Mental Health Services
for Clark and Madison Counties, Inc.

A Culture of Compassion and Caring

Senate Finance Health and Medicaid Subcommittee
Public Testimony on H.B. 49 – Behavioral Health Redesign
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Chairman Hackett, Ranking Member Tavares and members of the Senate Finance Health and Medicaid Subcommittee, thank-you for the opportunity to provide testimony today on H.B. 49 regarding provisions related to the Behavioral Health Redesign. My name is Sue Fralick, Senior VP of Operations with Mental Health Services of Clark and Madison Counties, Inc. with six service locations in Springfield and one in London.

Our total estimated revenue for 2017 is 13 million dollars, 45% of which is Medicaid. We have 133 full time staff and 66 part time and on call staff. We have been serving citizens in Clark County since 1970, and Madison County since 1987. We served 6,046 people from 4/1/16-3/31/17 (unduplicated).

We serve adults with all degrees of mental illness from general to the severe and persistent mentally ill (SPMI), many of which also have co-occurring substance use disorders. We serve children and adolescents who are severe emotionally disturbed, as well as the general population of children and adolescents with mental illness, substance use disorders and those with both.

Our continuum of care for **adults** includes a 16 bed adult inpatient unit, 24 hour emergency crisis services, 5 day per week day treatment/partial hospital programming, psychiatric services, nursing services, clinic services, individual and group services for mental health and substance use disorders, medication box supervision for SPMIs, psychotropic medication injections, Vivitrol programming for opioid addiction, community psychiatric support services in homes and the community, and transitional housing and group homes.

For **youth** we provide assessment services in the community, 5 day per week day treatment/partial hospital programming which includes nursing services, psychiatric services, individual and group services for mental health and substance use disorders, community psychiatric support services for IEP students in three school districts, and parenting groups.

I am here to talk with you today as a provider of care, treatment and services for 39 years.

Throughout the Behavioral Health Redesign process, which is a large undertaking and much needed overhaul to behavioral health services, it has been apparent that the Ohio Department of Medicaid (ODM) and the Department of Mental Health and Addiction Services (MHAS) have been open to working through many complex issues as demonstrated by the multiple revisions to the rules and handbook.

It is very challenging to merge business and quality of care issues, and maintain a good balance between the two. I have experienced both state Departments learning about Ohio's behavioral health providers, the services we provide, the way we provide them, and the outcomes we achieve for our patients, their families and our communities from our service delivery systems. This willingness to learn from those "in the trenches" is recognized and much appreciated.

A good outcome of all this communication between the Departments and the providers has been improvements from the initial model in how services can be delivered which we believe impacts patient safety and quality of care. There are still opportunities that need a closer conversation such as crisis services, group counseling, nursing and day treatment. A good balance between business and quality of care is still needed. The populations

we serve do not “turn off” their needs and issues. Providers invest time and money in training and educating their staff to help patients who display risky behaviors and those whose illness tells them to reject help. The community behavioral health system is recognized for the workforce development opportunities it provides. However, by the time staff receive their independent license, they no longer choose to work in the community or work the late shifts, but rather have very marketable experience that allows them to move into jobs with more stable hours and office work environments.

The service codes need to match the available workforce, the reimbursement needed for the level of care, and the time of day we provide services. We will need to redesign how much crisis care we can provide and when and where we provide it. The same with nursing care as the salary and rates do not work from the business side. We have had to ask other systems to help by providing additional financial support to keep our seriously disturbed youth partial hospital (day treatment) programming open as it prevents psychiatric hospitalization which is hard for children to access anymore.

Another opportunity that needs a closer look is the impact to communities as behavioral health providers change service delivery practices as a result of BH Redesign. Communities may expect an increase in emergency room visits if a provider needs to change their crisis delivery model. Similarly, we can expect an increase in jail usage and/or legal involvement. Today, only 28% of our SPMI population is currently involved in the court system. There could be an increase in homelessness. We currently only have 11 adults with SPMI who are homeless. We can expect more need for emergency services involvement. In a 4 month period our organization identified 16 patients who had 7 or more EMS runs and received a total of 146 EMS runs at a cost to the “community” of $40,307.68. This is predicted to increase as service delivery changes have to occur to balance our business side with our care delivery side.

To accurately redesign our service delivery system we need some kind of assurance for timely payment. Our organization has approximately 107 days cash on hand to manage any issues that might delay payments. As we speak, we have over $200,000 outstanding in unpaid Buckeye My Care Ohio claims due to MCO credentialing and IT system issues. We have not seen payment for Buckeye My Care Ohio outpatient claims since October 2016. ODM unexpectedly announced a policy change in March 2017 that would require community behavioral health services “needing” to be reclassified under hospital based outpatient services. If this prevails, our organization will have many unfunded costs in the areas of IT, billing redesign, credentialing, workforce training, and legal costs.

HELP!! We need reasonable timelines for implementation and appreciate the House seeing this and delaying implementation by 6 months. We need more discussions and continued collaboration. We need to then finalize rules and billing procedures. Right now our IT vendors tell us they are not ready for testing and need final documents to update our software. We need a service coding and billing crosswalk to know what services can and cannot be “billed” same day so we can design service delivery and do not have to wait a month or more to learn our mistakes and loose revenue. Providers have no room for errors. Once all the changes are final, we then have to get our IT system programmed correctly and tested. Then we need to educate staff, families, community members and the patients about changes that affect them.

Thank you sincerely for your time and consideration today.