NEW YORK STATE

OFFICE OF MENTAL HEALTH

PUBLIC HEARING

NEW YORK STATE'S IMD TRANSFORMATION PROGRAM

WAIVER APPLICATION

Virtual Hearing

October 26, 2022

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PRESENT:

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Department of Health
Bureau of Adult Special Populations

PANELISTS:

Department of Health
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Office of Mental Health
Anita Daniels, Associate Commissioner

Jeremy Darman, Deputy Commissioner
State and Local Operations

Office of Addiction Supports and Services
Trishia Allen, General Counsel

Pat Lincourt, Associate Commissioner

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MS. AMY CLINTON: My name is Amy Clinton and I work for the Bureau of Adult Special Populations at the Department of Health.

Before we get started, I would like to let folks know that closed captioning is available for this webinar in order to enable them. Please look at the bottom of your screen. The left hand side of your screen, find the CC. And, when you click on it and it says, show closed captions, that should get them started.

Also, we have American Sign Language interpreters with us today for this webinar, I'd like to acknowledge and thank our interpreters, Stephanie and Lauren. In order to get the interpreters video on the same stage as the presentation, please right click on the interpreters video icon, and then select, move to the stage. And, you should see their video side by side with the slide deck. If anybody has any trouble accessing either the closed captions or the sign language interpreter, please let us know in the chat box.

In compliance with social distancing

guidelines due to COVID-19 and in alignment with approved CMS exceptions to satisfy the public hearing requirements outlined in 42 CFR 431.408, the State is holding two virtual public hearings in connection with this waiver amendment request.

Public hearings are required for all 1115 waiver amendments in order to afford the public an opportunity to provide comments regarding the State's waiver amendment applications.

Comments which are made during a public hearing may supplant, supplement or reiterate written comments that are submitted through alternative comment channels, such as the 1115 e-mail or the mailing address, which we will reiterate at the end of this presentation.

A recording and transcription of this hearing will be available on the MRT Waiver website about three to five days after the hearing. This is the same website where you found copies of the application proposal.

Language translation is available upon request.

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I'd like to introduce today's panelists, starting with Trisha Schell-Guy, Director of the Division of Program Development and Management at the Department of Health.

MS. TRISHA SCHELL-GUY: Good afternoon. Thanks, Amy.

MS. CLINTON: Serena Master, Director of the Bureau of Adult Special Populations at the Department of Health.

MS. SARINA MASTER: Hi, everybody. Thanks, Amy.

MS. CLINTON: Anita Daniels, Associate Commissioner at the Office of Mental Health.

MS. ANITA DANIELS: Hi, good afternoon, everyone.

MS. CLINTON: Jeremy Darman, Deputy Commissioner, State and Local Operations at the Office of Mental Health.

MR. JEREMY DARMAN: Afternoon, everybody.

MS. CLINTON: Trishia Allen, General Counsel for the Office of Addiction Services and supports.

October 26, 2022

MS. TRISHIA ALLEN: Good afternoon, everyone.

MS. CLINTON: And, Pat Lincourt, Associate Commissioner for the Office of Addiction Services and supports.

MS. PAT LINCOURT: Good afternoon.

MS. CLINTON: For today's agenda, we will go through the background, the purpose and the objectives of this Waiver Amendment request. Agencies will outline program designs. We'll go through, briefly, the financial data that is in the Waiver, as well as how the State intends to evaluate outcomes and objectives in this Waiver. We'll talk quickly about the submission timeline and then give folks time for the public comment period. Trisha Schell-Guy:

MS. SCHELL-GUY: Great. Thank you so much, Amy. So, beginning with the background, I would like to spend a couple of minutes to explain to folks what an IMD is, or an Institution for Mental Disease, and why we need a waiver, why we even need to do this waiver for services that are provided to individuals in an

IMD.

