



**REPORT TO THE
HAMILTON COUNTY TAX LEVY REVIEW COMMITTEE**

MENTAL HEALTH LEVY

JUNE 4, 2012



Hamilton County, Ohio, Mental Health Levy Report of the Operations and Tax Levy Review

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I. INTRODUCTION

Hamilton County retained TATC, Inc., and Management Partners, Inc., to conduct an analysis of the use of mental health levy funds during the current tax levy period of 2007 to 2012. These funds are administered by the Hamilton County Mental Health and Recovery Services Board.

TATC and Management Partners have conducted this analysis under contract to the Hamilton County Tax Levy Review Committee as part of the Committee's responsibility for review of County operations and finances associated with the Mental Health Levy as well as providing a recommendation to the Hamilton County Board of County Commissioners regarding future tax levy support for the activities provided under the Mental Health Levy.

A. PROJECT SCOPE AND ACTIVITY

The review of Mental Health Levy services provided by the Mental Health and Recovery Services Board (MHR SB), as requested by the Tax Levy Review Committee, includes the following principal areas:

- Evaluation of current operating efficiency relative to the MHR SB strategic plan, peers, and reasonable expectations;
- Compliance with, and maximization of, current and planned funding contracts;
- Recommendations for Tax Levy contract provisions between Hamilton County and MHR SB assuming successful passage of the proposed Tax Levy; and,
- Recommendations for costs savings and/or revenue enhancements.

Specific tasks included:

1. Identify, and develop an understanding of, the services funded by levy resources by category of service;
2. For all services provided, in whole or in part by levy dollars, list the cost per unit of services for each category of service, including the cost per client and cost per year for the previous five year levy period and determine whether the level of services provided is appropriate;

3. Analyze the quality of services provided, including determining the number of clients served during the previous levy period, and review waiting lists (including how such list is defined); review feedback from recipients of service including whether facilities are clean, safe, and providing proper care and present recommendations for improvement as appropriate;
4. Compare MHR SB with private providers and other governmental agencies;
5. Evaluate the financial results of MHR SB operations over the past five years, including analysis of variances from budget and comparison of financial trends with services delivered over the same time;
6. Conduct an historical review of the MHR SB budget and projections, including review of the MHR SB strategic plan for the next levy period for comprehensiveness, reasonableness of assumptions, and likelihood of success;
7. Analyze any alternative sources of funding to ensure that any of these sources of funding are being utilized first;
8. Report and analyze MHR SB compliance with the terms of the current Agreement by and between the Board of County Commissioners of Hamilton County, Ohio, and MHR SB, entered into on April 9, 2008, and make recommendations for future contractual conditions upon passage of the levy; and,
9. Prepare a Final Report that includes:
 - a) Recent history and overview of MHR SB operations;
 - b) Analysis of corporate structure including organization chart;
 - c) Operations analysis;
 - d) Financial analysis;
 - e) Possible threats or other issues to MHR SB during the next Tax Levy period;
 - f) Effectiveness of strategic planning; and
 - g) Summary of principal observations and recommendations.

B. PRINCIPAL OBSERVATIONS AND RECOMMENDATIONS

The principal observations and recommendations of this report include the following:

1. MHR SB is a well-run organization that has sought to maximize the value of the levy for the citizens of Hamilton County. Our analysis shows that the agency has managed its services within its allocated resources, despite an increase of over 16 percent in its client base during the current levy period.

2. The combined levy request for the upcoming levy period estimates a negative fund balance. This includes the potential loss of funds caused by the Duke Energy property appraisal appeal as well as the transfer of the Probate Court Civil Commitment program from the Indigent Care Levy.
3. As of July 2012, the State of Ohio will be assuming responsibility of the management of Medicaid-funded programs for mental health services. This will have a dramatic impact on the revenue structure, staffing, and service delivery planning of MHR SB. The Board is currently considering organizational and service options as a result of the anticipated changes.
4. We suggest that Hamilton County fund MHR SB with a fixed yield levy for the coming levy period. Even this option will require substantial service reductions, and MHR SB is considering a reduction plan that will eliminate six positions and reduce program funding by nearly \$4.1 million beginning July 1, 2012. Given the Duke assessment appeal and the proposed transfer of a probate court program from the indigent levy to the mental health levy, the MHR SB actions do not appear to be sufficient.
5. Hamilton County has two options to address the revenue shortfall. We recommend either option, or a combination thereof. The first option is to increase the levy to cover the anticipated deficit, at least insofar as the probate court program. The second is to apply a series of expense reduction strategies to eliminate the deficit. As noted, MHR SB has already begun the work on this aspect of the strategy.

II. MENTAL HEALTH AND RECOVERY SERVICES BOARD

In this chapter, we provide a review of the Mental Health and Recovery Services Board. The review includes:

- Overview of MHRSB organization, including a summary of compensation changes during the current levy period;
- MHRSB services;
- Customer assessment;
- Review and assessment of strategic planning
- Comparative analysis with other Ohio counties;
- Compliance with the current levy agreement;
- Financial operations and efficiency measures; and
- Observations and recommendations.

A. MHRSB ORGANIZATION

The Mental Health and Recovery Services Board is the product of the merger of separate boards in 2006. Hamilton County created the Mental Health Board under the auspices of Ohio HB 648, authorizing formation of county-based Community Mental Health Boards. The role of the Board is for planning, funding, and evaluating outpatient mental health services. In 1989, under authority granted by Ohio HB 317, the Hamilton County Commissioners established separate Boards of Alcohol and Drug Addiction Services (ADAS) and Mental Health in Hamilton County. Subsequently, in 2006, the County merged the separate entities into a single Mental Health and Recovery Services Board.

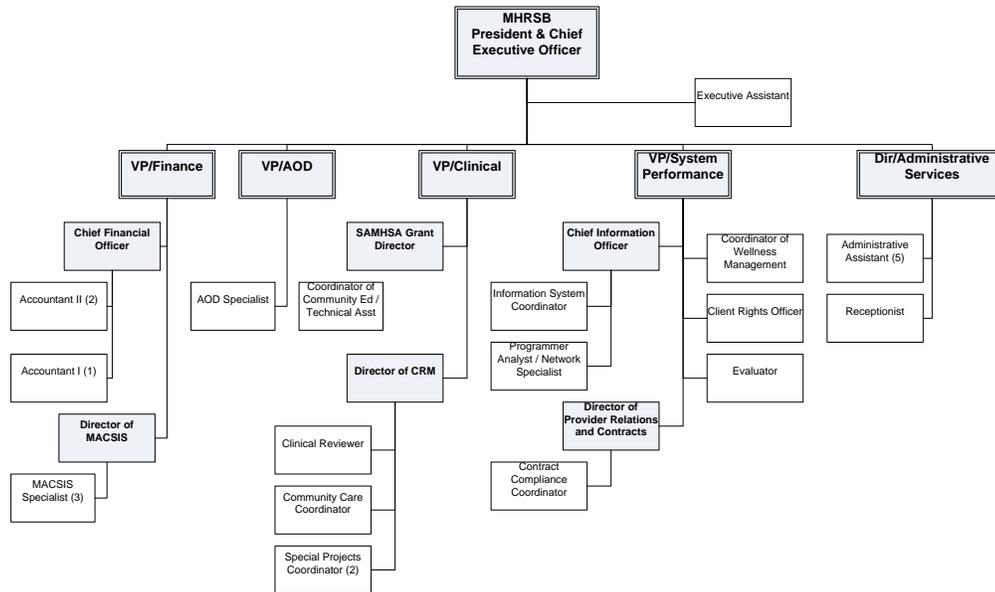
The combined board has eighteen volunteer members for two-, three-, or four-year terms. The Board of County Commissioners appoints ten members to the Board. The Director of the Ohio Department of Mental Health appoints four, and the Director of the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) appoints four. The membership appointments of the board attempt to reflect the composition of the county as to race and sex. Statutory appointments include a MH psychiatrist, an AOD advocate, a mental health and an AOD professional, a mental health and an AOD family member, and a mental health and AOD consumer.

Effective July 2013, the State will be merging the two parallel agencies into a single entity. It is expected that this merger will result in a change in State appointment authority.

State law prohibits MHRSB from direct service delivery. As a result it is responsible for service planning and provides for delivery through a network of private provider agencies. The target populations are adults who are severely mentally disabled (SMD), children who are severely emotionally disabled (SED) and adults who are dually diagnosed with substance abuse and mental illness (SAMI). Secondary target populations of the Board include adults with mental health needs who are not seriously mentally disabled (Non-SMD), children with mental health needs who are not seriously emotionally disabled (Non-SED) and for both children and adults with mental health needs who are in the criminal justice systems (CJS).

1. Organization

The chart below presents the full organization of MHR SB:



MHR SB consists of 37 employees, a reduction of 5 persons since the start of the current levy period. There are six organizational units within MHR SB:

- **Executive Office.** This office consists of the President/Chief Executive Officer, and one support staff for the CEO. The responsibilities of the Executive Office are to support the operations of the policy making and governance structure of Board and to translate Board policy into administrative direction and supervision of the operating departments. Answering to the CEO are four vice-presidents (Finance, AOD, Clinical, and System Performance) and one Director of Administrative Services.
- **Clinical Services.** This unit is responsible for the management of clinical services provided through MHR SB. It consists of two work units:
 - **SAMHSA Grant.** This unit administers the grant to MHR SB from the Substance Abuse and Mental Health Services Administration for the Journey to Successful Living program. It consists of a grant director and a coordinator of community education/technical assistant. The grant began in 2009 and is scheduled to run through 2015. Its 2011 funding is \$2.0 million. As described by SAMSHA,

“Hamilton County's Journey to Successful Living (Journey) will serve youth and young adults, ages 14-21, with serious mental health challenges, who are

transitioning to adulthood. These youth will be involved with the mental health and substance abuse system, child welfare system, juvenile justice system, and/or mental retardation and developmental disability system. Journey will build upon an existing system of care, collaborations and infrastructure, by adding partners from schools, social services, vocational rehabilitation, housing, primary care and the business community to create a broad based, sustainable systemic change inclusive of policy reform and infrastructure development that will be maintained after federal funding has ended. To accomplish this, Project Journey will establish a sustainable system of care that will: 1) be youth-focused, family driven and culturally and linguistically competent, with sensitivity to the overrepresentation of African American youth; 2) transform the current infrastructure by developing new policies, protocols and tools that facilitate comprehensive service planning designed to address needs of youth/young adults transitioning to adulthood and their families; 3) ensure the best, most efficacious treatment practices are available through expansion of non-traditional services and use of evidence-based and promising practices; 4) increase workforce competency through comprehensive training and technical assistance; 5) build a cross system data information system to better inform planning and practice; and 6) incorporate a comprehensive evaluation to improve the infrastructure and quality of the project, and to improve sustainability after the grant ends.”

- **Clinical Resources Management (CRM).** Consisting of a director and four staff, this unit provides for only adult services. Among its duties are:
 - Pre-screening of clients for probate court, with approximately 950 prescreens in the past year;
 - Pre-screening for patients in hospitals;
 - Manages out-patient community probate, with 250-300 adults probated to the Board;
 - Prepares the bi-annual community plans (State mandated strategic planning);
 - Prepares applications for grants;
 - Supports programs of the Mental Health Courts, intended to divert clients from the criminal justice system. Among these programs are housing assistance, mobile crisis, psychological emergency services, and the PATH program for homeless persons;
 - Coordinates grants and programs with other agencies, including the Suicide Prevention Coalition, Centerpoint Services, Cincinnati Public Schools; and Emergency Preparedness;
 - Conducts training for case managers on court presentations;
 - Reviews applications for the assignment of persons to the State psychiatric hospital;

- Provides care planning and coordination for persons coming out of hospitalization.
- **Finance.** This Department is a general administrative unit, responsible for the financial operations of MHR SB and the management of MHR SB use of MACSIS, the State case management system.
 - **Chief Financial Officer.** This business unit is responsible for all of the financial transactions and cost analysis of MHR SB. This includes all medical payments, provider payments, and non-personnel expenses. MHR SB uses Hamilton County's financial system. This unit reviews and approves that total billings submitted by individual agencies that contract with the board are within contracted amounts. Invoices are submitted by the Board to the County Auditor for direct payment to the agencies. Unit rate setting is determined on a Medicaid and non-Medicaid eligibility. For now, the non-Medicaid unit rate is the equivalent of the Medicaid unit rate.
 - **MACSIS.** MHR SB currently uses the State-required Multi-Agency Community Services Information System (MACSIS) for the payment of client services. The majority of MHR SB payments are made through this system. The system also maintains enrollment and eligibility information, claim changes, and funding status changes. The MACSIS Director and three specialists are responsible for performing the financial and client transactions processed in the system. With the State's elevation of Medicaid to state administration, MACSIS will be eliminated, and MHR SB will need to acquire its own client system. We discuss this further in this report.
- **AOD (Alcohol and Other Drugs).** This is the work unit responsible for the alcohol and drug addiction services component of MHR SB. It is not funded through the Mental Health Levy. Staff members in this unit administer the programs relating to substance abuse.
- **System Performance.** This unit combines several different support functions of MHR SB. The Chief Information Officer and two staff provide the operating support for the Board's information technology systems. The Director of Provider Relations and Contracts and a Contract Compliance Coordinator are responsible for managing provider contracts. The Coordinator of Wellness Management, Client Rights Officer, and an Evaluator work with providers to resolve client service issues.
- **Administrative Services.** This unit provides clerical support for MHR SB. It also is responsible for principal administrative functions, including human resources management and property management.

