**INSTALLMENT 1**

# By the Numbers 4

Developing a Common Understanding for the Future of Behavioral Health Care

# Overview, History, and Financing of Behavioral Health

LANDSCAPE AND ANALYSIS OF THE INTERSECTION BETWEEN THE BEHAVIORAL HEALTH AND CRIMINAL JUSTICE SYSTEMS

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The Mental Health & Addiction Advocacy Coalition is comprised of over 120 member organizations statewide, including health and human service agencies, the faith based community, government and advocacy organizations, courts, major medical institutions, the corporate arena, and behavioral health agencies serving children and adults. The MHAC's mission is to foster education and awareness of mental health and addiction issues while advocating for public policies and strategies that support effective, well-funded services, systems, and supports for those in need, resulting in stronger Ohio communities. MHAC supporters include: Eva L. & Joseph M. Bruening Foundation, The Cleveland Foundation, Community West Foundation, The Greater Cincinnati Foundation, The George Gund Foundation, Interact for Health, The McGregor Foundation, The Sally and John Morley Family Fund, Mt. Sinai Health Care Foundation, The Nord Family Foundation, Peg's Foundation, The Daniel and Susan Pfau Foundation, Saint Luke's Foundation, and Woodruff Foundation.

The Center for Community Solutions is a nonprofit, nonpartisan think tank focused on solutions to health, social and economic issues. Through applied demographic research, policy analysis and advocacy, Community Solutions provides data and analysis that is critical to inform the work, effectiveness and decision-making of direct services organizations, funders and policy makers.

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# Introduction: **Overview of the Behavioral Health and Criminal Justice Systems in Ohio**

Over the last seven years, The Center for Community Solutions (Community Solutions) and the Mental Health & Addiction Advocacy Coalition (MHAC) have repeatedly partnered to produce *By the Numbers*. This series of reports provides data and context to policymakers and advocates, with the intention of increasing their knowledge of Ohio's mental health and substance use disorder (SUD) services. The goal of this series is to support sound, data-driven policy decisions and improvements in the delivery of these services. Community Solutions and the MHAC have partnered once again to produce the fourth edition of *By the Numbers,* entitled *By the Numbers 4: Developing a Common Understanding for the Future of Behavioral Health Care, Landscape and Analysis of the Intersection between the Behavioral Health and Criminal Justice Systems*. This latest edition examines the current state of behavioral health services[1] for adults involved with the criminal justice system, including barriers to accessing services. In conducting research for this report, the project team surveyed Alcohol, Drug Addiction and Mental Health Services (ADAMHS) boards across Ohio about the types of services provided to people with a behavioral health disorder who are in some way involved with the criminal justice system. The report also examines data from a survey of jail administrators, the Ohio Department of Rehabilitation and Correction (ODRC), and the *Stepping Up Initiative*. These resources and others are explored to identify best practices and opportunities to expand and develop these practices in Ohio. The report discusses the impact of Medicaid expansion, and other initiatives in Ohio that aim to better connect people who are dealing with the criminal justice system, to health coverage and services. In short, this edition of *By the Numbers* emphasizes the importance of timely and appropriate treatment and support services for people with behavioral health disorders, and how these services can reduce this population's involvement with the criminal justice system.

Research over the last several years has aimed to quantify the individuals affected by the intersection of behavioral health and criminal justice. Studies have identified an overwhelming proportion of people with behavioral health disorders within the criminal justice system, going as far as to say that jails and prisons are the largest provider of behavioral health care in some jurisdictions. People living with a behavioral health disorder are disproportionately engaged in some way with the criminal justice system. A report from the Treatment Advocacy Center finds that nationwide, approximately 20 percent of jail inmates and 15 percent of state prison inmates have a severe mental illness.[2] Data from a 2010 report shows that three times as many people with severe mental illness are in jails and prisons than in hospitals.[3] Based on data collected in the National Inmate Survey, 58 percent of state prison inmates and 63 percent of sentenced jail inmates experienced drug use or dependence.[4] These figures compare to only about 5 percent of the general adult population who fall into this category.[5]

The overrepresentation of people with behavioral health disorders in the criminal justice system is the result of a number of factors that have evolved throughout the country's history into pressing societal issues, many of which are addressed in this report. The impact of the opioid crisis adds additional urgency to developing and implementing sound policy to reduce the impact of incarceration on people with a behavioral health disorder.

# 2 Definitions of Prisons and Jails

In Ohio, both jails and prisons house incarcerated individuals. This report will remain consistent with state and federal definitions when referring to both types of facilities.

## Jails

The U.S. Department of Justice (DOJ) defines jails as "correctional facilities that confine persons before or after adjudication and are usually operated by local law enforcement authorities."[6] According to DOJ, jail sentences are typically for one year or less. DOJ notes that jails also:

- Receive individuals pending arraignment and hold those awaiting trial, conviction or sentencing
- Remit probation, parole and bail-bond violators and absconders
- Temporarily detain juveniles pending transfer to juvenile authorities
- Hold mentally ill persons pending transfer to appropriate mental health facilities
- Hold individuals for the military, for protective custody, for contempt and for the courts as witnesses
- Release inmates to the community upon completion of sentence
- Transfer inmates to federal, state or other authorities
- House inmates for federal, state or other authorities because of crowding of their facilities
- Sometimes operate community-based programs as alternatives to incarceration[7]

Under Ohio law, jail refers to "a jail, workhouse, minimum security jail, or other residential facility used for the confinement of alleged or convicted offenders that is operated by a political subdivision or a combination of political subdivisions of this state."[8] Ohio law applies standards to jails based on their category. Jail categories include: full-service jail, minimum security jail, twelve-day facility, twelve-hour facility, and temporary holding facility.[9]

**Full-service jails** are typically county and large city jail operations.

**Minimum security jails** generally work in conjunction with a full-service jail. They function similarly to a full-service jail, except that they have pre-requisites for qualifying incoming prisoners. Prisoners must be adults, sentenced to either traffic offenses, misdemeanors, or fourth or fifth degree felonies and must be minimum risk offenders, as defined by the Ohio Revised Code.

