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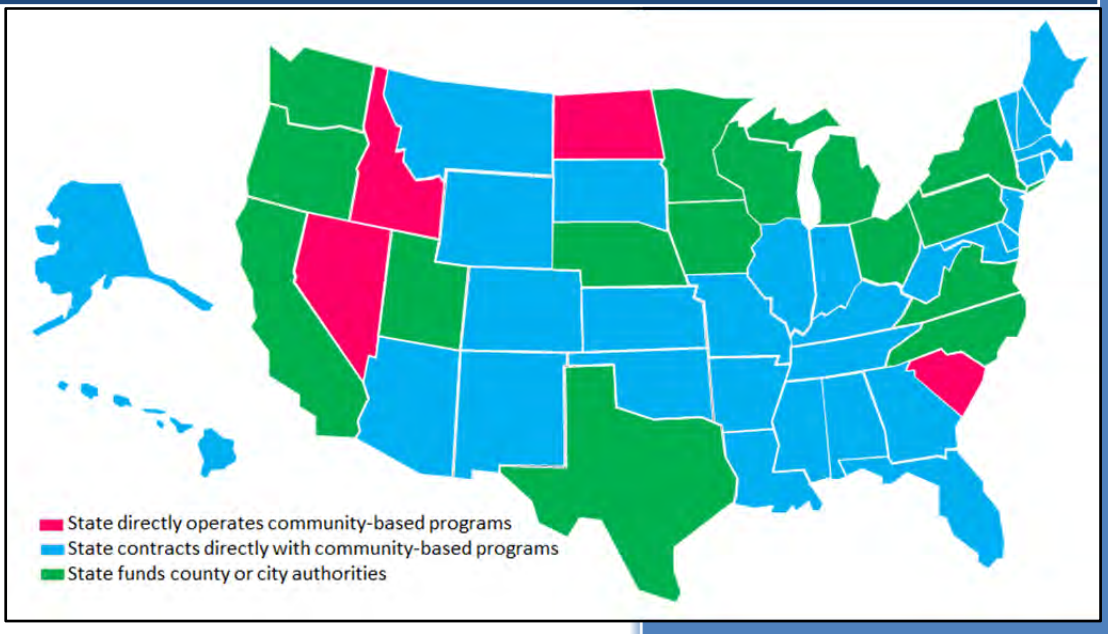
For Policy Priorities

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



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Executive Summary

Nevada faces great challenges in its behavioral health system and is exploring how to move from a governance system that is centrally controlled by the state to one that provides more local input and is responsive to community needs. This report reviews governance models throughout the United States and looks in depth at seven states: Arizona, Missouri, North Carolina, Ohio, Oregon, Virginia, and Washington. This analysis provides insight into how other states have addressed similar challenges and which strategies have been more successful than others.

While Nevada's mental health system is unique on many fronts, this review shows that the Silver State is not alone in reexamining its governance structure. Other states are also looking at how to restructure their mental health systems to integrate physical and behavioral health, address rising costs, and adapt to Medicaid changes arising out of the Affordable Care Act.

Nevada decision makers should follow four guiding principles in redesigning the governance structure of the mental health system:

1. Provide the best care at the lowest cost;
2. Encourage savings across programs and agencies;
3. Ensure that money follows the client from the hospital to community; and
4. Hold providers accountable for positive outcomes.

Nevada will also need to consider several key decision points as it develops a new governance system. These decisions can be grouped into several categories: overall structure, governing board structure, funding, and outcomes/information technology.

Overall Structure

1. What should be the role of the state in community mental health? Decision makers will need to determine if the state should transition from a provider role to an oversight role. If responsibility for services is given to local providers, the state will need to decide how to maintain standardization, consistency, and accountability.
2. Should Nevada be divided into regions to provide services? Regions need to be small enough to be responsive to local needs but large enough to run a fiscally viable behavioral health program.
3. What type of entity should manage services? Nevada will need to decide whether to devolve authority to local governments or private providers (nonprofit or for-profit).
4. What are the human resources implications of changing the entity providing services? The state will need to address personnel issues for state staff wishing to transfer to the new entities providing services, including salary levels, retirement credit, sick time, and vacation time.
5. Should there be a pilot project before moving to the whole state? Implementing a pilot project may help work out all the elements that should be included in a contract before statewide implementation.
6. How should physical and behavioral health services be integrated? To address healthcare needs holistically, the state will need to develop a system that integrates behavioral health and physical healthcare while ensuring that behavioral health needs are adequately addressed.

