

STRESS TEST REPORT

Second Edition

ON THE IMPACT OF THE NEW YORK STATE OFFICE OF MENTAL HEALTH'S PROPOSED CLINIC RESTRUCTURING INITIATIVE

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This is a report of the Coalition Stress Test on the impact of the New York State Office of Mental Health's proposed clinic restructuring initiative. Twenty Article 31 agencies with clinic treatment programs were reviewed representing New York City, Westchester, Nassau and Suffolk Counties. The 20 agencies in this review, whose names are listed in Appendix B, operate seventy-three Article 31 clinics. In addition, there were two other agencies in the sample that are not included in the analysis because they did not operate Article 31 clinics. Other reports will focus on the agencies with the non-Article 31 clinics as more data becomes available.

The agencies were asked to complete the Projection Tool that was developed by the New York State Office of Mental Health for the purpose of enabling the agencies to project how they will do financially if and when the State Restructuring Plan goes into effect. The predominant features of the Restructuring are the elimination of COPS¹ and an increase in the Medicaid fee-for-service rate. State regulations envision a phase-in, enabling the agencies to gradually move to full implementation over a four year period. After the required information is supplied, the projection tool projects how much Medicaid revenue a clinic (or group of clinics if the information is aggregated) will generate in the new system and compare that with the amount of Medicaid revenue it generated in a base year. The agencies will thereby determine whether they will receive a greater or lesser amount of Medicaid revenue in each of four years.

The projection tool does not project total revenue – only Medicaid, including Medicaid Managed Care and Medicare/Medicaid Crossover – because it disregards other payers such as Medicare, other third-party insurers and self pay. Neither does it project surplus or deficit; expenses are not part of the calculation. All that is projected is the amount of Medicaid revenue generated in the new system compared to the base year. The OMH Projection Tool assumes that revenues from other payers will likely remain constant.

Our instructions to the survey agencies were to be realistic in their projections. We wanted them to envision a future without drastic changes. There are some new opportunities like billable outreach that we encouraged them to project but we discouraged them from assuming a large-scale increase in productivity unless they had been working toward that kind of change and expect it to occur. We discouraged them from projecting either a best-case or a worse-case scenario. Initially, many agencies assumed we wanted the worst case because that would support successful advocacy. We maintained consistently that this was not the purpose of data collection or analysis. The Coalition wanted the most objective set of conclusions in this review in order to maintain credibility. We are confident that each of the agencies followed our instructions and were realistic in their projections.

¹ In the existing OMH Medicaid clinic reimbursement methodology, supplemental Medicaid payments are made to providers designated as Comprehensive Outpatient Providers Services (COPS) agencies. These agencies are required to perform specific functions to qualify for these payments. In addition the payments replaced net deficit funding formally provided by OMH and Local Governmental Units (Counties and NYC). The COPS payments are being phased out in the proposed new OMH clinic reimbursement methodology.

Once each agency submitted its projections, all the information was aggregated and subjected to various data analyses. None of the data is attributed to any specific agency in compliance with assurances that we provided to keep their specific data undisclosed.

THE BOTTOM LINES

As seen in Table 1, the 20 sample agencies project that, in the aggregate, they will lose about \$33 million in Medicaid revenue during the fourth year or almost \$80 million over the 4 year period. This amounts to about a 36% decrease of the agencies’ pre-implementation revenue base by the fourth year and about 22% cumulatively. In the first year, the loss is \$6,352,100 or about 7% and becomes progressively worse over the course of the phase-in because of the diminishing legacy payments.² (Although there have been discussions about a modification of the rules regarding Medicaid Managed Care payments, this analysis does not take that information into consideration.)

**TABLE 1:
BOTTOM LINES**

Phase-In Year	1	2	3	4	Cumulative
Phase in Revenue (\$)	84,746,984.26	75,794,422.27	66,841,860.28	57,889,298.29	285,272,565.10
Current Total (\$)	91,099,084.41	91,099,084.41	91,099,084.41	91,099,084.41	364,396,337.63
Phase in Vs. Current (\$)	(6,352,100.14)	(15,304,662.13)	(24,257,224.13)	(33,209,786.12)	(79,123,772.52)
% Change	-6.97%	-16.80%	-26.63%	-36.45%	-21.71%

Data Source #1 (Note: The sources of data for all tables and charts are noted below the table or chart and are listed in Appendix A)

Although there were some individual clinics that were able to increase revenues as a result of Clinic Restructuring and although some of the agencies were able to increase revenues during the phase in because of the legacy payments, all of the agencies in the sample had less revenue in the fourth year of the phase-in and every year thereafter. The losses of Medicaid revenue in the fourth year ranged from a low of -7.59% to a high of -60.56%.

