Report to the OACBHA Resource Modernization Workgroup

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Submitted by:

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Overview

The Ohio Association of County Behavioral Health Authorities (OACBHA) is the statewide organization that represents the interests of Ohio's local Alcohol, Drug Addiction, and Mental Health (ADAMH) Boards. The Association and its member Boards have developed the *Recovery Is Beautiful: BluePrint for Ohio's Community Mental Health and Addiction Services*. In this *BluePrint*, the Boards have set out to implement Recovery-Oriented Systems of Care (ROSCs) in their communities, focusing on providing access to community mental health and addiction services. A ROSC places its primary focus on individuals in need of recovery services and on their families, building on their strengths and incorporating a coordinated and collaborative approach across the community. The foundation of Ohio's ROSC is made up of locally managed continuums of care designed to provide person-centered prevention, treatment, and support services to help individuals and families impacted by mental illness and addiction achieve and sustain long-term recovery.[1]

The *BluePrint* establishes a framework for ROSCs in which the Boards are the "hub" for their local communities that coordinate across systems to ensure that local entities are prepared to identify and address emerging and standing issues related to mental illness and addiction in their areas. The Boards are working to implement ROSC in their communities, and are at various stages. The Resource Modernization Workgroup was convened as a second phase of the *BluePrint* work in order to develop a resource strategy for implementing Recovery-Oriented Systems of Care at the local level. The Workgroup was charged with determining the resources necessary for Ohio to become a dynamic, sustainable, and integrated ROSC and developing a methodology to fund a complete ROSC for all individuals and family members.

Within the Ohio behavioral health system there are strengths to build on in implementing ROSC, with an increased focus on recovery. There are numerous efforts across the state to increase collaboration among systems, agencies, and professionals. Boards serve as the locus for many of these collaborations including local opiate task forces, suicide prevention coalitions, family and children first councils, and community corrections planning boards, and other groups.

There are challenges to implementing ROSC as well, including workforce issues, waiting lists for services, lack of investment in infrastructure, payment methodologies that reward the quantity versus quality of services provided, and regulatory barriers. While these challenges are real and will impact the pace at which Boards can move forward with ROSC, the greater challenge appears to be the constantly shifting landscape for behavioral health services in Ohio. The increasing tendency of the Ohio Department of Mental Health and Addiction Services (OhioMHAS) to make direct allocations and require pass-through funds to providers, and the plan to shift most Medicaid behavioral health services financing to managed care organizations, are both factors that will need to be addressed as Boards work to align services within a ROSC.

[1] RECOVERY is Beautiful, Recovery-Oriented Systems of Care in Ohio, OACBHA, 2016.

Ohio's counties are diverse, with variation in both resources and culture. Developing local Recovery-Oriented Systems of Care will require an evolution of how funds are allocated and utilized at the local level. OACBHA is committed to ensuring a full continuum of services that are accessible to all Ohioans. This will be accomplished by enacting policy reforms and ensuring adequate funding with appropriate distribution methodologies to allow for blending, braiding, and leveraging funds at the local level.

Background

OACBHA

OACBHA is the statewide organization that represents the interests of Ohio's local Alcohol, Drug Addiction, and Mental Health (ADAMH) Boards. There are 51 Boards in Ohio, representing various groupings of the state's 88 counties.[2] The Association works with a variety of governmental bodies including the Ohio General Assembly, the Office of the Governor, the Ohio Department of Mental Health and Addiction Services, the Ohio Department of Medicaid, and other state departments along with other organizations and coalitions that support and enhance mental health and addiction prevention, treatment, and support services. OACBHA provides the Boards with a forum to address statewide issues and a means to communicate their positions and concerns with a single voice. The Boards are statutorily empowered to plan, develop, fund, manage, and evaluate community-based mental health and addiction services. Boards are funded through a combination of federal, state, and local sources and are responsible for ensuring that mental health and addiction services and recovery supports are available to those who need them, regardless of their ability to pay.

The Association and its member Boards have developed the *Recovery Is Beautiful: BluePrint for Ohio's Community Mental Health and Addiction Services*. In this *BluePrint*, the Boards have set out to implement Recovery-Oriented Systems of Care in their communities, focusing on providing access to community mental health and addiction services. A ROSC places its primary focus on individuals in need of recovery services and on their families, building on their strengths and incorporating a coordinated and collaborative approach across the community. The foundation of Ohio's ROSC is locally managed continuums of care designed to provide person-centered prevention, treatment, and support services to help individuals and families impacted by mental illness and addiction achieve and sustain long-term recovery.[3] The *BluePrint* includes five principles that will drive the development of local Recovery-Oriented Systems of Care: focusing on clients and families; ensuring timely access to care; promoting healthy, safe, and drug-free communities; prioritizing accountable and outcome-driven financing; and managing systems of care locally.

The *BluePrint* establishes a framework for ROSCs in which the Boards are the "hub" for their local communities that coordinate across systems to ensure that local entities are prepared to identify and address local emerging and standing issues related to mental illness and addiction by offering:

[2] http://www.oacbha.org/mappage.php
[3] RECOVERY is Beautiful, Recovery-Oriented Systems of Care in Ohio, OACBHA, 2016.

- Community-based mental health and addiction prevention, treatment, and wellness services
- Crisis care and acute care treatment services
- An array of recovery supports that are individualized, person-centered, trauma-informed, and culturally competent

Purpose of the Engagement

The Ohio Association of County Behavioral Health Authorities (OACBHA) entered into contract with the National Association of State Mental Health Program Directors Research Institute (NRI) to help it develop a resource strategy for implementing Recovery-Oriented Systems of Care (ROSCs) across Ohio at the local level. NRI partnered with the Technical Assistance Collaborative, Inc. (TAC) to provide additional subject matter expertise for the project. The NRI/TAC team is hereafter referred to as the "Consultants."

The goal of the NRI contract was to help OACBHA determine the resources necessary for Ohio to create a dynamic, sustainable, and integrated ROSC. The initially defined objectives of the project were:

1. Identification of the components of a complete ROSC continuum (starting with Continuum generated by the Resource Modernization Workgroup) and assessment of Ohio's preparedness/willingness to move to a recovery-oriented system of care.
2. Identification of available local, state, and federal resources.
3. Identification of gaps in access, services, and resources across the state, once the continuum is identified.
4. Development of a strategy for procuring additional funding.
5. Development of a process for the allocation of funds.

As represented in the NRI-TAC RFP response, the activities to be undertaken in order to achieve the above objectives included:

- On-site and remote consultation to the Resource Modernization Workgroup.
- Data-gathering and analysis to compare what is currently being done in Ohio counties with other systems across the country.
- Presentation of local and national policy, as well as best practices.
- Interviews with key informants, including county- and state-level officials identified by OACBHA, to analyze the current policy, regulatory, funding and service delivery environment.

Methodology

Research

The Consultants conducted considerable research into funding trends across the country, focused in particular on states with county-administered behavioral health programs, and on how states

administer and fund Recovery-Oriented Systems of Care. This research serves as the backdrop to our findings and recommendations specific to Ohio.

A complete list of documents and reports reviewed can be found in Appendix A.

Data Analysis

The Consultants reviewed and analyzed services and financial data to identify existing and available resources to fund ROSC services in Ohio, and to identify gaps in services and funding resources by Board area. Fiscal Year 2015 data used for this analysis include:

- All Board-level budget reports (040 Reports)
- Medicaid expenditures for mental health (MH) services and for alcohol and other drugs (AOD) services
- State grants passed through the Boards but targeted to specific providers for specific purposes
- Direct grants to providers which the Boards have no ability to influence
- State hospital utilization
- 2015 Ohio county population estimates from the U.S. Census Bureau

Data that were not included in the analysis include expenditures by other state agencies for behavioral health services (e.g., child welfare, corrections), first and third party funding, and grants that are solely obtained and administered by local providers.

Interviews/Focus Groups

The Consultants conducted a series of key informant interviews and focus groups in order to augment the quantitative analysis provided by the data. The purpose of the interviews and focus groups was to:

- Identify existing components of a ROSC, priority populations receiving services, available resources for services, and perceived gaps in services and resources
- Uncover current policy, regulatory, and funding strategies that may need to be addressed in order to fully realize a ROSC

Interviewees were invited by the Association to participate. Interviews were conducted both by telephone and in person. Phone interviews were conducted with:

- Ohio Citizen Advocates for Addiction Recovery
- The Buckeye Association of School Administrators
- The National Alliance for the Mentally Ill – Ohio
- Representative Robert Sprague and Senator David Burke
- The Ohio Department of Medicaid

In addition, three group phone interviews were conducted with:

- The Ohio Council of Behavioral Health and Family Services Providers and the Association of Area Agencies on Aging
- The Ohio Hospital Association and the Ohio State Medical Association
- Managed care organizations serving Ohio Medicaid:
    - CareSource
    - United Healthcare
    - Buckeye Community Plan of Ohio
    - Molina Healthcare
    - Paramount

Finally, two focus groups were conducted at the OACBHA office in Columbus with:

- Consumers and family members representative of both the mental health and AOD systems
- Representatives from multiple touch points within the criminal justice system, including judges, prosecutors, police, sheriffs, jails and prisons, and legal advocates.

Additional qualitative sources of information gathered by the Consultants included findings from structured surveys of key stakeholders in ROSC pilot Boards and input from Resource Modernization Workgroup members; several participated in in-person discussions, while others participated via telephone.

National /State Context

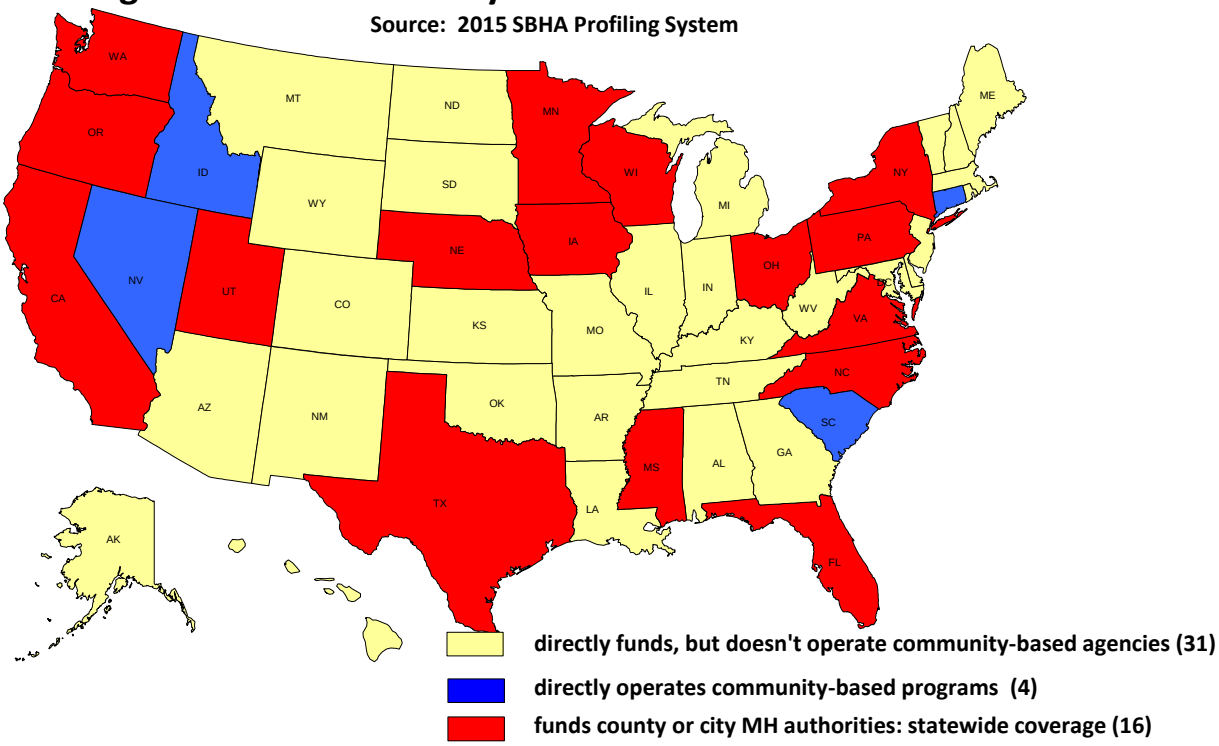
National Scan

State Funding of Behavioral Health Services

States primarily fund behavioral health services in one of three ways: by passing funding through local county or municipal authorities to directly administer the provision of services; by directly funding and contracting for, but not operating, community services; or by directly operating community programs.

