Commenters recommended strengthening Facilitated Enrollment Services, outreach and data sharing, and transitions to other coverage to mitigate potential coverage losses. The State acknowledges these concerns and has discontinued these authorities consistent with CMS guidance while continuing

enrollment supports to facilitate coverage transitions.

Other comments addressed the phase-out of CPT and HEALR and potential alternative approaches to sustain workforce investments; continuation of HERO's data and analytics functions and its proposed role in identifying potential fraud, waste, and abuse; and the potential funding gap between MHGBI and AHEAD implementation. The State appreciates these recommendations and will consider them, as appropriate, consistent with federal guidance and the authorities requested through this extension.

Tribal Notification

New York State is home to nine state recognized Tribal Nations: Cayuga Nation, Oneida Indian Nation, Onondaga Nation, Saint Regis Mohawk Tribe, Seneca Nation, Shinnecock Indian Nation, Tonawanda Seneca Nation, Tuscarora Nation, Unkechaug Indian Nation (Poospatuck). In accordance with 42 CFR § 431.408(b), on July 8, 2026 Tribal letters were sent out. Tribes were provided at least 30 days to comment. The Department of Health advised the above-mentioned tribes and associated tribal health centers by letter of the intent to request an extension of the Section 1115 demonstration (refer to attachment). During this notice period, no comments were received from any of the aforementioned tribes.

Budget Neutrality Summary

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY) DY 29 (4/1/27 - 3/31/28)	DY 30 (4/1/28 - 3/31/29)	DY 31 (4/1/29 - 3/31/30)	DY 32 (4/1/30 - 3/31/31)	DY 33 (4/1/31- 3/31/32)	TOTAL
Medicaid Populations						
MEG 1: TANF Children 1-20	$ 10,582,077,106	$ 10,985,384,151	$ 11,404,158,171	$ 11,838,748,580	$ 12,290,056,375	$ 57,100,424,382
MEG 3: SSI 0-64	$ 22,330,341,671	$ 23,491,189,679	$ 24,712,411,430	$ 25,997,105,611	$ 27,348,599,378	$ 123,879,647,770
MEG 4: SSI 65+	$ 6,255,114,919	$ 6,672,364,833	$ 7,117,443,719	$ 7,592,211,781	$ 8,098,653,399	$ 35,735,788,652
MEG 5: Non-duals 18-64	$ 2,776,709,707	$ 2,921,224,376	$ 3,073,260,848	$ 3,233,212,366	$ 3,401,489,016	$ 15,405,896,313
MEG 6: Non-duals 65+	$ 1,157,533,201	$ 1,234,747,557	$ 1,317,112,803	$ 1,404,972,204	$ 1,498,693,493	$ 6,613,059,258
MEG 7: MLTC Adult 18-64 Duals	$ 3,157,396,823	$ 3,320,998,449	$ 3,493,086,783	$ 3,674,100,889	$ 3,864,503,211	$ 17,510,086,156
MEG 8: MLTC Adult 65+ Duals	$ 20,974,353,265	$ 22,373,427,587	$ 23,865,831,769	$ 25,457,799,135	$ 27,155,961,786	$ 119,827,373,541
TOTAL	$ 67,233,526,693	$ 70,999,336,632	$ 74,983,305,523	$ 79,198,150,565	$ 83,657,956,658	$ 376,072,276,072

