Comments Regarding New York State's Amended Home and Community-Based Services Statewide Transition Plan

Thank you for the opportunity to comment on New York State's Amended Home and Community-Based Services (HCBS) Statewide Transition Plan (STP) as required by the Centers for Medicare and Medicaid Services' (CMS) HCBS Final Rule. The Coalition of Behavioral Health Agencies (The Coalition) represents nearly 140 community-based, non-profit behavioral health providers that serve over 450,000 New Yorkers of every age. Our members serve the entire continuum of behavioral health care in every neighborhood in New York City, Westchester, Rockland, Orange, Nassau and Suffolk counties Coalition members provide access to the whole range of outpatient mental health and substance abuse services, including supportive housing, crisis, peer, employment, Personalized Recovery Oriented Services (PROS), Club Houses, education and food nutritional services, as well as many other supports that promote recovery. Our members have been providing these types of services in the community since the dawn of the deinstitutionalization movement.

According to its conclusion, the "revised Statewide Transition Plan incorporates all of New York's agency/office-specific transition plans and seeks to address CMS' written concerns with our initial submission by providing greater specificity regarding our plans to assess and, where necessary, remediate congregate and provider-owned settings, other settings that may not qualify as an individual's own home, and non-residential program settings. Each agency/office has also undertaken a much more detailed review of state-level regulation, policy and guidance and detailed areas of non-compliance, along with specific milestones and a timeline for remediation."

The Coalition will address its comments to the settings in the STP in which its members provide transitioning home and community-based services provided through 1915-c waivers. The New York State Office of Mental Health (OMH), Office of Alcoholism and Substance Abuse Services (OASAS) and Office of Children and Family Services (OCFS) have been the agencies that provided oversight in these settings. Although, Coalition members include agencies that provide service in settings that are subject to Office for People With Developmental Disabilities (OPWDD) oversight, it is not a large proportion and, historically, The Coalition's focus has been on behavioral health; therefore, that is the portion of the STP on which we will focus.

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Behavioral Health HCBS

According to OMH, "[t]he Behavioral Health Home and Community Based Services (BH HCBS) will provide opportunities for adult Medicaid beneficiaries with mental illness and/or substance use disorders to receive services in their own home or community. Implementation of BH HCBS will help to create an environment where managed care plans, service providers, plan members, families, and government partners to help members prevent and manage chronic health conditions and recover from serious mental illness and substance use disorders." (p.3, OMH HCBS STP)

In the STP, OMH elucidates set of core principles that include person-centered, recovery-oriented, integrated, peer supported, data and evidence-based trauma-focused care that will drive HCBS in behavioral care. (P.3-4, OMH HCBS STP). The Coalition strongly endorses this approach.

The move to more community-based settings also promise significant Medicaid savings as the need for in-patient capacity decreases. As noted in the OMH HCBS STP:

> New York's extensive State Psychiatric Centers' inpatient capacity includes 24 facilities with nearly 4,000 budgeted beds. Among these are a number of hospitals operating with fewer than 100 beds. This situation had led to disproportionately high State-operated inpatient per capita costs as more individuals with mental illness are supported successfully with community-based mental health services, while the inpatient footprint has remained disproportionately large. The evidence of this imbalance is clear: while New York's State-operated inpatient facilities serve approximately 1% of the total number of people served in the public mental health system, they account for 20% of gross annual system expenditures. With the inclusion of other acute inpatient facilities (Article 28 or 31 psychiatric hospitals), inpatient psychiatric costs amount to approximately half of the total spending on public mental health services.
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> The OMH is in the process of creating the mental health system that New York needs in the 21st Century—a system focused on prevention, early identification and intervention, and evidence-based clinical services and recovery supports. OMH is rebalancing the agency's institutional resources to further develop and enhance community-based mental health services, which are also consistent with the Americans with Disabilities Act (ADA). The US Supreme Court's 1999 Olmstead decision held that the ADA mandates that the State's services, programs, and activities for people with disabilities must be administered in the most integrated setting appropriate to a person's needs. (p.2, OMH HCBS STP)

The move away from inpatient care for individuals living with behavioral health issues will allow hospitals to claim that they have created significant saving of New York's

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Medicaid dollars. However, it is the services provided by community-based providers that will allow people to move from institutional settings to communities.