2. Compensation

The TLRC has requested that we comment on MHR SB's history of adjustments in employee compensation during the current levy period. The following table presents the average wage adjustments that MHR SB has provided to its employees during the levy period:

MHR SB Merit Increases, 2008 - 2012 Levy Period

Year	2008	2009	2010	2011	2012
Average Increase	2.82%	2.63%	2.55%	2.62%	0.0%

MHR SB typically provides wage adjustments in July each year. For 2012, it has frozen compensation and is not providing increases for any employees.

B. MHR SB SERVICES

1. Overview of Services

MHR SB does not provide client services directly. Rather, it is responsible for planning the County's mental health service strategies and then using available funding to contract with private providers to work with enrolled clients.

The services that can be delivered through the provider model include:

- **Community Psychiatric Supportive Treatment (CPST)** - This is a rehabilitation and environmental support system of targeted case management activities that are considered essential in helping persons gain access to necessary services. The goal of community psychiatric supportive treatment is maximum symptom reduction and a return of the person to the best possible functional level. Individual community support activities may include: development of interpersonal skills, community coping skills, adapting to home, school or work

environments, symptom monitoring and management, financial management, and personal development. CPST is provided both as an individual service and in small groups.

- **Counseling/Therapy** - Individual counseling/psychotherapy is a series of time-limited, structured sessions with a therapist, where the consumer works toward the accomplishment of mutually agreed upon treatment goals.
- **Residential Treatment and Housing** - Intensive residential treatment facilities are designed for short-term stays. Residential treatment facilities conduct transitional, congregate programs that provide a variety of mental health and other support services. Such services include assistance with basic personal care, management of personal space, training for increased, independent community living, and appropriate integration of the client's treatment plan with residential treatment. Housing Subsidy is for active clients who are living in an apartment covered by Ohio tenant landlord law. Generally, an exit strategy for the subsidy exists.
- **Pharmacological Management** - Pharmacological Management is a service conducted for the purpose of prescribing and/or supervising the use of psychotropic medication and other medications. At times, this service may also include medical assessment and medical treatments. This service is provided in face-to-face contact between a licensed physician/psychiatrist or a registered nurse and an enrolled client. Medical/somatic service includes the responsibility for evaluating the client's progress, adjustment to medication, and need for medication change.
- **Partial Hospitalization** - This is a day measured program for adults or children, which addresses the needs of clients with significant behavioral health problems who require a structured goal-oriented program which provides an integrated set of individualized treatment interventions.
- **Psychiatric Interview/Assessments/Evaluations** - Face to face clinical evaluation provided at specified times or in response to treatment, or when significant changes occur. Process of gathering information to assess client needs and functioning in order to determine appropriate service based on identification of the presenting problem, evaluation of mental status and formulation of a diagnostic impression.
- **Crisis Intervention** - These services provide for immediate interventions in emergency situations and timely interventions for crisis situations. Interventions take into consideration the person's preference and should provide services necessary to stabilize the crisis situation. These services also include linkage and referral to other providers in order to resolve the crisis situation and 24-hour consultation with a psychiatrist.
- **Prevention and Education** - Prevention services are based on a needs assessment and are provided according to identified priorities. A wide range of

ages and diverse populations are targeted for prevention services. These may include activities such as competency skill building, stress management, self-esteem building, and mental health promotion. Education services focus on educating the community about the nature and composition of a community support program. This service helps the community focus on issues that affect the population served or an identified under-served population.

- **In Patient Hospitalization** - Inpatient services are provided at psychiatric hospitals or on the psychiatric unit of a community-based hospital. Residence and treatment are provided to consumers with the goal of stabilization and return to the community.
- **Employment and Vocational Services** - Employment Services provide job skills training or support on and off the work site during the term of employment. Vocational services assist the consumer with identifying, obtaining, or maintaining employment. This service is focused on preferences of the consumer and oriented toward career exploration and training for integrated, competitive employment. Vocational services promote the coordination of providers and systems in order to maximize rehabilitation opportunities for consumers.
- **Consumer Operated and Peer Support** - Individuals with similar mental health issues provide peer support services to consumers. Self-Help/Peer support is intended to provide consumers with information and support from those who have had similar life experiences. Providers must be certified by the Ohio Department of Mental Health as a consumer operated agency.
- **Other Mental Health Services** - This incorporates a variety of services which are defined by local Mental Health Boards. Other Mental Health Services are certified by the Ohio Department of Mental Health. Services operated by the Sheriff's Department, the Probation Department, Juvenile Court and Pre-trial are included in this category. Additional services included in this category include; Co-treatment when more than one staff member provides treatment to a consumer in the same block of time for safety or therapeutic reasons, Banking-Payee Services, Intensive In-Home Services, Outreach Services, Mobile Crisis Runs and On-Site Emergency Services at a hospital.

2. MHR SB Clients By Service Type and Funding Source

As shown in the following table, over the past five years MHR SB has seen a steady increase in its service demand.

Number of Clients	2008	2009	2010	2011
Children	6,516	6,705	7,137	7,619
Adults	12,667	13,245	14,360	14,684
Total	19,183	19,950	21,497	22,303

It is informative to observe the mix of service demand that this client base represents. The following tables present the demand by year and by service. We include tables for persons receiving Medicaid and those not receiving Medicaid, and a total. These tables present duplicated count; one person may receive more than one service and could be counted in both service rows. Also, MHR SB estimates that approximately 17% of its clients receive both Medicaid and non-Medicaid services.

Service Provided	Medicaid Clients				
	By Service Type, By Year				
	2007	2008	2009	2010	2011
Group Counseling	946	973	971	1,119	1,150
Individual Counseling	6,985	7,030	7,846	8,576	9,472
Crisis Bed	0	0	0	0	0
Group Case Management	490	549	640	751	685
Individual Case Management	7,526	7,555	7,813	8,710	9,382
Diagnostic Assessment	6,801	6,654	7,398	7,745	8,154
Diagnostic Assessment Physician	1,211	1,280	1,309	1,379	1,503
Employment/Vocational	0	0	0	0	0
Housing	0	0	0	0	0
Med/Somatic	6,530	7,001	7,303	7,706	8,052
Other Mental Health	0	0	0	0	0
Partial Hospital	683	679	701	743	747
Residential Support	0	0	0	0	0
Respite Bed	0	0	0	0	0
Social/Recreational	0	0	0	0	0
Temporary Housing	0	0	0	0	0

Service Provided	Non-Medicaid Clients				
	By Service Type, By Year				
	2007	2008	2009	2010	2011
Group Counseling	277	278	307	295	285
Individual Counseling	1,911	2,012	2,006	2,380	1,967
Crisis Bed	150	119	43	82	75
Group Case Management	285	293	358	398	343
Individual Case Management	4,784	4,666	4,692	5,098	4,997
Diagnostic Assessment	2,929	2,822	2,830	3,025	2,357
Diagnostic Assessment Physician	872	1,046	817	882	874
Employment/Vocational	523	561	471	462	506
Housing	628	734	737	670	640
Med/Somatic	3,047	3,679	3,735	3,897	3,629
Oher Mental Health	2,236	2,361	1,941	1,744	1,632
Partial Hospital	94	83	66	75	53
Residential Support	385	270	358	355	356
Respite Bed	144	89	96	112	94
Social/Recreational	442	381	369	430	311
Temporary Housing	357	217	221	196	244

Service Provided	Total Clients				
	By Service Type, By Year				
	2007	2008	2009	2010	2011
Group Counseling	1,223	1,251	1,278	1,414	1,435
Individual Counseling	8,896	9,042	9,852	10,956	11,439
Crisis Bed	150	119	43	82	75
Group Case Management	775	842	998	1,149	1,028
Individual Case Management	12,310	12,221	12,505	13,808	14,379
Diagnostic Assessment	9,730	9,476	10,228	10,770	10,511
Diagnostic Assessment Physician	2,083	2,326	2,126	2,261	2,377
Employment/Vocational	523	561	471	462	506
Housing	628	734	737	670	640
Med/Somatic	9,577	10,680	11,038	11,603	11,681
Oher Mental Health	2,236	2,361	1,941	1,744	1,632
Partial Hospital	777	762	767	818	800
Residential Support	385	270	358	355	356
Respite Bed	144	89	96	112	94
Social/Recreational	442	381	369	430	311
Temporary Housing	357	217	221	196	244

The following chart, provided by MHR SB at its kick-off presentation to the TLRC, presents the distribution of funding by service type.

Service Provided	Percentage of Funds
Community Psychiatric Supportive Treatment	35
Counseling	16
Residential Treatment and Housing	12
Partial Hospitalization	9
Pharmacological Management	8
Psychiatric Interview/Assessment/Evaluation	7
Oher Mental Health	4
Employment/Vocational	3
In-Patient Hospital	2
Crisis Intervention	2
Prevention & Education	1
Consumer Operated & Peer Support	1

The following table presents the average cost per unit of service for MHR SB for 2011:

Service	Cost Per Unit
Diagnostic Assessment	\$120.32
Group Counseling	\$9.69
Individual Counseling	\$22.43
Group Community Psychiatric Supportive Treatment (CPST)	\$9.59
Individual CPST	\$21.29
Medical Somatic Service	\$208.17
Partial Hospitalization	\$116.81

3. MHR SB Providers

Currently, MHR SB contracts with 51 service providers. Of these, 25 are exclusively mental health providers, 15 provide services relating to alcohol and other drugs, and 11 provide services to both. The following table shows the percentage distribution of funding to the largest provider agencies.

Service Provider	Percentage of Funds
Talbert House	18
Greater Cincinnati BH	17
CCHB	9
Children's Home	7
St. Joseph's Orphanage	7
Central Clinic Child and Adult	6
St. Aloysius	4
Beech Acres	3
Central Clinic MHAP	3
Excel Management	3
Lighthouse	3
MCSA	3
Central Clinic Court Clinic	2
Hamilton County Agencies	1
All Other Agencies	14

C. CUSTOMER ASSESSMENT

The project team facilitated focus group sessions with agency representatives and consumers of the Hamilton County Mental Health and Recovery Services Board in conjunction with the tax levy review. We conducted two different sessions during March 2012 to gather comments and input relative to agency operations and mental health service providers working in a contractual capacity with the Board.

We used a modified strategic SWOT (Strengths-Weaknesses-Opportunities-Threats) technique. In each session, we asked the participants to list individually their perceptions regarding the delivery of mental health services. In the course of the listings, the participants had the opportunity to discuss those items that seemed to be more significant.

We have arranged the comments to capture the key service related strengths, weaknesses, opportunities and threats from focus group participants.

The following table presents the results of the client session.

CLIENT PERCEPTIONS	
Strengths	Weaknesses
<ul style="list-style-type: none"> • Journey Program (14-21 year olds) youth-driven with adult input – helps with transition from youth to young adults – staff is very knowledgeable <ul style="list-style-type: none"> ○ Journey family rep helps link families with other systems (schools / other agencies) – good information and knowledge ○ Good wrap-around services (therapy/doctor/psychologist) – all working together ○ Different groups help with resources ○ Journey: great resource for families – family centered program; helps in keeping the family together with whole family support • Police officer/security guard training (IT training) • MAP (Mental Health Access Point) – a strength – 1 place to call; service coordination • Central Clinic – excellent resource for patients with mental illness (Board has a seat for consumers’ voice) • Recovery Center is peer run (employee and consumers); it is unique, not found in many places; staff is well equipped to handle needs of consumers 	<ul style="list-style-type: none"> • Services do not move fast enough in mental health – you can’t put people on hold when they are having a crisis. • Navigating social security system (Medicaid) for mental illness is hard – Job and Family Services (JFS) staff did not know how to process • Support to families for information about Medicaid • Information maze about Medicaid/Medicare benefits

CLIENT PERCEPTIONS	
Opportunities	Threats
<ul style="list-style-type: none"> • Police Officers need to know who to contact, how to contact, and how to best identify mental health issues • Joint development of client/consumer treatment plans • Promote greater cooperative relationships in the prescription of medicine. • Show the face of mental illness with the message “those who get help don’t go to jail; are productive citizens, etc.; mental illness looks like you and me.” • Medicare in Hamilton Co. – emphasis on individualizing to the consumer; treat the whole person, not the symptom. 	<ul style="list-style-type: none"> • MH Levy – loss of funding • The unknown • Voters not knowing enough about mental health services; how levy funds support the services • Stigma (that comes from support) • People not understanding and stigmatizing those with an illness

The following table presents the results of the provider session.

PROVIDER PERCEPTIONS	
Strengths	Weaknesses
<ul style="list-style-type: none"> • Outcomes focused; leadership by tracking outcomes • Central front door to services; nationally recognized “front door” • Board has good partnerships with other mental health systems, and specialty courts (including Job and Family Services and other organizations) • Good stewards of resources • Board is not competing with agencies in the area of service delivery • Multi-systems approach to consumer wellness (especially in the use of 	<ul style="list-style-type: none"> • Greater confusion due to Medicaid elevation • Medicaid rates have not changed in past 15 years – flat income • Lack of coordination between federal, state, and county agendas – puts pressure on providers to move in directions that are not always coordinated – creates continuous pressure and uncertainty • 85% of funds to most severe clients; but non-severe clients need help and support so they do not develop severe needs

PROVIDER PERCEPTIONS	
Hamilton County courts)	<ul style="list-style-type: none"> Resources are stretched due to increased needs
Opportunities	Threats
<ul style="list-style-type: none"> Multiple boards and providers - opportunity to realign to decrease redundancy and work with other regional boards to explore consolidation and joint funding Revisit and realign services based on current/projected needs of population Tax levy – opportunity to interact with consumers by the public – need for increase due to increased needs Opportunity to educate the public on ever changing needs of providing mental health services Other Mental health issues impact child welfare – need to ask for increased mileage – no loss of funding 	<ul style="list-style-type: none"> Integration of physical and behavioral health (Complicated data collection and barriers between/within systems Integration with justice and other systems – especially in time of declining resources Decreasing resources – increased clients, more needs Continued risk of program skimming and loss of services due to loss of funds Funding pressures make it harder to compete Medicaid splitting - mental health hospital funded thru different funding pool State funding formulas are not equitable (urban areas have greater needs); urban/rural funding shifts, with greater proportion of funds being allocated to rural areas Cuts in other systems (i.e., child welfare – JFS) compound the problem

A review of the comments of the focus group participants indicates.

