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TO: The Honorable Members of the Assembly Committee on Health
FROM: Linda A. Hall, Executive Director
DATE: February 3, 2016
RE: Support for AB 711, AB 712 and AB 713 – Increasing Access to Mental Health

Good Morning Chairman Sanfelippo and members of the Committee. My name is Linda Hall and I am Executive Director of the Wisconsin Association of Family & Children's Agencies. Thank you for the opportunity to speak to you today about increasing access to mental health services by decreasing unnecessary administrative barriers.

WAFCA is a member association that partners to improve the lives of families and children. Our statewide network of 50 member agencies and leaders provide a wide array of community-based mental health and supportive services.

Every year 1 in 4 adults have a diagnosable mental illness which is more than all the people with heart disease and cancer combined.[1] Annually, 1 in every 5 children has a diagnosable mental health condition.[2] Getting treatment to children leads to improved grades and graduation. For adults, treatment means better attendance at work and less lost productivity for employers. Unfortunately, many people in Wisconsin are unable to access a mental health professional when they need one.

I would like to speak to three of the bills before you today that will increase the number of mental health professionals and our capacity to serve individuals with mental health needs.

Qualified Treatment Trainees (AB 711)
Wisconsin has a shortage of mental health practitioners. Qualified Treatment Trainees are trained, master's degreed behavioral health professionals or graduate students who are ready to provide therapy with appropriate supervision but need to accumulate 3,000 supervised hours before they can be licensed by the Division of Safety and Professional Services (DSPS). Accumulating these hours typically takes two years.

While QTT services are paid under the fee-for-service / card services portion of the Medical Assistance program, some MA health maintenance organizations (HMOs) do not pay them, preferring instead to only pay for licensed therapists. Requiring MA HMOs to pay for QTTs' services would increase opportunities for degreed therapists to earn a living while accumulating their supervised hours and increase access to care.

Recognize Accreditation when Re-certifying Outpatient Mental Health Clinics (AB 712)
Many mental health clinics are accredited by a national accrediting body with standards of care that are much more rigorous and more focused on quality improvement and quality care than standards in state law. While Department of Health Services' rules since 2009 have required DHS to waive portions of the clinic recertification review for agencies that are accredited, DHS has yet to waive any of the recertification process for any accredited clinic. This bill would add the rule language to state statutes. The bill would also synchronize the DHS recertification to the accreditation renewal timeframe.

Wisconsin Association of Family & Children's Agencies
131 W Wilson Street #901 | Madison WI 53703
Office: 608.257.5939 | Fax: 608.257.6067 | wafca.org

Recognizing accreditation would save time and money for DHS. For clinics, it would eliminate duplicative reviews, create an incentive to become accredited, and, thereby, increase practice standards. Accepting accreditation as an alternative to state inspection of mental health clinics is a practice that has been adopted by more than twelve states. DHS would continue to have the authority to conduct a review when there is reason to believe that a full review is necessary and to investigate allegations of substandard care. This language is similar to that already in place for accredited child care centers and to 2013 WI Act 236 which required DHS to waive certain hospital inspections for accredited hospitals.

Access and Prior Authorization of Mental Health Services under Medical Assistance (AB 713)

Most of the families that county human services departments refer to us are of modest means and many rely on Medical Assistance. Medical Assistance never pays the full cost of care. For mental health treatment, MA pays about 40% of costs. Actually the 60% payment to costs gap is even larger, because we spend more time outside of the therapy visit filling out lengthy prior authorization forms.

Private insurance and managed care companies years ago, after careful study, concluded that extensive prior approval processes are not cost-effective or necessary. Multiple studies demonstrated that practitioners work with people who are truly in need of care and individuals use as much, or even less, therapy than they need.

The Medical Assistance program has also studied its Prior Authorization program and determined that it approves more than 90% of submissions. However, the weeks they take to approve outpatient applications and the 2+ months they take to approve children's intensive in-home therapy and day treatment applications cost providers time and money and decrease access to critical mental health treatment.

