Joint Medicaid Oversight Committee
Medicaid Behavioral Health Re-Design Panel Testimony

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September 22, 2016

Senator Burke and members of the Joint Medicaid Oversight Committee,

Thank you for the opportunity to testify today on the potential impact of the changes proposed as part of Ohio's Behavioral Health Re-design on agencies and organizations providing substance abuse services. My name is Jennifer Riha and I am the Vice President of Operations of A Renewed Mind Behavioral Health in Northwest Ohio. Over the past several years, A Renewed Mind has significantly expanded its array of services in the 16 counties we serve to include the full continuum of care ranging from prevention and outpatient services to intensive residential substance abuse treatment services both for adolescents and adults, recovery housing and Medication Assisted Recovery programs, including nation leading collaborations with criminal justice systems and FQHCs. Employing over 250 staff, A Renewed Mind provides integrated mental health and addiction treatment utilizing a team based approach to care.

Like all community behavioral health providers in Ohio, A Renewed Mind has had to be innovative in its efforts to grow the impact of and access to our services, invest in infrastructure and recruit and retain high quality staff while operating in an environment where costs continue to rise; but, Medicaid reimbursement, which is the only funding source for the majority of our patients, has not risen in almost two decades. In recent years, the Office of Health Transformation with the Ohio Department of Medicaid and Ohio Mental Health and Addiction Services has piloted promising approaches to effective behavioral healthcare and alternative methods of payment. It is our understanding that the changes proposed in Ohio's Behavioral Health Re-design are also intended to modernize, improve access to and increase the effectiveness of behavioral health services in the state of Ohio. A Renewed Mind fully supports this vision and is committed to participating in efforts to improve the availability and quality of care available to our communities.

Modernizing behavioral healthcare, closing gaps in service availability and funding the "right" things are essential to the future of behavioral healthcare in Ohio. However, in our own internal analysis of the impact of the changes proposed in the re-design, we have come to the conclusion that certain parts of the changes proposed would have potentially disastrous impacts on the substance abuse services provided by community behavioral health agencies. We would like to take this opportunity to detail what our specific concerns are in each area and hopefully demonstrate to you how the impact of these changes could unintentionally reduce access to care across the state.

Medical Services. As each of you already know so well, currently across the state and the nation, there is an Opiate epidemic. Recently, legislation was passed which allowed some physicians who have

Suboxone certification to have more patients on their caseload. We appreciate all of the efforts and work that went into supporting that change to increase access to care. However, in all of our offices where we employ physicians to provide addiction medicine, the physicians have very limited availability (doing addiction medicine part time) and work as part of a team which includes nurses to ensure they can provide care to the maximum number of patients their certification will allow within the time they can allot. This is accomplished with the intensive support of the nurses to take care of components such as drug tests; coordinating with patients regarding refills; doing face to face follow up visits between visits with the prescriber to monitor compliance with the Medication Assisted Treatment protocols, check vitals and tolerance to the medications, and ensure the patient has the social support needed to maintain sobriety. All of these components, which are currently provided by nurses (based on physician orders) take between 30 minutes and two hours per week per patient depending on how far along in recovery the patient is.

The re-design proposes cutting the reimbursement for these visits, in which the patient sees a nurse (RN or LPN) by 48% from $176.28 per hour to an average (LPN v. RN) maximum of $92.50 per hour. For each prescriber who has a certification maximum of 100 patients, and for which his/her patients are spread between early recovery and maintenance (which impacts the amount of nursing time needed), the annual cut to the agency's revenue in nursing reimbursement would be $418,900.00. With three FTE prescribers, this equates to a cut of $1.25 million in reimbursement for the medical support services provided by nurses at A Renewed Mind which allow our agency to run a comprehensive Medication Assisted Treatment program.

A reduction in revenue of this size is not sustainable to continue our current service model. So, we are faced with the challenge of planning for how to adjust the agency's procedures to try to continue to offer these services. Currently, the models we are exploring include moving to a "clinic" model in which patients are scheduled in "waves" and every patient is scheduled to see the prescriber at each visit and the nurses are only used to start visits and gather vital signs. We recognize that the possible negative outcomes of moving to this model include 1) longer wait times for patients per visit due to multi-patient scheduling per slot to ensure no "down-time" for prescribers, 2) delays in scheduling new patients; due to the physician having to see all patients for follow up visits versus those patients seeing a nurse for some maintenance visits; 3) a potential decrease in patient/ staff rapport due to no longer having nurses available for phone calls and unscheduled follow up visits to address somatic symptoms of withdrawal; 4) consideration of elimination of 50% of the nursing positions across the agency (approximately 6 well-paying jobs).

