Testimony on H.B. 1
Ohio Senate Finance and Financial Institutions
Director Sandra Stephenson
April 30, 2009

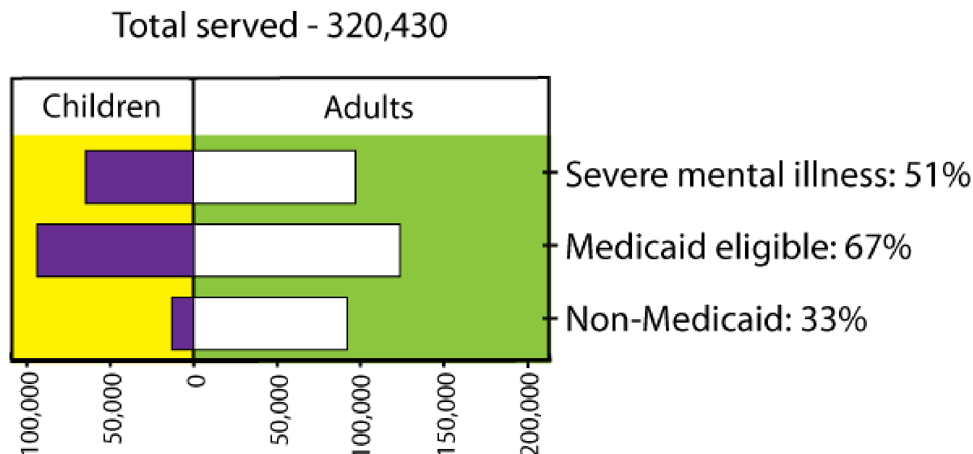
Current Status and Overview

At the Ohio Department of Mental Health (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 a mental illness – is not only possible, but should be our expectation.

ODMH works to ensure access to quality mental health services for Ohioans at all levels of need and life stages. Each year, it is estimated that approximately two million Ohioans will need mental health services for problems ranging from situational stress to severe and chronic mental illness.

In state fiscal year 2008 (FY 08), Ohio's community mental health system provided care to approximately 320,000 people, including more than 100,000 children. More than 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.



The Economic Case for Treatment

Many people who receive treatment are able to sustain employment, live independently, pay taxes and are active in their communities. For almost everyone with a brain disorder, recovery is a hopeful process and treatment outcomes are equal to or better than those in physical healthcare.

Youth Outcomes (at three months)

According to surveyed parents, **half** improve and another **third** are stabilized in areas such as delinquency and acting-out.

Three-fourths show improvement or are stabilized in their functioning in school, the community and at home.

Adult Outcomes (at six months)

Four out of five report stabilization or improved symptoms related to depression and anxiety.

Mental health clinicians report nearly **nine out of ten** patients are stabilized or improve in socialization 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.

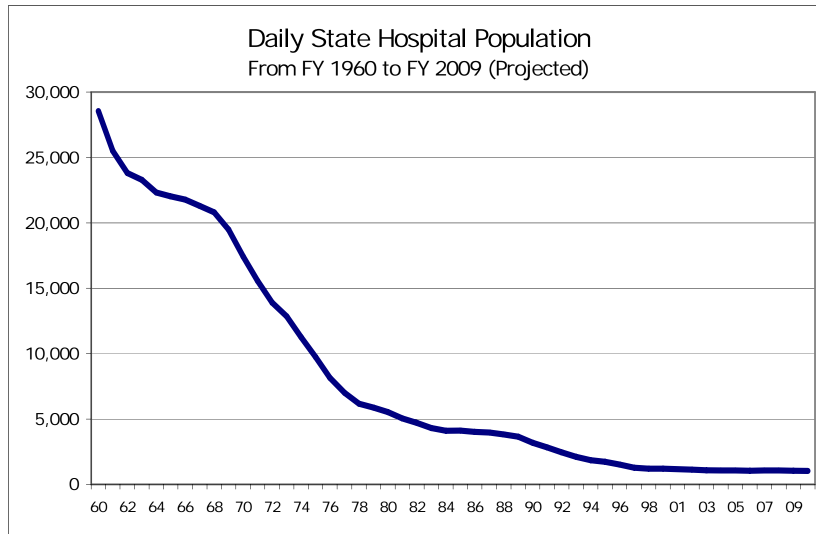
Though treatment is successful and justified economically, many people who need mental health care still do not get it. Barriers include poor detection of mental illnesses by general health practitioners, inability to pay and reluctance to seek care. Stigmatization and the belief that effective treatments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