Figure 1: States' Primary Mechanism to Fund Providers

Source: 2015 SBHA Profiling System



As shown in Figure 1:

- Sixteen states, including Ohio, provide funding to city or county authorities to administer publicly funded behavioral health services for a sector of the population.
- Thirty states and the District of Columbia directly fund, but do not operate, community behavioral health programs, contracting directly with private providers to deliver services.
- Four states directly operate community programs, staffed with state employees.

As in Ohio, states whose counties administer behavioral health services typically have a statutory basis for this responsibility. However, Ohio has 76 counties that contribute local funding to support local services through property tax levies. A report released by the National Association of Counties and the

National Association of County Behavioral Health and Developmental Disability Directors notes that "America's **3,069 counties** are integral to America's behavioral health system. Counties annually invest **$70 billion** in community health systems, including behavioral health services."[4]

Recovery Oriented Systems of Care (ROSCs)

The Substance Abuse and Mental Health Services Administration (SAMHSA) originally defined a ROSC as "a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resiliencies of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems."[5] The ROSC concept has since been broadened to include individuals with a mental health disorder.

The *BluePrint* utilizes William White's definition of a ROSC, "Recovery-Oriented Systems of Care are networks of formal and informal services developed and mobilized to sustain long-term recovery for individuals and families impacted by severe substance use disorders [or mental illness]. The system in ROSC is not a treatment agency, but a macro-level organization of a community, a state, or a nation.

The central focus of a ROSC is to create an infrastructure with the resources to effectively address the full range of mental health and substance use problems within communities. The specialty behavioral health disorder field provides the full continuum of care (prevention, early intervention, treatment, continuing care, and recovery) in partnership with other disciplines and service systems such as primary care, housing and vocational agencies, and faith-based organizations. A ROSC encompasses a menu of individualized, person-centered, and strength-based services within a self-defined network. Services are designed to be accessible, welcoming, and easy to navigate. A fundamental value of ROSCs is the involvement of clients, their families, and the community to continually improve both the quality of services and access to those services.

State and local government entities, such as the State of Connecticut, the City of Philadelphia, and others that have fully implemented ROSC have noted positive outcomes in one or more of the following areas: decreased use of crisis services (e.g., ER visits, inpatient services, etc.); increased rates of competitive employment; decreased contact with the criminal justice system; and decreased system costs (e.g., psychiatric inpatient services, placement of youth in residential treatment). While there's no guarantee that all Boards would experience the same return on investment, this transformation is an important step in the ongoing effort to improve the lives of Ohio's most vulnerable citizens.

National Status of ROSC Implementation

In 2011[6] and 2013,[7] SAMHSA sponsored studies to determine how far states had progressed with implementation of a ROSC. The studies involved the distribution of surveys to state mental health

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[4] "Behavioral Health Matters to Counties," A Joint Release of the National Association of Counties and the National Association of County Behavioral Health and Developmental Disability Directors, October 15, 2015.

[5] http://www.samhsa.gov/sites/default/files/rosc_resource_guide_book.pdf

[6] NRI, Inc. & Abt Associates, Inc. (2011). State Mental Health Agency Recovery-Oriented Systems of Care and Health Care Reform. Substance Abuse and Mental Health Services Administration Partners for Recovery Initiative contract no. HHSS2832007000081

[7] NASADAD & Abt Associates, Inc. (2013). State Progress Toward Recovery-Oriented Systems of Care. Substance Abuse and Mental Health Services Administration Partners for Recovery Initiative contract no. HHSS2832007000081

agencies and state substance abuse services agencies, respectively. Key findings from the surveys included:

- ✓ Out of 42 responding state mental health agencies, 35 (83%) responded that they were reforming their mental health treatment system to become a ROSC.
- ✓ Of the 45 responding state substance abuse agencies, 40 indicated that they were considering a systems change effort based on the ROSC model.
- ✓ All 35 state mental health agencies that indicated they were transforming their systems to ROSCs were working with other state agencies to coordinate services and funding.
- ✓ Evidence-based practices implemented to meet the needs of recovery-oriented treatment included:
  - Supported employment
  - Assertive Community Treatment
  - Illness self-management
  - Supported housing
  - Peer support
- ✓ Most frequently reported barriers and challenges to implementing the ROSC model included:
  - Financial constraints
  - Systemic and organizational barriers
  - Lack of resources

Funding of ROSC

Thirty-eight state mental health agencies reported that they had dedicated funding to promote and sustain recovery-oriented services, especially peer services.

Funding Source	Number of States	Percentage of States
Mental Health Block Grant	33	79%
State General Funds	30	71%
Medicaid	21	50%
Other Funds	22	52%

A final conclusion of the studies was that "States expressed a need for mental health, substance abuse, and Medicaid agencies to work together to create an empowered and empowering ROSC." While the SAMHSA initiative was directed towards states, the findings and challenges are relevant for OACBHA's efforts to implement ROSC in Ohio. The complete ROSC survey PowerPoint presentation can be found in Appendix B. Because the final survey reports have not yet received SAMHSA clearance, they are not available for distribution.

Context: Behavioral Health Services in Ohio

Role of the Counties and Boards in Administering Behavioral Health Services in Ohio

Ohio's community behavioral health system relies on local Alcohol, Drug Addiction, and Mental Health Boards to take the lead at the local level to establish a unified system of care for individuals in need of mental illness and addiction services. The local Boards are charged with the development of high-quality, cost-effective, and comprehensive services.

The Boards are the local authority for all public mental health and addiction treatment and recovery services. In the midst of the evolving health care environment in Ohio, the Boards maintain the responsibility to assess, plan, and manage prevention, treatment, and recovery support services for their entire community, and continue to pay for Ohioans' treatment and services when they have insufficient health care coverage. Additionally, Boards are responsible for establishing community-wide task forces to address emerging mental health and addiction issues, and for ensuring that there is a system of recovery supports to foster long-term recovery in individuals living with mental illness or addiction, regardless of who pays for the initial treatment.

Title [3] III COUNTIES, Chapter 340 - ALCOHOL, DRUG ADDICTION, AND MENTAL HEALTH SERVICES, provides the legislative authority for the role of counties and Boards in administering behavioral health services.[8] The statute provides the authority for the Boards, specifying requirements for Board composition and powers and duties of the Boards. Chapter 5122 also outlines Board responsibilities in relation to state hospitalization. In addition, Chapter 5705.221 provides counties the authority to establish a tax or "levy" to augment the funds received from the Ohio Department of Mental Health and Addiction Services (OhioMHAS) for the provision of county alcohol, drug addiction, and mental health programs and services. Establishment of the local levy is voluntary and at the discretion of each county.[9] Seventy six of Ohio's eighty-eight counties have levies established in support of mental health or addiction services, while twelve do not.

In Ohio, local Boards are operationalizing their statutory authority through the development of Recovery-Oriented Systems of Care. Boards continue to assess, plan, fund, manage, and evaluate prevention, treatment, and recovery support services for their community. A fundamental principle of a ROSC is that clients are key. Clients are drivers of decisions about service and support needs. Services are built and systems are put in place so that individuals are able to access an array of services and supports when and where they need them. Ohio's regulatory environment and funding methodology need to be updated to continue to support the transition to Recovery-Oriented Systems of Care.

For example, in spite of the statutory language requiring funds to be allocated to each county, OhioMHAS has started allocating funding for targeted services directly to providers, bypassing the Boards. While the direct grants compose only about one percent of public behavioral health funding statewide, the Boards do not have access to the $20 million in these direct grants for determining how best to meet the needs of their communities.

State Behavioral Health Agency in Ohio

OhioMHAS was established on July 1, 2013, with the consolidation of the former departments of alcohol and drug addiction services and mental health. The transition to a single agency was intended to result in greater value to taxpayers, better alignment in community planning, and more coordinated services to Ohioans.

[8] http://codes.ohio.gov/orc/340
[9] http://codes.ohio.gov/orc/5705.221

OhioMHAS has three main responsibilities in meeting the behavioral health needs of Ohioans: Funding, regulatory oversight, and administration of state psychiatric hospitals, including forensic beds.

Funding

Funding allocated by OhioMHAS for community mental health and addiction services comes from federal block grants and state general revenue funds. Per state statute,[10] federal and state funds are passed on to the 51 community Alcohol, Drug Addiction and Mental Health (ADAMH) Boards. While OhioMHAS views access to treatment as fundamental to its mission, the agency also views its role as evolving to focus more resources on prevention and recovery supports. As of July 1, 2015, preliminary data* for state fiscal year 2015 show that of those served within the publicly funded mental health and addiction system, **393,905** adults and children received mental health services and **97,673** adults and youth received alcohol and other drug treatment services.[11]

Regulatory Oversight

OhioMHAS reviews and monitors the statewide mental health and alcohol, drug, and gambling addiction services system that consists of more than 900 community behavioral health provider agencies. As of July 2015, the Bureau of Licensure and Certification was responsible for regulatory oversight of 422 community mental health agencies, 83 private psychiatric hospital inpatient units, 154 community residential programs and more than 430 addiction prevention and treatment providers.[12]

Administration of State Psychiatric Hospitals, Including Forensic Beds

The state's responsibility to provide public hospital care is defined in Ohio's constitution and revised code. State-run regional psychiatric hospitals are modern facilities providing short-term, acute inpatient care as requested by local systems of care. Hospital services under OhioMHAS include comprehensive inpatient care at six sites around the state for approximately 1,000 adults on a daily basis. The typical acute care stay is eight to ten days, depending upon a person's response to treatment. During state fiscal year 2015, there were 7,761 admissions for inpatient care at OhioMHAS hospitals, and 374,714 bed days were utilized. Forensic patients (those sent for evaluation or committed by criminal courts) make up about 60 percent of the inpatient population at any given time.[13] Local Boards play a key role in state hospitalizations as they are responsible for pre-screening for civil hospital admissions and partner with the state hospitals to develop discharge plans for clients coming out of state hospitals. Boards are also responsible for the coordination of the forensic population, including communication with the court system and fulfilling the forensic monitor role as those individuals transition back into the community.

Appendix C shows State Hospital bed utilization by Board, and the associated cost for fiscal year 2015.

