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Testimony before the Senate Medicaid Committee
Ohio Department of Mental Health and Addiction Services FY 16-17 Budget
House Bill 64

May 14, 2015

Good afternoon Chair Burke, Vice Chair Manning, Ranking Member Cafaro and members of the Senate Medicaid Committee. Today, I appreciate the opportunity to present the budget for the Ohio Department of Mental Health and Addiction Services (MHAS) for State Fiscal Years 16 and 17.

The past four years have brought great change to the public mental health and addiction system; change that was necessary to stabilize and rebuild the safety net for Ohioans who are in need of treatment. With the support of Governor Kasich and the legislature, we have been able to offer hope to more people in the midst of an opiate or other addiction or facing a mental health crisis. The first Kasich budget elevated responsibility for Medicaid match funding to the state level, freeing up local boards from the financial risk of providing match and allowing local systems to focus on local priorities. The second budget consolidated responsibility for state level administration of mental health and addiction services by creating the Ohio Department of Mental Health and Addiction Services.

Finally, in January 2014, eligibility for Medicaid health coverage was extended to all adults up to 138% of poverty, making clinical services available to more people. Medicaid has had a significant impact especially on individuals with mental health and addiction disorders, which I will discuss in detail later in my testimony. The benefit of Medicaid allows greater attention to be paid to other critical services and supports that are not Medicaid reimbursable, such as prevention, housing, and employment supports; all of which help reduce reliance on public assistance in the long run.

While progress has been made, our work is not done. This budget continues to build on the collective efforts over the past several years in several key areas, which I will highlight for you today.

Overview of the OhioMHAS budget

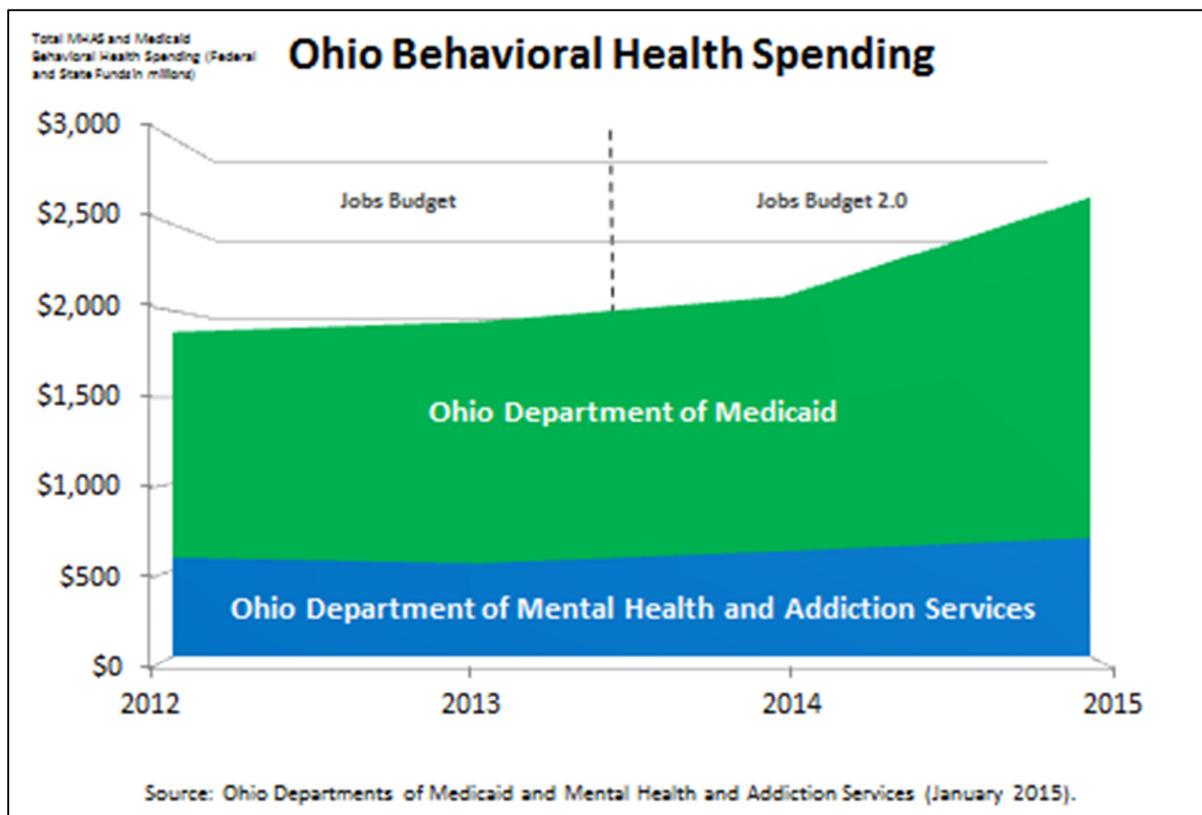
Overall, the OhioMHAS budget has a slight increase from FY 15 to FY 16 in GRF funding. The increase is attributable to a \$12.5 million transfer of funds from DRC to fund recovery services work, an increase of \$3.5 million in lease rental bond payments, and the addition of \$1,174,357 into the central administration line to cover the DAS rent initiative. An additional increase of slightly less than \$7 million in FY 17 will cover the cost of a full year's worth of the community portion of the DRC/MHAS partnership, which will be discussed in detail later in the testimony.

