



Proposed Funding Levels Push Community Mental Health System to Brink of Collapse

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Summary

Governor Strickland's FY 2010-2011 budget framework proposes deep cuts in General Revenue Fund (GRF) funding for the community mental health system that will leave many Ohioans who have mental illness unable to access mental health treatment services in their communities. Once the costs of Medicaid and inpatient hospitalization are factored out, only \$32.4 million, or 4 percent, remain to offset non-Medicaid expenses statewide for the next two years. This translates to the paltry sum of less than \$324,000 per county board per year.

The FY 2010-2011 cuts follow years of stagnant funding levels that have not kept pace with increasing demand for services. The growth of the Medicaid program and in the number of offenders committed to state hospitals for treatment by the court system are eating up increasing shares of GRF for community mental health services and, in some cases, local levy funding. In addition, there has been no change in provider rates since 1997, resulting in a loss of skilled mental health workers, decreased system capacity, and decreased access to services for consumers.

The convergence of all of these factors threatens to destabilize what was once considered to be one of the best community mental health systems in the country.

Background

Ohio's mental health system is state supervised and locally administered by 50 county boards of mental health or combined alcohol, drug addiction, and mental health boards. The system is financed through a combination of federal, state, and local dollars. The boards are responsible for management of their community mental health system, which includes inpatient hospitalization and community services managed through contracts with private providers such as residential, crisis intervention, case management, and other support services. Part of this responsibility is the payment of all Medicaid community mental health services, which include counseling, psychotherapy, diagnostic assessment, and crisis intervention. This system, created by the Mental Health Act of 1988, encourages treatment in the lowest cost and least restrictive setting.

Unlike the parts of Ohio's Medicaid program administered by other agencies, Medicaid services for mental health leave significant gaps in coverage. First, for the Medicaid-eligible population, many services needed to remain in the community and actively participate in society are not covered (i.e., supported housing, vocational services, and wraparound services). Second, Medicaid eligibility is limited to two main categories – covered children and families (CFC) and aged, blind, and disabled (ABD) – leaving many with severe mental illness ineligible for this program. To prevent states from refinancing their state mental hospitals, which were the primary means of care for mental illness at the time, federal Medicaid policy has excluded payment for services in institutions for mental disease

(IMDs) for adults ages 22 to 64 since the 1960s. This exclusion has hampered the development of a comprehensive system of care.

Proposed GRF Funding Levels

Where Medicaid leaves significant gaps in coverage, these gaps have been filled with state and local funds. Over the past decade, Medicaid eligibility has been expanded in Ohio to include low-income working parents, pregnant women, and additional children.¹ State funding for mental health has not been adjusted to account for these changes in eligibility and service utilization, meaning that state and local funding that once had been directed to non-Medicaid services are increasingly needed to cover the non-federal share of Medicaid services. The majority of GRF funding for the community mental health system is allocated through two line-items, Community and Hospital Mental Health Services (334-408) and Local Mental Health Systems of Care (335-505). As shown in Figure 1, GRF funding has fallen dramatically in recent years. GRF funding for mental health totaled \$983 million in the FY 2006-2007 biennium and, under the Governor’s Conference Committee framework, will be reduced to \$774 million in the FY 2010-2011 biennium, a reduction of more than \$200 million.

Figure 1. Mental Health GRF Subsidy Funding

Line Item	Line Item Name	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
334-408	Community & Hospital MH Services	\$ 389,904,182	\$ 400,694,314	\$ 397,540,684	\$ 379,324,545	\$ 379,092,870	\$ 377,332,336
334-505	Local MH Systems of Care	\$ 95,231,237	\$ 97,333,565	\$ 106,511,686	\$ 64,123,194	\$ 4,300,000	\$ 13,294,308
Total		\$ 485,135,419	\$ 498,027,879	\$ 504,052,370	\$ 443,447,739	\$ 383,392,870	\$ 390,626,644

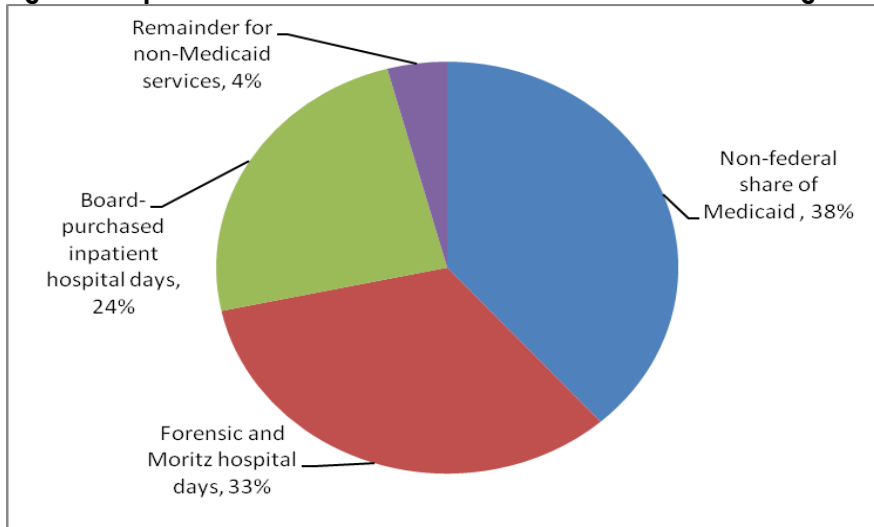
Source: Governor’s Proposed Budget Framework for FY 2010-2011, Draft Appropriation Line Items

