



Testimony on the State Operating Budget by Sandra Stephenson, Director,
Ohio Department of Mental Health, before the Ohio House of Representatives’
Human Services Subcommittee, March 10, 2009

Good Afternoon Chairwoman Brown, Ranking Member Burke and members of the Ohio House Committee on Finance and Appropriations – Health and Human Services Subcommittee. Thank you for the opportunity to testify today. I am Sandra Stephenson, Director of the Ohio Department of Mental Health (ODMH). I would like to begin with a brief summary of the content of my testimony.

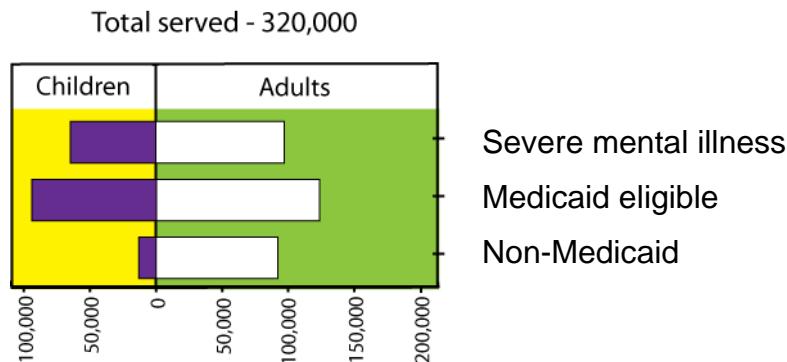
I will first discuss our mission and the environment in which the public mental health system operates; including our history and current challenges. I will continue by outlining how we have managed Fiscal Year ‘08-‘09 budget reductions. Then, I’ll outline our vision of where the system is headed and how the budget proposal before you leads us in the right direction.

I. Current Status and Overview

At ODMH, our core mission is **the promotion and establishment of mental health as a cornerstone of health and wellness for individuals, families and communities throughout Ohio.**

During the past two decades, treatment and support services for mental illness have improved significantly. We know that treatment works! Good treatment is effective, and recovery – to live a long, fulfilling life despite the presence of an illness – is not only possible, but should be our expectation.

ODMH has worked to ensure access to quality mental health services for Ohioans at all levels of need and life stages. In Fiscal Year ‘08, Ohio’s community mental health system provided care to approximately 320,000 people, including more than 100,000 children. Nearly 97,000 of the adults served are disabled by severe and persistent mental illness. More than 7,000 adults were served in our hospital system. These large numbers represent only those receiving direct services and do not include the thousands of Ohioans who benefit from prevention, education and outreach.



In challenging economic times, mental health resources are essential, as Ohioans face unprecedented loss of jobs, health insurance and homes. With this knowledge we continue to look critically at all aspects of our agency and are committed to move forward in a way that best preserves vital services to the community.

Ohio's unemployment rate is now at 8.8%. Research from the North Texas Health Science Center found that for every 1% rise of unemployment across the U.S. there will be corresponding increases in the following:

- 1,800 more suicides
- 1,300 more homicides
- 8,000 more first-time admissions to mental hospitals
- 6,500 more first-time admissions to state prisons

II. The Economic Case for Treatment

It is estimated that nearly two million Ohioans will need mental health services during their lives for problems ranging from situational stress to severe and chronic mental illness. Many people who receive treatment now are able to sustain employment, live on their own, pay taxes, and participate in the community. For almost everyone with a brain disorder, recovery is a hopeful process and treatment outcomes are equal to or better than those achieved in physical healthcare.

Treatment of youth reduces problems and increases functioning.

Based on outcomes rated by parents, after only three months in treatment, **half** of the youths improve and another third are stabilized in problem areas such as delinquency, acting-out and internalizing problems. **Three-fourths** of youth in treatment for three months also show improvement or are stabilized in their functioning in school, at home and in their community, as rated by their parents.

Treatment of adults reduces symptoms of mental illness and increases functioning.

Four out of five adults in treatment of only six months report that they experience stabilized or improved symptoms, such as depression and anxiety. Mental health professionals treating these adults also report that nearly **nine out of ten** in treatment for just six months are stabilized or show improvement in the areas of socialization, role performance and problem behaviors.

The economic impact of not treating mental illness is far greater than the cost of treatment. Mental illness is the second most costly health problem in the United States, after heart disease but ahead of all other health problems, including cancer. It is the leading cause of suicide and the leading health-related cause of disability, a driver of chronic homelessness and school failure, a significant challenge in the adult and juvenile correctional systems, and a major consequence of child abuse and trauma. If left untreated, mental illness costs Ohio more than \$5 billion annually, with most of the cost arising from lost productivity and other associated problems.

