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Of Behavioral Health & Family Services Providers

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Senate Community Revitalization Committee
Testimony on SB 105
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Chairman Johnson, Vice Chair Hoagland, Ranking Member Sykes, and members of the Senate Community Revitalization Committee thank you for the opportunity to testify today on SB 105, legislation that would significantly modify county ADAMHS Boards' roles, duties, and powers, while also establishing quality standards and regulations over recovery housing residences.

My name is Teresa Lampl and I am the CEO of the Ohio Council – a statewide trade and advocacy organization that represents over 165 private businesses that provide prevention, treatment, crisis, and recovery services in all corners of Ohio. Our membership organizations employ thousands of Ohioans within the healthcare industry and vary in size, geographic locations, populations served, and range of services and levels of care offered. We believe that providing nationally accredited, high-quality, mental health and substance use disorder services benefits individuals, families, and communities.

Certainly, the Ohio Council and our members appreciate Senator Johnson's leadership and this Committee's efforts to combat and address the opioid epidemic and the mental health crisis in Ohio. We agree that Ohio's system of care for people in need of mental health and substance use disorder treatment is fractured due to overwhelming need for care and insufficient human and financial capital to respond. We also agree that Ohio communities, patients, and providers remain stressed to the breaking point because of the unrelenting opioid epidemic, lingering effects of the pandemic, and volatile labor markets and wage pressures.

There are several provisions in SB 105 that do not directly affect community behavioral health providers and appear to advance sound public policy. The Ohio Council would support or have no position on these non-controversial provisions if offered in a different bill. These non-controversial provisions include changing the ORC language from "alcoholism" to "alcohol use disorder;" allowing for the restructuring of ADAMH board composition and maintaining participation of individuals with lived experience or their family members; and the establishment of quality standards through national accreditation for recovery housing.

However, SB 105, as currently drafted, contains several provisions that are *controversial, expensive to implement, and have not been subject to discussion, debate, or review with all system stakeholders*. SB 105 has been characterized as a modernization of the ADAMHS boards' roles, and a simple cleanup of outdated, historical language within section 340 of the Ohio Revised Code. However, it is much more complicated, nuanced, and has far reaching implications for patients, providers, and the system of care available in local communities. Moreover, several provisions, once implemented, would introduce additional layers of bureaucracy, regulations, and costs for county

governments and providers. ADAMHS Boards would need to hire more staff to fulfill the new responsibilities required under the bill – growing government and most likely competing for the same staff that behavioral health organizations are seeking to recruit and retain to provide mental health, substance use, and recovery services.

Unfortunately, the Ohio Council must oppose SB 105 due to these controversial provisions that would place providers in an unfair and unbalanced contracting position with the county ADAMHS boards, and greatly increase the costs of compliance with the new regulatory requirements and administrative processes.

As background, the landscape and regulatory environment for the delivery of behavioral health services has changed greatly in the past decade. OhioMHAS-certified providers have completely overhauled their clinical and operational practices in response to state policy changes. Such changes include establishing a Medicaid fee schedule, elevating, and centralizing Medicaid payments with the state, rescinding antiquated cost reporting requirements, implementing behavioral health redesign, and the integration of Medicaid managed care in Ohio. ADAMHS board practices and expectations, on the other hand, have largely not evolved to reflect these significant enhancements. In fact, ADAMHS boards are no longer the predominate payer for most behavioral health provider organizations. A recent Ohio Council survey of community behavioral health providers found that:

- Providers contract with 20+ payer types (such as commercial insurance, Medicaid managed care organizations, state agencies, local governmental entities, philanthropic organizations, and other funding institutions).
- A majority of providers contract with multiple ADAMHS boards, each with unique contract requirements and data requests, even though they have the same statutory duties and responsibilities thus creating inefficiencies and costs.
- 71% of providers received 30% or less of their total funding from ADAMHS boards, and 52% receive less than 20% of total funding from ADAMH boards.