Medicaid

The committee has already heard testimony from Director McCarthy about the Medicaid program, but I wanted to be sure to take some time today to put a focus on what the added benefit has meant to people with mental health and addiction disorders. While the data we are gathering about the newly eligible population is very new, early analysis tells us a few key things.

First, behavioral health is an area of pent-up demand. Many of the people in the Group 8 category who accessed mental health or addiction services were previously unknown to the public behavioral health system – approximately 17,252 individuals through September 30. For whatever reason, these individuals did not receive services previously through local boards. They are now eligible for coverage and have received clinical care with a value of \$21.8 million (\$12.6 million AoD, \$9.2 million mental health).

Medicaid coverage has resulted in an influx of treatment resources for mental health and addiction, representing a once-in-a-generation opportunity to facilitate Medicaid and non-Medicaid services working together to meet the needs of Ohioans with mental health and addiction disorders. Central to the state's commitment to extend Medicaid access is the objective to connect more individuals to services and care that can be found in the community. This has been realized through the state's investment in mental health and addiction services. Today, people who just a year ago had nowhere to turn for health care now have close-by access to treatment and services through Medicaid and can access other needed recovery supports through OhioMHAS and its local partners.



Another way that Medicaid benefits have helped increase resources in the public mental health and addiction system is to free up resources at the local level that were previously used to cover clinical treatment for individuals who are now covered by Medicaid. The chart below estimates the impact of this reinvestment broken down by local board area. Note that this data is an annualized estimate based on information from the first three quarters of the fiscal year. These funds are now able to be used by local systems based on locally-driven decisions.

Board Area	Annualized Estimate of Amount available for reinvestment to AoD/MH Recovery Services *
Allen, Auglaize, Hardin	\$ 631,108
Ashland	\$ 162,142
Ashtabula	\$ 307,385
Athens, Hocking, Vinton	\$ 512,624
Belmont, Harrison, Monroe	\$ 347,928
Brown	\$ 56,976
Butler	\$ 1,778,223
Clark, Greene, Madison	\$ 1,751,865
Clermont	\$ 468,693
Columbiana	\$ 615,222
Cuyahoga	\$ 4,860,525
Defiance, Fulton, Henry Williams	\$ 763,122
Delaware, Morrow	\$ 626,113
Erie, Ottawa	\$ 454,547
Fairfield	\$ 378,174
Franklin	\$ 7,362,047
Gallia, Jackson, Meigs	\$ 428,011
Geauga	\$ 240,188
Hamilton	\$ 4,027,444
Hancock	\$ 314,829
Huron	\$ 128,629
Jefferson	\$ 370,378
Lake	\$ 1,544,794
Licking, Knox	\$ 1,322,370
Logan, Champaign	\$ 170,971
Lorain	\$ 1,831,575
Lucas	\$ 4,401,214
Mahoning	\$ 1,138,716
Marion, Crawford	\$ 857,363
Medina	\$ 226,292
Miami, Darke Shelby	\$ 427,105
Montgomery	\$ 4,528,043
Muskingum Area	\$ 742,629
Portage	\$ 747,030
Preble	\$ 103,238
Putnam	\$ 12,867
Richland	\$ 663,607
Ross, Paint Valley	\$ 1,163,947
Scioto, Adams, Lawrence	\$ 1,302,768
Seneca, Sandusky, Wyandot	\$ 313,174
Stark	\$ 1,915,394
Summit	\$ 3,111,005
Trumbull	\$ 1,127,471
Tuscarawas, Carroll	\$ 604,050
Union	\$ 185,772
VanWert, Mercer, Paulding	\$ 260,740
Warren, Clinton	\$ 809,065
Washington	\$ 134,445
Wayne, Holmes	\$ 946,309
Wood	\$ 456,118
Total	\$ 57,634,248

