UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

THE UNITED STATES OF AMERICA, Plaintiff, v. STATE OF NEW YORK, Defendant.	Civ. Action No. 13-CIV-4165 (NGG)
RAYMOND O'TOOLE, ILONA SPIEGEL, and STEVEN FARRELL, individually and on behalf of all others similarly situated, Plaintiffs, v. KATHY HOCHUL, in her official capacity as Governor of the State of New York, JAMES V. McDONALD, in his official capacity as Commissioner of the New York State Department of Health, ANN MARIE SULLIVAN, in her official capacity as Commissioner of the New York State Office of Mental Health, THE NEW YORK STATE DEPARTMENT OF HEALTH, and THE NEW YORK STATE OFFICE OF MENTAL HEALTH, Defendants.	Civ. Action No. 13-CIV-4166 (NGG)

SECOND SEMI-ANNUAL REPORT

SUBMITTED BY

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INDEPENDENT REVIEWER*

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Contents

I. Introduction

The Independent Reviewer's Tenth Annual Report[1] recapped the history of this case which led to a Third Stipulation and Order of Settlement approved by the Court on March 8, 2024. That order extended the Court's jurisdiction and oversight until June 30, 2025 unless the Court approves an earlier termination.[2] The extension also provides for the continued monitoring and oversight by the Independent Reviewer ("IR") not only of the transition process but also of continued support of the class members who have already been moved to community housing. In light of the relatively short duration until the anticipated termination of the Court's oversight, the extension shortened the requirement for periodic reports from the IR from annually to semi-annually. This is the second Semi-Annual Report submitted under the Third Stipulation.

The original Settlement Agreement gave a class of approximately 4,000 persons with Serious Mental Illness ("SMI") residing in 23 Impacted Adult Homes[3] in New York City the choice to move into supported housing or other appropriate community housing with the services and supports they need.[4] This report covers the period from October 1, 2024 to March 7, 2025 and discusses the progress made in implementing the Settlement Agreement during this period.

The numerical and statistical information contained in this report was provided by the State in response to a request from the IR, and the assistance is gratefully acknowledged. Unless noted specifically, all of the data is current as of March 7, 2025.

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[1] Independent Reviewer's Tenth Annual Report, Doc. # 315, filed April 2, 2024, in 1:13-cv-04165-NGG-ST, hereinafter "Tenth Annual Report."

[2] Third Stipulation and Order of Settlement. Doc. # 304-1 filed December 19, 2023 in 1:13-cv-04165-NGG-ST. (hereinafter "Third Stipulation"); Memorandum Order, Doc. #416 filed on March 8, 2024 in 1:13-cv-04165-NGG-ST.

[3] An Impacted Adult Home is an adult home in New York City with a certified capacity of 120 or more in which 25 percent or more of the residents or 25 residents, whichever is less, have serious mental illness. Second Amended Stipulation and Order of Settlement, Doc. #160, filed May 18, 2017 in 1:13-cv-04166-NGG-ST.

[4] Stipulation and Order of Settlement was filed on July 23, 2013. *United States of America v. State of New York*, EDNY Doc. #5, 13-cv-04165.

II. Methods

Since October 2024, the IR and his associates have engaged in a variety of activities to monitor the implementation of the Settlement Agreement, the March 2018 Supplemental Agreement,[5] as well as the Third Stipulation and Order of Settlement, and to provide the State and Plaintiffs with information as early as possible to enable them to act as warranted to achieve successful implementation of their legal obligations. In the course of these activities, described below, the IR and his team either met in person or were otherwise involved in discussions about the care and treatment of 85 class members.

The Third Stipulation anticipates that the Court's supervision of this matter will terminate as of June 30, 2025 if the State has complied with its obligations. The State anticipates that thereafter most of the special oversight and monitoring mechanisms it had put in place for this class would be discontinued and responsibility for future oversight of medical and mental health services, supported housing and congregate care would be assumed by the normal monitoring conducted by the State Department of Health ("DOH") and the Office of Mental Health ("OMH").[6] To understand how less intensive monitoring and oversight processes work, the IR team selected a sample of 30 class members out of the group of 705 who had transitioned to the community no more recently than 1/1/2023 (*i.e.,* two or more years ago) and, if they had been initially enrolled in more intensive Adult Home Plus care management with its 1:12 caseload ratio, had likely been "stepped down" to mainstream health home care management and/or disenrolled from health homes entirely. We conducted structured visits with these class members and reviewed the records of the Housing Contractors ("HC"), Health Homes ("HH") and Managed Long Term Care plans ("MLTCs"), and as relevant peer-run agencies, ACT Teams, and Program of All-Inclusive Care for the Elderly (PACE) which provided them with services and supports. The results of our review of this sample are reported in Section VI and Appendix A to this report.

The IR team continued its review of Decision Making Templates ("DMT") submitted by the State to assess the State's determination that the class members had made an informed decision

[5] Supplement to the Second Amended Stipulation and Order of Settlement, Doc. # 196-1, filed March 12, 2018 in 1:13-cv-04166-NG-ST. hereinafter "Supplemental Agreement."

[6] New York State Post-Settlement Plans, Doc. # 353-1, filed on May 6, 2025 in 1:13-cv-04165-NG-ST, p. 2, para. B.

not to transition from their adult homes. The results of that review are described more fully in Section III. B below.

The third wave of the State's Special Focused Initiative ("SFI")[7] did not begin in December 2024, as originally projected, as the State refocused its plans and prepared to interview all remaining members of the Yes group (class members who had expressed a desire to move out of their adult homes). The IR and his team worked with the State to develop a training program for State and provider staff that they called the Person-Centered Transition Process ("PCTP"). The PCTP initiative was designed to orient State staff to take a more person-centered approach to interviewing all members of the Yes group while also infusing all settlement provider work with a more person-centered approach. IR staff attended all PCTP trainings for State and provider staff, then all of the individual Yes member case conferences and some of the Interdisciplinary Team ("IDT") meetings. IR staff continued to participate in pre- and post-transition and Case Review Committee ("CRC") calls, including follow-up with the State and providers on outstanding issues identified during these calls. This work is described in greater detail in Section IV below.

The IR staff also continued to take part in monthly calls with OMH and the peer bridger agencies. The IR continued to attend the bi-monthly meetings convened by the State with the leadership of provider agencies to discuss progress in the implementation of the court orders and address emerging issues, and IR staff attended the alternating bi-monthly meeting for all provider staff. The IR and staff attended regular meetings with the parties as well as periodic status conferences with the Court.

