9

HINMAN
STRAUB
ATTORNEYS AT LAW

121 STATE STREET
ALBANY, NEW YORK 12207-1693
TEL: 518-436-0751
FAX: 518-436-4751

Joint Legislative Hearing
2012 Executive Budget
Mental Hygiene
February 14, 2012

Federation of Mental Health Services, Inc.
NYS Licensed Agencies Providing Mental Health Services
Dr. John C. Rossland, President

Good Morning. Thank you for the opportunity to present testimony today at the Joint Legislative Executive Budget hearing for Mental Health. I am Dr. John Rossland, the President of the Federation of Mental Health Services, Inc. (the Federation) and a licensed psychologist who has worked in OMH mental health clinics for 35 years. The Federation is a consortium of New York State Licensed out-patient Article 31 Mental Health Clinics. Traditionally, we were known as Non-Comprehensive Outpatient Clinics (Non-COPS clinics) and now we are known as Level II COPS clinics. We provide an estimated 30% of all clinic visits to recipients in New York State. I am pleased to be a part of a community of professionals with a strong leader and advocate at the helm of the Office of Mental Health, i.e. OMH- Commissioner Michael Hogan.

Today, I want to bring to your attention a way for the State to increase patient care while keeping costs stable or even reducing costs. The way to do this is to continue with Rate Reform without significant new mandated changes such as a full carve-in to Medicaid Managed Care. I will also draw your attention to two other issues-our suggestion for the implementation of a waiver authorized in the 2011-12 State Budget concerning utilization thresholds for Article 31 Mental Health Clinics and the MRT suggested extension of the licensure waiver until 2016.

Clinic Rate Restructuring

In 2006, the Legislature provided money to fund an independent study of the Article 31 out-patient mental health reimbursement system. The purpose of the study, as stated in the 2006 budget, was "...to make recommendations for changes designed to ensure that the financing and reimbursement system provides for the equitable reimbursement of providers of mental health services and is conducive to the provision of effective and high quality services." The study was completed by Public Consulting Group, Inc. (PCG).

The system reviewed by PCG was the structure which was established in 1991- namely the use of regional fee schedules for recognized services (a base Medicaid rate) with the addition of provider specific supplemental COPS payments (add-ons) to compensate providers for the cost of providing services. This uneven and inequitable reimbursement system was in place for over two decades with widely variable provider payments—often by as much as $200- $500. The payment variation was often arbitrary because it wasn't based on case mix or services provided and instead it was based on the controversial and costly provider specific history of deficit funding. The PCG study which was released in 2007 stated that "at times the same service is reimbursed at different rates based solely on the facility's license." In fact, the study concluded "...the current system of financing outpatient mental health services ...should be replaced with a more equitable and more rational system of payment. The current system is outdated, inequitably funded and is based on a rate structure that has outlived its usefulness."

This PCG study was the beginning of a laborious process spearheaded by OMH to provide much needed rate reform which led to the currently adopted APG reimbursement system. OMH in fact created Part 599 regulations to change the old payment system over a four year period of time.

Rate Reform has only just begun but it is being implemented retroactively to October 1, 2010— I raise the issue because so many major changes are taking place at once with Universal Managed Care, BHOs and Health Homes, etc. that I am concerned that Rate Reform will either be derailed or modified again in a manner inconsistent with patient needs.

Regarding the matter of derailing rate reform I would like to introduce a strong word of caution. Rate Reform must continue through the final phase (4 years and we are already in year 2) to prevent the loss of Federal Funds. Medicaid rules and policies under the Deficit Reduction Act of 2005 specifically targeted payments like COPs for elimination. The Rate Reform will eliminate the COPs funding over this 4 year implementation. Again, due to the DRA, CMS mandated this restructuring. Failure to implement the restructuring could result in a loss of $170 Million dollars to New York State. *(6/2009 study done by DMA Health Strategies for OMH.)*

Rate Reform when fully implemented will increase the productivity of clinics- meaning that clinics will serve more patients thereby enhancing consumer access and quality of treatment. The old bifurcated (COPs vs. Non-COPs) system resulted in complicated financial disincentives for COPs clinics to see more recipients thereby resulting in long waiting lists for patients and limited access to care.