** Unassigned \$ 1,028,344

* Annualized estimate is based on three quarters of claim information

** Unassigned are MITS claims associated with county "other".

Note: Claim data used to create this estimate were sourced from MITS and MACSIS. In instances where claims are paid outside of those systems, they can not be included in this analysis at this time.

One example of what this means locally comes out of the Four County ADAMHS board in northwest Ohio. The board director, Les McCaslin, notes that his community will see approximately \$1.3 million in local savings due to Medicaid, according to his local estimates. Those funds will be reinvested in expanding the FQHC partnership in the area, resulting in treatment for mental health, medication assisted treatment, substance abuse, dental, and primary care all in one building in Bryan and a similar integrated care setting in Defiance. This is progress toward integrated care that will benefit NW Ohio in the long-run.

To arrive at the numbers in the figure above, OhioMHAS began by identifying people with Medicaid eligibility in the expansion group from the eligibility files we receive from the Department of Medicaid. From there, we looked at claims from the Medicaid MITS system and the OhioMHAS MACSIS system (which processes many non-Medicaid payments for boards) to identify the Medicaid services (paid by Medicaid and boards) with dates of service in calendar years 2012, 2013, and 2014. We then grouped people into one of four categories using eligibility and service patterns. Analysis then focused on the following two groups: one with individuals who previously received non-Medicaid board services but who became eligible under Medicaid expansion on or after January 2014 and individuals who had a mix of Medicaid and non-Medicaid services who became eligible under Medicaid expansion on or after January 2014. The total amount of Medicaid and non-Medicaid paid behavioral health claims associated with the Medicaid expansion eligibility periods were assigned to a board area by county of residence and then annualized to represent a full year estimate based on data from the first three quarters of calendar year 2014. It is my belief that these numbers are a conservative and responsible estimate based on data analysis.

Finally, I know that Medicaid benefits are making an impact through the stories and anecdotes that I hear as I travel the state and talk to boards, providers, and the people they serve. For instance, I attended an event in Mansfield in February where a couple told their personal story. They were both addicted to drugs, they had lost custody of their children, the wife had spent time in prison, and neither one of them were working. Through the extension of Medicaid benefits, the couple was able to seek treatment for their addictions and their physical health needs. As a result, they are both sober, have regained custody of their children, the husband has found gainful employment, and they both have great hope for the future. This recovery success story illustrates the impact and potential savings in other parts of state spending – less recidivism, less use of the child welfare system, and an increase in tax revenues through more people having jobs. This story repeats itself across the state.

There is more work to be done. Too many Ohioans remain in crisis due to their addiction and/or mental health disorder. Access to treatment providers remains a challenge. Too many people with serious and persistent mental illness receive care in nursing homes, prisons, and psychiatric inpatient hospitals. Coordination of the physical and behavioral health Medicaid benefits remains a challenge. These are the things that need to change in order to build upon increased access to Medicaid and produce the kinds of outcomes that will continue to improve Ohioans' ability to recover.

We know that Medicaid-enrolled Ohioans with behavioral health treatment needs represent 27 percent of Medicaid members but accounts for almost half (47 percent) of Medicaid spend. The most expensive five percent account for over half of the behavioral health expenditures. Only 50 percent of the behavioral health population on Medicaid is seen by providers certified by

MHAS. In order to strengthen the clinical services offered through the Medicaid program and to better integrate physical and behavioral health coverage, the Department of Medicaid and MHAS are proposing significant reformation of the behavioral health benefit over the course of the FY 16-17 biennium. Key reforms will happen in three phases and will focus on individuals with high-end needs while also bending the cost curve in the long run:

