



Managing Risk – Maximizing Opportunity

*Medicaid Managed Care and OMH Licensed Rehabilitation
Services in Residential Settings*

An Analysis

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INTRODUCTION

New York State plans to move all Medicaid programs into managed care by 2013/2014. Services affected include rehabilitation services in residential settings that are a unique and essential part of the service system for recipients with the most serious and persistent psychiatric illnesses, providing an alternative to long term hospitalization, jails, prisons, nursing homes, shelters and homelessness. Non-profit agencies in New York provide extensive support and rehabilitation services to recipients in different stages of recovery from a mental illness and a variety of co-morbid conditions, including chemical dependency, in community residences and apartments licensed by the New York State Office of Mental Health (OMH) throughout the state. The programs provide 24/7 staffing, medication monitoring, skill building, rehabilitation, as well as case management and care coordination of mental health and health care, which lead to independent living. Every person enrolled in a residential program in 2011 was reported to OMH as having a serious mental illness, which requires a mental illness diagnosis and severe functional impairment.¹ Recovery would be nearly impossible for many without these programs.

Managed Care companies will certainly want access to these services as they are proven alternatives to higher cost service settings; they have been instrumental in driving down the state's psychiatric inpatient census over the past 25 years. However, these services are extremely labor intensive for the population served and cannot be replaced or enhanced by other community based programs, e.g., Personal Recovery Oriented Services (PROS) and Health Homes. Residential staff is available to recipients 24 hours a day, seven days a week - a service dimension impossible to match with Health Home delivered Care Coordination, whose staff to recipients ratios of 1 -100 will be insufficient. Managed Care Plans' existing case management models with much higher ratios will also fall short. PROS requires progress at a certain rate and so does not provide a place for the most ill who are most likely to cycle in and out of high cost services such as hospitals and emergency rooms.

Residential support services keep homeless-prone people in their housing, preventing recidivism to the streets and to shelters; they address and assist recipients, on-site, and in-person with immediate management of day to day stressors that can destabilize recipients and derail care coordination efforts provided by Health Homes. In fact, residential services will be the foundation that ensures the effectiveness and desired outcomes of Care Coordination for those with the most severe and persistent psychiatric disabilities. Residential providers have heard in the past that they need no additional resources because the system will wrap recipients in supports (ICM, SCM, ACT, AOT, etc.) Those supports made little positive difference for recipients and providers in the residential arena in the past and we are sure that the new Health Home care coordination will not make a difference now, particularly because the new services are even less comprehensive than the old.

¹ OMH – 2011 PCS Summary Reports - http://bi.omh.ny.gov/pcs/Summary%20Reports?pageval=prog-smi&yearval=2011&p_agegrp=&p_categ=Residential#ProgramTypechart

Managing Risks/ Maximizing Opportunities

This Analysis Report outlines the potential negative consequences, challenges and opportunities that will be created by transitioning the New York State Office of Mental Health (OMH) licensed rehabilitation services benefit provided in residential settings to managed care. The report also outlines specific ways that BHO- IIs and SNPs can work with providers to ensure that this resource is best used to help bend the cost curve of Medicaid while providing a more responsive and flexible rehabilitation benefit to recipients.

Objectives of the Report

- Provide background of the current framework of residential rehabilitation services in New York
- Outline potential unintended consequences to ending the carve-out of rehabilitation services benefits currently provided in residential settings
- Explain how adding this program to managed care without first determining if it will actually work could jeopardize decades of work and the significant investment into properties that NY State has made
- Detail opportunities to enhance or modify the services currently provided to eligible New Yorkers through a transition to managed care
- Offer recommendations for successful implementation strategies should the state decide not to continue to carve-out the rehabilitation services benefit provided in residential settings

Executive Summary

There are 8,870 OMH licensed community residence slots operated by non-profits in New York that would be affected by the state's plan to move rehabilitation services provided in residential settings to managed care. There are 4,509 congregate² slots and 4,361 treatment apartment slots³. There are also 1,071 congregate slots operated by the state of New York that would not be affected. Developed in 1983, the OMH congregate certified community residence program model is the only 24-hour, seven day a week supervised setting with rehabilitation services for severely and chronically psychiatrically disabled recipients who need a high level of behavioral health and health care. Similarly, the apartment treatment program is the only scattered site apartment program that can accommodate high levels of service needs, including medication management.

