

## ACPG Treatment Reimbursement Sub-Committee

### DHHS Gambling Treatment Rate Survey **RESULTS**

Instructions: The ACPG Treatment Reimbursement Subcommittee is asking you as a DHHS funded gambling treatment provider to share your experience and thoughts about the current reimbursement system. Please respond to the questions below as best you can. You may skip questions where you do not have an opinion.

**As of October 4, 2018: Six completed surveys were submitted**

1. Are you an administrator overseeing a DHHS grant funded gambling treatment program?

Yes (**N=6**)      No      If not, please describe your role.

2. Rate the impact of the current rates on **client care** within your gambling treatment program?

0 = No impact (**1**)    1= minimal (**1**)    2 = significantly detrimental (**1**)    4 = critically detrimental (**3**)

**Average = 2.5**

3. Rate the impact of current rates on **employee retention** within your agency?

0 = No impact    1= minimal (**4**)    2 = significantly detrimental    4 = critically detrimental (**2**)

**Average = 2.0**

4. Rate the impact of the current rates on your program's **sustainability** as a publicly funded gambling treatment provider?

0 = No impact    1= minimal (**1**)    2 = significantly detrimental (**3**)    4 = critically detrimental (**2**)

**Average = 2.5**

5. Does the current DHHS Gambling Treatment rates support the cost of doing business?

Yes    No (**6**)    If not, please explain.

- 1) My center is unable to operate at full capacity due to the current rates. Essentially, there has never been a sufficiently large enough budget (i.e. only the grant income) to hire necessary clinical and administrative personnel to conduct a non-profit business. There is not a sufficient reimbursement to pay clinicians what they could earn in private practice or other agencies, should they need to make a living solely from treating gamblers and their families. The director is not able to earn enough to get the administrative, fundraising, outreach, training/education of the workforce, supervision, as well as clinical work that the director needs to do to keep the center running. There are no other known grants which are gambling-specific, for a gambling-specific outpatient clinic such as we are, to assist in the operation of the center at the community, state, or federal level. I know, I have spent 10+ years looking for that kind of grant or foundation support. The only other financial support is donations from the casino industry, businesses, and concerned individuals. Attempting to raise that money to sustain the business as it takes more time than the director has available, along with the necessities of keeping the current program running. Thus, our center is at the mercy of what income can be brought in through the gambling grant, the few clients who have insurance, and our donations. Should the rates be increased to a "living wage," our center would be more likely to be sustainable and expand to hiring Spanish-speaking counselors to serve the totally unserved Spanish-speaking population as well as hire an administrative assistant to help with the upcoming Medicaid demands.

- 2) Rates are far below regular rates for other patients; Subsequently, the gambling treatment is run at a "loss" if compared to our regular rates for most patients. For example, most patients pay between \$80-\$120 per session compared to the \$67 state rate. The \$10 co-pay is rarely affordable to patients who are trying to figure out gas money or bus-fairs for treatment.
- 3) The reimbursement rates are significantly lower than alternative funding sources. The Gambling Treatment Reimbursement rates support a minimal salary of a therapist without any offset to other costs.
- 4) When the State adopts a fee-for-service model such as the disordered gambling monies, they usually compare rates with other reimbursement models such as SAPTA and Nevada Medicaid which are severely lower than what a provider could survive on.
- 5) We are grateful to receive some private funding from the casino industry but nothing is guaranteed. Without this additional help we would not be able to stay in business based on DHHS rates.
- 6) 19 days of treatment is not enough time to make a significant impact

6. If the rates do not change by July 1, 2019, will you continue to be a DHHS funded Gambling Treatment Provider?

Yes (3)      No      Uncertain (3)

7. What do you propose as the reimbursement rates for each level of service:

50-minute outpatient therapy session:

Intern rate **75,110, 72, 104.01, 75**      *Average = \$87*

CGAC rate **125, 18% increase, 138, 90, 138.68, 100**      *Average = \$118*

Other: **125 for QMHP coverage (specify)**

90-minute therapy group:

Intern rate      **40, 35, 32, 30**      *Average = \$34.25*

CGAC rate      **60, 18% increase, 44, 40, 45**      *Average = \$47.25*

Other: (specify) **60 for 180 minutes group**

120-minute therapy group: (specify if per group or per-client)

Intern rate      **54, 18% increase, 50, 40, 45**      *Average = \$47.25*

CGAC rate      **80, 63, 50, 60**      *Average = \$63.25*

Other: (specify) **80**

Assessment / intake:

Intern rate      **240, 150, 216, 185.67, 240**      *Average = \$206.40*

CGAC rate      **375, 18% increase, 190, 270, 247.56, 300**      *Average = \$276.40*

Other: (specify) **375, 150**

Residential day treatment rate: **200, 18% increase, 175**      *Average = \$187.50*

Other (please specify):

