New York State Office of Mental Health
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What is the purpose of New York State IMD request? The broadest sense behind this waiver is to acknowledge some levels of care in mental health and SUD systems are so critical that we have operated for years using only state dollars in critical resources as a continuum part of that critical care. Now we are looking to take advantage of opportunities at the federal level to obtain additional resources and money to strengthen the entire system and improve care for folks residing in and transitioning out of these institutional settings.

I wanted to frame for folks what exactly is an IMD waiver amendment. We're using the 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 a term you hear often in New York State. It is the same authority that our managed care program exists under it is the same authority that the health equity waiver exists under and it's the same authority that is authorized many pilots and demonstrations in the state and across the country. This 1115 waiver is asking CMS to waive a portion of §1905 of the Social Security law that prohibits financial participation for certain individuals in certain IMDs namely in-state psychiatric centers and residential addiction programs.

There are caveats. Many of them outlined in several state Medicaid Director 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 in limits, as I said before, limits on total length of stay.

Somewhat unique to New York we are 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 stay criteria. The services will include care management, discharge planning and clinical services to ensure these individuals have a warm hand off 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 inpatient settings.

CMS will not approve this type of waiver this whole 1115 IMD waiver indefinitely. Typical approvals last five years. Nor do the federal dollars to cover long lengths of stay indefinitely. As we move forward there will be a host of standard terms and conditions that dictate the conditions we must demonstrate in that the five-year term. If successful, would likely seek to continue 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 who reside in QRTPs. That is the acronym for Qualified Residential Treatment Programs and other child welfare institutions that would meet the definition of an IMD.

Now that we talked about background and purpose, I want to take a minute to highlight the overall objectives we hope to achieve with the federal funding we are gaining from this waiver. 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 the system to be able to provide the highest quality paper health services in these settings. We need to make sure we have robust transition services insufficient access to any community-based treatment and support that a Medicaid member may need.

Now we will get into the details of the actual program design of this waiver. Before I turn it over to my colleagues to do that, I will take a minute to level set. So people understand that while this waiver is specifically for services in IMDs it really is two distinct tasks of CMS. That being said, I think it is really important to highlight this is been a collaborative and double effort between the Department of Health, the Office of Mental Health and addiction services and supports to design a program that will support the entire Medicaid population. The first program, the SMI program, is to obtain financial federal participation for individuals that have SMI not 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 day 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 that have more than a 30-day length of stay. Then there is the SUD, substance use disorder component that is seeking financial participation of all individuals. in the SUD world in the OASAS system this includes community-based detox programs, community based inpatient programs in all three elements of 820 residential care.

This is not a retrospective look. This is a prospectively. 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 is 30 days overall, over all three levels of care that does not mean individuals in a residential program can only stay for 30 days. It is a 30 day per average of all the program. I'm sure my OASAS colleagues will talk more about that. You get into or detail is Anita Daniels from the Office of Mental Health.

Thank you, Trisha. We spent the last 10 years or so looking at making sure folks are integrated into the community so we are looking forward to this potential project to transform, strengthen and improve our system of care that Trisha talked about. We partner with 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 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.

OMH will conduct a conference of assessment of how are psychiatric centers are currently facilitating the discharge of long stay patients. This platform will include the assessment of psychiatric stability, functional environment all 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 about earlier an array of in-reach services which we are looking to support successful community integration. Some of these things are not new. But we want to continue to enhance those so is acting mobile integration teams, homecare integration teams, ongoing and improvement of peer and family bridgers to improve those family connections. During with pathway homecare managers will really be embedded in partner with inpatient teams to facilitate the discharge process and we are really looking forward to capitalizing on a program that OASAS has to use peer-led recovery centers.

Specific evidence-based clinical programs are being planned and utilized to enhance recovery by reducing our inpatient length of stays which has been a focus for us for many many years. We are looking at Ifunction, a training platform the AIDS staff in assessing the functional limitations of an individual.

We are looking at recovery oriented cognitive therapy or CTR which provides concrete actionable steps to promote recovery and resiliency for patients who have extensive behavioral, social and physical health challenges. We are looking at CogREM. A behavioral intervention targeting problems with cognition with of course the ultimate goal of improving once dated a community function.

Lastly, we are excited about launching a medication empowerment curriculum pilot developed from the work of Pat Deegan in collaboration with the center of practice for innovation or CPI to improve decision-making and skills for medication independence. Of course, with the ultimate goal OMH will continue to prioritize supporting families and transitional support teams in addition to prioritizing CPI's family systems engagement training module for our clinical team spirit thank you for your time. I will turn it over to Jeremy Darman.

Anita talked a lot about activities we have to deploy within our state psychiatric centers but also how critical some of the community transition services and building of the

community is to making sure people's recovery is stable and successful. The transitions from inpatient onto the community can be very difficult. It is a very critical time.

