



Testimony of

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At the Hearing on
Oversight - Mental Health Clinic Reimbursement Restructuring

The Committee on Mental Health, Mental Retardation,
Alcoholism, Drug Abuse and Disability Services
Hon. G. Oliver Koppell, Chair

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INTRODUCTION

Chairman Koppell and distinguished members of the Committee, thank you for convening this hearing and affording us the opportunity to testify before you today on the Mental Health Clinic Restructuring project. By holding this public inquiry, you are affirming the critical importance of its outcome on the residents of local communities and neighborhoods in our City as well as those local community based agencies that provide mental health services to them.

My name is Phillip A. Saperia. I am the Executive Director of The Coalition of Behavioral Health Agencies, the umbrella advocacy organization of New York's behavioral health community, representing over 120 non-profit community-based mental health and substance abuse agencies in metropolitan New York City. I am joined at this table by Patricia Gallo Goldstein, The Coalition's Deputy Executive Director, who is coordinating our participation in the extensive process surrounding this clinic reform project. Our members constitute a broad cross section of service providers – single purpose and multiservice; all sizes from very small to very large; treatment and rehabilitation-oriented; outpatient and residential; focused on linguistically and culturally specific populations and on many special-needs and high needs individuals and groups – serving more than 350,000 individuals each day in every neighborhood of the five boroughs of New York City and in neighboring counties.

CLINIC REFORM—Description of the Problem

Publicly funded mental health clinics serve hundreds of thousands of children and adults in New York City, and are an essential component of local mental health treatment. Clinics are the first intervention in the lives of people with mental illness and emotional disturbance. They are the only accessible treatment source for poor and moderate income city residents, ranging from people who are homeless, to people with Medicaid and/or Medicare, to the working poor with inadequate or no health insurance. They serve special populations, including people with multiple disabilities and intensive needs (e.g. court mandated clients; individuals discharged from prisons and inpatient hospitalizations; and consumers with co-occurring behavioral, substance abuse and/or health disorders). They serve ordinary New Yorkers with situational disorders that result from trauma, a high stress life event or a major loss, such as the death of a loved one, family breakups or being laid off from a job and the consequential potential loss of home and security. Their clients include children and families, immigrants, non-English speakers, the aged and homebound. The clinics operated by our member not-for-profit organizations have been integrating evidence-based practices into their programs, and providing ever stronger

community outreach, and treatment follow-up to insure that they reach and effectively engage the people who need and can benefit from their services.

Rate reform is essential to maintain the viability of New York City's clinic treatment system. Gross under-reimbursement has precipitated a crisis, because the gap between payments and actual costs has reached an unsustainable level. To avoid closing, clinic operators have made drastic changes that can seriously affect the numbers of clients and communities they serve. Due to the structural financial deficits resulting from inadequate Medicaid rates, growing numbers of uninsured/underinsured patients, and hugely substandard commercial and managed care insurance rates, member agencies have been forced to 1) Close Clinics: In a 5-year period, Coalition's member agencies closed more than a dozen clinics, close to 10% of the total number in NYC, affecting several thousand consumers. 2) Reduce access for people without Medicaid and Medicare: Reduced access is coming at a time when our members report growing caseloads of New Yorkers suffering from anxiety and depressive disorders resulting from job loss, family pressures and related stress in the moribund economy. In order to stay fiscally viable, clinics are turning away people with insurance that pays only 40-50% of the actual treatment cost, or people who have no means of paying for care.

The Coalition met with the new Commissioner of Mental Health, Dr. Michael Hogan, very early in his tenure in 2007, to discuss the problems we have just described and to present him with a study that we had commissioned, showing gross disparities between cost and reimbursement. It is gratifying that the Commissioner grasped the impact of what we were describing and in the summer of 2007, directed SOMH to undertake a process that has deeply engaged many providers, stakeholders and consumers to broadly restructure the way the State delivers and reimburses publicly supported clinic-based mental health treatment services.

This clinic reform project is entering a critical final phase as the State plans to phase-in a new methodology for determining Medicaid clinic rates, while simultaneously phasing out current base rate payments and rate add-ons like Comprehensive Outpatient Program Services (COPS) on January 1, 2010. However, at this very late point in the deliberations, there remains significant uncertainty on fundamental issues—many as-yet unannounced choices that could compromise the program if not resolved in time. While the new system is scheduled to go live in almost 6 months, maximum lead time is essential for these changes to be implemented in a planned way, rather than trying to untangle resultant service problems when the roll-out is taking place. Then it will be too late to address and remedy negative consequences on consumers, families and service providers.

RATE ISSUES

As we race to the implementation of the new model the State Office of Mental Health still has not made available all of the financial information needed for providers to determine their fiscal viability in the new system. The community is still waiting for updated rate information. How does one budget projected revenue without knowing the rates? We have repeatedly asked OMH to develop a “costing model.” Coalition agencies have been forced to plan their budgets for next fiscal year without the benefit of full financial information from the State. We also have major concerns with inadequate clinic reimbursement rates paid by public and private health insurance programs.

State Health Insurance Programs

We are appreciative that OMH has recognized the need to increase the Medicaid fee-for-service rate. However, despite strenuous efforts on their part, OMH has not been able to secure rate equivalence for Medicaid Managed Care, Family Health Plus and Child Health Plus programs—significant payers in the community based clinics. On average, Medicaid Managed Care pays 33% to 50% of the actual cost of treatment, while Family and Child Health Plus also similarly and significantly underpay. Provider agencies will be further compromised as the State plans to enroll ever increasing numbers of individuals into Medicaid managed care, Child Health Plus and Family Health Plus at lower payment rates than fee-for-service reimbursement. These rate issues must be resolved before proceeding with clinic reform implementation or the consequences will be dire for the people you represent and whom our providers serve.