Governing Board Structure

7. How should governing boards be organized to facilitate coordination across agencies? The state will need to decide whether to have regional governing boards, whether the boards should have operating authority or advisory authority, what types of people should be on boards, how to address rural areas, and whether there should be local advisory councils.
8. What is the appropriate role for providers on governing boards? To avoid potential conflicts of interest, the state should consider creating an advisory role for providers.

Funding

9. What funding sources should be part of the system? Decision makers will need to determine whether the new system should be solely focused on Medicaid or whether it should also include state General Funds and grant funding.
10. Should there be a local match? A local match requirement can lead to more locally responsive services. The state will need to determine how a local match should be funded, either from existing funds or a new required or optional tax approved at the county level.
11. How should Medicaid-funded behavioral health services be administered? The state will need to determine what Medicaid payment model to use, such as fee-for-service, managed care organizations, or accountable care organizations.
12. What funding will be available to transition to a new governance structure? The state should consider what grant funding or federal waivers may be available to help offset the cost of planning and implementing a new governance structure.

Outcomes and Information Technology

13. How can the state create incentives to achieve positive outcomes with the least expensive, most appropriate care? Decision makers will need to determine whether incentives should be structured as rewards or penalties, whether to build formulas and requirements to discourage hospital use, whether to create programs to ensure that funds follow clients after leaving a psychiatric hospital, whether to implement incentives that reward agencies for reducing costs only if they also improve outcomes, how to encourage innovation, and which outcomes to track.
14. How can the behavioral health system provide supportive housing services? The state should consider how it can more effectively coordinate with existing housing authorities and how it can leverage resources to meet housing needs.
15. What information technology changes are needed to implement a new governance system? Moving towards a more decentralized, outcome based behavioral health system will require development of a well-designed information technology system that provides consistent data throughout the state.

Redesigning Nevada's mental health system will take careful planning and foresight. Several states are using a multi-year approach to transition to a new governance structure. In addition, implementation of the Affordable Care Act and Medicaid expansion have generated an era of constant evolution, uncertainty, and opportunity. Nevada will need to design a behavioral health governance system that is robust and flexible enough to adapt to new situations, while emphasizing quality outcomes. Nevada's decision makers can draw from guiding principles and lessons learned from other states to design a system that works for Nevada's unique situation.

Introduction

Improving Nevada's behavioral health system has become a top priority for the Governor, Legislature, and other private and public stakeholders. Several high profile issues have brought increased attention to behavioral health, including the loss of accreditation at the Rawson Neal Psychiatric Hospital in 2013.[1] In addition, insufficient staffing and facilities for behavioral health have resulted in overcrowded emergency rooms.[2] In response to these issues, Governor Brian Sandoval convened the Behavioral Health and Wellness Council in December 2013 to "examine ways of improving and strengthening the systems of support and delivery of services to those living with behavioral health conditions in Nevada."[3]

Nevada is relatively unique in that it uses state staff to directly provide community mental health services. As of 2013, only three other states have a similar governance model: Idaho, North Dakota, and South Carolina.[4] Some stakeholders have asserted that the quality of services could be improved and more tailored to the community by providing more local control and input.

In its May 2014 report, the Nevada Behavioral Health and Wellness Council indicated that redesigning the mental health governance system will be a top priority over the next couple of years.

> *Foremost among the statewide questions that the Council plans to address is the question of governance, control, responsibility, and funding of mental health services in Nevada, especially including aggressive efforts to assure and continuously improve the quality and continuity of care. This is a topic that the Council plans to address comprehensively over the next two years. By looking at systems of governance across the U.S., we hope to be able to design a system that empowers and enables communities to make important decisions about the mental health of their citizens.*[5]

To provide a roadmap for decision making for the Behavioral Health and Wellness Council, Legislature, and Governor, this report provides guiding principles for designing a quality mental health governance model and includes an overview of the types of governance models used by states. It then furnishes a comparative analysis of mental health models in the United States. It concludes with key decision points that Nevada decision makers will need to consider in reforming the governance structure.