- In general, there was strong support for the operation of MHR SB, particularly regarding intervention and advocacy on behalf of clients.
- The MHR SB management of the provider contract system and the integrated systems approach also appears to be strongly supported.

- Most of the concerns regarding weaknesses in the system seem related to Medicaid related programs, both insecurity over Medicaid generally and the upcoming State elevation of Medicaid.

D. STRATEGIC PLANNING

The biannual Community Plan that MHR SB is required to prepare for the State serves as its strategic plan. In our previous levy review of MHR SB, we commented that this plan does not include most of the elements typically found in a viable strategic plan. Rather, the document is primarily a data collection and reporting exercise. This has not changed from the previous report. As such, the plan presents a status quo and does not assert a future vision of mental health services for Hamilton County.

Much of the data presented in the Plan are combined data for both Medicaid and non-Medicaid financed services. The upcoming elevation of the Medicaid program to State management could well mean that much of the current plan may be rendered moot. This is still unknown.

E. COMPARISON WITH OTHER OHIO COUNTIES

In this section, we review the work performance of MHR SB with seven other Ohio counties. We include the data tables in Attachment A of this report. Our conclusion from the comparative analysis is that MHR SB performs at or above the level of the other counties.

Our analysis includes the levy programs of Hamilton, Butler, Clermont, Cuyahoga, Franklin, Lucas, Montgomery, and Summit Counties. Our observations from the comparative data are as follows:

- Demographically, Hamilton, Franklin, and Cuyahoga Counties are most similar, as large urban counties. Hamilton has the lowest market penetration, of the three urban counties, at 2.7 percent of the population being served. Cuyahoga serves 3.3 percent and Franklin serves 3.15 percent.

- At 17.83 percent, Hamilton has the second largest percentage of persons receiving both Medicaid and non-Medicaid support. Franklin has the highest percentage at 18.91 percent.
- Overall, Hamilton has the third highest level of persons receiving non-Medicaid support. Summit is highest at 49.69 percent, and Franklin has 49.03 percent. Hamilton has 41.03 percent.
- Hamilton is in the middle of the comparative group in both revenue and expenditures per capita; however, Hamilton ranks second in expenditures per client. The highest average is Clermont County at \$4,950, with Hamilton's average being \$4,361.
- Except for partial hospitalization services, Hamilton is at, or below, the average unit costs for all services. However, this statistic is constrained by the inclusion of Medicaid fixed rates for most services and the general use of Medicaid rates for non-Medicaid payments. This forces the unit cost of service analysis into a very narrow window.
- The unit cost data will become more significant as the State assumes the Medicaid payment program and counties have greater flexibility in their own rate setting.

It is informative to compare the 2011 data to the data reported in the previous levy report. The comparison shows substantial cost increases for all of the counties in the five-year period.

County	Change in Total Expenditures Per Capita			
	2011	2006	Change	Pct Change
Hamilton	\$119.68	68.31	\$51.37	75.21%
Butler	\$82.28	36.13	\$46.15	127.73%
Clermont	\$83.35	36.85	\$46.50	126.20%
Cuyahoga	\$101.67	74.06	\$27.61	37.27%
Franklin	\$125.05	70.72	\$54.33	76.82%
Lucas	\$141.16	72.93	\$68.23	93.55%
Montgomery	\$118.36	65.57	\$52.79	80.51%
Summit	\$141.26	63.47	\$77.79	122.56%

Only Cuyahoga County experienced a smaller change in per capita costs than Hamilton County. Overall, these large changes reflect the economic times, inflationary costs in the health care industry, and an increase in both case load and case severity.

F. COMPLIANCE WITH CURRENT LEVY AGREEMENT

As part of the current levy, Hamilton County and MHR SB entered into a service agreement for MHR SB to continue to provide mental health services funded by the levy.

That agreement included numerous actions to be taken by MHRSB. The following table summarizes those requirements and the status of MHRSB compliance.

Requirement	Compliance Status
<p>Improve quality and customer service in the following ways:</p> <ul style="list-style-type: none"> • Conduct annual operational field audits • Require contract agencies to submit an agency quality assurance plan • Require contract agencies to submit an annual summary report of agency quality management activity including standard review requirements • Conduct, or require contract agencies to conduct, annual client satisfaction and client outcome surveys 	<p>Audits are completed annually. MHRSB staff members conduct compliance field audits of each agency annually, and plans of correction and follow-up audits may be required.</p> <p>Provider agencies are required to submit:</p> <ul style="list-style-type: none"> • Quarterly quality assurance (QA) indicators • Annual QA performance summary • Biannual performance improvement surveys • Annual clients satisfaction reports • Ohio Consumer Outcomes/Ohio Youth Scales data for all clients
<p>Complete an independent audit of HCMHRSB's fiscal operations by December 31st of each year, and submit a copy to the County at that time.</p>	<p>This is done. MHRSB audits have shown clean option statements, clean internal control statements, and clean compliance statements.</p>
<p>Continue to manage the cost of services by requiring the use of the standardized schedule of subsidies, based upon federal Title XX standards.</p>	<p>All MHRSB agencies are contractually required to use the MHRSB schedule of subsidies (sliding fee schedule). Compliance with this is monitored as part of the compliance audit conducted of all agencies.</p>
<p>Review high cost services. Within the boundaries of federal and state Medicaid regulations the HCMHRSB will conduct utilization management for high cost services, develop comparative costs for similar services, and develop incentives for agencies to reduce costs while building improved access to assessment, intake, and service delivery.</p>	<ul style="list-style-type: none"> • The Mental Health Access Point (MHAP) reviews all high cost service authorizations and develops monthly analyses and reports. • MHRSB has implemented the Centers for Medicare and Medicaid (CMS) fixed rates as of October 2010 • MHRSB has fostered consolidation

Requirement	Compliance Status
	<p>of provider agencies for efficiencies; an example is the consolidation of Centerpoint and IKRON.</p> <ul style="list-style-type: none"> • MHRSB implemented its Outcomes Performance Improvement Program in 2009.
<p>Continue to work with community providers in the planning and development of an accessible, responsive mental health system of service that is both medically appropriate and cost effective.</p>	<p>Interviews with MHRSB staff and the provider focus groups indicate that this is on-going.</p>
<p>Increase partnerships with other agencies to create more collaborative programs. The HCMHRSB will include an annual report of progress and an estimate of the benefits of such collaborations with its annual budget request to the County.</p>	<p>Examples of this collaboration include:</p> <ul style="list-style-type: none"> • Family Access to Integrated Recovery (FAIR) with Hamilton County Jobs and Family Services • Pathways, with the Ohio Rehabilitation Services Commission and Hamilton County Developmental Disabilities Services • Growing Well, with the Cincinnati Public Schools and Cincinnati Public Health Department
<p>Implement an accounting system by the mid-term of the levy to more accurately and readily track program and service spending from funding sources. The system will identify which programs use levy funds and what percentage of levy funds are devoted to specific programs and services.</p>	<p>MHRSB designed and implemented a database using Microsoft Access to meet this requirement.</p>

Requirement	Compliance Status
<p>By the mid-term of the levy, develop system enhancements and training that supports clients in resolving complaints regarding Community Psychiatric Supportive Treatment service at any agency. Follow rules established in statute and agency certification guidelines. The HCMHRSB shall annually provide client based training and/or distribute training materials in client rights and consumer grievance procedures.</p>	<p>MHRSB provides regular training of providers to accomplish this requirement. Additionally, MHRSB Client Rights Officer assists in the resolution of client complaints and grievances.</p>
<p>Annually, as part of the HCMHRSB's fiscal year budget review and agency contracting process, address rising Medicaid service demand.</p>	<p>Annually, each Medicaid agency is required to complete a MHRSB-developed budget software package that includes service by service projections of Medicaid use for the upcoming year. Annual agency allocations are adjusted based on these projections and included in the MHRSB budget.</p> <p>With the upcoming State elevation of Medicaid, this may become a moot point for MHRSB.</p>
<p>By levy mid-term, develop a plan to address increased demand for services of early childhood/school aged child population.</p>	<p>Early childhood plan was developed using SAMHSA & ODMH guidelines. MHRSB contracted with Central Clinic to provide infant/early childhood programming for 67 children annually.</p> <p>Client data earlier in this report demonstrated the growth of the school age population in the MHRSB service group.</p>
<p>By levy mid-term, develop a plan to address increased service demand from the criminal justice system for mental health services.</p>	<p>A plan was developed to assess the needs of persons arrested. Court Clinic had expertise and relationships with criminal justice and mental health and hired staff to do the assessments and link to services.</p> <p>Another planning effort with a</p>

Requirement	Compliance Status
	collaborative team of judges, lawyers, probation, pretrial services and mental health providers resulted in a Felony Mental Health Court. Mental Health Agencies provide leadership, assertive case management, pharmacological management, residential services and day reporting to clients participating in Felony Mental Health Court.
Annually, as part of the MHR SB budget and contracting process, address the need for an increase in the number of housing certificates for the homeless/mentally ill population.	MHR SB has purchased an additional 576 units (months of rent subsidy) from Excel Development Co. annually. Additional support services have been established to assist clients in maintaining independent housing.
By the end of CY 2008, increase early intervention services to non-SMD consumers.	The number of persons receiving individual counseling has increased from 8,374 in 2007 to 10,268 in 2010.
By the end of the CY 2008, begin to publish, either on the MHR SB web site or in a separate publication, a Quarterly Mental Health Performance Report to strengthen transparency and accountability with the public.	MHR SB has published regular Quarterly Mental Health Outcomes Reports since FY 2007 and information from those reports is posted on the MHR SB web site.
By the end of CY 2008, develop a GIS data-layer to geographically pinpoint service populations and agencies to visually identify service needs in Hamilton County communities.	MHR SB has completed this task.
Acknowledge and plan for possible changes in children's Medicaid eligibility.	Medicaid billing for children has increased by approximately 30% since 2007.

G. FINANCIAL OPERATIONS

The following table summarizes the operating revenues and expenses of the MHR SB levy program over the current levy period.

Line Item Description	Actual				Estimated	TOTAL
	CY 2008	CY 2009	CY 2010	CY 2011	CY 2012	CY08-CY12
REVENUES						
Local Revenues						
Mental Health Levy						
Real Estate	\$29,489,540	\$29,512,234	\$29,170,101	\$29,888,362	\$29,086,537	\$147,146,774
Trailer	\$22,624	\$15,039	\$13,492	\$11,456	\$20,000	\$82,611
Personal Property	\$1,969,848	\$449,685	\$131,270	\$92,059	\$0	\$2,642,862
Payment in Lieu of Taxes	\$3,614,060	\$4,705,614	\$4,751,540	\$3,739,799	\$2,701,829	\$19,512,842
Rollback & Homestead	\$3,014,048	\$3,038,906	\$3,042,849	\$3,054,551	\$2,968,720	\$15,119,074
Public Utility	\$705,435	\$775,013	\$744,160	\$346,983	\$0	\$2,571,591
Subtotal Tax Levies	\$38,815,555	\$38,496,491	\$37,853,412	\$37,133,210	\$34,777,086	\$187,075,754
Capital and Rental Income	\$407,583	\$95,935	\$124,112	\$96,898	\$97,892	\$822,420
Other Match	\$2,180,984	\$1,422,038	\$288,000	\$2,822,740	\$3,820,789	\$10,534,551
Miscellaneous	\$38,702	\$94,403	\$147,424	\$25,119	\$30,000	\$335,648
TOTAL LOCAL	\$41,442,824	\$40,108,867	\$38,412,948	\$40,077,967	\$38,725,767	\$198,768,373
Special Revenues						
State Grants	\$23,395,032	\$26,131,110	\$19,189,898	\$16,257,744	\$4,168,807	\$89,142,591
Medicaid	\$23,226,147	\$30,796,007	\$33,578,711	\$42,776,617	\$28,048,617	\$158,426,099
Federal Grants	\$0	\$90,563	\$729,730	\$1,536,113	\$4,400,987	\$6,757,393
ODMH Direct Payments	\$744,926	\$623,993	\$567,542	\$584,509	\$584,509	\$3,105,479
TOTAL SPECIAL REVENUES	\$47,366,105	\$57,641,673	\$54,065,881	\$61,154,983	\$37,202,920	\$257,431,562
Other Financing Sources						
Proceeds from long-term obligations	\$0	\$0	\$0	\$0	\$0	\$0
Proceeds from sale of capital assets	\$0	\$0	\$0	\$0	\$0	\$0
TOTAL OTHER FINANCING SOURCES	\$0	\$0	\$0	\$0	\$0	\$0
TOTAL CURRENT OPERATING REVENUE	\$88,808,929	\$97,750,540	\$92,478,829	\$101,232,950	\$75,928,687	\$456,199,935
EXPENDITURES						
Expenditures - MHR SB						
Agency Provider Contracts	\$78,762,232	\$90,056,502	\$91,979,760	\$90,752,455	\$80,908,784	\$432,459,733
ODMH Direct Payments	\$744,926	\$623,993	\$567,542	\$584,509	\$584,509	\$3,105,479
Subtotal Purchased Services	\$79,507,158	\$90,680,495	\$92,547,302	\$91,336,964	\$81,493,293	\$435,565,212
Salaries, Benefits and Taxes	\$2,627,794	\$2,788,324	\$2,886,264	\$3,008,582	\$2,169,606	\$13,480,570
One-time Staff Reduction Expense						\$0
Operating Expenses	\$663,220	\$492,014	\$691,418	\$682,835	\$852,500	\$3,381,987
Capital Outlay	\$11,287	\$244,435	\$941	\$1,765	\$65,000	\$323,428
County Auditor & Treasurer Fees	\$503,414	\$495,584	\$475,891	\$484,344	\$521,582	\$2,480,815
Subtotal MHR SB	\$83,312,873	\$94,700,852	\$96,601,816	\$95,514,490	\$85,101,981	\$455,232,012
Expenditures - Other						
Duke Appeal Refund Impact	\$0	\$0	\$700,695	\$516,627	\$394,088	\$1,611,410
Probate Court Civil Commitment	\$0	\$0	\$0	\$0	\$0	\$0
Levy Administration						\$0
Subtotal Other	\$0	\$0	\$700,695	\$516,627	\$394,088	\$1,611,410
TOTAL EXPENDITURES	\$83,312,873	\$94,700,852	\$97,302,511	\$96,031,117	\$85,496,069	\$456,843,422
ANNUAL CHANGE IN BALANCE	\$5,496,056	\$3,049,688	(\$4,823,682)	\$5,201,833	(\$9,567,382)	(\$643,487)

At the time of the last levy review, the financial model was designed to result in approximately a zero change in fund balance between the start and end of the levy period.

