



Department of Mental Health

John R. Kasich, Governor
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Ohio Department of Mental Health
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Good morning, Chairman Burke, Ranking Member Goyal, and members of the House Finance Health and Human Services Subcommittee. I appreciate the opportunity today to discuss the Fiscal Years 2012-13 budget for the Ohio Department of Mental Health.

The Department offers an array of services and supports to Ohioans. In total, more than 200,000 adults and 100,000 youth are served through the mental health system annually. To do this, we work with 50 Alcohol, Drug Addiction and Mental Health or Community Mental Health Boards and more than 400 community providers, promoting mental health as a cornerstone of overall health. The Department also operates six regional psychiatric hospitals across the state to treat adults with mental illness, including those with a forensic status admitted through the justice system. In addition, we license private psychiatric hospitals and certify community mental health services. Our Office of Support Services provides pharmaceuticals, supplies and food to state facilities and other community agencies.

During my time as director, we have been reviewing our key programs and engaging stakeholders in the process. For example, the Transitions committee includes consumer and family representatives, as well as community provider and county board executives. It is clear that there are a number of fundamental principles on which the department and its stakeholders can agree:

- People deserve treatment services which are medically necessary and appropriate.
- To recover, individuals need behavioral health treatment AND better overall health care, a place to live, a job to provide income and social opportunities for support.
- Ohio's Mental Health Act of 1988 was focused on the right philosophy – community-centered treatment – but it has been historically underfunded.
- Financial predictability and sustainability are critical to the system of care.
- Locally generated resources should be available for local priorities.
- Common sense government must eliminate unfunded mandates and reduce arduous regulation.

This budget contains a series of major reforms within the mental health system, which I will summarize in my testimony today. To enact these reforms, we have significantly restructured our agency's line items. Most notably, the traditional "408" line item is eliminated and in its place are separate and distinct GRF line items for the department's three main subsidy purposes: state hospital care, Medicaid payment and non-Medicaid community services. Further reform in Fiscal

Year '13 moves Medicaid funding within our department to the Ohio Department of Job and Family Services. This results in a slight increase of 4.4 percent in GRF for the mental health system in FY '12 and a slight decrease of 4.6 percent in FY '13. In some instances, people looking at the budget lines have misinterpreted this as a large cut. However, it is simply a movement of funds that will continue to pay for the same behavioral health services to Medicaid-eligible consumers, only through ODJFS line item 525. The overall impact of the ODMH budget is shown in the chart below. In FY '13, appropriation of \$163.5 million GRF and \$292.5 million federal share will appear in the ODJFS budget instead of the DMH budget. The second row of this table demonstrates the year-over-year funding change including those resources.

	FY 11	FY 12	Change	FY 13	Change
GRF	\$461.6	\$482.1	4.4%	\$296.3	-38.5%
GRF – incl. Medicaid approp. to JFS	\$461.6	\$482.1	4.4%	\$459.8	-4.6%
All Funds	\$1,196.5	\$1,076.5	-10.0%	\$544.6	-49.4%
All funds - incl. Medicaid approp. to JFS	\$1,196.5	\$1,076.5	-10.0%	\$1,000.6	-7.0%

Funds are in millions. Numbers exclude dollars from extension of enhanced FMAP.

