The Ohio Council
Of Behavioral Health & Family Services Providers

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Senate Finance Committee
H.B. 49
Testimony by Hubert Wirtz, CEO
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Chairman Oeslager, Ranking Member Skindell, and members of the Senate Finance Committee, thank you for this opportunity to provide testimony today on H.B. 49 regarding our concerns related to the state's Behavioral Health Redesign initiative along with a provision in the House-passed bill related to mental health and addiction services parity. I am CEO of The Ohio Council of Behavioral Health & Family Services Providers, which represents over 150 addiction treatment and prevention, mental health and family services providers from across Ohio.

Behavioral Health Redesign

The Ohio Department of Medicaid (ODM) and MHAS have maintained a strong commitment during the Medicaid behavioral health (BH) Redesign initiative to develop a modernized and updated set of behavioral health services in Medicaid that, at a minimum, sustains current service capacity, access and workforce. The Ohio Council has long supported alignment with industry service coding standards, improved care integration and movement to value-based payment models. We have also appreciated the hard, collaborative work that all parties have invested in this very complex initiative.

You have now heard from a number of community behavioral health provider organizations either in testimony or in your home district regarding concerns about the implementation of the BH Redesign on July 1, 2017 without having all of the plans, tools and an adequate timeline to make the clinical and operational changes and train staff appropriately to successfully implement these changes. While there is support for the goals of the Behavioral Health Redesign, no one wants to see the degradation of access, capacity and workforce in Ohio.

At a time when our state is facing an opiate and drug overdose crisis and people are needlessly dying by suicide at alarming rates, the Department of Medicaid has proposed some changes that will reduce treatment access and service capacity. Our inpatient psychiatric facilities are full, our emergency rooms are warehousing suicidal children and adults for 3-4 days until an inpatient bed opens, our jails are exploding with people that have untreated addiction or mental illness, families are relinquishing custody of their children to access behavioral health care at alarming rates, and our morgues are not large enough to handle the number of dead bodies. This weekend, the Columbus Dispatch reported that overdose deaths increased by 36% to over 4,100 people. That only accounts for 82 of Ohio's 88 counties, and all of the overdose deaths are not represented because coroners do not have the resources that they need to accurately report cause of death for all people. Now is not the time to move hastily to implement Medicaid changes that may further reduce addiction and mental health treatment services or reduce the behavioral health workforce that is responding on the front lines of our states worst public health crisis.

You have heard statements made by the administration that sometimes do not reflect the full story of this work over the past several years. While complex change is difficult and never perfect, complex change should have a reasonable chance of being successful, holding unintended consequences to a minimum. While lack of final IT requirements, misaligned and inconsistent rules and a yet to be finalized provider manual make provider operational preparation and clinical training

challenging at best for a proposed July 1, 2017 start date, there are also a number of policy and community service changes that are of great concern. For example, crisis service reimbursement rates are reduced by 29% with service limited to no more than 2.5 hours per day; and group counseling reimbursement rates are reduced by 30% for addiction treatment and up to 66% for mental health treatment.

The following paragraphs summarize the concerns that providers and the Ohio Council have identified as we have engaged over the past two plus years in the change process:

- **Providers Intent.** The providers engaged in behavioral health redesign are mostly nonprofits who are in the middle of perhaps the state's historically worst healthcare crisis. Ohio is #1 in opioid deaths. Ohio has a climbing suicide rate. Demand for mental health and addiction treatment services has grown as more Ohioans are able to access health care for the first time in decades. Demand for children's services and for people with severe and persistent mental illness continues to outstrip capacity. And in these unprecedented times, Ohio is also overhauling behavioral health codes and services and then rolling these services into managed care in six months.

