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

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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)[1] 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[2], 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. Converting inpatient beds in State Psychiatric

Centers to Transition to Community Residential Programs (TCRPs) 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[3]). 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.[4]

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.[5] 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.[6] 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.[7]

From calendar year 2010 through 2018, the rate of unintentional drug-related overdosedeaths 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

Data Year(s)	Crude death rate
2010	5.0
2011	6.6
2012	7.0
2013	8.2
2014	8.7

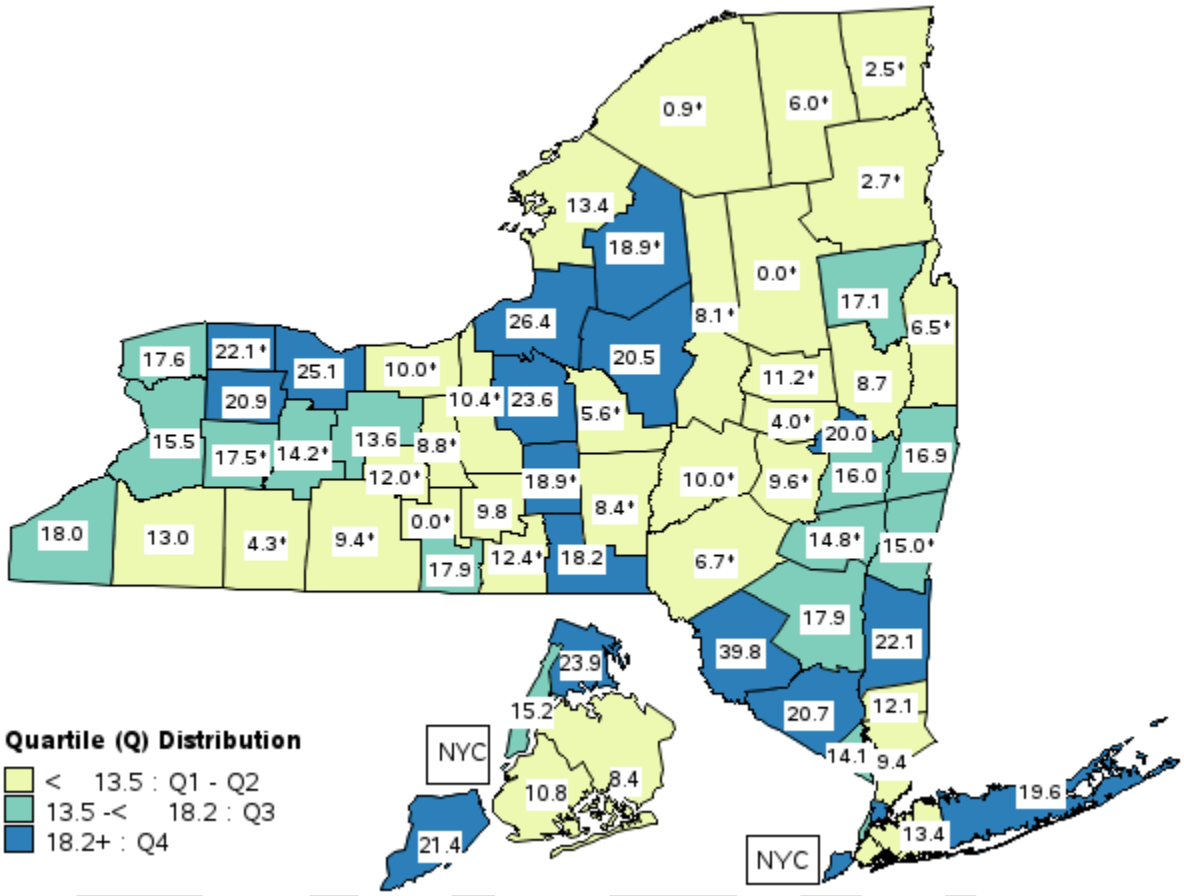
2015	10.9
2016	15.6
2017	16.8
2018	15.1

Data Source: Vital Statistics Data as of August 2020.[8]

There is also a data dashboard maintained by DOH which can be found at: https://webbi1.health.ny.gov/SASStoredProcess/guest?_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.

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



Data Source: Vital Statistics Data as of August 2021[9]

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.[10] 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.[11]

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 & Biploar 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 the 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 thefollowing:

- 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 inresidential 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 LOCDTR 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.[12] 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.[13] 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 Midwifes (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.[14] 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.[15]

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.[16] 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.[17]

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.[18]

- 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.[19] The CDC is updating its guideline and the CDC Clinical Practice Guideline for Prescribing Opioids–United States, 2022 is currently under public review.[20]

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.[21]

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.[22] 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 conversion of beds in 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 fullLOCADTR 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 forSUD 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 approvedMedicaid 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 forensically involved individuals, sex offenders, 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

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		
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 **more likely to access specialty**	Proportion of individuals with specialty mental health services in the year following discharge	Medicaid Claims

mental health services (e.g. ACT, PROS) than IMD-eligible individuals discharged from a non-IMD psychiatric bed		
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		
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 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 **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
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 will conduct a 30-day tribal comment period from October 4, 2022 - November 10, 2022. All comments will be considered prior to finalizing the amendment request.

Public Notice and Processing

In compliance with 42 CFR 431.408(a)(1), the Department of Health will conduct a 30-day public comment period from October 5, 2022 - November 4, 2022. All comments will be considered prior to finalizing the amendment request.

Public Hearings

In compliance with 42 CFR 431.408(a)(3), the State will conduct two virtual public hearings on October 26th and 31st, 2022. All comments will be considered prior to finalizing the amendment request.

Notes

[1] 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

[2] CBC, http://www.cbcare.org/innovative-programs/pathway-home/

[3] https://www.samhsa.gov/behavioral-health-equity/obhe-data

[4] 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 [Accessed July 2019].

[5] "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&amp:ACSTrackingID=USCDC_1026-DM71895&ACSTrackingLabel=December+Drug+Overdose+News+Updates+%2B+SUDORS+MMWR&amp:deliveryName=USCDC_1026-DM71895

[6] 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.

[7] 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

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[9] 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 [Accessed July 2019].

[10] New York State Opioid Annual Report 2020 https://www.health.ny.gov/statistics/opioid/data/pdf/nys_opioid_annual_report_2020.pdf

[11] 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

[12] 14 NYCRR 817.3(d)(1)

[13] 14 NYCRR 817.3(d)(1) and 14 NYCRR 800.4

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