Initially, I think it's important to mention that Medicaid is the largest payer of behavioral health services in New York State and in the United States. That being said, there are still some behavioral health services that Medicaid does not cover. IMDs have a long history in Medicaid. They go all the way back to 1965.

At that time, Congress established Medicaid as a public health insurance program. It was, it was and continues to be a partnership between states and the federal government. However, at that time and continuing through to today, there are populations and services that the federal government feels are states' responsibility. And thus, would not be eligible for any federal financial contributions.

One of these excluded services is for individuals that are in institutions for mental disease, or we'll just keep calling it IMD 'cause it's shorter. The intent there being that institutionalized individuals are a state

responsibility and that the restrictions put on federal funding provide incentives to the states to invest in community alternatives and not have people remain institutionalized for longer than is necessary.

So, IMDs are defined in federal law. They're defined as, and it's on the screen for you, a hospital, nursing facility, or other institution with more than 16 beds, so, 17-plus, that is primarily engaged in providing diagnosis, treatment or care of persons with a mental disease. Mental disease is an out of date term, but it is still the term that's in the statute. It includes individuals with mental health conditions or substance use disorder. It does not include the IDD population. And, there also are a few exceptions in the law, including individuals who are over 65 years of age, and persons 21 and under that are residing in an in-patient psychiatric facility for youth. So, we do have those in New York State. We do get federal share for those. They include OMH's residential treatment facilities or RFTs and

OASAS's residential rehab services for youth or RRSY.

One of the other things I want to point out in addition to that 16-bed trigger is the primarily engaged language. That also is very important in defining an IMD because, essentially, it's a math problem. Essentially, you are primarily engaged if more than 50 percent of the individuals you serve, have a behavioral health.

Okay. Next slide, please. Great.

So, what's the purpose of New York State's IMD waiver request? Why are we doing this? In the broadest sense, the idea behind this is to acknowledge that some levels of care in the mental health and SUD systems are so critical that we have operated them for years with only state resources. And, they are integral parts of our continuum of care. So now, we're looking to take advantage of some opportunities that have arisen at the federal level to obtain additional resources so that we can strengthen our entire system and that we can

improve care for folks that reside in these IMD settings and are transitioning out of these settings into the next level of care.

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So, what exactly is an IMD waiver amendment? What does that mean? From a process perspective, we are using federal authority under Section 1115 of the Social Security Act to ask CMS to approve a demonstration project that promotes the objectives of the Medicaid program.

So, 1115 is something that you have probably heard very frequently, especially lately as we have put forward the HealthEquity waiver. It's a term that is used often in New York and across the country. It's how our managed care system of our managed care delivery system is authorized and how we do many different pilots and demonstrations in the state of New York.

So this 1115 IMD waiver is asking CMS to waive a portion of Section 1905 of the Social Security law that prohibits the federal government from contributing financially to certain services delivered to individuals --

well, to any services, I should say -- to individuals in certain IMDs. So, namely, state psychiatric centers and community-based in-patient and residential addiction programs. So, to recap, we're asking them to waive the provision that would not permit them to fund those services in those programs.

There are some caveats. Many of them are lined out in the several state Medicaid directors letters that have been issued by CMS over the last several years addressing these types of waivers. Some of these caveats include limits on lengths of stay making the average length of stay no more than 30 days with an absolute limit of no more than 60 days. Somewhat unique to New York in this, in this application is that we are also asking CMS to approve a targeted set of in-reach services, reimbursable in-reach services for individuals in the state psychiatric centers who would not otherwise meet the 30-day average length of stay. So, they have been, they would be there longer than those 30 days. These in-reach services that we're seeking

include things like care management, discharge planning, and clinical services to include a, or to ensure -- excuse me -- a warm handoff once these individuals leave the state psychiatric centers. And, they would be provided 30 days prior to release to some of the most vulnerable and disadvantaged patients with the goal of strengthening community engagement for these patients to keep them out of the emergency department and prevent a return to an in-patient or state PC.

