

Chapter 15: Finance

The purpose of this chapter is to describe financing of services for adults and children diagnosed with mental health and substance abuses disorders, including existing resources, particular strengths of current initiatives, and needs. The chapter includes narrative information gathered through focus groups and personal interviews, as well as existing data from the Oklahoma Health Care Authority (OHCA), Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) and other sources.

A. Existing Resources

This section presents an overview of sources of funding for mental health and substance abuse services. We begin with funds appropriated by the State Legislature. There are a number of State agencies that have responsibility for serving persons with mental health and substance abuse problems; because of this, existing resources are best understood by looking at each agency. We then move on to a description of Federal sources of funding, concluding with brief descriptions of county and Tribal funding, third party private insurance, and other miscellaneous sources.

1) State Appropriations

State funds support mental health and substance abuse services principally through State Appropriations. Each agency receives an annual budget from the State Legislature. These funds are generally expended in one of the following ways: State agencies hire state employees to deliver services within state facilities (e.g., Griffin Memorial Hospital). State agencies contract with vendors to deliver services (e.g., private, non-profit community mental health centers). And finally, state funds are used to match Federal funds (e.g., the State Medicaid program managed by the Oklahoma Health Care Authority).

Exhibit 15.1 contains the ODMHSAS FY2006 expenditures of state appropriated funds. The total expenditures were \$157,319,814 which included \$133,763,475 for mental health services, \$1,630,729 for services for a program designed to serve people with co-occurring disorders, and \$21,925,610 for substance abuse services.

Exhibit 15.1. Oklahoma Department of Mental Health and Substance Abuse Services FY2006 State Appropriation Expenditures

State Hospitals	\$40,514,639
Community Mental Health	\$88,811,262
Residential Care	\$4,437,574
Subtotal Mental Health	\$133,763,475
Co-occurring treatment unit with the Tulsa Center for Behavioral Health program	\$1,630,729
Substance Abuse Services	\$21,925,610
Total FY 2006 Expenditures	\$157,319,814

As shown in Exhibit 15.2, the Oklahoma Health Care Authority (OHCA) had total expenditures of \$197,598,258 for behavioral health in FY2005. These expenditures included \$143,467,687 for children and \$54,130,571 for adults.

Exhibit 15.2. OHCA FY2005 Behavioral Health Expenditures by Service Type by Child and Adult

Behavioral Health Services for Children	
Service Type	Expenditures
Inpatient (Acute)	\$5,095,022
Inpatient (Freestanding Hospital and RTCs)	\$61,823,614
Outpatient Behavioral Health (Private)	\$31,964,512
Outpatient Community Mental Health Services (Public/Contracted)	\$8,458,849
Psychologist	\$2,211,643
Psychiatrist	\$1,481,140
Other Outpatient Behavioral Health Services	\$125,913
Residential Behavior Management Services	\$32,172,073
Target Case Management (TCM)	\$134,921
Children Total	\$143,467,687
Behavioral Health Services for Adults	
Service Type	Expenditures
Inpatient (Acute)	\$8,743,465
Inpatient (Freestanding Hospital and RTCs)	\$743,149
Outpatient Behavioral Health (Private)	\$14,635,863
Outpatient Community Mental Health Services (Public/Contracted)	\$26,839,865
Psychologist	\$869,109
Psychiatrist	\$1,314,612
Other Outpatient Behavioral Health Services	\$325,318
Residential Behavior Management Services	---
Target Case Management (TCM)	\$659,190
Adult Total	\$54,130,571
Total All Behavioral Health Services	\$197,598,258

Department of Corrections: DOC reports spending of \$10,745,363 for prison mental health services during State Fiscal Year 2005. These included \$5,238,184 for professional services and \$2,514,700 for pharmacy services within publicly operated prisons. In addition, there were an estimated \$2,603,960 for these services in privately operated prisons. These costs were met entirely by State appropriations. These do not include the costs of housing/incarceration, nor do they include the percentage of time/costs incurred by staff under "medical services". They also do not include prison substance abuse expenditures and Community Corrections expenditures for mental health

and substance abuse services.