This is certainly a negative outcome for the review agencies. We believe the revenue projections of the agencies in the sample portend serious revenue and service disruptions not only for them but for numerous similarly situated agencies. In the following section, the sample is compared to all agencies in the downstate area with Article 31 clinic treatment programs (Downstate 31

² The proposed OMH clinic restructuring Medicaid reimbursement changes are scheduled to be phased in over four years at 25% each year. Thus, in the first year, the new reimbursement methodology will account for 25% of the providers' Medicaid reimbursement and the current system 75% and so on until the new methodology is fully phased in and the current methodology is fully phased out by the fourth year. In the OMH proposal and in the Projection Tool the phased current Medicaid reimbursements are referred to as "legacy" payments.

Aggregate),³ all agencies in the downstate area with Article 31 clinic treatment programs that receive Level 1 COPS supplements (Downstate 31 COPS Aggregate), and all clinic treatment programs in the State of New York (State Aggregate). The Downstate Article 31 Aggregates do not include data from county operated clinics. Data in the State Aggregate do not include data from New York State operated clinics.

³ In the proposed regulations covering clinic treatment programs, the term “downstate” refers to the following counties: Bronx, Kings, New York, Queens, Richmond, Nassau, Suffolk, Dutchess, Orange, Putnam, Rockland and Westchester. Dutchess, Orange, Putnam and Rockland Counties are not represented in this analysis.

COMPARISONS BETWEEN THE SAMPLE AND OTHER GROUPS

As can be seen in Table 2, the sample is very similar to the Downstate 31 COPS Aggregate. Total expenses per unit of service of the sample agencies are about \$152 while total expenses per unit of service of the Downstate 31 COPS Aggregate is almost identical, about \$151. The Downstate 31 Aggregate has less expense per unit of service, about \$128 per unit, probably because there are many agencies in that group that do not provide fringe benefits for large numbers of staff who work on a per-session basis. The State Aggregate has an exceedingly high cost per unit of service, about \$186 per unit.

With respect to the number of units of service per clinical FTE, the sample clinics are most like the Downstate 31 COPS Aggregate, 949 and 962 respectively. The Downstate 31 Aggregate has a high number of units per FTE, probably because there are numerous agencies in that group that employ large numbers of clinicians on a per-session basis. Their contribution to this measure of productivity makes the productivity measure of the Downstate 31 Aggregate artificially high. In those agencies, time spent waiting for consumers who do not appear for their appointments, is not generally included in calculation. However, time of most salaried employees spent away from work because of vacations and sick and personal time is part of the calculation. Thus, dividing the units of service by the clinical FTE count is an ineffective measure of productivity even though it is frequently used. The State Aggregate lags considerably behind the others.

Table 2
COMPARISONS: RATIOS

	Sample Art. 31 Clinics	Downstate 31 Aggregate (All Downstate Art. 31 Clinics)*	Downstate 31 COPS Aggregate (All Downstate COPS 1 Agencies with Art. 31 Clinics)*	State Aggregate (All Clinics in NYS)**
Total Expenses per Weighted Unit of Service (\$)	152.08	127.51	150.55	185.78
Weighted Units of Service per Clinical FTE	949	1,081	962	772

Data Source #2. *Not including County government clinics. ** Not including State operated clinics.

As seen in Table 3, the sample represents a high proportion of the units of service, clinical full time equivalents, total expenses and Medicaid revenues of the Downstate 31 Aggregate, approximately 40%. It represents an even higher proportion of the Downstate 31 clinics COPS Aggregate. It is startling to observe that the sample of only 20 agencies receives almost 20% of all the Medicaid revenues in the state.