To accomplish this, revenues were estimated higher than necessary for the start of the period, with expenses catching up in the last part. The financial summary shows that this pattern generally held during the levy period. However, a large part of this success is due to reductions that MHRSB has made, particularly staff reductions in the current and past year. In those two years, MHRSB eliminated a total of six positions, which accounts in part for the drop in staffing from the previous levy period.

MHRSB was also able to achieve other efficiencies through reorganization. The principal changes included assigning MACSIS administration to Finance and transferring Provider Relations to System Performance. The SAMHSA grant obtained in 2009 has helped expanded juvenile services that might otherwise have fallen within the levy obligations.

As a result, MHRSB operating fund balance at the end of the levy period is estimated at \$4,008,387, after allowing for outstanding encumbrances and the capital fund (which is restricted). This fund balance will become critical in supporting MHRSB activities in the coming levy period.

H. OBSERVATIONS AND RECOMMENDATIONS

Overall, we find MHRSB to be a well-organized and effective public organization. It has continued to manage a growing service demand with limited resources. Client and provider feedback indicate positive support for MHRSB planning and performance.

There are however, two serious immediate challenges facing MHRSB. These are the State elevation of Medicaid mentioned throughout this report, and the potential revenue shortfall caused by growing service demand in the upcoming levy period.

1. *State Elevation of Medicaid*

In late 2011, the State of Ohio announced that it was going to assume responsibility for the Medicaid supported mental health program. Under this state elevation, the Ohio Department of Mental Health would administer all Medicaid services and providers, effective July 1, 2012. Effectively, this would mean that MHRSB would no longer be

responsible for all Medicaid services, providers, and clients from that date forward. MHRSB would have some residual responsibility for payment of services provided prior to July 1, 2012, specifically, the invoices which are received after the cut-over date. The bulk of this residual work would last about three months, but Medicaid rules permit providers up to a full calendar year to invoice work. Administratively, given that Medicaid represents approximately 48 percent of the funding of MHRSB and about half of the billing activity, this change represents a major reduction in both the financial resources available to MHRSB and the amount of work to be performed by MHRSB. It will also require that MHRSB invest in a new client/provider based information system.

Programmatically, this change risks a major disconnection between MHRSB and the overall planning and delivery of mental health services in Hamilton County. Preliminary information that MHRSB has received from the State is that the Ohio Department of Job and Family Services, which administers Medicaid for the State, does not plan to share Medicaid, provider, or client information with local boards. If this holds true, then MHRSB will lose access to approximately half of the information pertaining to publicly supported mental health services in Hamilton County. The change could also result in overlapping, and cost-duplicative services for the 17 percent of the MHRSB case load that receives both Medicaid and non-Medicaid services.

Also, it is uncertain what role MHRSB may be expected to play in quality assurance and client satisfaction. There are two potential scenarios. The first is that the State will assume this responsibility; it has been the case throughout the United States that state agencies are less effective in providing these services than are local agencies, so it can be expected that quality and client concerns will slip. The second scenario is that the State will expect the local boards to retain this duty. In this instance MHRSB will need access to relevant data that will be resident at the State level and should secure guarantees of one hundred percent funding. Even then, at issue will be the ability of MHRSB to adjudicate and/or direct corrective action.

The elevation is not without merit for MHR SB. Staff members note that the removal of the Medicaid program provides greater latitude in a number of important areas. Chief among these are the ability to:

- Institute industry best practices in mental health care that have previously not been possible because of Medicaid restrictions;
- Move away from the “Any Willing Provider” model of contractual services required by Medicaid to an MHR SB-driven program of selecting providers on the basis of quality and rates and thus reducing the provider pool;
- Negotiate and/or set more cost effective rates; and
- Develop a more effective information technology system.

As a result of these changes, MHR SB is undertaking a major review of its staffing and provider systems. This review includes the probability of changes to the provider pool, greater emphasis on quality and state-of-the-art treatment approaches and modalities, and the mix of services to be provided.

As part of this levy review process, the TLRC Mental Health subcommittee, the MHR SB executive staff, and the project team conducted a half-day work session, emphasizing primarily the issues relating to State elevation of Medicaid. At that meeting, MHR SB staff presented an overview of the issue as well as MHR SB strategies. We include that presentation as Attachment B of this report.

There are two immediate financial impacts to the State elevation of Medicaid, which we have incorporated into the financial analysis in the next chapter of this report.

- The loss of Medicaid funds, and the attendant work related to the administration of Medicaid services, will require MHR SB to reduce its staff. The exact magnitude of staff reduction has not yet been determined, pending final decisions by the State about how it will implement its administration of the program. However, discussions with MHR SB executive staff indicate that the reductions could result in the loss of between six and ten positions; this is beyond the six positions that MHR SB has eliminated in the past two fiscal years. Recognizing that some reduction will occur, but not certain how many or when, we have chosen to base our financial analysis on an estimate of a reduction of six additional positions.
- MHR SB must invest in a new client/provider management technology system since the MACSIS system that has used for the past twenty years will no longer be available. MHR SB has combined with its peer agencies in Franklin and

Cuyahoga Counties to create a Council of Governments for the purpose of jointly designing and implementing a new system. Called SHARES (Shared Healthcare and Recovery Enterprise System), this system would replace MACSIS with a more robust approach to client and provider management. The three agencies have drafted a preliminary request for proposals for a technology firm to develop the application, and they anticipate initiating the acquisition process in the near future. The MHR SB cost estimate for 2013 includes \$1,000,000 in capital funds for system acquisition.

2. Anticipated Revenue Shortfall

The second issue of concern is the anticipated shortfall in revenue in the coming levy cycle. We present the detail of this possibility in the next chapter on the financial forecast for the levy. The financial forecast factors in the previously discussed elimination of six positions as a result of the State elevation of Medicaid, so the shortfall calculated represents additional needs beyond those positions. The shortfall is driven by several factors:

- The continued flat property tax values in Hamilton County and the resultant reduction in tax yield;
- The long-term impact of the Duke Energy appeal of its real property values;
- The transfer of levy responsibility of the Probate Court's Civil Commitment Program from the Indigent Levy to the Mental Health Levy;
- Probable increases in costs associated with providing duplicate services to persons who are served with both Medicaid and non-Medicaid funds;
- The increasing service demands confronting MHR SB; and
- Incremental cost increases in provider services.

We see three options to resolve the revenue issue. The first option is to increase the levy sufficiently to achieve a five-year balanced budget, with some operating reserves. The second option is to expand MHR SB current program planning in order to be more encompassing and aggressive. And, the third is a combination of both strategies.

There are several possible components to an MHR SB strategy to reduce future costs. Among these are:

- **Changes to the Staffing Model.** MHR SB is already examining its options regarding staffing. Options include assessing staff competencies and realigning work, possible contracting of some positions, and possible elimination of positions. MHR SB has already eliminated six positions in the past two fiscal years and has identified up to six additional positions for reduction in the coming fiscal year. Given the already small staff of MHR SB and the reductions coming as a result of the Medicaid elevation, the staff of MHR SB are nearing a minimum level necessary to administer the mental health program effectively. We do not believe that this strategy will yield significant additional savings.
- **Eligibility Strategies.** A second set of strategies relates to eligibility standards. Much of the eligibility is established by federal and state law, and MHR SB may have limited capacity to make substantial changes. Nonetheless, MHR SB will need to consider what it can do with this option and act accordingly.
- **Use of Waiting Lists.** Up to now, MHR SB has been able to avoid waiting lists. However, it may be necessary to constraint program enrollment in the future.
- **Service Reductions.** While undesirable, particularly for current clients, MHR SB will need to consider services that it is providing and determine whether those services are requisite to quality care, whether they can be redesigned to be more cost effective, or can be provided by other means. Ultimately, this may have to become the principal cost management strategy.
- **Delivery Strategies.** These strategies relate to the MHR SB provider model and relationships. MHR SB will need to work closely with providers to remove all possible costs in order to avoid provider cost increases and even to achieve further cost reductions. MHR SB is already initiating this process and anticipates working closely with providers to maximize services while minimizing future costs.
- **Other Revenue Sources.** As shown by the SAMHSA grant, MHR SB has the ability to secure other sources of funding. It may need to invest resources necessary to be more aggressive in identifying and pursuing other revenues to offset levy shortfalls.

It is possible that the worst case scenario may not occur. In most local government or local government-financed functions, the agencies are able to build fund balances through rigid adherence to financial management, and MHR SB has demonstrated its capacity to do so. Additionally, there are signs that the economy is starting to improve and many local governments are beginning to see property values stabilize and even grow. However, the financial data generated by Hamilton County does not indicate that trend for the next several years. The more conservative approach therefore, is to assume economic conditions as they exist today.

For that reason, we recommend that the County direct a course of action intended to move to fund balance sooner rather than later. MHR SB has already identified nearly \$4.1 million in service reductions for the coming fiscal year, but final action on those reductions has not been taken. Additionally, as discussed in the next section of this report, those reductions are nearly—but not completely—sufficient in a fixed yield revenue scenario. They are only about half of what will be necessary in a fixed millage rate scenario. MHR SB is beginning to consider its options for 2013. To the extent that final levy recommendations leave a projected shortfall, the TLRC should recommend that MHR SB continue to develop within the next year a specific set of strategies and actions necessary to eliminate any remaining projected deficit.

3. County-Wide Integration of Service Delivery

As Hamilton County continues to pursue strategies that will continue its tradition of quality public service while constraining costs, it may become desirable to consider services from a different perspective. TATC and Management Partners, and our project team in particular, have had the great opportunity to be an active part of your cost and revenue management strategies through providing various tax levy studies. In doing so, we have approached each task from a singular perspective, that is, one levy and one study. This has been our task this year as we conduct review of the Senior Services and Mental Health levies.

Yet, in doing the individual studies, we note many similarities among the agencies. Our studies over the past years have included Mental Health, Senior Services, Children's Services, and Developmental Disabilities. Common elements in each delivery model include processes for Medicaid management, call centers and customer intake, eligibility determination, case management, provider management, and fiscal management. While the specific details and regulations may vary from one service to another, the fundamental work processes are similar.

The rule of thumb in conducting studies of service efficiency is that efficiencies are found principally in three areas: staffing, business processes, and support systems. Each

has its own economy of scale. For each, there needs to be a base level of operations, such as a minimum number of staff, certain work steps, and certain levels of technology support. Once an agency has reached those base levels, no additional cost savings or operational efficiencies can be reasonably achieved.

In order to accomplish economies of scale, there must first be scale. That means the organization must enlarge itself in order to find additional efficiencies. To accomplish this in Hamilton County's setting implies combining similar work or work processes so that there is a greater scale, then applying additional operational efficiencies. We do not know necessarily that combining the call center activity of each agency, for example, may present the opportunity for additional savings. We do know from our experience with other governments, that there is a good likelihood of those savings if the technical and procedural issues can be resolved.

The various agencies already have some elements of cooperation. They each have some form of inter-agency agreement on working with clients who have multiple service issues that cross between agency areas of responsibility. Each of the agencies can clearly demonstrate both cost savings and improved client service through these cooperative arrangements. This cooperation is a good starting point for identifying broader avenues of joint program support and delivery. The difference between the current model and our suggestion is that the current system is client-based; that is, the service is coordinated on the basis of an individual client and usually occurs after client intake is complete. The model we suggest here is organization-based, which means that the coordinated structure is in place for all clients.

For that reason we suggest that the TLRC consider the possibility of examining all of the social service agencies receiving tax levy support to determine whether such service consolidation is feasible and whether it can yield additional cost savings for Hamilton County.

III. FINANCIAL ANALYSIS AND FORECAST

This section of the report includes our analysis of the financial operations of the Mental Health and Recovery Service Board (MHRSB) for the previous tax levy period and projects future needs.

Working with MHRSB financial management staff members, we developed historical detail to support issue analysis and the financial forecasting process. We, then, developed an understanding of the Board's initial financial forecast including base level of services over the financial forecast period. Finally, in conjunction with MHRSB operational management and financial staff, we developed information on operational and organizational issues expected to impact fund revenues and expenditures during the forecast period.