Department of Rehabilitation Services: DRS reports mental health spending of \$2,985,482 in SFY 2004. This includes vocational rehabilitation expenditures for persons with psychiatric disability and other persons with a non-psychiatric disability who were receiving mental health services.

Department of Health: OSDH reported spending of \$19,075,996 on mental health services in SFY 2004 which this includes the Early Intervention program.

Office of Juvenile Affairs (OJA): OJA reported spending of \$2,380,000 and \$2,170,000 on mental health services in State fiscal years 2005 and 2006 respectively, and \$3,210,000 and \$3,070,000 on substance abuse services in State fiscal years 2005 and 2006 respectively.

2) Federal Funding Sources

Medicaid: Nationally, Medicaid is a jointly funded, federal-state health insurance program for low-income and people in need, administered by both the states and the federal Center for Medicare and Medicaid Services (CMS). In general, federal Medicaid covers children, aged, blind, and/or disabled individuals, and other people who are eligible to receive federally assisted income maintenance payments. Medicaid is an entitlement program, so anyone who meets the eligibility criteria and receives a medically necessary covered service from a Medicaid provider is entitled to have that service covered by Medicaid. Medicaid will not cover treatment in an Institution for Mental Disease (IMD) for persons 22 – 64 years of age. (An Institution for Mental Disease is a residential facility (*e.g.*, hospital, developmental center, nursing home) with 16 or more beds where more than fifty percent of the residents are persons with mental illness or mental retardation. Medicaid also does not generally cover costs of education, employment, or room and board except as part of a certified inpatient program. For example, the costs of room and board are allowable for residential treatment facilities for children and youth (RTF) and inpatient care in both general hospitals and state psychiatric hospitals.

Nationally, the federal government covers 50% to 83% of the costs of Medicaid services, depending on the state's *per capita* income, leaving the remainder of cost to the state. In Oklahoma, the federal government covers approximately 70% of Medicaid cost. The Oklahoma State Medicaid Plan is primarily administered as "Fee for Service" in which there are defined "covered services" and "covered populations" eligible for services. Oklahoma experimented with Medicaid Managed Care a number of years ago, but this had to be abandoned as managed care entities withdrew their plans. Medicaid-covered services are specified in two parts. One set of services is mandated by the federal government. There is also a set of optional services that a state Medicaid authority may choose to cover. Each state creates a State Medicaid Plan to specify the covered services and terms of Medicaid for their state.

Medicare: Medicare, also under the auspices of CMS, is a Federal insurance program for persons age 65 or older, and persons with disabilities. Medicare has two parts, Part A and Part B. Part A is Hospital Insurance, primarily covering inpatient services. This coverage is free to most eligible persons, and can be purchased by others. Medicare coverage of mental health inpatient services is capped at 190 days per patient per lifetime. This limitation applies only to psychiatric hospitals, not to psychiatric inpatient care in general hospitals. Part B is Medical Insurance, with coverage including mental health outpatient services, and physical or occupational therapy. Part B must be purchased by eligible participants.

Federal Grants:

Mental Health Block Grant: The Center for Mental Health Services' Community Mental Health Services Block Grant awards formula grants to the States to provide mental health services to people with mental disorders. In FFY'06 the amount of Oklahoma's grant was \$4,493,977. Through the Community Mental Health Services Block Grant, CMHS supports existing public services and encourages the development of creative and cost-effective systems of community-based care for people with serious mental disorders. With the current changes in the health care delivery system, improving access to community-based systems is especially important. CMHS is the Federal agency that oversees Federally-mandated State Mental Health Plans and Implementation Reports.

Substance Abuse Prevention and Treatment Block Grant: The Substance Abuse and Mental Health Services Administration (SAMHSA) provides Substance Abuse Prevention and Treatment (SAPT) Block Grant formula awards to States. In FFY'06 the amount of Oklahoma's grant was \$17,660,794. Of the block grant award, approximately 75% is used for substance abuse treatment services for those in need who do not have the ability to pay for such services. Oklahoma funds state facilities and contracts with private, non-profit agencies to provide a continuum of care for substance abuse clients, including detoxification, residential, halfway, intensive outpatient and outpatient services. Approximately 20% of the block grant funding is set aside for primary prevention programs. Oklahoma funds a network of 19 prevention programs that serve all 77 counties.

