Public Team Meeting
October 26, 2022
3:30 PM – 5:00 PM (ET)

We are going to give folks one more minute and then we will get started. okay. Welcome everybody. Thank you for joining us today. The first of two public hearings that we are having on New York State's IMD waiver application program. 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 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 would 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 interpreter’s video icon and then select move to the stage. 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 message me in the chat box.

In compliance with social distancing guidelines 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 were made during a public hearing may supplant, supplement, or reiterate written comments that are submitted through alternative comment channels, such as the 1115 email with 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 3-5 days after the hearing. This is the same website where you found copies of the application proposal. Language translation is available upon request.

I would 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. Sarina Master, Director of the Bureau of Adult Special Populations at the Department Of Health.

Hi everybody.

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

Good afternoon, everyone.

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

Good afternoon, everybody.

Trishia Allen, General counsel for the Office of Addiction Services and Supports.

Good afternoon, everyone.

And Pat Lincourt. Associate Commissioner for the office of addiction services and supports.

Good afternoon.

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 will 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 will talk quickly about the submission timeline and then give folks time to the public comment period. Trisha Schell-Guy?

Thank you so much. Beginning with the background I would like to spend a couple minutes to explain to folks what an IMD is or an institution for mental disease and why we need a waiver. Initially, I think it is 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 and continues to be a partnership between the states and the federal government. However, at that time and continuing through to today their 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 will call it IMD because it is shorter. The intent there being that institutionalized individuals are estate 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 longer than is necessary.

IMDs are defined in federal law. They are defined as a hospital, nursing facility or other institution with more than 16 beds so 16+ that is primarily engaged in providing diagnosis, treatment or care of a person with mental disease. Mental disease is an out-of-date term but it still the term in the statute. Includes individuals with mental health conditions are substance use disorder. It does not include the IDD population and there 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 inpatient psychiatric facility.

We do have those in New York State. We can get federal share for the strictly include OMH's residential treatment facilities or OASAS. 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 is a math problem.

Essential you are primarily engaged if more than 50 percent of the individuals you serve have a behavioral health.

So what is the purpose of New York State IMD waiver request? Why are we doing this? In the broadest sense the idea behind this is to acknowledge that some levels of care and mental health and SUD Systems are so critical that we have operated them for years with only state resources. They are integral parts of our continuum of care. Now we are 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 resign in these IMD settings and transitioning out of these settings into other levels of care.

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

This 1115 IMD waiver is asking CMS to waive a portion of section 1905 at the Social Security law that prohibits the federal government from contributing financially to certain services delivered to individuals -- Any services I should say -- to certain individuals in certain IMDs. State psychiatric centers and community-based inpatient and residential addiction programs. We are asking them to waive the provision. It would not permit them to fund the services in those programs.

There are some caveats. Many of them are outlined in the several state directors' letters that have been issued by CMS over the last several years addressing these types of waivers. Some of these 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 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. They would be there longer than those 30 days. These in-reach services that we are seeking include things like care management, discharge planning and clinical services to include -- to ensure a warm handoff once these individuals leave the state psychiatric centers.

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 inpatient or state PC. CMS will not approve this type of waiver indefinitely nor will they allow federal dollars to cover long lengths of stay.

As we move forward with negotiating the waiver, there will be a host of standard terms and conditions that will dictate many of the terms and conditions demonstrated throughout the five-year term and my colleagues will go over some of that when they get a little 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, for Qualified Residential Treatment Programs, or other child welfare institutions that meet the definition of an IMD. That will be coming.

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. We want to use the funds that we realize from this waiver to transform, strengthen and improve our system so we can provide the highest quality behavioral health services in the least restrictive setting.

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

Next, we will get into the details of the actual program design of this waiver. I'm going to start with the slide and I will pass it along to my colleagues. Before I turn it over to my agency, colleagues I want to level set a little bit so people understand that while the waiver is specific to services and IMDs. It is two distinct asks of CMS. That being said, it has been a very collaborative effort among DOH, OASAS and OMH. Addressing in understanding the needs of each agency and population.

The first program is seeking federal financial participation, so federal dollars, for individuals with individual mental illnesses receiving services and psychiatric centers. This ask would generate federal share patient who has an average length of stay of 30 days or less and this would be claimed retrospectively so after a patient's status over after 30 days or less that is when the claiming would happen. that also claims this section that I described in the application for the-- there is the substance use disorder component which is seeking federal financial participation for all individuals in any IMD.

This would include in the SUD World there are community-based detox programs, and the elements of residential care practices. Prospective look at everyone in these programs. In doing that we need to adhere to and demonstrate an overall 30-day length of stay across all of these programs.

Now I am going to turn it over to Anita Daniels from the Office of Mental Health to provide more detail on the SMI initiatives.

