Comments by Terry Russell
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Before the
Joint Medicaid Oversight Committee
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Thank you Madame Chair and members of the Committee, I appreciate the opportunity to be here to talk to you today about the Medicaid Redesign for behavioral health. By way of background, I am Terry Russell, Executive Director of both the National Alliance on Mental Illness of Ohio and the Ohio Federation for Children's Mental Health. Combined, these organizations serve as Ohio's voice on mental illness for individuals and families across the lifespan.

I have a few comments I would like to make on behalf of those with serious mental illness who rely on the public system for their physical and mental health needs and the families who care about them. Before I do, I have a disclaimer to make. My perspective of the mental health system in Ohio is seen through the eyes of the many people who contact our office or who participate in our educational classes and support groups offered throughout the state. Most of these people are in crisis or have a loved one in crisis. It is on their behalf that I am here today.

To begin, I want to say that NAMI Ohio is grateful to the Administration for placing an emphasis on those who live with serious and persistent mental illness. They are among the most vulnerable people in the state, and we appreciate that Governor Kasich recognizes this and wants to take steps to get them the care they need.

To this end, NAMI Ohio supports the movement of the behavioral health benefit to Managed Care. We believe that the care coordination component that accompanies this process has enormous potential to improve outcomes, especially for the most ill. Too often, individuals with severe and persistent mental illness fall through the cracks because there is no one to help them get and stay connected to needed services and supports. The type of services and supports needed vary from person to person, but should include supportive housing, crisis and planned respite for caregivers, support groups, after school activities for youth, help transitioning from the hospital to the community, and peer support.

Another important feature in the redesign must be the establishment of a consumer and caregiver feedback loop that is built into the infrastructure of the Managed Care Plan. This could include

behavioral health consumer advisory councils, patient experience surveys, or focus groups with a built in process for incorporating the feedback into the delivery of care.

It is also important that in this transition, we do not lose sight of the importance of open access to medications. Despite the success of the exemption for psychiatrists from prior authorization; hurdles are constantly being erected to limit access to other prescribers through the use of step therapy. At a minimum, we believe that step therapy requirements for mental health medications should be transparent and readily accessible to patients and health care providers. In addition, we believe that there should be a clearly defined process for exempting patients from step therapy when it is medically appropriate to do so.

Additionally, we are encouraged by the introduction of antipsychotic medications with fewer side effects and longer acting injectables and hate to see barriers put in place to limit access to these lifesaving medications. I understand that there will be a bill introduced soon to allow properly trained pharmacists to administer injectable medications. This would significantly enhance access, especially for those patients who live a considerable distance from their health care provider and for whom transportation is a barrier to care.

With regard to the 1915i plan amendment, NAMI Ohio strongly supports efforts to replace the spend down program for those living with serious and persistent mental illness. Spend down is incredibly cumbersome and can be very difficult for this population -- many of whom live with confused thinking -- to monitor and manage. We acknowledge that funds for this effort are limited, and as such, we recognize the need to limit eligibility to the most serious and persistent mental illnesses. Additionally, we believe that the range of services specified in the proposal are the right services but would like assurance that these services are going to be available to all of those in Medicaid who meet the eligibility requirements and not just those in the 1915i program. Lastly, with regard to 1915i, we are very concerned about limiting eligibility based on where a person resides. Clearly, individuals living in adult care facilities are some of our most needy yet we are hearing that they may be precluded from receiving Medicaid services. That would be disastrous.

We are encouraged by efforts at the federal level to address the needs of individuals and families in crisis in H.R. 2646 and S. 1945. These bills include provisions to clarify the circumstances in which HIPAA permits health professionals to communicate critical information to family members when their loved one is in crisis, and the inclusion of training for health care providers about the circumstances in which information *can* be shared with caregivers; and creates an exception to the federal law which prohibits Medicaid from paying for acute inpatient care in state or private free standing psychiatric hospitals for those in need of short term (less than 30 days) immediate inpatient care.

Combined, all of these efforts will go a long way toward addressing the needs of individuals in crisis. I look forward to answering any questions you may have.