**TABLE 3
COMPARISONS: PERCENTAGES**

	Units of Service (Weighted)	Total Clinical FTEs	Total Expenses	Total Medicaid Revenue
% of the Sample Agencies to the Downstate Aggregate (All Downstate Article 31 Agencies)*	38.73%	44.09%	46.19%	40.87%
% of the Sample Agencies to the Downstate 31 COPS Aggregate (All Downstate COPS 1 Agencies with Article 31 Clinics)*	60.66%	61.45%	61.27%	49.62%
% of the Sample Agencies to the State Aggregate (All Clinics in NYS)**	6.54%	5.31%	5.35%	19.48%

**Not including County government clinics. ** Not including State operated clinics.*

Data Source: Total Medicaid Revenue from Source #3. Other information, Source #2

An analysis of averages, displayed in Table 4 is also edifying. The sample agencies are bigger and have more output than either of the downstate aggregates and of the state as a whole. For example, the sample agencies produce an average of 38,381 weighted units of service each while the Downstate 31 Aggregate and the Downstate 31 COPS Aggregate produce less than 22,000 each and the State Aggregate is considerably behind that. There are similar findings for Total Clinical FTEs and Total Expenses.

**TABLE 4
COMPARISONS: AVERAGES**

	Units of Service (Weighted)	Total Clinical FTEs	Total Expenses (\$)	COPS RATE (\$)***
Averages of Sample Agencies	38,381	40.43	5,836,994	136.88
Averages of the Downstate 31 Aggregate (All Downstate Agencies with Art. 31 Clinics)*	21,107	19.53	2,691,288	NA
Averages of the Downstate 31 COPS Aggregate (All Downstate COPS 1 Agencies with Art. 31 Clinics)*	21,721	22.59	3,270,209	112.68
Averages of the State Aggregate (All Clinics in NYS)**	15,420	19.97	2,864,688	NA

Not including County government clinics. ** Not including State operated clinics. *This is an arithmetic average, not a weighted average. Data Source: COPS Rate from Source #3. Other information from Source #2*

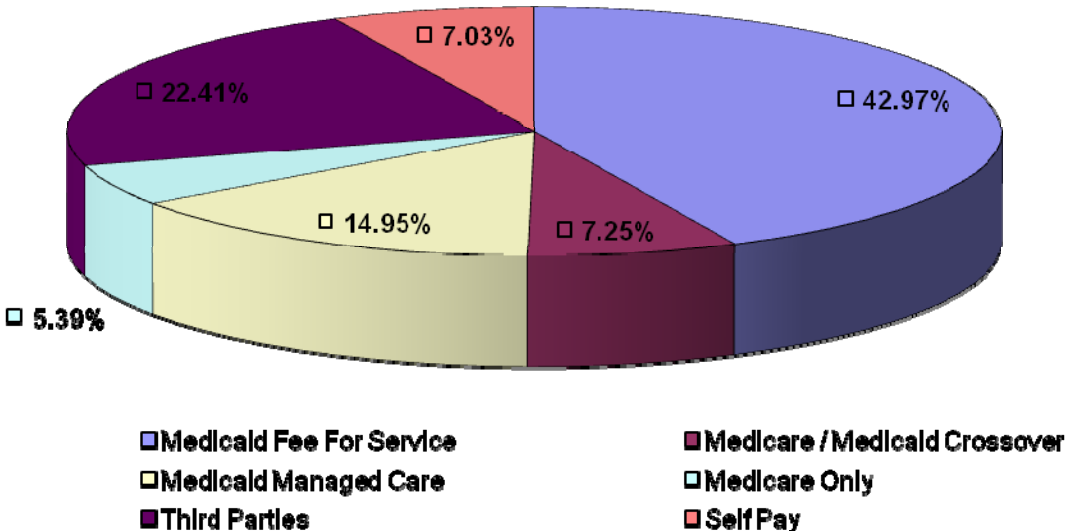
COPS

The single most important characteristic of the proposed restructuring plan is the elimination of the COPS supplement. All of the agencies in the Coalition Stress Test sample receive Level 1 COPS supplements. This is a predominant, although not exclusive, reason why all agencies in this Stress Test sample showed revenue losses while many agencies in the state, with different characteristics, are believed to have shown revenue gains in their own projections. As can be seen in Table 4, above, the average (arithmetic average – not weighted average) COPS rate for the sample is \$136.88. The COPS rate for the Downstate 31 COPS Aggregate is somewhat lower, about \$113. The statewide (arithmetic) average COPS rate for all agencies that have Level 1 COPS supplements is about \$106.

