Testimony

of

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Commissioner

and

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New York City Department of Health and Mental Hygiene

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Good afternoon Chairpersons Koppell, Wills, and members of the Committees. Congratulations, Council Member Wills, on your recent election and appointment to this important post. I am Dr. Tom Farley, New York City Health Commissioner. I am joined today by Dr. Adam Karpati, Executive Deputy Commissioner for Mental Hygiene.

The Department of Health and Mental Hygiene is responsible for protecting and promoting the physical and mental health of all New Yorkers. We advocate for public policies, strive to improve quality of care and access to services, and provide services to those in need – either directly or through contracts with organizations in the community.

The Division of Mental Hygiene works in collaboration with our sister City agencies, as well as with our State partners in the Office of Mental Health, Office of Alcoholism and Substance Abuse Services, Office for People with Developmental Disabilities, and the Department of Health. The Division is responsible for the Department's efforts to reduce the burden of mental illness, substance use disorders, and developmental delays and disabilities faced by New Yorkers by funding more than 1,000 community-based programs that provide medical treatment, rehabilitation, housing, case management, family support, and other services. We are also responsible for administering the Early Intervention Program for children with developmental delays, through contracts with more than 100 community-based providers who conduct evaluations, coordinate services, and provide services such as speech therapy, special instruction, and physical and occupational therapy.

While we remain committed to improving services for our populations, the difficult fiscal climate at the City and State level will, unfortunately, mean service reductions for Mental Hygiene. Today we will highlight some recent initiatives in Mental Hygiene, discuss our budget challenges, and describe a legislative priority that we hope the Council will support.

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State Budget Overview

Although the Governor announced a budget agreement last night, it is not yet clear what impact the budget will have on our mental hygiene programs. There are several proposals involving spending reductions and efficiencies, including provisions affecting the Early Intervention (EI) program. Funding for all optional services under Article 6 is at risk, including about $3.7 million to support the administration of the Early Intervention program. Since Early Intervention itself is not an optional service, we strongly oppose this cut.

In addition to the Early Intervention-specific proposals, we also expect that the final State budget will include substantial reductions in local assistance, which could be passed along to the City as well as directly to providers in New York City.

As you are aware, as part of the budget planning process, the Governor convened a Medicaid Redesign Team to develop recommendations that reduce the cost of New York State's Medicaid program, while maintaining or improving quality of care for those enrolled. The team approved a package of 79 such proposals in late February, which have been incorporated into the Governor's budget proposal that is now before the State Legislature. Several of the proposals relate to behavioral health and, if adopted, will have a substantial impact on New Yorkers with serious mental illnesses and substance use disorders.

The most significant recommendation around behavioral health to come out of the Medicaid Redesign Team is a plan to bring managed care to the currently fragmented system that serves people with serious mental illnesses and substance use disorders. We feel that this plan – which will in two years' time establish an integrated payment system that covers both physical and behavioral health services – will improve care and care coordination, maintain a dedicated, specialized focus on these often vulnerable, high-need populations, and promote the integration of physical and behavioral care. Importantly, it also establishes a role for City government in system planning and oversight.

We are also excited about the proposed expansion of two programs we have implemented in New York City. The first, screening, brief intervention, referral, and treatment, or SBIRT, in health care settings has proven effective for reducing risky or dangerous alcohol and drug use, and we hope to expand our own successful program into private physicians' offices.

The Medicaid Redesign Team's recommendations also propose a three-fold expansion of the City's Managed Addiction Treatment Program, or MATS, a comprehensive case management program for Medicaid enrollees with high levels of expenditures for alcohol and drug treatment services within the one to three years prior to program enrollment. Initial Medicaid utilization analyses post-MATS enrollment show significant cost savings for enrollees, averaging a projected $27,000 per person per year.

Finally, two additional critically important programs that are aligned with our own policy priorities have been included in the Medicaid Redesign Team package. An interagency work group is established to create 5,000 -10,000 supported housing opportunities for individuals at risk of nursing home placements. Additionally, care coordination through "health homes" is proposed for high-cost, high-needs individuals. The State is eligible for a 90% federal match for this care coordination, authorized by federal health care reform legislation.

Programmatic Highlights

Dr. Karpati will take you through rest of our testimony, starting with programmatic highlights.

As you may remember, the Department conducted a media campaign in the subway system in both English and Spanish over the holiday season highlighting the dangers of excessive drinking. Alcohol-related morbidity, including chronic illnesses, violence and accidents, is preventable, yet the burden in the City is quite high. For example, one in ten hospitalizations in the City is alcohol-related. Recent binge drinking was reported by half of underage drinkers and by 42% of adult drinkers. Recent data show significant increases in alcohol-related emergency department visits for all age groups over the past several years. We are particularly concerned about younger initiation to drinking among adolescents.