You have to be very focus and supportive of individuals as they move into the community. Easily, you can, if you have a crisis situation or psychiatric crisis on discharge you want to prevent the person going back in the hospital. So we need to make sure that through this project we are investing in building up the supports in the community to support people in the least restrictive setting.

The reinvestment from 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 military providers in the community and we will be building on those. We will be building on those programs to help through the inpatient discharge process. So people can work with our unit staff during discharge planning and then follow the person out into the community and support them when they are in their new residential whether it is a transitional residential or permanent residence to make sure they are supporting tenure, engagement and other meaningful life activities.

And I think, you know, a lot of this really comes down to making sure people are stable in their housing. I think the more we keep people in housing directly in their community with a want to be, the more successful we can be. Many times we hear from OMH, we are getting the many services from the right time and the right amount so we can cut down on length of stay. Like Anita said, we have about 50% of our senses that are considered long stay on the adult side. I think we really need to reduce that number and I think we can increase the number of people who are admitted and discharged within the 60 day, maximum 60 day and average 30-day cohort.

Throughout the investments we make here in the processes we build I think it's not just about investing in services but it's about creating this stronger framework in connection between our PCs in our community. Our psychiatric centers are not completely independent of the rest of the world. We want to build them into the community. I think the last point here we want to talk about is that we will have many performance metrics that we will follow through this waiver. We already have very many are our state hospital system in the community site for transparency. And to make sure these projects are 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 we are looking at provider performance in making sure what they are doing matters and also at the end of the day that we really are supporting recovery because this is about supporting individual's recovery in the community at the end of the day.

Please review those. Take a look and you can also comment on those. Look forward to hearing all your feedback today in the future on this project. Thank you, I will turn it over to OASAS now.

The waiver program for SUD initiatives is a little bit different. At the purpose of our interest in the waiver is to bring community-based detox, inpatient and residential services, as Trisha talked about, completely into the Medicaid reimbursability. The entire continuum of care then is available to people through Medicaid managed care and fee-for-service Medicaid reimbursability. So all of the pieces of our residential redesign would be connected Into the continuum and all of it is rehab focused and all of it is Medicaid reimbursable. 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 the 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.

One of our goals is also to increase the community-based nonhospital residential support and to be sure treatment is rehab focused and that is provided within the community and supported there. next slide.

Part of that is moving people appropriately through those community-based levels of care. The OASAS required level of care determination is with the LOCADTR or another -- which is a national placement criteria or another OASAS placed criteria. All providers are using LOCADTR -- all managed-care companies are utilizing LOCADTR within the Medicaid program. All of our providers also use LOCADTR. It allows for the admission criteria to be determined as to where a person would enter into care whether that is at a detox or an inpatient or residential element of care.

And also for the concurrent review in the continuum review of appropriateness for that level of care to continue to consider whether person's needs would best be met. Also, our policy will be modified to reflect that all of those criteria for residential programs, including the requirements for the types of services in the hours of clinical care and credentials of the staff delivering it that would apply in those elements of care to allow for the Medicaid reimbursability. Much of this we have talked about with our provider system as we brought reintegration into the Medicaid reimbursability. The overall goal here is similar. It is to have individuals serve closest to the community with rehab as the ultimate goal.

And to bring the entire continuum of care into the Medicaid program.

I will hand this over to Ilyana Meltzer.

Good morning, everyone. We wanted to close the OASAS portion of this conversation by putting the particular waiver in context with other SUD initiatives that are currently in place in developing alongside that are also leveraging federal and state authorities with the eye of strengthening the SUD delivery system in particular with expanding points of access across the continuum. Some of the initiatives we wanted to share today where they continued delivery of services in community. Also they continued utilization and expansion of telehealth services. The implementation of mobile service units that provide a complement of SUD treatment services including access to medication. The

mobile units will assist to broaden the reach of opioid programs and regions that may not have had access before. We are looking at increased 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 NYSDOH AIDS Institute to provide services to individuals and unstable housing or who are in crisis and support individuals access to care including access to critical medications.

Finally wanted to signal another initiative that supports individuals and community. That includes working with OASAS provider community to develop comprehensive integrated outpatient treatment programs for providers to combine existing opioid treatment programs and outpatient programs or to develop new programs with an integrated land spirit with that I will transition over to Sarina Master who will speak about the fiscal portion of this particular waiver.

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. That estimate assumes there is continued measured increases that that placement into the community is a successful placement. And that we will be leveraging the enhanced crisis support services.

This demonstration is going to be budget neutral. All demonstrations have to be budget neutral per federal requirements. What that means is this waiver will not increase overall Medicaid expenditures. We expect to offset any of the costs associated with the waiver with savings achieved for 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.

I know this font in this purple arrow is a little small. 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 the targeted in-reach services in the 30 days prior to their discharge from a state psychiatric center.

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 take a closer look at the numbers. But I will just say that it looks like the OMH B group, those eligible for the 30 days in-reach services, are expected to stay study at in enrollment of -- the OMH A group which is the 30-day average length of stay will initially start at 450 people in the eligibility area. The OASAS cohort is estimated at 2218 and those two populations are expected to steadily rise by a few hundred people per year over the five-year period.

