

JOINT  
SENATE HEALTH & WELFARE COMMITTEE  
AND  
HOUSE HEALTH & WELFARE COMMITTEE  
Friday, February 12, 2016

ATTACHMENT 18

02/12/16  
Jessica Chilcott

February 13, 2016

**Chairman Heider, Chairman Wood, Members of the Committee**

**I want to thank you for this opportunity to speak to you today. And to thank all of you who assisted in prompting the evaluation of the Idaho Behavioral Health Plan by the Office of Performance Evaluations and to commend the office for their work.**

**I would like to take this opportunity to provide an additional perspective on some of the statements.**

**It was noted that the Department of Health and Welfare was concerned about the rising costs of psychosocial rehabilitation (PSR) services and that "PSR was sometime inappropriately used to replace missing social services" (p.19). I am uncertain what social services that PSR would have been replacing. However, I can, with confidence, state that in the communities in which I practice additional services have not appeared. The roll out of the Idaho Behavioral Health Plan in 2013 promised the addition of peer and family support services. These services are still mostly nonexistent in Region 1.**

**It was noted that in the fee for service payment model the payment amounts "are determined by a fee schedule set by the state" At this juncture it is unclear how the reimbursement rates are determined. I will note that the rates are inadequate to cover the cost of doing business. The administrative burden created by the utilization management process has been financially devastating for some, particularly the small rural, agencies. Meanwhile, agencies are told that they need to "alter their business practices." It is not clear what this means however, the two simplest methods for reducing the financial impact would be for agencies to eliminate CBRS or to pay their direct service staff less. The elimination of CBRS is undesirable from an access perspective. I would hope that it would be unnecessary to explain why paying staff less is undesirable.**

**Beyond questions of whether or not PSR and CBRS are the same service (they are not). And whether or not case managers should be fairly compensated for their work (they should). I have larger concerns. I am concerned because we have hundreds of Idahoans with mental illness who are not able to access the services that they need because their recovery goal is not in line with Optum's recovery goal for them, or because Optum does not recognize CBRS as a valid treatment for their diagnoses. Or their CBRS hours have been reduced but none of the "value added" services have appeared to assist. A full continuum of care should have been ready to implement before clients began losing the few services that they did have access to.**

**I am further concerned by the fractured state of the Idaho Behavioral Health System. I am concerned because the providers have such an enormous level of distrust in Optum and the Department. This distrust has been built from intentional miscommunication from both the Department and Optum. It has been built from the apparent opacity when attempting to have questions answered. It also comes from what we have observed as the outcome in other jurisdictions where Optum administers the funds. This distrust has been built from seeing damage done to our clients, people we care about, as they are unable to access the help that they need.**

**Moving forward I would suggest that the Divisions of Medicaid and Behavioral Health communicate with each other and stakeholders prior to changes in services regarding a shared vision for what we as Idahoans want for our behavioral health system. It has become apparent in communicating with both the Division of Medicaid and the Division of Behavioral Health that they do not have the same goals. Managed care may have saved the State money but, I fear that we have not yet seen what those dollars will cost us.**

**I would also ask that a rate study be completed to examine the current fee structure for services. Provider reimbursement rates have been largely stagnant for the last 15 years. More to the point we saw several rates drop with the roll out of managed care. Current rates are not sufficient to cover the costs of doing business even from the most generous inflationary perspective. No amount of "altering business practices" is going to make the rent, utilities, and insurance cost less.**

Suggestions for use of the \$28 million dollars include: increasing the baseline authorization for CBRS from 3 months to 6 months. This would give providers enough time to try to develop a therapeutic alliance with the client while at the same time reducing the administrative costs to agencies because of the hours long process of completing the utilization management forms required to access CBRS. Restore case manager's ability to receive appropriate compensation for their work: including an appropriate rate for case management activities completed over the phone. Provide a mechanism for reimbursement for care coordination activities. Providers have long recognized the value of ongoing communication with a client's other providers including their doctor, school, and psychiatrist. This coordination of care is a corner stone of the medical home models gaining popularity in Idaho, provide a mechanism for providers to be paid for this time.

