



Testimony of
Edward C. Smith, Esquire
General Counsel/Senior Policy Associate
The Coalition of Voluntary Mental Health Agencies, Inc.

Before the New York City Council
Committee on Mental Health, Mental Retardation, Alcoholism,
Drug Abuse, and Disability Services

Council Member Margarita Lopez, Chair

*Caps, COPS & the Lack of Funding for
Mental Health Services for Children*

March 1, 2004

The Coalition of Voluntary Mental Health Agencies, Inc.
90 Broad Street, New York, NY 10004-2205
ph. (212) 742-1600; fax (212) 742-2080
mailbox@cvmha.org; www.cvmha.org

Chairwoman Lopez and distinguished Committee members, thank you so much for allowing us this opportunity to speak before you today. My name is Edward Smith, and I am offering testimony today on behalf of the Coalition of Voluntary Mental Health Agencies, the umbrella advocacy organization of New York's mental health community, representing over 100 non-profit community-based mental health agencies in New York City and surrounding areas. Our members constitute a broad cross section of service providers – focused on adults and children; all sizes from very small to very large; treatment and rehabilitation-oriented; outpatient and residential; specializing in linguistically and culturally specific populations and on many special-needs – serving more than 300,000 clients in the five boroughs of New York City and its environs.

We would like to thank you and all of the distinguished members of this Committee for scheduling this hearing to address funding for mental health services for children. We appreciate your recognition that despite high demand for children's mental health services in New York City we continue to struggle with how to expand capacity to serve unmet children's mental health needs in an environment where State policy, budget deficits, and regulatory decisions restrict the expansion of community-based mental health services. I will direct my remarks to the fiscal and regulatory issues that we believe are barriers to the expansion of the delivery of mental health services in New York State.

Today, I will speak about the features of Comprehensive Outpatient Program Services (COPS) and "Medicaid Neutrality and how they cap any increase in spending and expansion of mental health services without regard for need. I have appended to

this testimony, the regulations governing COPS, Title 14 NYCRR Part 592, as well as the regulations governing additional criteria for outpatient programs, commonly referred to as “Medicaid Neutrality” or “Fiscal Neutrality,” Title 14 NYCRR Part 551.13.

According to the United States Surgeon General’s Report, most children in need of mental health services do not get them. It reported that only one in five youngsters with a serious emotional disturbance was able to access mental health services.

In New York State, our mental health system for children is dramatically more under-funded than the adult system. Both sectors are woefully under-funded and lacking in capacity as we have testified on many occasions. There are far too few services available, and those that exist suffer from insufficient and stagnant reimbursement rates. Simply put, New York’s mental health treatment system for children is full. Waiting lists are so common as to no longer be noteworthy. Many kids spend so long waiting that they are no longer children by the time a service is available to them.

In the name of fiscal prudence, we are tolerating a vast human waste, loss, and family disruption. In the name of fiscal prudence we are squandering precious human potential. In fact, we are short-changing our children in the short term and spending much more in the long-run. Unfortunately, the regulatory and fiscal restrictions or barriers such as COPS and Medicaid Neutrality in New York State create barriers to access of care by individuals with mental illness. Efforts to expand mental health services to fill the gaps in services for the unmet need of targeted and identified populations have been very difficult, and frequently unsuccessful.

The Medicaid Neutrality cap effectively puts a limit on the amount of spending for mental health services. It is applied to mental health services alone among the health disciplines. It arose out of a tacit early 1990s agreement between the OMH Commissioner Searles and the New York State Division of the Budget (DOB). While the State was maximizing the federal contribution to mental health services by transferring programs to Medicaid funding, there was a concern that DOB would lose control of the Medicaid budget. If operating certificates and program capacity increases were granted based solely on a demonstration of necessity, the State would be unable to restrict the program growth, it was feared, and the Medicaid budget would increase to meet the need. As a way to maintain control over Medicaid budgets, an agreement was made to limit the State share of Medicaid spending on mental health services. This cap is not explicitly stated in law or regulation. It is implemented in circuitous ways. For example, the mental hygiene regulations in 14 NYCRR §551.13, state that “in reviewing outpatient projects, the Office of Mental Health shall consider...for Medicaid or local assistance, the impact, source, and availability of the State share of such funds.”

