Testimony of
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NYS Coalition for Children's Mental Health Services
February 27, 2013

Before
The Joint Legislative Budget Hearing on Mental Hygiene

The Honorable John A. DeFrancisco, Chairman, Senate Finance
and
The Honorable Herman D. Farrell, Jr., Chairman, Assembly Ways & Means

"'The current behavioral healthcare system for children and their families is underfunded. Per capita investment in behavioral health for adults far outweighs investment in children, which could be remedied through reinvestment of existing resources." – Children's Behavioral Health Subcommittee Report to the Medicaid Redesign Team, Oct 2011

Chairmen Farrell and DeFrancisco, Assemblywoman Gunther and Senator Carlucci, thank you for this opportunity to testify about the Governor's Executive Budget for 2013-14.

I am Andrea Smyth, the Executive Director of the NYS Coalition for Children's Mental Health Services, a statewide association of over 40 nonprofit children's mental health providers. We offer quality outpatient, community-based and residential services for children and their families in every county in New York.

The Coalition urges that the Legislature revisit the original recommendations to the Medicaid Redesign Team as they pertain to children's behavioral health and conform the Medicaid spending decisions to those recommendations. Continued Legislative oversight of the implementation is essential for success.

Representatives from the Coalition did participate on the children's behavioral health subcommittee and we believe the following principles should be influencing Medicaid spending decisions as we enter year 3 of MRT implementation:

6. **Money saved should be reinvested smartly to improve services for behavioral health** - "The recommendations . . . are to be accomplished largely through the redistribution of existing resources; as inpatient and emergency room services decrease resources will be reinvested into community supports and rehabilitation services. Appropriate development and substitution of less costly and more appropriate alternatives to inpatient care" should be the goal of the behavioral health redesign.

And, reinvestment is justified specifically for the children's behavioral health system because:

"The current behavioral healthcare system for children and their families is underfunded. Per capita investment in behavioral health for adults far outweighs investment in children, which could be remedied through reinvestment of existing resources."

Since 2010, the Coalition estimates that more than $10 million in state-share savings is attributable to downsizing the nonprofit children's behavioral health system (RTF beds, Family Based Treatment elimination, Art 31 clinic closures). Additional service losses in child and

adolescent state-operated inpatient beds and general hospital child and adolescent units have occurred, although the Coalition cannot quantify the Medicaid savings associated with those service closures. And savings have been taken from the children's behavioral health system through rate freezes and lack of trend factors, resulting in further underfunding.

7. **Distinction in design and operation must be made to address the unique needs of children and their families** – For the general pediatric population, the recommendations includes: "Identify . . . the benefit package . . . for . . . Medicaid Managed Care . . . and commercial insurance plans. Ensuring access to a number of front-line services/benefits to prevent, screen and treat behavioral health disorders are the most important components to preventing long-term disability, significantly altering the trajectory of disability as a child enters adulthood, and reducing long-term costs. These recommendations consist of ensuring robust access to a number of interventions . . . including: routine [behavioral health] screening, including at well-child visits; crisis services available on a 24/7 basis; first-level interventions available within seven days; assessment, using accepted tools and diagnostic methods . . ."

And, for the high-need population, the recommendation includes: "Identify the enhanced elements of the benefit package and processes for a Special Behavioral Healthcare Managed Care Plan for children with special needs. . . . eligibility for the specialty managed care program should be based on a combination of clinical/functional status, i.e., DSM diagnosis of serious emotional disturbance or substance use disorder or the presence of complex symptoms and behaviors even in the absence of a formal diagnosis, and utilization of specialty services or risk of such utilization. In addition, because of their high risk for behavioral health problems, children with an individualized educational plan (IEP) or who are served in the child welfare or juvenile justice systems should have presumptive eligibility for enrollment in the specialty managed care program; for these children, the clinical and utilization thresholds should be lower than for the general child population and enrollment processes should be streamlined and facilitated."

9. **Regulatory burden should be minimized.** To date, regulatory relief is still a promise, but not a reality for Medicaid service providers in New York.