PAYER MIX

Payer mix also figures prominently in predictions about how agencies will be affected when and if the clinic restructuring initiative is implemented. Graph 1 shows the payer mix for the entire sample.

**GRAPH 1
PAYER MIX**



These figures are percentages of units of service. Data Source #4

As seen in Graph 1, almost 43% of the consumers served by the agencies in the sample have Medicaid coverage. Over 7% receive Medicare/Medicare crossover revenue which equals the Medicaid rate. Therefore, about 50% of the units of service produced by the sample will be billed at the Medicaid rate. Medicare coverage is least used, slightly over 5%. Every agency in the

survey had some consumers with Medicaid coverage. However, the sample agencies vary considerably in their Medicaid percentages: As seen in Table 5, over 90% of the consumers in one agency had Medicaid fee for service coverage and in another agency only less than 4% had such coverage. The Median (or the Medicaid percentage in the middle of the agency distribution) was over 41%. Medicaid Managed Care, a revenue source garnering much discussion, ranged from several agencies with no Medicaid Managed Care to over 31% of one agency’s revenue. The Median, disregarding those without Medicaid Managed Care payments, was over 13%. Information regarding the other payer sources can also be seen on Table 5.

**TABLE 5
PAYER MIX STATISTICS**

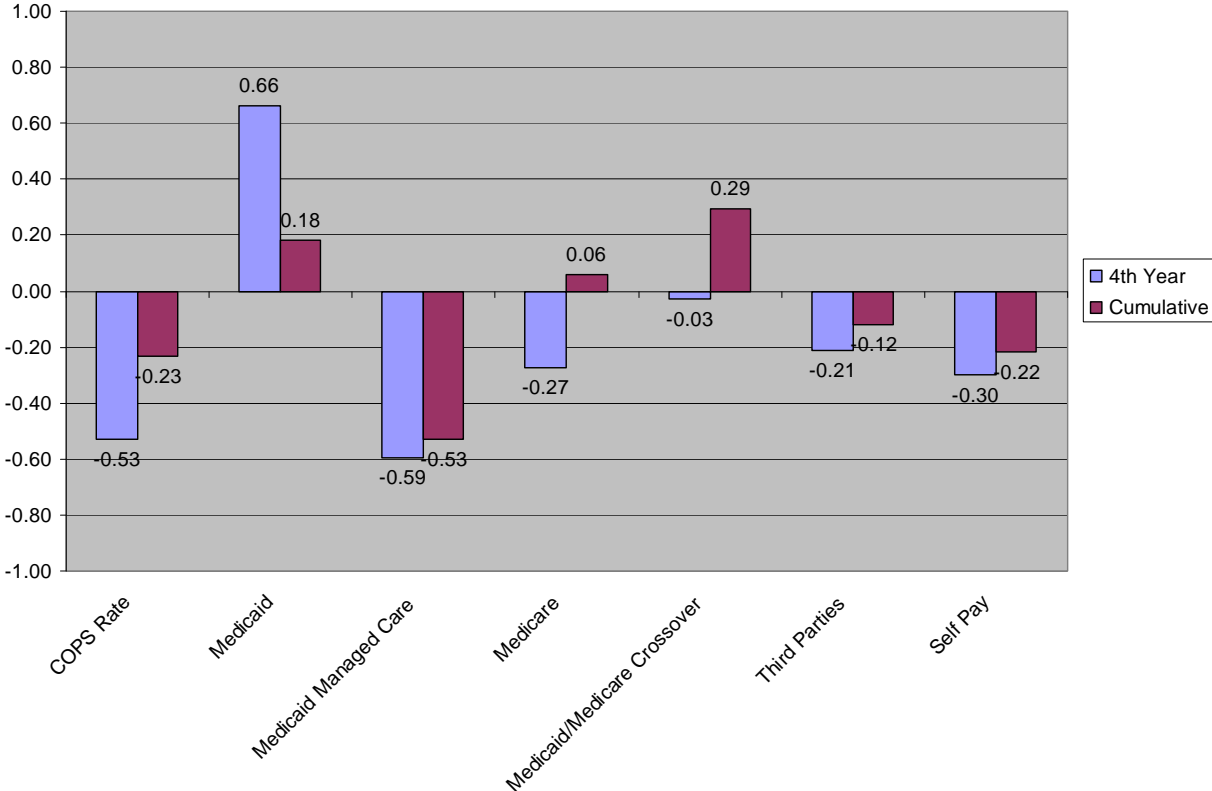
	Medicaid Fee for Service	Medicare/Medicaid Crossover	Medicaid Managed Care	Medicare Only	3rd Party	Self-Pay
Agencies with Payer Type*	20	16	18	15	19	19
High	90.23%	30.14%	31.33%	71.82%	62.48%	23.68%
Low	3.39%	0.63%	0.18%	0.75%	5.30%	0.71%
Median	41.22%	7.34%	13.41%	6.94%	17.69%	6.20%
*The numbers in this row represent the agencies in the survey that had units of service paid by the payer noted in the column heading. Agencies that did not have such payments are disregarded in computing the median.						

