



Other State Behavioral Health Systems

Virginia SJ47 Joint Subcommittee
Presentation

August 7, 2018

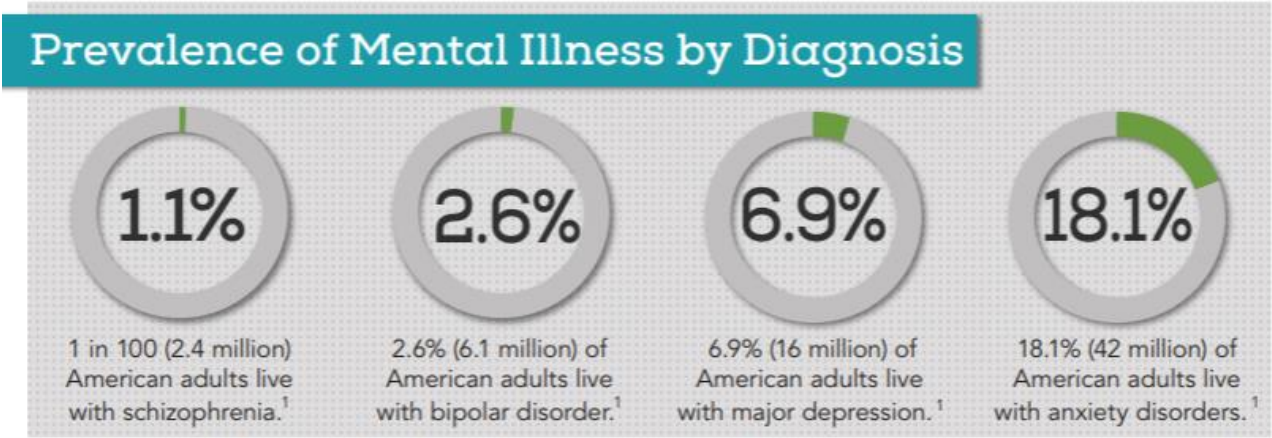
Agenda

- ✓ Persisting Issues in Mental Health
- ✓ Key Structural Variables
 - ✓ Proximity to Governor
 - ✓ Location in State Government
 - ✓ State vs. County-Based Systems
 - ✓ Medicaid Relationship
 - ✓ State Hospital Authority
 - ✓ Other Service Populations
- ✓ Recent Reforms in Other States
- ✓ Payment Models



Persisting Issues in Mental Health


Data on Behavioral Health in the US (adults)




This slide cites statistics provided by the National Institute of Mental Health. www.nimh.nih.gov, the Substance Abuse and Mental Health Services Administration, New Evidence Regarding Racial and Ethnic Disparities in Mental Health and Injustice at every Turn: A Report of the National Transgender Discrimination Survey.

Data on Behavioral Health in the US (adults)


Consequences



10.2m
Approximately 10.2 million adults have **co-occurring** mental health and addiction disorders.¹



26%
Approximately 26% of **homeless** adults staying in shelters live with serious mental illness.¹



24%
Approximately 24% of **state prisoners** have "a recent history of a mental health condition".²

Impact



1st
Depression is the leading cause of disability worldwide, and is a major contributor to the global burden of disease.¹




-\$193b
Serious mental illness costs America \$193.2 billion in lost earning every year.³




90%
90% of those who die by suicide have an underlying mental illness. Suicide is the 10th leading cause of death in the U.S.³


Treatment in America



60%
Nearly 60% of adults with a mental illness didn't receive mental health services in the previous year.⁴



50%
Nearly 50% of youth aged 8-15 didn't receive mental health services in the previous year.¹



African American & Hispanic Americans used mental health services at about 1/2 the rate of whites in the past year and Asian Americans at about 1/3 the rate.¹

This slide cites statistics provided by the National Institute of Mental Health. www.nimh.nih.gov, the Substance Abuse and Mental Health Services Administration, New Evidence Regarding Racial and Ethnic Disparities in Mental Health and Injustice at every Turn: A Report of the National Transgender Discrimination Survey.

