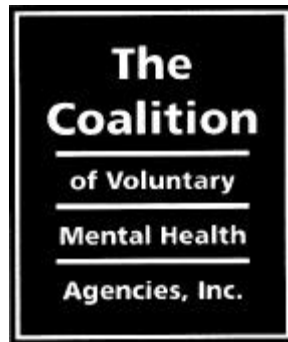


Testimony of Joshua Rubin on behalf of



and



For the Joint  
Senate Finance Committee and  
Assembly Ways and Means Committee  
on the Proposed Fiscal Year 2001

New York State Budget

February 7, 2000

Chairman Stafford, Chairman Farrell, distinguished Committee members, good afternoon and thank you for this opportunity to speak with you. My name is Joshua Rubin and I am testifying today on behalf of The Coalition of Voluntary Mental Health Agencies, Inc. and the New York State Council for Community Behavioral Healthcare. The Coalition is New York City's advocacy organization representing a network of over 100 nonprofit community based providers of mental health services. The New York State Council represents a network of over 50 community-based agencies from all across New York State. We operate outpatient clinics, inpatient acute care, continuing day treatment and partial hospitalization programs, intensive case management, children's mental health programs, psychiatric rehabilitation, psycho-social services, clubhouses, outreach programs, alcoholism and substance abuse treatment programs, special programs for people with co-occurring psychiatric and addictive disorders and much more. Together, our member agencies serve more than half a million clients and deliver the entire continuum of mental health care from Buffalo to Montauk, Staten Island to Woods Falls.

I would like to begin today by commending the Governor's budget proposal. We welcome his recognition of the disrepair of the community-based mental health system. The plan he has crafted provides an opportunity to begin to address the crisis in community mental health care. As welcome as the infusion of funding to the system is, we must note that it does not completely make up for the years of neglect from which the mental health system and the people we serve have suffered.

### **Trended Adjustments**

First and foremost among the missing elements in the Governor's proposal is the lack of any funding to repair the badly damaged mental health infrastructure that already exists. Mental health rates, grants and fees are the only healthcare rates in the State that do not keep pace with inflation. Absent a trending mechanism, mental health reimbursements are effectively cut every year as providers are asked to furnish the

same services with fewer real dollars.

It has reached the point where many providers **lose** money on every unit of service they provide. This situation is obviously untenable and a number of providers in this past year, after pinching every penny they could, using up their cash reserves and exhausting their lines of credit have been forced to either close their doors or offer themselves up for acquisition.

When you passed the Health Care Reform Act in December you tied increases for hospital, home health care and residential health care facilities rates to the Consumer Price Index (CPI). For those providers that connection to the CPI represented a **decrease**. Previously they had been averaging 3.4 percent per year during the 1990's. Mental health rates, on the other hand, increased less than 4 percent **in total** over the last decade. The CPI increased over 29 percent during that time period, leaving mental health providers millions of real dollars in the hole.

For this year we are requesting a modest 3.9% adjustment to match the CPI increase since the last mental health rate adjustment in 1997. More importantly though, what the community mental health system needs to ensure its well-being into the future is a **permanent** solution to this problem. Mental health rate, grant and fee increases should be tied to the CPI. Almost every other health care reimbursement in the State is, so mental health rates should be as well.

The lack of inflation pacing adjustments results in countless problems for voluntary agencies. Foremost among these is that staff placement and retention is more difficult than ever before. Not only can voluntary providers no longer compete with State jobs that pay an average of \$10,000 per year more, but increasingly compete for staff with fast-food restaurants that offer higher salaries. Staff morale is low, and declining fast. Turnover rates have surpassed 27% in many agencies, and many vacancies go unfilled

for months because the salaries offered are so uncompetitive.

More important is the negative impact this lack of adjustments has on the quality of care New Yorkers with mental illness receive. Every time a direct care worker leaves, the continuity of care for his or her clients is disrupted. The relationship they had built, an essential component of the recovery process, is destroyed. Add to this the difficulty of replacing them with qualified staff; the cost of want ads, the time spent interviewing replacements, the interruption of the routine for staff and clients. The quality of care suffers. Clients suffer.

In 1997 you heard our pleas and passed, over a Gubernatorial veto, a 2.5 percent Cost of Living Adjustment (COLA) for some of the lowest paid workers in mental health agencies. This relief was very welcome, but it was a one-time solution to a permanent problem. Moreover, the 1997 COLA did nothing to address the growing disparity between Other Than Personnel Services budgets and OTPS costs. The costs of rent, equipment, transportation, communications, supplies, postage are all increasing; but voluntary sector providers are not receiving increases to cover those costs. If this problem is not addressed, more agencies will be forced to shut their doors simply for lack of money to pay the rent.

Furthermore, some agencies – those whose only funding stream is Medicaid – were left out of the 1997 and earlier adjustments entirely. These agencies have not received any rate increases at all in over a decade. They are even more underfunded than the rest of the mental health care delivery system. They are going out of business at an even more alarming rate. These agencies require an additional \$15 per visit adjustment or they will not survive.