So, CMS will not approve this type of waiver indefinitely, nor will they allow federal dollars to cover long lengths of stay. So, as we move forward with negotiating this waiver, there will be a host of standard terms and conditions that will dictate many of the conditions that must be demonstrated throughout that five-year term. And, my colleagues will go over some of that when they get a little bit more into the program.

And then, finally sometime in 2023, our plan is to add services delivered to children in

the child welfare system that reside in QRTPs or Qualified Residential Treatment Programs and other child welfare institutions that meet the definition of an IMD. So, that will be coming next.

So, now we talked about background. We talked about purpose. I wanted to take a minute to highlight some of the overall objectives that we hope to achieve with the federal funding that we gain from this waiver.

This is another step towards transforming the behavioral health system by promoting improved access to community-based mental health and substance use disorder services. And, we want to use the funds that we realize from this waiver to transform, strengthen and improve our system so that we can provide the highest quality behavioral health services in the least restrictive setting.

To do that, we need to make sure that we have robust care transition services available and sufficient access to those community-based treatment and support services that these members

will need.

Next, please.

Next, we're going to get into the details of the actual program design of this waiver. So, I'm going to start with this slide, and then I'll pass it along to my colleagues. So, before I turn it over to my O-Agency colleagues, I just want to level set a little bit so people understand that while this waiver is specific to services in IMDs, it's really two distinct asks of CMS. That being said, it has been a very collaborative effort among DOH, OASAS and OMH addressing and understanding the needs of each of the agencies and the populations.

So, the first program is seeking federal financial participations of federal dollars for individuals with serious mental illness receiving services in state psychiatric centers. This ask would generate federal share for any patients who have an average length of stay of 30 days or less. And, this would be claimed retrospectively. So, after a patient stay is over, if that stay is 30 days or less, that is

when the claiming would happen. This also contains the section I described in the, in the application requesting federal financial participation for the 30 days of in-reach services prior to discharge.

Then, there's the substance use disorder component, which is seeking federal financial participation for all individuals in any IMD. So, this, this would include in the SUD world their community-based detox programs, in-patient programs, and the three elements of Part 820 residential care. This is a prospective look at everyone in these programs. And, in doing that, we need to adhere to and demonstrate an overall 30-day length of stay across all of these programs.

Next slide.

So now, I'm going to turn it over to Anita Daniels from the Office of Mental Health to provide more detail on the SMI initiatives.

MS. DANIELS: Thanks, Trisha, thanks. Hi, everyone.

So, those of you who are familiar with

the work that the Office of Mental Health do, you all know that for well over a decade or more, we've really been focused on really looking at folks that are served in our hospital, state psychiatric system. I'm really focusing on reducing their length of stay. So, so we're excited about this potential opportunity and these potential additional dollars from the federal government to really help us enhance the work that we've done. I think Trisha said it best, transform, strengthen and improve.

So, we, we in, the OMH system, our state psychiatric centers really stay committed to the partnership and really talking about creating this continuum or hub of services to support an individual not in their in-patient care and in their community program.

Through this waiver, we hope to maximize the ability of our state psychiatric centers, which are predominantly centrally located in their communities to provide an enhanced service delivery system, really continuing to emphasize community integration and recovery in the

community. This enhanced delivery system will include transitional housing that integrates better mental health and substance use disorders. So, we're really looking forward to partnering with our OASAS partners on that employment and education supports, of course, also, primary care.

We're also looking forward to those, our community partners potentially receiving some modest events investment from this federal matching fund to help us promote engagement and community tenure.

Next slide.

So, one of the things that OMH will embark on is conducting a comprehensive assessment of how our psychiatric centers are currently facilitating discharge for those hospitalized one year or more. We're, we've focused on creating a data platform that will help to standardize this assessment across all PCs and really includes an in-depth assessment of psychiatric stability, functional or environmental barriers, placement needs for those

who are ready for discharge.