The ADAMHS board contracts are out of step with contemporary payer relationships and requirements. *There is no standard for accountability, transparency, or procurement of taxpayer funded services through the ADAMHS board system.* Regardless of how small the contract, boards routinely require providers to disclose proprietary or sensitive business information that then becomes a public record. Further, boards continue to require providers, by contract, to follow processes and use forms that are out-of-date and associated with administrative rules rescinded when Medicaid established a fee schedule in 2011. Simply put, no other payer – public or private – demands the level of intrusion into the provider's business. This is costly, staff intensive, and diverts resources from clinical service delivery.

A provider that resists or refuses to submit the requested information or form to an ADAMHS board is then subject to the threat of either losing funding or termination of contracts. These egregious actions, in combination with several ADAMHS boards' failures to follow the 120-day notice process are what has led to legal action by providers to protect their business practices and be able to sustain services to patients and communities. To be clear, taking legal action is the last thing a provider wants to pursue, and is the ultimate last resort a provider considers – because it is costly, disruptive, and demonstrates a local system's failure to prioritize the needs and interests of patients

needing and receiving services. Indeed, there have only been a handful of situations that have led to legal action – and all of them were initiated by providers in order to sustain services to the patients and communities when an ADAMHS board failed to follow ORC 340.036.

That brings us to our specific concerns with SB 105:

1. **Proposed changes to ORC 340.036: Elimination of the 120-day notice and dispute resolution process in board/provider contracts.**

   The 120-day notice provision is a *fundamental patient protection that ensures continuity of patient care* when contracts are amended or terminated. Removing this provision would introduce uncertainty and volatility for private businesses, create a power imbalance in the board/provider contracting process, and put patients at risk during any transition process.

   Additionally, the 120-day notice and dispute resolution process are the only consistent contract requirements mandated under Ohio law. These provisions were placed in statute years ago to provide contractual balance between boards and providers while ensuring a continuity of care for the community. There is no procurement process or other safeguards to support transparency in funding decisions. Other than those two parameters, contracts vary greatly from county to county and region to region. From a business perspective, providers seek uniformity, stability, and efficiency in the contract process so providers can focus their resources on patient care and health outcomes.

   Finally, under current law, both boards and providers may seek to change or terminate the contract, and if there is disagreement, the dispute resolution process is outlined in law. Further, Ohio's community behavioral health system has been attempting to establish a procurement process with contracting standards and a mediation process since a settlement agreement was reached in 2007 among state agencies, boards, and providers from a previous system-wide lawsuit filed in 2002. Yet, boards have continuously resisted efforts to achieve this goal – asserting that local interests and control should prevail over any attempt at standardization. SB 105 removes the dispute resolution process and instead requires the contract include a process *by which only the board can terminate the contract early for any cause the board considers necessary*. This puts patients and communities at grave risk for disruption of services and is woefully out-of-step with 'transition of care' planning that exists in all other provider healthcare contracts.

2. **New duties create redundant and burdensome regulations:**

   SB 105 gives ADAMHS boards a new and formal role in the OhioMHAS certification process. OhioMHAS would have to notify boards of all new and renewal certification/licensure applications within 14 days of receipt. The board will then have 30 days to respond with any feedback and can even request a meeting with OhioMHAS within the first 14 days of the review period. This extraordinarily rigid and time-consuming regulatory process would cause additional delays and uncertainty for providers seeking to open business, hire employees,

and expand services in Ohio communities. To be clear, data from OhioMHAS and the Ohio Department of Medicaid clearly documents that need for behavioral health services exceeds the available workforce and no community has sufficient capacity to respond to the mental health and substance use demand. Coupled with the elimination of the 120-day notice, this overly bureaucratic and administratively burdensome and time-consuming mandate may leave a community with gaps in service or worse, no services at all.

Further, while boards could offer comments, provide feedback, and hold up any provider's efforts seeking certification, licensure, or a renewal – the boards would have no obligation to contract with those providers. This unfair balance of power and government intrusion would impact community behavioral health providers, but would also extend to hospitals, FQHCs, and other providers of mental and behavioral health services.

