HMA

HEALTH MANAGEMENT ASSOCIATES

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

PREPARED FOR
HAMILTON COUNTY TAX LEVY REVIEW COMMITTEE

MAY 23, 2022

Research and Consulting in the Fields of Health and Human Services Policy, Health Economics and Finance, Program Evaluation, Data Analysis, and Health System Restructuring

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HMA would like to express their appreciation to Lisa Webb, Senior Policy Manager with the Hamilton County Budget & Strategic Initiatives Department, the Mental Health and Rehabilitation Service Levy subcommittee, the staff of the Hamilton County Mental Health Recovery Services Board, and their provider network for their assistance during the review process and in the development of this report.

I. Introduction

Hamilton County retained Health Management Associates (HMA) to conduct an analysis of the use of mental health levy funds during the current tax levy period of 2018 to 2022 and administered by the Hamilton County Mental Health and Recovery Services Board (MHRSB). HMA 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. We also provided considerations to the Hamilton County Board of County Commissioners regarding future tax levy support for the activities provided under the Mental Health Levy.

Objectives

The primary objectives of this evaluation were to assess and/or make recommendations regarding:

- Current operating efficiency of the MHRSB relative to:
  - MHRSB's strategic plan
  - MHRSB's peers
  - Reasonable expectations
- Compliance with, and maximization of, current and planned funding contracts
- Recommendations for Tax Levy contract provisions between Hamilton County and MHRS assuming successful passage of the proposed Tax Levy
- Recommendations for costs savings and revenue enhancements

Approach

HMA submitted a data and information request to MHRSB at the onset of the project and reviewed these documents and materials to inform the analysis and recommendations to the Mental Health Levy Subcommittee. HMA conducted virtual interviews with 14 providers currently contracted by MHRSB and receiving levy funds, as well as staff at MHRSB. In addition, HMA interviewed Hamilton County Department of Job and Family Services staff and staff of the Hamilton County Sheriff, Juvenile Court and Adult Probation offices. These efforts supported the HMA team in completing the following tasks as part of the tax levy review:

1. Identify, and develop an understanding of the services funded by levy dollars 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.
3. Analyze 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).
4. Comparison with Private Providers and Other Governmental Agencies.
5. Report on the impact of COVID-19 on Hamilton County's MHRSB Levy needs.
6. Evaluate financial results of MHRSB operations over the past five years, including analysis of variances from budget and comparison of financial trends with services delivered over the same time.
7. Historical review of MHRSB budget and projections.
8. Analyze any alternative sources of funding to ensure that any of these sources of funding are being utilized first.
9. Report and analyze MHRSB compliance with the terms of the current Agreement by and between the Board of County Commissioners of Hamilton County, Ohio and MHRSB and make recommendations for future contractual conditions upon passage of the Levy.
10. Prepare draft and final reports.

II. Recent History and Overview of Mental Health and Recovery Services Board (MHRSB)

Overview

Hamilton County MHRSB provides leadership in public behavioral health care as the authority charged under ORC §340 with planning, funding, managing, and evaluating behavioral health care in Hamilton

County. MHRSB is statutorily prohibited from providing direct care to clients and instead contracts with numerous non-profit agencies to provide direct care in a community based (non-hospital) setting.[1] Hamilton County created the MHRSB under the auspices of Ohio HB 648, authorizing formation of county-based Community Mental Health Boards. 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 (MH) in Hamilton County. The current MHRSB is the product of the merger of the separate ADAS and MH boards in 2006.

The Board's primary 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), and both children and adults with mental health needs who are in the criminal justice systems (CJS). Secondary to the populations reflected above is the intent to provide mental health services, as resources allow, for those adults and children having a less severe need.

Recent History & Environmental Factors since the Last Levy Review Period

As with previous levy review cycles there are several environmental factors and changes that need to be considered when reviewing the MHRSB performance over the most recent levy cycle, and that will have impact on the upcoming cycle. In addition to the COVID-19 pandemic and the opioid crisis, there are multiple converging factors facing Ohio alcohol, drug addiction and mental health services boards and their provider networks. This includes an anticipated continued increase in demand for behavioral health services combined with unprecedented and expanding workforce shortages. This environmental climate is contributing to a potential evolution of the county behavioral health board and provider roles and highlighting the need to adapt delivery systems. Additional factors impacting the Board include continued changes at the state level, such as the implementation of OhioRISE (Resilience through Integrated Systems and Excellence), a specialized managed care program for youth with complex behavioral health and multi-system needs. It also includes Ohio's roll-out of a nationwide 988 behavioral health hotline, mobile crisis services available to respond to those in need, and crisis stabilization services within a clinical setting to further support individuals with intensive needs. Each of these factors and the proposed federal funding are described briefly below and will be considered and further discussed within the recommendations later in this report.

Covid-19

The impact of the COVID-19 pandemic was significant in the most recent MHRSB funding cycle and these impacts are likely to continue into the next levy cycle. The MHRSB demonstrated exemplary leadership and resiliency when faced with challenges brought by the pandemic, supporting contracted providers by securing and distributing personal protective equipment (PPE) and technology that allowed for the pivot of service delivery from in-person to technology-based interventions. The progress that had been made in addressing the opioid epidemic nationally, suffered a setback, with overdoses rising again during the pandemic. Preliminary data for Ohio predicted a 6.6% increase in opioid overdose deaths during the period between October 2020 and October 2021.[2] In addition, the isolation from the lockdown, job loss and stress from disruptions to in-person learning all contributed to an increase in demand for mental health and substance use disorder services. The federal public health emergency (PHE) did provide flexibilities and additional funding to offset these challenges. The U.S. Department of Health and Human Services (HHS) must decide whether to extend the COVID-19 PHE every 90 days to maintain these health care flexibilities and waivers. In place since January 27, 2020, the PHE has been renewed nine times since the original declaration. The current HHS extension for the PHE was effective April 16, 2022, extending through July. HHS did not communicate the required notice for plans to end the current extension on May 16th. Therefore, the PHE is currently extended. Congress also recently extended the current COVID-19 pandemic telehealth waivers for five months beyond the end of the PHE.

Among the rules that have been temporarily set aside are those applying to reimbursement for telehealth and audio-only services, including those provided to treat mental health and substance use disorders. When the PHE ends, the more flexible regulatory environment will also return to the original rules and requirements. After two years of operating under emergency rules, many providers, including behavioral health providers in Hamilton County will have to transition back to the pre-pandemic requirements, which may include financial and operational adjustments. In addition, under the 2020 Families First Coronavirus Relief Act, states received enhanced federal match for their Medicaid

[1] Hamilton County Mental Health and Recovery Services Board Strategic Plan 2017
[2] Overdose data reported to CDC accessed at https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

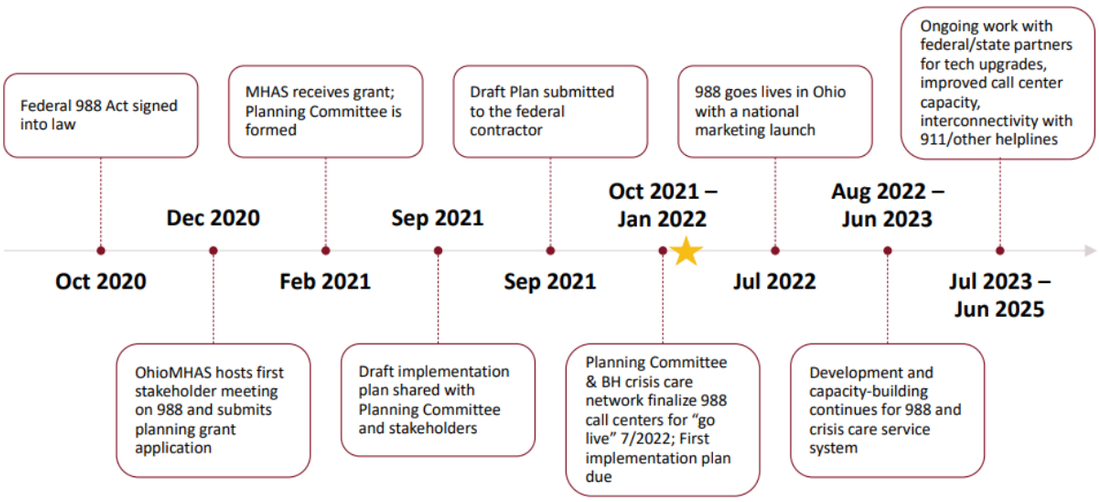
programs as they faced tax revenue shortfalls. However, states were required to suspend monthly eligibility redeterminations to qualify for the additional federal financial support (all states, including Ohio have complied with this requirement).[3] When the suspension ends, Medicaid eligibility for some may also end, increasing reliance on levy funding to cover behavioral health services.

988 & Increased Focus on Crisis Response

Beginning in 2019, the State began investing in and planning for the expansion of crisis services across Ohio to comply with October 2020 federal legislation that requires all states to transition from a 10-digit National Suicide Prevention Lifeline number to 988 by July 16, 2022. As part of these efforts, states are building mobile crisis teams and crisis stabilization unit capacity to support callers in need of face-to-face intervention. Ohio's efforts to date and the state timeline for implementation include the following:

- OhioMHAS is coordinating planning, implementation, and statewide operation of the National Suicide Prevention Lifeline (NSPL), including call, chat, and text coverage for Ohioans in all 88 counties, including planning for funding sustainability
- January 19, 2022, an RFP was released for a **statewide 988 back-up provider** for the hotlines that will take the 988 calls within Ohio
- **Crisis Capacity Building (MH/SUD Stabilization Centers):** $15 million to develop standardized and quality crisis access in community as alternatives to arrests or emergency room visits
- **Crisis Stabilization Flex Fund:** $11.5 million to prevent or stabilize substance use or mental health-related crises
- **Crisis Infrastructure Development:** $9.25 million to develop, evaluate, and expand crisis services for adults, children, and families in a variety of settings[4]

As states prepare to expand crisis services, they are pursuing Medicaid reimbursement where possible. As Medicaid coverage is added, mobile crisis and suicide/crisis hotline services may be less reliant on levy funding.



The current timeline crosses over into the next levy cycle and includes development of services, and in some cases, Medicaid reimbursement, for services currently contracted by MHRSB, such as the hotline and mobile crisis services.[5]

OhioRISE

Scheduled for implementation in 2022, OhioRISE is a new component of Ohio's managed care program and first-ever integrated program to help children who have complex and serious behavioral health needs. It will feature intensive care coordination and coverage of new and enhanced behavioral health services, including a new Medicaid waiver program that will help families prevent custody relinquishment. In February 2022, the Ohio Department of Medicaid (ODM) announced the 20 regional care partners selected to serve as the care management entities (CMEs) that will support youth enrolled in OhioRISE. Aetna was awarded the contract to serve as the OhioRISE health plan and will be

[3] Capretta, James C., State of Reform. *The status of Public Health Emergency declarations*. March 16, 2022
[4] Investments included in 2019 Crisis Academy: Building on Our Strengths. Presentation by Lori Criss, Director, Ohio Department of Mental Health & Addiction Services. Monday, October 28, 2019.

[5] Ibid

responsible for the development and implementation of the following services statewide for OhioRISE enrollees:

- **Intensive and Moderate Care Coordination:** two levels of this service (intensive and moderate) will be consistent with principles of High-Fidelity Wraparound and be delivered by the Care Management Entity-qualified agency.
- **Intensive Home-Based Treatment (IHBT):** OhioRISE will make changes to existing IHBT services and align with the Family First Prevention Services Act (FFPSA).
- **Psychiatric Residential Treatment Facility (PRTF):** this service is aimed at keeping youth with the most intensive behavioral health needs in-state and closer to their families and support systems.
- **Mobile Response and Stabilization Service (MRSS):** provide youth in crisis and their families with immediate behavioral health services to ensure they are safe and receive necessary supports and services (this new service will also be available to children who are not enrolled in OhioRISE).
- **Behavioral Health Respite:** provide short-term, temporary relief to the primary caregiver(s) of an OhioRISE plan enrolled youth, in order to support and preserve the primary caregiving relationship.
- **Primary Flex Funds:** services, equipment, or supplies not otherwise provided through the Medicaid state plan that address an identified need in the service plan, including improving and maintaining the individual's opportunities for full participation in the community.[6]

For youth enrolled in Medicaid managed care but not enrolled in the OhioRISE plan, Ohio Medicaid MCOs and the fee for service program will continue coverage for the Medicaid's existing behavioral health services and MRSS. The Ohio Medicaid MCOs also will be responsible for assuring access to the Child and Adolescent Needs and Strengths (CANS) assessment to determine when a child needs the enhanced services of the OhioRISE plan. Planned services, including care coordination and crisis services, under the OhioRISE program may overlap with existing services supported by the MHRSB. Two of its current contractors, Lighthouse Youth and Family Services and Cincinnati Children's, were awarded contracts to serve as the CMEs for West and East Hamilton County, respectively.

Workforce Challenges

Even prior to the pandemic, workforce shortages have been a looming crisis for behavioral health providers in states across the nation, and Ohio is no exception. The supply of professionals in the field is not keeping pace with the growing demand for services. Data from the Ohio Department of Mental Health and Addiction Services (OhioMHAS) show a 353% increase in demand for behavioral health treatment between 2013 and 2019 with an average annual increase of 29%. The state data forecasts a 5.6% annual rise in statewide demand each year over the next decade.[7] Behavioral health agencies are struggling to attract and retain a qualified workforce to meet the increased demand for services due to a variety of factors, including natural attrition and stress, missing or unrecognizable advancement pathways for new or aspiring clinicians, a lack of parity in the private insurance market that drives reliance on public payers, the economic impacts of the pandemic, and rigid credentialing requirements.[8]

ORC 340 Workgroup

Ohio Revised Code Chapter 340 governs the structure and outlines the role and responsibilities of the local alcohol, drug addiction, and mental health services (ADAMHS) boards. The OhioMHAS has convened a stakeholder workgroup to identify sections of ORC 340 in need of review, define specific challenges and explore potential solutions. Members of the workgroup include OhioMHAS staff,

[6] Summary of OhioRISE services and structure accessed at https://managedcare.medicaid.ohio.gov/managed-care/ohiorise/0-ohiorise on March 28, 2020.
[7] Ohio Department of Mental Health & Addiction Services. (2021). Understanding Supply and Demand Within Ohio's Behavioral Health System https://data.ohio.gov/wps/portal/gov/data/projects/03-mhas-workforce
[8] The Ohio Council (2021). Breaking Point Ohio's Behavioral Health Workforce Crisis https://www.theohiocouncil.org/assets/BreakingPoint/TheOhioCouncil_Whitepaper_BreakingPoint.pdf

ADAMHS boards (including HCMHRSB), providers, advocacy groups, and trade association representatives.