Thank you,

  
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**P.S. Please take the opportunity to send SB 1204 or SB1205 to the floor with a "do pass"**

02/12/16  
Jamie Gibson

First, thank you for taking the time to learn a little about my son Michael and the difficulties that he faces every day. I could write literally hundreds of pages about him, but I do not wish to take more of your time than is necessary. To give you a little background on Michael, he just celebrated his 10th birthday last Sunday. He has always had difficulty in many areas, but is usually a fairly happy child. He is currently in the third grade at Edgemont Gardens Elementary in Idaho Falls. He attends school in a general education classroom and receives supports from the special education department in math, reading, and testing. He also receives speech therapy and occupational therapy in the school once per week.

In addition to the supports and therapies that he receives at school, he also receives private speech therapy and occupational therapy once per week and counseling sessions twice per week. As you can see, he is a busy boy.

In March 2014, we requested a referral for counseling from Michael's Healthy Connections provider. At the time he was showing aggressive tendencies and we wanted to address the problem before it became a larger issue. At the time we were unsure if the aggression was a result of mental health issues or a side effect of the seizure medication that he was taking. Our best guess is that it was a combination of both.

In April 2014 we met with David Spencer at Pearl Health Clinic in Ammon, ID. He did a CDA on Michael and made the recommendation for weekly Individual Therapy and CBRS. He also requested additional psych testing to make a more definitive diagnosis than PDD-NOS.

In May 2014, Michael began seeing David Spencer weekly for Individual Therapy. We also met with Matt Bishop from Pearl Health Clinic to begin the process of CBRS. Michael was approved for 3 hours a week of CBRS for 90 days with a singular diagnosis of PDD-NOS. Michael also received in depth psych testing.

In June 2014 we met with Dr. Daniel McGrath at Pearl Health Clinic to receive the results of the testing. Michael received a primary diagnosis of ASD and a secondary diagnosis of Borderline Intellectual Functioning.

In July 2014 we sent a reauthorization for CBRS beginning in August 2014. The service was approved, but Optum made the recommendation to transition to DD services. We did the research and determined that DD services would not be as beneficial as the services that he was currently receiving.

In October 2014 we sent a reauthorization for CBRS beginning in November 2014. The service was approved. Michael also began using Neurofeedback in place of the traditional Individual Therapy he had been receiving. It has proven beneficial in both treating some mental health issues and decreasing the frequency of Michael's seizures. This was done at the recommendation of his

counselor and with the approval of his Neurologist.

In January 2015 we sent a reauthorization for CBRS beginning in February 2015. The service was approved.

In April 2015 we sent a reauthorization request for CBRS beginning in May 2015. The service was denied. When Michael's case manager/ CBRS worker spoke with the agent at Optum that denied the request he was told that Autism is a cognitive impairment, not a mental health impairment and Optum would not pay with only an ASD diagnosis. When he provided proof that the treatment had been effective, he was told "They did not care." At the time we chose to withdraw the request and do more testing. We felt that there were more issues, but to that point they had just been included under the ASD umbrella.

In May 2015 we entered into a private pay contract with Pearl Health Clinic. Michael has built a trusting relationship with his current worker over the last year. We felt that removing the service would cause a definitive regression in the progress that we had seen. We agreed to pay \$25 an hour for services. This contract has been in place since May 12, 2015. As a result the number of hours has been reduced due to financial constraints. Michael also received additional psych testing.

In June 2015, the psych testing had been completed and his diagnosis had changed. Michael's primary diagnosis was changed from ASD to OCD. He was also diagnosed with Anxiety Disorder, Major Depressive Disorder, and Attention Deficit/ Hyperactivity Disorder. We submitted a request for services on June 15, 2015 for services to begin June 22, 2015. The request was denied and we requested a review of the denial. Michael's case manager called it a peer to peer review. Optum called Pearl Health Clinic after hours on June 25, 2015 to state that the request was still denied and that a letter would be sent. The letter was dated June 30, 2015. I received the letter July 8, 2015. We submitted a request for a Fair Hearing by email on Friday July 10, 2015.

A Fair Hearing was held October 13, 2015. The hearing officer found that Optum's decision would be upheld because the information that was provided to them at the time of the initial determination would lead to denial of services. We obtained the services of an attorney that specializes in cases of people with disabilities, she is appealing the decision.

At her recommendation, we again submitted for services in November of 2015. In the authorization request, we were careful to make sure that we addressed all of the issues that had been brought up in the preliminary order from the Fair Hearing. The authorization was denied again. This would not have been an issue, except that the decision was made in less than 24 hours. When Michael's case manager spoke with Julie Dephue at Optum (the person that made the determination) her only answer was that the State Attorney General's office had already decided that he did not qualify. She did not even read the authorization to the best of our knowledge, but made a determination based on non medical reasons.