This analysis also includes the impact associated with shifting funding of the Probate Court Civil Commitment operation from the Indigent Care Levy to the Mental Health Levy. While the decision to accept this responsibility rests with the Mental Health and Recovery Services Board, for the purposes of the financial analysis we are anticipating that the MHRSB will accede to the request of the Board of County Commissioners and provide the necessary funding. We have estimated the average funding impact at approximately \$641,000 per year during the forecast levy period for a total impact of \$3.2 million over five years.

This analysis includes recognition of the existing and potential liabilities in fund availability associated with the pending Duke Energy tax appeal. We have incorporated information provided from the Auditor's Office relative to existing liabilities in the period

2010-2012 as well as forecast potential liabilities based on present knowledge and understanding of the appellant's action. We believe that a conservative approach requires including these liabilities to reflect the impact that they could have on available funds should the appellant prevail in their action. These amounts represent the actual or estimated tax payments made under protest that could be returned following resolution of the action. These amounts in the model total approximately \$1.0 million in the current levy period and approximately \$2.9 million in the forecast levy period.

The Project Team took the following steps in order to derive anticipated tax levy fund requirements:

- Recognize that a portion of the fund balance remaining at the end of the current levy period (2012) will be required to meet outstanding encumbrances as identified by MHR SB.
- Recognize the independent nature of the MHR SB and maintain the current anticipated non-capital fund balance at approximately \$3.9 million for cash flow purposes.
- Assume operational expenditures are the same in each of the three options introduced above and represent a desired base level of operation from which to assess impacts from varying levels of tax fund availability.
- Assume various property tax revenue streams as presented in the three options.
- Assume modest 0.5% increase in annual property tax revenues over the forecast levy period.
- Assume elimination of Medicaid program revenues in first year of forecast period.
- Assume other revenue sources generally produce no annual increase in resources.
- Assume annual cost of agency provider contracts increases approximately 0.5% per year.
- Incorporate consistent assumptions regarding one-time and continuing costs / savings associated with Medicaid processing elevation and resulting organizational impacts as discussed above.
- Incorporate \$1 million expense in CY 2013 associated with financial system replacement (paid for with identified agency capital funds).

The MHRSB has been, and continues to be, an organization in transition. The organization is currently challenged by the State's decision to elevate processing of Medicaid clients from the local boards to the State. This will have an impact on the financing, operational practices and underlying organization necessary to support the redefined client service roles. The following revenue and expenditure tables include information that reflects this programmatic change to client service. We have also incorporated a proxy figure for one-time costs as well as estimates of the annual anticipated savings associated with reorganization and staff reductions as part of this change. The organizational impact is meant to be conservative given the uncertainties in the existing State plans and how they will impact local boards over the next five years.

As of the preparation of this report, the Mental Health and Recovery Services Board has not submitted an official request to the Tax Levy Review Committee. The MHRSB staff has identified three options for levy funding for the Board's consideration. These are described below:

- Fixed Rate (Renewal): Request millage at current period level (2.99)
- Renewal Plus Increase: Request millage increase of 0.14 (3.13)
- Fixed Yield: Request millage at level expected to yield current annual receipts from the property tax levy (3.19)

All three of these options incorporate an anticipated reduction of six staff from the current authorization levels for the MHRSB. Similarly, all three will require substantial reductions in MHRSB services immediately and through the upcoming levy period. Of the options, we recommend that the TLRC consider the Fixed Yield option. This option holds

the tax levy yield constant, although it will require a rate increase. Further, this option does the least damage to the MHR SB service program.

The Fixed Rate option holds the millage rate constant while allowing the yield to vary. It will require the greatest reduction in MHR SB service delivery. The remaining option changes both the tax rate and yield. We believe that the Fixed Yield and Fixed Rate models represent the ends of the funding spectrum and, more appropriately, serve as the basis for our analysis of future funding needs.

Because any of the options will require reductions in MHR SB services, the MHR SB staff has prepared a reduction program effective July 1, 2012, which is currently under discussion by the Board. The following table presents the reduction plan submitted by staff to the Board:

Program Area	Amount of Reduction	Basis for Action	Anticipated Impact
Adult Crisis Services	\$459,173	Psychiatric Emergency services have moved to another facility, resulting in a decline in persons seen	May have minimal short term impact. If case loads increase in long term, then persons may not have adequate access to emergency room services.
Child Crisis Services	\$498,886	This service has less occupancy than anticipated. MHR SB will no longer purchase total capacity.	MHR SB will maintain one bed for crisis services for children. If the need increase, children and families may experience a delaying in receiving this service.
Criminal Justice County Programs	\$606,367	This reduces funding for a facility that has been privatized and can now bill Medicaid.	There will be less resources in the criminal justice to identify persons

Program Area	Amount of Reduction	Basis for Action	Anticipated Impact
		This includes a 20% cut to other County programs that are not providing behavioral health treatment.	needing mental health services, resulting in less diversion and persons not receiving needed services.
School Based Services	\$90,000	Given that the first priority is treatment services, the School Based coordination is not longer possible to fund.	It may be more challenging for families to navigate among systems. Decreased service coordination may cause duplication of services and decreased cost efficiency.
Housing	\$315,000	This component has had less occupancy than other housing services; therefore, funding will be decreased to maximize use of MHRSB funds.	There will have to be coordination for access to other housing programs, which could cause a delay in timely service access. Consumers may have to resort temporarily to the use of alternative shelters. This may increase demand on other systems.
Inpatient Services	\$1,435,000	With the change in State rules, MHRSB will no longer be responsible, or receiving funds, for preventing admissions to State hospitals.	Use of the State psychiatric hospital for acute care may increase the number and length of consumer hospitalizations. This, in turn, may impact cost.
MCSA	\$375,912	This project has been restructured, resulting in improved efficiencies, which resulted in savings.	This funding had been earmarked for the development of new, more efficient evidence-based practices for children.

Program Area	Amount of Reduction	Basis for Action	Anticipated Impact
			Reduction of the funding will impede the development of these services.
MHAP	\$312,421	It is anticipated that the State elevation of Medicaid will result in fewer persons coming to MHAP.	This may lead to difficulty in care coordination for Medicaid clients who also receive non-Medicaid services.
Total	\$4,092,759		

The following table summarizes the net impacts associated with Fixed Yield and Fixed Rate scenarios. The Net Annual Program Impact represents the annual shortfall in levy funding associated with the Duke Appeal and Probate Court as well as Other Impacts necessary to balance total available revenues with expenditures on an annual basis. The Other Impacts represent the annualized reduction in MHR SB operations and services that will be necessary to maintain a positive fund balance at the end of the upcoming levy period, *over and above the planned \$4,092,759 reduction beginning July 1, 2012.*

Option Impacts	Fixed Yield Option	Fixed Rate Option
Millage Change	3.19 0.20	2.99 0.00
Annual Average Fiscal Impacts		
Probate Court	\$641,764	\$641,764
Duke Appeal	\$576,069	\$576,069
Levy Administration	\$20,000	\$20,000
Additional Expense Reduction Requirements	\$0	\$3,477,248
Net Annual Program Shortfall	\$1,237,833	\$4,715,081
Attributable to Operations of MHR SB	\$596,069	\$4,073,317
Not Attributable to Operations of MHR SB	\$641,764	\$641,764

In the Fixed Yield option, which we recommend, the total mental health levy fund will still experience an annual shortfall of \$1,237,833. Of this amount, \$596,069, is directly attributable to the operations of the Mental Health and Recovery Services Board, representing the MHRSB portion of the Duke assessment appeal and expenses for levy administration. Beyond the planned reductions for July 1, MHRSB will need to reduce its operational costs and/or its program service costs by this additional rounded \$600,000 in order to finish the upcoming levy period with a positive operating fund balance. The remainder of the shortfall is attributable to the proposed transfer of the probate court program from the indigent care levy to the mental health levy.

If the TLRC and Board of County Commissioners selects the Fixed Rate option, then the mental health levy fund faces an annual shortfall of \$4,715,081. Of this, \$4,073,317 is attributable to the operations of MHRSB, and the remaining \$641,764 comes from the proposed transfer of the probate court program. MHRSB staff has identified potential program reductions of an estimated \$3,800,000, for possible implementation on July 1, 2013. Even this this additional program reduction, MHRSB will still have an annualized shortfall of \$273,317.

The spending plan provided by MHRSB is the same for each and includes adjustments related to Medicaid processing changes, the staff reductions, and the \$4,092,759 in program reductions effective July 1, 2012. As noted, the forecast spending plan presented makes the necessary reductions to live within the Fixed Yield option, with the exception of the additional funding requirements for the Duke Appeal and Probate

Court. The shortfalls will require either further reductions existing MHRSB program spending or alternative revenue.

The tables on the following pages present the Fixed Yield as provided by MHRSB. In this option, the tax levy is set to provide a static, or unchanging total level of tax fund support over the forecast period as actually provided by the tax levy in the current five-year period. The County Auditor estimates that this would require a millage of 3.19 or an increase of 0.20 from the current millage of 2.99 to yield approximately \$187.1 million during the five-year period.

**Hamilton County Mental Health Levy
Fixed Yield Option
Five Year Revenue Forecast for Calendar Years 2013 - 2017**

Line Item Description	Actual				Estimated CY 2012	TOTAL CY08-CY12	Forecast					TOTAL CY13-17
	CY 2008	CY 2009	CY 2010	CY 2011			CY 2013	CY 2014	CY 2015	CY 2016	CY 2017	
Local Revenues												
Mental Health Levy												
Real Estate	\$29,489,540	\$29,512,234	\$29,170,101	\$29,888,362	\$29,086,537	\$147,146,774	\$32,150,806	\$32,319,188	\$32,488,401	\$32,658,473	\$32,829,391	\$162,446,259
Trailer	\$22,624	\$15,039	\$13,492	\$11,456	\$20,000	\$82,611	\$0	\$0	\$0	\$0	\$0	\$0
Personal Property	\$1,969,848	\$449,685	\$131,270	\$92,059	\$0	\$2,642,862	\$0	\$0	\$0	\$0	\$0	\$0
Payment in Lieu of Taxes	\$3,614,060	\$4,705,614	\$4,751,540	\$3,739,799	\$2,701,829	\$19,512,842	\$1,676,973	\$1,676,973	\$1,676,973	\$1,676,973	\$1,676,973	\$8,384,865
Rollback & Homestead	\$3,014,048	\$3,038,906	\$3,042,849	\$3,054,551	\$2,968,720	\$15,119,074	\$3,215,085	\$3,231,918	\$3,248,844	\$3,265,843	\$3,282,931	\$16,244,621
Public Utility	\$705,435	\$775,013	\$744,160	\$346,983	\$0	\$2,571,591	\$0	\$0	\$0	\$0	\$0	\$0
Subtotal Tax Levies	\$38,815,555	\$38,496,491	\$37,853,412	\$37,133,210	\$34,777,086	\$187,075,754	\$37,042,864	\$37,228,079	\$37,414,218	\$37,601,289	\$37,789,295	\$187,075,745
<i>Average Annual Rate of Increase</i>		-0.8%	-1.7%	-1.9%	-6.3%		6.5%	0.5%	0.5%	0.5%	0.5%	
Capital and Rental Income	\$407,583	\$95,935	\$124,112	\$96,898	\$97,892	\$822,420	\$100,829	\$103,854	\$106,970	\$110,179	\$113,484	\$535,316
Other Match	\$2,180,984	\$1,422,038	\$288,000	\$2,822,740	\$3,820,789	\$10,534,551	\$3,159,415	\$3,159,415	\$3,159,415	\$3,159,415	\$3,159,415	\$15,797,075
Miscellaneous	\$38,702	\$94,403	\$147,424	\$25,119	\$30,000	\$335,648	\$15,000	\$15,000	\$15,000	\$15,000	\$15,000	\$75,000
TOTAL LOCAL	\$41,442,824	\$40,108,867	\$38,412,948	\$40,077,967	\$38,725,767	\$198,768,373	\$40,318,108	\$40,506,348	\$40,695,603	\$40,885,883	\$41,077,194	\$203,483,136
<i>Average Annual Rate of Increase</i>		-3.2%	-4.2%	4.3%	-3.4%		4.1%	0.5%	0.5%	0.5%	0.5%	
Special Revenues												
State Grants	\$23,395,032	\$26,131,110	\$19,189,898	\$16,257,744	\$4,168,807	\$89,142,591	\$4,234,449	\$4,234,449	\$4,234,449	\$4,234,449	\$4,234,449	\$21,172,245
Medicaid	\$23,226,147	\$30,796,007	\$33,578,711	\$42,776,617	\$28,048,617	\$158,426,099	\$300,000	\$0	\$0	\$0	\$0	\$300,000
Federal Grants	\$0	\$90,563	\$729,730	\$1,536,113	\$4,400,987	\$6,757,393	\$2,817,192	\$2,762,772	\$2,762,772	\$2,762,772	\$2,762,772	\$13,868,280
ODMH Direct Payments	\$744,926	\$623,993	\$567,542	\$584,509	\$584,509	\$3,105,479	\$584,509	\$584,509	\$584,509	\$584,509	\$584,509	\$2,922,545
TOTAL SPECIAL REVENUES	\$47,366,105	\$57,641,673	\$54,065,881	\$61,154,983	\$37,202,920	\$257,431,562	\$7,936,150	\$7,581,730	\$7,581,730	\$7,581,730	\$7,581,730	\$38,263,070
<i>Average Annual Rate of Increase</i>		21.7%	-6.2%	13.1%	-39.2%		-78.7%	-4.5%	0.0%	0.0%	0.0%	
Other Financing Sources												
Proceeds from long-term obligations	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Proceeds from sale of capital assets	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
TOTAL OTHER FINANCING SOURCES	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<i>Average Annual Rate of Increase</i>		NA	NA	NA	NA		NA	NA	NA	NA	NA	
TOTAL CURRENT OPERATING REVENUE	\$88,808,929	\$97,750,540	\$92,478,829	\$101,232,950	\$75,928,687	\$456,199,935	\$48,254,258	\$48,088,078	\$48,277,333	\$48,467,613	\$48,658,924	\$241,746,206
<i>Average Annual Rate of Increase</i>				9.5%	-25.0%		-36.4%	-0.3%	0.4%	0.4%	0.4%	