Health and Social Impacts

- Mood disorders, including major depression, dysthymic disorder and bipolar disorder, are the third most common cause of hospitalization in the U.S. for both youth and adults aged 18–44.
- Mental illness is associated with increased occurrence of chronic diseases such as cardiovascular disease, diabetes, obesity, asthma, epilepsy and cancer.
- Mental illness is associated with lower use of medical care, reduced adherence to treatment therapies for chronic diseases and higher risks of adverse health outcomes.
- More than 90% of children who die by suicide have a mental health condition.
- Individuals living with serious mental illness face an increased risk of having chronic medical conditions. Adults in the U.S. living with serious mental illness die on average 25 years earlier than others, largely due to treatable medical conditions.
- Serious mental illness costs America \$193.2 billion in lost earnings per year.
- Approximately 20% of state prisoners and 21% of local jail prisoners have “a recent history” of a mental health condition.
- 70% of youth in juvenile justice systems have at least one mental health condition and at least 20% live with a serious mental illness.
- African Americans and Hispanic Americans each use mental health services at about half the rate of Caucasian Americans and Asian Americans at about one-third the rate.

<https://www.nami.org/learn-more/mental-health-by-the-numbers>
<http://www.apa.org/helpcenter/data-behavioral-health.aspx>

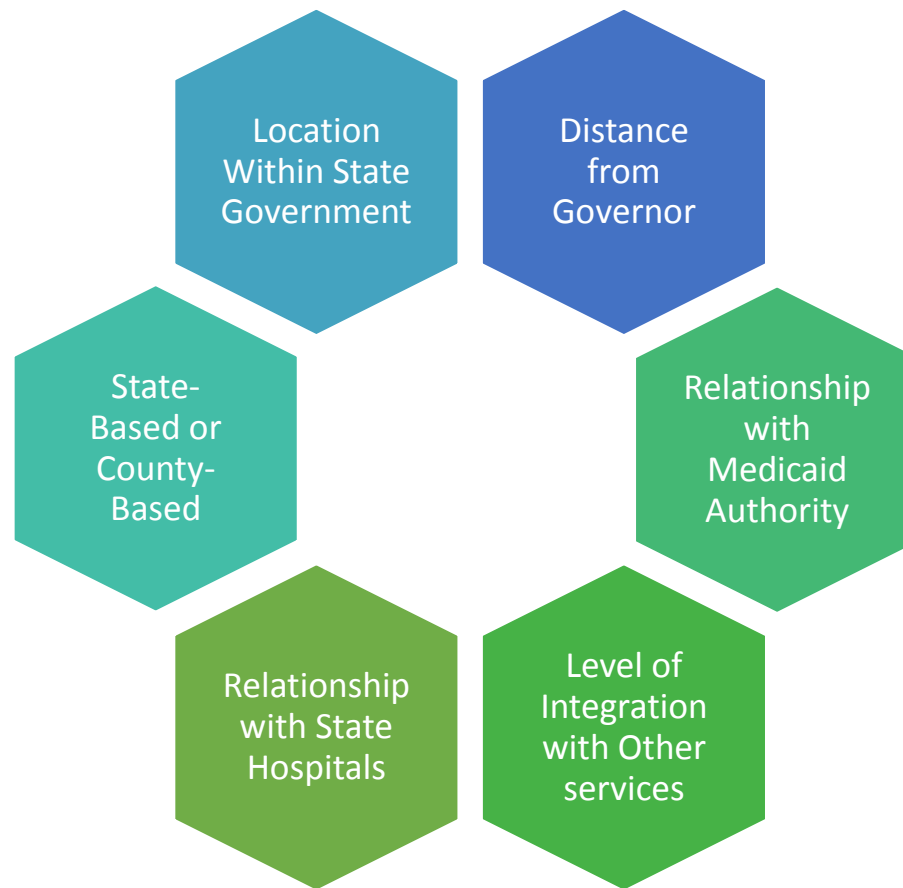
Key Variables in Structuring and Financing Behavioral Health

Overview of the Structure of Behavioral Health Care Service Systems Nationwide

- Behavioral health delivery systems involve a complex combination of public and private financing as well as public and private practitioners of care.
- Public-sector services are financed through a variety of local, state, and federal appropriations as well as Medicaid and Medicare coverage.
- Private systems of care have different structures but coexist and often overlap with public-sector services.
- While the majority of public sector services are delivered by states, federally supported service systems developed by the Department of Defense and the Department of Veterans Affairs share characteristics of both the private- and public-sector systems of care.