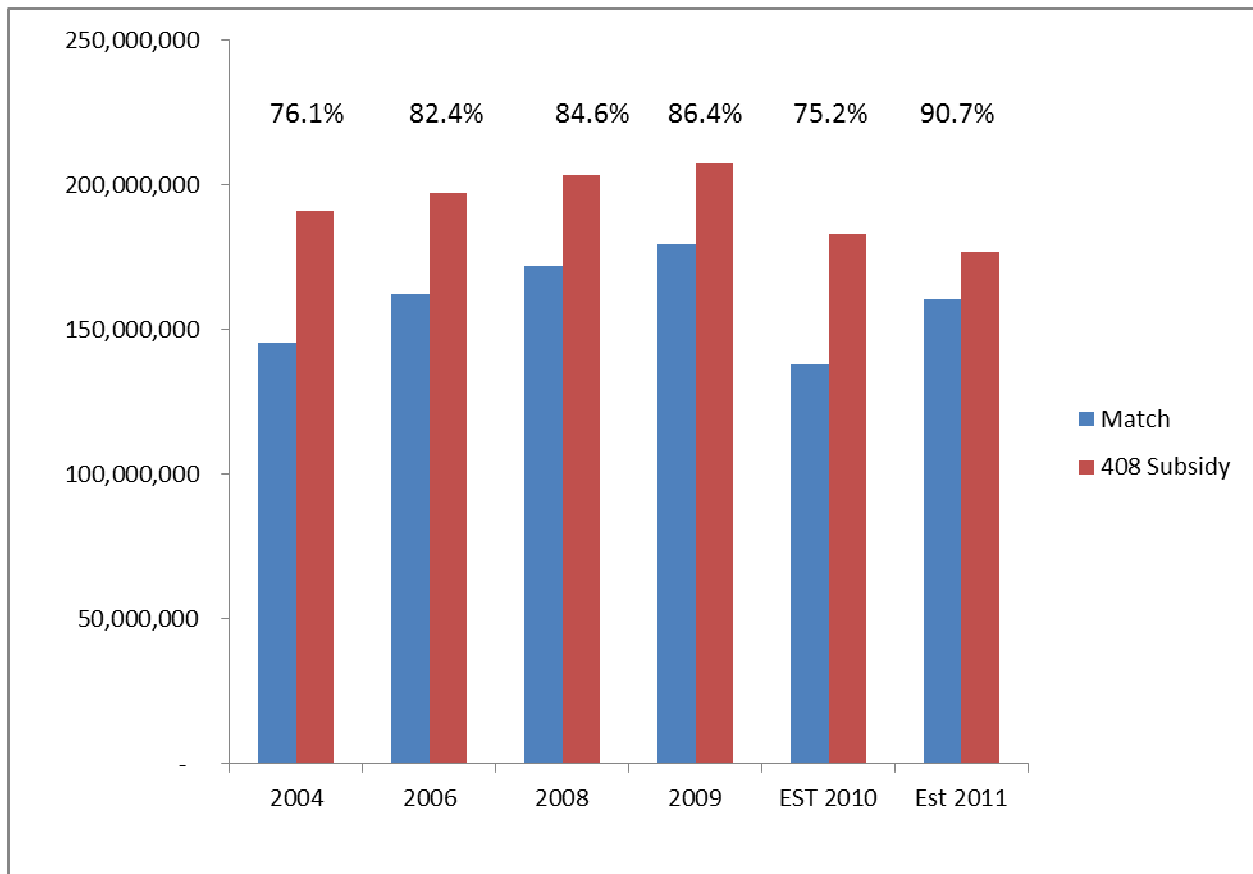
Medicaid “Elevation”

The role of Medicaid in our system was discussed during Office of Health Transformation testimony before the full Finance Committee. The Executive Budget shifts responsibility for all behavioral health Medicaid funding and program management to the state level.

- In Fiscal Year '12, boards will continue to reimburse providers and process claims for Medicaid through Mental Health’s payment system, MACSIS, as they are currently doing. However, the financial responsibility will be the state’s -- funds for these Medicaid claims will be forwarded to the boards from the Department’s new 501 line item.
- In Fiscal Year '13, the funding for Medicaid claims moves from the Mental Health budget to Job and Family Services’s 525 Medicaid line. JFS will take over the responsibility of paying providers directly rather than paying through the local boards. Discussions have already begun with JFS on the mechanism to be used to accomplish payment, and we will involve boards in planning for the logistical changes as well.

The decision for the state to take on the financial responsibility of Medicaid claims was made because we recognize that Medicaid in the behavioral health system is not sustainable as currently designed. In recent years, boards have reported an increasing need to use local levy and other non-Medicaid sources of funding to meet their Medicaid obligations. This trend would continue to siphon local funds, building toward 2014 when federal health care reform increases eligibility and will add significantly to the Medicaid caseload.