To right size MA's prior authorization process AB 713 proposes a number of changes, including:

1. *Allow 24 mental health therapy visits (6 months) before requiring prior authorization* for services like Medical Assistance's authorized HMOs typically do instead of 15 visits (3 months).
2. *Allow 15 days of child and adolescent day treatment before requiring prior authorization* to allow practitioners to observe the child, gather information necessary for MA's required assessments and prepare a treatment plan for more extended treatment. The current process means that agencies often provide three weeks or more of treatment before they find out if the prior authorization will be approved and they will be paid. This wait is after a physician has prescribed day treatment for the child. The existing burdensome and expensive process has led many day treatment programs to close. In 2008, there were 51 day treatment programs, but that number declined to 33 in 2015. Fewer day treatment programs for children with significant mental health conditions leads to more hospitalizations and out-of-home care.
3. *Reduce the MA three pages of prior authorization questions to four elements* as recommended by the Wisconsin Council on Mental Health (diagnostic criteria and symptoms, patient and provider identification; modality and frequency of treatment; and goals and discharge criteria for treatment); and
4. *Recognize a preferred provider status for providers* with a minimum of 5 years' experience as a certified MA provider, no instances of substantiated fraud in the 5 years prior to requesting preferred provider status, and 90% of prior authorization requests approved for 3 years previous to requesting preferred provider status. Claims from these providers should be processed in a manner similar to claims that do not require prior authorization.

I appreciate your attention to our concerns about administrative issues that prevent WAFCA members from serving more children and families. AB 711, 712 and 713 address these issues in ways that will allow us to increase our care for individuals in the community and support them in living fuller, more satisfying lives.

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[1]The Numbers Count: Mental Disorders in America, National Institutes of Mental Health (http://www.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-in-america/index.shtml)

[2]Knopf, D. et al (2008).The Mental Health of Adolescents: A National Profile San Francisco, CA. Natl Adolescent Health Info. Center.

TO: Rep. Sanfelippo, Chairman, Assembly Committee on Health
FROM: Tanya Lettman-Shue, Clinical Programs Director of Outpatient Services, Journey Mental Health Center.
DATE: February 3, 2016
RE: Support for AB 711, AB 712 and AB713 to increase access to mental health services

Chairman Sanfelippo and members of the Assembly Committee on Health. My name is Tanya Lettman-Shue and I am Clinical Programs Director of Outpatient Programs at Journey Mental Health Center. On behalf of Journey, I would like to thank you for the opportunity to express our support for AB 711, AB 712 and AB713 all three propositions are important pieces of legislation that will allow providers to increase access to mental health services by decreasing unnecessary administrative barriers.

Journey is a local not-for profit agency that contracts with the state, county, and local insurer to provide family based services, substances use disordered, and adult mental health service to the uninsured, under-insured, and MA populations in Dane County. We serve approximately 8,500 consumers in our outpatient service unit each year.

With regard to AB 711- Qualified Treatment Trainees. As one of the largest service providers of mental health services in Dane County we have established close ties to our local Universities. We have instituted an advanced intern clinic, which provide placements for approximately 20 masters level trained clinicians with an opportunity to obtain experience in an agency that has an ample consumer base, a strong foundation for the clinical supervision, and the ability to get additional training around evidence based practices. Those masters level staff are licensed as QTT's and many of them go on to become Journey staff members. We often struggle to determine which consumers can be assigned to the QTT clinicians, as the MA health maintenance organizations choose to only authorize services for fully licensed clinicians. This puts the consumer into a position where they are forced to wait for an opening on a licensed clinicians caseload, putting off the treatment that they are seeking in the moment, when we have QTT who are available to see the consumer. Also many of the our newest QTT staff have training in the most up to date evidence based practices and / or they are able to offer an area of specialty practice such as a culturally specific approach to the African American or Gender Expansive consumer, or access to therapy in the consumer's native language. In those cases where a consumer would be better served by a QTT, that the consumer is denied the opportunity due to the therapist's QTT status.