**Twelve-day jails** are primarily intended for local city, villages, and township jurisdictions. They are used for booking and processing fresh arrests and allow local ordinance offenders to serve their jail sentences locally.

**Twelve-hour jails** are primarily intended for local city, village, and township jurisdictions to have a jail facility for booking and processing fresh arrests.

**Temporary holding facilities** can hold prisoners for a maximum detention time of six hours. These incarceration facilities do not fall under Ohio's minimum jail standards, and instead are operated by "guidelines" established by the Bureau of Adult Detention.[10]

## Prisons

Whereas jails are typically operated by counties or municipalities, prisons fall under the jurisdiction of the state and federal governments. As distinguished by DOJ, "State and federal prisoner populations differ from the jail inmate population in terms of conviction status, offense distribution, and average length of stay. The federal prisoner population is also unique from the state prisoner population, most notably in offense distribution. Similarly, prison facilities differ from local jail facilities in average size, treatment and programming resources and crowding, among other characteristics."[11]

In Ohio, prison is defined as "a residential facility used for the confinement of convicted felony offenders that is under the control of the department of rehabilitation and correction but does not include a violation sanction center operated under authority of section 2967.141 of the Revised Code."[12] ODRC has 28 institutions. Three Ohio institutions are operated by private companies under contract with the state. ODRC summarizes the scope of its responsibilities in the statement below:

"All adults convicted of felonies for which the statutory minimum is at least six months come into the state's prison system… Many convicted felons are not, however, sent to prison. Instead, they are supervised in the community through probation or other community corrections alternatives. Convicted felons who have served a specific amount of time in prison can be, if eligible, placed back into the community through a system called Parole. Parole is a period of supervision prior to full release from the state's correctional system. This function, too, belongs to the ODRC."[13]

Operated by the Federal Bureau of Prisons, federal prisons incarcerate individuals convicted of violating federal law. One federal prison exists in Ohio, Federal Correctional Institution (FCI) Elkton, located in Columbiana County. FCI Elkton is a low-security correctional facility with an adjacent low-security satellite prison.[14] In addition, a Residential Reentry Management Field Office is located in Cincinnati, Ohio.

## Community Corrections

ODRC's Bureau of Community Sanctions supports community sanctions and residential services through grant and contractual funds to local jurisdictions and private vendors. These alternatives support adult offenders re-integrating into the community or those who would otherwise be in jails or prisons. The Bureau lists the programs as follows:

"Programs funded by the Bureau include Halfway Houses, Community-Based Correctional Facilities, Community Residential Centers, Permanent Supportive Housing, and Community Corrections Act grant programs including Intensive Supervision Probation, Standard Probation, Prosecutorial Diversion, Non-Supervisory Treatment Programs, Electronic Monitoring, and Community Work Service. Additionally, the Bureau has provided Probation Improvement Grants, Probation Incentive Grants, and SMART Ohio Grants in order to alleviate voids in services."[15]

The availability of services for mental health and SUDs for incarcerated individuals varies depending on the type of correctional facility and existence of financial resources. This will be addressed in detail in later sections of this report.

# History of Policies

## Deinstitutionalization and Criminalization of Behavioral Health Disorders

In the early 1840s, Dorothea Dix began a national movement in the United States to address the dire situations faced by individuals with behavioral health disorders. These individuals were often plagued by homelessness or faced inhumane care and treatment in the few facilities that existed at the time, mainly poor houses or prisons. Dix's efforts led to the establishment of state facilities to house and treat individuals with behavioral health disorders. Now referred to as institutions or hospitals, these facilities were the predecessors to today's treatment system.

The 1950s brought about major transitions in the behavioral health community and the early institutions Dix first introduced. Societal norms began to change, and individuals with behavioral health disorders were treated as though they had physical health disorders. The creation of the first effective antipsychotic medication in 1955 provided individuals in secluded institutions with the ability to receive alternative treatment in the community.[16] These societal changes contributed to the historical movement known as deinstitutionalization. Deinstitutionalization refers to the replacement of long-stay psychiatric hospitals with smaller, community-based alternatives providing less isolated care for those with mental illnesses.[17]

On October 31, 1963, days before his assassination, President Kennedy signed the Community Mental Health Act. This Federal Act would support the funding and construction of community mental health centers. These community mental health centers were intended to provide behavioral health services in communities to assist with transitions due to mental health hospital closures. Due, in part, to Kennedy's untimely death, only half of the facilities envisioned were ever created and the community mental health system was never fully funded.[18]

On December 31, 1955, the total count of individuals residing in psychiatric hospitals in the United States was 558,239, including 28,663 patients in Ohio.[19] In 2017, Ohio public psychiatric hospitals had an average daily resident population of 1,084.[20] The 94 percent reduction in psychiatric hospital utilization from 1955 to 2017 paints the picture of dramatic deinstitutionalization in the past six decades.