We have empirical data for this statement because Non-COPs clinics see 2-3 times the number of patients for the dollars expended by the State. (*Public Consulting Group report for OMH 6/13/2007).* Additionally, many Non-COPs clinics serve large numbers of Hispanic patients. With Rate Reform, payments have adjustments for factors which influence the cost of providing services thereby eliminating the financial disincentives for reduced access to care by COPs clinics.

Rate Reform also incentivizes quality treatment. With OMH's release of their Standards of Care and Part 599 Regulations as a first step, the requirement to meet standards of care through rate reform will provide financial incentives to provide quality treatment by all clinics. Included in this "first step" is a newer method to address the funding of indigent care. Additionally, quality will improve with Rate Reform because the old but still current "add-on" system leads to the unintended use of funds and Rate Reform will mean that the payments serve the patients by being based on actual services to patients. In other words, the "Money follows the patients and their needs."

So therefore, I appeal to you to please keep it a priority to move Rate Reform ahead as has been intended by the Office of Mental Health. The complications and concerns for modifications to the Rate Reform are in the layering of Medicaid Managed Care, BHOs, and Health Homes. With the movement of patients into and out of various new structures such as these and the concurrent desire by the Executive to eliminate fee for service mental health Medicaid care (which forms the basis for the new rate structure) we are both confused and concerned as to how all these pieces of the puzzle will be integrated with Rate Reform as it is currently under way. We caution that the integration must carefully enable the equalization of payments to all clinics (The primary purpose of Rate Reform) while not lowering the already low low rates of non-COPs clinics- as compared to the COPs clinics. The cost savings by reducing $300 rates (COPs clinic common

rates) to the universal standardized $125 rate due in year 4 of Rate Reform are obvious. Again, caution must be exercised to allow the non-COPs clinics to remain viable—creating new payment formulas that reduce all clinic rates will harm the non-COPs clinics. (We have unfortunately seen a large formula driven reduction for year 1 fees of some non-COPs clinics and while we are trying to work through this with OMH and receive a usable formula we are at least hopeful that as we approach year 4 – equalization will be realized at the $125 rate and viability secured—if the clinics can just hang on financially to get to that point.)

Utilization Thresholds

The Medicaid Redesign Team proposal #26 created the authority for utilization thresholds relating to clinic visits. The 2011-12 enacted State budget included the substance of this MRT proposal. The budget language does, however offer flexibility to the applicable Commissioners in the implementation of regulations to "...waive utilization thresholds for patients of clinics certified pursuant to article 16, 31, or 32 of the mental hygiene law who are enrolled in specific treatment programs or otherwise meet criteria as may be specified by such commissioners." *(Chapter 59, Laws of 2011.)* The Office of Mental Health meanwhile is in the process of adopting emergency regulations that use 30 and 50 visit thresholds. The Federation recommends that the budget language authorizing a waiver be more proscribed to force the commissioner to enable flexibility for certain populations. We recommend that recipients fitting the description and criteria established by the Office of Mental Health for Serious and Persistent Mental Illness (SPMI) be exempt from the thresholds.

The Utilization Thresholds are inconsistent with existing patient needs and may not protect the most vulnerable

The Office of Mental Health has established thresholds for reducing fees by 25% and 50% for visits over 30 sessions and 50 sessions per year respectively in OMH-licensed out-patient clinics. These low thresholds – for many patients appear contrary to current Standards of Practice, the new 599 Regulations, and are inconsistent with evidenced based approaches. *(e.g., Duke University Assisted Outpatient Treatment Study on continuity of care and the current OMH Care Monitoring Committee Report on 6,000 cases, both of which indicate that continuity of care significantly reduces hospital, Emergency Room, and prison recidivism* http://omh.ny.gov/omhweb/cmi [1]Limiting visits in such a drastic way could lead to a discontinuance of care for four to five months every year for recipients, and is simply unfair to those recipients who obtain considerable support from continuous care at our clinics. It is perhaps dangerous to the greater community. We understand the need to control costs but it must be effectuated in a way that does not lead to gaps in services, more crisis situations, and costly emergency room and inpatient hospital stays.[2] While we would prefer not to have these thresholds for any recipients, we suggest and support the adoption of regulations pursuant to the recently enacted Statute (C59 L2011), that allows for the waiver of the utilization thresholds for patients meeting specific criteria. We assert that the following types of patients be excluded:

- **Those with an extended Impairment in Functioning due to Mental Illness**

  Documentation that the individual has experienced two of the following four functional limitations due to a designated mental illness over the past 12 months on a continuous or intermittent basis:

  a. Marked difficulties in self-care (personal hygiene, diet, clothing avoiding injuries, securing health care or complying with medical advice).
  b. Marked restriction of activities of daily living (maintaining a residence, using transportation, day to day money management, accessing community services).
  c. Marked difficulties in maintaining social functioning (establishing and maintaining social relationships, interpersonal interactions with primary partner, children or other family members, friends, neighbors, social skills, compliance with social norms, appropriate use of leisure time).
  d. Frequent deficiencies of concentration, persistence or pace resulting in failure to complete tasks in a timely manner (ability to complete tasks commonly found in work settings or in structured activities that take place in home or school settings, individuals may exhibit limitations in these areas when they repeatedly are unable to complete errors in tasks, or require assistance in the completion of tasks).

Or

- **Reliance on Psychiatric Treatment, Rehabilitation and Supports**

  A documented history shows that the individual at some prior time met the threshold above, but the symptoms and/or functioning problems are currently attenuated by medication or psychiatric rehabilitation and supports. Medication refers to psychotropic medications which may control certain primary manifestations of mental disorder; e.g. hallucinations, but may or may not affect functional limitations imposed by the mental disorder. Psychiatric rehabilitation and supports refer to highly structured and supportive settings which may greatly reduce the demands placed on the individual and thereby, minimize overt symptoms and signs of the underlying mental disorder.

- **A proposed compromise**

  - For maximum efficacy, High Risk and Seriously Mentally Ill Recipients should be seen 1 time per week for Individual Psychotherapy.

  - This would result in (45) sessions per yr. (with factoring in missed sessions, vacations and holiday closings)

  - 10 additional Psychiatric (MD) sessions a year are usually required (scheduling psychiatric and psychotherapeutic sessions on the same day can be a scheduling nightmare and reduces the # of treatment days)

- The above results in a total # of treatment sessions equaling 55 visits per year (presuming that collateral sessions with adults are not included in the thresholds)
- 55 sessions at $100/session= $5,500/yr
- It should be noted that many Medicaid Managed Care Plans already allow Medicaid recipients either 60 or unlimited visits; for example, Health First, HIP, Health Plus, and GHI.

This $5,500/yr can be compared to a recipient in crisis who is only seen for 30 visits and then ends up in the ER or the Hospital for in-patient care. The ER and hospital in-patient stay will likely cost $1,500 and $15,000 respectively. Accordingly, ensuring sufficient visits at outpatient clinics seems both prudent for recipient care and cost effective.

<u>Potential Consequences of low thresholds:</u>

- More recipients will stop treatment after the threshold visits.
- The recipients who stop treatment may be the ones that are the most difficult and expensive to engage and treat.
- A churning effect will emerge in the second half of the year where difficult clients cannot find a "mental health treatment home."
- Expensive medication usage will increase beyond its present high level with a concomitant increase in long-term side effects (cardio metabolic risk, etc.)
- Motivated providers who have embraced the mission of caring for the most seriously mentally ill will become demoralized and seek to limit the exposure and risk that discontinuous care brings.

<u>Sufficient Clinic Visits are consistent with ongoing OMH initiatives</u>

The clear purpose of community mental health services is to keep the most vulnerable New Yorkers connected to treatment services. This is both good care and good economics. Over the last few years the Office of Mental Health has adopted several initiatives to enhance this mission. Some of these are:

a. The introduction of Part 599 Regulations and the Standards of Care in the last two years which involve the "Tracer Methodology" auditing system which overwhelmingly emphasizes effective engagement, retention and linkages to programs. The 30/50 visit threshold unless the SPMI population is waived, would undermine OMH's own recently formed policies.