Factors to Consider When Evaluating State Mental Health Agencies (SMHAs)

From state to state, the costs and outcomes of behavioral health services vary considerably. A number of “key variables” contribute to this variability.



Agency Reporting Structures: Overview

- All behavioral health agencies are led by an official who plays a critical role in providing leadership and serving as an intermediary between the state and the agency staff, and the public.
- Leaders of SMHAs that are not a part of a larger umbrella often report directly to the governor.
- Others report to the leader of the umbrella agency, such as the secretary of health and human services.
- The number of organizational layers between an agency's leader and the state's governor influences the expenditures.
- The closer the proximity to the governor, the greater the spending per capita.

Reporting Structure and Spending Patterns

Analysis of state variation in mental health spending illustrates how bureaucratic structure influences financing. As in other areas of government, spending reflects different balances of autonomy and accountability.

- SMHAs that are independent departments within the state government spend more per capita (\$132.02) than those SMHAs that are under an umbrella agency (\$113.03).
- SMHAs with one level between the commissioner and the governor spend significantly more per capita (\$158.07) than those SMHAs whose commissioners report directly to the governor (\$107.89).
- SMHAs that operate county or city-based systems have the highest per-capita expenditures (\$147.92) compared to those that operate (\$89.41) or fund (\$103.14) community-based services.
- SMHAs that fund services through exclusive fee-for-service payment models spend the most per capita (\$153.27), compared to those that exclusive use managed care (\$135.02), and those using a combination of fee-for-service and managed care approach (\$114.87).

Proximity to Governor

The table below shows the different ways that states have chosen to structure their agencies' reporting structure to the governor. Some agencies work in close proximity to the governor, and others in far remove.

Proximity to Governor	Number of States
Reports Directly to Governor	7
Reports through 1 Intermediary	23
2 Intermediaries	16
3 or More Intermediaries	2
Unknown/Not Reporting	3

- Virginia's state agency reports to the governor through a single intermediary, which is typical of other states.

Agency Structure of SMHAs

The structure of a behavioral health agency refers to the placement of the agency within the state's larger department or organizational structure.

- SMHAs are either independent agencies or a unit of a larger agency, often referred to as an umbrella agency or a super-agency.
 - Examples of umbrella and super-agencies include: Department of Health, Department of Human Services, and Department of Public Health.
- Agencies that are located within another large agency often reside along other programs such as Medicaid and Medicare, Public Assistance, and Public Health services.
- The way a SMHA is organized within the state government influences how much it spends per capita.
- Independent SMHAs within the state government spend more per capita than those under an umbrella agency.