We have also chosen to appeal this decision and it is currently being handled by Michael's attorney. It has been combined with the previous appeal, and we are anticipating a determination soon.

I know that when it comes to deciding what treatments are correct for a child, the input of the parents is often discounted because they are not professionally trained to treat or diagnose mental health conditions. This is a terribly flawed approach because a parent is the person that knows their child better than any professional. A parent is the one that deals with the behaviors caused by mental health issues every day, they are the ones that receive calls from schools, they are the ones that can see the minor changes daily. Up to this point, other than the treating professionals that work with my son, no one has listened to my input. I, as a parent, have been denied the right to advocate for my child and paint the entire picture, instead, a clinician that has never met my child has made a decision based on a 13 page form. This form contains numerous boxes to check (many of which do not apply to the service we are requesting), places to quote best practice guidelines, and basic information such as age and address. Less than 25% of the form is specific to what the needs are and how they will be addressed.

There have been many recommendations made as to what my son needs, but all of these are coming from individuals that have never met or treated him. All the professionals that work with him are in agreement as to what has been effective. We know that CBRS services have been effective, because we as a team have worked with him and understand him at a level that cannot be achieved by reading a form or even medical records. We understand Michael, and because of that, the opinions of his treatment team should be placed above the opinions of any other clinician. This team is comprised of professionals from multiple disciplines, including education, Occupational Therapy, Speech Therapy, and mental health services, working together to reach the best overall outcome. There is not a single person on the team that has treated or worked with him for less than a year. This is important to understand, because he is a unique individual, with unique challenges and needs. A decision should be based on what will provide the best outcome for him as a person, not just in one specific area.

We have reached a point that he has lost most, if not all, of the progress that he made learning to cope with the symptoms of his mental health issues. The reason for this is obvious to anyone looking at the entire picture, that services were terminated before he was ready. At the time of his initial denial in June, our guess was that he would only need 6 months at the most to be ready to graduate. The fact is that the treatment for mental health is not something that we can put a clock on, it is something that each person will achieve in their own way and time.

We have been told time and again that he needs Developmental Disability (DD) Services. No one could tell us what services he needed from DD, just that DD was a better fit for him. I finally got an answer from someone at the Department of Health and Welfare on January 20, 2016. I was told that what he needed was Habilitative Intervention. I understand the HI is a life saver for many families that have children on the spectrum, I have even researched it myself. The truth is that the behaviors often associated with his autism are being adequately addressed through other means. The issues that we are dealing with are the mental health symptoms. He has obtained the functional skills that HI could provide for him. Due to a medical condition, some skills must be modified or observed, but he does possess them.

The clinician that contacted me on January 20, explained to me the difference between a symptom and a behavior, the way I understand it, a behavior is the result of a symptom. HI services are stated to treat behaviors. From the DD services handout found on the department website:

*1. Develop Functional, Adaptive Skills. When goals to address skill development are identified on the plan of service, the intervention must provide for the acquisition of functional skills such as riding the bus, cooking, banking, dressing, keeping a schedule and community safety skills.*

*2. Diminish Maladaptive Behaviors. When goals to address maladaptive behavior are identified on the plan, the intervention must include the development of replacement behavior/skills rather than merely the elimination or suppression of maladaptive behavior that interferes with the child's overall general development, community and social participation.*

That is not what he needs, he needs the skills to cope with the symptoms of his mental health issues, he was learning those skills in CBRS. If HI is used the way that it is stated, he will not gain those skills, he would just learn to use a more appropriate behavior. HI services will never address the root cause of the behaviors in the way that CBRS has been able to do.

Another important issue that has never been addressed, but should be when discussing my son's mental health is that he is fearful of new people and new routines. Is this something that we are working on? Of course it is, but it would do him a disservice to force him into both and pull the support that he is comfortable with at the same time. It took Michael a significant amount of time to build a relationship of trust with his former CBRS worker, and that is not always a relationship that Michael is capable of building. We have kept the relationship active through weekly Case Management Services, though not providing the same service as before, it allows Michael the ability to see that the routine and people have not changed, even if what they do has changed. It is one step in the path to the goal. The fact that this relationship has been built is important to Michael's mental health treatment, and not a relationship that is guaranteed with a new service provider.