PATH: The Projects for Assistance in Transition from Homelessness (PATH) is a Federal formula grant program providing funding to states to assist individuals with serious mental illness who are homeless or at risk of becoming homeless. In FFY'06 the amount of Oklahoma's grant was \$372,000. States use these funds to provide services such as outreach, mental health treatment, support services, and some housing services, generally through contracts with political subdivisions and/or county nonprofits.

Other Discretionary Federal Services Grants: Some federal grant funds are available to individual providers to support specific programs. One example is the National Child Traumatic Stress Network, which provided grants to a set of community treatment and service centers to implement and evaluate community-based treatments. Each year, the Substance Abuse and Mental Health Services Administration (parent agency of CMHS)

releases several different grant programs for mental health and substance abuse services for which state and local governments and provider agencies may apply. These programs generally run for a minimum of one to a maximum of five years, after which federal funding ends. While these grants represent a fraction of the funds supporting the public mental health and substance abuse system in Oklahoma (about \$14 million), they can be very important sources of funding to the programs involved with them.

As shown in Exhibit 15.3, Oklahoma received an estimated \$36,336,685 in SAMHSA grant awards in FY 2005, or \$10.24 per capita. These monies include formula funding block grants and discretionary funding. Compared to surrounding states, Oklahoma ranked third highest with Colorado and New Mexico receiving more per capita.

Exhibit 15.3. SAMHSA Grant Awards
State Summaries FY 2005

STATE	Population	Grant Monies	Calculated
	2005		Per capita
United States	296,410,404	\$444,926,323	\$1.50
Kansas	2,744,687	\$17,580,738	\$6.41
Arkansas	2,779,154	\$23,794,667	\$8.56
Texas	22,859,968	\$222,667,529	\$9.74
Missouri	5,800,310	\$58,717,408	\$10.12
OKLAHOMA	3,547,884	\$36,336,685	\$10.24
Colorado	4,665,177	\$51,234,697	\$10.98
New Mexico	1,928,384	\$34,594,599	\$17.94

Social Security Administration:

SSI/SSDI: The Federal Social Security Administration maintains two income support programs for persons with disabilities. SSI (Supplemental Security Income) is a federal income program funded by general tax revenues. It is designed to help aged, blind, and disabled people, who have little or no income or work history. It provides cash to meet basic needs for food, clothing, and shelter. SSDI (Social Security Disability Income) is a federal income supplement program for qualifying workers who have become disabled and their families.

TANF: Temporary Assistance to Needy Families (TANF) provides income assistance to low-income families. These funds are provided by the federal government to families who meet income, eligibility, and work requirements. There is a lifetime limit of five years on eligibility for cash assistance. Some clients of the public mental health system are eligible for TANF. Oklahoma uses TANF funds to support substance abuse programs that serve the TANF population (\$3 million annually).

Housing and Urban Development (HUD)

Programs of the US Department of Housing and Urban Development (HUD) are open to States, to local government applicants, to providers, and to individuals.

Section 8: HUD Section 8 is a Federal program providing housing subsidy vouchers to elderly persons, persons with disabilities, and low-income families. Eligibility is determined based on total annual gross income and family size, and subsidy amounts are determined by annual income, reasonable rent, and actual rent.

Shelter Plus Care: Shelter Plus Care (S+C) is a HUD program providing long-term housing and supportive services for persons with disabilities who are homeless. This includes persons with serious mental illness, chronic drug and/or alcohol problems, and AIDS or related diseases and their families who are living on the streets, in emergency shelters, or in other places not intended for human habitation (*e.g.*, abandoned buildings, cars). Program grants provide rental assistance payments through four components:

1. Tenant-based Rental Assistance (TRA);
2. Sponsor-based Rental Assistance (SRA);
3. Project-based Rental Assistance with (PRAW) or without rehabilitation (PRA); and
4. Section 8 Moderate Rehabilitation Program for Single Room Occupancy dwellings.

A number of private not-for-profit mental health providers in Oklahoma City and Tulsa have been successful in applying for HUD grants to support housing for persons who are seriously mentally ill.

3) County Funding

County government may also contribute to mental health and substance abuse services. For example, in Oklahoma County, the county pays for jail mental health services. In Canadian County, there is a dedicated sales tax to support mental health, substance abuse, and juvenile justice services for children and adolescents.

