

# Mental Health Governance: A Review of State Models & Guide for Nevada Decision Makers

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Nevada Behavioral Health and  
Wellness Council



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# Why look at Nevada's Mental Health Governance Structure?

- Highly centralized
- Limited local input
- Some stakeholders assert quality could be improved with more local control & input
- We can learn lessons from how other states have decentralized services



# Overview

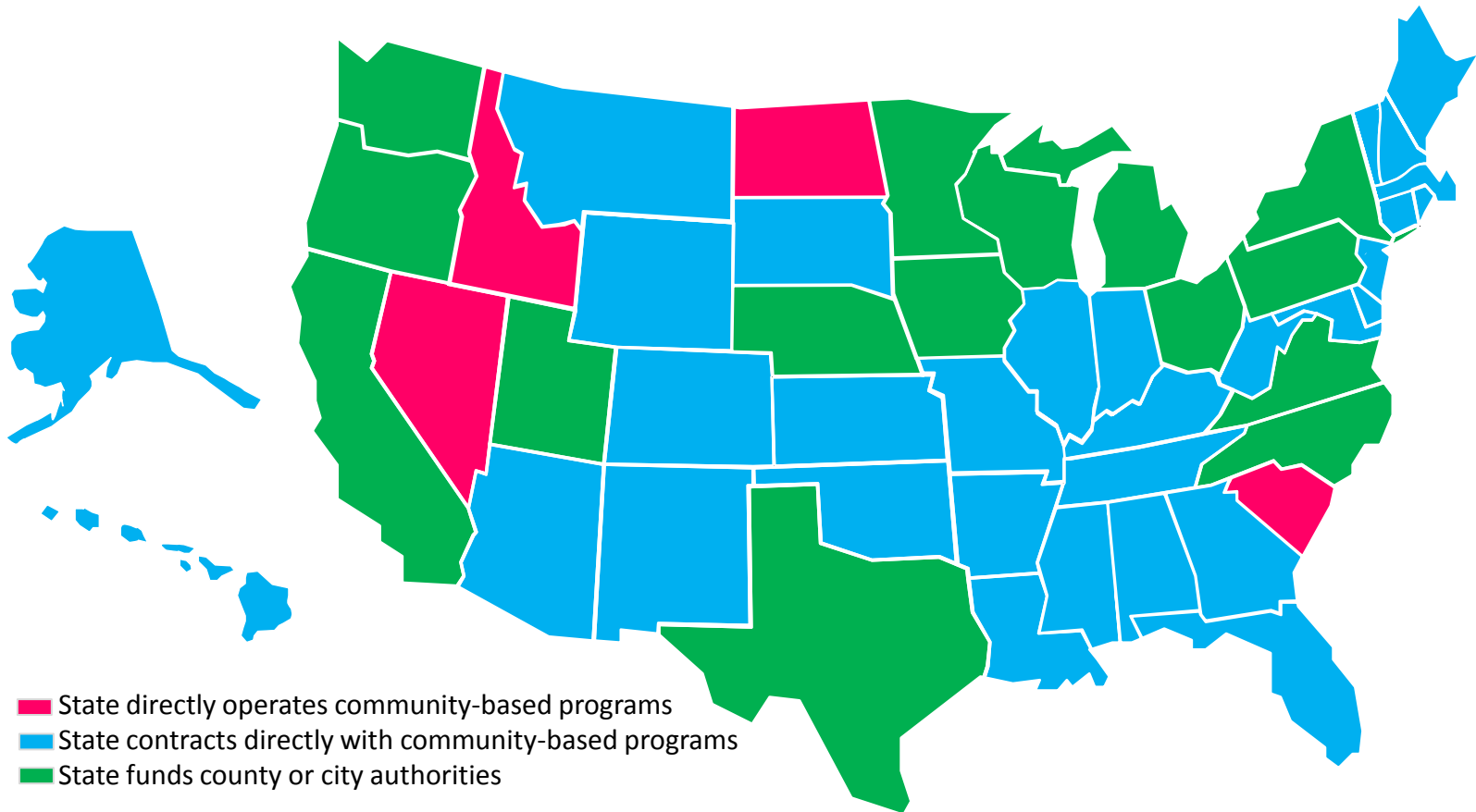