HI is also a much more time consuming treatment, my understanding from an unscientific poll of people I know that use HI, it is on average 5 to 8 hours a week. There is also Habilitative Supports, a separate service that works in addition to HI. When this is added to the two session a week of counseling that he is required, the session of speech therapy, and the session of occupational therapy that he needs every week, he is never given the time to just be a kid. He spends all of his waking hours in school or therapy. Regardless of the fact that he has different needs, he still needs the time to be a kid and do that things that he enjoys doing. To take that rest and relaxation time from him would do as much damage as not providing him with services at all.

The final recommendation that has been made is that he seek medication to deal with his mental health issues. This is part of the reason that a full understanding of the whole individual is important. Michael has epilepsy. It is a simple statement that I feel is glanced over by all of the professionals making recommendations to treat his mental health. The fact that he has epilepsy with an unknown cause is a game changer. He currently takes large doses of two different medications to attempt to stop his seizures. This combination has been the most effective of any that we have tried, yet

he is still having seizures and the frequency, duration, and intensity of the seizures is escalating. He currently has a service dog in training because his seizures have become severe enough that he needs constant support and monitoring. Within the last two weeks, he has had two seizures that have caused him to stop breathing. He had one two days ago and vomited during the seizure. The reason that this is important is because both the medications that are used to treat his epilepsy and the medications that could be used to treat any of the mental health issues that he has affect brain chemistry, that is how they work. There is no way to know how a combination of medications will affect both his medical and mental health. When you look at possible interactions between his current anti-seizure medications and all possible mental health medications, there is not a single combination without moderate interactions, and many have severe interactions. That is a risk that I am not willing to take with my child, especially since it has been empirically proven that his mental health issues can be effectively treated without medication.

There is no choice when it comes to medication for his epilepsy, without the medication, he seizes so frequently that he is not able to function. There is no surgery that will fix the problem. We have learned that he is more likely to seize when his anxiety levels are too high. This is becoming an issue, and I fear for his physical safety if we are not able to get him the skills he needs, and was building until services were removed. When he is anxious, he gets nauseous, he gets dehydrated, all of these cause him to have more seizures. The more seizures that he has, the more anxiety he has, and it is a cycle that may one day be deadly. It may seem that I am over reacting, but this is a reality within my life and his. If for one second I thought that a treatment plan other than what we were requesting would be effective, I would jump on it.

Again, thank you for your time. I know that Michael is not the only child that is being forced to suffer because he is being denied access to the treatments that work for him. It affects not only him and his quality of life, but his family and their quality of life. It is a matter of more than just dollars and cents, the decisions that you are charged to make have real life consequences for Idaho families.

Jamie Gibson

February 11, 2016



02/12/16  
Vanessa Johnson

February 12<sup>th</sup> 2016

RE: Health and Welfare Programs

Chairman Heider, Vice Chair Nuxoll, and Esteemed members of the health and welfare committee.

Good Morning and Thank you for giving me the opportunity to speak today.

My name is Vanessa Johnson, I graduated from Boise State University in 2006 and have worked in our community serving our citizens who have been diagnosed with a severe mental illness for the past 10 years, currently I am the director of community based services at Access Behavioral Health and I am a graduate student at Simmons College out of Boston.

Community Based Services for individuals with a mental illness has been served for years under a program called Psychosocial Rehabilitation (PSR) and when managed care became effective this service's name was changed to Community Based Rehabilitation Services (CBRS). This service has been drastically cut, I was here a couple weeks ago and listened to the OPE report of Optum Idaho and am glad it has finally been clarified that decreasing community based service costs was a top priority of Health and Welfare in implementing managed care. Optum has successfully decreased the costs of providing this service stating that it is ineffective and not evidence based practice. However, as this service has declined rates of hospitalizations, psychiatric holds, police interventions, and homelessness have risen. I am not sure if you would call that a cost savings.

I would like to take a step back and explain that Psychosocial rehabilitation is a model of service delivery, which provides an umbrella of interventions which can fall beneath the model. Many evidence based practice interventions fall under this umbrella, such as social skills training,

psychoeducation, and supported education. SAMHSA refers to PSR as an evidence based practice, as does multiple research studies across several countries. Boston uses a tailored model of PSR for their community based service delivery, this is a state which ranks amongst the highest in mental health system performance and service delivery.