The State has not done any subsequent review of recipient characteristics and adequate staffing levels, which have changed drastically over the nearly three decades, since the program's inception. Further, Cost of Living Adjustments (COLAs) have been few and far between, the programs are not re-based, have no rate appeal process, and no trend of any kind, resulting in programs that have lost approximately 40% in real dollars to inflation since 1991⁴ (see Appendix B) while serving recipients with more and more challenging medical, psychiatric and medication needs. In fact, in 1992 recipients were typically all taking the same two medications with no co-morbid conditions. Staff training was minimal. However, a survey in 2003 showed that recipients were typically on 5 – 9 different medications with multiple behavioral and physical diagnoses requiring a much high level of supervision, attention, care management, and staff training.⁵

Prior to embarking on such a significant system transformation, a number of factors need to be considered. A global analysis of the service delivery system must occur and should include a close assessment of the following:

- Strategies for Creating More Effective Programs Through Managed Care - While the state is attempting to save money as it moves behavioral health to managed care, this goal should not come at the expense of those in need of services; therefore we must also focus on creating more effective programs in this transformation. The State hopes to use an 1115 waiver to create or expand new program models for high users of Medicaid, an important initiative that could help bend the Medicaid cost curve. Included should be a consideration to convert some community residences to crisis use, step down programs, and other specialized services that could solve some intractable housing and service gaps among high users of Medicaid.
- Rate Setting Methodology, the Impact of Property Costs and Realistic Program Savings - Medicaid rates for rehabilitation services in residential programs are complicated by the numerous sources of revenue that interact and impact each other, resulting in varying rates among programs

² Medicaid reimburses operating costs for OMH licensed congregate programs up to 16 beds. NYCRR 14 Section 593.3.

³ Apartments that house 2-3 recipients while providing intensive services, including medication monitoring.

⁴ http://www.inflationdata.com/Inflation/Consumer_Price_Index/HistoricalCPI.aspx

⁵ ACL Survey results

that provide the same service. Although Medicaid does not pay for property costs, property costs create differences in the Medicaid rates for services among providers, which could potentially jeopardize that property funding. We recommend that property costs be protected to avoid the unplanned consequence of negatively impacting the state's ability to pay the debt associated with those programs.

In addition, there is concern that managed care will seek to drive rates down based on a misunderstanding of how the current rates are formulated, resulting in program unsustainability. The State needs to ensure an adequate base rate for all programs.

- Program Services, Who Provides Them, and Ensuring Continuation and Enhancement - Because property and services funding interact and impact each other through SSI/SSDI and Medicaid, the state must ensure that only one provider operates all aspects of a community residence program, i.e., both property and services. Moreover, if, as providers suspect will be the case, Managed Care Plans want recipients to move through the service more quickly, skill development must be more intensive. Ideally, a provider will have a cadre of specialized, skilled rehabilitation specialists that can be deployed to work intensively with recipients to gain or re-gain skills that allow them to move on much more quickly than they can now.
- Vacancies/Dual Eligibles/Uninsured/Public Assistance Medicaid Beneficiaries - Current rates take into account inevitable vacancies that result from recipients who are Medicaid ineligible or from delays in the movement of referrals. In addition, policymakers must be mindful that many people entering a residential program will not have established public benefits or entitlements such as Medicaid prior to admission so that they will not be enrolled in a managed care plan that would otherwise authorize their stay. For those enrolled in Public Assistance Medicaid there can be as much as a yearlong wait to be enrolled in the SSI Medicaid program. Additionally, approximately 30% of recipients are dually eligible for both Medicare and Medicaid (dual eligibles) and will not be in managed care plans until a much later date.^[1] Mechanisms for admission authority and payment, such as a continuation of Fee for Service Medicaid, will need to be created to ensure that providers can submit bills for those not enrolled in managed care.
- Eligibility and Admissions - Eligibility to the community residence program reimbursed by Medicaid is currently made in compliance with NYS regulations.⁶ Additionally, admissions are both regulated⁷ and subject to various agreements in contract and policy with the state and LGUs' Single Point of Access systems (SPOA/SPA). However, providers need to control final admission decisions, basing them on solid risk assessments, thereby ensuring appropriate and responsibly delivered services to a manageable mix of recipients particularly if they indemnify payers and SPOA from liability.

^[1] DOH is piloting a managed care option for dual/eligibles that will only be operational in a limited number of areas by 2015

⁶ NYCRR 14 Section 593.5; NYCRR 14 Section 595.8

⁷ Ibid

- Program Obligations and Resource Levels/ Skill Development & Skill Loss – As mentioned, a full review has not been done since 1983, when staffing and resource levels were matched to the recipients that providers actually served. With a different rate and staffing structure, staff could engage in intensive skill building and discharge planning so that recipients would move through the programs more quickly. As it is now, due to a lack of fundamental resources, recipients may be staying longer than they need to; other community based programs will not be able to change this. For those who cannot develop the skills necessary to move on in a reasonable amount of time, or who are experiencing skill loss extended stays could be included in arrangements with the managed care plans.
- Utilization Review and Discharge Planning - Currently, the residential program staff, in consultation with the recipients and the recipients’ clinical staff, make decisions regarding utilization and discharge. Furthermore, discharge is regulated by OMH, which includes mandates to plan for discharge upon admission, recipient inclusion, and among other things includes due process rights⁸ when a recipient disagrees with a plan for discharge. It is unclear how due process fares in a managed environment. In addition, the housing component of the program complicates discharges. Unlike in a clinic where, when a recipient comes to the end of a proscribed number of clinic visits, her life is not upended, a discharge from a residential program requires the provider to ensure an alternative place to live. Therefore, discharge planning is critical to a recipient’s continued stability and development. Although managed care plans may want to direct discharges and discharge activities, treatment professionals must be free to continue to determine length of stay based on the real time status of recipients’ mental health as well as ensuring that the discharge plan includes a viable living arrangement.