Methodology

For this analysis, we reviewed the governance structure of all 50 states and looked in depth at seven states: Arizona, Missouri, North Carolina, Ohio, Oregon, Virginia, and Washington. Given Nevada's unique mental health governance structure, demographic characteristics, and economy, there are not any clearly ideal comparison states. Instead, these states were selected to provide a diversity of perspectives to inform Nevada's decision making process. The selected states provide insight into both state and locally controlled models. Some were selected because they are experimenting with innovative models while others were chosen for their stable structures. In addition, four of these states have expanded Medicaid eligibility (Arizona, Ohio, Oregon, and Washington) while three have not (Missouri, North Carolina, and Virginia).

For the seven states studied in depth, we reviewed state statutes, contracts, websites, and publicly available reports and evaluations. We also interviewed a variety of stakeholders in each state to learn about how well the system has worked in practice and to ask how it could be improved. To gain a diversity of perspectives, we interviewed state representatives, county/region representatives, associations of providers, consumer groups, and law enforcement officials.

Part 1: Overview of Nevada's Mental Health Governance Structure

Overview of System

Nevada's behavioral health system is highly centralized at the state level and local input is fairly limited. The Commission on Behavioral Health oversees the entire system and has the authority to establish policies to ensure adequate development and administration of services for mental illness, substance abuse, and intellectual disabilities [Nevada Revised Statutes (NRS) 433.314]. Mental health services are provided in three regions using state employees while substance abuse services are provided using contract providers.

The administration of services is bifurcated. Adult behavioral health services are provided by the Division of Public and Behavioral Health within the Department of Health and Human Services, while services for children are provided by the Division of Child and Family Services (Clark and Washoe Counties) and the Division of Public and Behavioral Health (rural areas). Services are funded primarily by Medicaid, state General Funds, and Federal grant funds.

Implementation of Medicaid expansion greatly affected behavioral health services. The percentage of behavioral health clients with Medicaid jumped from 27 percent in December 2013 to 77 percent in September 2014.[6] However, the provider network has been inadequate to support this growth. A recent survey performed by the Department of Health and Human Services found that only 25 out of 130 psychiatrists throughout the state indicated they would take adult Medicaid patients. State representatives indicate that there is greater availability of private providers for children's mental health services, but the number of providers is still inadequate.

In Clark and Washoe Counties, all of the adults in the newly eligible population must participate in managed care, which covers both physical and behavioral health. In all other counties, Medicaid services are reimbursed on a fee-for-service basis. The Division of Public and Behavioral Health has become a provider to the managed care organizations and the Division of Child and Family Services is applying to be a provider to address the shortage of mental health professionals. Both divisions also furnish services on a fee-for-service basis under Medicaid.

This structure creates an awkward and conflicted relationship whereby the state is the provider in the managed care structure it created. The state effectively negotiates rates with the managed care organizations twice: once to establish a "per member per month" rate for the overall managed care contract; and a second time to set reimbursement rates as an individual provider. The Division of Child and Family Services also indicates that it cannot bill for the full Medicaid rate when it serves a child who is in a managed care plan, so the Medicaid expansion has had a negative impact on the state's budget.

Structure of Governing Boards and Coordination Across Agencies

While Nevada counties do not currently provide community mental health services, statutes have been in place since 1965 that allow counties or groups of counties to establish community mental health programs using state funds (NRS 433C). Counties that administer services are also required to have a mental health advisory board of 7 to 15 members appointed by their governing bodies (NRS 433C.160). The board must include providers of mental health services, consumers, agencies and occupations involved in mental health, and the general public. There are not currently any mental health advisory boards in place.

In practice, the only mechanism for local input is through the Children's Behavioral Health Consortia. There are three regional consortia: one in Clark County, one in Washoe County, and one in rural Nevada (NRS 433B.333). There is also a statewide Children's Behavioral Health Consortium that coordinates the efforts of the three groups. This group was created administratively and is not required by statute. The consortia are responsible for creating a long-term strategic plan for children's mental health services and an annual list of priorities (NRS 433B.335). Each regional consortium includes representatives from the following categories:

- The Division of Child and Family Services (Clark and Washoe) or the Division of Public and Behavioral Health (rural);
- The agency that provides child welfare services;
- The Division of Health Care Financing and Policy;
- The school board;
- The juvenile probation department;
- The chamber of commerce;
- A private provider of mental healthcare;
- A provider of foster care;
- A parent of a child with an emotional disturbance; and
- An agency that provides substance abuse services.

While these consortia have effectively brought local communities together around children's issues, they are advisory and have no policy or oversight authority. No corresponding structure exists to provide input for adults.