In Ohio, there are currently six state-run psychiatric hospitals that serve individuals who have severe behavioral health disorders.[21] Out of 1,081 total available beds, there are 1,041 beds currently in use.[22] Across those six facilities, there is an average of 16 daily admissions and 17 daily discharges.[23]

Today, the movement Dix started in the 19th century has come full circle. While the United States is working to better provide behavioral health services in the community, individuals with behavioral health disorders who become engaged with the criminal justice system find themselves being served in a setting similar to the outdated institution model. The large decrease in institutions coupled with inadequate services in the community could be a contributing factor for the large increase in individuals in prisons and jails with behavioral health disorders. This is contradictory to Dix's original goals and the process of deinstitutionalization.

The initial transformation brought about by deinstitutionalization led to a society grappling with how to better understand the needs of individuals with behavioral health disorders. In Ohio, there were just under 15,000 individuals in prison in 1978.[24] By 2006, that number had tripled to more than 50,000 individuals and has since remained relatively constant.[25] Specific data on what role population increases have had on this swelling number is limited. Scholars often cite the growth in sentencing lengths and the increase in offenders sent to prison as reasons for the incarceration increase.[26] Data from 2015 indicated that more than one in five individuals in Ohio prisons have a mental illness.[27] Nationwide,

prisoners are two to four times more likely than the general population to have psychotic and major depressive disorders.[28]

## Federal and State Policies Related to Drugs and Drug Use

Federal policy toward drug use has varied throughout history. Many historical scholars argue that the first national campaign to end drug use by the American government began with the prohibition of alcohol in the 1920s. Even before prohibition era, the world was gripped by an opioid crisis. In the early 1910s, an international opium conference convened in the Hague, where world powers agreed to limit the growing world supply of opium.[29] In 1914, the Harrison Narcotic Act was passed in the United States, creating a registry of all persons prescribing and selling opium, and allowing the federal government to regulate narcotic drug sales.[30] Prohibition began in 1920 and lasted for more than a decade, ending in 1933. The nationwide ban on the production, importation, and consumption of alcohol began after a growing national crusade. This crusade was spearheaded by members of the Temperance movement, who were concerned about the impact of alcohol on society. However, the illegal status of alcohol soon gave way to the creation of a black market and organized crime supporting the sale, consumption, and production of illegal alcohol.

The end of the prohibition of alcohol made way for the modern day "War on Drugs." As use of other banned substances began to rise in modern society, organized crime shifted from Al Capone to the drug cartels known to play a role in the continuation of modern substance use crises that have gripped the state and nation.[31]

## Impact of Federal Drug Policies

During the administrations of Presidents Nixon and Reagan, the federal government began to take action on sweeping criminalization reforms specific to ending the crack cocaine crisis. The "Just Say No" campaign was an early prevention effort to stop the spread of drug use among the nation's youth. The most recent National Drug Control Strategy, released in 2016 by the Obama administration, outlines progress in reducing drug use through a "balanced and comprehensive approach to the drug policy that incorporates both public health and public safety approaches."[32]

The act of declaring "war" on a specific part of the populace – individuals with a SUD, in this case – and labeling them as criminals has created institutional rifts in how government looks at individuals with SUDs in the United States. In particular, criminalization of drug use has raised concerns of racial inequities in incarceration. Data from the U.S. Department of Health and Human Services shows that although African Americans represent only 14 percent of all drug users and a similar proportion of the general population, they make up 35 percent of those arrested for drug offenses, 53 percent of drug convictions, and 45 percent of drug offenders currently in prison.[33] In Ohio, the American Civil Liberties Union estimates that African Americans are 4.1 percent more likely to be arrested for marijuana possession than whites.[34]

Through government reforms and better medical treatment, there are concerted efforts underway to attempt to reduce the stigma associated with SUDs, and to portray them as less of a personal or moral failing and more as a public health crisis, necessitating policy solutions. Continuing to recognize SUDs as a disease is an important pretext toward reducing the racial disparities that exist in the criminal justice system.

## State Efforts to Address Drug Use and Criminal Sentencing

Ohio has joined other states in reviewing what it can do to reduce the number of its residents in jails and prisons. The economic turmoil faced by many states at the onset of the Great Recession in late 2007 led state governments to examine spending associated with prisons and to consider what strategies they could employ to safely reduce the prison population. This review led many Ohio legislators to look at the large increase in state spending on incarceration in recent decades.

In 2011, the 129th General Assembly passed House Bill 86, the "Justice Reinvestment Act," which averted prison growth by 2,900 people by encouraging judges to place first-time offenders of felony levels four and five[35] on probation.[36] Currently, the state of Ohio has its lowest rate of entry into state prisons in 27 years.[37] Governor John Kasich and General Assemblies serving during his terms in office have worked to dismantle legislation, like Senate Bill 199 (115th G.A.) that created mandatory longer sentence lengths for aggravated and repeat offenders.[38]

The state mid-biennium budget review in the 130th General Assembly, House Bill 483, incorporated a provision that created the Criminal Justice Recodification Committee. The committee was tasked with reviewing the expanded criminal code in Ohio, targeting ways the state can better "prosecute, sentence, and rehabilitate criminal offenders in this state."[39]

