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.

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[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.

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House Finance Health and Human Services Subcommittee
H.B. 49
Testimony by Hubert Wirtz, CEO
March 21, 2017

Chairman Romanchuk, Ranking Member Sykes, and members of the House Finance Health and Human Services Subcommittee, thank you for this opportunity to testify on H.B. 49, the FY 2018-2019 biennial budget. I am Hubert Wirtz, CEO of the Ohio Council of Behavioral Health & Family Services Providers. We are a statewide trade and advocacy organization that represents over 150 addiction treatment prevention and treatment, mental health and family services providers from across Ohio. My testimony today will focus on two areas: The proposed Department of Mental Health Addiction Services (MHAS) appropriations and areas of needed additional investment and the impact of the Medicaid Behavioral Health (BH) Redesign initiative on access, capacity and workforce in Ohio's behavioral health system.

MHAS Appropriations and Need for Additional Investment

We appreciate that the proposed MHAS FY 2018-2019 intends to sustain existing investment in Ohio's behavioral health system. While this stability is important, we must and can do better.

Every day we are bombarded with the devastation of the opiate and heroin epidemic that is raging across Ohio. We hear about another overdose, another suicide, or the debilitating impact of mental illness, alcoholism, or addiction. Too often children, their families and adults that experience a mental, emotional, or behavioral illness struggle to find access to services.

Along with other members of the Coalition for Healthy Communities, which represents consumers, families, providers, professional groups and county ADAMH boards, we offer the following recommendations should the legislature choose to make further investments in Ohio's behavioral health system:

- Creation and funding of 6 regional mental health crisis stabilization centers ($6 million per year)
- Creation and funding of 9 regional withdrawal management (detox plus early treatment) centers that includes 6 regional centers and one each in Cleveland, Columbus and Cincinnati. ($9 million per year)
- Funding for housing and/or rental/operating subsidies for individuals with behavioral health conditions for when housing is hard to find ($10 million per year)
- Increase capacity for child/adolescent inpatient psychiatric services by 100 fully staffed beds with 20 designated as "intensive care" ($45 million all funds). Ohio currently has about 11 inpatient psychiatric beds per 100,000 children, well below the 50 beds per 100,000 recommended national benchmark.

- Expand access to peer services for children, youth and adults with mental illness, an area of very limited investment by the state that will be covered under BH Redesign.
- Provide universal prevention services in all Ohio school buildings ($22-36 million per year)
- Establish state level responsibility and accountability to develop consumer education on mental health and addiction insurance parity. This includes establishing a consumer hotline to collect information and help families understand and access their benefits. However, lagging numerous other states, Ohio should move rapidly from a complaint-driven system to one with more top-down oversight and enforcement so that consumers receive the behavioral health services that this long-standing bipartisan federal law makes available to them.

The Ohio Council would also like to express its support for the multi-system youth (MSY) recommendations and, in particular, the establishment of a state-level youth and family crisis stabilization fund under the Family & Children First Cabinet Council to prevent custody relinquishment and address the needs of youth and families in crisis and unable to access appropriate levels of care ($33 million per year).

Medicaid Behavioral Health Redesign Initiatives

The Ohio Department of Medicaid (ODM) and MHAS have maintained a strong commitment during the Medicaid behavioral health (BH) Redesign initiative to develop a modernized and updated set of behavioral health services in Medicaid that, at a minimum, sustains current service capacity and access. The Ohio Council has long supported alignment with industry service coding standards, improved care integration and movement to value-based payment models. We have also appreciated the hard, collaborative work that all parties have invested in this very complex work.

However, despite much progress over these many months, we have serious concerns about negative access, capacity and workforce impacts. First, based on robust analysis among a large sample of providers statewide, we project a loss of $40 million from the "budget neutral" modeling that was done by the state's actuarial consultant. Second, the administration asserts that the BH Redesign will result in an actuarial model-projected $53.4 million investment in behavioral health services, but their analysis relies in part on a set of variables and workforce that do not exist in Ohio. Third, we are nearing the end of March with a July 1, 2017 implementation date and final ODM and MHAS rules have not been aligned and have just been filed, a final Medicaid Provider Manual has not been completed and IT specifications have not been finalized and tested.

While we appreciate that the state intends to move the claims payment/IT testing up to early May, 2017 from mid-June, we are concerned that this will occur simultaneously with state's own internal testing. This could create complications as provides scramble to be ready to start July 1, 2017. We also appreciate some of the policy/reimbursement changes that the state announced late last week. These are responses to issues that we have raised for many months as flaws in the actuarial model developed. We have not had a chance yet to analyze the full impact of these latest changes but it is of concern that incremental changes continue to be rolled out. This adds new costs and challenges for providers to be ready for the July 1, 2017 implementation, particularly given the limited training and skill building opportunities since final policies and specifications are still under development.

Given the addiction/opiate crisis and mental health access challenges that Ohio faces, the Ohio General Assembly should expect a BH Redesign transition that at least sustains services needed by individuals with serious mental illness, serious emotional disorders and substance use disorders, including opiate addiction. There should also be an expectation that the changes will not result in cost-shifting to other public systems (i.e.,

child welfare, schools, ADAMH Boards, first responders, courts, jails and prisons) or private sector providers (hospitals).

I have attached a "Timelines and Guardrails for the Medicaid Behavioral Health Redesign Transition" 2-pager developed by the four (4) organizations shown on the first page. Let me restate the goals of the organizations:

- 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.

Thank you for the opportunity to testify today, and I would be happy to answer questions.