Agency Location

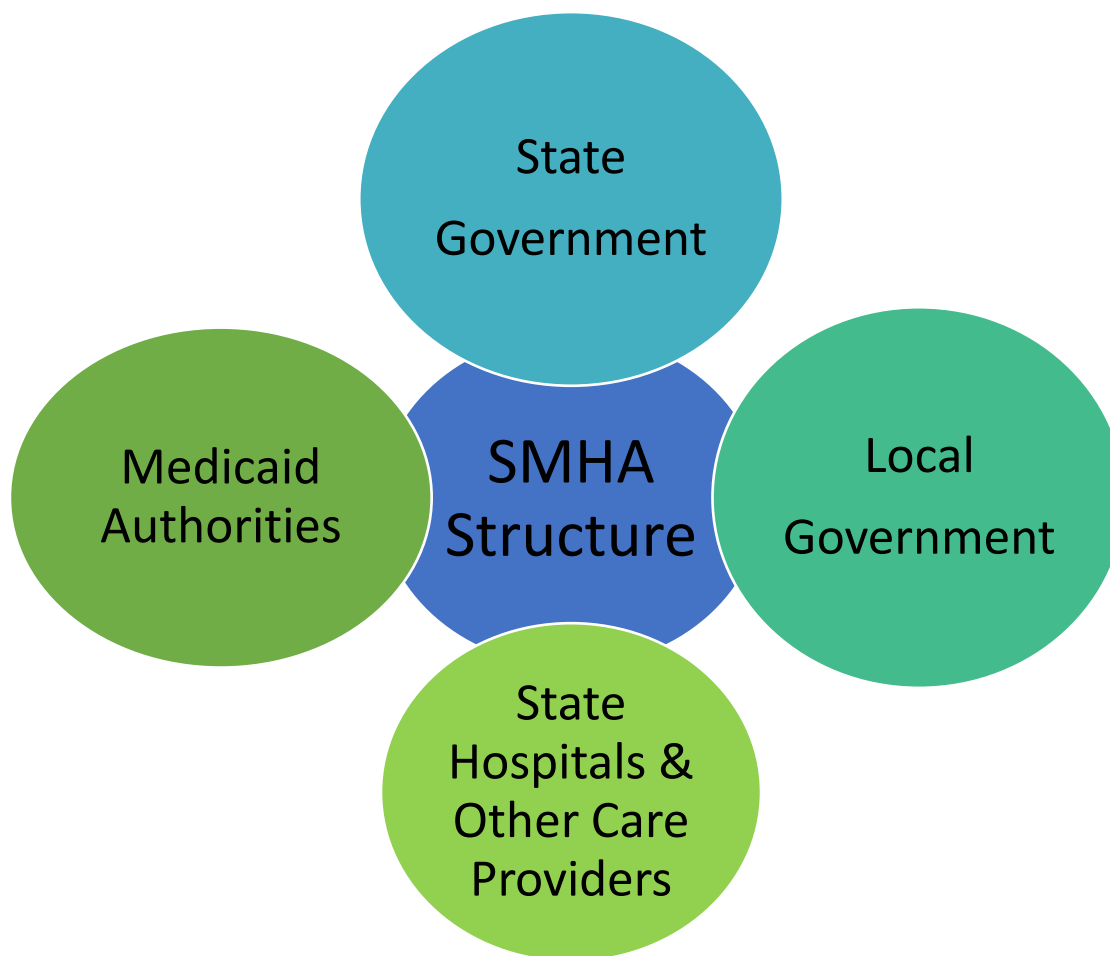
States have several choices about where the SMHA should sit within state government. Most tend to establish the SMHA as a state agency or place it under a human services department.

Agency Location	Number of States
Independent Agency	13
Under Health Department	8
Under Human/Social Services	20
Under Combined HHS	7
Aging and Disability Services	1
Unknown/Not Reporting	2

- Virginia's DBHDS is an independent agency.
- A number of states in recent years have chosen to relocate their SMHAs from human services to their health departments.

NRI State Mental Health Agency Profiling System: 2015.

The structure of a SMHA has wide-ranging implications on its relationships with:



State-Based vs. County-Based

The three primary methods of organization and funding of community mental health services by SMHAs are:

State-Operated

State is the direct service provider for community services

- SMHA-operated community mental health services tend to rely more on state general funds, and less on Medicaid and other reimbursement for services.
- This model tends to have the highest administrative costs due to SMHAs having to pay directly for all aspects of service administration.

Locally-Operated

County/City is the direct service provider for community services

- SMHA role in community services limited to funding, oversight, and limited coordination.
- This model tends to have the highest per capita expenditure overall

State-Contracted

Private organizations are the direct community service provider

- SMHA directly funds community service providers to deliver services.
- This model has the second highest per capita expenditure on average out of the three

State-Based vs. County-Based

Identifying the differences and implications of being a state-based agency versus a county-based agency is critical to understanding the behavioral health agency's roles, responsibilities, and authorities across levels of government for services provided within the community.

