Testimony of

The Coalition of Voluntary Mental Health Agencies, Inc.

NYS Council for Community Behavioral Healthcare

For the Joint

Senate Finance Committee and

Assembly Ways and Means Committee

on the Proposed Fiscal Year 2000

New York State Budget

February 10, 1999

Chairman Stafford, Chairman Farrell, distinguished members of the Senate and Assembly, good afternoon and thank you for allowing us the opportunity to speak with you today. My name is Gayle Farman, I am Executive Director of the New York State Council for Community Behavioral Healthcare. With me today is Joshua Rubin, here representing The Coalition of Voluntary Mental Health Agencies. Taken together, our two organizations represent over 150 non-profit community-based behavioral health care agencies located in New York City and 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. Our members represent the full continuum of behavioral health services, and together serve more than 450,000 clients annually in the neighborhoods where they live.

We would like to begin today by applauding the Executive's continued commitment to the Community Reinvestment Act. We were very gratified to see the full funding in Governor Pataki's budget proposal. We hope this policy will be endorsed and continued by the legislature. However, we are concerned about the proposed elimination of 215 State shared staff. This reduction of a commitment made to communities more than 20 years ago will significantly harm our capacity to serve seriously mentally ill adults and seriously emotionally disturbed children. In many localities these positions form the backbone of county and voluntary agencies' professional staff. This proposed "buy-out" of staff at 56% of the cost ($6.5 million to replace $11 million in savings) would require that these highly trained and experienced staff be replaced with poorly trained novices. Our preference is to retain these shared staff under the current arrangement. The Intensive Case Manager shared staff positions have been retained in the Governor's proposal and so should the remaining 215 direct care positions which are of no less value in our communities. If a "buy out" is to be implemented, a resource neutral allocation is needed.

We also hope that any additional revenues realized this year from the sale of State hospitals by the Empire Development Corporation will be Reinvested into the community-based system.

While we feel the Governor's budget proposal is a good point from which to begin, there are serious problems faced by the community-based system that need to be addressed. The greatest of these problems is the Sisyphean battle against inflation in which the community-based behavioral healthcare system is engaged. Cost of Living Adjustments have come rarely and have not succeeded in keeping pace with inflation. The 2.5% Cost of Living Adjustment added to last year's budget by the legislature was welcome relief for many of our members and we are grateful for it, but it was not nearly enough to keep pace with the 11.8% inflation rate since 1995,[1] when the sector received a nominal 3 month COLA.

The salary crisis has reached an extreme. 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 entry-level positions at fast-food restaurants that can offer higher salaries. Staff morale is low, and declining fast. Some employees are forced to work second and third jobs to avoid the need for public assistance. Turnover rates have surpassed 27% in many agencies. Many vacancies go unfilled for months because the salaries offered are so uncompetitive. Yet another reason why it is so unlikely that 215 State shared staff positions would be easily filled.

Every time a direct care worker leaves, the continuity of care for his or her clients is disrupted. The relationship they had built, a key 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. The quality of administration suffers. The client suffers.

[1]King, Robert, "City schools' best friend: Pataki", New York Daily News, February 8, 1999, page 29.

Furthermore, the bill that allocated last year's COLA was so complex that the Department of Budget **hopes** to have it implemented by April 1st, a full year after the period covered by the adjustment. And even once it is implemented large portions of the sector will be left out. Many agencies whose only funding stream is Medicaid have not seen a rate adjustment since 1990, and did not receive one last year. Agencies that provide an annual adjustment as a result of a collective bargaining agreement were unable to capture the revenue from last year's COLA to cover that cost. Employees who by virtue of experience, seniority or education are compensated slightly better than their counterparts were left out of a COLA that went solely to the lowest paid workers. It makes no sense to penalize the best employees for being good at what they do.

Moreover, the COLA last year 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, some agencies will be forced to shut their doors for lack of money to pay the rent.

We hope that this year the legislature can craft a permanent, comprehensive solution to this problem. We suggest a one-time living-wage adjustment to bring salaries somewhere near where they would be if they had kept pace with inflation over the last decade, and the creation of an annual trended rate increase tied to a third-party index, similar to the hospital reimbursement system and the MR/DD system. This trend should apply to the entire sector and cover both personnel services and OTPS.