Source of the data on which this is based is Source #4

The conventional wisdom is that those agencies with a high proportion of Medicaid will do well or come out “even” in the transition and those with a high COPS rate will not. In order to determine if this is the case, a correlation analysis was conducted.⁴ The outcomes being measured were the fourth year of the phase-in and cumulative increases or decreases in revenue, contrasting the amount the agency would receive as a consequence of the new system with the amount they received in the base year. As can be seen in Graph 2, the results are as predicted but only to a limited degree.

⁴ A correlation analysis produces a number between -1 and +1 indicating the degree of association between two variables. A positive value for the correlation implies a positive association, i.e. a high proportion of Medicaid is associated with an increase in revenue because of Clinic Restructuring. A negative value for the correlation implies an inverse association, i.e. a high COPS rate is associated with a decrease in revenue because of Clinic Restructuring.

CHART 2 CORRELATION COEFFICIENTS



The coefficients are derived from multiple sources. Revenue outcome data comes from Source #1. COPS rates are from Source #3 and Payer Mix information comes from Source #4.

The COPS Rate is inversely proportional to revenues in year 4. That is, the higher the COPS rate, the lower the increase in revenue for the clinic (or the greater the loss of revenue). However, the correlation coefficient is only -0.53 indicating that it is not a very strong association. This means that there are other factors, such as a combination of payers, which also influence the result. A high proportion of Medicaid is positively associated with revenue in year 4; the higher the proportion of Medicaid, the better the agency does as a result of restructuring. This association is slightly stronger, 0.66. The proportion of Medicaid Managed Care is, like the COPS rate, inversely proportional to revenues, both for year 4 and the cumulative result, 0.59 and 0.53 respectively. Other payer sources are not associated with revenue resulting from restructuring. Again, this analysis does not take into consideration any change in policy that may occur with respect to Medicaid Managed Care payments.

DEMOGRAPHY OF THE SAMPLE

Table 6 shows the ethnic and age breakdown of the consumers served by the agencies in our sample as well as the communities in which they live. The table also shows agency expenditures across the demographics.

An analysis of demography demonstrates how consumers and the communities in which they live might be affected by clinic restructuring. As agencies have completed the projection tool, some executives have expressed concern that some clinics might have to be closed and/or that the clinics may have to change their payer mix, reducing services to consumers who do not have Medicaid because of the dramatic difference in rates.

The agencies collectively serve 46,603 people: 36% of them are Caucasian, 28% are Hispanic, and 20% are African American.

Thirty-eight percent of the people served by the clinics are under the age of 20. About 8% are elderly, 65 and over. Although this proportion is lower than the number of elderly people in New York State (13.4%),⁵ or the New York City Metropolitan Area (12/9%)⁶, it is consistent with the number of elderly consumers in outpatient programs reported in the 2007 OMH Patient Characteristics Survey, both statewide and within the metropolitan area.⁷

The geographical distribution of the sample is not totally representative of the communities partially because agencies with Article 28 clinics have been excluded from this analysis but this imbalance will be rectified in future reports.