# 4 Financing of Behavioral Health Services

## Medicaid

Medicaid is an entitlement program enacted through amendments made to the Social Security Act in 1965 through the Health Insurance for the Aged Act. The program is administratively different from Medicare in that it is mutually financed, and administered, by both the federal government and the states. In order to receive funding from the federal government, states must adhere to the requirements set forth in federal law in regards to the program's operation, benefits, and oversight. States have flexibility to design their Medicaid programs in ways that address needs of their residents. A comprehensive document, known as a State Plan, outlines a state's eligibility standards, benefits, and enrollment procedures and must be approved by the Centers for Medicare and Medicaid Services.[40]

States are not required to provide behavioral health services to adults through Medicaid.[41] While beneficiaries through age 21 qualify through the mandatory Early Periodic Screening Diagnosis and Treatment benefit, which can include access to behavioral health services, states must first elect to provide such services to adults through their State Plan. In Ohio, the current behavioral health benefit structure is listed below.[42]

Medicaid, pursuant to federal law, can only reimburse for medically-related services. In addition to Medicaid, there are many non-Medicaid services which are financed through a variety of funding sources. The two primary sources of this type of funding come from the state's general revenue fund and through local levy funds. A diversity of non-Medicaid services are provided through local networks; these are listed below.

### Medicaid Covered Services

- Alcohol and Drug Addiction
- Alcohol/Drug Screening Analysis/Lab
- Urinalysis
- Ambulatory Detoxification
- Assessment
- Case Management
- Crisis Intervention
- Individual or Group Counseling*
- Induction of Buprenorphine
- Injection of Naltrexone**
- Intensive Outpatient**
- Medical Somatic
- Methadone Administration
- Mental Health
- Community Psychiatric Supportive Treatment
- Health Home Comprehensive Care Coordination
- Individual or Group Counseling*
- Individual or Group Counseling***
- Injections
- Mental Health Assessment
- Partial Hospitalization
- Pharmacological Management
- Psychiatric Diagnostic Interview
- Psychological Testing

** Ohio Department of Mental Health and Addiction Services (ODMHAS) Certified Providers. ** To Treat Addiction. *** Non-ODMHAS Certified Providers. **** Additional services have been added under Specialized Recovery Services and the Behavioral Health Redesign*

### Non-Medicaid Services

- Treatment and Other Health Services
- Hospitalization at state operated psychiatric hospitals
- Residential Treatment
- Treatment in Jails

**Non-Health Services**

- Housing
- Transportation
- Education
- Consultation
- Crisis Stabilization
- Employment
- Peer Support
- Prevention
- Protective Services
- Court Services
- Hotlines
- Referral Services

Important to understanding the combination of funding and programmatic approaches to covering behavioral health services is the “elevation” of Medicaid matching funds to the state level. As described previously, Medicaid is a jointly operated and financed program between the state and federal governments. This mutual process of financing, often referred to as “matching,” involves using state dollars to draw down federal reimbursement for Medicaid-reimbursable medical services. This process of matching resources is expressed as a percentage of total Medicaid spending known as Federal Medical Assistance Percentage (FMAP). Depending on a given state’s per capita income or the Medicaid policy being pursued by the state, the FMAP amount can vary. For example, in Mississippi, a state with some of the lowest per capita income in the country, the FMAP is very high at 76 percent.[43] This means that in Mississippi, about 76 cents of every Medicaid dollar spent comes from the federal government.

Before the biennial budget of state fiscal years (SFY) 2012 and 2013, the state’s match was the responsibility of the ADAMHS boards. ADAMHS boards, which are defined in Ohio Revised Code Section 340.03, are responsible for coordinating the mental health, addiction treatment, and recovery system in Ohio, and are organized in either single or multi-county arrangements. Boards rely on a combination of federal, state, and local funding to provide non-Medicaid services and, before elevation, provided the state with monies to draw down federal Medicaid funds through the FMAP process. Elevation, simply put, “elevated” the provision of state match from the local boards to the state government.[44]

## Impact of Medicaid Expansion

As noted previously, the state has the ability to provide optional services and benefits to various covered groups outlined in the Medicaid-related Social Security Act (SSA) provisions. Initially, with the passage of the Patient Protection and Affordable Care Act (ACA), the expansion of coverage to non-disabled adults (also known by their SSA term “Group VIII”) was mandatory. However, as an outgrowth result of *National Federation of Independent Business v. Sebelius*, the Supreme Court of the United States determined that the Medicaid expansion was unconstitutional as it was coercive of states, thus making Medicaid expansion an optional policy.[45]

Governor Kasich extended Group VIII coverage in 2014 through a State Plan Amendment. Currently, there are about 670,000 Ohioans who receive their coverage through the expansion.[46] The Ohio General Assembly required the Ohio Department of Medicaid (ODM) to conduct an evaluation of the impact of expansion which was released at the end of 2016. In this report,[47] claims data showed that 31.9 percent of Group VIII enrollees had been indicated for Anxiety and/or Depression and 32.3 percent of Group VIII enrollees were clinically diagnosed with substance abuse or dependence. Before the Group VIII expansion, these individuals were not eligible for Medicaid unless their conditions met the clinical thresholds of disability. With the elevation of Medicaid to the state level, along with the expansion of benefits, the state was able to provide coverage to hundreds of thousands of Ohioans with behavioral health conditions who otherwise would have had to rely on the local system for access to treatment services.

ODM’s evaluation goes on to show how the impact of this coverage affects individuals with behavioral health conditions. First, individuals with a mental health or SUD indicated they were more likely to access a regular source of treatment and medications, though the data did suggest that individuals with these diagnoses did not always receive treatment. Beyond the condition-specific data, it is important to note that many individuals found it easier to maintain or seek employment, afford housing and food, and saw a significant improvement in personal finances. This is important as there are numerous studies showing the links between housing insecurity,[48] [49] food insecurity,[50] [51] medical debt,[52] and poor behavioral health outcomes.