  Community providers care about their capacity to meet the overwhelming demand they see every day. Providers care about getting people the treatment they need, not filling up Ohio's hospitals, ERs, jails, homeless shelters, and morgues. Providers care about having a high-quality workforce. To those ends, providers and the Ohio Council of Behavioral Health and Family Services Providers were instrumental in jump-starting the modernization of payment approaches to services and have been highly engaged in behavioral health redesign for more than 2 years.
- **Lack of Preparation.** Despite more than two years of work and a highly-engaged provider community, the administration is not prepared to meet its own redesign deadline. Providers have been in every meeting supporting their efforts and trying to provide feedback along the way. At many points, critical concerns about the impact of policy decisions on access, capacity, and workforce went unheard or overlooked. The administration's training efforts have often been incomplete and inconsistent, given that throughout the process program manuals, rules, rates and IT specs were often changed and still are not finalized. The latest updates to the redesign timeline illustrate how compressed the timeline has become.
  - JCARR will hold their first hearing on rules May 30th. The rules under consideration are wrought with oversights, contradictions and conflicts between agencies, missing rates or rate flaws noted in public comment for months.
  - Limited IT testing began May 10th, nearly five months after the original date by which all of the state's rules and guidance were to be finalized. Under the current schedule, some features, like prior authorization, will undergo no testing before July 1.
  - Despite the administration having two years to finalize their program and IT functions, providers and their software vendors will get fewer than six weeks to implement the final version of the codes and provider manual, which are not yet available in mid-May.
- **Flawed Funding.** The administration says they provided an additional $53m of investments to pay for BH Redesign code changes. Independent actuarial and multiple provider assessments continue to indicate reimbursement loss of approximately $40m in our system due to misaligned coding for workforce and rates. The State's actuarial vendor, Mercer, is the same company that provided the State with faulty Medicaid expansion figures. Further, Mercer's investment projections were developed based on service delivery by and rates for a workforce that is nonexistent in Ohio; that is, for highly credentialed professionals that are neither currently working in the behavioral health system, nor are available in the necessary volume from regional training programs, institutions of higher education, or other sectors. Without addressing the workforce and rate flaws, the Administration's predicted outcomes cannot be achieved on the ground.
- **Timely Reimbursement.** The state has indicated that mechanisms for timely reimbursement being suggested by providers are unconstitutional or contradictory to their program values and goals. However, during past transitions the administration has implemented "pay and post"; "stop/loss"; or "shadow billing" procedures for nursing homes, hospitals and recently with MyCare Ohio, when they required managed care to use a pay and post

procedure during a transition period. We suggest the state use the same strategy to ensure timely payment for community behavioral health services so that providers don't go out of business waiting for payment.

- **MyCare Ohio Experience.** The administration often says that they and providers have learned from the MyCare Ohio experience. The fact is that three years later, we still have providers that are owed significant arrears. Providers have learned that it's better to "measure twice and cut once" than to move forward with rushed, flawed, and incomplete work. MyCare is a demonstration project in only 29 counties, encompassing a small population of people dually-eligible for Medicaid and Medicare. Two-thirds of the Ohio counties, including nearly all of rural and Appalachian Ohio, have had no experience with MyCare and managed care. Because of this variation in experience, we strongly recommend creating a mechanism to allow better-positioned providers to voluntarily act as early adopters to move forward with redesign implementation prior to full implementation so that the rest of the field can learn from their experience and have the time needed to move forward without risk of closing services.
- **Artificial Deadlines.** The administration claims behavioral health redesign is necessary to provide new services on July 1st, and they want six months of testing the codes before BH carve in to managed care on January 1, 2018. No state or federal law requires the July 1st deadline. The original state plan for BH redesign implementation included starting to test software in September 2016 and having a three-part provider phase-in to the new service code with some providers starting in January 2017, others in April and July 2017. The original implementation plan also intended a 12 month period of testing the codes and developing the actuarial payment rates for the managed care carve in. Rushing to a finish line won't lead to success. It is unreasonable to expect service providers to implement a wholesale change of clinical and business practices in less than six weeks or expect the MyCare Ohio managed care plans to be ready to pay claims by then. And, there are no guarantee the MITS system will be ready for July 1 either.

The Ohio Council urges that the Senate support the six-month delay proposed by the House. We would also request the Senate to consider three amendments that we have proposed which ensures adequate IT Beta testing of new Medicaid billing codes and payment rates prior to implementation; ensuring adequate cash flow to providers during the implementation transition period; and allowing early voluntary adoption of BH Redesign changes.

<u>Mental Health and Addiction Services Parity</u>

In the Ohio Council's testimony on H.B. 49 in the House, we urged the House to establish, similar to many other states, state level responsibility and accountability to develop consumer education on federal mental health and addiction services insurance parity requirements. This would include establishing a consumer hotline to collect information and help families understand and access their benefits.

We urge the Senate to support a provision included by the House in H.B. 49 that requires the Superintendent of Insurance, with OhioMHAS, to develop consumer education on mental health and addiction services insurance parity, including a consumer hotline to collect information and help consumers understand their insurance benefits (H.Sub. 3901.90, 5119.89).

Thank you again for this opportunity to provide testimony.