So, our discharge planning process will include an array of services. Some of these things I list aren't new to folks, but we're looking to really see how we can enhance them and do that work a little bit differently. So, using our active mobile integration teams, our home care management teams, our ongoing and very active and aggressive recruitment of peer and family bridgers to improve those engagement and connections, and partnering with our Pathway Home Care manager, who really will be embedded and be active members of our discharge planning process. And again, I talked about our potential partnership with OASAS to capitalize on the use of their peer led recovery centers.

One thing we're excited about is really utilizing some new evidence-based clinical programs reducing their length of stays. We're looking at the I function, which is a functional skills assessment and training software platform that aids staff in assessing the functional limitations of individuals and the areas of

safety, well-being, medical treatments, financial health, social support and technology.

Again, we're looking at, really becoming innovative with recovery-oriented cognitive therapy or CTR, which provides, will provide our clinicians a concrete action of the steps to promote recovery and resilience for patients. COG REM behavioral intervention targeting problems with cognition with the ultimate goal of improving day-to-day community functioning. And, we're excited about, really, adopting a medication empowerment curriculum pilot developed from the work of Pat Deegan and in collaboration with the Center for Practice Innovation or CPI to improve shared decision making and skills for medication independence with the ultimate goal of community stability.

So, we will also really have a focus on prioritizing supports for families during this time. We're really focusing on family bridgers and transition support teams, in addition to prioritizing CPS, family system engaged in training model for our clinical teams.

So again, looking forward to. to transforming, strengthening and improving the work that we do in our state-operated psychiatric centers. So, it's my pleasure to send, turn it over to my colleague, Jerry, Jeremy Darman.

MR. DARMAN: Thanks a lot, Anita. I'm going to talk just a little now about the, you know, how we really move the the work that we're doing through the discharge planning and the clinical work on the in-patient unit into the community and really sustain that to make sure people have this sort of continued level of support.

So, I think, as people know, the transition from in-patient into the community can be really difficult, especially people who've been there for more extended periods of time. So, you can have crises, you know, situational crisis, psychiatric crises, arising that could lead to re-admission if we don't have the proper pieces in place. So, I think, you know, this waiver is a real opportunity to support critical time intervention informed programs for people

moving out of in-patient psychiatric centers. So, we'll be able to give real intensive and comprehensive in-reach while they're still on in-patient during that transition process. And then, follow the person and stay with them as they move into transitional or permanent supported housing. So, I think that the services staying with people once they're in the community is really essential for supporting residential tenure engagement, really getting involved in meaningful life activities. And, I know providers, it's also a support to providers so they can really have somebody that's there for them during that transition and after someone moves into the community.

So, I think, you know, as we've, we've said for a long time at OMH the right services at the right time in the right amount, you know, all of these efforts will be informed by that, making sure that, that we're meeting people exactly where their needs are, and that we know will be able to help us reduce, reduce the length of stay, which is one of the real aims of this

project.

I, I think throughout the program development, also the, the, we'll be building, we'll be strengthening our relationships with, with ambulatory providers who will be able to come in and do the in-reach to our facilities with some incentive. There will be an ability to actually generate revenue from that. And, and again, I think emergency services providers, like CPEPs and EDs and also our residential providers will have more support there in the community to, to be there when a person is in crisis, help reengage, and work on a disposition so they can stay in the community.

And then, finally, you know, I think as people saw, if you read a lot of the Waiver documents, we have a series of performance measures come in there as examples. I think some of those are measures that you're quite familiar with. So, so, the waiver will be informed by standardized key performance indicators. I look forward to people, you know, you can comment on what those might be that, that best really

reflects success. So, you can, you can look at that in the document, and that's something that'll really, I think, show whether we're making progress.

So, I look forward to hearing everyone's comments today and in the future on this. And, thank you very much. I'll pass it over to OASAS now.

MS. ALLEN: So, sorry. This is Trishia Allen. I, I will start and then, Pat, if you want to join in anywhere where I miss a point that you maybe want to make.