Historically, the siloed nature of behavioral health has made it difficult to coordinate services with other agencies such as law enforcement and county social services. A more collaborative culture has begun to emerge with the advent of groups such as the Behavioral Health and Wellness Council and the Southern Nevada Forum-Healthcare Subcommittee. These entities bring together multi-disciplinary groups to discuss and implement changes that affect both public and private agencies.

Local Funding for Behavioral Health

Local funding is not currently dedicated to behavioral health. However, as part of the Indigent Accident Fund, counties are required to establish a tax rate of one cent on each $100 of assessed valuation of property. These funds (approximately $8 million in 2013) are transferred to the state General Fund to be used as a match for Medicaid (NRS 428.285).

Information Technology

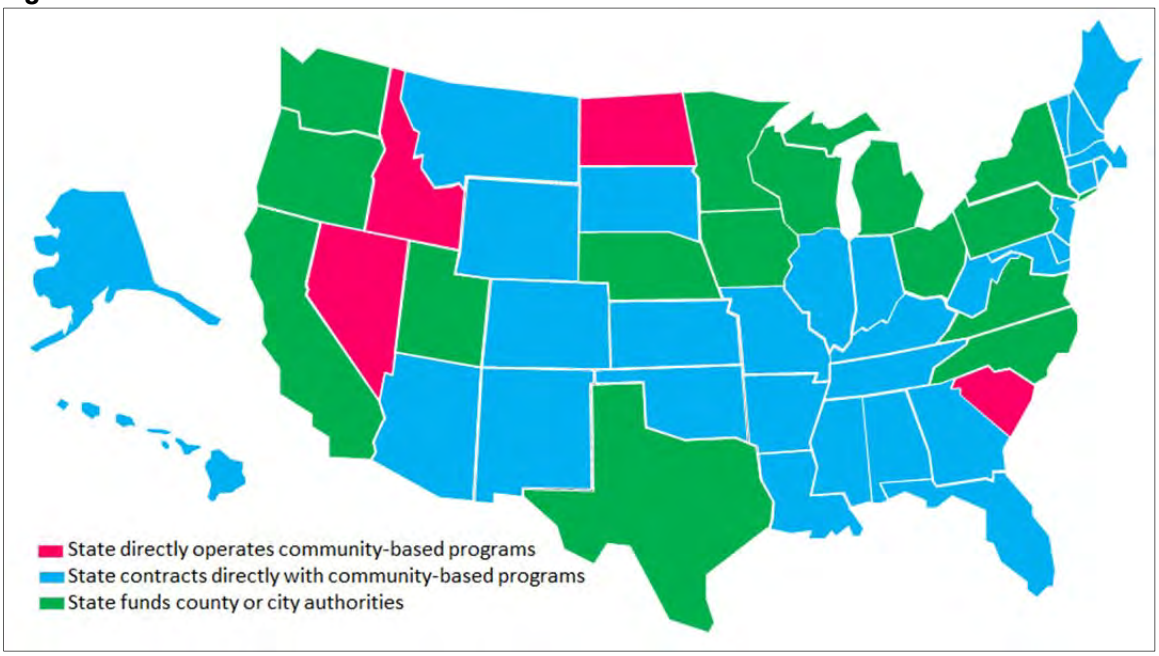
Nevada currently has separate information technology systems in the two divisions that administer behavioral health programs, which creates challenges in compiling and tracking data between the two systems. The existing technology infrastructure also makes it challenging to gather outcome data, which puts the state at a disadvantage when applying for competitive grants.

Part 2: Mental Health Governance Models in the United States

There are currently three major models of mental health governance in the United States (see Figure 1):

- The state directly operates community-based programs (four states)
- The state contracts directly with community-based programs (31 states)
- The state funds county or city authorities to operate community-based programs (15 states)

Figure 1: Mental Health Governance Models: 2013



Source: NRI Analytics Improving Behavioral Health, State Mental Health Agency Profiling System: 2013

Appendix A contains additional information on the characteristics of each state's governance model, including the primary mechanism to provide community-based health services, the extent to which county or city authorities administer mental health services, whether counties come together to form multi-county mental health authorities, whether city or county governments contribute to mental health services, whether local contributions are required by the state, whether a board or council has direct oversight of the state mental health authority, and whether the state is expanding Medicaid.

