The Ohio Council
Of Behavioral Health & Family Services Providers

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JCARR Testimony – OAC 5160-8-05 and Chapter 5160-27
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Chairman Duffey, Vice Chairman Uecker, and members of JCARR, thank you for the opportunity to testify today on proposed rules filed by the Department of Medicaid intended to support implementation of the behavioral health (BH) redesign. My name is Teresa Lampl and I am an Associate Director with the Ohio Council of Behavioral Health & Family Services Providers. We are a statewide trade and advocacy association that represents over 150 private businesses that offer addiction treatment and prevention, mental health, and family services to over 600,000 Ohioans annually.

The Ohio Council and our members are diligently working to implement the behavioral health redesign coding and rate changes on January 1, 2018. Keeping to this timeline is necessary to sustain current service levels and network adequacy and expand needed treatment service to address the surging opiate and overdose deaths, addiction crisis, and rising suicide rates.

The intent of the General Assembly's budget and policy priorities has clearly been to support and expand access to behavioral health services. Ohio's Medicaid program, including the BH Redesign, is a critical tool in responding to the behavioral health crisis we face in our state. There are still a number of unresolved policy and reimbursement issues within BH Redesign that have not been addressed and were judged to fall outside of JCARR jurisdiction. These unresolved BH Redesign issues should cause concern for policymakers. Data from providers continues to predict a significant reduction in Medicaid spending for behavioral health services that will result in a loss of existing treatment service capacity in many areas of Ohio.

That said, there are three main issues we are asking JCARR to hear and understand the documented structural and policy concerns that have not been resolved and fall within the JCARR prongs. Two of these issues were discussed during the IP meeting facilitated by the Chair in June. We hope you will encourage ODM to consider our concerns and seek assurances that the state agency has satisfied their obligations for rule making under Chapter 119.

1. <u>Federal Medicaid Authority for "Bundled" Services Authorized in OAC Chapter 5160-27</u>: On the surface, it appears ODM has simply changed the title of OAC 5160-27-06 from *Mental Health Day Treatment Service* to *Therapeutic Behavioral Group Service – Hourly and Per Diem*. However, the rationale provided for this language change has much broader implications and could result in the dismantling of existing service rather than expanded access to new treatment options.

   Based on new information ODM shared with the Ohio Council in an August 18th written response on these proposed rules, we are concerned CMS may require "separate regulatory authority" to offer MH Day treatment services because this is considered a bundled service and could not be included under the proposed definition of "Therapeutic Behavioral Service (TBS)" as intended by ODM. Changing the title of OAC 5160-27-06 but continuing to reference "day treatment" in (A) may not be enough to resolve this issue and it creates risk for Ohio Medicaid.

Further, this revelation creates concern that ODM may need "separate regulatory authority" from CMS beyond what is proposed in the MH state plan amendment (SPA) that relies on TBS as an umbrella authority to cover other bundled services, including ACT (OAC 5160-27-04), IHBT (OAC 5160-27-05), and nursing services (OAC 5160-27-11). Each of these services, ACT, IHBT, and nursing, assume multiple clinical interventions that could be delivered and billed separately are instead pulled together into a more comprehensive or "bundled" service and payment. Bundled services allow providers more flexibility to treat individuals with higher or more complex needs. We now have documentation that CMS has expressed similar "bundled service" concerns with ACT (OAC 5160-27-04) and to some degree, nursing services (OAC 5160-27-11) as CMS has raised with mental health day treatment or TBS Group Services-Hourly and Per Diem (OAC 5160-27-06).

The Ohio Council submitted a public records request on September 1st to obtain the current Medicaid Rehab Option SPA language under consideration as well as communications between ODM and CMS regarding the BH Redesign. In a meeting on September 5th with ODM, we were informed that ODM has not formally submitted the Medicaid Rehab Options SPA to CMS for approval, but has submitted a draft and is communicating with CMS on these draft documents.

Last Friday, ODM provided us with some of the public information we requested, including the Medicaid Rehab Option SPAs that were formally submitted to CMS in March (MH on 3/7/17; SUD on 3/21/17). We also received written correspondence between ODM and CMS between March 3rd and July 14th that document the informal and formal questions CMS asked ODM. These documents reveal that CMS has asked ODM many of the same questions providers have been asking ODM for months.

Specifically, CMS has questioned the decreased Medicaid expenditures reported under these SPAs, requested clarification and description of bundled services including mental health day treatment, ACT, and nursing services, and asked ODM for specific descriptions of the substance use disorder (SUD) treatment services being covered under each ASAM level of care. We understand ODM and CMS also engaged in phone calls that were either not documented or those summaries were not released under our public records request. As such, we do not know ODM's response.