Commercial Insurance Programs

Parity for commercial insurance rates has never been a part of the clinic restructuring plan even though insurance companies also pay a mere 33% - 50% of the current Medicaid fee-for-service rate. Low reimbursement from commercial insurance companies has already forced agencies to discontinue treatment services for people enrolled in commercial insurance plans. In New York City, mental health clinics are often the only accessible source of treatment for residents with moderate to low incomes. Moreover, they offer the gold standard of clinic care because of their professional consultation capacities, quality assurance mechanisms, specialty supervision and the ability to offer continuity of care since they mostly employ full time professional staff, who get to know, assist and accompany clients on their trajectory of recovery. Most ironically, during a time in which parity laws are finally being passed by Federal and State governments (Timothy’s Law in New York), access to treatment services is becoming restricted. Parity is a myth if services are not available in quality and quantity required by the demand.

In many working and middle class neighborhoods of New York City, without far-sighted reform, mental health treatment by our experienced clinics will become limited or unavailable for people suffering from conditions that can arise from trauma, high stress life events or major losses, including death of a loved one or job and home loss. The State must address the inadequate rate payments of private insurers or many New York City working and middle class residents will go without care. The resulting physical and emotional disengagement of working and middle class people from the public mental health system will make it harder to keep taxpayer support flowing to it, especially when hard times intensify the competing demands for funds. Where will one go for affordable treatment? In many neighborhoods, the supply of private practitioners is insufficient to provide mental health treatment to this cohort, and in some neighborhoods of the City, private practitioners are almost non-existent. We must also point out that existing private practitioners are limited or barred by their circumstances of solo or small group practices from providing services to very high needs clients who present a potential danger or set of problems that require a more extensive service system to address.

Last, but certainly not least of the payment issues, is the projected inadequacy of rates to meaningfully serve the geriatric populations and other high needs consumers, all of whom require greater intensities of care and service. OMH and DOH have yet to present remedies to these problems and the potential loss of care to these populations is very critical and potentially devastating.

BILLING ISSUES

30 vs. 45 Minute Rate Structure

The current plan intends to reimburse clinics for services provided based on 45 minute billing rates, even though Federal Medicaid standards permit clinics to bill for the full rate at 30 minutes or 45 minutes. While community-based mental health clinics have historically been able to bill a 30 minute visit at the full rate, the current plan is to reimburse those visits at 67% of the full rate. That will harm even further the precarious bottom line of clinics and will limit the capacity of clinics to meet the high demand for service in many of our communities. Moreover, certain populations such as young children, older adults and medically fragile people cannot sustain an intensive 45 minute session. Certain treatment modalities, such as play therapy require specialized training and expertise. Within the workforce there is a scarcity of clinicians who have this experience. A reduced rate for 30 minute sessions disincentivizes specialty treatment and has the consequence of barring treatment to many who need it. In neighborhoods of high need, 45 minute sessions will result in longer waiting lists for consumers and lowered revenue for providers, further increasing the risk of clinic cutbacks and closings.

We urge OMH to follow Medicaid regulations that permit full payment for 30 minute clinic visits.

Billing Structure and Technological Upgrades

Billing code structures will change in order to bring New York State into compliance with HIPAA regulations (Federal privacy and confidentiality requirements). The implementation of a new system using procedure codes (called CPT codes) will require modified billing software and extensive staff training; still further unfunded mandates for providers to meet. In addition, the New York State Department of Health (DOH) is in the process of replacing the current “threshold visit” methodology with Ambulatory Patient Groups (APG). APGs will allow providers to report every service delivered, and the new methodology will automatically group them into discounted categories. This system has never been used before in the behavioral health sector, and is currently being “retooled” to fit it. The implementation of APGs will also require agencies to purchase new software and train staff, costs which will not be reimbursed by the State, yet more unfunded mandates.

We are concerned about the potential glitches that will inevitably result from learning and using new systems in the next 6 months. In order to avoid potential disaster scenarios, The State needs to plan for protection of the financial flow during the implementation period, and help programs focus on sound budgeting and planning.

SUMMARY CONCLUSIONS

The Coalition is greatly concerned that the clinic reform effort, as currently evolving, could:

- 1) Deprive many neighborhoods of services for needy residents of our City;
- 2) Require new models of professional staffing that will result in the wholesale loss of full time jobs in clinics that provide health care and other employment benefits; many local community residents, City Council community constituents, are employed by our member agencies who will feel this dislocation; agencies that are unionized will either go out of business or try to negotiate a way out of unionized workforce. Workforce issues around clinic reform are dramatic and, as yet, unaddressed;
- 3) Limit access to community clinic services to working and middle class City Council constituents as well as to high needs consumers living in many Council districts;
- 4) Render meaningless both Timothy’s Law and federal parity laws;
- 5) Force clinics to close and deprive services to the fragile elderly, children with serious emotional disturbances and their families and needy adults in every community.

We thank you for your time today and for elevating this crucial policy matter to a public hearing. It is obvious that we seek the engagement of all our elected officials in both the substantive and political processes around clinic reform. We are available to answer any questions you may have.