The workgroup will be conducted through open meetings and will produce a summary report which will outline the challenges, potential solutions, and future policy considerations for further review and discussion by the State and General Assembly. The initial meeting of the workgroup occurred in March of 2022 and the workgroup plans to meet monthly through June 2022. In the Fall of 2022, there will be public listening sessions in each of the 5 regional psychiatric hospital catchment areas outside of Central Ohio. In addition, a survey was released in March 2022 to rank the sections of revised code in the order of priority and to indicate what sections present challenges for workgroup consideration.[9]

Increased Federal and other Funding for Behavioral Health

As the ongoing impact of the opioid and COVID-19 pandemic has highlighted the importance of behavioral health service access, new and enhanced funded has become available. Most notably through federal funding and upcoming state opioid settlement dollars. On March 23, 2022, President Biden released his proposed budget for fiscal year 2023. While the budget still awaits congressional approval, it includes Investments in mental health and suicide prevention programs, particularly among youth; expands access to mental health benefits; and increases enforcement of mental health parity including provisions removing lifetime limits on services for behavioral health care and applying mental health and addiction parity to Medicare. The budget proposes reforms to address the increased demand for mental health through the expansion and development of the mental health workforce for primary care clinics, non-traditional sites, and those serving Medicaid beneficiaries.

The budget proposes $536 billion in net Medicaid outlays for 2023, which includes:

- Addressing the mental health crisis by making permanent the current demonstration for Certified Community Behavioral Health Clinics ($24 billion in costs over 10 years)
- Providing $7.5 billion for planning grants and a Medicaid provider capacity demo for mental health treatment
- Requiring state Medicaid programs to allow reimbursement for mental health and physical health visits provided to a Medicaid enrollee which happen on the same day
- Establishing a $2.5 billion fund for CMS to reward states for certain improvements in behavioral health

In addition to the full budget request released by the White House Office of Management and Budget, each agency submits a written justification of their budget requests to the appropriations and authorizing committees of jurisdiction in Congress. It is generally believed there is the likelihood of bipartisan action this year regarding behavioral health and the opioid crisis, but the budget approval process has just begun as of the writing of this report.

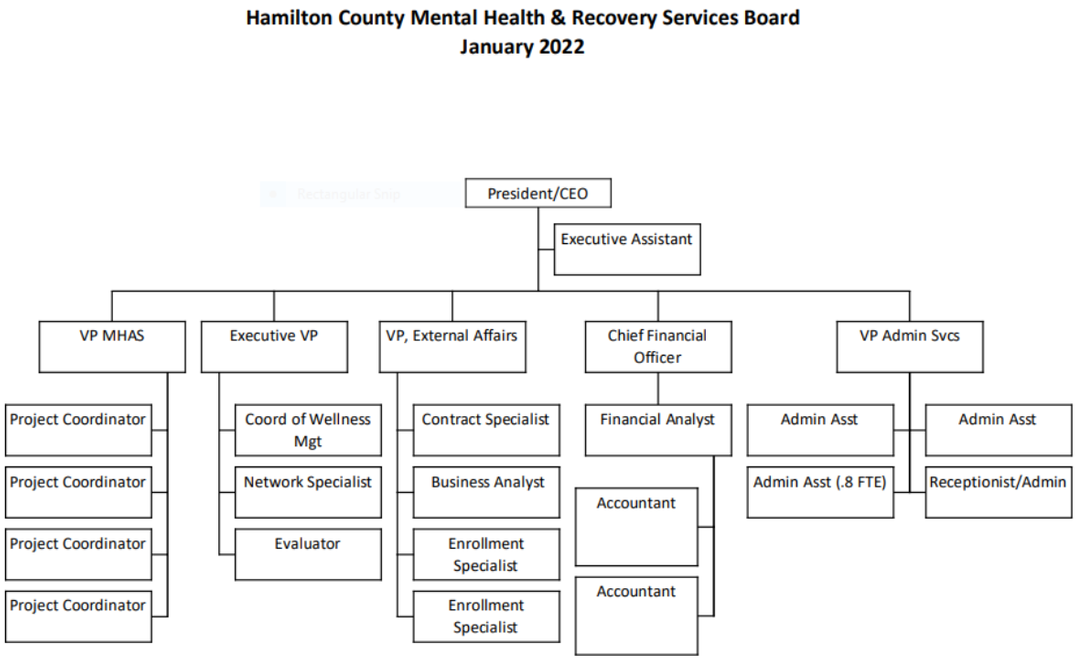
III. Analysis of Corporate Structure

Board of Trustees

A 14-member board of trustees governs the Board. Eight trustees are appointed by the Hamilton County Commissioners and six by the Director of OhioMHAS. The membership appointments of the board attempt to reflect the composition of the county specific to race and gender. Statutory appointments include a mental health and an alcohol and other drug (AOD) professional, a mental health and an AOD family member, and a mental health and AOD consumer.

[9]Summary of ORC 340 Workgroup information accessed at https://mha.ohio.gov/community-partners/advisory-groups/340-workgroup on March 29, 2022.

MHRSB Organizational Chart



MHRSB day-to-day Board operations are carried out by the Board president and staff. The Board president works with a staff of approximately 26 employees. Staff includes social workers and administrators who plan and evaluate services; technology professionals who maintain a management information system to track services; licensed mental health professionals who coordinate services; and accountants, clerical, and other support employees.

Organizational Units

There are six organizational units within MHRSB:

Executive Services - President/CEO

The primary role of Executive Services is developing and leading a system of care that supports the MHRSB mission and goals and meets stakeholder expectations. This also includes establishing system-wide procedures that achieve compliance with all legal obligations, reporting requirements, and outcome expectations. The Executive Services unit also plans budgetary and funding strategies that allow the MHRSB to achieve its mission while achieving efficiencies that demonstrate appropriate stewardship of tax dollars. Executive Services is also responsible for identifying and pursuing additional funding sources beyond the Levy that support the MHRSB objectives. Lastly, Executive Services oversees policies and procedures consistent with priorities and resources, monitoring the organization at all levels for effectiveness and efficiency.

System Performance – Executive Vice President

The System Performance unit monitors and analyzes performance of contracted system providers and programs including, evaluating, and reporting the impact of services for the Hamilton County system. System Performance identifies and promotes new innovative practices for Hamilton County. Lastly, System Performance plans, designs, and manages the various information systems and technology necessary to manage the business of the Hamilton County MHRSB.

Administrative Services - Vice President Administrative Services

The Administrative Services unit manages all phases of human resources activities for the MHRSB including workforce planning, regulatory compliance, performance management, policy development, compensation, and employee relations. Administrative Services also coordinates building repair, maintenance, security, and space planning. The unit evaluates Board productivity and makes recommendations to improve efficiency and workflow. Lastly, the Administrative Services unit develops and implements procedures for systematic retention, protection, retrieval, transfer, and disposal of records and prepares responses to public records requests.

External Affairs - Vice President External Affairs

The External Affairs unit develops, updates, monitors, and manages all contracts related to the MHRSB services, while ensuring the integrity of the client rights system in Hamilton County. This includes collecting all consumer enrollment information and creating and maintaining electronic member files; review of claims posted in SHARES and reported by manual invoice; and providing related technical support and assistance, including training to providers. Lastly, External Affairs develops and writes applications for OhioMHAS and other capital/housing funds and provides technical support for similar agency applications.

Finance – Chief Financial Officer

The Finance unit performs all accounting functions, including processing all financial transactions via Hamilton County's Performance system (e.g., appropriations, encumbrances, receipts, and expenditures); developing annual budgets and financial forecasts in line with priorities, economic changes, service needs, and expectations; and generating monthly cash basis financial statements and annual GAAP financial statements. The Finance unit also monitors financial results such as a) provider payments against contracted amounts; b) types of services delivered versus budgeted; c) monthly receipts and expenditures versus the budget, and d) actual Levy Plan results.

Mental Health and Addiction Services – Vice President MHAS

The Mental Health and Addiction Services unit directs the planning process for the mental health and addiction system of care. The unit consults and coordinates with other system stakeholders regarding community issues such as the Hamilton County Response to the Opiate Epidemic, the Homeless Coalitions, Family Access to Integrated Recovery for Job and Family Service involved individuals and children, and administration of the Multi County-Systems Agency (MCSA). This unit also coordinates project/program reporting (e.g., Ex-Offender Mini-grant, Forensic Monitor, PATH, and Family Centered Services and Supports FCSS) and monitors initiatives such as MHAP, Keys to Health, Behavioral Health Juvenile Justice (BHJJ) project, as well as Drug Court, Mental Health Court, and prevention services. Lastly, Mental Health and Addiction Services researches and develops grant opportunities to expand non-board funding for local services and programs (e.g., Drug Court Enhancement, Behavioral Health and Juvenile Justice BHJJ, and Journey).

Compensation

The Tax Levy Review Committee has requested that HMA comment on the MHRSB's history of adjustments in employee compensation during the current levy period. The following table presents the total MHRSB personnel costs for the calendar years during the levy period, including the impact of reductions in staff that were made in response to environmental and budgetary factors.

The MHRSB staffing has undergone minor changes since the last levy cycle review, including shifting of existing positions in the following ways:

- In 2017, elimination of an administrative assistant position, with specific responsibilities to a provider agency (MHAP)
- In 2019, elimination of SAMHSA Grant Director position aligned with the individual's retirement, as well as an end to the formal grant period
- In 2020, elimination of Coordinator of Community Education and Technical Assistance position that was tied to a SAMHSA grant that concluded, with the individual reassigned as a Project Coordinator under the Board's MHAS Office

It was estimated that the net savings from the changes were $183,656.30.

2017-2021 Cash Basis Payroll Costs - All Fund Sources

Year	Amount	$ Change	% Change
Calendar Year 2017 - Actual	$2,697,081.20		
Calendar Year 2018 - Actual	$2,750,618.12	$53,536.92	1.98%
Calendar Year 2019 - Actual	$2,855,150.93	$104,532.81	3.80%
Calendar Year 2020 - Actual	$2,833,627.08	$(21,523.85)	-0.75%
Calendar Year 2021 - Actual	$2,860,488.01	$26,860.93	0.95%
Change from 2017-2021		**$163,406.81**	**6.06%**

MHRSB Merit Increases, 2018-2022 Levy Period

Year	2018	2019	2020	2021	2022
Average Increase	3%	2%	2%	2%	3%

IV. Operations Analysis

Overview of Services

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 services that can be delivered through the provider model include:

Assessment, Non-Physician: (Previously known as Diagnostic Assessment). A face-to-face interview with a registered client so that a reasonably full understanding of the nature of the problem can be gained to recommend appropriate treatment. With child clients, the interaction may also include face to face contact with family members (parents, guardians, foster parents) and/or essential others external to the agency. The child client does not need to be present.

Community Psychiatric Supportive Treatment – Individual and Group (CPST): (Previously known as Community Support Program – CSP). Community psychiatric support 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 CPST is to maximize symptom reduction and a return to the person's best possible functional level. 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.

Consultation: Consultation services address mental health needs in varied community settings (e.g., daycare centers, classrooms, health clinics, etc.). This service helps professionals in these settings identify potential mental health needs of their respective populations.

Consumer Operated Service: Services planned, developed, administered, delivered, and evaluated by persons, a majority of whom are consumers of mental health services. Services include the Warm-line twenty-four-hour peer-operated call-in service for consumers who need support and the consumer-operated Recovery Center.

Counseling and Therapy – Individual: 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.

Counseling and Therapy – Group: Group counseling/psychotherapy is a service provided to a group of participants. This differs from individual counseling/psychotherapy in that the group has predefined goals and objectives.

Education: Mental health 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.

Employment Service: Employment Services provide job skills training or support on and off the work site during the term of employment. Employment services include instruction to the client on the job, monitoring of performance and productivity, support, and feedback about job performance, establishing and maintaining on-going communication with the site supervisor and maintaining data on the client's work performance and personal adjustment.

Forensic Evaluation: Forensic evaluation services address mental health and legal issues. These services include but are not limited to competency to stand trial, pre-sentence investigations, domestic violence evaluations, evaluation for revocation of parole, and an evaluation of the psychological effects of an act upon the victim.

Hot Line service: Services are provided for short-term intervention and crisis management. This service is available twenty-four hours per day, seven days per week.

Information and Referral Services: These services provide the public with assistance in understanding the mental health system as it relates to psychiatric care and assist the public in accessing appropriate programs of service.

Inpatient 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.

Intensive In-Home Service: Intensive in-home services are provided in the client's natural environment (home, school, etc.) to prevent the need for treatment outside of the natural environment. Intensive in-home services are designed to provide individualized support services responsive to the client's needs at the time of delivery.

Mobile Crisis Team Services: The Mobile Crisis Team (MCT) can intervene in crisis situations anywhere in Hamilton County for persons of all ages. Team members are under direct supervision of qualified psychiatrists through telephone contact and can initiate, when indicated, referral of patients to the nearest emergency service for medical or psychiatric evaluation.

On-Site Emergency- Crisis Intervention Services: This service mainly serves Hamilton County residents but may benefit residents from other parts of the state and country who experience a psychiatric emergency in Hamilton County.

Other Mental Health Services: "Other Mental Health Services" is an OhioMHAS designation which incorporates a variety of services defined by local Mental Health and Recovery Services Boards. Other Mental Health Services are certified by OhioMHAS. Services operated by the Sheriff's Department, the Probation Department, Juvenile Court and Pre-trial are included in this category. Additional services 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, administration of the Multi-County System Agreement, housing assistance, administration, planning and coordination of mental health services.

Outreach Services: Outreach services are provided to persons who are not enrolled as consumers in the mental health system. These persons may need treatment but are not yet connected with the system. Outreach services are designed to identify and begin to engage those persons.

Partial Hospitalization: A day 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.

Payee Services: Payee services are provided to consumers who require assistance with managing their SSI/SSDI or other financial benefits. The payee works with the client to develop and maintain a monthly budget and is responsible for ensuring that the consumer's bills are paid in a timely manner.

Peer Support Services: Individuals with similar mental health issues provide peer support services to consumers. Peer support is intended to provide consumers with information and support from those who have had similar life experiences.