4) Tribal Funding

Some Oklahoma Tribes support mental health and substance abuse services for members, using revenues derived from Tribal businesses. In addition, the Bureau of Indian Affairs provides some support through the Indian Health Service.

5) Third Party Private Insurance

Commercial Insurance: A person may be covered by commercial insurance in three ways.

- 1) Direct purchase of coverage by the person, or on behalf of the person.
- 2) Purchase of coverage by an employer on behalf of an employee.
- 3) Coverage under the insurance policy of a family member such as a spouse or parent.

Mental health coverage varies from policy to policy, depending upon coverage. Most commercial insurers include only limited inpatient and outpatient services under their

plans. They are not designed for adults with serious and persistent mental illness who may also need rehabilitative, residential and other support services or for children who are seriously emotionally disturbed.

6) Other Funding Sources

There are two other sources of funding, one of which is direct fees paid by clients, most often on a sliding fee scale for outpatient services. Many human services providers also raise funds through donations, gifts and other voluntary contributions from the communities they serve. This can also include donated time the value of which is not captured in the financial information.

B. Strengths

The Oklahoma Health Care Authority (OHCA) has established strong working relationships with the Oklahoma Department of Human Services (OKDHS), ODMHSAS, OSDH, and OJA. These agencies work collaboratively on the design of the state Medicaid program and on identifying and resolving difficulties as they arise. OHCA has added new programs and reimbursement rates on the recommendation of the other agencies (e.g., Systems of Care).

Agencies also cooperate through the transfer of funds from one to another. For example, ODMHSAS receives funds to contract for substance abuse services on behalf of TANF recipients from OKDHS, and to contract for residential substance abuse services for prisoners from the Department of Corrections (DOC).

OHCA officials state that the Medicaid benefit package has evolved over the years to the point where it is quite comprehensive, particularly for children. They view behavioral health services as just another necessary benefit with all other medical services. Through the development of provider credentialing requirements, they believe that the quality of services has improved over the past ten years.

OHCA has established a Behavioral Health Advisory Council that meets quarterly. The group includes broad representation among providers and consumers. A recent meeting had over seventy participants. The OHCA Director attends, as well as other senior management, and leadership sees this as an important opportunity to hear about what's not working. It is also an opportunity to update participants about Medicaid program changes that are under consideration by the State agencies and by the State Legislature. They also do annual focus groups; in the past year, attention was on the planning by the Adult Recovery Collaborative.

ODMHSAS has aggressively pursued federal grant funds. As shown in Exhibit 15.3 above, this has resulted in over \$36 million, a 23% addition to the agency's budget.

C. Needs and Existing Barriers

Policy

There is a general belief among providers that Oklahoma does not provide adequate funding to serve persons in need of mental health and substance abuse services,

whether they are provided through the ODMHSAS or through other state agencies. This belief is supported—at least for mental health—by available national comparison data. In FY2003, Oklahoma reporting spending \$138,000,000 state appropriations only for mental health services. This is the most recent year for which comparison data from other states are available. This translated to \$39.43 per capita. The national average for *per capita* mental health spending in FY2003 was \$91.12, more than twice Oklahoma’s rate of spending. Oklahoma ranked 46th among all states in *per capita* mental health spending. Exhibit 15.4, below, shows comparisons between Oklahoma and other states in the geographic region. In comparison to other states, the rate of spending for Oklahoma is much lower in every category except research, training and administration. Spending is very low in the category “other 24-hour services” which largely covers residential services. As discussed in Chapter VIII. Housing, this is an area where there are very significant unmet needs.