[10] http://codes.ohio.gov/orc/340
[11] 2015 OhioMHAS Annual Report
[12] Ibid
[13] Ibid

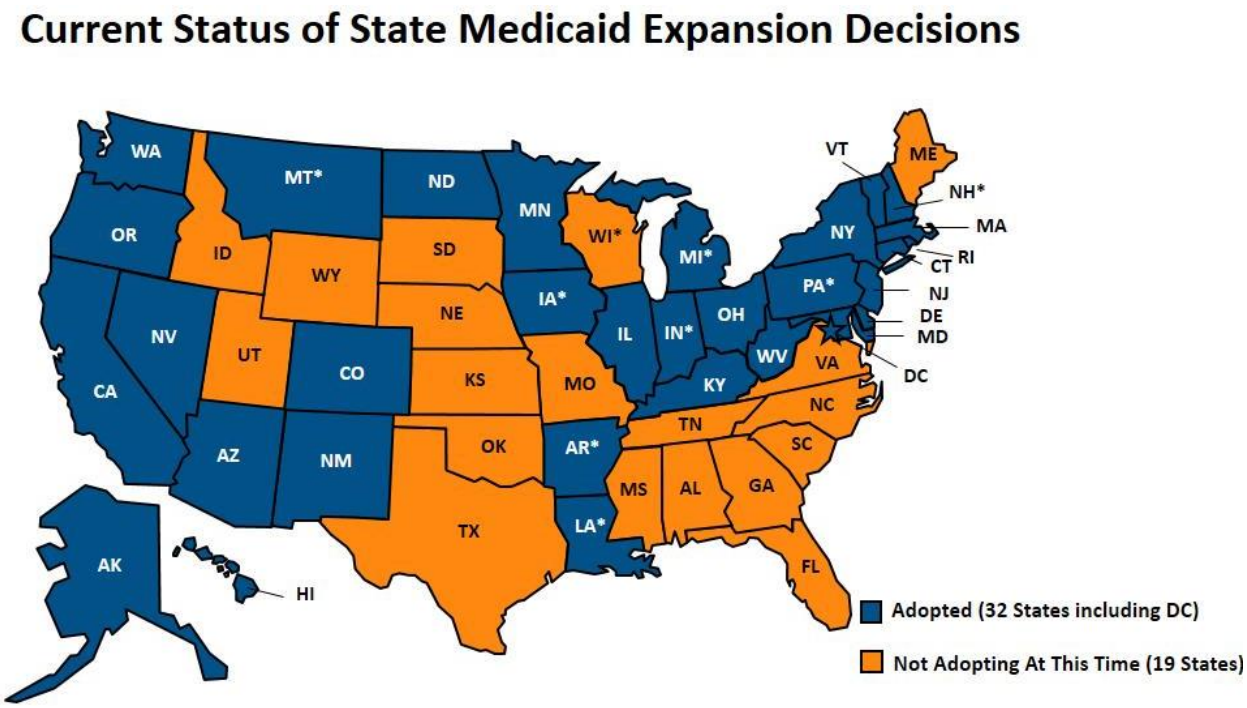
The Role of Medicaid

Ohio's Biennial Budget for State Fiscal Years 2012-2013 (HB 153) transferred the full financial responsibility for Medicaid-funded substance abuse and mental health benefits from the Ohio Department of Mental Health (ODMH) and the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) to the Ohio Department of Job and Family Services. The Ohio Medicaid program provides a comprehensive package of mental health and addiction services. Some services are limited by dollar amount, number of visits per year, or setting in which they can be provided. At this time, Ohio's community behavioral health Medicaid program is undergoing a series of changes.

Medicaid Expansion

Figure 2 below depicts the status of states regarding participation in Medicaid expansion as allowed under the Affordable Care Act. To date, 31 states and the District of Columbia have expanded Medicaid.[14]

Figure 2:



In 2013, Governor John Kasich announced his decision to accept Medicaid expansion for Ohio, resulting in extended Medicaid eligibility for more than 500,000 Ohioans. Medicaid expansion has resulted in increased access to clinical treatment services for Ohioans in need. However, Medicaid does not cover the costs of all of the recovery support service needs for individuals, and local Boards are continuing to

[14] Source: Kaiser Family Foundation. Accessed from: http://kff.org/health-reform/slide/current-status-of-the-medicaid-expansion-decision/

work to provide access to recovery supports, including housing, employment services, peer support and more.

Behavioral Health Redesign

The Ohio Department of Mental Health and Addiction Services and Ohio Department of Medicaid are currently working to modernize Ohio's community behavioral health Medicaid services. This work includes a number of major redesigns to the system.

The state is aligning billing codes with the National Correct Coding Initiative, updating rates for services, implementing billing requirements for rendering providers, and expanding some services under the Medicaid Rehabilitation Option. These changes are underway now with an implementation timeline that spans the next fiscal year. Following the implementation of these changes, the full community behavioral health service benefit will shift from its current fee-for-service arrangement to become part of the state's managed care contracts as of January 1, 2018.

Additionally, the state is eliminating the Medicaid spend-down program and putting in place a Specialized Recovery Services Program for individuals with a severe and persistent mental illness who will no longer be eligible for Medicaid through a spend-down. This program goes live on August 1, 2016 and is designed to provide eligible individuals with access to recovery management services, individualized placement and support (IPS), supported employment, and peer recovery services.

While local Boards do not manage the Medicaid behavioral health benefit, they do have the responsibility for coordinating the local network of services and working to ensure that clients have appropriate access to both clinical treatment services and recovery supports. As the system undergoes these major changes, a critical role of Boards will be to lead their local communities in ensuring that the transition for clients is as seamless as possible.

As states move greater responsibility for administration of behavioral health care to managed care plans, both state and local behavioral health authorities are finding it necessary to evaluate and re-define their roles. While Medicaid can cover a wide array of services and supports depending on a state's CMS-approved state plan and waiver authorities, there remain services and supports, as well as populations that will not qualify under Medicaid. With appropriate state funding, behavioral health authorities can fill those gaps in coverage as well as provide key functions in their state and communities to ensure that residents have access to a full array of services and supports to meet their needs. Managed care and local boards must work collaboratively to ensure that clients don't suffer from fragmentation of care and that treatment and recovery support services are connected appropriately. Ohio's local Boards are beginning to address these challenges through the implementation of the *BluePrint*.

Legislative Interest

Effective July 1, 2017, the local Boards must be compliant with ORC 340.03(A)(11) which sets forth statutory components of a continuum of care that provides for prevention, treatment, support, and rehabilitation services and opportunities for individuals in need of mental health treatment and support.

The continuum could serve as a foundation for all Boards across Ohio if the necessary resources to establish the continuum are available. The service array includes:

- Outreach, information, and referral
- For individuals receiving behavioral health treatment, assistance in obtaining basic necessities of life
- An array of addiction and mental health services
- Emergency services and crisis intervention
- Employment/vocational services
- Services to develop social, community, and personal living skills
- Access to housing and the provision of residential treatment and support
- Support, assistance, consultation, and education for families, friends, persons receiving addiction or mental health services, and others
- Recognition and encouragement of families, friends, and neighborhood networks as natural supports for persons receiving addiction or mental health services
- Grievance procedures and protection of the rights of persons receiving addiction or mental health services
- Community psychiatric supportive treatment services
- Any additional component the department, pursuant to section 5119.21 of the Revised Code, determines is necessary to establish the continuum of care

The local Boards will also need to comply with *ORC 340.033* which establishes the minimum array of treatment and support services for all levels of opioid and co-occurring drug addiction. Per the statute,

> *The AOD continuum must provide: ambulatory and sub-acute detoxification, non-intensive and intensive outpatient services, medication-assisted treatment, peer mentoring, residential treatment services, recovery housing pursuant to section 340.034 of the Revised Code, and twelve-step approaches; services in the service district of each board of alcohol, drug addiction, and mental health services, except that sub-acute detoxification and residential treatment services may be made available through a contract with one or more providers of sub-acute detoxification or residential treatment services located in other service districts; services in an integrated manner and without delay when changing or obtaining additional treatment or support services for such addiction; and services to individuals who had a previously unsuccessful treatment experience.*

Several of the services and supports identified in the continuums are essential components of a ROSC. The legislation could be very helpful in moving implementation forward in Ohio. However, absent appropriate metrics concerning amount, scope, and duration for services along with a directive for how accessible services will be appropriately and systematically funded, the Boards will be challenged to come into compliance.

Findings

The Consultants identified several findings from the qualitative and quantitative studies that are noteworthy in considering the implementation of ROSC.

Strengths of the Behavioral Health System in Ohio

The interviews and focus groups identified a number of positive and promising indicators for the behavioral health system and the individuals who rely on the system for care:

- There is an increased focus on behavioral health services in Ohio.
- There is a strong focus on Recovery — OACBHA recently sponsored the "Recovery is Beautiful" conference which was attended by 109 stakeholders, representing the Boards, provider agencies, consumers, and family members. Dr. Arthur Evans (Philadelphia Department of Behavioral Health and Intellectual DisAbility Services), Lonnetta Albright (GLATC) and Director Gary Mohr of the Ohio Department of Rehabilitation and Corrections were keynote speakers. Additionally, OACBHA hosted Ohio's first-ever joint mental health and addiction Recovery Conference with over 1,100 attendees. The Recovery Conference focused on advocacy, empowerment, and celebrating recovery.
- There are numerous efforts across the state to increase collaboration among systems, agencies, and professionals. Boards serve as the hub for many of the collaborations including local opiate task forces, suicide prevention coalitions, family and children first councils, and community corrections planning boards, and other groups.
- Local relationships are key — representatives from the education and criminal justice systems identified local examples and the benefits to those communities.
- According to John B. McCarthy, director of the Department of Medicaid, when individuals enter the behavioral health system, their Medicaid costs go down. "When consumers are engaged they get help…the system works."
- Also according to Director McCarthy, Integrated Health Homes were showing savings of two to five percent in Medicaid expenditures.
- Counties with Specialty Courts are effectively linking individuals with behavioral health disorders to treatment instead of incarcerating them.

Gaps in Services

Consistent with the *BluePrint's* identification of a need to focus on timely access to care, there was consensus across stakeholder groups and representatives that there are significant gaps in services across the Boards in Ohio, though the extent of the gaps in services and the types of services lacking varied across counties and Boards. The most frequently identified gaps in care included:

- Same-day access to detoxification and addiction treatment
- 24/7 crisis intervention services, including mobile capacity
- Readily accessible outpatient MH and AOD treatment
- Peer supports and recovery coaches
- Family education and supports
- Housing
- Employment/Supported Employment
- Care coordination between high-intensity inpatient services and outpatient treatment
- Court diversion initiatives
- Access to treatment and supports for children with serious emotional disturbance who are not wards of the court

To quantitatively assess gaps in service capacity, the Consultants recommend that a full statewide needs assessment be completed. The analysis would be done at the Board level and include the number of consumers served and penetration rates by type of service and target population, and waitlist data (where available) as a proxy for unmet need. Historical and current trends in data should be used to project future needs and indicate where specific services are falling short of the demand, or are projected to be insufficient in the future. Keeping in mind that a strength of Ohio's behavioral health system is that the structure of the Boards is to manage systems of care locally and drive innovation through working with local partners to determine what works best in their communities, the specific allocation of funds within a local Board area is driven by the priorities determined by that Board. Therefore, the state allocating funds to build up a particular type of service that is deemed insufficient according to data analysis, *independent of input from each local Board*, would not be effective.

While not technically a service, a significant gap identified by the Consultants is the meaningful input of consumers, families, and persons in recovery in Ohio's behavioral health system as evidenced by responses received in the focus group of engaged consumers/family members. The *BluePrint* calls for a primary focus on clients and families, and local communities are working to engage more clients and families to help drive the policy and programmatic decisions at the local level. Client and family representatives serve as statutorily appointed members of the Governing Board for each ADAMH Board. Additionally, the Association has a Recovery Is Beautiful Advisory Committee made up of individuals in recovery and family members that is helping drive the implementation of the *BluePrint*. The focus on fully involving clients and family members in the local Recovery-Oriented Systems of Care will be critical to the success of Ohio's transition to ROSC.

Needed Enhancements to Existing Services

The stakeholder feedback validated some of the work of the *BluePrint* and indicated that beyond filling in specific service gaps, enhancements to service capacity or the system in general could result in better outcomes for individuals in need of care. The most frequently identified needed enhancements included:

- Information and referral so that individuals, families, primary care practitioners, and community members know how to access behavioral health treatment and supports when needed.
- Outreach and intake based upon a "no wrong door" approach to accessing care.
- Waiting lists and wait times for outpatient services must be reduced and preferably eliminated.
- Services must be available at times beyond normal business hours. Access to services during the evenings and possibly weekends will help to decrease emergency department visits and admissions for children and youth as well as adults.
- Not only should peer support and recovery coaches exist as stand-alone services, they should be embedded in other services such as crisis intervention, addictions treatment, and transitional care from inpatient settings.
- Collaborative approaches among Boards could create access to specialty services in rural areas where a single county cannot support the need. A number of joint projects across board areas already exist to achieve economies of scale. There are projects in place to address housing, residential treatment needs, crisis care, and more. Ensuring a regulatory environment that continues to support this type of collaboration is critical.
- Prevention, treatment, recovery, and advocacy working together to maximize each others' efforts.