With regard to AB 712 – Recognizing accreditation. Journey Mental Health Center has been a proud CARF accredited organization and has just undergone our 3rd audit, having received a 3-year renewal. Having been a part of both recertification from DHS and from CARF, I can verify that the national accreditation process is much more rigorous and provide a higher level of accountability across all parts of our agency. When a recommendation is made by the accreditation agency there are clear justifications and a quality improvement plan that needs to be submitted to the accreditation agency within 3 months of review. We are currently in this process and I am finding that this is helpful in that the team of auditors from CARF is comprised of other nationally accredited agency heads and we are able to draw upon that knowledge base as we seek to improver our services. In this circumstance DHS's recertification proves to be duplicative and draws away both therapeutic and administrative resources that could be better served by attending

to the needs of the consumer obtaining services at our agency.

With regard to AB 713 – Access and Prior Authorization. Many of the consumers that come into service at Journey are individuals that have complicated care needs. They are struggling with many psychosocial stressors such as unemployment, underemployment, lack of access to transportation, physical health challenges, and many who have had a lack of access to treatment service until the implementation of the Affordable Care Act. They are individuals who are resilient, searching for access to service, and eager to utilize the resources that are being provided so that they can build a better support network, improve their coping skills, and gain additional knowledge about becoming an advocate in their own lives. They are not the "walking well" that require minimal sessions to complete an episode of treatment. That having been said many of our consumers do have successful completion of treatment before 24 sessions are utilized. Removal of this cumbersome Prior Authorization process after the current 16 sessions, would free up the front line staff to focus on the consumer.

In those circumstances where more than 24 session would be required limiting the collection of information on the prior authorization to the scope or practice, measurements toward the treatment plan goals, and new information relative to the consumer's condition would help to streamline the process and clarify for clinicians what the current reviewers are seeking in order to approve or deny a request.

Thank you for you time and attention to these matters,

Sincerely

Tanya Lettman-Shue
Director of Clinical Services
Journey Mental Health Center

Children's Hospital of Wisconsin

TO: **Assembly Committee on Health**
FROM: **Tracy Oerter, Director of Mental Health Services for Children's Hospital of Wisconsin**
DATE: **February 3, 2016**
RE: **Support of AB 713 – Prior Authorization for Mental Health Services**

Good afternoon Chairman Sanfelippo and members of the committee. Thank you for allowing me this opportunity to submit testimony today on AB 713 which relates to prior authorization of mental health services. My name is Tracy Oerter and I am the Director of Mental Health Services at Children's Hospital of Wisconsin.

Children's Hospital of Wisconsin serves children from every county in the state. We have inpatient hospitals in Milwaukee and the Fox Valley. We care for every part of a child's health, from critical care at one of our hospitals to routine checkups in our primary care clinics. Children's also provides specialty care, urgent care, dental care, emergency care, school health nurses, Foster care and adoption services, family resource centers, child health advocacy, health education, pediatric medical research and the statewide poison hotline.

AB 713 would allow up to 24 mental health therapy visits before requiring a prior authorization form. This bill will eliminate administrative barriers to treatment by limiting the collection of information on the prior authorization form to relevant information to treatment, such as: diagnostic criteria and symptoms, patient and mental health services provider identification, modality and frequency of treatment, and goals and discharge criteria.

Children's has 15 mental health clinics and 20 school-based clinics throughout Wisconsin. We have approximately 30,000 clinic visits annually. A majority of the patients we serve are Medicaid, ranging between 55%-85%, depending on the clinic location. Children's supports these changes to remove barriers for children in need of timely access to mental health services. We appreciate the need for checks and balances in the provision of services and agree that prior authorization is a necessary tool to manage the program. We think this bill strikes the right balance and allows initial limited access of critical mental health services before the prior authorization process. We strongly feel that targeted reforms to Medicaid fee for service prior authorization that eliminate unnecessary administrative burdens and ensure that criteria and policy requirements are consistently and accurately applied is necessary in order to provide access to care for kids who need these important services.

The time Children's spends completing prior authorizations is time that could be used serving patients. These prior authorization forms are time consuming, labor intensive and often returned and sent back several times with questions that are sometimes irrelevant, out of scope of the provider, or are repetitive. This bill will eliminate the need for returning forms by limiting the information collected to the scope of practice of the provider. Changing the prior authorization process and removing the barriers to providing care for both youth and adults will allow for better access to services and provide these patients with the help they need before it becomes necessary to utilize crisis or inpatient services.