III. Status of the case

A. Number of active class members

In each Annual Report, we track progress in implementing the court orders in this case and the work remaining to be done, in part by identifying the number of class members who are still "active" and part of the current workload of the State and its settlement providers. Fig. 1 displays

[7] The SFI is discussed in more detail in section IV of the semi-annual report. (Independent Reviewer's Semi-Annual Report, Doc. #335 filed November 5, 2024 in 1:13-cv-04165-NG-ST. hereinafter "Semi-Annual Report.")

the progressive reduction of the number of active cases since the Settlement Agreement was originally entered.[8]

Figure 1 below presents a snapshot of the status of class members as of April 1, 2025 as reported by the State. The number of class members residing in adult homes has dwindled to 1,205. Of these, 1,161 have made an informed decision to remain in the adult home after having been given the opportunity to transition to supported housing or another appropriate community setting with support services. Another 44 are actively involved in some stage of the transition process.

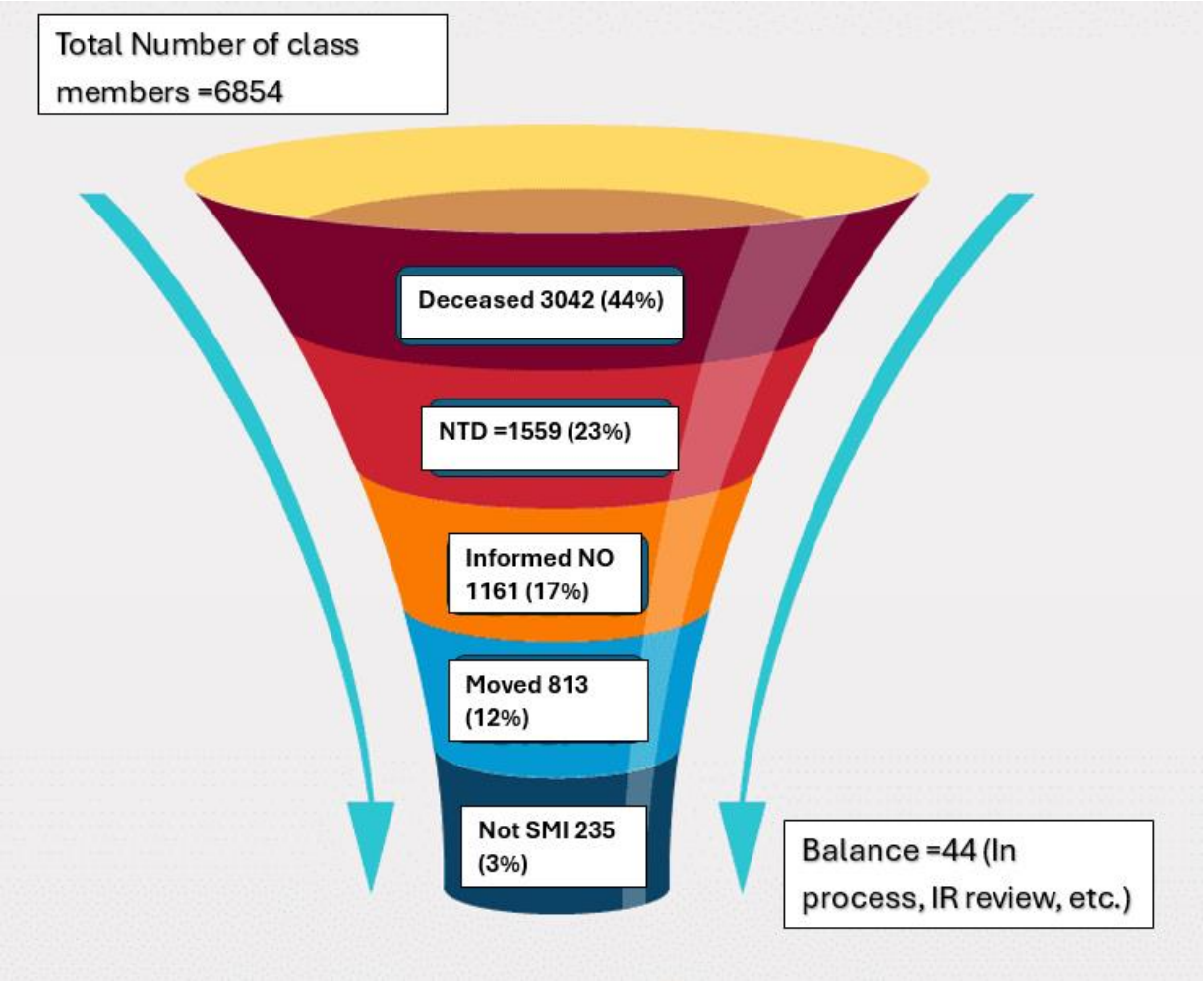

Fig. 1. Active class members

[8] The majority of the reduction has occurred due to deaths of class members, non-transitional discharges ("NTD") which occur outside the process of implementing the Settlement Agreement; and informed decisions by class members to remain in their adult homes.

B. NO case reviews

The Supplemental Agreement entered into in 2018 made important changes to the Settlement Agreement and implementation process. First, it capped the class so that no persons with SMI who were admitted to the transitional adult homes after September 30, 2018 would be members of the class (Section G.1.). Such admissions were prohibited in any event,[9] so this provision was not envisioned as particularly impactful. (Section V below discusses screening and admissions) Second, it established a Decision Date by which class members had to declare their willingness to be assessed for transition to community housing or forfeit the opportunity to transition under the Settlement Agreement. (Section G. 2) The Decision Date for all class members expired on November 8, 2023.

To ensure that class members were making an informed decision to pass up their opportunity to transition from the Impacted Adult Homes, the IR created an Informed Decision-Making Tool ("DMT") to be utilized by the State and settlement providers to document their efforts to provide information required by the Settlement Agreement[10] to class members, and the class members' responses. Every case of a class member reported by the State as having declined the opportunity to transition from the adult home is reviewed by the IR team to ensure that they received the required information and made an informed decision. The process for reviewing these cases is described more fully in the Tenth Annual Report (Tenth Annual Report, Section IV. C.) The Third Stipulation between the parties which extends the case until June 30, 2025 provides that the IR's determination is conclusive, and if a class member has been determined to have made an informed decision by the time of the Decision Date, the State will have no further obligation to that person under the Settlement Agreement.[11]

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[9] 14 NYCRR Part 580.6(c)(2); 14NYCRR Part 582.6(c)(2).

[10] The Settlement Agreement required Housing Contractors to conduct in-reach to class members in the Impacted Adult Homes and to provide them with information about the benefits of supported housing, provide opportunities for them to speak to persons living in supported housing, to view photographs and/or virtual tours of sample apartments and to facilitate visits to supported housing apartments. Doc. # 160, filed May 18, 2017 in Case 1:13-cv-04166-NGG-ST.

[11] Third Stipulation and Order of Settlement. Doc. #304-1, filed 12/19/23 in 1:13-cv-04165-NGG-ST, ¶ C.1.

Since the creation of the No Case review process, as of January 21, 2025 the IR has received DMTs and/or supporting documents that 1,384 class members had made an informed decision not to move. These were reviewed and discussed collectively by the IR's team.

