Clinic Reform—Problems and Challenges in Meeting OMH Goal of Client Centered Care

1) Contemplated changes in clinic reimbursement and model are far reaching and will have profound results on service delivery for consumers and families. OMH has performed neither a system-wide nor sample stress test of the new reforms, allowing the possibility of substantial clinic failures under the new rubric and significant loss of access to care for consumers. If the new system is implemented with the flaws intact, without testing and modeling, it will lead to immediate closing of unionized clinics, which are the most costly to run, and will soon thereafter lead to the closing of clinics in neighborhoods and communities in New York City and throughout New York State, particularly where there are no care alternatives. We ask, therefore, that the implementation of the clinic reimbursement reforms only occur after there has been a comprehensive effort to model the impact of the reforms on an array of different clinics to assess its full fiscal impact;

2) OMH is creating "peer groups" with differential reimbursements that will lead to or continue inequities in the distribution of resources; e.g. counties will get a higher rate than community based providers, supporting a public unionized workforce with health and other fringe benefits. Also, DTCs (Article 28s) will continue to receive a capital pass-through to pay for facility costs that is unavailable to the Article 31 voluntary clinics. Clinics should be reimbursed fairly and consistently, reflective of the needs of their patients and regardless of license or auspice category;

3) Inadequate or inconsistent payment by Medicaid and Commercial Managed Care Plans will force many voluntary providers to cease service to working and middle class families with serious mental illness and serious emotional disturbance who are insured by Managed Care policies. Parity, State and Federal, will be a myth in the face of lack of access to services. The public mental health clinics that survive the transformation will serve only indigent people with serious and persistent mental illness or serious emotional disturbance who receive Medicaid fee-for-service. Steps should be taken to require Medicaid and Commercial managed care plans to pay the same clinic rate as fee-for-service Medicaid and to regulate the unwarranted denial of care by abusive utilization review practices by certain of these plans;

4) The value of a 30 minute visit, certified by CMS as a full visit, will be paid at a unsustainable rate by the new reform regulations, forcing many poor and otherwise underserved consumers, particularly children, from care. Current limited capacity will be stretched by the new (and clinically unjustified) 45 minute standard and many needy clients will be placed on waiting lists and be denied care in many metropolitan New York City neighborhoods and other New York State communities where there are no alternative sites of care. Decreases in available community-based treatment services will also make it more difficult to discharge consumers who are ready to leave in-patient treatment facilities;

5) The professional workforce, now largely full time, with health care and other workplace benefits, will be unsustainable under the new reimbursement. The result will be a part time staff without healthcare and other fringe benefits, more difficulty in maintaining continuity of consumer care and relationships and more problems in supervision and quality assurance efforts. Such a move will demoralize the workforce and devalue the professions, making it more difficult to attract new young people to the mental health professions;

6) The looming implementation of the professional licensing law for social workers and other mental health professionals will lower the supply of valued professionals and increase the costs of hiring LCSWs, another financial blow to precarious clinics. Without an exemption for the public system (OASAS, OMH, OMRDD and OCFS-licensed or funded programs), the inflexibility of the current regulations will lead to lowered output, less revenue and serious bottlenecks in the capacity for service delivery.

7) The innovation of an indigent care pool for mental health is a constructive and critical component of clinic reform, but the pool should reimburse clinics for indigent care at adequate and sustainable rates in order to succeed at diverting these patients from emergency rooms and hospitals, which are far more costly and less rehabilitative ways of helping people deal with mental health issues and crises.