Comments from the NYS Council for Community Behavioral Healthcare
regarding OMH Part 551 proposed amendments published in NY State Register, April 2024

The New York State Council and the 150 mental health and substance use disorder provider organizations it represents appreciates the opportunity to share comments regarding the proposed amendments to OMH Part 551.

While we applaud the Office for its apparent desire to track OMH outpatient clinic changes in capacity, we believe there are better ways to accomplish this goal without imposing significant administrative burdens on impacted providers and on the Office, that would likely result in delays in program growth to meet community need.

Our primary concern with the changes being proposed focus on 551.6 and what appears to be a requirement where providers would need to file an EZ PAR when staffing patterns of impacted MHOTRS programs change by 5.5 FTEs in either direction. **It is unclear to us whether this requirement would be triggered each time the program adds / reduces staff by 5.5 FTEs, or whether this would be a once-a-year calculation using the average over a 12-month period to determine if the 5.5 FTE threshold has been triggered.** Regardless of the Office's response to this question and given high workforce turnover rates, we wonder whether the Office has considered and actually analyzed the impact of this proposed change on a range of agencies that operate MHOTRS services that are of various sizes and that are located in different areas of the state before it implements any of the changes and especially those related to requirements for when providers must file EZ PARS.

Assuming the requirement is for the agency to file an EZ PAR whenever the 5.5 FTE threshold is crossed, NYS Council members are extremely concerned with the administrative burden this new requirement would impose on already overwhelmed programs that can barely keep up with current regulatory requirements. Many providers must modify FTEs to respond to changes in demand for care and as we know, these demands can change rapidly and without warning. In addition, many MHOTRS are now starting to work with hospital systems to help those systems meet regulatory requirements to secure appointments within 7 days of discharge and need the ability to respond quickly.

Related questions:

- What is the Office trying to accomplish with the proposed changes to 551.6? It is unclear what the objective is.
- Did the Office discuss these changes with the field (prior to posting amendments in the NYS Register) in order to possibly identify a simple way to accomplish its objectives?
- How does the new regulation interact with use of per diem and consulting staff when it comes to counting FTEs?
- Does the 'expansion of staff' reference refer to those working for the Article 31 programs or all OMH Programs and Services?

- Regarding the addition of "Limited Liability Companies" to be included under 551.3 Applicability, does this allow private practice conglomerates to apply for OMH funding?

- 551.6 (d)(1)(ii) p.9: How is "change to physical space" defined?

- 551.9 (i) p.15 Comment: OMH should be required to give warning to the provider before cancelling approval.

NYS Council members are concerned that filing an EZ PAR each time either threshold (5.5 FTEs for MHOTRS clinics or 15% of census for other outpatient programs) is triggered will overburden providers and OMH, creating additional delays in the PAR approval process that is already (often) too long partially due to staffing issues at OMH. This influx of additional administrative requests will greatly tax the system and result in further delays in access to care.

To be frank, it is unclear why the Office has proposed to move in the direction of limiting or slowing clinic growth when there are significant waiting lists for care around the state. Any obstacles that slow the process by which a clinic can expand to meet demand should be minimized if not done away with entirely. It is also unclear why OMH would be implementing these restrictions while other regulatory agencies like DOH do not have similar processes for licensed clinics, and private practices are free to expand at will.

Another area of concern is around the definition of "Capital Project." Previously, it was a dollar amount that triggered the need to submit a PAR, $250,000 and $600,000, requiring an EZ PAR or Comprehensive PAR respectively. Now it appears the provider will need to do this regardless of the cost of the change if it falls within the new definition under 551.4e (4). This will result in much more work for the provider.

In summary, we think the Office should rescind the proposed regulatory changes and engage in a dialogue with the field to establish whether there is a better way to accomplish its objectives. At the end of the day, OMH MHOTRS should be allowed to significantly expand with either no concurrent approval or by way of an Administrative Action (after the fact) as long as they are in good standing. This is how we can facilitate rather than impede access to care at a moment in time when resources are scarce, workforce shortages are pervasive and the efficient and effective operation of these programs is critical to meet demands for care and save lives.

We would like to be helpful to the Office in achieving whatever its objectives with this exercise. We look forward to engaging with the Office in order to understand how we can be helpful. I remain available to you at 518 461-8200 at your convenience.

Thank you.

Lauri Cole, Executive Director
New York State Council for Community Behavioral Healthcare