State Centered Models

While Nevada is one of only four states that directly operate community-based services, most states do not provide a substantial role for local governance. In the majority of cases (31 states), the state contracts with providers. Of these, 20 states provide services on a regional basis. These contractors are private entities with their own governance structures. States have varying levels of control over these boards. In Arizona, the state has requirements for the composition of private agency governing boards while Missouri does not. These states often establish local or regional advisory committees to provide public input. Many local councils place an emphasis on being an avenue for consumer input and require a certain number of consumers or family members to be on the committee.

Local Control Models

In the minority of cases (15 states), the state has devolved authority to local public agencies to directly operate community-based programs or contract out for these services. These states give counties and cities the option to group together on a regional basis. Large urban counties tend to form a single region while smaller, more rural counties tend to group together.

Some of these local entities bill for services on a fee-for-service basis. However, as Medicaid services have evolved, some counties have been asked to serve as managed care organizations, where they receive a capitated per member per month amount for behavioral health services. As this has occurred, regions have become larger geographically to be able to absorb the risk, as in both North Carolina and Washington. A downside to larger regions is that the regions lose their local character and local influence becomes diluted. There is wide variation in the structure, composition, and responsibilities of these local governing bodies as discussed below.

1. **Structure of Boards:** If a single county department is responsible for providing services, the governing body of the county often serves as the governing board, such as King County, Washington. In contrast, the City of Richmond, Virginia created a Behavioral Health Authority, which is separate from the city government. When groups of counties come together to provide services, they often establish a separate public agency that has members appointed by the respective counties.

2. **Composition of Boards:** The boards typically are appointed by local governments, but can also be appointed by state agencies. The composition of the local boards also varies across the nation. Some states, such as North Carolina, Oregon, and Virginia have specific requirements about the types of people who must be on the board while Washington allows regions to define who should sit on the board through interagency agreements.

   Boards typically have a minimum number of consumers and family members. They also often include people with expertise necessary to run a healthcare organization, such as professionals in the areas of mental health, finance, law, and administration. Local elected officials also often serve on boards. Of the states that we reviewed, Virginia is the only one that specifies that law enforcement officials should be on the board. Oregon has a unique board where the county elected officials serve on the same board as the chief executive officers of the risk-bearing managed care organizations.

   Several of the states profiled, including Missouri, Ohio, and Virginia, have conflict of interest provisions that prevent people with a financial interest from sitting on the board, Oregon is a notable exception where the managed care companies serve on the board and are responsible for making financial decisions.

3. **Responsibilities of Boards:** The responsibilities of local governing boards also vary substantially. In most cases, the boards are responsible for appointing a chief executive, approving the budget, and managing funds. In other cases, the board is advisory to the county board, which has ultimate authority. Virginia has four types of local governing boards defined in statute, each with varying levels of authority over the chief executive and contracting.

Guiding Principles for a Quality Governance Structure

As Nevada decision makers consider what should be included in a new governance structure for behavioral health, it is important to establish guiding principles to help frame the overall vision for a quality system. These principles should incentivize providing high quality care that improves people's lives and leads to recovery. The following guiding principles were developed in consultation with Dr. Joel Dvoskin, the Chair of the Nevada Behavioral Health and Wellness Council.

1. **Provide the best care at the lowest cost:** The dual goals of quality care and low costs are often at odds with each other. Providing the best care can be costly. Efforts to provide the best care can result in people receiving more care than needed, or in unnecessarily expensive settings. In many healthcare systems throughout the nation, incentives have been created to reduce costs through "capitated plans" that provide a set amount per member per month. However, these plans can create incentives to discriminate against consumers with the most costly and complicated behavioral health issues. Capitated plans can also reduce reimbursement rates to mental health providers, which creates a disincentive to provide services.

   The best systems incentivize both quality care and low costs by allowing an organization to share a greater percentage of savings if it meets performance outcomes. North Carolina's plan to create Accountable Care Organizations will feature this type of incentive. Programs can also require contractors to reinvest a portion of the incentive savings into additional services.

2. **Encourage savings across programs and agencies:** Behavioral health and related services often are provided in silos. Different agencies oversee the compendium of services necessary to address behavioral health issues, including physical health, law enforcement, housing, and social services. A quality governance structure will create incentives to spend money in one area to reduce costs in another. Entities can accomplish this goal by either establishing collaborative relationships between agencies or by integrating services into one agency.

