NEW YORK STATE

OFFICE OF MENTAL HEALTH

PUBLIC HEARING

NEW YORK STATE'S IMD TRANSFORMATION PROGRAM

WAIVER APPLICATION

Virtual Hearing

October 31, 2022

October 31, 2022

PRESENT:

LILLIE JOHNSON, Host

AMY CLINTON, Moderator
Department of Health
Bureau of Adult Special Populations

PANELISTS:

Department of Health
Trisha Schell-Guy, Director
Division of Program Development and Management

Sarina Master, Director
Bureau of Adult Special Populations

Office of Mental Health
Anita Daniels, Associate Commissioner

Jeremy Darman, Deputy Commissioner
State and Local Operations

Office of Addiction Supports and Services
Pat Lincourt, Associate Commissioner

Ilyana Meltzer,
Division of Addiction Treatment and Recovery

October 31, 2022

MS. AMY CLINTON: Good morning, everyone. And, thank you very much for joining us this morning. Our second public hearing on New York State's IMD Transformation Program Waiver Application.

My name is Amy Clinton and I work in the Bureau of Adult Special Populations in the New York State Department of Health.

Before we begin our presentation, I wanted to go through and let folks know that closed captioning is available for this webinar. To engage closed captioning, please find the CC icon in the lower left of your screen. And when you click on it, click, next on, show closed captioning.

Also, this morning, our American Sign Language interpreters are available for this webinar. And, to move them to the presentation area or stage so that you can see them, please right click on the interpreters video icon and select, move to presentation stage. I'd like to acknowledge our interpreters this morning, Stephanie and Kelly. And, thank you both very

much.

In compliance with social distancing guidelines due to COVID-19 and in alignment with approved CMS exceptions to satisfy the public hearing requirements as stated 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 1115 waiver amendments in order to give the public an opportunity to provide comments regarding the State's waiver amendment application.

Any comments made during the public hearing may supplant, supplement, or reiterate written comments that are submitted or already submitted through alternative comment channels as described later in this presentation. A recording and transcription of this hearing will be available on the MRT website. It is the same link that you went to to see a copy of the proposal and attached documents. The recording for this webinar will be available three to five days after the hearing and language translation is available upon request.

October 31, 2022

I'd like to introduce today's panelists. Starting with Trisha Schell-Guy, who is the director of the program, of the Division -- excuse me -- of Program Development and Management at the Department of Health.

MS. TRISHA SCHELL-GUY: Good morning.

MS. CLINTON: Next, we have Sarina Master, who is the Director of Bureau of Adult Special Populations, also at the Department of House.

MS. SARINA MASTER: Good morning.

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

MS. ANITA DANIELS: Thanks, Amy. Hi, everyone.

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

MR. JEREMY DARMAN. Good morning, everyone. Good to see you.

MS. CLINTON: We've got Pat Lincourt, Associate Commissioner for the Office of

Addiction Services and Supports.

MS. PAT LINCOURT: Good morning, everyone.

MS. CLINTON: And Ilyana Meltzer, Division of Addiction Treatment and Recovery.

MS. ILYANA MELTZER: Morning, everyone.

MS. CLINTON: Our agenda today will include an outline of the background, purpose and the waiver objectives. We will talk about the program design, as well as some financial data with regards to this waiver amendment; talk briefly about the evaluation, and we'll outline the submission timeline before we then get into the public comment period. Trisha?

MS. SCHELL-GUY: Thank you so much, Amy. So, beginning with some background, I'd like to just take a few minutes to explain what an institution for mental disease or IMD is, and why it is that we need a waiver for the services that are provided to individuals residing in these IMDs. Initially, it's important to mention that Medicaid is the largest payer of behavioral health services in New York and across 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, all the way back to the inception of the program back in 1965. At that time, Congress established Medicaid as a public health insurance program that was a partnership and continues to be a partnership between states and the federal government. However, there were populations and services that the federal government felt were state responsibilities and, therefore, were not eligible for any federal financial contributions on the part of the federal government.