This bill will also help providers by recognizing a preferred provider status for providers with a minimum of 5 years' experience as a certified MA provider, with no instances of substantiated fraud in the 5 years prior to requesting preferred provider status, and 90% of PA requests approved for the 3 years previous to requesting preferred provider status. While limiting fraud is an important goal, the level of fraud in seeing Medicaid patients with complex mental health problems is low.

Children's Hospital of Wisconsin

This change will allow experienced providers with impeccable records to see more critical patients and spend less time filling out paper work.

We do want to point out that we have not experienced the same barriers to services and laborious prior authorization process in the Medicaid health maintenance organization process. For this reason, we do not agree that legislation is necessary to govern the Medicaid HMO process in this arena. Children's is also itself a Medicaid HMO and we do not think it necessary or appropriate to include the provision of the bill that requires Medicaid health maintenance organizations to use uniform application, provider recertification and prior authorization forms and processes. As a Medicaid HMO that manages the access to care balanced with the appropriate cost restraints, we have a process in place that is working and therefore strongly urge you to remove the section and focus on the area of concern which is the fee for service prior authorization.

We urge you to support AB 713 and give children and adults the access they need to these critical mental health services. Medically and psychosocially complex children need better access to care and the prior authorization requirements stand in the way of private providers to accept these patients, and for primarily Medicaid providers to see more patients and provide more services to the patients who need it the most.

Chairman Sanfelippo and committee members, I thank you again for the opportunity to submit testimony. If you have any questions, comments or concerns please feel free to contact me via email at tracy.oerter@cssw.org or via phone at 414-266-2912.

NATIONAL ASSOCIATION OF SOCIAL WORKERS, WISCONSIN CHAPTER TESTIMONY TO THE ASSEMBLY COMMITTEE ON HEALTH ON WEDNESDAY FEBRUARY 3, 2016 ON ASSEMBLY BILL 713

Representative Sanfelippo and members of the Assembly Committee on Health.

Thank you for this opportunity to speak on behalf of Assembly Bill 713 related to prior authorization for mental health services under the Medical Assistance program. I would also like to thank Representative Tittl for his sponsorship of this important piece of legislation.

My name is Marc Herstand; I have served as the Executive Director of the National Association of Social Workers, Wisconsin Chapter for over 23 years. In this position I represent 1800 social workers who work in a diverse group of practice arenas including independent practice, state certified clinics, mental health institutions, hospitals, nursing homes, schools, non-profit organizations, county human services departments and other venues.

This bill is important because it would help reduce costly and unnecessary paperwork that impedes the ability of licensed mental health professionals to serve Medicaid clients for mental health services. These requirements have led some providers to stop accepting Medicaid reimbursement because of the excessive paperwork and cost. Medicaid pays less than private insurance and you would think the State of Wisconsin, in order to attract providers, would want to make the process simpler, not more difficult than serving private insurance clients. This has not been the case.

NASW WI has been working on easing prior authorization requirements for licensed mental health professionals since 2007 when we developed, wrote up and submitted a list of seven issues regarding MA prior authorization with suggested updates. Although some limited changes occurred a number of years later regarding increasing the monetary cap for prior authorization, many of the problems our members faced in 2007 remain today. In July 2014 NASW WI along with the Wisconsin Association of Family and Children's Agencies submitted a series of six recommendations for change to DHS because of continuing on-going problems with prior authorization.

This bill will address some of the long term problems with Prior Authorization by 1) Limiting the amount of information that may be collected on a prior authorization form, 2)Requiring the Department of Health Services to allow 24 mental health therapy visits before requiring prior authorization for additional visits and 3) Requiring that a health maintenance organization that provides mental health services under the MA program use a uniform application, provider recertification and prior authorization forms and processes prescribed by DHS.

