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December 21, 2022

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State Demonstrations Group  
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Baltimore, MD 21244-1850

Dear Ms. Cash:

Pursuant to the terms of the New York State Medicaid Section 1115 Demonstration Medicaid Redesign Team (MRT) Waiver (11-W-00114/2), New York State (NYS or the State) is pleased to submit the enclosed waiver amendment proposal to the Centers for Medicare and Medicaid Services (CMS) for its approval.

New York State (NYS) is requesting approval from the Centers for Medicare and Medicaid Services (CMS) for an amendment to its Medicaid Redesign 1115 Demonstration to authorize federal Medicaid matching funds for reimbursement to Institutions for Mental Diseases (IMD) for inpatient, residential, and other services provided to Medicaid enrolled individuals with behavioral health diagnoses including serious mental illness (SMI), serious emotional disturbance (SED), and substance use disorder (SUD). This demonstration will allow the state to promote improved access to community-based behavioral health services and aid in the state's efforts to continue to transform the behavioral health service system.

The objective of the demonstration is to transform select state psychiatric inpatient facilities and substance use disorder residential treatment facilities by improving care transitions and access to community-based treatment and support services, and improving health and behavioral health outcomes in individuals with chronic and/or serious mental illnesses. These sites will focus on reducing the statewide average length of stay, increasing community investments, and promoting local engagement and community tenure. The IMD demonstration project will include the use of crisis services, respite, step down and short-term residential services, intensive community support services, crisis diversion centers, coordinated specialty care for first episode psychosis, and integrated community participation. These services, in concert with time-limited inpatient service capacity, focus on expert intermediate care treatment and provide a robust continuum of care designed to support the needs of New Yorkers with SMI and SUD.

Also as part of this demonstration, NYS is requesting authorization of Medicaid coverage for a targeted set of in-reach services up to 30 days prior to discharge from state-operated inpatient psychiatric centers including care management, clinical consultations, peer services, and pharmaceutical management. These in-reach services would be made available to individuals who do not fall into the 30-day average length of stay cohort outlined in this waiver.

This initiative will improve community reintegration for individuals at risk of avoidable readmissions or long-term hospitalization in such facilities.

This demonstration project serves three main purposes:

- Allows the state to further redesign and grow the behavioral health community system while reducing IMD admissions and lengths of stay.
- Permits the state to maximize the ability of state psychiatric facility campuses, which are centrally located in communities with underserved populations, to serve as enhanced service delivery systems for community integration and recovery in the community.
- Permits the state to fund a complete continuum of SUD services including reintegration, as well as the enhancement of services that are currently not Medicaid funded including the expansion of telehealth access, the creation of mobile MAT units, and allowing all outpatient programs to do methadone treatment, among other initiatives

The primary goal will be transformation with a focus on:

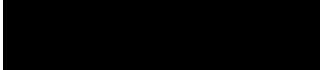
- Reduction of inpatient and transitional residential lengths of stays.
- Community integration and maintenance with a focus on recovery.
- Overall reduced costs of care.

New York State has fully complied with federal transparency requirements in preparation for formally submitting this waiver amendment proposal. The State transmitted tribal and public notices referencing the preliminary proposal draft (October 5, 2022), conducted virtual public hearings (October 26, 2022, and October 31, 2022), and received six verbal and written comments. The State's engagement with stakeholders informed the structure and substance of this submission and have been addressed in the attached waiver amendment application.

The State is submitting a draft of the IMD Transformation Demonstration Program Memorandum of Understanding between the Department of Health, Office of Mental Health, and Office of Addiction Supports and Services and will submit the final once the document has undergone the state's official approval process.

The partnership between CMS and New York State continues to be important to the success of the underlying 1115 Demonstration MRT Waiver and will also be critical to this amendment's success. We look forward to our continued collaboration. If you have any questions, please contact me at [\[REDACTED\]](#)

Sincerely,

  
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# NEW YORK STATE MEDICAID REDESIGN TEAM (MRT) WAIVER

1115 Research and Demonstration Waiver  
#11-W-00114/2

**IMD Transformation Demonstration Program**

**New York State Department of Health  
Office of Health Insurance Programs**

One Commerce Plaza

Albany, NY 12207

December 21, 2022



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**New York State Department of Health  
Medicaid Redesign 1115 Demonstration Amendment Application:  
IMD Transformation Demonstration Program**

**I. Historical Narrative Summary of the Demonstration**

**Introduction**

New York State (NYS) is requesting approval from the Centers for Medicare and Medicaid Services (CMS) for an amendment to its Medicaid Redesign 1115 Demonstration to authorize federal Medicaid matching funds for reimbursement to Institutions for Mental Diseases (IMD) for inpatient, residential, and other services provided to Medicaid enrolled individuals with behavioral health diagnoses including serious mental illness (SMI), serious emotional disturbance (SED), and substance use disorder (SUD). This demonstration will allow the state to promote improved access to community-based behavioral health services and aid in the state's efforts to continue to transform the behavioral health service system. The State of New York is currently working with advocates and providers to develop an initiative for services for SED children and will be submitting a demonstration amendment later in the year to add Qualified Residential Treatment Programs (QRTPs) to this request, including amending the SMI implementation plan to include QRTPs and other services for SED children.

This demonstration builds on the transition of Medicaid Behavioral Health services from a primarily fee-for-service environment to a managed care environment as one key initiative of the State's Medicaid Redesign Team (MRT). This transition to Medicaid Managed Care is intended to improve clinical and recovery outcomes for individuals with SMI and SUD; reduce the growth in costs through a reduction in unnecessary emergency and inpatient care; and increase network capacity to deliver community-based recovery-oriented services and supports.

The objective of the demonstration is to transform the role of some state psychiatric inpatient facilities and substance use disorder residential treatment facilities, improve care transitions and access to community-based treatment and support services, and improve health and behavioral health outcomes in individuals with chronic and/or serious mental illnesses by transforming selected (pilot site) state-run psychiatric hospitals, facilities, and campuses from long-term care institutions to community-based enhanced service delivery systems. These pilot sites will focus on reducing the statewide average length of stay, increasing community investments, and promoting local engagement and community tenure. The IMD demonstration project will include the use of crisis services, respite, step down and short-term residential services, intensive community support services, crisis diversion centers, coordinated specialty care for first episode psychosis, and integrated community participation. These services, in concert with time-limited inpatient service capacity, focus on expert intermediate care treatment and provide a robust continuum of care designed to support the needs of New Yorkers with SMI and SUD.

Also as part of this demonstration, NYS is requesting authorization of Medicaid coverage for a targeted set of in-reach services up to 30 days prior to discharge including care management, clinical consultations, peer services, and pharmaceutical management. These in-reach services would be made available to individuals who do not fall into the 30-day average length of stay cohort outlined in this waiver. This initiative will reduce inpatient lengths of stay for Medicaid enrolled individuals in state-operated psychiatric center IMDs and improve community

reintegration for individuals at risk of avoidable readmissions or long-term hospitalization in such facilities.

New York requests that this demonstration cover a complete array of Level of Care Determination (LOCADTR)<sup>1</sup> levels of care (LOCs) as a component of an essential continuum of care for Medicaid-enrolled individuals with opioid addiction or other SUDs consistent with its approved State Plan for Hospital services as well as Rehabilitative outpatient and residential services in all settings. Specifically, NYS requests that the demonstration be effective immediately upon approval to use IMDs as a Medicaid-covered setting. New York State is committed to continuing its system transformation to improve access to care and enhancing opportunities to access high quality care for individuals living with serious mental illness.

In 2015, NYS transitioned behavioral healthcare services into Mainstream Medicaid Managed Care and through the 1115 Waiver established Health and Recovery Plans (HARPs), which provide access to Behavioral Health Home and Community Based Services for eligible Medicaid beneficiaries, in addition to a focus on integrating care through individualized complex care coordination. Initial results from these initiatives indicate that mental health and substance use disorder inpatient utilization is decreasing, and utilization of community-based mental health and substance use disorder services is increasing. These are desired trends that suggest the focus of care for individuals with SMI/SED/SUD is shifting to the community. The IMD waiver is an opportunity to build on these initial improvements for Medicaid enrollees who may require inpatient and residential care in an IMD.

### **Program Background and Description for People with Serious Mental Illness**

Since 2011, New York State Office of Mental Health (OMH), in partnership with Office of Addiction Services and Supports (OASAS), and the Department of Health (DOH), has accomplished system transformation to increase community integration, and achieve better healthcare outcomes, control costs, and ensure efficient administrative structures. To accomplish these goals for individuals living with SMI, Targeted Care Management was transitioned to the Health Home Program in 2012.

To improve outcomes and reduce the IMD average length of stay (ALOS), NYS has invested in critical time intervention strategies to expedite community transition, support, and integration. In addition to authorizing coverage for Behavioral Health Home and Community Based Services for eligible Medicaid beneficiaries enrolled in HARPs, the New York State Medicaid Section 1115 Waiver has also enabled NYS to provide all Medicaid enrollees with access to community settings such as Clinic and Intensive Outpatient services provided by Licensed Behavioral Health Practitioners and services delivered in residential substance use disorder facilities.

New York State has also expanded services offered by Assertive Community Treatment (ACT) Teams by nearly 21% over the five-year period from 2014 through 2018, facilitating step-down from inpatient to community-based services for the highest risk members. For individuals with SMI who are not eligible for ACT services, the Health Home Plus program provides support for successful community transitions.

In addition, in 2015, NYS was one of 23 states awarded a planning grant under the Protecting Access to Medicare Act of 2014 (Pub. L. 113–93) and in 2016 was one of eight states chosen by CMS to implement Certified Community Behavioral Health Clinics (CCBHCs).

These CCBHCs have yielded optimistic outcomes, including a 27% decrease in Behavioral Health (BH) services average cost per month, a 26% decrease in BH Emergency Room services average cost per month, and a 30% decrease in physical health Emergency Room services average cost per month. These results are for the first year of the demonstration, from July 1, 2017, through June 30, 2018, and they reflect the experience of members receiving services from the CCBHCs.

This waiver will allow NYS to further improve health outcomes through community integration. Under Section 31.02 of the NYS Mental Hygiene Law, OMH licenses inpatient psychiatric hospital service capacity in both stand-alone hospitals and in NYS DOH-licensed general hospitals. There are currently 107 DOH-licensed general hospitals operating, which provide 5,364 psychiatric beds. In addition, OMH operates a total of 23 psychiatric hospitals pursuant to Section 7.17(b) of the Mental Hygiene Law, from which the adults who will be deemed eligible for waiver participation will be selected.

Additionally, NYS is positioning State-operated campuses, through other critical time intervention models that include Mobile Integration Teams, to engage individuals in community-based services and reduce lengths of stay wherever possible. Programs such as Pathway Home™, initially developed by a community provider with a combination of federal and state funding<sup>2</sup>, which provides critical time interventions and care management, will be leveraged and built upon for this demonstration.

### Substance Use Disorder Facilities

OASAS directly operates 12 Addiction Treatment Centers and oversees over 1,600 addiction treatment programs. In addition, expanded regional programming including Centers of Treatment Innovation (COTIs) and Open Access Centers and Recovery Community Centers, treat New Yorkers wherever they may be in their recovery journey.

### Summary of All OASAS Services

LOCATDR Service Description	NYCRR Title 14	# of providers	# of Facilities	# of beds / slots	Count Served Cohort CY2019	Avg Length of Stay (days) for CY2019 Cohort	Vacancies as of 11/30/21 (Beds)	ASAM Level
Medically Managed Inpatient Detoxification	816	17	18	350	32,079	3.7	120	4-WM
Medically Supervised Inpatient Detoxification	816	23	26	703	32,769	4.1	318	3.7-WM
Inpatient Treatment	818	62	65	2,492	49,553	15.7	354	3.7



LOCATDR Service Description	NYCRR Title 14	# of providers	# of Facilities	# of beds / slots	Count Served Cohort CY2019	Avg Length of Stay (days) for CY2019 Cohort	Vacancies as of 11/30/21 (Beds)	ASAM Level
Residential Rehabilitation Services for Youth	818	7	9	240	955	108.8	65	3.7
Residential Services - Stabilization / Rehabilitation (w/out Reintegration)	820	17	32	1,154	6,724	50.3	268	3.5 / 3.3
Residential Services - Stabilization / Rehabilitation (with Reintegration)	820	17	35	1,849	4,892	110.9	352	3.5/3.3/3.1
Residential Services - Reintegration Only	820	15	29	730	977	201.8	107	3.1
Day Rehabilitation	822	28	35	NA	6,977	117.7	NA	2.5
Intensive Outpatient (Cohort Data is CY2021 Annualized)	822	28	40	NA	387	185.4	NA	2.1
Medically Supervised Outpatient Withdrawal	822	10	10	259	2,981	12.4	NA	2-WM
Outpatient Clinic	822	271	425	NA	158,158	185.4	NA	1
Opioid Treatment Program	822	56	103	40,886	54,976	481.2	NA	1
Residential Services - Intensive Residential	819	13	22	1,285	8,626	149.8	211	Comparable to ASAM 3.3

LOCATDR Service Description	NYCRR Title 14	# of providers	# of Facilities	# of beds / slots	Count Served Cohort CY2019	Avg Length of Stay (days) for CY2019 Cohort	Vacancies as of 11/30/21 (Beds)	ASAM Level
Residential Services - Community Residence	819	38	50	1,021	4,860	155.7	98	Comparable to ASAM 3.1
Residential Services - Supportive Living	819	22	27	659	1,965	209.2	159	Comparable to ASAM 3.1

**Efforts to Decrease Lengths of Stay in Mental Health Hospitals**

New York’s Delivery System Reform Incentive Payment (DSRIP) program is the main mechanism by which the state has implemented its Section 1115 Medicaid Redesign Team (MRT) Demonstration Waiver Amendment with the primary stated goal to reduce avoidable inpatient and emergency department hospital use by 25% over five years.

In Summer 2017, NYS OMH applied Lean principles including Value Stream Mapping to identify processes that impacted LOS and successful discharges. Lean is a process improvement tool, adopted by NYS government agencies, which was inspired by private-sector manufacturers to streamline their operations. Later that summer, there were Lean “refresher” courses, a project overview, and a review of operational expectations communicated to facility leadership.

In the Fall of 2017, regional continuous improvement (known as Kaizen) events were held in order to officially “kick-off” the use of patient LOS trackers, and eight psychiatric centers implemented trackers in select units within their hospitals. Currently, all State psychiatric centers are using LOS patient trackers.

The implementation of these trackers and the culture change they foster further prepared the field for transforming the NYS mental health system to make community-based recovery a reality. By further rebalancing institutional inpatient and community-based services, NYS can continue to support managed, recovery-oriented care, improve overall population health, and increase access to quality mental health services across the state.

The impact of Lean initiatives varies across facilities and geographical regions. Overall, the inpatient tracker provided valuable lessons regarding the approach to standardization of processes and workflows across State psychiatric centers. The implementation of the tracker clearly illuminated the benefits of data-driven performance measures to focus on the quality of inpatient services rendered and reduce lengths of stay.

Opportunities remain for continued focus on quality of care and discharge readiness for adults in inpatient settings. However, the process has heightened awareness of issues that contribute to longer lengths of stay and actions needed to address them, resulting in an improved team approach; better discharge planning; and tracking of vital documents and other information necessary to secure community services.

We offer the following lessons learned and common categories of barriers to discharge, followed by related clinical management principles and strategies to address each barrier in order to illustrate current and future efforts to reduce lengths of stay:

- Realistic post-discharge expectations should be set. The individuals OMH serves deserve a chance at independent living as independent adults with autonomy and the ability to make choices. For instance, rather than a guarantee of success and complete safety in the community, a reasonable discharge expectation could be: An individual will be able to live in the community without presenting a high risk of harm to self or others given current symptoms and behaviors and will demonstrate adequate functioning to be able to reasonably engage in activities of daily living (ADLs).
- Contingency planning for crises with family members and/or other community supports is often needed and will be a focus in this demonstration. Recovery is frequently an uneven path, often achieved in very small steps. If a patient does not have to return to an inpatient IMD level of care – even if they intermittently need acute community inpatient services, progress is made.
- Patients often live with serious historical risk factors (violence, self-harm, fire setting, sex offenses, etc.), but without any recent evidence of high-risk behaviors. The approach for these cases is to conduct and document thorough, comprehensive risk assessments – using outside expert consultation when necessary – and then make a community discharge plan that mitigates future risk as much as possible.
- There are many psychopharmacological interventions that can be initiated in the inpatient setting that may enhance chances of success in the community. Examples include clozapine and long-acting injectable antipsychotics for psychosis, and anti-addiction medications including long-acting injectable naltrexone for substance use disorders. Individuals must have continued, ready access to these medications as soon as they leave the facility. In addition, simplifying medication regimens as much as possible prior to discharge enhances chances of adherence.
- Psychosocial programming in the inpatient setting should be targeted as much as possible to learning and practicing real-world community living skills. A plan to continue practicing such skills should be discussed with outpatient providers prior to discharge, as appropriate. Additionally, more proactive engagement with outpatient service providers during the last 30 days of an individual's inpatient stay to enable more informed "warm hand-offs" to aftercare providers will reduce the likelihood of skill regression.
- For patients with regression as the main driver of challenging behaviors, often in combination with character pathology, it may be necessary to recognize that the inpatient setting is not mitigating risk level and may in fact be worsening their challenging behaviors over time. In these cases, it can be necessary to proceed with discharge planning during ongoing challenging behaviors. The rationale for attempting to proceed with discharge during ongoing risk would need to be very carefully documented, and the

discharge plan would need to demonstrate robust efforts to mitigate this risk in the community, with ample support, monitoring, and contingency planning included.

- While serious mental illnesses such as schizophrenia are often associated on their own with significant cognitive deficits, any suspicion of cognitive decline must be followed by thorough medical and neurologic evaluation, especially in older patients and those with significant medical comorbidities. It is possible that someone may have a reversible medical cause of cognitive decline (i.e., altered mental status, delirium, or encephalopathy). This can sometimes be subtle, but every effort should be made to identify and diagnose medical causes of altered mental status. Others may have dementia, a diagnosis of which will have obvious disposition and placement implications.
- Assuming anxiety is at least a partial driver of resistance to discharge, principles of anxiety treatment such as psychopharmacological interventions (as appropriate), are applied. Examples might include having incrementally longer conversations about the idea of discharge with the treatment team; going on incrementally longer and farther passes off the inpatient unit with a staff member, family member, or other community support; visiting community residence options with staff; and “trial” overnight visits to a planned discharge destination.
- Social support can be a powerful way to decrease anxiety around discharge. Again, peer specialists should be included whenever possible in helping patients move towards a transition out of the hospital. In addition, a few PCs are experimenting with discharging two or more long stay patients at the same time and to the same residential setting, to increase natural supports and environmental familiarity.
- Patients who are resistant to discharge may not feel confident in their ability to function in the community, which might contribute to anxiety. Therefore, robust community living skills programming should be available on the inpatient setting and continued assistance with and training for living skills should be incorporated, as appropriate.

These examples illustrate that patients who tend to drive long stays are highly complex cases, involving multiple comorbid and often treatment refractory psychiatric, substance use, and medical comorbidities, often compounded by substantial high-risk histories and serious psychosocial problems. While mental health and support services in many communities are robust and expanding, every case requires work and creativity in order to develop a feasible discharge plan. Rarely is a single strategy or resource identified as the key to a successful discharge.

Through intensive and informed work at IMDs, individuals and population groups will be identified for targeted interventions such as those described above. Specific programs will be developed to work directly with individuals to facilitate discharge settings and reduce inpatient lengths of stay.

### **SUD Initiatives to improve access to care**

This demonstration builds upon an extensive, existing array of New York Medicaid covered behavioral health (BH) services, including evidence-based services and will improve upon and enhance services that are currently covered only under non-Medicaid sources such as state and other federal funding. OASAS is constantly strengthening the addiction-support continuum of

care and will continue this work throughout the waiver demonstration. Examples of these initiatives include:

- Expanding telehealth access;
- Scaling up Mobile MAT unit services (currently contracting for 10 mobile units with a potential for up to 35 statewide), and expanding the reach of Opioid Treatment programs (OTP) through medication units, or satellite clinics;
- Integrating the continuum of care by pursuing DEA and SAMHSA approval for each outpatient program to provide methadone as clinically indicated;
- Developing peer and clinical outreach services within the outpatient system;
- Implementing street outreach programs in collaboration with the AIDS Institute (NYSDOH) to promote harm reduction; and,
- Funding networks of providers to expand access to medication on demand, provided in reach to emergency departments and other point of care providers. The networks include the full continuum of prevention, treatment and recovery services and are tasked with implementing evidence - based services, improving access to medications for OUD, distributing naloxone, and expanding primary prevention and recovery services to individuals throughout the region. The networks are required to monitor measures of success and to work to improve regional quality metrics, with a focus on improving continuity of care by coordinating care across the network.

New York Medicaid covers all ambulatory LOCADTR LOCs, as well as medication for addiction treatment (MAT), residential and inpatient services, and withdrawal management. New York's Medicaid State Plan includes authority for a complete continuum of care as approved in State Plan Amendment (SPA) #16-0004, 91-0039, 91-0075, 09-0034, 19-0017, 19-0013, 19-0018, 06-61, and 08-39, 21-0064. The demonstration will permit OASAS to provide critical access to medically necessary SUD treatment services and medically necessary physical and BH care in the most appropriate setting for the member. This approach is designed to address the demonstration goals detailed below under Hypothesis and Evaluation, including improving health care outcomes for individuals with SUD (reducing hospital emergency department use and inpatient admissions, reducing hospital readmissions, and improving the rates of initiation, engagement, and retention in treatment).

## **Compelling Case**

### **SMI Population**

The proposed demonstration will allow NYS to reimburse state operated IMDs for person-centered, highly effective inpatient, residential, and crisis management treatment for individuals aged 21 to 64. The waiver will support further gradual and deliberate system transformation to reduce over-reliance on the most restrictive and expensive level of care. The waiver's proposed flexibility to determine appropriate LOS at IMDs within a 30-day average will allow the State to increase patient flow through the intensive level of care, give more people appropriate access to advanced treatment while linking them upon discharge to robust community care, expand and strengthen community supports for those most in need, and systematically create a care delivery model that offers just in time services for those adults approaching, experiencing or leaving inpatient psychiatric treatment in an IMD.

Redesign of inpatient care across the state will drive focus on promoting efficient and timely inpatient treatment to reduce institutionalization. Timely transitioning inpatients of State

Psychiatric Centers to Transition to Community Residential Programs (TCRPs), which will offer a supportive “step-down” alternative to inpatient settings. Through specifically formed partnerships with like-minded community providers, the TCRP environment will offer 24/7/365 community crisis respite and stabilization, reducing risk of readmission.

Evidence-based algorithms specifically aimed at treatment resistant illnesses, targeting psychosocial interventions focused on promoting independent living skills and using standardized treatment planning tools for measuring symptoms, risk of harm, functioning and engagement in care will combine to reduce lengths of stay and increase community integration. Communities surrounding the Office of Mental Health Psychiatric Centers will receive modest investment from federal matching funds realized through the demonstration.

Federal matching funds made available by this waiver will allow NYS to strengthen community-based services and decrease demands on Article 28 facilities in communities. Reinvestment of funding realized through the waiver will allow NYS to strengthen rapid response to individuals and families in crisis. NYS will prioritize evolving and strengthening partnerships with community-based not-for-profit providers, Comprehensive Psychiatric Emergency Programs (CPEPs) and Emergency Departments (EDs). NYS will also focus on applying critical time intervention methodologies with clear performance targets to prevent admissions wherever possible.

NYS has a long-standing goal to integrate mental health, substance use disorder, and physical health services to support the health and recovery of high-needs individuals. This goal will be furthered by this waiver as NYS continues to integrate services in a defined system of care that ensures the right interventions are provided in the least restrictive environment.

The proposed demonstration will also allow NYS to improve community reintegration by providing in-reach services to individuals who do not fall into the 30-day average length of stay cohort outlined in this waiver. Medicaid coverage for a targeted set of in-reach services up to 30 days prior to discharge including care management, clinical consultations, peer services, and pharmaceutical management. This would also enable NYS to enroll individuals in Medicaid managed care plans without delay. Every year, approximately 2,500 individuals aged 21 to 64 with SMI are discharged from NYS OMH operated psychiatric center IMDs. Individuals to be discharged from State operated psychiatric center IMDs often require assistance with transitioning back into the community and locating available clinical services, social services, and housing enabling them to manage symptoms effectively and live in the least restrictive community-based setting. These transitions are especially difficult for individuals who have resided in institutions for longer than 60 days.

One of the largest impediments to achieving higher rates of successful discharge is the lack of access to Medicaid-funded services immediately upon discharge. Upon discharge, OMH, in collaboration with the Department of Health, works as expeditiously as possible to reactivate Medicaid coverage or submit new Medicaid applications for qualifying individuals, depending on their Medicaid coverage status while they are in the institution. This process occurs only after discharge because individuals aged 21-64 receiving care in IMDs are not eligible for Medicaid with federal participation during their admission to the institution, due to the federal IMD exclusion.

Discharges are carefully planned and executed to assist individuals in successfully transitioning to community settings and a key goal is to reduce avoidable emergency, inpatient hospital care, or prolonged institutionalization. A State operated IMD discharge planning best practice is for

outpatient providers such as Assertive Community Treatment, care coordination, clinic and other community supports, to engage with the individual and their inpatient treatment team prior to discharge.

Despite NYS' efforts, following an IMD admission, access to Medicaid-funded services for these individuals is often delayed, depriving them of immediate access to critical services, other than those NYS makes available without federal financial participation.

NYS recognizes individuals being discharged from State operated IMDs are a particularly vulnerable population for whom warm hand-offs to community-based providers are critically important to ensure successful community tenure. Even under the best of circumstances, a person discharged without prior contact with a future care manager or provider, or without sufficient access to medications, is more likely to not engage with critical service providers when they re-enter the community. Contact between service providers and the institutionalized individual needs to occur prior to discharge to facilitate continuity of care after discharge and use of medications appropriate for community-based settings. Additionally, decreasing the time it takes for individuals to be assigned to and reenrolled in a Medicaid Managed Care plan will enable better management of the population and the opportunity to utilize alternative payment methodologies to improve health care outcomes.

Authorizing Medicaid coverage for targeted in-reach services for individuals in a defined In-reach Waiver population prior to discharge from state-operated psychiatric center IMDs will also help advance NYS' health equity goals and align with the State's MRT waiver. Individuals receiving long term care in State operated IMDs are disproportionately non-white, even though compared to the national average, the rate of SMI is higher among non-Hispanic white adults than Hispanic or non-Hispanic Black adults (5.7%, as compared to 4.9% or 4%, respectively<sup>3</sup>). Individuals with SMI have high psychiatric and physical health burden yet are often difficult to engage in ongoing care. They comprise a small percentage of the Medicaid population but drive a significant percentage of Medicaid expenditures for both physical and behavioral health. They have high rates of comorbid substance use disorders, chronic health conditions, and functional impairment. Accordingly, this population experienced diminished life expectancies of 15-20 fewer years than the general population mainly because of the effects of smoking and avoidable chronic health conditions. These challenges disproportionately affect individuals from communities of color and low socioeconomic status. Because of lack of engagement in treatment, a number of these individuals become homeless or come into contact with the criminal justice system and remain a risk to themselves or others.

NYS seeks approval from CMS to provide a targeted set of in-reach Medicaid services for Medicaid eligible individuals 30 days prior to discharge from State operated IMDs, including care management and discharge planning, clinical services to facilitate warm handoffs to aftercare providers, including but not limited to peer services, medication management plan development, delivery of certain high priority medications, and sexual and reproductive health information and connectivity. This will ensure active engagement in services upon release, increase rates of successful community reintegration for this especially vulnerable population, and advance NYS' health care equity goals.

### **SUD Population**

Modernizing New York's Medicaid system of delivering SUD treatment services has been an ongoing and sequential process. The State made some progress towards its goals of providing a comprehensive SUD benefit package of services with the implementation of SPA #16-0004

and the 1115 waiver amendments of 2015. However, not all levels of care were included in the benefit package and access to necessary services remained limited by the restriction of bed size in residential settings.

This demonstration will address New York’s opioid crisis and support the State’s effort to implement an enhanced comprehensive and lasting response to the opioid epidemic as well as similar challenges with use of substances other than opioids. New York is experiencing one of the most significant public health crises in its history. The striking escalation of opioid use and misuse, and prevalence of fentanyl over the last five years is impacting individuals, families, and communities throughout the State. One of the main goals of this demonstration is to reduce overdose deaths, particularly those due to opioids.

Among NYS residents, the number of overdose deaths involving any opioid increased each year between 2010 and 2017, with an overall increase of 200 percent from 1,074 in 2010 to 3,224 in 2017. In 2018, overdose deaths involving any opioid decreased from 2017 (3,224) by seven percent to 2,991 deaths. Despite the recent decline, the 2018 age-adjusted rate of 15.1 deaths involving any opioid per 100,000 population in NYS is still nearly triple that of 5.4 in 2010. The number of overdose deaths involving commonly prescribed opioids increased by 42 percent from 737 deaths in 2010 to 1,044 in 2017, followed by a four percent decrease in 2018 to 998 deaths. Most of these opioid-related mortality trends were driven by deaths involving synthetic opioids other than methadone (SOOTM), with annual increases from 2010 to 2017. Despite a small decrease in SOOTM-related deaths in 2018, there was still an overall increase of 1,169 percent from 2010 from 2018. Overdose deaths involving SOOTM were largely associated with fentanyl and its analogs.<sup>4</sup>

In NYS, there were 3,617 opioid overdose deaths among residents in 2019, of which 2,338 involved synthetic (i.e., human-made) opioids other than methadone (SOOTM), a 7.1% increase over 2018, (65 percent), followed by 1,145 overdose deaths involving heroin, and 939 involved commonly prescribed opioids. Early 2020-2021 data indicates synthetic opioids, including illicit manufactured fentanyls involved 64% of > 100,000 estimated U.S. Drug Overdose deaths during May 2021 -April 2021.<sup>5</sup> The prevalence of fentanyl adulterated and substituted heroin (FASH) and counterfeit opioid and other pills (e.g., oxycodone, alprazolam, etc.) has increased in local drug supplies in many states, including NYS.<sup>6</sup> Furthermore, the number of overdose deaths involving cocaine has also been increasing in NYS since 2010, largely driven by the co-presence of fentanyl, with a slight decrease from 2017 to 2018.<sup>7</sup>

From calendar year 2010 through 2018, the rate of unintentional drug-related overdosedeadths in New York grew from 5 per 100,000 to 16.8 per 100,000.

**New York State - Overdose deaths involving any opioid, crude rate per 100,000 population**

<b>Data Year(s)</b>	<b>Crude death rate</b>
<b>2010</b>	5.0
<b>2011</b>	6.6
<b>2012</b>	7.0
<b>2013</b>	8.2
<b>2014</b>	8.7
<b>2015</b>	10.9



<b>2016</b>	15.6
<b>2017</b>	16.8
<b>2018</b>	15.1

Data Source: Vital Statistics Data as of August 2020.<sup>8</sup>

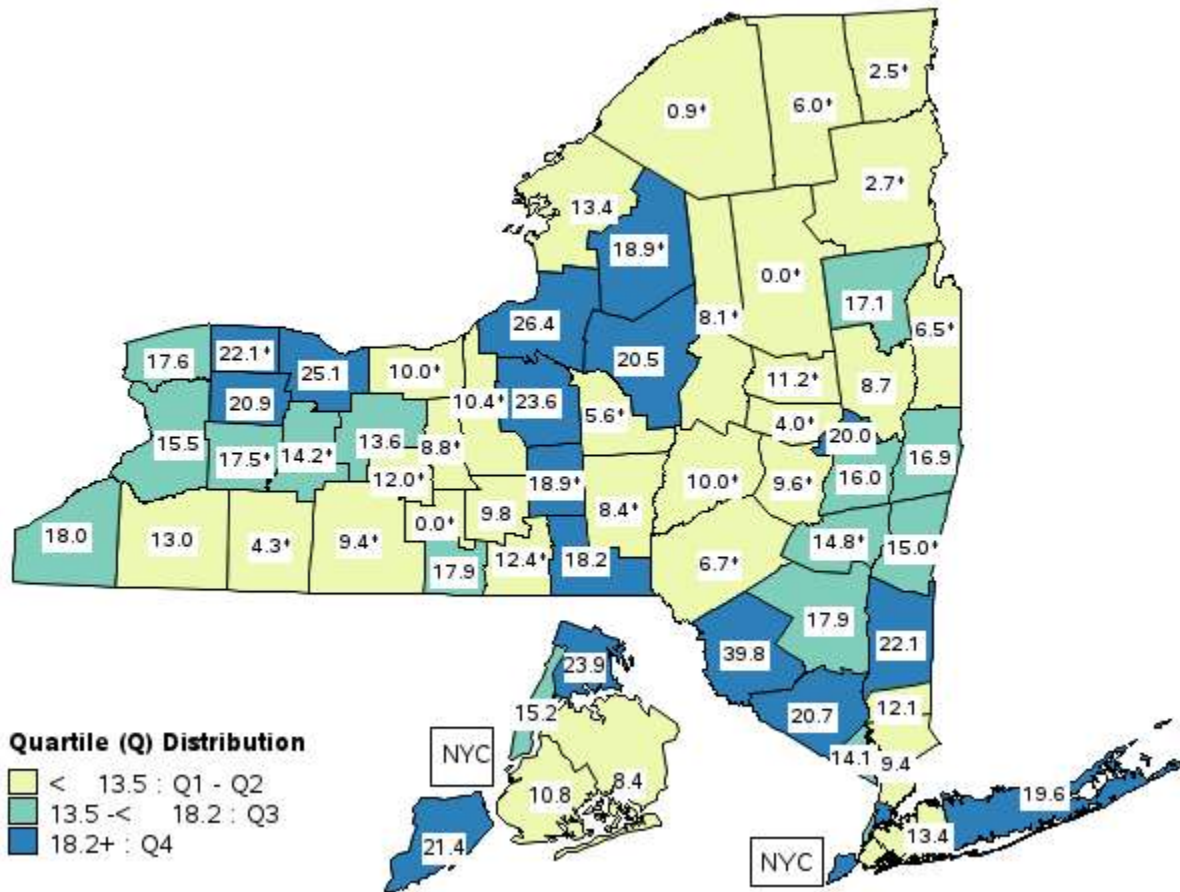
There is also a data dashboard maintained by DOH which can be found at:

[https://webbi1.health.ny.gov/SASStoredProcess/quest?\\_program=/EBI/PHIG/apps/opioid\\_dashboard/op\\_dashboard&p=sh](https://webbi1.health.ny.gov/SASStoredProcess/quest?_program=/EBI/PHIG/apps/opioid_dashboard/op_dashboard&p=sh)

A yearly report which covers NYS specific data on fatal and nonfatal opioid overdoses, opioid prescribing, opioid use disorder treatment and overall opioid overdose burden. This information can be found at:

[https://www.health.ny.gov/statistics/opioid/data/pdf/nys\\_opioid\\_annual\\_report\\_2020.pdf](https://www.health.ny.gov/statistics/opioid/data/pdf/nys_opioid_annual_report_2020.pdf).

## Overdose deaths involving any opioid, crude rate per 100,000 population, 2019



Data Source: Vital Statistics Data as of August 2021<sup>9</sup>

### Notes

- \* The rate is unstable this doesn't change in light of the questions
- ~County of residence was assigned based on ZIP Code for cases in which patient county of residence was listed as unknown or missing, but a valid NY ZIP Code was present.

These statistics on opioid-related deaths and overdoses underscore the need to transform and support the continuum of SUD services in New York State. State-only funds and federal Substance Abuse and Mental Health Services Administration (SAMHSA) block grant funds are used to support some residential services for individuals enrolled in Medicaid. Despite significant improvements to the publicly funded treatment delivery system that sits outside Medicaid, there remain critical unmet needs for residential SUD treatment. This demonstration is necessary to address those unmet needs.