1. Update billing codes and services definitions to align with national standards and to identify specific service activities. Mental health pharmacological management and AoD medical/somatic services are being targeted for this first phase update.
2. Budget neutral redesign of the behavioral health benefit that focuses on aligning services according to a person's acuity level and need. This will include the addition of several new services based on proven models, such as Assertive Community Treatment (ACT), Intensive Home Based Treatment (IHBT), high-fidelity wraparound, peer services, supportive employment, and residential services for substance use treatment. Also, Community Psychiatric Supportive Treatment (CPST), case management, and health home services will be disaggregated to allow specific components to be aligned to a person's acuity level and need.
3. Transition to managed behavioral healthcare in order to improve care coordination and outcomes. A year's worth of claims experience under the redesigned benefit will enable rates to be set for managed care. The administration is working with stakeholders, including consumers, boards, plans, and providers on both the redesign and the transition to managed care in order to identify issues and work through them with the goal of making this change as smooth as possible.

It should be noted that the House made changes to both funding and language that would prohibit the transition of the behavioral health benefit to Medicaid managed care.

While the Medicaid benefit transformation focuses primarily on helping Ohioans access the proper clinical care to promote recovery, there are also mental health and addiction service needs that extend beyond the reach of the Medicaid program. The OhioMHAS executive budget proposal focuses on many of these needs and suggests targeted investments to help meet them. These investments work to break down traditional "silos" to forge new partnerships and strengthen current ones to deliver services, as well as focus on tackling root causes for a person's involvement in the public mental health and addiction services system. These elements can be broken down into four general themes: Support for Children and Families, Savings Lives – Every Life Counts, Criminal Justice Interface, and Housing and Employment as Recovery Supports. The amounts listed below are as originally proposed by the executive. Key House changes will be noted at the end of my testimony.

Support for Children and Families

Strong Families, Safe Communities - \$3 million annually

In FY 14-15, following the tragic shooting at Sandy Hook Elementary, Governor Kasich invested a total of \$5 million in a partnership between DODD and MHAS to work with families in crisis with youth who are at risk to be a danger to themselves and others due to mental illness or developmental disability. This project has resulted in 14 grants impacting 46 counties aimed at helping children who are "at risk" and developing best practices to intervene and keep families from reaching a crisis point. Examples of funded

services include rapid response teams, family mentoring and support, and screening for high risk children. Continued investment will fund community projects across the state that focus on care coordination and crisis intervention through collaboration.

Early Childhood Mental Health - \$5 million annually

As a part of the governor's overall investment in early childhood, the goal of this initiative is to focus Ohio's experts in early childhood mental health to reduce and eliminate preschool to third grade school expulsions. Early Childhood Mental Health Counselors/Consultants will be positioned statewide to provide rapid response to early learning settings where parents, center directors or teachers have a need for help to stabilize a student's emotional or behavioral classroom adjustment. I am pleased to be joined today by Angel Rhodes, Governor Kasich's early childhood advisor, who will describe this project in more detail.

Targeted Populations Prevention - \$1.5 million annually

Prevention services are a critical part of the OhioMHAS mission. The budget continues a focus on evidence-based prevention strategies by strengthening investment in this area from a statewide perspective. In particular, this funding will target specific populations known to be at-risk of developing behaviors that lead to addiction, such as children of incarcerated parents.

Saving Lives – Every Life Counts

Suicide Prevention - \$1 million annually

Recent high profile suicides have again called attention to the critical issue of suicide prevention. In the state of Ohio, 1,534 suicides were recorded in 2012 – 1,534 too many. The budget proposes to strengthen statewide efforts to prevent the avoidable tragedy of suicide through education and awareness, screening of individuals at high risk, pharmacotherapy, psychotherapy, and follow-up care after a suicide attempt.

Trauma-Informed Care - \$100,000 annually

A trauma-informed care approach is a consumer/client oriented practice that is critical to helping people heal. It has been shown to reduce the need for seclusion and restraint. In 2014, MHAS and DODD began working together on an initiative to promote this approach across the state through regional collaboration. This investment enables OhioMHAS to continue its cross-agency efforts to promote trainings and practices that are trauma-informed.

