NYS Conference of Local Mental Hygiene Directors, Inc.

41 State Street, Suite 505, Albany, NY 12207 • (518) 462-9422 • www.clmhd.org

The New York State Conference of Local Mental Hygiene Directors, Inc.

Testimony to the Joint Budget Committee on Mental Hygiene Regarding the 2013-2014 Executive Budget Proposal

February 27, 2013

Robert C. Long, MPA,
Commissioner, Onondaga County Department of Mental Health, & NYSCLMHD Chair

Kelly A. Hansen,
Executive Director

Members of the Senate and Assembly Joint Committee on Health and Mental Hygiene, I want to thank you for having us here today to provide you with our feedback and recommendations on the Governor's Executive Budget Proposal.

My name is Kelly Hansen and I am the Executive Director of the New York State Conference of Local Mental Hygiene Directors. I am joined by Mr. Robert Long, who is the Chair of the Conference and the Commissioner of the Onondaga County Department of Mental Health.

The Conference of Local Mental Hygiene Directors is established pursuant to Article 41 of New York State Mental Hygiene Law and is a statewide organization comprised of the Directors of Community Services (County Commissioners of Mental Health) for the 57 county departments of mental hygiene, and the New York City Department of Health and Mental Hygiene. Each of our members is responsible for the planning, development, implementation and oversight of services to individuals with mental illness, substance use/addictive disorders, and developmental disabilities at the county level.

Our members are also responsible for administering the Assisted Outpatient Treatment (AOT) program locally, and have more recently been given the added responsibility to administer a new mental health practitioner reporting process under the New York SAFE Act. This provision of the SAFE Act, both by its timing and by its addition of unfunded local mandates has become our priority budget issue.

NY SAFE ACT: Mental Health Practitioner Reporting Certain Patients to the Local Director of Community Services

Chapter 1 of the laws of 2013, the "NY SAFE Act," adds a new Section 9.46 to the NYS Mental Hygiene Law which requires all mental health practitioners, as defined in the statute, to report to the local Director of Community Services (our members) or their designee, any person they are treating who they believe is likely to engage in conduct that would result in serious harm to self or others. The DCS is then required to confirm that the reporter is in fact a "mental health practitioner," and then assess the practitioner's report and make a clinical determination if we agree or disagree that the person is likely to engage in such conduct. We would then need to submit the name of the patient and the practitioner, along with other identifying information to the NYS Division of Criminal Justice Services. This new legal mandate is due to take effect on March 16, 2013. That is **seventeen days from today.**

Initial discussions regarding this new provision of law with some hospital counsels from across the State indicate that it is their belief that all admissions to psychiatric units (whether voluntary or

involuntary) will require a report pursuant to 9.46 to be filed with the DCS or designee. The most recent available hospital data show **over 210,000 psychiatric discharges** in the year 2010 alone.[1]

This will likely translate into over 200,000 reports to be received, evaluated, and passed on to DCJS from hospitals alone; and this number does not include the numerous others who might meet the 9.46 criteria who are not admitted to hospitals and whose names will be reported to the DCS or designee by practitioners in other settings, such as outpatient clinics and private practices. What makes the situation more egregious is that, since another part of the new law requires OMH to collect and report the names of all persons who are involuntarily committed to a hospital, most of the names we report will be duplicative of those reported by OMH.

Our members are simply not currently staffed and equipped to conduct this type of evaluation and reporting. The need to receive and assess all of these new reports will require the hiring of at least hundreds of additional local clinical and administrative staff on a statewide basis. In an initial fiscal impact calculation, the Conference has estimated that the SAFE Act reporting requirement would cost localities approximately $10-15 million annually to hire additional staff in order to comply with the 9.46 requirements to receive, investigate, and submit reports to the Division of Criminal Justices Services.

This is actually quite a conservative estimate, as it used an upstate salary average of around $55,000 per year for a Licensed Clinical Social Worker. Such staff, when we are even able to find one to hire, can command higher salaries in downstate and New York City, which would increase the fiscal estimate of this provision. While the Executive Budget includes over $30 million to State agencies to implement SAFE on the State Operations and Capital end, there is **no funding** provided to localities for the significant and recurring costs associated with this legislation.

Furthermore, due in part to the poor way in which the new statute is drafted, New York City and the other 57 counties in the State could become liable for damages and legal costs resulting from lawsuits which will be brought by persons affected by the DCS's agreement or disagreement with the diagnosis of the mental health professional. While reporting mental health practitioners were granted liability protection in the statute; the DCSs were not granted the same and remain open to liability.