Additional residential reintegration SUD services will be included for Medicaid members with this demonstration. This transition to Medicaid reimbursement of residential and inpatient IMD services will ensure access to a comprehensive, coordinated system of SUD care for children and adults in Medicaid. Prior to this demonstration, New York Medicaid had not adopted a complete array of SUD treatment services using a national placement criteria system (e.g.,

LOCADTR) or national provider standards. Most importantly, for some Medicaid-covered individuals in need of SUD treatment, there were limited options for residential community-based SUD treatment services.

The complete SUD benefit package includes support for evidence-based practices, such as multi-systemic therapy (MST), Functional Family Therapy (FFT) and Multidimensional Family Therapy (MDFT) for children with SUD conditions. It also modernizes the SUD treatment benefit to align with the most current edition of LOCADTR criteria for outpatient, inpatient and residential treatment. Providers have been trained to use the most current edition of LOCADTR criteria to provide multi-dimensional assessments that inform placement and individualized treatment plans that increase the use of community-based and non-hospital residential programs and assure that inpatient hospitalizations are utilized appropriately for situations in which there is a need for safety, stabilization, or acute withdrawal management. Improving LOC placement utilizing LOCADTR criteria has translated into reduced SUD-related admissions and readmissions.

Avoiding potentially preventable admissions and readmissions remains a NYS focal point; special consideration has been given to the potentially preventable admission and readmission rates of individuals with OUD. Statewide, the number of admissions for any opioid increased 27.6 percent between 2010 and 2016 before declining slightly in 2017, 2018 and 2019.<sup>10</sup> Areas of the state outside of NYC showed a 54.6 percent increase in the number of admissions for any opioid between 2010 and 2016, while there was a 1.7 percent decline among NYC residents admitted during this period.

During 2019, the counties with the highest crude rates of admissions to treatment for opioids were mostly rural counties. It is important to recognize that admissions rates are affected by the availability of treatment at the local level. Throughout this period, more than twice as many males as females were admitted for treatment for any opioid. However, between 2010 and 2016, there was a 40.4 percent increase in the number of females admitted for any opioid, while males increased by 22.8 percent. The 25-34 age group consistently had the highest crude rate of clients admitted for opioids between 2010 and 2019.<sup>11</sup>

### **Demonstration Amendment Vision**

The State of New York is systematically redesigning components of the behavioral health service delivery system to promote community engagement and sustainment, thereby reducing the average inpatient length of stay.

This demonstration project serves three main purposes:

- Allows the state to further redesign and grow the behavioral health community system while reducing IMD admissions and lengths of stay.
- Permits the state to maximize the ability of state psychiatric facility campuses, which are centrally located in communities with underserved populations, to serve as enhanced service delivery systems for community integration and recovery in the community.
- Permits the state to fund a complete continuum of SUD services including reintegration, as well as the enhancement of services that are currently covered only under non-Medicaid

sources including the expansion of telehealth access, the creation of mobile MAT units, and allowing all outpatient programs to do methadone treatment, among other initiatives

The primary goal will be transformation with a focus on:

- Reduction of inpatient and transitional residential lengths of stays.
- Community integration and maintenance with a focus on recovery.
- Overall reduced costs of care.

New York State continues its focus on reducing utilization in Emergency Departments for Medicaid beneficiaries who are awaiting behavioral health treatment in specialized settings.

**For the SMI population**, thoughtful combinations of appropriate pharmacology, active treatment and skills maintenance are cornerstones of the inpatient psychiatric service offerings within the State-operated IMDs.

Reimbursement for lengths of stay at State-operated IMDs within a 30-day statewide average will allow NYS to preserve needed psychiatric inpatient capacity and strengthen community linkages, which are essential components in delivering the best possible outcomes for New Yorkers. Those inpatients discharged within fewer than 60 days will be part of the waiver cohort, if the average length of stay for this cohort is less than 30 days. The intention is to increase the proportion of patients who are effectively discharged from these facilities within 60 days.

Admitting, stabilizing, and preparing patients for discharge efficiently are all contributors to improved patient flow and contribute toward reserved capacity for essential admissions.

Authorizing coverage for a targeted set of in-reach Medicaid services for individuals 30 days prior to discharge from State operated IMDs, including care management and discharge planning, clinical services to facilitate warm handoffs to aftercare providers, including but not limited to peer services, medication management plan development, delivery of certain high priority medications, and sexual and reproductive health information and connectivity will ensure active engagement in services upon release, increase rates of successful community reintegration for this especially vulnerable population, reduce lengths of stay and avoidable readmissions, advance NYS' health care equity goals and realize the vision of this waiver amendment.

Efforts toward reducing preventable readmissions to hospital and residential settings will be enhanced by increasing the availability of telehealth, telephonic and mobile crisis services as well as intensive outpatient services and services provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals, and residential treatment settings throughout the state. Through the improvement of care coordination post-discharge following acute care in hospitals and residential treatment facilities, homelessness and justice involvement can also be reduced.

**For the SUD population**, New York is requesting this demonstration to enable Federal Financial Participation (FFP) under Medicaid for SUD residential treatment and other health care services provided in accordance with state regulations consistent with evidence-based LOCADTR criteria for individuals discharged within 30 days on average. The demonstration builds upon the state's successful implementation of Health Homes and effective utilization of residential addiction services for managed care enrollees in the current 1115 demonstration

waiver and leverages this strong foundation to ensure New York's Medicaid beneficiaries have access to the entire continuum of SUD services as defined by LOCADTR LOCs.

## II. Changes Requested to the Demonstration

### Covered Services for Individuals with SMI

The following are services that the State has established to reduce the length of stay in inpatient stays.

The enhanced service delivery model will be based upon community re-integration with an initial focus on assessment of how PCs are facilitating the discharge of long stay patients (patients who have been inpatient more than one year) and what supports can be put in place to foster stability in the community. Leveraging the existing structure implemented in 2017, the current enhanced programming will support more timely discharges through the Value Stream Mapping and monthly review of case level challenges that are barriers to discharge. Offerings developed and led by consumers of mental health services will be made available whenever possible.

The services to be provided through this demonstration project include:

- Crisis intervention services, which are intended to reduce acute symptoms and restore individuals to pre-crisis levels of functioning. Examples of where these services may be provided include emergency rooms and residential settings. Provision of services may also be provided by a mobile treatment team, generally at a consumer's residence or other natural setting (not at an inpatient or outpatient treatment setting). Examples of services are screening, assessment, stabilization, triage, and/or referral to appropriate program or programs. Consumer- and peer-operated offerings which may be available to waiver participants include:
  - Living Room model
  - Peer-run Drop-in center
  - Warmlines as a 24/7/365 referral source to peer support
- Transition to Community Residential Programs will offer a "step down" for individuals moving toward independence. The Transition to Community Residential Program (TCR) serves adults with serious mental illness stepping down from long term inpatient hospitalization to community living. Providing in-reach to the TCR, Residential Transition Support Teams (RTS) focus on improving residents' life skills; maximizing positive connections to community resources; reducing reliance upon emergency services and hospitals through diversion, intervention, medication education and improved symptom management. These new residential and rehabilitative services are intended to be transitional, to break the cycle of institutionalization and prepare the residents to transition to more independent housing with fewer supports. Consumer-operated offerings which may be offered to waiver participants include:
  - Intensive and Sustained Engagement and Treatment (INSET)
  - Peer Bridger program
  - Compeer, which works as a complement to psychiatric therapy for people in recovery from mental illnesses and emotional challenges, leverages volunteers who commit to weekly meetings with those in recovery.
- Recovery centers are composed of peer supported activities that are designed to help individuals with a psychiatric diagnosis live, work, and fully participate in communities.

These activities are based on the principle that people who share a common condition or experience can be of substantial assistance to each other. Specific program activities build on existing best practices in self-help/peer support/mutual support and assist individuals in identifying, remembering, or discovering their own passions in life. Activities also serve as a clearinghouse of community participation opportunities; and support individuals in linking to those community groups, organizations, networks or places that will nurture and feed an individual's passions in life. Social recreation events with a focus on community participation opportunities will be the basis for exposing individuals to potential passion areas through dynamic experiences, not lectures or presentations. Examples of peer-developed and peer-run offerings include:

- Self-Directed Care Funding and Administration
  - Clubhouse
  - Benefits & Work Incentive Options Navigation
  - Supported Education
  - Self Help offerings (AA, NA, Hearing Voices Network, Depression & Bipolar Support Alliance)
- Mobile Integration Teams (MIT) provide an array of services delivered by multidisciplinary professionals and paraprofessionals to successfully maintain each person in his or her home or community. The intent of this state-operated program is to address the social, emotional, behavioral, and mental health needs of the recipients and their families to prevent an individual from needing psychiatric hospitalization. Examples of services include, but are not limited to, health teaching, assessment, skill building, psychiatric rehabilitation and recovery support, in-home respite, peer support, parent support and skills groups, crisis services, linkage and referral, and outreach and engagement. The services provided by this team can be provided in any setting, including an individual's residence, school, or inpatient or outpatient treatment setting. Mobile Integration Teams can also include a Peer Community Inclusion component for individuals which choose it.
  - Pathway Home™ is operated by a community-based organization. Teams are multi-disciplinary, and staffed by masters-level clinicians, case managers, registered nurses, and peers. Teams follow the evidence-based practice of the critical time intervention model of care, engaging clients intensively during the first 30 days after discharge from an inpatient setting. Teams work with clients until they have settled back into the community and are linked with the services they need. While every situation is unique, successful community integration with this wrap-around service in place takes about six to nine months, on average.

Current Enhanced Programming supporting more timely discharges are based on:

- Community Re-integration: Initial focus on assessment of how Psychiatric Centers are managing to discharge long stay patients and what supports can be put in place to facilitate discharge and foster stability in the community include:
  - Monthly long stay calls to identify case level challenges to discharge
  - MIT-Mobile Integration Teams developed to support the transition of people from the PC to the community
  - Obtaining Entitlements: Solution focused ways to address obtaining entitlements-PC LEAN/Kaizen events related to obtaining documents and entitlements

- Medicaid Activation/Suspended status for activation of local district Medicaid at discharge
- LOS Tracker initiated
- **Sustained Engagement Support:** Includes these components designed to increase engagement among individuals who are involved in State-Operated outpatient services:
  - Outreach Specialists located in Albany, NY and the greater New York City metro area.
  - Monitoring all adults who have been unsuccessfully discharge from State-operated Outpatient Clinic or ACT team
  - Telephonic outreach and engagement services to facilitate a return to State-Operated services or linkage to a community provider
  - Serves adults who were discharged due to loss of contact, declination of services, and incarceration.
- **Identified Populations:** Through the direct work with the PCs, populations were identified, and programs were developed to work directly with the identified populations to facilitate discharge to the best available settings. Examples include:
  - Forensic Civil Re-integration Unit to look at Forensic related discharges from the civil PC
  - Refractory and Special Needs: Psychiatry and Psychology Consults to target case specific psychiatric interventions
  - Medical Needs:
    - a. Skilled Nursing Facility: Community Mental Health Nursing as liaison to skilled nursing facility to facilitated SNF placement from the PC
    - b. Community Homecare Service Access: LTC Demonstration Pilot
- **Addressing Legal Needs:** Collaboration with OMH Counsel's Office to establish a process for reviewing advanced directives and bringing legal actions to obtain court-appointed guardians for identified patients who need fiduciaries and/or surrogate decision makers in place to enable successful discharges from the State PCs. This collaboration is based on person-centered, realistic assessments of the person's ability and preparation for independent living in the community.
- **Housing Related:** Housing Coordination among PC staff, housing providers, community housing service providers, OMH Field Office and OMH Central Office staff allows for facilitation of placement in available new housing and to fill openings with housing service providers. Residential Best Practices initiative began and continues to date to build best practice methods into residential services by using available resources.

## **Comprehensive Description of Strategies for Addressing SUD Goals and Milestones**

The State's initial approach to key system reform milestones will be addressed in the comprehensive Implementation Plan submitted concurrently with this demonstration request. The Implementation Plan addresses system reforms required in the CMS State Medicaid Director Letter (SMDL) # 17-003, dated November 1, 2017, and outlines a path toward an IMD exception using the 1115 demonstration authority. A brief summary of the State's current environment and planned interventions for each milestone is listed below.

### **Milestone 1: Access to Critical LOCs for people with SUDs**

New York's current SUD Medicaid treatment system includes coverage of the following:

- Screening, Brief Intervention and Referral to Treatment (SBIRT) Services
- Outpatient;
- Intensive Outpatient;
- Outpatient Rehabilitation
- Medication Assisted Treatment including Methadone Maintenance (medications, as well as counseling and other services, with sufficient provider capacity to meet the needs of Medicaid beneficiaries in the State);
- Ambulatory withdrawal management;
- Intensive LOCs in residential settings and withdrawal management;
- Intensive LOCs in inpatient hospital settings;
- Medically-managed and medically supervised withdrawal management;
- Residential Rehabilitative Services for Youth (RRSY); and
- Health Home for children and Adults with Serious Mental Illness, Serious Emotional Disturbance, or another chronic conditions and Co-Occurring SUD.

New York Medicaid currently covers adult SUD residential services under approved State Plan Amendment #16-004. However, the State has not yet implemented reintegration services under that State Plan. New York will begin reimbursing for reintegration services delivered by providers whose qualifications are consistent with LOCADTR, state regulations, and the already approved State Plan Amendment. A reimbursement SPA 21-0064 was submitted and approved to update reimbursement methodologies.

## **Milestone 2: Use of LOCADTR Placement Criteria**

Currently, New York requires all mainstream Medicaid managed care plans and HARPs to review SUD admissions and placements using utilization management standards under the LOCADTR criteria. This practice is consistent with the FFS Medicaid, block grant and State-funded SUD delivery systems. The State also requires Medicaid managed care plans and HARPs to utilize LOCADTR principles for utilization review. The comprehensive on-line authorization and utilization review documentation for LOCADTR can be found at <https://oasas.ny.gov/locadtr>.

LOCADTR requires that providers assess treatment needs based on SUD-specific, multi-dimensional assessment tools that reflect evidence-based clinical treatment guidelines. LOCADTR is designed for substance use treatment providers and referral sources working with individuals who experience substance use disorders. The LOCADTR guides decision making regarding the appropriate level of care for a client. The LOCADTR is meant to ensure that all individuals in need of treatment for a substance use disorder have access to care and are placed in the setting closest to the client's community that provides a safe and effective setting for treatment. In addition to helping providers and clients, the data collected through the LOCADTR will be analyzed to assess provider and system level performance, inform needs assessments, and inform the relationship between Level of Care determinations and client outcomes. All personal health information collected will be protected and never re-disclosed.

LOCADTR level of care is determined by a variety of factors, including:

- Assessment of the clients' need for crisis or detoxification services (for instance, determining possible medical complications from withdrawal);



- Risk factors (such as the presence of severe medical and psychiatric conditions); and,
- Resources available to the client (for example, a social or family network who are supportive of recovery goals)

New York's SUD treatment services are consistent with LOCADTR standards and while not perfectly aligned, New York's system also reflects the full continuum of services contemplated in the American Society of Addiction Medicine Criteria. The managed care organizations and OASAS staff certify that providers are providing interventions consistent with the LOCADTR as outlined in code and policy guidance. All SUD treatment services provided comply with the current regulations and LOCADTR criteria for all prior authorization and utilization review decisions resulting in continuity across the Medicaid delivery systems.

New York has trained, reviewed, and certified that all providers utilize multi-dimensional assessments as outlined in LOCADTR to create individualized treatment plans. DOH, or its designee, ensure appropriate UM is in place for SUD services for all LOCs, including prior authorization for SUD residential treatment services for individuals seeking admission. DOH and OASAS ensure Medicaid members have access to interventions at the SUD LOC appropriate for each person's diagnosis and individual circumstances. LOCADTR is used by treatment providers in FFS with utilization review performed by the State. OASAS staff review both managed care and fee-for-service medical records on a regular basis and verify that the LOCADTR was performed, and that the performance review team agrees with the admission. The requirements to use the LOCADTR are in regulation regardless of payer.<sup>12</sup> DOH has current provider agreements requiring the use of LOCADTR placement criteria for providers of SUD treatment services.

### **Milestone 3: Use of LOCADTR Program Standards for Residential Provider Qualifications**

In the future, incomplete OASAS regulations and Medicaid policy manuals will be modified to reflect all LOCADTR criteria for residential programs, including requirements for the particular types of services and hours of clinical care and credentials of staff. The policies already include a requirement that residential treatment providers offer MAT onsite or facilitate access offsite with a MAT provider not associated with the residential treatment owner.<sup>13</sup> New York will also continue to implement the process for initial certification and ongoing monitoring of residential treatment providers to ensure compliance with the State regulation requirements which are consistent with LOCADTR placement standards.

### **Milestone 4: Provider Capacity of SUD Treatment including MAT**

To ensure there is necessary information regarding access to all providers, including outpatient providers, OASAS maintains a website that is updated regularly. This report can be found at the following link <https://webapps.oasas.ny.gov/providerDirectory/>. The State also maintains a toll-free number called the HOPEline at 1-877-8-HOPENY where operators provide referrals to assessment services in a caller's area.

The State maintains a treatment availability dashboard for outpatient and bedded programs as well that can be accessed at: <https://findaddictiontreatment.ny.gov/> This dashboard allows the State to monitor capacity of all SUD treatment providers including those offering MAT. It also allows New York residents to search for an open slot in a treatment program in their area. The treatment availability dashboard displays treatment programs with real-time availability for particular areas.

New York currently contracts for 98,835 adult SUD residential treatment beds/slots across 214 providers. Of these, 5,712 of these certified SUD residential, withdrawal management and inpatient SUD treatment beds are in facilities with more than 17 beds and meet the definition of an IMD. See the table below for the number of IMD beds and providers providing each non-Medicaid residential level of care in New York.

LOCATDR Service Description	NYCRR Title 14	# of providers	# of Facilities	# of beds / slots	Count Served Cohort CY2019	Avg Length of Stay (days) for CY2019 Cohort	Vacancies as of 11/30/21 (Beds)	ASAM Level
Medically Supervised Inpatient Detoxification	816	20	22	646	29,919	4.1	292	3.7-WM
Inpatient Treatment	818	28	31	1,589	30,938	15.7	159	3.7
Residential Services - Stabilization / Rehabilitation (w/out Reintegration)	820	15	29	1,092	6,436	50.3	263	3.5 / 3.3
Residential Services - Stabilization / Rehabilitation (with Reintegration)	820	16	33	1,813	4,870	110.9	343	3.5/3.3/3.1
Residential Services - Reintegration Only	820	9	19	572	842	201.8	88	3.1
TOTAL / AVG			134	5,712		22.6		

In NYS, more than 78,600 patients were prescribed at least one buprenorphine prescription for outpatient treatment of OUD in 2019. The crude rate of buprenorphine prescribing for OUD increased by 28.5 percent from 314.8 per 100,000 population in 2016 to 404.5 per 100,000 in 2019. The rate was more than two times higher in NYS excluding NYC than that for NYC during 2016-2019.

The NYSDOH Buprenorphine Access Initiative began in July 2016 with the goal of increasing the number of healthcare practitioners certified to prescribe buprenorphine and thus, increase

the number of patients receiving buprenorphine. In 2019 DOH AIDS Institute implemented a statewide AIDS Institute Provider Directory which includes a directory of buprenorphine prescribers. This website allows individuals to search for prescribers in their area by zip code and distance they are willing to travel. Coupled with clarifications done by DOH AIDS Institute and NYS education department a significant increase in waived buprenorphine providers in NYS has occurred. Based upon the DEA record of waived buprenorphine providers in NYS, there has been an increase of 1,182 providers in 2018, with a total of 5,174 at the end of 2018 (Table 1b).

**Table 1b. Number of Buprenorphine-Waived Providers in NYS, by Type of Waiver**

	2017	2018	2019
MD/DO- 30 patients	2,716	3,302	4,190
MD/DO- 100 patients	672	742	762
MD/DO- 275 patients	236	280	318
NP- 30 patients	287	567	928
NP- 100 patients	N/A*	69	143
NP- 275 patients	N/A*	N/A*	18
PA- 30 patients	81	185	282
PA- 100 patients	N/A*	29	62
PA- 275 patients	N/A*	N/A*	8
Total providers	3,992	5,174	6,711

\* Note: NP/PAs could not prescribe in NYS until May 2017

In NYS, the crude rate of patients who received at least one buprenorphine prescription for OUD increased between 2016 (314.8 per 100,000 population) and 2019 (404.5 per 100,000), representing a 29 percent increase (Figure 50). It is encouraging that more qualified practitioners have completed the required training and have received their SAMHSA DATA 2000 Waiver and DEA X-designation so that they have the capacity to prescribe buprenorphine for the treatment of OUD. These qualified practitioners include physicians, Nurse Practitioners (NPs), Physician Assistants (PAs), Clinical Nurse Specialists (CNSs), Licensed Midwives (LMs) and are in various settings increasing access to this life-saving medication.

## **Milestone 5: Implementation of Opioid Use Disorder (OUD) Comprehensive Treatment and Prevention Strategies – Opioid Prescribing Guidelines and Other Interventions to Prevent Opioid Misuse**

### ***Opioid Prescribing Guidelines***

Opioid prescribing guidelines are seen as a critical tool for practitioners to aid in prescription and treatment planning, especially for those clinicians who are prescribing opioids outside the area of active cancer treatment, palliative care, and end-of-life care. In general, opioid prescribing guidelines are intended to inform clinical practice, improve communication between clinicians and patients related to opioid therapy risks and benefits, improve the safety and effectiveness of pain treatment, reduce the risks associated with long-term opioid therapy, and assist in addressing opioid use disorder (OUD), overdose, and death.<sup>14</sup> It is important to note that the Centers for Disease Control and Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain, is not mandated by law and is intended as one of many tools to inform clinical judgment, but not supersede treatment planning and decision-making. This is a major difference between guidance and interventions to prevent or reduce opioid misuse that are mandated by public health law or state regulation. Though some states issue their own guidelines for prescribing opioids, the Bureau of Narcotic Enforcement (BNE) within the New York State Department of

Health (NYSDOH) refers to federal guidance such as the CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016 as reference for practitioners related to opioid prescribing.

### ***Other Federal Guidelines***

The Department of Health and Human Services (DHHS) Centers for Medicare and Medicaid Services (CMS) issued guidance to the states in 2019 related to implementation of the Medicaid Drug Utilization Review (DUR) provisions that were included in Section 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act, also referred to as the SUPPORT Act. This is an example of guidance that is intended to guide states on the implementation of a Federally mandated program. The provisions in the SUPPORT Act include measures to combat the opioid crisis in part by supporting strategies for reducing opioid use disorder and misuse through treatment and recovery initiatives, improving prevention strategies including community level interventions, and expanding efforts to address illicit synthetic drugs.<sup>15</sup>

### ***Other Interventions to Prevent Opioid Misuse (Mandated Programs)***

In August 2012, NYSDOH enacted the Internet System for Tracking Over-Prescribing (I-STOP) Act, to improve the effectiveness of the New York State Prescription Monitoring Program (NYS PMP). In 2012, under Title 10, Part 80 Rules and Regulations on Controlled Substances; Section 80.63 – Prescribing, New York State required most prescribers to consult the NYS PMP Registry when writing prescriptions for Schedule II, III, and IV controlled substances. Additionally, sections 80.71, 80.73, and 80.74 require that data for all Schedule II, III, IV, and V controlled substance prescriptions dispensed by State-licensed pharmacies and dispensing practitioners be submitted to New York State within 24 hours.<sup>16</sup> In July 2016, under NYS Public Health Laws Chapter 45, Article 33, Title 4; Section 3331 Scheduled Substances Administering and Dispensing by Practitioners, NYS limited the initial prescribing of opioids for acute pain to no more than a seven-day supply of any schedule II, III, or IV opioid, within the scope of a practitioner’s professional opinion or discretion.<sup>17</sup>

Efforts such as the implementation of the Prescription Monitoring Program, NYS’ mandated duty to consult the PMP, and other NYS Public Health Laws and Regulations such as the limitation of initial opioid prescribing to a seven-day supply contributed to positive health outcomes. Data (listed below) from the NYSDOH Opioid Annual Report, gathered in subsequent years following the release of the CDC Guideline and NYS mandates demonstrated notable changes in how opioids were prescribed and patient patterns of use.<sup>18</sup>

- Opioid prescriptions for more than a 7-day supply decreased steadily, from 28.7 percent in the first quarter of 2017 to 15.3 percent in the fourth quarter of 2019.
- A substantial reduction occurred in the crude rate of patients who received opioid prescriptions from five or more prescribers at five or more pharmacies in a six-month period (“doctor shoppers”) between 2016 (2.9 per 100,000 population) and 2019 (1.2 per 100,000).
- Opioid analgesics prescribed in higher dosages (> 90 morphine milligram equivalents (MME)) are associated with higher risks of overdose and death. In NYS, the percentage of patients receiving one or more opioid analgesic prescriptions with a total daily dose of

90 or greater MME for at least one day, declined between 2016 (13.5 percent) and 2019 (11.0 percent).

- The number of incidents in which patients were both opioid-naïve and received long-acting opioid prescriptions declined between 2017 (22,622) and 2019 (14,967) in NYS.

The CDC Guideline for Prescribing Opioids for Chronic Pain, however, also had a dramatic impact. Many practitioners, not just in NYS but nationally, perceived the 2016 CDC guidance as a “mandate” causing them to radically alter their prescribing practices, such as changes in dosage, abrupt tapering or sudden discontinuation of opioids. By 2018, the CDC issued a statement on the misapplication of its guidance titled, “CDC Advises Against Misapplication of the Guideline for Prescribing Opioids for Chronic Pain” to address some of the confusion and radical changes in prescribing that occurred.<sup>19</sup> The CDC is updating its guideline and the CDC Clinical Practice Guideline for Prescribing Opioids—United States, 2022 is currently under public review.<sup>20</sup>

### ***Other Interventions (Prescriber Education)***

Under Public Health Law (PHL) §3309-A (3), prescribers licensed under Title Eight of the Education Law in New York to treat who have a DEA registration number to prescribe controlled substances, as well as medical residents who prescribe controlled substances under a facility DEA registration number, must complete at least three hours of course-work in pain management, palliative care, and addiction. Education must cover the following topics: New York State and federal requirements for prescribing controlled substances; pain management; appropriate prescribing; managing acute pain; palliative medicine; prevention, screening and signs of addiction; responses to abuse and addiction; and end of life care. The Bureau of Narcotics Enforcement (BNE), within the NYSDOH, and in partnership with the SUNY University at Buffalo offers an accredited training to meet the Mandatory Prescriber Education training needs.<sup>21</sup>

### ***Increasing Utilization and Improving Functionality of PDMPs***

The NYSDOH maintains a strong commitment to utilizing the New York State Prescription Monitoring Program (NYS PMP) as a critical tool in addressing the opioid drug overdose crisis and substance use disorder (SUD). Since 2013, New York State has required most prescribers to consult the NYS PMP Registry when writing prescriptions for Schedule II, III, and IV controlled substances. The NYS PMP collects and maintains data on all Schedule II, III, IV, and V controlled substance prescriptions dispensed by State-licensed pharmacies and dispensing practitioners. NYSDOH understands sharing prescription data across state lines improves the comprehensiveness of NYS PMP reports, which expands visibility for practitioners to make better-informed decisions about prescribing based on a fuller picture of the patient’s controlled-substance history and patterns of use. NYSDOH has engaged in interstate data sharing through the PMP Interconnect (PMPI) hub since 2015 and the Rxcheck hub since 2021.

The BNE, within the NYSDOH uses federal funding through the CDC Overdose Data to Action (OD2A) grant to expand interstate interoperability capabilities through integration with the RxCheck hub. BNE is also using this funding to support a pilot program to integrate NYS PMP data into healthcare systems electronic health records (EHRs). Additionally, the OD2A funding supports expansion of NYS PMP Registry’s functionality by building enhancements to the user interface of the patient search landing page. This project is currently ongoing (as of May 2022); however, as part of this effort, NYSDOH added a Morphine Milligram Equivalent (MME)

calculator in 2021 to the NYS PMP. Calculating the MME allows for a standard for comparing different opioids. The MME/day metric is often used as a gauge for overdose potential of the amount of opioid that is being given to an individual. Calculating the Total Daily MMEs of opioids helps practitioners to identify patients who may benefit from closer monitoring, reduction or tapering of opioids, prescribing of naloxone, or other measures to reduce risk of overdose. The MME calculator offered by NYSDOH can be used for estimating MMEs for a patient taking one or more opioid medications. It is intended as a reference tool to aid practitioners in treatment decision-making but should not supersede clinical judgment.

Improving the functionality of the NYS PMP Registry aids in identification of high risk prescribing and patient behaviors, provides practitioners with visual indicators that can assist them in their prescribing practices at the point of care, and ultimately decreases the rate of opioid misuse and OUD. Several New York State agencies make use of the NYS PMP (both its PMP Registry services and data collection) to assist in achieving programmatic goals. As the NYSDOH Prescription Drug Monitoring program continues to evolve to include a PMP-EHR integration program, State agencies and statewide hospital / healthcare systems receiving funding from the DHHS CMS (described in SMDL-16-003) may find expanded programmatic opportunities within the PMP Registry resources.

### ***New York's Expanded Coverage of, and Access to, Naloxone for Overdose Reversal***

New York State has expanded efforts related to addressing opioid overdose through Article 33, Title 1 Section 3309.<sup>[22]</sup> These efforts include a number of steps to make naloxone more widely available. NYS is a leader in the implementation of public health programming to prevent death from opioid overdoses.

Its multi-pronged approach focuses on building overdose response capacity within communities throughout the State. The core of this program is for community laypersons to be trained by organizations registered with the NYSDOH to administer naloxone (an opioid antagonist also known by the brand name Narcan) in the event of a suspected opioid overdose.

- There are currently more than 800 registered Community Opioid Overdose Prevention (COOP) programs, with over half a million individuals trained by them since the initiative's inception in 2006. Of these, 78,000 were public safety personnel and the rest were community responders.
- In 2019, there were 1,558 naloxone administration reports by law enforcement (LE) to the NYSDOH and 2,749 reports by COOP programs.
- In total, including unique administrations by Emergency Medical Services (EMS) agencies, there were 16,710 reported naloxone administrations in NYS in 2019. There were 12,403 unique naloxone administrations reported electronically by EMS agencies during 2019, about a 10 percent decrease statewide from 13,724 administrations in 2018, with a seven percent decrease in NYC and a 13 percent decrease in NYS excluding NYC.

### **Milestone 6: Improved Care Coordination and Transitions between LOCs**

New York has multiple interventions for coordinating the care of individuals with SUD and transitioning between LOCs including, but not limited to, facility credentialing, discharge, referral and transition requirements, and care management initiatives at DOH and OASAS.

Under the demonstration, New York will utilize the health home model and strengthen the transition management component for SUD populations between LOCs.

In addition, under the demonstration, in order to ensure improved care coordination and transitions between LOCs, New York will also monitor access and healthcare outcome measures by demographic information, including race and ethnicity. New York State will evaluate the use of peers and other care connection mechanisms to ensure improved care coordination and overall health outcomes for individuals in care.

### **III. Demonstration Goals and Objectives**

#### **SMI Demonstration Goals and Objectives**

Building upon the success of significant reforms to improve access to specialized care and enhance opportunities for individuals living with serious mental illness in NYS, this demonstration will allow OMH to continue its commitment to system transformation through a redesign of state psychiatric hospitals with the primary goals of reducing utilization and average length of stay and improving health outcomes through reinvestment in community-based transitional, ambulatory and crisis services.

New York intends to specifically establish the following goals for evaluation, and in support of SMD #18-011:

- Goal 1: Improve access to specialized inpatient mental health services, reduce utilization and lengths of stay in Emergency Departments among IMD Waiver eligible adults
- Goal 2: Reduce preventable readmissions to acute care hospitals among IMD Waiver eligible adults
- Goal 3: Increase availability of crisis stabilization services
- Goal 4: Improve access to community-based health and behavioral health care services
- Goal 5: Improve care coordination, quality of care and recovery in the community following episodes of acute psychiatric inpatient care
- Goal 6: Assess the impact of the demonstration project on the costs of IMD Inpatient stays and mental health services (including inpatient, emergency, and ambulatory care)

Select inpatient campuses will be transitioned to offer enhanced services. These services settings will include transitional housing, employment and education supports, as well as an integrative model of mental health and substance-use disorder services and primary care.

NYS will maintain its focus on shortening the time to community transition for inpatients (i.e., reduce length of stay) by improving member stability during initial stay and providing more intensive follow up in the community.

Individuals will have timely access to inpatient treatment to reduce longer and more costly admissions to institutional settings. Through the targeted increase in flow across select inpatient psychiatric facilities to transitional services, individuals will have access to a “step-down” continuum of care that will provide necessary supports aimed at reducing readmission rates.

Funding realized through this waiver will allow for re-investment in community-based services and decrease demands on Article 28 facilities in under-served geographic areas.

The aforementioned goals support the specific goals outlined by CMS in the SMI/SED guidance (SMD #18-011).

## **SUD Demonstration Goals and Objectives**

The objective of this demonstration is to provide critical access to a full array of SUD treatment services for New York Medicaid enrollees and improve the delivery system for these services to provide more coordinated and comprehensive SUD treatment for these individuals.

This demonstration seeks to improve outcomes for Medicaid members diagnosed with SUD by providing critical access to SUD treatment services, including inpatient and residential SUD treatment in IMDs, as part of a full continuum of treatment services that follow LOCADTR LOCs. Under this demonstration, New York will continue to implement a comprehensive, integrated SUD benefit that includes residential treatment settings. However, existing IMD limitations create barriers to ensuring members are able to access SUD treatment at a LOC appropriate to their needs using the LOCADTR criteria. New York seeks demonstration authority to remove Federal Medicaid restrictions on IMDs as SUD treatment settings in FFS and beyond 15 days in managed care delivery systems. The new Medicaid SUD treatment continuum will enhance critical access to the full LOCADTR SUD treatment continuum.

New York's SUD residential treatment provider network is primarily comprised of programs with more than 16 beds, for which Medicaid payment is prohibited by the federal IMD exclusion. There are only 12 SUD Medicaid-eligible residential treatment programs in New York with 16 treatment beds or fewer, which are therefore not subject to the IMD exclusion. That capacity is, of course, very limited (165 beds). The Medicaid eligibility expansion and the opioid crisis have concurrently increased the need for residential SUD treatment beds. Without IMD facilities, which have greater than 16 beds, there is insufficient capacity of SUD residential treatment services in the State to address the extent of the opioid epidemic in the State under Medicaid. This is particularly true since the State expanded Medicaid eligibility (full expansion effective January 2014). Therefore, enhancing Medicaid funding at this juncture – by enabling payment of all SUD residential treatment services in IMDs consistent with LOCADTR through this waiver and making the other changes to improve the quality of the SUD treatment system described herein – is critical to helping address the surge of SUD treatment needs for Medicaid enrollees associated with the opioid crisis.

As detailed above, the demonstration will remove Medicaid payment barriers for SUD residential treatment. By ensuring critical access to residential treatment capacity, New York will be able to provide an effective SUD treatment continuum of care with interventions capable of meeting individuals' changing needs for various LOCs.

## **IV. Eligibility, Benefits, Cost Sharing and Delivery System**

### **Eligibility**

Medicaid eligibility requirements will not differ from the approved Medicaid State Plan

### **Cost-Sharing**

Cost sharing requirements under the demonstration will not differ from the approved Medicaid State Plan.



## **Delivery Systems**

This demonstration will not change the current delivery system structure. All Medicaid services will continue to be delivered through either managed care or the FFS delivery system. However, as described elsewhere in this demonstration waiver application, through this demonstration, the State will make various improvements to the SUD, SED, and SMI benefit service system statewide, including adding a residential LOCADTR LOC, care management initiatives that are available and improving coordination of care, and improving transitions of care. Overall, while continuing to use a FFS and managed care delivery system structure, the demonstration will streamline, clarify, and improve the content of each LOC and improve transitions in the care management system.