**Mental health governance models**

**Guiding Principles for Quality Governance Structure**

**Governance Models in 7 States**

**Key Decision Points**

# Mental Health Governance Models

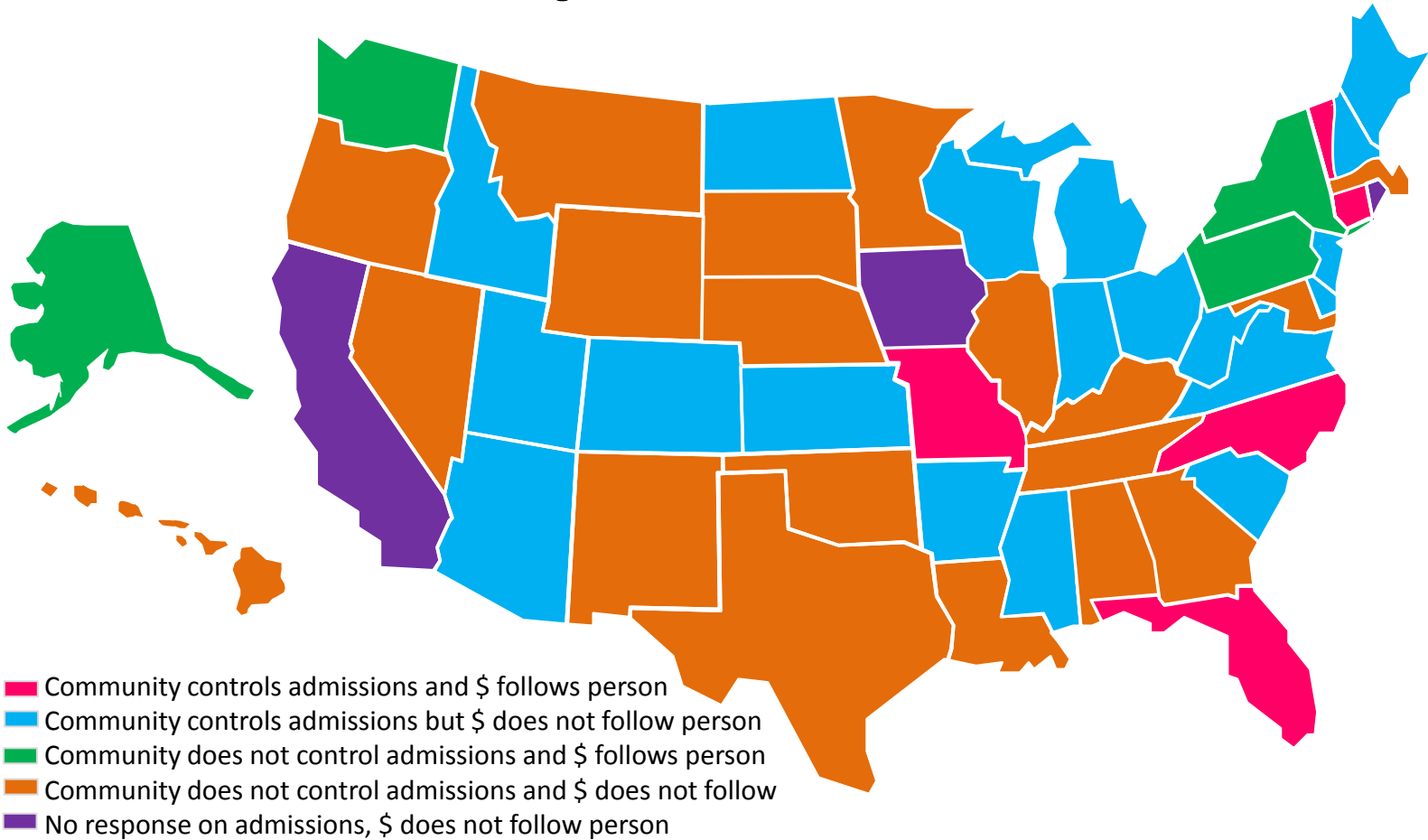


- State directly operates community-based programs
- State contracts directly with community-based programs
- State funds county or city authorities

# Guiding Principles



# Hospital Incentives



# State Case Studies

- Seven state governance models reviewed
  - ✓ Overall structure for behavioral and physical health
  - ✓ Structure of governing boards
  - ✓ Coordination across agencies
  - ✓ Local funding for behavioral health
  - ✓ Incentives and evaluation
  - ✓ Information technology