Though treatment is successful and justified economically, many people who need mental health care still do not get it. Barriers include poor detection of mental illnesses by general health practitioners, inability to pay and reluctance to seek care. Stigmatization and the belief that effective treatments do not exist remain serious barriers to seeking care.

III. The Public Mental Health System

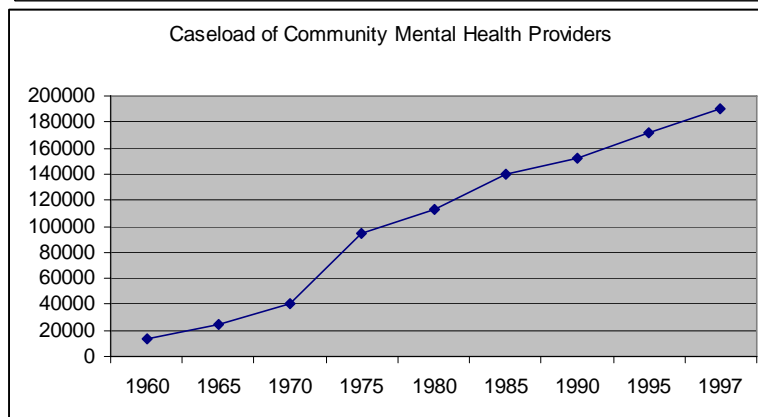
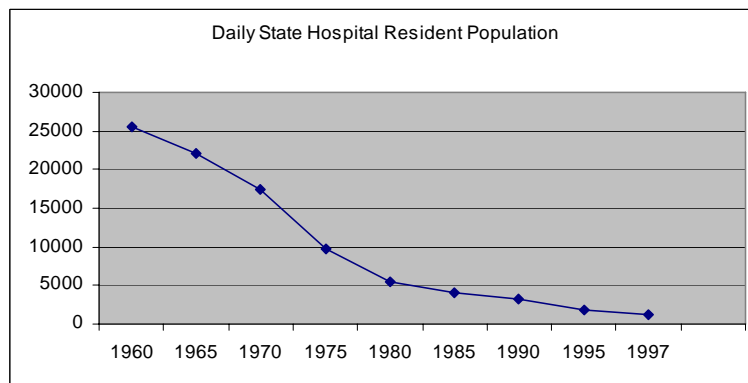
While most Ohioans have some insurance coverage for mental illness, people with severe and persistent mental disorders, such as schizophrenia, bipolar disorder or major depression often end up disabled, poor and dependent on the public system. This public system serves as a safety net, providing for the uninsured, people of poverty and consumers who require more specialized care.

The state bears the responsibility to provide hospital care as defined in Ohio's Constitution. As attitudes have changed and treatment progressed, more and more opportunity exists for consumers to successfully live in the community. ODMH has a proud history of using advances in treatment to improve consumer outcomes. The significant shift from institutional care to less costly community care from the 1950s through the 1990s has increased system efficiencies, decreased staffing, and promoted the right of citizens to receive care in the least restrictive environment.

A catalyst of community-based care was the Mental Health Act of 1988, which redirected funding from client care in the state hospital system to community-based services. A major feature of this legislation was an option given to county mental health boards to accept the risk and responsibility to pay for inpatient services provided to their residents at state psychiatric hospitals in exchange for an additional allocation of state funds. This fostered an environment that stimulated an appropriate balance between community and institutional care.