## **SMI Benefits**

There are two components to this proposal. First, NYS will consider Medicaid-enrolled individuals for the IMD Waiver cohort based on their clinical presentation and their assessed capability to stabilize and prepare for community tenure within 3-4 weeks of admission to an IMD. NYS will retrospectively identify waiver eligible IMD patients for whom NYS will claim federal financial participation for services provided, based on an average LOS for the cohort of 30 days.

It is expected that approximately 450 individuals between the ages of 21 and 64 will meet the criteria for waiver participation annually. The number and proportion of IMD patients who meet the demonstration criteria in Year 2 and after may increase, depending on work achieved and lessons learned during the demonstration.

There will be clear and consistent exclusions from the IMD Waiver cohort. Excluded populations will include individuals residing in State operated forensic psychiatric centers or sex offender treatment programs, and individuals clinically designated as “long stay” (one year or longer).

To mitigate eligibility coverage gaps, promote more timely discharge planning, and ensure payment under the waiver, Medicaid coverage and suspension codes specific to waiver-eligible patients who have received inpatient psychiatric care in State PCs will be updated. Systems changes include: 1) enhancement of existing NYS Medicaid coverage codes to allow claiming with federal financial participation for inpatient psychiatric and other, non-duplicative services for adults between 21-64 years old deemed waiver eligible who are residing in a State PC IMD; and 2) the creation of a new Medicaid billable Rate Code specific to the IMD 21-64 years-old State PC population.

Additionally, NYS will provide targeted in-reach Medicaid services 30 days prior to discharge for Medicaid enrolled individuals residing in State operated IMDs in a defined in-reach waiver population. The In-reach waiver population shall be eligible to receive all targeted in-reach services 30 days prior to discharge, including care management and discharge planning, clinical services to facilitate warm handoffs to aftercare providers, including but not limited to peer services, medication management plan development, delivery of certain high priority medications, and sexual and reproductive health information and connectivity.

The in-reach Waiver population shall not include individuals for whom the state claims federal financial participation for inpatient psychiatric services under this demonstration (the IMD Waiver population). To avoid duplication of payment, for individuals for whom the state claims

federal financial participation for inpatient psychiatric services under this demonstration (the IMD Waiver population), NYS will only permit billing for in-reach care management services 30 days prior to discharge.

### **SUD Benefits**

New York submitted, and CMS approved, Medicaid reimbursement SPA 21-0064 for SUD reintegration treatment services consistent with LOCADTR standards. With this SPA, the State will have a full array of services using the current LOCADTR criteria effective November 1, 2021. The demonstration is expected to be implemented on or after October 1, 2022, or with CMS approval, whichever is later.

The demonstration will permit Medicaid recipients in New York with SUD to receive high-quality, clinically appropriate Medicaid State Plan-approved SUD treatment services in outpatient and community-based settings, as well as in residential and inpatient treatment settings that qualify as an IMD.

### **SMI Enrollment**

The NYS Office of Mental Health will identify Medicaid-enrolled members for waiver demonstration eligibility based on suitability and location and prepare them for community integration step down.

This work will be done by highly skilled clinicians who are extremely familiar with the entire community and its continuum of care/services/resources. While certain communities and State PC campuses will be selected for re-design, the selection of waiver participants will not be limited to targeted communities.

Cohorts of potential enrollment into the IMD Waiver include referrals from community (Article 28) hospitals and direct admissions to NYS-operated IMDs. More specifically, careful pre-admission screening for both direct admissions and transfers will prompt staff to consider individuals for enrollment into the IMD waiver cohorts. Also, stabilization, careful attention to psychopharmaceutical interventions and active treatment upon admission to State PCs will all foster readiness for discharge and community re-integration.

For the In-reach Waiver population, NYS will also remove the exclusion from Medicaid managed Care enrollment for individuals residing in state operated IMDs to streamline enrollment of this population into a Medicaid managed care plan upon discharge.

### **SUD Enrollment**

The Office of Addiction Services and Supports will identify Medicaid-enrolled members for waiver demonstration eligibility who have SUD and are receiving services in residential or inpatient treatment settings that qualify as an IMD, so long as the IMD ALOS is 30 days or less.

Strengthening the IMD LOC will enable OASAS to ensure that Medicaid enrollees also receive high-quality, clinically appropriate Medicaid State Plan-approved SUD treatment services in outpatient and community-based settings, and that discharge planning and transitional services are strengthened to support the full continuum of care.

## **Maintenance of Effort Commitment**

New York is committed to maintenance of effort (MOE) on funding for outpatient community-based mental health services in its application. Under the terms of an SMI 1115 demonstration, the State would assure that resources would not be disproportionately drawn into increasing access to treatment in inpatient and residential settings at the expense of community-based services. New York understands the expectation under the demonstration that it must maintain a level of state appropriations and local funding for outpatient community-based mental health services for Medicaid beneficiaries for the duration of this demonstration that is no less than the amount of funding provided at the beginning of the demonstration.

## **Network Adequacy and Provider Readiness Analysis**

New York has conducted a thorough assessment of its current availability of mental health services throughout the state as of State Fiscal Year 2020 (from April 2019 through March 2020).

This assessment reflects current availability of mental health services, including the types and counts of providers offering mental health care, as structured in CMS's proposed table. In some cases, NYS's mental healthcare system and provider types did not include types outlined on CMS's proposed table (i.e., Community Mental Health Centers). In other cases, NYS's system included core provider types which were not included in the CMS template. Where that occurred, we have proposed additional columns and offered descriptions of these provider types.

## **Program Integrity**

Participating psychiatric hospitals and licensed clinic, residential, and rehabilitative services providers meet federal program integrity requirements.

New York State has a process for conducting risk-based screening of newly enrolled providers and revalidating existing providers. This process includes requiring all providers enrolled in Medicaid to execute provider agreements and other controls to safeguard against fraudulent billing as well as other compliance issues.

As part of its ongoing effort to comply with the NYS Governmental Accountability, Audit and Internal Control Act of 1987, as amended in Chapter 510 of the Laws of 1999, OMH requires facilities to submit an internal control risk assessment survey (i.e., the FICRA) each year to the Bureau of Audit (Audit).

The FICRA is used to evaluate controls over select fiscal and operational areas and is an integral part of the Commissioner's annual Internal Control Summary and Certification to the Division of the Budget. The fiscal and operational areas covered by the FICRA are cash; fleet vehicles practices/fuel cards; inventory control; patient accounts; patient property/unclaimed funds; payroll; pharmacy operations; procurement cards; purchasing/contracts; receiving; and, travel cards.

Each year, the OMH Bureau of Audit completes and compiles detailed assessments that are used to evaluate controls over select fiscal and operational areas and are an integral part of the

Commissioner's annual Internal Control Summary and Certification submitted to the NYS Division of the Budget. The fiscal and operational areas covered are cash; patient accounts; patient property/unclaimed funds; payroll; purchasing/contracts; receiving; procurement cards; travel cards; fleet vehicle practices/fuel cards; inventory control; and, pharmacy operations. Facility-completed assessments identify high risk areas and to plan for upcoming audits and reviews.

## **V. Requested Waivers and Expenditure Authorities**

New York seeks to maintain all current demonstration waivers and expenditure authorities. For this amendment, New York will request to add expenditure authority for payments to Institutions for Mental Disease (IMDs) for individuals aged 21 to 64, per Section 1905(a)(30)(B) of the Social Security Act and *State Medicaid Director Letter # 15-003, New Service Delivery Opportunities for Individuals with a Substance Use Disorder*, *State Medicaid Director Letter # 17-003, Strategies to Address the Opioid epidemic* and *State Medicaid Director Letter #18—011, Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance*.

New York's continued success in treating individuals with SMI is predicated on the availability of a comprehensive, flexible, and integrated range of community-based services to meet an individual's needs, including the needs of those with co-occurring SUD needs.

New York seeks recognition of its mental health hospital and substance use residential programs as essential services under the continuum of Global Commitment to Health Section 1115 Medicaid program benefits. This proposed SMI/SED/SUD 1115 amendment will allow the State to sustain its care continuum and move toward the full integration envisioned in the All-Payer Model Agreement and Global Commitment to Health Demonstrations.

The State seeks such waiver authority as necessary under the SMI and SUD demonstrations to receive federal match on costs not otherwise eligible for match for certain services rendered to individuals who are hospitalized in a State-operated Institute for Mental Disease (IMD) and in residential addiction programs.

### **Waiver Authority**

There are no waiver authorities expected to be needed for this amendment.

### **Expenditure Authority**

New York is requesting expenditure authority under Section 1115 to claim as medical assistance the following services that are not otherwise coverable under Medicaid:

- **Residential and Inpatient Treatment for Individuals with Substance Use Disorder (SUD), Serious Mental Illness (SMI), or Severe Emotional Disturbance (SED).** Expenditures for otherwise covered Medicaid services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for substance use disorder (SUD) or a serious mental illness (SMI) or severe emotional disturbance (SED) who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD).

## VI. Summaries of External Quality Review Organization (EQRO) Reports, Managed Care Organization (MCO) and State Quality Assurance Monitoring

New York State’s work to advance quality outcomes and promote recovery will be guided through formal Evaluation Plans. These plans will be robust and multi-modal. Specific quality indicators and measures of improvement will span the behavioral health, physical health and rehabilitation and recovery domains. Measures such as employment rates, criminal justice involvement and housing stability will guide the focus on community-based recovery.

We are encouraged by results from Medicaid Managed Care, which indicate that enrollment in Medicaid Managed Care Plans is associated with improved follow-up after mental health inpatient care. Mental health readmission rates may be falling in enrolled individuals, although it is likely still too soon to confirm.

Screening rates are better for Managed Care enrollees than for FFS beneficiaries, but significant quality gaps exist in all populations related to:

- o Treatment of depression
- o Treatment of diabetes
- o Smoking cessation

Work remains to be done by OMH and its Office of Population Health and Evaluation, as well as OASAS, to develop and test outcome measures related to functioning.

For this waiver, NYS will build on the infrastructure currently in place and quality improvement activities underway related the broad implementation of Medicaid Managed Care in NYS. The New York State Performance Measurement Center, the Institute for Program and Policy Innovation and the application of rigorous data analysis and insight development principles will support and surround this waiver initiative.

### SUD Monitoring Protocol

New York plans to submit a draft SUD monitoring protocol within 150 days of demonstration amendment approval. At a minimum, New York will report all required SUD metrics.

Metric Number	Description	CMS Recommended/ Required
1	Assessed for SUD Treatment Needs Using a Standardized Screening Tool	Recommended
2	Medicaid Beneficiaries with Newly Initiated SUD Treatment/Diagnosis	Recommended
3	Medicaid Beneficiaries SUD) Diagnosis (monthly)	Required
4	Medicaid Beneficiaries with SUD Diagnosis (annually)	Required
5	Medicaid Beneficiaries Treated in an IMD for SUD	Required
6	Any SUD Treatment	Required

Metric Number	Description	CMS Recommended/ Required
7	Early Intervention	Required
8	Outpatient Services	Required
9	Intensive Outpatient and Partial Hospitalization Services	Required
10	Residential and Inpatient Services	Required
11	Withdrawal Management	Required
12	Medication Assisted Treatment	Required
13	SUD Provider Availability	Required
14	SUD Provider Availability - MAT	Required
15	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD)	Required
16	SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge	Recommended
17(1)	Follow-up after Emergency Department Visit for Alcohol or Other Drug Dependence (FUA-AD)	Required
17(2)	Follow-up after Emergency Department Visit for Mental Illness (FUM-AD)	Required
21	Concurrent Use of Opioids and Benzodiazepines (COB-AD)	Required
22	Continuity of Pharmacotherapy for Opioid Use Disorder	Required
23	Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries	Required
24	Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries	Required
25	Readmissions Among Beneficiaries with SUD	Required
26	Overdose Deaths (count)	Required
27	Overdose Deaths (rate)	Required
28	SUD Spending	Recommended

Metric Number	Description	CMS Recommended/ Required
29	SUD Spending Within IMDs	Recommended
30	Per Capita SUD Spending	Recommended
31	Per Capita SUD Spending Within IMDs	Recommended
32	Access to Preventive/ Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD (AAP)	Required
33	Grievances Related to SUD Treatment Services	Recommended
34	Appeals Related to SUD Treatment Services	Recommended
35	Critical Incidents Related to SUD Treatment Services	Recommended
36	Average Length of Stay in IMDs	Required
Q1	State HIT Metric 1	Required
Q2	State HIT Metric 2	Required
Q3	State HIT Metric 3	Required

**SMI Monitoring Protocol**

New York plans to submit a draft SMI/SED monitoring protocol within 150 days of demonstration amendment approval. At a minimum, New York will report all required SMI/SED metrics.

**VII. Financial Data**

The waiver eligible cohort will include individuals from all State-operated adult, non-forensic facilities or residing in residential addiction treatment programs, discharged within 30 days on average. Principles, interventions, techniques, and tools, as described throughout, offer the potential to impact length of stay for adults age 21 and older.

New York State aspires to grow the waiver population during the waiver period. As inpatient assessment, stabilization, and treatment are optimized, NYS will be able to increase the total number of individuals discharged within 30 days or less.

**VIII. Budget Neutrality**

The total cost of this amendment is estimated to be \$268.37 million over five years. The total estimated increase in enrollment for this demonstration is estimated to be 6,146 in year five. The impact of each population is listed below.

## SMI Population

Estimated SMI population enrollment in the IMD program for inpatient services is approximately 450 in the first year increasing to approximately 1200 members in the first five years. However, it is not anticipated that this amendment will substantively increase the overall annual average demonstration enrollment of 4.8 million members. This population is anticipated to increase the annual average demonstration cost of \$40 billion by \$22.69 million. More detailed enrollment and cost estimates by demonstration year are included below.

The estimated SMI population for in-reach Medicaid services is approximately 1,600 individuals annually. This population is anticipated to increase the annual average demonstration cost by an additional \$800,000.

## SUD Population

Estimated SUD population enrollment in the IMD program is approximately 2,218 in the first year increasing to approximately 3,346 members in the first five years. It is not anticipated that this amendment will substantively increase the overall annual total demonstration enrollment of 4.8 million members. This population is anticipated to increase the annual average demonstration cost of \$40 billion by \$30.19 million for this amendment. More detailed enrollment and cost estimates by demonstration year are included below.

### 1115 Waiver Amendment Projected Enrollment

Proposal	DY24	DY25	DY26	DY27	DY28
Projected Enrollment	4,709,605	4,720,694	4,732,039	4,743,646	4,755,524
Total IMD Amendment Enrollment	4,268	4,673	5,228	5,734	6,146
SMI	2,050	2,100	2,350	2,600	2,800
SUD	2,218	2,573	2,878	3,134	3,346
Total Projected Enrollment:	4,713,873	4,725,367	4,737,267	4,749,380	4,761,670

### 1115 Waiver Amendment Estimated Funding Schedule (in \$Millions)

Proposal	DY1	DY2	DY3	DY4	DY5	Total
SMI Population	\$13.40	\$14.75	\$21.92	\$28.95	\$34.41	\$113.42
SUD Population	\$20.88	\$25.60	\$30.27	\$34.86	\$39.34	\$150.95
Total Estimated Cost:	\$35.08	\$41.15	\$52.99	\$64.61	\$74.55	\$268.37

## VIII. Evaluation

New York will conduct a multi-method, comprehensive statewide evaluation using an independent evaluator to document the impact of the IMD Waiver on health care service delivery, quality, health outcomes, and cost effectiveness. In addition, program components that posed particular successes or challenges for implementation and outcomes for this population will also be examined.

### SMI Hypotheses and Evaluation

NYS will evaluate this IMD Waiver amendment in alignment with all CMS requirements. An evaluation design will be developed to test the hypotheses identified below and will include the methodology, measures, and data sources to support the expected impact of the amendment.



Additionally, it is expected that the current evaluation plan will be folded into the current approved 1115 Waiver evaluation design.

The evaluation hypotheses focus on whether the interventions in this Waiver amendment will improve the access to specialized inpatient mental health services, reduce avoidable psychiatric inpatient readmission and overall inpatient and ED utilization in the IMD eligible population. Further, it is expected that improved community linkages post discharge, including care coordination and community based and integrated primary and behavioral health care will increase for the IMD eligible population. Additionally, quality of care is also expected to improve for individuals in the IMD population. Finally, it is expected that there will be an increase in crisis stabilization services, including mobile crisis and crisis stabilization center expansion. Included in the chart below are the evaluation goals, hypotheses, and examples of measures and data sources. The evaluation hypotheses, measures, and data sources are subject to change and may be further clarified based on input from CMS during the approval process.

**Proposed Approach:** The methodology is expected to depend on the proposed questions, hypotheses, target populations, and measures. For example, identifying the expansion of crisis stabilization centers in NYS may provide descriptive statistics over time pertaining to the number of new programs, while a full comparison of the community-based outcomes following an IMD inpatient episode may require the development of an appropriate comparison group and necessitate more advanced statistical models.

**GOAL 1: Improving Access to Health Care for the Medicaid population**

<b>Hypotheses</b>	<b>Example Measures (Not Final)</b>	<b>Data Sources</b>
Goal 1a: Improve access to specialized inpatient mental health services, reduce utilization and lengths of stay in EDs among IMD Waiver eligible adults		
Admissions for IMD Medicaid beneficiaries to State Psychiatric Inpatient IMD Units will <b>increase over time</b>	Monthly IMD admission numbers and proportions	MHARS (State Psychiatric EHR) Medicaid Claims
Lengths of stay for IMD eligible Medicaid beneficiaries admitted to IMD Psychiatric Hospitals will <b>decrease over time</b>	Average Length of Stay	MHARS (State Psychiatric EHR)
Psychiatric ED visits will <b>decrease</b> for individuals admitted to an IMD psychiatric hospital	Average psychiatric ED visits in year following IMD discharge	Medicaid Claims
Goal 1b: Increase availability of Crisis Stabilization Centers		
Utilization of crisis stabilization centers will increase as the number of crisis service providers increase	Utilization of crisis services over time Number of crisis programs	Medicaid Claims CONCERTS (OMH Licensing database)
Goal 1c: Improve access to community based and integrated primary and behavioral health care services		
Individuals discharged from an IMD psychiatric hospital will be <b>more likely to access specialty</b>	Proportion of individuals with specialty mental health services in the year following discharge	Medicaid Claims

<b>mental health services</b> (e.g. ACT, PROS) than IMD-eligible individuals discharged from a non-IMD psychiatric bed		
Individuals discharged from an IMD psychiatric hospital will be <b>more likely to access Home and Community Based Services (HCBS)</b> than IMD-eligible individuals discharged from a non-IMD psychiatric bed	Proportion of individuals with HCBS services in the year following discharge	Medicaid Claims
Access to the targeted in-reach and person-centered community-based services will be available to all vulnerable groups, including tribal communities, cultural (racial/ethnic), and socio-economic disadvantaged communities	Proportion of individuals with access to the recovery hub and other targeted services, stratified by vulnerable groups	MHARS (State Psychiatric EHR)

## GOAL 2: Improve Quality of Care

<b>Hypotheses</b>	<b>Example Measures (Not Final)</b>	<b>Data Sources</b>
Goal 2a: Improve Quality of care, and recovery in the community following episodes of acute psychiatric inpatient care		
Individuals discharged from an IMD psychiatric hospital will be <b>more likely to have higher rates of quality metrics for health monitoring and prevention</b> than IMD-eligible individuals discharged from a non-IMD psychiatric bed	State run HEDIS Measures, including multiple health and behavioral health measures	Medicaid Claims
Goal 2b: Reduce preventable readmissions to acute care hospitals among individuals discharged from IMD units		
Individuals discharged from an IMD psychiatric hospital <b>will be less likely</b> than individuals with an inpatient stay at a non-IMD psychiatric hospital in the same period of observation	Potentially Preventable Psychiatric Hospital Readmission rate – State run 3M measure	Medicaid Claims

## SUD Hypothesis and Evaluation

The demonstration will evaluate whether the New York Medicaid SUD treatment system is more effective through a provision of a complete coordinated continuum of care using LOCADTR placement criteria and standards, including SUD residential treatment services. The delivery system reforms are particularly important to address the needs of the Medicaid expansion population, which has historically been underserved.

New York's independent evaluator will measure and monitor the outcomes of the SUD demonstration. The evaluation will focus on the key goals and milestones of the demonstration. Researchers will assess the impact of providing the full continuum of SUD treatment services, particularly residential treatment, on hospital emergency department (ED) utilization, inpatient hospital utilization and readmission rates. Both a midpoint evaluation and an evaluation at the end of the five-year waiver period will be completed. The evaluation will be designed to demonstrate achievement of the demonstration's goals, objectives, and metrics. As required by CMS, the evaluation design will include the following elements:

- General background information
- Evaluation questions and hypotheses
- Methodology
- Methodological limitations
- Attachments

### GOAL 1: Improve quality of care and population health outcomes for Medicaid enrollees with SUD

Hypotheses	Example Measures (Not Final)	Data Sources
The Demonstration will decrease hospital admissions among Medicaid enrollees with at least one SUD treatment visit.	Annual inpatient stays year over year	Medicaid Data Warehouse
Enrollees who receive residential SUD services will have lower hospital readmission rates compared to a matched cohort of members who <b>did not</b> receive residential SUD services.	Monthly readmissions year over year	Medicaid Data Warehouse
Enrollees with a crisis visit for SUD will have improved rates of initiation and engagement of alcohol and other drug use treatment (IET)	IET measure HEDIS	Medicaid Data Warehouse
Enrollees will have fewer opioid-related overdose deaths.	Year over year opioid deaths	DOH overdose database

### GOAL 2: Increase enrollee access to and use of appropriate SUD treatment services based on LOCADTR criteria

Hypotheses	Example Measures (Not Final)	Data Sources
The Demonstration will increase the supply of the critical LOCs for Medicaid enrollees.	Number of admissions to OASAS residential levels of care year over year	Medicaid Data Warehouse
The Demonstration will increase the use of residential and MAT for Opioid and alcohol for Medicaid enrollees.	Number of prescriptions for opioid and alcohol medications to individuals who have a Medicaid claim to residential services year over year	Medicaid Data Warehouse

Fewer overrides for services not available and clinical justification for residential services	Year over year overrides	LOCADTR
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**GOAL 3: Improve care coordination and care transitions for Medicaid enrollees with SUD**

<b>Hypotheses</b>	<b>Example Measures (Not Final)</b>	<b>Data Sources</b>
The Demonstration will increase the rate of Medicaid enrollees with SUD-related conditions who are also receiving primary/ambulatory care.	The number of monthly primary/ambulatory care claims per enrollee with SUD-related conditions	Medicaid Data Warehouse
The Demonstration will improve follow-up after discharge from ED	HEDIS Follow-up ED visit	Medicaid Data Warehouse
Enrollees with SUD will have increased treatment engagement as measured by treatment duration (CET)	QARR Continued Engagement to Treatment measure.	Medicaid Data Warehouse
Medicaid IMD providers will demonstrate consistency in program design and discharge planning policies.	Review of IMD program and discharge policies and procedures	OASAS Site Review
Increase Number of Medicaid enrollees with SUD who are enrolled in Health Home	Year over year	Medicaid Data Warehouse

**GOAL 4: Maintain or reduce Medicaid cost of individuals with SUD**

<b>Hypotheses</b>	<b>Example Measures (Not Final)</b>	<b>Data Sources</b>
The Demonstration will be budget neutral to the Federal government.	Annual total cost of care for individuals with SUD	Medicaid Data Warehouse
Total Medicaid SUD spending during the measurement period will remain constant after adjustment for the new residential services and any other new SUD treatment services including care coordination developed under this Demonstration.	Medicaid SUD-related claims	Medicaid Data Warehouse
Total Medicaid SUD spending on residential treatment within IMDs during the measurement period will remain constant after adjustment for the new residential services and any other new SUD treatment services including care coordination developed under this Demonstration.	Medicaid IMD residential treatment claims	Medicaid Data Warehouse
Costs by source of care for individuals with SUD incurring high Medicaid expenses during the measurement period will remain constant after adjustment for the new residential services and any other new SUD treatment services including care coordination developed under this Demonstration.	Medicaid claims by source of care	Medicaid Data Warehouse

## **IX. Compliance with the Tribal and Public Notice Process**

### **Tribal Notice**

In compliance with 42 CFR, 431.408(b), the Department of Health conducted a 30-day tribal comment period from October 4, 2022 - November 10, 2022. No comments were received during the tribal comment period.

### **Public Notice**

In compliance with 42 CFR 431.408(a)(1), the Department of Health conducted a 30-day public comment period from October 5, 2022 - November 4, 2022. While all comments have been considered and responded to, no edits were made to the amendment request.

### **Public Hearings**

In compliance with 42 CFR 431.408(a)(3), the State conducted two virtual public hearings on October 26<sup>th</sup> and 31<sup>st</sup>, 2022. While all comments have been considered and responded to, no edits were made to the amendment request.

### **Public Comments and State Responses**

This section contains a summary of comments, suggestions, and questions received during the public comment period, as well as the State's response to the feedback. The State received three written comments regarding the amendment application, as well as an additional three comments received verbally from the virtual hearings from individuals, advocacy groups, community providers, and other stakeholders.

- **General Comments of Support**

There were several commenters who expressed support for the IMD Transformation Demonstration Program waiver amendment application and NYS's approach. NYS appreciates their support and looks forward to working with all stakeholders to implement the waiver amendment.

- **The State received a comment raising concerns around OMH's proposed systems transformation and reinvestment of savings; the capacity of community services, including workforce turnover; and access to community housing.**

The State is committed to investing in community-based programming that supports individual recovery and reduces avoidable lengths of stay and admissions. The revenue generated from this waiver will support these goals and strengthen existing and new services and programming. The waiver as proposed will not create any exemptions from the IMD waiver for State OMH operated or licensed residential programs.

- **The State received a comment requesting that mental health services for youth known to foster care and child welfare systems and with a diagnosis of IDD, be kept in mind when the State prepares to submit its IMD waiver amendment for facilities that service children with Serious Emotional Disturbance (SED).**

The Federal requirement regarding a Child Welfare SED IMD Waiver is specific for Child Welfare facilities that are also Qualified Residential Treatment Programs (QRTP) and meet certain criteria. These QRTPs may have children/youth who have an I/DD, which will be considered as a component of the IMD determinations. QRTPs with children/youth who have I/DD may be part of the IMD Waiver if served in a Child Welfare facility identified to meet the Waiver requirements.

- **The State received a comment that noted the waiver does not make allowances for individuals with SUD who need longer lengths of stay than the average of 30 days, and requests confirmation in the proposal that medium and long-stay providers will not be required to cut lengths of stay down to 30 days.**

If approved, the waiver does not require that lengths of stay for each individual be no more than 30 days; rather it requires that average length of stay for all individuals in all SUD IMDs be no more than 30 days. The waiver also does not require that individuals be discharged at 30 days. The State recognizes some individuals require stays in excess of 30 days.

## Notes

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<sup>1</sup> The New York State Office of Addiction Services and Supports (OASAS), in partnership with The National Center on Addiction and Substance Abuse (CASA Columbia), has designed, built, and tested a web-based tool that will aid substance abuse treatment providers in determining the best level of care for a client with a substance use disorder. This tool is named the LOCADTR, which stands for Level of Care for Alcohol and Drug Treatment Referral.

<https://oasas.ny.gov/system/files/documents/2019/10/LOCADTRManual3.0.pdf>

<sup>2</sup> CBC, <http://www.cbcare.org/innovative-programs/pathway-home/>

<sup>3</sup> <https://www.samhsa.gov/behavioral-health-equity/obhe-data>

<sup>4</sup> New York State Department of Health. “Opioid Prevention Program: Data to Action. Fentanyl-related deaths in New York State outside of New York City, 2015-

2017.” [https://www.health.ny.gov/statistics/opioid/data/pdf/nysdoh\\_dta1\\_fentanyl.pdf](https://www.health.ny.gov/statistics/opioid/data/pdf/nysdoh_dta1_fentanyl.pdf)

[Accessed July 2019].

<sup>5</sup> “Trends in and Characteristics of Drug Overdose Deaths Involving Illicitly Manufactured Fentanyls - United States, 2019–2020.” Centers for Disease Control and Prevention, Centers for Disease Control and Prevention, 16 Dec. 2021,

[https://www.cdc.gov/mmwr/volumes/70/wr/mm7050e3.htm?s\\_cid=mm7050e3\\_w&ACSTrackingID=USCDC\\_1026-](https://www.cdc.gov/mmwr/volumes/70/wr/mm7050e3.htm?s_cid=mm7050e3_w&ACSTrackingID=USCDC_1026-)

[DM71895&ACSTrackingLabel=December+Drug+Overdose+News+Updates+%2B+SUDORS+MMWR&deliveryName=USCDC\\_1026-DM71895](https://www.cdc.gov/mmwr/volumes/70/wr/mm7050e3.htm?s_cid=mm7050e3_w&ACSTrackingLabel=December+Drug+Overdose+News+Updates+%2B+SUDORS+MMWR&deliveryName=USCDC_1026-DM71895)

<sup>6</sup> Ciccarone, D., Ondocsin, J., & Mars, S. G. (2017). Heroin uncertainties: Exploring users’ perceptions of fentanyl-adulterated and -substituted ‘heroin.’ Ciccarone. International Journal of Drug Policy, (46), 146–155.

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<sup>7</sup> Unclassified fentanyl flow to the United States - dea.gov. Drug Enforcement Administration. (2020, January). Retrieved August 2020, from [https://www.dea.gov/sites/default/files/2020-03/DEA\\_GOV\\_DIR-008-20%20Fentanyl%20Flow%20in%20the%20United%20States\\_0.pdf](https://www.dea.gov/sites/default/files/2020-03/DEA_GOV_DIR-008-20%20Fentanyl%20Flow%20in%20the%20United%20States_0.pdf)

<sup>8</sup> SAS stored process web application - government of New York. (n.d.). Retrieved May 21, 2022, from [https://webbi1.health.ny.gov/SASStoredProcess/guest?\\_program=/EBI/PHIG/apps/opioid\\_dashboard/op\\_dashboard&p=it&ind\\_id=op51](https://webbi1.health.ny.gov/SASStoredProcess/guest?_program=/EBI/PHIG/apps/opioid_dashboard/op_dashboard&p=it&ind_id=op51)

<sup>9</sup> New York State Department of Health. Data to Action: Fentanyl-related deaths in New York State outside of New York City, 2015-2017. [https://www.health.ny.gov/statistics/opioid/data/pdf/nysdoh\\_dta1\\_fentanyl.pdf](https://www.health.ny.gov/statistics/opioid/data/pdf/nysdoh_dta1_fentanyl.pdf) [Accessed July 2019].

<sup>10</sup> New York State Opioid Annual Report 2020 [https://www.health.ny.gov/statistics/opioid/data/pdf/nys\\_opioid\\_annual\\_report\\_2020.pdf](https://www.health.ny.gov/statistics/opioid/data/pdf/nys_opioid_annual_report_2020.pdf)

<sup>11</sup> New York State Opioid Annual Report 2020, p. 11 and pg. 62 [https://www.health.ny.gov/statistics/opioid/data/pdf/nys\\_opioid\\_annual\\_report\\_2020.pdf](https://www.health.ny.gov/statistics/opioid/data/pdf/nys_opioid_annual_report_2020.pdf)

<sup>12</sup> 14 NYCRR 817.3(d)(1)

<sup>13</sup> 14 NYCRR 817.3(d)(1) and 14 NYCRR 800.4

<sup>14</sup> Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. MMWR Recomm Rep 2016;65(No. RR-1):1–49. DOI: <http://dx.doi.org/10.15585/mmwr.rr6501e1>

<sup>15</sup> DHHS CMS Informational Bulletin: [https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/cib080519-1004\\_64.pdf](https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/cib080519-1004_64.pdf)



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<sup>16</sup> NYS Codes, Rules, and Regulations Part 80 - Rules And Regulations On Prescribing and Dispensing Controlled Substances. <https://regs.health.ny.gov/content/section-8063prescribing#:~:text=An%20emergency%20means%20that%20the,no%20alternative%20treatment%20is%20available>.

<sup>17</sup> New York State Public Health Law Article 33 Section 3331 (5).  
<https://www.nysenate.gov/legislation/laws/PBH/3331>

<sup>18</sup> New York State Opioid Annual Report 2020.  
[https://www.health.ny.gov/statistics/opioid/data/pdf/nys\\_opioid\\_annual\\_report\\_2020.pdf](https://www.health.ny.gov/statistics/opioid/data/pdf/nys_opioid_annual_report_2020.pdf)

<sup>19</sup> CDC Advises Against Misapplication of the Guideline for Prescribing Opioids for Chronic Pain. <https://www.cdc.gov/media/releases/2019/s0424-advises-misapplication-guideline-prescribing-opioids.html>

<sup>20</sup> <https://www.cdc.gov/media/releases/2022/s0210-prescribing-opioids.html>

<sup>21</sup> NYSDOH. Mandatory Prescriber Education Guidance.  
[https://www.health.ny.gov/professionals/narcotic/mandatory\\_prescriber\\_education/docs/guidance.pdf](https://www.health.ny.gov/professionals/narcotic/mandatory_prescriber_education/docs/guidance.pdf)

<sup>22</sup> New York State Public Health Law Article 33 Section.  
<https://www.nysenate.gov/legislation/laws/PBH/3309>

New York State Department of Health  
and Office of Addiction Services and Supports

## **Implementation Plan**

for

Substance Use Disorder Demonstration Waiver  
Pursuant to Section 1115 of the Social Security Act

Submitted to the U.S. Centers for Medicare and Medicaid Services  
December 21, 2022

## OVERVIEW

This Implementation Plan is submitted in conjunction with the New York Department of Health submission of a substance use disorder (SUD) demonstration waiver pursuant to Section 1115 of the Social Security Act. New York is committed to providing a full continuum of care for people with opioid use disorder (OUD) and other SUDs and expanding access and improving outcomes in the most cost-effective manner possible.

### Goals:

1. Increased rates of identification, initiation and engagement in treatment for OUD and other SUDs;
2. Increased adherence to and retention in treatment for OUD and other SUDs;
3. Reductions in overdose deaths, particularly those due to opioids;
4. Reduced utilization of emergency departments and inpatient hospital settings for OUD and other SUD treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services;
5. Fewer readmissions to the same or higher level of care where readmissions is preventable or medically inappropriate for OUD and other SUDs; and
6. Improved access to care for physical health conditions among beneficiaries with OUD or other SUDs.

### Milestones:

1. Access to critical levels of care for OUD and other SUDs;
2. Widespread use of evidence-based, SUD-specific patient placement criteria;
3. Use of nationally recognized, evidence-based, SUD program standards to set residential treatment provider qualifications;
4. Sufficient provider capacity at each level of care, including medication assisted treatment (MAT);
5. Implementation of comprehensive treatment and prevention strategies to address opioid misuse and OUD; and
6. Improved care coordination and transitions between levels of care.

## Section I – Implementation Plan Milestone Completion

This section contains information detailing New York’s strategies for meeting the six milestones over the course of the Demonstration. Specifically, this section:

1. Includes a summary of how, to the extent applicable, New York already meets each milestone, in whole or in part, and any actions needed to meet each milestone, including the persons or entities responsible for completing actions;
2. Describes the timelines and activities that New York will undertake to achieve the milestones; and
3. Provides an overview of future plans to improve beneficiary access to SUD services and promote quality and safety standards.