Overdose deaths from illicit drugs continue to decline overall, an encouraging trend, although accidental poisoning deaths by prescription opioids are increasing. Unintentional poisonings from prescription opioids in the city increased by 20% from 2005 to 2009. And the rate in Staten Island is twice that of the other boroughs. We will soon release a report on prescription opioid use and related morbidity and mortality. In addition, we will publish recommendations for physicians around opioid prescribing.

Expanding access to supported housing for people with mental health and substance use problems is a major priority for us. Through the New York/New York III program, in collaboration with City and State partners, we have successfully expanded supportive housing to several populations at risk of homelessness, including families, older youth exiting foster care, and people whose primary illness is substance abuse. Of the 4,850 total scatter site and congregate units the City is responsible for establishing by 2016, we have awarded 83% of contracts, and have filled 43% of the awarded units. Although the units filled for scattered site units is over 93%, there remain challenges in developing congregate site units, namely identifying appropriate locations and contractors and overcoming neighborhood resistance.

New Yorkers with psychiatric disabilities often face challenges of unemployment, housing instability, and poverty. In an effort to promote financial literacy for individuals with serious mental illnesses, the Department sponsored a forum for mental health consumers on economic self-sufficiency in late January. The event was billed as a mental health consumers' guide to earning and saving without losing benefits. Presenters focused on asset development, debt management, work incentives, Medicaid buy-in and individual development accounts. Due to the overwhelming demand, we plan to hold another forum this summer, and will develop additional strategies to increase financial literacy among consumer and provider communities.

We continue to work with Early Intervention providers to maximize parent involvement and participation in helping their children's development. To that end, we are offering intensive and extended training for Early Intervention providers, including direct mentoring by Division staff in techniques for parent engagement and empowerment. To date, nearly 600 service coordinators, interventionists, and clinical leaders have been trained, and we expect an additional 300 to participate through the end of this fiscal year.

Finally, we are also pleased to report that we are moving forward on implementing two recent grant awards. Under the Health Care Efficiency and Affordability Law for New Yorkers Capital Grant Program (the HEAL NY Program), we have begun efforts to assist mental health providers adopt electronic health records and establish interactive health information networks to enhance care coordination for patients with schizophrenia and depression. Similar progress has been made with our Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) grant, through which we are promoting the wellness of young children in Hunt's Point and East Harlem through integration of behavioral and physical health services and coordination across child-serving systems. We are excited about these opportunities, and look forward to updating you on our progress.

FY11-FY12 Outlook

This past November, the Department had to reduce its budget of City funds by 5.4% for FY 2011 and 8% for FY 2012. As you know, these cuts come after five successive rounds of reductions to City agencies over the past two years. For the Mental Hygiene division, the November plan meant a reduction target of close to $10 million, just under half of which will be implemented in the current fiscal year.

The cuts made in the Department and in our Division are always painful. As I mentioned in my testimony before this Committee in February, we are in a position

where our prior strategies of converting City funding to Medicaid, eliminating funding for programs that were closing and cutting from underperforming programs are no longer available. We are now forced to make cuts to programs that are generally performing well. In the November plan, the reductions to Mental Hygiene included cuts to outpatient substance use treatment programs, mental health programs not using best practice service models, supplemental funding to the remaining Article 16 clinics in our portfolio, and funding and given to the Health and Hospitals Corporation. We have tried to minimize the number of people affected by these reductions as much as possible, and our staff will be actively involved in assisting consumers with transition plans, including sharing information and making connections to other available resources.

We do not make these decisions lightly, and I want to share with you our prioritization process for making reductions to programs. In some cases we make proportional reductions across a portfolio, while in other cases the cuts are more targeted. This decision is informed by how City funds are allocated to program types within the larger portfolio as well as considerations about service priorities. Those considerations include assessments of whether programs serve substantial numbers of consumers, the availability of similar services elsewhere in the City, and the availability of alternative funding streams for a program type, including the ability to leverage Medicaid funding. When we initiate targeted cuts to programs that are generally performing well, we do so because in our assessment such a cut will have a lesser impact on the system's ability to serve those who are most in need than making cuts to other services.

In such difficult financial times, we use every available opportunity and strategy for strengthening the service system to reach the populations we care about – including exercising and improving our oversight roles, exploring new funding opportunities, and actively participating in policy development at all levels of government.

Legislation

Before Commissioner Farley and I take your questions, I want to mention one legislative proposal that we hope you will support in Albany. We are vigorously supporting a proposal that would require private insurance plans to pay their fair share of Early Intervention costs. This would close loopholes in State law that have permitted insurers to unfairly shift the cost of EI services to taxpayers since 1993, and save the City and the State tens of millions annually. Before the Early Intervention program was created in 1993, insurance companies covered these services. Now that they are provided through EI, which has a rigorous screening process, insurers should cover these services again. I hope that the members of these committees will support our effort to protect Early Intervention services in the long-term for the children and families who need it.

Thank you once again for the opportunity to testify, and thank you for your steadfast support of our mental hygiene programs. Commissioner Farley and I are happy to answer any questions at this time.