Written Testimony of Pam Gehlmann, MA, NCC, LPC
Regional Director, Western PA, Pinnacle Treatment Centers
February 7, 2024

Good morning. I would like to thank the Committee for inviting me here to testify and for your interest in the Centers of Excellence.

BACKGROUND

My name is Pam Gehlmann, and I am the Regional Director in Pennsylvania with Pinnacle Treatment Centers. Pinnacle Treatment Centers operates 15 facilities with Centers of Excellence (COE) programs throughout the Commonwealth. Of those, 3 facilities, Mt. Pocono Medical in Monroe County, Miners Medical in Luzerne County, and Alliance Medical Services in Cambria County, were among the initial 45 COE's awarded grants in 2016 launching this valuable program. As the Executive Director of Alliance Medical Services at that time, I witnessed the inception of this initiative as well as its growth and evolution. I have witnessed the impact that these programs have had in our patient's lives and I have witnessed the strain that these programs face as they deal with the ever-changing expectations as the oversight and on-going management has shifted to the Behavioral Health Managed Care Organizations (BH-MCO's).

ADMINISTRATIVE INCONSISTENCIES & BURDEN

Since the move from grant funded and directed-payment COE programs, during which time all COEs operated in line with and were assessed against one consistent set of requirements established by the Pennsylvania Department of Human Services, to the BH-MCO oversight model, the understanding of the original fidelity of the program has been blurred and operational structure has been reinterpreted. The BH-MCOs have been meeting together and with Pitt Peru, which has been contracted by DHS to provide technical assistance, data collection, and guidance to COE's, for the past few years to discuss the

development of fidelity guidelines. These guidelines are meant to be an expansion of the original requirements that outline the operational processes and policy requirements of the COE's. This process has not included feedback from provider stakeholders. Although BH-MCO's have had various meetings with their contracted COEs to discuss COE services, this has been little more than the BH-MCOs trying to catch up and learn about how the COEs operate and giving their interpretation of what they may be doing correctly or incorrectly. After many comments in these meetings as well as to our Pitt PERU contacts, several COEs were invited to review the new proposed fidelity guidelines and asked to provide feedback. We were given feedback on our feedback and told that it would be passed along to the BH-MCO's. We still have not been given any definitive launch date for these guidelines or if any feedback provided will be taken into consideration before finalization. That being said, the biggest concern about these guidelines is how they will be interpreted.

The fidelity guidelines are just that, guidelines. Our concern is how we already see these guidelines being interpreted differently between the different BH-MCO's. Some of them seem to see the COEs as a short-term crisis focused model, meaning intake patients during crisis points and discharge them when the crisis has passed, whereas others see the COEs as longer-term engagement and on-going support model. The original directive for COEs was to engage patients in treatment services, provide on-going support services, and keep them engaged long-term. We all know that the longer a patient is engaged in services, the better chance they have of long-term success in their recovery. The original intent of the COEs was to engage patients and assist them with getting into treatment and work to keep them engaged long-term. This brings me to another concern regarding interpretation of the guidelines. Some BH-MCOs interpret them to mean 75% off all COE services should occur in the community. Although I agree that it is necessary to assist patients with various community resources in the community itself as well as foster collaboration with community partners, I think it is more important to meet patients where they are and what is most convenient for them. For many COEs, like those at our Pinnacle locations, our

COE staff operate out of our clinics. Despite a large network of community connections and resources, most patients still self-refer to our facilities. Many of these patients need COE services, but to view these referrals and engagements as less worthy of counting toward our efforts is just wrong. These clinics are a daily or weekly touch point for our patients and sometimes the most positive part of their day. We see them on a regular basis in our facilities as part of their treatment protocol, so it stands to reason that most of our interaction with them is in our facilities, where it is most convenient for them. COEs have been given the message that those facility-based touch points are not nearly as important as those in the community. If a patient is coming to the facility, it only makes sense to meet with them there if that would have the most impact for the patient rather than making an appointment to see them at the local McDonalds just to meet the expectations of a BH-MCOs interpretation of community-based service or meet a percentage expectation. Our COE staff accompany patients to doctor's appointments, court hearings, CYS appointments. They assist them with getting food, clothes, and shelter as well as support services for their families. My biggest concern is always helping our patients get the help and resources they need, but it should not be trying to meet an arbitrary percentage so that a BH-MCO can check a box on an audit tool.

