Reform and Restructuring of Article 31 Clinic Reimbursement Methodology

This paper proposes replacing the current static reimbursement methodology with a uniform system-wide rate that reflects direct and indirect costs of delivering clinic services and that will ensure successful outcomes for consumers

Article 31 mental health clinics are facing both a programmatic and financial crisis. Since mental health clinics provide vital services to consumers seeking treatment and recovery, the risk to the survival of community based clinics has real consequences for vulnerable individuals; potentially exacerbating homelessness, emergency room visits, re-hospitalization, drug addiction, physical illness, unemployment and interaction with the criminal justice system.

Current reimbursement mechanisms are stagnant, archaic and unsupportive of the principles of active treatment, rehabilitation and recovery promoted so widely from Washington to Albany. Medicaid reimbursement for mental health clinics is fragmented and the rate methodology fails to address inflationary expenses borne by providers. It fails to reflect variances in who is served and in what setting. Nor is reimbursement tied to any measure of outcome for those receiving treatment.

We believe that inadequate reimbursements and growing costs have led to the closing over the past three years of seven community-based mental health clinics in New York City alone. Many others are sharply reducing their client loads or are at risk of closing entirely. The demand for clinic treatment is increasing at exactly the same time the supply of services is diminishing as a consequence of incurred deficits. Furthermore, the demand for community-based clinic treatment is being driven by State policies that rely on these programs for aftercare and alternatives to institutionalization.

In response to this crisis, the Coalition of Behavioral Health Agencies has spent the better part of two years examining the numerous costs incurred by dozens of clinic providers. The Coalition also examined the inadequate and restrictive nature of the Medicaid reimbursement that these providers receive for providing this care. Based on the study, The Coalition developed a proposal for a more creative and cost-sensitive method of reimbursement; one that accounts for a range of costs - direct and indirect - associated with providing service to diverse consumers in a variety of settings. The proposal also suggests a method of provider accountability. This new system is designed to ensure favorable outcomes while leading to systemic cost savings including the reduction of Medicaid spending for higher cost behavioral and primary/acute care in institutional settings.

Background

For nearly fifty years, Article 31 clinics have formed the backbone of the community-based mental health sector. In the single year of 2003, over 90,000 men, women and children received treatment from community-based Article 31 clinics, comprising almost 80% of New Yorkers who sought publicly-funded mental health care.

But while this treatment modality is among the most commonly utilized, it is also increasingly one of the most poorly funded. Current Medicaid rates for mental health clinics, not including COPS, cover roughly half of what it costs for most clinic providers to offer basic treatment and care to their consumers. For those clinic providers who regularly see consumers with complex forensic histories, co-occurring addictive disorders or who have endured long periods of homelessness, the discrepancy between cost and reimbursement grows exponentially. The same is true for high need geriatric clients and seriously emotionally disturbed (SED) children.

Existing clinic reimbursement rates do not account for inflationary factors like yearly rent hikes, fuel and energy expenses and the cost of training, retaining, and supervising professional staff. The standards continue to increase for client tracking, accountability and successful outcomes, but reimbursements fail to keep pace with the costs of service. The rates do not account for a variance in the types of populations served, thus offering the same basic rate for a costly visit to a homebound elderly and infirm consumer that it does for an office visit for a more ambulatory individual. The rates only marginally account for the much higher cost of treating children and adolescents.

Our Recommendation

The undersigned organizations support the Coalition's conclusions and advocate for a new system of reimbursement for Article 31 clinic providers that will support a more efficient and sustainable therapeutic relationship between providers and consumers, and will help reduce State costs in more expensive and dehumanizing settings such as hospitals, jails, shelters and prisons. To safeguard providers and the State from Federal audits, the proposal will ensure that essential non-Medicaid services will only be funded by non-Medicaid dollars. Case management services connected to the treatment of certain high-service need consumers will help expedite the coordination of behavioral, primary and acute care. The State will also fund rehabilitation services that Medicaid will not cover as the system moves to client centeredness and toward a greater recovery orientation.

The Coalition recommends a system of reimbursement for Article 31 clinic providers in which rates are:

- Tied to certain performance based measures for State target populations;
- Based on uniform regional rates; adjusted according to the respective staffing model (i.e. contract vs. full time staff with benefits);
- Annually adjusted using an established inflation indicator;

- Periodically rebased to reflect new technologies and requirements;
- Inclusive of a property pass-through component to address skyrocketing rental and energy costs;
- Adjusted by supplementary reimbursement to address the high-service needs of target priority populations; and
- Calculated to assure adequate funding to support supervision, training, quality improvement and infrastructural support.

Statement on **Reform and Restructuring of Article 31 Clinic Reimbursement Methodology** is endorsed by:

Coalition of Behavioral Health Agencies, Inc.
New York State Council for Community Behavioral Healthcare
UJA/Federation of New York