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Testimony Of

Andrea Smyth, Executive Director

New York State Coalition for Children's Mental Health Services

The Joint Legislative Budget Hearing on Mental Hygiene

February 11, 2014

John A. DeFrancisco, Chairman, Senate Finance Committee

and

Herman D. Farrell, Jr., Chairman, Assembly Ways and Means Committee

"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 2014-15.

I am Andrea Smyth, the Executive Director of the NYS Coalition for Children's Mental Health Services, a statewide association of over 50 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 support the following proposals in the Executive budget:

- $5 million for transition planning for the foster care system as currently exempt children are moved into Medicaid Managed Care
- $10 million for transition planning for plans, counties and providers to prepare their infrastructure for the transition to Medicaid Manage Care
- $25 million for pre-investment into community based services, which includes support for a 150 slot expansion of the children's home and community based waiver services program – and expansion that has already begun with Balancing Incentive Plan funds (64 new slots in 2013). Extend the pre-investment funds so they can be used for the development of both state-operated AND non-profit children's crisis/respite beds, as development of this service was highly recommended by every Regional Planning group established under the Regional Center of Excellence planning process.
- Nurse Practitioner modernization proposal; which is greatly needed in the children's behavioral health field to combat the severe child psychiatrist shortage.

The Coalition urges that the Legislature support, but modify the following proposals:

- Continue the APG pass-through to children's behavioral health outpatient providers until December 2017, with an amendment that specifies "or until 12 months after the full transition of currently exempt child and adolescent populations and services is complete"
- Authorize the new Reinvestment Program, "Community Based Behavioral Health Services Reinvestment Program", with an amendment that prioritizes the preservation of existing children's mental health outpatient capacity as essential community providers and

authorizing a children's essential community provider program to preserve the children's safety net providers through December 2017 or until the transition of currently exempt child and adolescent populations into Medicaid managed care is complete."

- Accept the Executive's recommendation to takeover ratemaking for the Child Health Plus insurance product, but amend the proposed 2014 rate freeze to exempt children's outpatient behavioral health visits and instead include the following except for the purpose of reimbursing providers licensed pursuant to article 28 of the public health law and article 31 of the mental hygiene law for ambulatory behavioral health services provided to those under the age of 21, such reimbursement shall be in the form of fees for such services which are equivalent to the payments established for such services under the ambulatory patient grouping (APG) rate-setting methodology as utilized by the departments of health or the office of mental health for rate setting purposes for behavioral health services provided April 1, 2014 through December 31, 2017 or until the transition of currently exempt child and adolescent populations into Medicaid managed care is complete.
- Amend eligibility for the proposed $1.2 billion capital cost fund to include Residential Treatment Facilities, a subclass of hospitals licensed under Art 31 of the Mental Hygiene Law
- Ensure the charge to the "Raise the Age" Commission (the Commission on Youth, Public Safety and Justice) is charged not only with reviewing sentencing and criminality policies for youthful offenders, but also is charged with identifying the array of services and supports that will be necessary to implement revised policies. The Coalition believes and upstate Juvenile Justice Residential Treatment Facility (RTF) and expansion of other community services that might be court-ordered will be required to link offenders with appropriate behavioral health services.

The Coalition urges the Legislature to add the following to the State Budget:

- Extension of the March 31, 2015 sunset date for the existing community mental health Support and Workforce Reinvestment act until March 31, 2016. This will ensure that whatever negotiations over state-operated bed downsizing can be concluded and the Legislature is able to ascertain the appropriate reinvestment values.

- Direct the Department of Health and the Office of Mental Health to institute a rate code modifier for Medicaid behavioral health clinic visits under the age of 21
- A partial year implementation of the Human Services COLA for the non-profit workforce.

Children's Behavioral Health Clinic Preservation Initiative:

With good reason, the transition of the exempt children's populations into Medicaid Manage Care is being carefully crafted and is not scheduled to begin until late 2016. While being among the last populations to be transitioned is appropriate, an unintended consequence is that the children's behavioral health care providers will go the longest under the Medicaid cost containment initiatives. Transitional support is required immediately to sustain the existing, behavioral health capacity for children's outpatient services. I refer now to the pie charts attached to the back of your testimony. Those show the fiscal status, as determined by the Office of Mental Health, of the roughly 40 "kids-only" clinics currently operating around the state. Based on this information, and because 2014 will be the first year that the Medicaid APGs will not be blended with supplements, 30 of the 39 "kids only" clinics are at severe risk of closure in 2014 because their significant deficits are growing.