This report highlights the various concerns and unintended consequences that may result from instituting managed care. As the State embarks on moving rehabilitation services provided in residential settings to managed care, we urge policymakers to be aware of the unique issues facing these programs and the recipients they serve.

Ultimately, we recommend a carve-out of this program type from managed care.

Short of a carve-out, we recommend phasing in managed care in the form of demonstrations before rolling it out statewide.

⁸ NYCRR 14 Section 595.9 was the result of a legal settlement between OMH and Disability Advocates (DAI). DAI sued OMH asserting that recipients are entitled to due process when discharged from a residential setting.

I. Who Will Be Impacted By This Change?

There are 8,870 licensed community residence slots operated by non-profits in New York that would be affected by moving rehabilitation services provided in residential settings to managed care. There are 4,509 congregate⁹ slots and 4,361 treatment apartment slots¹⁰. There are also 1,071 congregate slots operated by the state of New York that would not be affected. Developed in 1983, the OMH congregate certified community residence program model is the only 24-hour, seven day a week supervised setting with rehabilitation services for severely and chronically psychiatrically disabled recipients who need a high level of behavioral health and health care. Similarly, the apartment treatment program can accommodate high levels of rehabilitation service needs, including medication management, at relatively low cost in a scattered site apartment setting.

The program was developed in 1983 without a subsequent review of recipient characteristics and adequate staffing levels. In 1983, recipients had similar diagnoses, were all on the same two medications, were largely compliant due to years of institutionalization, had few if any medical conditions and were expected to be engaged in a program five days a week. Today, many recipients have very challenging medical needs, active substance use disorders, severe behavioral issues related to their psychiatric disabilities, and complicated medication regimens as part of their psychiatric and medical care plans. However, they are no longer required to attend program off site¹¹, necessitating that staff be on site during the day, thereby stretching the few remaining staff over all evening, overnight and weekend shifts.

Opportunity: Programs could be reformed to serve more specialized populations, e.g., geriatric, geriatric-like, youth, medically compromised or used for hospital avoidance, crisis and respite care.

Providers are reimbursed at very low levels. Cost of Living Adjustments (COLAs) have been few and far between, the programs are not re-based, have no rate appeal process, and no trend of any kind. Although there have been legislative increases from time to time, the programs have lost approximately 40% in real dollars to inflation since 1991¹² while serving recipients with more and more challenging medical, psychiatric and medication needs. (See Appendix B)

II. Strategies for Creating More Effective Programs through Managed Care

Recommendation: Managed care, properly managed, could create opportunities for providers and recipients to engage in services that are programmatically more effective. With a variety of services packages within a highly desirable residential setting, these programs could be converted to serve even lower functioning recipients than they do today ensuring that hospital and emergency room visits are even

⁹ NYCRR 14 section 593.3. Medicaid reimburses operating costs for OMH licensed congregate programs up to 16 beds.

¹⁰ Apartments scattered throughout communities that house 2-3 recipients with intensive services, including medication monitoring.

¹¹ NYCRR 14 section 595.8(d)

¹² http://www.inflationdata.com/Inflation/Consumer_Price_Index/HistoricalCPI.aspx

further minimized than they are now. New care models that create a full continuum of care would be a good fit for 1115 MRT waiver investment.

For example, a 12-bed community residence could be converted to a 6-bed crisis residence used to avoid acute hospitalizations. The goal would be to wrap a decompensating person in intense supports for a short time to avoid a hospitalization and return them to their community quickly with a robust community discharge plan. Residential providers are central in every community because they manage recipient's complete lives from where they live. Arguably, they know the health and behavioral health systems in each community better than any other provider, making them uniquely positioned to work quickly to stabilize and return recipients to the most natural environments.

A 14-bed community residence could be converted to a 14 bed step down program where recipients, no longer in need of acute services in a hospital, can go if they are in need of longer term care. It would be the equivalent of a physical rehabilitation setting for people coming out of hospitals after a traumatic brain injury or other injuries requiring rehabilitation.

Other examples include:

- Long term care for geriatric or geriatric-like residents whose functioning is deteriorating due to age related illnesses and conditions - once in a program they could age in place;
- Programs for youth aging out of foster care or coming out of long-term children's hospitalizations that are just too immature to live on their own without intensive supervision

III. Rate Setting Methodology: The Impact of Property Costs:

Medicaid rates for rehabilitation services in residential programs are complicated by the numerous sources of revenue and how those sources of revenue impact one another, resulting in varying rates among programs that provide the same service. All programs of the same size in given geographic areas have the exact same approved operating costs but property costs create large differences in provider Medicaid rates.

Risk: A managed care company might look solely at the Medicaid rates of providers in deciding with whom to work; however, this would compromise the considerable investment that New York has made into properties across the state. A review of the funding is essential to understanding why.