The determination regarding the source of savings and where those savings will be reinvested is crucially important. The Department of Health is required, "to reinvest funds allocated for behavioral health services, which are general fund savings directly related to savings realized through the transition of populations covered by this section from the applicable Medicaid fee-for-service system to a managed care model…for the purpose of increasing investment in community based behavioral health services..." (Social Services, art. 11, § 365-m [5], as added by L 2014, Ch. 60).

This reinvestment of funds could be vital for stabilizing the community-based behavioral health system; as such, The Coalition recommends a significant portion of the funds must be dedicated specifically to support and enhance the community based provider system to ensure consumers/clients have access to care in their community by providers they trust.

As discussed in more detail below, we do have concerns about the assessment and remediation processes to which providers will be subjected in order to ascertain whether the settings are compliant or to become compliant for HCBS. The community-based behavioral health sector has been overwhelmed with assessments, surveys, webinars, in-person trainings and the like during the past years of transition to Medicaid managed care and, now, the ramp up to value-based payments. With yet another set of regulations for compliance and the requirements of staff time to compete self-assessments, The Coalition is concerned that providers may not participate in HCBS.

While The Coalition sees value in a State assessment of its portfolio of treatment, supportive housing and family care housing, to determine whether providers comply with standards set forth by the federal settings regulations to provide HCBS, we are concerned that remediation requirements may be difficult with which to comply. Providers of supportive housing have been historically underfunded with increased housing costs limiting providers' ability to provide services.

<u>Self-Assessment</u>
The OMH HCBS STP requires a provider self-assessment for adult OMH residential providers to complete and self-assess compliance with the HCBS settings criteria. Providers must complete an HCBS Settings Residential Program Assessment for each housing site.

Providers of supportive scattered-site housing will not be required to complete an assessment for each site and one assessment can be completed to represent the entire housing program; providers of Apartment Treatment Programs have not been so excluded. Nearly 2,795 Apartment Treatment sites serve 4,783 individuals. (p. 5, OMH

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HCBS STP) Providers serve multiple sites and, therefore, the State should consider treating providers of Apartment Treatment similar to supportive scattered-site housing.

It is instructive to review the Checklist for Final Submission to OMH found on p. 10 of the STP (below).

CHECKLIST FOR FINAL SUBMISSION TO OMH:
The final submission from Apartment Treatment, CR-SROs, and SP-SROs programs to OMH will include:

- HCBS Residential Settings assessment for each site
- Attestation signed by the Provider's Executive Director
- Additional supporting evidence such as maps, pictures of setting and/or other information
- List of non-compliant sites owned/operated by the provider (please include name of site and physical address)
- Corrective Action Plan if required via the electronic assessment or OMH

The final submission from Supportive Housing programs to OMH will include:

- HCBS Residential Settings assessment
- Supported Housing Attestation signed by the Provider's Executive Director
- Corrective Action Plan, if requested by OMH

When completing the assessment:

- Providers will establish a team of appropriate staff to complete the assessment.
- Providers must have their Executive Director sign and submit the attached attestation form with all their site-specific assessment to OMH.
- Providers will include additional supporting evidence such as maps, pictures of the setting and/or other information that provides strong evidence the setting is a community-based setting where possible. The Guidance document will indicate when a map, picture, and/or other information are needed.

These requirements our extremely burdensome and will require vast amounts of staff time both during and *after* submission of the assessment plan(s) are submitted by providers. OMH and DOH should consider a less time consuming labor-intensive approach.

<u>Compliance & Remediation</u>
The self-assessment tool helps to shed light on the standards that supportive housing providers will have to meet, once the requirements become mandatory in March of 2019. We have serious concerns about the ability of providers of Community Residence Single Room Occupancy Programs (CR-SRO) and Supportive Single Residence Occupancy Programs (SP-SRO) to comply with the mandates of the HCBS Settings Compliance Plan (Compliance Plan), particularly with regard to Category 1: Physical

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Characteristics and Setting and Category 2: Policies, Procedures and Staff Competencies.