Enhancing Access to Naloxone Statewide - \$500,000 annually

Ohio's overdose death rate continues to be too high, with approximately 1,539 deaths due to opioid overdose in 2013. One way to have an impact on reducing overdose death is to make naloxone, a drug that immediately reverses the effect of an opiate overdose, more available to first responders, family, and friends of individuals who are fighting addiction. I know that the legislature understands this issue well. The demand for naloxone has increased dramatically as a result of House Bill 170 from last General Assembly which expanded the use of naloxone, and the future potential of House Bill 4 will further increase demand. The price has also increased, as naloxone is currently on the national drug shortage list. By partnering with other stakeholders, such as ODH's

Project DAWN, ADAMH and local health boards, the Board of Pharmacy, the Attorney General, and law enforcement, these funds will be used to enhance access across the state, reduce preventable deaths, and encourage people to enter treatment.

Criminal Justice Interface

Recovery Services Partnership with DRC

One of the most exciting and innovative opportunities proposed in the FY 16-17 budget is a new partnership with the Ohio Department of Rehabilitation and Correction (DRC) to improve addiction services within the state prison system. According to DRC, approximately 50,495 individuals are incarcerated within DRC facilities. Of these, 80% have histories of addiction. Nearly 30,000 of those incarcerated have a considerable or moderate treatment need, but current resources limit treatment availability to reach approximately 4,500 of those in prison. Those who receive services to treat addiction have much lower recidivism rates than those who do not receive such services (10.4% for those treated vs. 27% for general population).

In order to make improvements and expand the reach of recovery services in the prisons, this budget leverages the clinical expertise and recovery-oriented mission of OhioMHAS partnered with DRC's success in keeping recidivism rates low to provide quality addiction services to more people within the walls of the state prisons. Enhanced care inside the prison walls includes adding to the recovery services staff to provide individual and group treatment and adding two therapeutic communities, a proven model of treatment that uses the influence of peers to promote recovery. Additional programming will encourage a seamless transition to services upon release to further lower the rate of recidivism, including a connection with the Medicaid program to ensure continued clinical services where applicable. Expanded use of Medication Assisted Treatment will further reduce the risk of future relapse. The budget will also increase access to recovery supports, such as sober housing and employment services, upon release to ensure stable recovery and even further lower the recidivism rate.

Employees of DRC's Bureau of Recovery Services will transfer to OhioMHAS and report under the direction of MHAS' Medical Director, Dr. Mark Hurst. However, the goal is to make the transfer with very little disruption to the staff, who will continue to work within the prisons, retain their DRC badges, and maintain their rates of pay and benefits.

The proposal is three-pronged with a total budget of \$27.4 million in FY 16 and \$34.3 million in FY 17:

1. Transfer current \$12.5 million addiction treatment budget from DRC to MHAS. This budget largely consists of personnel who will become employees of OhioMHAS.
2. Augment services within the state prison system to increase treatment resources to levels that meets identified need. This includes hiring approximately 60 additional personnel to work within the prison setting.
3. Expand resources for outpatient recovery supports and treatment for released inmates.

While these statistics and percentages illustrate the clear need to place a greater emphasis on recovery services in the prison setting, I also want to share with the committee a very clear illustration of why this partnership is a wise investment. I met Dewayne Lee at the OASIS therapeutic community program at Pickaway Correctional Institution while he was serving time in prison for the second time due to crimes he committed while addicted to cocaine and crack. Mr. Lee was college educated and gainfully employed before falling prey to the lure of drugs. The treatment he received through OASIS worked well for him, even leading him to pursue further education as a chemical dependency counselor. Dewayne was released on January 1, 2014. Three days later, he was married. Eleven days after that, he received his CDCA license and after receiving additional training, received his LCDC III certification nine months later. Mr. Lee now works as a treatment counselor at a medication assisted treatment program in Mansfield and works part-time at Healing Hearts Counseling Center. He was recently accepted into a Master's program at Ashland University to further his education and learn skills to help even more people.

Dewayne's story is only one of many successes. Through this proposed recovery services partnership between DRC and MHAS, the aim is to have thousands more men and women achieve recovery and accomplish their goals as a result of help they received while in prison.