Psychosocial rehabilitation is an evidence based model, however the restrictions that have been placed on this service model over the years, not just through our current managed care provider, have prevented the full utilization of this evidence based model of treatment. Psychosocial rehabilitation became the catch all service in Idaho because there was no other community based service to provide, now this service has been renamed to something that does not have any evidence base and denied to clients based on claims that the service is not evidence based and does not meet medical necessity. Medical necessity guidelines are not posted or available, however the adopted best practice guidelines from the American Psychiatric Association and the American Academy of Child & Adolescent Psychiatry have links posted for provider to use under the Guidelines/Policies/Manuals section.

On the American Psychiatric Association page it states:

"In accordance with national standards, including those of the Agency for Healthcare Research and Quality's National Guideline Clearinghouse, these guidelines can no longer be assumed to be current." <http://psychiatryonline.org/guidelines>

Outdated are all diagnosis listed except eating disorders and OCD.

On the American Academy of Child & Adolescent Psychiatry page it states:

"AACAP practice parameters are not intended to define the sole standard of care. As such, the parameters should not be deemed inclusive of all proper methods of care, nor exclusive of other

methods of care directed at obtaining the desired results.”

[http://www.aacap.org/AACAP/Resources\\_for\\_Primary\\_Care/Practice\\_Parameters\\_and\\_Resource\\_Centers/Practice\\_Parameters.aspx](http://www.aacap.org/AACAP/Resources_for_Primary_Care/Practice_Parameters_and_Resource_Centers/Practice_Parameters.aspx)

“ In accordance with national guidelines, AACAP practice parameters are considered to be current if published within the past five years. Parameters older than five years (asterisked in the list below) may not reflect current knowledge and practice and as such should not be considered current until they are updated.”

[http://www.aacap.org/AACAP/Resources\\_for\\_Primary\\_Care/Practice\\_Parameters\\_and\\_Resource\\_Centers/Practice\\_Parameters.aspx](http://www.aacap.org/AACAP/Resources_for_Primary_Care/Practice_Parameters_and_Resource_Centers/Practice_Parameters.aspx)

Outdated information includes child diagnosis such as ADHD, Anxiety disorders, Bipolar disorder, Conduct disorder, ODD, Stimulant medications, substance use, suicidal behavior and many others.

The only other service that has been added as a community based service is Peer Support Services, a wonderful service, but only 25 people per region, per year are trained. Many of these individuals find themselves unable to work after the training, or do very well working for 10 to 20 hours per week. Two of the significant leaders in Boise for Peer Support services committed suicide last year and a system to fully support this service has not been implemented.

CBRS or PSR whichever you prefer to call it cannot be a catch all service, however neither can peer support services, or the counseling and medications regimen Optum requires in some unwritten mandate.

PSR and Peer Support services policies should be written and supported in a way that captures their evidence based models. The current system of restrictions on community based services is

having a detrimental effect on those who live with a mental illness and our community as a whole.

Attached to my written testimony you will find a list of articles and web sites that I have referenced.

Thank you,

Vanessa Johnson

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<http://www.samhsa.gov/gains-center/grants-grantees/early-diversion>

<https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/bpg.html>

02/12/16  
Matthew Montoya

Good morning, my name is Matthew Montoya. I have been a billing specialist for Access Behavioral Health Services for over three years. My first introduction to Medicaid billing came at a time when Molina Medicaid Solutions was still dealing with the difficult and drawn out transition that had begun in June of 2010. During this time, providers statewide were having problems getting reimbursed for Medicaid services; our agency was not immune to this problem, even though we had participated in the pilot program. One of the primary roles I undertook at that time was sifting through the pages of remittance advice statements that showed all our paid, denied, pending, and reversed claims. Considering the volume of claims our agency submits, these were pages of information that had to be manually combed through, looking for minor discrepancies in payment. Throughout the next couple years, we would encounter multiple ongoing claim issues that ended up costing a lot of administrative time to correct. Even though we have had ongoing issues, ranging from claims processing to implementing and complying with CMS guidelines, we had finally come to a comfortable relationship and understanding of what to expect between the state and the administering of claims by Molina. We still submit claims to Molina as all services were not part of the new managed care system. One problem we continually encounter with the Department of Health and Welfare is the lack or confusing billing guidelines for the various Medicaid programs that exist. This problem has only become greater with the addition of another vendor administering Medicaid claims. Now, faced with the decision by the Idaho State Legislature, to award the managed care contract to an out-of-state business, Optum/United Behavioral Health, we are again facing claim issues that are preventing reimbursement for mental health services. Since September, I have spent a considerable amount of time dealing with the specifics of Optum's billing guidelines, that they themselves have created for their commercial products, some of which was discussed during the provider trainings prior to the go live date, and some of which I have learned along the way and continue to learn as new issues arise.