The Coalition asks that the following adjustments be made to the Executive Budget recommendations to 1) insure that the benefits and investments that are being offered to support restructuring be distributed with parity between health and behavioral health entities; 2) that

funding saved through the downsizing and restructuring of the children's behavioral health system be returned to support the remaining children's behavioral health providers so they can transform traditional services into shorter-term, responsive and community-based services; 3) capital debt restructuring not just be offered to high cost, high debt hospitals and nursing homes, but also to the lower-cost residential children's providers who must also transition and prepare for new and diverse ways of providing services to children and adolescents.

Here are the specific items the Coalition asks you to amend in the Governor's budget proposal:

1. Reject a sunset date on the Ambulatory Patient Grouping (APG) pass-through from OMH to DOH which ensures adequate reimbursement for lower cost outpatient mental health clinic services and instead require a two-year study of the outcomes, impact and stability of outpatient behavioral health clinics under Medicaid Managed Care. If we are not going to support the "Appropriate development and substitution of less costly and more appropriate alternatives to inpatient care lower" as was recommended to the MRT, then redesign will fail.
2. Reject giving authority to the commissioner to move the exempt populations and services (special needs children, foster care children, children receiving day treatment) into Medicaid Managed Care and retain oversight to ensure the proper patient protections and services supports are in place before authorizing enrollment. Late last year, DOH auto-enrolled 800 youth receiving cost-effective Home and Community based Waiver services into Medicaid Managed Care. The children were already receiving lower cost alternatives to out-of-home care and had a care coordinator, a service that is the equivalent to Health Home care coordination, yet were being discharged into mainstream Medicaid Managed Care without the behavioral health safety net that was keeping them from inpatient psychiatric care. Without diligent oversight over program design, efforts to meet quantitative targets may overshadow qualitative decisions
3. Embrace the cost-neutral test for stabilizing children's behavioral health services. Allow Medicaid savings achieved by closure of children's residential treatment facility (RTF) beds to be used to re-base the rates from the 2008 cost year and make the rate methodology responsive to statistical changes and length of stay reforms that have been achieved since then. RTFs have reduced the average length of stay by 40% over the last 4 years. This is evidence that despite not receiving Medicaid trend factor adjustments since

the 2008 costs were frozen, RTFs have made progress in service reforms, including in-home family work to facilitate quality discharges, to prepare for managed care. Further reformation is not possible without resources to support pilot projects, worker re-training and clinical enhancements that adjust the treatments and bed utilization into services the managed care environment will support.

4. Extend the authority to develop regulations that address the capital cost components of rates of payment by governmental agencies to children's residential providers (proposed for hospitals, nursing homes and other outpatient health care providers). This will protect public bond debt and ensure that as continuing efforts to downsize child and adolescent state operated inpatient capacity that RTFs are better designed to meet diverse needs of children who need out-of-home treatment.
5. Authorize the commissioner to waive state regulations that are unfunded mandates and deem federal regulations to be sufficient in an effort to provide financial relief to non-profits. And, initiate a regulatory review and report back to the Legislature on regulatory and payment reforms for the children's behavioral health system. The Coalition has recommended reform of state regulations that exceed federal requirements in the past (physician's role in restraints, psychiatric nurse practitioner scope of practice in certain settings, outdated admission certification rules and redundant single point of access procedures, inflexible bed utilization rules) and modernization requires the long-promised regulatory relief.
6. Address the Medicaid trend factor freeze policy as it pertains to lower cost service alternatives. The average per diem cost at an RTF is one-fourth of the per diem cost of a state-operated child and adolescent inpatient bed. After five years without trended costs on a 2008 cost basis, RTFs are beginning to close. If Medicaid redesign is to be successful, then supports for lower cost alternatives must be initiated before the lower cost alternatives are eliminated.
7. Fund the Human Services COLA so that valuable non-Medicaid services such as family support services and peer supports are available in sufficient volume for the children and families requiring behavioral health services.
8. Preserve prescriber prevails until a suitable replacement policy, such as "gold carding" can be reviewed and implemented. Significant patient protection advocacy related to access to

suitable prescription drugs has been necessary within the children's behavioral health care system since the October 2011 Medicaid prescription drug carve-in.

9. Address the educational needs of children whose behavioral health care needs; provide adequate support for 853 Schools and ensure the general equivalency diploma reforms allow for specialized test-taking provisions.

