

Good Morning, My name is Brian Stoesz and I am the CEO of the Pennsylvania Division for Summit BHC.

The Summit BHC Organization has 3 operating treatment facilities (Turning Point – 109 beds, St Joseph Institute – 40 beds and Mountain Laurel Recovery Center – 58 beds) in the state of Pennsylvania that provide an array of treatment services for adults with substance use and co-occurring mental health conditions. Our facilities offer a full spectrum of treatment services, including detoxification, short-term residential, long-term residential, partial hospitalization (PHP), intensive outpatient (IOP), traditional outpatient (OP), and a transitional living component. In addition to our 3 facilities in Pennsylvania – Summit BHC has 2 facilities in Georgia, 2 in Texas, 2 in California, 1 in Louisiana, 1 in Missouri and 1 facility in South Carolina. In the very near future Summit BHC will be opening 2 other facilities in the Eastern part of the United States. Summit's mission is to provide quality, intimate treatment to those impacted by substance abuse and addiction.

I want to thank you for the opportunity to provide testimony today on this important topic of accessing treatment. Today I will be touching on the following points:

- Inadequate reimbursement rates (Managed Medicaid and County)
- Billing complexities which cause undo delays in reimbursement.
- Barriers related to length of stay
- Barriers related to commercial insurance deductible and copay amounts

Summit BHC's Pennsylvania treatment facilities provide treatment services to those in need across the payer spectrum. Our 109 bed Turning Point facility in Franklin Pa, serves largely (93%) individuals and families who are currently utilizing county funding or Managed-Medicaid for their health insurance coverage. Therefore, we would like to bring to your attention how the lack of an adequate Medicaid reimbursement, cumbersome billing processes and barriers to adequate length of stay impact access to care for those in need of substance abuse treatment in our state.

- In the current system, publicly funded reimbursement rates are established through an RFP process in which providers are able to annually submit their rates for review and approval by the Single County Authorities and the Managed Medicaid entities. The rate setting process only allows providers to include the basic costs of patient care, but establishes a cap on administrative costs, which prevents the provider from even getting close to the true cost of doing business. Furthermore, it is not unusual for some Managed Medicaid entities to provide reimbursement rates that fall even below the reduced cost of care rates established by the RFP process through the Single County Authorities. In addition, rates for longer term residential care programs are frequently even lower than short term, although the regulatory requirements of services to be provided and the costs associated with providing such services are equal to short term residential care. As a result, the availability of such programs throughout the state is rather limited. When Summit BHC purchased the Turning Point Facility on March 28, 2016 the rate of reimbursement from county/managed Medicaid entities averaged \$157.00 a day. It was only after going through the XYZ

process we were able to get our rate increased to an average rate of \$180.00 a day. When you compare this rate to an in-network contract rate of \$550.00 a day with a commercial provider or \$800.00 rate of reimbursement for out of network commercial coverage – there is a marked difference. This low rate of reimbursement makes it very difficult to make on-going facility improvements, secure qualified staff, etc....

- In addition to the lower rate of reimbursement with in the county/Medicaid arena comes a complex and inconsistent billing process. Whether it is stated or not counties and individuals function independently when it comes to billing. Claim submissions will get kicked back for wrong color forms with one person/county but not another, some individuals/counties require authorizations – others don't, some counties pay quickly – others appear to drag the process out. The process is inconsistent and cumbersome.
- Length of stay is an on-going issue within the treatment industry – in both the commercially insured and Medicaid funded arenas. At our Turning Point facility for example – the average length of stay for the client in our care for the month of October was 15.4 days – which included detox services. Most of the clients (70% or more) coming to Turning Point have had multiple failed treatment experiences – with similar length of stays. Almost all the literature you read regarding addiction treatment talks about the critical importance a longer treatment stay plays in the recovery process – yet we continue to run into obstacles when we attempt to maximize that length of stay. The focus on maintaining a shorter length of stay to maximize cost effectiveness in actuality is costing more money than allowing a client to stay longer to reap the full benefit of his/her treatment experience. At this time, more than ever, it is extremely important that programs are funded at a level that enables the provision of high quality, evidence based and effective treatment at appropriate length of stays, to improve long term outcomes. It is my hope this is something that can be looked at moving forward.
- In addition to our Turning Point facility – Summit BHC has two other facilities, St Joseph Institute & Mountain Laurel Recovery Center, which serve primarily the private pay and/or commercially insured client. Through the ACA and the MHPAEA, the majority of these individuals now have a benefit that covers treatment for substance use disorders. Unfortunately, those benefits are frequently unable to be accessed due to extremely high deductibles or copay amounts. It has not been unusual to encounter in-network plans that have \$4,000-6,000 deductibles and out-of-network plans that have deductibles that are \$10,000-12,000. These are plans for which the individual has paid their portion of the monthly premium and yet they are still unable to access the coverage (for which they have already paid) because of their inability to satisfy the “extreme” deductible and/or co-pay - without causing financial hardship to their families. In our experience – most people simply don't have the money to cover these front end costs and those that do – opt to not seek treatment because of the financial burden it would present. These types of plans offer little relief for those in need of substance abuse treatment services.

Brian Stoesz – HR 590 Testimony 11-29-16

With the opioid crisis upon us – I firmly believe now is the time to take a focused look at the issues outlined above. Once again – thank you for giving me the opportunity to provide testimony today on this very important topic.