Children's clinic Medicaid rates (APGs) were fully "transitioned" on October 1, 2013. Many children's providers experienced a 66% reduction in their 30 minute visit rate and a 56% drop in their 45 minute visit rate. This means Medicaid rates have been reduced, yet the child and adolescent population has not yet been fully transitioned from Fee for service Medicaid into Medicaid managed care. The plans and commercial insurers are still two years away from having to adjust their behavioral health rates to reflect the true cost of the whole-population behavioral health needs. And, the reality of the situation is that kids come to our clinics with their parents' health insurance. The APG calculations did not take into account that the kids' clinics would experience a more diverse payer mix than adult clinics would have. Take Child Health Plus for example, the average rate paid by CHP for a behavioral health visit is $67.11, while the APG rate is and average of $130 per visit. As you may have heard from the Health Exchange Director last month, 22,000 previously uninsured youth have been newly enrolled in CHP. If those new enrollees need mental health services and my clinics serve them at $67.11 per visit, their operating deficits will grow with each subsequent visit.

Article 31 clinics are not eligible for Vital Access Provider status, children's clinic providers have two more years to wait until plans become fully aware and familiar with the full cost of specialty behavioral health care, and without action this state will lose this essential community provider capacity.

We ask for three courses of action: direct DOH and OMH to institute a rate code modifier on the APG rates when youth under the age 21 receive behavioral health clinics services; approve DOH takeover of CHP rates, but reject freezing the behavioral health visit rates at the 2014 level and instead allow for the APG pass-through; and allow the newly proposed Community Behavioral Health Services Program to include a children's behavioral health essential community provider program so transitional support can be provided in 2015 and 2016 to fiscally distressed kids clinics.

Capital costs:

Allow Residential Treatment Facilities to be eligible for the proposed capital funds that will support transition and reconfiguration of the "built" children's behavioral health care services to be more responsive to communities.

Crisis Bed Pilots to Allow for Access to a Scarce Services:

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 to children in crisis who have been diverted from the emergency room or not admitted to a general hospital after presentation in the emergency department.

This change would improve the short-term mental health treatment options for children and families in crisis situations. As you may know, a state senator in Virginia was physically attacked by his son, and the son subsequently completed suicide, the morning after the Senator brought his son to the emergency room but was denied admission. The development of crisis/respite beds should not be limited to pilots at state-operated children's psychiatric centers. These beds must be developed in geographic areas that allow for quick access.

If the federal Waiver is approved, we believe this important initiative could be supported as a Delivery System Reform Incentive Programs (DSRIP) initiative, but we urge the Legislature to identify some priorities, like the conversion of excess residential capacity into crisis beds to assist

with emergency department diversions and quicker access to safe, out-of-home services for youth and families in crisis.

Regulatory Relief

Please authorize the proposed nurse practitioner modernization act. Restore prescriber prevails and reject the application of the proposed off-label prescribing restrictions for prescribers at OMH licensed facilities. The shortage of child psychiatrists and other authorized prescribers is not only driving up the cost of behavioral health care, it is negatively impacting on capacity. To adequately respond to increasing demands, we need sensible steps such as allowing experienced psychiatric nurse practitioners to supervise other nurse practitioners. We also need our available prescribers to have the ability to treat their patients with the most appropriate prescription drugs and not be impeded by the additional bureaucracy these initiatives represent. Lastly, we urge OMH to release long-awaited modernization of the nearly 40 year-old restraint and seclusion regulations currently in use.

Raise the Age and Community MH Reinvestment

I have attached position papers with more specific recommendations about these two important priorities.

Submitted by: Andrea Smyth Date: February 11, 2014

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NEW YORK STATE COALITION FOR CHILDREN'S MENTAL HEALTH SERVICES

2014 BUDGET REQUEST – PRESERVE CHILDREN'S MENTAL HEALTH CLINICS

Support policy and funding changes that, combined, will constitute a "Children's Mental Health Clinic Initiative". Without intervention, 30 of the 39 outpatient clinics licensed to serve only kids are at severe risk of closure in 2014.

What:

With good reason, the transition of the exempt children's populations into Medicaid Managed Care is being carefully crafted and will not occur until late 2016. While being among the last populations and services to be transitioned into Medicaid Managed Care is appropriate, an unintended consequence is that children's behavioral health care providers will go the longest under Medicaid cost containment initiatives. Transitional support is required to preserve children's behavioral health essential community providers.

