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Testimony before the Ohio House Health and Human Service Subcommittee
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Good morning Chairman Romanchuk, Ranking Member Sykes and members of the House Finance Subcommittee on Health and Human Services. Thank you for the opportunity to share information on the potential impact of the proposed budget on the most vulnerable residents of Northeast Ohio.

My name is Elizabeth Newman and I am the President and CEO of The Centers for Families and Children, headquartered in Cleveland. The Centers is one of the largest outpatient providers of behavioral health services in the region. When combined with our other core service offerings – namely preschool, child care and workforce development services, our staff of 600 professionals assists over 23,000 people each year through 14 locations throughout Cuyahoga, Lake and Summit Counties. Our multi-service approach fuels The Centers' unique ability to integrate services, becoming a valuable "one-stop-shop" connecting individuals and families to the resources and supports they need to build a better life and a brighter future.

We understand the priority of the Speaker on the issue of addiction, and many of the proposed budget increases will undoubtedly enhance The Centers' capacity to more effectively address the opiate crisis. We also want to emphasize that people living with mental illness – especially severe and persistent mental illness – are among the most vulnerable members of our population. Our country's social safety net was designed to support vulnerable people with the same challenges, including poverty that our clients face every day.

As a result, I will address three areas in my testimony: 1) the challenges of preparing for behavioral health redesign 2) the benefits of Medicaid expansion, and 3) the impact of premiums on the people we serve.

Preparations for Behavioral Health Redesign

Over the last year, The Centers for Families and Children has been privileged to provide input into the "Behavioral Health Redesign" process which will change the way behavioral health and related services are paid for by Medicaid statewide. We remain supportive of the redesign efforts and believe that the "carving in" of behavioral health services into Medicaid managed care has the potential to improve client outcomes while lowering overall health care costs. In fact, our organization budget for the next two years is based upon changes to billing codes and some increased rates that take effect in July 2017.

We cannot talk about behavioral health redesign without discussing the limitations presented by our workforce. The proposed rates and existing workforce shortages severely limit our ability to provide adequate services. These specific reductions include:

- **Nurses, Psychiatric Nurse Practitioners, RNs and LPNs** remain an essential part of our capacity to deliver behavioral health services, especially given the shortage of Psychiatrists in Ohio and nationwide. The proposed 15 percent rate reduction for Nurse Practitioners (NP) will reduce our service capacity at a time when we are watching the need for prescribers grow and impact other community providers and hospital systems as well. We would like to see the restoration and improvement of rates for key positions of Psychiatric Nurse Practitioners. Also, the new ODM rules regarding nursing services, disrupts team based service delivery, as only one provider may bill on the same day for services provided to the client in the office.

- **Counseling and Behavioral Health Services**, are an essential part of effectively serving people suffering with mental illness, but the proposed rate structure and new rule changes will create limitations on the kind of service, workforce and setting of needed services. While redesign incentivizes hiring professionals with a minimum of an undergraduate degrees and a clinical license, in practice this is a difficult goal. Licensed behavioral health providers are a limited resource and the increased competition among healthcare organizations to hire them, creates an environment where the improved reimbursement rates for unlicensed behavioral health work is necessary. Often we have to hire a person with a bachelors' degree, train them and provide tuition assistance to encourage them to achieve their clinical license. This is a costly process for community behavioral health organizations where unlicensed providers are often the bulk of our personnel. The new rule changes decrease the reimbursement rate by 32% for care coordination that leads to better client outcomes. Also, the complex nature of our clients, requires the common practice of our workforce providing transportation services utilizing their personal vehicles. Medicaid reimbursement is now prohibited for this essential service where our staff can efficiently use time with a client on the way to an appointment to provide guidance and support. The new system must encourage and support the work of experienced unlicensed providers.

- The role of **pharmacists**. Since 2013, The Centers for Families and Children has maintained one of the largest clinical pharmacy residency programs in the state. This accredited training program recruits pharmacists with doctorate level education, to work with our behavioral health clients to direct medication and prescription management. Medication compliance remains an enormous challenge given that our average client is taking more than 5 medications daily. Through hands on, personalized care, our pharmacy staff has more than tripled our rates of medication compliance which contribute to positive health outcomes. The program has been largely funded through Medicaid, but this service will no longer be recognized as of July 1, 2017 putting the future of this successful and innovative program at risk.

