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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 Diane Wright, and I represent Greater Cincinnati Behavioral Health Services, located in southwest Ohio, in Hamilton and Clermont Counties. Our roughly 600 staff provide mental health and substance abuse services, including specialized services for people with mental health and substance abuse disorders who are homeless or have legal involvement, and for adolescents aging out of the children's mental health system, in addition to our vocational, psychiatric, residential and counseling services. Our services have roots in our community that go back to the late 1800's, and our agency was on the front lines of providing support when people with mental illness began to be released in great numbers from state hospitals. I have been a proud staff member of this agency for over 23 years. We've been named a Top Workplace in Greater Cincinnati for seven years in a row, and our staff are passionate about our mission of providing quality services to over 15,000 people each year through our many programs.

I've made the trip to Columbus today on behalf of our organization and the people we serve. While our organization absolutely supports the need to align our coding with national standards – it makes us better able to serve our clients – we are deeply concerned about the time frames proposed for this undertaking.

Here is just one example of one small piece of the changes that must, in the current plan, happen before July 1:

One intervention we provide for many clients is a service called Community Psychiatric Supportive Treatment. Some people refer to this as "case management." Right now, we use one code to bill for this service, with some add-on codes based on where the service is provided. Under the redesign, this type of service must be divided out into 36 possible code combinations, depending on the nuanced type of service, and which type of professional provides the service – plus the location coding. AND, for our agency, more than eight thousand active

clients will have to have updated service plans, showing that the specific services are authorized.

Because changes have continued to be made in the proposed billing processes and requirements, we have not been able to set up coding and billing processes that may continue to change. For example, up until just a couple of weeks ago, the state was indicating that a client would not be able to see a nurse and a doctor on the same day. This would have been devastating to our work with many clients who are difficult to engage, and struggle with transportation. Happily, the state was able to change this requirement at the last minute, but that has meant that agencies in the state who started building their electronic processes, and doing client education on changes, are having to go back and re-work their system, and re-educate clients.

As one of the largest providers of Assertive Community Treatment or ACT services in the state, we were happy to see the state seek ways to reimburse ACT as a discreet service; however, the way the service was structured for payment presumes that our ACT clients are easily engaged into very regular meetings with doctors. Our ACT teams have met the fidelity review requirement, but we do not anticipate being able to manage the reimbursement rates or process for this service the way it is currently structured. Clients eligible and receiving ACT services are the most difficult to engage and only receive the service because they do not engage in treatment as usual. If an ACT client refuses, as many do, to see a doctor, but receives multiple interventions each week in the community, we would struggle to be able to sustain our ACT teams under the proposed reimbursement rates.

We have been happy to work with the state, giving feedback, and participating in weekly phone calls and many meetings, but given the depth and breadth of these changes, we worry that adhering to a July 1 start date sets the state up for dramatic challenges, including delayed reimbursement. We support the House amendment that that allows for a 6 month delay and reasonable time for proactive testing and training period, rather than a "test while we go" approach.

Additionally, to assure our clients and communities maintain access to behavioral health services, we need some mechanism to assume the continued flow of resources during both the transition to the new coding system and integration of the behavioral health benefits into managed care. Our experience with MyCare Ohio has taught us that challenges are likely to occur.

Thank you for your time this morning.