## Milestones

### 1. Access to Critical Levels of Care for OUD and Other SUDs

New York offers a range of services at varying levels of intensity across a continuum of care because each type of treatment or level of care may be more or less effective depending on each beneficiary's individual clinical needs. To meet this milestone, New York's current SUD Medicaid treatment system includes coverage of the following:

- Screening, Brief Intervention and Referral to Treatment (SBIRT) Services
- Outpatient;
- Intensive Outpatient;
- Outpatient Rehabilitation
- Medication Assisted Treatment including Methadone Maintenance (medications, as well as counseling and other services, with sufficient provider capacity to meet the needs of Medicaid beneficiaries in the State);
- Ambulatory withdrawal management;
- Intensive LOCs in residential settings and withdrawal management;
- Intensive LOCs in inpatient hospital settings;
- Medically-managed and medically supervised withdrawal management;
- Residential Rehabilitative Services for Youth (RRSY); and
- Health Home for children and Adults with Serious Mental Illness, Serious Emotional Disturbance and Co-Occurring SUD.

This Demonstration builds upon an extensive, existing array of New York Medicaid covered behavioral health (BH) services, including evidence-based services and will improve upon and enhance services that are currently covered only under non-Medicaid sources, including state funding and other federal funding.

New York Medicaid covers all ambulatory LOCADTR LOCs, as well as medication-assisted treatment (MAT), residential and inpatient services and withdrawal management. New York's Medicaid State Plan includes authority for a complete continuum of care as approved in State Plan Amendment (SPA) #16-0004, 91-0039, 91-0075, 09-0034, 19-0017, 19-0013, 19-0018, 06-61, and 08-39. The Demonstration will permit DOH to provide critical access to medically necessary SUD treatment services in the most appropriate setting for the member as part of a comprehensive continuum of SUD treatment services.

The Demonstration would permit DOH to provide medically necessary medical and BH care (including co-occurring mental health [MH] and SUD treatment services) in the most appropriate setting for individuals receiving residential and inpatient SUD treatment services. This approach is designed address the demonstration goals detailed below under Hypothesis and Evaluation, including improving health care

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outcomes for individuals with SUD (reducing hospital emergency department use and inpatient admissions, reducing hospital readmissions, and improving the rates of initiation, engagement and retention in treatment).

New York Medicaid currently covers adult SUD residential services under approved State Plan Amendment #16-004. However, the State has not yet implemented reintegration services under that State Plan. New York will begin reimbursing for reintegration services delivered by providers whose qualifications are consistent with LOCADTR, state regulations, and the already approved State Plan Amendment. A reimbursement SPA will be submitted to update reimbursement methodologies.

OASAS directly operates 12 Addiction Treatment Centers and oversees over 1,600 addiction treatment programs. In addition, expanded regional programming including Centers of Treatment Innovation (COTIs), Open Access Centers and Recovery Community Centers, treat New Yorkers wherever they may be in their recovery journey.

**Summary of All OASAS Services**

<b>LOCATDR Service Description</b>	<b>NYCRR Title 14</b>	<b># of providers</b>	<b># of Facilities</b>	<b># of beds / slots</b>	<b>Count Served Cohort CY2019</b>	<b>Avg Length of Stay (days) for CY2019 Cohort</b>	<b>Vacancies as of 11/30/21 (Beds)</b>	<b>ASAM Level</b>
Medically Managed Inpatient Detoxification	816	17	18	350	32,079	3.7	120	4-WM
Medically Supervised Inpatient Detoxification	816	23	26	703	32,769	4.1	318	3.7-WM
Inpatient Treatment	818	62	65	2,492	49,553	15.7	354	3.7
Residential Rehabilitation Services for Youth	818	7	9	240	955	108.8	65	3.7

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Residential Services - Stabilization / Rehabilitation (w/o Reintegration)	820	17	32	1,154	6,724	50.3	268	3.5 / 3.3
Residential Services - Stabilization / Rehabilitation (with Reintegration)	820	17	35	1,849	4,892	110.9	352	3.5/3.3/3.1
Residential Services - Reintegration Only	820	15	29	730	977	201.8	107	3.1
Day Rehabilitation	822	28	35	NA	6,977	117.7	NA	2.5
Intensive Outpatient (Cohort Data is CY2021 Annualized)	822	28	40	NA	387	185.4	NA	2.1
Medically Supervised Outpatient Withdrawal	822	10	10	259	2,981	12.4	NA	2-WM
Outpatient Clinic	822	271	425	NA	158,158	185.4	NA	1
Opioid Treatment Program	822	56	103	40,886	54,976	481.2	NA	1

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Residential Services - Intensive Residential	819	13	22	1,285	8,626	149.8	211	Comparable to ASAM 3.3
Residential Services - Community Residence	819	38	50	1,021	4,860	155.7	98	Comparable to ASAM 3.1
Residential Services - Supportive Living	819	22	27	659	1,965	209.2	159	Comparable to ASAM 3.1

This Demonstration is necessary to address critical unmet needs for residential SUD treatment that continue to exist despite significant improvements to the publicly-funded treatment delivery system outside of Medicaid. State-only funds and federal Substance Abuse and Mental Health Services Administration (SAMHSA) block grant funds are used to support some residential services for the for individuals enrolled in Medicaid.

Additional residential SUD services will be included under the Medicaid State Plan with this demonstration. This transition to Medicaid reimbursement of residential and inpatient IMD services will ensure access to a comprehensive, coordinated system of SUD care for children and adults in Medicaid. Prior to this Demonstration, New York Medicaid had not adopted a complete array of SUD treatment services using a national placement criteria system (e.g., LOCADTR) or national provider standards. Most importantly, for some Medicaid-covered individuals in need of SUD treatment, there were limited options for residential community-based SUD treatment services.

The complete SUD benefit package will include support for evidence-based practices already implemented in the State, such as multi-systemic therapy (MST), Functional Family Therapy (FFT) and Multidimensional Family Therapy (MDFT) for children with SUD conditions. It also modernizes the SUD treatment benefit to align with the most current edition of LOCADTR criteria for outpatient, inpatient and residential treatment. Providers will be trained using the most current edition of LOCADTR criteria to provide multi-dimensional assessments that inform placement and individualized treatment plans that will increase the use of community-based and non-hospital residential programs, and assure that inpatient hospitalizations are utilized appropriately for situations in which there is a need for safety, stabilization, or acute withdrawal management.



Below is a table that describes how New York meets Milestone 1 for Medicaid beneficiaries, including a variety of services at different levels of intensity across a continuum of care.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
<b>Criteria for completion of milestone</b>	<b>Provide an overview of current SUD treatment services covered by the state in each level of care. For services currently covered in the state plan, list the benefit category and page location; for services currently covered in a Demonstration, include the program name and Special Term and Condition number.</b>	<b>Provide an overview of planned SUD treatment services to be covered by the state in each level of care: indicate whether planned services will be added to the state plan or authorized through the 1115.</b>	<b>Provide a list of action items needed to be completed to meet milestone requirements, if any. Include persons or entities responsible for completion of each action item. Include timeframe for completion of each action item.</b>
Coverage of outpatient services	New York Medicaid covers SUD outpatient treatment services under the following sections of the Medicaid State Plan using the LOCADTR level of care criteria: <ul style="list-style-type: none"> <li>• Outpatient hospital (SPA 06-61, 08-39)</li> <li>• FQHC</li> <li>• Physician services</li> <li>• Rehabilitation services (3.1-a (3b-37)).</li> </ul>	All LOCADTR levels are covered.	No further action needed

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Milestone Criteria	Current State	Future State	Summary of Actions Needed
Coverage of intensive outpatient services	New York Medicaid covers SUD intensive outpatient treatment services, including partial hospitalization, under the following sections of the State Plan: <ul style="list-style-type: none"> <li>• Outpatient hospital</li> <li>• FQHC</li> <li>• Rehabilitation Services</li> </ul>	All LOCADTR levels are covered.	No further action needed
Coverage of MAT (medications as well as counseling and other services with sufficient provider capacity to meet needs of Medicaid beneficiaries in the State)	New York Medicaid covers MAT (for non-OU and OUD) and associated counseling/services under the following sections of the State Plan: <ul style="list-style-type: none"> <li>• Physician services</li> <li>• Rehabilitation Services</li> </ul> Medication-Assisted Treatment (MAT) 1905(a)(29) Page 3.1-a (8)	All MAT is covered.	No further action needed
Coverage of intensive levels of care in residential and inpatient settings	New York Medicaid covers residential SUD in a non-hospital setting under the Rehabilitative Option.  New York Medicaid covers the following inpatient SUD treatment: <ul style="list-style-type: none"> <li>• Inpatient hospital services</li> <li>• Inpatient hospital for individuals aged 65 or older in institutions for</li> </ul>	New York Medicaid enrollees do not have access to residential services under the LOCADTR LOC for Reintegration (similar to ASAM 3.1). Under this demonstration, the State will begin authorizing this residential level of care.	Within 24 months, New York will authorize and begin to reimburse for Medicaid individuals to receive services for the LOCADTR LOC for Reintegration.

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Milestone Criteria	Current State	Future State	Summary of Actions Needed
	mental diseases <ul style="list-style-type: none"> <li>• Inpatient psychiatric facility services for individuals under 22 years of age</li> </ul>		
Coverage of medically supervised withdrawal management	New York Medicaid covers medically supervised withdrawal management in a hospital and non-hospital setting. <ul style="list-style-type: none"> <li>• Inpatient withdrawal management in a general hospital setting</li> <li>• Inpatient withdrawal management in a non-hospital setting</li> <li>• Ambulatory withdrawal management under the following authorities:                             <ul style="list-style-type: none"> <li>• Outpatient hospital</li> <li>• Rehabilitative Free-standing services</li> <li>• FQHC services</li> </ul> </li> </ul>	All LOCADTR levels are covered.	No further action needed

## 2. Use of Evidence-based, SUD-specific Patient Placement Criteria

Under this milestone, New York has implemented the LOCADTR, which is evidence-based, SUD-specific patient placement criteria. To meet this milestone, New York will ensure that:

- Providers assess treatment needs based on SUD-specific, multi-dimensional assessment tools, linked to the ASAM Criteria; and
- Utilization management approaches are implemented to ensure that
  - (a) beneficiaries have access to SUD services at the appropriate level of care,
  - (b) interventions are appropriate for the diagnosis and level of care, and
  - (c) there is an independent process for reviewing placement in residential treatment settings.

Below, New York identifies how it requires all providers to use the LOCADTR evidence-based, SUD-specific placement criteria to provide treatment that reflects diverse patient needs and evidence-based clinical guidelines. This table includes current and intended actions and associated timelines needed to meet Milestone 2 (*Use of evidence-based, SUD-specific patient placement criteria*). This milestone has already been met.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Criteria for completion of milestone	Provide an overview of current state use of evidence-based, SUD-specific patient placement criteria and utilization management approach to ensure placement in appropriate level of care and receipt of services recommended for that level of care	Provide an overview of planned state implementation of requirement that providers use an evidence-based, SUD-specific patient placement criteria and use of utilization management to ensure placement in appropriate level of care and receipt of services recommended for that level of care.	Specify a list of action items needed to be completed to meet milestone requirements. Include persons or entities responsible for completion of each action item. Include timeframe for completion of each action item

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<p>Implementation of requirement that providers assess treatment needs based on SUD-specific, multi-dimensional assessment tools that reflect evidence-based clinical treatment guidelines</p>	<p>New York providers are required to utilize assessments that are directly tied to the LOCATDR criteria for treatment planning.</p> <p>New York has implemented a universal training program for providers to assess treatment needs based on the LOCATDR's multi-dimensional tools and to base treatment needs on those assessments.</p> <p>New York requires all Medicaid SUD providers through regulation to use the for level of care (LOC) assessments using the LOCADTR, consistent with provider training.</p> <p>Under the regulations, providers are required to develop recommendations for placement in appropriate levels of care based on the LOCADTR and multi-dimensional assessments.</p>		<p>No further action needed</p>

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<p>Implementation of a utilization management approach such that            (a) <b>beneficiaries have access to SUD services at the appropriate level of care</b></p>	<p>New York currently enrolls Medicaid enrollees in MMCPs, which are required to utilize the LOCADTR as the utilization management tool for all Medicaid SUD services, as well as the patient placement criteria to review residential placements using the LOCADTR placement criteria.</p> <p>New York has ensured that program standards are set for beneficiaries to have access to SUD services at the appropriate LOC based on the LOCADTR dimensions of care.</p> <p>New York already requires through MMCP contract language that for utilization management MMCPs use LOCADTR language consistent with provider training.</p> <p>All website, provider information and internal documentation are</p>		<p>No further action needed</p>

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	<p>consistent with the LOCATR.</p> <p>OASAS has a website with a provider search function for Medicaid beneficiaries and providers at all LOCADTR LOCs.</p>		
<p>Implementation of a utilization management approach such that            (b)  <b>interventions are appropriate for the diagnosis and level of care</b></p>	<p>Today, MMCPs utilize the LOCADTR to review utilization for ambulatory, residential care and inpatient hospital care.</p> <p>New York has developed program standards to ensure that providers' interventions are appropriate for the diagnosis and each LOCADTR LOC. All Medicaid websites, criteria, manuals, and provider standards will consistently refer to the latest ASAM edition.</p>		<p>No further action needed</p>

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Implementation of a utilization management approach such that <b>(c) there is an independent process for reviewing placement in residential treatment settings</b>	<p>The current Medicaid MMCPs already use the LOCADTR for residential and inpatient utilization review.</p> <p>The placement criteria currently in use can be found at the following link:  <a href="https://oasas.ny.gov/locadtr">https://oasas.ny.gov/locadtr</a></p> <p>New York uses the LOCADTR for utilization review of Medicaid inpatient and residential placements. All website, provider information and internal documentation is consistent with the LOCADTR.</p>		No additional action needed.



### **3. Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities**

Through this Demonstration, New York will receive federal financial participation (FFP) for a continuum of SUD services, including services provided to Medicaid enrollees residing in residential treatment facilities that qualify as institutions for mental diseases (IMDs). To meet this milestone, New York will ensure that the following criteria are met:

- Implementation of residential treatment provider qualifications (in licensure requirements, policy manuals, managed care contracts that meet the LOCADTR criteria, which is a nationally recognized, SUD-specific program standards regarding the types of services, hours of clinical care and credentials of staff for residential treatment settings;
- Implementation of a State process for reviewing residential treatment providers to assure compliance with these standards; and
- Implementation of a requirement that residential treatment facilities offer MAT on-site or facilitate access off site.

OASAS regulations and Medicaid policy manuals contain standards consistent with LOCADTR criteria for residential programs, including requirements for the particular types of services, hours of clinical care and credentials of staff for residential treatment that are not complete. The policies already include a requirement that residential treatment providers offer MAT onsite or facilitate access offsite with a MAT provider not associated with the residential treatment owner.<sup>1</sup> New York will also continue to implement the process for initial certification and ongoing monitoring of residential treatment providers to ensure compliance with the State regulation requirements which are consistent with LOCADTR placement standards.

Below, New York already incorporates nationally recognized, SUD-specific LOCADTR program standards into their provider qualifications for residential treatment facilities through their regulations, policy manuals and other guidance to meet Milestone 3 (*Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities*).

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<sup>1</sup> 14 NYCRR 817.3(d)(1) and 14 NYCRR 800.4

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Criteria for completion of milestone	Provide an overview of current provider qualifications for residential treatment facilities and how these compare to nationally recognized SUD-specific program standards, e.g., the ASAM Criteria	Provide an overview of planned use of nationally recognized SUD-specific program standards in improving provider qualifications for residential treatment facilities.	Specify a list of action items needed to be completed to meet milestone requirements. Include persons or entities responsible for completion of each action item. Include timeframe for completion of each action item
Implementation of residential treatment provider qualifications in licensure requirements, policy manuals, contracts, or other guidance. Qualification should meet program standards in the LOCADTR, which is a nationally recognized, SUD- specific program standards regarding, in particular, <b>the types of services, hours of clinical care, and credentials of staff for residential treatment settings</b>	OASAS regulations already outline the types of services, hours of clinical care, and credentials of staff for residential treatment setting, which are consistent with the LOCADTR. Medicaid contracts already reflect that residential providers must meet these requirements for residential programs, including requirements for the particular types of services, hours of clinical care and credentials of staff for residential treatment. 14 NYCRR 817.3(d)(1) and 14 NYCRR 800.4		No additional action needed.

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Implementation of a state process for reviewing residential treatment providers to ensure compliance with these standards	<p>All SUD residential providers are licensed by the New York OASAS. All SUD residential providers are monitored and certified to provide the LOCADTR LOC for which the provider is enrolled in the Medicaid program.</p> <p>The monitoring of the providers will include a review of the facility’s infrastructure, as well as how the infrastructure is applied to ensure compliance with the state standards consistent with the LOCADTR and state regulations supporting the LOCADTR. The monitoring includes initial certification, monitoring and recertification.</p>	New York will also continue to implement the process for initial certification and ongoing monitoring of residential treatment providers to ensure compliance with the State regulation requirements which are consistent with LOCADTR placement standards.	No additional action needed.
Implementation of requirement that residential treatment facilities offer MAT onsite or facilitate access off-site	New York already has in place a regulatory requirement that residential treatment facilities offer multiple versions of MAT on- site or facilitate access off-site (14 NYCRR 817.3(d)(1) and 14 NYCRR 800.4) All residential treatment providers already offer at least one version of MAT on-site or facilitates access off-site.	None needed – New York currently meets criteria.	No additional action needed – New York currently meets criteria.

#### 4. Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD

To meet this milestone, New York will complete an assessment of the availability of providers enrolled in Medicaid and accepting new patients in the critical levels of care listed in Milestone 1. This assessment will determine the availability of treatment for Medicaid beneficiaries in each of these LOCs, as well as availability of MAT and medically supervised withdrawal management, throughout the State. This assessment will identify gaps in availability of services for beneficiaries in the critical LOCs and develop plans for enhancement of capacity based on assessments of provider availability.

To ensure there is necessary information regarding access to outpatient providers, OASAS maintains a website that is updated regularly. This report, which can be found at the following link <https://webapps.oasas.ny.gov/providerDirectory/>. The State also maintains a toll-free number called the HOPEline at 1-877-8-HOPENY where operators provide three referrals to assessment services in a caller’s area.

The State maintains a treatment availability dashboard for outpatient and bedded programs as well that can be accessed at: <https://findaddictiontreatment.ny.gov/>. This dashboard allows the State to monitor capacity of all SUD treatment providers including MAT. It also allows New York residents to search for an open slot in a treatment program in their area. The treatment availability dashboard displays treatment programs with real-time availability for particular areas.

New York currently contracts for 98,835 adult SUD residential treatment beds across 214 providers. All but 5,712 of these certified SUD residential, withdrawal management and inpatient SUD treatment service providers have more than 17 beds and meet the definition of an IMD. See the table below for the number of beds and providers providing each non-Medicaid residential level of care in New York.

LOCATDR Service Description	NYCRR Title 14	# of providers	# of Facilities	# of beds / slots	Count Served Cohort CY2019	Avg Length of Stay (days) for CY2019 Cohort	Vacancies as of 11/30/21 (Beds)	ASAM Level
Medically Supervised Inpatient Detoxification	816	20	22	646	29,919	4.1	292	3.7-WM

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Inpatient Treatment	818	28	31	1,589	30,938	15.7	159	3.7
Residential Services - Stabilization / Rehabilitation (w/o Reintegration)	820	15	29	1,092	6,436	50.3	263	3.5 / 3.3
Residential Services - Stabilization / Rehabilitation (with Reintegration)	820	16	33	1,813	4,870	110.9	343	3.5/3.3/3.1
Residential Services - Reintegration Only	820	9	19	572	842	201.8	88	3.1
TOTAL / AVG			134	5,712		22.6		

In NYS, more than 78,600 patients were prescribed at least one buprenorphine prescription for outpatient treatment of OUD in 2019. The crude rate of buprenorphine prescribing for OUD increased by 28.5 percent from 314.8 per 100,000 population in 2016 to 404.5 per 100,000 in 2019. The rate was more than two times higher in NYS excluding NYC than that for NYC during 2016-2019.

The NYSDOH Buprenorphine Access Initiative began in July 2016 with the goal of increasing the number of healthcare practitioners certified to prescribe buprenorphine and thus, increase the number of patients receiving buprenorphine. In 2019 DOH AIDS Institute implemented a statewide AIDS Institute Provider Directory which includes a directory of buprenorphine prescribers. This website allows individuals to search for prescribers in their area by zip code and distance they are willing to travel. Coupled with clarifications done by DOH AIDS Institute and NYS education department a significant increase in waived buprenorphine providers in NYS has occurred. Based upon the DEA record of waived buprenorphine providers in NYS, there has been an increase of 1,182 providers in 2018, with a total of 5,174 at the end of 2018 (Table 1b).

**Table 1 Number of Buprenorphine-Waived Providers in NYS, by Type of Waiver**

	2017	2018	2019
MD/DO- 30 patients	2,716	3,302	4,190
MD/DO- 100 patients	672	742	762
MD/DO- 275 patients	236	280	318
NP- 30 patients	287	567	928
NP- 100 patients	N/A*	69	143
NP- 275 patients	N/A*	N/A*	18
PA- 30 patients	81	185	282
PA- 100 patients	N/A*	29	62
PA- 275 patients	N/A*	N/A*	8
Total providers	3,992	5,174	6,711

\* Note: NP/PAs could not prescribe in NYS until May 2017

In NYS, the crude rate of patients who received at least one buprenorphine prescription for OUD increased between 2016 (314.8 per 100,000 population) and 2019 (404.5 per 100,000), representing a 29 percent increase (Figure 50). The rate was more than two times higher in NYS excluding NYC than in NYC during 2016-2019. It is encouraging that more qualified practitioners have completed the required training and have received their SAMHSA DATA 2000 waiver and DEA X-designation so that they have the capacity to prescribe buprenorphine for the treatment of OUD. These qualified practitioners include physicians, Nurse Practitioners (NPs), Physician Assistants (PAs), Clinical Nurse Specialists (CNSs), Licensed Midwives (LMs) and are in various settings increasing access for this life-saving medication.

The table below summarizes the current and future actions, including associated timelines, to meet Milestone 4 (*Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment*). This milestone will be met within 12 months of Demonstration approval. *Note: It is necessary to ensure the complete implementation of the new service array in Medicaid prior to the capacity assessment being conducted.*

The anticipated penetration rate and geographic distributions of providers at each LOC is noted where available.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Criteria for completion of milestone	Provide an overview of current provider capacities throughout the state to provide SUD treatment at each of the critical levels of care listed in Milestone 1.	Provide an overview of planned improvements to provider availability and capacity intended to improve Medicaid beneficiary access to treatment throughout the State at each of the critical levels of care listed in Milestone 1.	Specify a list of action items needed to be completed to meet milestone requirements. Include persons or entities responsible for completion of each action item. Include timeframe for completion of each action item
Completion of assessment of the availability of providers enrolled in Medicaid and accepting new patients in the following critical levels of care throughout the state including those that offer MAT: <ul style="list-style-type: none"> <li>• Outpatient Services;</li> <li>• Intensive Outpatient Services;</li> <li>• Medication Assisted Treatment</li> </ul>	The State maintains a treatment availability dashboard for outpatient and bedded programs as well that can be accessed at: <a href="https://findaddictiontreatment.ny.gov/">https://findaddictiontreatment.ny.gov/</a> . This dashboard allows the State to monitor capacity of all SUD treatment providers including MAT. It also allows New York residents to search for an open slot in a treatment program in their area. The treatment availability dashboard displays treatment programs with	New York will examine the potential to enhance access monitoring reporting under the Demonstration.  This initiative will leverage the current dashboard for ongoing access monitoring and recruitment and enrollment of new facilities as	No additional action needed.

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<p>(medications as well as counseling and other services);</p> <ul style="list-style-type: none"><li>• Intensive Care in Residential and Inpatient Settings;</li><li>• Medically Supervised Withdrawal Management.</li></ul>	<p>real-time availability for particular areas.</p>	<p>needed.</p>	
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## 5. Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Misuse and OUD

To meet this milestone, New York will ensure that the following criteria are met:

1. Continue efforts to increase utilization and improve functionality of the NYS Prescription Monitoring Program
2. Continue efforts to expand interstate PMP data sharing and PMP-EHR integration.
3. Provide reference to relevant opioid prescribing guidelines along with other interventions such as practitioner-focused training programs, to prevent and/or reduce prescription drug misuse
4. Expanded coverage of and access to naloxone for overdose reversal

Part of New York State Department of Health's (NYSDOH) efforts to address the opioid and prescription medication crisis includes several mandates that are focused on the practitioner's role in prevention or risk reduction. NYSDOH requires practitioners who prescribe controlled substances to consult the NYS PMP Registry when writing prescriptions for Schedule II, III, and IV controlled substances. The data that populates the registry (dispensing data for Schedule II, III, IV, and V controlled substance prescriptions) is required to be submitted to New York State within 24 hours of dispensing. NYSDOH has also limited the initial prescribing of opioids for acute pain to no more than a seven-day supply of any schedule II, III, or IV opioid, within the scope of a practitioner's professional opinion or discretion. Additionally, NYSDOH has required by mandate that practitioners who treat humans and have a DEA registration number to prescribe controlled substances, as well as medical residents who prescribe controlled substances under a facility DEA registration number, must complete at least three hours of course work in pain management, palliative care, and addiction. These efforts, in addition to referral to relevant opioid prescribing guidelines assist practitioners in engaging in informed prescribing practices and improves their ability to recognize areas of concern related to patient patterns of behavior.

Attachment A describes the State's plans for enhancing its health IT infrastructure to improve the NYS Prescription Monitoring Program (PMP) as part of the state's efforts to address SUD.

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Criteria for completion of milestone	Provide an overview of current treatment and prevention strategies to reduce opioid abuse and OUD in the state.	Provide an overview of planned strategies to prevent and treat opioid abuse and OUD.	Specify a list of action items needed to be completed to meet milestone requirements as detailed above. Include persons or entities responsible for completion of each action item. Include timeframe for completion of each action item
Continue efforts to increase utilization and improve functionality of the NYS Prescription Monitoring Program	<ul style="list-style-type: none"> <li>Since 2012, New York State has required most prescribers to consult the NYS PMP Registry when writing prescriptions for Schedule II, III, and IV controlled substances. Establishing a duty to consult ensures practitioners have a fuller picture of their patient's controlled-substance history, which can inform treatment decisions, especially where practitioners recognize high risk patient behaviors.</li> <li>Additionally, NYS requires that data for all Schedule</li> </ul>	<ul style="list-style-type: none"> <li>The Bureau of Narcotic Enforcement (BNE), within NYSDOH is working to enhance the NYS PMP Registry to improve utilization and functionality.</li> <li>BNE will continue to provide the MME calculator as resource for practitioners to</li> </ul>	<ul style="list-style-type: none"> <li>BNE will work with NYS ITS to build out the technical architecture.</li> </ul> <p>BNE will conduct stakeholder engagement with PMP users to test system development and provide additional feedback regarding functionality.</p>

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	<p>II, III, IV, and V controlled substance prescriptions dispensed by State-licensed pharmacies and dispensing practitioners be submitted to New York State within 24 hours. The requirement for data submission within 24 hours of dispensing makes helps to ensure that the data within the PMP registry is timely and accurate.</p> <ul style="list-style-type: none"> <li>In 2021 NYS implemented a Morphine Milligram Equivalents (MME) calculator. Calculating the Total Daily MMEs of opioids helps practitioners to identify patients who may benefit from closer monitoring, reduction or tapering of opioids, prescribing of naloxone, or other measures to reduce risk of overdose.</li> </ul> <p>Since July 2016, NYS has limited the initial prescribing of opioids for acute pain to no more than a seven-day supply of any schedule II, III, or IV opioid, within the scope of a practitioner’s professional opinion or discretion.</p>	<p>identify patients who may benefit from closer monitoring, reduction or tapering of opioids, prescribing of naloxone, or other measures to reduce risk of overdose.</p> <p>BNE is currently working on project to redesign the PMP Registry patient search landing page. The enhancements will include an indicator that notes the type of medication prescribed (Opioid, Benzodiazepine, or Stimulant), whether the prescription is current, a highly visual summary dashboard that notes the number of pharmacies or practitioners visited by the patient in the past 30 days, and how many prescriptions are</p>	
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		<p>present for Opioid, Benzodiazepine, or Stimulant to assist the practitioner in avoiding overlapping prescriptions that could lead to overdose. Ultimately these visual indicators will aid practitioners in identifying patient risk behaviors and assist in identifying patients who may benefit from closer monitoring, reduction or tapering of opioids, prescribing of naloxone, or other measures to reduce risk of overdose.</p>	
<p>Continue efforts to expand interstate PMP data sharing and PMP-EHR integration</p>	<ul style="list-style-type: none"> <li>BNE, within NYSDOH has managed interstate PMP data sharing through the PMP Interconnect (PMPi) since 2015. In June 2021 BNE began interstate data sharing through the RxChek hub. As of March 2022, BNE has data sharing agreements with 34 states, as well as Puerto Rico, Washington DC, and Military Health Services through the PMPi</li> </ul>	<p>BNE continues to identify new states with which to develop data sharing agreements and will continue to explore the capacity of the RxCheck hub to further interstate</p>	<p>BNE continues to work with the Governance Board to aid in identification of state partners for interstate data sharing, as well as expand system knowledge to support NYSDOH's growth in the area of PMP-EHR integration.</p>

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	<p>and Rxcheck hubs.</p> <ul style="list-style-type: none"> <li>• BNE has been working on a pilot project to integrate NYS PMP data into healthcare system electronic health records.</li> <li>• As of May 2022, BNE has initiated the process for PMP data sharing and EHR integration with the US Department of Veterans Affairs (VA).</li> </ul>	<p>interoperability.</p> <p>The PMP-EHR integration pilot project has demonstrated proof of concept and BNE is working to expand the number of sites engaged in PMP-EHR integration. BNE is exploring multiple options to meet this goal.</p>	
<p>Implementation of opioid prescribing guidelines along with other interventions to prevent opioid abuse</p>	<p>Centers for Medicare and Medicaid Services (CMS) issued guidance to the states in 2019 related to implementation of the Medicaid Drug Utilization Review (DUR) provisions that were included in Section 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act, also referred to as the SUPPORT Act.<sup>2</sup> New York has amended the Medicaid State Plan to reflect the new Drug Utilization Review provisions required in Federal law The provisions in the SUPPORT Act include</p>	<p>None needed – New York currently meets criteria.</p>	<p>None needed – New York currently meets criteria.</p>

<sup>2</sup> DHHS CMS Informational Bulletin: [https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/cib080519-1004\\_64.pdf](https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/cib080519-1004_64.pdf)

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	<p>measures to combat the opioid crisis in part by supporting strategies for reducing opioid use disorder and misuse through treatment and recovery initiatives, improving prevention strategies including community level interventions, and expanding efforts to address illicit synthetic drugs.</p> <p>In July 2016, NYS limited the initial prescribing of opioids for acute pain to no more than a 7-day supply.<sup>3</sup> In NYS, opioid prescriptions for more than a 7-day supply decreased steadily, from 28.7 percent in the first quarter of 2017 to 15.3 percent in the fourth quarter of 2019.<sup>4</sup></p> <p>Opioid prescribing guidelines are seen as a critical tool for practitioners to aid in prescription and treatment planning, especially for those clinicians who are prescribing opioids outside the area of active cancer treatment, palliative care, and end-of-life care. In 2016 the Centers for Disease Control and Prevention (CDC) issued the <i>CDC Guideline for Prescribing</i></p>	<p>None needed – New York currently meets criteria.</p>	<p>None needed – New York currently meets criteria.</p>
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<sup>3</sup> New York State Public Health Law Article 33 Section 3331 (5). <https://www.nysenate.gov/legislation/laws/PBH/3331>

<sup>4</sup> New York State Opioid Annual Report 2020. [https://www.health.ny.gov/statistics/opioid/data/pdf/nys\\_opioid\\_annual\\_report\\_2020.pdf](https://www.health.ny.gov/statistics/opioid/data/pdf/nys_opioid_annual_report_2020.pdf)

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	<p><i>Opioids for Chronic Pain — United States, 2016</i> as reference for practitioners related to opioid prescribing.<sup>5</sup></p> <p>Opioid prescribing guidelines are intended to inform clinical practice, improve communication between clinicians and patients related to opioid therapy risks and benefits, improve the safety and effectiveness of pain treatment, reduce the risks associated with long-term opioid therapy, and assist in addressing opioid use disorder (OUD), overdose, and death. The CDC is updating their guideline and the CDC Clinical Practice Guideline for Prescribing Opioids—United States, 2022 is currently under public review.<sup>6</sup></p> <p>Under Public Health Law (PHL) §3309-A (3), prescribers licensed under Title Eight of the Education Law in New York who are licensed to treat humans and who have a DEA registration number to prescribe controlled</p>	<p>None needed – New York currently meets criteria.</p> <p>NYSDOH (BNE and Office of Drug User Health) are currently working on revisions to this training.</p>	<p>None needed – New York currently meets criteria.</p> <p>This process will require meetings with SUNY UB and NYSDOH partners</p>
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<sup>5</sup> Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. MMWR Recomm Rep 2016;65(No. RR-1):1–49. DOI: <http://dx.doi.org/10.15585/mmwr.rr6501e1>

<sup>6</sup> <https://www.cdc.gov/media/releases/2022/s0210-prescribing-opioids.html>

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	<p>substances, as well as medical residents who prescribe controlled substances under a facility DEA registration number, must complete at least three hours of course-work in pain management, palliative care, and addiction. Education must cover the following topics: New York State and federal requirements for prescribing controlled substances; pain management; appropriate prescribing; managing acute pain; palliative medicine; prevention, screening and signs of addiction; responses to abuse and addiction; and end of life care. BNE, within the NYSDOH, and in partnership with the SUNY University at Buffalo offers an accredited training to meet the mandatory Opioid Prescriber Education training needs.<sup>7</sup></p> <p>New York State enacted a Good Samaritan Law in 2011 that provides protections for individuals from certain drug-and-alcohol-possession-related charges and prosecution in the event they seek help for someone during an overdose</p>		
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<sup>7</sup> NYSDOH. Mandatory Prescriber Education Guidance. [https://www.health.ny.gov/professionals/narcotic/mandatory\\_prescriber\\_education/docs/guidance.pdf](https://www.health.ny.gov/professionals/narcotic/mandatory_prescriber_education/docs/guidance.pdf)



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	<p>event. See Chapter 154 of the Laws of 2011; NYS Penal Law §220.78. Brochures that are distributed to educate about the Good Samaritan Law can be found at this link:  <a href="https://www.health.ny.gov/publications/0139.pdf">https://www.health.ny.gov/publications/0139.pdf</a></p> <p>NYS OASAS by regulation and guidance, requires providers to educate about overdose prevention and must make Naloxone available to all patients, prospective patients. 14 NYCRR §800.6. Guidance can be found at this link:  <a href="https://oasas.ny.gov/system/files/documents/2020/05/naloxone-prescribing.pdf">https://oasas.ny.gov/system/files/documents/2020/05/naloxone-prescribing.pdf</a></p>		
<p>Expanded coverage of, and access to, naloxone for overdose reversal</p>	<p>NYS has taken a number of steps over the past decade to make naloxone more widely available, including expanded efforts related to addressing opioid overdose through Article 33, Title 1 Section 3309. This multi-pronged approach focuses on building overdose response capacity within communities throughout the State. The core of this program is for community laypersons to be trained by organizations</p>	<p>None needed – New York currently meets criteria.</p>	<p>None needed – New York currently meets criteria.</p>

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	<p>registered with the NYSDOH to administer naloxone (an opioid antagonist also known by the brand name Narcan) in the event of a suspected opioid overdose.</p> <ul style="list-style-type: none"><li>• There are currently more than 800 registered Community Opioid Overdose Prevention (COOP) programs, with over half a million individuals trained by them since the initiative's inception in 2006. Of these, 78,000 were public safety personnel and the rest were community responders.</li><li>• In 2019, there were 1,558 naloxone administration reports by law enforcement (LE) to the NYSDOH and 2,749 reports by COOP programs.</li><li>• In total, including unique administrations by Emergency Medical Services (EMS) agencies, there were 16,710 reported naloxone administrations in NYS in 2019. There were 12,403 unique naloxone administrations reported electronically by EMS agencies during 2019, about a 10 percent decrease statewide from 13,724 administrations in</li></ul>		
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	<p>2018, with a seven percent decrease in NYC and a 13 percent decrease in NYS excluding NYC.</p> <p>In 2011, New York implemented a Good Samaritan law which allows individuals to seek emergency assistance in the case of an overdose without fear of being charged or prosecuted for possession of a controlled substance under 8 ounces, alcohol, marijuana, drug paraphernalia or sharing substances.<sup>8</sup></p>		
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<sup>8</sup> Good Samaritan Law was enacted as Chapter 154 of 2011; Publicly available brochure can be found at: <https://www.health.ny.gov/publications/0139.pdf>

## 6. Improved Care Coordination and Transitions between Levels of Care

New York will implement policies to ensure residential and inpatient facilities link beneficiaries, especially those with OUD and other SUDs, with community-based services and supports following stays in these facilities. The table below outlines New York's current procedures for care coordination and transitions between LOCs to ensure seamless transitions of care and collaboration between services, including:

- Current content of specific policies to ensure these procedures;
- Specific plans to help beneficiaries attain or maintain a sufficient level of functioning outside of residential or inpatient facilities; and
- Current policies or plans to improve care coordination for co-occurring physical and mental health conditions.