Pharmacologic Management: (Previously known as Medication/Somatic). Pharmacologic Management is a service conducted for the purpose of prescribing and/or supervising the use of psychotropic medication and other medications. This service is provided in face-to-face contact between a licensed physician/psychiatrist or a registered nurse and an enrolled client. Pharmacologic Management service includes the responsibility for evaluating the client's progress, adjustment to medication, and need for medication change.

Prevention Services: Mental health 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.

Psychiatric Diagnostic Interview with Physician: (Previously known as Diagnostic Assessment). The provider must be a physician. Face to face interview with a registered client so that a reasonably full understanding of the nature of the problem can be gained and appropriate treatment can be recommended. With child clients, the interaction may also include face to face contact with family members (parents, guardians, foster parents) and/or essential others external to the agency. The child client does not need to be present.

Residential Care – Comprehensive (includes Crisis/Respite): Intensive residential treatment facilities are designed for short-term stays. They are licensed and fully staffed to provide a range of mental health services that support intensive psychiatric stabilization for clients experiencing acute episodes of emotional difficulty.

Residential Care – Community Residence: Community residences are private homes or separate apartments licensed by the state as Residential Care Facilities which are owned/operated by a private provider. These homes/apartments generally house one to five clients who are supervised by the provider/owner. Placement in these facilities is for the purpose of providing transitional support for increased independent living and personal care as assessed need indicates. Therapeutic Foster Care for children is included in this service.

Residential Support Services: Residential support services are provided, by associated personnel, to consumers in permanent apartments, single room occupancy or permanent shared living arrangements. For example, a network of housing currently exists where consumers share a home or reside in an apartment building where a resident manager also resides. This resident manager provides support and monitors the consumer with a focus on improvement of daily living. Most residential support is provided by off-site personnel; however, support can be available 24 hours a day, seven days a week.

Residential Treatment Facility: Residential treatment facilities offer 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. All residential treatment facilities are licensed and fully staffed.

Social & Recreational Services: Social and recreational services are provided in facilities, whenever possible, that are used for social and recreational purposes by other members of the community. These services promote coordination among similar providers and the community in order to maximize rehabilitation opportunities for consumers.

Subsidized Housing: Subsidized housing differs from community residence in that minimal or no mental health services are coupled with the rental or occupancy. These funds are used largely for housing development, management, and subsidy support. This housing is available only to those who are severely mentally ill and are enrolled as consumers of mental health services.

Temporary Housing: Time limited Quick Access housing program with a maximum authorized length of occupancy and goals to transition to permanent housing. Meals are generally not included but are arranged elsewhere. Treatment services are not provided. Clients served are homeless or at high risk of becoming homeless.

Vocational Services: 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.

MHRSB Clients by Service Type and Funding Source

Specific to State requirements of the MHRSB, the Board is required to submit an annual community plan and the Boards' Annual Budget (FIS-040) to OhioMHAS. These plans are approved by the State and are integral components of recent Ohio Revised Code requirements for the provision of mandatory Essential

Service Elements. As such, OhioMHAS evaluates the plan and budget submissions for compliance with the Ohio Revised Code. According to Ohio Revised Code 340.03 A(11), the following continuum of services are required of the MHRSB. It is important to note that the requirement is as "resources allow" and any changes to an approved annual plan, including elimination of service, must be approved by the State.[10]

> ORC 340.03 (A) (11) Establish, to the extent resources are available, a continuum of care, which provides for prevention, treatment, support, and rehabilitation services and opportunities. The essential elements of the continuum include, but are not limited to, the following components in accordance with section 5119.21 of the Revised Code:
> (a) To locate persons in need of addiction or mental health services to inform them of available services and benefits;
> (b) Assistance for persons receiving addiction or mental health services to obtain services necessary to meet basic human needs for food, clothing, shelter, medical care, personal safety, and income;
> **(c) Addiction and mental health services, including outpatient, residential, partial hospitalization, and, where appropriate, inpatient care;**
> **(d) Emergency services and crisis intervention;**
> (e) Assistance for persons receiving services to obtain **vocational services and opportunities for jobs**;
> (f) The provision of **services designed to develop social, community, and personal living skills**;
> (g) Access to a wide range of **housing and the provision of residential treatment and support**;
> (h) **Support, assistance, consultation, and education** for families, friends, persons receiving addiction or mental health services, and others;
> (i) Recognition and encouragement of families, friends, neighborhood networks, especially networks that include racial and ethnic minorities, churches, community organizations, and community employment as natural supports for persons receiving addiction or mental health services;
> (j) **Grievance procedures and protection of the rights of persons** receiving addiction or mental health services;
> (k) **Community psychiatric supportive treatment services**, which includes continual individualized assistance and advocacy to ensure that needed services are offered and procured.

Number of Clients Served

Number of Clients	2018	2019	2020	2021***
Children*	2,137	2,271	1,830	Unavailable
Adults*	17,472	18,565	14,961	Unavailable
Total**	**19,609**	**20,836**	**16,791**	**Unavailable**

**Estimated split between Children (10.9%) and Adult (89.1%) provided by MHRSB staff*

***Unduplicated count of clients under POS and Cost Reimbursement contract*

**** Complete number of clients served information unavailable for 2021 & 2022 per MHRSB staff*

Totals reflects aggregate client counts based upon assumption that clients in Contract Count condition are unique and not duplicative of those appearing in the Purchase of Service (POS) and Cost Reimbursement (CR) categories. Because adjudication of claims through SHARES and GOSH must consider eligibility of service through Medicaid, the GOSH system has an interface (270-271 process) with the State of Ohio's Medicaid claiming system that serves to ensure that local levy funding is not used to pay for services that should be reimbursed through Medicaid funds. As the state allows service providers up to 365 days for submission of claims to the state's Medicaid Information Technology System (MITS), claims processing through GOSH cannot be final until that 365-day period has concluded, thus a full set CY 2021 claims information is not yet available.

Service Count Type Description	2016	2017	2018	2019	2020 *
Purchase of Service	7,116	7,064	7,182	7,464	7,469
Cost Reimbursement	20,982	21,293	19,609	20,836	16,791
Contracted Services	13,760	13,760	13,760	13,760	13,760
Totals	**41,858**	**42,117**	**40,551**	**42,060**	**38,020**

[10] http://codes.ohio.gov/orc/340.03v1

MHRSB indicated CY 2021 volumes, based on claims that have been accounted for to-date, at 38,469. However, with seven of its largest provider agencies requesting claims submission extensions, this CY 2021 volume figure should be considered preliminary. It is likely this volume figure will grow to pre-2020 (pre-pandemic) levels upon final claims adjudication throughout the year.

1) **Purchase of Service data** – client identifying information is derived from claims submissions by agencies. At the end of a payment period (once all claims are received and processed/paid) client identifying information is aggregated and unduplicated to allow a total client count for those individuals. Agencies only receive funds for clients once they have submitted an approved service claim for an appropriately enrolled client in the claims management system (i.e., SHARES, GOSH).
2) **Cost Reimbursement data** – many agencies receive cost reimbursement funding similar in form to grant payment systems wherein funding is based upon expenses incurred and agencies are reimbursed for those actual expenses following delivery of the contracted services. Cost reimbursement payment methods are commonly used for new and innovative forms of programming when a service need is identified, but there is no purchase of service coding structure available and/or the cost associated with the programming required is, yet, unknown. Client information (first and last name) is required from the agency and that data is aggregated and unduplicated, but agencies receive payment regardless of their client identifying information submissions and this can result in client undercounts.
3) **Contracted Service data** – client identifying information is not available, though the contract with the agency informs on the number of individuals expected to be served during the contract period. The agency is paid based upon a pre-determined contract amount through an agreement with the board.

*CY 2020 numbers are assumed to be significantly impacted by the COVID pandemic for numerous reasons, among these: 1) an actual decrease in those served is expected due to agency capacity issues primarily caused by staff departures and illness, and also impacted by social distancing and quarantine requirements within facilities; 2) client concerns related to the transmissibility of the virus likely resulted in some reduction in service utilization; 3) agency staff turnover and resource limitations impacted the process of data compilation and submission.

The table immediately below provides the number of POS service units provided during 2018 – 2020.

	Number of POS Units		
Service Description	2018	2019	2020
BH Counseling and Therapy	46,642	52,941	45,278
Comm Residence-GCBHS(Larchwd/Madson/Bellevue/Lstr)	4,131	4,363	4,359
CommRes - Tender Mercies - Dana Hotel	18,742	19,690	17,125
Community Psychiatric Supportive Tx	125,753	136,205	95,331
Consultation	22,177	19,336	11,581
Co-Treatment Not Billable as Named Service	6,777	8,176	4,411
Court Testimony 1 (Non-traditional 3115 service)	6,435	2,684	2,458
EBP-Functional Family Therapy Supports	437	2,473	2,700
Education Programs for Youth/Adult Groups	14,822	14,875	10,592
Employ/Voc NonEBP - Project Work	65,639	74,854	33,182
Employment Service - Group	69,569	74,034	32,055
Employment Service - Individual	22,105	19,170	22,799
Employment/Vocational, NOS	4,301	2,177	1,609
Forensic Liaison/Monitors Services	4,552	5,139	3,700
FostCare - Presley Ridge - Therapeutic Foster Care	516	175	-
Hotline	18,494	17,631	20,278
In-Home Behavioral Management Service, Daily	340	71	71
MH Assessment Non-Phys.	4,958	5,108	3,505
MH PREVENTION	51,964	43,157	33,813
Partial Hospitalization less than 24 hours	929	313	215
Payee	4,152	4,152	4,152
Pharmacologic Mgt	12,279	13,102	9,149
Pressley Ridge-IHBT In-Home Service, 15 min	2,559	2,451	1,877
Psychiatric Diagnostic Evaluation-Physician	111	60	33
Psychosocial Rehab Support, Contact	22,154	22,574	10,275
ResCare- Greater Cincinnati BHS - Kemper House	4,543	4,398	2,599
ResCare- Talbert House - Montgomery Place	3,830	3,483	2,737
ResCare- Talbert House - The Bridge	882	798	774
RespCare - TalbertHouse - QuickAccess -HamiltonPl	836	6	-
Soc Rec - Therapeutic - Group	30	-	-
Soc Rec - Therapeutic Individual	5,953	3,758	2,638
Social & Recreational, NOS	13	16	-
SubsidizdHsing - Excel - PermSuptiveHsng - HAPPrgm	120,916	117,088	121,668
Supported Employment EBP -Skill development -Group	11,891	12,094	13,694
TOTALS	679,432	686,552	514,658

MHRSB Providers

Currently, MHRSB contracts with 25 behavioral health organizations. The following table shows the distribution of budgeted funding to the mental health provider agencies per year. HMA conducted virtual interviews with 14 providers currently contracted by MHRSB and receiving levy funds. Those we did not interview are typically small contracts for “niche” services. For example, Freestore Foodbank provides only payee services for adult clients. The Board has a small contract with the Salvation Army to provide emergency shelter services for families as well as a contract with an agency that provide a specialized residential.

AGENCY	2018	2019	2020	2021	2022
ADJUSTMENT TO BREAKOUT FAIR BY PARTNER	$ 424,425	$ 772,671	$ 772,671	$ 772,671	$ 772,671
BEECH ACRES	$ 748,000	$ 748,000	$ 713,000	$ 715,250	$ 790,250
CAMELOT CARE CORP.	$ 8,331	$ 8,331	$ 8,331	$ 8,581	$ 8,581
CCHB	$ 3,587,367	$ 3,587,367	$ 3,587,367	$ 3,617,370	$ 3,617,370
CEN CLNC - MHAP	$ 1,968,515	$ 1,970,515	$ 1,970,515	$ 1,973,747	$ 1,973,747
CEN CLNC OUTPATIENT SERVICES	$ 3,710,274	$ 3,600,208	$ 3,665,208	$ 3,682,666	$ 3,682,958
CROSSROADS	$ 427,192	$ 427,192	$ 427,192	$ 429,350	$ 429,350
DIRECT PURCHASES	$ 1,612,454	$ 1,612,454	$ 1,612,454	$ 1,612,454	$ 1,615,814
EXCEL	$ 2,274,225	$ 2,288,862	$ 2,288,862	$ 2,349,234	$ 2,974,704
FREE STORE/FOODBANK	$ 434,805	$ 434,805	$ 434,805	$ 447,849	$ 447,849
GCBHS	$ 6,140,404	$ 6,158,566	$ 5,868,637	$ 5,994,527	$ 5,998,849
HC JUV. CRT.	$ 323,183	$ 323,183	$ 323,183	$ 323,183	$ 323,183
HC PRE-TRIAL	$ 61,063	$ 61,063	$ 61,063	$ 61,063	$ 61,063
HC PROBATION	$ 388,344	$ 388,344	$ 388,344	$ 388,344	$ 388,344
HC SHERIFF'S DEPART.	$ 290,864	$ 290,864	$ 290,864	$ 290,864	$ 290,864
IKRON	$ 1,174,713	$ 1,174,713	$ 1,174,713	$ 1,196,474	$ 1,196,474
LIGHT HOUSE	$ 870,685	$ 870,685	$ 870,685	$ 518,235	$ 538,985
MHRSB - HOPE, NOT RESIDENTIAL	$ 984,425	$ 984,425	$ 984,425	$ 984,425	$ 984,425
MNTL HEALTH AMERICA	$ -	$ 126,747	$ 126,747	$ 126,747	$ 222,645
PRESSLEY RIDGE	$ 163,623	$ 163,623	$ 163,623	$ 168,532	$ 168,532
RECOVERY CENTER	$ 130,845	$ 130,845	$ 455,774	$ 455,774	$ 455,774
TALBERT HOUSE	$ 7,341,185	$ 7,341,185	$ 7,341,185	$ 7,608,233	$ 7,608,234
TENDER MERCIES	$ 670,469	$ 670,469	$ 670,469	$ 688,783	$ 738,783
ST. JOSEPH ORPH.	$ 856,674	$ 856,674	$ 699,779	$ 1,004,241	$ 1,046,242
MNTL HLTH ASSC	$ 126,747	$ -	$ -	$ -	
TOTALS	$ 34,718,812	$ 34,991,791	$ 34,899,896	$ 35,418,599	$ 36,335,692

Quality of Services

MHRSB Management and Reporting of Program and Financial Information

The MHRSB has processes in place for both contract monitoring and quality assurance for purchased services. Some providers offer a full continuum of mental health services while others provide specialty services. The number of providers has remained stable over the course of the current levy period.