Medicaid Match compared to Line Item 408 Subsidy with ARRA



The chart above shows the growth in overall Mental Health Medicaid match (non-Federal share) between 2004 and 2011, and the proportion of the major GRF subsidy line item used by the boards to pay the match. The effect of the enhanced FMAP can be seen in Fiscal Year 2009 through 2011. Although the subsidy line item decreased substantially over this time period, the enhanced reimbursement provided through the American Recovery & Reinvestment Act (ARRA) offset the subsidy reduction. Even with the additional ARRA funding, it is estimated that Medicaid will consume 90.7 percent of the 408 subsidy in FY 11. Following this trend forward, the Medicaid program is an unsustainable obligation for the board system.

Another key factor, not shown in the graph, is that Medicaid expenditures for community mental health services grew by \$83.1 million from State Fiscal Year 2005 to 2009, a growth rate of 20.8 percent. The increase in the number of Medicaid clients being served on a monthly basis accounted for over \$68.8 million (or 83 percent) of this growth, while the increase in monthly expenditure per client accounted for \$13.7 million (or 17 percent) of the total growth. Without the ARRA stimulus resources, there would not have been enough GRF subsidy to support the growing match obligation in Fiscal Year 2010 or 2011. Due to the growing proportion of funds used for Medicaid match at the local level, the department is “elevating” the Medicaid match obligation to the state. This also results in more consistency with the rest of Medicaid.

Medicaid Cost Containment

As the state takes on responsibility of funding the Medicaid services for behavioral health, it will also manage the benefit and impose moderate cost containment measures. Historically, Medicaid services in Ohio's behavioral health system have not been limited by factors such as amount, scope or duration. The Department has been engaged with stakeholders for the past 18 months to discuss potential benefit package and service limitations which will continue to allow people with mental illness to get the care they need. This process, led by our Transitions work group, examined Ohio data as well as practices in other states.

While consensus was not reached among work group members, the Department will use their work as the basis for plans to implement service utilization limits, payment modifications and parameters for community mental health benefits for long-term nursing facility stays. The chart below compares the discussions of the team (again, no consensus) to what is assumed in the budget. We continue to be engaged with providers and other stakeholders to incorporate their feedback on these limits and on the best way to operationalize the draft changes.

Service	Workgroup	Proposed	% of clients not impacted
Community psychiatric supportive treatment	130 hours	104 hours	96%+
Pharmacy management	24 hours	24 hours	98%+
Counseling	100 hours	52 hours	97%
Diagnostic assessment by an MD	4 hours	2 hours	95%
Diagnostic assessment	10 hours	4 hours	90%+
Partial hospitalization	90 days	30 days	50%

*Children are entitled to all medically necessary services per EPSDT requirement.

I would like to take an opportunity to highlight one service listed in the table above by way of example. *Community psychiatric supportive treatment* (CPST) encompasses an array of services delivered by individual professionals or multidisciplinary teams to address the mental health needs of each client. Clients served include adults, children, adolescents and family members. The intent of CPST is to provide specific, measurable and individualized services, which can vary with respect to hours, type and intensity, depending on the person.

The Ohio Department of Mental Health has proposed basic benefit limits that specify the amount, frequency and duration of services as required by federal Medicaid regulations. With CPST, the department has proposed a benefit limit of 104 hours per year. Ohio billing data over the last five years shows that 104 hours falls in the 96 percentile. This means that 96 percent of clients who received CPST services in SFY 2008 received 104 hours or fewer. The average annual rate of use for adults is currently 18.2 hours for individual treatment and 26.9 hours for group treatment. For children, the average annual rate of use is 16.7 hours for individual and 21.8 hours for group. So in a substantial majority of cases, actual CPST usage is far below the annual ODMH proposed limits.

ODMH reviewed evidence-based practices to assure that these limits would not impact a community provider's ability to utilize those best practices. The Program of Assertive Community Treatment (PACT) is the most researched evidence-based practice; it promotes two hours or more of service contact per week, which obviously falls within the 104 hours that the department has proposed.

We are also planning to modify the reimbursement approach for CPST. This service is reimbursed at \$21.33 per 15-minute unit, which equates to \$85.33 an hour. The majority of those currently delivering services are unlicensed staff classified as Qualified Mental Health Specialists. Thus, our current system has unlicensed staff billing CPST services at \$85.33 per hour. On average, both adults and children receive slightly less than one hour of treatment per visit; for group CPST, the average for both adults and children is approximately 90 minutes.