- State-based behavioral health agencies provide consistent standards of service provision and management across the state.
- States with county-based behavioral health systems often have to contend with internally fragmented standards and service provisions, disparities in health outcomes and access to care in different parts of the state, and less-efficient coordination of care, making any state-wide transformation a difficult undertaking.
- States with county-based behavioral health systems are better able to leverage local health care dollars and more overall funding available. Many large states rely on county-based system for funding and administrative reasons.
- Both state-based and county-based entities contract with providers as well as operate their own facilities.

State-Based vs. County-Based

State choices tend to reflect wider relationships between state and local governments, and are highly influenced by state geographical and population sizes.

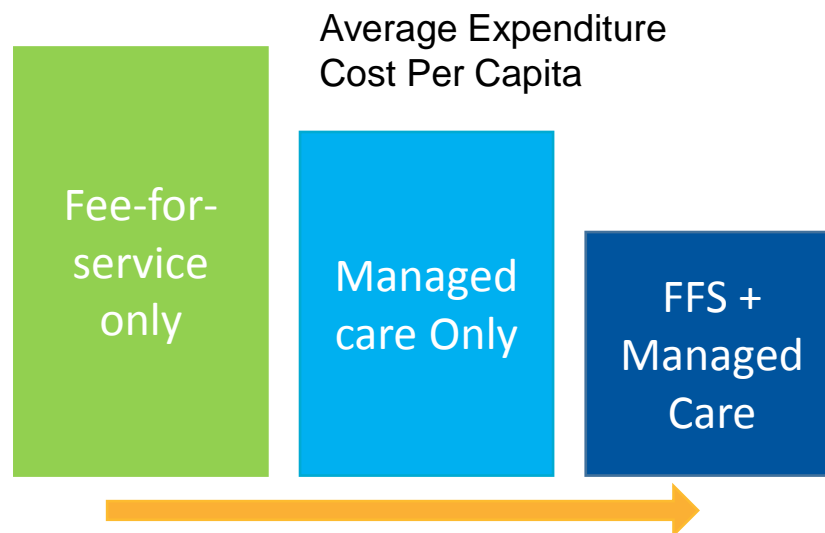
Direct Service Provider	Number of States
State-Operated	5
Locally-Operated	14
State-Contracted	32

- Virginia's Community Service Boards are an example of a county- or locally-based system.
- A few states, such as South Carolina, continue to operate community services directly through their state agency.
- Most of the nation's largest states feature locally-operated services, including New York, California, Texas, Pennsylvania, and Ohio.

NRI State Mental Health Agency Profiling System: 2015.

Relationship with Medicaid Authority

- SMHAs are sometimes responsible for setting rates for mental health services and administering Medicaid benefits for mental health, but this depends on how the agency is situated in relation to the Medicaid authority.
- In some cases, state Medicaid programs delegate oversight to their SMHAs, which retain authority to set Medicaid rates and define behavioral health regulations.
- The extent of the relationship between SMHAs and the state's Medicaid Authority directly affects expenditure.
- The three most common Medicaid mental health services funding structures are:



Relationship with Medicaid Authority

State choices tend to reflect wider relationships between state and local governments, and are highly influenced by state geographical and population sizes.

Relation to Medicaid	Number of States
Located in different department	21
Located under same umbrella dept.	28
Located within Medicaid agency	1
Unknown/Not Reporting	1

- Virginia's DBHDS is separate from DMAS, the Commonwealth's Medicaid authority.
- States with close organizational relationships between the SMHA and Medicaid authority are usually better equipped to coordinate Medicaid-financed community services with the rest of the system.

NRI State Mental Health Agency Profiling System: 2015.