Transitional Housing day rate: **155**

8. How did you derive the proposed rates (i.e., what are they based on)?

- 1) I did not fill in the "per group" rate, as a "group" by my definition constitutes two or more clients in a group therapy setting with a CPGC-Intern or CPGC, and would not be reimbursed as a whole rate regardless of the number of persons in the group: the fee-for-service structure I understand is that every group member is billed separately. My proposed rates are a compilation of the current strategic plan fee-for-service rates (which are less than national rates), knowledge of rates of reimbursement from insurance providers, Medicaid and private pay for clinicians doing similar work in Nevada combined with the cost of overhead and an administrative assistant at \$25.00 per hour.
- 2) Comparisons with other treatment rates and also compared Nevada state rates with rates of other states reimbursements for similar treatments.
- 3) We base this on similar reimbursement rates from other key stakeholders.
- 4) Discussions with the subcommittee - intern rates at 80% of counselor rates; increase in QMHP coverage instead of paying at intern rates currently; increase in individual and group rates; and increase in residential services based on the two facilities currently providing residential services for disordered gamblers. Plus I think it is high time that the state stood by our gambling counselors to ensure that we are growing our industry and providing services; thereby reducing unmet need numbers.
- 5) National SAPTA average rates with a 10% increase.
- 6) An average of payments we receive from other providers: SAPTA, Medicaid, Veterans, Self-pay, etc.

9. How would you justify the proposed rates as appropriate for a publicly funded treatment system?

- 1) Although our current funding stream has been averaging around \$1.3 million for the entire grant and that will not support funding increases, my justification is to establish the need through this survey and other actions leading to the strategic plan so that a foundation of need can be put in writing and taken out to interested parties to request additional funding, grants, donations, etc. to support the people willing to do treatment for gamblers and families in Nevada. There are waiting lists forming at most of the grantees' centers, there are clinicians asking for work and interns and supervisors looking for ways to provide that work, however there is not enough money available to pay them to do the work at this time. Nevada can attract more licensed and interested practitioners, more funding sources willing to build more centers, and we can be sustainable if we have a reimbursement structure that honors what people and businesses are truly worth. I also believe I could spend a week researching how private practice and agency workers are being paid and justify these numbers. Hospitals and agencies paying clinicians to do behavioral health, with all benefits included, pay at least this much, and private practitioners certainly do. We are a unique, boutique-sort of provider list, specializing in a

particular mental health treatment niche, and should be paid as specialists, particularly considering the usual funding challenges gambling families have. Our clients are attempting to work and often do not fit neatly into insurance or Medicaid parameters, so they regularly fall through the cracks and are solely dependent upon our grant. The grant should be tailored to meeting their needs and providing reimbursement that fits the business model.

- 2) First, Medicare was reimbursing \$84.74 per session of psychotherapy. But more importantly, when dealing with addiction, there are additional costs to society associated with poor treatment or ineffective treatment. Subsequently, if more funding is needed for addiction treatment, it is justified. Gamblers also have higher rates of no-show, missed appointments, or late cancellations that we are not reimbursed for. Thus, these are lost revenues related to treatment that we do not experience with other mental health populations such as those with anxiety or depression.
- 3) The proposed rates would be a competitive reimbursement rate that allows agencies to cover all direct and indirect costs.
- 4) If the State does not start to consider the actual cost of providing a service, then many providers may opt out based on an inability to balance their budgets. Consider the CCBHC PPS-1 rate, or the FQHC PPS rates, or tribal PPS rates - all take into consideration the actual cost of doing business. In doing so it will hopefully prompt more facilities to want to apply for and offer services to gamblers in their areas. We are a state that has gambling, alcohol flowing freely, and much unmet need for behavioral health issues - maybe it is time to start thinking more about re-assessing reimbursement and delivery methods in our state.
- 5) Services we provide are complete and unique. In this area of treatment, we offer a robust package fitting the needs of the gambler and their friends, family, and concerned others. To keep up this level of care, the rates should at least be at an average so we can operate fully with licensed, qualified staff to do this; the rates must change to support these changes.
- 6) I don't see it as a publicly funded treatment program. It is funded by a tax on the slot machines. It is making the casino industry responsible for the treatment of their gamblers that become addicted.

10. Is there anything else you believe the ACPG Reimbursement Sub-committee should know or consider when forwarding its recommendation to DHHS?

- 1) This is overdue; the workforce needs decent pay and an incentive to come into our specialized treatment world and help those who are waiting.
- 2) Also, DHHS will need our assistance in planning a strategy to not only ask for more monies from the gambling/casino dollars but also from state general funds. What will that argument look like, how can we justify additional funds? Can we make an argument on our behalf for administrative funding; positions to support the clinical side of services?
- 3) The cap for residential treatment only pays for about 19 days once the assessment fee is deducted. The cap needs to be raised.
- 4) CAP increase from \$2200 to \$3000 for individuals, from \$3000 to \$4400 for residential, and Cap increase for aftercare from \$10 per person to \$15 per person up to two years post graduation.