



Testimony of

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At the Public Hearing on the  
2007 NYC Local Government Plan  
for Mental Health Services

New York City Department of Health and Mental Hygiene  
Division of Mental Hygiene

Lloyd Sederer, M.D., Executive Deputy Commissioner

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## **INTRODUCTION**

Thank you for the opportunity to testify before you today on the 2007 NYC Local Government Plan for Mental Health Services. My name is Phillip Saperia, and I am the Executive Director of the Coalition of Voluntary Mental Health Agencies, the trade association and umbrella advocacy organization of New York's mental health community, representing over 115 non-profit community-based mental health agencies in New York City and surrounding areas. Our members constitute a broad cross section of service providers – 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 – serving more than 350,000 individuals in the five boroughs of New York City and its environs.

Before testifying today, we would like to commend the Division of Mental Hygiene for seeking input from stakeholders prior to issuing the local mental hygiene plan for the City of New York. This strikes us as a far more reflective process than the State's practice of issuing a Plan and then asking for feedback from the mental health community. It is our hope that your office will incorporate our suggestions, and those of our colleagues here today, into the forthcoming Plan so that it may accurately capture the current fiscal and programmatic needs of the City's community mental health sector. However, we are concerned that the current mechanism for soliciting feedback on the planning process does not allow the Division to capture valuable input from a much larger universe of providers. We recommend a re-examination of the planning process used in the past which ensured that at a minimum all contracted agencies were invited

to participate in this process. The Division might consider using the newly restructured Federation to expand the planning process for mental health services.

***Question 1: What unmet needs and/or obstacles – by service type, specific population or geographic area – exist?***

We have identified a number of key areas within the sector where we think DMH ought to direct its attention in the year ahead.

- **Cost of Living Adjustment.** Providers who contract with the Division of Mental Hygiene are, in effect, doing the work of government. They offer a wide range of housing and services for consumers from a variety of backgrounds, in neighborhoods in every corner of the city. But many of these programs receive the same reimbursement dollars today that they did five, ten, or even fifteen years ago. As a result, providers have no mechanism to account for inflationary increases such as fuel and energy, rent and salaries. The Governor's Executive Budget for SFY 2006-2007 includes a 2.5% increase for each of the next three years for virtually all non-trended mental health programs. In proposing a multi-year COLA, the Governor's office acknowledged that inflation erodes program dollars and therefore the scope and depth of services, and that yearly adjustments are necessary in order to maintain the quality and reach of those programs. We ask the City to add a mental hygiene COLA to the Mayor's Fiscal 2007 Executive Budget proposal that will, at the very least, match the increase proposed by the Governor.
- **Adolescents.** Adolescents have historically been underserved by the public mental health system. From a shortage in culturally competent, trained mental health professionals and adolescent-specialist psychiatrists, to an under-funded school-

based mental health program, to a disproportionately high number of uninsured adolescents, there are numerous obstacles that adolescents and their families face when trying to obtain treatment. The Governor's \$62 million proposal to strengthen and expand the delivery of children's mental health will go a long way to evolving a more coordinated system of care. However, local government has a crucial role in developing strategies and funding services on a local level that will help treat adolescents with mental health issues before the symptoms become more acute and they are expressed in socially pathological and hurtful ways. Adequate assessment and strategic interventions will help adolescents avoid most costly and personally debilitating settings as they get older.

- **Seniors.** Geriatric mental health is emerging as a major area of concentration for the community mental health sector, just in time for the surge in older populations as baby boomers enter their senior years. Our members report that the need for geriatric mental health services is far greater than that for which they are currently funded. Many of our members who currently serve senior consumers with mental health needs incur high collateral costs (for which no reimbursement is available) in order to provide these services, particularly to those who are homebound. The City Council recognized this trend and voted last June to fund a \$1.1 million geriatric mental health initiative. We are asking the Council to restore and enhance this funding in the fiscal year ahead, and we ask that the Division consider expanding its own portfolio and resources in this emerging area to more adequately respond to the unique needs of programs, particularly Article 31 clinics and continuing day treatment, that serve seniors with mental illnesses. In addition, we urge the Division

to include geriatric mental health into the portfolio of a senior level official, to whom providers will be able to direct geriatric-specific programmatic and fiscal questions.

- **Integrated Treatment.** Coalition members report a sharp increase in the number of clients they serve who suffer from co-occurring mental health and chemical dependency disorders. Unfortunately, many of these clients are directed to one program for their mental health diagnosis, and another program for their alcohol or drug addiction. This fragmented service delivery system often results in poor outcomes for clients, which in turn contributes to higher costs associated with hospitalization, emergency room use and detoxification. The Division should consider moving towards an Integrated Dual Disorder Treatment (IDDT) model to more effectively and holistically treat adults and adolescents with co-occurring disorders.
- **Housing.** Congratulations are due to the Mayor and his Commissioners for the new agreement struck with the State to fund and produce 9,000 units of supportive housing over the next ten years. The Coalition supports this Administration's emphasis on the provision of housing to poor and disabled populations.