However, some providers bill this service at six or more hours per day, which equates to \$511.98. That charge is notable because it's close to the per diem rate at our inpatient hospitals offering acute care by a clinical team of highly trained professionals. Even with the rate adjustment for units of service that my department is proposing for Fiscal Years 12/13, six hours of CPST equals \$320.

Integration of Behavioral Health and Physical Health Care

Because mental health is the cornerstone of overall health, our department is leading efforts in Ohio to move toward an integrated approach to behavioral and physical health care. Data show that people with serious mental illness in Ohio often die at least 13 years earlier than individuals without mental illness. Adults with severe mental illness represent about 10 percent of Ohio's two million Medicaid enrollees, yet account for 26 percent of total Medicaid spending. This is largely due to co-existing physical health conditions. Individuals with severe mental illness have about twice the rate of hospitalizations and emergency room visits for chronic health conditions including diabetes, pneumonia and asthma.

Historically, individuals needing both physical and mental health services are treated within separate "silos," without the benefit of shared information or proper referrals among their doctors and other health care providers. Truly integrated care means treating both physical and mental health conditions in a comprehensive, coordinated way, where all of the individual's health care providers work together and regularly communicate. The Governor's Office of Health Transformation is seeking to improve care coordination approaches for certain high-cost individuals served by Medicaid, including those with severe mental illness. Delivery system improvements, including the concept of health homes, will be developed for implementation in Fiscal Year '13. As part of the Health Transformation team, I am excited to be part of this effort to both improve outcomes and lower the long term Medicaid spending curve.

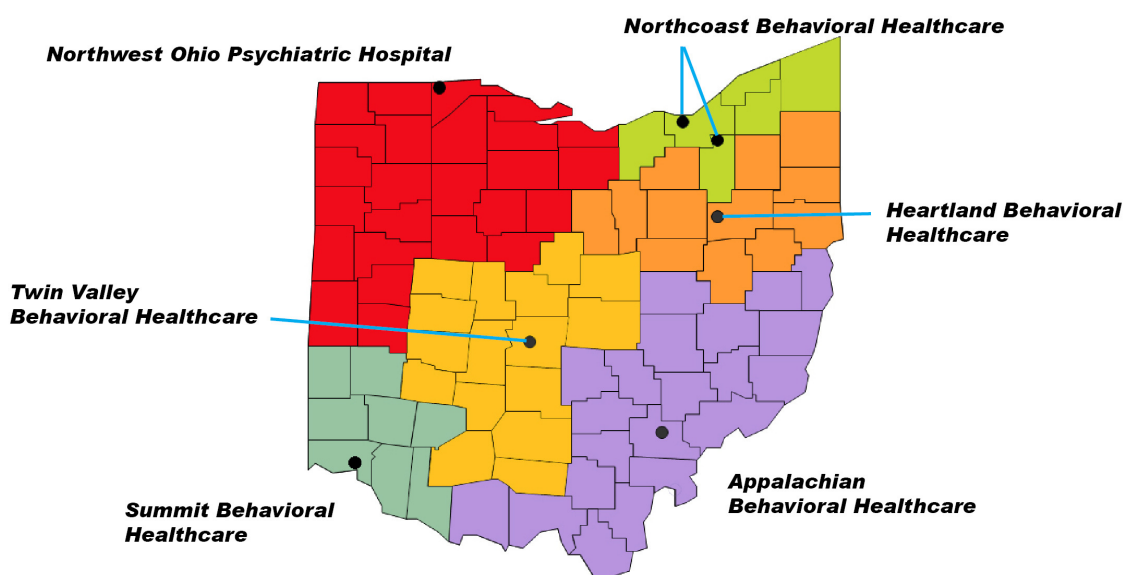
Regional Psychiatric Hospitals

Previously funded through the 408 line, state hospital operating funds have been moved to a new GRF line item, 334-412. This line item funds the state hospital operations for both forensic and civil care. By creating a separate line item, hospital funding will not mingle with Medicaid funding.