We are also concerned by the lack of vision for children's services in evidence in the Governor's budget proposal. The seriously emotionally disturbed children who are among our society's most vulnerable are not obtaining the services they need. The waiting list for RTF beds is approaching 300. There has been a shortage of home and community based waiver slots for years. Home-based crisis intervention, day treatment

and other intensive, step-down community based mental health services are in much too short supply. Programs like these, which provide the intensive wrap-around care designed to keep kids in the community are seriously underfunded and unavailable to the high-end users who need them the most.

Every day we fail to take the opportunities to reach children who could be helped by intervention. Millions of New York's children attend schools that offer them no mental health services. It makes sense to craft a mental healthcare delivery system that encompasses the schools, a child's natural environment. In doing so we would eliminate barriers to care and reinforce positive supports like peers and teachers. These prevention and treatment services should include a curriculum that is skills-building in nature. We should build upon child resiliency and strengths based programming already supported by the Office of Child and Family Services. School-based programming should also be developed with a focus toward identifying adolescents who do not have an academic focus, but who can build skills toward employment.

We should also allocate funds for family ombudsman, family outreach and parent participation programs. Mental health treatment for children is much more effective if their parents are involved. If families could be assured that they would not be forced to incur financial burdens as a result of their participation, these programs could be even more effective. These school-based programs should have mental health based funding (OMH and DMH) for services by mental health, not educational, providers. If we can reach the children who do not present themselves at our provider sites we can hope to avoid the type of tragedies that we saw in Springfield, Oregon and Paducah, Kentucky last year. We have the opportunity to serve more children; it would be a shame to pass it up.

A further opportunity to get services to more children who need them would be created by eliminating the OMH Medicaid cost neutrality provision and spending cap. The OMH cap on Medicaid services has no counterpart for DOH services, leading to a serious inequity. In the early 1990's OMH imposed a Medicaid neutrality cap on the granting of

new Certificate of Need licenses. Despite this, in the intervening years, there has been expansion of community mental health services for adults, while community-based services to children and adolescents have lagged. At this point, the crisis in unavailability of children's mental health services, especially for high-need SED children and adolescents, stems both from the unavailability of adequate funding for such services and from the Medicaid cap, which limits expansion capacity throughout the system.

Another area of the Governor's budget that we felt lacked a vision for the future was in services for people with co-occurring psychiatric and addictive disorders. People with dual diagnoses are a large and growing portion of those served by behavioral healthcare providers. The Office of Mental Health and the Office of Alcoholism and Substance Abuse Services have been working together to address the needs of this complex population. We applaud this effort to develop a memorandum of understanding and an integrated treatment model. To further these stated goals we propose that the two offices cooperate on a joint cross-training program. Providers of mental health services need help in identifying and treating their clients with chemical dependency problems. Similarly, providers of substance abuse services need help in identifying and treating their clients with mental health problems. Furthermore, by cross-training workers from both sectors the state could facilitate the open exchange of information and breaking down of cultural barriers between the provider populations.

What little programming there is for people in dual recovery is underfunded and inadequate. For eight years the Residential MICA Enhancement program has provided some stepped-up services. We believe the program should be expanded and that the rate should be adjusted to keep pace with inflation. Furthermore we propose the creation of a pilot program to provide a similar enhancement to allow day treatment programs to add a dual diagnosis treatment component.

In an area with so few services and such a short history we believe pilot programs are an excellent way to encourage innovation. As such we propose two other pilots. We feel

that early intervention with adolescents who have developed symptoms of either a mental illness or substance abuse problem will help to avoid the development of a co-occurring condition. We suggest a program to identify these high-risk youth and provide them with intensive outpatient treatment, rehabilitation and case management. Additionally we believe that dually diagnosed individuals, who have extremely high rates of recidivism, would benefit greatly from a comprehensive support team designed specifically for them. These teams would provide direct treatment to a selected group of heavy service users. The teams would include mental health and substance abuse professionals as well as peer workers. They would provide services in client's living, vocational and social environments. If implemented we believe these teams would substantially reduce psychiatric hospitalizations, emergency room visits and inpatient substance abuse treatments.