Addiction Treatment Program - \$2.5 million each year

This program was originally included in the last biennial budget bill by the legislature. Currently, there are 274 individuals enrolled in ten participating specialty dockets located in seven counties, and the FY 16-17 budget proposes to continue this project. Looking forward to the FY 16-17 biennium, there is a possibility of expansion to additional courts by capitalizing on the use of Medicaid as a payer for clinical services, which was not available when the pilot was originally contemplated. The program's evaluation is being conducted by Case Western Reserve University and is expected to be published in December 2015. Early results indicate a high rate of compliance with treatment.

Specialty Dockets - \$1 million each year

The Mid-Biennium Review included \$4.1 million to fund payroll for specialty dockets. As OhioMHAS has implemented the payroll program, approximately \$1 million of the total appropriation was used to fund new positions used to expand dockets. This funding in FY 16-17 will enable OhioMHAS to work with other partners such as the Ohio Supreme Court and DRC to seek ways to cooperatively promote the expansion of specialty dockets across the state.

Community Forensic Centers – \$2,979,349 total, addition of \$350,000 annually

Forensic Centers are responsible for providing forensic evaluation services for Ohio's criminal court system and have had level funding since FY 2008. This slight increase will help centers keep up with the cost of doing business while continuing to provide high quality evaluation services to Ohio's courts.

Probate Court Costs – \$1,284,210 total, addition of \$500,000 annually

This funding helps to cover costs to determine a person's competency to stand trial, a function primarily performed by the probate courts in the counties where the six

OhioMHAS psychiatric hospitals are located. Currently, there is not enough funding available to fully cover court costs, which is the reason for the increase. Additionally, a language change will make it easier to seek reimbursement from other courts when there is a shortfall.

Community Strategies to Impact Hospital Capacity - \$3 million annually

On a routine basis, the OhioMHAS state psychiatric hospitals are operating at peak capacity. With approximately 1,181 beds available, there is never a waiting list, but sometimes diversion to another state hospital may be required. Bottom line, the hospitals are busy places. As a result, MHAS is constantly seeking innovative ways to free up additional capacity for those in need of this critical safety net service.

Working in concert with our state hospital CEOs, we have been able to identify a few key projects that will help free up capacity by partnering with the criminal justice system. One example is a proposed pilot for the hospital in Appalachia, which sees a disproportionately high number of transfers to and from local jails. Many of the jails in Southeast Ohio do not have good access to mental health services at their facility, leading to a hospital transfer for evaluation and treatment that could be avoided. By working with local sheriffs and ADAMH boards to make services available in the jail, a small investment will negate the need for a costly transfer and unnecessary security risks, while opening a bed at the hospital for someone else who is experiencing a crisis.

Another example is the growing need for community-based competency restoration services for misdemeanor cases. In southwest Ohio, the hospital sees a number of patients each year who are hospitalized for competency restoration, but who no longer require a hospital level of care. These individuals may return to the community with approval from the court under a structured program with intensive supports to continue to work toward competency restoration. This program will be developed with the cooperation of the courts and the continued involvement of the hospital to ensure continuity of care.

Housing and Employment as Recovery Supports

A major emphasis of OhioMHAS and its local partners in an environment of extended Medicaid coverage is greater emphasis on services called "recovery supports." Recovery supports are the kinds of things that are necessary to live a stable life, but are not clinical in nature. Two good examples are housing and employment.

Residential State Supplement (RSS) - \$15 million total annually

RSS is a critical program that connects individuals with disabilities, primarily mental illness, to housing. The FY 16-17 budget continues the additional investment initiated in the MBR which funds an additional 800 slots. As of the end of April, an additional 601 people have been added to the program and an additional 111 have applications pending. Language is also included in the bill to allow more flexibility to administer the program and make changes to allowable fees and subsidy amounts as discussed in the program review required by the legislature in the last budget bill.

Recovery Housing - \$2.5 million annually

Recovery housing is a growing resource for the state of Ohio. It is a sober environment that is not permanent, but presents an environment conducive to a person’s continued recovery from addiction. Working with the legislature during the MBR, an investment of \$5 million in GRF and \$5 million in capital funding is anticipated to result in an additional 660 beds across the state of Ohio. Continued investment to keep growing this important resource, as well as to support best practices that ensure quality is necessary.