Why:

- 51% or 22 of the 39 kids-only clinics are considered "distressed" by OMH; 8 more are "concerned" which means now that the legacy rate has ended (10/31/13) those 8 will fall into the "distressed" category too. Without assistance, 30 of these 39 clinics are at severe risk of closure in 2014 because the deficits are increasing.
- The APG rates do not adequately reflect the cost or productivity assumptions appropriate for children's mental health outpatient services.
- Child Health Plus is one of the highest volume third party customers for children's clinics and often provides among the worst reimbursement rates ($67.16 on average compared with $130 for the average APG rate)
- Children's clinic Medicaid rates (APGs) were "transitioned" before the populations are being transitioned. Therefore, the Medicaid rates have been reduced, but the commercial insurers have not taken over responsibility for the non-Medicaid eligible kids with severe emotional disturbances. Kids' clinics were not afforded appropriate payer-mix protections. Kids come to clinics with their parents' insurance status and commercial insurers have to adjust their behavioral health rates to reflect the true cost of the whole-population behavioral health needs.
- CHP enrollment is exploding through the NY State of Health Exchange – the Exchange Director testified, that as of January 10, 2014, approximately 22,000 new youth who were previously uninsured had been enrolled into Child Health Plus – without the APG pass through for behavioral health visits, clinics that serve the CHP population will increase their deficits with every additional visit.
- Article 31 clinics are not eligible for Vital Access Provider status; children's services have not had equivalent Medicaid Redesign investments as the adult mental health community has seen (supported housing investments).

Legislative Action Requested:

- Amend Part C of the S.6358/A.8558 to include children's behavioral health essential community providers as a priority funding target, because the unintended consequence of transitioning children's behavioral health services last is that those providers will stay the longest under the existing Medicaid cost containment provisions.
- Authorize the takeover of Child Health Plus rate-making by the Department of Health, but reject the rate freeze at 2014 levels and require the APG pass-through for behavioral health visits through December 2017 or whenever the full transition to Medicaid Managed care is complete for currently exempt children's population and services
- Direct OMH and DOH to investigate a rate code modifier for Medicaid behavioral health clinic visits to youth under 21 years of age.

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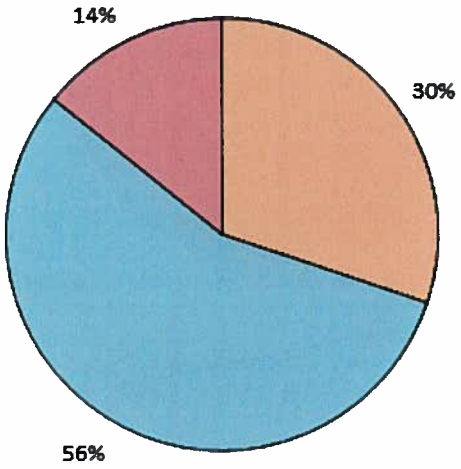
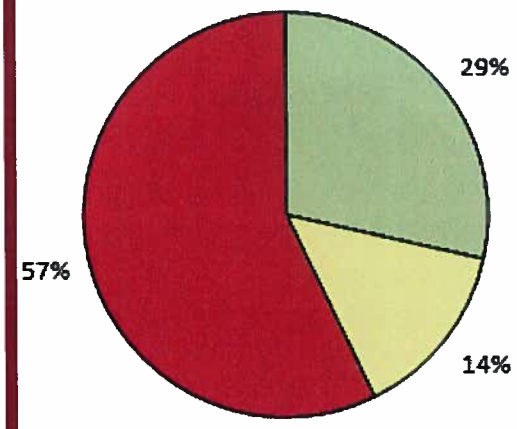
CLINIC PRESERVATION
ARTICLE 31 OUTPATIENT CLINICS - HIGHEST VOLUME PROVIDERS



Outpatient Clinics by Type - Statewide

- Article 28
- Article 31
- County Run

CLINIC PROVIDERS SERVING CHILDREN ONLY



HUDSON RIVER REGION (n=7)

Albany, Columbia, Dutchess, Greene, Orange, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, Washington, Westchester

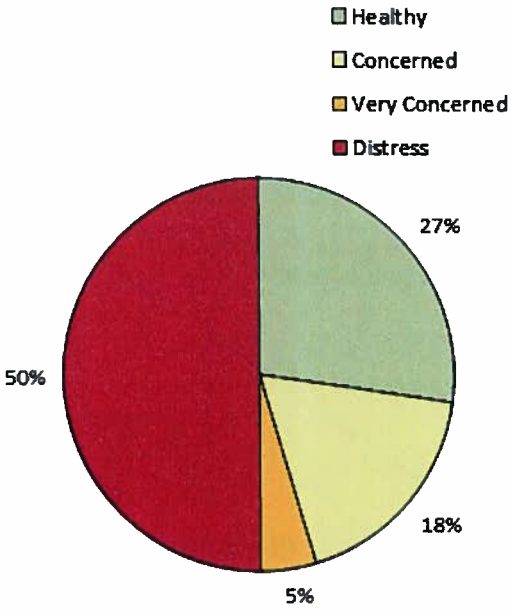
Clinics that serve both kids and adults =28*