So, from the SUD initiatives side of the IMD waiver, we are looking to pull in our community-based detox, in-patient rehab and residential services, as well as our residential reintegration. So, for a little bit of context, during the original behavioral health carve-in and residential redesign, OASAS incorporated our service, our 820 services into the residential benefit under Medicaid. And, in the most recent state plan amendment that we put forward, which I think was 2164, which we did in the context of,

an enhanced FMAP proposal, we pulled in the last element of the 820 services. So, those are the residential reintegration services.

The overarching goal is to allow for a full continuum of services to be available to individuals in need of substance use disorder services from detox all the way to the less intensive residential reintegration services with the hope that we can pull in Fed share for both the fee for service and for additional days in the Medicaid-managed Care Universe.

So, a couple of things that we are focusing on is ensuring that people are making the connections in between the services. So, making sure that we are using, kind of, right services, right time, that people are going into the level of care that is most appropriate for their need and not cycling in and out of a hospital or going to a higher level of care than they need for their particular circumstances. We are also trying to ensure that we are decreasing hospital admissions and readmissions, focusing on overdoses, ensuring that people are getting

access to medication-assisted treatment and other best practices so that we can improve outcomes overall. Pat, anything to add?

MS. LINCOURT: No. Thanks, T, that's good. So, one of the ways that we identify the correct level of care is through the LOCADTR. And, it determines, through an assessment and a decision tree, the best recommendation for the appropriate level of care. The residential services have always been a very important part of the continuum for SUD care. Many people need that safe environment. And, the elements of care allow for stabilizing people who are in need, who are experiencing cravings, who may be using unsafely, who may have some cognitive impairment through their substance use to have a safe place for treatment to stabilize. The rehabilitation is an important part of how, allowing people to, you know, gain recovery skills to have long term management of the substance use disorder. And, as T said, now bringing in the reintegration will, allows for provi-, for people to then have a safe place to reintegrate. And, you can come

into whichever one of those elements best fits for your presenting issues.

The LOCADTR also has a concurrent review module where, that clinicians use to guide decision making about when a person is ready to move to a different level of care. And so, the, you know, what we're doing here will allow for that we have now the managed care plans able to see the entirety of that continuum of care by bringing in the, the IMD waiver. We will have, the providers will have the full expanse of reimbursement for services. And, the LOCADTR criteria will help to guide that decision making.

So, T, I'll turn it back to you.

Next slide.

MS. ALLEN: Thank you. So, part of the waiver program and the hopes that OASAS, what OASAS is hoping to achieve here, is really, in addition to this continuum, leveraging the mechanisms for delivery to improve outcomes. So, what we're really focusing on across the continuum is expanding access to services through things like telehealth. And, these are things

that we've seen that we have been working on it as an agency, and we'll continue to look to expand. So, mobile medication units, that's something that we've been working on, and now that the federal government has opened up the ability to do mobile methadone, that's something that we will continue to look to expand so that we can really get to locations that maybe don't have services or enough access to services for people to really be firmly engaged in that. We're also looking to broaden the reach of the opioid treatment programs, you know, ensuring that there's regions that are not suffering from any lack of services.

And then, we're also looking at how we're delivering those services. Are there ways that we can be more, providing services more directly to people who are unstably housed or are in crisis. So, that's where we're looking at doing thee outreach programs where we're working with the Department of Health to increase services that are more harm reduction focused, meeting people where they're at, offering

services in the community. You know, we're also leveraging our peer work force in our out-patient system to have that lived experience as a critical component in our treatment system. We found that they, they really do have a tremendous effect on the patients and, and really work to engage with them and bring them into services.

And then, we are also pursuing federal ability to have each outpatient program provide methadone as a way to increase access to all versions of medication-assisted treatment, which are authorized by the FDA, especially given the ongoing opioid epidemic. So, those are our goals.