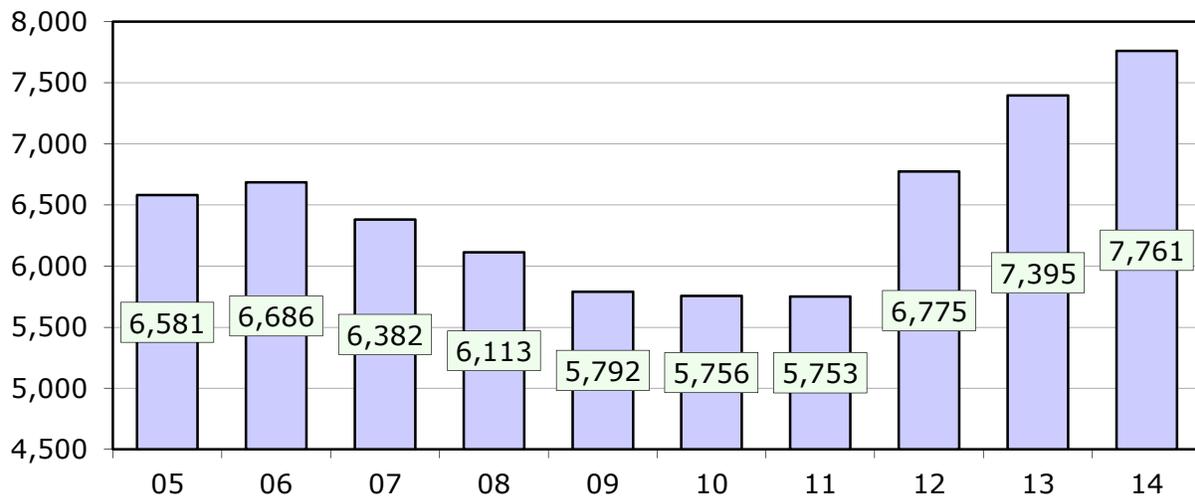
Workforce and Employment - \$1 million annually

I know that a common complaint that many of you hear from employers is concern about workforce readiness and the inability of job applicants to pass a drug test. This targeted effort will work with employers and potential job applicants to reduce the number of positive drug screens, to encourage the implementation of second chance programs, and to help people in recovery obtain a job, which is a critical step toward sustained wellness.

Regional Psychiatric Hospitals

The operation of six quality psychiatric hospitals remains a core priority for the Ohio Department of Mental Health and Addiction Services. As previously mentioned, the department operates a total of 1,181 beds at six facilities across Ohio. Since 2011, admissions have increased by approximately one-third.

Hospital Admissions by Fiscal Year



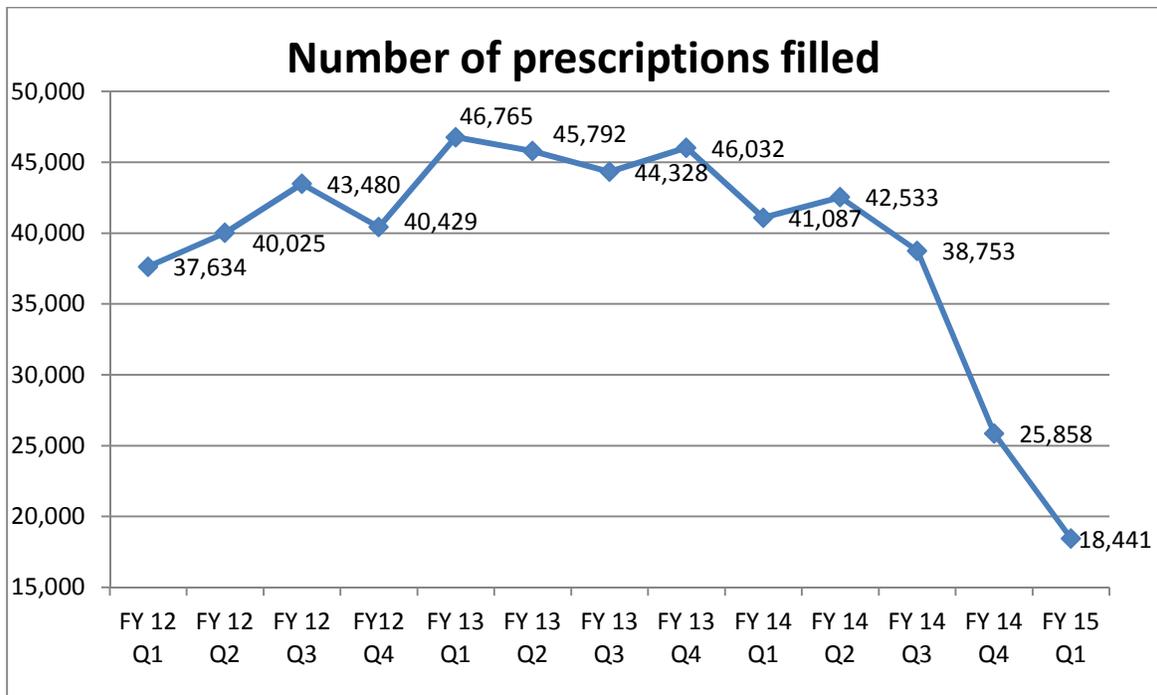
OhioMHAS has closely examined its data and there is not one single reason for the increase in admissions. In general, the state hospitals are subject to the ever-changing health care environment, just like every other provider. We continue to work toward potential solutions to the increase in admissions, including working with the Department of Medicaid to better integrate state services with the Medicaid benefit. While that work continues, the reality is that increased admissions mean increased costs. Our hospitals take pride in their track record of pursuing cost savings and increasing efficiency. In 2006, the average cost per bed day was \$570 compared to \$585 in 2013. Further efficiencies are being pursued by identifying cost