Of the 1,384 records received, seven class members had died or were non-transitionally discharged (outside the Settlement process) while the DMTs were under review, and in another three cases the documents were returned to the State as they could not be reviewed for technical reasons (*e.g.,* files were corrupted or were protected by security systems).

Of the remaining 1,374 cases, the IR agreed that the member had made an informed decision not to transition in 1,326 cases (97%). A number of these members subsequently died or were non-transitionally discharged following the IR's review.[12] In 48 cases (3%), the IR determined there was insufficient evidence that the class member had made an informed decision not to move.

The Independent Reviewer informed the State of the insufficient evidence determinations between three months to two years ago. Since then, the status of a number of the 48 members has changed. According to the State's Weekly Report ending April 25, 2025, nine of the members became NTDs, four died and two transitioned to supported housing. Only 33 of the 48 members remain active cases in their adult homes.

To the extent that a member's ambivalence about moving, perhaps in combination with the service provider's poor or inconsistent documentation, led to the Independent Reviewer's finding of insufficient evidence, the State should consider including the member in the Person-Centered Transition Planning process described in Section IV.

During the past six months, the IR shared the results of 34 "No Case" reviews with the Plaintiffs and Defendants. As noted in the Tenth Annual Report and the first Semi-Annual Report which was filed on November 5, 2024, the detailed review of individual class member's experiences identified settlement providers' practices that required improvement or changes. While not all of them ultimately affected the class members' decisions to remain in adult homes,

[12] The difference between the 1,320 cases reported here and 1161 reported by the State is that the State's figure excludes the deaths and non-transitional discharges that occurred ***after*** the Independent Reviewer's determination.

and the overall approval rate from the IR's review of DMTs remains high, these reviews did identify the need for improvement in supporting those who were interested in moving, something that remains important in the waning days of the Settlement Agreement.[13]

As a result of these reviews of DMTs, for class members who are still in the transition process, we recommended that the State ensure that settlement providers' staff review the history of each of these class members to identify the length of their interest in moving, the obstacles they have encountered, and the failure of settlement provider staff to act quickly or at all when they expressed interest in moving. Out of such an individualized understanding of each person's experience, a truly person-centered plan can be developed and implemented. This is the last chance to do this for class members who have been waiting for years. The State's efforts to work with the class members still in the transition process are described in the next section.

IV. Person-Centered Transition Planning (PCTP)

The Independent Reviewer's issuance of its first Semi-Annual Report on November 5, 2024, provided a first-hand report on the experiences of a sample of class members who were in the transition process or had recently transitioned to community housing. That report provoked a discussion of the differing perspectives of members and providers on the efforts being made to assist those who were interested in moving out of adult homes. At a status conference on 11/21/24, Judge Garaufis endorsed the value of more direct communication by the State with class members who were interested in moving, rather than relying primarily on the provider's perspectives. He directed the State to meet with all members of the Yes category at the time and to provide a report to the Court on the personal obstacles they faced.[14]

Following the status conference, the IR team collaborated with the State in planning the class member interviews to be conducted by State staff. In planning for the interviews, the State also designed a two-part training to prepare both their own staff and, more broadly, to enhance settlement service providers' understanding of person-centered care. They called this initiative the PCTP.

[13] Semi-Annual Report, pp. 9-10.

[14] Minute Entry in Case No. 1:13-cv-04165-NGG-ST, 11/21/24

The PCTP training itself consisted of two parts: first, State staff designed and recorded an approximately three-hour self-scheduled training including polls and quizzes, with participation requested in advance of live training. Then, State staff delivered an approximately three-hour live training on 1/15/25 and 1/16/25; the training was offered both days and all settlement service providers were asked to attend once. The live training built on content covered in the preliminary training and included a mix of didactic material, polls, and discussions. The live training was recorded and subsequently the State has offered both trainings to provider agencies to share with newly hired staff.

At the close of the live training, the State solicited suggestions for additional training topics to help providers further the person-centered orientation of their work. Popular requests included: Compassion Fatigue and Burnout, Motivational Interviewing, Crisis Intervention and De-Escalation, Smoking Cessation for Improving Mental Health, and Working with Co-Occurring Mental Health & Substance Use Disorders. The State reports that additional training is being developed in response to these requests.

The State documented that across both training sessions 176 State and service provider staff were in attendance. The PCTP recorded preliminary training was viewed by 143 State and service provider staff; as it was supposed to be viewed in advance of the live training, there is substantial overlap between its attendees and the 176 live training attendees. For the latter training, the following types of staff were present: 15 staff from OMH, eight from DOH, and 103 staff representing eight HCs, four HHs, ten CMAs including Pathway Home teams, and the peer-run agencies. No ACT Team nor MLTC providers participated in either training; it is unclear if these providers were invited and/or required to attend. One PACE staff member engaged with the initial, recorded training only. The Office of the IR team members also participated in both trainings but are not included in these counts.

In fulfillment of the Court's order, the second component of the overall PCTP initiative was a multi-step engagement process with 28 Yes group class members to date. These members were selected from the overall Yes group through the following criteria: 1) did not already have a move in process; 2) were not in the process of converting to a NO (*i.e.*, in the DMT process); 3) were not in the reassessment process; and 4) were available generally (*i.e.*, were not hospitalized or in a Skilled Nursing Facility (SNF), were reachable and agreeable to meeting with State staff).

The 28 members who met these criteria and their corresponding service providers have been asked to participate in the following:

- A person-centered interview between the member and a State staff person;
- A PCTP case conference involving all the member's service providers and State staff, during which the State reports on the results of their interview, the group troubleshoots current barriers to the transition process, and plans next steps;
- A PCTP IDT meeting involving State staff, providers, and the members themselves;
- Subsequent communications have varied based on the progress and preferences of the member and their providers; in some cases, follow-up and communication has occurred via additional meetings, in others it has been via email, and in others, both;
- Subsequent activities have also varied based on the progress and preferences of the member and their providers. Such activities have included offering and carrying out:
    - apartment and neighborhood tours (and retours);
    - longer term apartment visits, including overnight visits;
    - offers to visit other members moving into and/or living in the community; and
    - offers for State and provider staff to communicate with other people of importance to the member; etc.

Some key outcomes as of 4/4/25 include:

- A total of seven members were offered overnight apartment stays: two have been completed, two are in process, and three were declined;
- Four members have transitioned to the community;
- Three members have accepted apartments and have move dates pending;
- A total of five members have decided not to move: three have completed DMTs that were submitted to the IR and two more are in process.