In summary, by completely changing the model of service delivery to using only prescribers to see every patient for every Medication Assisted Treatment visit and utilizing the newly proposed E &M codes and rates, we believe we can potentially sustain current funding; but, the predictable impacts are lost jobs for nurses, reduced patient satisfaction, reduced access to care for individuals with addiction, potential "burn out" for both prescribers and the remaining nurses and a negative impact on the patients' perception of client care.

Group Services. Currently, 33% of the outpatient counseling that happens at A Renewed Mind is group counseling. The average length of an outpatient group is 90-120 minutes. The behavioral health re-design proposes reducing the reimbursement for group therapy provided by a licensed clinician for 90 minutes from $57.12 per person in the group to a maximum of $33.37 per person in the group, assuming each person in the group meets the criteria for Interactive Complexity at each group session. This is, at minimum, a 42% reduction in funding for every 90 minute group session per person in the group. If the person does not meet Interactive Complexity criteria, the rate drops to $21.63 per person in the group.

For groups that are scheduled for 120 minutes, the reduction is $76.16 to a maximum of $33.37 (a 56% reduction OR, without Interactive Complexity a 72% cut in funding to $21.63). This variance is because the redesign proposes an "encounter" based reimbursement for group counseling sessions—meaning no matter how long the licensed clinician spends with the clients in counseling, the reimbursement is capped at either $21.63 or $33.37.

Peculiarly, the proposed reimbursement for unlicensed staff is not based on an encounter methodology and continues to allow unlicensed staff (ex. Chemical Dependency Counselor-Assistants) to be reimbursed according to how much treatment is actually provided in the group counseling session. The reduction per 15 minutes for group counseling in this scenario is 32% (for 90 minutes, it is reduced from $57.12 to $38.64 and for 120 minutes, it is reduced from $76.16 to $51.52).

In neither scenario, does the provider manual appear to reduce the existing standards for group counseling nor does the rate chart expand who eligible providers are, meaning the reimbursement is being cut without any reduction in provider's costs.

Using an average of the proposed cuts in reimbursement and using the reference point that 50% of our group counseling is provided by non-licensed providers (ex. CDC-A's) vs. licensed clinicians, this equates to a cut of $228,262.00 for group counseling provided annually (based on the amount of group counseling services provided in FY16) As we analyze this reduction, we've looked at both offering more individual counseling services or offering more frequent; but, shorter, group services to try to make up the deficit per unit by increasing the volume. We've determined that in most of the geographic regions we serve, we cannot increase the volume in a way that would be impactful enough due to the physical constraints of the buildings we lease or own, the number of staff we employ and the number of vehicles and drivers we have to transport people to/from group. Thus we are left with the option of offering more individual counseling as an alternative, which then reduces access to care in the geographic regions we serve.

In summary, we believe we may be able to offset 75% of the proposed reduction in funding by transitioning to more individual counseling and/or by possibly providing shorter groups more frequently (other than IOP) in some areas; but, it will mean reduced capacity for care in the community. Additionally, if we reduce the number of counseling groups we provide, we will need to eliminate the jobs of 3-4 drivers.

Urinalysis. A Renewed Mind conducted 13,122 urine drug screens in FY16. The results of these tests are used to make prescription decisions, determine treatment compliance, measure progress in treatment, monitor for potentially life threatening drug interactions and are provided, with authorization, to court systems, child welfare systems, school systems and other community support systems to ensure the ongoing success and integration of our patients into their communities. The average length of time that it takes a licensed or certified staff person to do a urine drug screen is 20 minutes. The proposed change in the BH re-design model is to reduce the reimbursement for this from $60.00 per test to $11.48 per test and not to reimburse it at all in our residential centers. This is a reduction of $636,679.44 annually.

The actual cost to pay our lowest certified staff person for 20 minutes, buy an instant read testing cup, buy medical gloves, office supplies, pay for the medical disposal service, etc. to do one urine test exceeds $11.48. So, for every urine test we would do, we would be operating at a deficit. We have not developed any sustainable strategies to overcome this reduction since 1) the rate chart did not reduce the criteria for who can do urine testing to include non-certified staff (meaning staff costs will remain constant) and 2) while we may be able to negotiate with our vendors to reduce our supplies costs minimally; it is not enough to offset the loss. The only possible solution to address this significant of a cut that we have identified would be to look at how we might reduce the organization's overhead costs (ex. benefits, infrastructure costs, combining administrative staff with other organizations, etc.). The potential job loss impact of these changes are undetermined at this time.

In summary, the proposed deduction in funding for this service is so great that other than cutting into the agency's infrastructure, including job loss, no other solution is being proposed.