The bill also grants boards with expanded roles in any OhioMHAS investigation (notice and outcome report) and mandates that OhioMHAS conduct an investigation if requested by a board within 14 days. This language does not require any standard of evidence or cause to initiate the investigation – and grants unfettered authority to interfere with the business operations of any provider at will.

3. **Duplication of coordination activities**:

SB 105 expands the role of the ADAMHS boards to *coordinate public benefits and to improve the management and administration of government programs*. This provision mandates a significant expansion and duplication of government function. First, it is unclear how the term "public benefits" is being defined. However, it appears to grant ADAMHS boards an overreaching role in managing and administrating other public programs that are statutorily or contractually assigned to other state agencies, county government entities, local boards, jails, municipalities, and other entities. *Moreover, these new oversight powers and responsibilities appear to fall well outside the scope of the ADAMHS board domain* of acting as a pass through of federal funds and ensuring the delivery of services to individuals with mental illness and substance use disorder challenges. We would expect the ADAMHS boards to hire more administrative staff to fulfill these new duties – draining more resources that would be better spent serving patients and developing prevention, treatment, and recovery programs. It's unnecessary, costly, and wasteful duplication that could be avoided by ADAMHS boards adopting practices that embrace collaboration and population health planning. Moreover, the state already pays billions of dollars every year to Medicaid managed care plans to coordinate care and support healthy outcomes for over 3 million Ohioans in the Ohio Medicaid program. The last thing these Ohioans need is another layer of government getting between them and their recovery.

Further, SB 105 would require the Ohio Departments of Medicaid and Mental Health and Addiction Services to develop a process and rules allowing for the sharing of private health information and individual patient data with the various ADAMHS boards. Ostensibly, the sharing and transferring of this private individualized health information would be used to fulfil the boards' newly expanded duties and responsibilities related to coordinating public

benefits, improving the management and administration of government programs, and to fulfil their community planning role. To be clear, ADAMHS boards already have access to county level-aggregated data, including Medicaid data, which is sufficient to meet their community planning needs. This legally questionable, risky, and hyper-focused desire of the ADAMHS boards for individual Medicaid data appears tied to a return to the past when they managed the Medicaid program – rather than evolving and transitioning to the modern practices relying on population health and collaboration. Again, this is an unnecessary, costly, and wasteful duplication of services that are contractually the obligation of the several Medicaid managed care plans, who are responsible for the coordination of Medicaid covered services.

SB 105 needlessly inserts greater bureaucracy and uncertainty into the delivery of mental health and substance use disorder services while diverting scarce resources away from patients and into administrative activities. It would also create an unfair imbalance in the contractual relationship between ADAMHS boards and providers by growing government, expanding oversight of healthcare businesses, and expanding rules and regulations impacting businesses.

From the Ohio Council perspective, we strongly believe this legislation and the goals underpinning it would benefit by pressing pause on this bill and allowing the OhioMHAS led Chapter 340 Workgroup to continue its work. In 2022, OhioMHAS convened a diverse set of stakeholders, including providers, ADAMHS boards, family members, and advocates to review ORC Chapter 340, and to develop recommendations that modernize and meet the needs of a 21st century community behavioral health system. As a result, we believe the OhioMHAS 340 Workgroup is best prepared to continue this collaborative stakeholder process, aimed at developing recommendations to enhance the system and modernize the role of ADAMHS boards to meet the needs of Ohioans facing mental health and addiction challenges throughout Ohio.

Finally, *I must comment that the timing of today's opponent testimony is occurring in the middle of contract negotiations between the county ADAMHS boards and providers*. In some communities throughout the state, collaborative business relationships exist, but unfortunately many other providers were uncomfortable offering testimony either in person or in writing due to concerns that their opinions on this legislation would jeopardize their respective negotiation process. Fear of reprisal and negative backlash is a sad but true reality that providers must deal with in their communities. Mr. Chairman and members of this committee, I ask you consider this information as you determine the next steps in this legislative process.

Thank you for considering my testimony. I'm happy to answer questions.