Overall, the PCTP initiative seems to be a robust attempt to better get to know and truly center individual class members in the transition planning process. The PCTP trainings were thorough and engaging; during the live training it was especially encouraging to observe how many settlement service providers contributed comments and questions. It has been similarly

encouraging to observe the level of engagement the State has tried to foster with the 28 involved class members. Their interview protocol is in-depth and even some members long known to the State, providers, and IR staff were "brought to life" by information they shared during interview. It has also been helpful to have these members present during discussions about them (*i.e.*, during IDT meetings) so that their ideas and preferences are clearly represented. During some IDT meetings, members have expressed feelings of ambivalence about moving, frustration about the wait to move, and other heightened emotions; State and provider staff have responded with active listening and patience. State and provider staff have also engaged in truly person-centered gestures that have not always been present in past settlement service provision. For example:

- During an IDT meeting with a member interested in basketball, Comunilife staff took the time to ask him about his favorite players and teams;

- During a case conference for a member who was concerned about loneliness in the community yet also reticent to try socializing, Community Access peers and the Risewell ACT Team discussed approaches to help him feel more comfortable going out and meeting new people; they also exchanged contact information so that they could coordinate efforts to encourage him to attend respective agency social events;

- In preparing a member who had a lengthy wait to move to an accessible apartment, ICL and State staff generously offered to purchase a variety of highly specific items (*e.g.*, mugs and plush throws emblazoned with his favorite football teams) to help him set up his apartment.

The limitations of the PCTP initiative are not about it itself, rather with its extremely limited scope (*i.e.,* with only 28 members served to date). Witnessing the richness of this experience for class members leads one to wonder how different Settlement Agreement implementation would have been had PCTP been launched earlier, impacting a much larger portion of the class. As it is, we encourage the State to continue to orient work with Yes members around this approach, including: 1) developing additional PCTP trainings to support providers' stated needs to further their own person-centered practices, and 2) encouraging provider agencies which have not yet engaged in PCTP trainings (*e.g.*, ACT Teams and MLTCs) to view training recordings and participate in future trainings.

We also encourage the State to consider how a PCTP approach, even if modified, could be used to support Yes members who have been excluded from the initiative to date. State feedback on this Report includes a commitment to continue the PCTP and engage Yes members when and if

they return to adult homes from hospital or SNF stays. We suggest the approach would benefit Yes members in the reassessment process as well; a more person-centered orientation to standardized assessments and potential shifts in housing eligibility could help them regardless of their ultimately assessed housing level.

Finally, the PCTP is relevant to post-transition services and supports. We encourage the State to systematically infuse these services and supports with a more person-centered orientation, and to carry this systematic person-centered orientation into post-settlement planning, including the Post-Settlement Wellness Monitoring program.

V. Admissions & screening process

As discussed in the Eighth Annual Report, on July 9, 2021 the IR filed the Preadmission Screening Report with the Court, reporting on a study of the State's preadmission screening process for SMI at Transitional Adult Homes ("TAH").[15] The report raised serious concerns about the ability of the process used by adult homes to screen prospective admissions for SMI.[16] In response, and as recommended in the report, the State mandated that all TAHs use a standardized mental health evaluation ("MHE") form developed in conjunction with the OMH for all new admissions. The State also committed to contracting with an independent agency to conduct the mental health screenings and did so in January 2022. A Dear Administrator Letter ("DAL") was distributed to all of the homes on March 14, 2022, and they were directed to start using the new screening process effective April 1, 2022. Since that time, both the preadmission screening and any MHEs required as a result of a completed screen have been carried out by the State contractor.

Based on information provided by the State, between October 1, 2024 and March 7, 2025, under the current system there were 952 preadmission screens completed by the State contractor for admission to Impacted Adult Homes. Of these, 432 (45%) admissions were approved as not having SMI and 430 (45%) were found to meet SMI criteria and could not be admitted without an

[15] "Transitional Adult Home" means an adult home with a certified capacity of 80 or more beds and a Mental Health Census of 25 percent or more of the resident population. Transitional Adult Homes include NYC Impacted Adult Homes. "NYC Impacted Adult Home" means an adult home located in New York City with a certified capacity of 120 or more beds and a Mental Health Census of 25 percent or more of the resident population or 25 persons, whichever is less.

[16] Eighth Annual Report; pp. 11-12.

evaluation. The remaining 90 (10%) were closed for administrative reasons.[17] Of the 309 MHE that were requested during this period, 108 (35%) persons were found suitable for admission as their mental health needs could be met in an Adult Care Facility (ACF) and 126 (41%) showed evidence of an SMI and could not be admitted unless they were returning to a TAH and had obtained a waiver. The remaining 75 (24%) were closed for administrative reasons, and included 16 that were discharged elsewhere and six for whom a recent MHE was used, rather than performing a new evaluation. (See Table 3 below)

Determinations by Independent Evaluator	Preadmission Screens	MHE
Can Admit (non-SMI)	432	108
Cannot Admit Without an MHE	430	
Cannot Admit–Evidence of SMI		126
Administrative Closure	90	75
Totals	**952**	**309**

Table 3. Results of Preadmission Screens and Mental Health Evaluations conducted by Independent Evaluator October 2024 – March 2025

From October 2024 through January 2025 there were 231 admissions reported by 17 of the Impacted Adult Homes. This included 15 class members, one Post-Class Cap Resident, and 215 Others. Of the 15 class members who were admitted, seven were admitted to homes that were Non-TAH at the time and did not require a preadmission screen. Five returning class members were evaluated as having SMI and were granted waivers. Of the three remaining class members who were admitted, two did not require an MHE and one received an MHE and was found to not have SMI and was suitable for admission. Of these admissions, 202 were to TAHs and 29 were to non-TAH, and did not require a screen at the time of admission.

Currently nine of the Impacted Adult Homes are no longer designated as transitional, and as a non-transitional home are not required to pre-screen for SMI or report on their monthly admissions.[18] Since our last Semi-Annual Report filed November 5, 2024, Garden of Eden was re-designated as a transitional home. Of note, the State also performed an analysis of their

[17] Reasons provided for Administrative Closure for Preadmission Screens included incomplete referral; application withdrawn; and not enough Medicaid information/unable to determine. For the Mental Health Evaluations this also included discharged elsewhere; and a recent MHE was used rather than performing a new one.

[18] The nine adult homes are Brooklyn Adult Care Center, Central Assisted Living, Mariners Residence, Mermaid Manor, New Haven Manor, Oceanview Manor, Sanford Home, Surfside Manor and Wavecrest Home for Adults.

admissions during the time that the home was not prescreening. The State ran each name through OMH's Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) databases and found that 18 flagged for SMI, who were identified for post cap in-reach.

As noted on the State's monthly reports to the Court on admissions to Impacted Transitional Adult Homes, there were 202 admissions from October 2024 - January 2025. All 202 admissions were prescreened and 53 (26%) were flagged for potential SMI, including six returning class members. The State contractor's MHE confirmed that 5 (9%) of the 53 had SMI; one of the returning class members was found not to have SMI. The associated adult homes pursued and were granted a waiver for each of the five and all six were admitted.