We urge the Assembly Committee on Health to vote to support Assembly Bill 713

131 West Wilson Street, Suite 903, Madison, WI 53703
(608) 257-6334 • Toll Free (WI only): (866) 462-7994 • FAX: (608) 257-8233 • naswwi@naswwi.org • www.naswwi.org

NORTHWEST Journey

TO: Rep. Sanfelippo, Chairman, Assembly Committee on Health
FROM: Kristi Nelson, Director of Day Treatment and Clinical Services
DATE: February 3, 2016
RE: Support for AB 713 to increase access to mental health services

Chairman Sanfelippo and members of the Assembly Committee on Health. My name is Kristi Nelson and I am the Director of Day Treatment and Clinical Services for Northwest Counseling and Guidance Clinic and Northwest Journey. On behalf of NWCGC, I would like to thank you for the opportunity to express our support for AB 713 and the importance of increasing access to mental health services by decreasing unnecessary administrative barriers.

Currently, Northwest Journey has eleven day treatment programs throughout the state. We serve well over 400 children each year (468 children served in 2015). The children referred to our programs have attempted outpatient counseling unsuccessfully and/or have received inpatient mental health care. Our children have struggles with suicidal/homicidal ideation, self-harming behaviors, depression, anxiety, and oppositional behaviors. Northwest provides these children with group counseling, individual therapy, and family therapy. AB 713 would allow access to our programs more readily, as in many instances, this access is delayed due to lengthy prior authorization requests. We have had numerous children referred to our programs, who are at risk for inpatient hospitalization, and immediate admission into our services could prevent this level of care. Yet, in many circumstances these children end up requiring hospitalization while awaiting approval of funding for our programs.

Additionally, reviewers are asking that we provide records of services provided many years ago. Without the provision of these records, funding is frequently denied. It is incredibly challenging to obtain records from past providers, who have not served these children for five or more years, in some cases. Our agency eagerly seeks records from providers who have/continue to work with children within the last year (in some cases, longer) as those are the records most pertinent to the current functioning of the child. These records, along with a comprehensive family and multi-disciplinary team interview, have allowed us to serve the children referred to our programs very successfully and when funding is not a hurdle, quite immediately.

We urge your support for this bill. If you have any questions or if we can be a resource to the Committee as you consider this and the other mental bills set before you, please do

not hesitate to contact me. I can be reached at 920-309-0119 or kristik@nwcgc.com. I would be happy to provide some specific case examples and detailed outcome information.

Sincerely,

Kristi Nelson

Kristi Nelson, LPC

Family Service Madison

A community based non-profit serving and celebrating families since 1910

TO: Rep. Sanfelippo, Chairman, Assembly Committee on Health
FROM: Marcus Murphy, Program Director and Therapist
DATE: February 3, 2016
RE: Support for AB 713 to increase access to mental health services

Chairman Sanfelippo and members of the Assembly Committee on Health. My name is Marcus Murphy and I am the director of the Steps to Success Intensive Mental Health Day Treatment Program at Family Service Madison, an agency that has been meeting the needs of the residents of Dane county since 1910. At FSM, I am also an outpatient therapist and a facilitator of Alternatives to Aggression which is a group for men who have been charged with domestic violence. On behalf of those with whom I work and those for whom I work, and on behalf of WAFCA would like to thank you for the opportunity to express our support for AB 713 and the importance of increasing access and the speed of access to mental health services by decreasing unnecessary administrative barriers.

- Family Service Madison has one day treatment program (Steps) which served 35 unduplicated individuals in 2015. Including family members, Steps served 101 individuals. Steps serves youth age 11-14.

- 737 unduplicated participants were served through Family Service Madison's outpatient services which include counseling for children and adults, WISE Star for Older Adults and Caregivers, EAP services as well as 5 anti-violence groups.

- One child with whom we worked last year originally started in juvenile detention. He was in detention for getting into a fight with another youth at Dane County Shelter Home. He was placed in Shelter after having been kicked out of residential treatment for being too violent. If appropriate services were not procured for him in the community he was headed back to another residential treatment facility, at a cost of over $10, 000 per month. Steps was able to provide the right environment for this young man to be successful and ultimately close his case with Dane County Department of Human Services. He now is a thriving high school student without the need for any outside services.