Challenges to Implementation of ROSC in Ohio

Like other states and communities across the country, Ohio faces a number of challenges, identified by the interviews and focus group participants, in order to successfully implement a ROSC statewide. Many of these barriers formed the basis of the recommendations which appear later in this report; however, some address complex issues that are outside the scope of this report. Challenges identified by participants include:

- Workforce shortages, particularly psychiatrists. Participants expressed that OhioMHAS should work to develop workforce recruitment incentives. Finding and keeping appropriately trained and licensed staff in the public behavioral health system continues to be a challenge as more and more entities are seeking the services of professional clinical staff.
- Outcomes are not being measured using a standardized format or methodology, and as a result there is no systemic way to evaluate provider performance. Only Medicaid providers will be subject to value-based purchasing in 2018. The *BluePrint* also recommends that Boards implement outcomes-based contracting mechanisms.
- There has been no infrastructure investment since 1988. Insurance and Medicaid do not pay for the enhancements necessary in the evolving health care environment, such as electronic health records, technology, and data systems. So, effectively, the burden for the provision of a standardized data system has been shifted to local Boards.

- Boards need oversight of all local programs — health care is local. Boards know which providers offer quality care. Boards understand where there are gaps in services and need full control in order to develop comprehensive community plans. By directly funding providers, OhioMHAS limits local control.
- Boards do not have access to service utilization data across funding streams.
- The system is set up to pay for units of service, instead of promoting funding flexibility to meet the needs of the client. Community mental health centers do not have an incentive to release clients because of the fee-for-service model.
- In some instances, clients never come off the rolls of a provider. Because one of the key values of ROSC is self-direction, clients could stay in treatment for longer periods of time. This could present challenges to provider capacity. It will be important for the provider to work collaboratively with clients to ensure timely transitions to different levels of care.
- Medicaid does not pay for training on the latest evidence-based practices, which slows or inhibits the adoption of innovation.
- Medicaid expansion has increased the client population faster than the growth of the provider networks.
- Wait times for detox services can be several weeks long. In some communities, the quickest way in may be court-ordered detox.
- The complexity of the system is a challenge for clients, because they don't know whom to go to.
- Regulatory barriers for peer support: Current and former clients seeking employment as peer support staff are subject to criminal background checks which becomes a barrier for some.
- Drug-related felony convictions are a barrier to employment and housing opportunities.
- All agreed that it was preferable to keep people out of the criminal justice system, yet that was identified as the most likely and effective "gate" for people to gain access to treatment.
- Cost savings as a result of coordinated managed care aren't required to be reinvested back into the system.
- Funding seems to follow the latest crisis and is therefore reactive and unstable.
- Stigma: public attitudes and perception about mental illness and addiction continue to cause challenges for the community behavioral health system. The work of Recovery Is Beautiful to change the conversation about mental illness and addiction in Ohio is necessary, but more work is needed on a much broader scale in order to truly eliminate stigma in Ohio and across the country.
- The statutory continuum of care requirements have become one of the primary factors influencing community service delivery system. This language, which requires a major focus on a

singular disease state, may put the Boards at a disadvantage for planning and funding a local ROSC, particularly when the community may have different needs than those identified in the continuum of care.

While these challenges are real and will impact the pace at which Boards can move forward with ROSC, the greater challenge appears to be the constantly shifting landscape for behavioral health services in Ohio. As the behavioral health system in Ohio continues to evolve, there will be challenges associated with the changes. The ROSC framework provides a good structure for local communities to utilize as they navigate the changes and strive to ensure access to a full continuum of care that is appropriately resourced.

Variation in Per Capita Funding Across Boards

The total amount of behavioral health services funding across all public sources — including Medicaid expenditures, state general funds, federal grants, local levies and grants, state pass-through grants, and direct grants to providers — varies considerably by Board from a low of $39.02 per capita to a high of $219.29 per capita. NRI grouped the total resources distributed across counties in 2015 into five ranges of funding which span from a low of $60 or less per capita to a high of more than $150 per capita.

Figure 3 below depicts total fiscal year 2015 behavioral health funding by Board, including Medicaid mental health and AOD expenditures; state, federal and local funds that flow through the Boards; and direct grants from OhioMHAS to local providers. Expenditures by other state agencies for behavioral health services (e.g., child welfare, corrections, etc.), first and third party funding, and grants that are solely obtained and administered by local providers are unknown and not included in any of the data analyses.

Figures 4 and 5 are a different representation of the data presented in Figure 3. These maps show per capita funding for mental health services (Figure 4) and AOD services (Figure 5). The reader is encouraged to pay particular attention to the legend in each map because the scales vary.

Figure 3:

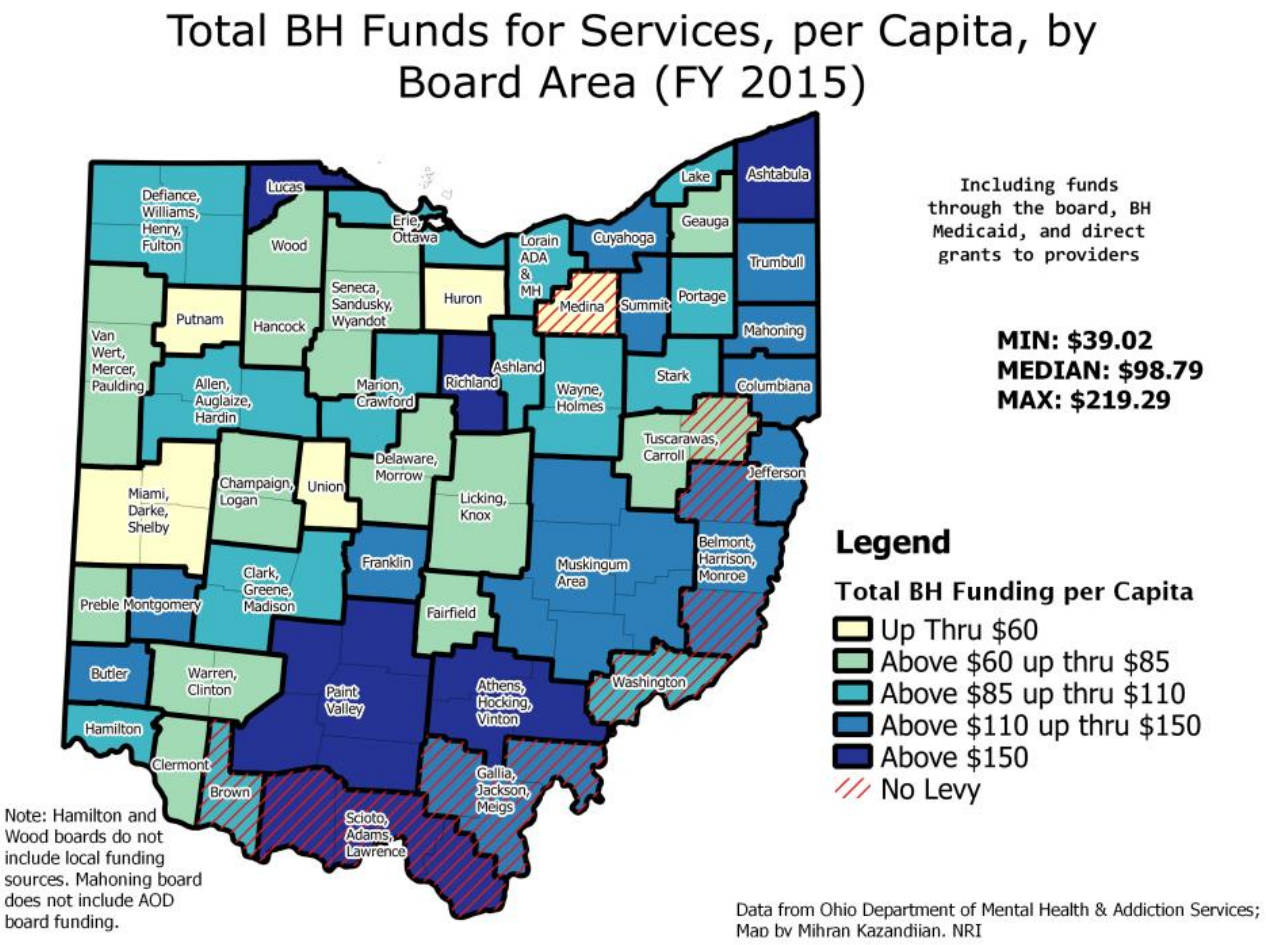

Total BH Funds for Services, per Capita, by Board Area (FY 2015)
Including funds through the board, BH Medicaid, and direct grants to providers
MIN: $39.02
MEDIAN: $98.79
MAX: $219.29
Legend
Total BH Funding per Capita
Up Thru $60
Above $60 up thru $85
Above $85 up thru $110
Above $110 up thru $150
Above $150
No Levy
Defiance, Williams, Henry, Fulton
Lucas
Wood
Erie, Ottawa
Lorain ADA & MH
Cuyahoga
Lake
Ashtabula
Geauga
Trumbull
Portage
Mahoning
Columbiana
Putnam
Hancock
Seneca, Sandusky, Wyandot
Huron
Medina
Summit
Van Wert, Mercer, Paulding
Allen, Auglaize, Hardin
Marion, Crawford
Richland
Ashland
Wayne, Holmes
Stark
Tuscarawas, Carroll
Jefferson
Delaware, Morrow
Union
Champaign, Logan
Miami, Darke, Shelby
Licking, Knox
Franklin
Clark, Greene, Madison
Preble
Montgomery
Fairfield
Muskingum Area
Belmont, Harrison, Monroe
Butler
Warren, Clinton
Paint Valley
Athens, Hocking, Vinton
Washington
Hamilton
Clermont
Brown
Gallia, Jackson, Meigs
Scioto, Adams, Lawrence
Note: Hamilton and Wood boards do not include local funding sources. Mahoning board does not include AOD board funding.
Data from Ohio Department of Mental Health & Addiction Services; Map by Mihran Kazandjian, NRI

Figure 4:

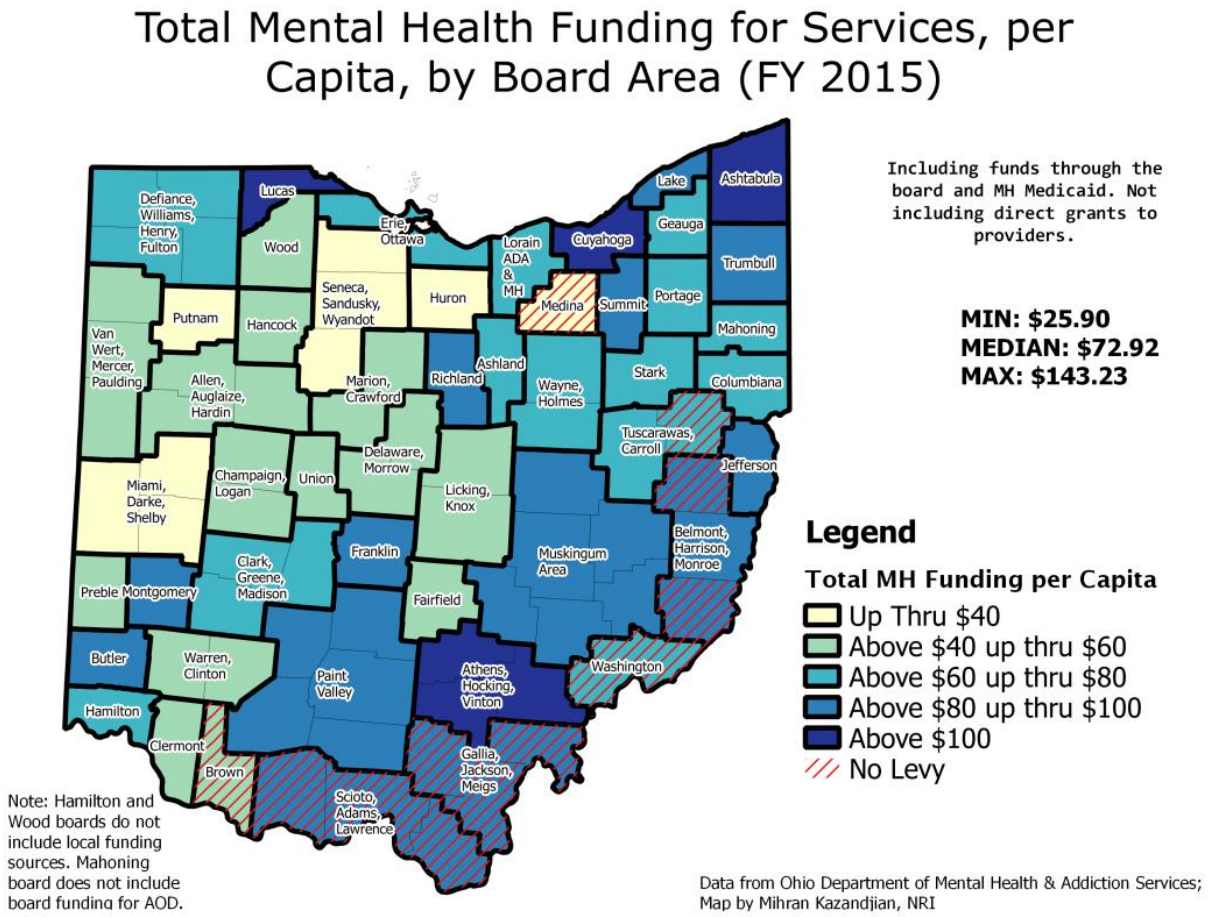
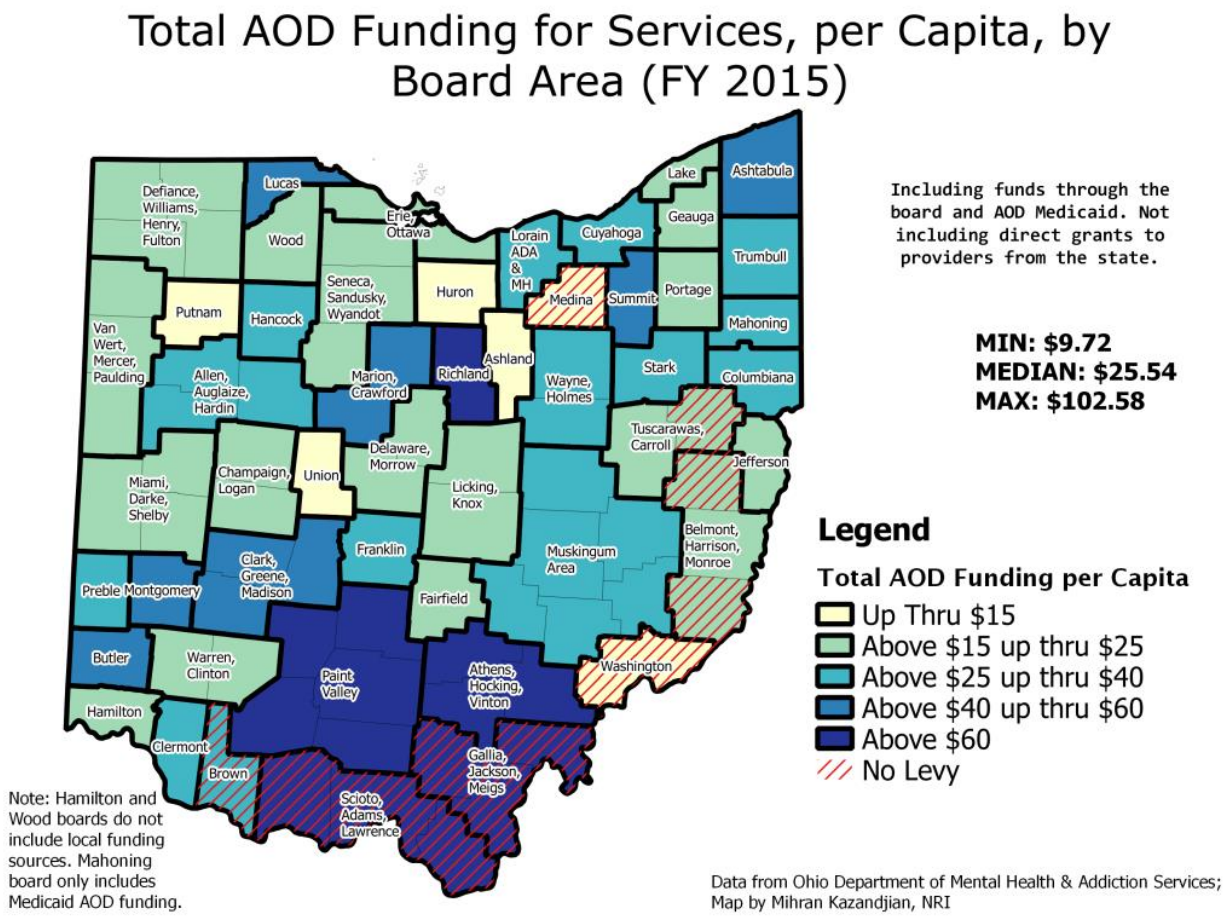

Total Mental Health Funding for Services, per Capita, by Board Area (FY 2015)
Including funds through the board and MH Medicaid. Not including direct grants to providers.
MIN: $25.90
MEDIAN: $72.92
MAX: $143.23
Legend
Total MH Funding per Capita
Up Thru $40
Above $40 up thru $60
Above $60 up thru $80
Above $80 up thru $100
Above $100
No Levy
Defiance, Williams, Henry, Fulton
Lucas
Wood
Erie, Ottawa
Lorain ADA & MH
Cuyahoga
Lake
Ashtabula
Geauga
Trumbull
Seneca, Sandusky, Wyandot
Huron
Medina
Summit
Portage
Mahoning
Putnam
Hancock
Van Wert, Mercer, Paulding
Allen, Auglaize, Hardin
Marion, Crawford
Richland
Ashland
Wayne, Holmes
Stark
Columbiana
Tuscarawas, Carroll
Jefferson
Delaware, Morrow
Champaign, Logan
Union
Licking, Knox
Miami, Darke, Shelby
Franklin
Muskingum Area
Belmont, Harrison, Monroe
Clark, Greene, Madison
Preble
Montgomery
Fairfield
Butler
Warren, Clinton
Paint Valley
Athens, Hocking, Vinton
Washington
Hamilton
Clermont
Brown
Gallia, Jackson, Meigs
Scioto, Adams, Lawrence
Note: Hamilton and Wood boards do not include local funding sources. Mahoning board does not include board funding for AOD.
Data from Ohio Department of Mental Health & Addiction Services; Map by Mihran Kazandjian, NRI

Figure 5:


Total AOD Funding for Services, per Capita, by Board Area (FY 2015)
Defiance, Williams, Henry, Fulton
Lucas
Wood
Erie, Ottawa
Lorain ADA & MH
Cuyahoga
Lake
Ashtabula
Geauga
Trumbull
Portage
Medina
Summit
Mahoning
Columbiana
Stark
Wayne, Holmes
Tuscarawas, Carroll
Jefferson
Belmont, Harrison, Monroe
Muskingum Area
Washington
Athens, Hocking, Vinton
Gallia, Jackson, Meigs
Scioto, Adams, Lawrence
Brown
Clermont
Hamilton
Butler
Warren, Clinton
Paint Valley
Preble
Montgomery
Clark, Greene, Madison
Fairfield
Franklin
Licking, Knox
Delaware, Morrow
Union
Champaign, Logan
Miami, Darke, Shelby
Van Wert, Mercer, Paulding
Putnam
Hancock
Seneca, Sandusky, Wyandot
Huron
Ashland
Richland
Marion, Crawford
Allen, Auglaize, Hardin
Including funds through the board and AOD Medicaid. Not including direct grants to providers from the state.
MIN: $9.72
MEDIAN: $25.54
MAX: $102.58
Legend
Total AOD Funding per Capita
Up Thru $15
Above $15 up thru $25
Above $25 up thru $40
Above $40 up thru $60
Above $60
No Levy
Note: Hamilton and Wood boards do not include local funding sources. Mahoning board only includes Medicaid AOD funding.
Data from Ohio Department of Mental Health & Addiction Services; Map by Mihran Kazandjian, NRI

Variation in Per Capita Funding Across Funding Streams

In addition to the variation in total funding across Boards, there is variation in the amount of per capita funding sources across the different funding types. Medicaid claims for behavioral health services ranged from a low of $19.47 per capita to a high of $186.15 per capita. Board-administered state, federal block grant and local funds ranged from a low of $9.02 per capita to a high of $62.48 per capita. Finally, direct grants to providers ranged from a low of $5,000 to a high of $7.2 million; and pass-through grants ranged from a low of $5,000 to a high of $3.4 million. Only three counties, Huron, Medina and Union, did not receive any pass-through grant funding. Figures 6, 7, and 8 below depict total behavioral health per capita funding, by funding source for each Board Area.

Figure 6 shows total behavioral health Medicaid allowable amounts per capita. “Allowed amounts” refers to the dollar amounts that Medicaid reimbursed for services, which may differ from the amount that the provider billed. These Medicaid expenditures were attributed to the client’s Board of residence, as opposed to the location of service, to avoid artificial inflation of Medicaid expenditures in an area with a large service provider.

Figure 7 shows funding that flows through each Board from state sources. Figure 10 on page 29 later in the report shows the total dollar amounts and percentages of state funding that flow to and through the Boards.

Figure 8 shows per capita funding from local levies. Twelve counties have no levy; some of these counties are located within a multi-county Board where one county has a local levy and the other does not.

A complete set of maps depicting Board funding can be found in Appendix D.

Figure 6:

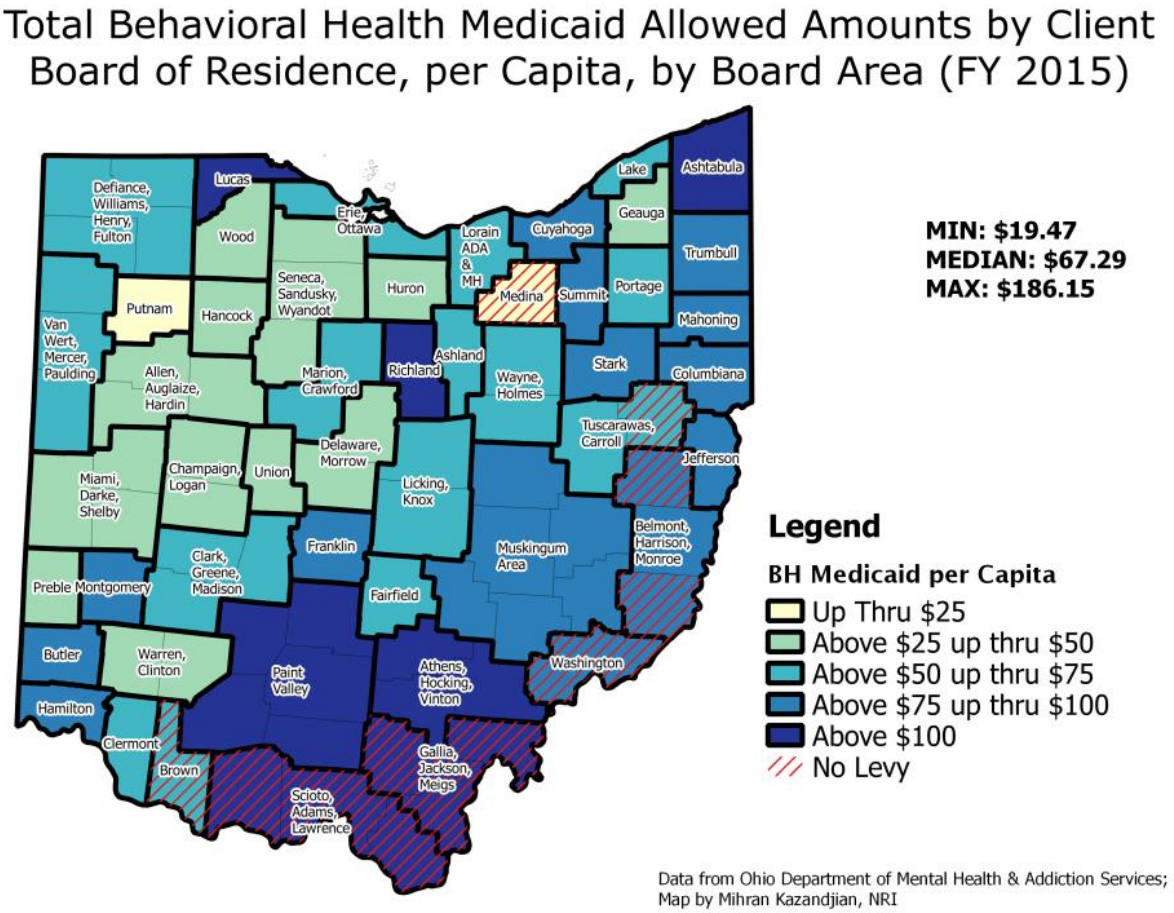

Total Behavioral Health Medicaid Allowed Amounts by Client Board of Residence, per Capita, by Board Area (FY 2015)
Defiance, Williams, Henry, Fulton
Lucas
Wood
Erie, Ottawa
Lorain ADA & MH
Cuyahoga
Lake
Ashtabula
Geauga
Trumbull
Putnam
Hancock
Seneca, Sandusky, Wyandot
Huron
Medina
Summit
Portage
Mahoning
Van Wert, Mercer, Paulding
Allen, Auglaize, Hardin
Marion, Crawford
Richland
Ashland
Wayne, Holmes
Stark
Columbiana
Tuscarawas, Carroll
Jefferson
Delaware, Morrow
Champaign, Logan
Union
Licking, Knox
Miami, Darke, Shelby
Belmont, Harrison, Monroe
Franklin
Muskingum Area
Clark, Greene, Madison
Preble
Montgomery
Fairfield
Butler
Warren, Clinton
Paint Valley
Athens, Hocking, Vinton
Washington
Hamilton
Clermont
Brown
Gallia, Jackson, Meigs
Scioto, Adams, Lawrence
MIN: $19.47
MEDIAN: $67.29
MAX: $186.15
Legend
BH Medicaid per Capita
Up Thru $25
Above $25 up thru $50
Above $50 up thru $75
Above $75 up thru $100
Above $100
No Levy
Data from Ohio Department of Mental Health & Addiction Services;
Map by Mihran Kazandjian, NRI

Figure 7:

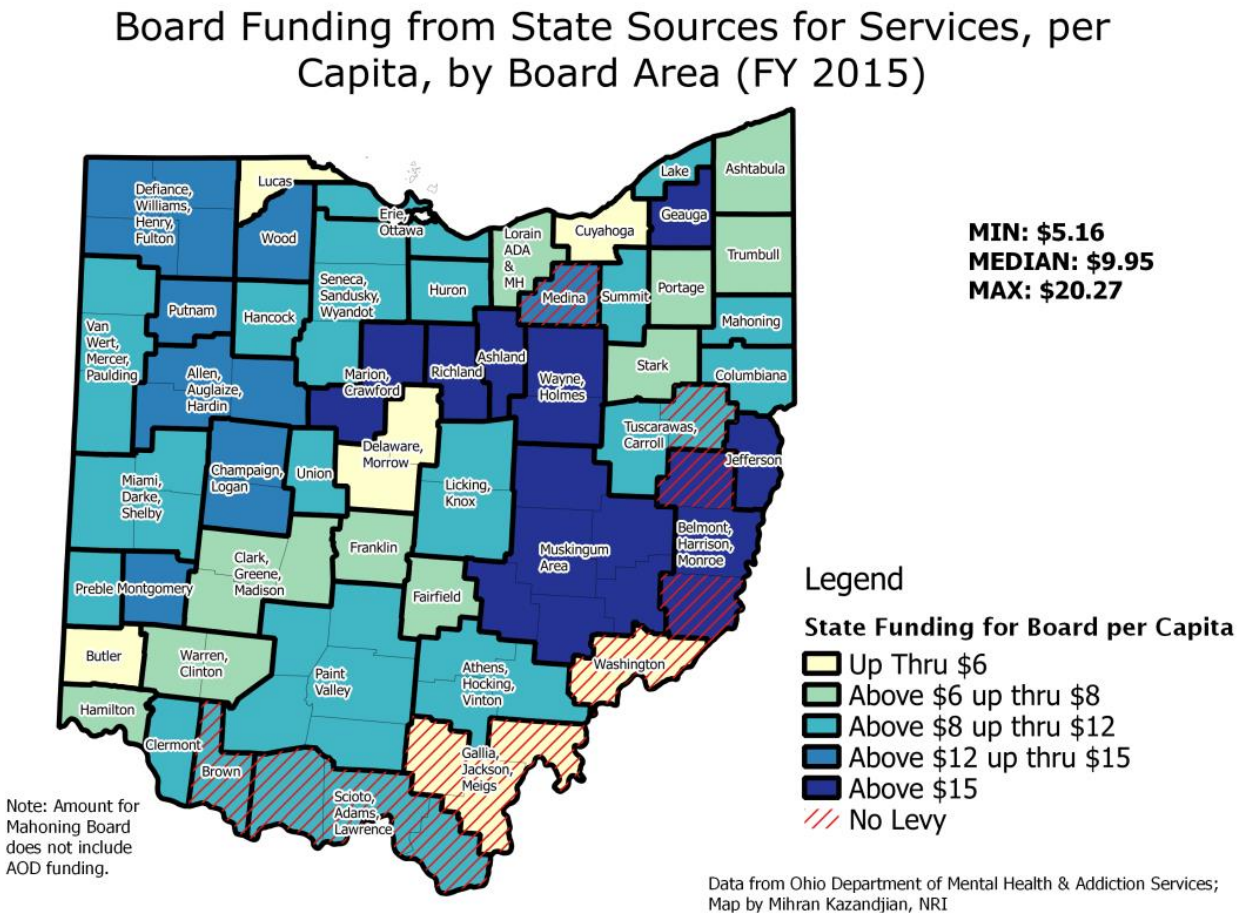
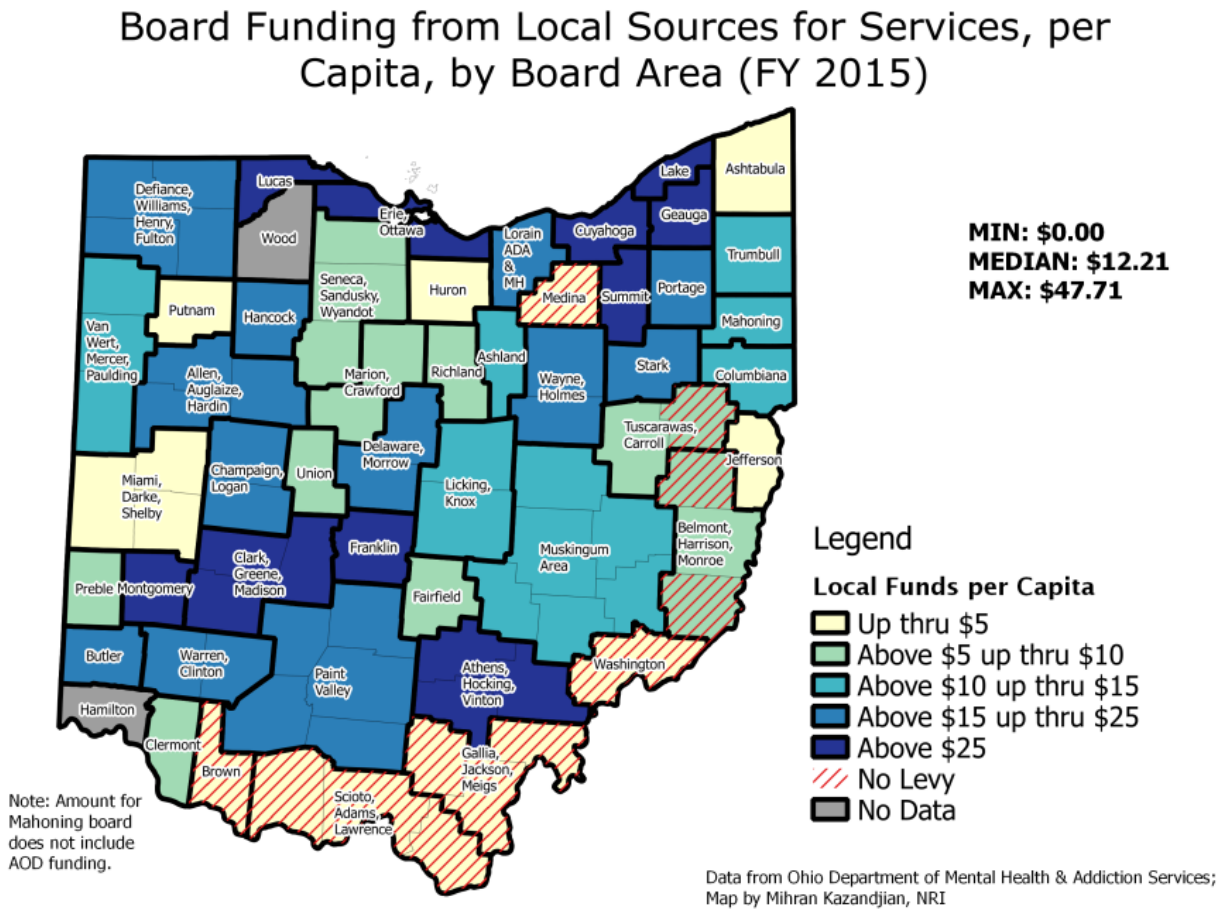

Board Funding from State Sources for Services, per Capita, by Board Area (FY 2015)
Defiance, Williams, Henry, Fulton
Lucas
Wood
Erie, Ottawa
Lorain ADA & MH
Cuyahoga
Lake
Ashtabula
Geauga
Trumbull
Seneca, Sandusky, Wyandot
Huron
Medina
Summit
Portage
Mahoning
Putnam
Hancock
Van Wert, Mercer, Paulding
Allen, Auglaize, Hardin
Marion, Crawford
Richland
Ashland
Wayne, Holmes
Stark
Columbiana
Tuscarawas, Carroll
Jefferson
Delaware, Morrow
Union
Champaign, Logan
Miami, Darke, Shelby
Licking, Knox
Belmont, Harrison, Monroe
Franklin
Muskingum Area
Clark, Greene, Madison
Preble
Montgomery
Fairfield
Butler
Warren, Clinton
Paint Valley
Athens, Hocking, Vinton
Washington
Hamilton
Clermont
Brown
Gallia, Jackson, Meigs
Scioto, Adams, Lawrence
Note: Amount for Mahoning Board does not include AOD funding.
MIN: $5.16
MEDIAN: $9.95
MAX: $20.27
Legend
State Funding for Board per Capita
Up Thru $6
Above $6 up thru $8
Above $8 up thru $12
Above $12 up thru $15
Above $15
No Levy
Data from Ohio Department of Mental Health & Addiction Services; Map by Mihran Kazandjian, NRI

