



Testimony of

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Before the
New York State Office of Mental Health

On the 2007 Update and Interim Report to the
2006-2010 Five-Year Comprehensive Plan
for Mental Health Services

July 30, 2007

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BACKGROUND

Good afternoon. My name is Michael Polenberg, and I am the Director of Policy and Advocacy for The Coalition of Behavioral Health Agencies. 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 would like to thank Commissioner Michael Hogan and his staff at the New York State Office of Mental Health for initiating formal briefings and hearings across the State concerning the implementation of key components included in the 2006-2010 5.07 Plan. We see this venue as allowing for respectful interchange between OMH and other stakeholders about how the Plan is developed and implemented and seeking suggestions for making the document a real guidepost for the future.

We hope that this interchange, together with dogged advocacy efforts from stakeholders across the State, will help inform OMH about the need to direct significant amount of new resources to strengthen and expand services for New Yorkers with psychiatric disabilities. Indeed, over the last several years, we have seen remarkable investments: from a much welcomed three-year CPI-indexed COLA for virtually all

mental health programs, to historic increases in the number of new mental health housing units, to the strengthening of clinics that treat vulnerable adults and children, to the largest single-year appropriation in State history for children's mental health -- the sector has received much needed (and long overdue) funding increases to help stabilize dozens of program models while expanding access to care to thousands of previously underserved populations.

But while public input at these forums allow for a wide range of creative suggestions and ideas, the planning process itself has historically been one-sided. Only after a plan has been developed has public input been sought. Recently, though we've seen encouraging signs that stakeholders will be more heavily involved in the planning process. We applaud Commissioner Hogan and his colleagues at OASAS, led by Commissioner Karen Carpenter-Palumbo, for convening a statewide taskforce to look for ways to provide more integrated and recovery-driven care to New Yorkers with co-occurring addictive and psychiatric disorders. Similarly, we are encouraged by our collaborative efforts over the past month with senior officials at OMH, the Division of Budget and the Department of Health to re-examine and ultimately reform the archaic rate reimbursement structure for Article 31 clinics. We urge OMH to continue reaching out to key stakeholders in order to facilitate a system of care that provides the best care to the most people.

We would add, however, that planning can only be as effective as the data that that supports it. We have asked repeatedly for OMH to share pertinent data with us to

help our providers steer their resources towards the most service-needy consumers across multiple systems. We ask you once again to consider our appeal.

In keeping with Commissioner Hogan's request, we will direct our comments today to the following three areas: mental health services for children and families; the current state of State-funded mental health housing and the need for model reform; and the coordination of care between OMH and other State agencies in order to provide the most effective care to New Yorkers with multiple disabling conditions. But we would be remiss if we failed at least to mention the high service needs of geriatric consumers as well as consumers with multiple co-morbid conditions.

We also would like to comment briefly on Commissioner Hogan's observation about the decreased "flexibility" of the State planning process given the increased role that Medicaid plays in virtually all mental health programming. OMH's charge -- to offer services that are "consumer and family centered and consumer and family driven" -- is being tested in a funding and regulatory environment which has gradually become Medicaid-centered and Medicaid-driven. We appreciate the Commissioner's recognition of this challenge, and we look forward to working with him and his staff to identify a regular and predictable source of funding for non-Medicaid billable activities.

MENTAL HEALTH SERVICES FOR CHILDREN AND FAMILIES

Children's Mental Health Act of 2006

The Coalition supports the Children's Mental Health Act of 2006, and firmly believes that it is an important step towards providing comprehensive, coordinated mental health prevention, early intervention and treatment services for children through age 18. However, we are concerned that there is no dedicated funding stream to support the services proposed in the bill. Furthermore, the law will impose additional requirements to the Department of Education, which is already an overburdened system. Such funding is particularly critical if the State hopes to incorporate social and emotional development standards into elementary and secondary school educational standards and programs. Special consideration should also be paid to the mental health services that are currently offered by the Department of Education. Furthermore, we urge that local governments be brought into the planning process around the measure's implementation.