The MHRSB renews contracts annually. All contracted providers must be certified by the State and are checked to ensure they are not on any provider exclusionary lists. The Board also checks the System for Award Management (SAM) database (https://www.sam.gov/) for verification if the federal government has disqualified a person from entering into a contract that uses federal dollars because the person has defrauded the federal government.

The MHRSB continues to measure the impact of services provided through its network of contract agencies. An outcomes report is produced every quarter representing the previous two-year period and the outcomes experienced for persons served during that period. This report also serves as a performance improvement measurement tool for contract providers and the county system. Specifically, the report assists in discerning strengths and weaknesses within provider agencies, and within the Hamilton County system, allowing for focused performance improvement initiatives where indicated. The MHRSB and contract providers work collaboratively in the development of these reports. Any changes in the methods and measures utilized in this reporting is achieved through this collaboration. More recent reports include historical scores for indicators across multiple quarters as well as continued reporting of the system-wide scores for comparison and monitoring purposes for the Board and its providers.

Hamilton County's Outcomes initiative leverages the administration of two survey instruments, developed through an effort initiated by the former Ohio Department of Mental Health. The Ohio Adult Scales completed by adult consumers is a compilation of extant validated instruments. The second instrument, designed for parents of youth between the ages of 5 and 18, is the Ohio Youth Problems, Functioning and Satisfaction Scales (Ohio Youth Scales-Parent Short Form) developed by Dr. Ben Ogles while at Ohio University. Minimum completion intervals for both instruments include at initiation of service, annually, and upon discharge, though agencies are encouraged to conduct surveys more frequently where indicated.[11] Examples of current indicators for adults identified by the surveys include symptom distress, overall quality of life, housing quality of life, financial quality of life, social connectedness, improvement in physical health, problem severity, and functioning. For youth, parent ability to deal with child's problems, parent satisfaction in relationship with child, reduced stress, and

[11] Summary of methods for conducting report taken from MHRSB Mental Health Consumer Outcomes Quarterly Report Period: 1/01/2020 – 12/31/2021. Report #59

optimism for their child's future are among indicators captured. These scales also capture aspects of customer satisfaction such as clients indicating respectful treatment by the agency (adults), client indicating medication concerns addressed (adults), satisfaction with services received (youth), and parents feeling heard and valued (youth).

Specific to financial monitoring, each MHRSB provider contract includes an *Allocation Summary* detailing the authorized services and funding. The summaries are prepared by the CFO based upon decisions made by MHRSB Executive Management. The allocation amounts are approved by the MHRSB Board of Trustees. Each allocation is assigned a funding source (e.g., Mental Health Levy, State Block Grant, State General Fund, Federal Grant, etc.). The funding sources are assigned based upon the type of service and population served (e.g., State General Funds received for Forensic Center Evaluations are dedicated to Common Pleas Evaluations provided by Court Clinic). If a service within a Provider's allocation is funded with State or Federal funds as well as Mental Health Levy funds, the State or Federal funds are used before the levy funds. Using the information from the summaries, the Finance Department maintains a "Monitor" for each provider. The Monitor reflects each funding source, contract type (e.g., purchase of service, cost reimbursement), contract amounts, payments made, and contract balance.

Waiting List

During interviews with administrative and program staff across the system, HMA included a discussion related to the use of waiting lists. Responses varied by role in the system and by the types of services that were being rendered by the interviewees.

The Hamilton County MHRSB reported that they do not have wait lists for services. Mental Health Access Point (MHAP) provides interim services for individuals awaiting intakes or other services with contracted providers. Consumers who are eligible and interested in services funded with MH Levy funds are assessed at MHAP, triaged, referred to the appropriate level of care and then managed for continued services. MHAP provides interim services for people who have been diagnosed and have not yet enrolled in the recommended level of care either due to lack of capacity or by client choice. While MHAP does not utilize a waitlist, there is about a 3 day wait for an adult intake, however, they will see people in an emergent situation. They also fill gaps in services by connecting a person with a case manager until a case manager at a new agency is available. MHAP also assures medication and medication management services are continued and provide some psychiatry on a limited basis.

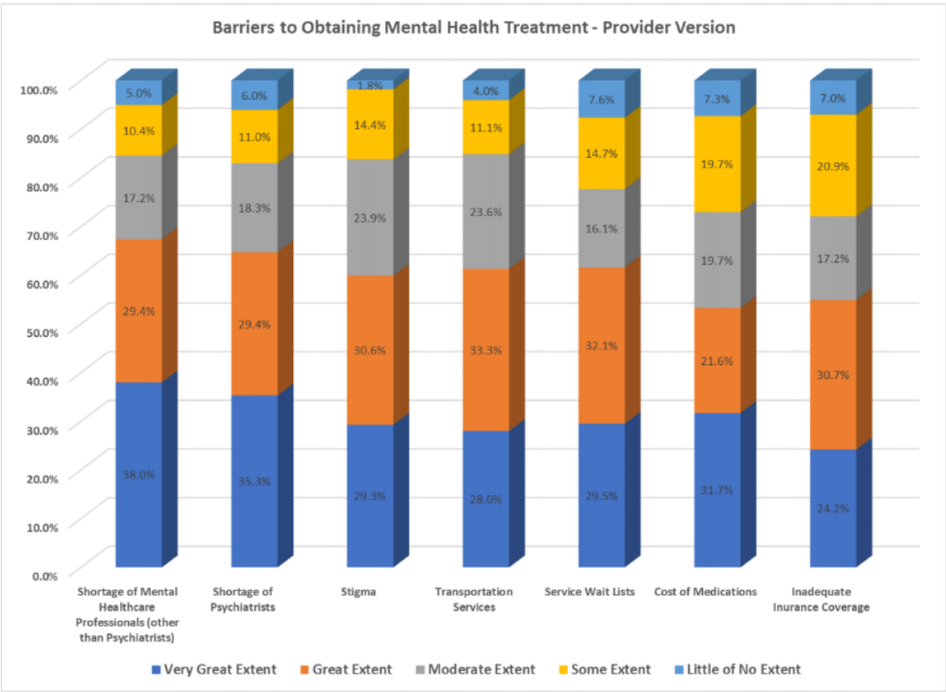
Most agencies serving clients for an outpatient level of care indicated that they do not have waiting lists. Many have moved to an open access or same day appointment model of entry. A client can walk into an agency and be seen that day for an assessment, thus adding additional quick access for services. Providers have indicated that in addition to open access, they are using other strategies to avoid implementing a wait list for mental health services. Some have incorporated more counseling services in lieu of case management services or prioritized SUD services if the individual is dually diagnosed. Outreach workers have filled gaps in case management functions. Telehealth has also been used to expand services and mitigate waiting lists.

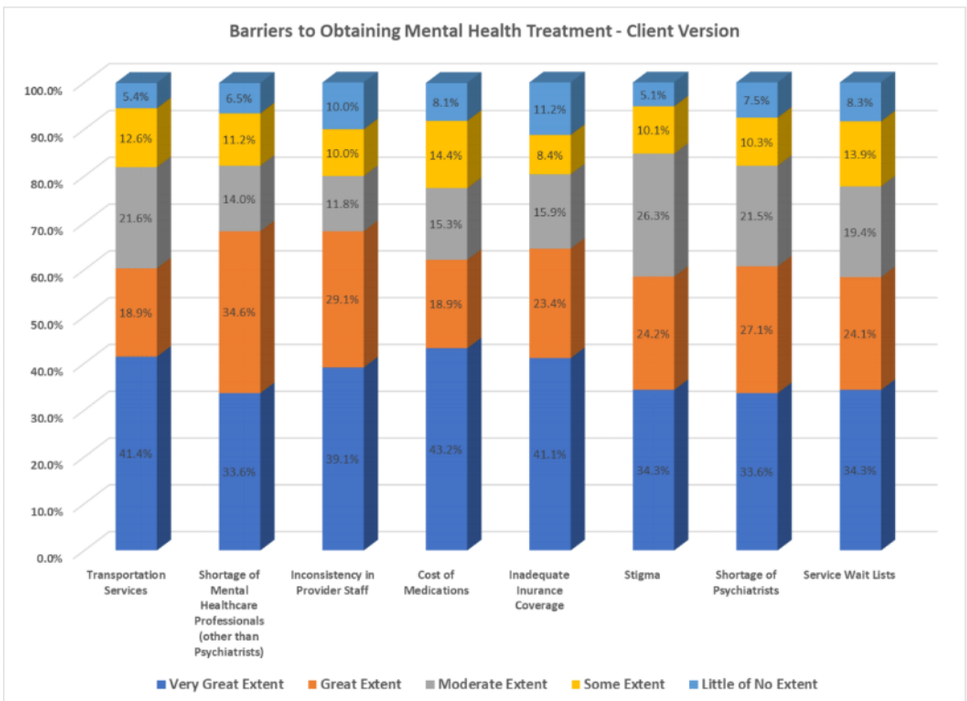
There are a few examples where there is a waiting list for initial assessment for children and assignment to on-going services for children. However, this was attributed to a staffing shortage rather than an increase in referrals for services. Also, a provider indicated that they are experiencing a waitlist for services in school settings. as well as for services in school settings.

Agencies providing recovery supports are seeing the need to implement waiting lists. These services are not covered by Medicaid and include housing, mental health peer support, and supported employment activities. These providers are also coming up with ways of extending service capacity to get people some level of service despite a waiting list. For example, they are providing services in groups rather than individually, with shorter waiting lists being implemented if a person prefers an individual service. Providers are also using intake coordinators to stay connected with people on waiting lists or to offer referrals and warm handoffs if there is a more immediate need.

It should also be noted that the surveys used in the updated needs assessment included service wait lists as a possible barrier to obtaining mental health treatment. As indicated below, both providers and clients indicated service waiting lists were a barrier to a very great extent, at 29.5% and 34.3%.[12]

The graphs that follow detail the findings by the respondent group and are ordered by level of perceived barrier from highest to lowest based upon weighted categorical scores.





Consumer Perceptions

Due to the pandemic and inability to conduct focus groups in person, consumer perceptions were drawn from satisfaction indicators reported within the MHSRB quarterly reports as well as client satisfaction survey data provided by contracted providers.[13]

[12] HCMHRSB Needs Assessment, February 2022

[13] Source: MHRSB Mental Health Consumer Outcomes Quarterly Report Period: 1/01/2020 – 12/31/2021. Report # 59.

For adults, the Ohio Scales include questions regarding being treated with respect by the agency. For youth, parent satisfaction was used as an indicator of consumer perceptions. [14] For adults the respect indicator ratings remained steady by provider, with a range from a low of 48.5% to a high of 89.6%. A slight increase in satisfaction during the pandemic was noted for most providers, as well as the system overall.

Percent of Clients Indicating Respectful Treatment at the Agency

Consumers are asked at each survey whether they "… have been treated with dignity and respect at this agency" (#15). The follow-up response to this item was selected for use in comparing responses as this would be the most recent response and would be reflective of the most experience/time with the agency.

Percent of Clients Reporting they are Always Treated with Dignity and Respect

Agency	Report #									
	50	51	52	53	54	55	56	57	58	59
System	72.1%	71.8%	72.0%	73.4%	73.8%	75.1%	75.5%	76.3%	76.3%	73.9%
Central Clinic	84.2%	82.2%	82.4%	81.2%	83.3%	86.2%	87.7%	89.6%	88.5%	87.1%
Central Community Health Board	61.6%	60.9%	61.2%	61.6%	63.1%	67.0%	66.9%	67.5%	73.2%	62.6%
Crossroads Center	61.2%	60.5%	63.2%	65.0%	71.1%	72.3%	70.8%	68.7%	71.1%	77.8%
Greater Cincinnati Behavioral Health	72.3%	71.6%	71.2%	73.2%	73.9%	74.8%	74.1%	74.0%	72.9%	70.5%
IKRON	74.8%	77.9%	78.2%	77.9%	79.1%	81.3%	80.0%	80.9%	80.8%	79.8%
Lighthouse	77.8%									
Recovery Center	71.2%	76.3%	75.2%	73.5%	77.2%	76.2%	81.1%	81.1%	84.4%	86.5%
Talbert House	72.7%	72.4%	73.6%	75.3%	74.1%	74.8%	78.1%	80.9%	81.1%	80.6%
Probate Clients		51.0%	52.9%	48.5%	57.1%	52.6%	51.3%	53.2%	55.6%	62.7%

Note: Report numbers (50-59) reflect quarterly reports covering a two-year period, beginning in the fourth quarter of calendar year 2018 (#50), through a two-year period beginning in quarter one of calendar year 2020 (#59).

For parents of youth receiving services, the range of respondents reporting moderate or extreme satisfaction with services ranged from a low of 4.9% to a high of 100% for multiple providers. As with adults, satisfaction ratings by parents increased over the course of the pandemic, with the exception of an outlier who saw a significant drop in satisfaction that may have been impacted by the number of clients served and available to participate in the Ohio Scales reassessment during this time.

Satisfaction with Services Received

The parent version of the Ohio Youth Scales inquires as to "How satisfied are you with the mental health services your child has received so far?" Response choices are based upon a six-point scale varying from (1) extremely dissatisfied, to (6) extremely satisfied.

Following are the percentages of those responding either moderately satisfied or extremely satisfied.

Percent Satisfied with Service

Agency	Report #									
	50	51	52	53	54	55	56	57	58	59
System	80.9%	79.6%	80.3%	82.1%	83.7%	83.3%	84.6%	85.0%	85.8%	80.3%
Beech Acres	88.1%	87.1%	84.9%	85.9%	86.4%	62.7%	60.9%	40.0%	29.0%	4.9%
Camelot Community Care	80.0%	66.6%	50.0%	66.6%	100.0%	100.0%	100.0%	100.0%	100.0%	
Central Clinic	100.0%	100.0%	100.0%	77.8%	84.6%	91.6%	85.8%	77.7%	87.5%	85.8%
Lighthouse	63.9%	65.8%	61.2%	65.5%	72.8%	72.5%	73.7%	70.9%	72.8%	77.0%
Pressley Ridge	93.8%	86.7%	84.7%	84.6%	84.6%	100.0%	100.0%	100.0%	100.0%	100.0%
St. Joseph	79.7%	78.7%	81.9%	82.7%	84.0%	84.7%	85.4%	86.0%	87.6%	86.2%
Talbert House	83.2%	81.5%	79.7%	82.9%	84.4%	84.0%	86.4%	89.7%	89.2%	82.4%

Note: Report numbers (50-59) reflect quarterly reports covering a two-year period, beginning in the fourth quarter of calendar year 2018 (#50), through a two-year period beginning in quarter one of calendar year 2020 (#59).