Financially, Medicaid represents roughly $650 million of the $940 million the state spends on SUDs. Of this amount, about $279 million comes from expansion.[53] Key to understanding this investment is understanding how much of the state’s funds are obligated to cover services. Whether it is related to substance use or mental health, the financing of behavioral health through expansion is largely provided by the federal government; with the current FMAP at 94 percent for 2018, the federal government finances 94 percent of the cost of coverage.[54] It is worthy to note that this amount goes down to 90 percent, and remains at 90 percent, by 2020 unless Congress changes the law.

Data suggests that increased access to coverage for individuals involved in the criminal justice system reduces recidivism.[55] In fact, while ODRC continues to collect data on its efforts to connect individuals to coverage, early results are promising.[56]

## Overview of Behavioral Health Redesign

The Behavioral Health Redesign (Redesign) is made up of a four-step strategic plan by the state of Ohio that began in 2012. The first phase changed responsibility for the Medicaid match reimbursement for behavioral health treatment services from the local ADAMHS boards to the

state. The second phase expanded Medicaid in 2014 to provide coverage to approximately 670,000 low-income adults. Since its inception, 500,000 people in the expansion group have received care for mental health needs, and many have also accessed SUD treatment services. Ohio is currently in the third phase, modernization, leaving the final phase, integration, slated to begin July 1, 2018.

The Redesign is the process of modernizing the publicly-funded behavioral health system. The Ohio Governor's Office of Health Transformation (OHT) outlined goals to rebuild community behavioral health system capacity by integrating physical and behavioral health care, modernizing the system, and providing coverage through private Medicaid managed care organizations. The Kasich administration included a provision in the SFY 2016-SFY 2017 state operating budget that added behavioral health services to Medicaid managed care contracts. In collaboration, OHT, ODM, and the Ohio Department of Mental Health and Addiction Services (ODMHAS) initiated the Redesign in March 2015. The key components include:

- Aligning billing codes with the National Correct Coding Initiative[57]
- Re-pricing Medicaid reimbursement rates for treatment services
- Updating the menu of Medicaid covered services

## Shaping the Redesign

OHT, ODM, and ODMHAS brought together 91 provider agencies and advocacy groups, and 51 county ADAMHS boards, as stakeholders to redesign the behavioral health system. Stakeholders provided feedback and recommendations to ensure the state was aware of the impact of each policy proposal on the system. Redesigning the behavioral health system required providers to consider changes to their menu of treatment services, to use new billing codes and reimbursement rates, and to evaluate workforce needs. Providers prepared by internally deconstructing and rebuilding the way they would deliver care, while continuing to provide services to clients. Agencies trained staff, upgraded IT systems, and determined how to continue delivering services with new reimbursement rates. As a result, providers serving Medicaid clients made complete transformations of their business practices within their agencies. Many providers continue to work on these changes that went into effect January 1, 2018.

## Redesign Services

As part of the Redesign, new behavioral health services were added to the Medicaid menu of covered treatments, one of which is Assertive Community Treatment (ACT). It is an evidence-based practice that improves outcomes for people with severe mental illnesses who are most at-risk of homelessness, psychiatric hospitalization, or institutional recidivism. ACT is delivered by a team that follows a fidelity scale to ensure the treatment modality is followed closely, as it was designed to ensure its effectiveness and outcomes. The service is already offered by some provider agencies who value its treatment results. Investing in this treatment service can reduce arrests and incarceration because of the outreach into community settings that connect care and wraparound supports to a hard-to-reach population with severe mental illness.

Under the Redesign, ODM selected the American Society of Addiction Medicine's (ASAM) criteria to standardize addiction treatment services covered by Medicaid. The ASAM criteria are required in more than 30 states.[58] These criteria use a detailed assessment process that then suggests what level of care individuals need. The levels of care range from early intervention, outpatient, and intensive outpatient/partial hospitalization, to residential inpatient services provided by the community behavioral health system. Reimbursable services provided within each level of care offer treatment services such as assessment, psychiatric diagnostic, counseling, medication administration, drug screens, peer recovery support, case management, and withdrawal management. The ASAM criteria will streamline the way services are provided in a more unified system. This new standardization may help reduce incarceration and recidivism by providing the most appropriate placement in the right level of care.

Included in ASAM's continuum of care is residential inpatient services. Previously, SUD residential treatment programs operated under the assumption that they were considered Institutions of Mental Disease (IMDs), and thus subject to the IMD exclusion. The IMD exclusion prohibits federal Medicaid reimbursement to states for adult patients in a residential treatment facility with more than 16 beds. Since the state chose the ASAM criteria, SUD residential treatment programs do not fall within the definition of IMDs. Certified community behavioral health providers offering SUD residential treatment can now provide care to as many people as possible without being limited by the IMD exclusion. Coverage for SUD residential treatment without restrictions on the number of beds in the midst of battling the opioid crisis will allow many more Ohioans access to treatment. It will expand the capacity of the system and will reduce wait times for treatment services.