New York has multiple interventions for coordinating the care of individuals with SUD and transitioning between LOCs including, but not limited to, facility credentialing, discharge, referral and transition requirements, and care management initiatives at DOH and OASAS. OASAS Providers utilize LOCADTR continuing care module to conduct ongoing assessments on the appropriateness of a level of care and to determine subsequent levels of care. OASAS has also utilized State Opioid Response dollars to support regional networks designed to improve successful transitions between residential and outpatient settings. Additionally grant funding has been utilized to support transportation initiatives which assist individuals with making successful connections to care.

Under the Demonstration, New York will utilize the health home model and strengthen the transition management component for SUD populations between LOCs. DOH and OASAS will create a clear delineation of responsibility for improved coordination and transitions between LOCs to ensure individuals receive appropriate follow-up care following residential treatment.

In addition, under the Demonstration, in order to ensure improved care coordination and transitions between LOCs, New York will also monitor access and healthcare outcome measures by demographic information, including race and ethnicity. In addition, New York intends to implement coverage of enhanced individualized care coordination for individuals with SUD that is designed to identify, prevent, and address health inequities and challenges related to social determinants of health. New York State will evaluate the use of peers and other care connection mechanisms to ensure improved care coordination and overall health outcomes for individuals in care.

This milestone will be met within 12 to 24 months of Demonstration approval.

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Implementation of policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities	Provide an overview of current care coordination services and transition services across levels of care.	Provide an overview of planned improvements to care coordination services and transition services across levels of care	Specify a list of action items needed to be completed to meet milestone requirements. Include persons or entities responsible for completion of each action item. Include timeframe for completion of each action item
Additional policies to ensure coordination of care for co-occurring physical and mental health conditions	<p>New York has multiple interventions for coordinating the care of individuals with SUD and transitioning them between LOCs, including, but not limited to, facility credentialing, discharge planning requirements, and care management initiatives with MCCPs.</p> <p>Service coordination in all ASAM LOCs is</p>	Under the Demonstration, OASAS will improve coordination and transitions between LOCs to ensure that individuals receive services and supports following stays in facilities and are retained in care.	OASAS will improve discharge planning and transition planning in the residential and ambulatory LOCs using LOCADTR standards within 12 months of Demonstration approval

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Milestone Criteria	Current State	Future State	Summary of Actions Needed
	required. Service coordination, includes, but is not limited to, provider-specific and LOC-specific activities that enhance and improve linking members between Medicaid treatment services and enhance and improve the likelihood of engagement in treatment.		

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## **Section II – Implementation Plan Administration**

Please provide the contact information for the state's point of contact for the Implementation plan.

Name and Title:

Email Address:

## **Section III – Implementation Plan Relevant Documents**

Please provide any additional documentation or information that the state deems relevant to successful execution of the implementation plan.

## **Attachment A: Template for Substance Use Disorder Health Information Technology Plan Attachment A Section I.**

As a component of Milestone 5, Implementation of Strategies to Increase Utilization and Improve Functionality of PDMPs, in SMDL 17-003, states with approved Section 1115 Substance Use Disorder (SUD) demonstrations are generally required to submit a SUD Health Information Technology (IT) Plan as described in the Special Terms and Conditions (STCs) for these demonstrations within 90 days of demonstration approval. The SUD Health IT Plan will be a section within the state's SUD Implementation Plan Protocol and, as such, the state may not claim federal financial participation for services provided in Institute for Mental Disease until the SUD Health IT Plan has been approved by CMS.

In the event that the state believes it has already made sufficient progress with regards to the health IT programmatic goals described in the STCs (i.e., PMP functionalities, PMP query capabilities, supporting prescribing clinicians with using and checking the PMP, and master patient index and identity management), it must provide an assurance to that effect via the assessment and plan below (see Table 1, "Current State"). SUD Demonstration Milestone 5.0, Specification 3: Implementation of Strategies to Increase Utilization and Improve Functionality of PMP

The specific milestones to be achieved by developing and implementing a Health IT Plan that can be used to address SUD include:

- Enhancing the health IT functionality to support PMP interoperability and integration.
- Enhancing and/or supporting clinicians in their usage of the State's PMP through improved functionality, education, and prescribing guidelines.

The State should provide CMS with an analysis of the current status of its health IT infrastructure "ecosystem" to assess its readiness to support PMP interoperability. Once completed, the analysis will serve as the basis for the health IT functionalities to be addressed over the course of the demonstration — or the assurance described above.

The Health IT Plan should detail the current and planned future state for each functionality/capability/support — and specific actions and a timeline to be completed over the course of the demonstration — to address needed enhancements. In addition to completing the summary table below, the State may provide additional information for each Health IT/PMP milestone criteria to further describe its plan.



Table 1. State Health IT/PDMP Assessment and Plan

Milestone Criteria	Current State	Future State	Summary of Actions Needed
<p><i>5. Implementation of comprehensive treatment and prevention strategies to address Opioid Abuse and Opioid Use Disorder, that is:</i></p> <ul style="list-style-type: none"> <li>Enhance the State's health IT functionality to support its PDMP. Enhance and/or support clinicians in their usage of the State's PDMP</li> </ul>	<p>Provide an overview of current PDMP capabilities, health IT functionalities to support the PDMP and supports to enhance clinicians' use of the state's health IT functionality to achieve the goals of the PDMP.</p>	<p>Provide an overview of plans for enhancing the State's PDMP, related enhancements to its health IT functionalities and related enhancements to support clinicians' use of the health IT functionality to achieve the goals of the PDMP</p>	<p>Specify a list of action items needed to be completed to meet the Health Information Include timeframe for completion of each action item</p>
<b>PDMP Functionalities</b>			
<p>Enhancing and/or supporting clinicians in their usage of the State's PMP through improved functionality.</p>	<ul style="list-style-type: none"> <li>NYSDOH provides access to the NYS PMP Registry 24 hours/day, 7 days a week. Through the PMP Registry practitioners can review the controlled substance history of their patients, identify prescriptions prescribed by the searching practitioner or by other practitioners, designate a designee to search on their behalf, review their own prescription writing history, their search history, and review the searching history of their designees.</li> <li>The MME calculator provides an opioid dosage's equivalency to morphine. Calculating the MME allows for a standard for comparing different opioids and provides a tool for gauging the</li> </ul>	<p>Within the next two-year (2022-23) BNE plans to incorporate two phases of revisions into the PMP Registry patient search landing page. These enhancements are intended to enhance the functionality and usability of the PMP Registry. These will include an indicator that notes the type of medication prescribed (Opioid, Benzodiazepine, or Stimulant), whether the prescription is current, a highly visual summary dashboard that notes the number of pharmacies or practitioners visited by the practitioner in the past 30 days, and how many prescriptions are present for Opioids, Benzodiazepines, or Stimulants to assist the practitioner in avoiding overlapping prescriptions that could lead to overdose. Ultimately these visual indicators will aid practitioners in identifying patient risk behaviors and assist in identifying patients who may benefit from closer monitoring, reduction or tapering of opioids, prescribing of naloxone, or other</p>	<p>Through combined support from NYSDOH and the CDC funded Overdose Data to Action Grant, BNE will work with NYS ITS to build out the technical architecture. BNE plans to conduct stakeholder engagement with PMP users to test system functionality and provide additional feedback regarding functionality.</p>

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	<p>overdose potential of the amount of opioid that is being given to an individual. The MME calculator also assists the practitioner in identification of patients who may benefit from closer monitoring, reduction or tapering of opioids, prescribing of naloxone, or other measures to reduce risk of overdose.</p>	<p>measures to reduce risk of overdose</p>	
<p>Enhancing and/or supporting clinicians in their usage of the State’s PMP through education.</p>	<ul style="list-style-type: none"> <li>• BNE has provided a series of demonstration tutorials intended to expand practitioners’ capacity to access, use, and understand the functionality of the NYS PMP Registry. There are four trainings available focused on how to use and run reports, reporting suspicious activity, appointing designees, and a training geared toward residents and interns prescribing opioids under a medical teaching facility DEA registration number.</li> <li>• BNE, in partnership with the SUNY University at Buffalo offers two trainings targeted for physicians, physician assistants, nurse practitioners, and pharmacists. One is an accredited training to meet the educational requirements for the mandated Opioid Prescriber Education course work. The second is an overview training regarding the essential components of the NYS</li> </ul>	<p>BNE is working on an additional training series for pharmacists and dispensing vendors related to data submission to the PMP Registry and error correction to ensure the timeliness and accuracy of PMP data. Training development will be ongoing for the next two years.</p> <p>BNE is currently updating the mandated Opioid Prescriber Education training, with a target for completion within the next year.</p>	<p>This work is scheduled and continues on a routine basis. It requires meetings with internal BNE partners.</p> <p>This work is being done in collaboration with the NYSDOH Office for Drug User Health and the State University of New York (SUNY) at Buffalo (UB). Scheduled work group meetings will be held to review and revise content and provide feedback to UB.</p>

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Milestone Criteria	Current State	Future State	Summary of Actions Needed
	Prescription Monitoring Program.		
Enhanced interstate data sharing.	<ul style="list-style-type: none"> <li>BNE, within NYSDOH has managed interstate PMP data sharing through the PMP Interconnect (PMPi) since 2015. In June 2021 BNE began interstate data sharing through the RxChek hub. As of March 2022, BNE has data sharing agreements with 34 states, as well as Puerto Rico, Washington DC, and Military Health Services through the PMPi and Rxcheck hubs.</li> </ul> <p>States may not participate in interstate data sharing due to several factors, with the most common barrier being:</p> <ul style="list-style-type: none"> <li>A state is focusing on connecting with their border states first.</li> <li>A state is currently transitioning to a new PDMP system.</li> <li>A state has prioritized other PDMP projects over interstate connectivity.</li> </ul> <p>BNE has been working on a pilot project to integrate NYS PMP data into healthcare system electronic health records. As of May 2022, BNE initiated the process for EHR integration with the US Department of Veterans Affairs (VA).</p>	BNE continues to identify new states with which to develop data sharing agreements and will continue to explore the capacity of the RxCheck hub to further interstate interoperability.	<p>BNE continues to work with the Governance Board to aid in identification of state partners for interstate data sharing, as well as expand system knowledge to support NYSDOH’s growth in the area of PMP-EHR integration.</p> <p>BNE will work with the VA and their integration vendor to ensure NYSDOH receives appropriate audit files in order for BNE to meet their responsibility in monitoring PMP access and use.</p>

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<p>PMP-EHR Integration. Enhanced clinical workflow for prescribers and other state and federal stakeholders.</p>	<ul style="list-style-type: none"> <li>BNE has been working on a pilot project to integrate NYS PMP data into healthcare system electronic health records.</li> </ul> <p>As of May 2022, BNE initiated the process for EHR integration with the US Department of Veterans Affairs (VA).</p>	<p>The PMP-EHR integration pilot project had demonstrated proof of concept and BNE is working to expand the number of sites engaged in PMP-EHR integration. BNE is exploring multiple options to meet this goal.</p>	<p>BNE continues to work with the Governance Board to aid in identification of state partners for interstate data sharing, as well as expand system knowledge to support NYSDOH's growth in the area of PMP-EHR integration.</p>
<p>Enhanced connectivity between the state's PDMP and any statewide, regional or local health information exchange.</p>	<p>In previous years BNE explored PMP data sharing using health information exchanges (HIE) through the Regional Health Information Organizations (RHIOs) in NYS. At the time the RHIOs were not compatible with NYS security requirements. This resulted in NYSDOH exploring PMP-EHR integration, rather than data sharing through HIE. Currently, BNE is not supporting PMP data integration through HIE, though there is potential to revisit this in the future.</p>	<p>Potential exploration of the feasibility of PMP data sharing through HIE.</p>	<p>Potential exploration of the feasibility of PMP data sharing through HIE.</p>
<p><b>Use of PDMP – Supporting Clinicians with Changing Office Workflows / Business Processes</b></p>			
<p>Develop enhanced provider workflow/business processes to better support clinicians in accessing the PMP prior to prescribing an opioid or other controlled</p>	<p>BNE, within the NYSDOH has demonstrated capacity to integrate PMP data into a healthcare system's EHRs</p> <p>BNE has initiated the process for EHR integration with the US Department of Veterans Affairs (VA).</p>	<p>The PMP-EHR integration pilot project had demonstrated proof of concept and BNE is working to expand the number of sites engaged in PMP-EHR integration. BNE is exploring multiple options to meet this goal, including the use of RxCheck as a method for supporting PMP-EHR integration.</p>	<p>BNE will partner with federal and state partners through the Governance Board membership to identify additional options for expanding NYSDOH's PMP-EHR integration project.</p>

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Milestone Criteria	Current State	Future State	Summary of Actions Needed
<p>substance to address the issues which follow</p>	<p>In previous years BNE explored PMP data sharing using health information exchanges (HIE) through the Regional Health Information Organizations (RHIOs) in NYS. At the time the RHIOs were not compatible with NYS security requirements. This resulted in NYSDOH exploring PMP-EHR integration, rather than data sharing through HIE. Currently, BNE is not supporting PMP data integration through HIE, though BNE is exploring the feasibility to revisit this in the future.</p>	<p>BNE is looking at the potential feasibility of revisiting PMP data sharing through HIEs.</p>	<p>There is potential for NYSDOH to revisit the potential for integration through HEIs, but this is not a current active project.</p>
<p>Develop enhanced supports for clinician review of the patients' history of controlled substance prescriptions provided through the PDMP — prior to the issuance of an opioid prescription</p>	<p>The Bureau of Narcotic Enforcement (BNE), within NYSDOH is working to enhance the NYS PMP Registry to improve utilization and functionality. In 2021 NYS implemented a Morphine Milligram Equivalents (MME) calculator. Calculating the Total Daily MMEs of opioids helps practitioners to identify patients who may benefit from closer monitoring, reduction or tapering of opioids, prescribing of naloxone, or other measures to reduce risk of overdose.</p>	<p>Within the next two-year (2022-23) BNE plans to incorporate two phases of revisions into the PMP Registry patient search landing page. These will include an indicator that notes the type of medication prescribed (Opioid, Benzodiazepine, or Stimulant), whether the prescription is current, a highly visual summary dashboard that notes the number of pharmacies or practitioners visited by the practitioner in the past 30 days, and how many prescriptions are present for Opioids, Benzodiazepines, or Stimulants to assist the practitioner in avoiding overlapping prescriptions that could lead to overdose. Ultimately these visual indicators will aid practitioners in identifying patient risk behaviors and assist in identifying patients who may benefit from closer monitoring, reduction or tapering of opioids, prescribing of naloxone, or other measures to reduce risk of overdose.</p>	<p>BNE will work with NYS ITS to build out the technical architecture.          BNE will conduct stakeholder engagement with PMP users to test system development and provide additional feedback regarding functionality.</p>

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Milestone Criteria	Current State	Future State	Summary of Actions Needed
<b>Master Patient Index / Identity Management</b>			
Enhance the master patient index (or master data management service, etc.) in support of SUD care delivery.	The NYS PMP is not currently using a master patient index. The PMP is primarily used as one of many tools to support clinical decision making and is not currently used for tracking purposes.	If there is a future role for the NYS PMP it will need to be identified in collaboration with the Bureau of Narcotic Enforcement.	If there is a future role for the NYS PMP it will need to be identified in collaboration with the Bureau of Narcotic Enforcement.
<b>Using PMP Data to aid in efforts to manage Medicaid payments for opioids</b>			
Leverage the above functionalities/capabilities/supports (in concert with any other state health IT, technical assistance or workflow effort) to provide support tools for practitioners to minimize the risk of inappropriate opioid overprescribing which can aid in management of efforts to mitigate inappropriate opioid payments by Medicaid inappropriately pay for opioids	Basic and advanced functionality of PMP allows practitioners to have an additional tool for their clinical decision making related to controlled substance providing. NYS Law related to 7-day supply also serves as a mechanism to decrease overprescribing. Practices can use Automated at Point-of-Service for Medicaid FFS to limit initial opioid prescriptions for a 7-day supply consistent with NYS Law as a;	Understanding where PMP data, NYS laws, and Federal guidance, in collaboration with Medicaid health IT systems can work together to inform prescribing practices.	

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**Attachment A Section II — Implementation HIT Administration**

Please provide the contact information for the State’s point of contact for the SUD Health IT Plan.

Name and Title: Pat Lincourt  
Email Address: pat.lincourt@oasas.ny.gov

**Attachment A Section III — Relevant Documents**

Please provide any additional documentation or information that the State deems relevant to successful execution of the implementation plan.

## **Section 1115 SMI/SED Demonstration Implementation Plan**

**Overview:** The implementation plan documents the state’s approach to implementing SMI/SED demonstrations. It also helps establish what information the state will report in its quarterly and annual monitoring reports. The implementation plan does not usurp or replace standard CMS approval processes, such as advance planning documents, verification plans, or state plan amendments.

This template only covers SMI/SED demonstrations. The template has three sections. Section 1 is the uniform title page. Section 2 contains implementation questions that states should answer. The questions are organized around six SMI/SED reporting topics:

1. Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings
2. Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care
3. Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services
4. Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration
5. Financing Plan
6. Health IT Plan

State may submit additional supporting documents in Section 3.

**Implementation Plan Instructions:** This implementation plan should contain information detailing state strategies for meeting the specific expectations for each of the milestones included in the State Medicaid Director Letter (SMDL) on “Opportunities to Design Innovative Service Delivery Systems for Adults with [SMI] or Children with [SED]” over the course of the demonstration. Specifically, this implementation plan should:

1. Include summaries of how the state already meets any expectation/specific activities related to each milestone and any actions needed to be completed by the state to meet all of the expectations for each milestone, including the persons or entities responsible for completing these actions; and
2. Describe the timelines and activities the state will undertake to achieve the milestones.

The tables below are intended to help states organize the information needed to demonstrate they are addressing the milestones described in the SMDL. States are encouraged to consider the evidence-based models of care and best practice activities described in the first part of the SMDL in developing their demonstrations.

The state may not claim FFP for services provided to Medicaid beneficiaries residing in IMDs, including residential treatment facilities, until CMS has approved a state’s implementation plan.



**Memorandum of Understanding:** The state Medicaid agency should enter into a Memorandum of Understanding (MOU) or another formal agreement with its State Mental Health Authority, if one does not already exist, to delineate how these agencies will work with together to design, deliver, and monitor services for beneficiaries with SMI or SED. This MOU should be included as an attachment to this Implementation Plan.

**State Point of Contact:** Please provide the contact information for the state's point of contact for the implementation plan.

Name and Title: Suzanne B. Feeney, Director, Program Management

Telephone Number:

Email Address: [REDACTED]

**1. Title page for the state’s SMI/SED demonstration or SMI/SED components of the broader demonstration**

*The state should complete this transmittal title page as a cover page when submitting its implementation plan.*

<b>State</b>	<i>New York State</i>
<b>Demonstration name</b>	<i>Enter full demonstration name as listed in the demonstration approval letter.</i>
<b>Approval date</b>	<i>Enter approval date of the demonstration as listed in the demonstration approval letter.</i>
<b>Approval period</b>	<i>Enter the entire approval period for the demonstration, including a start date and an end date.</i>
<b>Implementation date</b>	<i>Enter implementation date(s) for the demonstration.</i>

This template is being finalized for review and approval by OMB through the Paperwork Reduction Act (PRA). Until such time, its use is optional, although it conveys the nature and extent of implementation information that CMS is seeking on SMI/SED demonstrations. When this template is OMB approved, then the state will be required to use it.

**2. Required implementation information, by SMI/SED milestone**

*Answer the following questions about implementation of the state’s SMI/SED demonstration. States should respond to each prompt listed in the tables. Note any actions that involve coordination or input from other organizations (government or non-government entities). Place “NA” in the summary cell if a prompt does not pertain to the state’s demonstration. Answers are meant to provide details beyond the information provided in the state’s special terms and conditions. Answers should be concise, but provide enough information to fully answer the question.*

*This template only includes SMI/SED policies.*

Prompts	Summary
<b>SMI/SED. Topic 1. Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings</b>	
<p><i>To ensure that beneficiaries receive high quality care in hospitals and residential settings, it is important to establish and maintain appropriate standards for these treatment settings through licensure and accreditation, monitoring and oversight processes, and program integrity requirements and processes. Individuals with SMI often have co-morbid physical health conditions and substance use disorders (SUDs) and should be screened and receive treatment for commonly co-occurring conditions particularly while residing in a treatment setting. Commonly co-occurring conditions can be very serious, including hypertension, diabetes, and substance use disorders, and can also interfere with effective treatment for their mental health condition. They should also be screened for suicidal risk.</i></p> <p><i>To meet this milestone, state Medicaid programs should take the following actions to ensure good quality of care in psychiatric hospitals and residential treatment settings.</i></p>	
<b>Ensuring Quality of Care in Psychiatric Hospitals and Residential Treatment Settings</b>	

Prompts	Summary
<p>1.a Assurance that participating hospitals and residential settings are licensed or otherwise authorized by the state primarily to provide mental health treatment; and that residential treatment facilities are accredited by a nationally recognized accreditation entity prior to participating in Medicaid</p>	<p><i>Current Status: Provide information on current state policies and requirements for ensuring quality of care in psychiatric hospitals and residential settings.</i></p> <p>Milestone achieved.</p> <p>All NYS-operated psychiatric hospitals are operated by the NYS Office of Mental Health (OMH) and subject to the CMS Conditions of Participation. OMH is contracted with The Joint Commission (TJC) for ensuring they meet the CMS Conditions of Participation. The state-operated psychiatric hospitals are surveyed by TJC on a triennial basis and receive an unannounced Inspection of Care audits annually.</p> <p>In addition, privately-operated IMDs are hospitals licensed by OMH pursuant to Article 31 of the NYS Mental Hygiene Law, subject to OMH regulations regarding operational, programmatic, and billing standards. Although such privately-operated facilities will not participate in the initial IMD waiver, OMH ensures quality of care in NYS psychiatric hospitals through routine inspection and recertification activities and such facilities are also accredited by nationally recognized accreditation entities. All NYS Psychiatric Residential Treatment Facilities meet CMS conditions of participation by maintaining accreditation with one of the following The Joint Commission, the Commission on Accreditation of Rehabilitation Facilities, or the Council of Accreditation Services for Families and Children. New York State ensures quality of care in NYS PRTFs through Inspection of Care surveys, Conditions of Participation Surveys and routine inspection and recertification activities.</p>
	<p><i>Future Status: Describe planned activities to address milestone not already met and any other plans for enhanced quality assurance policies for inpatient and residential treatment settings.</i></p> <p>No changes are expected.</p>
	<p><i>Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action.</i></p> <p>None.</p>

Prompts	Summary
<p>1.b Oversight process (including unannounced visits) to ensure participating hospital and residential settings meet state’s licensing or certification and accreditation requirements</p>	<p><i>Current Status: Provide information on current state policies and requirements for ensuring quality of care in psychiatric hospitals and residential settings.</i></p> <p>Milestone achieved.</p> <p>All NYS-operated psychiatric hospitals are operated by the NYS Office of Mental Health (OMH) and contracted with The Joint Commission (TJC) for ensuring they meet the CMS Conditions of Participation. The state-operated psychiatric hospitals are inspected by TJC on a triennial basis and receive an unannounced Inspection of Care audit annually.</p> <p>Accreditation by The Joint Commission offers deemed status with CMS. The process for NYS-operated psychiatric hospitals to achieve survey readiness and subsequent accreditation is rigorous and includes the following:</p> <p><b><u>QUALITY IMPROVEMENT TRACKER</u></b> – Facilities are continually assessed for potential vulnerabilities using the Quality Improvement Tracker. In collaboration with the Lean program and Clinical Risk Management, External Review staff collects information from Quality Directors and facility leadership related to potential condition level findings, recurrent findings, active treatment and staffing. These data are reviewed monthly among Operations, Health Services, Nursing Services, Capital Operations and physician leadership. Facilities with an elevated vulnerability status receive additional technical assistance and consultation.</p> <p><b><u>SHARING BEST PRACTICES</u></b> – External Review conducts periodic “distance learning” and onsite sessions with facility staff on challenging topics and new standards. Information is maintained and shared using tools such as an internal SharePoint site.</p> <p><b><u>TECHNICAL ASSISTANCE VISITS</u></b> – Focused support and assistance about TJC or CMS topic areas presenting survey vulnerability. This may include review of policies, procedures, audits, tracers and environmental observations, as well as staff education.</p> <p><b><u>SURVEYS</u></b> – External Review Liaisons are on site for CMS and TJC surveys and report on the status of the survey to the Director of External Review daily. The Director of External Review follows up as indicated.</p>

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Prompts	Summary
	<p><b><u>JOINT COMMISSION RESOURCES (JCR) CONTRACTOR VISITS</u></b> – These visits focus on topics of specific interest to facility leadership. Each participating facility receives a two-day visit from a JCR contractor.</p> <p><b><u>LIGATURE REMEDIATION CALLS</u></b> – External Review hosts monthly (or as needed) calls with facility leadership and Capital Operations to determine the status of existing ligature risks in hospitals. The calls focus on the status of risk assessments, remediation efforts, staff education, mitigation plans and compliance with related policies. External Review tracks progress and maintains the Condition Level Tracker.</p> <p><b><u>UNANNOUNCED SURVEYS</u></b> – In cooperation with State Operations, Health Services, and Capital Operations, External Review coordinates and conducts on site unannounced surveys to identify survey vulnerabilities. These surveys address previous Readiness Assessments, facility Plans of Corrective Actions (POCAs), and the status of Quality Improvement and the Condition Level Trackers. Reports of the findings identify areas of non-compliance which are shared following the survey. Facilities provide written responses and are responsible for addressing areas identified as needing improvement.</p> <p>External Review also conducts the following assessments:</p> <ul style="list-style-type: none"> <li>• <b>Special Issues Survey Readiness visit:</b> <ul style="list-style-type: none"> <li>○ Timeframe: 9-12 months following the facility’s TJC survey</li> <li>○ Focus: Implementation of Evidence of Standards Compliance (ESC), National Patient Safety Goals (NPSG), and high-profile areas</li> </ul> </li> <li>• <b>Full Survey Readiness Assessment:</b> <ul style="list-style-type: none"> <li>○ Timeframe: 18-21 months following the facility’s TJC survey</li> <li>○ Focus: Review of TJC standards and the CMS 2 Special Conditions of Participation for Psychiatric Hospitals (as applicable), review of TJC Document List</li> </ul> </li> <li>• <b>Full Survey Readiness Assessment follow-up conference call:</b> <ul style="list-style-type: none"> <li>○ Timeframe: Will be scheduled following the submission of the RAR</li> <li>○ Focus: Review of the Readiness Assessment Response (RAR)</li> </ul> </li> <li>• <b>Full Survey Readiness Assessment follow-up visit:</b> <ul style="list-style-type: none"> <li>○ Timeframe: 24-30 months following the facility’s TJC survey</li> <li>○ Focus: Review of implementation of the RAR</li> </ul> </li> <li>• <b>Focused technical assistance visits:</b> <ul style="list-style-type: none"> <li>○ Timeframe: As needed</li> </ul> </li> </ul>

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Prompts	Summary
	<ul style="list-style-type: none"> <li>○ Focus: Address issues as identified by the External Review liaison and/or the facility Quality Director</li> </ul> <p><i>Inspections of Care Surveys continue annually for Medicaid funded psychiatric hospitals.</i></p> <p>In addition, all licensed Article 28 and Article 31 inpatient psychiatric facilities are re-certified every three years by the Office of Mental Health’s Bureau of Inspection and Certification. Collaborative Agreements between OMH and three accrediting agencies supports deemed status. All licensed RTFs are recertified every three years by the Office of Mental Health’s Bureau of Inspection and Certification.</p>
	<p><i>Future Status: Describe planned activities to address milestone not already met and any other plans for enhanced quality assurance policies for inpatient and residential treatment settings.</i></p> <p>Unannounced site visits were conducted by Joint Commission Resources prior to the 2022 survey cycle. Other activities listed above will continue.</p> <p>Software available for purchase through Joint Commission Resources will support State psychiatric center adherence to standards. This software package, known as Accreditation Manager Plus, was used in the 2022 survey cycle.</p> <p>Following the 2022 TJC survey cycle completion, the Office of Quality Improvement will assess lessons learned and determine which changes are needed to the readiness review process.</p> <p>The IOC survey process will continue to evolve to support patient safety and documentation findings.</p>
	<p><i>Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action.</i></p> <p>Implement AMP software by August 2021, led by External Review staff in OMH Central Office and carried out at each State-operated hospital under the direction of each Quality Director.</p> <p>De-brief from TJC surveys and modify survey readiness activities by the end of calendar year 2023.</p>

Prompts	Summary
<p>1.c Utilization review process to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight on lengths of stay</p>	<p><i>Current Status: Provide information on current state policies and requirements for ensuring quality of care in psychiatric hospitals and residential settings.</i></p> <p>Milestone achieved.</p> <p>The NYS Office of Mental Health (OMH) Community Reintegration Unit (CRU) focuses on assisting the state-operated psychiatric hospitals in the safe and timely movement of patients through the continuum of state -operated care, back to the individual’s community of choice. The CRU team accords high priority to medically complex, high-risk, and special needs patients. These special populations comprise the majority of long-stay individuals and often have the most significant barriers to discharge.</p> <p>Through regular transitional care planning calls, the CRU team works with state-operated psychiatric hospitals to identify discharge barriers, develop plans to manage these populations early in their hospitalization and work towards community (re)integration. The CRU team provides consultation to the state-operated psychiatric hospitals and facilitates connections with subject matter experts for medical, psychiatric, behavioral, and programmatic concerns. The CRU team works with state and community partners to coordinate supports and interventions to reduce lengths of stay, expedite safe discharges, and foster long-term stability in the community.</p> <p>The CRU team also participates in pre-admission calls with the state-operated psychiatric hospitals to assist with screening individuals to determine the individual’s appropriateness for admission, a lower level of care before an individual is admitted into the state-operated psychiatric hospital.</p> <p>In addition, the state-operated psychiatric hospitals each have a utilization review management plan which includes regular and routine review of records to ensure patients are at an appropriate level of care.</p> <p>The CRU team provides consultation to the state-operated psychiatric hospitals to facilitate connections with experts for medical and psychiatric consults, and with state and community partners to coordinate supports and interventions to reduce lengths of stay, expedite safe discharges, and foster long-term stability in the community.</p> <p><i>Future Status: Describe planned activities to address milestone not already met and any other plans for enhanced quality assurance policies for inpatient and residential treatment settings.</i></p>



Prompts	Summary
	<p>No changes are expected.</p> <p><i>Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action.</i></p> <p>None.</p>
<p>1.d Compliance with program integrity requirements and state compliance assurance process</p>	<p><i>Current Status: Provide information on current state policies and requirements for ensuring quality of care in psychiatric hospitals and residential settings.</i></p> <p>Milestone achieved.</p> <p>OMH’s Medicaid Compliance Program includes a system for routine identification of compliance risk areas specific to the provider type, for self-evaluation of such risk areas, including but not limited to internal audits and as appropriate external audits, and for evaluation of potential or actual non-compliance as a result of such self-evaluations and audits, credentialing of providers and persons associated with providers, mandatory reporting, governance, and quality of care of medical assistance program beneficiaries; 18 NYCRR 521.3(c)(6).</p> <p>OMH has various processes and systems for routine identification of its risk areas, including self-evaluation, auditing and monitoring activities relating to operational compliance risk areas. The Compliance Officer shall maintain written documentation of monitoring activities, as well as a prioritized list of those identified risks. These are detailed in OMH Official Policy Manual, Medicaid Compliance Program.</p> <p><i>Future Status: Describe planned activities to address milestone not already met and any other plans for enhanced quality assurance policies for inpatient and residential treatment settings.</i></p> <p>No changes are expected.</p> <p><i>Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action.</i></p>

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Prompts	Summary
	None.
<p>1.e State requirement that psychiatric hospitals and residential settings screen beneficiaries for co-morbid physical health conditions, SUDs, and suicidal ideation, and facilitate access to treatment for those conditions</p>	<p><i>Current Status: Provide information on current state policies and requirements for ensuring quality of care in psychiatric hospitals and residential settings.</i></p> <p>Milestone achieved.</p> <p>New York State-operated and licensed psychiatric hospitals are required to conduct comprehensive assessments on the physical and behavioral health needs of individuals within twenty-four hours of admission and provide or facilitate access to treatment for all identified comorbidities, substance use disorders, and suicidal ideation. Individuals with physical health needs that exceed the ability of a state hospital are treated by community providers through direct contract with the state.</p> <p>Additionally, the New York State Office of Mental Health has a Medical Director solely dedicated to physical health needs of hospital inpatients. This leader oversees OMH’s Bureau of Health Services which includes dental and pharmacy services.</p> <p><i>Future Status: Describe planned activities to address milestone not already met and any other plans for enhanced quality assurance policies for inpatient and residential treatment settings.</i></p> <p>No changes are expected.</p> <p><i>Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action.</i></p> <p>None.</p>
<p>1.f Other state requirements/policies to ensure good quality of care in inpatient and residential treatment settings.</p>	<p><i>Current Status: Provide information on current state policies and requirements for ensuring quality of care in psychiatric hospitals and residential settings.</i></p> <p>Milestone achieved.</p>

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Prompts	Summary
	<p>The NYS Office of Mental Health employs a thorough quality improvement philosophy based in LEAN and Six Sigma principles. Monthly review of each State hospital along key performance domains allows teams to surface and solve problems. Tools include the Office of Quality Improvement (OQI) Tracker and the Inpatient Care Tracker.</p> <p>Periodic licensing reviews evaluate care delivery and quality according the specific, measurable criteria. In addition, ad hoc monitoring reviews take place, as needed. Performance Improvement Plans may be required following patterns of aberrant results, and/or incidents involving allegations or abuse/neglect or other reportable incidents. Subsequent review and follow-up on corrective actions is required.</p> <p>Licensed settings have quality-related infrastructure which includes, at a minimum, Risk Management, Incident Review Committees and patient rights programs to ensure quality and compliance with mandatory quality reporting and proactive continuous quality improvement activities.</p> <p><i>Future Status: Describe planned activities to address milestone not already met and any other plans for enhanced quality assurance policies for inpatient and residential treatment settings.</i></p> <p>NYS OMH is in the process of operationalizing policies and procedures for each state-operated psychiatric hospital’s governing body to incorporate additional data and metrics reviews into routine meetings.</p> <p><i>Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action.</i></p> <p>Access to data must be regularly available, accessible, and easily understood by treatment setting leaders. OMH’s Office for Population Health and Evaluation is equipped to support these efforts and is implementing additional structures to achieve these goals for state-operated and community based licensed providers by late-2022.</p>
<p><b>SMI/SED. Topic 2. Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care</b></p>	

