Ohio House of Representatives
Finance Subcommittee on Health and Human Services

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Interested Party Testimony on HB 49

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Chairman Romanchuk, Ranking Member Sykes, and members of the Health and Human Services Subcommittee, thank you for the opportunity to offer testimony on HB 49.

I represent the Ohio Association of Child Caring Agencies (OACCA), a statewide association of child and family service providers that are united together to develop the best care possible for Ohio's children and families. The association was founded in 1973 as Ohio's first statewide child advocacy organization. We provide leadership for Ohio's at-risk children, families, and the community providers that serve them.

Our member agencies provide foster care, community mental health, residential treatment and group home care, adoption, and independent living services. Collectively, they serve over 125,000 Ohio kids and family members each year. The majority of children they serve are involved in multiple public systems including child welfare, juvenile justice, and behavioral health. Most of our members are certified by ODJFS, OhioMHAS, and/or ODM.

My testimony will focus on three main topics: Multi-System Youth, Children Services Funding, and the Behavioral Health Medicaid Re-Design.

Multi-System Youth

We appreciate the work performed by the Joint Legislative Committee on Multi-System Youth (MSY) and we support the committee's policy recommendations. We find special value in the proposed establishment of a state crisis stabilization fund to address unmet and uninsured needs of Ohio's MSY and their families who are in crisis and unable to access care and services. Creating a new state fund would enable community systems to access resources quickly and serve families who are often on the brink. This is an excellent strategy to preserve families and prevent custody relinquishment to children services. We are hopeful the Legislature will provide an investment to start-up this program.

Children Services Funding

It's not a surprise to anyone here that the high level of opiate and prescription drug abuse is causing serious problems to your constituents, their families, our communities, and our public systems. We appreciate the multi-pronged approach taken by every level and branch of government in our state to address the problem. One of the most critical pathways to focus our attention – and resources – is our county public children services system. These agencies are on the front-lines every day preserving and strengthening families in need, and when necessary, providing children with protection and out-of-home care, until family reunification is safe and possible.

Ohio has a strange financial model for funding these county agencies. Unlike almost every other state in the country, about 91% of Ohio's public children service agencies (PCSA) funding comes from the federal government and local county taxes and levies. State government provides about 9% of the total funding. During a time when our communities are experiencing a multi-year opiate crisis, our county PCSAs need more resources to effectively respond. Counties have been essentially flat-funded by the state since 2010. Our state would benefit tremendously by increasing the investment for the next biennium by at least $30 million, which is a figure proposed by the Public Children Services Association of Ohio (PCSAO). This funding would help PCSAs and their partner community agencies to respond to the opiate crisis, recruit additional foster and adoptive homes, provide additional support to kinship and primary families, assist with rising placement costs, recruit and retain a vital workforce, and leverage additional federal funding.

Behavioral Health Medicaid Re-Design

We appreciate the Legislature's – particularly JMOC's – leadership on the State's Behavioral Health Medicaid "Re-Design" initiative. This major package of Medicaid reforms is incredibly complex and necessary and we are hopeful for its successful implementation. The Re-Design effort is long overdue, and if done right, could empower community behavioral health providers to offer greater access to a wider array of services to children and families in need, such as family preservation and integrated physical health care provided on-site in behavioral health centers.

The status of the Re-Design – the rates, rules, and manuals – are still in flux. Many positive policy changes have been made over the last several months including a commitment to invest over $40 million new dollars into the program. However, many very important issues remain unresolved, including assurance that the committed investment would actually be expended.

Providers are balancing the need to have 1) final state policies in place with 2) further changes and improvements to be made to the Re-Design. Ultimately, they need a reasonable window of time to plan how to implement these changes. They need months – not weeks – to prepare their software systems, hire the right people, re-assign

existing employees, learn the new services and rules, and make other operational changes. They describe the dilemma as **trying to build a plane while flying it.**

We are hopeful the State will complete construction of the plane and test it first. We must be reasonably certain that this new complex Medicaid program won't break during take-off. There is real concern that some providers could quickly go out of business, close down programs, or limit access to services in other ways.

Certainly a massive governmental reform initiative as complex as the Medicaid Re-Design won't ever be perfect. We can't expect perfection prior to implementation. But we do expect that our government has at least tested the reforms, is committed to monitoring its implementation, and will be capable to respond to identified areas of concern after implementation starts. It's our hope that the reforms will result in improved access to services for Ohioans in need.

It's not just providers who care about the success of the Re-Design. The clients and families they serve do too, as do ADAMHS and Children Services Boards, schools, and other community stakeholders. This Medicaid program is an essential part of our communities and we must be extra cautious when we re-design and launch it.

We urge the Legislature to consider a proposal (enclosed) from a coalition between our association, The Ohio Council of Behavioral Health and Family Services Providers, the Public Children Services Association of Ohio, and the Center for Community Solutions. The proposal aims to ensure the reforms at least sustains access to services needed by kids, families, and adults struggling with mental illness or substance use disorders, including opiate addiction. There should also be an expectation that the reforms won't simply shift costs from Medicaid to local public systems such as children services. Specifically, our coalition's goals are to:

1. Maintain and improve access for Ohioans in need of substance abuse and mental health services
2. Use the existing and available workforce, rather than relying on unrealistic assumptions
3. Actualize the Administration's stated $53.4 million investment in behavioral health services
4. Establish a reasonable implementation timeline that supports clinical and business practice change and claims payment/IT system testing

Thank you for taking the time to hear my testimony today. Our association stands ready to support your efforts to address all three of these complex issues.

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
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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.

[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.