

The Coalition of Voluntary Mental Health Agencies
(New York City and environs)

The New York State Council
for Community Behavioral Healthcare

The Coalition of Voluntary
Mental Health Agencies of Nassau

Community Mental Health Services

**New York State Budget
Fiscal Year 2004**

A Briefing Book

February 2003

Budget Action Needed

Support the infrastructure of the community mental health system

- **Uphold annualized COLA/Medicaid fee increase from last year at \$30 Million (OMH estimate)**

The community mental health sector is still troubled by years of neglect in which inflationary expense increases were met with reimbursements that remained static. Relief is only now being felt in the form of last year's legislative initiative which funded a 3% COLA and a 10% Medicaid increase for workforce recruitment and retention. Allowing the measure to expire would result in financial cutbacks and serious reductions in service.

- **Institute structural trended rate increase to protect the future vitality of the sector**

Year after year, fixed contract dollars and rate reimbursements rob agencies of their purchasing power in the face of rising rents, inflation, insurance cost increases, workforce demands and other cost escalators. Creative management can take cost cutting and efficiencies only so far without impacting on quality of service delivery. Unlike other healthcare sectors—even other behavioral healthcare sectors—community mental health agencies do not receive a trended increase to help them keep up with the rising costs of providing service. An annual trended rate adjustment would reflect more accurately and predictably the costs of doing business in New York and help to stabilize agencies and their mental health workforce, a key factor in consumer rehabilitation and recovery.

- **Prevent the loss of existing residential services for people with mental illness by providing a one-time increase**

The cost to provide Supported Housing and other community residential services, has far outpaced increases to contract rates. A failure to account for the cost of rent and increasingly complex services has led programs to the brink. Needed is a significant bump and an examination of structural funding solutions.

Protect the integrity of community Reinvestment

- **Immediate Reinvestment**

Reinvestment makes the logical connection between patients who have been discharged from State psychiatric inpatient hospitals and adequate funding in the community mental health sector. That the methodology has been re-introduced is a positive step, but the community needs the resources this year in order to provide care for already-discharged and about-to-be discharged consumers.

- **Maintain integrity of Reinvestment budget-line**

Reject the budget's incorporation of \$180 million of previously authorized Reinvestment funds into the mental health base budget; Reinvestment must remain separately lined out so we can continue to track and protect this legislatively authorized priority funding stream.

Children's Mental Health

- **Support expansion of children's outpatient services through Reinvestment**
- **Support earmarking of 10% of proposed beds for children's residential services.**
- **Maintain and preserve Child Health Plus A (Medicaid) eligibility for children and adolescents at 133% of the federal poverty level**
- **Reject the proposal to increase the local share of Medicaid to 37%**

Support the infrastructure of the community mental health system

The 3% cost of living adjustment (COLA) and 10% Medicaid fee increase initiated and approved last year by the legislature and proposed to be annualized by the Governor in this year's budget just went into effect on December 1, 2002 and will be funded through the end of the fiscal year—March 31, 2003. These increases were approved in response to mounting evidence that the quality of care in community mental health agencies was in serious jeopardy because of workforce turnover and unchanging contract rates.

Preliminary data from a state-wide survey of community mental health agencies measuring turnover for FY2002 puts average turnover rates between 29% and 59% depending on the kind of staff. This is comparable to results from our FY2000 survey, which indicated turnover rates between 37% and 54%. At these rates, turnover remains a serious impediment to the development of the stable consumer/caregiver relationship which is so fundamental to rehabilitation and recovery.

Agencies are counting on the previously approved COLA and Medicaid fee increase to hold the line against the rising cost of doing business. Earmarked for workforce recruitment and retention, these funds will assist in maintaining the continuity of the community workforce. Ending this already-approved increase would destabilize the community mental health sector and translate directly into serious reductions in service.