One of these excluded services is for individuals that reside in an institution for mental disease. The intent being that institutionalized individuals are a state responsibility and that restrictions on federal funding would provide incentives to invest in community alternatives for these individuals.

IMDs are defined in federal law as a hospital, nursing facility, or other institution

with more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with a mental disease. Mental disease is an antiquated term, but it is still the term used in statute, and it includes individuals with mental health or substance use disorder. It does not, however, include individuals with intellectual developmental disabilities.

There are a few exceptions to who or what would be considered an IMD population or setting. That includes individuals over the age of 65 and persons 21 years or older that reside in an in-patient psychiatric facility for youth in New York State. We certainly have settings where individuals over 65 reside in our long term care facilities and, as far as youth go, those in-patient psychiatric facilities include OMH's residential treatment facilities and OASAS's residential rehab services for youth or RRSYs.

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So, so what is the purpose of New York State's IMD request? In the broadest sense, the idea behind this waiver 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 using state only dollars and state resources as an integral part of that continuum of care. So now, we are looking to take advantage of opportunities at the federal level to obtain additional resources in the, in, in money to strengthen the entire system and to improve care for folks residing in and transitioning out of these institutional settings.

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So, I wanted to frame for folks what exactly is an IMD waiver amendment. From a process perspective, we are using the federal authority that is under Section 1115 of the Social Security Act to ask CMS members to approve a demonstration project that promotes the objectives of the Medicaid program. 1115 is a term that you hear often in New York State. We, it's, it's the same authority that our managed care program exists under. It's the same authority that the HealthEquity waiver that

people have been talking about exists under. And, it's the same authority that has authorized many pilots and demonstrations in this state and across the country.

This 1115 waiver is asking CMS to waive a portion of Section 1905 of the Social Security law that prohibits federal financial participation for services delivered to individuals in certain IMDs, mainly in state psychiatric centers and community-based in-patient and residential addiction programs. There are some caveats, many of them outlined in the several state Medicaid directors letters that have addressed these types of waivers over the last several years, including limits on length of stay, requirements for average length of stay, and limits, as I said before, limits on total length of stay.

Somewhat unique to New York, we are also asking CMS to approve a targeted set of reimbursable in-reach services for individuals who are in state psychiatric centers who would not meet the 30-day average length of state

criteria. These services will include care management, discharge planning, and clinical services to ensure that these individuals have a warm handoff to the community setting after they are released. 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 to help keep these folks out of emergency departments and prevent a return to state psychiatric and other in-patient settings. CMS will not approve this type of waiver, this whole 1115 IMD waiver indefinitely. Typical approvals last for five years. Nor will they allow federal dollars to cover long lengths of stay indefinitely.

As we move forward with negotiating this waiver, there will be a host of standard terms and conditions that dictate all of the conditions we must demonstrate throughout this five-year term. If successful, we will likely seek to continue this demonstration past the five years for additional five-year terms.

Finally, sometime in 2023, we plan to

add services delivered to children who are in the child welfare system that reside in QRTPs, that's the acronym for Qualified Residential Treatment Programs, and in other child welfare institutions that would meet the definition of an IMD.

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So now, now that we've talked about background and purpose, I wanted to take a minute to highlight the overall objectives that we helped to, hope to achieve with the federal funding that we're gaining from this waiver. So, this waiver is another step towards transforming the behavioral health service system -- sorry about that -- by promoting improved access to community-based mental health and substance use disorder services. We want to use these funds to transform, strengthen, and improve our system to be able to provide the highest quality behavioral health services in the least restrictive settings. To do that, we need to make sure that we have robust care transition services and sufficient access to any necessary community-based treatment and support that a Medicaid

member may need.

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So now, we're going to get into the details of the actual program design of this waiver, and before I turn it over to my O-agency colleagues to do that, I'm going to just take a minute to level set so people understand that while this waiver is specifically for services in IMDs, it really is two distinct asks of CMS.

