Timelines and Guardrails
For the Medicaid Behavioral Health Redesign Transition

The Ohio Department of Medicaid (ODM) and the Department of Mental Health and Addiction Services (MHAS) have been steadfast during the behavioral health (BH) Re-design process to their commitment to develop a modernized and updated set of behavioral health services in Medicaid that, at a minimum, sustains current service access and capacity. We value that commitment and their openness to working through many complex issues. As we consider the impact of the proposed BH Redesign plan (BH Redesign) and the July 2017 implementation, we are deeply concerned that the BH Redesign may not achieve the stated goal. The Administration asserts that BH Redesign will result in a $53.4 million investment in behavioral health services, but their analysis relies upon a set of variables and workforce that does not exist in Ohio. We anticipate a loss of behavioral health services across most communities in Ohio resulting in a disproportionately negative impact on services for individuals with serious mental illnesses (SMI), youth with serious emotional disorders (SED) and those living with the chronic disease of addiction.

Our goals

- Maintain and improve access for Ohioans in need of substance abuse and mental health services
- Use the existing and available workforce, rather than relying on unrealistic assumptions
- Actualize the Administration's stated $53.4 million investment in behavioral health services
- Establish a reasonable implementation timeline that supports clinical and business practice change and claims payment/IT system testing

Guardrails

1. **Use the existing and available workforce, rather than relying on unrealistic assumptions about the availability of more highly credentialed practitioners.**
   At a minimum, maintaining the existing behavioral health workforce is a key to maintaining existing service capacity. Across all districts of Ohio's House of Representatives, the average number of residents with a bachelor's degree or higher is 26.1%, with the range across districts of 11-62%[1]. Current vacancies in the behavioral health workforce go unfilled today.[2] The number of additional licensed staff that would be required by BH Redesign to replace staff with lesser credentials does not exist, and the disparity across Ohio is dramatic.

[1] Center for Community Solutions Legislative District Profiles http://www.communitysolutions.com/districts Released February 2017
[2] Policy Matters Ohio. Budget Bite: Funding for Public Higher Education. March 8, 2017. 67% of the college graduates in the class of 2014 had an average student loan debt of $29,353.

2. **Commitment to serve adults and youth with severe and complex behavioral health needs and chronic addictions.**

   The proposed model disproportionately impacts services that SED and multi system youth, and individuals with SMI or the chronic disease of addiction rely on, and erodes service capacity. Currently, crisis services, nursing, group counseling, MH day treatment, and SUD residential service will not be sustainable as designed. The significance of the legislative work on multisystem youth and its intersection with BH Redesign cannot be understated. The children and youth served by multiple systems are those who are most likely to experience large gaps in care, to be inappropriately served or to be shuffled between systems. Work directed toward improving opportunities for multisystem youth has the potential to benefit all children and youth served by the systems that serve multisystem youth.

3. **A timely payment mechanism is necessary.**

   Based on a recent survey, providers in this system have limited cash reserves with 58% having less than 60 days cash on hand and 39% have less than 30 days cash on hand. It is highly likely that a transition would create problems and delays with payment. As Ohio Medicaid has done in the past, an immediate payment mechanism, such as "pay and post", is required in order to protect service capacity.

4. **Reasonable timelines for implementation are needed.**

   Providers need time to test the impact of BH Redesign and make the necessary changes to their business and clinical practices without disrupting existing services. They cannot initiate final software testing, clinical and business process alignment, and staff training until the rules and manual are harmonized and finalized, and the state's IT build is finalized and appropriately tested with a sample of providers. ODM and MHAS plan to file draft rules with JCARR on April 14, 2017 and indicate that providers will be able to begin IT testing "in early May", simultaneously with the state's MITS testing. This is not adequate for a July 1, 2017 start date.

   Implementation should occur no sooner than six months following final filing of ODM and MHAS rules, issuance of a final BH provider manual and the availability of finalized and tested IT specifications.

5. **Protections are needed to prevent cost-shifting to other public systems, particularly PCSAs.**

   The service changes should be implemented in such a way that the replacement services do not cause expenditures for existing Medicaid services to be cost shifted to local governmental entities, or other sources of state or local funding, including but not limited to, public children services agencies (PCSAs), ADAMHS Boards, courts, jails, schools and hospitals.

6. **A guarantee is needed that the state's investment of $53M will result in additional service capacity.**

   The Administration reports the Executive budget includes the projected $53.4 million investment for BH Redesign based on their actuarial model, but analysis from providers throughout the state point to a *loss* of approximately $40 million of existing service capacity. The administration is strongly committed to a behavioral health investment. However, because it's budgeted, does not mean it can be spent if the assumptions are unrealistic.