On June 2, 2017, CMS issued a formal "Requests for Information" regarding the SPA for mental health services that sought language changes and additional assurances for ACT services (OAC 5160-27-04) to address the "bundled services" question we are raising today. CMS also asked additional questions about mental health day treatment on July 14th. To our knowledge, ODM has not provided CMS with the requested assurances or those documents were withheld from our public records request.

We ask JCARR to specifically seek the necessary assurances from ODM that CMS has also requested so that the proposed MH Rehab Option State Plan Amendment relying on TBS as an umbrella sufficiently provides the regulatory authority necessary to cover services defined in OAC 5160-27-04, 5160-27-05, 5160-27-06, and 5160-27-11. This is necessary so that Ohio's Medicaid program does not result in the loss of mental health treatment services or create undue risk to the state of Ohio for audit findings and recovery of payments.

2. Medicaid BH Provider Manual: The Manual is not referenced or included in administrative rule but is the primary, and in some instances, the sole source of information that describes the Medicaid service delivery, eligible providers, and billing and reimbursement methodology. This is particularly true for substance use disorder (SUD) services, which are defined in detail in the Manual but are

vaguely described in OAC 5160-27-09 and mirror the SPA language that CMS is requesting be defined and clarified. ODM is relying on a legal disclaimer in the Manual that indicates the document is for education and training purposes only in lieu of incorporating by reference in rule; however, providers and the Medicaid MCOs are using and relying on information in the Manual to construct business rules, reimbursement, and clinical practice. ODM indicated on September 5th it would either eliminate the Manual in its entirety or would review the legal disclaimer to consider adding additional language to clarify the OAC rules supersede all information in the Manual. This later approach might partially address our concern, but leaves open the question of whether the Manual is subject to Chapter 119. The Ohio Council supports elimination of the manual if not incorporated in administrative code.

Failure to include a reference to the Manual in rule circumvents the legislative and regulatory public review process. It would allow ODM the ability to change requirements or impose new limits without the checks and balances intended to assure policy and payment changes are in the best interest of Ohioans. We have previously provided JCARR with a legal analysis prepared by the Vorys law firm and assert that the Manual meets the definition of a "rule" as "a standard having a general and uniform applicability to providers" and should be subject to ORC Chapter 119 rule making and JCARR review. Furthermore, the legal analysis provides example of case law that found it is the "true effect of the Manual – not how ODM characterizes it – that determines whether it is subject to Chapter 119."

We encourage JCARR to carefully review the legal analysis and the applicability of Chapter 119 to require incorporation of the Manual by reference in OAC Chapter 5160-27. If incorporation by reference is deemed not to apply, we request JCARR support our request that ODM eliminate the Medicaid provider manual entirely to reduce the risk of compliance audit finding and assure the rules are the governing authority.

3. Place of Service Codes: ODM agreed to address this issue during the Interested Parties meeting held on June 14th. The revised language in 5160-27-02 (G) appropriately defines, by referencing the CMS website, place of services (POS) code definitions and Ohio's state specific definition of POS 99 as well as when it may be used. However, this language does not address the use of POS codes in the reimbursement methodology to adjudicate Medicaid claims payment. ODM intends to limit payment for some services by limiting the allowable POS codes, which is presently defined only in the Medicaid BH Provider manual. The use of POS codes to limit claims payment must be incorporated in administrative rule to satisfy Chapter 119 requirements. This could be accomplished by incorporating by reference in rule the BH Provider Manual as described above or through additional language clarification in OAC 5160-27-02.

ODM and the administration missed the opportunity to work with stakeholders between the May 29th JCARR hearing, June 14th Interested Parties Meeting, and the re-filing of the rules on August 25th. There was sufficient time to collaborate, roll up our sleeves, and tackle the remaining few issues to find workable solutions before the statutorily required October 1 final rule filing set by the General Assembly in HB 49. Instead, we are back before JCARR seeking review of these complex issues.

We ask JCARR to carefully review these three outstanding ODM regulatory issues and proposed rules, ask questions, and seek answers to understand the risks described above that could undermine treatment services in communities across Ohio. We know CMS has asked for additional assurances and we ask you to seek the requested assurances from ODM and affirm the Department satisfied their obligations for rule making under Chapter 119.

It is preferable for these three issues to be resolved before the BH Redesign is implemented, but it is essential that progress continues to support implementation of BH Redesign on the current timeline of January 1st.

Moving forward, we understand we will likely be back before JCARR with further rule language adjustments as ODM resolves issues with CMS. We will also need to work with the General Assembly to seek legislative action in the future to resolve our remaining concerns and maintain essential behavioral health service and treatment capacity for children and adults in all 88 counties across Ohio in order to maintain the January 1st implementation.

Thank-you for the opportunity to testify today. I am happy to respond to your questions.