In reference to the audit tool, it is worth noting that all the BH-MCO's are developing their own separate audit tool that they will use to evaluate compliance with their particular interpretation of the guidelines. Some already have tools in place and others are still in development. For facilities that contract with multiple BH-MCO's, this means added confusion and constant readjustment of documentation and tracking. When asked about various interpretations of the guidelines by the BH-MCOs, Pitt Peru advised that it is all about how it is documented. I would rather that the COE staff worry about helping patients with services and documenting them in a concrete, consistent manner rather than worrying about the nuances in the documentation and whether or not it will meet the interpretation of the various BH-MCO's. Some facilities within our Pinnacle network are contracted with 3 and 4 of the BH-MCO's so

varied expectations and requirements can become confusing and burdensome, not to mention the time it takes away from clinical work. We are placing paperwork over patient care during an unprecedented workforce crisis. The COEs cannot be sustained in this way.

DATA COLLECTION ISSUES

Another area that can be confusing and burdensome is the data collection related to COE services provided. We firmly agree that specific data points need to be identified and collected to continue to demonstrate the efficacy of the COE services. Since the inception of the COEs, the process has gone from an overwhelming hand-tracked spreadsheet system to the use of RedCap, where COEs enter specific data regarding services provided. There are ways of connecting provider electronic health records with RedCap for easier data collection and those larger providers with good IT support have been able to or are in the process of doing this to allow for more consistent and thorough data collection. Many smaller providers, however, continue to struggle. To compound that struggle, BH-MCO's are now requiring or will be requiring additional and, in some cases, duplicate data collection outside of RedCap. Pitt Peru provides the BH-MCO's with outcomes data gathered from RedCap already. There is no rationale or reason for requiring data collection beyond what Pitt PERU already collects in addition to MCO claims data. If there is in fact a need for additional data, streamlining its collection with the existing process would be far less burdensome and enable COE staff to focus more on patient needs.

VARIANT PAYMENT MODELS

The last challenge that I want to mention today is that of variance in payment models among the BH-MCO's. Although I know that BH-MCO's have the right to dictate their payment models for all of the contracted services, but the finalization of their payment models has been a long, drawn-out process that has caused stress to the budgeting systems of our organizations. One BH-MCO has a clear Value Based Payment (VBP) model that made the budgeting reasonable. Another BH-MCO moved to a fee for

service model that has made it difficult for COE programs solely contracted with them to see a way that is fiscally feasible to continue providing COE services. Two other BH-MCO's have said they will move to a VBP at some point in the coming year or so. Again, the vagueness in the timelines has made budgeting difficult as some programs are on a July-June budget year and others are on a calendar year budget year.

OUR ASKS

With all of that being said, we understand that there needs to be guidelines governing operations of the COE's to ensure that we are all providing a quality standard of care for our patients. We understand that the BH-MCO's have the right to audit programs to ensure that those standards are being followed. We understand the importance of data to demonstrate outcomes. So, what do the providers want? We want a single source of data gathering and collection. If RedCap is going to continue to be the system used, then the BH-MCO's need to use that data without requesting additional data collection. We want consistency in the application and interpretation of the guidelines by all BH-MCO's. We want an interpretive guide that spells out what documentation is needed to meet the Fidelity Guidelines that all BH-MCO's use when determining compliance during audits. And last, we want one audit tool that they are all required to use.

I appreciate your time and interest in the Centers of Excellence program, and I thank you again for having me here today.