OhioGuidestone
SOLUTIONS FOR CHILDREN, FAMILIES & COMMUNITIES

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House Health and Human Service Finance Subcommittee

House Bill 49

Chairman Romanchuk, Ranking Member Sykes, and members of the House Health and Human Services Subcommittee, thank you for the opportunity to offer testimony on House Bill 49 and impending behavioral health redesign for Medicaid. My name is Mary Stiles, and I serve as General Counsel for OhioGuidestone with offices in seven counties throughout Ohio.

OhioGuidestone is a non-profit organization dedicated to providing comprehensive and integrated programs aimed at creating long-term solutions that help children, families and communities become stronger. Services range from behavioral health and residential treatment, to parenting and family skill building, to foster care, to education and workforce training programs; all designed to produce better outcomes for individuals, children and families. We meet families where they are and help them reach a brighter future.

Core to these services and their success are a variety of behavioral health services and programs that OhioGuidestone provides in homes, schools and community based settings. The vast majority of the clients we serve are Medicaid eligible.

This fact underscores our apprehension at the transition to behavioral health redesign. The transition is being rushed too fast, rather than taking the necessary time to responsibly navigate the transition with the provider community. A hastily designed transition will have a destabilizing effect on providers and ultimately impact care to our clients. We ask you, the members of the General Assembly to delay implementation.

First, while the Ohio Department of Medicaid and the Ohio Department of Mental Health and Addiction Services published enumerated rules in late January, the rules lack organization, consistency, clarity and meaningful content. At OhioGuidestone, we find it difficult, if not impossible to design and bill services without knowing the content of the rules we are required to follow. For example, the enumerated rules refer to definitions of substance use disorder assessment and substance use disorder peer recovery service, but the referenced sections do not contain definitions of these services. How do we develop or revise a service, so that we can bill for it on July 1, when we have not been given the final rule defining what that service is required to include? Providers are being asked to spend already scant resources to develop treatment programs that may very well prove to be out of compliance once the final rules are available. This would force providers to redundantly and unnecessarily expend additional resources.

Second, the implementation timeline does not accommodate technology implementation, billing system updates and the staff training necessary to execute successful redesign. Each of these activities will take time to execute and are vital to the transition process. Further, each of these steps is entirely dependent on the one before; we cannot complete the rebuilding of our EMR until we have clear rules providing service definitions and documentation requirements; we cannot finalize billing system updates until the EMR is revised; and we cannot train staff until both have been completed. With less than four months until implementation, it is unlikely providers will be sufficiently prepared to navigate the conversion.

Additionally, until recently the implementation timeline only allowed for two weeks of test billing the new codes and systems before going live on July 1 of this year. Although, we appreciate Directors Plouck and Sears' decision to open the testing window on May 1 to allow additional testing and resolution of problems, it only compresses the time available to providers to complete the necessary system upgrades and training discussed above.

The challenges I've outlined lead to very real cash flow problems for providers on the front lines of providing critical behavioral health services. A recent survey showed that behavioral health organizations in the strongest financial positions only have an average of 2-months cash reserves. Delayed payments for services rendered will quickly make it difficult to meet payroll obligations and continue providing treatment. Past experience with this type of system redesign has not inspired confidence in this process. MyCareOhio providers were given a transition period where, purportedly, claims would continue to be processed while the provider was obtaining (or deciding whether to obtain) contracts with the managed care organizations. The claims that OhioGuidestone submitted during this transition period were denied and, to date, payment has not been received for these services.

Finally, and this is a critical component, behavioral health redesign was intended to be taken together as a package, fundamentally rebalancing rates for services. Implementing certain rate changes such as the very large reduction in rates for nursing and pharmacological management, while delaying other changes will result in severe revenue reductions and undue financial hardship for non-profit providers like OhioGuidestone. A piecemeal implementation could force organizations with insufficient cash reserves to shut down entirely – thereby jeopardizing access to the vital care and treatment provided by community behavioral health organizations. As a result, a piecemeal implementation cannot be the alternative.

In conclusion, for all the reasons stated above, OhioGuidestone respectfully requests this committee delay the implementation date of all components of behavioral health redesign, including nursing and pharmacological management changes, in order to facilitate a thoughtful and well-managed transition that will ensure the stability of Ohio's behavioral health safety net for Ohio's most vulnerable children and families.

Thank you, Mr. Chairman, for the opportunity to testify. I am happy to answer any questions that the committee may have.