The regulation caps expansion of outpatient mental health services if the expansion results in an increase of the State share of Medicaid expenditures for mental health services. The restriction is unrelated to the assessment of the needs of the community or the quality of the program. It simply caps the State spending on outpatient mental programs at decades old funding levels. In essence, the State has placed a moratorium on expansion of outpatient mental health services unless an agency or provider identifies alternative funding sources to cover the anticipated increase in spending of the State share of Medicaid.

I'd now like to address the limitations imposed on service delivery by COPS. COPS was the first major federal revenue maximization designed and implemented by the State. Very simply, the financial value of COPS was the substitution of a federally subsidized Medicaid rate for contracts previously funded at 100% by the State and City. The "gain" from this substitution is obvious. It brings the federal government in as a substantial funding partner for State and local services and reduces the commitment required by State and City.

The COPS rates were paid as "supplemental" rates, over and above each provider's regular Medicaid fees, and subject to different maximums. The COPS money as a supplement to the base rate, however, comes with its own set of limitations and restrictions that are barriers to expansion of mental health services

OMH limited a provider's COPS revenue potential by establishing maximum COPS revenue for each provider. OMH allowed each provider to retain COPS revenue totaling 110% of the value of the contracts "supplanted" by COPS, also known as the "10% COPS corridor". This means that the volume of COPS reimbursements a provider receives is **fixed and capped**. A provider may increase their COPS revenue by 10% only. Once a provider achieves the 110% maximum of the Medicaid revenue reimbursements associated with COPS, the provider will not receive any additional COPS dollars. This effectively freezes reimbursements at 1990 levels for 2004 service costs. Furthermore, only agencies that had contracts in 1990 have a COPS supplement. The system permits no new applicants for COPS supplements—effectively barring the introduction of new services since the base rate of \$66.00 is inadequate to pay for necessary specialized services to children and families.

The net effect of these regulations is that expansion of mental health services has been frozen in time. Referring to these limitations, The Citizens Committee for Children in its recent report, Paving the Way: New Directions for Children’s Mental Health Treatment Services, noted that the choices faced by providers were bleak: “In these circumstances, the mental health agency could absorb the loss created by unreimbursed visits, rely on other resources such as a private grant, to cover its costs, decide against increasing services, or cut back visits at the main clinic treatment site and use the Medicaid savings to pay for new services.” The Coalition does not believe that any of these options are acceptable and certainly do not contribute to developing a solid comprehensive system of care for recipients of mental health services.

In August 2003, The New York City Department of Health and Mental Hygiene released a report which examines the unmet mental health needs of the children in the Bronx entitled Children’s Mental Health Needs Assessment in the Bronx. It showed that the need for children’s services in the Bronx was greater than the capacity of the service delivery system to provide them. Large numbers of children in the Bronx are eligible for Medicaid, yet still cannot access needed services. We have no doubt that if service expansion resulted in an increase of the State share of Medicaid spending, the State would prevent that expansion. Again, according to Paving the Way: New Directions for Children’s Mental Health Treatment Services: “As a result, expansion of outpatient mental health services has been severely limited and grossly insufficient outpatient treatment capacity continues to force children to wait weeks and months for a first appointment or seek care first in a hospital emergency room.”

Moreover, a no-growth system, by its very nature, reduces options for children and adults with mental illness to receive the continuity of care that they need. While continuity of care is crucial for adults with mental illness, it is even more critical for children and adolescents.

COPS, Medicaid Neutrality, and the caps associated with both of them eliminate any potential for the mental health system in New York to grow to meet the mental health needs of children and their families. These artificially imposed caps on services are barriers to care and should be reexamined and eliminated. Until the COPS cap and the Medicaid Neutrality cap are lifted, we will continue to see children on long waiting lists, unable to access care and treatment that will enable them to reach their full potential. Until these caps are lifted, voluntary agencies will be unable to expand their care offerings to meet the critical need.

Four years ago, in March, 2000, Phillip Saperia, the Executive Director of The Coalition of Voluntary Mental Health Agencies testified on a related issue before the Subcommittee on Mental Health, then chaired by Councilwoman Clarke. Much of my testimony today is a reiteration of what he said four years ago. It is sadly notable that nothing has changed. In fact, available data and our experiences would suggest that circumstances are far worse.

The Coalition joins with you, Councilmember Lopez and with the other members of City Council, in seeking ways to remove the straight jacket around children's mental health service providers that prevent them from offering specialized services to children who are now denied access. Thank you for bringing these issues to public attention by way of this hearing today.