We would be remiss if we failed to mention the needs providers face with respect to the implementation of mandatory Medicaid managed care and the coming on-line of mental health special needs plans. $30 million have been allocated for SNP start-up. We laud the Governor's decision to continue this funding and request the help of the legislature in ensuring that the mental health community gets their fair share of this allocation. Additionally we would like the legislature to insist that the Commissioners of Health and Mental Health allocate dollars for technical assistance in addition to those allocated to the counties that may or may not be used for technical assistance as SNP plans go up. It will be badly needed.

In addition to technical assistance, community-based providers need help to transition to a managed care environment. The transformation of the State's Medicaid program into a managed care system poses significant risks for traditional Medicaid providers. At the same time that they must contend with lower Medicaid managed care reimbursement, the data requirements and administrative expenses connected to managed care are increasing, while the numbers of uninsured patients turning to their organizations is on the rise. Moreover, with operating revenues that barely cover -- and frequently do not cover -- their costs and reserves that are slim or non-existent, they are

poorly positioned to make the investments necessary to succeed under managed care. You understood this last year and allocated the necessary funds. Sadly, they did not survive the budget vetoes. Please ensure that we do not wait to long too allocate this essential funding.

Furthermore we urge you to do whatever is in your power to help the Executives of the State and New York City negotiate a multi-year agreement to continue the New York/New York program to house homeless people with mental illnesses. The units built by the first New York/New York agreement are credited with reducing homeless shelter occupancy by nearly 2500 people per night. That translates into a savings of over $50 million per year. In addition to the human and humane benefits, building housing for people with mental illness who are homeless or at risk of homelessness saves money.

Community supports like housing, residential beds, day treatment slots, clubhouses, ACT teams, supportive case managers, intensive case managers and peer counselors are crucial elements of an effective comprehensive mental health. A group of doctors and scientists recently concluded a study that demonstrates very clearly the way things could work. The study, the New York City Involuntary Outpatient Commitment Pilot Program, had many unclear outcomes, but some of the findings are incontrovertible. "The service coordination/resource mobilization function of the Coordinating Team seemed to make a substantial positive difference in the post-discharge experience of both experimental and control groups."[2] Clients in the study received the type of coordinated seamless support for which we have long advocated. The Bellevue staff provided a great deal of support and "back-up services."[3] All of the clients received the case management services that we feel are so important to successful community treatment.

Clients in the project received the enhanced services that worked. The wrap-around

[2]Policy Research Associates, "Final Report: Research Study of the New York City Involuntary Outpatient Commitment Program," ii.

[3]Ibid. Page 9.

support they obtained in the study reduced the number of hospitalizations by nearly 45%,[4] kept nearly 75% of the clients in treatment,[5] and helped 83% of the clients stay on the right side of the law.[6]

Not only is it more humane to provide appropriate community services to people with mental illnesses, it is less expensive too. It costs $10,000 per year to keep someone in supported housing. A supervised community residence with crisis intervention capabilities costs $33,000 per year. Compare this with $113,000 per person per year on an inpatient ward. It doesn't make sense not to provide these services.

In addition to the Budget priorities mentioned above, we will continue to support insurance equality for mental health. The continued discrimination against people with mental illness by the insurance industry, and the continued tacit approval of the New York State government, stigmatizes people with mental illness. Why should a person with Alzheimer's, diabetes or heart disease get full insurance coverage when a person with schizophrenia gets severely limited coverage? The costs associated with mental health insurance parity are minimal or non-existent.[7] Furthermore, 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 re-admittances and lost labor. Not to mention the human cost in lost lives. We urge the legislature to do something this year to end discriminatory insurance practices for those with mental illness.

---

[4]Ibid. Table 6.

[5]Ibid. Table 9.

[6]Ibid. Table 7.

[7] 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.

Lastly, the New York State Council and The Coalition support the Governor's Budget proposal for the Office of Alcoholism and Substance Abuse Services. While the proposal includes $17 million for new initiatives funded by Federal Substance Abuse Prevention and Treatment (SAPT) grants and asset forfeiture revenues, alcoholism and substance abuse prevention and treatment services are available to less than 20% of the children and adults who need them statewide. There is no additional state funding in the Executive Proposal for alcoholism and substance abuse treatment and prevention initiatives that would address the overwhelming need statewide. We will actively work with the Legislature in the coming weeks to support increases for specific prevention and treatment initiatives, and to support the overhaul of the Rockefeller Drug Laws to address enforcement, prevention and treatment.

We 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 good start which has been presented 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.