   An example of agencies collaborating together is occurring in a pilot program in North Carolina where a physical health network is collaborating with a local mental health agency to integrate physical and behavioral healthcare services. Savings in physical health are shared with the local mental health agency to offset increased costs. Other states such as Oregon, have integrated funding for both physical and behavioral health, which provides internal flexibility to spend in one area to achieve savings in another.

3. **Ensure that money follows the client from the hospital to community**: Hospital psychiatric care is the most expensive type of behavioral healthcare that can be provided. States have tried various options to create incentives to reduce hospital care and provide less expensive services in the community. Many states have reduced the number of hospital beds and closed state hospitals. However, a major shortcoming of this approach is that sufficient resources often are not targeted at providing appropriate, less costly care.[7]

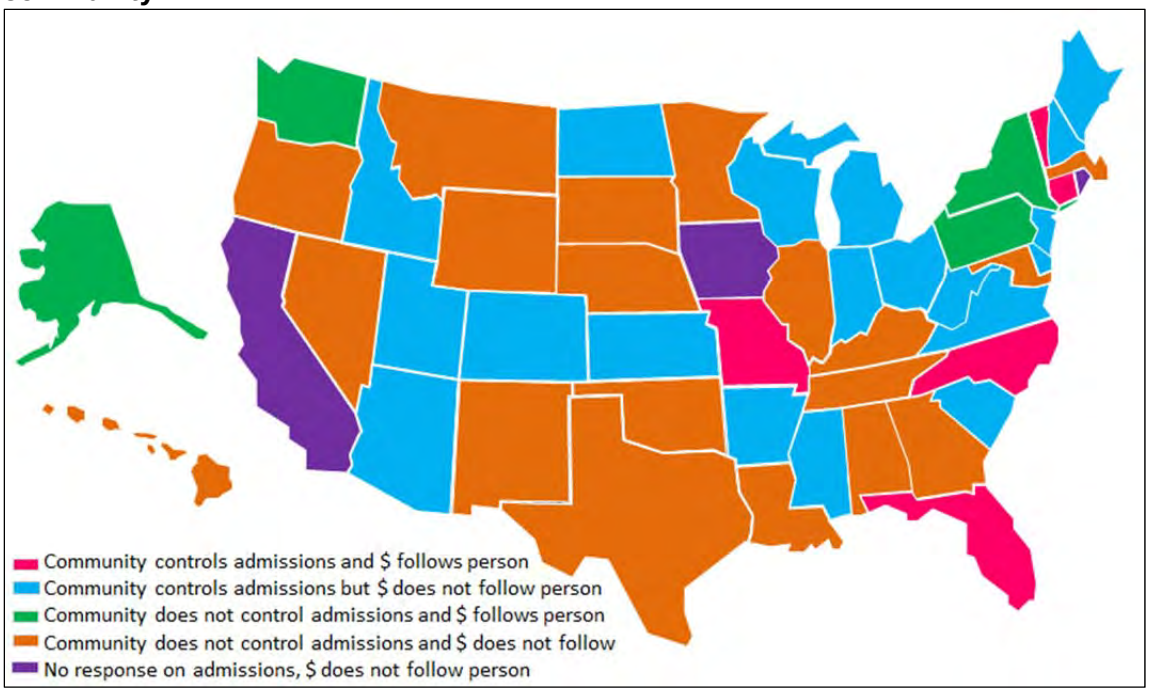
   Programs where money follows the client from the hospital to the community can help address this missing link. Programs targeted at a discrete population often have the most success. For example, Missouri moved 100 voluntary by guardian inpatients to the community and used redirected inpatient state funds for enhanced services and residential supports to ensure the

success of those placements and minimize any risk to public safety. Another example is the Community Hospital Integration Projects Program (CHIPPs) in Pennsylvania, which allows money previously used for state hospital psychiatric treatment to be used for specific persons discharged to the community (see inset box).[8] In addition, Connecticut has achieved success with its Discretionary Discharge Fund, which provides funding to move people from the hospital to the community.[9] A review of the program showed that it reduced hospitalizations and helped the majority of participants maintain or improve functioning (see inset box). In contrast, Ohio and Washington implemented incentive programs that did not effectively control utilization of hospital beds. The Ohio program was discontinued after two years.