Prior to the go live date, we submitted a provider roster to Optum on multiple occasions. However, even after receiving this information, they failed to include one of our nurse practitioners. This resulted in the denial and delay of this provider's claims for well over a month. Even though we continued to provide all necessary information to have this provider added to our practice, it still took a month for Optum to correctly load this provider into their system so that claims would not be denied. It took more than a month after that to sort out and reprocess all of these denied claims. This is just one example of no matter how much we tried to prepare for this transition, in educating ourselves, repeatedly making inquiries, and complying the best we could with their billing guidelines, something that could have been prevented was not, and the time it took for Optum to respond was borderline negligent. It has been routinely brought up that we should have adjusted our business model in preparation of this transition, but how do you prepare for something that is entirely out of your hands? Now that the grace period has come and gone, I am still getting denials on claims that we are trying to reprocess with dates of services going back to September. Yet, instead of reprocessing these claims, they are being denied yet again, for timely filing. Even though we had submitted these claims on time, it has taken us this long to identify all the claims that were originally incorrectly denied. Does it seem reasonable that claims during this grace period should be exempt from this 90 day timely filing rule? Furthermore, why has a 90 day timely filing rule been instituted when the national standard for timely filing is one year from the date of service?

Perhaps the biggest short coming for me as a biller, has been Optum's claims processing system, a system that has had many technical drawbacks and has been spread across a wide range of products under the Optum brand that makes up the system as a whole. I could not begin to describe the challenges a single claim has in even entering into the processing system specific to Idaho, since the product they use is based on a national system for the processing of not only Idaho's Medicaid claims, but their entire commercial and Medicare supplement claims nationwide. Optum's claims web portal, Provider Express, lacks many of the features providers have grown to rely on for timely adjudication and processing of claims, as well as accurate information, which doesn't seem to be reflected across all of Optum's different healthcare claim systems. There seems to be a huge disconnect between the system Optum has set-up for Idaho and these various other systems that operate under the Optum brand.

There have been multiple occasions where the information reporting on the electronic remittance advice statements does not match the information found on the provider portal. Additionally, information found on Provider Express does not match up with the remittance advice statements that they generate. It's yet another example of poor communication between Optum/United Behavioral Health's own systems that are in conflict with one another. Even talking to the customer service agents, they too have agreed that the information will vary from Provider Express to the information found on the remittance advice. I have yet to get an answer as to why these discrepancies exist. My frustration goes back to always being told, that Optum does not have any control over the handling or technical issues that take place with Provider Express. Instead I am referred to calling a different number specifically for this website, working with a service department that has no knowledge about how Idaho Medicaid claims should be handled.

Although I could attest to the many instances individual claims may be denied, pended, or otherwise held for payment, I would like to highlight some areas that are still of concern to us as a provider and to me in doing my job as a biller.

There are members that have incorrect eligibility information being reported, or not reported to Optum. In such cases, we can confirm with Health and Welfare that these members should be active. However, we have to call Optum's customer service department and ask them to submit an eligibility request to the State, which may take up to five business days for a response. In some cases, the information coming back does not report original effective dates. If a member should not be covered for a month while eligibility information is being verified, and an original effective date is not loaded correctly, then neither us nor Optum can pull up previous claim history on that member. Right now, I am waiting to hear back on one such member. All of the December claims have been denied. Although after submitting an eligibility request and now finding this member active, we cannot reprocess any of the December claims because these claims are nowhere to be found since the effective date is January 1<sup>st</sup>. We also cannot resubmit these claims on our own, as they would deny for duplicate services. I am still waiting on a response as to when this issue will be corrected.