⁵ <http://quickfacts.census.gov/qfd/states/36000.html>

⁶ Derived from the same database as the New York State proportion.

⁷ <http://bi.omh.state.ny.us/pcs/Summary%20Reports?pageval=prog-age>

TABLE 6 - DEMOGRAPHICS

	Total	Persons Served 46,603	100%	Units of Service (Weighted) 770,579	100%	Total Expenses \$117,769,764	100%
Ethnicity							
Nonhispanic of Single Race:							
White	16,385	35.16%	246,577.26	32.00%	\$ 39,023,294	33.14%	
Black/African American	9,436	20.25%	160,223.01	20.79%	\$ 24,610,564	20.90%	
Asian or Pacific Islander	1,558	3.34%	31,428.04	4.08%	\$ 4,410,551	3.75%	
American Indian and Alaska Native	44	0.09%	685.33	0.09%	\$ 105,785	0.09%	
Some Other Race	3,356	7.20%	60,343.50	7.83%	\$ 9,178,334	7.79%	
Nonhispanic of Two or More Races	569	1.22%	11,940.35	1.55%	\$ 1,913,160	1.62%	
Of Hispanic Origin	13,038	27.98%	224,249.92	29.10%	\$ 33,265,346	28.25%	
Of Unknown Ethnicity	2,219	4.76%	35,131.59	4.56%	\$ 5,262,730	4.47%	
Age							
Under 5 years	408	0.88%	10,357.18	1.34%	\$ 1,581,058	1.34%	
5 to 9 years	4,112	8.82%	78,681.81	10.21%	\$ 12,104,380	10.28%	
10 to 14 years	7,130	15.30%	126,955.26	16.48%	\$ 19,398,795	16.47%	
15 to 19 years	6,258	13.43%	100,939.89	13.10%	\$ 15,489,603	13.15%	
20 to 24 years	2,057	4.41%	31,671.89	4.11%	\$ 4,945,492	4.20%	
25 to 44 years	9,632	20.67%	150,633.18	19.55%	\$ 22,908,639	19.45%	
45 to 64 years	13,089	28.09%	204,307.03	26.51%	\$ 30,757,652	26.12%	
65 years and over	3,502	7.51%	61,052.09	7.92%	\$ 9,728,952	8.26%	
Of Unknown Age	414	0.89%	5,980.67	0.78%	\$ 855,194	0.73%	
Geographical Area							
Bronx	5,847	12.55%	94,757.19	12.30%	\$ 14,538,679	12.35%	
Brooklyn	9,670	20.75%	155,912.95	20.23%	\$ 21,457,924	18.22%	
Manhattan	6,461	13.86%	107,952.22	14.01%	\$ 16,812,732	14.28%	
Queens	8,567	18.38%	169,459.18	21.99%	\$ 24,637,781	20.92%	
Staten Island	1,331	2.86%	19,210.98	2.49%	\$ 2,752,678	2.34%	
Westchester	3,575	7.67%	76,310.03	9.90%	\$ 13,378,079	11.36%	
Nassau	3,668	7.87%	40,495.52	5.26%	\$ 7,685,102	6.53%	
Suffolk	7,095	15.22%	97,955.33	12.71%	\$ 15,046,885	12.78%	
Other	389	0.83%	8,525.60	1.11%	\$ 1,459,903	1.24%	

Data Source #5

Overall, the survey agencies produced 770,579 units of service. The manner in which the Units of Service are distributed virtually mirrors the way the Persons Served are distributed although children under 14 years of age appear to receive more units of service per person than their older counterparts. Services to that group also received proportionately more agency financial resources than others;

In all, the survey agencies spent \$117,769,764 and the pattern of spending seems to mirror the other distributions reflected in Table 6.

SUMMARY AND CONCLUSIONS

This is a report of the Coalition Stress Test of the New York State Office of Mental Health proposed clinic restructuring initiative. Twenty Article 31 agencies with 73 clinic treatment programs were reviewed representing New York City, Westchester, Nassau and Suffolk Counties.

