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Senate Medicaid Committee
Sub. H.B. 64
Testimony by Hubert Wirtz, CEO
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Chairman Burke, ranking member Cafaro and members of the Senate Medicaid Committee, thank you for this opportunity to testify on Substitute H.B. 64, the FY 2016-2017 biennial budget. I am Hubert Wirtz, CEO of The Ohio Council of Behavioral Health & Family Services Providers. The Ohio Council represents over 150 addiction prevention and treatment, mental health and family services providers from across Ohio. My testimony today will focus on the administration's propose for Medicaid Rebuilding Behavioral Health System Capacity.

While my focus here will be on the important proposed Medicaid behavioral health policy changes, I would be remiss if I did not recognize and express appreciation for the proposed continued investment by the administration in behavioral health prevention, treatment and support services, and the investment made by the General Assembly in the current biennial budget. These investments and the expanded Medicaid Rebuilding Plan all should work together to expand access to a full continuum of care for people with behavioral health illnesses.

While moving in the right direction, we are still concerned about access to behavioral health services and workforce capacity to provide those services. According to the Health Policy Institute of Ohio's (HPIO) "2014 Health Value Dashboard" published in December 2014, Ohio ranks 42nd nationally in access to behavioral health services. This is made up of two access profiles: Percent of adults ages 18 and older with past year mental illness who reported perceived need for treatment/counseling and was not received; and percent of individuals ages 12 and older needing but not receiving treatment for illicit drug use in the past year.

The administration's Medicaid proposal includes "budget assumptions" that propose to re-build and modernize the continuum of care for individuals with addiction and mental health disorders in a manner that is budget neutral and continues efforts to improve the integration of physical and behavioral health care. The vision described in the Office of Health Transformation (OHT) supporting documents is generally consistent with our efforts to improve behavioral health service access and capacity, expand the types of services available, and create better integration of care that supports individual and family health, wellness, and recovery. Reconstructing 20 years of programs and processes will require measured planning, tempered by the availability of resources of the current provider infrastructure and workforce to be successful. While we recognize the desire of the Ohio Department of Medicaid (ODM) to have flexibility and broad discretion to implement their vision of behavioral health reform, we are concerned by the lack of legislative oversight and accountability in Substitute H.B. 64.

Integrated care is not a single model of practice transformation or singular policy activity. Integration requires multifaceted, multidisciplinary practice and policy change to support transformation across a continuum of care and array of practice settings. The Ohio Council wants to make sure that these proposed initiatives address a number of key policy objectives that support innovation and achievement of integrated health care, which include:

- **Whole Person, Population Health**: A policy orientation recognizing health promotion across the lifespan and in the context of family and community.
- **Comprehensive Continuum of Care**: Create a family-centered, trauma-informed continuum of care that includes prevention and health promotion, early intervention, treatment, acute and chronic care management, family and peer supports, and recovery and social supports. Specific attention must be paid to including a mechanism to support sustainable evidence-based and evidence-informed services that promote health, wellness, and recovery.
- **Care Coordination**: Understand and define care coordination activities at both the payer and practice levels to maximize use of data and support person-centered planning and care delivery.

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- **Behavioral Health System Re-Design**: Optimize use of standard health care practices and coding while incorporating the value and history of the current behavioral health team based care delivery model to create simplified paths that result in more time with patients and less cost for administrative process and business inefficiency.
- **Value-Based Purchasing**: Build new and sustainable value-based purchasing models that include shared savings and shared risk. Identifying metrics and measures to demonstrate the impact of mental health and substance use services on improving outcomes, increasing health across the life span, and generating savings.
- **Network Adequacy**: Ensure adequacy of health plan provider networks to include access and availability of specialty behavioral health care provider organizations that deliver care for complex populations through multi-disciplinary, team based programs and include existing community collaborations and partnerships.
- **Workforce Development**: Support training on effective treatment approaches for working with mental illness and substance use disorders, encouraging cross disciplinary training, and incentivizing integrated, recovery focused, and evidence-informed practice.

Budget Request: Add temporary language that provides oversight and accountability for implementation of behavioral health system reforms to safeguard behavioral health service access and capacity, and rebuild system infrastructure and workforce. This amendment language, developed collaboratively by three organizations, is attached and includes a summary and operational/implementation timelines, that describes:

- Language that triggers the removal of care management language contained in ORC 5167.03 that prohibits the inclusion of behavioral health in managed care, after key targets and timelines are met (The House restored ORC 5167.03 to the bill).
- A process for the work, stakeholders involved and periodic reports to JMOC in order to establish some legislative oversight and accountability.
- Establishing a 3-year timeline through July 1, 2018; still an aggressive timeline given the scope of operational and system changes.
- Defines “budget neutral” related to service system modernization and capacity building.
- Maintaining current prior authorization exemption for mental health services for certain youth until managed care implemented for behavioral health services with a trigger to remove language when timelines are met.
- A process for implementation of managed care for youth served in child welfare and youth receiving adoption assistance no sooner than January 1, 2017 (consistent with the administration’s timeline) with a trigger to remove this language, in ORC 5167.03 after key targets and timelines are met.
- Establishing a process to define “network adequacy” related to behavioral health specialty services.
- Proposing that $23 million (a portion of $69 million in the Executive Budget for the start-up of managed care for behavioral health in the 2nd half of SFY 2017) be invested to develop additional service capacity needed for the transition to managed care and to reduce the reliance on higher cost services.

In summary, we support the overall direction of administration to further reform and invest in Ohio’s behavioral health treatment and support services. This proposed amendment establishes longer, yet still aggressive, timelines and “guardrails” in budget language for the work associated with the major components of the Rebuilding Plan. In addition, the implementation of mandatory managed care for youth in the custody of child welfare and youth receiving adoption assistance will proceed on the time table indicated by the administration, but with modest guardrails to guide the work. We believe that the vision, combined with the supports described in this amendment, will provide the best opportunity to be successful in improving timely access to needed services for Ohioans with behavioral health illnesses.

I would be happy to answer any questions.