Prompts	Summary
	<p><i>Understanding the services needed to transition to and be successful in community-based mental health care requires partnerships between hospitals, residential providers, and community-based care providers. To meet this milestone, state Medicaid programs, must focus on improving care coordination and transitions to community-based care by taking the following actions.</i></p>
	<p><b>Improving Care Coordination and Transitions to Community-based Care</b></p>
<p>2.a Actions to ensure psychiatric hospitals and residential settings carry out intensive pre-discharge planning and include community-based providers in care transitions.</p>	<p><i>Current Status: Provide information on the state’s current care coordination benefits/requirements including actions to connect beneficiaries with community-based care including pre-discharge planning, post discharge follow-up, and information-sharing among providers.</i></p> <p>Milestone achieved.</p> <p>The New York State Office of Mental Health (OMH) has an ongoing, intensive program to assist individuals in preparing for discharge to the community. All people being discharged from a psychiatric center work with a discharge planner who helps connect them to services in their community.</p> <p>Additionally, New York State suspends Medicaid for individuals admitted and state psychiatric hospitals. Hospital discharge planners work with counties to reactivate Medicaid upon discharge. New York has a Medication Grants program to ensure access to medication upon discharge for uninsured and other individuals until they become stable in the community. For long stay populations, New York provides intensive support services to help them reintegrate into the community. This includes state - operated Mobile Integration Teams (MIT) that wrap community support services around discharged patients during transition to the community, and for as long as they need them to remain in the community.</p>
	<p><i>Future Status: Describe planned improvements to care coordination benefits/requirements and connections to community-based care, including pre-discharge planning, post discharge follow-up, and information-sharing among providers.</i></p> <p>The NYS OMH is in the process of incorporating screenings for Assertive Outpatient Treatment prior to individuals being discharged from a state-operated psychiatric hospital. Discharge planning assesses individual readiness for independent community living through review of ability to self-administer medications, procure and prepare nutritious food, and support oneself in the housing/residential settings available to them at the time of discharge.</p>

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Prompts	Summary
	<p><i>Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action.</i></p> <p>None.</p>
<p>2.b Actions to ensure psychiatric hospitals and residential settings assess beneficiaries' housing situations and coordinate with housing services providers when needed and available.</p>	<p>Milestone achieved.</p> <p><i>Current Status:</i></p> <p>The State Psychiatric Center inpatient and residential staff are required to begin discharge planning upon admission. Planning includes a comprehensive evaluation of the individual's skills, abilities, life goals, economic supports, community supports and prior life circumstances that led to hospitalization or residential placement. Teams then actively work to stabilize the individual's symptoms, restore and build life skills for self-sufficiency, engage their social supports, connect them to financial benefits, complete referrals and coordinate the transition of care to appropriate community mental health, medical and housing providers.</p> <p>NYS-operated inpatient psychiatric facilities assess an individual's housing needs prior to discharge. If it is determined that an individual needs housing services, the psychiatric facility works with the Single Point of Access (SPOA), or the Human Resources Administration in New York City, to provide a referral to housing providers. Once the housing provider accepts the referral to house an individual upon discharge from the psychiatric facility, the residential entity works with the psychiatric facility to determine the best placement and the wrap-around services needed to ensure the individual is stable and successfully housed in the community. These wrap-around services could include clinic, care management, Assertive Community Treatment, and Personalized Recovery Oriented Services. For psychiatric residential treatment facilities, the Children's Single Point of Access (C-SPOA) guides the referral process; potential wrap-around services include Youth ACT and CFTSS.</p> <p><i>Future Status: Describe planned improvements to care coordination benefits/requirements and connections to community-based care, including pre-discharge planning, post discharge follow-up, and information-sharing among providers.</i></p>

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Prompts	Summary
	<p>Future status includes enhanced individual preparation for discharge through better housing applications, more detailed preparation for housing interviews and clear articulation of individual strengths at the point of discharge. OMH is placing enhanced focus on individual strengths and knowledge of necessary skills for independent living, as part of placement in housing settings.</p> <p><i>Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action.</i></p> <p>Facility discharge planning staff and Central Office State Operations staff continue to refine housing and placement procedures in collaboration with hospital-based peer advocates. These improvements are underway and are expected to continue into late 2022.</p>
<p>2.c State requirement to ensure psychiatric hospitals and residential settings contact beneficiaries and community-based providers through most effective means possible, e.g., email, text, or phone call within 72 hours post discharge</p>	<p><i>Current Status: Provide information on the state's current care coordination benefits/requirements including actions to connect beneficiaries with community-based care including pre-discharge planning, post discharge follow-up, and information-sharing among providers.</i></p> <p>Milestone achieved.</p> <p>Staff conduct a post-discharge follow up phone call to individuals within 48-hours of discharge from state-operated psychiatric centers. This phone call provides an opportunity to review discharge plans, including medications and aftercare appointments, answer questions and address any issues or concerns. Follow up calls should be made as needed until the individual has been successfully linked with an outpatient treatment provider. Additional contacts are made, when possible, to collaterals and/or other involved providers, as clinically indicated, to support the engagement in aftercare services. In addition, staff access the Psychiatric Services &amp; Clinical Knowledge Enhancement System (PSYCKES) database, which maintains and arrays robust Medicaid claims data, to assess patient-specific needs and risk levels. Providers have access to PSYCKES and use it to assess important treatment indicators such as prior hospitalizations, medication histories and co-morbid physical health conditions, when known.</p>

Prompts	Summary
	<p><i>Future Status: Describe planned improvements to care coordination benefits/requirements and connections to community-based care, including pre-discharge planning, post discharge follow-up, and information-sharing among providers.</i></p> <p>Future status includes continuation of the PSYCKES High Risk Quality Collaboratives to help licensed providers better serve hard to engage and high - risk individuals.</p> <hr/> <p><i>Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action.</i></p> <p>None</p>
<p>2.d Strategies to prevent or decrease lengths of stay in EDs among beneficiaries with SMI or SED prior to admission</p>	<p><i>Current Status: Provide information on the state's current care coordination benefits/requirements including actions to connect beneficiaries with community-based care including pre-discharge planning, post discharge follow-up, and information-sharing among providers.</i></p> <p>Milestone achieved.</p> <p>All New York State community hospitals and emergency departments (EDs) or emergency rooms have access to PSYCKES. PSYCKES provides information on Medicaid individual behavioral and physical health histories, Health Home status, outpatient providers, and medications. Additionally, all EDs and inpatient facilities are required to engage in discharge planning. New York State is in the process of enhancing crisis stabilization programs to divert people from EDs. New York State also has twenty-one licensed Comprehensive Psychiatric Emergency Room Programs (CPEPs) designed to assess and appropriately treat individuals with SMI and SUD. Continuous assessment of individuals' needs by all providers engaged in their care is a priority. These providers work with the individual to support continued stability in the community and ensure the implementation of recovery-based services for that individual.</p> <p>Finally, New York State's DSRIP focused on reducing unnecessary admissions and readmissions for people with mental illness or substance use conditions and learnings from DSRIP are being applied.</p> <hr/> <p><i>Future Status: Describe planned improvements to care coordination benefits/requirements and connections to community-based care, including pre-discharge planning, post discharge follow-up, and information-sharing among providers.</i></p>

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Prompts	Summary
	<p>Expand crisis diversion programs and mobile crisis teams.                      Incorporate lessons learned through DSRIP into standard community practice.                      Increase the number of CPEPs in the State, including programs located in populous areas outside of NYC.                      Fund CPEPs for Peer Specialists and Peer Bridgers to improve viable connections to treatment and services in the community.                      Implement best practices identified in the High Risk Quality Collaborative (HRQC) for CPEPs and EDs.                      Implementation of improved and frequent data metrics from the CPEPs to OMH.</p> <p><i>Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action.</i></p> <p>Submitted a State Plan Amendment to expand Medicaid funded mobile crisis services, crisis residences and crisis stabilization centers for adults and to fund crisis intervention services for both adults and children retroactive to 2022.</p>
<p>2.e Other State requirements/policies to improve care coordination and connections to community-based care</p>	<p><i>Current Status: Provide information on the state's current care coordination benefits/requirements including actions to connect beneficiaries with community-based care including pre-discharge planning, post discharge follow-up, and information-sharing among providers.</i></p> <p>Milestone achieved.</p> <p>In addition to PSYCKES, all individuals that are members of Health and Recovery Plans (HARPs), which are Special Needs Medicaid Managed Care Plans for individuals with serious mental illness and substance use disorders are automatically eligible for Medicaid Health Home care coordination.</p> <p>Additionally, New York State is a CCBHC demonstration state. There are currently 13 CCBHCs, all of whom provide care coordination as a required service. Furthermore, NYS has 44 providers who received directly from SAMHSA a two- year CCBHC Expansion Grant. These grants require enhanced care coordination.</p> <p>New York State has designated Specialty Mental Health Care Management Agencies (CMAs) within the NYS Health Home networks to serve the highest need individuals with SMI, including those being discharged from State PSYCHIATRIC CENTERS. Specialty CMAs will provide Health Home Plus (HH+), an intensive level of care</p>

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Prompts	Summary
	<p>management support that includes experienced care managers providing face to face interventions, helping individuals to remain in the community.</p> <p><i>Future Status: Improvements include enhanced care coordination for people with SMI and connections to community-based care, including pre-discharge planning, post discharge follow-up, and information-sharing among providers. These will occur</i></p> <p>As noted above, New York has designated Specialty Mental Health Care Management Agencies (CMAs) to serve individuals with SMI                      The State received approval to move the OMH Article 31 clinic into the rehabilitation State Plan Amendment option. This change, is enacted, will further support individuals in the community and assist in preventing hospitalizations by allowing clinicians to go off-site to support individuals who may be approaching crisis and/or who may have disengaged from care. This change will also extend Peer Support services to better engage high need individuals.</p> <p><i>Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action.</i></p> <p>None.</p>
<p><b>SMI/SED. Topic 3. Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services</b></p>	
<p><i>Adults with SMI and children with SED need access to a continuum of care as these conditions are often episodic and the severity of symptoms can vary over time. Increased availability of crisis stabilization programs can help to divert Medicaid beneficiaries from unnecessary visits to EDs and admissions to inpatient facilities as well as criminal justice involvement. On-going treatment in outpatient settings can help address less acute symptoms and help beneficiaries with SMI or SED thrive in their communities. Strategies are also needed to help connect individuals who need inpatient or residential treatment with that level of care as soon as possible. To meet this milestone, state Medicaid programs should focus on improving access to a continuum of care by taking the following actions.</i></p>	
<p><b>Access to Continuum of Care Including Crisis Stabilization</b></p>	

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Prompts	Summary
<p>3.a The state’s strategy to conduct annual assessments of the availability of mental health providers including psychiatrists, other practitioners, outpatient, community mental health centers, intensive outpatient/partial hospitalization, residential, inpatient, crisis stabilization services, and FQHCs offering mental health services across the state, updating the initial assessment of the availability of mental health services submitted with the state’s demonstration application. The content of annual assessments should be reported in the state’s annual demonstration monitoring reports.</p>	<p><i>Current Status: Provide information on the status of the state's assessment of mental health provider availability and an overview of the current continuum of care, including crisis stabilization, the state’s ability of the state to track availability of beds, and the use of patient assessment tools.</i></p> <p>Milestone achieved.</p> <p>The New York State Office of Mental Health provides information about the public mental health system as part of the annual 507 planning process required by State law. Comprehensive reports are required every five years, and interim reports are completed annually.</p> <p>In addition, every two years the New York State Office of Mental Health conducts the Patient Characteristics Survey (PCS), which collects demographic, clinical, and service-related information for each individual that receives a public mental health services within a defined time period.</p> <p>Furthermore, the Bed Availability System, which is part of New York’s Health Commerce System, is a self-service portal used by licensed hospitals to share their available bed capacity. Inpatient mental health providers report available capacity on a regular basis.</p> <p><i>Future Status: Describe plans to expand community-based services, including references to the financing plan as appropriate, and the state’s plans to improve annual assessments of the availability of mental health providers and the state’s ability to track availability of beds, and plans to encourage widespread use of patient assessment tools.</i></p> <p>No changes are expected.                      The content of annual assessments will be reported in the state’s annual demonstration monitoring reports.</p> <p><i>Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action.</i></p> <p>None.</p>
<p>3.b Financing plan</p>	<p><i>Current Status: Provide information on the status of the state's assessment of mental health provider availability and an overview of the current continuum of care, including crisis stabilization, the state’s ability of the state to track availability of beds, and the use of patient assessment tools.</i></p>

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Prompts	Summary
	<p>Milestone achieved.</p> <p>New York State tracks daily availability of community inpatient psychiatric beds. New York State Medicaid program covers a continuum of clinical and rehabilitation mental health services including community-based mental health clinics, intensive outpatient clinical programs, personalized recovery-oriented services program (PROS), and Assertive Community Treatment (ACT).</p> <p>NYS licenses, funds and/or operates 108 ACT teams across the state, with several teams specially designed to serve the shelter population, and individuals with forensic histories. There are 81 licensed PROS programs across the state, which provide psychosocial rehabilitation and treatment, helping individuals to regain the skills and supports necessary to remain in the community and promote life role goals in areas of independent living, employment, education and socialization.</p> <p>The NYS 1115 Managed Care Waiver allows for approved clinic rehabilitation through the State Plan Amendment. Adults with SMI in Medicaid Managed Care are eligible for enrollment in a specialized Health and Recovery Plan (HARP), which provides specialized behavioral health expertise and access to Health Home care management. Members of HARPs also have access to an array of rehabilitative services such as Psychosocial Rehabilitative Services, Peer Support, Supported Employment, Supported Education.</p> <p>NYS licenses 22 comprehensive psychiatric emergency programs (CPEPs) to deal with emergent mental health needs. Several CPEPs serve children, as well as adults.</p> <p>New York State is working to increase the availability of non-hospital crisis stabilization services. The New York State Office of Mental Health is working with local governments to coordinate a state-wide crisis response system which enables all New Yorkers to access mobile crisis (including telephonic triage, mobile response, telephonic follow-up, and mobile follow-up) services, and is in the process of implementing Crisis Residential Programs for children, adolescents, and adults. NYS has demonstration authority through the 1115 Waiver Crisis Intervention Benefit to reimburse state-approved providers for these services provided to adults, and a children’s crisis intervention EPSDT state plan amendment. for children/youth up to twenty-one. NYS will be licensing crisis residences under the NYS 589 regulations.</p>

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Prompts	Summary
	<p>In addition, New York State currently has federal demonstration authority for thirteen Certified Community Behavioral Health Centers (CCBHCs) to operate throughout the state until September of 2023. New York State has submitted a State Plan Amendment to continue to operate the CCBHCs after the demonstration period ends and to potentially increase the number of CCBHCs receiving a Medicaid rate prior to the end of the demonstration.</p> <p><i>Future Status: Describe plans to expand community-based services, including references to the financing plan as appropriate, and the state’s plans to improve annual assessments of the availability of mental health providers and the state’s ability to track availability of beds, and plans to encourage widespread use of patient assessment tools.</i></p> <p>Continued expansion of mobile and crisis stabilization services.                      Work with CMS to get an approved CCBHC State Plan Amendment that could be used to enable CCBHC Expansion grants to continue after the SAMHSA grant has ended through the provision of a Medicaid rate.</p> <p><i>Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action.</i></p> <p>None.</p>
<p>3.c Strategies to improve state tracking of availability of inpatient and crisis stabilization beds</p>	<p><i>Current Status: Provide information on the status of the state's assessment of mental health provider availability and an overview of the current continuum of care, including crisis stabilization, the state’s ability of the state to track availability of beds, and the use of patient assessment tools.</i></p> <p>Milestone achieved.</p> <p>The New York State Office of Mental Health launched an electronic bed tracking system in September 2018 to improve the method in which information is collected and maintained statewide. The Bed Availability System (BAS) expects all hospitals in New York State to report psychiatric inpatient bed availability twice daily. OMH Field Offices, County Mental Health Directors and all general hospitals, psychiatric hospitals, and OMH State-operated hospitals have access to the search tool for immediate, up-to-date information.</p> <p><i>Future Status: Describe plans to expand community-based services, including references to the financing plan as appropriate, and the state’s plans to improve annual assessments of the availability of mental health providers and the state’s ability to track availability of beds, and plans to encourage widespread use of patient assessment tools.</i></p> <p>No changes are expected.</p>

Prompts	Summary
	<p><i>Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action.</i></p> <p>None.</p>
<p>3.d State requirement that providers use a widely recognized, publicly available patient assessment tool to determine appropriate level of care and length of stay</p>	<p><i>Current Status: Provide information on the status of the state's assessment of mental health provider availability and an overview of the current continuum of care, including crisis stabilization, the state's ability of the state to track availability of beds, and the use of patient assessment tools.</i></p> <p>Milestone achieved.</p> <p>During pre-admission and referral to civil, adult psychiatric centers, all providers across NYS submit an Inpatient Referral Form (IRF), which is an online standardized admission assessment tool available to all referral sources. The IRF is submitted through the state's Health Commerce System (HCS) in order to maintain security of Protected Health Information. The IRF surveys an individual's clinical status at the time of referral to determine whether inpatient setting is needed.</p> <p>Using the IRF, staff may query the referring provider to ensure that their request for inpatient level of care is needed, and why. Also, discussion may take place regarding whether recommendations can be offered that may help the patient engage in alternative, less restrictive care settings.</p> <p>Upon admission, the patient's team engages in clinical assessment and uses shared decision-making approaches with the patient to ensure the development of a treatment plan designed to be inter-disciplinary, active-treatment focused, and patient-centered.</p> <p>During intermediate care admission, ongoing evaluation for active psychotic symptomatology occurs using standardized assessment tools such as PHQ9, GAD7, and mania scores.</p> <p>Ongoing evaluation of patient's medical comorbidities as related to antipsychotic/mood stabilizing medications, i.e. AIMS, metabolic monitoring, etc. takes place to ensure the patient's appropriateness for continued stay in a psychiatric facility. In addition, upon reviewing case status, if patient appears to be refractory, consultation service is available for behavioral or psychopharmacological recommendations.</p>

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Prompts	Summary
	<p><i>Future Status: Describe plans to expand community-based services, including references to the financing plan as appropriate, and the state’s plans to improve annual assessments of the availability of mental health providers and the state’s ability to track availability of beds, and plans to encourage widespread use of patient assessment tools.</i></p> <p>NYS will continue its efforts to ensure providers and insurers are working together to promote access for individuals into structured levels of care. NYS also plans to continue its work to align practices with OMH’s Guiding Principles. Identification of all available wrap around service to support patient and engagement with community for discharge placement with treatment team will continue.</p> <p><i>Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action.</i></p> <p>None.</p>
<p>3.e Other state requirements/policies to improve access to a full continuum of care including crisis stabilization</p>	<p><i>Current Status: Provide information on the status of the state's assessment of mental health provider availability and an overview of the current continuum of care, including crisis stabilization, the state’s ability of the state to track availability of beds, and the use of patient assessment tools.</i></p> <p>The NYS Office of Mental Health (OMH) displays provider and program information to the public via the OMH Program Finder/Mental Health Program Directory (<a href="https://my.omh.ny.gov/bi/pd/saw.dll?PortalPages">https://my.omh.ny.gov/bi/pd/saw.dll?PortalPages</a>).</p> <p>As part of the 1115 Waiver implemented in 2015, behavioral services were carved into Medicaid Managed Care and a special needs plan called a Health and Recovery Plan (HARP) was created to provide behavioral health services to individuals with significant mental illness and substance use disorder needs. As part of this transition, NYS incorporated an array of behavioral health home and community-based services (BH HCBS) into the HARP to assist individuals meet their recovery goals. To access BH HCBS, HARP enrollees have to complete a functional needs assessment to assist with determining areas in which there are unmet needs and which BH HCBS they are eligible for. More recently, the State has worked with CMS to streamline access to these services by moving some of the Adult BH HCBS to rehabilitation state plan</p> <p>In July 2019 OMH expanded its tele-mental health regulations to include additional practitioners (psychologists, social workers, mental health counselors, marriage &amp; family therapists, creative arts therapists, and psychoanalysts); to include home offices and private practices {prescribers may be anywhere in the US; other practitioners must be in</p>

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Prompts	Summary
	<p>NYS}; to allow recipients to be located at home, or at another temporary location within/outside NYS while receiving services; and to include ACT and PROS as eligible treatment settings. During the COVID-19 Disaster Emergency, OMH provided both regulatory and billing flexibility to enable a significant expansion in the provision of tele-mental health. OMH extended waivers to allow greater tele-mental health flexibility, including: an emergency attestation process to enable rapid initiation of tele-mental health; ability to obtain consent to initiate services verbally and document in the Electronic Health Records; allowing services to begin without an in initial in-person visit; expanding the types of providers able to provide services; allowing New York State (NYS) licensed providers living outside of NYS to provide tele-mental health services in NYS; and allowing telehealth for inpatient admission evaluations including involuntary admissions. One of the most significant expansions was allowing for services to be able to be provided over the telephone and other audio/visual platforms, including common smartphones.</p> <p><i>Future Status: Describe plans to expand community-based services, including references to the financing plan as appropriate, and the state’s plans to improve annual assessments of the availability of mental health providers and the state’s ability to track availability of beds, and plans to encourage widespread use of patient assessment tools.</i></p> <p>In an effort to increase access to mental health services, OMH is planning to make many of the telehealth regulatory flexibilities permanent, including: the ability to provide services using telephonic means; expanding practitioner types to include peers and paraprofessionals; expanding where practitioners may be located beyond NYS; removal of the first visit in-person requirement; and allowing telehealth to satisfy one of the MHL Article 9 required physician certificates.</p> <p><i>Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action.</i></p> <p>None.</p>
<p><b>SMI/SED. Topic_4. Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration</b></p>	
<p><i>Critical strategies for improving care for individuals with SMI or SED include earlier identification of serious mental health conditions and focused efforts to engage individuals with these conditions in treatment sooner. To meet this milestone, state Medicaid programs must focus on improving mental health care by taking the following actions.</i></p>	
<p><b>Earlier Identification and Engagement in Treatment</b></p>	

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Prompts	Summary
<p>4.a Strategies for identifying and engaging beneficiaries with or at risk of SMI or SED in treatment sooner, e.g., with supported employment and supported programs</p>	<p><i>Current Status: Provide information on current strategies to increase earlier identification/ engagement in treatment, integration of behavioral care in non-specialty settings, and specialized programs for young people with SED/SMI.</i></p> <p>Milestone achieved.</p> <p>New York State has numerous initiatives in place to identify and engage Medicaid beneficiaries with, or at risk of, SMI or SED. These include:</p> <ol style="list-style-type: none"> <li>1. A range of Children and Family Treatment and Support Services including: Crisis Intervention, Community Psychiatric Supports and Treatment, Psychosocial Rehabilitation, Family Peer Support Services, and Youth Peer Support and Training. Many of these services were formerly HCBS services; moving them to the State Plan allows more children and families to access them sooner, before functional deficits set in.</li> <li>2. Children’s HCBS Waiver with services including: Community Habilitation, Day Habilitation, Caregiver/Family Support and Services, Community Self Advocacy Training and Support, Prevocational Services, Supported Employment, Respite Services (planned and crisis), Palliative Care, Environmental Modifications, Adaptive and Assistive Equipment and Non-medical Transportation. These services support children, youth, and families and can prevent the need for residential and inpatient services.</li> <li>3. First Episode Psychosis services</li> <li>4. School-based mental health clinics allow school-age children broader access to clinical services. NYS has seen tremendous growth in school-based clinics; currently, we have 845 across the state.</li> <li>5. Project TEACH offers education and training, psychiatric consultation, and referral services available to all prescribers in NYS. The overall goal is to enhance the capacity of pediatric primary care to address the needs of children and adolescents with mild to moderate mental illness, thus increasing the likelihood that problems will be identified and addressed earlier.</li> <li>6. Other (please add as appropriate): NYS OMH is partnering with the NYS DOH to cultivate workforce capacity to address infant and early childhood mental health (IECMH). Over 800 individuals have been trained to use the DC:0-5, which is the most appropriate diagnostic tool for this population. There are plans to train approximately 150-300 more in the coming year.</li> <li>7. Personalized Recovery Oriented Services- includes psychosocial rehabilitation interventions supporting individuals with education and employment goals, offering the full Individual Placement and Support (IPS) evidenced-based practice.</li> <li>8. Adult BH HCBS for HARP enrollees provides several employment support and education services</li> </ol>

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Prompts	Summary
	<p><i>Future Status: Describe planned strategies to increase early identification/ engagement in treatment, integration of behavioral health care in non-specialty settings, and availability of specialized programs for young people with SED/SMI.</i></p> <p>NYS will request authorization of Medicaid coverage for a targeted set of in-reach services up to 30 days prior to discharge for individuals hospitalized in a State-operated IMDs. These services include care management, clinical consultations, peer services, and pharmaceutical management. These services will help to increase engagement in treatment and reduce inpatient lengths of stay for Medicaid enrolled individuals in state-operated psychiatric center IMDs.</p> <p><i>Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action.</i></p> <p>Future Status initiatives will require planning and coordination among billing and operational staff within the NYS State-operated IMD structures. Such planning and coordination will be documents in project plans with timelines and accountabilities, pending CMS approval of NYS application.</p> <p>For the In-reach Waiver population, NYS will remove the exclusion from Medicaid Managed Care enrollment for individuals residing in state operated IMDs to streamline enrollment of this population into a Medicaid Managed Care plan upon discharge.</p>
<p>4.b Plan for increasing integration of behavioral health care in non-specialty settings to improve early identification of SED/SMI and linkages to treatment</p>	<p><i>Current Status: Provide information on current strategies to increase earlier identification/ engagement in treatment, integration of behavioral care in non-specialty settings, and specialized programs for young people with SED/SMI.</i></p> <p>New York State has a robust set of programs designed to bring behavioral health care into non-specialty settings. These include:</p> <ol style="list-style-type: none"> <li>1. Co-licensed FQHCs, which can deliver the full range of mental health and physical health services</li> <li>2. Integrated licensed clinics that can provide primary care as well as mental health treatment</li> <li>3. Project TEACH which provides psychiatric consultation to pediatricians and other prescribers</li> </ol>

Prompts	Summary
	<p>4. First Episode Psychosis programs</p> <p>5. NYS is supporting the implementation of HealthySteps within pediatric primary care settings. This is a primary prevention model which identifies needs in families with infants and very young children while they are participating in a pediatric well-child office visit. HealthySteps Specialists screen for Adverse Childhood Experiences, Maternal Depression, and social and emotional developmental milestones, then provide needed guidance and intervention. They prevent the use of harsh parenting techniques, increase school readiness, and reduce emergency room visits, among other positive outcomes.</p> <p>6. Children and Family Treatment and Support Services (CFTSS): child and family treatment and support services are intended to be mobile and can be delivered in schools, homes, and other community settings, broadening access and effectiveness.</p> <p>7. <u>DSRIP integrated care programs designed to bring behavioral health into primary care settings.</u></p> <p><i>Future Status: Describe planned strategies to increase early identification/ engagement in treatment, integration of behavioral health care in non-specialty settings, and availability of specialized programs for young people with SED/SMI.</i></p> <p>NYS will continue to expand availability of the programs listed above. In addition, NYS will request authorization of Medicaid coverage for a targeted set of in-reach services up to 30 days prior to discharge for individuals hospitalized in a State-operated IMDs. These services include care management, clinical consultations, peer services, and pharmaceutical management. These services will help to increase engagement in treatment and reduce inpatient lengths of stay for Medicaid enrolled individuals in state-operated psychiatric center IMDs.</p> <p><i>Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action.</i></p> <p>Future Status initiatives will require planning and coordination among billing and operational staff within the NYS State-operated IMD structures. Such planning and coordination will be documents in project plans with timelines and accountabilities, pending CMS approval of NYS application.</p> <p>For the In-reach Waiver population, NYS will remove the exclusion from Medicaid Managed Care enrollment for individuals residing in state operated IMDs to streamline enrollment of this population into a Medicaid Managed Care plan upon discharge.</p>

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Prompts	Summary
<p>4.c Establishment of specialized settings and services, including crisis stabilization, for young people experiencing SED/SMI</p>	<p><i>Current Status: Provide information on current strategies to increase earlier identification/ engagement in treatment, integration of behavioral care in non-specialty settings, and specialized programs for young people with SED/SMI.</i></p> <p>New York State is in the process of establishing Crisis Stabilization programs for children and adults. 9 Intensive Crisis Stabilization Awards were made in July 2022. An RFP for 3 additional ICSCs was re-issued on 11/4 (2 NYC EDR, 1 CR EDR) An RFP for 12 Supportive Crisis Stabilization Centers was released with awards anticipated in November 2022 All Crisis Stabilization Centers are required to have identified areas to serve children and are required to have staff available 24/7 who are trained in working specifically with children/youth/young people with SED/SMI.</p> <p>OMH is in the process of launching 2 new ACT Teams with an intentional focus on serving Young Adults (18-25), one in Brooklyn, NY and another in Erie County.</p> <p><i>Future Status: Describe planned strategies to increase early identification/ engagement in treatment, integration of behavioral health care in non-specialty settings, and availability of specialized programs for young people with SED/SMI.</i></p> <p>Reimbursement for crisis intervention services through a rehabilitation State Plan Amendment to CMS in 2022, including mobile crisis, crisis residence and crisis stabilization centers for Medicaid beneficiaries throughout the State, across the lifespan.</p> <p><i>Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action.</i></p> <p>None</p>
<p>4.d Other state strategies to increase earlier identification/engagement, integration, and specialized programs for young people</p>	<p><i>Current Status: Provide information on current strategies to increase earlier identification/ engagement in treatment, integration of behavioral care in non-specialty settings, and specialized programs for young people with SED/SMI.</i></p> <p>Project TEACH, a program that strengthens and supports the ability of New York’s pediatric primary care providers to deliver care to children and families who experience mild-to-moderate mental health concerns, has been in place in NYS since 2010. Statewide this program has offered over 18,000 consultations to 3,687 PSYCHIATRIC CENTERPs to date and has completed 6,066 referrals to specialty providers. These consultations began as telephonic and are now</p>

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Prompts	Summary
	<p>also available as telepsychiatry sessions, reflecting NY’s ongoing commitment to investing in multi-modal technology in order to extend access.</p> <p>In addition, OMH created the bureau of Transition Aged Youth (TAY) which is dedicated to focusing on the needs of individuals with mental health needs between the ages of 16-25. The TAY Bureau works with Adult and Children Program Divisions within OMH, and with the NYS Office of Children and Family Services to identify issues and barriers to care. In 2019 the TAY Bureau traveled statewide to meet with YouthPower, TAY populations, and their families to understand the current service landscape and issues.</p> <p><i>Future Status: Describe planned strategies to increase early identification/ engagement in treatment, integration of behavioral health care in non-specialty settings, and availability of specialized programs for young people with SED.</i></p> <p>No additional strategies are in place at this time. NYS will continue to expand availability of the programs listed above.</p> <p><i>Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action.</i></p> <p>None</p>
<p><b>SMI/SED.Topic 5. Financing Plan</b></p>	
<p><i>State Medicaid programs should detail plans to support improved availability of non-hospital, non-residential mental health services including crisis stabilization and on-going community-based care. The financing plan should describe state efforts to increase access to community-based mental health providers for Medicaid beneficiaries throughout the state, including through changes to reimbursement and financing policies that address gaps in access to community-based providers identified in the state’s assessment of current availability of mental health services included in the state’s application.</i></p>	
<p>F.a Increase availability of non-hospital, non-residential crisis stabilization services, including services made available through crisis call centers, mobile crisis units, observation/assessment centers, with a coordinated</p>	<p><i>Current Status</i></p> <p>There are 13 separate 988 Crisis Contact Centers throughout NYS that provide mental health crisis and suicide prevention services. There are 2 additional 988 Crisis Contact Centers in development. All 62 counties in NYS have access to an in-state 988 Crisis Contact Center.</p> <p>NYS currently has mobile crisis capacity in 50/62 counties in NYS. These services are based on identification by county mental hygiene directors and work collaboratively with local mental health and substance use providers and law enforcement based on the needs of their communities.</p>

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Prompts	Summary
<p>community crisis response that involves collaboration with trained law enforcement and other first responders.</p>	<p>Several crisis stabilization centers are in development and exist throughout New York State in different forms and licensing options.</p> <p><i>Future Status</i></p> <p>NYS has proposed a comprehensive crisis response system that includes the implementation of 988 as a single point of access for mental health crisis and suicide prevention. This system, described in the State Plan Amendment, will bring together local mobile crisis services, including crisis stabilization and crisis residences.</p> <p>The 988 Crisis Contact Centers will work collaboratively with their communities for streamlining access to other components of the comprehensive crisis response system, including mobile crisis teams, crisis residential programs, and crisis stabilization centers. 988 Crisis contact Centers are working with local 911 Public Service Answering Points will have identified protocols for the transfer of non-emergency behavioral calls to 988 Crisis Contact Centers.</p> <p>Mobile Crisis Services will be available 24/7 in all 62 counties in NYS. Mobile crisis teams will be created based on the needs of the communities they serve, including mobile crisis teams consisting of a licensed professional and peers or paraprofessionals, EMS and a licensed professional or co-response of law enforcement and a licensed professional.</p> <p><i>Summary of Actions Needed</i></p> <p>NYS will seek federal approval to expand Medicaid funded mobile crisis services to adults and fund crisis stabilization services for both adults and children in the end of 2021 or by April 1, 2022.</p>
<p>F.b Increase availability of on-going community-based services, e.g., outpatient, community mental health centers, partial hospitalization/day treatment, assertive community treatment,</p>	<p><i>Current Status</i></p> <p>NYS currently has 13 CCBHC demonstrations programs and 44 SAMHSA CCBHC Expansion grants. The demonstration program is currently slated to end September of 2023 and NYS is committed to continuing these programs through the available federal options (e.g., SPA). NYS is also reviewing options to maintain CCBHC Expansion grant programs that have received 2 years of funding from SAMHSA.</p>

Prompts	Summary
and services in integrated care settings such as the Certified Community Behavioral Health Clinic model.	<p><i>Future Status</i></p> <p>NYS will make CCBHC a permanent program structure through the appropriate federal program option and will use CCBHC Expansion grants as a mechanism to increase the number of CCBHCs in the state.</p> <hr/> <p><i>Summary of Actions Needed</i></p> <p>NYS will work with CMS on the CCBHC SPA submitted and follow up any other new federal actions that would make CCBHC a permanent program structure to expand the number of CCBHCs.</p>
<b>SMI/SED. Topic 6. Health IT Plan</b>	
<p><i>As outlined in State Medicaid Director Letter (SMDL) #18-011, “[s]tates seeking approval of an SMI/SED demonstration ... will be expected to submit a Health IT Plan (“HIT Plan”) that describes the state’s ability to leverage health IT, advance health information exchange(s), and ensure health IT interoperability in support of the demonstration’s goals.”<sup>1</sup> The HIT Plan should also describe, among other items, the:</i></p> <ul style="list-style-type: none"> <li>• <i>Role of providers in cultivating referral networks and engaging with patients, families and caregivers as early as possible in treatment; and</i></li> <li>• <i>Coordination of services among treatment team members, clinical supervision, medication and medication management, psychotherapy, case management, coordination with primary care, family/caregiver support and education, and supported employment and supported education.</i></li> </ul> <p><i>Please complete all Statements of Assurance below—and the sections of the Health IT Planning Template that are relevant to your state’s demonstration proposal.</i></p>	
<b>Statements of Assurance</b>	
Statement 1: Please provide an assurance that the state has a sufficient health IT infrastructure/ecosystem at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration. If this is not yet the case, please describe how	<p>The State has signed agreements with several health information exchange (HIE) entities known in New York State as Qualified Entities (QE) to exchange health data across the state amongst all participating health providers. Currently the state is sharing a limited dataset (ADT, allergies, demographics) but is working to expand to include additional information (medications, labs, treatment plans, etc.) within the next 18 months.</p> <p>In addition, all state-operated facilities will have direct portal access to QE data and can view health data from outside providers to provide more coordinated care. This includes the ability to receive clinical alerts and use secure direct messaging with outside providers.</p>

<sup>1</sup> See SMDL #18-011, “Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance.” Available at <https://www.medicare.gov/federal-policy-guidance/downloads/smd18011.pdf>.