Several providers also noted that they conduct their own agency specific customer satisfaction surveys and that this data is routinely submitted to MHRSB with other required data reporting. HMA's review of these reports indicated high levels of satisfaction among contracted providers.

V. Financial Analysis

Historical review of the Mental Health and Recovery Services Budget and Projections.

The figures for the internal summary financial statements below were provided by MHRSB management. We have included calendar contract years (CY) 2016-2017 in addition to the current levy period CYs for historical comparison purposes. Management has reflected CY 2016-2020 financial results on a cash basis (funds received and paid out during year regardless to which contract year applicable) whereas CYs 2021 and 2022 projections reflect anticipated funding and contract expenses relevant to the contract year regardless of funds flow timing. For the levy Period of CY 2018 through CY 2021, the organizations receiving funds directly from the levy appear to have performed within the budget in aggregate. In fact, a comparison of the Contract Expense line item, actual vs. budget for CYs 2018 – 2020, reflects that the actual expenses were lower than originally budgeted amounts by an average of 8.6% (this result may be skewed to a degree due to lower CY 2020 actual expenditure results stemming from the Covid-19 pandemic disruption). The beginning fund balance in CY 2018 was approximately $25.4 million, $177.7 million in levy proceeds are projected to be received, approximately $189 million is projected to have been expended (contract expense, MHRSB operating expenses and other) and the ending CY 2022 levy period fund balance is projected to decrease to approximately $10.3 million. The baseline historical total expenses (CYs 2016 – 2020) averaged approximately $35 million per year, whereas MHRSB has projected $42.2 million and $40.6 million for CYs 2021 and 2022, respectively (increases of 20% and 16%).

Should CY 2021 and CY 2022 actual results come in lower than these projections (which is quite possible given the favorable performance in actual vs. projected amounts in prior years), the remaining fund balances for CYs 2021 and 2022 would be commensurately higher than below.

	CY 2016 Cash Basis	CY 2017 Cash Basis	CY 2018 Cash Basis	CY 2019 Cash Basis	CY 2020 Cash Basis	CY 2021 Projected	CY 2022 Projected
Beginning Fund Balance	$ 26,879,447	$ 25,953,533	$ 25,405,054	$ 24,923,843	$ 22,994,144	$ 24,895,806	$ 18,892,510
Revenue	$ 34,534,821	$ 34,339,385	$ 35,076,610	$ 34,837,816	$ 35,729,315	$ 36,257,704	$ 35,777,752
Expenditures:							
Total Provider Contracts	$ 33,125,193	$ 31,589,992	$ 32,499,252	$ 33,542,958	$ 30,806,526	$ 38,800,344	$ 37,322,548
HCMHRSB Operating	1,867,113	2,784,630	$ 2,621,977	$ 2,794,493	$ 2,572,723	$ 3,013,698	$ 2,702,290
Planned Capital Expenditure*							$ 3,700,000
Auditor and Treasurer Fees	468,429	441,243	$ 436,591	$ 430,066	$ 448,403	$ 446,959	$ 500,000
BOE/TLRC Expenses		72,000	$ -	$ -	$ -	$ -	$ 117,000
Total Expenditures	$ 35,460,735	$ 34,887,864	$ 35,557,820	$ 36,767,516	$ 33,827,652	$ 42,261,001	$ 44,341,838
Ending Fund Balance	$ 25,953,533	$ 25,405,054	$ 24,923,843	$ 22,994,144	$ 24,895,806	$ 18,892,510	$ 10,328,423
Change in Ending Fund Balance		$ (548,479)	$ (481,210)	$ (1,929,700)	$ 1,901,663	$ (6,003,297)	$ (8,564,086)
* Residential building replacement			-				

Additionally, we had asked the MHRSB staff to compile internal financial statement below to reflect financial results (and projections) on an accrual basis (meaning year for which contracted service expenses were incurred, regardless of when paid) to allow for a consistent comparison of results per year. Levy revenues are generally received within the applicable service years and therefore there is no difference between these financial statement comparisons. A comparison of total expenses for historical years 2016 -2020 reflects they were relatively in-line in aggregate over this period (.5% difference). However, a comparison of projected CY 2021 total expenses reflects significantly different results, particularly regarding the Provider Contracted Services line item. MHRSB's originally presented CY 2021 Provider Contracted expenses reflect $38.8 million ($42.3 million in total), made up of $35.4 million in budgeted expenses and $3.4 million of CY 2020 encumbered funds. CY 2021 Provider Contracted expenses per the supplemental accrual based financial statements below reflect $32.9 million ($36.4 million in total expenses), consisting of $24.2 million in actual expenditures and $8.7 million in expected contract encumbrances to be paid out subsequently. There is a resulting difference of $5.9 million (18% higher). A portion of this difference may be attributed, in part, to CY 2020 encumbrances not yet paid. It is unclear based on these comparisons whether the projected $38.8 million in CY 2021 Provider Contract expenses will materialize within a significant degree.

	CY 2016 Accrual Basis	CY 2017 Accrual Basis	CY 2018 Accrual Basis	CY 2019 Accrual Basis	CY 2020 Accrual Basis	CY 2021 Projected	CY 2022 Projected
Beginning Balance	$ 26,879,447	$ 21,334,471	$ 18,256,231	$ 17,578,002	$ 16,434,215	$ 19,034,760	$ 18,892,510
Less: Provider payments for Prior Years	$ (4,938,081)						
Adjusted Beginning Balance	$ 21,941,367	$ 21,334,471	$ 18,256,231	$ 17,578,002	$ 16,434,215	$ 19,034,760	$ 18,892,510
Revenue	$ 34,534,821	$ 34,339,385	$ 35,076,610	$ 34,837,816	$ 35,729,315	$ 36,257,704	$ 35,777,752
Expenditures:							
Provider Contracts							
Paid in current year for current period	$ 28,820,992	$ 27,854,166	$ 25,431,165	$ 26,633,826	$ 24,610,740	$ 24,176,383	$ 37,322,548
Paid in subsequent year for current period	$ 3,985,183	$ 6,265,587	$ 7,265,105	$ 6,123,219	$ 5,496,904		
Encumbered to be paid in future years						$ 8,762,914	
Total Provider Contracts	$ 32,806,175	$ 34,119,753	$ 32,696,270	$ 32,757,046	$ 30,107,644	$ 32,939,297	$ 37,322,548
HCMHRSB Operating	$ 1,867,113	$ 2,784,630	$ 2,621,977	$ 2,794,493	$ 2,572,723	$ 3,013,698	$ 2,702,290
Planned Capital Expenditure*							$ 3,700,000
Auditor and Treasurer Fees	$ 468,429	$ 441,243	$ 436,591	$ 430,066	$ 448,403	$ 446,959	$ 500,000
BOE/TLRC Expenses		$ 72,000	$ -	$ -	$ -	$ -	$ 117,000
Total Expenditures	$ 35,141,716	$ 37,417,625	$ 35,754,838	$ 35,981,604	$ 33,128,770	$ 36,399,954	$ 44,341,838
Ending Balance	$ 21,334,471	$ 18,256,231	$ 17,578,002	$ 16,434,215	$ 19,034,760	$ 18,892,510	$ 10,328,424
Change in Ending Fund Balance		$ (3,078,240)	$ (678,228)	$ (1,143,788)	$ 2,600,545	$ (142,250)	$ (8,564,086)
* Residential building replacement			-				

A. Was the previous levy request adequate to meet community need?

The fund appears to have been adequate over the course of levy period. At the beginning of the current levy period beginning 1/1/2018 the fund balance was $25,405,054 and ended at $24,895,806 as of 12/31/2020 (last period of actual results) per MHRSB presented financials above. It should be noted that the levy expenditures in calendar year (CY) 2020 were somewhat below normal levels stemming from the disruptive effects of the COVID-19 pandemic which contributed to fund level being maintained at this level. The MHRSB projects that the fund balance would be $18,892,510 as of 12/31/2021, a $6,003,297 reduction, due to significantly higher projected spend in CY 2021 versus prior year actual amounts. As noted in the section above, it is unclear whether these CY 2021 figures will materialize as projected. The MHRSB projects that the fund balance would decrease another $8,564,086 in CY 2022 resulting in an ending fund balance of $10,328,423, due to a combination of $4,864,086 spending above available CY 2022 levy funds and a special $3,700,000 funding draw down for the planned residential treatment center replacement.

B. Can the current MHRSB cost-structure be sustained without ongoing increases in the tax levy? Why or why not?

The MHRSB has been diligent in trying to balance its expenditures with available funding as evidenced by the financial figures reflected above. However, there are several current and emerging factors that present challenges to the current levy level remaining sufficiently viable to fund future behavioral health needs in Hamilton County. Those factors include inflation, expected changes in Medicaid enrollment, and service demand and needs in distinct areas as identified by the MHRSB.

U.S. inflation is running at the highest level in over 40 years, hitting 8.5 percent in March. As MHRSB staff have indicated, the current levy funding levels in place since 2007 have already been impacted by normal inflationary levels (approximately 3%) over the last 15 years. MHRSB has estimated that inflation has eaten up approximately $10-$17 million or 23%-33% of annual level fund levels over this period. This challenge is only further compounded by inflationary levels that have risen over the past two years, increasing two-to-three times the historical averages. While it is unclear how long these higher inflationary levels will be sustained, consensus among many economists and federal agencies indicates moderation beginning in the latter half of CY 2022 with further normalization throughout 2023.

Since the inception of the Public Health Emergency (PHE), state Medicaid programs were required to meet “maintenance of effort” requirements that including ensuring continued coverage of Medicaid enrollees. However, when the PHE period ends, possibly by September 30, 2022, Medicaid agencies can begin the process of redeterminations. It is expected this may result in ten to fifteen percent of current Medicaid enrollees losing their eligibility. This process will undoubtedly take quite some time for the State and its resources to work through, likely through CY 2023. These enrollees that have behavioral health needs would then fall back into the MHRSB environment for care delivery and funding. MHRSB has estimated that anywhere from 5,800 to 8,700 Hamilton County residents could be impacted in this regard.

MHRSB staff have identified several areas with an increase in service level demand and need. For the CY 2022 projections MHRSB included an additional $1.9 million above CY 2021 budget amounts for the following services: housing support, mobile crisis team, crisis intervention training and parent coaching. Additionally, the MHRSB projections for CY 2023 include another $2.2 million for these items as well as the following: suicide prevention hotline, school-based suicide prevention, crisis services and crisis stabilization beds, mental health crisis intervention training for law enforcement, mobile response stabilization services, employment/vocational support services, and behavioral health workforce support.

C. Review cost allocation for MHRSB administrative costs to the Levy. Is the allocation methodology reasonable? Why or why not?

In reviewing the MHRSB's policy and procedures regarding cost allocation methodology, both the methodology and its application seem reasonable. Additionally, MHRSB's financial audits do not indicate any internal control issues related to expenses or cash management.

Pursuant to MHSRB's Finance policies, all Provider invoices are keyed into the Monitor to ensure that payments are within contract limits. All invoices are reviewed and signed by the CFO (Executive Vice President in the absence of the CFO). Once approved by the CFO, the invoices/payments are keyed into the Performance accounting system by the Finance staff. The account code used for each transaction is based upon the contract year and fund source. Each electronic transaction is then approved by the President/CEO (Executive Vice President in the absence of the President/CEO). The electronic transaction and the related paper copy of the invoice are sent to the County Auditor's Office for payment. A copy of the invoice is also maintained by the MHRSB Finance Department.

County Auditor personnel match each electronic transaction to the related paper invoice to ensure that funds are properly encumbered and that amounts, and account coding agree. Once approved by the County Auditor's Office, the Performance system assigns a payment number and a payment date for the transaction. MHRSB Finance staff log-on to the Performance system daily to determine which payments have been issued. Each payment number and payment date are handwritten on the paper invoice maintained at the MHRSB. The MHRSB is audited annually as part of the Single Audit of Hamilton County.

E. Working from the spreadsheets developed in Tasks 1, 2 and 5, the client service work volume, and historic trends in waiting lists, assemble observations regarding the adequacy of the previous levy request to meet community need. If the fund analysis shows a projected unappropriated fund balance at the end of the current levy period that is above what was originally projected, review the fund history with MHRSB financial managers and executive management to determine the reasons for that balance.

The original level was projected to result in a levy fund balance of $5.5 million at the end of the levy period. Current projections have the ending levy fund balance at $10.3 million which represents approximately 3.5 months of total agency mental health levy expenditures (based on $35.7 million average actual annual expenditures from period 2016-2019). As noted under section A above, the $10.3 million projected ending level balance assumes MHRSB's projections will materially align with final actual spending levels and thus this projection is likely conservative for the period ending 2022. A $10.3 million levy fund balance would be significantly below the $24.9 million historical average of maintained fund balances (based on 2013 – 2020).

F. Prepare a five-year revenue and expenditure forecast for the upcoming levy period. The forecast should apply known revenues and expenditures, adjusted for inflation as appropriate and should also consider known conditions that will significantly impact either revenues or expenditures. To the extent possible, apply a per client revenue and cost basis to reflect both revenues and expenditures based on an increase or decrease in client base over the time period.

The MHRSB has projected that without an increase in funding over the next Mental Health Levy five-year period, their reserves would turn to deficits by CY 2025 with increasing deficits through CY 2027. Some of the major assumptions in the MHRSB's projections include:

- Two percent (2%) increases in provider contract amounts for rate and payment increases. This equates to approximately $4,066,000 over the course of the next five years relative to CY 2022 baseline.

- Six percent (6%) increase in CY 2023, or $2,200,000, for expansion and additional services to meet projected demand, including the following:
    - Crisis Services – Mobile Response and Stabilization Services, Suicide Prevention Hotline, School based Suicide Prevention Strategies
    - Supportive Housing Expansion– HomeLink Housing Support Team, Housing Assistance Program
    - Employment Vocational Support
    - Behavioral Health Workforce Support
- Two percent (2%) increase in other MHRSB operational expenses (e.g., salaries and wages, benefits, other non-wage expenses) which equates to approximately $227,000 over the course of the next five years relative to the CY 2022 baseline.