## Integrating Behavioral Health Services

The final phase of Redesign is the integration of behavioral and physical health care. All providers that bill Medicaid must contract with at least one of Ohio's five Medicaid managed care plans for payment of services. These plans are CareSource, UnitedHealthcare, Molina Healthcare, Paramount, and Buckeye Health Plan. Managed care plans will provide care coordination, by ensuring consumers receive both physical and behavioral health care services with a goal of better patient outcomes. The desired goals of integrating physical and behavioral health services are (1) improved health outcomes for those with behavioral health disorders, (2) increased coordination, and (3) decreased utilization of the most expensive services in the Medicaid benefit package. Behavioral health clients are often the costliest in the Medicaid system. As noted by OHT in 2016, "Medicaid members needing treatment for mental health or substance abuse disorders represent 27 percent of Ohio Medicaid enrollment but account for 47 percent of Medicaid spending."[59] One way to improve this is by coordinating care with community behavioral health providers. Managed care plans already contract with the state to provide physical health care to Medicaid beneficiaries and will now be able to coordinate behavioral health care with providers in their networks.

As managed care and behavioral health providers begin working together, the system will undergo another set of changes that providers must be ready to implement. ODM put a one-year guarantee on the reimbursement rates for services rendered. This means that on July 1, 2019, managed care plans are no longer required to follow the negotiated rates, prior authorization rules, and benefit limits under the Redesign. However, the treatment services for which ODM requires managed care plans to reimburse are just a baseline. The health plans can cover other behavioral health treatment services negotiated by providers when contracting.

Both the Redesign and moving to Medicaid managed care are significant changes to Ohio's Medicaid behavioral health treatment system that offer challenges and opportunity. Many stakeholders share concerns about the impact on workforce, capacity, and access to care. The landscape may look much different over the next several years.

# Recommendations

Our research brings together information to examine the intersection of the criminal justice and behavioral health systems. While information exists across Ohio, there remains a need for data that fully captures key information at different points along a cycle that people with a behavioral health disorder have experienced as it relates to the criminal justice system.

Beyond questions about data, our research has resulted in a series of policy recommendations for moving forward.

### Increased Support for Community Behavioral Health

- The role that deinstitutionalization played in increasing the number of individuals with behavioral health disorders in the criminal justice system can be significantly impacted by providing additional behavioral health resources to communities.
- Additional services and broader access to behavioral health services for communities can assist with providing the proper tools to treat an individual's behavioral health needs before a crisis may occur and provide ongoing care and treatment.
- Tools such as early screening and diversion programs can address behavioral health issues at an early stage and remediate concerns before the criminal justice system becomes involved.

### Sentencing Reform

- By supporting key pieces of legislation that promote effective rehabilitation, in addition to the recommendations from the Criminal Justice Recodification Committee that aim to remove provisions like mandatory sentencing, the state can move away from incarcerating high numbers of individuals with behavioral health disorders.
- These reforms can also reduce disparities that exist in the criminal justice system specific to race and socio-economic circumstances by allowing courts to properly examine and identify appropriate sentencing for individuals.
- Removing bail bond requirements that make it easier for wealthier individuals to be released over individuals of lower socio-economic status, rather than based on the severity of an offense, should be reexamined.

### Medicaid Eligibility

- Medicaid eligibility should be active the moment individuals enter a halfway house.
- If Medicaid payment cannot be made for services that help divert individuals post-release from any type of involvement with the criminal justice system, ADAMHS boards or state general revenue funds should finance services, regardless of county.
- Work requirements in the Medicaid program should exempt anyone returning from a correctional facility for at least one year.
- The landscape of the behavioral health treatment system may undergo significant changes. It will be important to closely monitor any mergers, affiliations, closures, and layoffs. Data should be tracked to ensure access to care remains across the state. The Joint Medicaid Oversight Committee should continue to monitor the implementation of the Redesign and move to managed care over the next several years.

# End Notes


1. The term “behavioral health services” is used throughout the text to encompass any service providing treatment or prevention of mental illness or substance use disorder.

2. Treatment Advocacy Center Office of Research & Public Affairs. “Serious Mental Illness (SMI) Prevalence in Jails and Prisons.” *Treatment Advocacy Center*. Last modified September 2016. http://www.treatmentadvocacycenter.org/storage/documents/backgrounders/smi-in-jails-and-prisons.pdf.

3. Torrey, E. Fuller, M.D., Aaron D. Kennard, M.P.A, Don Eslinger, Richard Lamb, M.B., and James Pavle. “More Mentally Ill Persons Are in Jails and Prisons Than Hospitals: A Survey of the States.” *Treatment Advocacy Center*. Last modified May 2010. http://www.treatmentadvocacycenter.org/storage/documents/final_jails_v_hospitals_study.pdf.

4. U.S. Department of Justice Bureau of Justice Statistics. *Drug Use, Dependence, and Abuse Among State Prisoners and Jail Inmates, 2007-2009*. By Jennifer Bronson, Ph.D., Jessica Stroop, Stephanie Zimmer, and Marcus Berzofsky, Dr.P.H. Report no. NCJ 250546. June 2017. https://www.bjs.gov/content/pub/pdf/dudaspji0709.pdf.

5. Ibid.

6. Bureau of Justice Statistics. “Local Jail Inmates and Jail Facilities.” https://www.bjs.gov/index.cfm?ty=tp&tid=12.

7. Ibid.

8. Ohio Revised Code (ORC)§2929.01(R)

9. Ohio Administrative Code 5120:1-7-02

10. Adams, John F. “Email from Bureau of Adult Detention, Ohio Department of Rehabilitation & Correction.” E-mail message to Joan M. Englund. March 12, 2018.

11. Bureau of Justice Statistics. “State and Federal Prisoners and Prison Facilities.” https://www.bjs.gov/index.cfm?ty=tp&tid=13.