In Fiscal Year '12, the portion of hospital costs associated with board bed days will be allocated to boards for their purchase of bed days from state hospitals. Boards will remain responsible to pay for civil bed days at a per diem charge. If boards use fewer bed days than planned, they will retain that savings to purchase additional community resources.

For Fiscal Year '13, the Department will work with the Ohio Association of Community Behavioral Health Authorities and its members to explore development of an improved approach to inpatient bed day planning -- perhaps one that is regionally-based around each hospital catchment area. While there is no specific plan for a new approach to hospital planning in FY 13 at this time, we have included some permissive statutory tools that may be helpful should a new approach ultimately be adopted in concert with the boards.

It is noteworthy that funding in the hospital line item decreases by 4.9 percent in Fiscal Year 13 when compared to FY 12. This change is attributable to the fact that there are 27 pay periods during FY 12 and only 26 pay periods in FY 13. Our hospitals employ 2000 personnel so payroll has a significant impact on the budget. At this time, we have no plans to close any facilities beyond the consolidation of the Cleveland and Northfield campuses of Northcoast Behavioral Healthcare, as was announced earlier this year. This consolidation is expected to maintain existing bed capacity in the region and save the department \$4 million in each year of the biennium, allowing us to direct additional resources to the community in non-Medicaid funding.



Community Non-Medicaid Funding

Non-Medicaid subsidy funding for the boards will be centralized in the GRF 505 line item. The funds contained in this line were previously associated with line items 404, 408 and 505. The consolidation of these lines will support a clear focus on non-Medicaid community services and supports. The use of this funding is subject to the discretion of the individual board, but our department has articulated some priorities for which we plan to offer technical assistance and identify best practices to build on local successes. These priorities include:

- Emergency services and crisis intervention,
- Housing,
- Services for children with serious emotional disorders, and
- Support for individuals who have high needs or are involved with the justice system, including those re-entering the community from hospitals or the corrections system.

Line item 505 funding will be distributed to local boards in a manner that brings as much stability as possible to our system at this time of change. In Fiscal Year '12, our allocations will attempt to

bring each board area as close to its Fiscal Year '11 non-Medicaid GRF support as possible. To be clear, the GRF non-Medicaid resources available in the line item are short by approximately \$15-16 million so the Department will be unable to fully accomplish this goal. To manage within that constraint, it is necessary to reduce proportionately the amount of GRF non-Medicaid community resources that had been available this year on a board-by-board basis. While the actual amount is less than the non-Medicaid GRF subsidy available in FY '11, this allocation approach helps the boards maintain year-to-year predictability in the local planning process, and avoids creating winners and losers among the boards. Historically, the boards have requested that the department avoid redirecting limited resources between boards, and I have already received letters of support from many boards for the way that we are proposing to allocate the line item 505 resources.

It should be noted, however, that the effect of this strategy of stabilization will vary from board to board. ODMH has identified several board scenarios that present distinct challenges and opportunities moving forward in a system in which the state takes responsibility for Medicaid.

1. Counties with levy funding that will be freed up by Medicaid elevation – Franklin County is a good example of a county which has had to use all of its GRF funding from the state on Medicaid and has also dipped into its own property tax levy to meet its commitment, spending around \$4 million in FY 11. In FY 12, that \$4 million will be freed up to be used for other community resources because the board will not have a Medicaid commitment. Alternatively, the county will receive no additional 505 non-Medicaid subsidy, which is the same as in previous years when Franklin used all state subsidies to pay Medicaid obligations.
2. Counties with no local levy contribution and a high Medicaid population – Today, there are 14 counties which have no property tax levy for mental health services. Many of these counties are small and rurally populated, and mostly in Southeast Ohio where there is high Medicaid population. One example is Scioto/Adams/Lawrence. It will be relieved of the responsibility of administering Medicaid; however, with no remaining local contribution, it will face challenges in continuing to operate. Our department will work with these types of boards to determine what other department resources may be available to assist with the provision of non-Medicaid services to the community.
3. Boards with either a small levy or no levy and a low Medicaid population – An example is Medina County, which has no levy but will receive a \$1.5 million allocation from the state. This subsidy amount is aligned with the amount of GRF that the county has been receiving historically and is reflective of the fact that a majority of services in the area are to the non-Medicaid population.