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY) DY 29 (4/1/27 - 3/31/28)	DY 30 (4/1/28 - 3/31/29)	DY 31 (4/1/29 - 3/31/30)	DY 32 (4/1/30 - 3/31/31)	DY 33 (4/1/31- 3/31/32)	TOTAL
Medicaid Populations						
MEG 1: TANF Children 1-20	$ 11,305,012,644	$ 11,931,240,396	$ 12,592,225,014	$ 13,289,901,238	$ 14,026,262,031	$ 63,144,641,325
MEG 3: SSI 0-64	$ 20,468,235,993	$ 21,068,626,678	$ 21,686,645,633	$ 22,322,821,116	$ 22,977,644,623	$ 108,523,974,042
MEG 4: SSI 65+	$ 5,822,018,007	$ 6,099,966,848	$ 6,391,181,417	$ 6,696,302,785	$ 7,015,985,938	$ 32,025,454,995
MEG 5: Non-duals 18-64	$ 2,420,297,537	$ 2,460,309,991	$ 2,500,987,268	$ 2,542,342,596	$ 2,584,389,466	$ 12,508,326,859
MEG 6: Non-duals 65+	$ 1,024,184,017	$ 1,059,579,966	$ 1,096,200,234	$ 1,134,085,199	$ 1,173,279,523	$ 5,487,328,939
MEG 7: MLTC Adult 18-64 Duals	$ 2,762,355,994	$ 2,810,132,824	$ 2,858,792,103	$ 2,908,357,029	$ 2,958,845,726	$ 14,298,483,677
MEG 8: MLTC Adult 65+ Duals	$ 18,558,234,896	$ 19,199,637,413	$ 19,863,196,536	$ 20,549,704,022	$ 21,259,907,651	$ 99,430,680,519
Medicaid Aggregate - WW only						
MEG 9: HCBS Expansion	$ 866,879	$ 910,819	$ 957,020	$ 1,005,600	$ 1,056,587	$ 4,796,905
MEG 10: Demonstration Only Services in MMMC						
MEG 11: Transportation (to HRSN Services)						
MEG 12: Cooking Supplies						
MEG 13: Medicaid Hospital Global Budget Initiative						
MEG 14a: Student Loan Repayment	$ 1,328,250	$ 841,500	$ 792,000	$ 792,000		$ 3,753,750
MEG 14b: Career Pathways Training (CPT)	$ 25,875,229	$ 4,525,229	$ 4,525,229	$ 4,525,229		$ 39,450,916
MEG 15: DSHP						
MEG 16: HERO (Health Equity Regional Organization)						
MEG 18: Institution to Community	$ 55,081,228	$ 57,875,274	$ 60,811,006	$ 63,895,729	$ 67,136,855	$ 304,800,092
MEG 19: Brokerage Fees						
TOTAL (Excluding WW-only)	$ 62,360,339,088	$ 64,629,494,116	$ 66,989,228,206	$ 69,443,513,985	$ 71,996,314,959	$ 335,418,890,355
VARIANCE	$ 4,873,187,605	$ 6,369,842,516	$ 7,994,077,318	$ 9,754,636,580	$ 11,661,641,699	$ 40,653,385,718

HYPOTHETICALS ANALYSIS

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY) DY 29 (4/1/27 - 3/31/28)	DY 30 (4/1/28 - 3/31/29)	DY 31 (4/1/29 - 3/31/30)	DY 32 (4/1/30 - 3/31/31)	DY 33 (4/1/31- 3/31/32)	TOTAL
New Adult Group	$ 22,398,035,164	$ 23,488,593,096	$ 24,632,275,632	$ 25,831,588,652	$ 27,089,288,619	$ 123,439,781,164
Family of One Non-1915 Children	$ 57,014,234	$ 59,906,378	$ 62,945,126	$ 66,138,127	$ 69,492,991	$ 315,496,856
SUD IMD TANF Children 1 to 20	$ 139,553	$ 146,391	$ 153,564	$ 161,089	$ 168,982	$ 769,579
SUD IMD TANF Adults 21 to 64	$ 2,064,158	$ 2,163,238	$ 2,267,073	$ 2,375,893	$ 2,489,935	$ 11,360,297
SUD IMD SSI 0 to 64	$ 3,906,286	$ 4,101,601	$ 4,306,681	$ 4,522,015	$ 4,748,116	$ 21,584,699
SUD IMD New Adult Group	$ 39,281,747	$ 41,088,707	$ 42,978,788	$ 44,955,812	$ 47,023,780	$ 215,328,834
SUD IMD FFS	$ 76,103,498	$ 79,756,465	$ 83,584,776	$ 87,596,845	$ 91,801,494	$ 418,843,078
HRSN Direct Services						
HRSN Infrastucture (Social Care Networks)						
TOTAL	$ 22,576,544,640	$ 23,675,755,877	$ 24,828,511,641	$ 26,037,338,432	$ 27,305,013,917	$ 124,423,164,507

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY) DY 29 (4/1/27 - 3/31/28)	DY 30 (4/1/28 - 3/31/29)	DY 31 (4/1/29 - 3/31/30)	DY 32 (4/1/30 - 3/31/31)	DY 33 (4/1/31- 3/31/32)	TOTAL
New Adult Group	$ 22,398,035,164	$ 23,488,593,096	$ 24,632,275,632	$ 25,831,588,652	$ 27,089,288,619	$ 123,439,781,164
Family of One Non-1915 Children	$ 57,014,234	$ 59,906,378	$ 62,945,126	$ 66,138,127	$ 69,492,991	$ 315,496,856
SUD IMD TANF Children 1 to 20	$ 139,553	$ 146,391	$ 153,564	$ 161,089	$ 168,982	$ 769,579
SUD IMD TANF Adults 21 to 64	$ 2,064,158	$ 2,163,238	$ 2,267,073	$ 2,375,893	$ 2,489,935	$ 11,360,297
SUD IMD SSI 0 to 64	$ 3,906,286	$ 4,101,601	$ 4,306,681	$ 4,522,015	$ 4,748,116	$ 21,584,699
SUD IMD New Adult Group	$ 39,281,747	$ 41,088,707	$ 42,978,788	$ 44,955,812	$ 47,023,780	$ 215,328,834
SUD IMD FFS	$ 76,103,498	$ 79,756,465	$ 83,584,776	$ 87,596,845	$ 91,801,494	$ 418,843,078
HRSN Direct Services						
HRSN Infrastucture (Social Care Networks)						
TOTAL	$ 22,576,544,640	$ 23,675,755,877	$ 24,828,511,641	$ 26,037,338,432	$ 27,305,013,917	$ 124,423,164,507
HYPOTHETICALS VARIANCE	$ -	$ -	$ -	$ -	$ -	$ -