b. The use of Case Management, Assertive Community Treatment (ACT) *(ACT patients are typically seriously and persistently mentally ill and have had frequent hospitalizations)* and Assisted Outpatient Treatment (AOT) where

staff work, under a court order, actively in the community to ensure connection with clinical services.

c. The introduction of PSYCKES to track past and present medications and medical illnesses and their reciprocal relationships.

d. The Care Monitoring Initiative which has essentially become a Phase I BHO responsibility tracks continuity of care and vigorously (sometimes with an additional burden to providers) investigates gaps in service, hospital and ER utilization and discontinuity in medication.

e. Office of Mental Health certification reviews which are vigorous in reviewing the linkage process and continuity of care.

f. The recent introduction of strenuous standards for 24/7 availability and "hospital diversion" policy.

All these initiatives strongly promoted by the Office of Mental Health have made it clear to providers that discontinuity of care is strongly discouraged.

Furthermore, in recent years there has been a steady emphasis on the need to adopt "evidence based practices". In simple terms, this means adopting methods that have been shown to work in experimental and empirical studies as opposed to those practices and standards of care which are derived from an accumulated clinical practice knowledge bases.

In this environment, where the Office of Mental Health has rightly emphasized follow-up and continuity, we are concerned that a potential threshold of 30 visits that would create a disincentive to continue care—especially for the SPMI population.

Accordingly, we respectfully request that, consistent with C59 of the Laws of 2011, patients meeting the SPMI criteria be granted a waiver from the utilization thresholds.

Licensure

Another area that the Executive Budget addresses that will impact Article 31 Mental Health Clinics is the licensure of professional staff. The existing law waives the licensure requirement for social workers who are employed by a program or service operated, regulated, funded, or approved by the department of mental hygiene or the office of children and family services, or a local governmental unit as that term is defined in Article 41 of the mental hygiene law or a Social Services District as defined in Section 61 of the social services law—until 2013.

The Executive budget extends this waiver into the year 2016. This extension is critical to enable clinics, who are currently licensed by OMH and who provide supervision to these professionals who work in their facilities, to both retain staff and to seek funding to locate and train professionals with the applicable licenses. Not only is it critical, it is vital for the service of Spanish speaking patients. There are large numbers of Hispanic recipients

of mental health services in Article 31 clinics and there are not sufficient numbers of licensed professionals to provide service. There are, however, clinics that hire trained professionals to treat this population and who, with the appropriate supervision, are able to both relate well to the clients/patients and demonstrate success with these populations. The extension of the waiver to 2016 (as recommended by the MRT) is vital to maintain a sufficient level of patient services for the Hispanic population.

4841-1271-4766, v. 6

---

[1] **The Duke University Study**
This was a study conducted at the behest of the New York State of Office of Mental Health by The Duke University School of Medicine, June, 30th, 2009. The purpose of the study was to evaluate the effectiveness of AOT in preventing relapse or deterioration before hospitalization was needed.

> "AOT is largely used as a transition plan to improve the effectiveness of treatment following a hospitalization and as a method improve the effectiveness of treatment" in the community following a hospitalization, and as "a method to reduce hospital recidivism".

It is readily apparent that the effectiveness of AOT as an after hospital planning tool, is dependent on the availability of appropriate clinic services in the community, who can accept the patient after hospitalization.

Most of New York State's experience with AOT originates in the New York City region where approximately 70% of all AOT cases are found. AOT was systematically implemented citywide in New York City with well-delineated city-wide policies and procedures. In the remainder of the state, AOT was implemented and utilized at the discretion of counties.

The Duke study generally supports the position that keeping clients connected and engaged in treatment reduces hospitalizations, arrests, violence, personal victimization and improved treatment compliance for those clients engaged in AOT services. Furthermore, it states that "...during the first six months on AOT, service engagement was comparable to the service engagement of voluntary recipients not on AOT. After 12 months or more on AOT, service engagement increased such that AOT recipients were judged to be more engaged than voluntary recipients. This suggests that after 12 months or more, when combined with intensive services, AOT increases service engagement [even with very seriously mentally ill recipients (sic)] compared with voluntary treatment alone. This clearly indicates that 12 months or more of uninterrupted treatment is preferable. Clinic Treatment is almost invariably a central component of the AOT treatment regime.

