

Testimony before the
House Finance
Subcommittee on Health
and Human Services

Presented By: Adam Jacobs
BASIC Coalition

Mr. Chairman, members of this Committee, thank you for the opportunity to speak to you today.

My name is Adam Jacobs. I am a psychologist and the President of the Wingspan Care Group, Ohio's largest child service agency, but today I am represent an ad hoc statewide coalition of large child service agencies across Ohio.

Ohio is working to carve-in community behavioral health services. I respectfully ask you to consider the exclusion children and adolescents from this carve in to Manage Care and maintain their Behavioral Health Carve Out.

Maintaining the BH Carve Out for children makes the best clinical sense, and physical sense. This is because the behavior problems children pose, the costs associated with these problems and Ohio's system of care for children is very different than for adults. To briefly explain.

Ohio's Children receiving Medicaid fall into two buckets; those eligible because they are in the custody of public institution such as a Children's Service Board or Juvenile Court, and those eligible for Medicaid because they are poor.

This first group of children are often placed in residential or foster care.

- There are no state hospitals for children. Thus, children in need of this service/level of care are treated in private residential treatment facilities. Juvenile courts and child welfare agencies ("public entities") pay the board and care costs for nearly all of these placements statewide. Board and care includes care coordination of all care, including physical healthcare. Carve-out Medicaid pays for the behavioral health treatment services. With carve-in, if Medicaid rates are cut by MCO's this cost will be passed on to the public entities and force some public entities and providers out of the market. That is, some public entities will no longer be able to fund needed residential placements, and some providers will not be willing or able to accept the increased financial risk of limited benefits and lower rates. Managing treatment episodes will be more costly as providers' care coordination teams will have to work with the MCO care management teams, adding unnecessary cost and duplication. Should Medicaid benefits

be exhausted during a child's residential stay, the public entity will need to decide whether to pick up that cost or direct a premature discharge likely without the necessary services authorized to facilitate a successful transition of the child into the community.

- Foster care contract per diem rates include only traditional case management costs – the cost of case management for a child with routine physical health needs and no behavioral health needs. Most placements with private agencies are made because the child's care management needs exceed the capacity of traditional case management – the children have significant behavioral health care needs and often have significant related physical healthcare needs (e.g. medication management, obesity related to medication use). This behavioral health care coordination is currently paid for by CPST. The budget proposes unbundling CPST to remove case management and care coordination. With carve-in, child welfare agencies will be forced to pay for care coordination and case management services currently paid for by Medicaid CPST.
- While current carve-out Medicaid rates do not adequately fund in-home services, providers are committed and struggle to continue to provide them. Community based contracts between providers and public entities most often obligate the provider to bill Medicaid for the behavioral healthcare services provided to CFC families and the private entity to pay for services provided to families without Medicaid. For high need populations public entities will also pay for related services, e.g. transportation. With carve-in these contracts will likely result in increased financial liability to the public entities as a result of Medicaid rate cuts and/or reduced benefits leaving children and families with reduced or maybe no access to these services - services targeted to keep children out of hospitals, foster care, residential treatment, and jail.
- Urban and rural school districts in poor communities rely on providers in their schools to deliver needed behavioral health services to their students both at school, at home, and year round. With carve-in the likely outcome will be reduced services to children resulting in decreased attendance, performance, and increased disruption of already fragile learning environments. Because schools are funded based on student attendance and academic performance, reduced service leading to reduced attendance and performance will likely jeopardize school district funding.
- Carve-in will result in the erosion of the current provider system as a result of: 1) likely rate cuts for existing Medicaid services to the traditional, non carve-out rates in the current MCO contracts; 2) MCO's increased hiring of behavioral health professionals for their care management teams leaving providers without needed staff because the MCO's can pay more than providers can, and; 3) carve-in will eliminate the any willing provider Medicaid requirement shutting out providers unable to negotiate with the MCO's for inclusion in their networks.

We believe carve-in will result in reduced services to children despite clear medical necessity because the outcomes required in the MCO contract don't incentivize their provision. That is, the MCO's will not be required to make behavioral health services available or be held accountable if they don't. The current contract outcome

requirements related to children's behavioral health are: 1) Follow up after hospitalization within 7 days; 2) Initiation and engagement of AOD treatment; 3) Metabolic monitoring of children on anti-psychotics, and; 4) Use of first line psychosocial care for children on anti-psychotics.

None of these deliverables correspond to the way carve-out Medicaid is being used to treat children today. These deliverables can be achieved, save ODM money, put money in the pockets of the MCO's, completely dismantle the existing provider system and erode local public systems at the same time. Despite the fact that Ohio ranks 46th in Medicaid spending on children and has a behavioral healthcare workforce shortage, Ohio is ranked 10th nationally in its provision of access to care and reduced prevalence rates of mental illness for children. Total Medicaid spending on children's behavioral health – federal and state together – is less than 2% of the state's total Medicaid spending. Ohio's share is even further reduced by those children eligible for Medicaid through the CHIP program because the federal share is higher for this population. Carve-out has paved the way for the development of a solid children's behavioral healthcare provider system. The desire to garner savings in a budget line that is less than 2% of total Medicaid spending is not worth its destruction.