There are four sources of revenue for OMH licensed residential programs:

- *Supplemental Security Income (SSI)*
- *Social Security Disability Income (SSDI)*
- *Medicaid*
- *NYS Net-Deficit funding.*

The expected revenue from each income source and allowable costs

are set in contract.¹³

Although Medicaid does not pay for property costs, property costs create differences in the Medicaid service rates among providers. SSI/SSDI revenue is used to pay the gross property costs, which include the “room and board” for which SSI/SSDI is meant to pay. In the vast majority of cases SSI/SSDI is sufficient to pay all of a provider’s gross property costs and, in many cases, some services costs. In those cases where there is enough SSI/SSDI to pay for all of the gross property costs and some of the services costs, the remaining services costs that Medicaid needs to cover is reduced, thereby reducing the Medicaid rate.

EXAMPLE: Two 12 bed programs have the same allowable services costs but one was built in 1995 and the other in 2012. The 1995 program has enough SSI/SSDI income to pay for all of its relatively low property costs, leaving enough left over to pay 25% of its services costs. Medicaid would pay for the remaining 75% of services costs. The 2012 program has the exact same amount of SSI/SSDI revenue and the exact same allowed services costs, but the SSI/SSDI revenue is not enough to pay for its much higher property costs requiring NYS to add net-deficit funding. In this case, Medicaid would pay for 100% of the services costs compared to 75% of the services costs in the program built in 1995, resulting in a higher Medicaid rate for the program built in 2012. Both programs in the example provide the exact same services and have the same exact services costs, but have very different Medicaid rates.

RISK: For the very few providers that have property costs greater than the SSI/SSDI revenue, State Net-Deficit funding covers the remaining property costs. In the newest programs, because of higher construction costs compared to programs built many years ago, the SSI/SSDI income is less likely to cover all the property costs or, if it does, it will provide less than in the older programs.¹

Recommendation: Property costs must be protected; the state must set adequate base rates. The buildings that house community residences represent a major state investment of capital dollars into rehabilitation in housing. Licensed residential programs have capital costs that include bonds and other property costs, such as utilities, that are included in the global budget of a residential provider. Any attempt to negotiate lower

Medicaid rates with residential providers that have relatively high Medicaid rates as a result of higher property costs (due to newer, more expensive buildings or those that underwent renovations), may have the unplanned consequence of negatively impacting the state’s ability to pay the debt associated with those programs.

Recommendation: Managed Care companies must not be allowed to only refer recipients to programs that have lower Medicaid rates in the hopes of achieving lower services costs. The state must ensure that managed care companies do not make the mistake of only referring recipients to programs that have lower Medicaid rates, which will result in the state not being able to cover the debt and other property costs on all the programs because they are all dependent on a threshold occupancy rate of residents who pay the SSI Congregate Care Level II (CCL II) rate. Because the housing and services components are intertwined with SSI/SSDI and the Medicaid rate, with the lowest cost properties carrying the lowest Medicaid rates, the

¹³ OMH sends each provider a Gross-Income-Net (GIN) worksheet that breaks down revenue and expense categories in detail.

perverse result could be that the most modern and desirable buildings will not be supported by enough referrals and high enough occupancy rates because these programs carry the highest property costs and therefore, the highest Medicaid rates.

Recommendation: All aspects of a community residence program need to stay with one provider. The state must ensure that only one provider operates all aspects of a community residence, i.e., both property and services, because of how the SSI/SSDI and Medicaid interact. Separating room and board from services

Risk: Separating property from services would not work in this environment because the SSI/SSDI may pay for varying levels of services depending on the property costs.

would result in some “room and board” providers paying the services provider for some portion of the services. In addition, separating services from property could result in the “room and board” provider that pays for food, linens, furniture, etc., relying on another service provider’s staff to buy those things because it is the service provider’s staff that plan meals, teach cooking, make the meals, ensure that bedrooms are clean, etc. It would not only be impossibly complicated, but it would surely impact each provider’s cash flow negatively, exacerbating a problem that they all have now. Similarly, it will be complicated to have managed care pay for the services while the provider pays room and board, including

property debt, after it collects the SSI/SSDI from recipients.

Recommendation: Recipients’ skills training in the programs needs to be ensured and enhanced. The contracts for licensed residential services include a services budget recommendation that is identical, albeit inadequate, in all programs of a certain size and within a region.¹⁴ The model was developed in 1983 and has never been changed. Although licensed residential programs have received some increases over the past 30 years, the programs are now operating with 40% less in real dollars than they were 22 years ago while recipients’ needs have become more challenging and expectations for recovery have increased. If, as providers expect, Managed Care Plans want recipients to move through the service more quickly, skills development must be much more intensive. Ideally, a provider will have a cadre of specialized, skilled rehabilitation specialists that can be deployed to work intensively with recipients to gain or re-gain skills that allow them to move on much more quickly than they can now.

