November 8, 2023

Members of the House Interim
Committee On Behavioral Health and Health Care
900 Court St. NE
Salem, Oregon 97301

RE: Management of Medicaid-Funded Home and Community-Based Behavioral Health Services

Chair Nosse and Members of the Committee:

My name is Iris Sexton and I'm the Vice President of Residential Services for New Narrative.

New Narrative is a 501(c)(3) non-profit mental health provider based in Tigard, Oregon and in operation for over 45 years with locations in Multnomah and Washington Counties. We provide integrated mental health, residential and peer services at over 40 locations. Our residential programs span the housing continuum from licensed residential treatment programs to supported and independent housing. We strive to provide resources so people seeking mental health care can develop the tools to thrive, not just survive.

First, I would like to thank the Oregon Health Authority for acknowledging our current system has some challenges and moving quickly to address these issues. We are grateful to be in partnership and hopeful we can move toward a more effective and efficient system. Today I would like to help frame some of the information you heard from the perspective of a provider on the ground in these Medicaid funded residential treatment settings. New Narrative currently operates 11 Residential Treatment Homes and Facilities which accept referrals from across the state, and we are on track to open two additional treatment facilities in the next 3 months.

The experiences I would like to share today are not specific to Comagine as the Independent Qualified Agent (IQA), but rather are challenges working with any IQA and within an acuity-based payment structure.

As a provider, we accept a new resident based on their need for residential services. However, we do not have an authorization for care or know what tier level payment will be authorized until after they move in, complete both our internal intake and assessment process, and engage in a Comagine interview which includes Comagine writing up documentation and a plan that is then signed by multiple individuals involved in the care team. In the best case scenario this process takes about 30 days. We have had situations where it has been 90 days before obtaining an authorization; the average is around the 60-day mark. This time delay is due to

administrative burden and residents sometimes experience distress and may not be open to engaging in these conversations immediately. While we wait for an approved authorization we provide services, but without any guarantee of the payment we will receive. Aside from the budgetary challenges in this situation, we are also faced with adapting programming and mobilizing resources to meet resident needs as we see them the program that may not be captured by the assessment completed by the IQA.

We are paid per night that a resident is in their bed. For example, when a resident has acute medical issues and might need to go to the hospital for treatment, our payment is reduced to a retainer payment which ranges from just 23% - 64% of their full daily rate. This reduction is not indicative of a similar reduction in staffing or overhead for the program while that resident is out of the facility. If a resident is in a non-treatment location, such as visiting family, the provider does not receive any payment. As residents approach discharge, ideally, they would be spending more time away from the facility to move toward a successful transition. The current payment structure does not support this best practice.

In theory, acuity-based payment appears to be a reasonable method to determine rates of pay. But as acuity decreases, as it will as treatment progresses, the provider experiences a financial obstacle. We know that staffing patterns are simply not as dynamic as resident needs – we are not hiring and terminating staff as a single resident's acuity score changes. Staffing patterns are at a ratio per OARs which does not reduce below a certain point regardless of acuity, and the administrative and overhead costs for the provider do not change – things like utilities for the program or administrative costs for example. My teams have seen improvements in the collaboration with Comagine, but at the end of the day this is still a methodology with significant challenges for providers.

Working to decrease the administrative burden associated with working with an IQA to reduce the time between the start of service delivery and confirmation of an authorization including rate would support providers in continuing to build effective and sustainable programs. Additionally, adjusting retainer payments to better reflect the fixed costs of the program and expanding the situations that prompt a retainer payment are tangible steps that could support movement toward a more effective and efficient services delivery system.

Thank you for the opportunity to testify today.

In partnership,

Iris Sexton, LCSW
VP of Residential Services