12. ORC §2929.01(AA)

13. Ohio Department of Rehabilitation & Correction. “About the ODRC.” Last modified 2018. http://www.drc.ohio.gov/about.

14. Federal Bureau of Prisons. “FCI Elkton.” https://www.bop.gov/locations/institutions/elk/.

15. Ohio Department of Rehabilitation & Correction. “Bureau of Community Sanctions.” Last modified 2018. http://www.drc.ohio.gov/community.

16. Torrey, E. Fuller, M.D. “Deinstitutionalization: A Psychiatric ‘Titanic.’” *In Out of the Shadows: Confronting America’s Mental Illness Crisis*. New York: John Wiley & Sons, 1997. Accessed December 2017. https://www.pbs.org/wgbh/pages/frontline/shows/asylums/special/excerpt.html.

17. Lamb, H. Richard, MD, and Linda E. Weinberger, PhD. “Perspectives on Criminalization.” *The Journal of the American Academy of Psychiatry and the Law* 41, no. 2 (2013): 287-93. http://www.treatmentadvocacycenter.org/storage/documents/perspectives_on_criminalization.pdf.

18. Associated Press. “Kennedy’s vision for mental health never realized.” *USA Today*, October 20, 2013. Accessed April 19, 2018. https://www.usatoday.com/story/news/nation/2013/10/20/kennedys-vision-mental-health/3100001/.

19. Torrey, E. Fuller, M.D. “Deinstitutionalization: A Psychiatric ‘Titanic.’” *In Out of the Shadows: Confronting America’s Mental Illness Crisis*. New York: John Wiley & Sons, 1997. Accessed December 2017. https://www.pbs.org/wgbh/pages/frontline/shows/asylums/special/excerpt.html.

20. Ohio Department of Mental Health and Addiction Services. MH Hospital Population 1962-2017. Accessed February 20, 2018. FY 2017 is unofficial.

21. Torrey, E. Fuller, M.D. “Deinstitutionalization: A Psychiatric ‘Titanic.’” *In Out of the Shadows: Confronting America’s Mental Illness Crisis*. New York: John Wiley & Sons, 1997. Accessed December 2017. https://www.pbs.org/wgbh/pages/frontline/shows/asylums/special/excerpt.html.

22. Ohio Department of Mental Health and Addiction Services. *Hospital Services Midnight Census Report: As of May 20, 2018* at Midnight. May 21, 2018. Accessed May 21, 2018. http://reports.mha.ohio.gov/pcs/dailycensus.pdf

23. Ibid.

24. Aiken, Joshua. “Ohio’s Prison and Jail Populations.” Chart. *Prison Policy Initiative*. May 2017. Accessed December 2017. https://www.prisonpolicy.org/graphs/OH_Prison_Jail_Population_1978-2015.html.

25. Ibid.

26. Mitchell, Michael. “The Causes and Costs of High Incarceration Rates.” *Center on Budget and Policy Priorities* (blog). Entry posted October 29, 2014. Accessed January 2018. https://www.cbpp.org/blog/the-causes-and-costs-of-high-incarceration-rates.

27. Johnson, Alan. “Ohio’s Prisons Hold 10 Times as Many Mentally Ill as its Psychiatric Hospitals Do.” *Columbus Dispatch*, April 19, 2015. Accessed December 2017. http://www.dispatch.com/article/20150419/NEWS/304199871.

28. Duwe, Grant. *Rethinking Prison: A Strategy for Evidence-Based Reform*. American Enterprise Institute, November 2017. Accessed January 2018. http://www.aei.org/wp-content/uploads/2017/11/Rethinking-Prison.pdf.

29. Hari, Johann. *Chasing the Scream: The First and Last Days of the War on Drugs*. New York: Bloomsbury USA, 2015.

30. Ibid.

31. Quinones, Sam. Dreamland: *The True Tale of America’s Opiate Epidemic*. New York: Bloomsbury Press, 2015.

32. Executive Office of the President of the United States. *National Drug Control Strategy*. Government Printing Office, 2016. https://obamawhitehouse.archives.gov/sites/default/files/ondcp/policy-and-research/2016_ndcs_final_report.pdf.

33. The Sentencing Project. Reducing Racial Disparity in the Criminal Justice System: A Manual for Practitioners and Policymakers. 2008. Accessed March 2018. http://www.sentencingproject.org/wp-content/uploads/2016/01/Reducing-Racial-Disparity-in-the-Criminal-Justice-System-A-Manual-for-Practitioners-and-Policymakers.pdf.

34. American Civil Liberties Union. *The War on Marijuana in Black and White.* 2013. Accessed March 2018. https://www.aclu.org/report/report-war-marijuana-black-and-white.

35. Ohio Criminal Sentencing Commission. "Felony Sentencing Quick Reference Guide." Last modified May 2017. https://www.supremecourt.ohio.gov/Boards/Sentencing/resources/judPractitioner/felonyQuickRef.pdf.

36. Council of State Governments Justice Center. "Ohio." Accessed March 2018. https://csgjusticecenter.org/jr/oh/.

37. Kasich, John. "State of the State." Address, Columbus, OH, March 6, 2018.

38. Diroll, David. *Prison Crowding: The Long View, with Suggestions.* Ohio Criminal Sentencing Commission, 2011. Accessed March 2018. https://www.supremecourt.ohio.gov/boards/Sentencing/resources/publications/monitoringreport2011.pdf.