In light of ongoing concerns about the ability of the adult homes to effectively screen and accurately report prospective admissions for SMI, the IR previously recommended that "the State needs to implement a more assertive preadmission screening process for SMI, especially for the adult homes originally covered by this case, which does not rely entirely on self-reporting by the adult homes." In May 2024, amendments to sections 487.4 and 487.10 of Title 18 were proposed, and subsequently adopted in December 2024, which stated that:

> *. . .if the facility has ever reported an individual as having Serious Mental Illness, such facility must continue to report that individual as having Serious Mental Illness until the department or its designee has conducted a mental health evaluation of that individual to confirm a change in status, and communicates written approval to the facility to discontinue reporting such individual as having Serious Mental Illness. Nothing in this paragraph shall require the department, or its designee, to conduct an independent mental health evaluation for an individual who resides in an adult home that is not defined as a transitional adult home as of January 1, 2022. For all facilities, a roster of all residents shall be submitted to the department on a quarterly basis in the manner prescribed by the department.*

As stated in the last Semi-Annual Report, with the Third Stipulation scheduled to end on June 30, 2025, it is essential that the State strictly enforce the amended regulations regarding the admission of individuals with SMI to TAHs and the quarterly reporting requirements. Without that protection, it is possible that conditions may return to what they were before the Settlement Agreement.

VI. Interviews with class members

A major part of the work of the IR team during this reporting period was visiting and interviewing a sample of 30 class members who had moved out of their adult homes no more recently than 1/1/2023 (*i.e.,* have been living in supported housing for at least two years, with an average tenancy of approximately seven years). These interviews were paired with records reviews and conversations with State and settlement service provider staff; the purpose of the overall review was to explore the quality and level of services and supports members experienced in longer-term community life, and whether such services and supports matched their needs, including needs that might change over time. The results of this work are reported in Appendix A to this report.

VII. Conclusions

The parties have been working on this case for over two decades, from its inception with the filing of a complaint in 2003; to a bench trial in 2009; the issuance of a remedial order by Judge Garaufis in 2010; and the subsequent decision of the Second Circuit Court of Appeals to vacate it on technical grounds; the intervention of the United States Department of Justice ("DOJ") and the subsequent filing of a new complaint by the DOJ and the named plaintiffs in 2013; and the simultaneous entry of a Settlement Agreement with the State of New York. It has taken more than another decade to reach a point where the end of this litigation is in sight. It has required the energies of dedicated staff working for the State Defendants and the array of provider agencies that have been involved in this effort; the support, collaboration and advocacy the attorneys for the Plaintiffs and the DOJ; and the steady guiding hand of the Court to bring this case to this point. There is much to celebrate but also a note of caution. All involved would be well advised to harken to the words of wisdom offered by Aleksandr Solzhenitsyn:

> Now listen to the rule of the last inch. The realm of the last inch. The job is almost finished, the goal almost attained, everything possible seems to have been achieved, every difficulty overcome — and yet the quality is just not there. The work needs more finish, perhaps further research. In that moment of weariness and self-satisfaction, the temptation is greatest to give up, not to strive for the peak of quality. That's the realm of the last inch — here, the work is very, very complex, but it's also particularly valuable because it's done with the most perfect means. The rule of the last inch is simply this — not to leave it undone. And not to put it off — because otherwise your mind loses touch with that realm.

> And not to mind how much time you spend on it, because the aim is not to finish the job quickly, but to reach perfection.[19]

VIII. Recommendations

The recommendations which follow are drawn from the IR team's activities in monitoring the implementation of the court orders during this report period, and especially influenced by the interviews with class members described in Appendix A to this report.

1. As part of its post-settlement and more specific Post Settlement Wellness Monitoring plans **the State should create a systematic care management review process for all class members. This process should consider the level, types, and on-the-ground realization of care management services and supports in response to potentially changing member needs and preferences. Given factors observed in our 2025 Interviews Report, such as the aging of the class and inconsistent follow up when member problems and needs have been raised post-transition, we suggest the State consider a review frequency of every six months, such that emerging problems and changing needs can be discovered and addressed before they decline to the point of reportable incidents.**

   Level. Many members of this class were discharged from their adult homes before the State created the Adult Home (AH) Plus program of intensive care management with its 1:12 staffing ratio. Many others were stepped down from AH Plus prior to the 12/1/2019 implementation of Health Home (HH) Plus transitional care management, with its 1:20 ratio. Additionally, as both AH and HH Plus were designed as time-limited services, with enrollment for each typically running at most one year, many members initially served by these programs have been stepped down to mainstream HH care management, which has no specific caseload limit and a more limited scope of support. Simultaneously, with time the class has aged, their medical and mental health conditions have changed and, in many cases, their support needs have increased. **Given this confluence of changing needs and changing levels of support, there is a need to institute a State-led process of regular and periodic review of the adequacy of the level HH care management each class member receives, including those members who do not receive any care management (and, thus, fall outside the scope of the HH's own reviews of member needs).**

   Types. Related, the landscape of member enrollment in and disenrollment from MLTCs has, to our knowledge, been tracked less than other types of care management. This is

[19] From *In the First Circle*, by Aleksandr I. Solzhenitsyn (Author), Harry Willets (Translator) Deckle Edge, October 13, 2009.

understandable, as MLTC eligibility and enrollment are more member-dependent; some class members have been found ineligible for MLTCs and others have chosen not to enroll. Additionally, MLTC enrollment does not have a step down process parallel to that of AH Plus and HH Plus so members who are MLTC-enrolled may be able to stay enrolled indefinitely. However, in the course of our 2025 interviews, we encountered some class members not enrolled in MLTCs based on a decision made up to a decade earlier. These members may have been independent and healthy enough at the time of their initial transition not to qualify nor desire MLTC services. However, there does not appear to be any systematic means of reviewing members' changing needs and eligibility for additional services such as those offered by MLTCs**. Thus, as part of a State-led process regular and periodic review of HH care management, MLTC care management status should also be reviewed for each class member.**

Also salient in our 2025 interviews was feedback from multiple members and some of their service providers (*e.g.,* HC case managers, HHAs, peer bridgers) that they did not think the level of care management or scope of services they had been assessed for were adequate for their needs. For example, members over the age of 70 and/or with multiple chronic health conditions such as Type II diabetes requiring daily insulin injections were surprised and upset to be disenrolled completely from HH care management; other members experiencing periodic increases in mental health symptoms wondered why they couldn't step back up to AH or HH Plus care management; and some members were trying or already in an appeals processes with MLTCs due to what they considered inadequate HHA hours. **Such scenarios indicate that within a State-led care management review process there is also the need to hear directly from members about their perceived needs and preferences, and to educate and support the class as a whole around advocacy steps if they believe care management entities are not providing adequate services and supports.**

Realization of existing care management. A periodic review would also provide the opportunity **to assess how well existing care management services and supports described in member care plans have been carried out, and what actions may be taken when needed services and supports are not realized in a timely manner. It would also be an opportunity to consider whether class members facing challenges would benefit from additional types of settlement services, such as peer services.**

Finally, such a review process – as well as the State's overall post-settlement plan – would benefit from systematic tracking of member enrollment with service providers beyond the settlement. In the course of our 2025 interviews, it became apparent that at least a small group of members receive Home and Community Based Services (HCBSs) from their Medicare Advantage plans; in at least one case a member receives crucial HHA services from

Medicare Advantage,[20] not an MLTC. Another member who otherwise receives no type of care management is enrolled in HARP and might be able to increase HCBSs, such as Community Oriented Recovery and Empowerment (CORE) services, through it; other members enrolled or eligible to enroll in HARP might similarly benefit from increased HCBSs. Tracking and reporting on service providers beyond the settlement could be a "win-win," in that the State could demonstrate that certain members are actually better supported than if only settlement-specific service provision is shown, while at the same time members enrolled in outside services could benefit from State monitoring of the realization of those services.