That being said, I think it's really important to highlight that this has been a very collaborative and thoughtful effort between the Department of Health, the Office of Mental Health, and the Office of Addiction Services and Supports in designing a program that will support the entire Medicaid population. Those with SMI, those with SUV, those with co-occurring in these settings.

So, the first program, the SMI program, Serious Mental Illness program, is to obtain federal financial participation for individuals that have SMI and are receiving services in state psychiatric centers. This ask would generate

federal share for any patients that have an average length of stay of 30 days or less and would be claimed retrospectively after that patient's stay is over. This is also the section of the waiver that is requesting federal financial participation for the 30 days of in-reach services prior to discharge from those folks who have more than a 30 day average length of stay or 30 date length of stay.

Then, there's the SUD, the Substance Use Disorder component, which is seeking federal financial participation for all individuals in any IMDs serving the SUD population. So, in the SUD world and the OASAS system, this includes community-based detox programs, community-based in-patient programs, and all three elements of 820 residential care. This is not a retrospective look. This is a prospective look at everyone that is in these programs. For this, we will need to demonstrate a 30-day overall length of stay. I want to be clear, that's 30 days overall over all three levels of care. That does not mean that individuals in the residential

program can only stay for 30 days. It's a 30-day average of all of the program. And, I'm sure my OASAS colleagues will talk a little bit more about that.

So now, to get into more detail on the SMI initiatives is Anita Daniels from Office of Mental Health.

MS. DANIELS: Thank you, Trisha. So. good morning again, everyone. So, our state in-patient operation system is really looking forward to their continued work. We spent, really, the last ten years or so really looking at making sure that folks are integrated into the community. So, we're really looking forward to this potential project to transform, strengthen, and improve our system of care that Trisha talked about. So, OMH remains committed to ensuring our state psychiatric centers partner with their local stakeholders to ensure a continuum or a hub, if you will, of services available to support individuals and their families. Through this waiver, we will maximize the ability of our state psychiatric centers, which are located in

communities, to serve as an enhanced service delivery system emphasizing community integration and recovery in the community. This enhanced delivery system will include transitional housing that integrates most, both mental health and substance use disorder, employment, and educational supports, as well as primary care. Communities in the surrounding areas receive modest investment from the federal matching funds to continue for us to promote local engagement and community tenure.

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OMH will conduct a comprehensive assessment of how our state psychiatric centers are currently facilitating the discharge of those folks with us one year or more. This data platform created will standardize across all state PCs and include the assessment of psychiatric stability, functional or environmental barriers, and placement needs for those who are ready for discharge. The discharge planning process will include an individualized assessment of services needed to foster stability

in the community.

Trisha also talked earlier about an array of in-reach services, which we are looking to support successful community integration. And, some of these things aren't new, but we want to continue to enhance those so it's active mobile integration teams, home care management teams, ongoing and active recruitment of peer and family bridgers to improve those engagements and connections, partnering with our pathway home care managers, who will really be embedded, and partner with our in-patient teams to facilitate discharge process. And, we're really looking forward to capitalizing on a program that OASAS has that to use their peer led recovery centers.

Specific evidence-based clinical programs are being planned and utilized to enhance recovery by reducing our in-patient length of stays, which really has been a focus of us for, for many, many years. So, we're looking at I function of functional skills assessment and training software platform that aids staff in assessing the functional limitations of an

individual. We're looking at recovery-oriented cognitive therapy or CTR, which provides concrete, actionable steps to promote recovery and resiliency for patients who really have extensive behavioral, social, and physical health challenges. We're looking at COG REM, a behavioral intervention targeting problems with cognition with, of course, the ultimate goal of improving one's day-to-day community functioning.