Child and Family Clinic Plus

While we vigorously applaud OMH for appropriating \$62 million in annualized funding for the "Achieving the Promise" initiative, the Coalition does have some concerns about the mechanics of Child and Family Clinic Plus. For example, we believe that the projected annual revenues based on the clinic plus calculator will not cover the cost of implementing the program (e.g. outreach, education, travel time, coordination with schools, training, screening, assessment and treatment.) In addition, the projected annual revenue gives credence to the idea that the budget cannot support the salary of a screener with the currently required qualifications. Furthermore, the Coalition is

concerned that Medicaid managed care companies and other third party insurance companies will not financially support the enhancements that this program proposes (e.g. home visits). We ask that OMH reconsider the minimum qualifications for a screener and provide supplemental funds for services that insurance companies will not pay for.

HOUSING PRIORITIES

The Coalition welcomed the “guiding principles” for reforming State-funded mental health housing issued in May by Senior Deputy Commissioner Robert Myers. As we noted in our response to OMH later that month, we stand ready to re-examine all of the current licensed and unlicensed OMH-funded models – most of which are more than twenty years old – to determine what aspects from these models most effectively promote recovery and community integration, and which aspects should be reconsidered or eliminated altogether.

Fundamentally, The Coalition believes that a major challenge facing the State is how to allow housing providers to deliver the right staff and the right level of specialized mental health care and case management to consumers where and when they need it. In essence, this means that the service dollars should follow the consumer, and not be so rigidly tied to the unit of housing in which they live. Instead, housing providers are unduly constrained by archaic regulatory barriers that dictate staffing levels, the number of face-to-face meetings, and so on. These regulations can actually inhibit the delivery of a recovery-based system of care.

The Coalition is currently finalizing the details of our recommendation for how to reform the way housing is funded and structured, which we will share with you shortly.

COORDINATION OF CARE

As we mentioned earlier, The Coalition is very pleased that OMH and the State Office of Alcoholism & Substance Abuse Services (OASAS) are collaborating on how best to deliver services to New Yorkers with co-occurring psychiatric and addictive disorders. We agree with the philosophy of “no wrong door” for persons in need of treatment for co-occurring disorders, and in fact have been offering comprehensive training to providers on the evidence-based practice Integrated Dual Disorder Treatment (IDDT) to hundreds of staff members of mental health and substance agencies over the past two years.

This practice, however, is predicated on the ability to offer treatment for co-occurring disorders in one setting without fear of Medicaid audit reprisals. Currently, licensed mental health providers must treat co-occurring addictive disorders secondarily to the “primary diagnosis” of a mental health disorder; the reverse holds true for licensed substance abuse providers. Failure to closely abide by strict licensing requirements that require this somewhat arbitrary distinction can lead to significant audit reprisals and financial take-backs. The provision of truly integrated care is thus disincentivized for providers, which is why we applaud the new initiative by OMH and OASAS to collectively examine the existing barriers to care.

THE ROLE OF MEDICAID

Over the past eleven years, New York State has sought to shift the cost of mental health services to the Federal government by “Medicaid-ing” a range of programs that heretofore were funded by State dollars, such as ACT, case management and others. Conceived as a strategy for preserving gross program dollars while saving State expenditures, the result has been the loss of flexibility and control over how these programs operate and who they can serve. With every Medicaid conversion, the State cedes some degree of program design and population eligibility to Washington. Furthermore, even as the State has converted mental health programs to Medicaid, we are told by State and Federal officials that Medicaid expenditures must be cut, and cut severely.

We are gratified, then, when we hear Commissioner Hogan acknowledge that certain mental health programs will require the infusion of State dollars. We hope that we can participate in the planning process to develop a new funding stream of State dollars for the sector now that the expected proceeds from the closure of psychiatric beds are running dry. Once again, we urge next year’s planners to include specific proposals and methodologies for preserving Medicaid funding from those who would look to erode it, and to develop a new funding stream of State dollars to succeed reinvestment.

SUMMARY

The 2007 Update and Interim Report for the 2006-2010 Five-Year Comprehensive Plan for Mental Health Services is an impressive document. We appreciate the efforts that OMH undertook in researching who is currently being helped, what they are being treated for, and where they are receiving services. We acknowledge the willingness of OMH to reach out to a diverse group of stakeholders to help inform the agency on how to better address the needs of mental health consumers throughout the State. And we hope that forthcoming plans will incorporate the recommendations outlined in this testimony. Thank you very much.