2. A final type of care management raised in the previous Semi-Annual Report again bears attention here: Several class members have been enrolled with ACT Teams but nevertheless have experienced significant, persistent service gaps both prior to and post-transition. In part, this is a result of some ACT Teams having a narrow view of their role as primarily addressing class members' mental health needs. As enrollment in ACT precludes the simultaneous provision of and billing for other care management services, this narrow conception of the role leaves members without critical supports in many domains where they need it and where, importantly, the ACT model itself would prescribe provision of services ranging from medication and money management to community integration. Since this recommendation was last raised, AHI State staff have communicated concerns about individual ACT Teams to the OMH NYS Field Office, but it is unclear what the Field Office has or will do to address the unmet needs of class members enrolled in ACT. **The State – including OMH beyond AHI State staff -- urgently needs to address ACT service gaps and encourage ACT Teams with low fidelity to the model to realize all service domains needed and desired by each enrolled class member. Alternatively, AHI State staff might consider whether such class members would be better served by an AH Plus care manager recognized to have more comprehensive responsibilities.**

3. In the previous Semi-Annual Report, we also recommended ACT Teams, which had been conspicuously absent from AHI settlement provider trainings and meetings, be required to attend meetings such as bi-monthly all-staff provider meetings, more recent PCTP trainings, etc. In its response to this Semi-Annual Report, the State committed to inviting ACT Teams to meeting and trainings. We have observed isolated instances of attendance which are encouraging, yet overall ACT Teams largely continue to be absent. For example, at least some ACT staff were present for member-specific PCTP case conferences and IDTs, yet no ACT

[20] We again emphasize we did not have systematic access to Medicare records and while we were able to ascertain a few interviewed members were enrolled in Medicare Advantage plans and review corresponding records, at least two additional members self-reported and/or were reported by settlement service providers to be enrolled in Medicare (plan type and provider unknown). This further points to an opportunity to undertake a more systematic review of Medicare records and the additional services and supports some members may receive and/or be eligible for through this program.

Teams or individual staff members attended PCTP trainings. **We thus repeat that we recommend the State work with OMH to ensure all ACT Teams involved in the Settlement attend the same trainings and meetings all other providers attend.**

4. For a significant number of class members in our 2025 interviews sample, money management is a severe and ongoing problem. Most class members rely upon financial entitlements and live below or close to the poverty line, with very little room for error in how they manage their very limited resources. Some members, for a variety of reasons, have accumulated substantial debt, with no clear pathway to satisfy their obligations. This is an area where the adage "an ounce of prevention is worth a pound of cure" truly applies, and providers would be well advised to be proactive in monitoring this aspect of the care plans they develop. We recognize that this can be a difficult area of service provision, especially if members are secretive about their financial decisions which may involve substance use and/or other illicit behaviors. However, given its significant and lasting impact on all other life domains, money management must be addressed further.

   In reviewing provider records and speaking to providers over the course of our 2025 interviews, we observed that:

   i) a great deal of money management support is attempted by HC staff, with peer bridgers also supporting members who have moved more recently; yet, HH and ACT Team care managers -- whose roles as prescribed by evidenced-based models and NYS DOH and OMH guidelines include money management support -- evidenced comparatively low involvement; and

   ii) the support offered often involved the repetition of a few basic approaches, such as open discussion about spending habits and "the envelope" approach, both of which have tended to achieve limited if any improvements.

   As the State is already developing additional provider training in relation to its 2025 PCTP initiative, we recommend that a money management training also be developed and offered to all settlement service providers. We further recommend that such training be framed by a discussion of the role Health Home and ACT Team care managers can and should play in ongoing support of money management, according to their respective models of care. Such a training may also benefit from cross-training on: 1) legal services available to low income individuals who accrue debt, and 2) harm reduction approaches more generally.

5. As this case nears the settlement deadline of June 30, 2025 and time becomes of the essence for class members who are still awaiting housing matching their needs and preferences, as recommended in the previous Semi-Annual Report, if the primary housing contractor seems to

have difficulty locating such housing within a reasonable time, the State should circulate the housing referral to other Housing Contractors (HCs) that may be able to locate such housing. Referrals may be especially helpful for members with more specific or individualized needs and preferences, such as accessibility needs.

6. In the course of our 2025 interviews, it was striking to observe how frequently apartment and building problems were raised; of all life domains discussed with members and providers it was the most problematic. While some problems were caused or complicated by factors other than HCs (*e.g.,* members damaging apartments themselves, unresponsive landlords) one of the most striking findings of our entire review was that often settlement service providers were aware of apartment and building problems, yet they allowed them to persist, sometimes for months. That providers could be aware of and document such problems, yet stood by over prolonged periods of time, often as the problems worsened, suggests the greatest concern is not with any given problem in an apartment or building itself, but rather with unresponsive service provision that is not in line with the Settlement Agreement.

   In January 2025 the State circulated an Apartment Checklist, to be used for visiting and monitoring the state of member apartments. **We suggest this Checklist be compared to our findings, including provider records documenting problems *and* documenting the problems persisting for long periods of time without clear steps towards resolution. We further suggest that in light of the seriousness of persisting problems the Checklist "Follow Up/Recommendations" section should be expanded to encourage a more robust State follow up protocol.** As the State has not yet circulated all details of its Post Settlement Wellness Monitoring Plan, we are unsure how and to what degree apartment and building problems will be tracked and monitored; for now we recommend this Plan take a similarly proactive approach to problem follow up.