Authorizations have been nothing short of a nightmare. I'm sure many here could speak about all the frustrations in even trying to obtain an authorization, but again, as a biller, when I see a denied claim because of no authorization, even though we have submitted a valid authorization with the claim,

it's nothing short of astonishing that a company this size with as many resources as they have, cannot even process a simple claim with its corresponding authorization. To Optum's credit, they know this is an issue and have helped in the reprocessing of a vast amount of claims that denied at the beginning of December. However, this is an ongoing issue that still has no resolution. Subsequently, our issues with the authorizations have only begun, as this is only the first round we have gone through in obtaining the majority of category 3 authorizations. We now have to deal with the fact that a majority of these authorizations are all set to expire around the same time. This has led to problems in authorizations for the same member, same service, overlapping with the dates these authorizations are valid. That means that there may be two valid authorizations for the same service. How do we then determine which authorization we should be billing with if both are showing as active and valid? We are not sure, but we are having claims denying when there are two valid authorizations on file.

Lastly, if this contract remains in place, I would hope that through these testimonies, that some effort will be made to improve the relationship between Optum and Idaho's providers. I would encourage Idaho's legislature, to make the following changes:

- Continue to make enhancements to the online web portal, to allow for better and concise access to eligibility, authorizations, claims, and payments.
- Build upon the relationship with Optum and providers to develop a billing model that works for everyone, which may include adopting rules that were in place with Molina and were outlined in IDAPA.
- Change the 90 day timely filing to a year from the date of service.
- Engage the providers in more in-depth trainings that could range on a variety of topics, but include best billing practices, not best business practices in favor of Optum.
- Streamline the authorization process, hire more staff to deal with reviews, and treat our staff that has been on hold for hours with the courtesy of professionalism.

Thank you for your time today in your careful consideration of improving a relationship that has been strained. We are putting our trust into you to make logical and reasonable decisions that truly affects the quality of care our patient's deserve.



02/12/16  
Jennifer Zielinski

Joint Health and Welfare Committee  
Jennifer Zielinski- 2/12/2016

My name is Jennifer Zielinski, the Program Coordinator with Idaho Parents Unlimited, Idaho's parent, training and information center as well as the family to family health information center. I come before you today representing parents of children with mental health disorders. I also represent myself as a parent of our adopted daughter, Chelsea, who came from Idaho's foster care system due to neglect and abuse. In the area of children's mental health, our 30 year old organization has never received the amount of crisis phone calls from parents searching for out of home placements for their children, like we have in past year. For the first time, we cannot report positive health outcomes for these families. We are reporting crisis, families are falling apart, their jobs are effected, their marriages impacted, there's an increase in school issues, and their other children are dealing with the stress and fear from all of the trauma. I have a stack of denial letters that Optum Idaho has sent out to parents who were seeking an average of just three hours a week for the only home and community based service Idaho offers, CBRS. The denials come back with recommendations of family therapy and medication management. ~~Most of these families who call our office are raising children are in need of treatment, which would include an array of intensive therapies and interventions.~~ Though we believe that family counseling, medication management, and individual counseling can be effective as part of an array of services, our state needs to address the need for real comprehensive treatment specific to the individual's needs, not based solely on diagnoses.

For the past eight years we have searched for treatment for Chelsea whose rage, aggressive behaviors, and social and emotional delays were increasingly getting worse. We have been through two investigations due to false accusations of neglect. Chelsea's current diagnoses are reactive attachment disorder, schizoaffective disorder, anxiety, ADHD, and social and emotional delays. One of the many times Chelsea was hospitalized at St. Alphonsus Behavioral Health center due to <sup>her</sup> a mental breakdown <sup>in 2012</sup> they falsely accused me of harming Chelsea. That nine month investigation revolved around my going to counseling so that I could learn how to be a better parent to Chelsea. No treatment and no services appropriate to meet her individual needs. Our youngest daughter was born into a family where she watched her sister physically attack me on a daily bases. Our two older kids could no longer bring friends over for fear that they would witness Chelsea's rage. Our family was forced into isolated from our own family, friends, and community. The risks of trying to raise Chelsea <sup>we for</sup> without the appropriate services or treatment forced us to place her in a residential care facility. The nightmare didn't stop there. About six months after she had been there, we got a call from an investigator who told us that Chelsea's care givers were arrested for sexual abuse of minors. Chelsea has been victimized again! ~~She should have been able to receive treatment while living in our loving home where she was safe.~~ ~~Instead,~~ I spent eight years being falsely accused, turned away, ignored, and left to navigate a mental health system that doesn't address the serious needs for children like Chelsea. To top it off, she is only ten years old!