Those of you who are familiar with the work that the Office of Mental Health do you know for well over a decade or more we have really been focused on looking at folks that are served in our hospital, the state psychiatric system and really focusing on reducing their length of stay. We are excited about this potential opportunity and these potential additional dollars from the federal government to really help us enhance the work we have done. I think Trisha said it best transform, strengthen and improve. 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 inpatient 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 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 disorder. We are looking forward to partnering with our OASAS partners on that employment and education supports of course also primary care. We are also looking forward to community partners. Potentially receiving modest investment from the federal matching funds to help us promote engagement and community tenure.

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 focused on creating a data platform that will help to standardized this assessment across all PC's and really includes an in-depth assessment of psychiatric stability, functional or environmental barriers, placement needs for those who are ready for discharge.

Our discharge planning process will include an array of services. Some of these things I list are not new but we are looking to see how we can enhance them and do the work differently. Using our active mobile integration teams, home care management teams, ongoing and very active recruitment of peer and family bridgers. Partnering with pathway home care managers who really will be embedded and be active members of our discharge planning process. And again, I talked about potential partnership with OASAS to capitalize on the use of their peer led recovery centers.

One thing we are excited about is really utilizing new evidence-based clinical programs. Reducing length of stay is. We're looking at the I function which is a functional skills assessment and training that form. In those areas of safety, well-being, medical treatments, financial health, social support and technology. Again, we are looking at really becoming innovative with recovery oriented cognitive therapy or CTR which will provide clinicians a concrete-actionable steps to promote recovery and resilience for patients. CogREM, behavioral intervention targeting problems with cognition with the ultimate goal of improving day-to-day community functioning. We are excited about adopting a medication empowerment curriculum pilot 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.

Really focusing on family bridgers and transition support teams in addition to prioritizing CPI family system engagement training model preclinical teams. Again, looking forward to transforming, strengthening and improving the work that we do in our state operated psychiatric centers. I will turn it over to my colleague, Jeremy Darman.

I will talk a little know about how we really move the work that we are doing through the discharge planning in the clinical work in the inpatient unit in the community and really sustain that to make sure people have this continued level of support. I think as people know the transition from inpatient into the community can be difficult, especially people who have been there for more extended period of time. You can have crises, situational

crises and psychiatric crises that can lead to readmission if we don't have the proper pieces in place.

I think this waiver is a real opportunity to support critical time intervention informed programs for people moving out of inpatient psychiatric centers. We will be able to give real intensive and comprehensive in-reach while they are still on inpatient during the transition process and then follow the person and stay with them as they move into transitional or permanent supportive housing. I think the service is staying with people once they are in the community is essential for supporting residential tenure, engagement, really getting involved in meaningful life activities. I know for providers it is also a support to providers so they can really have somebody that is there for them during the transition after someone moves into the community.

As we have said, for a long time it OMH, the right services at the right time and the right amount all of these efforts will be informed by that making sure we are meeting people exactly where their needs are and that we know will be able to help us reduce the length of stay which is one of the real aims of this project.

I think throughout the program development also we will be building and strengthening our relationships 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 again, I think emergency services providers and also residential providers will have more support in the community to be there when a person is in crisis and 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 had a series of performance measures in there as examples. I think some of those are measures you are familiar with. The waiver will be informed by standardized performance indicators. I look forward to people, you know, you can comment on what those might be that best really reflect success.

You can look at that in the document that is something I think will really show whether we are making progress. I look forward to hearing everyone's comments today and in the future on this. Thank you very much.

This is Trishia Allen. I will start and then Pat if you want to join anywhere if I miss the point you want to make. From the SUD Initiative side of the IMD waiver we are looking

to pull in our community based detox, inpatient rehab and residential services as well as our residential reintegration.

For little bit of context during the original behavioral health carbon and residential redesign OASAS incorporate our 820 services under Medicaid. And in the most recent estate plan amendment we put forward which I think was 2164 which we did in the context of enhanced FMAP proposal. We pulled in the last element of the 820 services. 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 we can pull in bed share for the fee for service and for additional days in the Medicaid managed care universe.

A couple of things we are focusing on is ensuring that people are making the connections in between the services. So making sure we are using right services, right time people are going into the level of that is most appropriate for their need and not cycling in and out of the hospital are going into a higher level of care that they need for their particular circumstances.

We are also trying to ensure that we are decreasing hospital admissions and readmissions focusing on overdoses, ensuring people getting access to medication assisted treatment and other best practices so that we can improve outcomes overall. Anything to add, Pat?

No, that is good. One of the ways we identify the correct level of care is through the LOCADTR. 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, maybe using unsafely, may have cognitive impairment due to their substance use to have a safe place for treatment to stabilize.