And last, we're excited about launching a medication empowerment curriculum pilot developed from the work of Pat Deegan and, and in collaboration with the Center for Practice Innovation or CPI to improve shared decision making and skills for medication independence, of course, with the ultimate goal of community stability. OMH will continue to prioritize supporting families during times of need by utilizing family bridgers and transitional support teams, in addition to prioritizing CPIs, family systems engaging, engagement training module for our clinical teams.

So, thank you for your time. I next

turn it over to my colleague, Jeremy Darman. Thank you all.

MR. DARMAN: Thanks a lot, Anita. So, Anita talks a lot about activities, really, that we have to deploy within our state psychiatric centers, but also, you know, how critical some of the community transition services and, and building up the community is to making sure that people recovery is stable and successful because the transition, the transitions from in-patient out of the community can be very, very difficult. It's a, it's a very critical time. You have to be very focused and supportive of individuals that, as they move into the community easily. You can, if you have a crisis situational or psychiatric crisis post-discharge, you really want to prevent a person from having to go back to the hospital. And so we really need to make sure that through this project, we are investing in and building up these supports in the community to support people in the least restrictive setting.

So, the, the reinvestment from the, the

work here is going to support critical time interventions for people who need that intensive and comprehensive in-reach. We have a lot of good ambulatory providers in the community and we'll be building on those. We'll be building on those programs to help through the in-patient discharge process so people can work with our unit staff during discharge planning and then follow the person out into the community and then support them when they're in their new residential, whether it's a transitional residential or permanent residence, to make sure that they're supporting tenure and engagement and other meaningful life activities.

And, and I think that, you know, a lot of this really comes down to, to making sure people are stable in their housing. So, I think that the more we keep people in, in housing directly in their community where they want to be, the more successful we can be. So, you know, I think you've heard it many times from OMH, we really want to make sure that we are getting the right services in the right time at the, in the

right amount so we can cut down on our length of stay. Like Anita said, we have about 50 percent of our census that is considered long stay on the adult side. That's over one year on census. So, I think we, we really need to reduce that number and I think we can increase the number of people who are admitted and discharged within this 60-day maximum, 60-day and average 30-day cohort.

So, throughout the investments that we make here and the processes we build, I think it's not just about investing in services, but it's about creating this, this stronger framework and connection between our PCs and the community that, you know, our psychiatric centers are not completely independent of the rest of the world, really. We want to build them into the community.

And, I, I think the last point here that we want to talk about is, is that we will have many performance metrics that we will follow through this waiver. We already have very many for our state hospital system and the community side. And, for transparency and to make sure

that these projects are actually working, we will have a set of key performance indicators. There are several recommended metrics in the waiver applications that people can review and comment on. I think the key thing is we want to make sure that we're looking at, you know, provider performance and making sure what they're doing matters. But also at the end of the day, that we really are supporting recovery. Because this is about supporting individuals recovery in the community at the end of the day.

So, please review those. Take a look. You can also comment on those and I look forward to hearing all of your feedback today in the future on this project. Thank you. I'll turn it over to OASAS now.

MS. LINCOURT: Thank you, Jeremy. So, the waiver program for SUD initiatives is a little bit different. At the purpose of, of our interest in the waiver is to bring community-based detox, in-patient and residential services as Trisha talked about completely into the, that the Medicaid reimburse ability. The entire

continuum of care then is available to people through Medicaid-managed care and fee for service Medicaid reimburse ability. So, all of the pieces of our residential redesign would be, would, would be connected into the continuum and all of it is rehab focused and all of it is Medicaid reimbursable.

So, the additional residential reintegration portion or element of our residential redesign will be included for Medicaid members in this demonstration so that adds the reintegration and a rate of payment for reintegration across fee for service and Medicaid-managed care. It also allows for the fee for service reimbursement across all of the residential services.

And, what we're, you know, one of our goals is also to increase that community-based non-hospital residential support and to be sure that treatment is rehab focused and that it is provided within the community and supported there.

