



Testimony of

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Before

The Charity Care Task Force of the Department of Health  
Hon. Richard Gottfried, Chair Assembly Health Committee and  
Hon. Kemp Hannon, Chair Senate Health Committee

On Indigent Care for Outpatient Community Based  
Behavioral Health Care

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The Coalition of Behavioral Health Agencies, Inc. seeks to testify at this hearing, despite the seemingly narrow charge to the Indigent Care Technical Advisory Committee (TAC): *to assist in an evaluation of the Hospital Indigent Care Pool, including the methodology by which Pool funds are distributed; the type (clinic, emergency or inpatient care) and volume of services provided; the costs incurred by hospitals in relation to receipt of Hospital Indigent Care Pool distributions; and, the relationship between Indigent Care Pool monies and hospital obligations under the newly enacted Hospital Patient Financial Aid Law.*

The Coalition is the umbrella advocacy group and trade organization of New York's behavioral health community, representing over 100 non-profit community-based mental health and substance abuse providers. Our members constitute a broad cross section of outpatient service delivery agencies in New York City – of every size and service modality – serving more than 350,000 adults and children in the five boroughs of New York City and its environs.

The Coalition is pleased to offer testimony at this hearing, sponsored by the Department of Health, the Indigent Care Technical Advisory Committee and Assembly Member Richard Gottfried and Senator Kemp Hannon, Chairmen, respectively of the Assembly's and Senate's Health Committee.

Our understanding is that Charity Care/Indigent Care Pools were set up in New York State in 1983 to assist hospitals that provided uncompensated care to

health-needy, primarily uninsured and often poor, individuals. *The Health Care Reform Act (HCRA) provides for \$847 million to fund the Hospital Indigent Care. These funds are considered Medicaid Disproportionate Share Payments for hospitals and as such are eligible for federal matching funds. (There is a separate \$60 million Pool to cover indigent care at comprehensive diagnostic and treatment centers.)* **Despite the urgent parallel need, access to this pool of funds was never extended to Article 31 outpatient mental health clinics nor to Article 822 outpatient chemical addiction clinics.**

Coverage for mental health is much more constrained than for physical healthcare. There is general agreement that around 2.5 million New Yorkers, or 13% of New York State's overall population of 20 million, lack health insurance coverage. The Coalition is gratified that these hearings are focusing on how these tragic circumstances can be rectified. Nevertheless, the physical health-only focus of this hearing ignores the millions more who have health insurance for general medical services, yet lack coverage for behavioral health services.

Among the 87% of New Yorkers who have coverage, Medicare covers only \$1,750 of outpatient services and that is only after imposing a deductible and the equivalent of a 50% co-payment. In spite of Timothy's Law, not only do self-insured ERISA plans cover less than full mental health treatment, but Family Health Plus and Child Health Plus cover only 20 outpatient mental health visits and 30 inpatient days. Healthy New York has no mental health or substance

abuse benefit at all. So—while only 13% are uninsured overall, probably one third of New Yorkers lack any coverage for case management, mental health day programs or more than just incidental outpatient mental health services. The failure to cover individuals for this least expensive service results in symptom exacerbation and unnecessary, more costly inpatient care.

In the early '90s arrangements were made to cover some uncompensated mental health care for Article 31 community based clinics through various Medicaid maximization supplements such as Comprehensive Outpatient Services (COPS). However, these supplements were never really “comprehensive.” They were unavailable to many clinics (for historic reasons), unevenly applied across eligible clinics and capped without regard to the demand for services. Moreover, the locus of clinical treatment for tens of thousands of mental health patients moved into community based clinics, including children, who were seriously emotionally disturbed; adults on Assisted Outpatient Commitment; those with co-morbid substance addictions; parolees etc. The State’s failure to establish an uncompensated care pool for the Article 31 community based clinics has left this sector financially stretched and unable to respond to the shifting service demands in communities. Many poor, Medicaid ineligible, uninsured and underinsured individuals continue to go without care or appropriate levels of care.

Moreover, the federal government is now changing audit standards and more stringently defining Medicaid funding rules to Medicaid eligible persons and services, rigorously applying the standard of “medical necessity.” As a result, the State’s reliance on the Medicaid supplement to mental health outpatient programs through the frozen COPS mechanism of the 90’s—which provided some, although inadequate mental health care to indigent individuals—is in danger of being dismantled. Therefore, an existing, albeit somewhat irrational system of care, for some indigent individuals will disappear and such care will be left to further deplete limited charitable sources or will not be provided except in most dire circumstances. As a consequence, over the past three years, many mental health clinics around the State are closing their doors or reducing their capacity to their respective communities.

Governor Spitzer has made clear his goal and intention to insure every New Yorker. New York State’s new Timothy’s Law has created parity for mental health conditions and services for the uninsured, and the U.S. House of Representatives and the Senate have included chemical addictions in their versions of parity legislation. Clearly, many elected officials understand the need for these services among all people, rich or poor. The Coalition supports these public policy directions and seeks a rational system of funding behavioral health care for the Medicaid ineligible, the underinsured, the inadequately reimbursed managed care client and all those who lack the means to pay for needed care.

However difficult the Charity/Indigent Care Pool has been, both to administer and apply in an apolitical manner, it is a sound concept for financing indigent/uncompensated care and The Coalition would like to see a similar system applied to outpatient community based behavioral health care systems. Doing so will require an expenditure of State funds and may or may not bring about a Federal match. But it is undeniable that provision of these services in a timely way, will reduce the toll on families that results from untreated behavioral health conditions and offset costs for the State by reducing the inappropriate use and the runaway costs for emergency rooms, inpatient admissions, jail beds and homeless shelters. Everyone benefits when individuals have access to needed behavioral health services.

Admittedly, a system of accountability for the use of such funds would be required. The Coalition has proposed a rate methodology reform for Article 31 mental health clinics that includes a method of accountability for service provision to high-need and high-user clinic consumers. With proper data, available to providers as well as consumers, accountability could be built into a system of charity/indigent care for outpatient behavioral health care. Clear State rules for reporting free or below cost care and a means for ensuring the reliability of the data will help make such a system work.

In summary, it is time for charity/indigent care pools to be set up to tend to the outpatient behavioral needs of New York State residents who need care,

regardless of ability to pay. It is recognized that such care will save the State money in the long run. The pools must be adequate to the need and access to them must be fair, rational and subject to a system of accountability. A thoughtful approach to covering uncompensated behavioral health care can save lives, families, communities—as well as save unnecessary public expenditures.