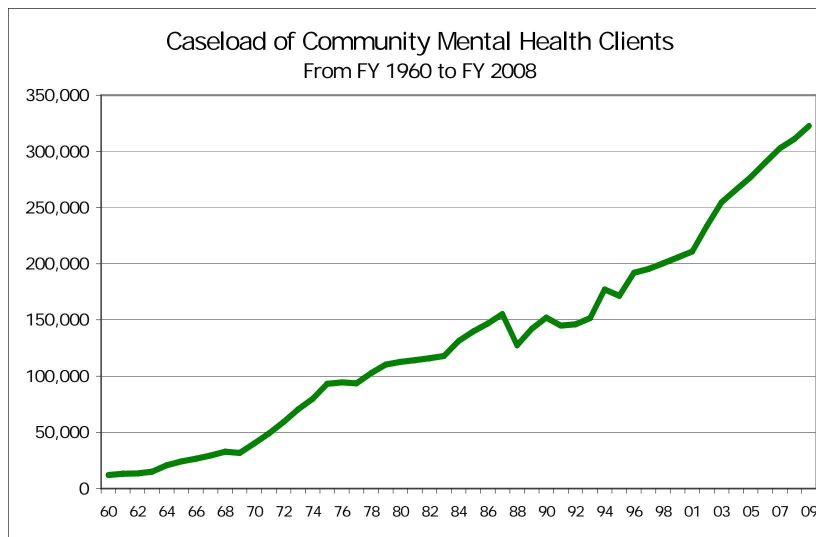
The Public Mental Health System

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 provides for the uninsured, people of poverty and consumers who require more specialized care.

As attitudes have changed and treatment progressed, more and more opportunity exists for consumers to successfully live in the community. The significant shift from institutional care to less costly community care from the 1950s through the 1990s increased system efficiencies, decreased hospital staffing and promoted the right of citizens to receive care in the least restrictive environment.





<u>Notes:</u>

1. Daily state hospital population based on average daily resident figures by fiscal year.

2. Community caseloads represent end of the year figures from 1960 to 2000. From 2000 to 2008, caseloads are based on unduplicated clients served in the MACSIS billing and reporting system.

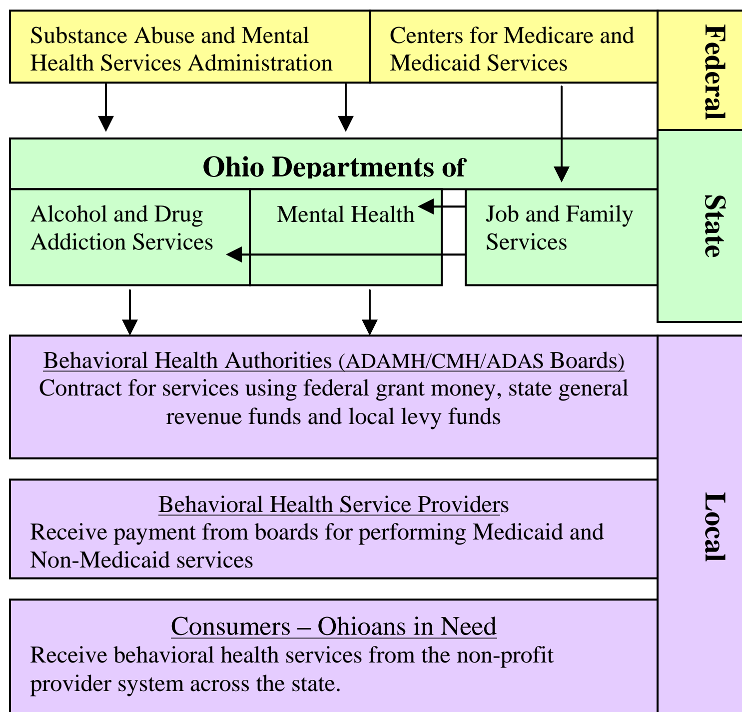
Ohio Mental Health Act of 1988

A catalyst of community-based care was the Ohio 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 boards to accept the responsibility of paying 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 dollars fund services 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 mental illness to live successfully in the community.

