The Impact of Reimbursement Rates on Access to and Delivery of Behavioral Health Services

Susan A. Storti, PhD, RN, NEA-BC, CARN-AP
President & CEO

Overview of Issues

- Disparity between physical health and behavioral health reimbursement rates
- Insufficient rates for the delivery of general outpatient services across the spectrum of service delivery (i.e., CMHOs, SUD Treatment providers, private practitioners)
- Insufficient growth of rate levels over time in comparison to increasing costs of services
- Differences between Medicaid and non-Medicaid rate structures
- Individual client needs determine the service intensity. Service intensity directly affects payment rates and provider costs.

Overview of Issues

- Variable rates for long-standing contracted providers versus the rates for newer contracts
- Lack of structure to periodically review reimbursement rates
- Workforce Implications:
  - Impedes ability to hire
  - Benefits and wages (utilizing wage scales established 10+ years ago)
- Unfunded programmatic mandates and clinical supervision
- Lack of services and levels of care (i.e. adolescent residential SUD treatment – $10 million spent out-of-state as reported by DCYF 2016-2017; paying RI based agencies $180/day; paying out-of-state agencies $900/day)

Overall Impact

- Subsidizing outpatient services, emergency services, children's outpatient services, etc. resulting in substantial loss of revenue
- Subsidizing prescriber services (average loss of $100,000 per prescriber)
- Exhausted lines of credit
- Lack of certification for some facilities and/or providers to provide services
- Absence of reserve to address capital needs
- Reduction and/or restructuring of services
- Reducing and/or closing of outpatient services
- Difficulty recruiting and retaining qualified staff

Overall Impact

- High turnover rate among front-line staff (i.e., case managers, substance use disorder counselors, etc.)
- Loss of benefits and/or income (i.e., furlough days equated to between 10-15% pay cut)
- Programs paying for reduction in workforce in unemployment tax as high as $750,000
- Inadequate rates are driving providers from the system and deterring the addition of new ones
- Diminish the ability of remaining providers to offer evidenced-based practices, high-quality care
- Medicare reimbursement – insufficient rates limits the number of providers willing to accept patients

Considerations…

- Cost of living adjustment every year in payer contracts
- Creation of a Task Force to examine cost-based reimbursement models
- Legislation to establish periodic review of reimbursement rates

Examples:

- Nevada
- Colorado
- Massachusetts

State	Schedule for Review	Legislation	Description
NV	4 years	Assembly Bill No. 108 - An Act Relating to Medicaid: requiring the Division of Health Care Financing and Policy of the Department of Health and Human Services (effective July 1, 2017)	To review the adequacy of Medicaid reimbursement rates every 4 years. If the Division finds that the rate of providing the service or items, does not accurately reflect the actual cost of providing the service or items, this bill requires the Division to calculate the rate of reimbursement that accurately reflects the actual cost of providing the service or item and recommend that rate to the Director for possible inclusion in the State Plan for Medicaid

State	Schedule for Review	Legislation	Description
CO	At least every 5 years	Senate Bill 15-228 – Medicaid Provider Rate Review - Concerning approves for the periodic review of provider rates under the "Colorado Medical Assistance Act", and in connection therewith making an appropriation. (approved June 5, 2015)	The General Assembly adopted Senate Bill 15-228 which created a process for the periodic review of provider rates under the Colorado Medical Assistance Act. In accordance with section 25.5-4-401.5, C.R.S., the Department established a rate review process that involves four components: - assess and, if needed, revise a five-year schedule of rates under review; - conduct analyses of service, utilization, access, quality, and rate comparisons to an appropriate benchmark for services under review and present the findings in a report published the first of every May; - develop strategies for responding to the analysis results; and - provide recommendations on all rates reviewed and present in a report published the first of every November

State	Schedule for Review	Legislation	Description
MA	Annually for institutional providers, and at least biennially for non-institutional providers	Senate, No. 2400, Part I – Administration of the Government, Title XVII – Public Welfare, Chapter 118E Division of Medical Assistance, Section 13D (2012)	13D - The executive office, or a governmental unit designated to perform ratemaking functions by the executive office shall: (i) determine, after public hearing, at least annually for institutional providers, and at least biennially for non-institutional providers, the rates to be paid by each governmental unit to providers of health care services and social service programs, provided, however, that for the purposes of this section, social service program providers shall be treated as non-institutional providers; (ii) determine, after public hearing, at least annually, the rates to be charged by each state institution for general health supplies, care or rehabilitative services and accommodations; (iii) certify to each affected governmental unit the rates so determined; (iv) determine, after public hearing, at least annually, and certify to the division of industrial accidents of the department of labor and industries, rates of payment for general health supplies, care or rehabilitative services and accommodations, which rates shall be accommodations, which rates shall be paid for services under chapter 152; (v) upon request of the division of insurance, assist the division of insurance in the performance of its duties as set forth in section 4 of chapter 176B; and (vi) may establish fair and reasonable classifications upon which any rates may be based for rest homes, nursing homes and convalescent homes; provided, however, that the executive office shall not cause a decrease in a rate or add a penalty to a rate because such home has an equity position which is less than 0.

Questions