Recommendation: Use the opportunity of transitioning to managed care to reconsider how the rates are formulated around differing levels of service. In addition to an average, adequate base rate, either an additional blended rate that allows providers to increase or decrease service levels per individual need, or different rates for different program types at higher levels of care are two examples of how to approach payments for more specialized care. Geriatric or geriatric-like recipients should be able to age in place with providers that are paid adequately to care for them; they often do not do well in the DOH licensed long-term care system so that an alternative is needed.

IV. Vacancies/Dual Eligibles/Uninsured

Recommendation: Payment mechanisms must take vacancies and the uninsured into account. Providers will need to continue to bill fee-for-service for dual eligibles and others not yet in managed care. There

¹⁴ There are three operations budgets – one for upstate, one for lower Hudson and one for NYC and L.I.

must be a guarantee that the BHO/SNP will continue to approve coverage for those in the programs prior to their enrollment in managed care. Without these mechanisms there will be massive losses for residential programs.

Current rates take into account inevitable vacancies that result from recipients who are Medicaid ineligible or from delays in the movement of referrals, particularly an issue since LGUs control referrals through Single Point of Access. It does this by the inclusion of a “collectable factor” that serves to increase the global program budget, covering the uninsured, non-eligibles and vacancies that are often out of the control of the provider. There will need to be a mechanism to continue this.

Approximately 30% of recipients are dually eligible for both Medicare and Medicaid (dual eligibles) and will not be in managed care plans until a much later date.^[1] The state may not want to move forward with a plan to include residential services in managed care until all recipients are actually in managed care. Short of that, fee-for-service, or some other mechanism that ensures payment, must continue for dual-eligibles.

Many people entering a residential program from jails, prisons, hospitals and homelessness do not have benefits and entitlements in place at the time of admission, which could result in high levels of unreimbursed care. Unreimbursed care has a disproportionate impact on residential providers because a residential provider cannot physically serve more people than the number of beds it operates. One person could be 1/8th to 1/16th of total yearly revenue in a program, unlike in a clinic where one person might be 1/1440th of the yearly revenue of just one clinician.^[2] Moreover, a clinic can add clients to make up for unreimbursed care. Residential providers cannot. Fee-for-service, or another mechanism that ensures payment, must continue for those not enrolled in managed care.

In the future system, residential care will be a benefit in only Medicaid Behavioral Managed Care (BHOs or SNPs) but there could be up to a yearlong lag between time of admission and enrollment in a BHO/SNP. The residential provider helps recipients apply for Public Assistance (PA) and PA Medicaid, while simultaneously applying for SSI/SSDI, which can take up to 12 months to be approved. While recipients are enrolled in PA Medicaid, they are in managed care for physical health care services that includes a small behavioral health component that does not include residential care. Currently, the residential provider bills Medicaid fee-for-service for rehabilitation services in residential care while the person is in PA Medicaid waiting for SSI/SSDI. In the coming system, only after an SSI/SSDI claim is approved will the person be eligible to enroll in a managed care BHO or SNP that covers rehabilitation services in residential care. That recipient may have already been in a residential rehabilitation program for a year before enrolling in a plan that covers the service. There must be a mechanism for admissions to be authorized and payments to be made during the period of enrollment in PA Medicaid.

^[1] DOH is piloting a managed care option for dual/eligibles that will only be operational in a limited number of areas by 2015

^[2] Based on 6 visits a day, 5 days a week for 48 weeks in one year for one clinician.

V. Eligibility and Admissions

Eligibility to the community residence program reimbursed by Medicaid is currently made in compliance with NYS regulations.¹⁵ A person must have a designated mental illness diagnosis, and one of the following:

- Receives social security income or social security disability insurance enrollment due to a designated mental illness;
- Has an extended impairment in functioning due to a designated mental illness, or
- Is reliant on psychiatric treatment, rehabilitation and supports.¹⁶

Eligibility to the programs should remain the same so that this resource continues to be used for those with high needs.

Recommendation: Providers need to control admission decisions, basing them on solid risk assessments, thereby ensuring that they responsibly deliver appropriate services to a manageable mix of recipients.

Currently, admissions are both regulated¹⁷ and subject to various agreements in contract and policy with the state and LGUs' Single Point of Access systems (SPOA/SPA). Providers indemnify payers and LGUs from liability because the providers have final admission authority, making informed decisions about admissions by assessing risk. The LGU agreements vary from community to community but they all adhere to the state mandated policy that providers have the final decision making authority in admitting or rejecting recipients. This is because recipients referred, who all may meet the regulatory criteria, will present with varying levels of disability and, therefore, appropriateness for the programs. The programs are staffed *minimally (often one paraprofessional on evening, overnight and weekend shifts)* so that some recipients with extreme challenges may not be appropriate for the programs. Although the staffing could easily be changed with higher rates, allowing providers to serve more challenging people, providers are concerned that managed care companies will seek to use these 24/7 supervised settings to serve an even more challenging cohort than they serve now *without adding to the providers' resources*. In order for providers to admit more challenging people and to continue to indemnify payers, they must be paid more and be allowed to deny admission to those who pose too great a risk to themselves, the staff and other recipients.