Figure 2 illustrates two strategies used by states: (1) allowing a community agency to control hospital admissions; and (2) creating programs where money follows the person from the hospital into the community. Simultaneous use of both strategies can help create a structure that reduces hospital use and encourages more appropriate and less costly care options. However, success of these measures depends on a variety of factors, including the amount of funds available for alternative services, availability of support services, and the ability of community agencies to coordinate with hospitals. This figure shows that:

- Five states employ both strategies;
- 19 states allow a community agency to control admissions but do not have programs where money follows the client;
- Four states do not allow a community agency to control admissions but do have programs where money follows the client; and
- 19 states do not use either strategy.

Figure 2: Control of Hospital Admissions and Provisions for Money ($) to Follow Client to Community



Source: NRI Analytics Improving Behavioral Health, State Mental Health Agency Profiling System: 2013

Money Follows the Client Spotlight

Pennsylvania Community/Hospital Projects Program

Pennsylvania has created the Community/Hospital Integration Projects Program (CHIPPs), which identifies specific people to move from the state hospital to the community. In return for closing out a state hospital bed, the local county mental health agency receives a grant that funds discharge plans, builds a community service system infrastructure, and establishes oversight functions to manage the program.

The goal of the program is to discharge people served in Pennsylvania state hospitals who have extended lengths of stay and/or complex service needs to less restrictive community-based programs and supports. Based on the number of hospital beds targeted for closure, the county and the state hospital create a mutually agreed upon list of individuals and develop a Community Services Plan. A key component of the program is that no person should be discharged if adequate community services are not in place. If a person exits CHIPPs, a new person in the state hospital is selected for the program.

The goal of the program is to provide needed resources for successful community placement of individuals, build local community capacity for services, and prevent unnecessary future hospital admissions. There are several key components to the program:

- Develop a Community Support Plan prior to discharge from the hospital that articulates what services will be provided;
- Provide a case manager or Assertive Community Treatment Team to coordinate care;
- Provide a consumer/family satisfaction team to monitor and evaluate the satisfaction of people receiving CHIPPs-funded services;
- Provide consumer directed services such as drop-in centers and peer mentors;
- Promote and develop integrated supportive housing using CHIPPs funds; and
- Collaborate with the criminal justice system if the participant is arrested.

CHIPPs began in 1991. As of June 30, 2011, 3,007 individuals have been discharged into the community and $260.2 million has been provided to support these discharges. The Pennsylvania Office of Mental Health and Substance Abuse Services reports that 80 percent of the state mental health budget is now spent on community services.

Connecticut Discretionary Discharge Fund

Connecticut has created a Discretionary Discharge Fund, which provides funding to help move adults out of state hospitals into the community. It also assists those at high risk of re-hospitalization. The fund is used to create person-centered re-integration plans, including enhanced community-based treatment and recovery supports. Services are tailored to a client's discharge plan, which can include group home settings, gender specific treatment, and specific environments that are trauma informed.

This program has demonstrated positive outcomes. A study of participants showed that 71 percent needed no hospitalization after 15 months and the overall use of hospital days by participants declined by 69 percent. The study also revealed that 54 percent of participants maintained the same level of functioning after 15 months and 32 percent had increased levels of functioning.

4. **Hold providers accountable for positive outcomes:** The final guiding principle is that providers need to be held accountable for generating positive outcomes for persons receiving behavioral health services. Several of the states we studied have implemented performance contracts. Oregon and Missouri have established monetary incentives for achieving positive outcomes while Virginia's performance contracts are used more for remediation than to incentivize performance.

Part 3: Governance Models in Selected States

As noted in the introduction of this report, this analysis reviews the mental health governance models of seven states in-depth: Arizona, Missouri, North Carolina, Ohio, Oregon, Virginia, and Washington. This section provides the following information for each state: an overview of the system, the structure of local governing boards, information about how the state coordinates services across agencies, the extent to which local funding is provided for behavioral health, the types of incentives and evaluation efforts currently in place to provide positive outcomes, and information technology issues.

Arizona

Overview of System

Arizona's behavioral health system is centrally controlled by the Arizona Department of Health Services/Division of Behavioral Health Services, which contracts with private Regional Behavioral Health Authorities and smaller Tribal Behavioral Health Authorities [Arizona Revised Statutes (ARS) 36-3401 et seq]. These authorities are risk-bearing managed care entities that are responsible for administering all public behavioral health dollars, including Medicaid, state, local, and other federal funding sources. The authorities are required to maintain a comprehensive network of behavioral health providers that deliver prevention, intervention, treatment, and rehabilitative services to the affected populations. There are currently six regions, which will be reduced to three in October 2015.