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Prompts	Summary
<p>this will be achieved and over what time period</p>	
<p>Statement 2: Please confirm that your state’s SUD Health IT Plan is aligned with the state’s broader State Medicaid Health IT Plan and, if applicable, the state’s Behavioral Health IT Plan. If this is not yet the case, please describe how this will be achieved and over what time period.</p>	<p>Not applicable.</p>
<p>Statement 3: Please confirm that the state intends to assess the applicability of standards referenced in the <a href="#">Interoperability Standards Advisory (ISA)</a><sup>2</sup> and 45 CFR 170 Subpart B and, based on that assessment, intends to include them as appropriate in subsequent iterations of the state’s Medicaid Managed Care contracts. The ISA outlines relevant standards including but not limited to the following areas: referrals, care plans,</p>	<p>The State intends to utilize standards referenced in the <a href="#">Interoperability Standards Advisory (ISA)</a> when appropriate and when standards exist.</p>

<sup>2</sup> Available at <https://www.healthit.gov/isa/>.

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Prompts	Summary
<p>consent, privacy and security, data transport and encryption, notification, analytics and identity management.</p>	
	<p><i>To assist states in their health IT efforts, CMS released <a href="#">SMDL #16-003</a> which outlines enhanced federal funding opportunities available to states “for state expenditures on activities to promote health information exchange (HIE) and encourage the adoption of certified Electronic Health Record (EHR) technology by certain Medicaid providers.” For more on the availability of this “HITECH funding,” please contact your CMS Regional Operations Group contact.<sup>3</sup></i></p> <p><i>Enhanced administrative match may also be available under MITA 3.0 to help states establish crisis call centers to connect beneficiaries with mental health treatment and to develop technologies to link mobile crisis units to beneficiaries coping with serious mental health conditions. States may also coordinate access to outreach, referral, and assessment services—for behavioral health care--through an established “No Wrong Door System.”<sup>4</sup></i></p>
	<p><b>Closed Loop Referrals and e-Referrals (Section 1)</b></p>
<p>1.1 Closed loop referrals and e-referrals from physician/mental health provider to physician/mental health provider</p>	<p><i>Current State: # and/or % of Behavioral Health Providers who have adopted “Certified” EHRs (CEHRT-Certified EHR Technologies) and utilize it for e-referrals and or closed loop referrals.</i></p> <ol style="list-style-type: none"> <li><i>1) # and/or % of Behavioral Health Providers who utilize “Direct” secure messaging for e-referrals and or closed loop referrals</i></li> <li><i>2) # and/or % of Primary Care Providers who have adopted “Certified” EHRs (CEHRT-Certified EHR Technologies) that are utilizing it for e-referrals and or closed loop referrals with mental health providers</i></li> <li><i>3) # or % of Primary Care Providers who utilize “Direct” secure messaging for e-referrals and or closed loop referrals with Mental Health Providers</i></li> </ol> <p>NYS does not have the ability accept closed-loop referrals at this time.</p>
	<p><i>Future State: Describe the future state of the health IT functionalities outlined below:</i></p>

<sup>3</sup> See SMDL #16-003, “Availability of HITECH Administrative Matching Funds to Help Professionals and Hospitals Eligible for Medicaid EHR Incentive Payments Connect to Other Medicaid Providers.” Available at <https://www.medicaid.gov/federal-policy-guidance/downloads/smd16003.pdf>.

<sup>4</sup> Guidance for Administrative Claiming through the “No Wrong Door System” is available at <https://www.medicaid.gov/medicaid/finance/admin-claiming/no-wrong-door/index.html>.

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Prompts	Summary
	<p><b>There are no plans to implement any closed loop referrals at this time.</b></p> <p><i>Summary of Actions Needed: Specify a list of action items, milestones and responsible individuals/departments needed to make progress in moving from the current to future state:</i></p> <p><b>There are no plans to implement any closed loop referrals at this time.</b></p>
<p>1.2 Closed loop referrals and e-referrals from institution/hospital/clinic to physician/mental health provider</p>	<p><i>Current State: Describe the current state of the health IT functionalities outlined below:                      Example: The state is planning to conduct individual phone surveys and track beneficiaries who are not reporting hours due to technical difficulties. If the state identifies a substantial number of beneficiaries are not reporting hours due to technical difficulties, the state will consider providing additional notices to beneficiaries and/or training CE partner entities who help beneficiaries enter hours into the state’s online portal.</i></p> <p><b>NYS does not have the ability accept closed-loop referrals at this time.</b></p> <p><i>Future State: Describe the future state of the health IT functionalities outlined below:</i></p> <p><b>There are no plans to implement any closed loop referrals at this time.</b></p> <p><i>Summary of Actions Needed: Specify a list of action items, milestones and responsible individuals/departments needed to make progress in moving from the current to future state:</i></p> <p><b>There are no plans to implement any closed loop referrals at this time.</b></p>
<p>1.3 Closed loop referrals and e-referrals from physician/mental health provider to community based supports</p>	<p><i>Current State: Describe the current state of the health IT functionalities outlined below:                      Example: The state is planning to conduct individual phone surveys and track beneficiaries who are not reporting hours due to technical difficulties. If the state identifies a substantial number of beneficiaries are not reporting hours due to technical difficulties, the state will consider providing additional notices to beneficiaries and/or training CE partner entities who help beneficiaries enter hours into the state’s online portal.</i></p> <p><b>NYS does not have the ability accept closed-loop referrals at this time.</b></p> <p><i>Future State: Describe the future state of the health IT functionalities outlined below:</i></p> <p><b>NYS does not plan to implement closed loop referrals due to a lack of resources.</b></p>

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Prompts	Summary
	<p><i>Summary of Actions Needed: Specify a list of action items, milestones and responsible individuals/departments needed to make progress in moving from the current to future state:</i></p> <p>NYS does not plan to implement closed loop referrals due to a lack of resources.</p>
<b>Electronic Care Plans and Medical Records (Section 2)</b>	
<p>2.1 The state and its providers can create and use an electronic care plan</p>	<p><i>Current State: Describe the current state of the health IT functionalities outlined below:</i></p> <p>The state currently uses an internally developed and maintained documentation system known as the Mental Health Automated Recording System (MHARS) in its state-operated psychiatric centers and outpatient clinic settings. Adoption has recently been standardized yet many locations struggle to consistently document in MHARS due to a lack of resources. Licensed mental health providers use a variety of proprietary and commercial off-the-shelf electronic health records which support electronic care plans.</p> <hr/> <p><i>Future State: Describe the future state of the health IT functionalities outlined below:</i></p> <p>OMH is actively involved in obtaining a modernized Electronic Health Record. This functionality is expected to be part of the solution</p> <hr/> <p><i>Summary of Actions Needed: Specify a list of action items, milestones and responsible individuals/departments needed to make progress in moving from the current to future state:</i></p>

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Prompts	Summary
	<p>OMH will release an RFP by June of 2023 and expects implementation to begin in 2024.</p> <hr/> <p><i>Current State: Describe the current state of the health IT functionalities outlined below:</i></p> <p>The state currently uses an internally developed and maintained documentation system known as the Mental Health Automated Recording System (MHARS) in its state-operated psychiatric centers and outpatient clinic settings. Adoption has recently been standardized yet many locations struggle to consistently document in MHARS due to a lack of resources. Licensed mental health providers use a variety of proprietary and commercial off-the-shelf electronic health records which support electronic care plans.</p> <hr/> <p><i>Future State: Describe the future state of the health IT functionalities outlined below:</i></p> <p>Due to a lack of funding, there are no plans to change New York’s health IT functionalities in state-operated psychiatric centers at this time.</p> <hr/> <p><i>Summary of Actions Needed: Specify a list of action items, milestones and responsible individuals/departments needed to make progress in moving from the current to future state:</i></p> <p>None</p>
<p>2.2 E-plans of care are interoperable and accessible by all relevant members of the care team, including mental health providers</p>	<p><i>Current State: Describe the current state of the health IT functionalities outlined below:</i></p> <p><i>Example: The state is planning to conduct individual phone surveys and track beneficiaries who are not reporting hours due to technical difficulties. If the state identifies a substantial number of beneficiaries are not reporting hours due to technical difficulties, the state will consider providing additional notices to beneficiaries and/or training CE partner entities who help beneficiaries enter hours into the state’s online portal.</i></p>

Prompts	Summary
	<p><i>Current State: Describe the current state of the health IT functionalities outlined below:</i></p> <p><i>Example: The state is planning to conduct individual phone surveys and track beneficiaries who are not reporting hours due to technical difficulties. If the state identifies a substantial number of beneficiaries are not reporting hours due to technical difficulties, the state will consider providing additional notices to beneficiaries and/or training CE partner entities who help beneficiaries enter hours into the state’s online portal.</i></p> <p>Not at this time.</p>
	<p><i>Future State: Describe the future state of the health IT functionalities outlined below:</i></p> <p>OMH is actively involved in obtaining a modernized Electronic Health Record. This functionality is expected to be part of the solution to challenges stemming from information fragmentation affecting patient care and quality.</p>
	<p><i>Summary of Actions Needed: Specify a list of action items, milestones and responsible individuals/departments needed to make progress in moving from the current to future state:</i></p> <p>For OMH operated facilities OMH will release an RFP by June of 2023 and expects implementation to begin in 2024</p> <p>For local providers NYS does not promote any specific systems or guidance, and this occurs through a variety of platforms (e.g. Foothold).</p>
	<p>Not at this time.</p>
	<p><i>Future State: Describe the future state of the health IT functionalities outlined below:</i></p> <p><i>Summary of Actions Needed: Specify a list of action items, milestones and responsible individuals/departments needed to make progress in moving from the current to future state:</i></p>

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Prompts	Summary
<p>2.3 Medical records transition from youth-oriented systems of care to the adult behavioral health system through electronic communications</p>	<p>2.3 Medical records transition from youth-oriented systems of care to the adult behavioral health system through electronic communications</p> <p><i>Current State: Describe the current state of the health IT functionalities outlined below:</i></p> <p><i>Example: The state is planning to conduct individual phone surveys and track beneficiaries who are not reporting hours due to technical difficulties. If the state identifies a substantial number of beneficiaries are not reporting hours due to technical difficulties, the state will consider providing additional notices to beneficiaries and/or training CE partner entities who help beneficiaries enter hours into the state’s online portal.</i></p> <p>Within certain parts of the mental health delivery system (e.g. clinic, residential treatment facilities), local providers have the ability to electronically transmit medical records from youth-oriented systems of care to adult behavioral health systems. NYS does not promote any specific systems or guidance, and this occurs through a variety of platforms (e.g. Foothold).</p> <p><i>Future State: Describe the future state of the health IT functionalities outlined below:</i></p> <p>OMH is actively involved in obtaining a modernized Electronic Health Record. This functionality is expected to be part of the solution to challenges stemming from information fragmentation affecting patient care and quality.</p> <p><i>Summary of Actions Needed: Specify a list of action items, milestones and responsible individuals/departments needed to make progress in moving from the current to future state:</i></p>

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Prompts	Summary
	<p>For OMH operated facilities OMH will release an RFP by June of 2023 and expects implementation to begin in 2024. For local providers NYS does not promote any specific systems or guidance, and this occurs through a variety of platforms (e.g. Foothold).</p>
<p>2.4 Electronic care plans transition from youth-oriented systems of care to the adult behavioral health system through electronic communications</p>	<p><i>Current State: Describe the current state of the health IT functionalities outlined below:</i></p> <p><i>Example: The state is planning to conduct individual phone surveys and track beneficiaries who are not reporting hours due to technical difficulties. If the state identifies a substantial number of beneficiaries are not reporting hours due to technical difficulties, the state will consider providing additional notices to beneficiaries and/or training CE partner entities who help beneficiaries enter hours into the state’s online portal.</i></p> <p>Within certain parts of the mental health delivery system (e.g. clinic), local providers have the ability to electronically transmit medical records from youth-oriented systems of care to adult behavioral health systems. NYS does not promote any specific systems or guidance, and this occurs through a variety of platforms (e.g. Footholds).</p> <hr/> <p><i>Future State: Describe the future state of the health IT functionalities outlined below:</i></p> <p>OMH is actively involved in obtaining a modernized Electronic Health Record. This functionality is expected to be part of the solution to challenges stemming from information fragmentation affecting patient care and quality.</p> <hr/> <p><i>Summary of Actions Needed: Specify a list of action items, milestones and responsible individuals/departments needed to make progress in moving from the current to future state:</i></p>

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Prompts	Summary
	<p>For OMH operated facilities OMH will release an RFP by June of 2023 and expects implementation to begin in 2024.</p>
<p><b>Consent - E-Consent (42 CFR Part 2/HIPAA) (Section 3)</b></p>	
<p>3.1 Individual consent is electronically captured and accessible to patients and all members of the care team, as applicable, to ensure seamless sharing of sensitive health care information to all relevant parties consistent with applicable law and regulations (e.g., HIPAA, 42 CFR part 2 and state laws)</p>	<p><i>Current State: Describe the current state of the health IT functionalities outlined below:</i>  <i>Example: The state is planning to conduct individual phone surveys and track beneficiaries who are not reporting hours due to technical difficulties. If the state identifies a substantial number of beneficiaries are not reporting hours due to technical difficulties, the state will consider providing additional notices to beneficiaries and/or training CE partner entities who help beneficiaries enter hours into the state’s online portal.</i></p> <p>Individual consent is mandated in New York State. Once consent is obtained and electronically communicated to the HIE, all appropriate members of the care team will have access. Patients may also access their own healthcare information.</p> <p><i>Future State: Describe the future state of the health IT functionalities outlined below:</i></p> <p><b>No changes planned.</b></p> <p><i>Summary of Actions Needed: Specify a list of action items, milestones and responsible individuals/departments needed to make progress in moving from the current to future state:</i></p>
<p><b>Interoperability in Assessment Data (Section 4)</b></p>	
<p>4.1 Intake, assessment and screening tools are part of a structured data capture process</p>	<p><i>Current State: Describe the current state of the health IT functionalities outlined below:</i>  <i>Example: The state is planning to conduct individual phone surveys and track beneficiaries who are not reporting hours due to technical difficulties. If the state identifies a substantial number of beneficiaries are not reporting hours</i></p>

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Prompts	Summary
<p>so that this information is interoperable with the rest of the HIT ecosystem</p>	<p><i>due to technical difficulties, the state will consider providing additional notices to beneficiaries and/or training CE partner entities who help beneficiaries enter hours into the state’s online portal.</i></p> <p>Not all data is currently structured data. This is due to reliance on older electronic health systems that are not all meaningful use certified. In addition, not all screening tools have structured data sets associated with them.</p> <p><i>Future State: Describe the future state of the health IT functionalities outlined below:</i></p> <p>The state is working to implement structured data where clinically appropriate.</p> <p><i>Summary of Actions Needed: Specify a list of action items, milestones and responsible individuals/departments needed to make progress in moving from the current to future state:</i></p> <p>Assessment of current source data systems and working collaboratively to address lack of structured standards.</p>
<p><b>Electronic Office Visits – Telehealth (Section 5)</b></p>	
<p>5.1 Telehealth technologies support collaborative care by facilitating broader availability of integrated mental health care and primary care</p>	<p><i>Current State: Describe the current state of the health IT functionalities outlined below:</i>  <i>Example: The state is planning to conduct individual phone surveys and track beneficiaries who are not reporting hours due to technical difficulties. If the state identifies a substantial number of beneficiaries are not reporting hours due to technical difficulties, the state will consider providing additional notices to beneficiaries and/or training CE partner entities who help beneficiaries enter hours into the state’s online portal.</i></p> <p>The state is expanding telehealth technologies (telepsychiatry) to support collaborative care.</p> <p><i>Future State: Describe the future state of the health IT functionalities outlined below:</i></p> <p><i>Summary of Actions Needed: Specify a list of action items, milestones and responsible individuals/departments needed to make progress in moving from the current to future state:</i></p>
<p><b>Alerting/Analytics (Section 6)</b></p>	
<p>6.1 The state can identify patients that are at risk for discontinuing engagement in their treatment, or have stopped engagement in their treatment, and can notify their care teams in</p>	<p><i>Current State: Describe the current state of the health IT functionalities outlined below:</i>  <i>Example: The state is planning to conduct individual phone surveys and track beneficiaries who are not reporting hours due to technical difficulties. If the state identifies a substantial number of beneficiaries are not reporting hours due to technical difficulties, the state will consider providing additional notices to beneficiaries and/or training CE partner entities who help beneficiaries enter hours into the state’s online portal.</i></p>

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Prompts	Summary
<p>order to ensure treatment continues or resumes (Note: research shows that 50% of patients stop engaging after 6 months of treatment<sup>5</sup>)</p>	<p>OMH’s Sustained Engagement Support Team is part of NYS OMH’s relentless efforts to increase engagement among individuals who are involved in State-Operated outpatient services.</p> <ul style="list-style-type: none"> <li>• SES Outreach Specialists located in Albany and NYC</li> <li>• Monitoring all adults who have been unsuccessfully discharge from State-operated Outpatient Clinic or ACT team</li> <li>• Conduct telephonic outreach and engagement services in an effort to facilitate a return to State-Operated services or linkage to a community provider</li> <li>• Patients are identified as unsuccessful discharges upon outpatient clinician completing the MHARS Disposition 116 Form and selecting Disposition type – Termination, no further service and then Termination Type – Unsuccessful Discharge options.</li> <li>• When episode of care is an adult outpatient licensed clinic, day treatment, or ACT program and the Disposition type selected is Termination, no further service, a selection from the Termination Type dropdown is required entry. It is optional entry for all other episode of care programs.</li> <li>• This includes adults who were discharged due to loss of contact, declination of services, and incarceration.</li> </ul> <p><i>Future State: Describe the future state of the health IT functionalities outlined below:</i>                      No changes planned.</p> <p><i>Summary of Actions Needed: Specify a list of action items, milestones and responsible individuals/departments needed to make progress in moving from the current to future state:</i></p>
<p>6.2 Health IT is being used to advance the care coordination workflow for patients experiencing their first episode of psychosis</p>	<p><i>Current State: Describe the current state of the health IT functionalities outlined below:</i>                      Example: The state is planning to conduct individual phone surveys and track beneficiaries who are not reporting hours due to technical difficulties. If the state identifies a substantial number of beneficiaries are not reporting hours due to technical difficulties, the state will consider providing additional notices to beneficiaries and/or training CE partner entities who help beneficiaries enter hours into the state’s online portal.</p> <p>Milestone achieved.</p>

<sup>5</sup> Interdepartmental Serious Mental Illness Coordinating Committee. (2017). *The Way Forward: Federal Action for a System That Works for All People Living With SMI and SED and Their Families and Caregivers*. Retrieved from [https://www.samhsa.gov/sites/default/files/programs\\_campaigns/ismicc\\_2017\\_report\\_to\\_congress.pdf](https://www.samhsa.gov/sites/default/files/programs_campaigns/ismicc_2017_report_to_congress.pdf)

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Prompts	Summary
	<p>Early intervention programs for first-episode psychosis (FEP) require population-based methods to identify individuals with FEP. This study adapted a previously published method to estimate incidence of first psychotic diagnosis in a state Medicaid program. Incidence of first psychotic diagnosis in this Medicaid population was higher than previously found in insured populations.</p> <p>State and federal dollars have combined to build programs across the state within Western New York, Central New York, the Hudson Valley, New York City and Long Island. We expect to have 23 sites operational by early 2020. Over time, OMH hopes to double the number of teams to serve the population in need. What does this entail? Creating teams involves identifying and training staff, helping them to liaison with the community and conduct outreach to identify individuals who are eligible. The teams need to serve both teens and young adults, and to provide youth-friendly, recovery-oriented care in the community that focuses on the goals of the patients. Data collection and measurement-based care support a quality and value-driven approach. Clinicians and patients provide data to the NKI data center and OPME which is then fed back to the teams to identify programmatic strengths and weaknesses. Quality improvement is ongoing and dynamic.</p> <p><i>Future State: Describe the future state of the health IT functionalities outlined below:</i></p> <p>Future work will focus on algorithm refinements and piloting outreach. Administrative data algorithms may be useful to providers, Medicaid MCOs, and state Medicaid authorities to support case finding and early intervention.</p> <p><i>Summary of Actions Needed: Specify a list of action items, milestones and responsible individuals/departments needed to make progress in moving from the current to future state:</i></p> <p>New York State’s Office of Mental Health will continue to support the OnTrack NY program which is focused on algorithm refinements and piloting outreach. These actions will continue throughout 2022 and into 2023.</p>
<p><b>Identity Management (Section 7)</b></p> <p>7.1 As appropriate and needed, the care team has the ability to tag or link a child’s electronic medical records with their respective parent/caretaker medical records</p>	<p><i>Current State: Describe the current state of the health IT functionalities outlined below: Example: The state is planning to conduct individual phone surveys and track beneficiaries who are not reporting hours due to technical difficulties. If the state identifies a substantial number of beneficiaries are not reporting hours due to technical difficulties, the state will consider providing additional notices to beneficiaries and/or training CE partner entities who help beneficiaries enter hours into the state’s online portal.</i></p> <p>The State is currently doing no work in this area.</p>

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Prompts	Summary
	<p><i>Future State: Describe the future state of the health IT functionalities outlined below:</i></p> <p>There are currently no plans to tag or link a child’s electronic medical records with their respective parent/caretaker medical records.</p> <p><i>Summary of Actions Needed: Specify a list of action items, milestones and responsible individuals/departments needed to make progress in moving from the current to future state:</i></p>
<p>7.2 Electronic medical records capture all episodes of care, and are linked to the correct patient</p>	<p><i>Current State: Describe the current state of the health IT functionalities outlined below:</i></p> <p>. Example: The state is planning to conduct individual phone surveys and track beneficiaries who are not reporting hours due to technical difficulties. If the state identifies a substantial number of beneficiaries are not reporting hours due to technical difficulties, the state will consider providing additional notices to beneficiaries and/or training CE partner entities who help beneficiaries enter hours into the state’s online portal.</p> <p>The State uses a master data management (MDM) application to assist in ensuring all episodes of care are captured and linked to the correct patient.</p> <p><i>Future State: Describe the future state of the health IT functionalities outlined below:</i></p> <p><b>No specific plans to change this are currently in place.</b></p> <p><i>Summary of Actions Needed: Specify a list of action items, milestones and responsible individuals/departments needed to make progress in moving from the current to future state:</i></p>

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**Section 3: Relevant documents**

*Please provide any additional documentation or information that the state deems relevant to successful execution of the implementation plan. This information is not meant as a substitute for the information provided in response to the prompts outlined in Section 2. Instead, material submitted as attachments should support those responses.*

**MEMORANDUM OF UNDERSTANDING**

**Between**

**New York State Department of Health,**

**New York State Office of Mental Health, and**

**New York State Office of Addiction Services and Supports**

**Regarding the Administration of the SMI/SUD IMD Waiver**

Agreement effective \_\_\_\_\_ by and between the New York State Department of Health (DOH) having its principal office at Corning Tower, Empire State Plaza, Albany, New York 12237, the New York State Office of Mental Health (OMH) having its principal office located at 44 Holland Avenue, Albany, New York 12229, and the New York State Office of Addiction Services and Supports (OASAS) having its principal office located at 1450 Western Avenue, Albany, New York 12203 (hereinafter, “party” or “agency” or collectively “parties”).

**WHEREAS**, DOH is the designated single state agency for Medical Assistance (Medicaid) pursuant to section 201(1)(v) of the New York State Public Health Law (PHL) and is responsible for the supervision of the Medicaid State plan as required by Title XIX of the Social Security Act; and

**WHEREAS**, OMH is the New York State Mental Health Authority responsible for planning, care and services for people with mental illness pursuant to Article 7 of the New York State Mental Hygiene Law; and

**WHEREAS**, OASAS is the New York State Agency responsible for planning, care and services for people with addiction disorders or who are at risk of having an addiction disorder pursuant to Article 19 of the New York State Mental Hygiene Law; and

**WHEREAS**, OMH operates psychiatric centers for the care, treatment and rehabilitation of people with mental illness pursuant to section 7.17(b) of the New York State Mental Hygiene Law, which are Institutions for Mental Diseases (IMD) pursuant to 42 C.F.R. § 435.1010; and

**WHEREAS**, OASAS certifies inpatient and residential facilities of greater than 16 beds for the care, treatment and rehabilitation of people with addiction disorders pursuant to Article 32 of the New York State Mental Hygiene Law, which are also Institutions for Mental Diseases pursuant to 42 C.F.R. § 435.1010.

**WHEREAS**, in accordance with the provisions of Title XIX of the Social Security Act and section 12003 of the 21st Century Cures Act, DOH plans to submit an 1115 waiver amendment request to waive certain Medicaid requirements related to the prohibition of federal financial participation for services provided to adults with a serious mental illness (SMI) or substance use disorders (SUD) who reside in Institutions for Mental Diseases (IMD) (SMI/SUD-IMD Waiver) and to improve care for adults with SMI and SUD, consistent with guidance issued by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) entitled “SMD #18-011 RE: Opportunities to Design Innovative Service Delivery Systems for

Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance” (SMD #18-011) and “SMD #17-003 RE: Strategies to Address the Opioid Epidemic (SMD #17-003); and

**WHEREAS**, DOH, OASAS and OMH desire to collaborate to design, deliver, and monitor services for beneficiaries with SMI and SUD and memorialize their commitment to exchange information necessary to implement the SMI/SUD-IMD Waiver; and

**NOW, THEREFORE**, the parties hereto agree as follows:

## **SECTION I. SCOPE AND PURPOSE**

This Agreement sets forth the respective roles and responsibilities of the parties with respect to the administration of the SMI/SUD-IMD Waiver, subject to the approval of CMS.

## **SECTION II. DEFINITIONS**

1. “Fee-For-Service (FFS)” means Medicaid coverage for which payments are made to a Medicaid-enrolled provider directly by the Medicaid program for any Medicaid covered services rendered to a Medicaid recipient, and not by a Medicaid Managed Care plan.
2. “Medicaid” means the program of medical assistance for needy persons established under Title 11 of Article 5 of the Social Services Law and pursuant to Title XIX of the Social Security Act.
3. “SMI/SUD-IMD Waiver Participant” means: a beneficiary aged 21-64 who is receiving either (a) inpatient psychiatric hospital services in an OMH-operated psychiatric center for a short-term stay, pursuant to SMD #18-011; (b) a targeted set of in-reach services up to 30 days prior to discharge from a State-operated Psychiatric Center; or (c) community-based detoxification, inpatient rehabilitation, or residential services in a facility certified by OASAS which meets the definition of an IMD, pursuant to SMD #17-003. SMI/SUD-IMD Waiver Participants do not include individuals receiving psychiatric hospital services in an OMH-operated psychiatric center pursuant to any provision of the criminal procedure law, corrections law, penal law, or Article 10 of the mental hygiene law.

## **SECTION III. RESPONSIBILITIES OF DOH**

DOH is the single State agency designated to administer or supervise the administration of the Medicaid State Plan, and nothing in this Memorandum of Understanding shall be construed as constituting a delegation to OMH or OASAS of the authority to supervise the Medicaid State Plan or to develop policies, rules, or regulations on Medicaid program matters. In consultation with OMH and OASAS, DOH shall:

1. design, draft, and negotiate federal approval of the SMI/SUD-IMD Waiver application and any further amendments thereto;
2. submit a proposal to the state legislature and Division of Budget to amend section 366 of the social services law to provide authority for coverage of the services approved in the SMI/SUD-IMD Waiver;

3. monitor the implementation of the SMI/SUD-IMD Waiver, including evaluating performance measures and determining if the desired outcomes of the SMI/SUD-IMD Waiver have been achieved;
4. serve as the primary point of contact to report to and correspond with CMS regarding the SMI/SUD-IMD Waiver;
5. upload Medicaid rates and implement changes to the Medicaid suspension processes to identify SMI/SUD-IMD Waiver Participants and claim federal financial participation for services rendered to SMI/SUD-IMD Waiver Participants;
6. where required and pursuant to appropriate data use agreements between the parties, which the parties shall work diligently to execute; securely share protected health information (PHI) and Medicaid Confidential Data by and between the parties, consistent with state and federal law, to enable the parties to jointly monitor, oversee, and ensure the effectiveness of the SMI/SUD IMD Waiver, and
7. where required and pursuant to appropriate data use agreements between the parties, which the parties shall work diligently to execute; securely share protected health information (PHI) and Medicaid Confidential Data by and between the parties, consistent with state and federal law, to enable the parties to jointly monitor, oversee, and ensure the effectiveness of the SMI/SUD IMD Waiver.

#### **SECTION IV. RESPONSIBILITIES OF OMH**

In consultation with DOH and OASAS, OMH shall:

1. provide monthly admission and daily discharge information and other information as necessary to DOH, including identifiable demographic information from OMH's electronic medical record system, regarding potential SMI/SUD-IMD Waiver Participants for purposes of claiming for inpatient psychiatric and in-reach services under the waiver;
2. work diligently to carry out the objectives of the waiver, including reducing average inpatient lengths of stay, supporting mental health systems transformation, and increasing access to community-based mental health services for individuals with SMI with available resources, including resources made available as a result of claims for federal financial participation authorized by the SMI/SUD-IMD Waiver; and
3. subject to the approval of the director of the Division of the Budget, establish fee-for-service rates for inpatient psychiatric services provided in state-operated psychiatric centers.

#### **SECTION V. RESPONSIBILITIES OF OASAS**

In consultation with DOH and OMH, OASAS shall:

1. provide information as necessary to DOH, including identifiable demographic information from OASAS's secure systems, regarding potential SMI/SUD-IMD Waiver Participants for purposes of claiming for inpatient and residential services under the waiver;
2. work diligently to carry out the objectives of the waiver, including reducing average inpatient lengths of stay, supporting addiction services systems transformation, and increasing access to community-based addictions services and support for individuals with SUD with available resources; and
3. subject to the approval of the director of the Division of the Budget, establish fee-for-service rates for inpatient and residential addiction services provided by community-based facilities certified by OASAS.

## **SECTION VI. DATA SHARING AND CONFIDENTIALITY**

1. The parties acknowledge that in carrying out their respective roles and responsibilities under this Agreement, a party may need to create, maintain, access, or receive confidential information, including PHI, governed by various federal and state confidentiality laws listed below. The parties agree that information relating to SMI/SUD IMD Waiver Participants and services shall be securely maintained and used only for the purposes intended by this Agreement and in conformity with:
  - a) New York State Social Services Law Section 367-b(4);
  - b) New York State Social Services Law Section 369(4);
  - c) Article 27-F of the New York State Public Health Law and New York State regulations at 18 NYCRR 360-8.1;
  - d) Social Security Act, 42 USC 1396a (a)(7);
  - e) Federal regulations at 42 C.F.R. 431.302, 42 C.F.R. Part 2;
  - f) The Health Insurance Portability and Accountability Act (HIPAA), and Federal regulations at 45 C.F.R. Parts 160 and 164; and
  - g) New York State Mental Hygiene Law Section 33.13.
  
2. In the case of Medicaid Confidential Data, including enrollment, eligibility, and about Medicaid applicants or recipients in the possession of DOH in its capacity as the single state agency for administration of the New York State Medicaid Program, the parties acknowledge the exchange of such data shall only be authorized by DOH for purposes directly related to the administration of the Medicaid Program pursuant to federal regulations codified at 42 C.F.R. 431.302 and any exchange of Medicaid Confidential Data shall be subject to written agreements – executed by the agencies.

## **SECTION VII. TERM AND TERMINATION OF AGREEMENT**

This Agreement shall become effective on the date of the last signature by the parties and shall continue until terminated by a party. This Agreement may be terminated by any party upon thirty (30) days' notice to the other party. The confidentiality provisions of this Agreement shall survive termination of this Agreement.

## **SECTION VIII. AMENDING THIS AGREEMENT**

In the event that a party identifies a need to amend this Agreement, the parties shall work collaboratively to amend this Agreement. This Agreement may be amended at any time upon the mutual, written agreement of the parties.

**THE FOREGOING IS ACCEPTED AND AGREED TO BY:**



**Signatures on the following page**

NEW YORK STATE DEPARTMENT OF HEALTH

\_\_\_\_\_  
Signed  
Name:  
Title: Executive Deputy Commissioner

\_\_\_\_\_  
Date

NEW YORK STATE OFFICE OF MENTAL HEALTH

\_\_\_\_\_  
Signed  
Name: Ann Marie T. Sullivan, MD  
Title: Commissioner

\_\_\_\_\_  
Date

NEW YORK STATE OFFICE OF ADDICTION SERVICES AND SUPPORTS

\_\_\_\_\_  
Signed  
Name: Chinazo Cunningham, MD  
Title: Commissioner

\_\_\_\_\_  
Date

# MISCELLANEOUS NOTICES/HEARINGS

## Notice of Abandoned Property Received by the State Comptroller

Pursuant to provisions of the Abandoned Property Law and related laws, the Office of the State Comptroller receives unclaimed monies and other property deemed abandoned. A list of the names and last known addresses of the entitled owners of this abandoned property is maintained by the office in accordance with Section 1401 of the Abandoned Property Law. Interested parties may inquire if they appear on the Abandoned Property Listing by contacting the Office of Unclaimed Funds, Monday through Friday from 8:00 a.m. to 4:30 p.m., at:

1-800-221-9311  
or visit our web site at:  
[www.osc.state.ny.us](http://www.osc.state.ny.us)

Claims for abandoned property must be filed with the New York State Comptroller's Office of Unclaimed Funds as provided in Section 1406 of the Abandoned Property Law. For further information contact: Office of the State Comptroller, Office of Unclaimed Funds, 110 State St., Albany, NY 12236.

## PUBLIC NOTICE

Department of Health

### IMD Transformation Demonstration Program

In compliance with 42 CFR 431.408(a)(1), the New York State Department of Health is pleased to announce that it will conduct two virtual public hearings, to provide an overview of the State's proposed 1115 waiver amendment request, IMD Transformation Demonstration Program, during which the public may provide oral comments. This notice further serves to open the 30-day public comment period which will close on November 4, 2022. During this 30-day comment period, the public will be afforded the opportunity to provide written comments. Any updates related to the public hearings will be sent via the New York State Office of Mental Health and the Office of Addiction Services and Supports listservs.

New York State (NYS) is requesting approval from the Centers for Medicare and Medicaid Services (CMS) for an amendment to its Medicaid Redesign 1115 Demonstration to authorize federal Medicaid matching funds for reimbursement to Institutions for Mental Diseases (IMD) for inpatient, residential, and other services provided to Medicaid enrolled individuals with behavioral health diagnoses including serious mental illness (SMI), serious emotional disturbance (SED), and substance use disorder (SUD). This demonstration will allow the state to promote improved access to community-based behavioral health services and aid in the state's efforts to continue to transform the behavioral health service system.

As a continuation of the transition of Medicaid Behavioral Health Services from primarily fee-for-service to a managed care environment this demonstration will: transform the role of some state psychiatric inpatient facilities and substance use disorder residential treatment facilities; improve care transitions and access to community-based treatment and support services; and improve health and behavioral health outcomes in individuals with chronic and/or serious mental illnesses by transforming some selected (pilot site) state-run psychiatric hospitals, facilities, and campuses from long-term care institutions to community-based enhanced service delivery systems.

The IMD demonstration project will include the use of crisis services, respite, step down and short-term residential services, intensive community support services, crisis diversion centers, coordinated specialty care for first episode psychosis, a full continuum of care for individuals with substance use disorder, and integrated community participation with a time-limited inpatient service capacity focused on expert intermediate care treatment.