79% of those serving both kids and adults are concerned, very concerned or distressed

NYC REGION (n=22)

Clinics serving both kids and adults =78*

*69% of those are concerned, very concerned or distressed



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NEW YORK STATE COALITION
FOR CHILDREN'S MENTAL HEALTH SERVICES

2014 BUDGET REQUEST – COMMUNITY MENTAL HEALTH REINVESTMENT

Amend and Extend the OLD REINVESTMENT (Community Mental Health Support and Workforce Reinvestment Program) and Authorize the NEW REINVESTMENT (Community Based Behavioral Health Services Reinvestment Program) with amendments.

What:

The original Community Mental Health Reinvestment Act contained carefully constructed formulas and decision-making over how state savings derived through the closure of state-operated psychiatric hospital beds should be spent. This year's budget allows the sucessor Community Mental Health Support and Workforce Reinvestment Program to sunset on March 31, 2015 despite continued debate about significant state savings through bed reductions and other service consolidations. The Article VII bill authorizes a new Reinvestment program, one that would be funded through savings achieved as we transition to Medicaid Managed Care to be reinvested into community behavioral health services identified by DOH, OMH and OASAS.

Why:

The Executive Budget correctly invests $25 million into expanding community based services to prepare for the future downsizing of state-operated psychiatric centers. National data comparisons show that New York's state-operated psychiatric hospital system is the largest and most expensive in the country. However, prior to downsizing the services that communities have come to rely upon, it is appropriate to build up the capacity of high-quality services that can provide alternatives to inpatient psychiatric services. This is especially true for the child and adolescent population for which crisis bed development and other intensive, but non-inpatient services are more appropriate. However, this investment does not preclude the need to capture the future savings of bed and facility closures that occur after January 2015. That is why we urge the Legislature to extend, with amendments, the Community Mental Health Support and Workforce Reinvestment Program's sunset date from March 31, 2015 until March 31, 2016. Amendments should include updating the per bed commitment to at least $110,000 per bed, considering the cost of living adjustments needs of the non-profit behavioral health care workforce and ensuring that Family Support Services are provided by credential individuals with lived experience and not supplanted by non-qualified state employees.

In addition, we urge the Legislature to accept the Executive Budget recommendation to create the, "Community Based Behavioral Health Services Reinvestment Program". However, we urge that S.6358/A.8558 be amended to prioritize not only residential services provided by OASAS, but also prioritize children's behavioral health essential community providers to preserve specialty service providers through the anticipated December 2017 full transition to Medicaid Managed Care of currently exempt youth populations and the specialty child and adolescent services.

Legislative Action Requested:

- Amend Part C of the S.6358/A.8558 to include children's behavioral health essential community providers as a priority funding target, because the unintended consequence of transitioning children's behavioral health services last is that those providers will stay the longest under the existing Medicaid cost containment provisions.
- Extend the sunset date in Section 7 of Part H of Chapter 56 of the Laws of 2013 to read, " . . . shall expire March 31, 2016 . . . "

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NEW YORK STATE COALITION FOR CHILDREN'S MENTAL HEALTH SERVICES

2014 POLICY PRIORITY – RAISE THE AGE

Support the creation of the Commission on Youth, Public Safety and Justice as proposed by Governor Cuomo. Amend the charge to the Commission so that it not only recommends how to "raise the age" of criminal responsibility from 16 to 18, but also recommends the array of services and supports necessary to address the anticipated demands on the Juvenile Justice system.

What:

We join other youth-focused organizations in supporting the Executive Budget proposal to allocate $250,000 to support the work of the Commission on Youth, Public Safety and Justice. The Commission will identify a comprehensive approach to adjusting the age of criminality in New York State by modernizing statutes, sentencing provisions and court procedures. It is time to Raise the Age in New York State and treat children and youth through developmentally appropriate means.

Why:

New York is one of only two states[1] in this nation that allows all children 16 and older to be prosecuted as adults, regardless of the alleged crime. In addition, in New York, children as young as 13 years old can be prosecuted as adults if they allegedly committed serious felonies and children as young as 7 years old can be found to be juvenile delinquents.