The rehabilitation is an important part of allowing people to gain recovery skills. To have long-term management of the substance use disorder. And as T said now bringing in the integration allows for people to vent have a safe place to reintegrate.

You can come into whichever one of those elements best fits for your presenting issues. The LOCADTR also has a concurrent review module that clinicians used to guide decision-making about when a person is ready to move to a different level of care. And so, what we are doing here will allow for -- we now have the managed care plans able to see the entirety of that continuum of care by bringing in the IMD waiver. We will -- the providers will have the full expanse of reimbursement for services.

And a LOCADTR criteria will help to guide that decision-making. So T, I will turn it back to you.

Part of the waiver program and what OASAS is hoping to achieve here is really in addition to the continuum leveraging the mechanisms for delivery to improve outcomes. What we are really focusing on across the continuum is expanding access to services for things like telehealth. These are things we have seen that we have been working on as an agency and will look to continue to expand. Mobile medication units. That is something we have been working on and now that the federal government has opened up the ability to do mobile methadone that is something we will look to continue to expand so we can get maybe to locations that don't have services. We are also looking to broaden the reach of the opioid treatment programs. Ensuring that there are regions that are not suffering from any lack of services. And then we are also looking at how we are delivering the services.

Are there ways we can be providing services more directly to people who are unstably housed or are in crisis? That is what we are looking at doing. Three outreach programs for we are working with the Department of Health to increase services that are more harm reduction focused, meeting people where they are at, offering services in the community. We are also leveraging our peer workforce and outpatient system to have the lived experience as a critical component in our treatment system. We found they really do have a tremendous effect on the patient's and really worked to engage with them and bring them into services.

We are also pursuing federal ability to have each outpatient program provide methadone as a way to increase access to all versions of medicated assisted treatment authorized by the FDA especially given the ongoing opioid epidemic. Those are our goals. I will turn it over to Sarina Master for the fiscal portion of the waiver.

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. This estimate includes

continued measured increases in community placement. Successful placement into the community settings in enhanced crisis support resources. This estimate, this waiver is estimated to be budget neutral.

In general, demonstrations have to be budget neutral per federal requirements. What this means is Medicaid expenditures will not 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 describe. The services are aimed at transitioning people to the community and keeping them healthy in the community. That is where we will see the savings.

If you look at the arrow over here. Under the font is a little small but it includes the estimated eligibility objections. If you can see in those boxes there is a group titled OMH A into group titled OMH B. OMH A represents those people in the cohort with the 30-day average length of stay. These are folks who were requesting the federal financial participation for. The group titled OMH B represents the group of people eligible for the targeted in-reach services and the 30 days prior to their discharge from a state psychiatric center.

I will not go through each number for each year. This slide deck will be available but I will high-level say that you can see we project that the OMH B group which is those eligible for the 30 day in-reach services will stay study at 2500 people per year over the five-year period. The OMH A folks in that group, which again is the 30-day average length of stay cohort, those will initially stay at 450 people in your one and the OASAS cohort is estimated to start at 2218.

Those two cohorts, the OASAS cohort and the OMH A group, are expected to rise steadily over the each of the five years over the couple hundred people. You have access to this slide if you want to see the exact numbers.

There will be two evaluations of this program and I will talk more about that in a second. The first one will be at year three and that is for the SUD Or OASAS population and then in year five, both will be evaluated.

The evaluation approach is very comprehensive. It is a multimethod statewide evaluation that will be conducted by an independent evaluator. This will be conducted at

the midway point for the SUD Folks and at the end of the demonstration for both the SUD and SMI cohorts. This independent evaluator will document the impact of the waiver on healthcare service delivery and utilization, healthcare 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 posed particular challenges for, you know, provided learnings for us and the implementation and outcomes of the waiver.

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.

This is the submission timeline. As you saw, public notice was posted to the state register in the public comment period began October 5 as well as the tribal comment period began on October 5. The public hearings are today as well as on October 31. The public comment period is going to end on November 4. If you have comments that you want to include, please send them by November 4 or at the next hearing.

The tribal comment period ends November 10. So for those, please include your comments by November 10. We will be incorporating the written and oral public comments and will be finalizing the amendment by November 30. 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.

I will hand us over to Amy Clinton to discuss the public comment period.

Thank you Sarina. We have a list of preregistered 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 you unmute yourself. When you get that message, please choose the option unmute me without making that selection you will not be able to unmute yourself. Also a word of warning, to make sure your phone is also unmuted to avoid that infamous double mute. Comments will be timed. Please limit your remarks to five minutes. Again, written comments will be accepted through November 4 by

email at the 1115 waivers@health.ny.gov or you can mail them so they are received by November 4th at the address there.

