The Ohio Council
Of Behavioral Health & Family Services Providers

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Testimony to Joint Medicaid Oversight Committee
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Good morning, I'm Hubert Wirtz, CEO of the Ohio Council of Behavioral Health & Family Services Providers. The Ohio Council represents nearly 160 community organizations that provide addiction prevention and treatment, mental health and family services to people across the lifespan – from early childhood to elderly adults. I appreciate the opportunity to share our perspective on where we are with the behavioral health system redesign work that has been underway now for some time – a process where success is important if we are to have meaningful, effective integration with managed care.

Let me start by expressing appreciation for the state's hard work, inclusiveness and attention to stakeholder engagement. We have taken very seriously the commitment to aligning the behavioral health system with the health care industry; to ensuring that we maintain access, capacity and workforce in the community behavioral health system; and the added resource investment. This investment is particularly important in the context of increasing service need, particularly in groups of people effected by increasing drug use addiction, and severe and persistent mental illness.

I want to also say that the Ohio Council and its members have long supported the purpose and goals of the redesign effort. These include:

- Population-based health care in the context of the Institute for Healthcare Improvement's Triple Aim (improve patient experience, improve population health/outcomes, and reduce per capita healthcare cost)
- Integration of primary and behavioral health care
- Better care management
- Payment reform

Despite the state's commitment to maintaining and investing in behavioral health system access, capacity and workforce, there are a number of remaining concerns that are worrisome and will likely have some serious unintended consequences:

- Nursing Rates: We appreciate that Medicaid has invested in psychiatric services by proposing rates at 100% of the Medicare maximum rate for professional services. However, the proposed rates for CNS/CNP/PA paid at 85% of the physician fee schedule are not sustainable. Limiting the reimbursement for CNS/CNP/PA practitioners (13% of our psychiatric workforce) impairs providers' ability to offset the 50% revenue loss associated with the TBS/PSR rates for RN/LPNs (64% of our psychiatric workforce). There is not a sufficient number of psychiatrists, child psychiatrists, addiction psychiatrists, or psychiatric nurse practitioners to sustain current service capacity. We anticipate a reduction in force for RN/LPN nursing positions (this has already begun), and nursing clinics to support medication adherence will be eliminated. Team-based psychiatric medical care will deteriorate and fragment (the opposite of what the state is rightly committed to promoting through the expansion of patient-centered medical homes).

- TBS/PSR/CPST Workforce: While the state has made some recent adjustments that address workforce issues temporarily, we remain concerned with how cumbersome and complex implementation of these services will become and the long-term negative workforce implications. The newly proposed education and experience requirements and the high turnover rates (25-30%) for people currently doing these services will have a serious negative workforce pipeline impact. Providers currently use many non-licensed and trained workers (41% of the behavioral health workforce). Providers have developed relationships with academic institutions to support

entry level positions and experience development. Following a proposed one-time grand fathering of the experience requirement, which we appreciate, we will have new barriers to our current workforce pipeline. The proposal regarding remaining CPST services is also troubling. What is proposed as a solution for licensed staff to continue to provide essential community based recovery support services will create financial disincentives for licensed staff to serve the most complex, risky and high need patients. It is perplexing that licensed staff providing CPST services would be paid less than what is proposed for TBS provided by unlicensed staff with BAs and MAs.

- SUD Residential: We remain concerned with the proposed staffing requirements for SUD Residential services. The proposed staffing requirements go well beyond the American Society of Addiction Medicine (ASAM) criteria, which does not explicitly define staffing. It does not recognize the current composition of residential staffing and adds requirements, particularly for medical, psychiatric, and nursing staff, that will create barriers for building these levels of care. While the recent state proposal indicates providers will no longer need to have a psychiatrist "on staff", it still requires access to a psychiatrist. We need additional details about what is expected under the model. Furthermore, we strongly feel the staffing requirements should be described in MHAS certification rules rather than Medicaid rules/provider manual. We need additional details as to how the staffing requirements will be applied from a payment perspective – how will staff vacancies or variations from the "requirements" impact payments.

- MH Day Treatment and Partial Hospitalization: The current model does NOT include partial hospitalization as a defined service, perpetuating a major gap in the continuum of care. The proposed hourly day treatment rate and TBS per diem rate for day treatment group activities will not support the existing services, particularly for children and youth. The TBS eligible provider requirements (BA, MA) are a major challenge that fails to understand the team based model of care used to sustain these services. Additionally, unbundling group activities from individual interventions adds unnecessary complexity and may be a model that cannot be supported by existing time based IT systems. Finally, we question the rate model assumptions used to develop these rates.

- Group Counseling: The proposed rates for group counseling services remain too low across the board for MH and SUD services. Group counseling is a primary modality for service delivery that extends service capacity and access to care, particularly for SUD services. Most group counseling sessions are 90 minutes. Even with the increased rates for CPT codes, the effect of moving to an encounter based code results in a significant revenue loss. Group rates for unlicensed SUD providers, TBS and CPST all result in revenue loss and will force organizations to reduce group counseling opportunities in favor of an individual focused service model that ultimately reduces overall service capacity. There are also substantive differences between the SUD group rates compared to the TBS rates for MH services and question the assumptions used to establish the TBS rates.