However, access to these services has been limited, even in New York City where the program has been most successfully implemented. Currently waiting periods for admission into AOT are substantial in all five boroughs. In the final analysis, it is the community clinics that provide post-hospitalization care to clients admitted to AOT services. It is also the community clinics that provide care to the many clients eligible for

AOT service, who cannot receive these services because of waiting lists. Barriers to treatment in this context are evidently not advisable, clinically, economically or socially.

[2] **Financial and Economic Considerations Summary**
Data Source: Saba, D.K. (Thomson Reuters), Levit, K.R. (Thomson Reuters), and Elixhauser, A. (AHRQ). Hospital Stays Related to Mental Health, 2006. HCUP Statistical Brief #62. October 2008. Agency for Healthcare Research and Quality, Rockville, MD, http://www.hcup-us.ahrq.gov/reports/statbriefs/sb62.pdf AHRQ, Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project, Nationwide Inpatient Sample, 2006

There are 1,350,700 Mental Health related hospital stays per year in the U.S.. Proportionally, there is a much higher number of hospital stays in the Northeast than the rest of the country. The average hospital stay for mental health is approximately eight days. The average cost for each stay is approximately $15,000 nationally. In the Northeast it is substantially higher. The most frequently occurring diagnosis related to mental health hospital stays is mood disorders; schizophrenia is the second most common diagnosis resulting in hospitalization. Clearly, psychiatric hospitalizations are extremely expensive and preferably avoided.

As shown in figure 1, the two leading causes of MH hospitalizations were mood disorders (729,500 stays) and schizophrenia (380,600 discharges). Together, these conditions were responsible for 82 percent of all stays for which MH was the principal diagnosis. While mood disorders were also commonly listed as secondary diagnoses (3.1 million discharges or 43 percent of stays with MH listed as a secondary condition), schizophrenia was listed less frequently as a secondary condition (0.5 million stays, or 6 percent of stays with MH as a secondary condition). Common secondary MH conditions included dementia and other cognitive disorders, with 1.7 million stays, or 24 percent of all stays with MH as a secondary condition. Additionally, anxiety disorders were noted in 1.3 million stays, or 19 percent of stays with MH as a secondary condition.

Hospital stays for mental health, by region

After adjusting for regional population differences, rates of MH hospitalization varied substantially by region. The rate of MH hospitalization in the Northeast (5.9 stays per 1,000 population) was twice as high as in the West (2.6 stays per 1,000 population).

Hospital stays for mental health, by payer

In 2006, government payers were billed for more than 60 percent of all MH discharges (figure 2). Relative to its shares of all hospital stays, Medicaid was billed for disproportionately more MH stays (26.4 percent of stays for MH conditions compared to 19.5 percent of all stays). Similar to its share of all hospital stays, Medicare was billed for just over a third of MH stays. On the other hand, private health insurance was billed for a disproportionately smaller share of all MH discharges compared to all discharges (23.8 percent versus 34.1 percent). Finally, a larger percent of MH stays were attributed to the uninsured population compared to uninsured stays for all diagnoses (8.5 percent versus 5.7 percent).

Cost Structure

As the table on the next page indicates, the mean charge per day (nationally), in a Psychiatric Hospital facility is $1, 900. The mean length of stay is 8.2 days and costs $15,400 dollars. It is estimated that in the northeast and especially New York City, that costs can be 1/3 higher than the national average.

Table 1. Characteristics of hospital stays for mental health compared to all stays, for all age groups, 2006

	Hospitals Stays	
	Mental health, principal diagnosis	**All diagnoses**
Number of hospital stays	1,350,700	39,450,200
Mean length of stay, days	8.2	4.6
Mean charge per stay, dollars	$15,400	$24,000
Mean charge per day, dollars	$1,900	$5,200
Percent admitted from the emergency department	49.3%	43.8%
Percent admitted from another hospital	6.2%	3.5%
Percent admitted from long-term facility	3.6%	1.3%

Source: AHRQ, Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project, Nationwide Inpatient Sample, 2006

Emergency Room Visits

It is estimated that the average cost of an emergency room visit, (which does not result in hospitalization) is between $1,500 and $2,000 dollars. Police costs, EMS services as well as emergency room services are included in this estimate.