And now, now I will turn it over to Serena Master for the fiscal portion of the waiver.

MS. MASTER. Thank you, Trishia. So, I wanted to go over some of the financial data. The total cost of this amendment is estimated to be $268.37 million over the five-year period. So, this estimate assumes continued measured increases in community placement, successful

placement into those community settings, and enhanced crisis support resources.

So, this estimate, this waiver is estimated to be budget neutral. In general, demonstrations have to be budget neutral per federal requirements. So what this means is that Medicaid expenditures won't be any higher in this waiver than they would have been before the demonstration. We expect to achieve savings through our reinvestment of the dollars into those enhanced services that our colleagues over at OASAS and OMH described. And, those services are aimed at transitioning people to the community and keeping them healthy in the community. That's where we're going to see those savings.

So, if you look at this arrow over here, I know the font is a little small, but it includes the estimated eligibility projections. So, if you can see in those boxes, there's a group titled OMH A and a group titled OMH B. So, OMH A represents those people in the cohort with the 30-day average length of stay. These are

folks we're requesting the federal financial participation for. And, the group titled OMH B represents the group of people eligible for those targeted in-reach services in the 30 days prior to their discharge from a state psychiatric center. So, I won't go through each number for each year. This slide deck will be available if you want to look at it. But, I will just high level say that you can see that we project that the OMH B group, which is those eligible for the 30-day in-reach services will stay steady at 2500 people per year over the five-year period. Those OMH A folks in that group, which, again, is the 30-day average length of stay cohort. Those will initially start at 450 people in year one and the OASAS cohort is estimated to start at 2,218. So, those two cohorts, the OASAS cohort and the OMH A group are expected to rise steadily over each of the five years by a couple hundred people. And again, you will have access to this slide if you want to see the exact numbers.

So, there will be two evaluations of this program and I'll talk about that more in a

second. The first one will be at Year 3, and that's for the SUD or OASAS population. And then, in Year 5, will be evaluated.

Next slide.

So, the evaluation approach is very comprehensive. It is a multi-method statewide evaluation that will be conducted by an independent evaluator. Again, this will be conducted at the midway point for the SUD folks and at the end of the demonstration for both the SUS and the SMI cohorts.

So, this independent evaluator will document the impact of the waiver on health care, service delivery and utilization, health care service quality, health outcomes, and cost effectiveness. The evaluation will examine different program components and look at the ones that led to successes, as well as the ones that pose particular challenges, or, you know, provided learnings for us in the implementation. In outcomes of the waiver.

So, ultimately, this assessor will be assessing whether the goals of each program were

met. Again, the methods are very comprehensive. They will utilize a pre- and post-design approach. It will be a mixed effect regression analysis to examine individual outcomes over time. There are multiple analyses that will be involved of variance and hypothesis testing to compare population and acuity characteristics.

Next slide.

So, this is the submission timeline. As you saw, public notice was posted to the State Register and the public comment period began on October 5th, as well as the tribal comment period began on October 5th. The public hearings are today, as well as on October 31st. And, the public comment period is going to end on November 4th. So, if you have comments that you want to include, please send them by November 4th or at the next hearing. The tribal comment period ends November 10th. So, for those, please include your comments by November 10th.

We will be incorporating the written and oral public comments and will be finalizing the amendment by November 30th. We plan to formally

submit the amendment application to CMS in December and we are hoping to have our implementation date be in the spring of 2023.

So, I will hand this over to Amy Clinton to discuss the public comment period.

MS. CLINTON: Great. Thank you, Sarina. So, we have a list of pre-registered commenters, which will indicate the order in which everyone will be called on to speak. I will call out your name and, when I do so, I request that you -- or, actually I don't request -- you will be getting a message saying that the host is requesting that you unmute yourself. And, when you get that message, please choose the option, unmute me. Without making that selection, you will not be able to unmute yourself. And, also a word of warning, to make sure that your phone is also in, unmuted to avoid that infamous double mute. Comments will be timed. Please limit your remarks to 5 minutes. Again, written comments will be accepted through November 4th by e-mail at the 1115waivers@health.ny.gov. Or you can mail them so that they are received by November

4th at the address there.