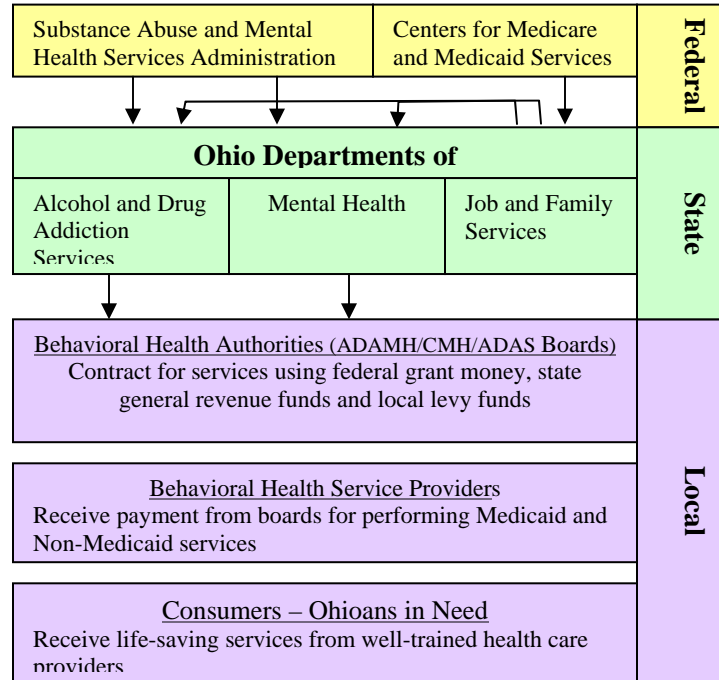
Through the legislation, incentives were constructed into agency line item 334-408. These funds make up the safety net required for youth and adults with severe and persistent mental illness, including hospitalization and essential services (medication, community-based services, crisis care, housing and employment) that allow individuals with serious mental illness to live successfully in the community. The department retains the primary responsibility to provide care to forensic patients and thus holds that money at the state-level. The money remaining in the line item incentivizes boards to use fewer hospital days by distributing the money they do not use in our hospitals directly to them to support community services.

The Act was truly transformational and the 'tension' it created to maintain this balance between hospital and community care is part of the platform from which the publicly-funded mental health system operates today. Formerly focused on long-term institutionalization, state hospitals have become small and specialized facilities providing short-term and intensive treatment as requested by local systems.



The organizational structure of the public mental health system reflects the dynamics of the flow of resources into treatment, including the hospital/community balance and the growing Medicaid population.

The community-based system consists of 50 local behavioral health boards and more than 400 private, generally not-for-profit providers, who deliver clinical services. Each board is required to submit an annual community plan for approval by the department.



IV. Management of Budget Reductions for Fiscal Years '08 and '09

Early last year, all state agencies were asked to work with the Office of Budget and Management to examine our needs based on the reality of our economy. We looked critically at all functions, balancing our core mission with the knowledge that mental health needs would increase. We took the following actions to move forward in a way that preserved our ability to serve the people of Ohio.

Budget reductions in dollars and percentages

	FY2008 original appropriation	FY 2009 adjusted	% Change	FY 2010	% Change
Central Office	\$23,750,000	\$20,240,000	-15%	\$17,204,000	-15%
Hospitals (408-hospital)	\$197,159,603	\$177,498,357	-10%	\$181,703,170	2%
Community (408-community, 506, 404, 405, 419, 505, 636)	\$320,388,761	\$319,079,883	0%	\$309,653,331	-3%

Budget reductions in FTEs

	7/1/08	Current	% Change
Central Administration	278	216	-22%
Hospitals	2,166	1,981	-9%

V. Challenges the Current System Faces

Escalating financial constraints during the past decade have placed the system in a tenuous balance of service delivery that is at a breaking point. The current financing structure for behavioral health creates an inherent system of inequity that results in inconsistent levels of consumer access and service delivery across the state. We are grateful that one-time federal funds will stave off significant cuts for the time being. However, we must continue to reform the behavioral health financing system to achieve efficiencies and controls that will lead to long-term sustainability. Both the local board and provider systems are under a great deal of stress. We must work together to reduce regulatory burdens and free up resources to serve those most in need.

Increasing pressure of Medicaid match for the local boards

A major strain on the local behavioral health boards is the responsibility to pay Medicaid Match. Boards are reimbursed approximately 60 percent of the cost for Medicaid services by the federal government. The remaining cost – or match – comes from both state and local sources. The state's portion comes in the form of allocations to the boards. However, these funds are also needed to purchase other critical, non-Medicaid services such as housing, housing supports, prevention programming, and vocational supports. These services are vital for consumers to live successfully in the community.

Medicaid is Ohio's largest single payer of behavioral health care services. Since 1998, the program has successfully enabled Ohio to leverage more than \$2.2 billion in federal reimbursement. However, a growing Medicaid program increases pressure on boards to ensure match dollars are available. This causes heavy reliance on local levy funds as boards feel continued pressure to use local dollars to meet their match obligations. About 40% of all consumers are indigent and uninsured, but not Medicaid eligible, and boards and providers are struggling to ensure services are available to this population as well.

Rising costs and stagnant reimbursement rates strain the provider system

A major strain on the provider system is increasing operational costs coupled with stagnate reimbursement rates. For the past decade, community Medicaid payment rate ceilings have not increased. In this environment, providers are unable to offer competitive salary and benefits to professionals, to invest in training for evidence-based practices, and to purchase advanced technology. Furthermore, there is a disincentive to realize efficiencies because the current Medicaid cost reconciliation structure doesn't allow providers to recoup their own savings. This financial pressure on providers coupled with recent budget reductions has placed programs and direct service staff at risk of being cut.