39. Obhof, Larry. "Obhof Commends Work of Criminal Justice Recodification Committee." News release. June 15, 2017. http://ocjrc.legislature.ohio.gov/Assets/Files/press-release-from-senator-obhof.pdf.

40. Medicaid and CHIP Payment and Access Commission. *Federal Requirements and State Options: How States Exercise Flexibility Under a Medicaid State Plan.* 2017. https://www.macpac.gov/wp-content/uploads/2017/03/Federal-Medicaid-Requirements-and-State-Options-How-states-exercise-flexibility.pdf.

41. Cannon, Ken, Jenna Burton, and MaryBeth Musumeci. "Adult Behavioral Health Benefits in Medicaid and the Marketplace - Background." The Henry J. Kaiser Family Foundation. June 11, 2015. Accessed April 16, 2018. https://www.kff.org/report-section/adult-behavioral-health-benefits-in-medicaid-and-the-marketplacebackground/.

42. Ohio Department of Medicaid. "Ohio Medicaid Covered Services." Accessed April 16, 2018. http://www.medicaid.ohio.gov/FOR-OHIOANS/Covered-Services.

43. The Henry J. Kaiser Family Foundation. "Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier." Accessed April 16, 2018. https://www.kff.org/medicaid/stateindicator/federal-matching-rate-and-multiplier/?currentTimeframe=0&sortModel=%7B%22colId%22:%22FMAP%20Percentage%22,%2 2sort%22:%22asc%22%7D

44. Ohio Governor's Office of Health Transformation. "Investing in Improvements in Mental Health." Last modified January 10, 2010. Accessed April 16, 2018. http://healthtransformation.ohio.gov/Portals/0/Investments in Mental Health.pdf?ver=2012-01-10-095442-227.

45. Musumeci, MaryBeth. "A Guide to the Supreme Court's Decision on the ACA's Medicaid Expansion." August 2012. Accessed April 16, 2018. https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8347.pdf.

46. Ohio Department of Medicaid. *Eligibles and Expenditures Report: November 2017.* 2017. Accessed April 16, 2018. http://medicaid.ohio.gov/Portals/0/Resources/Research/MedicaidEligExpReports/2017/Med-11.pdf.

47. Ohio Department of Medicaid. *Ohio Medicaid Group VIII Assessment: A Report to the Ohio General Assembly*. December 20, 2016. http://medicaid.ohio.gov/portals/0/resources/reports/annual/group-viii-assessment.pdf.

48. Chambers, Earle, Damaris Fuster, Shakira Suglia, and Emily Rosenbaum. *The Link between Housing, Neighborhood, and Mental Health*. MacArthur Foundation, n.d. Accessed April 16, 2018. https://www.macfound.org/media/files/HHM_Brief_-_Reverse_Mortgages.pdf.

49. Substance Abuse and Mental Health Services Administration. "Homelessness and Housing." Last modified September 15, 2017. Accessed April 16, 2018. https://www.samhsa.gov/homelessness-housing.

50. Elsevier Health Services. "Food Insecurity Can Affect Your Mental Health." *EurekAlert*, April 27, 2017. Accessed April 16, 2018. https://www.eurekalert.org/pub_releases/2017-04/ehs-fic042717.php.

51. Strike, Carol, Katherine Rudzinski, Jessica Patterson, and Margaret Millson. "Frequent Food Insecurity among Injection Drug Users: Correlates and Concerns." *BMC Public Health*. 2012. Accessed April 16, 2018. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3540007/

52. Hamel, Liz, Mira Norton, Karen Pollitz, Larry Levitt, Gary Claxton, and Mollyann Brodie. "The Burden of Medical Debt." January 2016. Accessed April 16, 2018. https://kaiserfamilyfoundation.files.wordpress.com/2016/01/8806-the-burden-of-medical-debt-resultsfrom-the-kaiser-family-foundation-new-york-times-medical-billssurvey.pdf.

53. Borchardt, Jackie. "Medicaid Expansion Freeze Remains in Ohio Budget Ahead of Final Votes." *Cleveland.com*, June 28, 2017. Accessed April 16, 2018. https://www.cleveland.com/open/index.ssf/2017/06/medicaid_expansion_freeze_rema.html.

54. Medicaid and CHIP Payment and Access Commission. "State and Federal Spending under the ACA." Accessed April 16, 2018. https://www.macpac.gov/subtopic/state-and-federal-spending-under-the-aca/.

55. Gates, Alexandra, Samantha Artiga, and Robin Rudowitz. "Health Coverage and Care for the Adult Criminal Justice-Involved Population." June 23, 2016. Accessed April 16, 2018. https://www.kff.org/uninsured/issue-brief/health-coverage-and-care-for-theadult-criminal-justice-involved-population/.

56. Based on in-person interviews with ODRC staff.

57. Ohio Governor's Office of Health Transformation. "Ohio's Priorities for Behavioral Health (BH) Redesign." Accessed March 21, 2018. http://mha.ohio.gov/Portals/0/assets/Initiatives/Roundtables/BH-Redesign-Updates-Clinical-Advisory-Roundtable.pdf.

58. American Society of Addiction Medicine. "What is the ASAM Criteria?" Accessed March 22, 2018. https://www.asam.org/resources/the-asam-criteria/about.

59. Ohio Governor's Office of Health Transformation. "Ohio's Medicaid Behavioral Health Redesign." Last modified June 2016. http://healthtransformation.ohio.gov/Portals/0/BH%20redesign%20one%20pager.pdf?ver=2016-06-14-135437-633

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