The primary goals will be transformation with a focus on:

- Reduction of inpatient and transitional residential lengths of stays.
- Community integration and maintenance with a focus on recovery.
- Overall reduced costs of care.

The waiver eligible cohort will include individuals from all State-operated adult, non-forensic facilities or residing in residential addiction treatment programs, discharged within 30 days on average. Principles, interventions, techniques, and tools, as described throughout the proposal, offer the potential to impact length of stay for adults age 21 and older.

New York State aspires to grow the waiver population during the waiver period. As inpatient assessment, stabilization, and treatment are optimized, NYS will be able to increase the total number of individuals discharged within 30 days or less.

NYS plans to make system changes allowing for waiver-eligible patients to remain covered by Medicaid during their inpatient stay, preventing coverage gaps. Also as part of this demonstration, NYS is requesting authorization of Medicaid coverage for a targeted set of in-reach services up to 30 days prior to discharge including care management, clinical consultations, peer services, and pharmaceutical management. These in-reach services would be made available to individuals who do not fall into the 30-day average length of stay cohort outlined in this waiver.

The two virtual public hearing/public forum meetings will be held on the following dates:

October 26th and 31st.

The full public notice and draft of the proposed IMD Transformation Demonstration amendment request is available for review under the "MRT 1115 Waiver Amendments" tab at: [https://www.health.ny.gov/health\\_care/medicaid/redesign/medicaid\\_waiver\\_1115.htm](https://www.health.ny.gov/health_care/medicaid/redesign/medicaid_waiver_1115.htm). For individuals with limited online access and require special accommodation to access paper copies, please call 518-473-5569.

Prior to finalizing the proposed amendment application, the Department of Health will consider all written and verbal comments received. These comments will be summarized in the final submitted version. The Department will post a transcript of the public hearings on the following website: [https://www.health.ny.gov/health\\_care/medicaid/redesign/medicaid\\_waiver\\_1115.htm](https://www.health.ny.gov/health_care/medicaid/redesign/medicaid_waiver_1115.htm)

Please direct all questions to [1115waivers@health.ny.gov](mailto:1115waivers@health.ny.gov)

Written comments will be accepted by email at: [1115waivers@health.ny.gov](mailto:1115waivers@health.ny.gov) or by mail at: Department of Health, Office of Health Insurance Programs, Waiver Management Unit, 99 Washington Ave., 12th Fl., Suite 1208, Albany, NY 12210

All comments must be postmarked or emailed by 30 days of the date of this notice.

**PUBLIC NOTICE****Department of Health****IMD Transformation Demonstration Program**

In compliance with 42 CFR 431.408(a)(1), this notice serves to open the 30-day public comment period which will close on November 4, 2022. In addition to this 30-day comment period where the public will be afforded the opportunity to provide written comments, the Department of Health will be hosting two virtual public hearings on October 26th and 31st, 2022, during which the public may provide oral comments. Any updates related to the public hearings will be sent via the New York State Office of Mental Health and the Office of Addiction Services and Supports listservs.

The two virtual public hearings will be held as follows:

**1. First Public Hearing**

a. Wednesday October 26, 2022, 3:30 pm – 5:00 pm

b. Pre-registration is required for anyone wishing to attend the hearing using this link: <https://meetny-events.webex.com/meetny-events/j.php?RGID=ra4ca24a1a9e2e60ef935eb4172291e33>. Individuals who wish to provide oral comment will need to respond “yes” to the question in the Webinar registration.

c. Individuals will speak in the order of registration. We kindly request that all comments be limited to five minutes per presenter to ensure that all public comments may be heard.

d. All registrants will receive an automated email confirmation of their registration. Those registered to speak will receive an additional confirmation one week prior to the event.

**2. Second Public Hearing**

a. Monday October 31, 2022, 11:00 pm – 12:30 pm

b. Pre-registration is required for anyone wishing to attend the hearing using this link: <https://meetny-events.webex.com/meetny-events/j.php?RGID=r6a567861b36b3235b79c08dbce775a52>. Individuals who wish to provide oral comment will need to respond “yes” to the question in the Webinar registration.

c. Individuals will speak in the order of registration. We kindly request that all comments be limited to five minutes per presenter to ensure that all public comments may be heard.

d. All registrants will receive an automated email confirmation of their registration. Those registered to speak will receive an additional confirmation one week prior to the event.

Prior to finalizing the proposed IMD Transformation Demonstration Program application, the Department of Health will consider all written and verbal comments received. These comments will be summarized and addressed in the final version that is submitted to CMS.

**Amendment Proposal Summary and Objectives**

New York State (NYS) is requesting approval from the Centers for Medicare and Medicaid Services (CMS) for an amendment to its Medicaid Redesign 1115 Demonstration to authorize federal Medicaid matching funds for reimbursement to Institutions for Mental Diseases (IMD) for inpatient, residential, and other services provided to Medicaid enrolled individuals with behavioral health diagnoses including serious mental illness (SMI), serious emotional disturbance (SED), and substance use disorder (SUD). This demonstration will allow the state to promote improved access to community-based behavioral health services and aid in the state’s efforts to continue to transform the behavioral health service system.

As a continuation of the transition of Medicaid Behavioral Health Services from primarily fee-for-service to a managed care environment this demonstration will: transform the role of some state psychiatric inpatient facilities and substance use disorder residential treatment facilities; improve care transitions and access to community-based treatment and support services; and improve health and behavioral health outcomes in individuals with chronic and/or serious mental illnesses by transforming some selected (pilot site) state-run psychiatric hospitals, facilities, and campuses from long-term care institutions to community-based enhanced service delivery systems. The IMD demonstration project will include the use of crisis services, respite, step down and short-term residential services, intensive community support services, crisis diversion centers, coordinated specialty

care for first episode psychosis, a full continuum of care for individuals with substance use disorder, and integrated community participation with a time-limited inpatient service capacity focused on expert intermediate care treatment.

The primary goals will be transformation with a focus on:

- Reduction of inpatient and transitional residential lengths of stays.
- Community integration and maintenance with a focus on recovery.
- Overall reduced costs of care.

Also, as part of this demonstration, NYS is requesting authorization of Medicaid coverage for a targeted set of in-reach services up to 30 days prior to discharge including care management, clinical consultations, peer services, and pharmaceutical management. These in-reach services would be made available to individuals who do not fall into the 30-day average length of stay cohort outlined in this waiver.

**Eligibility, Benefits, and Cost-Sharing Changes****Eligibility**

Medicaid eligibility requirements will not differ from the approved Medicaid State Plan.

**Cost-Sharing**

Cost sharing requirements under the Demonstration will not differ from the approved Medicaid State Plan.

**SMI Benefits**

New York State will be retrospectively identifying eligible patients that will allow NYS to claim federal financial participation for inpatient psychiatric and other non-duplicative services provided while receiving inpatient services at State run psychiatric centers. It is expected that approximately 450 individuals between the ages of 21 and 64 will meet the criteria for waiver participation annually. Individuals will be excluded from the cohort in the event they are forensically involved or have been identified clinically as “long stay” members.

NYS plans to make system changes allowing for waiver-eligible patients to remain covered by Medicaid during their inpatient stay, preventing coverage gaps.

**SUD Benefits**

The Demonstration will permit Medicaid recipients in New York with SUD to receive high-quality, clinically-appropriate Medicaid State Plan-approved SUD treatment services in outpatient and community-based settings, as well as in residential and inpatient treatment settings that qualify as an IMD.

**Enrollment and Fiscal Projections****Enrollment**

Waiver demonstration eligibility will be determined by highly skilled clinicians familiar with the community and its available resources and will include individuals discharged from all State-operated adult, non-forensic facilities or residing in residential addiction treatment programs, discharged within 30 days on average.

**Fiscal**

The total cost of this amendment is estimated to be \$268.37 million over five years, an average \$53.67 million increase to the annual demonstration cost of \$40 billion. The total estimated enrollment for this demonstration is estimated to be an increase of 6,146 (in year five) over the current average annual enrollment of 4.8 million.

**Hypotheses and Evaluation**

New York will conduct a multi-method, comprehensive statewide evaluation using an independent evaluator to document the impact of the IMD Waiver on health care service delivery, quality, health outcomes, and cost effectiveness. In addition, program components that posed particular successes or challenges for implementation and outcomes for this population will also be examined.

**SMI Evaluation**

NYS will evaluate this IMD Waiver amendment in alignment with all CMS requirements. An evaluation design will be developed to test the hypotheses identified below and will include the methodology, measures, and data sources to support the expected impact of the amendment. Additionally, it is expected that the current evaluation plan will be folded into the current approved 1115 Waiver evaluation design.

**GOAL 1: Improving Access to Health Care for the Medicaid population**

Hypotheses	Example Measures (Not Final)	Data Sources
Goal 1a: Improve access to specialized inpatient mental health services, reduce utilization and lengths of stay in EDs among IMD Waiver eligible adults		
Admissions for IMD Medicaid beneficiaries to State Psychiatric Inpatient IMD Units will increase over time	Monthly IMD admission numbers and proportions	MHARS (State Psychiatric EHR) Medicaid Claims
Lengths of stay for IMD eligible Medicaid beneficiaries admitted to IMD Psychiatric Hospitals will decrease over time	Average Length of Stay	MHARS (State Psychiatric EHR)
Psychiatric ED visits will decrease for individuals admitted to an IMD psychiatric hospital	Average psychiatric ED visits in year following IMD discharge	Medicaid Claims

**Goal 1b: Increase availability of Crisis Stabilization Centers**

Hypotheses	Example Measures (Not Final)	Data Sources
Utilization of crisis stabilization centers will increase as the number of crisis service providers increase	Utilization of crisis services over time Number of crisis programs	Medicaid Claims CONCERTS (OMH Licensing database)

**Goal 1c: Improve access to community based and integrated primary and behavioral health care services**

Hypotheses	Example Measures (Not Final)	Data Sources
Individuals discharged from an IMD psychiatric hospital will be more likely to access specialty mental health services (e.g. ACT, PROS) than IMD-eligible individuals discharged from a non-IMD psychiatric bed	Proportion of individuals with specialty mental health services in the year following discharge	Medicaid Claims
Individuals discharged from an IMD psychiatric hospital will be more likely to access Home and Community Based Services (HCBS) than IMD-eligible individuals discharged from a non-IMD psychiatric bed	Proportion of individuals with HCBS services in the year following discharge	Medicaid Claims
Access to the targeted in-reach and person-centered community-based services will be available to all vulnerable groups, including tribal communities, cultural (racial/ethnic), and socio-economic disadvantaged communities	Proportion of individuals with access to the recovery hub and other targeted services, stratified by vulnerable groups	MHARS (State Psychiatric EHR)

**GOAL 2: Improve Quality of Care**

Hypotheses	Example Measures (Not Final)	Data Sources
Goal 2a: Improve Quality of care, and recovery in the community following episodes of acute psychiatric inpatient care		

Hypotheses	Example Measures (Not Final)	Data Sources
Individuals discharged from an IMD psychiatric hospital will be more likely to have higher rates of quality metrics for health monitoring and prevention than IMD-eligible individuals discharged from a non-IMD psychiatric bed	State run HEDIS Measures, including multiple health and behavioral health measures	Medicaid Claims
Goal 2b: Reduce preventable readmissions to acute care hospitals among individuals discharged from IMD units		
Individuals discharged from an IMD psychiatric hospital will be less likely than individuals with an inpatient stay at a non-IMD psychiatric hospital in the same period of observation	Potentially Preventable Psychiatric Hospital Readmission rate – State run 3M measure	Medicaid Claims

**SUD Evaluation**

The demonstration will evaluate whether the New York Medicaid SUD treatment system is more effective through a provision of a complete coordinated continuum of care using LOCADTR placement criteria and standards, including SUD residential treatment services. The delivery system reforms are particularly important to address the needs of the Medicaid expansion population, which has historically been underserved.

**GOAL 1: Improve quality of care and population health outcomes for Medicaid enrollees with SUD**

Hypotheses	Example Measures (Not Final)	Data Sources
The Demonstration will decrease hospital admissions among Medicaid enrollees with at least one SUD treatment visit.	Annual inpatient stays year over year	Medicaid Data Warehouse
Enrollees who receive residential SUD services will have lower hospital readmission rates compared to a matched cohort of members who did not receive residential SUD services.	Monthly readmissions year over year	Medicaid Data Warehouse
Enrollees with a crisis visit for SUD will have improved rates of initiation and engagement of alcohol and other drug use treatment (IET)	IET measure HEDIS	Medicaid Data Warehouse
Enrollees will have fewer opioid-related overdose deaths.	Year over year opioid deaths	DOH overdose database

**GOAL 2: Increase enrollee access to and use of appropriate SUD treatment services based on LOCADTR criteria**

Hypotheses	Example Measures (Not Final)	Data Sources
The Demonstration will increase the supply of the critical LOCs for Medicaid enrollees.	Number of admissions to OASAS residential levels of care year over year	Medicaid Data Warehouse
The Demonstration will increase the use of residential and MAT for Opioid and alcohol for Medicaid enrollees.	Number of prescriptions for opioid and alcohol medications to individuals who have a Medicaid claim to residential services year over year	Medicaid Data Warehouse
Fewer overrides for services not available and clinical justification for residential services	Year over year overrides	LOCADTR

**GOAL 3: Improve care coordination and care transitions for Medicaid enrollees with SUD**

Hypotheses	Example Measures (Not Final)	Data Sources
The Demonstration will increase the rate of Medicaid enrollees with SUD-related conditions who are also receiving primary/ambulatory care.	The number of monthly primary/ambulatory care claims per enrollee with SUD-related conditions	Medicaid Data Warehouse
The Demonstration will improve follow-up after discharge from ED	HEDIS Follow-up ED visit	Medicaid Data Warehouse
Enrollees with SUD will have increased treatment engagement as measured by treatment duration (CET)	QARR Continued Engagement to Treatment measure.	Medicaid Data Warehouse
Medicaid IMD providers will demonstrate consistency in program design and discharge planning policies.	Review of IMD program and discharge policies and procedures	OASAS Site Review
Increase Number of Medicaid enrollees with SUD who are enrolled in Health Home	Year over year	Medicaid Data Warehouse

**GOAL 4: Maintain or reduce Medicaid cost of individuals with SUD**

Hypotheses	Example Measures (Not Final)	Data Sources
The Demonstration will be budget neutral to the Federal government.	Annual total cost of care for individuals with SUD	Medicaid Data Warehouse

Hypotheses	Example Measures (Not Final)	Data Sources
Total Medicaid SUD spending during the measurement period will remain constant after adjustment for the new residential services and any other new SUD treatment services including care coordination developed under this Demonstration.	Medicaid SUD-related claims	Medicaid Data Warehouse
Total Medicaid SUD spending on residential treatment within IMDs during the measurement period will remain constant after adjustment for the new residential services and any other new SUD treatment services including care coordination developed under this Demonstration.	Medicaid IMD residential treatment claims	Medicaid Data Warehouse
Costs by source of care for individuals with SUD incurring high Medicaid expenses during the measurement period will remain constant after adjustment for the new residential services and any other new SUD treatment services including care coordination developed under this Demonstration.	Medicaid claims by source of care	Medicaid Data Warehouse

**Waiver and Expenditure Authorities**

**Waiver Authority**

There are no waiver authorities expected to be needed for this amendment.

**Expenditure Authority**

New York is requesting expenditure authority under Section 1115 to claim as medical assistance the following services that are not otherwise coverable under Medicaid:

Residential and Inpatient Treatment for Individuals with Substance Use Disorder (SUD), Serious Mental Illness (SMI), or Severe Emotional Disturbance (SED). Expenditures for otherwise covered Medicaid services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for substance use disorder (SUD) or a serious mental illness (SMI) or severe emotional disturbance (SED) who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD).

**Submission and Review of Public Comments**

The full public notice and draft of the proposed IMD Transformation Demonstration amendment request is available for review under the “MRT 1115 Waiver Amendments” tab at: [https://www.health.ny.gov/health\\_care/medicaid/redesign/medicaid\\_waiver\\_1115.htm](https://www.health.ny.gov/health_care/medicaid/redesign/medicaid_waiver_1115.htm). For individuals with limited online access and require special accommodation to access paper copies, please call 518-473-5569.

Prior to finalizing the proposed amendment application, the Department of Health will consider all written and verbal comments received. These comments will be summarized in the final submitted version. The Department will post a transcript of the public hearings on the following website: [https://www.health.ny.gov/health\\_care/medicaid/redesign/medicaid\\_waiver\\_1115.htm](https://www.health.ny.gov/health_care/medicaid/redesign/medicaid_waiver_1115.htm)

Please direct all questions to [1115waivers@health.ny.gov](mailto:1115waivers@health.ny.gov)  
 Written comments will be accepted by email at: [1115waivers@health.ny.gov](mailto:1115waivers@health.ny.gov) or by mail at: Department of Health, Office of Health Insurance Programs, Waiver Management Unit, 99 Washington Ave., 12th Fl., Suite 1208, Albany, NY 12210  
 All comments must be postmarked or emailed by 30 days of the date of this notice.

**PUBLIC NOTICE**

Department of State  
 Notice of Review of Request for  
 Brownfield Opportunity Area  
 Conformance Determination  
 Project: 31 Tonawanda Street LLC  
 Location: Tonawanda Street Corridor  
 Brownfield Opportunity Area in City of Buffalo

In accordance with General Municipal Law, Article 18 - C, Section 970-r, the Secretary of State designated the Tonawanda Street Corridor Brownfield Opportunity Area, in the City of Buffalo, on November 27, 2017. The designation of the Tonawanda Street Corridor Brownfield Opportunity Area was supported by a Nomination or a comprehensive planning tool that identifies strategies to revitalize the area which is affected by one or more known or suspected brownfield sites.

Pursuant to New York State Tax Law, Article 1, Section 21, the eligible taxpayer(s) of a project site located in a designated Brownfield Opportunity Area may apply for an increase in the allowable tangible property tax credit component of the brownfield redevelopment tax credit if the Secretary of State determines that the project conforms to the goals and priorities established in the Nomination for a designated Brownfield Opportunity Area.

On August 22, 2022, 31 Tonawanda Street LLC submitted a request for the Secretary of State to determine whether the 31 Tonawanda Street LLC project, which will be located within the designated Tonawanda Street Corridor Brownfield Opportunity Area, conforms to the goals and priorities identified in the Nomination that was prepared for the designated Tonawanda Street Corridor Brownfield Opportunity Area.

The public is permitted and encouraged to review and provide comments on the request for conformance. For this purpose, the full application for a conformance determination is available online at: <https://dos.ny.gov/2202-31-tonawanda-street-boa-conformance>

Comments must be submitted no later than November 4, 2022, either by mail to: Benjamin Bidell, Department of State, Office of Planning and Development, 295 Main St., Suite 821, Buffalo, NY 14203, or [benjamin.bidell@dos.ny.gov](mailto:benjamin.bidell@dos.ny.gov)

**PUBLIC NOTICE**

Department of State  
 Notice of Review of Request for  
 Brownfield Opportunity Area  
 Conformance Determination  
 Project: 211 Main Street Redevelopment  
 Location: City of North Tonawanda  
 Brownfield Opportunity Area in City of North Tonawanda

In accordance with General Municipal Law, Article 18 - C, Section 970-r, the Secretary of State designated the City of North Tonawanda Brownfield Opportunity Area, in the City of North Tonawanda, on April 9, 2015. The designation of the City of North Tonawanda Brownfield Opportunity Area was supported by a Nomination or a comprehensive planning tool that identifies strategies to revitalize the area which is affected by one or more known or suspected brownfield sites.

Pursuant to New York State Tax Law, Article 1, Section 21, the eligible taxpayer(s) of a project site located in a designated Brownfield Opportunity Area may apply for an increase in the allowable tangible

property tax credit component of the brownfield redevelopment tax credit if the Secretary of State determines that the project conforms to the goals and priorities established in the Nomination for a designated Brownfield Opportunity Area.

On September 6, 2022, Enterprise Lumber & Silo, LLC submitted a request for the Secretary of State to determine whether the 211 Main Street Redevelopment project, which will be located within the designated City of North Tonawanda Brownfield Opportunity Area, conforms to the goals and priorities identified in the Nomination that was prepared for the designated City of North Tonawanda Brownfield Opportunity Area.

The public is permitted and encouraged to review and provide comments on the request for conformance. For this purpose, the full application for a conformance determination is available online at: <https://dos.ny.gov/2204-211-main-street-redevelopment-boa-conformance>

Comments must be submitted no later than November 4, 2022, either by mail to: Benjamin Bidell, Department of State, Office of Planning and Development, 295 Main St., Suite 821, Buffalo, NY 14203, or [benjamin.bidell@dos.ny.gov](mailto:benjamin.bidell@dos.ny.gov)

**PUBLIC NOTICE**

Department of State  
 Notice of Review of Request for  
 Brownfield Opportunity Area  
 Conformance Determination  
 Project: 1360 Niagara Street  
 Location: Tonawanda Street Corridor  
 Brownfield Opportunity Area in City of Buffalo

In accordance with General Municipal Law, Article 18 - C, Section 970-r, the Secretary of State designated the Tonawanda Street Corridor Brownfield Opportunity Area, in the City of Buffalo, on November 27, 2017. The designation of the Tonawanda Street Corridor Brownfield Opportunity Area was supported by a Nomination or a comprehensive planning tool that identifies strategies to revitalize the area which is affected by one or more known or suspected brownfield sites.

Pursuant to New York State Tax Law, Article 1, Section 21, the eligible taxpayer(s) of a project site located in a designated Brownfield Opportunity Area may apply for an increase in the allowable tangible property tax credit component of the brownfield redevelopment tax credit if the Secretary of State determines that the project conforms to the goals and priorities established in the Nomination for a designated Brownfield Opportunity Area.

On July 20, 2022, Ciminelli Real Estate Corporation submitted a request for the Secretary of State to determine whether the 1360 Niagara Street project, which will be located within the designated Tonawanda Street Corridor Brownfield Opportunity Area, conforms to the goals and priorities identified in the Nomination that was prepared for the designated Tonawanda Street Corridor Brownfield Opportunity Area.

The public is permitted and encouraged to review and provide comments on the request for conformance. For this purpose, the full application for a conformance determination is available online at: <https://dos.ny.gov/mentholatum-boa-conformance-application>

Comments must be submitted no later than November 4, 2022, either by mail to: Benjamin Bidell, Department of State, Office of Planning and Development, 295 Main St., Suite 821, Buffalo, NY 14203, or [benjamin.bidell@dos.ny.gov](mailto:benjamin.bidell@dos.ny.gov)



## Department of Health

**KATHY HOCHUL**  
Governor

**MARY T. BASSETT, M.D., M.P.H.**  
Commissioner

**KRISTIN M. PROUD**  
Acting Executive Deputy Commissioner

October 5, 2022

Dear Colleague:

New York State (NYS) is requesting approval from the Centers for Medicare and Medicaid Services (CMS) for an amendment to its Medicaid Redesign 1115 Demonstration to authorize federal Medicaid matching funds for reimbursement to Institutions for Mental Diseases (IMD) for inpatient, residential, and other services provided to Medicaid enrolled individuals with behavioral health diagnoses including serious mental illness (SMI), serious emotional disturbance (SED), and substance use disorder (SUD). This demonstration will allow the state to promote improved access to community-based behavioral health services and aid in the state's efforts to continue to transform the behavioral health service system.

As a continuation of the transition of Medicaid Behavioral Health Services from primarily fee-for-service to a managed care environment this demonstration will: transform the role of some state psychiatric inpatient facilities and substance use disorder residential treatment facilities; improve care transitions and access to community-based treatment and support services; and improve health and behavioral health outcomes in individuals with chronic and/or serious mental illnesses by transforming some selected (pilot site) state-run psychiatric hospitals, facilities, and campuses from long-term care institutions to community-based enhanced service delivery systems. The IMD demonstration project will include the use of crisis services, respite, step down and short-term residential services, intensive community support services, crisis diversion centers, coordinated specialty care for first episode psychosis, a full continuum of care for individuals with substance use disorder, and integrated community participation with a time-limited inpatient service capacity focused on expert intermediate care treatment.

The primary goals will be transformation with a focus on:

- Reduction of inpatient and transitional residential lengths of stays.
- Community integration and maintenance with a focus on recovery.
- Overall reduced costs of care

Also, as part of this demonstration, NYS is requesting authorization of Medicaid coverage for a targeted set of in-reach services up to 30 days prior to discharge including care management, clinical consultations, peer services, and pharmaceutical management. These in-reach services would be made available to individuals who do not fall into the 30-day average length of stay cohort outlined in this waiver.

## **Eligibility, Benefits, and Cost-Sharing Changes**

### **Eligibility**

Medicaid eligibility requirements will not differ from the approved Medicaid State Plan.

### **Cost-Sharing**

Cost sharing requirements under the Demonstration will not differ from the approved Medicaid State Plan.

### **SMI Benefits**

New York State will be retrospectively identifying eligible patients that will allow NYS to claim federal financial participation for inpatient psychiatric and other non-duplicative services provided while receiving inpatient services at State run psychiatric centers. It is expected that approximately 450 individuals between the ages of 21 and 64 will meet the criteria for Waiver participation annually. Individuals will be excluded from the cohort in the event they are forensically involved or have been identified clinically as “long stay” members.

NYS plans to make system changes allowing for waiver-eligible patients to remain covered by Medicaid during their inpatient stay, preventing coverage gaps.

### **SUD Benefits**

The Demonstration will permit Medicaid recipients in New York with SUD to receive high-quality, clinically-appropriate Medicaid State Plan-approved SUD treatment services in outpatient and community-based settings, as well as in residential and inpatient treatment settings that qualify as an IMD.

There is no anticipated impact on NYS Tribes.

## **Enrollment and Fiscal Projections**

### **Enrollment**

Waiver demonstration eligibility will be determined by highly skilled clinicians familiar with the community and its available resources and will include individuals discharged from all State-operated adult, non-forensic facilities or residing in residential addiction treatment programs, discharged within 30 days on average.

### **Fiscal**

The total cost of this amendment is estimated to be \$268.37 million over five years, an average \$53.67 million increase to the annual demonstration cost of \$40 billion. The total estimated enrollment for this demonstration is estimated to be an increase of 6,146 (in year five) over the current average annual enrollment of 4.8 million.

## **Hypotheses and Evaluation**

New York will conduct a multi-method, comprehensive statewide evaluation using an independent evaluator to document the impact of the IMD Waiver on health care service delivery, quality, health outcomes, and cost effectiveness. In addition, program components that posed particular successes or challenges for implementation and outcomes for this population will also be examined.



## SMI Evaluation

NYS will evaluate this IMD Waiver amendment in alignment with all CMS requirements. An evaluation design will be developed to test the hypotheses identified below and will include the methodology, measures, and data sources to support the expected impact of the amendment. Additionally, it is expected that the current evaluation plan will be folded into the current approved 1115 Waiver evaluation design.

### GOAL 1: Improving Access to Health Care for the Medicaid population

Hypotheses	Example Measures (Not Final)	Data Sources
Goal 1a: Improve access to specialized inpatient mental health services, reduce utilization and lengths of stay in EDs among IMD Waiver eligible adults		
Admissions for IMD Medicaid beneficiaries to State Psychiatric Inpatient IMD Units will <b>increase over time</b>	Monthly IMD admission numbers and proportions	MHARS (State Psychiatric EHR) Medicaid Claims
Lengths of stay for IMD eligible Medicaid beneficiaries admitted to IMD Psychiatric Hospitals will <b>decrease over time</b>	Average Length of Stay	MHARS (State Psychiatric EHR)
Psychiatric ED visits will <b>decrease</b> for individuals admitted to an IMD psychiatric hospital	Average psychiatric ED visits in year following IMD discharge	Medicaid Claims
Goal 1b: Increase availability of Crisis Stabilization Centers		
Utilization of crisis stabilization centers will increase as the number of crisis service providers increase	Utilization of crisis services over time Number of crisis programs	Medicaid Claims CONCERTS (OMH Licensing database)
Goal 1c: Improve access to community based and integrated primary and behavioral health care services		
Individuals discharged from an IMD psychiatric hospital will be <b>more likely to access specialty mental health services</b> (e.g. ACT, PROS) than IMD-eligible individuals discharged from a non-IMD psychiatric bed	Proportion of individuals with specialty mental health services in the year following discharge	Medicaid Claims
Individuals discharged from an IMD psychiatric hospital will be <b>more likely to access Home and Community Based Services (HCBS)</b> than IMD-eligible individuals discharged from a non-IMD psychiatric bed	Proportion of individuals with HCBS services in the year following discharge	Medicaid Claims
Access to the targeted in-reach and person-centered community-based services will be available to all vulnerable groups, including tribal communities, cultural (racial/ethnic), and socio-economic disadvantaged communities	Proportion of individuals with access to the recovery hub and other targeted services, stratified by vulnerable groups	MHARS (State Psychiatric EHR)

## GOAL 2: Improve Quality of Care

Hypotheses	Example Measures (Not Final)	Data Sources
Goal 2a: Improve Quality of care, and recovery in the community following episodes of acute psychiatric inpatient care		
Individuals discharged from an IMD psychiatric hospital will be <b>more likely to have higher rates of quality metrics for health monitoring and prevention</b> than IMD-eligible individuals discharged from a non-IMD psychiatric bed	State run HEDIS Measures, including multiple health and behavioral health measures	Medicaid Claims

Goal 2b: Reduce preventable readmissions to acute care hospitals among individuals discharged from IMD units		
Individuals discharged from an IMD psychiatric hospital <b>will be less likely</b> than individuals with an inpatient stay at a non-IMD psychiatric hospital in the same period of observation	Potentially Preventable Psychiatric Hospital Readmission rate – State run 3M measure	Medicaid Claims

## SUD Evaluation

The demonstration will evaluate whether the New York Medicaid SUD treatment system is more effective through a provision of a complete coordinated continuum of care using LOCADTR placement criteria and standards, including SUD residential treatment services. The delivery system reforms are particularly important to address the needs of the Medicaid expansion population, which has historically been underserved.

## GOAL 1: Improve quality of care and population health outcomes for Medicaid enrollees with SUD

Hypotheses	Example Measures (Not Final)	Data Sources
The Demonstration will decrease hospital admissions among Medicaid enrollees with at least one SUD treatment visit.	Annual inpatient stays year over year	Medicaid Data Warehouse
Enrollees who receive residential SUD services will have lower hospital readmission rates compared to a matched cohort of members who <b>did not</b> receive residential SUD services.	Monthly readmissions year over year	Medicaid Data Warehouse
Enrollees with a crisis visit for SUD will have improved rates of initiation and engagement of alcohol and other drug use treatment (IET)	IET measure HEDIS	Medicaid Data Warehouse
Enrollees will have fewer opioid-related overdose deaths.	Year over year opioid deaths	DOH overdose database

**GOAL 2: Increase enrollee access to and use of appropriate SUD treatment services based on LOCADTR criteria**

<b>Hypotheses</b>	<b>Example Measures (Not Final)</b>	<b>Data Sources</b>
The Demonstration will increase the supply of the critical LOCs for Medicaid enrollees.	Number of admissions to OASAS residential levels of care year over year	Medicaid Data Warehouse
The Demonstration will increase the use of residential and MAT for Opioid and alcohol for Medicaid enrollees.	Number of prescriptions for opioid and alcohol medications to individuals who have a Medicaid claim to residential services year over year	Medicaid Data Warehouse
Fewer overrides for services not available and clinical justification for residential services	Year over year overrides	LOCADTR

**GOAL 3: Improve care coordination and care transitions for Medicaid enrollees with SUD**

<b>Hypotheses</b>	<b>Example Measures (Not Final)</b>	<b>Data Sources</b>
The Demonstration will increase the rate of Medicaid enrollees with SUD-related conditions who are also receiving primary/ambulatory care.	The number of monthly primary/ambulatory care claims per enrollee with SUD-related conditions	Medicaid Data Warehouse
The Demonstration will improve follow-up after discharge from ED	HEDIS Follow-up ED visit	Medicaid Data Warehouse
Enrollees with SUD will have increased treatment engagement as measured by treatment duration (CET)	QARR Continued Engagement to Treatment measure.	Medicaid Data Warehouse
Medicaid IMD providers will demonstrate consistency in program design and discharge planning policies.	Review of IMD program and discharge policies and procedures	OASAS Site Review
Increase Number of Medicaid enrollees with SUD who are enrolled in Health Home	Year over year	Medicaid Data Warehouse

**GOAL 4: Maintain or reduce Medicaid cost of individuals with SUD**

<b>Hypotheses</b>	<b>Example Measures (Not Final)</b>	<b>Data Sources</b>
The Demonstration will be budget neutral to the Federal government.	Annual total cost of care for individuals with SUD	Medicaid Data Warehouse
Total Medicaid SUD spending during the measurement period will remain constant after adjustment for the new residential services and any other new SUD treatment services including care coordination developed under this Demonstration.	Medicaid SUD-related claims	Medicaid Data Warehouse
Total Medicaid SUD spending on residential treatment within IMDs during the measurement period will remain constant after adjustment for the new residential services and any other new SUD treatment services including care coordination developed under this Demonstration.	Medicaid IMD residential treatment claims	Medicaid Data Warehouse
Costs by source of care for individuals with SUD incurring high	Medicaid claims by source of care	Medicaid Data Warehouse

<p>Medicaid expenses during the measurement period will remain constant after adjustment for the new residential services and any other new SUD treatment services including care coordination developed under this Demonstration.</p>		
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## Waiver and Expenditure Authorities

### Waiver Authority

There are no waiver authorities expected to be needed for this amendment.

### Expenditure Authority

New York is requesting expenditure authority under Section 1115 to claim as medical assistance the following services that are not otherwise coverable under Medicaid:

**Residential and Inpatient Treatment for Individuals with Substance Use Disorder (SUD), Serious Mental Illness (SMI), or Severe Emotional Disturbance (SED).**

Expenditures for otherwise covered Medicaid services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for substance use disorder (SUD) or a serious mental illness (SMI) or severe emotional disturbance (SED) who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD).

### Submission and Review of Public Comments

A draft of the proposed amendment request is available for review at:

[https://www.health.ny.gov/health\\_care/medicaid/redesign/medicaid\\_waiver\\_1115.htm](https://www.health.ny.gov/health_care/medicaid/redesign/medicaid_waiver_1115.htm). For individuals with limited online access and require special accommodation to access paper copies, please call 518-473-5569. In addition, the Department of Health will be hosting two virtual public hearings on August 1<sup>st</sup> and 18<sup>th</sup>, during which the public may provide oral comments. Any updates related to the public hearings will be sent via the OMH and OASAS Listservs.

Prior to finalizing the proposed amendment application, the Department of Health will consider all written and verbal comments received. These comments will be summarized in the final submitted version. The Department will post a transcript of the public hearings on the following website: [https://www.health.ny.gov/health\\_care/medicaid/redesign/medicaid\\_waiver\\_1115.htm](https://www.health.ny.gov/health_care/medicaid/redesign/medicaid_waiver_1115.htm).

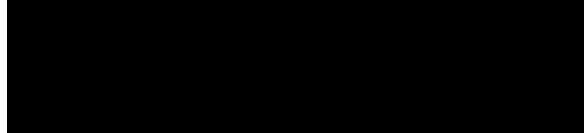
Written comments will be accepted by email at [1115waivers@health.ny.gov](mailto:1115waivers@health.ny.gov) or by mail at:

NYS Department of Health  
Office of Health Insurance Programs  
Waiver Management Unit  
99 Washington Avenue  
12th Floor, Suite 1208  
Albany, NY 12210

All comments must be postmarked or emailed by November 10, 2022.

We look forward to our continued collaboration.

Sincerely,



Trisha Schell-Guy, Director  
Division of Program Development & Management  
Office of Health Insurance Programs

cc: Phil Alotta, NYSDOH  
Michele Hamel, NYSDOH  
Selena Hajiani, NYSDOH  
Sean Hightower, HHS  
Nancy Grano, CMS