Goals toward sustaining the system

Together, the Departments of Alcohol and Drug Addiction Services (ODADAS), ODMH and Job and Family Services (ODJFS) are committed to proposing solutions that stabilize and sustain our system for both boards and providers, and most importantly, ensure an appropriate level of services for consumers. The reforms our agencies are constructing are intended to improve three significant areas: consumer access, transparency, and accountability.

State departments -- along with consumers, advocates, local boards and providers -- must be compelled to work together through the short-term challenges. The overarching goal is to design a system that maximizes consumer access, statewide consistency, administrative efficiency, compliance with federal Medicaid requirements and most importantly, sustainability.

In spite of the current financial situation, we will continue the efforts we've already started to achieve this goal while we focus on our core values and our mission. This will enable us to continue to provide the safety net for our most vulnerable Ohioans.

The elements of sustaining the system

We have ongoing work on specific initiatives that, upon completion, will bring us closer to our goals. I'll summarize them briefly, but welcome your interest at any later date to discuss our efforts in more detail.

Infrastructure initiatives

- The *Executive Medicaid Management Administration (EMMA)* was created in House Bill 119 of the 127th General Assembly as a platform from which to encourage statewide collaboration around Medicaid. The Ohio Departments of Aging, Health, MR/DD and Education along with OBM, ODJFS, ODADAS and ODMH each participate. By gaining a more holistic view of the system we serve our citizens better and gain efficiencies.
- *The Medicaid Information Technology System* will connect all the Medicaid agencies allowing for greater control, communication and coordination of services.
- *The Unified Long-Term Care Budget* came out of a workgroup established by HB 119. The purpose of the work is to streamline services to our unique populations who need long-term care for various reasons. By promoting a “no wrong front door” message, we will streamline cost and improve services.

Deregulation

ODADAS and ODMH are working on a demonstration project and plan to examine legislation, rules, policy and technology to assess their impact on providers and determine how barriers to services can be eliminated by reducing burdensome or unnecessary regulations, reducing administrative overhead and driving more dollars into consumer services.

Medicaid initiatives

- *Medicaid Elevation* moves Medicaid responsibility to the state level, allowing ODMH and ODADAS to accurately monitor, plan for and manage Medicaid growth and ensuring the program is administered statewide as federally required. It also returns the ability of local boards to meet unique community needs by assuring their planning capacity for state allocations and local levy funds, rather than requiring them to use these funds to finance Medicaid match.
- *Medicaid Fee Schedule Implementation* will help alleviate a portion of the financial stress felt by our provider system. It will enable them to utilize good business practices which provide the proper incentives for efficiencies and quality clinical services.
- *Surveillance and Utilization Review (SUR)* is a fully functioning statewide program that focuses on accountability from providers by monitoring potentially duplicative and/or unnecessary service. It is necessary to support a fee schedule reimbursement methodology and it addresses provider regulatory burden.
- *The Certified Public Expenditure (CPE)* process verifies amounts and sources of funds used to pay Medicaid claims within the system. This process enhances state financial modeling ability, assuring federal compliance and improving transparency.

Consumer Access and Choice Initiatives

- *Amount, duration and scope* is used to define the core set of services and set maximum availability of these services.
- *Benefit Packaging* is an administrative framework that supports utilization management at the local level.
- *A Common Set of Finance principles* provides a tool supporting a core set of treatment, prevention and recovery support services. Understanding what we value allows us to

invest in what matters instead of relying upon an outdated formula based upon historical data. These formulas currently in use do not reflect current demand or need and over time have resulted in inequitable levels of access based upon county/board area of residence.

VI. Executive Budget FY10-11

As an agency heavily reliant upon General Revenue funds, we are grateful that the Governor had the wisdom to allocate federal stimulus dollars to preserve the integrity of the mental health safety net.

Community and Hospital Mental Health Services (334-408)

As noted earlier when speaking about the transformation that happened in our system back in 1988, ALI 334-408 is our largest and most important source of funding. These funds are the primary source of support for: (1) the operation of ODMH's regional hospital system's operating budgets; (2) the 50 Alcohol, Drug Addiction and Mental Health Services/Community Mental Health Boards (ADAMHS/CMH) that plan and monitor community mental health services for consumers, including children and their families; and (3) the community mental health agencies that provide these services. In FY2010 and 2011 ODMH will hold **\$121,190,000** off the top for forensic patients, and distribute **\$85,810,000** to the boards for civil admissions. The remaining **\$176,724,688** will be distributed to boards to pay for community services.