- Children who are referred to intensive day treatment almost always have been involved in less intensive services such as outpatient counseling, family therapy and medication management with a psychiatrist without achieving the desired outcome. As a matter of fact, Medicaid and local HMOs expect this to be the case before they will authorize services except in extreme situations. Being able to engage more quickly in service provision would only lead to better outcomes sooner thus enabling providers to serve more clients. This bill proposes allowing for 15 days of treatment before an authorization is needed which is a step in the right direction. Thirty days would actually make **more** sense as this would allow enough time for the treatment team to assure that day treatment is the best course of action. We have found that there are some children who are best served in a combination of other services but in the meantime, while the child has attended Steps, we have been able to provide daily behavioral support. The ability to work daily with youth and their families allows for an unparalleled ability for clinical observation that otherwise can only occur in an inpatient setting which is not at all cost effective.

- The idea of there being a preferred provider status for providers who prepare authorizations is brilliant. Over the course of the 13+ years as the director of Steps to Success I have submit more prior authorization requests to Medicaid than I can count. I can only identify two or three at most that were not ultimately approved. Invariably however, these requests are sent back to me for some reason or another, often asking for assessments not even required at the time of the original authorization. This is a tedious process and an immense waste of time for providers as well as the state. A preferred provider status and subsequent streamlined authorization process would save everyone time and money.

- HMOs request one page of clinical information for an authorization. The provision of this bill that would streamline the information needed for authorization for services is desperately needed. Medicaid authorization requests for day treatment require five additional documents in addition to the already lengthy (6 page) authorization form. I think the math speaks for itself.

We urge your support for these bills that will help us do wonderful things. If you have any questions or if I can be a resource to the Committee as you consider these bills, please do not hesitate to contact me.

Respectfully submitted.

Marcus Murphy, LCSW
Program Director
Steps to Success
608-316-1126
marcusm@fsmad.org

Mental Health America of Wisconsin

Mental Health America of Wisconsin
Testimony on AB713; Shel Gross, Director of Public Policy
Assembly Committee on Health
Feb. 3, 2016

Mental Health America of Wisconsin (MHA) is providing testimony for information only on AB713 regarding prior authorization (PA) for Medicaid services.

Prior to working at MHA I spent 10 years in the Wisconsin Medicaid program as the policy analyst for mental health and substance abuse benefits covered by Medicaid. During those years I spent a considerable amount of my time working on PA concerns. I inherited a system that did not provide guidance on the criteria for authorization and required providers to complete a four page form for outpatient psychotherapy services. We developed and publicized criteria and reduced the form to two pages, one of which did not need to be redone for continuing authorizations.

Imagine my surprise when a number of years after leaving Medicaid to work at MHA I found myself drawn back into the concerns about PA through my role as Chair of the Legislative and Policy Committee of the Wisconsin Council on Mental Health. Mental health providers brought us concerns about the PA form--which had morphed back to four pages--as well as the PA process, which increasingly seemed to involve numerous returns for additional information before they would be approved. I was part of a number of meetings with providers and Department of Health Services (DHS) staff, none of which seemed to lead to productive changes in the form or the process, despite promises to do so. I know one provider who simply decided to stop taking Medicaid enrollees as a result.

I share this to provide a background for my understanding of the frustration that I think is behind AB713. Providers have tried, and not been successful, in working collaboratively with DHS. That does not mean that I think all the ideas in AB713 represent the best way to proceed. But I do support something being done to make the PA process less burdensome to providers. Medicaid does not reimburse providers particularly well, but the providers who see Medicaid enrollees are generally committed to serving this population. Reasonable oversight of services is necessary to be good stewards of the public dollars. But DHS' current practices have not been reasonable. And I would note this is a systemic issue not limited to mental health. I have heard individuals with other disabilities and family members of these persons voice similar complaints about the PA process for speech, language and occupational therapies and personal care, among others.

I also think part of the problem stems from the fact that after my time at DHS, the Office of the Inspector General (OIG) was established and the PA function was moved to that office. While there is always a fraud deterrent function in PA, this operates to a large degree through the sentinel effect--providers won't submit PA for inappropriate services because they won't be approved. But my perception is that fraud detection became a much more predominant goal of PA after it was moved to

600 West Virginia Street, Suite 502, Milwaukee, WI 53204 • P: 414.276.3122 • F: 414.276.3124
133 S. Butler Street, Room 330, Madison, WI 53703 • P: 608.250.4368 • F: 608.442.7907

OIG, resulting in the problems documented above. Fortunately, in my opinion, PA has now been moved back to Medicaid where perhaps it can resume its primary function of appropriateness of care.