- Crisis Counseling Service: As currently described in the proposed BH provider manual, it appears the focus of this service is to prevent out of home placement and inpatient care. It appears this service no longer permits facilitation of placement in out of home crisis stabilization services or inpatient admission. This creates a major gap in the continuum of care. How will providers be reimbursed for crisis service for facilitating inpatient care or out of home crisis stabilization services when that is the medically necessarily level of care needed? We remain concerned that the rate assumptions do not fully reflect the costs of operating these services 24/7 every day of the year. The proposed rate for crisis counseling is about a 30% reduction from the current rate and we fear may reduce the availability of this critical access point for treatment in acute situations.

- Complexity: In addition to Medicaid and MHAS rules, the state is still developing a provider manual (240+ pages) that is complex, inconsistent and will be a training and liability nightmare for providers. It is increasingly unclear what purpose the manual serves, particularly since no other provider group in Medicaid has such a complex document. It is also perplexing that six months after providers have trained their organizations on the manual, managed care organizations (MCOs), as part of the integration process, will not be required to adhere to this manual.

We feel that there is some remaining work to do in order to address these issues and get us closer to everyone's goals of maintaining/enhancing access, capacity and workforce in Ohio's behavioral health system. We have had four (4) asks for some time now:

- Stakeholder's need to see the consultants final assumptions used to establish rate/service modeling in order to better understand impact. We just received those assumptions last Friday and are in communication with the administration on rate/serve modeling issues.

- We have asked for a meeting with several providers and the state's consultants to go through a current-future state impact analysis. Given the state investment and the "red ink" analysis completed by many providers, we would like to understand the disconnect.

- It is important to have another meeting of the SUD residential work group – a commitment the state previously made – to resolve some lingering issues that could negatively affect this critical service.

- It is imperative to have another IT group meeting to address some critical technical, operational and timing issues that affect providers, MCOs and the MITS build (a meeting was just scheduled this Monday for October 3). Since implementation timing and training/cost/complexity is so important, I want to provide some concrete detail.

  <u>IT/EHR System Configuration</u>: Use of electronic health records and claims processing is an essential area of work within the BH Re-design process. Transitioning to coding and billing claims based on the treating or "rendering provider" is a significant policy change that requires specific clarification and exact specifications in order to re-build the IT infrastructure that are not yet available. The lack of technical information is a challenge for BH providers as well as the Medicaid managed care plans operating in MyCare Ohio. In addition to detailed business rules regarding services, we are also lacking clear guidance on the inclusion of rendering provider identification. The current rendering provider model deploys a two tier approach that uses individual National Provider Identification (NPI) numbers for some licensed professional staff and a combination of coding modifiers billed under the provider organization's Group NPI to identify other treating or rendering providers by either their professional license or level of education. This approach creates challenges for most IT/EHR systems that are designed to use either individual NPI numbers or Group NPI number as the primary key, but not both simultaneously. Adding to this challenge, ODM and MHAS have set two timelines for implementing the rendering provider policy. Licensed professionals required to submit claims with their individual NPI are expected to begin using the new process beginning January 1, 2017. All other staff within an organization will begin using the new coding modifiers to identify their level of licensure or training beginning July 1, 2017. With this timeline, BH provider organizations will have to re-build their claims processing and business rules twice – once to accommodate the use of individual NPI numbers and then 6 months later to accommodate use of the coding modifiers. Additionally, we understand ODM has at least a 3-6 month backlog in processing applications for professionals required to begin submitting Medicaid claims by January 1 that further delays provider organization's ability to prepare for this transition.

There is much happening in the state affecting demand for behavioral health services along with state policy directions that the Ohio Council fully supports:

- Transition of people to community treatment and supports from ODRC.
- County "Stepping Up Initiative" related to jails and the need for mental health and substance use disorder services.
- State Health Assessment/State Health Implementation Planning that identifies three (3) top statewide priorities, one of which is access to behavioral health services.
- Foster care youth shifting to Medicaid managed care.

- Potential cost shift to counties – impacts county ADMH Boards' statutory responsibility for continuum of care planning locally.
- Addressing the devastating toll of suicides and overdose deaths.
- Continued high use of emergency departments. We hear concerns from hospitals about people languishing in hospitals (boarding) without access to community services – and fear of cuts to crisis services.
- Every Student Succeeds Act (ESSA) – Ohio Department of Education partnering with community behavioral health providers.

In the context of these challenges and opportunities in Ohio, we potentially erode community behavioral health access, capacity and workforce at our peril. We are seeking a path forward to address some of the concerns that I have identified so that this hard, collaborative work will lead to outcomes that will strengthen community behavioral health services across Ohio.

Thank you.