And so, to start the public comments. Lydia Virgil at SOMOS [phonetic]. And, And up next will be Alex Dameron.

MS. LILLIE JOHNSON: So, Amy, it looks like Linda is either not with us or has joined under a different name. Linda, if you're here under a different name, you can chat it to the host and we can circle back around to you.

So, I am going to go on down the list. Alex, and I don't believe that I saw Alex either. Let me double check. Alright, Alex, the same thing. If you can, if you are here, please send the host a chat and we can unmute you. And, Lydia, okay. There we go. I'm going to press request unmute and you'll have to click, unmute me. Thanks for your patience, everyone.

MS. CLINTON: Go ahead, Lydia when you're ready.

MS. LYDIA VIRGIL: Thank you so much. Thank you. I was trying to unmute. Actually, at this point, my only comment is one that I will write. This is a very positive project and I

hope to see it come to fruition because there is this huge need for mental health for our communities, especially post-COVID. As we know, all of these behavioral health issues have come up. They have gotten more severe for those who had them, and people that didn't have them in the past, have them now. So, my, that's my only comment. Thank you so much for all of the work that you're doing.

MS. CLINTON: Great. Thank you, Lydia. Lillie, have we found Alex?

MS. JOHNSON: I, when I search I do not see Alex Dameron or Ron Richter, who were two of our registrants. So, I think we can move on to Harvey. And, if Alex or Ron are here, if you chat to me, we can put you in the queue. So, Mr. Rosenthal, I'm going to click the button and you'll have to click, unmute me, when the box pops up. And you're unmuted. You can go ahead now.

MR. HARVEY ROSENTHAL: Can you hear me okay?

MS. JOHNSON: Yep.

MS. CLINTON: We sure can. Go ahead.

MR. ROSENTHAL. Good. So, I'm, I'm Harvey Rosenthal and the CEO of the New York Association of Psychiatric Rehabilitation Services, represents a partnership of tens of thousands of New Yorkers with psychiatric disabilities and community services who support them in 85 agencies across the straight, state. I have a lot to say, so I'm going to try to go fast.

Our aim is being improved services, public policy and social condition of people with mental health, substance use and trauma related challenges. I've been the CEO for NYAPRS for just under 30 years. Our commitment is personal. I'm in long term recovery, as are most of my board and staff. We appreciate all of the thinking and work -- I've just heard a lot more of it -- that has gone into this proposal. And, together, we all hold the goal of reducing the length of hospital stays and recidivism and advancing recovery and self-determination community inclusion. We hold them as paramount.

We've come a long way in improving those services and we've done it without introducing Medicaid into state hospitals. So, I'm not sure why the ones sort of dictates the other. We feel this is a very slippery slope. It's a lot of change to make for what apparently will be for OMH only $15 million a year of, of federal share that becomes available.

You know, system transformation, we've come a long way to improving our services, as I said a moment ago. But, to change the entire system to become from a long term stay more chronic sort of system to one that moves people that quickly in 30 days that requires a sea change in staff beliefs and culture, language, pr-, roles, practices, and discharge planning. Some facilities, I believe, are closer than others, but we have a long way to go and we're not going to do that by March or, you know, by next year. So, you know this idea that we can make this amount of change in that small amount of time.

You know, I don't understand this part

of it. Apparently, we're going to manage care reimbursement, so we'll manage care plans, approve a 30-day admission, which they don't in the community. I'd like to hear more about that if we can.

The proposal does not reference how quick, how quicker and more successful care transitions will be achieved. Most of all, it anticipates sufficient capacity in the community for all these folks to go to. And, we know we don't have that now. We don't have enough short- , as you say, short term residential intensive community support, crisis stabilization. We don't have the state-of-the-art peer engagement supports programs like the inset model.

