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Leadership, voice and vision for child welfare in New York State

Council of Family and Child Caring Agencies

Testimony Presented by

Kathleen Brady-Stepien, President and CEO

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Council of Family and Child Caring Agencies

254 West 31 Street, New York, NY 10001 212.929.2626 | The Blake Annex, 1 Steuben Place, Albany, NY 12207

www.cofcca.org

My name is Kathleen Brady-Stepien. I am the President and CEO of the Council of Family and Child Caring Agencies (COFCCA). Our member agencies include over 100 not-for-profit organizations providing foster care, adoption, family preservation, juvenile justice, and special education services in New York State. I appreciate the opportunity today to address the Legislature regarding the need for state action to ensure in-state capacity for the full continuum of care in the child welfare system-- specifically to support the care of approximately 2,000 children and youth currently in residential foster care settings statewide.

You likely are familiar with the State's 1115 SED/SMI Medicaid waiver for Office of Mental Health (OMH) and Office of Addiction Services and Supports (OASAS) settings regarding the Medicaid Institutions for Mental Disease (IMD) Exclusion. I will be addressing the Administration's current plans to pursue a waiver amendment specifically related to Qualified Residential Treatment Programs (QRTPs) or residential foster care settings.

We acknowledge that the IMD/QRTP intersection is a significant challenge for New York and all states to assess and address. However, COFCCA has serious concerns related to the impact on in-state capacity for children and youth that are assessed to need residential care should the state submit a waiver for these settings. We assert that the best long term solution to ensuring adequate in-state capacity for residential care placements needed for children and youth in foster care who are assessed to need that level of care, to avoid out of state placements, is to provide for State only Medicaid and pursue a federal statutory fix to the IMD Exclusion/QRTP intersection.

Background
Under the federal Family First Act, our residential foster care settings transitioned to Qualified Residential Treatment Programs in order for the state to continue to be able to draw down Title IVE funds for residential stays of children and youth beyond 14 days. However, given the clinical nature of these settings as defined in the statute, CMS has interpreted that QRTPs over 16 beds likely fall into the Medicaid "IMD exclusion," therefore the federal Medicaid match for the medical care of residents in many of these settings could be prohibited.

In late fall 2021, CMS proposed a short-term option for states to avoid the loss of federal funding for two years, in the form of an ability to apply for an 1115 SMI/SED Demonstration waiver. However, it is clear that per the conditions of waiver submission as outlined by CMS, options for QRTPs that are determined to be IMDs are very limited at the end of the two year waiver period—seemingly, programs will either need to transition to a Residential Treatment Facility (Psychiatric center) model under the Office of Mental Health (specifically exempted from IMD exclusion in federal statute), significantly reduce bed capacity, or close at the end of the two-year waiver period.

Problem
We believe that the SMI/SED Demonstration would likely cause significant disruptions for children and youth in foster care both in the short-term and in the long-term.

One of our concerns relates to the application of Psychiatric Residential Treatment Facility restraint and seclusion requirements in QRTPs that would be required by CMS during the waiver period, which would necessitate additional staffing and significant costs to our residential settings. The Executive budget proposal includes $17 million within the Office of Children and Family Services (OCFS) Aid to Localities (ATL) appropriation, in part to address such financial costs of the state's plan to submit the waiver amendment for QRTPs. However, the budget proposal does not address the nationwide shortage of healthcare staff, specifically nurses. Given these shortages, it would be a significant challenge for our providers to hire the requisite staff to comply with these requirements, even if the state fully funds the actual cost.

Another concern relates to a requirement that per CMS guidance outlining the waiver option, the state would have to adhere to a 30-day average and a 60-day maximum length of stay (LOS) at the end of the two year waiver period. The

LOS requirements of the waiver simply do not fit within the structure of the Family First Act, or with the substantial needs of children and youth in these settings who have often experienced significant trauma and need intensive therapeutic intervention.

The Family First Act requires timelines for an independent assessment by a qualified assessor and a court review and approval of stays in a QRTP beyond 30 and 60 days. Since implementation, we have found that the almost all of these stays are approved as part of this process, again demonstrating the significant needs of the children and youth assessed to need this level of care.

CMS requires that as part of the waiver application, the state submit a plan to transition residents out of QRTPs that are deemed to be IMDs that cannot meet LOS following the waiver period. We know from a NYS DOH/OCFS presentation from June 2016 indicating that at that time the average length of stay in foster care statewide was 290 days, and 334 days in NYC. This is more than nine times what the federal government will require in two years at the end of the waiver period. The State has not to date shared data on current length of stay.

Solution

We believe it is essential that children and youth in NYS Office of Children and Family Services (OCFS) certified QRTPs have continued, consistent support of their health and behavioral health care costs, and that we avoid unnecessary and unintended disruptions in service provision for children, youth, and their families.

The best long term solution to ensuring adequate in-state capacity for residential care placements needed for children and youth in foster care who are assessed to need that level of care, to avoid out of state placements, is to provide for State only Medicaid and pursue a federal statutory fix to the IMD Exclusion/QRTP intersection.

Child welfare is the system of last resort in the state, often caring for children and youth needing support with mental health and/or developmental disabilities that end up in foster care due to a lack of capacity within those systems. The state must therefore be especially deliberate about taking action that could impact capacity within the child welfare system.

There is a well-documented shortage of children's psychiatric beds (https://www.propublica.org/article/mental-health-beds-new-york-children-disappearing) following steps taken to reduce residential capacity in this sector without additional appropriate investment in alternative services. We need to avoid any further disruption of services and/or lack of access to care for children and youth in our state.

Thank you. I am more than happy to answer any questions you may have. My contact information is below.

Kathleen Brady-Stepien | President and CEO
Council of Family and Child Caring Agencies
kbradystepien@cofcca.org | 518.453.1160 ext. 303
1 Steuben Place | Albany, NY 12207
254 West 31 Street | New York, NY 10001