Relationship with Medicaid Authority

Because Medicaid funds so much of the safety net, policy expertise needed for oversight and administration often lies in other departments. Within Medicaid, states have the option to centralize or de-centralize oversight of the program among multiple agencies

Medicaid Policy Authority	Number of States
Yes	16
No	29
Unknown/Not Reporting	5

- In Virginia, authority over Medicaid behavioral health services is retained by DMAS. DBHDS does not set Medicaid rates, write Medicaid policy, or oversee Medicaid contracts.
- States that centralize Medicaid authority tend to do so both for reasons of cost-containment and consistency and standardization of regulation.

NRI State Mental Health Agency Profiling System: 2015.

Authority Over State Hospitals

- SMHAs typically have their origin in the operation of state mental hospitals. Most SMHAs have kept this core function: operating and overseeing a state's system of institutional mental health care.
- Most variability in the functions of an SMHA can be found in their relationship to community services. Depending on the state's political and economic climate, states will play a more or less substantial role in funding comprehensive behavioral health services.
- SMHAs also play varying roles in coordinating transitions between the state's institutional and community mental health systems. Responsibilities for transition are typically a three-way coordination effort among community providers, the state hospitals themselves, and a "central office" that manages utilization statewide.
- There does not appear to be any dominant, or best-practice solution to decide how different stakeholders are to be accountable for hospital admissions and discharges. However, there is general consensus that the state maintains control over admissions, and community providers should have 'skin in the game' over discharges.

Authority over State Hospitals

A few small states do not operate a state hospital, but contract beds with private providers or neighboring state hospitals. In most cases in which states operate their own hospitals, the SMHA is tasked with responsibility for operation, funding, and administration.

State Hospital Authority	Number of States
Yes	55
No	6

- Virginia, like most states, serves as the direct service provider for most of the psychiatric beds in the state.
- In states where the SMHA does not oversee the state hospitals, authority is typically centralized in an agency, such as the state health department, that oversees regulation and administration of medical hospitals.

Other Service Populations

State choices tend to reflect wider relationships between state and local governments, and are highly influenced by state geographical and population sizes.

Authority over Other Populations	SUD	I/DD
Located in different department	4	14
Located under same umbrella dept.	11	25
Single state agency	35	11
Unknown/Not Reporting	1	1

- Virginia is one of 10 states that consolidates MH, SUD, and I/DD services under a single agency.
- Nearly all states have consolidated their MH and I/DD authorities have also integrated MH and SUD into a unified “behavioral health” authority.

NRI State Mental Health Agency Profiling System: 2015.

Recent Structural Reforms in Other States

Today's landscape of organizational reform is varied, and moving in opposite directions, depending on the needs of the state

- **INTEGRATION:** states consolidating or transferring behavioral health authorities to improve coordination of physical and behavioral health.
 - **Texas:** recently consolidated most of its safety net agencies under its Health and Human Services Commission to form a super-agency. (2017)
 - **New Jersey:** failed attempt to transfer mental health authority to the Department of Health to promote health integration. (2018)
 - **Washington:** behavioral health authority relocated from human services department to the state's Medicaid agency. (2018)

Recent Structural Reforms in Other States

Today's landscape of organizational reform is varied, and moving in opposite directions, depending on the needs of the state

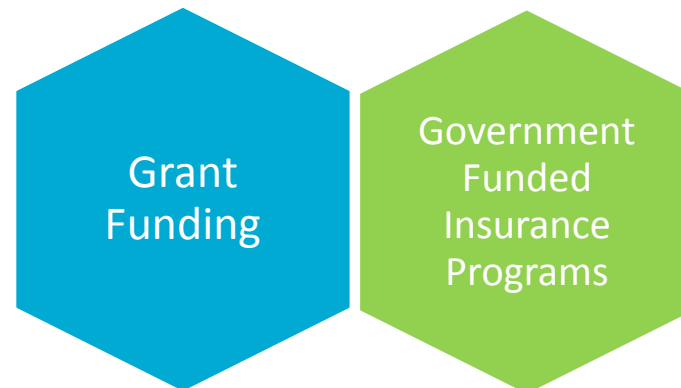
- **REGIONALIZATION:** states with county- and locally-based systems adopting regional organizational approaches to overcome disparities in service delivery.
 - **Iowa:** consolidated its county-based systems into a regional system of funding and resource-sharing. (2014)
 - **Wisconsin:** recently completed a number of pilots to determine whether a regional approach is feasible for its county-based system. (2013-17)
- **LOCALIZATION:** states devolving SMHA responsibilities for community services to Medicaid authority and county-based administration.
 - **California:** returned to its county-based system after years of enhanced state authority; SMHA restricted to state hospital administration. (2012)