As I said, I don't agree with all of AB713. I'm not a big fan of putting numbers of visits before PA is required in statutes. It is not clear what the right number should be and we might want to change that number at some point. I am also concerned with defining what information the DHS can collect; that doesn't allow a lot of flexibility. However, I have no problem with defining the sorts of things DHS cannot require as a way of defining some boundaries. I am also very supportive of a process of exempting some providers from the PA requirements, although I can't say whether the criteria identified in the bill are the best ones to use. But doing this, along with some process for making sure these providers continue to be exemplary, would go a long way to addressing all the concerns behind the bill, as I understand them.

I appreciate the efforts of the legislators who worked on this bill. There are many factors that impact access to mental health care. While my primary role is as an advocate for people living with mental illnesses, if there is no one willing to serve them because the system makes it too difficult then I have to be an advocate for providers as well. The current Medicaid Administrator is someone who has been very supportive of mental health services and I know he understands the issues involved here. But I don't depend upon Medicaid reimbursement to make a living. I may trust Mr. Moore to do the right thing but I don't blame providers if, not unlike Charlie Brown, they are a bit suspicious of trusting someone not to pull the football away again at the last minute despite promises to the contrary.

Testimony of Don D. Rosenberg, MS, MBA, LMCT, CICS, Licensed Psychologist
President and CEO of Shorehaven Behavioral Health, Inc.

Date: February 3, 2016

Re: Assembly Bill 713

I wrote an extensive response to the authors of this bill and was encouraged to be here today to present my analysis. I represent 80 clinicians and I have spoken with a number of other DHS35 clinic managers. We are the major providers of psychotherapy to Medicaid recipients. Commendably, the bill tries to solve problems; but it creates several significant problems. It could be an excellent bill for citizens suffering from mental health and substance abuse problems. Taking consumer's needs into account, we strongly recommend changes which will help solve the bill's significant deficiencies and will improve access to services, and without additional expense.

SIX PROBLEMS IN AB713

1. ACCESS TO MENTAL HEALTH SERVICES, ESPECIALLY FOR CHILDREN. We have severe problems of access to mental health and substance abuse services for Medicaid clients. E.g., in the last 4 weeks, a typical month, my clinic scheduled 200 out of 870 families that called us for help, only 23%. We have 178 on a wait list because we cannot find therapists to work at low wages and to do the extra work of prior authorizations that no one else requires save for Medicaid. The 670 are at risk for many negative outcomes. This bill does a little to help, but, with changes, it could do a great deal.

2. ACCESS TO SUBSTANCE ABUSE SERVICES 49.45(29w)(a) 3. By only referencing mental health, the bill pushes providers to the mental health side and continues to make substance abuse services harder to access. The bill needs to reference substance abuse wherever it references mental health.

3. RETENTION OF PSYCHOTHERAPISTS PROVIDING MEDICAID SERVICES. 49.45(29w) (a) 3. and 49.45(29w)(c) Prior Authorization paperwork is a major reason therapists leave Medicaid services. The bill changes the current 15 visits without prior authorization to 24. It fails to include crucial *current* language that authorization is 15 sessions PER YEAR and PER FACILITY. Without that wording, the bill makes authorization more onerous, not less. *Also, all major payers have abandoned prior authorization for routine outpatient services.* They consider it a violation of federal parity law and not cost effective. We recommend authorization for routine care be increased to 48 visits. You must make Medicaid easier to access so more providers are willing to see Medicaid clients.

4. THE BILL DOES NOT FAVOR LOW-EXPENSE OUTPATIENT CARE. 49.45 (29w) (a) 4. The bill favors expensive, restrictive services. Outpatient mental health and AODA care is cost effective due to the phenomenon of Medical Cost Offset; outpatient care reduces costs for more expensive psychological and medical care. Make it easy to access. So, FIRST, in 49.45(29w)(a)4, only adolescents are mentioned when this clause should reference children too. SECOND, to prevent abuse of this generous benefit, the paragraph needs to add "per calendar year." Otherwise, under the bill, families will be able to bring children to expensive day treatment services often. THIRD, the clause inadvertently penalizes In-Home family-based care, which, along with day treatment, is a health check service. The bill should reference both Day Treatment and In-Home, since they presently have the same authorization requirements. This will lead to reduced use of hospitalizations.