Children's Behavioral Health Initiatives

ODMH is proud to continue Governor Strickland's focus on programs that provide prevention, education and direct clinical services to children. Though we initially faced more severe cuts in every part of our budget, these two line items have been restored to 95 percent of the FY09 as appropriated after the first round of budget reductions.

➤ Family and Children First (335-405)

This program is a partnership of child-serving government agencies and community organizations. The primary focus of Family and Children First is low-income, at-risk, and multi-needs children and their families

➤ Behavioral Health Services - Children (335-404)

System of Care (SOC), formerly known as Access to Better Care (ABC), is a major children's initiative developed to respond to the growing realization that under-serving children with behavioral healthcare needs result in increased costs in other areas. More specifically, lack of access to care can lead to school failure, suicide, criminal behavior, unwanted pregnancy, and other costly problems that present a growing challenge for Ohio's education, foster care and juvenile justice systems. With the involvement and input of families, advocates, and state and local leaders, the SOC initiative has an emphasis on early intervention, and intensive home- and community-based treatment services.

Local Mental Health Systems of Care (335-505)

In FY09, this line item was funded at \$64,123,194. In FY10 it decreases 59.5 percent and then another 52.8 percent in FY11 with a resulting total of \$12,259,000. Before federal stimulus dollars were confirmed, it was critical with the shortfall we faced to preserve the tension in ALI 334-408 and sustain the current platform of the system. We did this by moving our ALI 505 GRF dollars into the 408 line item. For this reason, we were grateful for the inclusion of **Local Mental Health Subsidy - Federal Stimulus (335-636)** as it will help to offset any losses. This will allow us to use the next two years as planning time.

Federal Stimulus Funds

As you know, the executive budget was constructed based on the House passed version of the federal stimulus bill. At that time, the bill included a large flexible fiscal stabilization fund and enhanced FMAP. The final plan adopted by congress had a smaller fiscal stabilization fund but more enhanced FMAP. Our final budget was based on the new array of federal resources and federal tax policy changes that impact Ohio's revenues. As a result of this strategy, ODMH was able to increase funding compared to Fiscal Year '09 and Executive Budget levels.

- **Local Mental Health Subsidy - Federal Stimulus (335-636)**
This new line item houses the stimulus money being brought in by the fiscal stabilization fund. This line item along with the partial restoration of ALI 335-505 will allow the department to continue such successful programs as Behavioral Health /Juvenile Justice, Red Flags – suicide prevention in our school systems and Crisis Intervention Training – education for our police officers to better recognize and address mental illness while on in the field.
- **Increased Federal Medical Assistance Percentages**
From the Department of Mental Health, FY09 GRF county board subsidies are estimated at \$257.2 million. In FY10 county boards will receive \$277.6 million in GRF subsidy along with enhanced federal reimbursement of \$44.3 million. In FY11 county boards will receive \$282.8 million in GRF subsidy along with \$20.4 million in enhanced federal reimbursement.

Significant Policy Changes

We would appreciate your support on the significant policy changes contained within the language of the budget bill. We have provided a detailed handout on those four language changes.

- *Medicaid elevation* creates a workgroup to bring behavioral health stakeholders and policymakers together to plan for the transition of the financing responsibility and related management functions.
- *County collaboratives*, as local entities, should be able to make planning decisions to share costs or gain efficiencies. This language will allow ODMH the permissive authority to fund these partnerships.
- *Data collection* updates and clarifies ODMH's role related to data collection, pursuant to the Health Insurance Portability and Accountability Act (HIPAA).
- *Administrative fee cap* provides ODMH with the ability to set limits on the amount of administrative fees on allocations that boards receive from the state.

Stakeholder Outreach

ODMH has worked to strengthen communication with our key stakeholders. Specifically I and key leadership staff traveled to our seven regional psychiatric hospitals recently to engage in open dialogue with hospital employees, consumers, family members, boards, providers and advocacy groups. The purpose of the meetings was also to listen regarding issues around the state of recovery and resiliency in Ohio based on current allocation reductions. Participants were encouraged to share what they are experiencing at local level and offer any ideas and/or solutions they might have. Additionally, ODMH gave a brief overview of our newly developed strategic plan and shared any new information we had on our developing budget.

We hope to continue this exchange of ideas in the spirit of collaboration for the benefit of Ohioans. Thank you very much for your time today. At this time I will happily entertain any questions you may have for the department.