**Hamilton County Mental Health Levy
Fixed Yield Option
Five Year Levy Expenditure Forecast for Calendar Years 2013 - 2017**

Line Item Description	Actual				Estimated CY 2012	TOTAL CY08-CY12	Forecast					TOTAL CY13-CY17
	CY 2008	CY 2009	CY 2010	CY 2011			CY 2013	CY 2014	CY 2015	CY 2016	CY 2017	
Expenditures - MHR SB												
Agency Provider Contracts	\$78,762,232	\$90,056,502	\$91,979,760	\$90,752,455	\$80,908,784	\$432,459,733	\$43,317,732	\$44,334,943	\$44,521,083	\$44,708,154	\$44,896,160	\$221,778,072
ODMH Direct Payments	\$744,926	\$623,993	\$567,542	\$584,509	\$584,509	\$3,105,479	\$584,509	\$584,509	\$584,509	\$584,509	\$584,509	\$2,922,545
Subtotal Purchased Services	\$79,507,158	\$90,680,495	\$92,547,302	\$91,336,964	\$81,493,293	\$435,565,212	\$43,902,241	\$44,919,452	\$45,105,592	\$45,292,663	\$45,480,669	\$224,700,617
Salaries, Benefits and Taxes	\$2,627,794	\$2,788,324	\$2,886,264	\$3,008,582	\$2,920,500	\$14,231,464	\$2,169,606	\$1,869,189	\$1,869,189	\$1,869,189	\$1,869,189	\$9,646,362
One-time Staff Reduction Expense						\$0	\$700,000					\$700,000
Operating Expenses	\$663,220	\$492,014	\$691,418	\$682,835	\$852,500	\$3,381,987	\$860,000	\$674,000	\$674,000	\$674,000	\$674,000	\$3,556,000
Capital Outlay	\$11,287	\$244,435	\$941	\$1,765	\$65,000	\$323,428	\$1,065,000	\$65,000	\$65,000	\$65,000	\$65,000	\$1,325,000
County Auditor & Treasurer Fees	\$503,414	\$495,584	\$475,891	\$484,344	\$521,582	\$2,480,815	\$521,582	\$521,582	\$521,582	\$521,582	\$521,582	\$2,607,910
Subtotal MHR SB	\$83,312,873	\$94,700,852	\$96,601,816	\$95,514,490	\$85,852,875	\$455,982,906	\$49,218,429	\$48,049,223	\$48,235,363	\$48,422,434	\$48,610,440	\$242,535,889
Expenditures - Other												
Duke Appeal Refund Impact	\$0	\$0	\$518,514	\$309,976	\$185,221	\$1,013,712	\$521,270	\$547,333	\$574,700	\$603,435	\$633,607	\$2,880,345
Probate Court Civil Commitment	\$0	\$0	\$0	\$0	\$0	\$0	\$599,803	\$620,176	\$641,149	\$662,737	\$684,955	\$3,208,820
Levy Administration						\$0					\$100,000	\$100,000
Subtotal Other	\$0	\$0	\$518,514	\$309,976	\$185,221	\$1,013,712	\$1,121,073	\$1,167,509	\$1,215,849	\$1,266,172	\$1,418,562	\$6,189,165
TOTAL EXPENDITURES	\$83,312,873	\$94,700,852	\$97,120,330	\$95,824,466	\$86,038,096	\$456,996,618	\$50,339,502	\$49,216,732	\$49,451,212	\$49,688,606	\$50,029,002	\$248,725,054
Average Annual Rate of Increase		13.7%	2.6%	-1.3%	-10.2%		-41.5%	-2.2%	0.5%	0.5%	0.7%	

**ATTACHMENT A: COMPARATIVE DATA TABLES
(DATA FOR FISCAL YEAR 2011)**

Demographics	Hamilton	Butler	Clermont	Cuyahoga	Franklin	Lucas	Montgomery	Summit
Population	802,374	368,130	197,363	1,280,122	1,163,414	441,815	535,153	541,781
% Population Served	2.74%	2.56%	1.68%	3.30%	3.15%	4.87%	3.15%	3.99%
% Clients SMD	67.77%	57.78%	64.97%	62.70%	51.67%	54.30%	58.32%	50.35%
% Medicaid	76.80%	79.21%	77.52%	83.20%	69.88%	78.02%	75.24%	63.45%
% Non-Medicaid	41.03%	30.40%	34.22%	27.54%	49.03%	32.17%	39.43%	49.69%
% White	43.53%	85.12%	96.96%	34.65%	53.29%	58.11%	58.70%	65.05%
% Black	53.31%	11.11%	2.11%	51.51%	39.22%	35.49%	38.41%	32.16%
% Unknown	1.09%	3.16%	0.48%	5.88%	4.52%	4.64%	1.17%	2.00%
% age 0-17 Years	34.60%	34.69%	42.70%	39.37%	38.44%	34.41%	30.49%	33.82%
% Age 18-64 Years	62.62%	61.44%	55.07%	58.09%	59.70%	64.73%	67.28%	65.28%
% Age 65+ Years	4.06%	4.75%	3.31%	4.01%	2.93%	2.01%	3.28%	2.01%

Units of Service	Hamilton	Butler	Clermont	Cuyahoga	Franklin	Lucas	Montgomery	Summit
Diagnostic Assessment	24,131	12,267	3,443	45,075	34,502	23,390	13,437	24,797
Group Counseling	135,238	99,298	26,589	184,705	336,027	103,615	185,454	123,848
Individual Counseling	685,518	270,276	86,470	929,064	609,129	334,179	292,898	462,565
Group Community Psychiatric Supportive Treatment (CPST)	73,182	15,007	5,387	105,663	555,088	84,910	113,458	268,328
Individual CPST	1,205,926	257,240	104,831	2,057,667	1,518,357	540,919	553,813	610,677
Medical Somatic Service	28,493	18,408	3,047	81,813	80,006	53,871	36,787	30,931
Partial Hospitalization	63,619	8,122	7,243	122,569	43,954	36,199	9,665	19,149

Cost of Service	Hamilton	Butler	Clermont	Cuyahoga	Franklin	Lucas	Montgomery	Summit
Diagnostic Assessment	\$ 2,903,549	\$ 1,550,169	\$ 431,177	\$ 5,806,769	\$ 4,451,913	\$ 3,016,960	\$ 1,725,676	\$ 3,335,088
Group Counseling	\$ 1,310,915	\$ 911,291	\$ 259,301	\$ 1,823,060	\$ 3,300,862	\$ 1,007,732	\$ 1,776,653	\$ 1,222,178
Individual Counseling	\$ 15,375,575	\$ 5,978,748	\$ 1,861,330	\$ 20,805,847	\$ 14,897,635	\$ 7,396,248	\$ 6,516,437	\$10,804,837
Group Community Psychiatric Supportive Treatment (CPST)	\$ 701,776	\$ 146,038	\$ 52,607	\$ 982,967	\$ 5,434,364	\$ 831,079	\$ 1,065,920	\$ 2,485,705
Individual CPST	\$ 25,677,941	\$ 5,463,054	\$ 2,240,357	\$ 43,502,023	\$ 32,401,055	\$11,536,852	\$11,736,829	\$13,970,169
Medical Somatic Service	\$ 5,931,491	\$ 3,851,522	\$ 623,729	\$ 16,790,873	\$ 16,705,917	\$11,129,574	\$ 7,626,173	\$ 8,900,809
Partial Hospitalization	\$ 7,431,305	\$ 948,410	\$ 846,334	\$ 14,297,547	\$ 5,136,839	\$ 4,228,405	\$ 1,122,173	\$ 2,189,221

Financial Data	Hamilton	Butler	Clermont	Cuyahoga	Franklin	Lucas	Montgomery	Summit
FY 2011 Total Revenue	\$ 101,232,950	\$29,714,450	\$16,010,898	\$130,899,427	\$167,478,671	\$64,938,128	\$63,504,131	\$82,191,618
FY 2011 Total Expenditures	\$ 96,031,117	\$30,289,170	\$16,450,928	\$130,144,092	\$145,484,214	\$62,366,138	\$63,341,759	\$76,530,551
FY 2011 Total LEVY Revenue	\$ 37,133,210	\$ 9,647,198	\$ 2,368,964	\$ 24,438,562	\$ 62,915,255	\$12,958,761	\$27,295,946	\$37,720,375
Levy Revenue Per Capita	\$ 46.28	\$ 26.21	\$ 12.00	\$ 19.09	\$ 54.08	\$ 29.33	\$ 51.01	\$ 69.62
Total Revenue Per Capita	\$ 126.17	\$ 80.72	\$ 81.12	\$ 102.26	\$ 143.95	\$ 146.98	\$ 118.67	\$ 151.71
Total Expenditures Per Capita	\$ 119.68	\$ 82.28	\$ 83.35	\$ 101.67	\$ 125.05	\$ 141.16	\$ 118.36	\$ 141.26
Total Expenditures Per Client	\$ 4,361.28	\$ 3,216.78	\$ 4,950.63	\$ 3,080.77	\$ 3,973.24	\$ 2,896.71	\$ 3,754.25	\$ 3,543.90

Cost Per Unit of Service	Hamilton	Butler	Clermont	Cuyahoga	Franklin	Lucas	Montgomery	Summit	Average
Diagnostic Assessment	\$ 120.32	\$ 126.37	\$ 125.23	\$ 128.82	\$ 129.03	\$ 128.99	\$ 128.43	\$ 134.50	\$ 127.71
Group Counseling	\$ 9.69	\$ 9.18	\$ 9.75	\$ 9.87	\$ 9.82	\$ 9.73	\$ 9.58	\$ 9.87	\$ 9.69
Individual Counseling	\$ 22.43	\$ 22.12	\$ 21.53	\$ 22.39	\$ 24.46	\$ 22.13	\$ 22.25	\$ 23.36	\$ 22.58
Group Community Psychiatric Supportive Treatment (CPST)	\$ 9.59	\$ 9.73	\$ 9.77	\$ 9.30	\$ 9.79	\$ 9.79	\$ 9.39	\$ 9.26	\$ 9.58
Individual CPST	\$ 21.29	\$ 21.24	\$ 21.37	\$ 21.14	\$ 21.34	\$ 21.33	\$ 21.19	\$ 22.88	\$ 21.47
Medical Somatic Service	\$ 208.17	\$ 209.23	\$ 204.70	\$ 205.23	\$ 208.81	\$ 206.60	\$ 207.31	\$ 287.76	\$ 217.23
Partial Hospitalization	\$ 116.81	\$ 116.77	\$ 116.85	\$ 116.65	\$ 116.87	\$ 116.81	\$ 116.11	\$ 114.33	\$ 116.40

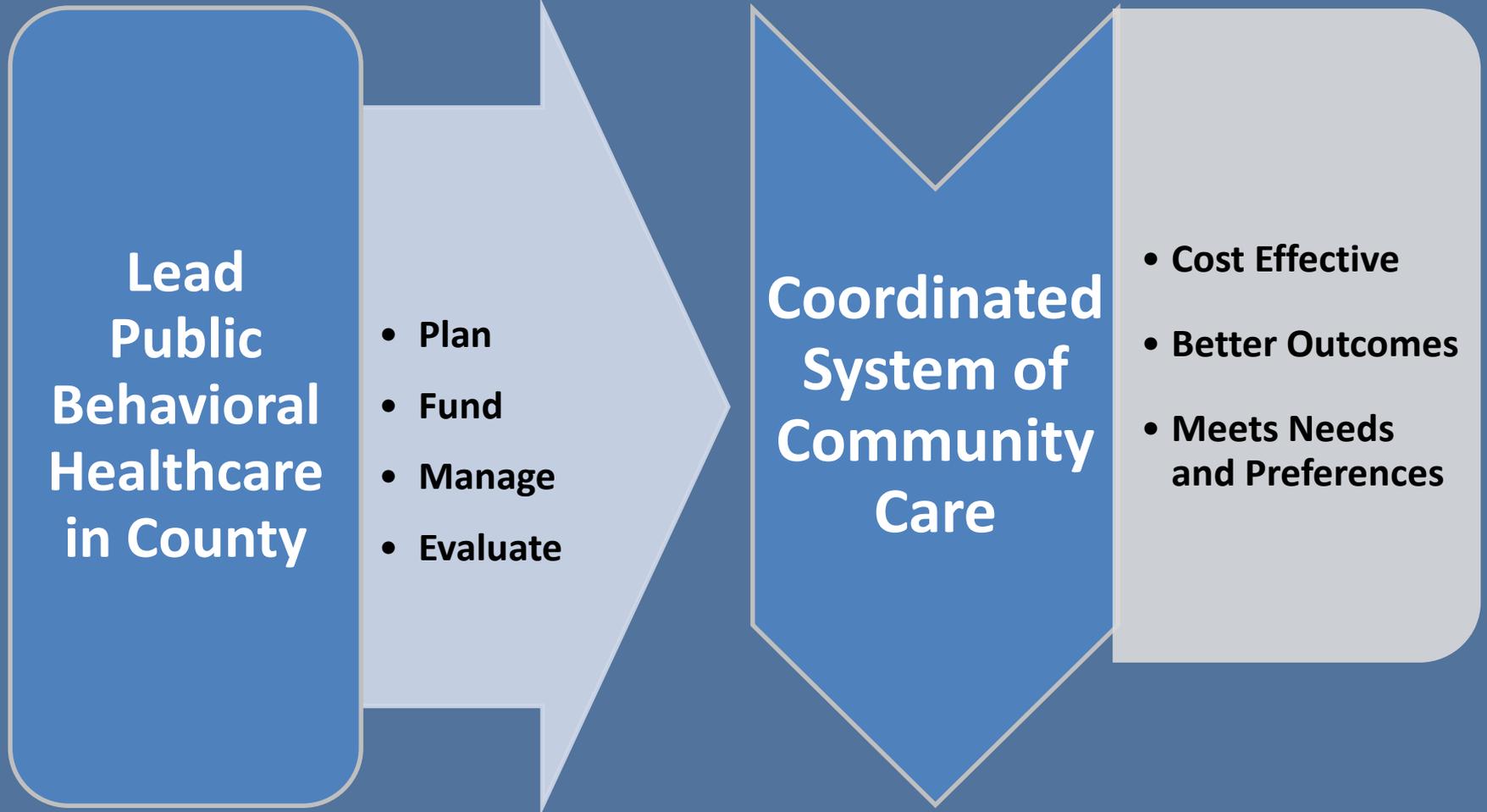
ATTACHMENT B: PRESENTATION ON ELEVATION OF MEDICAID

The following is a presentation presented by MHRSB Executive Management to the TLRC Mental Health Subcommittee. It presents the State's plan to assume responsibility for the management of Medicaid beginning July 1, 2012, anticipated impacts of that elevation, and MHRSB's current strategies for addressing the issues and opportunities that arise from the change.