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Part of that is in moving people appropriately through those community-based levels of care and the OASAS required level of care determination is with the LOCADTR or another national place, which is a national placement criteria, or another OASAS-approved criteria, but in the main, all providers are using LOCADTR to make all managed care companies are utilizing LOCADTR within a Medicaid program and all of our providers also use LOCADTR. And, it allows for the admission criteria to be determined as to where a person would enter into care, whether that's at a detox or an in-patient or residential element of care, and, also, for that concurrent review. And, the continuing review of appropriateness for that level of care to continue to consider where the person would needs would best be met. And also, you know, our policy will be modified to reflect that all of those criteria for residential programs, including the requirements for the types of services, any hours of clinical care and credentials of the staff delivering it that would

apply in those elements of care to allow for the Medicaid reimburse ability. Much of this, we've talked about with our provider system as we brought reintegration into the Medicaid reimburse ability.

So. the overall goal here is similar. It is to, to have individuals served in least restrictive levels of care closest to the community with rehab as the ultimate goal, and to bring the entire continuum of care into the Medicaid program.

So, I'm going to hand this over to Ilyana Meltzer to talk about how this fits with some of the overall goals.

MS. MELTZER: Sure. Hi. Thanks, Pat. Good morning, everyone. And so, we wanted to close the OASAS portion of today's conversation by putting this particular waiver in context with other SUD initiatives that are currently in place and developing alongside that are also leveraging federal and state authorities with the eye of strengthening the SUD service delivery system, in particular, by expanding points of access across

the continuum. And, some of the initiatives we just wanted to share today were -- excuse me -- the continued delivery of services in community. Also, the continued utilization and expansion of telehealth services, the implementation of mobile service units that provide a complement of SUD treatment services, including access to medications. The mobile units will assist to broaden the reach of opioid programs in regions that may not have had access before, so we're looking to increase access through those mobile units. OASAS has also had a strong movement to utilize peers with lived experience to support individuals throughout each step of their journey with engagement, treatment and recovery. We are also working collaboratively with the New York State Department of Health Aids Institute to provide street outreach services to individuals in unstable housing or who are in crisis and support individuals' access to care, including access to critical medications.

And then, finally, we just wanted to signal another initiative that supports

individuals and community that includes working with the OASAS provider community to develop comprehensive, integrated out-patient treatment programs for providers to either combine existing opioid treatment programs and out-patient programs or to develop new programs with that integrated lens.

And so, with that, I will transition over to Sarina Master, who is going to speak about the fiscal portion of this particular waiver. Thank you.

MS. MASTER: Thank you, Ilyana. So, I just want to talk about the fiscal piece a minute. The total cost of this amendment is estimated to be $268.37 million over five years. So, that estimate assumes that there is continued measured increases in community placement, that that placement into the community is a successful placement, and that we will be leveraging the enhanced crisis support services.

So, this demonstration is going to be budget neutral. All demonstrations have to be budget neutral per federal requirements. And,

what that means is that this waiver will not increase overall Medicaid expenditures. We expect to offset any of the costs associated with the waiver with savings achieved through our reinvestment of the dollars into the enhanced services that you just heard about, including crisis services aimed at transitioning people to the community, and aimed at keeping people safe and healthy in the community.

So, I know this font in this purple arrow is a little small, but . But it includes the estimated eligibility projections for this waiver. There is a group titled, OMH A, that represents those in the cohort with a 30-day average length of stay. And those 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 don't think I need to go through every number for every box. And, this will be made available for anyone who wants to go and take a closer look at the numbers. But, I will just say that, that it looks like the OMH B

group, those eligible for the 30 days in-reach services, are expected to stay steady at an enrollment of 2500 people per year throughout the five-year period. The OMH A group, which, again, is the 30-day average length of stay, will initially start at 450 people in the eligibility area. The OASAS cohort is estimated at 2,218 and those two populations are expected to steadily rise by a few 100 people per year over the five-year period.

So, there will also be evaluations which I will talk about in a second. There's two evaluation points, one at the midpoint of the waiver for the SUD program, and then both programs are being evaluated at the end.