LGUs handle the referral process through SPOA impacting vacancy rates. Referrals are currently handled differently in different parts of the state to varying effect; however, it is imperative that providers receive multiple referrals from which to choose so that when a vacancy becomes available, preferably through a planned discharge, a planned admission can take place. This is not to say that emergency admissions cannot occur; they do now. However, during the normal course of business, recipients that are discharged from hospitals or other high cost venues should be admitted to community residences in a planned way. In some areas of the state, referrals are controlled in an effort to force providers to admit specific consumers. However, providers need to take the time to ensure that complete information is gathered, a risk assessment is completed, consumers are eligible and interviewed and that the programs are a good fit. If a provider has only one referral, with incomplete information, a slot may stand vacant for days or weeks. It

¹⁵ NYCRR 14 Section 593.5; NYCRR 14 Section 595.8

¹⁶ NYCRR 14 Section 595.8

¹⁷ Ibid

results in the waste of a valuable resource and a loss of revenue for the provider. Generally, there should be no vacancies.

VI. Program Obligations and Resource Levels/ Skill Development and Skill Loss

Recommendation: Managed care plans must not be allowed, unilaterally, to make continued stay decisions superseding the decision-making of treatment professionals, nor limit payment to residential providers when a pre-determined length of stay is reached. The course of a serious psychiatric disability is not similar to the course of many physical illnesses where treatment is sought, treatment is given and recovery is all but assured. Reduced payments to providers at dates certain are counter-productive to skill development in seriously psychiatrically ill recipients of service.

Recommendation: As the state moves to managed care, there needs to be a fundamental change in the level of resources provided for the most basic service. A full review of the staffing and resource levels has not been done since 1983, when staffing and resource levels were matched to the recipients that providers actually served. Recipients' needs and the challenges they pose to providers in meeting those needs has increased almost exponentially, while staffing and rates have eroded. Moreover, enhanced, intensive services would need to be evaluated as a new service, which could be part of the MRT 1115 waiver investment.

Risk: Poor discharge planning, precipitous discharges, or discharges to sub-par environments result in instability, de-compensations, hospitalizations, emergency room visits, crime and people with mental health diagnoses in jails and prisons.

The programs could be used to do intensive, person centered skill development. However, with one paraprofessional on an evening or weekend shift who supervises approximately 40 – 150 medications at 6:00 p.m., ensures that meals are served and cleaned up, intervenes in any recipient disputes/crises, ensures that everyone's basic daily living needs are met, communicates to the next shift in a staff log, there is little time left for intensive skill development with individual recipients. This can change. With a different rate and staffing structure, staff could engage in intensive skill building and discharge planning so that recipients would move through the programs more quickly. As it is now, due to a lack of fundamental resources, recipients may be staying longer than they need to.

For those who cannot develop the skills necessary to move on in a reasonable amount of time, or who experience skill loss as a result of dementia, long term medication use, or a multiple of chronic illnesses, a tolerance for extended stays must be included in arrangements with the managed care plans. Recipients may want and need to retire from the system and from efforts to rehabilitate them. The state must continue to pay for those recipients' care either through Medicaid, an 1115 waiver program or 100% state funding.

Utilization Review and Discharge Planning

Recipient stability, and therefore hospital and emergency room avoidance, are dependent on sound utilization processes and discharge planning as well as a willingness to change course during a person's stay because of the cyclical nature of serious psychiatric illnesses. Currently, the residential program staff, in consultation with the recipients and the recipients' clinical staff, make decisions regarding utilization and discharge. Service plans are reviewed every three months and authorizations for services are renewed bi-annually or annually.¹⁸ A physician, physician's assistant or nurse practitioner in psychiatric care signs re-authorizations for services.¹⁹ Discharge is regulated by OMH, which includes mandates to plan for discharge upon admission, recipient inclusion, and recipient rights including due process rights²⁰ when a recipient disagrees with a plan for discharge, the timing of a discharge, or an unplanned discharge that must be implemented for the safety of the recipient or others or because the recipient refuses to take part in the services part of the program. It is unclear how due process fares in a managed environment.

The housing component of the program complicates discharges. Unlike in a clinic where, when a recipient comes to the end of a proscribed number of clinic visits, her life is not upended, a discharge from a residential program requires the provider to ensure an alternative place to live. In OASAS residential facilities, a provider is allowed to discharge recipients to shelters. In the OPWDD system, recipients are understood to be in the service or a comparable service for a lifetime. However, recipients in OMH licensed residential rehabilitation programs are not meant to stay beyond the time needed to resolve their most challenging skill deficits while providers are barred from discharging without an alternative housing plan – often a serious challenge in high cost New York. Therefore, discharge planning that includes housing is critical to an OMH recipient's continuing stability and development. **Discharge plans currently are made by the recipients, collaterals of the recipients' choice, treatment professionals and residential staff in accordance with OMH regulations.** Although managed care plans may want to direct discharges and discharge activities, treatment professionals must be free to continue to determine length of stay based on the real time status of recipients' mental health as well as ensuring that the discharge plan includes a viable living arrangement.