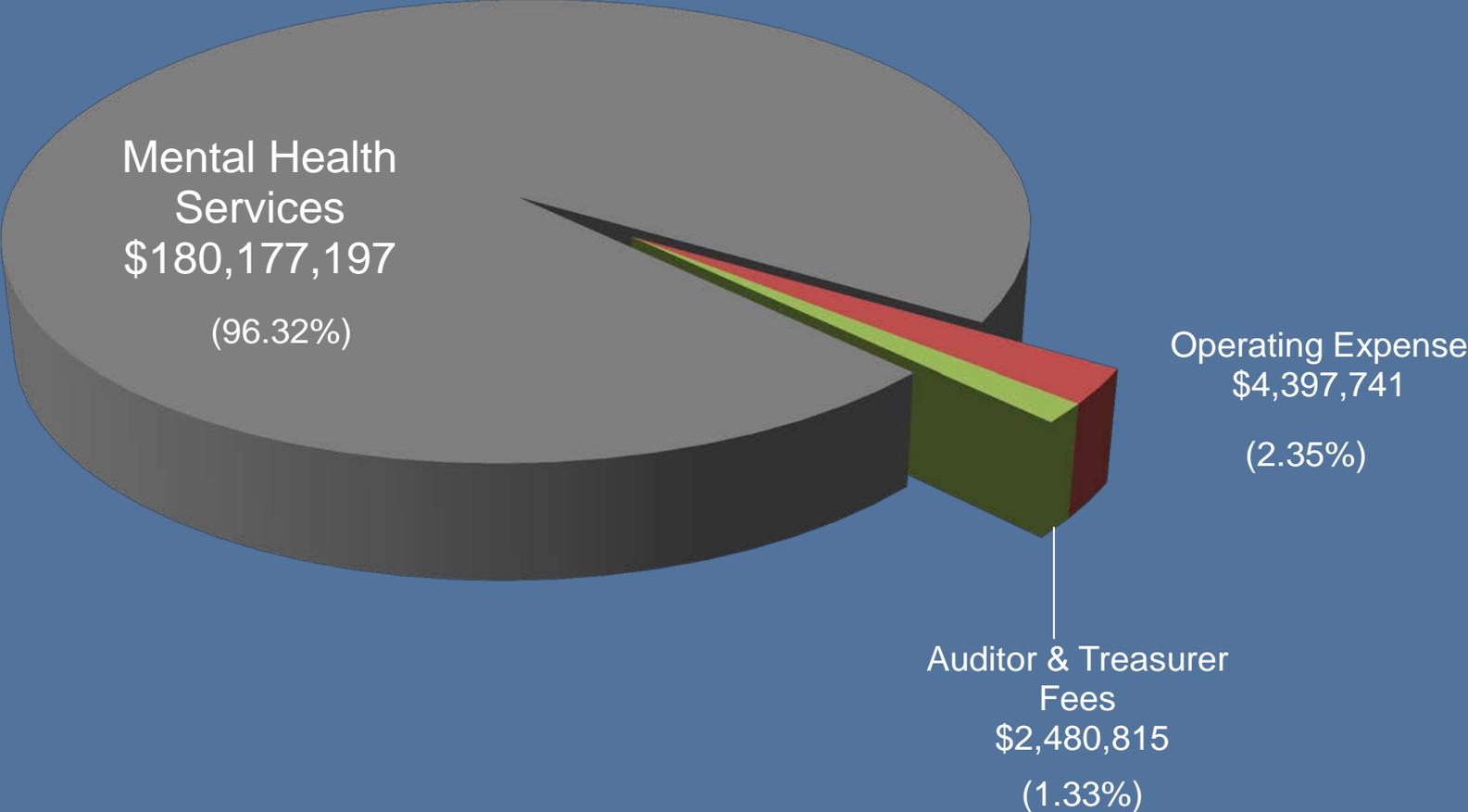


Hamilton County
Mental
Health and
Recovery
Services
Board

Authority Under ORC §340



Operating Expense as a Percent of Levy Revenue CYs 2008-2012



Emerging Developments

State

- Transfer of Medicaid clients to ODJFS

Healthcare

- Integration of physical and behavioral health care
- Sharing health information through technology

Economic

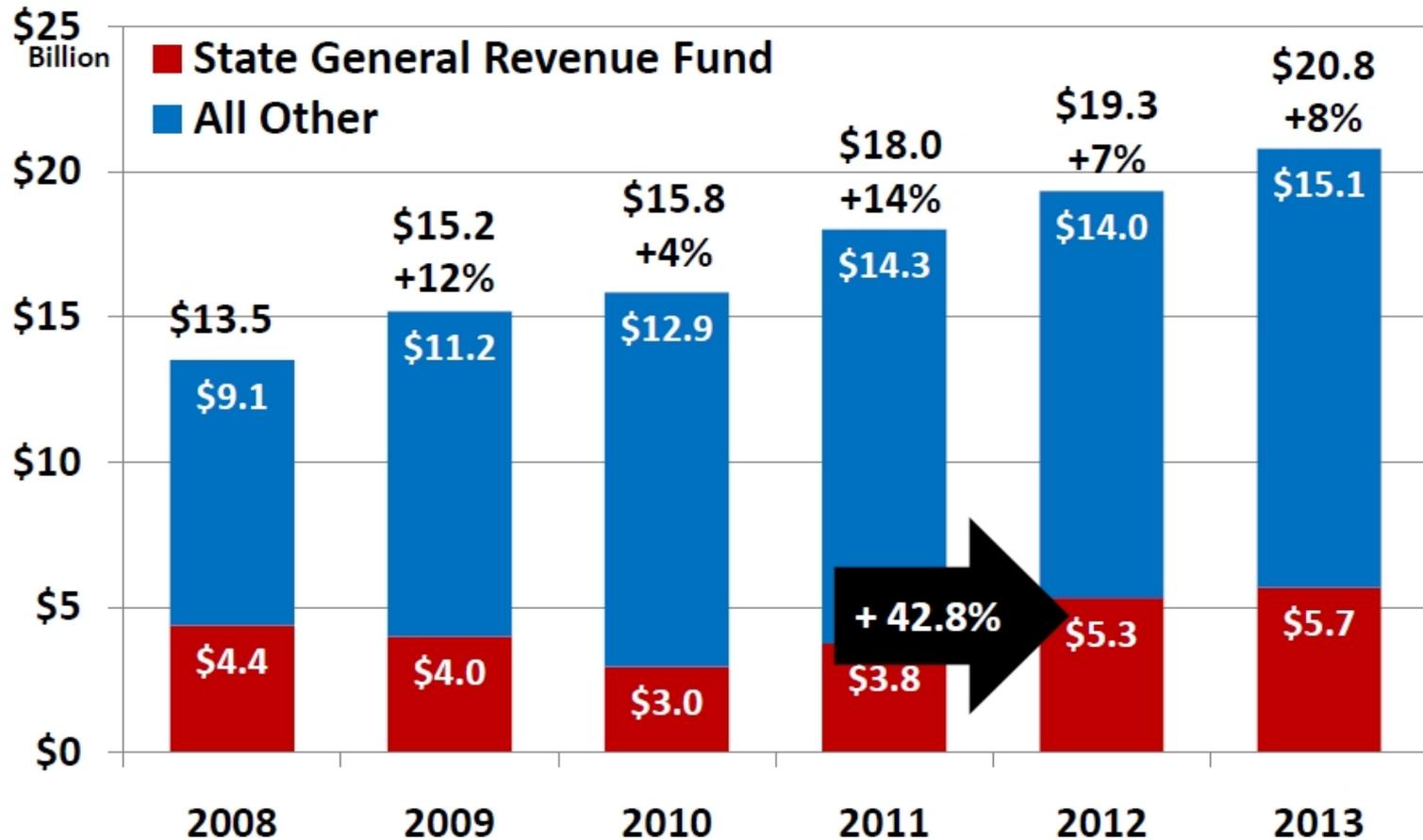
- Declining Levy revenues
- Decreased community funding from ODMH

Technology

- Shutdown of ODMH claims system
- Design and purchase local, more advanced, system

Ohio Medicaid Spending Trend

9 percent average annual growth, 2008-2011



Governor's Office of Health Transformation

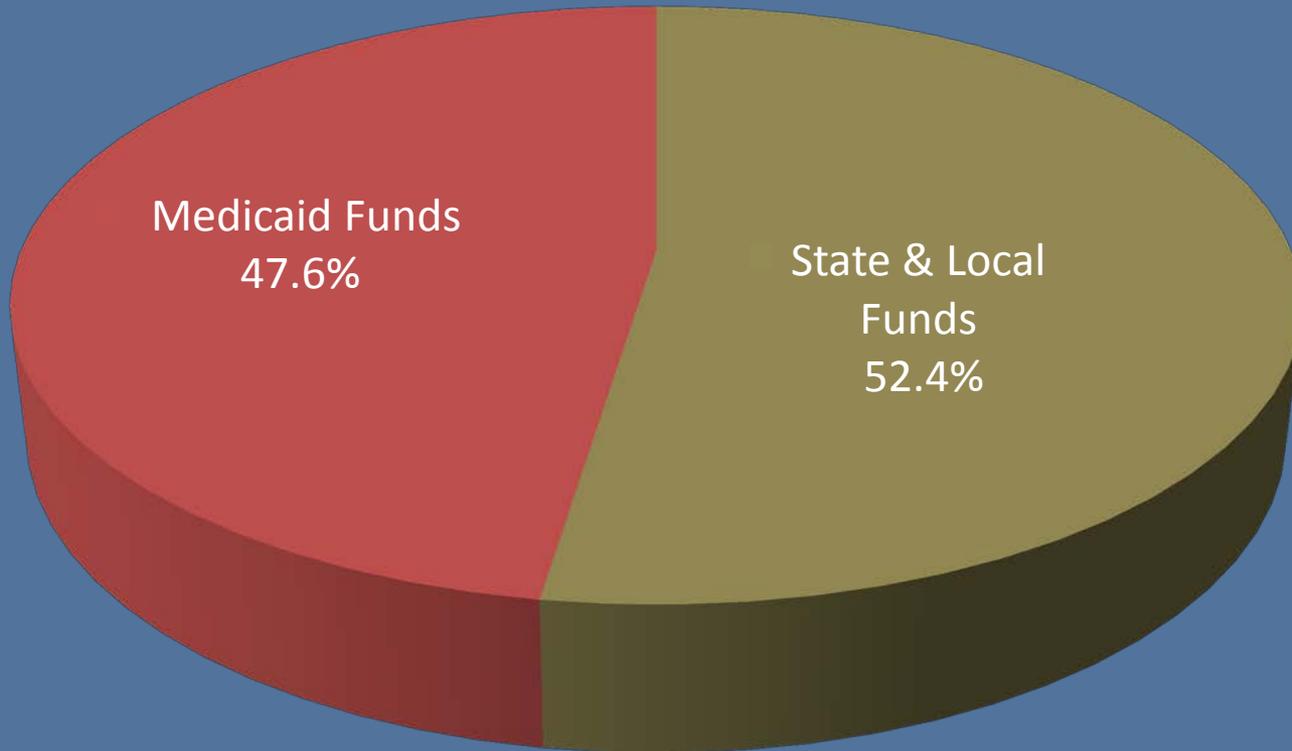
Source: Office of Health Transformation Consolidated Medicaid Budget, All Funds, All Agencies; actual SFY 2008-2010 and estimated SFY 2011-2013; "All Other" includes Federal Funds and Non-General Revenue Funds (non-GRF)

Constraints of Medicaid

State Requirements

- Fixed rates for costs of services
- Match federal dollars (usually 40%)
- 365 days for agency to bill for services rendered
- Use state's antiquated billing system with limited data access
- Any willing provider can be part of panel
- Limits ability to implement best practices

HCMHRSB FY 2012 MH Revenues



Impact of Medicaid Elevation on Clients, Services and Supports



Jane has Medicaid

- Assessment
- Community Psychiatric Support
- Pharmacological
- Counseling
- Partial
- Residential Treatment
- Resiliency Services
- Prevention and Education
- In-Home
- Early Childhood Mental Health
- Wrap Around