We see this provision as an **unfunded mandate** of an unknown and potentially disastrous magnitude, for which localities are neither equipped nor funded to implement. If the statute's intent is simply to gather names, then the mental health professionals can report directly to DCJS. If the intent is to really assess each of these reports then all of it can be done by a state agency which is already legally required to collect most of this information anyway. To require local authorities to take on this huge responsibility and enormous potential liability with no resources in the current financial atmosphere is both unreasonable and unrealistic.

[1] NYS Department of Health SPARCS dataset, accessed January 31, 2013
http://www.health.ny.gov/statistics/sparcs/annual/ip/2010/t2010_02.htm

Our request to the Legislature is simple: Remove the Director of Community Services from the reporting process. This would allow mental health practitioners to file reports directly with the Division of Criminal Justice Services. This process would be similar, then, to the Child Abuse Central Registry and to reports that will be filed under the new Justice Center which will begin operations in July of this year. If the Director of Community Services is not removed from the process, we request that you add $15 million to the budget to cover the local implementation costs for 9.46 MHL.

OASAS STATE AID FUNDING AUTHORIZATION

The Conference supports Executive Budget language that would allow for the continuation of the State Aid Funding Authorization (SAFA) process through local governmental units (LGUs) as we have done for decades. The budget amendments to Article 25 of the Mental Hygiene Law would address an ongoing issue we have faced with OASAS, which nearly resulted in the inability for LGUs to process state aid funding for their local providers last year.

The Conference has been working with OASAS; and OASAS, in turn with the State Comptroller's Office, for over a year to resolve this issue administratively, but no practicable solution could be reached without a legislative amendment. The Executive proposal would allow the existing SAFA process for distributing local assistance to continue, rather than requiring OASAS to hire additional State staff to process contracts in the stead of localities.

We must stress that in the absence of this budget language, localities may be unable to distribute state aid to local providers; resulting in serious cash flow issues that could ultimately disrupt services. Or, OASAS would have to try to direct contract with all voluntary providers, if they even have the resources to do so, leaving localities out of the process altogether; which we would strongly oppose.

We recognize this is an arcane and technical issue, which also has included some "clean up" language; and the Conference has been working with Legislative staff in both houses to go through any questions they or the members have.

ATYPICAL ANTIPSYCHOTIC PRESCRIBER PREVAILS

The Conference opposes the Executive proposal to eliminate prescriber prevails for atypical antipsychotic drugs under Medicaid Managed Care. The Legislature rejected the elimination of prescriber prevails for atypical antipsychotics in the 2012 budget, with its restoration beginning only last month, in January 2013.

The Executive proposal to reverse this policy will not only will be potentially harmful to people who have worked with their physician or nurse practitioner to find the appropriate dosage and type of medication to remain stable and healthy; but it is inconsistent with the State's aim to allow people to lead more independent and stable lives. With the recent attention to psychiatric issues and Assisted Outpatient Treatment under the NY SAFE Act, we are very concerned with this policy which will once again subject many people with serious mental illness to lengthy managed care review and the rejection of coverage for medications that in so many cases have worked for them for years.

We thank the Legislature for restoring portions of prescriber prevails during the 2012-13 budget negotiations, and encourage you to do the same this year.

SOCIAL WORK LICENSURE EXEMPTION

The Conference supports the Governor's proposal for a permanent exemption for those entities currently covered by the social work and mental health practitioner licensure exemption that is currently due to expire on July 1, 2013. We also would like to correct any misunderstanding that this is not a statewide issue: **the social work exemption is a statewide issue**. Upstate, downstate, rural, and urban areas; none of our providers are spared the difficulty in recruiting and affording licensed clinical staff at the levels that the licensure law would require if the exemption is removed.

This exemption from the scope of practice of mental health practitioners, social workers, and psychologists applies to "the activities or services of any person in the employ of a program or service operated, certified, regulated, funded or approved" by OASAS, OMH, OPWDD, DOH, DOCCS, SOFA, OCFS, a local governmental unit, or a local services district. This exemption allows staff in these settings to provide services under the already-strict and quality-controlled regulatory framework established by the State and Federal governments, without requiring a graduate level degree and years of supervised clinical practice for nearly all staff.

Our members operate over thirty OMH licensed clinics, and over twenty OASAS licensed clinics. And I can tell you with confidence that **we already try** to only hire licensed social workers (LCSWs in particular) to provide treatment services; however there are still too few of them available to do so. There are already great demands on the licensed social work workforce, as in most cases we still need an LCSW or above to provide supervision of other clinical staff and to bill commercial insurance or Medicaid. Moreover, with the expansion of behavioral health service access through the Insurance Exchange, with all plans at Federal and State parity, behavioral health access issues may become even more pronounced.