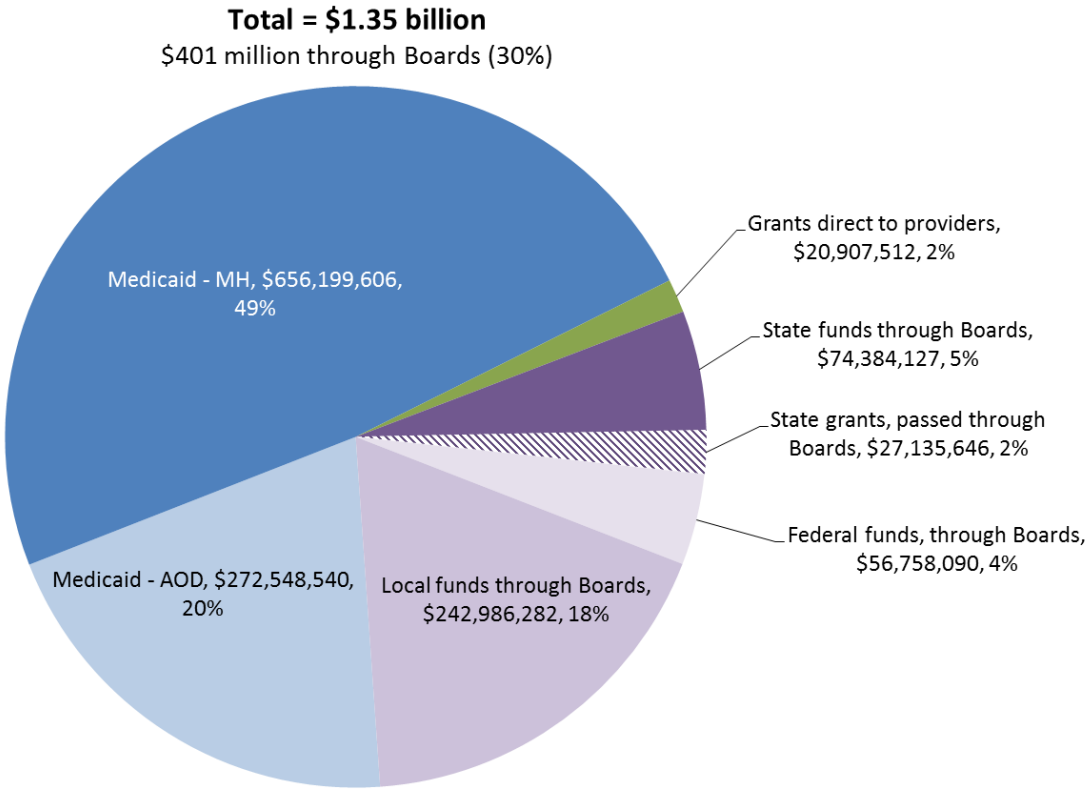
Figure 8:


Board Funding from Local Sources for Services, per Capita, by Board Area (FY 2015)
Defiance, Williams, Henry, Fulton
Lucas
Wood
Erie, Ottawa
Lorain ADA & MH
Cuyahoga
Lake
Ashtabula
Geauga
Trumbull
Portage
Medina
Summit
Mahoning
Seneca, Sandusky, Wyandot
Huron
Putnam
Hancock
Van Wert, Mercer, Paulding
Allen, Auglaize, Hardin
Marion, Crawford
Richland
Ashland
Wayne, Holmes
Stark
Columbiana
Tuscarawas, Carroll
Jefferson
Delaware, Morrow
Union
Champaign, Logan
Miami, Darke, Shelby
Licking, Knox
Belmont, Harrison, Monroe
Franklin
Muskingum Area
Clark, Greene, Madison
Preble
Montgomery
Fairfield
Butler
Warren, Clinton
Paint Valley
Athens, Hocking, Vinton
Washington
Hamilton
Clermont
Brown
Gallia, Jackson, Meigs
Scioto, Adams, Lawrence
MIN: $0.00
MEDIAN: $12.21
MAX: $47.71
Legend
Local Funds per Capita
Up thru $5
Above $5 up thru $10
Above $10 up thru $15
Above $15 up thru $25
Above $25
No Levy
No Data
Note: Amount for Mahoning board does not include AOD funding.
Data from Ohio Department of Mental Health & Addiction Services; Map by Mihran Kazandjian, NRI

Analysis of the Data

Figure 9 depicts statewide funding of behavioral health services in Ohio in Fiscal Year 2015; however, as the previous figures display, the ways this funding is realized within each Board and its counties are very different.

Figure 9: Ohio Public Behavioral Health Funding for Services: FY 2015



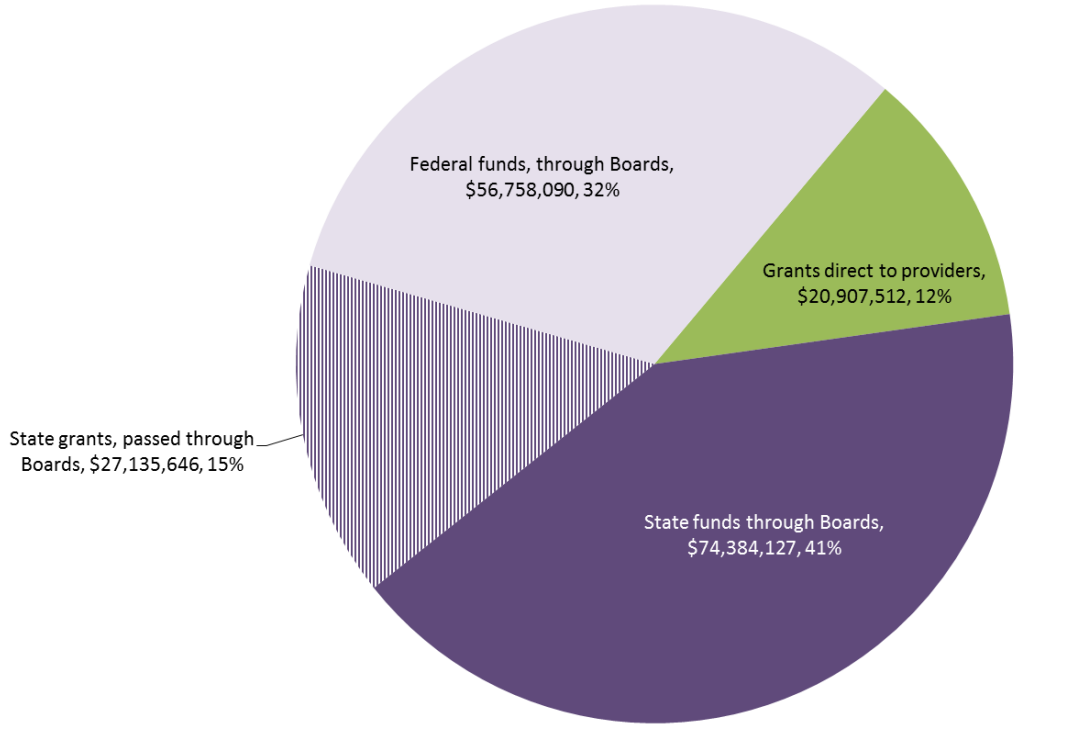
Note: Excludes State Hospitals
Hamilton and Wood Boards did not provide local funding sources. Mahoning county did not provide AOD Board funding
Source: Board 040 Reports, Medicaid Allowed Amounts, State grants. Data provided by OMHAS

Figure 10 below depicts the $179 million of OhioMHAS funding that flows to local behavioral health programs, $158 million (88%) of which flows through the Boards. However, only $131 million (78%) is controlled by the Boards when direct and pass-through grants to providers are excluded.

Figure 10: Funding from OhioMAS to Local Programs

Total = $179 million

$158 million through Boards (88%)



Note: Hamilton and Wood Boards did not provide local funding sources. Mahoning county did not provide AOD Board funding
Source: Board 040 Reports, Medicaid Allowed Amounts, State grants. Data provided by OMHAS

Implications of the geographic variation in funding streams and levels

The ongoing work to implement the *BluePrint* and the charge given to the Resource Modernization Workgroup recognizes that the implementation of a statewide ROSC must take into account the disparity in total funding across Boards, as well as among individual funding sources. Ohio's communities are unique and several factors come into play when looking at the funding picture for Boards throughout Ohio.

Factors Driving the Variation

Several factors the Consultants have identified are likely contributing to variation in the amounts supplied by certain funding sources and to the impact in meeting service needs.

Disparities in Income

Medicaid eligibility in Ohio is tied in large part to income, historically reserved for individuals with dependent children and an income up to 90 percent of the federal poverty level (FPL). Single adults without dependents were not eligible. Even with Medicaid expansion, Medicaid recipients typically have limited income and resources, though single adults without dependents and an income up to 133 percent of FPL are now eligible for coverage. High Medicaid expenditures per capita are found in

counties with urban centers and counties in southeastern Ohio. In addition to a higher concentration of Medicaid recipients, urban areas also have the highest concentration of providers generating Medicaid claims. Not surprisingly, the concentration of eligible recipients and enrolled providers results in higher Medicaid expenditures.

Culture

Most of the counties with the lowest Medicaid expenditures are found in western Ohio. The Consultants did not compare income levels in these counties with those in counties with higher Medicaid expenditures. However, the lower expenditures in western Ohio may be related to a combination of a limited number of Medicaid-enrolled providers and a conservative culture that embraces 'taking care of one's own' as opposed to relying on government assistance. This conservative culture also likely coincides with greater stigma associated with behavioral health disorders. Individuals in these communities may be receiving behavioral health interventions and treatment through their primary care providers or faith-based organizations rather than the specialty behavioral health system.

Levies

The Consultants originally anticipated that counties without a behavioral health levy would fall within the lower ranges of total per capita funding. This was not consistently the case however. Nine of the counties that do not have levy funds are in the upper ranges of total behavioral health funds per capita: Scioto, Adams, Lawrence, Gallia, Jackson, Meigs, Belmont, Harrison, and Monroe. Belmont, Harrison, and Monroe Counties have high levels of state funding, while Scioto, Adams, Lawrence, Gallia, Jackson, and Meigs have higher Medicaid expenditures.

Direct Grants and Pass-Through Funds

In 2015, OhioMHAS allocated $20.9 million in direct grants to providers and passed $27.1 million through the Boards to providers for targeted initiatives and populations. While these grants and pass-through funds are relatively small, representing only four percent of total behavioral health funding in Ohio, they do appear to contribute to total per capita funding variations across Boards.

Understanding the Effects of Funding Variation

All funding streams can be used to support components of ROSC, but no single funding stream can or should support the full array within a ROSC. Medicaid is a statewide program with a required scope of behavioral health benefits, and in theory provides coverage for the same set of services in every county. However in reality, as described earlier, local factors such as availability of providers and cultural acceptance of government assistance likely contribute to variation in how services are funded across counties and Boards. Access to the most flexible funding streams is critical for addressing local community needs. One can argue that the local levies are the most flexible funding sources available to the Boards, though twelve counties do not have levies to support behavioral health services.

Establishment of a ROSC, and the ability to come into compliance with providing continuums of care for individuals in need of behavioral health services, will be challenging without a base level of per capita funding for every county.

Some Specific Board Areas Are Consistently Underfunded

There are counties and Boards that have consistently higher levels of funding across the various funding sources — and, of greater concern, there are counties that have consistently lower levels of funding across the various funding sources.

Table 1. Boards Falling within the Bottom Range by Source of Funding within at Least Two Categories

Board Area	Total Per Capita $$	Total AOD Per Capita $$	Total MH Per Capita $$	Medicaid Expenditures Per Capita	Direct Grants to Providers	Pass-Through Funds to Providers
	Incl. Medicaid; state, fed, local thru Boards. See Fig. 3	*Incl. AOD $ thru Boards + AOD Medicaid. See Fig. 5*	*Incl. MH $ thru Boards + MH Medicaid. See Fig. 4*	*Incl. MH + AOD Medicaid. See Fig. 6*		
Ashland		X				X
Huron	X	X	X		X	X
Medina+	X	X	X	X		
Putnam	X	X	X	X		
Miami/Darke/Shelby	X		X		X	
Union	X	X				
Washington+		X				X

+ County does not have a behavioral health levy

As stated earlier in this report, no single funding source covers all ROSC services. A county should have a foundation of per capita funding across various sources in order to fully support a ROSC. The counties identified above appear to have consistent levels of funding in the bottom range(s) putting them at a significant disadvantage for implementing a ROSC and complying with the mental health and AOD continuums.