The MHRSB projections of expenditures, without a commensurate increase in mental health levy funding are reflected below. Under this projection scenario, the MHRSB levy fund would begin running into deficits in CY 2024 increase significantly to -$37.3 million by the end of CY 2027 in the absence of additional funding. However, we note this scenario does not depict a practical reality as the MHRSB would need to adjust expenditures to a level in line with what the levy revenues could support as they have done historically.

	MHRSB Projected _ If No Levy Increases					MHRSB Projected _ If No Levy Increases_%				
	CY 2023	CY 2024	CY 2025	CY 2026	CY 2027	CY 2023	CY 2024	CY 2025	CY 2026	CY 2027
Beginning Balance	$10,328,423	$2,580,840	($6,027,250)	($15,513,056)	($25,894,133)					
Revenue	$35,777,752	$35,777,752	$35,777,752	$35,777,752	$35,777,752	0%	0%	0%	0%	0%
Expenditures:										
Provider Contracts	$40,268,999	$41,074,379	$41,895,866	$42,733,783	$43,588,459	8%	2%	2%	2%	2%
MHRSB Operating	$2,756,336	$2,811,463	$2,867,692	$2,925,046	$2,983,547	2%	2%	2%	2%	2%
Auditor & Treasurer Fe	$500,000	$500,000	$500,000	$500,000	$500,000	0%	0%	0%	0%	0%
BOE/ TLRC Expenses	$0	-	-	-	$119,340					
Total Expenditures	$43,525,335	$44,385,842	$45,263,558	$46,158,829	$47,191,346	7%	2%	2%	2%	2%
Ending Balance	$2,580,840	($6,027,250)	($15,513,056)	($25,894,133)	($37,307,727)	-82%	-334%	-157%	-67%	-44%

As noted under other sections above under Section V, the baseline for the higher level of Provider Contract spending stems from CYs 2021 and 2022 amounts. The CY 2022 total expenditure projection of $40.6 million would be $4.4 million (12%) higher than the $36.2 million total expense average of CYs 2018-2019 (pre-pandemic current cycle periods). The CY 2023 projected total expenditures of $43.5 million would be $7.3 million (20%) higher than the historical average. The MHRSB was unable to provide a projection of the number of clients served or other volume projections for CY 2021 and future years in order to augment the analysis of these higher-than-historical average spending levels. However, MHRSB management has identified $1.9 million and $2.2 million ($4.1 million in total) specific expanded and new program expenditures in its CY 2022 and CY 2023 projections as outlined above. These expanded and additional programs have been identified by the MHRSB based on discussions with contracted providers and the needs they are seeing arise, particularly coming out of the COVID-19 pandemic. MHRSB's estimated level of new levy funding that would be required to meet the increase in expenditures as presented by the MHRSB are reflected below under Section G (third scenario).

G. Adjust the forecast for different levels of tax levy, assuming usage of any current levy fund balance and a zero unappropriated levy fund balance at the end of the new levy period.

HMA has compiled various mental health levy levels and associated expenditures below cumulatively for the next levy period, CYs 2023-2027. These compiled figures are intended to provide a range of projected outcomes for consideration and do not represent any suggested levy funding levels on the part of HMA. As noted in sections above, the MHRSB as indicated its actual ending levy fund balance as of 12/31/2020 was $24.9 million and the MHRSB projects it would spend down the fund balance by $14.6 million to $10.3 million by the end of CY 2022. The starting levy fund balance of $10.3 million reflects MHRSB's projections as of the date of this report, however HMA cannot assess the probability of whether this balance will be reached by the end of CY 2022.

The MHRSB CY 2023-2027 request reflects an ending levy fund balance of $8.4 million which represents approximately 3 months of operating expense (without encumbrances) which would appear reasonable

relative to previous projections. The following forecast scenarios at different levels of tax levy will thus all reflect this $8.4 million ending levy balance. These revenue and expense forecast scenarios for the next levy cycle (2023-2027) will be compared to the CY 2018-2022 levy figures provided by the MHRSB to demonstrate the contrast between the two levy periods.

The first levy forecast scenario below reflects a circumstance in which there is no levy increase for the next levy cycle. The CY 2023-2027 projected levy revenues under this scenario reflect estimates provided by the Hamilton County auditor. These levy revenues would represent an increase of almost $5 million (3%) over the course of the next levy period ($1 million annually). Conversely total expenses would need to contract by $4.5 million (-2%) in comparison to CY 2018-2022 amounts under this scenario, particularly regarding Provider Contract expenses. As noted previously, the CY 2018-2022 baseline figures presented are in part a function of MHRSB's higher-than-historical spending projected in 2021 and 2022. To the extent such expenditure due not arise to the levels projected in 2021 and 2022, the MHRSB would presumably have higher-than-projected levy funds to apply towards the CY 2023-2027 levy period. To the extent levy revenues could not support continued expenditures at the levels projected, the MHRSB would need to identify specific expenditure items to be impacted.

	Year 1	Year 2	Year 3	Year 4	Year 5		
	CY 2018 Cash Basis	CY 2019 Cash Basis	CY 2020 Cash Basis	CY 2021 Projected	CY 2022 Projected	Totals	Avg. P/Yr
Beginning Balance	$ 25,405,054	$24,923,843	$22,994,144	$24,895,806	$18,892,510	$ 25,405,054	
Revenues	$ 35,076,610	$34,837,816	$35,729,315	$36,257,704	$35,777,752	$177,679,197	$ 35,535,839
Expenditures:							
Provider Contracts	$ 32,499,252	$33,542,958	$30,806,526	$38,800,344	$37,322,548	$172,971,628	$ 34,594,326
MHRSB Operating	$ 2,621,977	$ 2,794,493	$ 2,572,723	$ 3,013,698	$ 2,702,290	$ 13,705,181	$ 2,741,036
Auditor & Treasurer Fees	$ 436,591	$ 430,066	$ 448,403	$ 446,959	$ 500,000	$ 2,262,018	$ 452,404
BOE/ TLRC Expenses	$ -	$ -	$ -	$ -	$ 117,000	$ 117,000	$ 23,400
Total Expenditures	$ 35,557,820	$36,767,516	$33,827,652	$42,261,001	$40,641,838	$189,055,828	$ 37,811,166
Planned Capital Expenditure	$ -	$ -	$ -	$ -	$ 3,700,000	$ 3,700,000	
Ending Balance	$ 24,923,843	$22,994,144	$24,895,806	$18,892,510	$10,328,423	$ 10,328,423	

	Year 1	Year 2	Year 3	Year 4	Year 5		
	CY 2023	CY 2024	CY 2025	CY 2026	CY 2027	Totals	Avg. P/Yr
Beginning Balance	$ 10,328,423	$8,393,103	$8,393,103	$8,393,103	$8,393,103	$ 10,328,423	
Revenues*	$ 36,157,356	$36,342,948	$36,528,541	$36,714,133	$36,899,725	$182,642,703	$ 36,528,541
Expenditures:							
Provider Contracts	$ 34,836,340	$33,031,485	$33,160,849	$33,289,087	$33,296,838	$167,614,599	$ 33,522,920
MHRSB Operating	$ 2,756,336	$2,811,463	$2,867,692	$2,925,046	$2,983,547	$ 14,344,084	$ 2,868,817
Auditor & Treasurer Fees	$ 500,000	$500,000	$500,000	$500,000	$500,000	$ 2,500,000	$ 500,000
BOE/ TLRC Expenses	$ -	$0	$0	$0	$119,340	$ 119,340	$ 23,868
Total Expenditures	$ 38,092,676	$36,342,948	$36,528,541	$36,714,133	$36,899,725	$184,578,023	$ 36,915,605
Planned Capital Expenditure							
Ending Balance	$ 8,393,103	$8,393,103	$8,393,103	$8,393,103	$8,393,103	$8,393,103	

Change in Levy Revenues	$ 1,080,746	$ 1,505,132	$ 799,226	$ 456,429	$ 1,121,973	$ 4,963,506	$ 992,701
Change in Levy Expenses	$ 2,534,856	$ (424,568)	$ 2,700,889	$ (5,546,868)	$ (3,742,113)	$ (4,477,804)	$ (895,561)

* CY 2023-2027 Levy revenues under this scenario reflect estimates provided by the Hamilton County Auditor as of 4/4/2022

The second levy forecast scenario below reflects a circumstance in which CY 2023-2027 levy revenues are adjusted for inflation. The TLRC has indicated they are under operating under the Hamilton County Commissioners' framework limiting consideration of future levy funding to certain historical inflationary impacts. The below projected levy revenue figures were provided by Hamilton County management and are based on CY 2018 actual levy revenue indexed to regional inflation factors through 2022. The results reflect a cumulative $201 million for the next levy period ($40.2 million per year), which would be $23.4 million (13%) higher than the previous levy period. An additional $13.9 million (7% higher) in expenditures above the current levy cycle could be accommodated in the next levy under these revenue and ending levy fund balance assumptions. Similar to our comments concerning the first scenario narrative above, the MHRSB would need to determine how this additional funding could best be deployed in serving the community and stakeholder groups.

	Year 1	Year 2	Year 3	Year 4	Year 5		
	CY 2018 Cash Basis	CY 2019 Cash Basis	CY 2020 Cash Basis	CY 2021 Projected	CY 2022 Projected	Totals	Avg. P/Yr
Beginning Balance	$ 25,405,054	$24,923,843	$22,994,144	$24,895,806	$18,892,510	$ 25,405,054	
Revenues	$ 35,076,610	$34,837,816	$35,729,315	$36,257,704	$35,777,752	$177,679,197	$ 35,535,839
Expenditures:							
Provider Contracts	$ 32,499,252	$33,542,958	$30,806,526	$38,800,344	$37,322,548	$172,971,628	$ 34,594,326
MHRSB Operating	$ 2,621,977	$ 2,794,493	$ 2,572,723	$ 3,013,698	$ 2,702,290	$ 13,705,181	$ 2,741,036
Auditor & Treasurer Fees	$ 436,591	$ 430,066	$ 448,403	$ 446,959	$ 500,000	$ 2,262,018	$ 452,404
BOE/ TLRC Expenses	$ -	$ -	$ -	$ -	$ 117,000	$ 117,000	$ 23,400
Total Expenditures	$ 35,557,820	$36,767,516	$33,827,652	$42,261,001	$40,641,838	$189,055,828	$ 37,811,166
Planned Capital Expenditure	$ -	$ -	$ -	$ -	$ 3,700,000	$ 3,700,000	
Ending Balance	$ 24,923,843	$22,994,144	$24,895,806	$18,892,510	$10,328,423	$ 10,328,423	

	Year 1	Year 2	Year 3	Year 4	Year 5		
	CY 2023	CY 2024	CY 2025	CY 2026	CY 2027	Totals	Avg. P/Yr
Beginning Balance	$ 10,328,423	$8,393,103	$8,393,103	$8,393,103	$8,393,103	$ 10,328,423	
Revenues*	$40,206,630	$40,206,630	$40,206,630	$40,206,630	$40,206,630	$201,033,152	$ 40,206,630
Expenditures:							
Provider Contracts	$ 38,885,615	$36,895,167	$36,838,938	$36,781,584	$36,603,743	$186,005,048	$ 37,201,010
MHRSB Operating	$ 2,756,336	$2,811,463	$2,867,692	$2,925,046	$2,983,547	$ 14,344,084	$ 2,868,817
Auditor & Treasurer Fees	$ 500,000	$500,000	$500,000	$500,000	$500,000	$ 2,500,000	$ 500,000
BOE/ TLRC Expenses	$ -	$0	$0	$0	$119,340	$ 119,340	$ 23,868
Total Expenditures	$ 42,141,951	$40,206,630	$40,206,630	$40,206,630	$40,206,630	$202,968,472	$ 40,593,694
Planned Capital Expenditure							
Ending Balance	$ 8,393,103	$8,393,103	$8,393,103	$8,393,103	$8,393,103	$8,393,103	

Change in Levy Revenues	$ 5,130,020	$ 5,368,814	$ 4,477,315	$ 3,948,927	$ 4,428,878	$ 23,353,954	$ 4,670,791
Change in Levy Expenses	$ 6,584,131	$ 3,439,114	$ 6,378,978	$ (2,054,370)	$ (435,208)	$ 13,912,645	$ 2,782,529

* CY 2023-2027 Levy revenues adjusted for inflation per Hamilton County management calculations

The third and last levy forecast scenario involves MHRSB's request as presented to TLRC mental health sub-committee members on February 7, 2022. This MHRSB presented projection reflects a cumulative $46.9 million increase (26%) in levy revenues over the previous levy period. Measured against CY 2022's levy revenue of $35.8 million, this would result in $9.1 million more per year. To put these requested levy revenue figures in context, MHRSB has indicated historical levy funds adjusted for inflation over the past fifteen years (2008-2022) would result in annual levy revenues of approximately $49.4 million which would be $13.6 million (38%) higher than the current levy $35.8 million levy revenue. MHRSB's request reflects an $37.5 million increase (21%) in expenditures above the previous levy period.