Clearly, any change of this scope comes with unintended consequences.

The complexity of the new billing requirements has huge operational implications for community behavioral health providers. Our ability to bill successfully for these services on a timely basis is directly tied to our ability to keep our doors open.

We recognize that many of our partners across the state are requesting a delay in the implementation due to a variety of concerns, but much of this is focused on the transition in billing. While we, like many others, have invested in preparing for these changes, we want to ensure that the state is also invested in us, and helping to make these new systems and processes work to prevent the disruption of service for people who need it most. Ultimately, comprehensive, integrated and accessible health care for people living with mental illness allows The Centers to help stabilize and strengthen our entire community.

Benefits of Medicaid Expansion

The goal of behavioral health redesign and efforts with managed care have focused on bringing value to the people we serve and the community as whole – quality versus quantity. As we continue to grow an integrated model of care, one that seeks to provide the right service in the right setting, to improve health outcomes while lowering overall cost, we do this in the shadow of the Medicaid expansion debate.

The Repeal and Replace or Repair discussion of the Affordable Care Act has the potential to derail years of progress. And let me be clear in stating that I am not here to argue that the ACA is a perfect policy. We believe that changes and improvements are necessary. We have also watched the positive impact of Medicaid expansion first-hand with the people and communities we serve.

Medicaid expansion has forced us to innovate as an industry. Through Medicaid expansion we saw more people seeking out behavioral health services at a point when interventions could be effective, and we could truly help improve client health. Early intervention coupled with prevention efforts, and better coordination of care, enabled innovative and cost effective solutions that worked. Through care coordination and information sharing, we are integrating care in ways we only used to dream about.

And we have seen compelling results. Not just improvements in health outcomes, but significant reductions in hospital readmissions and ER visits. Better care in the right setting at a lower cost. It has taken us three years to reach this point. We have invested a great deal of precious resources – money, time, and talent – into creating the collaborations and systems that make this work possible. If this progress is rolled back, we lose all this investment, and the idea that we would shift back as we wait for an alternative to the ACA to be developed and refined – it will amount to a huge setback for everyone – but especially the people we serve.

Impact of Medicaid Premiums on Behavioral Health Clients

Finally, Director Sears has proposed premiums for Medicaid recipients. We recognize this effort is to reduce overall Medicaid costs and encourage personal responsibility among beneficiaries by creating incentives to seek care in the right setting and adopt a healthy lifestyle. But, we caution any policy maker to consider the experience of low-income people living with mental health and addiction concerns. The majority of The Centers' clients cannot navigate the health care world that you and I are familiar with, from finding a physician to making an appointment. They face numerous and significant barriers, with their illness keeping them out of the workforce and damaging important supportive relationships with families and friends. If we want to lower costs and achieve better health outcomes, keeping these individuals out of the ER and the hospital, we must be willing to support a system that works for them starting with aggressive, community-based outreach.

The premium payment is another impediment for low-income families and individuals-like those on Medicaid- to access and maintain coverage. Further, the presence mental illness and addiction disorders often prohibits our clients from active engagement in their healthcare, which is why intensive case management and clinical pharmacy home visits are effective best-practices for this population. We would prefer that our clients not be in a position to have to choose between a Medicaid premium payment and other social needs including prescription purchases, rent and food. And the payment of a penalty for a missed premium payment, or required volunteer work, is not a realistic solution for the vast majority of the people we serve.

Finally, regardless of the policies made in Washington, at the State or the local level, mental health, addiction services, accessible primary care – these concerns do not go away. If we are not paying for health care these costs will show up in other systems – criminal justice, homeless services, and foster care as prime examples. We have made important progress and the innovation continues to achieve better outcomes at lower costs and regardless of the policy, this work must continue.

Thank you for this opportunity to address integrated behavioral healthcare on behalf of our community.