VII. Other Contract Issues

Recommendation: OMH must continue to provide oversight and be involved at critical junctures of decision-making regarding contract terms and deliverables, including outcomes expectations, rate setting, and unfunded mandates, e.g., new IT system requirements, increased staff requirements, shortened lengths of stay, etc. The state must continue to provide oversight so that providers are not compromised by demands that they cannot meet.

¹⁸ NYCRR Sections 593.6 (a), (b) and (f)

¹⁹ Ibid

²⁰ NYCRR Section 595.9 was the result of a legal settlement between the NYS OMH and Disability Advocates (DAI). DAI sued OMH asserting that recipients are entitled to due process when discharged from a residential setting.

VIII. CONCLUSION

Although living arrangements that are permanent are optimal, short term residential settings are often necessary in order for some recipients to make enough progress in recovery to manage their illnesses, which often includes managing complicated behavioral and physical medication regimens. In fact, every person enrolled in a residential program in 2011 was reported to OMH as having a serious mental illness, which requires a mental illness diagnosis and severe functional impairment.

A move to managed care must be done carefully so that this resource is optimized, not lost or compromised. Some of the programs could be reformed to serve even more challenging recipients of service in the mental health system than they serve now, particularly those with very serious co-morbid physical conditions, youth aging out of youth systems who still need supervision, those in psychiatric crises where a hospitalization might be avoided or a re-admission diverted, and those who no longer need psychiatric or medical hospital care but could use a shorter term rehabilitation setting that ensures stability and progress. A review of current very low rates and staffing levels, not done since 1992, is necessary to ensure quality of services.

All Recommendations:

- Carve this program type out of managed care.
- Short of a carve-out, phase in managed care in the form of demonstrations to ensure that it will work before rolling it out statewide.

If managed care is definite than we offer the following recommendations and cautions:

- The state must play an integral part in rate setting, either in regulation or contract, so that its large investment in property is not jeopardized by an incomplete understanding of how rates vary provider to provider due to property costs;
- The current base level of services dollars must be increased so that, at a minimum, providers are services with the same funding they had 22 years ago;
- Substantial rate enhancements and model changes will be needed if the programs are expected to move recipients through more quickly, provide hospital diversion, crisis or other specialty services;
- A “collectable factor” or equivalent mechanism must remain in any payment structure in managed care;
- OMH must ensure that one provider maintains control of both the service dollars and the property dollars to ensure continuity, quality of care and accountability as well as to minimize complexity that would result in higher administrative costs, cash flow problems and complicated contract arrangements between service and property providers;
- In order to protect the state’s ability to pay the bonds that finance the properties it must ensure that programs with higher property costs are not left vacant. Not all beds must be “managed care”

beds – the state or LGUs could pay directly for beds for special populations and non-Medicaid recipients;

- Maintain current eligibility requirements;
- Admission authority must remain with the provider unless legal responsibility is shared;
- Multiple referrals, in advance of vacancies, should be given to all providers so that vacancies are avoided;
- Treatment professionals must continue to make decisions regarding continued stay;
- Recipients must continue to have input in their service planning and continued stay;
- The state must continue to regulate and monitor discharges;
- Reduced payments to providers at dates certain should not be allowed due to the cyclical nature of the illnesses ;
- Before moving to managed care, the state should complete a comprehensive review of the rates and staffing levels in the existing programs establishing new thresholds - providers must be reimbursed adequately;
- Modifications in programs should be made to accommodate those who can benefit from intensive services with the goal to move them quickly through the programs;
- Recipients of service who cannot move on must be accorded an assisted living like environment for health and safety; modifications in programs should be made to accommodate those who can no longer make gains;
- Until such time that NY can move dual eligibles into managed care there must be a continuation of a direct Medicaid reimbursement mechanism for providers to be paid outside of managed care for these individuals;
- Due to the high numbers of dual eligibles in these programs, it may not make sense to move residential services into managed care at all until such time that New York State successfully moves all dual eligibles into behavioral managed care;
- OMH must be involved at critical junctures of decision-making around contracts, outcomes expectations, rate setting, and unfunded mandates, e.g., IT systems, increased staff requirements, shortened lengths of stay, etc.

Appendix A

Services Provided In Licensed Residential Rehabilitation Settings.

Non-profit residential agencies provide extensive support services to residents in different stages of recovery from a mental illness and/or chemical dependency, in community residences and apartments throughout the state. They employ an array of dedicated direct care staff; housing specialists; service coordinators; vocational, educational, and financial/benefits counselors; case managers and peer support specialists.