I continue to have discussions with the boards regarding this proposal. The goal for Fiscal Year '12 is stabilization: we are elevating Medicaid to take better control of the future and we are doing the best that we can to provide resources to communities on the non-Medicaid side of the house.

We recognize that the line item 505 allocation approach for FY '12 is not especially equitable, but it gets us as close as possible to the resources that are available in individual communities today. We are committed to moving to a new distribution methodology with any additional resources allocated to line 505 in the future, either in the FY 12/13 biennium or in later biennia. A new methodology, developed in collaboration with the boards in the last few years, will introduce the factors of population, poverty and prevalence to achieve a more rational funding plan for the future.

Regulatory Relief

The Department's budget proposal removes from statute the requirement for local boards to complete a community plan each year. With the Governor's Common Sense Initiative in mind, a decision was made that these community plans can be time-consuming and burdensome to complete in their current format. We will continue to engage in community planning with the boards and will gather information necessary to meet federal block grant requirements, but we want to establish a more value-added process whereby the state department offers technical assistance to meet the needs of local boards and their communities.

We are also engaged with providers and other stakeholders to determine what regulatory relief would be beneficial, while meeting the agency's goals and protecting individuals with mental illness.

Residential State Supplement Program (RSS)

The RSS program is a cash supplement to low-income adults with disabilities who do not require nursing home care. The supplement is used to pay for living arrangements approved by the program. To be eligible to participate, an individual's monthly income cannot be greater than \$600 if living in Community Adult Mental Health Housing and less than \$900 if living in a Residential Care Facility or an adult group home. Total assets cannot be more than \$1,500.

Currently, the program is run by the Department of Aging in cooperation with the Department of Health (licensing agency) and the Department of Job and Family Services (funding and payment). Approximately 75 percent of the individuals enrolled are adults under the age of 60 who have a primary diagnosis of serious mental illness. Given the population served, the RSS program will be consolidated at the Department of Mental Health with the hope of incorporating it into a larger housing strategy to meet the great need among people with mental illness. The program's funding was reduced significantly to a level that is problematic. I believe this was inadvertent and we are working with the Office of Budget and Management to rectify the error.

Forensic Issues

The Department's budget contains some changes resulting from our Forensic Strategies Workgroup's final report, which was issued in January 2010. There has been a two-decade increase in both the number and the percentage of patients with a forensic legal status in Ohio's Regional Psychiatric Hospitals. Some of this is due to an increase in the number of admissions for competency restoration. As a result, the state must hold an increasing amount of dollars for inpatient days for forensic patients, leaving a smaller portion of funds for distribution to communities.

The budget introduces a key strategy from the workgroup to give courts an *option* to divert nonviolent, misdemeanor offenders to more appropriate civil inpatient commitment or community treatment. This could avoid the situation of the non-violent misdemeanor offender spending 30 to 90 days in court-ordered treatment in an acute hospital setting at more than \$500 a day just to have his or her case dismissed. The civil inpatient commitment, if appropriate, would mean a 12-14 day inpatient stay and then linkage to community services. Under this proposal, courts would have control of safety and security, but ODMH would set the clinical level of care in the appropriate environment.

Conclusion

Before I close, I want to mention that the Department of Mental Health has taken cuts in several other lines which are reflective of the difficult budget environment. We anticipate being able to manage most of these reductions. Special attention should be paid to the Community Medication Subsidy (335-419), which sees a \$1.99 million, or 10 percent, reduction. This program, which provides psychotropic medications to individuals who cannot afford them, is a priority for the Department. There has been a trend over the past several years toward an increased use of generics has resulted in lower program costs. *We anticipate being able to serve the same number of individuals under the reduced funding level.* The use of generics will not be mandated so medications options will still be the decision of the treating clinician.

Thank you for the opportunity to give testimony on the budget for the Ohio Department of Mental Health. It is my hope that through the many major initiatives included in this budget proposal, a more stable, coordinated and comprehensive system of behavioral healthcare will result as we emerge from a challenging economic environment. I am certain that all of you understand the value and benefits of supporting mental health in our families and our communities. Our services help people recover to live full and meaningful lives. I am available to answer any questions of the committee at this time.