	Year 1	Year 2	Year 3	Year 4	Year 5		
	CY 2018 Cash Basis	CY 2019 Cash Basis	CY 2020 Cash Basis	CY 2021 Projected	CY 2022 Projected	Totals	Avg. P/Yr
Beginning Balance	$ 25,405,054	$24,923,843	$22,994,144	$24,895,806	$18,892,510	$ 25,405,054	
Revenues	$ 35,076,610	$34,837,816	$35,729,315	$36,257,704	$35,777,752	$177,679,197	$ 35,535,839
Expenditures:							
Provider Contracts	$ 32,499,252	$33,542,958	$30,806,526	$38,800,344	$37,322,548	$172,971,628	$ 34,594,326
MHRSB Operating	$ 2,621,977	$ 2,794,493	$ 2,572,723	$ 3,013,698	$ 2,702,290	$ 13,705,181	$ 2,741,036
Auditor & Treasurer Fees	$ 436,591	$ 430,066	$ 448,403	$ 446,959	$ 500,000	$ 2,262,018	$ 452,404
BOE/ TLRC Expenses	$ -	$ -	$ -	$ -	$ 117,000	$ 117,000	$ 23,400
Total Expenditures	$ 35,557,820	$36,767,516	$33,827,652	$42,261,001	$40,641,838	$189,055,828	$ 37,811,166
Planned Capital Expenditure	$ -	$ -	$ -	$ -	$ 3,700,000	$ 3,700,000	
Ending Balance	$ 24,923,843	$22,994,144	$24,895,806	$18,892,510	$10,328,423	$ 10,328,423	

	Year 1	Year 2	Year 3	Year 4	Year 5		
	CY 2023	CY 2024	CY 2025	CY 2026	CY 2027	Totals	Avg. P/Yr
Beginning Balance	$ 10,328,423	$11,721,006	$12,253,082	$11,907,442	$10,666,531	$ 10,328,423	
Revenues	$44,917,918	$44,917,918	$44,917,918	$44,917,918	$44,917,918	$224,589,590	$ 44,917,918
Expenditures:							
Provider Contracts	$ 40,268,999	$41,074,379	$41,895,866	$42,733,783	$43,588,459	$209,561,486	$ 41,912,297
MHRSB Operating	$ 2,756,336	$ 2,811,463	$ 2,867,692	$ 2,925,046	$ 2,983,547	$ 14,344,084	$ 2,868,817
Auditor & Treasurer Fees	$ 500,000	$ 500,000	$ 500,000	$ 500,000	$ 500,000	$ 2,500,000	$ 500,000
BOE/ TLRC Expenses	$ -	$ -	$ -	$ -	$ 119,340	$ 119,340	$ 23,868
Total Expenditures	$ 43,525,335	$44,385,842	$45,263,558	$46,158,829	$47,191,346	$226,524,910	$ 45,304,982
Planned Capital Expenditure							
Ending Balance	$11,721,006	$12,253,082	$11,907,442	$10,666,531	$8,393,103	$8,393,103	

Change in Levy Revenues	$ 9,841,308	$10,080,102	$ 9,188,603	$ 8,660,214	$ 9,140,166	$ 46,910,393	$ 9,382,079
Change in Levy Expenses	$ 7,967,515	$ 7,618,326	$11,435,906	$ 3,897,828	$ 6,549,508	$ 37,469,082	$ 7,493,816

Every 1% increase in levy funding would generate approximately $1.78 million in additional funding over the five-year levy period ($356,000 annually).

VI. Comparisons, Modeling, and Benchmarking

Proposed Benchmark Approach

Through this engagement we were asked to compare the cost of health care services provided in Hamilton County to those reported by similar counties. Hamilton County is a populous county (the third most populous in the state) with a high percentage of their population residing in a large urban center (Cincinnati). Our comparison counties (Butler, Clermont, Cuyahoga, Franklin, Lucas, Montgomery, and Summit) either fit a similar profile or are neighboring Hamilton County.

		Summary Information Benchmark Counties			
County	2010 Population	2016 Population	2020 Population	Population Rank	Largest City
Franklin	1,163,414	1,264,518	1,323,807	1	Columbus
Cuyahoga	1,280,122	1,249,352	1,264,817	2	Cleveland
Hamilton	802,374	809,909	830,639	3	Cincinnati
Summit	541,781	540,300	540,428	4	Akron
Montgomery	535,153	531,239	537,309	5	Dayton
Lucas	441,815	432,488	431,279	6	Toledo
Butler	368,130	377,537	390,357	7	Hamilton
Clermont	197,363	203,022	208,601	8	Milford

Source: U.S. Census Bureau

Attempts to compare public spending across localities are complicated by several factors related to how public programs are organized, administered, and funded. Absent an approach where budget and program staff responsible for each health care program in each comparison county is interviewed, benchmark efforts should focus upon metrics that are easy to access and interpret. This approach overcomes these challenges in comparing health care spending across differing jurisdictions by reviewing high level spending data, adjusting this information to account for differences in county population and supporting these comparisons with high level information on services funded in each county.

To complete our benchmark analysis, we reviewed budget information published by the county for their 2020 fiscal year along with documents describing the structure of their health care programs. Through this review we generated the following variables for our review:

- Total Funding: A measure of total public financial resources (Federal, State and Local) allocated to a relevant health program for a county's 2020 expenses.
- County Funding: A measure of total county funding allocated to a relevant health program for a county's 2020 expenses.
- Total Funding per Capita: A measure of total funding allocated to a relevant health program per resident in 2020 as estimated by the U.S. Census. This is meant to provide additional context to comparisons between counties with differing populations.
- Mean Spending: A measure of the average spending across all the available comparison counties.
- Deviation from Mean Dollars: A measure of the difference between reported spending in Hamilton County in 2020 and the calculated mean across all comparison counties (including Hamilton County).
- Deviation from Mean Percentage: A measure of the percentage difference between reported spending in Hamilton County in 2020 and the calculated mean across all comparison counties (including Hamilton County).

Data Limitations

- While the approach outlined above, in our view, is the most appropriate for completing a benchmark analysis, we do need to be aware of the limitations associated with this method. While reviewing this data one should be aware of the following:
- Limits in Available Data: In some instances, county budget documents did not make relevant information available for comparison. This is likely because the targeted health services were rolled into a larger budget document.
- Differences in How County Budgets are Structured: Our review of county budget documents revealed differences in how budget information is reported. Some public documents made information on gross funding (Federal, State, Local and Private) and some only provided detailed spending information for county dollars.
- Differences in How County Agencies are Structured: Services that may be funded through an agency or program may be differently funded in another county. We have worked as hard as possible to address these differences but there will be circumstances where a comparison between two budgeted amounts will be complicated by differences in how programs are organized across county agencies and programs.

- Differences in How Taxes are Levied: Six counties have a discreet Mental Health Levy. However, two counties (Cuyahoga and Montgomery) have a comprehensive Health and Human Services Levy that funds a wide array of social services.

Benchmark Analysis

Provided below are the results of our review across each of the types of funded health services in Hamilton County addressed in our review. These figures were derived from various county Boards of Mental Health reports and other publicly available sources as applicable. There are instances where the data across counties appears to be consistent and comparisons appear to be appropriate, and instances where there is considerable variance across county budget documents, where a benchmarking exercise dependent upon county budget documents may not be as appropriate.

Benchmark Analysis Behavioral Health Services				
County	2020 Budget Information		2020 Spending per Capita	
	Total Funds	County Funds	Total Funds	County Funds
Hamilton County	**$45,410,998**	**$35,148,112**	**$54.67**	**$42.31**
Butler County	$16,760,193	$10,125,191	$42.94	$25.94
Clermont County	Not Available	$3,100,000		$14.86
Cuyahoga County	$67,948,488	$40,363,659	$53.72	$31.91
Franklin County[15]	$97,345,739	$83,733,055	$73.53	$63.25
Lucas County	$29,771,584	$17,885,387	$69.03	$41.47
Montgomery County	$37,145,052	$25,303,146	$69.13	$47.09
Summit County	$45,929,569	$34,826,687	$84.99	$64.44
Mean	*$41,662,253*	*$29,329,014*	*$54.83*	*$42.45*

VII. Considerations for the Next Tax Levy Period

988 & Crisis Services Impact

The current efforts nationally and locally to create robust crisis systems represent a significant effort for everyone involved, including the MHRSB. While the MHRSB has historically provided significant resources and support to ensuring the availability of crisis services in Hamilton County, the current initiative calls for coordinating and integrating these efforts with national and state structures and a reach beyond the populations of focus for levy funding. Hamilton County currently has a levy supported hotline, mobile crisis services, and acute care services, similar to the visioned continuum of *someone to talk to* (regional call center/988 hotline), *someone to respond* (mobile crisis), and *a place to go* (crisis receiving and stabilization services). The national and regional 988 hotline is expected to go live in July 2022. These crisis systems, like 911 and emergency medical services (EMS), will require significant coordination and braided funding to meet the needs of any individual in crisis. Ohio, like most states, has a phased approach that began with establishing 988 vendors, and is now shifting to planning for mobile crisis and other stabilization services. This includes Medicaid coverage for some services within the continuum as well as state behavioral health funding and federal block grant funds to supplement funding.

OhioRISE

OhioRISE is planned for implementation in July, with multiple new services and supports for youth who are enrolled in this special needs Medicaid health plan. While the timing of full implementation of these is unclear, there is an anticipated impact for the MHRSB with the overlap some current contracted services, including the HOPE and FAIR programs who target the same population, with similar intervention strategies. Overlap includes care coordination, Mobile Response and Stabilization Service (MRSS), psychiatric residential treatment, flexible funds, and respite related services. Other impacts include continued competition for workforce, with Aetna, the state's OhioRISE vendor, recruiting staff from provider agencies (and potentially MHRSB) to work for the health plan. Any savings for the MHRSB

[15] Franklin County approved a .65 Mill increase to the 2.2 Mill levy in November 2020 (first increase in 15 years) which cis effective for 2022. These figures represent Franklin County ADAMH's projections at new millage rate.

will likely not be realized until these services are fully implemented, likely midway through or later in the next levy cycle.

Potential Changes to ORC 340

The Ohio Department of Mental Health and Addiction Services has convened a stakeholder workgroup to identify sections of ORC 340 in need of review, define specific challenges and explore potential solutions. The first step in the process was a survey completed by members of the workgroup. The survey was broken out into eight (8) groups of Ohio Revised Code sections. The members were tasked with ranking the groups in order of priority to their organization or constituency as well as indicate whether the section presents challenges or warrants workgroup attention. The top seven (7) ORC sections based on the average level of priority as indicated by respondents are listed below.[16]

1	R.C. 340.036	Authority for boards to contract for services and supports
2	R.C. 340.03	ADAMHS boards powers and duties
3	R.C. 340.032	Establishment of community-based continuum of care
4	R.C. 340.02	ADAMHS boards organization and size
5	R.C. 340.034	Recovery housing
6	R.C. 340.20	Review and assessment of data
7 (tied)	R.C. 340.05	Advocacy
7 (tied)	R.C. 340.011	Interpretation and construction of chapter

The summary report from the workgroup is anticipated to be completed by December 31, 2022. The impact of the report generated by the workgroup could vary based on the challenges, solutions and policy considerations that are brought forth. However, given the priority ranking of RC Sections 340.036, and 340.032 there could be policy recommendations for consideration related to how boards contract for services, board roles and responsibilities, and the required elements of the local continuum of care. Given the workgroup is not a decision-making body and recommendations will be further discussed and deliberated by the Administration and General Assembly, it is likely that any Revised Code amendments will not occur until well into the next levy cycle.

COVID-19

Among the many impacts of the COVID-19 pandemic is an increase in demand for behavioral health services at a time when providers are addressing their own challenges. The Kaiser Family Foundation reported in February 2021 that about 4 in 10 adults in the U.S. have reported symptoms of anxiety or depressive disorder, a share that has been largely consistent and up from one in ten adults who reported these symptoms from January to June 2019.[17] The National Council for Mental Wellbeing surveyed leadership of behavioral health services providers and reported that 52% of behavioral health organizations were seeing an increase in the demand for services.[18] This occurred while capacity to meet the demand was diminishing as a result of the pandemic, with 54% of organizations reporting closing programs while 65% have had to cancel, reschedule, or turn away patients.[19] In some cases, surveyed providers expressed concern for their individual organizational viability, with responding agencies having lost on average, nearly 23% of their annual revenue, including 39% reporting they could only remain solvent for six months or less.[20] Board contracted providers that we interviewed expressed similar experiences with both an increase in demand for certain services along with a shrinking workforce. It is important to note that the increased demand for behavioral health services includes populations outside those targeted by levy funds, including individuals with commercial insurance who may seek these services outside the public system.

Health and Human Services Secretary Becerra renewed the COVID-19 Public Health Emergency (PHE) until July 15, 2022. The Administration did not communicate an intention to end the PHE by the required timeline on May 16th. Therefore it is has now been extended through September 2022. In anticipation of

[16] 340 Review Stakeholder Workgroup Second Meeting Presentation, April 6, 2022, accessed at https://mha.ohio.gov/static/CommunityPartners/advisorygroups/April62022Presentation.pdf
[17] Nirmita Panchal , Rabah Kamal , Cynthia Cox, and Rachel Garfield. *The Implications of COVID-19 for Mental Health and Substance Us*. Published: Feb 10, 2021.
[18] [18] Accessed from https://www.thenationalcouncil.org/news/demand-for-mental-health-and-addiction-services-increasing-as-covid-19-pandemic-continues-to-threaten-availability-of-treatment-options/ on April 29, 2022.
[19] Ibid
[20] Ibid

the end of the PHE, States, Counties and other stakeholders should be reviewing the totality of temporary flexibilities that are available and preparing transition plans, which in some instances may include seeking separate waiver authority, modifying budgets and capacity, and developing outreach and communication plans. Among the changes is the end of the continuous enrollment requirement for most Medicaid beneficiaries who were enrolled in the program as of or after March 18, 2020. States, including Ohio, maintained continuous enrollment as a requirement to receive the enhanced federal match available during the PHE. States will have a 12-month unwinding period after the end of the PHE to initiate renewals for all enrollees in Medicaid, CHIP, and the Basic Health Program (BHP) and must complete renewals for this group within 14 months. According to a recent presentation by CMS, many states plan to prioritize redeterminations for individuals most likely to be ineligible for Medicaid/CHIP, while deprioritizing (postponing) renewals for certain populations to minimize beneficiary churn and ensure that eligible, vulnerable individuals retain coverage.[21] It is anticipated that some residents in Hamilton County will no longer be eligible for Medicaid when the renewal process takes place. This may be due to an increase in income, change in age that triggers a transition to Medicare, or other circumstances that effect eligibility. Those individuals who are eligible due to a disability, such as a serious mental illness, are not expected to be impacted by this change. However, the MHRSB contracted providers may see an increase in requests for service due to lack of insurance when the continuous coverage ends. The impact of this shift in coverage will likely not be realized until, at the earliest, the second half of 2023, assuming the PHE ends in July and the state is efficient in conducting the renewal process for all individuals who are due for redetermination of eligibility for Medicaid.

Workforce Challenges

Even prior to the COVID-19 pandemic, behavioral health providers were facing work force shortages across all disciplines, including psychiatry, nursing, and licensed therapists. This trend has been exacerbated in Ohio by growing competition for these staff from health plans and other industries prompting individuals to leave the health care field. Many point to low salaries combined with the work-related stress and lack of work from home or other flexibilities on the shortages. Given the MHSRB's ratio of funding in relationship to other streams such as Medicaid, it will be difficult for the Board to broadly impact salaries across contractors. However, there are a few contracts where targeted increases may support staff retention or recruitment, with additional funding providing for pay increases or recruitment and retention bonuses. This targeted small group of contractors primarily provide recovery support services including peer support and housing, where the Board provides a significant percentage of overall funding. The Board is well positioned to take a convenor role in the development of strategies to recruit and retain staff within Hamilton County behavioral health agencies, including collaborating on job fairs, shared training, and other employee supports. It is noteworthy that the MHRSB may also begin to feel similar pressure as vacancies occur, with the majority of Board staff positions drawing from the same work force. While the Board has maintained strong retention of many staff for decades, this will contribute to anticipated and potentially overlapping retirements through the next levy cycle.