So, if you could go to the next slide.

So, there will be, as I said, an evaluation. This is a very comprehensive multimethod evaluation. The state will be engaging an independent evaluator to conduct it at the midway point for SUD and at the end of the demonstration for both the SUD and the SMI programs. The evaluator is going to document the

impact of the waiver on the health care service delivery system and utilization, quality, health outcomes, and cost effectiveness. They will be examining the program to determine what led to programmatic successes, what areas pose particular challenges, and where the learnings were from the waiver. This, again, is going to be a very comprehensive assessment. The evaluations will utilize pre- and post-design approaches. There will be mixed effect regression analyses used to examine individual outcomes over time. There will be multiple analyses of variance, and there will be hypothesis testing to compare population and acuity characteristics throughout.

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So, here's the timeline that we have projected. As you know, the 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 October 5th. Today is the second of our two hearings. The previous one was on October 26th. Our public

comment period ends November 4th for the general public and November 10th for the tribal comment period. So, if you have comments and you did not get to speak today or at the last hearing, please submit your comments before then. We will take November to incorporate the written and oral public comments and to finalize the amendment. We expect to formally submit the amendment application to CMS in December 2022. And, we are target, targeting spring 2023 for our implementation date.

With that, I will turn it over to Amy Clinton to talk a little bit about the public comment period. Thank you.

MS. CLINTON: Thanks, Sarina. So, we have a list of pre-registered commenters, which will indicate the order in which you will be called on to speak. When you are, when your name is called, please -- you will receive -- excuse me -- a message from the host which indicates that you will need to press the option, Unmute yourself. And, when you do that, choose, unmute me. Without doing that, you will not be able to

become unmuted in order to speak. Also, make sure that your phone is unmuted to avoid that infamous double mute. With that, let's go ahead and start the public comment period. I'm starting with Ronald Richter at the JCCA.

MR. RONALD RICHTER. Can you hear me?

MS. CLINTON: Sure can. Go ahead, please.

MR. RICHTER: Okay. Terrific. Just give me one moment, please. I wasn't sure that you received my notification about providing public comments, so thank you.

MS. CLINTON: You're welcome.

MR. RICHTER: So, while children and their families are not part of the IMD waiver application that's being discussed today, clearly, young people that are 16, 17, even 18 years old and that are known to the foster care system and other child welfare systems, who have intellectual and developmental disabilities are among those struggling the most with the circumstances post-pandemic. We would ask that as the future waiver for children and young

people is being considered that the state considers seriously the changed landscape post-pandemic, especially given the dire needs that existed pre-pandemic for these young people. There have been longstanding gaps in the children's mental health system and those gaps end up being delivered upon the adult mental health system. And, as I know you are aware, many of the traumatized adults that the adult system works with are the result of unmet needs in the children's mental health system. Crisis services for older adolescents contributes mightily to what the adult system experiences.

In addition to the pandemic, the workforce crisis has exacerbated HealthEquity, particularly for our young people, and, if addressed in the IMD waiver, we could begin to make inroads and providing services to disproportionately impacted populations.

So, I contribute this as a preview to comments that, of course, we will contribute as young adults become adults and end up being delivered upon the adult system. So, with that,

I thank you so much for giving me the opportunity to be heard.

MS. CLINTON: Okay. Thank you, Ronald. Next up, Michael Williams, if you are on.

MS. LILLIE JOHNSON: So, our next speaker, Michael Williams, does not appear to be on. Michael, if you are, you could send me a private chat. The host, Lillie Johnson. And, I could unmute you if you're under a different name. Otherwise, I think we can proceed to the next person in the list.

MS. CLINTON: Okay. Thank you. Lydia Virgil, you're up next. And followed by that is Senator Brad Hoylman.

MS. JOHNSON: So, as of right now, our next two speakers, Lydia and Senator Hoylman, are also not on. So, it looks like we're going to have to skip ahead to the fifth person on the list, Amy.