# Arizona

- State control model
- Regional Behavioral Health Authorities
  - ✓ Private entities
  - ✓ Administer all funds through managed care
- Transitioning from 6 to 3 regions
- Moving to partial integrated care for physical and mental health
  - ✓ Only for adults with Severe Mental Illness
  - ✓ Physical health will continue to be separate for all other clients



# Missouri

- State control model
- 25 Mental Health Service Areas
  - ✓ Run by nonprofit Administrative Agents
  - ✓ Fee for service
- Physical health separate from behavioral health
- Local taxes for mental health
- Hospital incentive

# North Carolina

- Local control model
- 9 Local Management Entities- Managed Care Organizations (LME-MCOs) for behavioral health
  - ✓ Public entities formed by counties
  - ✓ Managed care
- Transitioning to 4 regions
- Physical health transitioning to provider-led Accountable Care Organizations
  - ✓ Will require agreement with LME-MCOs for integrated care

# Ohio

- Local control model
- 53 Community Mental Health Boards
  - ✓ Public entities formed by counties
  - ✓ Fee for service
- Physical health separate
  - ✓ Provide some mental health services
- Using funds freed up by Medicaid expansion for supportive housing services
- Hospital incentive program discontinued

# Oregon

- State/local control model
- Physical, behavioral, and dental health fully integrated into 16 Coordinated Care Organizations
  - ✓ Private entities with public and private partners
  - ✓ Providers and counties serve on governing boards
- One “global budget” for all Medicaid services
  - ✓ Counties continue to provide non-Medicaid services separately
- Financial incentives to produce positive outcomes

# Virginia

- Local Control Model
- Magellan serves as Behavioral Health Administrator
- Behavioral health services provided by
  - ✓ 40 Community Services Boards (30%)
  - ✓ Private providers (70%)
- Physical health separate
- Governor's Action Plan (GAP) will provide physical and mental health services in lieu of Medicaid expansion

# Washington

- Local control model transitioning to state control
- Current
  - ✓ 11 Regional Support Networks currently provide mental health through managed care (public entities)
  - ✓ Chemical dependency contracts separate
  - ✓ Physical health separate
- Future
  - ✓ Reducing number of regions to 10
  - ✓ By 2016, Behavioral Health Organizations will integrate mental health and chemical dependency
  - ✓ By 2020, physical and behavioral health will be integrated
  - ✓ Future role of counties uncertain

# Key Findings from Other States

- Affordable Care Act having big impact
- Integration of physical and behavioral healthcare becoming a major issue
- Amount of local control varies
- Various models for governing board structure
- Regions getting larger to absorb risk
- Local funding often leads to disparities
- Success varies with hospital incentives and performance based contracts

# Decision Points: Overall Structure

1. Role of state in community mental health?
2. Provide services regionally?
3. Type of entity that should manage services?
4. Human resources implications for state workers?
5. Do a pilot project first?
6. How should physical and mental health be integrated?



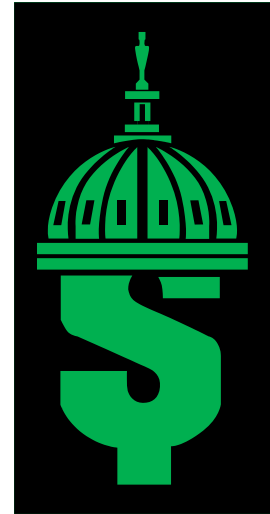
# Decision Points: Governing Board Structure

7. How should governing boards be organized?
8. Appropriate role for providers on governing boards?



# Decision Points: Funding

9. What funding sources should be included?
10. Should there be a local match?
11. How should Medicaid-funded services be administered?
12. What funding is available to transition to a new governance structure



# Decision Points: Outcomes and Information Technology

13. How can the state create incentives to achieve positive outcomes?

14. How can supportive housing needs be met?

15. What information technology changes are needed?



# Next Steps for Nevada

- Consider adopting guiding principles for a quality mental health governance system
- Consider lessons learned from other states
- Use decision points to help guide the process and create high quality contracts

***Policy and structure are important but leadership will be the key to implementation***

# Questions?

## About the Kenny C. Guinn Center for Policy Priorities

The Kenny C. Guinn Center for Policy Priorities (Guinn Center) is a 501(c)(3) nonprofit, bipartisan, think-do tank focused on independent, fact-based, relevant, and well-reasoned analysis of critical policy issues facing the state of Nevada. The Guinn Center engages policy-makers, experts, and the public with innovative, fact-based research, ideas, and analysis to advance policy solutions, inform the public debate, and expand public engagement.

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