7. Although the majority of the transitioned class lives in their own apartments, many still live with housemates. Optimal housemate matches may offer social engagement and mutual aid opportunities for all involved, but matches that are problematic for members may endanger their mental health, physical health, and even their lives. **As the State plans for and implements the Post Settlement Wellness Monitoring Program, particular and systematic attention should be paid to housemate situations.** Given experiences like HO's (see Appendix A) we specifically suggest:

   i) While the nature of supported housing inevitably involves residents experiencing behavioral health concerns, when one housemate shows signs of behavioral health decline, in-person provider visits should be increased both for the member showing symptoms and their housemate(s).

ii) There are many reasons a class member might not share housemate concerns with providers – feeling afraid they're "telling on" a housemate and it will compound their problems; feeling the need to please and/or not make trouble for their providers; simply forgetting; etc. – making it critical that providers check in proactively, frequently, and consistently about housemate dynamics. In other words, just because a member is not speaking up should not be taken as evidence that they feel safe with their housemate. Even seemingly minor concerns should be taken as a starting point to offer safety planning and/or alternative housing options.

iii) Finally, incidents of aggression and/or violence cannot be dismissed as one-off occurrences. Some such incidents may not repeat, but as experiences like member HO's demonstrate, any act of aggression should be treated as a warning of potentially repeating or escalating behavior. When a member has shown aggression towards other members or settlement services providers (*e.g.,* HO's housemate attempted to attack his care manager prior to attacking HO), their housemate should be given immediate options for housing apart from the aggressor.

8. We support the State's recent PCTP initiative, including the State and provider staff training and subsequent State staff-led interviewing and case conferencing process for a sub-group of remaining Yes class members. As whole, this initiative seems to be successful in engaging class members in transition planning that is truly person-centered, and that has not been evident in overall settlement implementation. **We encourage the expansion of the PCTP approach to all remaining class members in the Yes group who have not yet had the opportunity to take advantage of this initiative. We also suggest the State consider how elements of PCTP could be used in instances in which they reapproach members with DMTs found to contain insufficient evidence of an informed decision.** While each such member has experienced a unique service context, for some the lack of sufficient evidence of informed choice is related to a lack of diligent efforts to meet their needs and preferences. The reapproach is a final opportunity to offer person-centered communication and service provision to them, ultimately strengthening the evidence on which their ultimate determination rests.

   As our 2025 interviews with class members (*see*, Appendix A) show, a significant number experience secondary moves after their initial transition from the adult home. Such moves create the opportunity to engage in a similar type of person-centered transition planning to ensure subsequent apartment placements and wrap-around services best meet members' current needs and preferences.

9. As isolation and loneliness seem to affect a significant number of class members who have transitioned to community living, **there is a need for more attention to developing social connections and socialization options both during the transition planning process and as**

an systematic, ongoing component of post-transition monitoring. Such planning needs to be truly person-centered, taking into account the age, culture, other identities and interests of each class member. A good starting point may be increased offers and regularly scheduled visits to Clubhouses, other peer-run centers, and community resources like public libraries and places of worship. These resources have been suggested frequently in the past and are still relevant to remaining Yes members. Heading into post settlement planning, these resources are increasingly important to offer to transitioned class members, including those with long tenures in the community whose social networks may have changed over the years. Post Settlement Wellness Monitoring reviews may be one opportunity to assess and encourage transitioned members to explore additional social connections.

Both our 2024 and 2025 interviews with class members suggest many have family members living nearby, yet connections seem to have withered during long periods of institutionalization. While family reunification may not be the right choice for some members, for others family connections are a key natural support contributing to a safe, fulfilling life in the community. **Family reunification support should thus be systematically offered to all members of the class. We also recommend systematic, consistent offers to connect class members, especially newly transitioned members, to other former adult home residents living in the same buildings and/or neighborhoods as recommended in the previous Semi-Annual Report.**

* * *

We note that the majority of the recommendations presented here have been made previously, including increased attention to care management; increased engagement and training of certain service providers (*e.g.,* ACT Teams and MLTCs); ongoing attention to housing contractor stock and the use of inter-contractor referrals; and an increased, person-centered response to social isolation and loneliness. We repeat these recommendations because the work of the State and settlement service providers to date has resulted in mixed experiences and outcomes for class members. In their response to this Semi-Annual Report below, the State has indicated that they are already working and/or will work on implementing aspects of many of these recommendations. Their reported work to date and commitment to further work to ensure services and supports are available to the class post settlement is heartening.

State's Response

Second Semi-Annual Report Feedback:

- As the Independent Reviewer recommends in the Part IV. Person-Centered Transition Planning (PCTP) section of the Semi-Annual Report, the State has and continues to orient work with Yes members with a person-centered approach. In one case, a member of the Yes group who has had tours on hold for the six months that he has been in a skilled nursing facility, the State team and providers have visited the member frequently, helping him remain engaged in the transition process, even celebrating his birthday and purchasing him new shoes to celebrate progress towards rehabilitation. The State agrees with the Independent Reviewer's recommendation to infuse post-transition services and supports with a more person-centered orientation, and to carry out systemic person-centered orientation into post-settlement planning, including the Post-Settlement Wellness Monitoring program. To this effect, the State has drafted a wellness visit tool, which includes person-centered questions, to guide State staff who will begin conducting wellness interviews in June 2025. For example, one question asks the members to rate their overall satisfaction in their apartment. Another asks members to identify any resources or support for which they would like additional help. The State also intends to provide Person-Centered Transition Planning training for ACT and MLTCP programs, as they were previously not included in training sessions.
- The State has reviewed the Independent Reviewer's recommendations section of the Semi-Annual Report. In response to the recommendations:
    1. The State has created and embedded a systematic care management review process in the housing contractor monthly roster process, where the housing programs are required to report demographic updates and advise if from their perspective a member may benefit from care management services, or if a different level of care management services are needed. Additionally, the State team has developed an information guide on the different types of care management services and information on how to make referrals. The State intends to secure rosters on a consistent basis. Lastly, the wellness visit process, to be implemented in June 2025, includes a review of all services and requires members and State staff to comment on the need for additional services, including care management services.
        - The Health Home Plus transitional care management ratio is 1:20, not 1:15.
    2. The OMH Field Office has identified a liaison at SPOA to prioritize all class member referrals for ACT placement and maintains regular contact with SPOA to ensure case prioritization for class members. Additionally, the OMH Field Office

has identified a point of contact to address concerns with ACT teams. State staff maintains contact with the OMH Field Office, ACT point of contact. State staff have been successful in troubleshooting some issues with the help of the OMH Field Office. For example, one member's ACT team reported they would be unable to provide services because of a billing issue. This was immediately reported to the OMH Field Office liaison who called the ACT team leadership and provided technical support to resolve the issues. In another case, the Community Transitions Unit Director and the OMH Field Office liaison participated in a conference call with several members of an ACT team, where education on the settlement and person-centered care were reviewed, which resulted in the ACT team adjusting their perspective on helping a member, who they previously noted was "demented" and could not move, to engage in the transition process. While there may always be bad apples, the State believes the increased communication is helping to address individual issues and resolving them more efficiently.