* Services funded through Medicaid



John Does Not Have Medicaid

- Assessment
- Community Psychiatric Support
- Pharmacological
- Counseling
- Partial
- Employment and Vocational
- Housing
- Recovery Services
- Crisis Intervention Services
- PATH Homeless Services

* Services funded primarily through local levy and some state and grant funds

Opportunities with Medicaid Elevation

HCMHR SB Can Establish

- Rates for services
- Billing timeframes
- More advanced data management and claims system
- Provider panel
- Array of services including best practices
- Client eligibility criteria

Strategic Plan: State Developments

Define new MHR SB client benefits package in alignment with MHR SB mission, consumer needs, and funding availability

- Develop eligibility and enrollment guidelines inclusive of priority populations
- Determine array of services and programs that best meet client needs and projected outcomes
- Support and strengthen programs and services that use best and evidence based practices
- Align MHR SB and provider planning efforts to support services that promote wellness, recovery, and resiliency

Strategic Plan: State Developments

Redesign the behavioral health system centralized access point
MHAP

- Develop referral process for consumers who present with Medicaid benefits
- Implement eligibility and enrollment guidelines
- Establish utilization review and authorization process to manage care

Strategic Plan: State Developments

Determine provider panel in alignment with MHR SB mission and new benefit package

- Develop and implement provider selection criteria
- Develop application process to select providers
- Transition provider contracts from FY contract year to CY contract year

Strategic Plan: Health Care

Explore, create, and utilize opportunities for integration of behavioral and physical healthcare

- Continue BEACON project that pilots healthcare integration, innovative use of technology, and outcomes focus
- Establish and define partnerships and collaborations with Federally Qualified Health Centers and other physical healthcare systems to improve consumer care coordination

Strategic Plan: Economics

Evaluate funding decisions continually using a combination of business, health, and outcome criteria

- Discontinue funding for programs, services, and/or providers that no longer meet business, health, or outcome criteria or that might jeopardize the financial stability of the MHRSB
- Ensure that funded services continue to fulfill consumer needs and deliver a measurable health impact

Strategic Plan: Economics

Implement outcomes based funding

- Continue provider outcomes based incentive program
- Expand use of consumer health outcome information to optimize MHRSB planning and funding decisions

Strategic Plan: Technology

Design and purchase a customized data management system that expands current capabilities in data collection, processing, and reporting

- Create Council of Governments to develop and implement data management system
- Issue RFP, evaluate vendor responses, and select vendor
- Implement data management system internally and externally

Behavioral Healthcare Innovations

Develop and implement a pilot program that integrates:

- Alternative financing strategies
- Flexible programming
- Consumer outcomes
- Technology

The aim is to evaluate models intended to result in improved health for the client, a better healthcare system and cost efficiency

Restructure MHR SB Workforce to Meet Future Business Needs

Continuing Workforce Analysis

- Inventory of current competencies
- Determination of future required competencies
- Identification of competency gaps or excess
- Develop plan to fill gaps and eliminate excess

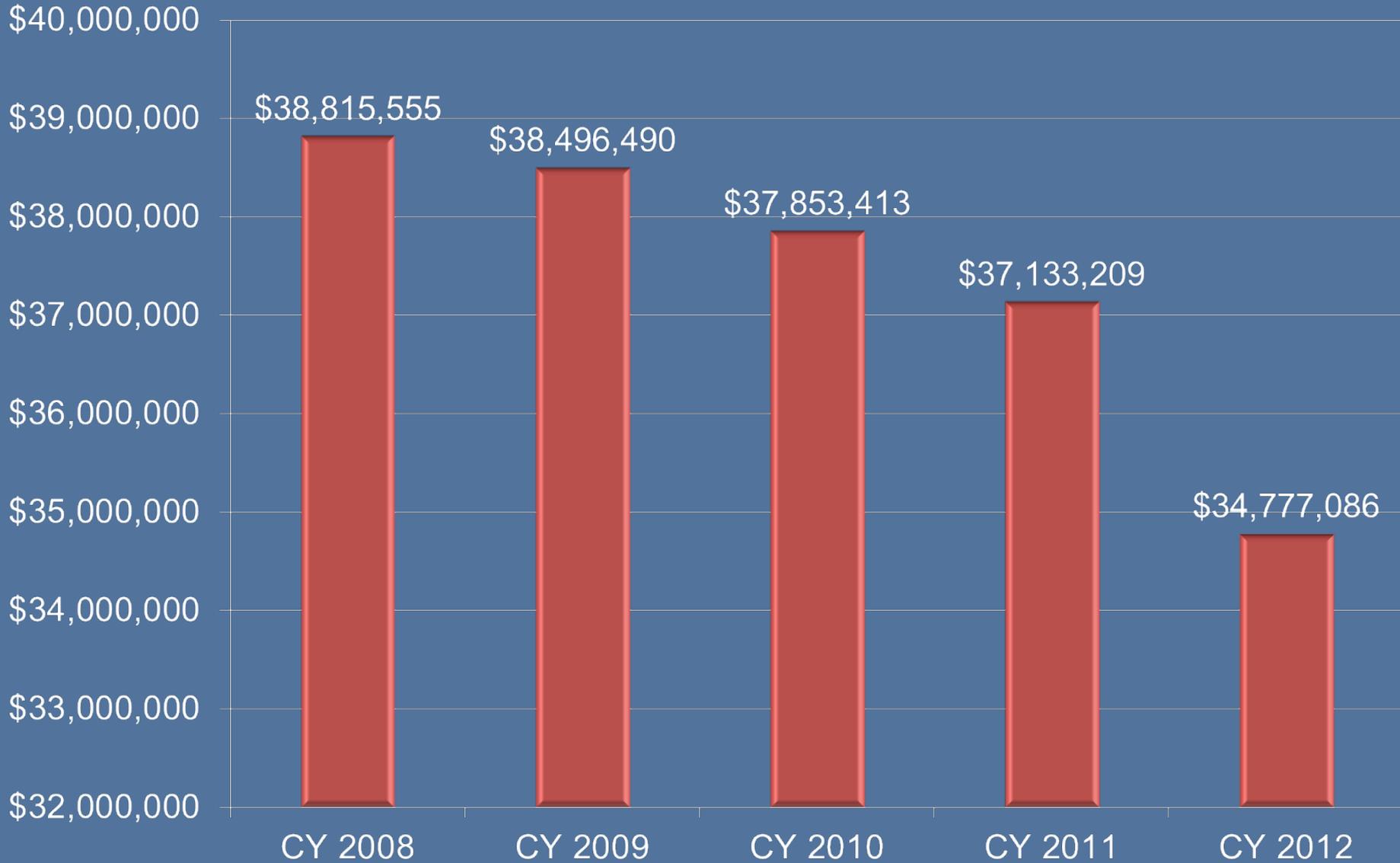
Initial restructuring has begun

- 2011: Abolishment of 4 funded positions (9.5%)
- 2012: Abolishment of 2 funded positions (5.0%)

Elimination of additional positions beginning January 2013

Possible outsourcing of some existing positions

Mental Health Levy Revenue From CY 2008 Through CY 2012



Effect of Duke Energy Appeal Levy Period 2008-2012

If Duke wins appeals, the County Auditor has determined that the maximum amount the Mental Health Levy will owe Duke is:

- CY 2010 \$ 700,695
- CY 2011 \$ 516,627
- CY 2012 \$ 394,088
- Total \$ 1,611,410

Effect of Duke Energy Appeal Levy Period 2013-2017

HCMHR SB estimates the maximum amount the Mental Health Levy will owe Duke is \$2.9 million total for the Levy Period 2013-2017.

Estimate Based Upon:

- The average increase in Duke's assessed value over the past three years
- And the average appealed value for CY's 11 and 12

Need for Carryover

Projected carryover as of December 31, 2012, is \$4.9 million

HCMHR SB requests that this carryover remain for the following reasons:

- \$1.6 million for Duke appeal for calendar years 2010-2012
- \$2.9 million for Duke appeal for calendar years 2013-2017
- \$400 thousand for run-out of FY '12 Medicaid

HAMILTON COUNTY MENTAL HEALTH AND RECOVERY SERVICES BOARD

POSSIBLE MENTAL HEALTH LEVY SCENARIOS

	Current Levy (2008-2012)	Straight Renewal Per County Auditor Letter Dated 3/28/12	Renewal Plus Increase Millage	Restoration to the Amount Generated by the 2008-2012 Levy Per County Auditor Letter Dated 4/18/12
Voted Millage	2.99	2.99	3.13	3.19
Millage in Addition to 2.99 Mill Renewal			.14 mill	.20 mill
Avg. Annual Levy Revenue over 5 years	\$ 37,415,149	\$ 33,937,901	\$ 36,313,554	\$ 37,471,340
Total Levy Revenue Generated over 5 years	\$ 187,075,744	\$ 169,689,507	\$ 181,567,772	\$ 187,356,702
Additional Annual Cost to the \$100,000 Homeowner			\$ 4.16	\$ 5.94
Total Annual Cost to \$100,000 Homeowner	\$ 48.38	\$ 48.38	\$ 52.54	\$ 54.32

IMPACT ON SERVICES

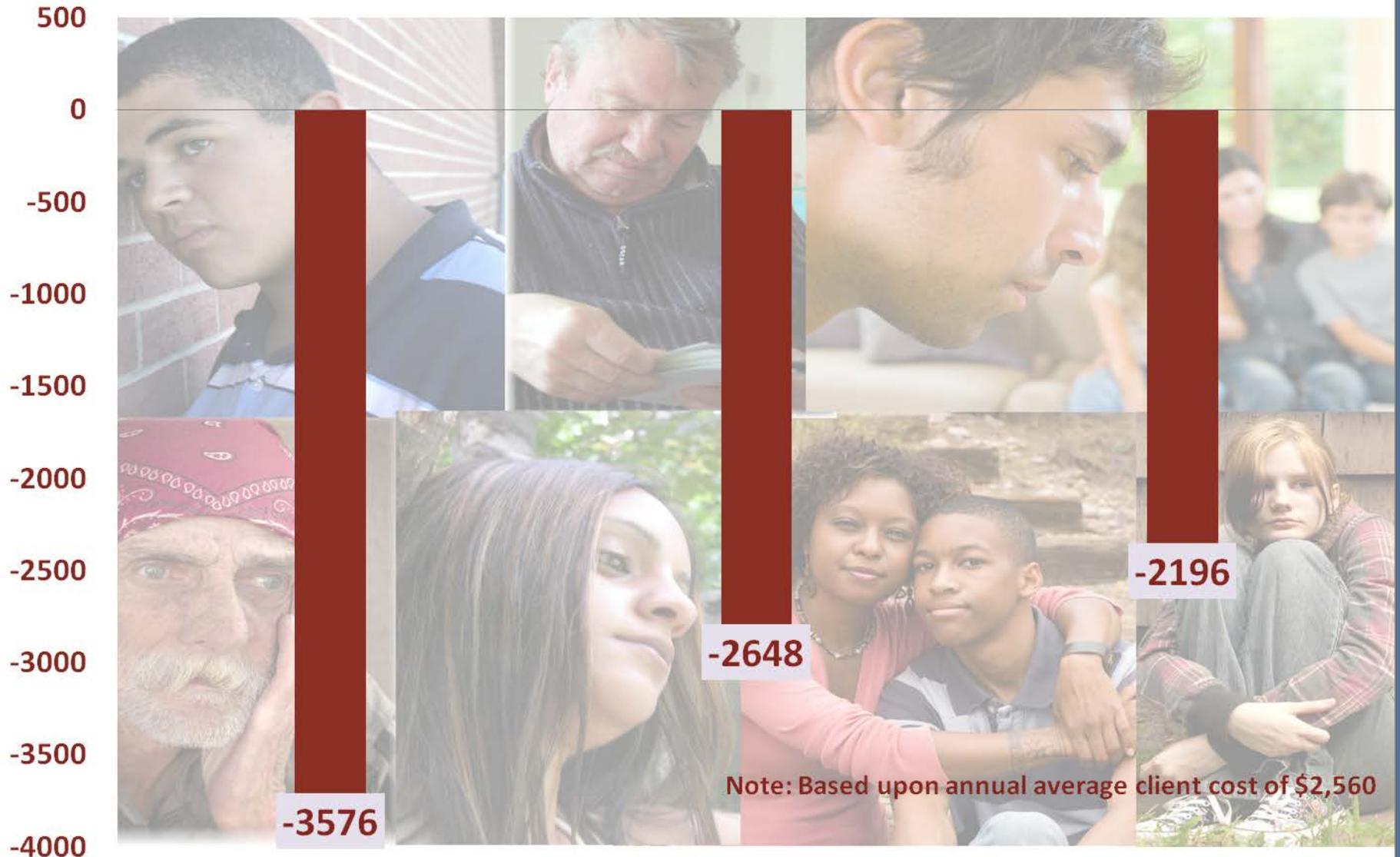
Current FY 12 Mental Health Expenditures	\$ 42,700,000	\$ 42,700,000	\$ 42,700,000	\$ 42,700,000
Reductions Effective 7/1/12 on Existing Services		\$ (4,000,000)	\$ (4,000,000)	\$ (4,000,000)
Reductions Effective 7/1/13 on Existing Services		\$ (4,762,099)	\$ (2,386,446)	\$ (1,228,660)
Total Reductions to Existing Services		\$ (8,762,099)	\$ (6,386,446)	\$ (5,228,660)
If New Services are Added to the Levy		\$ (391,783)	\$ (391,783)	\$ (391,783)
Total Reductions to Existing Services if New Services are added		\$ (9,153,882)	\$ (6,778,229)	\$ (5,620,443)

Estimated Client Impact at Varying Millage Levels

Straight Renewal

Renewal Plus .14

Renewal Plus .20



Note: Based upon annual average client cost of \$2,560