REINVESTMENT, PILOT PROJECTS and MODERNIZATION

Since 1993 the Legislature has supported reinvesting state savings generated by inpatient psychiatric bed reductions into community mental health services. This exchange has been an effective method of generating financial support for community based services alternatives for children and families. Bed closure and service consolidation will continue at OMH and OCFS state operated child and adolescent hospital and residential services. Yet, the Legislature has not created a role for itself in monitoring the amounts saved or the purposes selected for reinvestment. Last year, the Office of Mental Health correctly identified the need for information technology for behavioral health providers facing transition to managed care as a key reinvestment priority, yet no additional investment is recommended this year. The Legislature should play a role in identifying reinvestment priorities.

With regard to children's inpatient bed closures, one thing is perfectly clear: community based capacity is at a maximum and any further child and adolescent state hospital bed reductions, residential capacity reductions or general hospital inpatient reductions MUST be accompanied with community based alternative expansion in the community. Key services expansion must include crisis observation alternatives, respite beds, permanency planning, and family support services. Development of Regional Centers of Excellence for state-operated services should include identification and reconfiguration of community-based regional children's services to protect against exacerbation of insufficient children's behavioral health services.

We urge you to include the following proposed amendments:

<u>RE-basing</u>:

For rate periods on or after April 1, 2010, the commissioner, in consultation with the commissioner of the office of mental health, shall promulgate regulations, including emergency

regulations, that shall contain criteria for adjustments during 2013 based on length of stay and shall provide for periodic base year updates and adjustments to the utilization of base year costs and statistics. Such regulations shall be developed in consultation with the children's residential treatment facility industry, and shall go into effect no later than July 1, 2013.

*OMH data shows that the avg LOS in RTFs has decreased from 656 days in 2008 to 470 in 2012-13 – a 40% reduction

*Current rates assume 98% occupancy which is not occurring because the PACC process cannot keep pace with discharge rate

*Current base year assumptions do not support the clinical staffing enhancements necessary to reduce LOS

*The closure of the Children's Village RTF provides $2.2 million to support a "budget neutral" re-basing, if the Children's MRT Subcommittee's assumption that the children's mental health system is underfunded, no cost containment will be assumed under children behavioral health redesign, and children's behavioral health Medicaid resources will remain in the children's behavioral health system

Capital costs:

Notwithstanding any inconsistent provision of this section, and subject to the availability of federal financial participation, the capital cost components of rates of payment by governmental agencies for children's behavioral health care services, provided by residential treatment facilities on and after January 1, 2015 shall be determined in accordance with regulations promulgated by the commissioner, in consultation with the commissioner of the office of mental health. Such regulations shall be developed in consultation with the children's residential treatment facility industry.

*Being done for nursing homes and hospital inpatient/outpatient

*Necessary to make rates competitive in Medicaid managed care and prevent default on Dormitory Authority loans

*18 RTFs operating statewide

Pilots to Allow Lower Cost Services to Modernize for Medicaid Managed Care:

Authorizes the commissioner, to ensure adequate regional capacity for acute mental health care for children, to establish pilot programs at residential treatment facilities for the provision of intensive psychiatric treatment.

The Article VII bill would improve the short-term mental health treatment options for children leaving Office of Mental Health hospitals as a result of state hospital bed downsizing, by authorizing the commissioner to ensure the health and safety needs of certain communities are addressed as state resources are removed.

REGULATORY RELIEF

Please authorize commissioners to waive state regulations that are unfunded mandates and deem federal regulations to be sufficient in an effort to provide financial relief to non-profits struggling to meet quality standards and retain staff after 5 year without trended costs or cost of living adjustments.

PROVIDE ADEQUATE EDUCATIONAL SUPPORTS

Children' with severe emotional and behavioral challenges deserve access to quality education. The budget should include adequate resources to support 853 Schools, which provide educational and related services to students with disabilities who require residential care. The 853 Schools receive funding through a tuition rate methodology, but for the past 4 years have been functioning on a 2006 cost basis.

The Coalition supports the budget request of the Coalition of Special Act School Districts and the NYS Coalition of 853 Schools which would allow a growth amount equal to the personal income growth index on July 1, 2013.

We also urge that selection of the alternative General Equivalency Diploma vendor include a provision that allows special testing circumstances for individuals with special needs. Currently, students can prepare for segments of the GED exam, which minimizes anxiety and supports success. Without a continuation of this option, many youth with severe emotional disturbances will be unable to achieve high school equivalency diplomas and continue pursuit of higher education.

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