OARP

Ohio Alliance Of Recovery Providers

Testimony to House Finance Subcommittee on Health and Human Services

March 2, 2021

Thank You Chairman Roemer, Ranking Member West and Members of the Finance Subcommittee on Health and Human Services for the opportunity to testify on House Bill 110 and Governor DeWine's executive budget as it relates to the Ohio Department of Mental Health and Addiction Services and the Department of Medicaid.

I am Thomas Stuber and I present today as the President of the Ohio Alliance of Recovery Providers (OARP), an organization of 40 of the largest Addiction Treatment and Prevention Agencies throughout Ohio. OARP strongly endorses this legislation and the strategic objectives outlined in Director Criss's budget. I am also President of The LCADA Way, the largest Behavioral Health Agency specializing in Substance Use Disorder Treatment and Prevention in Lorain, Medina, and Erie Counties and want to speak about the impact on Providers.

I am in agreement with my peers presenting before you today on the key issues but for the sake of time, I will be primarily focused on three issues.

1) **Medicaid MCO Procurement. As Ms. Lampl has testified, this is of critical importance and it must be done right. I believe the process that Director Corcoran has followed will be effective. I serve on the Medicaid SUD 1115 Waiver Advisory Board. This Board is working closely with Director Corcoran in the Department of Medicaid and Director Criss in the Department of Mental Health and Addiction Services. While the use of**

managed care is to insure that expenses are kept in line and that needless services not be prescribed, it is essential that we protect those suffering from addiction by insuring that essential services, including sufficient quantity and duration of services, are provided. This is a chronic illness and must be treated as such. This requires that services be available throughout the individual's recovery including Recovery Check-ups similar to regular follow ups for those with heart conditions. We are currently in the midst of an Opiate Epidemic that is escalating. While we saw a reduction in overdose deaths following 2017, as a result of the Covid-19 pandemic we have far surpassed 2017 and are looking at a projected increase in overdose deaths that is 20+% higher than any year since the epidemic started. To reverse this we must insure adequate capacity and sufficient duration of treatment. This will require that the basis for approving treatment be driven by The American Society of Addiction Medicine (ASAM) criteria for placement and continued care. This is the nationally accepted model utilized to drive clinical decisions and that clinical care not be rationed based on financial decisions. It is also critical that the full continuum of care outlined in Section 337.40 which includes Recovery Housing identified in Section 337.70 be fully funded.

2) **Workforce Development. Those on this panel see it as our primary responsibility to insure that the addiction treatment field has a sufficient and quality workforce that possess the skill sets and experience required for us to deliver effective treatment to those suffering with substance use disorders, especially those suffering opiate addiction. There currently is not a sufficient workforce to address the demand for treatment. Additional funds supporting Training and Tuition Reimbursement will make a difference. Currently all members of OARP have clinical staff openings, some as many as 60 clinical positions. The LCADA Way has 20 clinical positions currently open. It is important to note that each day that a clinical position remains open as many as 12-20 individuals will not receive treatment. This is especially critical as we prepare to address the surge in demand for addiction treatment expected following the Covid-19**

pandemic. Therefore we strongly support the additional funding noted in section 337.90.

3) **My last comments are in support of the Student Wellness and Success Funds. We strongly support Section 3317.26, however there is a potential for these funds to not result in the desired benefits that drives this legislation. Although there is a requirement for consultation between the schools and either Alcohol, Drug, and Mental Health Services Boards or Community Based Treatment and Prevention Agencies there is still a considerable risk to not capitalize on an effective implementation plan. During the last budget there was an effort to provide K-12 Prevention Services to every child in Ohio. The difficulty was that there were no guardrails on how each District should use those funds. There were multiple schools that chose to hire their own staff rather that use Prevention Specialists certified by the Ohio Chemical Dependency Professionals Board. By requiring that schools contract with Community Prevention Provider Agencies Licensed by the Ohio Department of Mental Health and Addiction Services, you will insure that professionals trained in the delivery of Research-Based Models of Care, supervised by other Prevention Specialists, will be delivering the most effective programs. We will never simply treat our way out of the Opiate Epidemic. If we are not able to equip our children with the skills necessary to prevent their initial drug use before they make this potentially life changing decision with proven prevention practices delivered by trained Prevention Specialists we will continue to struggle with this epidemic long into the future.**

Again, Thank You for the opportunity to present and I am open to questions.

Thank You