There will also be evaluations which I will talk about in a second. There are two evaluation points. One at the midpoint of the waiver for the SUD program in both programs are being evaluated at the end.

There will be, as I said, an evaluation. This is a very comprehensive, multimethod evaluation. The state will be engaging an independent evaluator to conducted at the midway point for SUD and at the end of the demonstration for both SUD and SMI programs. The evaluator will document the impact of the waiver on the healthcare 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 posed 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 effects 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.

Here's the timeline we have projected. As you know, the public notice was posted to the state register in the public comment period began on October 5 as well as the tribal comment period began October 5. Today is the second of our two hearings. The previous one was on October 26. Our public comment period ends on November 4 for the general public and November 10 for the tribal comment period. If you have comments and you did not get to speak today or at the last hearing, please send your comments before then. The written and oral public comments to finalize the amendment. We expect to formally submit the loan application to CMS in December 2022. We are targeting Spring 2023 for our implementation day. With that, I will turn it over to Amy Clinton to talk a little bit about the public comment period. Thank you.

Thanks Sarina. We have a list of preregistered commenters. Which will indicate the order in which you will be called on to speak.

When your name is called, you will receive -- Excuse me. You will receive a message from the host which indicates he 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 come unmuted in order to speak.

Also make sure your phone is unmuted to avoid the in With that let's go ahead and start the public period it's Ronald Richter at the JCCA.

Can you hear me?

Sure can. Go ahead please.

Terrific. Give me one moment please. I wasn't sure that you received my notification about providing public comments. So thank you.

You are welcome.

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, 18 years old 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 consider seriously the changed post-pandemic especially given the dire needs that existed pre-pandemic for these young people. There have been long-standing gaps in the children's mental health system and those gaps and have been 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 health equity, particularly for our young people. And if it is just in the IMD waiver we could begin to make inroads in 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. With that, I thank you so much for giving me the opportunity to be heard.

Okay. Thank you, Ronald. Next up, Michael Williams. If you are on.

Our next speaker, Michael Williams. does not appear to be on. Michael, if you are you can send me a private chat, the host Lily Johnson and I could unmute you if you are under a different name. Otherwise, I think we can proceed to the next person in the list.

Okay. Thank you. Lydia Virgil, you are up next and followed by that is Senator Brad.

As of right now our next two speakers are also not on. It looks like we will have to skip ahead to the fifth person on the list, Amy.

Thank you for that. Ed, when you are ready.

Are you there?

We can hear you just fine.

Perfect. Thanks. I would like to first start off by saying the state hasn't been very clear or transparent plans for or the applications of this waiver application. Providers are already stretched too thin for a whole host of reasons. And having to wrap our heads around this waiver announcement in a this timeframe. I work for recovery. Aspects of the State’s plans and initial communications regarding the waiver have been extremely troubling. By their inherent design, residential programs respond to the needs of

individuals who will likely not be successful another shorter-term treatment programs. As evidenced by the Level of Care Determination, the people in our program the people in our programs have. do these factors they have longer lengths of stay in the proposed average 30 days in the proposal. Our programs and offer every individual for substance use disorder but is a subset of the population requires medium to long-term supports that suggest history of active use.

While I learned that the state plans for incrementing the waiver requires the length of stay to be a system wide aggregated average as mentioned by Tricia earlier to this was not clear in the plans with communications the state has set out. I don't know who that is. I will continue.

I think that might be the previous speaker. Ron, you might want to mute your phone. Thanks so much.

As I was saying I would like to see a clear and transparent statement including the states waiver application that the state will not be providing long-term residential providers. In addition part of the state's plan seems to rely on the transitional and supportive housing system. While this makes sense on paper, I can tell you the capacity for transitional and supportive housing comes nowhere close to meeting the current need. Cas Recovery operates multiple housing programs for people with substance abuse disorders and we can attest the need for housing far outweighs the capacity all across the state. We cannot meet the needs of people in our internal continuum little many referrals from other external sources. With this in mind, New York State needs to silly consider funding supportive housing programs and units more robustly. I know this waiver proposal isn't the place to fund supportive housing but the state needs to address the massive gap in the behavioral health system before creates more plans. Thank you for letting me comment. I appreciate it.

Thank you very much.

I don't see any of the other speakers who have signed up better on and no one has reached out and chat.

That concludes the public comment period today. I want to thank everyone for participating in thank our commoners for thoughtful comments. Just a reminder to please send in your written comments if you have them you can do that by email to the email that you see, 1115waivers@health.ny.gov or you can mail to the address with the postmark of November 4.

I want to thank our interpreters, Stephanie and Kelly again. And remind folks that this webinar is being recorded in the recording and the transcription will be available on our website within 3-5 days. Thank you again and everyone please have a good rest of the day.