savings in drug prescription practices, efforts to reduce outside contracts for physician coverage, and by re-bidding utility contracts.

Rising costs are compounded by changes in Medicare billing implemented by a new billing intermediary for the state of Ohio which will reduce the amount of Medicare reimbursement collected and as a result, the FY 16-17 executive budget includes a recommendation of an additional \$10 million in GRF funds for hospital operations. It is important to note that overall spending for the state hospitals is increasing by only \$5 million and every effort is being made to continue to hold down costs. In the end, the total proposed GRF appropriation for FY 16-17 remains less than the budgeted amount for FY 11 (a year which had 2,008 fewer admissions.) The increased GRF is simply necessary at this time in order to maintain quality inpatient psychiatric access to Ohioans.

Funding for Community Medications

Previously in my testimony, I discussed the multi-faceted impact of the extension of Medicaid benefits on the mental health and addiction system. One budget impact that has not been discussed is with regard to the need for continued subsidy for community medications. In FY 15, approximately \$9 million was set aside to be used by local boards to pay for medications for indigent clients. Primarily used for psychotropic medications, these funds are also used to supplement medication assisted treatment. Community medication program utilization has decreased 43% since last year because medications are now covered through the Medicaid program, decreasing the need for continued GRF investment. As a result, the 421 Continuum of Care line has been reduced by \$5.6 million per year in FY 16-17.



Administrative Savings

I am proud of the progress that the OhioMHAS team has made over the past 18 months toward the consolidation of two separate agencies into one new agency. You will recall that as a result of the consolidation, OhioMHAS was able to reduce administrative spending by \$1.5 million per year during the last biennium. As a result of a continued focus on streamlining functions, the administrative budget will be reduced by another \$1 million each year in FY 16-17 and the savings will be shifted into services.

House Changes

The House made several adjustments to OhioMHAS GRF lines:

- Reduction of \$2.5 million to 336511 Early Childhood Mental Health Counselors and Consultation
- Addition of \$5 million to a new line 336425 Specialized Docket Support
- Addition of \$4.5 million to 336422 Criminal Justice Services to add funding to the Addiction Treatment Program in order to expand to 16 new named counties.
- Addition of \$120,000 to 336406 Prevention and Wellness to fund efforts by Northeast Ohio Medical University for campus safety and mental health programs

The House also removed temp law sections related to the consolidation of the former departments of mental health and alcohol and addiction services that ensured continuity between the new and old agencies. Also removed was language related to the behavioral health continuum of care that support the redesign of the Medicaid benefit and make it easier for local communities to provide recovery supports. Finally, the House inserted language that will prohibit moving behavioral health into Medicaid managed care.

Chairman Burke and members of the committee, I thank you very much for your time and attention today. It is always a pleasure to work with the legislature as key interested partners to improve Ohio's system of mental health and addiction. I look forward to our continued collaboration, and I am happy to answer any questions at this time.