Policy Decisions That Impact how Board Funds Are Spent

The Consultants identified a number of policy issues determined at the county and Board levels that impact how funding is used.

Board Funding of Medicaid-Eligible Services

In a review of the Board-level budget reports (040 Reports), the Consultants identified patterns of non-Medicaid funding applied to Medicaid-reimbursable services. Crisis intervention services were most frequently funded with non-Medicaid sources. Board representatives acknowledged that it was often difficult to identify and verify a person's Medicaid eligibility during a crisis contact and unless the individual was known by the agency to be a Medicaid recipient, the service would be billed to state funding or local levies. Billing Medicaid for crisis intervention services is known to be challenging; it is commonly a lower-generating service for Medicaid. This is because Medicaid will cover the cost of the crisis service when it is delivered, but Medicaid will not cover the costs associated with providing 24/7 access to crisis services. This is an area where Board investment is critical to sustaining crisis programs in communities throughout Ohio. Additionally, the impact of the IMD exclusion impacts overall access to and funding of residential services.

In addition, local policies regarding the payment of services for Medicaid eligible individuals who have not yet accessed Medicaid may vary from Board to Board based on their financial ability to pay for services. In the best of situations individuals who are Medicaid eligible are helped to apply for and become Medicaid eligible.

Appendix E shows the percentage of total Board funding used for Medicaid-reimbursable services.

County Levies

Decisions about levies are made in conjunction with county partners and these decisions impact the ability to fund a ROSC in three ways:

- Of the 88 counties in Ohio, 76 have local levies; 12 have no local levy.
- The language included in the levy is also very important.
    - Some counties limit levies to county residents or to services provided within the county, preventing counties within a multi-county Board from participating in shared funding of specialized services
    - In some counties, the levy language only allows levy funds to be spent on mental health services, as opposed to all behavioral health services
- In the past several years, levy passage rates have been very good, but as a result of some changes to a state rollback on local property taxes, local communities are forced to make difficult decisions about running renewal or replacement levies.

The Boards will have to take these policies into account in making recommendations for how additional funding, should it be made available, is distributed.

Appendix F shows the Boards with local levies.

The Role of Other Systems and Agencies in ROSC

Many services that are critical to ROSC are not and should not be solely funded by the behavioral health system. Housing, employment, health care, and access to basic life necessities can be facilitated through sister agencies and "mainstream" funding sources. Local housing authorities, workforce boards, and faith-based agencies are examples of gateways to accessing natural supports in the community. Local leadership and relationships are essential to ensure that individuals with behavioral health disorders can participate in the community to the same degree as residents who do not have a disability. As outlined in the *BluePrint's* principle related to locally managing systems of care, Boards and counties are in the best position to determine how to use funding based on local strategies for service delivery. Fluctuations in funding patterns are impacted by the Boards' decisions about which services best meet needs and provide better outcomes for their specific community.

Housing is an excellent example of how Board funds can be leveraged to access additional funding to support individuals with behavioral health disorders. Boards throughout Ohio are working with community partners, provider agencies, metropolitan housing authorities, and more to leverage resources to develop housing stock in their communities for individuals with mental illness or addiction.

As the local hubs, Boards are well positioned to bring together coalitions and partnerships to continue leveraging resources for housing.

Limitations of the Data

The Consultants used all data at their disposal to perform the analysis for this report, however there are notable limitations to the data received and what we could glean from the data.

- The full details have not been made available regarding behavioral health services coverage under the new Medicaid Managed Care benefit to be implemented in January 2018.
- Expenditures by other state agencies for behavioral health services (e.g., child welfare, corrections), first and third party funding, and grants that are solely obtained and administered by local providers are unknown and not included in any of the data analyses.
- Boards reported there is likely variation in how certain costs are reported by counties on the 040 Report.
- Data was not provided to substantiate outcomes for existing services funded by the Boards. As a result, the report can only be viewed as assessing adequacy of funding amounts and should not be used to assess the adequacy of funded services.

The fiscal data utilized in this report comes from State Fiscal Year 2015; OhioMHAS indicated that much of the data had not been verified at the time of the request and therefore the data contained in all analyses are considered unofficial. When reviewing the data, the following factors must also be considered:

- In SFY 2015, the SAPT Block Grant Realignment was underway. In all four quarters of SFY 2015, the SAPT Block Grant quarterly distribution was down by approximately 20%.

- In SFY 2015, significant changes were made to the distribution of the GRF 507 line item. The line item that had a total appropriation of $47.5 million was utilized to: support prevention programming ($6.5 million); support recovery housing ($5 million); defray payroll costs so local courts could hire specialty docket staff ($4.4 million); increase funding for the Residential State Supplement program ($7.5 million); and address gaps in care in consultation with local ADAMH Boards, with an emphasis on crisis services and housing ($24.1 million).

- In SFY 2015, Medicaid Expansion was still ramping up in Ohio. The initial implementation of Medicaid expansion began on January 1, 2014 and for the next year the enrollment numbers for the Medicaid expansion population continued to increase as Medicaid expansion rolled-out in Ohio.

Recommendations for Resource Modernization

The *Recovery is Beautiful BluePrint* sets out a five-year plan with overarching goals and action steps designed to make the changes necessary to advance Ohio's community mental health and addiction system in the ever-changing health care landscape. The *BluePrint* affirms the Boards' commitment to assuring that residents of every Ohio community live healthier lives through improved access to quality mental health and addiction prevention, treatment, and recovery support services. In order to achieve the vision laid out in the *BluePrint*, Boards will need to develop local plans and establish the necessary goals and action steps to move their communities forward as Recovery-Oriented Systems of Care that meet the unique needs of their local communities.

The Boards are working to implement ROSC in their communities, though admittedly are at various stages. The Resource Modernization Workgroup was convened as a second phase of the *BluePrint* work in order to develop a resource strategy for implementing Recovery-Oriented Systems of Care at the local level. The Resource Modernization Workgroup was charged with determining the resources necessary for Ohio to become a dynamic, sustainable, and integrated Recovery-Oriented System of Care and developing a methodology for funding a complete ROSC for all individuals and family members.

Essential ROSC Components

In a report about its local efforts, the City of Philadelphia, a nationally recognized leader in the implementation of ROSC, states that… "A recovery-oriented system of behavioral health care will offer citizens an array of accessible services and supports from which they can choose those which are most effective and responsive in addressing their particular behavioral health condition or combination of conditions." The Boards have been challenged to reach consensus on what the minimum array of services should include. The Consultants recommend the following core ROSC services and offer a rationale for the inclusion of each one.

Service	Why a Recommended Core ROSC service
Locate and Inform	People often don't know what services and resources exist until they are in crisis. Systems are complex, often with different access points and procedures for accessing services
Assistance to obtain basic necessary services	This assistance can help to ensure that people obtain needed services, avoiding progression to the need for deeper-end, high cost services. Individuals can better focus on treatment goals when their basic needs are being met.
Inpatient/Residential/Outpatient Treatment/Medication	Core treatment services and medications for mental illness and addiction are critical components of a continuum of care designed to help individuals achieve recovery.

Service	Why a Recommended Core ROSC service
Housing	Treatment will be ineffective if the recipient doesn't have a safe, decent, affordable place to live.
Peer Specialists/Recovery Coaches	Peer support is identified in SAMHSA's Registry of Evidence-Based Practices; individuals with behavioral health disorders are more likely to be engaged in treatment and achieve better outcomes when supported by others who have similar lived experience.
Crisis Intervention and Detoxification Services	Crisis and detoxification services serve as the emergency access to the behavioral health system and can divert from unnecessary emergency department, inpatient admissions, and further involvement with the criminal justice system.
Supported Employment/Supported Education/Work	Lack of education and employment results in poor health/mental health/recovery.
Drop-in Center/Recovery Support Center	Social connectedness, respite, and consumer empowerment are critical for recovery.
Case Management/Care Coordination	People have complex needs requiring services and supports from multiple systems; Case Management/Care Coordination assures coordination and avoids duplication of services.
Prevention/Wellness	A growing body of research shows that eliminating physical, environmental and social stressors and strengthening protective factors can prevent both mental health and addiction disorders, and mitigate progression to debilitating, chronic conditions.

Funding and Allocation Strategies

In implementing a ROSC, there are likely to be multiple payer sources for the array of services and supports. The key is to identify and maximize the use of all potential sources of funding, allowing the Boards to maintain local control over funding and service innovation — and to serve as the safety net when no other resources are available.

The Consultants have identified the following strategy as a basis for determining a funding request.

- Determine the funding level necessary for a Board to provide the core set of ROSC services (mental health and AOD) and use as a funding benchmark for all Boards.
    - **The median total per capita behavioral health funding, excluding Medicaid expenditures, could serve as the benchmark**.

- Once the benchmark is established, determine an amount or percentage of new funding that would go to the underfunded counties/Boards.
- Commit to targeting extreme geographic funding disparities among Boards.
- Provide resources to smaller Boards to help them compete for alternative funding sources in addition to state funding.

Policy Strategies

Several policy and regulatory barriers were identified by the interview and focus group participants that impose challenges to ROSC implementation. The Consultants offer the following recommendations to address the identified issues.

1. Board control over local funding:
    a. Advocate with OhioMHAS to maximize flow of funding through the Boards to drive local control of systems of care.
    b. Ohio residents would best benefit from a robust local behavioral health system with sustained funding, as opposed to fluctuations in resources that are driven by crises and epidemics. Consistently available resources would better ensure that when crises do occur, resources can be appropriately deployed until the situation is resolved.

2. Maximize Medicaid revenues:
    a. Develop a strategy to analyze and describe the population receiving Board-funded Medicaid-eligible services.
        i. Address factors that impede either access to Medicaid or Medicaid coverage for eligible services
        ii. Educate state officials and legislators about impediments to billing Medicaid, such as cultural reluctance to accept government assistance, in order to support future requests for non-Medicaid funding

    b. If more services are identified for Medicaid coverage, support the ability of Boards to retain control of the cost savings through:
        i. Commitment to re-purpose any freed-up funding for ROSC services.
        ii. Commitment to using a percentage of new state funding to leverage other resources to create ROSC capacity, for example to incentivize developers to create additional housing resources
        iii. Commitment to use performance measures and outcome data in support of systems transformation toward value-based purchasing.

    c. Shift providers' historical reliance on other sources of funding toward Medicaid billing:
        i. Commit to transition contracted providers to Medicaid billing within a designated timeframe.
        ii. Promote state initiatives to train providers on Medicaid enrollment and billing.
        iii. By maximizing Medicaid revenue, services should be more readily available to the expanded eligible population, with less reliance on the criminal justice system in order to access treatment.

iv. Increased use of Medicaid dollars should allow the reallocation of funding for non-Medicaid billable recovery and support services for all clients; for example, peer supports, housing, and transportation.

d. Recommend that the state enact managed care contracts that include a full array of mental health and addiction treatment services.

3. Outcome Measurement:
    a. Boards should tie payment to outcomes for all programs, as recommended by the *BluePrint*.
    b. Boards should regularly receive service utilization data for all funding sources to understand the array of services and capacity in their local communities.
    c. Standardize data collection systems and reporting. Build Board infrastructure for data collection and capture the costs required to support data collection/data infrastructure on the 040 reports.

4. Workforce:
    a. Address human resource needs by pooling resources with other agencies and creating shared strategies for workforce recruitment, retention, and training.
    b. Promote learning collaborative to provide ongoing training and support for behavioral health direct care staff by:
        i. Minimizing down time.
        ii. Building support networks that share strategies, challenges, and successes among professional peers.
        iii. Promote the use of peer support specialists and recovery coaches to supplement professional staff.
        iv. Advocate for workforce incentives, for example:
            1. Ensure that loan repayment eligibility criteria include a broad array of behavioral health professionals
            2. Take advantage of the HRSA Mental Health Professional Shortage Area (MHPSA) designation for parts of Ohio
            3. Maximize internship opportunities for new professionals to work in underserved areas

List of Appendices