Demand for Recovery Supports

According to the February 2022 MHRSB Needs Assessment, housing and supported housing services were the categories most frequently cited as requiring additional capacity. Sixty-one percent of provider respondents, as compared to 49% in 2017, indicated additional needs in housing. Forty-two percent, as compared to 26% in 2017 of client respondents indicated additional needs in housing. Similarly, 60 percent of providers reported insufficiencies in supported housing (51 percent in 2017) and 32 percent of clients (22 percent in 2017) reported this to be an area of need. In addition, the need to increase the availability of recovery supports, including housing and supported employment, was identified in many of the provider interviews conducted as part of the mental health tax levy review process.

VIII. Effectiveness of Strategic Planning

The MHRSB prepared a 2017 strategic plan in response to local, state, and federal policy changes, changing demographics and service needs, and economic conditions. The strategic plan was intended to guide the MHRSB in updating priorities, focusing resources, aligning delivery system-wide goals, and

[21] https://www.medicaid.gov/resources-for-states/downloads/state-unwinding-best-practices.pdf

identifying intended results. A new or updated strategic plan for the next Levy period has not been developed. However, the MHRSB updated the needs assessment portion of the 2017 plan in February of 2022 using a pair of surveys to determine service sufficiency and need for mental health assistance within Hamilton County. The two surveys were focused on behavioral health service consumers and provider of behavioral health services. Both were designed to collect information related to treatment and recovery support services.

The updated needs assessment is very thorough in describing the approach to the surveys and describing the sufficiency of mental health treatment, support, and prevention services along with the impact of COVID-19. However, it does not indicate next steps in terms of how the findings will be used to update the strategic plan or adjust the goals, objectives or actions of Board moving forward.

While it is important to update the needs assessment, the goals and related objectives should be reviewed and updated to be reflective of the primary issues and concerns from the updated needs assessment. As articulated in the previous MH Tax Levy Review, the MHRSB may benefit from an element of independence for developing, conducting, and analyzing the surveys to create an additional level of credibility for the information as well as utilizing an independent entity to facilitate the planning process.

IX. Principal Observations and Recommendations

Principal Observations

As part of the review process, HMA was asked to analyze the MHRSB compliance with the terms of the current Agreement by and between the Board of County Commissioners of Hamilton County, Ohio and the MHRSB. HMA is also tasked with making recommendations for future contractual conditions upon passage of the Levy. The MHRSB does not currently have a signed agreement with the County Commissioners. The agreement was in development at the time the COVID-19 pandemic began and was not executed. For this analysis, HMA reviewed the recommendations from the 2017 mental health levy review report as well as the TLRC mid-cycle review of the MHRSB. Those recommendations would have resulted in the terms of the agreement had it been executed. Observations regarding compliance with these items are addressed below.

County Department Integration: While consolidation of administrative functions of the various levies would be complex, the 2017 mental health tax levy review report indicated there were opportunities for efficiencies. Because of the necessary involvement of multiple Boards, varying levy cycle periods, and state and federal requirements also influencing practice, the 2017 report suggested an initial step would be an inter-county review for specific and realistic consolidation opportunities. Understanding the sensitivities for all involved, it was recommended that the county administrative offices take the lead on this initiative, and it not be the primary responsibility of any single board that may potentially be impacted. Given this item was not the sole responsibility of the MHRSB, the Board is not determined to be out of compliance with this recommendation.

Provider Contracts: The MHRSB has identified goals associated with provider reimbursement within their 2017 Strategic Plan. The MHRSB has relied primarily on fee-for-service and cost-based reimbursement methods with provider contracts. A goal within their strategic plan is to convert cost reimbursement contracts to purchase of service. However, reimbursing based upon volume, as opposed to value, for services rendered can unintentionally incentivize pure volume over outcomes and efficiency. In the 2017 Mental Health Tax Levy Review Report, HMA provided options for alternative payment methodologies and how they could be applied to MHRSB contracted services. Based on the findings and trends in Section V., there appears to have been no shift in provider reimbursement methodologies in the current levy period.

Strategic Planning: Recommendations in the 2017 mental health tax levy review report for future strategic planning efforts included utilizing an independent entity for developing, conducting, and analyzing surveys and facilitating the planning process. It was suggested that an independent facilitator may lend credibility to the survey information gathered and could provide an ongoing reporting mechanism for stakeholder feedback to future levy cycle reviews as well as challenge the Board with an

external perspective. The 2017 report also recommended that strategic goals within the plan include measurable performance metrics and have associated timelines for completion. The recommendations related to the surveys were not acted upon when the needs assessment portion of the strategic plan was updated in February 2022. The 2017 Strategic Plan has not been updated to include measurable performance metrics for all goals and associated timelines for completion.

Recommendations

Contracting and Contract Monitoring

The MHRSB continues to maintain its positive and long-standing relationships with its provider network. During the interview portion of the review process, providers and other stakeholders expressed immense appreciation for the Board, its collaborative approach and leadership. Previous levy reports indicate very little change in the list of contractors over time. Interviews with providers also affirmed that the terms of the contracts rarely if ever change from year to year. Therefore, we recommend the MHRSB transition from an annual to a multi-year contracting cycle. This would eliminate administrative burden for both the Board and its provider network. Should new funding streams or new service needs arise, contracts could be amended or initially constructed to allow for these changes. Providers, including other County agencies such as juvenile and adult probation and the courts, were unanimously positive about this potential change. The reduction in administrative burden during non-renewal years could also support a return to more frequent and purposefulness of contract monitoring activities such as onsite compliance reviews and would allow the MHRSB to work with providers to thoughtfully plan and implement updates to the contracts, including a shift from cost-based reimbursement to value-based arrangements.

A review of provider reimbursement methodologies is recommended in conjunction with the transition to a multi-year contracting cycle. Transitioning methodologies will require a thoughtful planning process and staged implementation due to the significant administrative changes that will be required for the MHRSB and contracted providers. We recommend that the MHRSB consider a transparent planning process to shift from category 1 and 2 methods of reimbursement (see Table below) to categories that drive positive outcomes versus volume or the burden on both provider and the MHRSB to develop and validate cost reports. It is also recommended that the MHRSB not take a single approach across all providers given the variety of providers and types of services being funded.

Alternative Payment Methodology Category	Application to MHRSB Contracted Services
Category 1: Fee-for-Service (FFS) Without Link to Quality or Value	• Financial incentives focused on volume rather than outcomes or prevention • Current category for a portion of levy services
Category 2: FFS with Quality Incentives	• Incentives and penalties can be designed to achieve guideline-based care for levy population • Incentives can support process improvement/practice transformation to achieve better care coordination
Category3: Gainsharing / Risk-Sharing	• Bundles and episodes of care built around levy-focused conditions • Incentives for efficient care measured against a baseline • Effectively serving levy population generates savings to share
Category 4: Population-Based Payment	• Risk transferred to providers for full population or specific populations • High incentive to appropriately manage/coordinate care for levy population

Workforce

While one strategy to address behavioral health workforce shortages that is being discussed nationally involves increased rates or other funding to elevate salaries, the MHRSB is not well positioned to positively impact workforce shortages in this manner, with certain exceptions. When considering the ability to impact one of a provider's most significant expenses (staffing) through (POS) rate increases, the overall percentage of that provider's budget revenue would need to be significant. Most of the MHRSB contractors receive multiple revenue streams to support their operations and the MHRSB

funding is a small percentage of the overall budget. However, there are some contractors, predominantly housing and peer providers, for whom the MHRSB is a primary or solitary funder. Historically, the MHRSB has initiated rate increases as a percentage across all providers. We recommend that funding directed to address workforce shortages, specifically by supporting more competitive salaries or benefits, be targeted to small providers whose primary funding source is from the MHRSB. These are often small staffing teams delivering non-Medicaid covered, but necessary, recovery supports such as housing or peer support. We would also recommend a market analysis of MHRSB salaries across Ohio to ensure that as staff retire or face recruitment by other industries the County is confident that they can be somewhat competitive to maintain staffing. This more in-depth analysis could take into consideration factors such as tenure, across all positions, as well as provide a deeper analysis as to the impact of the absence of a levy increase over multiple cycles.

Another recommendation in terms of the MHRSB's ability to impact the workforce challenges facing providers, is to take a leadership and convener role with their provider network, to creatively problem solve and identify innovative ways to recruit and retain staff to the workforce. This may include network wide employee recognition events, job fairs, and/or employee or student intern peer support opportunities. There may also be opportunities to provide network wide training to support career advancement or confidence as an additional retention tool.

Standard Policies Related to Reimbursement & Program Management

The MHRSB contract boilerplate has language that specifies required timelines for the submission of claims. Specifically claims for services provided between January 1-June 30th within the calendar year of the contract must be submitted by September 30th of that same year. Services provided between July 1st and December 31st must be submitted by March 30th of the following calendar year. The two distinct timeframes take into account a state fiscal year that runs from July 1 through June 30th of the following calendar year and allow for a 90-day lag period for claims submission. However, the contract also allows for contracted providers to request an extension for claims submission. If approved the extension allows for submitted or resubmitted claims through September 30th within the next contract cycle or calendar year. There does not appear to be a formal policy around the timing of MHRSB review and payment of submitted claims after this September 30th deadline. At the writing of this report, seven contract agencies, roughly 30 percent, were working under extensions and had not completed their claims submissions for FY 2021 contracts. While an exceptions policy allows for the MHRSB to support a contractor when unexpected delays occur (e.g., involving delays in Medicaid coverage determinations), the extension through September impedes the timeliness MHRSB's accounting of final volume statistics and provider contract expenditures relative to the preceding service year. It is recommended that the MHRSB establish a written policy regarding its processes for review of claim submission extensions and internal timetables for final claims adjudication. Additionally, the MHRSB may want to consider a shorter cutoff timeframe for the claims submission extension process which would allow for more timely data on the previous year results to inform strategic planning from year to year.

Strategic planning

It is recommended that the MHRSB initiate a process for developing a new strategic plan, or at a minimum, update its 2017 strategic plan. Consistent with the 2017 mental health tax levy review report. It is further recommended that the MHRSB utilize an independent entity for developing, conducting, and analyzing surveys and facilitating the planning process. An effective strategic plan includes measurable performance metrics and associated timelines for completion for each goal and objective and be data informed, connecting directly to gaps and emerging needs identified in the MHRSB needs assessment and survey results. In addition, it is recommended that a more inclusive, interactive process be used for the development of the strategic plan, maximizing stakeholder engagement, and input not only in the needs assessment but the resulting goals setting to address those needs.

Leverage Relationship with Hamilton County JFS

Enhancing the partnership between the MHRSB and the Hamilton County Department of Job and Family Services (HCDJFS) should be explored given the overlap in priority populations and the often-significant behavioral health needs of children engaged in the child welfare system. Most children receiving behavioral health services and engaged in the child welfare system are eligible for Medicaid. Behavioral health and other services are directly reimbursed to providers and do not run through the MHRSB.

However, leveraging resources and collaborating on near term efforts to fill gaps will benefit both the MHRSB and the HCDJFS and those they serve. Areas to consider include capacity building and infrastructure development to support providers as Medicaid services are being ramped up through OhioRISE. One-time, shared investments to support services such as MRSS or other evidence-based practices through workforce training initiatives or the purchasing technology or other equipment needed to assist in the delivery of services. In addition, the contributions of both the MHRSB and the HCDJFS to the HOPE and FAIR programs should be examined to determine if the portion contributed by the HCDJFS could be increased, and the portion currently contributed by the MHRSB reduced and those resources shifted to cover other needed services and supports in the community. These recommendations are supported by the reserve funds that exist under the Children's Services Levy.

Crisis Services

As Ohio prepares to expand crisis services statewide, they are pursuing Medicaid reimbursement where possible. As Medicaid coverage is added, services such as mobile crisis and suicide/crisis hotlines may be less reliant on levy funding. The current timeline for expansion crosses over into the next levy cycle and includes development of services, and in some cases, Medicaid reimbursement, for services currently contracted by MHRSB, such as the hotline and mobile crisis services. The MHRSB should consider whether levy funding should continue for services such as the MHAP hotline once the state supported 988 regional line (operated by another vendor) is operational. In addition, other services currently supported by levy funds, such as the University of Cincinnati mobile crisis team, may have access to other funding streams, reducing reliance on the current levy funding levels that could be applied where there is greater need.

Crisis Now, which is led by the National Association of State Mental Health Program Directors (NASMHPD) and developed with the National Action Alliance for Suicide Prevention, the National Suicide Prevention Lifeline, the National Council for Mental Wellbeing, and RI International has promoted the availability of the Crisis Resource Need Calculator. The Calculator provides the ability to understand the potential healthcare cost associated with delivering care for all individuals requiring in-person behavioral health crisis care based on assumptions that the user can manipulate. The calculator then estimates the potential annual cost and the potential capacity needed to implement the Crisis Now model to help more people receive care. While the tool does have limitations, it provides insight that can help communities consider potential costs of scenarios such as using and expanding existing emergency departments and inpatient sites, adopting the Crisis Now model, or adopting a modified behavioral health crisis care model by adopting certain components or changing utilization assumptions.[22]

Recovery Supports

It is recommended that the MHRSB consider additional investments in recovery support, specifically housing, supported employment and peer support. Housing and supported employment are not covered by Medicaid and peer support services are included in a very limited manner in the Medicaid benefit for those with mental illness. Most providers indicated the demand for housing during the interview process. In addition, housing and supported housing services were the categories most frequently cited as requiring additional capacity in the February 2022 MHRSB Needs Assessment. As described in earlier recommendations, resources could be re-evaluated and shifted from other services over time as Medicaid reimbursement becomes more widely available for services that the MHRSB is currently paying for with levy funds. Given recovery support providers rely more heavily on Board funding, targeted increases in these areas will also have a more significant impact on those agencies.

[22] Summary of the Crisis Resource Need Calculator information accessed at https://calculator.crisisnow.com/#/ on May 6, 2022