The department retains the primary responsibility to provide hospital-level 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 support community services.

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



The community-based system of service delivery is divided into two major systems:

- Fifty local behavioral health boards receive both state and federal flow-through dollars from ODMH. These funds, coupled with local levy dollars where applicable, are used to pay for services from various provider agencies as determined by the unique mental health needs of the region.
- More than 400 private providers deliver clinical services and other essential supports. The providers are a generally not-for-profit system of small businesses that employ approximately 26,000 Ohioans across the state.

Management of Budget Reductions for FY 08-09

In challenging economic times, mental health resources are essential, as Ohioans face unprecedented loss of jobs, health insurance and homes.

Unemployment trends and service need

The North Texas Health Science Center found that for every 1% rise in unemployment across the United States there will be increases in the following incidents:

- 1800 more suicides
- 1300 more homicides
- 8000 more first-time admissions to mental hospitals
- 6500 more first-time incarcerations

According to the Department of Job and Family Services unemployment in Ohio has risen 4.2 % from January 2008 to March 2009.

In January 2008, all state agencies were asked to work with the Office of Budget and Management (OBM) 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. To move forward in a way that best preserved our ability to serve the people of Ohio, we took the largest percentage reduction at central office followed by the second largest percentage from the hospital system. Prioritizing reductions in this way enabled us to hold the community harmless for as long as possible.

Budget reductions in dollars and percentages

	FY 08 Original	FY 08 Adjusted	% Change	FY 09 Original	% Change	FY 09 Adjusted	% Change
Central Office	23,750,000	21,696,000	-8.9%	23,750,000	9.5%	20,240,000	-14.8%
Hospital	197,159,603	192,159,603	-2.5%	171,822,422	-10.6%	171,822,422	0.0%
Community	328,263,311	328,263,311	0.0%	333,547,594	-1.6%	293,079,226	-12.1%

Budget reductions in FTEs

	7/1/2008	Current	% Change
Central Administration	278	216	-22%
Hospitals	2,166	1,981	-9%

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 across the state.

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 have been reimbursed approximately 60 percent of the cost for Medicaid services by the federal government. This reimbursement will be enhanced due to the American Recovery and Reinvestment Act (ARRA) for 27 months resulting in an approximate increase of 8-10 percent. 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 percent 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 salaries and benefits to

professionals, to invest in training for evidence-based practices, or to purchase advanced technology. Furthermore, there is a disincentive to realize efficiencies because the current Medicaid cost reconciliation structure does not 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.

Stakeholder outreach

Together, with the Departments of Alcohol and Drug Addiction Services (ODADAS) and Job and Family Services (ODJFS), ODMH is 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.

State departments -- along with consumers, advocates, local boards and providers -- must be compelled to work together through short-term challenges. ODMH has worked to strengthen communication with our key stakeholders through ensuring equal participation on several system-wide, issue-specific workgroups and committees, as well as through organized open invitation forums that have taken place at our regional hospitals.

Goals toward sustaining the system

The overarching goal is to design a system that optimizes consumer access, statewide consistency, administrative efficiency, compliance with federal Medicaid requirements and most importantly, sustainability.

Despite the current financial situation, we will continue the efforts we have already started to achieve this goal while we focus on our core values and our mission. This will enable us to ensure the provision of behavioral health services for our most vulnerable Ohioans.

The elements of sustaining the system can be organized into four main categories for reform: Infrastructure, Deregulation, Medicaid and Consumer Access.

<u>Infrastructure</u>

- 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, Education and Mental Retardation and Developmental Disabilities 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 costs and improve services.

Deregulation

- *The Deregulation Demonstration Project* examines 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

- *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 use of 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 currently in use and housed at ODJFS. SUR 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

- *Amount, Duration and Scope* are applied to define the core set of behavioral health services and set optimum availability of these services.
- *Benefit Packaging* is a clinical 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 on the current formula based upon outdated historical data. These formulas in use do not reflect existing demand or need and over time have resulted in inequitable levels of access and service options based on residence.