To start the public comments Lydia Virgil and up next will be Alex Damron.

It looks like Lydia is not with us or is joined under a different name. Lydia if you are here under a different name you can chat to the host and we can circle back around to you. I am going to go on down the list. Alex. I do not believe I saw Alex either. Let me double check. All right. Alex the same thing if you are here please send the host a chat and we can unmute you and Lydia, there we go. I will press request unmute and you will have to click unmute me. Thanks for your patience, everyone.

Go ahead Lydia when you are ready.

Thank you so much. 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 who did not have them in the past have them now. That is my only comment. Thank you so much for all the work you're doing.

Great. Thank you, Lydia. Lily, have we found Alex?

When I search, I do not see Alex Damron or Ron Richter who were two of our registrants. 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. Mr. Rosenthal, I am going to click the button and you will have to click unmute me when the box pops up. You can go ahead now.

You can hear me okay?

We sure can. Go ahead.

I am Harvey Rosenthal. Represent thousands of New Yorkers with psychiatric abilities and community service that support 85 agencies across the state. I have a lot to say I will try to go past. Our aim is to improve services, public policy... I have been a CEO for upwards of under 30 years. Our commitment is personal. I and long-term recovery. We appreciate all the thinking and work. I have just heard a lot more that that is going into this proposal. Together we all hold the goal of reducing the length of hospital stays and recidivism and advancing recovery and self-determination and community inclusion. Withhold them as paramount. We have come a long way in improving the services. We have done that without introducing Medicaid into state hospitals.

I am not sure why the one sort of dictates the other. We feel this is a very slippery slope. There's a lot of change to make what apparently will be for OMH only $15 million a year. Of federal share that becomes available. You know, system transformation we have come a long way from improving our services as I said a moment ago. Changing the entire system to become a long-term state more chronic more chronic in the system to one that moves people that quickly and 30 days, that requires a sea change. Some facilities I believe are closer than others but we have a long way to go.

We are not going to do that by March or by next year. This idea that we can make this amount of change in that small amount of time, no, I don't understand this part of it. apparently we are going to manage care reimbursement. So well managed care plans approved a 30 day admission which they don't in the community? I would like to hear more about that if we can. The proposal does not reference how quicker and more successful care transitions will be achieved. Most about anticipates sufficient capacity in the community for all these folks to go to. We know we do not have that now. We don't have enough, as you say, short-term residential, crisis stabilization. We do not have the state-of-the-art peer engagement support programs. Furthermore, we are expensing unprecedented levels of staff they can see through years of underfunding. Do we 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 stranded in hospitals, nursing homes, adult homes, they live on the grounds of the state hospital all for the lack of housing. Now we are going to move people out in 30 days to housing. I am not sure how that is going to happen. I don't know if we have the capacity. Staffing capacity. We believe -- We can get to that.

Reinvestment. I'm not sure what calculations have and will be made to anticipate the level of funding. I heard something about modest investments. I'm not sure what that

means. But in community reinvestment from closure of state hospitals, that money can be not withstood and does not happen. I would like to note that happens here or we could lose that depending on another governor. Medicaid rules and requirements have judicially compromise the appropriate delivery of recovery in peer support services by radicalizing the services and setting a practice and documentation requirements that would be inconsistent with values and practices.

I heard in the announcement in the proposal that community residents will be included as part of that. We are very concerned about that to go from 16 beds to 24 or more and setting up institutions in the community. That would be a violation of Olmsted. I have to say I sort of object to this idea that some people will be long stay folks. I have seen this 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 happening here.

I saw something about, again in the proposal, about hospitals 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 are talking about that. I'm sure my time is just about run out and I will 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. 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 and all those buildings and all that waste is sitting there.

We really strong and urge that in the words of Jennifer Mathis, Jennifer of the Babylon 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 in t that which significantly has pressure on inpatient capacity as well as reduce incarceration of people with serious mental illnesses. The other thing I just want to say is the idea of just sort of leveraging all this wonderful change, which I hope could happen, on state hospitals that are very often not in the community. Old buildings on the grounds with these large old castles, things like that.

In trade, what that is going to be is a modern recovery system for people to go there and get that response. I worry about that. I worry about whether that's the place to do this in the state hospitals. I will stop there. I'm sure I've exhausted my time to I will send more comments.

Thank you very much Harvey. Lydia, we thank you as well. We appreciate both of your thoughtful comments. I know that we have confirmed that both Alex and Ronald are not on today. So this concludes our public comment period. Just a reminder to please submit any written comments that you have either by the email on the screen or by mail to be received by November 4. And a very special thank you to both of our ASL interpreters, Stephanie and Lauren. Have a great rest of the day everyone.

(End 4:22 PM)