3. To fold ACT teams into Settlement work, initiative Leadership created and circulated an ACT implementation and guidance one-pager in March 2024. Initiative Leadership staff also presented and provided an overview of settlement activities and ACT expectations during a monthly ACT leadership meeting in March 2024. State staff also maintains at least bi-weekly contact with ACT teams assigned to members in the "In Process Yes" group to coordinate care and with ACT teams for transitioned Class Members with incident or cases of concern reports. Although less than 10% of AHI Class Members, including confirmed No's, transitioned, and "In Process Yes" members, are enrolled in ACT teams, the State recognizes ongoing education and collaboration with ACT teams is necessary. To enhance communication and collaboration with ACT teams, current practices will continue. Additionally, Initiative Leadership staff have invited ACT representatives to all monthly Settlement Provider meetings. ACT representatives participated in the April and May settlement provider meetings. ACT teams are also on the distribution list for initiative updates and have been participating on post-transition incident calls.
4. Generally, the Housing Contractor teams do take the lead on money management discussions, particularly if they serve as someone's representative payee, because they have direct access and knowledge of someone's finances. The State did reserve time during the 5/5/25 All Provider meeting to review this recommendation with providers and solicited feedback on challenges in supporting money management needs. Notably, one health home lead mentioned that some level II programs want to exclusively take the lead on money management to avoid duplication and confusion. The State intends to offer money management training and will heed the recommendation to consider cross-training on harm reduction approaches.
5. Settlement Staff already lead weekly apartment matching meetings with all Housing Contractors. During these meetings, all "In Process Yes" cases are reviewed, and referrals are shared with all providers with housing in member's desired area(s). OMH Staff share a monthly inventory list, which outlines all available apartments and provides apartment specifications, which includes apartment addresses and identifies accessible units. Lastly, all members of the Yes group who are still awaiting housing that matches their needs and preferences have referrals open with Housing Contractors that cover their desired catchment area.

6. The apartment checklist has been modified and will be recirculated during the upcoming months and will address a more robust follow-up protocol. In addition, the State has outlined a Wellness Monitoring Protocol, which will include a program policy review, chart reviews, and in-person wellness visits, where the following domains will be examined: governance, health and safety, finances, food security, wellness, advocacy, occupancy, communication and correspondence, and overall satisfaction.
7. The Wellness Monitoring Protocol includes a review of a member's living situation, the process for housemate matching, and challenges experienced by members involving their housemate(s).
8. The State appreciates the Independent Reviewer's support of the PCTP initiative, including the consultation meetings and the augmentation of the provider trainings. The State has continued the implementation of the PCTP approach with all remaining Yes members.
9. Community integration is a core component of the transition planning process and is reviewed regularly on pre and post transition calls, case conferences, and provider meetings. State staff have shared numerous resources to augment community integration, including contact and referral information for PROS programs, psychosocial clubhouses, social day programs, the Office of the Aging resources, and social outings. Both peer programs offer community events for transitioned members, including cooking classes. The housing contractors also offer ongoing social events, including luncheons and tickets to shows. State and settlement providers discussed loneliness and isolation, brainstorming ideas and sharing good practices. The State will continue to broach this topic and share resources. State staff will continue to remind settlement providers to encourage class members to participate in activities/socialization outside of their homes that enriches their life in a way that fulfills their needs and desires. State staff will also share resources and encourage community involvement during wellness visits.

<u>Appendix Feedback:</u>

- The State has reviewed Appendix A thoroughly and commits to working with providers to ensure all issues are addressed as soon as possible. In addition, the State will incorporate some of the Independent Reviewer team's findings in future Post-Transition Wellness Monitoring protocols. For example:
    - The State will update the Housing Contractor checklist to include a reminder to confirm the resident has sufficient trash bags and toilet paper.
    - The State has included a question on whether members know the names and contact information for their providers, including care managers, in the wellness visit tool.
    - During the State's wellness visits, among other goals, the State lead will explore and discuss services, such as managed long-term care services, as applicable, including advising members how they may pursue enrollment.
    - All of the common problems identified by the Independent Reviewer pertaining to housing and neighborhood experiences are addressed in the updated housing checklist and the wellness visit tools, including

reviewing access to a working mailbox, functioning locks, the use of elevators, working stoves, adequate heating and cooling systems, etc. While the State agrees with the Independent Reviewer's summation that there are a myriad of factors contributing to housing problems, the State remains committed to expeditiously resolving circumstances that place member's safety and well-being at risk.

- To mitigate discrepancies between member and provider records, the State intends to complete their own wellness visits and monitor progress, including if appropriate, requesting corrective action plans for critical deficiencies. The findings of the wellness visits will be shared with housing program leadership and the OMH Field Office for review.
- During the wellness visits, State staff will inquire about members neighborhood experiences, including offering support to those who witness violent crimes, and offering the opportunity to relocate members who might be challenged by their area of living (i.e., too far from transportation).
- The State will address housemate experiences during wellness visits and review if residents play an active role in the choice of location, living arrangements and selection of furnishings for their housing. If housing is shared, State staff will review the HC's policies and charts to ensure they facilitate cooperative agreements on bill payments, division of household responsibilities etc. and have a system for matching housemates.
- For those members that have moved multiple times, as noted by the Independent Reviewer, the State will offer support and encourage providers to pay close attention to additional stressors that led to the moves or were a result of the move.
- State staff will prioritize addressing the procurement of IDs, particularly for transitioned members, as an urgent matter and request updates for those outlined as missing IDs in the Semi-Annual Report, as well as those learned about from Post-Transition Incident Reports, Cases of Concern, and Wellness Visits.
- State staff will prioritize the 14 members identified in the Semi-Annual Report as experiencing some to significant food insecurity and ensure there are immediate and long-term plans to help them improve their food security. In addition, the State has a food security domain in the Wellness Visit tool that reviews SNAP benefits and access to food, among other items.
- For the members identified as experiencing some problems with medication administration in the Semi-Annual Report, the State will confirm providers have a plan to implement and/or continue medication training in the community. In addition, the State has a wellness domain

in the Wellness Visit tool that includes questions about medication supply and administration and will continue to monitor this area.
    - The wellness and advocacy domain in the Wellness Visit tool has questions that address loneliness, increased needs around physical health and mobility, and changing and increased needs around cognitive and mental health, and substance use.
    - During the wellness visits, State staff will ask and gauge if members require assistance with connections to outside providers and assist with linkages.
    - The State will continue reconnecting members to peer services, as needed and desired.
    - The State will take into consideration the Independent Reviewer's recommendation to consider the capacity, in terms of both person-power and funding – to facilitate the expansion of peer services to meet the changing and increased needs of the class in the future.
- Although it was noted that two members were not eligible for HH or MLTC care management because their income was too-high to be eligible for Medicaid-funded services (VC, SL), one of those members (VC) was offered a non-Medicaid OMH care management slot and declined. The State will offer SL the same opportunity to enroll in a non-Medicaid OMH care management slot.