Demonstration Budget Template for States Using CHIP Funds

	10/1/2024-9/30/2025	10/1/2025-9/30/2026	10/1/2026-9/30/2027	10/1/2027-9/30/2028	10/1/2028-9/30/2029
	FFY25 Federal Fiscal Year 25	**FFY26** Federal Fiscal Year 26	**FFY27** Federal Fiscal Year 27	**FFY28** Federal Fiscal Year 28	**FFY29** Federal Fiscal Year 29
State's Allotment	$ 1,989,955,192	$ 2,104,707,273	$ 2,104,707,273	$ 2,104,707,273	$ 2,104,707,273
Funds Carried Over From Prior Year(s)	$ 867,840,478	$ 867,840,478	$ 1,523,127,423	$ 2,178,414,368	$ 2,833,701,313
SUBTOTAL (Allotment + Funds Carried Over)	**$ 2,857,795,670**	**$ 2,972,547,751**	**$ 3,627,834,696**	**$ 4,283,121,641**	**$ 4,938,408,586**
Reallocated Funds (Redistributed or Retained that are Currently Available)		$ -	$ -	$ -	$ -
TOTAL (Subtotal + Reallocated funds)	**$ 2,857,795,670**	**$ 2,972,547,751**	**$ 3,627,834,696**	**$ 4,283,121,641**	**$ 4,938,408,586**
State's Enhanced FMAP Rate	**65.00%**	**65.00%**	**65.00%**	**65.00%**	**65.00%**

COST PROJECTIONS OF DEMONSTRATION PROPOSAL					
Demonstration Population: CHIP Enrollees who receive 1115(a)(2) demonstration benefits					
Eligible User Months Annually					
Average Users Per Month	-	-	-	-	-
Benefit Costs					
Fee for Service	$ -	$ -	$ -	$ -	$ -
Fee for Service per member/per month rate @ # of eligibles					
Total Benefit Costs	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Federal Title XXI Share	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
State Share	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
TOTAL COSTS FOR DEMONSTRATION	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**

Program Costs					
Total Title XXI Program Costs (Separate CHIP State Plan) (federal share)	**$ 1,449,420,328**	**$ 1,449,420,328**	**$ 1,449,420,328**	**$ 1,449,420,328**	**$ 1,449,420,328**
Total Title XXI Program Costs (Targeted Low Income Children covered under the Medicaid State Plan))(federal share)	**$ 920,888,946**	**$ 920,888,946**	**$ 920,888,946**	**$ 920,888,946**	**$ 920,888,946**
Total Title XXI Program Costs (Demonstration)	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Total Federal XXI Share at enhanced FFP	$ -	$ -	$ -	$ -	$ -
Total State XXI Share	$ -	$ -	$ -	$ -	$ -
TOTAL PROGRAM COSTS (State Plan + Demonstration) (Federal Share)	**$ 1,449,420,328**	**$ 1,449,420,328**	**$ 1,449,420,328**	**$ 1,449,420,328**	**$ 1,449,420,328**

Total Federal Title XXI Funding Currently Available (Allotment + Reallocated Funds)	$ 2,857,795,670	$ 2,972,547,751	$ 3,627,834,696	$ 4,283,121,641	$ 4,938,408,586
Total Federal Title XXI Program Costs (State Plan + Demonstration)	$ 1,449,420,328	$ 1,449,420,328	$ 1,449,420,328	$ 1,449,420,328	$ 1,449,420,328
Unused Title XXI Funds Expiring (Allotment or Reallocated)	$ 540,534,864	Unknown	Unknown	Unknown	Unknown
Remaining Title XXI Funds to be Carried Over (Equals Available Funding - Costs - Expiring Funds)	$ 867,840,478	$ 1,523,127,423	$ 2,178,414,368	$ 2,833,701,313	$ 3,488,988,258