Senate Medicaid Committee
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Testimony Provided by
Leigh Johnson, LISW-S, Esq.
BASIC

Mr. Chairman and members of the Committee, thank-you for the opportunity to provide testimony today. My name is Leigh Johnson and I am representing BASIC, a statewide consortium of many of Ohio's largest children's behavioral healthcare providers. I am here today to ask you to maintain the Medicaid behavioral health carve-out for children and to help you understand how, if carved-in, this decision will drastically impact Ohio's children and cost Ohio additional dollars.

Ohio is working to carve-in payment of community behavioral healthcare services. Inclusion of the children eligible for Medicaid because they are poor - the "CFC" population – in managed care will be harmful to the children, their families and the public systems that serve them. We ask that children not be included in the carve-in for the following reasons:

1. Ohio has developed a solid children's behavioral healthcare system using less than 2% - **federal and state combined**- of the Medicaid budget. Ohio's share is even further reduced by those children eligible for Medicaid through CHIP because the federal share is higher for this population.

2. CFC children are the largest Medicaid population but they account for the least amount of Medicaid spending.. In fact, Ohio ranks 46th in overall Medicaid spending on children and at the same time ranks 10th nationally in its provision of access to care and reduced prevalence rates of mental illness for children. There are no state hospitals for children. Children in need of this level of care are treated in residential treatment facilities. Carve-in will add a layer of administrative cost to this service because residential providers today are the care managers and coordinators for these children. Carve-in will potentially shift federally subsidized Medicaid treatment costs from Medicaid to juvenile courts and public children service boards and their agencies.

3. Urban and rural school districts in poor communities rely on Medicaid providers in their schools to deliver needed behavioral health services to their students both at school, at home, and year round. Carve-in puts these services at risk, resulting in the potential for increased cost to school districts or the disruption of already fragile learning environments. Because schools are funded based on student attendance and academic performance, loss of Medicaid services could lead to reduced attendance and performance thus jeopardizing school district funding.

4. The way to cost savings may be through the adult SPMI and aging populations – but it is not through children. The MyCare demonstration project has exposed the challenges of a behavioral health carve-in even with a small population. Maintaining the

carve-out for children will; 1) allow Medicaid and the MCO's to focus on the high cost SPMI and aging population; 2) protect Ohio from the unintended consequence of adding non-Medicaid cost to the largest population in Medicaid; and 3) protect at-risk children from the unintended consequences of reduced access to needed behavioral healthcare services necessary to help them avoid becoming members of the high cost adult population. In summary, the desire to garner savings in a budget line that is less than 2% of total Medicaid spending is not worth the of risk to the total budget or to our children.

Thank-you for the opportunity to testify today. I'd be happy to answer questions.