Exhibit 15.4. Per Capita Mental Health Expenditure Profile – FY 2003

SMHA Mental Health Per Capita Expenditures for State Mental Hospitals, Community-Based Programs, and State Mental Health Support Activities by Type of Services Setting and By State, FY2003												
STATE	Inpatient	%	Other 24-Hour Services	%	Less than 24-Hour Services	%	Other Services	%	Research, Training & admin.	%	SMHA Expenditure Total	Total Rank
Oklahoma	\$17.61	44.7%	\$0.40	1.0%	\$19.24	48.8%	\$0	0%	\$2.18	5.5%	\$39.43	46
Arkansas	\$9.42	31.9%	\$9.43	31.9%	\$9.03	30.5%	\$0	0%	\$1.69	5.7%	\$29.57	50
Colorado	\$17.61	26.6%	\$0.49	0.7%	\$0.00	0.0%	\$47.84	72.2%	\$0.36	0.5%	\$66.30	33
Kansas	\$21.58	28.7%	NA	NA	\$0.00	0.0%	\$53.64	71.3%	\$0.00	0.0%	\$75.22	26
Missouri	\$32.42	48.2%	\$5.75	8.6%	\$27.33	40.6%	\$0	0%	\$1.80	2.7%	\$123.41	11
New Mexico	\$11.85	41.1%	\$1.34	4.6%	\$15.62	54.2%	\$0	0%	\$0.00	0.0%	\$28.80	51
Texas	\$17.44	44.7%	NA	NA	\$20.31	52.1%	\$0	0%	\$1.26	3.2%	\$39.02	47
US Average	\$33.78	37.1%	\$10.07	11.0%	\$45.30	49.7%	\$4.29	4.7%	\$2.27	2.5%	\$91.12	
US Median	\$31.60	42.0%	\$8.30	11.0%	\$32.70	43.5%	\$0	0%	\$1.63	2.2%	\$75.22	

Source: State Mental Health Expenditure and Revenue Report published by that National Association of State Mental Health program Directors Research Institute.

In its 2005 resolution concerning mental health and criminal justice issues, the Oklahoma Board of Corrections noted that there are “indications that the criminal justice system has become the primary service provider for offenders with mental illness, although it has not received sufficient funding to meet the needs of this population.” The lack of adequate funding to meet the needs of people with mental health problems in various parts of the criminal justice system is discussed in Chapter 8.

Reimbursement Rates. The general funding problems are present in the rates of reimbursement of providers for services. There are a number of specific problems related to rates that apply not only to Medicaid, but also to contracted services from ODMHSAS, OKDHS, OJA, and other state agencies. Providers assert that rates do not reflect their rising costs. Rate adjustments are rare, in some cases more than ten years has lapsed since the last time that a program received a rate adjustment. For example, the reimbursement rate for psychosocial rehabilitation services has not changed in thirteen years. As a result, providers find themselves raising the productivity requirements of staff to produce more billable services and/or paying staff at rates that are so low they

result in high turnover. Providers are also concerned about major disparities in rates. For example, rates for children's mental health services are reported to be two-thirds of the rates for adult mental health services, although the costs of providing care are the same. Some necessary time is not billable; for example, time of clinical staff coordinating care with other agencies is not directly reimbursable and the rates for covered services are not high enough to include these added costs.

Many program managers stated that reimbursement rates are insufficient to cover their costs: "We are expected to deliver the same level of services without new money. Eligibility criteria were relaxed by the state, so we have new demands for services, we're expected to serve a broader population, but we get no new money." Another manager said, "Clients would be better served if we got paid more for having more clients. We are capped on reimbursement for ODMHSAS contracts, no matter how many people we see." A CMHC director stated that "We break even only by paying 1/3 less for staff salaries than the market rate."

The state agencies are aware of these problems. While some do review rates on a regular basis, others do not. Even when rates are reviewed, requests for funding to adjust rates from the Legislature are often not supported.

Reimbursement. Reimbursement for mental health services under Medicaid is available to agencies that contract with ODMHSAS (generally, CMHCs), and to other agencies that have no contractual relationship with ODMHSAS, but have contracts with OHCA.

Free Care. ODMHSAS includes funding in its contracts to allow providers to offer free care. However, under these contracts, CMHCs cannot turn people meeting certain criteria away. By the end of year, they report giving away services and medications that ODMHSAS does not reimburse, because they have exceeded the contract cap. As one manager described it, "the last few months are a fiscal nightmare; we have to raise private money to meet needs." Staff at one CMHC said, "We have to serve whoever comes through the door, but they don't give us the resources to do it. Staff have to pay personally for materials to hand out to clients- the agency should be able to pay for this. We are not even given copies of the DSM IV – we're simply not provided with the materials that we need."