5. THE PROBLEM WITH PREFERRED PROVIDERSHIP. 49.45 (29w) (c) 1. creates a class of preferred providers whose authorizations will be automatically approved. The clinicians I polled all found this an exercise in wasting their time, since their employers still have to pay to have them write the documents, but for no reason. I am an example of the economics of this problem. I have written over 900 of these authorizations over 38 years. Of those, only 2 were ever altered. Medicaid saved about $900. But it took at least $10,000 to read them all. My employers paid at least $20,000 for me to write them, with an opportunity cost of not seeing clients, around $25,000 more. About 1/4 of that cost was paid by the United Way. You can see what drives providers away from this population. So make it that preferred providers no longer have to write them at all.

6. DEMANDS ON HMOs. 49.45(29w) (d) I cannot emphasize enough how troubling, even dangerous, this section is. This bill imposes procedures and paperwork on Badgercare HMOs where we providers have encountered no problems. The bill demands them to use Medicaid's excessive paperwork. Most of the HMOs have no prior authorization requirements at all. If this paragraph remains in the bill, it will cause numerous providers to drop out of providing services. Many Badgercare HMOs are national organizations with national standards, usually those of the *Council for Affordable Quality Healthcare* which does the credentialing; so the HMOs cannot use Medicaid credentialing documents. Furthermore, paragraph (d)2. requires HMOs to replace providers who drop out. Our HMOs struggle to find providers for Medicaid as it is and they have valid reasons not to follow this provision, such as questions about the integrity of a facility and lack of providers in a vicinity. Section (d) should be eliminated as paragraph 1 will cause severe problems for providers and seriously reduce access.

SOLUTIONS: Changes to the wording of each section of this bill can turn a very problematic bill into an excellent one.

Section 1. 49.45(29w)(a) 3. Allow 48 mental health or AODA visits per calendar year per facility before requiring prior authorization for additional mental health or AODA visits. Prior authorization requests and renewals may be granted for periods of up to 12 months.

49.45(29w) (a) 4. Allow 10 days of day treatment services to children up to the age of 21 per calendar year before requiring prior authorization for additional days of services. Allow 18 hours of in-home treatment plus travel time to children up to the age of 21 per calendar year before requiring prior authorization for additional hours of in-home SED services.

49.45(29w) (a) 5. a. through d. wherever the words "mental health" appear, change the wording to "mental health and AODA."

Section 2. 49.45(29w) (c) 2. In providing mental health and AODA benefits under this subchapter, the department shall not require prior authorization documents from preferred providers and will process claims from preferred providers in a manner similar to claims for services that do not require prior authorization.

49.45(29w) (a) 5.e. Prior authorization for any outpatient code will automatically include all codes of substantially equal value, including 90832, 90833,90834, 90836, 90839, 90840, 90845, 90846, 90847, 90849, 90876, 90880, 90887, 90899, 90853, H0022, H0005.

Lastly, 49.45(29w) (d) [Remove this section.]

Testimony of Don D. Rosenberg, MS, MBA, LMCT, CICS, Licensed Psychologist
President and CEO of Shorehaven Behavioral Health, Inc.

Date: February 3, 2016

Re: Assembly Bill 711

COMMENT: Regarding paragraph (b), *all HMOs in eastern Wisconsin save the Family Care organizations already honor qualified treatment trainees, allowing and paying for their services.* But their national organizations, the *National Council on Quality Assurance* and the *Council for Affordable Quality Healthcare,* cannot permit licensed trainees to have provider contracts. The solution has been to allow and bill for the services under the supervision of a licensed practitioner who is a contracted provider. So paragraph (b) cannot be followed unless this wording is added:

Recommended addition:

(c) An HMO will be considered in compliance with 2.(b) by permitting qualified treatment trainees to provide and bill for services in a DHS35 licenced clinic under a supervising licensed clinical social worker, licensed professional counselor, licensed marriage and family therapist, or licensed psychologist.