The sunset of these licensure exemptions would cost already highly regulated providers hundreds of millions of dollars per year in additional salaries and training to employ only graduate-level licensed clinical staff social workers with three or more years of supervised clinical experience. At

the same time, even if we could hire more licensed clinical social workers, county-operated programs must comply with all union contracts and civil service rules which can limit our options to reconfigure our workforce or eliminate non-licensed professionals (which we do not want to do anyway). Actually many of our non-licensed professionals are highly trained, experienced, and contribute to excellent team-based clinical care, and they should be able to continue serving our local residents.

MEDICAID MANAGED CARE APG-EQUIVALENT PAYMENTS FOR OASAS CLINICS

The Conference supports a proposal in the Health budget that would require Medicaid Managed Care Organizations to pay APG-equivalent rates for OASAS clinic services when such services become part of the Medicaid Managed Care benefit in the future (likely by 2014). OMH clinics already receive APG-equivalent payments, as outpatient mental health services are currently included in the Medicaid Managed Care benefit package. APG rates reflect the reasonable cost of delivering services at efficiently operated clinics – providers cannot stay in business if they are paid less than what it costs to deliver services.

While OASAS outpatient clinic services are currently carved out of Medicaid Managed Care, State DOH plans to carve them in by April 1, 2014, which makes this conforming provision critical. Funding for these rates will be supported with existing OASAS Medicaid funding that is currently applied to fee-for-service payments.

HEALTH HOME ENHANCEMENTS

The Conference supports the Executive appropriations for Health Home infrastructure grants and "Health Home Plus" rate enhancements.[2]

Health Home Plus

The Executive budget includes funding to enhance payments to some Health Homes serving the highest-need individuals included persons on Assisted Outpatient Treatment or Enhanced Voluntary Service agreements, and those leaving OMH psychiatric facilities.

The Conference strongly supports funding for these populations, particularly given our members' direct responsibility for oversight and operation of Assisted Outpatient Treatment programs locally. While the original Executive proposal provided $10 million for HH Plus; the one-year delay of

[2] Please note that the Governor's 30-day amendments have delayed the implementation of infrastructure funds and Health Home Plus until April 1, 2014 as part of the 2-year Health/Medicaid budget.

this initiative in the 30-day amendments appears to reduce the State portion of this sum by $2 million (net reduction is unclear at this time).

Infrastructure Funds

New York's Medicaid State Plan for Health Homes requires Electronic Health Record (EHR) capabilities for all network providers within 18 months of the approval of the Health Home. However, up to this point, most behavioral health providers and agencies have been unable to meet criteria for EHR payment enhancements; while physicians, hospitals, and other Article 28 settings have benefitted from these funds for years.

The Conference and its national counterparts have advocated at the federal level to permit parity in access to these funds by amending HITECH, but we have had little success in Congress to date. As such, these infrastructure funds are a critical measure to level the playing field and allow behavioral health provider settings to meet EHR requirements under the State Plan.

In addition to EHR enhancements, other funds to support Health Home infrastructure will help support the administrative activities which heretofore the Health Homes have attempted to extract from cash-strapped localities and targeted case management (TCM) providers.

STATE PSYCHIATRIC HOSPITAL CLOSURES

The Executive Budget proposes unlimited State discretion over the closure and consolidation of State psychiatric hospitals, while exempting such closures from the Community Reinvestment Law and shortening public notice requirements even more than in past years. The Conference fully supports the treatment and support of individuals with serious mental illness in the most integrated setting of their choice; however this is difficult to effectuate locally if the State plans to remove the majority of reinvestment funding that would be required under the annually suspended Mental Hygiene Law 41.55.

We recognize and support the Office of Mental Health's intention to reinvest a portion of State hospital closure savings into the community mental health system ($5 million annualizing to $10 according to OMH), and we look forward to more detail on how this funding will be allocated and the extent to which it is proportionate with individuals' service and support needs in the community.

While the development of more supportive housing, along with Health Home Plus funds for people exiting State hospitals are intended in part to offset any losses from the reinvestment suspension; such initiatives are still in the development stages, while localities and the people they serve require resources and supports *today*.

MENTAL HEALTH INCIDENT REVIEW PANELS

The Conference supports the creation of Mental Health Incident Review Panels which the State OMH could convene after a serious incident involving a person with mental illness has occurred in the community. Such incidents would involve a person with a serious mental illness being either the alleged perpetrator or the victim in an incident leading to physical injury, a serious and preventable medical complication, or a criminal incident involving violence. The panels would include local governmental units, OMH staff, and other representatives from the community.

The panels will help localities identify systemic issues that may contribute to such incidents, and use this information for quality improvement measures. Concerns over confidentiality and legal liability have prevented incident reviews of this nature to date; the Governor's proposal would address these concerns and allow for the State, LGUs, police departments, and others to communicate more freely and openly, which can help prevent such incidents in the future.