Services provided to recipients include:

- Assessment of residents' functional skills;
- Development and monitoring of individualized service plans that promote and support goals toward stable recovery and social integration;
- Personnel that work with recipients daily, weekly or monthly to help them meet their goals to more independent living and integration into the community at large;
- Management of medication compliance and skills training in medication management;
- Skills development in 11 areas, i.e., assertiveness/self-advocacy training, community integration services/resource development, daily living skills training, health services, medication management and training, parenting training, rehabilitation counseling, skill development services, socialization, substance abuse services, and symptom management;
- Coordination of client services in the community, including psychiatric, medical, chemical dependency, other treatment providers, financial, legal, employment and recreational services;
- Linkage to, and promotion of, social integration including recreational, educational, vocational, civic, social and therapeutic activities;
- Health care monitoring including acquisition and maintenance of health care benefits, appointment setting and compliance, transportation and liaison to providers;
- Assistance with resource management, including personal finances and benefits access;
- Provision of community based housing support services;
- Housing support including acquisition of affordable and secure housing, and skills to maintain a household.

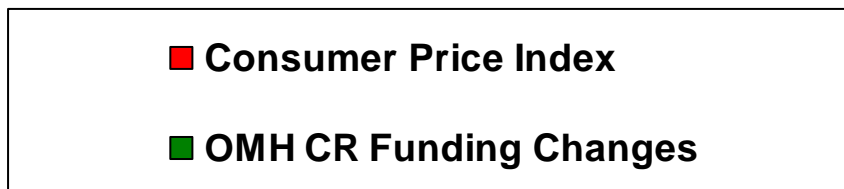
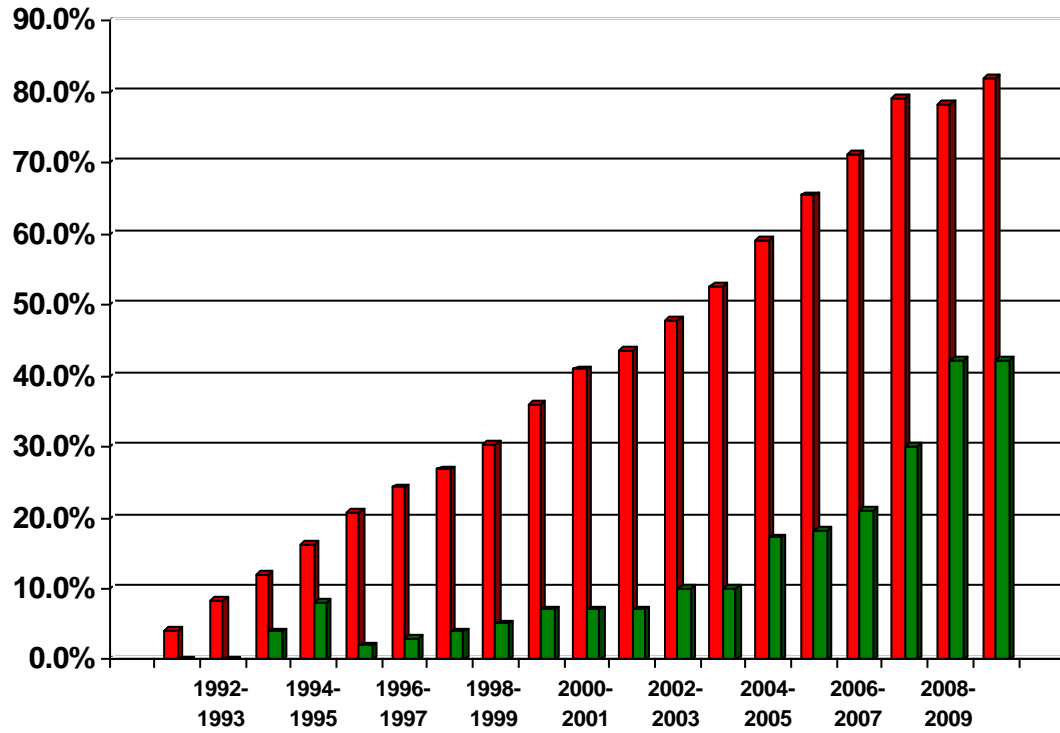
Cost effective licensed residential programs focus on the hard to serve creating positive outcomes for recipients, even those with complex medical needs.

Outcome highlights include:

- Successful transitions from institutional settings to the community
- Movement of people to higher levels of independent living
- Reduced admissions to inpatient care
- Reduced use of emergency rooms
- Improved general health and symptom management leading to less use of high cost services

APPENDIX B

LICENSED RESIDENTIAL FUNDING CHANGES 1991 to 2010 Cumulative
Comparison to the CPI



About ACL

The Association for Community Living (ACL) is a statewide membership organization of not-for-profit agencies that provide housing and rehabilitation services to over 32,000 people diagnosed with serious and persistent psychiatric disabilities. The day-to-day rehabilitative activities performed in community residential and other housing settings are vital for people who face the daily challenges of living with a psychiatric disability, but who want to live independent, productive and satisfying lives as members of the community.

Every day, 24 hours a day, thousands of skilled and dedicated professionals provide essential rehabilitative services that assist New York State citizens with serious and persistent psychiatric disabilities in rehabilitating their lives. These direct care and supervisory staff, and the community-based programs for which they work, provide essential services including counseling, crisis intervention, symptom management, self-medication training, vocational training, as well as a variety of other skills trainings.