The state is also responsible for providing for the cost of inpatient care for the forensic population. Forensic patients are offenders who have been committed to state hospitals for treatment by the court system. The courts, with recommendations from the hospital staff, determine when a forensic patient may be discharged. In addition to the overall decline in GRF funding and the growth in the Medicaid program, the money to finance inpatient hospitalization for the forensic population is taken first from the subsidy allocation, before state funds are distributed to the community mental health system. Demand for forensic care has grown substantially, further eroding state dollars available for community mental health. Forensic patients now occupy more than 50 percent of the beds in the state’s mental institutions.²

What Is Funded at Proposed Levels?

GRF subsidy funding is used to pay for inpatient hospitalization including forensic care, the non-federal share of Medicaid expenses, and non-Medicaid services. Figure 2 shows the share of each of these categories within the FY 2010-2011 biennial GRF subsidy allocation for mental health. Medicaid and inpatient hospitalization costs eat up the lion’s share of available funding. Once the costs of Medicaid and inpatient hospitalization are factored out, only \$32.4 million, or 4 percent, remain to offset non-Medicaid expenses statewide for the next two years. This translates to the paltry sum of less than \$324,000 per board per year.

Figure 2. Expected Statewide Allocation of Mental Health GRF Funding in the FY 2010-2011 Biennium³



The cost of inpatient hospitalization for FY 2010 has been set by the Department of Mental Health at \$525 per day, an increase of 9 percent over FY 2009 levels.⁴ The Department estimates that \$256.8 million, or 33 percent of available funds, will be needed over the next two years to cover the cost of providing inpatient hospital services to forensic patients and those held at Moritz, the state's maximum security hospital. Between 2005 and 2008, the use of forensic beds has increased by 6 percent while the use of board-purchased, or civil beds, has dropped 5 percent. The remaining \$187.2 million, or 24 percent, is the estimated cost of inpatient days that will be purchased by the county boards over the next two years.⁵

Medicaid expenditures are expected to total about \$1 billion over the FY 2010-2011 biennium. Using the enhanced match rate provided under the federal stimulus bill, the non-federal share would total \$297 million over the biennium, or 38 percent of total GRF funding.⁶

While the allocation of subsidy dollars appears sufficient to fund Medicaid and inpatient hospitalization at the state level, the current subsidy distribution formula is outdated and does not adequately fund the need in each board. Many boards must use local levy dollars to supplement state dollars to pay the non-federal share of Medicaid services. Local levy funding varies substantially by county board, and 13 counties currently have no levy support.⁷ The Department of Mental Health has been working with its stakeholders for more than a year to develop a new distribution formula, and tensions are high as an already insufficient pot of money is reallocated between boards.

What Does this Mean for the Mental Health System?

The proposed cuts would have both short- and long-term impacts.

First, the health and welfare of people will be in danger. Under current funding levels, thousands of individuals will not receive treatment and will be deprived of the chance to be stable and productive citizens. Others who lack adequate coverage will show up in other, more expensive systems. Failure to treat individuals with mental illness will result in increased emergency room use, increased hospitalization, and increased expenses in the criminal justice system.

Second, the system itself is also at risk. The ability of the mental health provider network to survive cuts of this magnitude is doubtful. Provider rates have not changed since 1997. As funding for non-Medicaid services dries up and as Medicaid rates fail to keep up with inflation, more and more providers of mental health services will leave the marketplace, decreasing system capacity and consumer access. When this financial crisis passes, the state's mental health system will have to be rebuilt, and the state will likely need to substantially increase rates to be able to attract—or bring back—skilled mental health service providers.

¹ For additional information on Medicaid eligibility, see <http://www.jfs.ohio.gov/OHP/consumers/whoqualifies.stm>.

² Ohio Department of Mental Health, Public Records Request, April 20, 2009 meeting, <http://www.mh.state.oh.us/partner-resources/fund-408-roundtable-dialogues.shtml>.

³ The chart was prepared using line-item data from the Governor's Proposed Budget Framework for FY 2010-2011 and information cited in endnotes 5 and 6.

⁴ The department sets rates annually. The rate has yet not been set for FY 2011 but is assumed to be flat for this analysis.

⁵ Information on inpatient hospitalization rates and demand was obtained from the Ohio Department of Mental Health, Public Records Request, April 20, 2009, meeting, <http://www.mh.state.oh.us/partner-resources/fund-408-roundtable-dialogues.shtml>.

⁶ Total Medicaid spending is extrapolated using appropriation levels for the federal share of Medicaid spending in the Community Medicaid Expansion line item (335-635). The federal Medicaid match rate is 73 percent in FY 2010 and 68.8 percent in FY 2011.

⁷ Ohio Association of County Behavioral Health Authorities, <http://oacbha.org/includes/downloads/levymap032008.pdf>.