Payment Models

Public Sector Funding Structure in Behavioral Health

For mental health, the majority of funding comes from the government from various sources serving a vast array of populations. This funding comes from a combination of federal, state, and local dollars.

- Federal funding is divided among federally funded insurance programs, funding for specific populations, and funding for substance abuse disorders.
- State/local funding comes through systems related agencies as well as state contributions to Medicaid and State Children's Health Insurance Programs (SCHIP).
- Direct federal funding for mental health services can be broken down into two major categories:



Grant Funding: Federal Block Grants

Federal block grant dollars, based on an approved state plan, flow from the federal government to the state to counties and other jurisdictions. The funding allocated to various projects is based on the county's priorities, but must be consistent with the state plan. Federal funding typically requires a local matching contribution.

- The state plan addresses administrative infrastructure requirements and identifies services that are available to eligible individuals within the state.
- The federal government reviews the state plan and approves the proposed coverage by the state.
- Once the funds are distributed, in accordance with the state plan, the state distributes the funds to counties, local communities, or other defined jurisdictions.
- In instances where the use of federal dollars is not permissible and excluded from the state plan, the state may submit a Medicaid waiver request to the federal government.

Medicaid Waivers

Specific Medicaid eligibility criteria, administrative features, and service options may be waived under a federal process called a Medicaid Waiver. This allows states to access federal money for approved uses that are innovative and non-traditional in nature

- States often seek waivers as a way to develop a more flexible and comprehensive service system that would not otherwise be permissible.
- Waivers, unlike block grants, do not involve a transfer of funds from the federal government to the states.
- Nevertheless, they need to be understood as part of an overall state funding strategy because the involved services become subject to partial or full federal reimbursement under Medicaid.

Three Primary Types of Waivers

1115: Research & Demonstration Project Waivers

- For experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and Children's Health Insurance Programs (CHIP).
- Gives states additional flexibility to design and improve their programs

1915(b): Managed Care Waivers

- Help provide services through managed care systems that would otherwise be limited by choice of approved providers
- Can allow a county or local government to act as a broker to help people in Medicaid select a managed care plan

1915(c)/(i): Home & Community Based Service Waivers

- Provide long-term care for in-home or in-community settings.
- Purpose is to avoid or minimize utilization within institutional settings.

Use of Medicaid Waiver Authorities

Most states have taken advantage of some form of Medicaid waiver authority.

Waiver Authority	Number of States
BH operates under 1115	17
BH operates under 1915(b)	14
BH operates under 1915(c)	13
BH operates under 1915(i)	15

Federally Funded Insurance Program: Medicaid

Medicaid is jointly funded by federal and state dollars. Each state determines how to manage Medicaid for its constituents.

- Eligible members are now entitled to medically necessary services, including mental health care. This has contributed to the growth of many states' behavioral health systems.
- With federal funding, the Medicaid program is the largest funding stream which provides financial support for mental health services.
- Both public and private providers can provide behavioral health services under Medicaid.
- In some states, local jurisdictions (counties) may be required to cover a small percentage of the Medicaid cost.
- The two main payment models under Medicaid are:



Major Payment Models

Most states have taken advantage of some form of Medicaid waiver authority.

Waiver Authority	Number of States
FFS only	13
Managed Care only	4
Combination	31
Other/Not Reporting	3

- Like most states, Virginia's behavioral health system represents a combination of fee-for-service and managed care payment models.
- System-wide performance-based payment models are still in their infancy in behavioral health.

NRI State Mental Health Agency Profiling System: 2015.

Questions?



www.publicconsultinggroup.com