Milestone Reimbursement. Providers who contract with the Department of Rehabilitation Services (DRS) report that the current funding system for supported employment services, known as "milestone" reimbursement, creates barriers to establishing new employment programs, since the largest payments to a program aren't made until the client has a three-month job retention. It was felt that this puts programs in a bind because they do not have a steady cash flow since payments are based on outcomes. A number of CMHCs stated that they had formerly operated on-site Supported Employment programs, but that the funding structure forced them to discontinue the programs. Not only are payments based on outcomes (milestones) for the clients; but, no dedicated money for follow along had been specified by DMHSAS. There is also a need for new funding to support additional employment programs through DRS and/or ODMHSAS. DRS is currently restructuring the payment system for supported

employment clients to better reimburse CMHC programs during the initial service phase.”

Program Models. Psychosocial Rehabilitation (PSR) programs include ICCD-certified clubhouses (only two in the state); these programs are currently not Medicaid-reimbursable. Other PSR programs are able to meet Medicaid requirements; however, a general concern was expressed regarding whether Medicaid rules are supportive of a recovery approach. Some Medicaid requirements violate clubhouse rules/philosophy. Some respondents indicated that there is a need to develop peer-run programs, but there is no current funding stream to support them.

Practices/Services

Documentation/Paperwork. In virtually all discussions with providers and some with consumers, the problems related to documentation of eligibility and development of treatment plan and notes were raised. Because documentation is integral to financing and requires such a significant proportion of resources, it is discussed here. Line staff at provider agencies estimated that 60-70% of their time was spent in documentation. State OHCA officials confirmed that this was their expectation, as well. Management of provider agencies indicated that line staff must spend 70% of their time in face to face contact with clients in order for programs to be fiscally viable, given current reimbursement rates. This does not include the time for documentation. Staff also need time for supervision and training. The net result is that staff must continually put in unpaid overtime in order to keep up. This causes major problems of morale and consequent staff turnover.

The documentation requirements are also the first order of business in meeting with a new client. This leads to client dissatisfaction. As one staff member expressed it, “If we could do the first session just listening to clients, rather than doing paperwork, the retention rates would be greater. Wait until the second session to start paperwork”. A frustrated client who was expecting to receive medication said, “you mean after all this I am not going to get to see a doctor today?” She had just spent two hours responding to questions required to establish eligibility.

Medicaid eligibility. Clients reported that it is very difficult to establish Medicaid eligibility if you are an adult without children, unless you are already on SSI (another very difficult process). Removal from the program is a second problem. Medicaid eligibility must be periodically re-established. When clients fail to do that, they are removed from the program, which is a major problem for persons who are poor and disabled. Efforts are now made to contact persons requiring recertification, but they are not always successful. OHCA officials indicated that mental health agencies, which swipe the individual’s Medicaid card (Soonercard), have immediate access to information regarding end dates of enrollment, and that they might take a role in assisting clients in maintaining their eligibility. Children also lose their eligibility automatically when they become 18. Officials of OKDHS, which has the responsibility for determining and maintaining eligibility, report that they do not have enough staff to do the outreach necessary to ensure that persons who are eligible remain enrolled.

Seeking Medicaid Reimbursement. Some substance abuse providers, who recently became eligible to bill the State Medicaid program, are struggling to understand the rules and requirements of this process. ODMHSAS has developed a consulting program to assist substance abuse providers with this. However, until these issues are resolved, they do create barriers to treatment.

While Medicaid offers the potential of increased federal funding, the experience of providers is that the process of authorization, documentation and auditing is so complex and adversarial that they choose to serve Medicaid eligible children. Others choose to rely on 100% state funding sources until these contract funds have run out. Providers may also choose not to provide public services because of low reimbursement rates, creating further gaps in the continuum of services. Providers report that they would expand services except for problems with financing and threat of financial penalties. An urban therapist said, "It might be o.k. to start with an agency that provides Medicaid services, but once you get established, it is easier and pays better to do private insurance and direct payment."