Furthermore, we're experiencing unprecedented levels of staff turnover and vacancy through the years of drastic underfunding. Do we really want to take the risks of this magnitude in this present environment and you know what I mean, in which we find ourselves? Housing capacity. We have

people in, stranded in hospitals, nursing homes, adult homes. You know, they live on the grounds of the state hospital, all for the lack of housing. Now, we're going to move people out in 30 days just to housing. I'm not sure how that's going to happen. We don't, I don't know if we have the capacity as good as -- staffing capacity, you know, I, we believe the -- well, we can get to that.

Reinvestment. I'm not clear about what calculations have and will be made to anticipate the level of funding. I heard something about, about modest investments. I'm not sure what that means. But in community rest, rent-, reinvestment from closure of state hospitals, that money, that money can be not withstood and doesn't happen. I'd like to know if that happens here or if we'll lose, you know, or we could lose that depending on another governor.

Medicaid rules and requirements have traditionally compromised the appropriate delivery of recovery and peer support services -- sorry -- by medicalizing the services in setting

up practice and documentation requirements that will be inconsistent with recovery values and practices. I heard in the announcement in the, in the proposal that Community residents will be included as part of that. We're very concerned about that. To go from 16 beds to 24 or more. It's something of institutions in the community and will be a violation of Olmsted.

I, I have to say I've sort of objected to this idea that some people will be long-stay folks. I think it's, it's, I've seen this, you know, sort of labeling of low functioning and then people are put on the other side of the room. Really don't want to see that happen here.

We, I saw something about, again, in the proposal about hospitals house- housing and other "facilities". At the federal level, the discussion has been around allowing Medicaid to go into for -profit hospitals. I'm not sure we're talking about that.

Sure, my time is just about run out. And, I would say this. If we want to save money, we have 24 state hospitals that sit there using

up our taxpayer money every minute right now. And, here we are taking these kinds of risks and assuming this amount of change, which we can do without this. And in this environment, while all that money in all those buildings and all that waste is sitting there. So, we really strongly urge that in the words of Jennifer Mathis, I'm on the Board of the Bazelon Center for Mental Health Law for about 20 years. Jennifer of the Bazelon Center says it makes little sense to forge ahead with the repeal of the IMD rule given the harmful consequences that may occur. And more significantly, it makes little sense to do so without first building the community service system that everyone agrees is lacking and that would significantly ease pressure on in-patient capacity, as well as reduce incarceration of people with serious mental illnesses. This is where she would start. The other thing I just want to say is the idea of sort of leveraging all this wonderful change, which I hope it could happen, on state hospitals that are very often not in the community -- old buildings on the

grounds with these large, you know, old castles, things like that. And, to, you know, portray that is what's going to be a modern recovery system and get people to go there and get that response. I worry about that. I worry about whether, you know, that's the place to do this in the state hospitals.

I'll stop there. I'm sure I've exhausted my time. I'll send more comments.

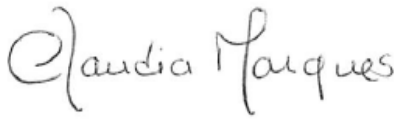
MS. CLINTON: Thank you very much, Harvey. And, Lydia, we thank you as well. We appreciate both of your thoughtful comments. I know that we've confirmed that both Alex and Ronald are not on today, so this concludes our public comment period.

Just a reminder to please submit in any written comments that you have, either by the e-mail on the screen or by mail to be received by November 4th. And, a very special thank you to both of our ASL interpreters, Stephanie and Lauren. Have a great rest of the day everyone.

CERTIFICATE OF ACCURACY

I, Claudia Marques, certify that the foregoing transcript of the NYS OMH Public Hearing on October 26, 2022 was prepared using the required transcription equipment and is a true and accurate record of the proceedings.

Certified By



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