MS. CLINTON: Okay, great. Thank you for that. And, that would be Ed Cichon of CAZ Recovery. Ed, when you're ready.

MR. ED CICHON: Are you there?

October 31, 2022

MS. CLINTON: Sure am. We can hear you just fine. Go ahead.

MR. CICHON: Alright, perfect. Thanks. So, I'd like to first start off by saying that the State hasn't been very clear or transparent about their plans for or the implications of this waiver application. Providers are already stretched way too thin for a whole slew of reasons, and having to wrap our heads around this waiver announcement and in an extremely limited timeframe hasn't felt completely transparent to me, unfortunately. As mentioned, I work for CAZ Recovery. We're an OASAS provider of residential programs for folks with substance use disorders in Western New York. And, aspects of the state's plans and initial communications regarding the waiver have been extremely troubling. By their inherent design, residential programs respond to needs of individuals who will likely not be successful in other, shorter term treatment programs. As evidenced by the level of care determination, the people in our programs need to have extensive and intensive treatment and

support. Due to these factors, residential programs tend to have longer length of stay than the proposed average of 30 days as outlined in the proposal. Our programs certainly aren't for every individual with a substance use disorder. But there is a subset of the population that truly requires medium to long term supports to address long histories of active use.

While I learned that the State plans for implementing the waiver requires a length of stay to be a systemwide aggregated average as mentioned by Trisha earlier, too, this was certainly not immediately clear in the plans or the communications the State had sent out.

MR. RICHTER: Yeah, hi. I'm trying to make a reservation for Wednesday night.

MR. CICHON: I don't know who that is, but I'll continue if that's okay.

MS. JOHNSON: I think that might be our previous speaker, Ron.

MR. RICHTER: At 7:00?

MS. JOHNSON: You might want to mute your phone. I will look for you in the list, so

we can mute you on this end.

MR. RICHTER: Okay. Thank you so much. Thanks so much. Really appreciate it.

MR. CICHON: I think we're good now. Alright. Thank you. So, as I was saying, I'd like to see a very clear and transparent statement, including the State's waiver application that the State will not be requiring medium and long term residential providers to reduce their individual lengths of stay to an average of 30 days.

In addition, part of the State's plan seems to rely on the transitional and supported housing system to help reduce lengths of stay and shorter programs, in particular, referrals and other connections. While this makes sense on paper, I can tell you that the capacity for transitional and supportive housing comes nowhere near close to meeting the current need. CAZ Recovery operates multiple support housing and transitional housing programs for folks with substance use disorders, and we can attest that the need for supportive housing far outweighs

capacity all across the State. Despite the variety of housing programs offered by CAZ Recovery, we can't meet the needs of the people in our internal contents continuum, let alone be many extra per, many referrals from other external sources.

With this in mind, New York State needs to seriously consider funding supportive housing programs and units much more robustly. And, I know that this waiver proposal isn't the place that funds supportive housing, but the State needs to address this massive gap in the behavioral health system before it creates more plans that rely on the presence of support housing, and even affordable housing, which are both fully lacking across this State. Thank you for letting me comment. I appreciate it.

MS. CLINTON: Okay. Thank you very much.

MS. JOHNSON: And Amy, just to let you know, I don't see any of the other speakers that have signed up are on, and no one has reached out to me in chat.

MS. CLINTON: Okay. Alright. Thank you. That concludes our public comment period today. And, I want to thank everyone for participating and thank our commenters for thoughtful comments.

Just a reminder to please send in your written comments if you have them. You can do that by e-mail to the e-mail that you see, 1115waivers@health.ny.gov. Or you can mail to the address with the postmark of November 4th. Thank you again. And, everyone, please have a good rest of the day.

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.

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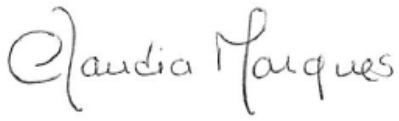

Date: November 29, 2022

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