According to the OMH HCBS STP, "Settings that **do not yet meet** HCBS settings standards at the time of this review will be required to develop a Corrective Action Work Plan outlining how the setting will achieve HCBS settings compliance." (p. 11) However, there is little or no specific guidance on how remediation will be accomplished other than elements of a mandated Compliance Plan.

For example, the model for both CR and SP-SROs is to have several units sharing a single bathroom. Category 1 of the Compliance Plan requires each individual consumer to have his or her own bathroom. The capital cost of compliance with this mandate could be monumental. Cognizant of the Medicaid cap and housing costs that are already out of pace with government reimbursements, we are concerned these additional expenses would likely fall on supportive housing providers who do not have the resources to pay for it.

Category: 2 of the Compliance Plan will also provide difficult obstacles to overcome. For example, many of the individuals housed in scatter-site supported housing are leaseholders or subtenants of the service providers. The leases may have clauses that require a unit to be drug or alcohol-free. These leases are counter to the housing-first approach that will be mandated HCBS Settings. How would a Remediation Plan address the existing multiple leases in place (with different expiration dates) that violate the State's housing first requirement?

With questions about whether HCBS are sustainable combined with costs of reporting and mediation, it proves prohibitive for supportive housing providers to comply with the STP as proposed.

Children & Families HCBS

HCBS for children will encompass New York's existing 1915-c waiver services, including OMH, Bridges to Health (B2H) and Care at Home I, II and soon the services provided by Children's Health Homes.

While these settings are compliant for HCBS purposes, our members that serve children and families are concerned about unintended barriers to access that will occur if the CMS HCBS Waiver rule on conflict free care coordination is applied in its strictest interpretation. Specifically, we fear services will be severely restricted if the available provider pool is forced to choose between providing direct services or providing care coordination.

New York has been a leader when it comes to offering quality HCBS for children. New York's model, which offers care coordination as well as services from a single agency to

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minimize the disruption of vulnerable homes, is now apparently at risk of falling short of a federal rule.

From our members' perspective, New York's HCBS model for children strongly supports family choice. The model that is currently in use in New York for children's HCBS waivers develops parental trust and encourages parental judgment, both of which are essential to the success of home-based services. Anything that restricts appropriate options from being offered to the family will garner distrust. The choice of provider and care coordinator should not be restricted.

The implementation of Health Homes serving children will create an even greater demand for appropriate services. The management and development of sufficient capacity is what providers and families are most focused on in this transition.

We would be very pleased to work with the State to urge CMS to consider family choice as well as ensuring adequate capacity and access to services as the transition continues from historic waiver services to new service models.

OASAS HCBS

We understand and are pleased that OASAS had significant input into the HCBS transition plan. The Coalition does have some comments and concerns, which are expressed below.

OASAS has determined that, "[i]ndividuals that enter an OASAS [intensive and community] residential setting are not eligible to receive HCBS services because such a setting IS NOT an HCBS eligible setting. It [is] a setting providing substance use treatment and in some cases withdrawal management. To the extent that such individuals are receiving HCBS services, they will be suspended until such time as the individual is released from the OASAS residential setting." (p.1, "Overview of the OASAS Service System"). The Coalition recognizes that the need for such settings is significant. The model for these OASAS residential settings is congregate with most facilities constructed so that participants will have roommates and have restrictions on his/her mobility. In addition, these settings are temporary, which would also exclude them from HCBS. Applying HCBS Settings criteria would be incredibly expensive and, arguably, inconsistent with the needs of the participants.

We do believe that robust discharge planning, including an evaluation for HCBS is absolutely appropriate for individuals leaving OASAS intensive and community residential settings. OASAS makes a similar point on page 2 of its "Overview" document and we appreciate this commitment.

OASAS also operates 2,100 of Permanent Supportive Housing (PSH) and "believes all PSH providers are compliant with the HCBS rules and will require providers to review

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the HCBS rules, analyze their individual apartment units and attest to compliance for each unit." (p. 2, "Overview). As we expressed with regard to the OMH HCBS STP, we are concerned with the costs to providers associated with assessment and remediation.

We thank you for this opportunity to comment on New York State's Amended HCBS STP.

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