### **Presumptive Medicaid Eligibility**

Also absent from the Governor's proposal is a program for presumptive Medicaid

eligibility. He has recommended allocating \$17 million to provide grants to counties that will enable them to supply medication to people coming out of jails, prisons and State psychiatric facilities. This money could be used to craft a much more comprehensive benefit for people with psychiatric disabilities.

The biggest problem with the proposal is that it assumes that medication is sufficient to stabilize a person with a mental illness during the very difficult transition from an inpatient setting to the community. Providing a person with pills alone is an ineffective way to treat a serious mental illness. Medication unaccompanied by treatment for a person with a serious mental illness is equivalent to painkillers with no cast for a person with a broken leg. They will be able to leave the hospital, but not for long.

Additionally, presumptive eligibility would maximize the impact of the State's dollars. The proposed medication management program relies entirely on State funds, while presumptive eligibility will use available Federal subsidies. Furthermore, if a consumer is eventually deemed eligible, Medicaid will fully reimburse for the cost of their care to 3½ months prior to the date they applied, meaning that there is **no** cost to the general fund for that client.

Presumptive eligibility will maximize the benefit of State dollars to people with mental illness and provide the continuity of care that they so desperately need.

### **Expanded Treatment Services**

Another important area that requires immediate attention is the necessary expansion of treatment services. The need for additional case management is dire and the Governor's proposal recognizes this with over \$50 million in new funding for different types of case management services. Case management, however, is not treatment. It helps consumers and their families navigate a complex system and ensures that they do not fall through the interstices, but it does not lessen their symptoms. Unless the

treatment system for children, adolescents and adults is also expanded, the capacity crisis remains unsolved. Case management, simply put, cannot be effective unless there are treatment services into which consumers can be case managed.

Expanded children's treatment services are especially crucial. Untreated childhood emotional disturbances become severe adult mental illnesses. If these children receive the treatment they so desperately need, it will reduce the burden on the adult mental system in the future. Money invested in children's treatment pays both human and financial dividends.

### **People with Co-Occurring Psychiatric and Addictive Disorders**

We are also concerned by the lack of services for people with co-occurring psychiatric and addictive disorders. These people have a convoluted, complex problem that requires a comprehensive, coordinated care system. New York led the nation in addressing the needs of this population, creating, in 1984, the first program in the country specifically designed to treat people in dual recovery from substance abuse and mental illness. Since then, however, New York's innovations have ceased. We propose two pilot case management programs that would catapult our State back to the forefront.

Because we lack a truly integrated care system, clients are faced with barriers between the different types of mental hygiene care that they need. MICA Case Management Teams would be an inexpensive and effective way to help consumers and their families overcome these gaps. These teams would consist of two case managers, one with a specialization in substance abuse treatment and the other with a specialization in mental health treatment. They could handle more clients than a single case manager and, for a relatively low cost, help consumers navigate both systems. As valuable as case management is for navigating the mental health or addiction treatment systems, it is more valuable for consumers who must navigate both.

For clients with the most intensive need Comprehensive Support Teams for People in Dual Recovery (CSTPDR) would be necessary. CSTPDR would be an aggressive outreach team that would see clients in their natural environments on a regular or semi-regular basis. The team would follow the client and enable him/her to access the appropriate treatment from the right sector at the correct time. They would intervene during times of crisis and regularly check on the client to ensure, during times of relapse, that the client would not back-slide too far before receiving treatment.

We propose that the State implement six pilot programs for each of these proposed case management teams. After a period of time sufficient for a full implementation, the legislature should review the outcomes and consider comprehensive program funding.

### **SNP Renewal**

Another important issue with which the legislature will be faced this year is the renewal of the mandatory Medicaid managed care authorization. In 1996, when you authorized the implementation of mandatory Medicaid managed care enrollment as proposed by the "Partnership Plan," you also authorized the development and implementation of six mental health Special Needs Plans (SNPs). On June 30 that authorization expires and you must renew the legislation if this process is to continue. We recommend that the SNP be re-authorized only if a number of outstanding issues are resolved. Among the most important steps needed to ensure SNP viability are:

First, commission an independent actuarial study that assures that the SNP benefit package can be supported by the premiums offered by the Office of Mental Health (OMH). The SNP benefit package developed by OMH is too broad for the SNP premium to support. The legislature must be sure the benefit package can be supported by the premium before it extends SNP authorization, so you should commission and review independent actuarial data.

Second, include transitional funding to support computer, reporting and accountability measures required by the SNP and start-up funding for the expected alternative programs not funded by the premium. If the premiums are insufficient to support the benefit package, then clearly they do not adequately support the extensive investments required for computer software, hardware, reporting systems, program creation and accountability measures also required by the RFP. The legislature should authorize additional transitional funding to cover these increased costs to providers of re-engineering and infrastructure development.

Third, ensure that there is a permanent Medicaid trend factor in the SNP rates. The proposed reimbursement methodology makes assumptions about declining inpatient usage and adjusts for those declines prior to paying the SNP. In addition, the SNP rates offered by OMH do not include a permanent Medicaid trend factor. The HIV SNP rates and mainstream managed care plans offered by the State Department of Health do include a trended increase each year. An increase in mental health SNP rates that is trended for inflation is permitted by the agreement between New York State and HCFA.