The agencies were asked to complete the Projection Tool that was developed by the New York State Office of Mental Health for the purpose of enabling the agencies to project how they will do financially if and when the State Restructuring Plan goes into effect. State regulations envision a phase-in, enabling the agencies to gradually move to full implementation over a four year period.

Our instructions to the survey agencies were to be realistic in their projections. We wanted them to envision a future without drastic changes. There are some new opportunities like billable outreach that we encouraged them to project but we discouraged them from assuming a large-scale increase in productivity unless they had been working toward that kind of change and expect it to occur. We discouraged them from projecting either a best-case or a worse-case scenario.

The agencies in our sample projected that they will lose about \$33 million collectively, in Medicaid revenue during the fourth year of the phase-in or almost \$80 million over the 4 year period. This amounts to about a 36% decrease of the agencies' pre-implementation revenue base by the fourth year and about 22% cumulatively. The losses become progressively worse over the course of the phase-in because of the diminishing legacy payments.

Although there were some individual clinics that were able to increase revenues as a result of Clinic Restructuring, all of the agencies did badly. In the fourth year of the phase-in and every year thereafter, the losses of Medicaid revenue ranged from 7.59% to 60.56%.

A correlation analysis showed that, to a limited extent, the higher the COPS rate and the higher the proportion of Medicaid Managed Care clients (not considering the proposed Medicaid Managed Care supplement), the worse the clinic does and the higher the proportion of Medicaid, the better it does. However, these associations are not particularly strong, meaning that other factors, such as combinations of payers in the mix, play significant roles in predicting how well any given agency will fare under the proposed restructuring. **Nevertheless, none of the agencies do well; every agency in the Coalition Stress Test sample experiences losses of revenue.**

As agencies have completed the projection tool, some executives have expressed concern that some clinics might have to be closed and/or that the clinics may have to change their payer mix, reducing services to consumers who do not have Medicaid because of the dramatic difference in rates. If this happens, not only will agencies experience losses but the consumers and their communities will do so as well.

APPENDIX A

SOURCES OF DATA

1. Aggregation of data supplied by the agencies in the sample through completing the Projection Tool supplied by the New York State Office of Mental Health, Version 3.1.
2. The “CFR All” on a database prepared by Glenn Gravino, consolidated from CFR and Medicaid databases provided by SOMH on their website. (Glenn 9-1-9_g Clinic CFR and MA Data for NYC 0708- ROS CY08).
3. The Medicaid All (3) tab on the same (as 3 above) database prepared by Glenn Gravino, consolidated from CFR and Medicaid databases provided by SOMH on their website. (Glenn 9-1-9_g Clinic CFR and MA Data for NYC 0708- ROS CY08).
4. Payer Mix information is primarily a compilation of data obtained by a survey of agencies in the state administered by Glenn Gravino and his associates. Data not obtained by him was obtained by the consultants using a similar methodology.
5. Demographic information was obtained from questionnaires prepared by the consultants and completed by representatives of the sample agencies.
6. Illustration accompanying the SOMH Projection Tool used to clarify the methods of completing the tool. The spreadsheet was modified first to be able to calculate the effects of a possible Medicaid Managed Care supplement and then the COPS rate originally entered was modified successively to determine the consequences of various COPS rates.

APPENDIX B

PARTICIPANTS IN THE STRESS TEST

Andrus Children's Center
Astor Services for Children and Families
Catholic Charities, Diocese of Rockville Centre
Catholic Charities Neighborhood Services
F.E.G.S.
Family and Children's Association
Fordham-Tremont CMHC*
Hudson Guild
Institute for Community Living, Inc.
International Center for the Disabled*
Jewish Association for Services for the Aged
Jewish Board of Family and Children's Services, Inc.
Jewish Child Care Association
North Shore Child and Family Guidance Center
Northside Center for Child Development, Inc.
Pederson-Krag Center
Puerto Rican Family Institute, Inc.
Service Program for Older People (SPOP)
Steinway Child & Family Services, Inc.
The Child Center of New York
Upper Manhattan Mental Health Center, Inc.
Westchester Jewish Community Services

**Not part of the sample of Article 31 clinics. Data from these agencies are not included in this report.*