The City's proposal to back-fill vacancies in New York/New York I & II beds with the "chronically homeless" is well-intentioned; housing should be prioritized for those most in need. We have serious concern about the absolute requirement to place chronically homeless clients in scatter-site apartments, particularly in places where providers have entered into commitments to landlords and communities about the level of services that will be provided for unstable and mentally ill clients with a variety of co-morbid conditions. Supported housing is service poor. If the City

intends to place difficult and needy consumers in scattered site housing, services for those clients will necessarily have to be significantly enriched. Housing providers require an enhanced rate to more adequately respond to the needs of a population that is proportionately more likely to include individuals who are actively abusing substances, not complying with medication regimens, and unable to maintain public benefits, including Medicaid. We ask the Division to work with its partners at DHS and HRA to ensure that providers receive the funding they need to adequately serve and work with the consumers they are being asked to prioritize.

- **Medicare Part D.** The new Medicare Part D prescription drug program often stands as a barrier between the clients served by our sector and their life saving medications. Resolving problems with Part D is crucial to ensuring an uninterrupted therapeutic regimen, but all too often, clients are unable to navigate the complexities of the program. The Department must continue to make access to medications a priority in the year ahead, as more and more New Yorkers encounter difficulty in the transition to Medicare Part D. As the transition to Part D continues to present hurdles to consumers, the Division should continue to invest resources to help educate and inform the mental health community.
- **Psychiatric rehabilitation.** The community mental health sector helps recipients attain life goals, realize dreams and to become connected to community in a way that is personally meaningful and rewarding. As we learn more about recovery from consumers – recovery as both a process and an outcome – we recognize that providers need ongoing assistance; to continue to advance competencies, and to continue to deliver services that are recovery-facilitating and rehabilitative in nature.

Agency staff require state-of-the-art training, and organizations need “tried and true” consultation to ensure that agencies’ missions, policies, procedures, goals and staff are aligned to be the most effective in helping recipients receive the assistance they need and desire during their struggles with mental illness. Staff training and organizational change takes resources. To ensure that New York City remains a leader in responsive and effective service provision, DOHMH contract agencies should be offered incentives to reduce the “costs” associated with incorporating new approaches, taking on innovation and participating in systems transformation.

***Question 2: What aspects of the service system are working well, and should be expanded?***

Over the past several years, the Division has been diligent in analyzing the proposal to incorporate the new PROS license in order to produce favorable outcomes for New York City’s mental health consumers and the providers who serve them. The Division, most notably Assistant Commissioner Jane Plapinger and her staff, have proceeded in a measured and considered way at every turn. They have repeatedly sought broad input from across the sector to better understand how the conversion to a Medicaid billing structure for rehabilitative services will affect stakeholders and services. We are grateful for the Division’s inclusive planning and thoughtfulness during these past several years, and look forward to our continued collaboration in the months ahead as PROS begins to take shape here in New York City.

We also want to acknowledge that in response to widespread contract-related problems, Executive Deputy Commissioner Sederer just recently reorganized the Division’s contracting office. We will address our many concerns with the contracting

process in the next section, but we do want to recognize Dr. Sederer for making this core function of the Division his personal priority in the year ahead. The Coalition will continue to participate in monthly contract-related stakeholder meetings convened by the Division and other vehicles designed to streamline and improve the contracting process.

***Question 3: What changes would improve the system?***

In four words: Fix The Contracting Process. It is unfortunate that many of the problems that providers are encountering – from getting a contract registered to receiving payment for the work rendered – were all too predictable when the merger between the former DMH and DOH was approved by voters in the fall of 2001. The Coalition argued strenuously that the newly formed Division of Mental Hygiene should retain its own Agency Chief Contracting Officer (ACCO) who would answer directly to the Executive Deputy Commissioner, given the large number of contracts entered into by the Division each year. Instead, there is just one ACCO for the entire Department of Health & Mental Hygiene, who answers directly to the Commissioner.

Certain problems are pervasive and persistent. There are major delays in the successful completion of contracts and the steady flow of funds that are needed by our agencies to meet regular payrolls, pay bills and satisfy other financial obligations as they continue to deliver services to New Yorkers in need. Some of our agencies report that they're owed hundreds of thousands of dollars from the Division for the work that they've performed over the last several years.

The Coalition is currently in discussion with the Commissioner, and will be meeting with him and his senior staff in the months ahead to determine how best to

resolve this serious problem. The Coalition will also ask the Council to restore a proposed cut of \$354,000 to the Division's contracting office, a cut which will likely further hinder an already problematic contracting process.

Finally, a very important fiscal matter concerns the Division's plan to revisit their proposed cap on administrative overhead. Doing the work of government is very expensive. The mental health sector spends an enormous amount of time on reports and audits, quality assurance and performance monitoring. Agencies are forced to allocate resources on technology in order to more effectively track information, bill Medicaid and issue reports for funders. Health and property insurance rates rise dramatically each year. None of these costs are picked up by government. The Division's proposal to cap administrative overhead costs would severely impact the provider community, and we urge a more thoughtful review before new restrictions are adopted. We propose allowing providers a "floating" cap of at least 14%

Thank you again for reaching out to stakeholders before issuing the local mental health plan and I'm available to answer any questions you may have.