That this COLA and Medicaid fee increase are so urgently required only underscores the need for a structural solution to the rising cost of providing community mental health services. For many years, this sector has gone without regular increases to counteract inflation, rent, and other cost-escalators. Last year's COLA and Medicaid fee increase have only begun to make up for years of cutting back. Without a long-term solution, contract dollars will fail to keep pace with the cost of inflation—the cost of rent; the cost of insurance; and the cost of recruiting and retaining a high quality workforce, that provides increasingly complex treatments and services.

Actions Needed:

- **Extend and annualize COLA/Medicaid fee increase: \$30 Million (OMH estimate)**
- **Institute structural trended rate increase to protect the vitality of the sector going forward**

Reinvestment

Begin Reinvestment on January 1, 2003

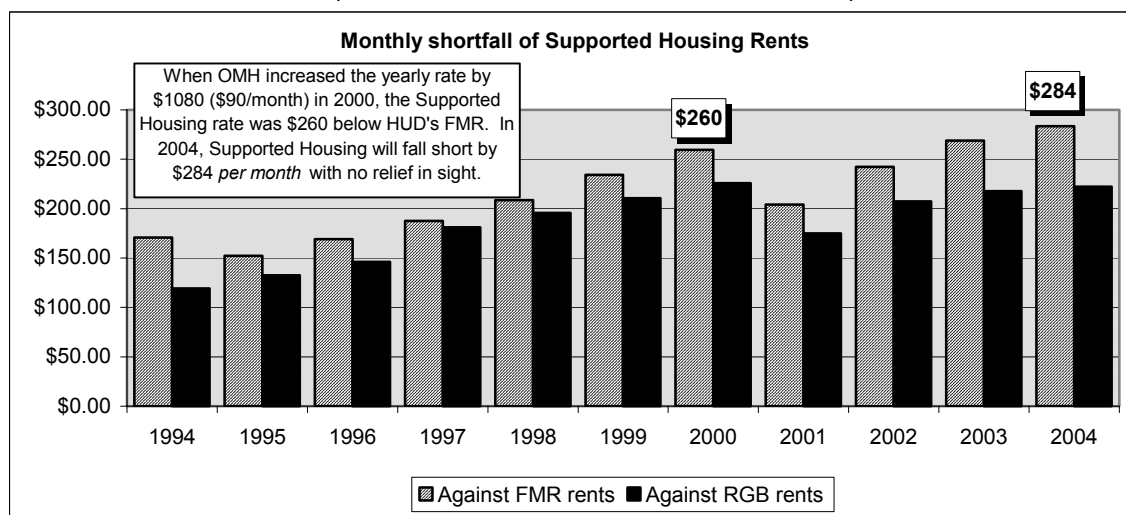
The Coalition has long been supportive of a methodology that directs savings from the downsizing of the outmoded state psychiatric hospital system to the more clinically appropriate community mental health sector. A smaller state psychiatric system necessitates more and better community services. Eliminating capacity in the hospital system *without* fortifying the community sector creates stress on the system of care. Although relatively few beds are scheduled for elimination in the coming year, the principle of Reinvestment is elemental and should be upheld—as it was last year when the legislature passed The Community Mental Health Support and Workforce Reinvestment Program. The plan to begin Reinvestment in '04-'05 is a welcome step in the right direction; however, in light of downsizing proposed for the current year, Reinvestment should begin this year.

Maintain the integrity of Reinvestment budget-line

Since its inception, the Reinvestment funding stream has been specifically delineated in the budget. This has allowed stakeholders and elected officials to track and monitor from year to year the funds that make available adult and children's services. The current Executive Budget proposal has eliminated Reinvestment as a separate funding line, hampering the ability of advocates to track and maintain these funds. This is an issue of accountability that should be continued in order to maintain public confidence in the spending and allocation of these funds.

Housing Infrastructure

Nowhere is the infrastructure need greater than for residential programs like OMH's Supported Housing. Current reimbursement levels are barely enough to cover the cost of rent. Fewer dollars remain after paying rent, often at a sacrifice to supportive services. For more than 4,500 Supported Housing beds in New York City alone, the difference between HUD's Fair Market Rents and Supported Housing rent allocations have already reached an all-time high of \$269 *per month*; by next year, it will be \$284 per month. The inadequacy of the rates is already impeding the development of new beds and the threat to the on-going viability of existing beds could easily lead to the eviction of people with mental illness already stabilized and on the road to recovery.