SUD Residential Services. The proposed "bundled" per diem rate for residential services for the level of care we provide is $213.70 per day. Currently, for a day of services "unbundled", we provide, on average $270.00 of services daily. Between our adolescent and adult residential treatment facilities, we serve, on average 24 individuals every day in residential care. This equates to a loss of funding of $493,188.00 annually. On top of the direct loss of funding, the proposed provider manual creates staffing and regulatory requirements for SUD residential services that far exceed existing requirements. The cost of the additional direct staffing requirements exceeds $110,000.00 for the agency annually—making the true loss in funding greater than $600,000.00 annually.

At this point we are faced with evaluating whether the agency can fiscally sustain keeping the adolescent residential treatment center open, (which is currently the only such center in the Northwest region of Ohio). The loss of which would equate to 20 jobs. At a bare minimum, we have determined that we will have to require that *every* patient must have a method of paying for room and board; whether it be through county ADAMHs board funding, self/ family payment, child welfare system funding, court funding, etc. Currently, there are some patients who are unable to pay their portion of room and board and we have found ways to still provide them with residential treatment; unfortunately, with this loss in funding, there will be no way for the agency to make such exceptions in the future. While we recognize that this may create a barrier to treatment for some individuals, we have been unable to identify any other method of potentially sustaining the programs ongoing.

In summary, the cost of running these residential programs weighed with the proposed cut in funding and the proposed increase in regulation and staffing requirements, will cause us to evaluate whether to continue to operate our adolescent residential substance abuse treatment center, which could mean the loss of 20 jobs and at a bare minimum, will require a change to our procedures which will feasibly reduce access to care.

In total, these four areas alone of the proposed behavioral health re-design have the potential impact of a loss of $2,657,000.00 in funding to A Renewed Mind. At the potential expense of access to care for the community, we can likely manage to reduce this loss to $1,257,000.00 with the potential loss of up to 30 jobs within our agency. The remaining $1.2 mm reduction will likely also force us to look at other program lines that have historically operated at a loss or with intermittent margins to determine if there are other programs we have to discontinue offering.

Of additional concern to us is the regulatory and administrative complexity that is being proposed through the introduction of the variety of codes and modifiers related to TBS, PSR and CPST; the "unbundling" of partial hospitalization services; as well as the internal compliance monitoring that will be required around moving to E&M coding; and the astonishing level of additional regulation that is being proposed through the provider manual—on top of all of the Ohio Revised Code sections and national accrediting body standards manual we are held to. All of these additional layers add significant cost and time to operating the agency, all of which takes away resources from direct client care.

The amount of resources (both financial and in time) that our agency has already begun to invest and will have to invest in the next twelve months is significant and is estimated to have a monetary impact of approximately $50,000.00 on the agency over the next 12 months through the components listed below:

- Re-designing our electronic health record,
- Changing policies and procedures,
- Updating our national accreditation, including onsite audits, to reflect changes in what services we begin to or discontinue providing,
- Staff training and
- Hiring of additional administrators just to implement, train and monitor the new procedures and standards

As stated earlier, A Renewed Mind and I, personally, fully support the improvement of the behavioral health system both in Ohio and nationwide. Some of the proposed changes in the behavioral health re-design appear to be on the right track and will likely truly improve access to care, effectiveness of care and have the long term impact of reducing the cost of care. However, the known fiscal impact on agencies such as ours, potential job losses for our workforce and negative impact on access to care in many communities across the state are cause for serious concern about the potential unintended consequences of some of the proposed changes. I would recommend that Ohio look to models from other states where investment in the behavioral health system has been done in such a way over a

measured period of time that it has truly improved patient health outcomes, maintained and strengthened capacity across the state and controlled costs in the long term.

Currently, it appears that Ohio has created an artificial deadline for itself to make significant changes to a critical sector of its infrastructure that have not been fully vetted and considered and have the potential to be disastrous and life-threatening to individuals and families across this state. Examples of this concerning approach can be observed at any of the state's trainings across the state over the past three months, in which the state's own staff, who are charged with training providers on these proposed changes, provide alarmingly inconsistent answers both between staff and from one training to the next, answer a significant number of the questions raised by provider staff by stating that the answers have not been determined yet and when presented with serious problems for communities and providers based on the content presented respond by stating that they have heard those concerns before; but, have no solution. This critique is not to say that there has not been valuable work done by the state's staff and contractors; but, rather to say that some of the proposed changes are not workable or sustainable and that there is no known reason to attempt to force them into practice at the expense of the citizens of Ohio when we can take the time now to take the work that has been done well and continue to build on it with a revised timeline that includes time to focus on solutions for the problems that have already been identified.

I truly appreciate the opportunity to share these concerns and thoughts with you today and would be pleased to answer any additional questions on these topics.