New York's laws are out of touch with the rest of the country, Supreme Court findings and the adolescent brain science research. Here are key facts that support the principles identified by the Raise the Age movement:

- Science has proven that brains are not fully developed until young adults are older than 20 years of age and frontal lobe development, the portion of the brain that controls impulsivity, develops last;
- Developments in psychology and brain science continue to show fundamental differences between juvenile and adult minds with frontal lobe brain activity closely associated with change capability and the ability of young people to accept and adapt when rehabilitative services are offered;
- The Supreme Court has twice[2] recognized that children are different from adults with regard to the justice system. In 2005, the Court ruled that the juvenile death penalty was unconstitutional based upon the retribution not being proportional if youth and immaturity compromises culpability. In 2010, the Court ruled that in non-fatal crimes, juveniles cannot be sentenced to life in prison without the possibility of parole, based on the fact that by denying the defendant the right to reenter society makes an irrevocable judgment about that person's value in society; and
- The Task Force on Community Preventive Services reviewed the effectiveness of laws relating to juveniles in the adult criminal justice system[3] and determined that adult punishment diminishes long-term public safety goals by making offenders more susceptible to re-offending and increases rates of violence among youth.

We urge the Commission to support:

- Ensuring that all youth are treated in an age and developmentally appropriate manner included raising the age of criminal responsibility so that the youth justice system includes: 1) providing rehabilitation services and treatment to all 16- and 17-year-olds as children, even those charged with violent felonies; 2) treating all 13- to 15-year-olds as children by repealing the Juvenile Offender Law; and 3) raising the minimum age at which a child can get be arrested to 12.
- Using the Family Court Act as the legal framework for all youth to allow for access to age-appropriate services and programs that help youth and increase public safety
- Funding court-ordered community programs and services to ensure access to the kinds of evidence-informed community-based services and alternatives to incarceration that have been proven to both help youth succeed and reduce recidivism; establishing new services, such as an Upstate Juvenile Justice Residential Treatment Facility (RTF) to treat offenders with severe emotional disturbances and to mirror the services now available downstate
- Adjusting probation procedures to increase the ability to divert cases from court and subsequent arrests.

1 North Carolina is the other state

2 Roper v Simmons; Graham v Florida

3 Washington, Pennsylvania, New York, Minnesota, Florida

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2014 LEGISLATIVE REFERENCE GUIDE

OLD REINVESTMENT:

Due to sunset March31, 2015 and not proposed for extension. ***To extend sunset: Amend Section 7 of Part H of Chapter 56 of the Laws of 2013.***

PRE-INVESTMENT:

$25 million to show good faith and expand community services prior to bed/facility closures. $11 million will be available through Balancing Incentives Program funding to add 150 children's Home and Community Based Waiver Services (HCBWS) slots between 4/2013 and 9/2015. 64 of the 150 new HCBWS slots have already been awarded to community providers and we urge the other 86 be awarded as soon as possible. (see BIP Plan Appendix E pgs.E.1-3 and E.1-4)

NEW REINVESTMENT HEALTH/MH:

Article VII p.110, line 41 – p. 111, line 26; please consider the following amendments to prioritize children's behavioral outpatient providers as essential community providers and eligible for transitional reinvestment support: Amend S.6358/A.8558, page 111, line 8 be amended to read, "services[.] and a children's behavioral health essential community provider program to preserve the children's safety net providers through December 31, 2017 or until the transition of currently exempt child and adolescent populations into medicaid managed care is complete."

CHILD HEALTH PLUS TAKEOVER:

s.6358/A.8558 – p 132, beginning on line 40; amend line 23 page 133 to read: thousand fourteen[.];except that for the purpose of reimbursing providers licensed pursuant to article 28 of the public health law or article 31 of the mental hygiene law for ambulatory behavioral health services provided to those under the age of 21, such reimbursement shall be in the form of fees for such services which are equivalent to the payments established for such services under the ambulatory patient group (APG) rate-setting methodology as utilized by the department of health or the office of mental health for rate-setting purposes for all services provided April 1, 2014 through December 31, 2017 or until the full transition of exempt child populations and services to medicaid managed care is complete.

Also in S.6358/A.8558:

Adding geographic accessibility to network adequacy criteria – The Children's Medicaid Redesign Team is still identifying Network Adequacy Standards. Therefore, please exempt specialty services and kids' services until there is an agreement around network adequacy standards for kids' carve in services; ***Modify that proposal to specify that the geographic accessibility criteria established prior to the transition of currently exempt populations and services will not apply to those services and populations.***