The problems facing Supported Housing are indicative of the problems across many residential programs in the mental health sector. The rates are so inadequate that staffing ratios—and quality of care—are beginning to suffer. A one-time bump for residential services is needed in order to prevent the loss of existing housing capacity.

Mechanisms that already exist in the behavioral health system could be more fully exploited in order to ensure the stability existing community mental health housing. These should be more thoroughly—and aggressively—pursued.

Actions Needed:

- **Prevent the loss of existing mental health housing beds by providing a needed infusion of funds.**

Housing Capacity

At a time when the State budget is facing major shortfalls and deficits, the proposal to create 2600 beds over the next three to six years is an important step to address the need for additional community residential services for people with mental illness. Although a significant and welcome move, the need is, sadly, far greater than capacity. Given the problem of adult home residents with mental illness, the rapidly rising use of shelters and other homeless services, and the on-going discharge of people with mental illness from state psychiatric hospitals, prisons, and jails, it is clear that additional housing units are needed and now.

After addressing the infrastructure of the community mental health sector through the preservation of last year's COLA and Medicaid fee increase, any additional resources should create community beds for adult homes residents with mental illness. Many people with mental illness are currently living in adult homes where the services they receive are woefully inadequate. In many cases, the facility itself is in such a poor state of repair as to endanger residents.

The problem for adult home residents is that they have no other place to go. This problem is emergent, and will only get worse in the 3-5 years before the 2600 beds are fully operational.

Beds that address the needs of adult home residents should be funded *today*. Capital funding can help to solve the long-term need, but the safety of adult home residents hangs in the balance. A quicker solution is to fund apartments specifically for residents of adult homes with mental illness.

Watching the Pot: Medicaid trends and developments which may impact the mental health sector in New York State

Perhaps the greatest influence on the long-term deployment of mental health services is Medicaid, the federally subsidized program that helps states fund healthcare services for, among others, people with mental illness. Medicaid works by matching federal dollars with state dollars for a multitude of health services. Most people with Serious Mental Illness (a term of art in the mental health sector) are Medicaid-enrolled or eligible and depend on this safety-net for the psychiatric and rehabilitation services which can put them back on the road to well-being.

The benefit to New York has been immeasurable. The federal government currently contributes 50% of the cost of Medicaid-eligible services; the counties provide 15%-20%. The financial advantage to New York State is clear: Medicaid maximization can reduce the state tax-levy dollars that are spent on healthcare services with no concomitant cutback in services. New York State has been particularly adept at drawing down federal Medicaid funds—so much so that New York gets more Medicaid dollars *per capita* than any other State.

Approximately 10 years ago, OMH began to convert many programs to Medicaid. While this conversion has saved the state millions over time, it has also made the healthcare sector—and particularly the mental health sector—less responsive to innovative treatments, local needs, and necessary treatment variations by population. Furthermore, services are now highly susceptible to changes at more remote levels—like the federal government. Until now, Medicaid has been relatively safe—a stable funding source with few major changes, but all that is about to change.

New York State is facing strong pressure from both local counties and from the federal government, which is also seeking to cut Medicaid costs and looking to shift costs back to the states. Counties are buckling under the strain of their Medicaid burden. Already, we are seeing proposals to stem the growth of Medicaid spending.

In his latest budget proposal, President Bush is attempting to change the way Medicaid is administered. The proposal effectively converts Medicaid to a block grant—a lump-sum of funds for healthcare with only a moderate decrease in regulation. No longer strongly tied to enrollment or usage, it will jeopardize a state's ability to fund services in times of economic downturn when enrollment would logically rise. Although this *may* result in a

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short-term windfall for states, it will almost certainly result in substantial long-term *cuts* where states—New York included—would have to make up the shortfall—or cut programs.