Executive Budget FY 10-11

Community and Hospital Mental Health Services (334-408)

These funds are the primary source of support for: (1) the operation of ODMH's regional hospitals; (2) the 50 local boards that plan and monitor community mental health services for consumers, including children and their families; and (3) the community mental health providers that deliver these services. In FY 10-11 ODMH will hold **$120,537,225** off the top for forensic patients and distribute **$86,462,775** 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. These programs are funded through two main line items: Family and Children First (335-405) and Behavioral Health Services - Children (335-404).

- *Family and Children First* 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* is the primary funding source for System of Care (SOC), formerly known as Access to Better Care (ABC). SOC is a major children's initiative developed to respond to the growing realization that under-serving children with behavioral healthcare needs results 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.

One-time Dollars: From Federal Stimulus to General Revenue Funds (GRF)

Our budget as introduced was based on the final ARRA adopted by Congress containing an array of federal resources and federal tax policy changes that impact Ohio's revenues. Before these federal stimulus dollars were confirmed, it was critical with the shortfall we faced that we

preserve the tension in 334-408 and sustain the current platform of the system. We did this by moving our 335-505 GRF dollars into the 334-408 line item. For this reason, we were grateful for the inclusion of Local Mental Health Subsidy - Federal Stimulus (335-636) in the as introduced version of the budget.

In the House, 335-636 saw a dramatic reduction coupled with an infusion of GRF dollars back into 335-505. Though we continue to be grateful for the dollars, we must register our related concern: This additional money – no matter the source – is likely to not be available to Ohio in the FY 12-13 biennium. In order to prepare for significant loss of future revenue, we must use the next two years to plan for and renew our commitment to reform.

- *Local Mental Health Systems of Care (335-505)* supports additional funding for basic services including: crisis intervention/hospital pre-screening; counseling and psychotherapy; community support program services; diagnostic assessment; consultation and education; and residential housing. In addition, these funds also support systemic improvements in service delivery including recovery, resiliency, SOC, school success, employment, evidence-based practices, quality improvements, and cross-system collaboration.
- *Local Mental Health Subsidy - Federal Stimulus (335-636)* originally housed the stimulus money brought in by the fiscal stabilization fund. This line item along with the partial restoration of 335-505, will allow the department to continue such successful programs as Behavioral Health /Juvenile Justice, suicide prevention programs in our school systems and Crisis Intervention Training, which is education for our police officers to better recognize and address mental illness while in the field.
- *Increased Federal Medical Assistance Percentages (FMAP)* were also contained in the ARRA. In FY 10 county boards will receive **$44.3 million** in enhanced FMAP which will supplement GRF subsidy. In FY 11 they will receive **$20.4 million** in enhanced FMAP.

Significant Policy 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.
- *Community Behavioral Health Services Study* creates a group to deliver implementation recommendations on two ongoing initiatives: Amount, Scope and Duration and Benefits Packaging.
- *County collaboratives* allows local entities to make planning decisions to share costs or gain efficiencies. This language will allow ODMH the permissive authority to fund these partnerships with the agreement of the local entities.

- *Data collection* updates and clarifies ODMH's role related to data collection, pursuant to the Health Insurance Portability and Accountability Act (HIPAA).
- *Exchange of treatment information* closes the gap between current provisions in Ohio's mental health statute and HIPAA regarding community mental health agencies and other health care providers for purposes of continuity of care.
- *Administrative fee cap* provides ODMH with the ability to set limits on the amount of administrative fees within allocations that boards receive from the state.
- *Medicaid Administrative Claiming* is language that recognizes the department's commitment to work with ODJFS to position boards to draw federal dollars for their present claiming functions. The initiative in contingent upon CMS approval

Conclusion

We are grateful that an influx of one-time federal funds will stave off significant cuts for the time being. However, despite these stimulus dollars being traded for GRF through changes made in the House, we must continue to anticipate their absence in the next biennium. Reform of behavioral health financing is absolutely vital to ensure our system is prepared for FY 12-13. We must 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. ODMH is committed to continue to work with all constituency groups to reduce regulatory burdens and inefficient infrastructure to free up resources to serve those most in need.