Prior authorization/Utilization Review. Prior authorization requirements have reportedly caused the reduction or elimination of two types of Medicaid mental health programs, case management and intensive children's outpatient services. Programs simply could not comply with the complex procedures that were established to authorize services initially and to seek approval to continue services. This is a problem for all programs. As one manager described it, "Pre-authorization and UR [utilization review] is also a problem – the attitude is that the mental health providers are trying to rip off Medicaid." OHCA officials acknowledge that this has been a problem with the organization with which they contracted to undertake prior authorization and utilization review. They have recently (July 1, 2006) contracted with a new vendor and expect that the situation will change and that programs that were discontinued may be re-established.

Audit and Recoupment. Providers described audit and recoupment procedures that they felt were punitive and risked undermining the fiscal stability of their programs. CMHC management said that they are exposed to too much risk for the level of reimbursement received. Medicaid audits can extrapolate the findings from a small sample of cases and recoup very large amounts that undermine providers' already marginal financial stability. It was also noted that audits are inconsistent, with some auditors disallowing claims that other auditors allow, and there was a general feeling that Medicaid auditors were not well-versed in mental health policy and practices.

Inconsistency and adversarial auditing and potential penalties have reduced flexibility and creativity in the continuum of community-based services. Past problems have made schools wary of providing behavioral health services because of the inconsistency in funding and threat of recoupment. OJA experience with IV-E funding and substantial recoupment have made them very cautious in using federal funding and creative services. The fee-for-service basis for paying for most behavioral health services does not support providers in rural areas because of transportation costs and time spent. Needed supervision is not covered in the rates for most services.

OHCA officials see their audit and recoupment policies as essential to maintaining quality of care. Poor record keeping—the primary basis for audit and recoupment—is indicative of poor quality care, in their view. They also note that the policies of the Center for Medicare and Medicaid (CMS), the Federal agency that supervises the Medicaid program, have recently introduced state comparisons of error rates that place greater pressure on state auditing. They also note that federal auditors are not always familiar with what are eligible services (*e.g.*, smoking cessation), and that Federal policies generally are running counter to efforts to streamline administration of the Medicaid at the state level. Because Medicaid is a joint federal-state program, the state must be careful to ensure that its programs and practices are consistent with CMS regulations and requirements.

Inconsistencies in funding. Some providers explained that there has been inconsistent funding levels for programs of the Department of Rehabilitation Services from year to year. This results in variations in the number of people who can be served. DRS has four priority groups based on level of disability; sometimes they have funds only to serve the most disabled.

Organization/Collaboration

Medicaid has significant contracts with providers who offer mental health services, but have no relationship with ODMHSAS. These providers operate under different standards than the community mental health centers which are under contract to ODMHSAS. This suggests that there are two publicly funded mental health systems, existing side by side - one managed by ODMHSAS and jointly funded by ODMHSAS and OHCA, and another that is outside the authority of ODMHSAS.

The lack of a blended funding stream to serve people with co-occurring disorders was the most frequently mentioned barrier to providing integrated mental health and substance abuse services by focus group participants. “We should be able to co-mingle mental health and substance abuse funds,” one mental health program manager said. “It’s hard to do co-occurring treatment when the funding streams are segregated.” Another provider asked “What about integrated funding?. Providers are asked to integrate their thinking about serving this population, but at the state level, the separate funding silos are reinforced.”

Some providers noted that reimbursement rates were lower for substance abuse services than for mental health: “The Department pays \$48 for a substance-abuse session but \$74 for a mental health session. There’s no reason for this disparity, and sometimes it drives agencies to game the system,” staff at one agency said. It was noted that, while many mental health consumers are Medicaid-eligible, many substance abuse clients are not, and that this issue needs to be addressed if integrated services are to be provided and funded. The Integrated Systems Initiative (ISI) Financial Subcommittee recommended that an enhanced Medicaid rate specifically for co-occurring treatment services should be developed, reflecting the additional cost involved in assessment and treatment for both mental health and substance abuse. (See Chapter VII for additional information about services for persons with co-occurring disorders.)

Data

In the initial section of this chapter, we presented an overview of existing resources. In many cases, we were able to identify the actual funding for mental health and substance abuse services. However, there are other circumstances where the information is either incomplete or missing. ODMHSAS needs mechanisms to allow it to identify all of the resources within Oklahoma that support mental health and substance abuse services and to track access and quality of services.