At the same time that New York State counties are looking for Medicaid relief, and that the federal government is looking to cap Medicaid expenditures, the State Office of Mental Health is moving forward with efforts to convert still more services to Medicaid. Chief among these is a program called PROS—Personalized Recovery Oriented Services. Although it is too soon to evaluate the quality of the PROS proposal, it is most certainly a Medicaid-funded program. In the context of increasing pressure on the Medicaid funding stream, this raises serious questions about the long-term viability and stability of this program.

The conversion to Medicaid notwithstanding, PROS represents a new paradigm in the design and delivery of New York’s community mental health services. The legislature should continue to work closely with OMH, consumers, and providers to monitor this important development.

It is clear that the move is on to curb Medicaid spending at the federal and local levels. We are seeing, too, the beginning of state-level efforts to cut Medicaid spending in the form of cuts to Child Health Plus and Article 28 hospitals. Will PROS and other already-‘Medicaid-ed’ services be up for elimination the next time Medicaid is cut?

Medicaid Reform and Children's Mental Health Services

Transferring and shifting children ages 6 to 19 with family income between 100% and 133% of the Federal Poverty Level (FPL) to Child Health Plus B directly threatens the progress and success NYS has achieved in enrolling children in Child Health Plus A (Medicaid). Children currently enrolled in Child Health Plus A have enjoyed the benefit of no limitations on mental health services and no disruption in their mental health care and treatment. If these children are transitioned to Child Health Plus B they are at risk of having a gap in coverage during the transition, and limitations and fewer benefits in their mental health treatment plan. They will, further, be subject to the variants of coverage under managed care plans, and disruption in continuity of care as they approach their 6th birthday.

Children in New York City, as well as other counties, will be impacted if the local share of Medicaid is increased to 37%. Given the current budget crisis in New York City, reduction in services or reduction in the number of children in need of services will be devastating to the progress we have made in providing mental health services to children and adolescents.

Action Needed:

- **Maintain and preserve Child Health Plus A (Medicaid) eligibility for children and adolescents at 133% of the federal poverty level**
- **Reject the proposal to increase the local share of Medicaid to 37%**

Hospital cuts that will Impact the mental health sector

Governor Pataki's Executive Budget includes a Medicaid cut of over \$595 million to Article 28 general hospitals. Included in this massive cut is a 5% rate reduction for inpatient psychiatric services. This cut—worth approximately \$46 million annualized—will result in staff reductions and bed closures across the state, at a time when inpatient census is extremely high. General hospital inpatient psychiatric units are an important and necessary part of the continuum of community mental health care, providing an acute care service which usually serves to keep individuals out of much more expensive longer-term care. This cut is therefore extremely shortsighted and must be rejected.

If the larger cut is enacted, it will result in an additional cut of approximately \$55 million to Article 28 hospital-based inpatient and outpatient mental health services (psychiatry accounts for approximately 10% of Article 28 hospital revenues statewide), even though the budget language is not mental health-specific. As above, a cut this large will result in serious service reductions statewide and therefore should be rejected.

We also urge rejection of the proposed elimination of the Alternative Reimbursement Methodology for inpatient psychiatry (ARM). Eleven hospitals utilize ARM, which was designed to assist these hospitals in caring for severely chronically ill individuals - many with substance abuse problems - who often require acute inpatient care. This small cut (\$3.8 million) may make it impossible for these hospitals to continue to serve these individuals, who, without this option for care, may end up on the street, in jail, or worse. We urge the Legislature and Executive to restore this small amount to the budget so that these individuals will continue to receive the care they need.

Actions Needed:

- **Overturn 5% rate reduction for inpatient psychiatric services in Article 28 Hospital Medicaid (\$46 million)**
- **Reject proposal to eliminate Article 28 Hospital Alternative Reimbursement Methodology**

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Lower East Side Service Center	Safe Space
Lutheran Medical Center-MH Clinic	Samuel Field YM-YWHA CAPE
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Metropolitan Center for Mental Health	SI Behavioral Network
Montefiore Medical Center	Sky Light Center
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Project Renewal	Urban Pathways
PSCH	Venture House
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*Signifies Associate Member

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