Fourth, relax the extraordinarily high level of regulation in favor of the insurance model on which the other SNPs are based. The RFP goes beyond mandating levels of service to include regulations about staffing ratios, alternative therapies and lengths of treatments. While we recognize that consumers need protections, the current level of detailed regulation is overly burdensome.

Fifth, recalculate and adjust COPs revenue to respond to volume adjustments in the number of visits provided during the first two years of SNP operation. Medicaid mental health providers' fees, as I mentioned earlier, have not increased in any substantial way in over 15 years. When New York State reduced its General Fund commitment to mental health care during the early 1990's, Medicaid providers began to receive Comprehensive Outpatient Program (COPs) payments to replace their old net deficit

(General Fund) funding. These supplements have been the stabilizing force for those community mental health care providers who receive it. If SNPs work as planned certain types of Medicaid visits will decline, reducing the amount of COPs funding available to communities. Unless COPs payments are recalculated and adjusted regularly during the first SNP procurement, this stabilizing funding stream will be lost and SNP development will jeopardize the existing community mental health system.

Finally, we feel that legislative review and oversight is very important. We believe that the Governor's proposal to extend the authorizing legislation in perpetuity would deprive the legislature of its ability prerogative and responsibility to review such profound changes to our system of care delivery. Therefore, we support an extension that is time-limited.

### **Reinvestment**

We are also pleased that the Governor fulfilled Reinvestment Year VI in his budget proposal. The funding he proposes indicates his recognition of the importance and value of this funding stream and the new services it has enabled in communities across the State. We would like the Community Reinvestment Act to be extended indefinitely. Moreover, revenue from the consolidation and sale of State psychiatric campuses should be added to the Reinvestment funding stream.

### **Shared Staff**

Another concern is the still-missing State shared staff positions that were lost last year when the Governor proposed cutting 215 of these important positions. We are appreciative that the legislature provided sufficient funding to restore 66, but 149 positions are still missing. The Intensive Case Manager shared staff positions were retained in the Governor's proposal and so should the remaining 149 direct care positions which are of no less value in our communities. We urge the legislature to allocate funding to restore these positions.

## **OMH Neutrality Cap**

Another issue that is of tremendous concern to us is the OMH Medicaid cost neutrality provision and spending cap. This cap artificially restricts the expansion of community services, preventing them from meeting actual need. DOH, OASAS and OMRDD are unrestrained by such a cap. This cap is yet another example of the discrimination with which people with mental illness are faced, and may in fact violate both Federal and State law. We urge you to eliminate this malignant form of discrimination which prevents people from accessing the services they need and to which they are entitled.

## **Parity**

In addition to the Budget priorities mentioned above, we will continue to support insurance equality for mental health. 28 of the 50 United States now mandate some form of mental health insurance parity. It is a shame on our State that we are so far behind the curve in ending one of the most insidious forms of discrimination with which people with mental illness are faced. The continued discrimination against people with mental illness by the insurance industry, and the continued tacit approval of the New York State government, further stigmatizes people with mental illness.

Why should a person with schizophrenia have severely limited coverage when a person with Alzheimer's, diabetes or heart disease gets full insurance coverage? The costs associated with mental health insurance parity are minimal or non-existent.<sup>1</sup> In any case, 91% of New Yorkers want to see an end to discrimination in health insurance and well over half are willing to pay increased premiums for it. In the long run, continuation of this inequity will cost uncountable dollars in emergency room visits, psychiatric hospital readmittances and lost labor, not to mention the human cost in lost lives. We urge both

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<sup>1</sup> Maryland reported a .2% cost decrease after full parity implementation. Rhode Island reported an increase of .33% after implementing statewide parity. New Hampshire insurance providers reported no cost increases as a result of severe mental illness health parity. According to a study published in the Journal of the American Medical Association, insurance equality would cost \$1 a year per employee under managed care.

houses of the legislature to agree upon a bill that will end discriminatory insurance practices for those with mental illness.

### **MTA ½ Fare Fairness**

We also hope that you will support a technical amendment to the MTA Half Fare Fairness bill of 1999. Although we feel that even before the law was passed last year the MTA was mandated to extend the half fare benefit to people with psychiatric disabilities, their insistence that there is a technical deficiency in the law you passed has held up implementation even until now. We are grateful that you spoke with such unanimity last year in passing the law that was eventually signed by Governor Pataki, but we must ask you to amend it this year so that the MTA no longer has any excuse to ignore the will of the legislature. Help us end discrimination against people with psychiatric disabilities on the New York City transit system once and for all.

I thank you for your time this afternoon. We appreciate your ongoing commitment to people in our State who live with mental illness, and hope that as this budget process continues, you will provide a targeted enhancement to the boost which has been offered by the Executive. The Coalition of Voluntary Mental Health Agencies and the New York State Council for Community Behavioral Healthcare look forward to working with the legislature to do just that. Thank you.