The Department is moving towards a model that partially integrates physical and behavioral health services that will be fully implemented in October 2015. Under the new model, the Regional Behavioral Health Authorities will be responsible for integrated physical and behavioral healthcare for Medicaid-eligible adults who have severe mental illness.[10] People who do not meet this criteria will not receive integrated care. Instead, these consumers will receive behavioral health services from the Authorities and physical health services from managed care organizations that are separate from the Authorities.

As of April 2014, one Regional Behavioral Health Authority (Mercy Maricopa Integrated Care in Phoenix) began providing integrated physical and behavioral healthcare services for adults with severe mental illness. The other two regions are scheduled to provide integrated services in October 2015. To facilitate integration, the state approved new rules that allow physical and behavioral health services to be collocated in a range of facilities such as outpatient treatment centers.[11] Because the integrated care model is new and not fully implemented throughout the state, it is too early to evaluate the effectiveness of the new model.

Structure of Governing Boards and Coordination across Agencies

The authorities have their own corporate/nonprofit governing boards. While there are no statutory requirements regarding these boards, the most recent contract with an authority includes a requirement that at least 25 percent of the board's voting members must be peers and family members who are or have been active participants in the authority's behavioral health system. It also stipulates that no contractors are allowed to serve as peer or family member representatives on the governing board.[12] In addition, Mercy Maricopa Integrated Care has chosen to include other stakeholders on its board, including providers, advocates, facilities representatives, fire and police representatives, and other subject matter experts.

The contract also includes detailed requirements for collaboration with system stakeholders, such as child

protective services, developmental disability, rehabilitative services, courts, corrections and veterans agencies; behavioral and physical health providers, peer and family members; and tribal nations.[13]

State law requires certain advisory boards, such as the federally-required planning board, regional Human Rights Commissions, and the Arizona State Hospital Advisory Board (ARS 36-217).[14]

Local Funding for Behavioral Health

County governments also provide some funding for mental health but a match is not required. In fiscal year 2012, county funds represented 3.4 percent of behavioral health funding.[15] The Regional Behavioral Health Authorities receive funding from counties through an intergovernmental agreement and manage the funds on behalf of the counties. Maricopa County also has a hospital tax that is managed by the Authority. The amount of local funding available for behavioral health has decreased in recent years due to the lingering impact of the economic downturn that began in 2008.

Incentives and Evaluation

Arizona has started using financial incentives to address the quality of care. The Mercy Maricopa contract contains extensive performance measures as directed by the Department and federal government. They include specific performance measures, and minimum performance standards and goals. Financial sanctions are imposed if significant improvement is not shown.[16]

The Department has a performance framework divided into four categories: impact on quality of life; access to services; service delivery; and coordination/collaboration. Each category includes data from a variety of sources: demographic data provided by clients; individual and family survey data; analysis of claims data; audits of client records; and data reported by the regional authorities. All data included in the framework are validated by the Department.[17]

Information Technology

Interviews with stakeholders suggests that data collection is a work in progress and significant efforts are needed and underway to streamline and integrate the Department's, authorities' and providers' systems. Given the rapid pace of current changes, both state and authority officials acknowledged the need to upgrade the data infrastructure, resolve issues with mapping into the state system, move away from the fee-for-service model, and focus information systems on outcome-related data.

Missouri

Overview of System

Missouri's behavioral health system is centrally controlled by the state but services are provided in communities by nonprofit agencies called Administrative Agents. The Missouri Mental Health Commission is appointed by the Governor and serves as the principal policy advisor to the Department of Mental Health. The Commission appoints the director of the Department, subject to confirmation by the Missouri Senate. The state is divided into 25 mental health service areas which are headed by the Administrative Agents. These agencies have long-standing contracts with the state that are not routinely rebid. The Administrative Agents provide mental health assessments and services in each region using their own staff or affiliate community mental health centers. The Administrative Agents also have cooperative agreements with the state hospitals to provide follow-up services for persons released from state hospitals. Substance abuse services are provided by contract service providers, which can serve all

consumers regardless of their county of residence. Five regional state offices provide technical assistance and monitoring activities.

The Administrative Agents are responsible for coordinating care but do not operate as risk-bearing managed care organizations. In contrast, Medicaid-funded physical health services are provided through managed care, primarily in counties along the Interstate 70 corridor.[18] Services in other counties are provided through fee-for-service.

Structure of Governing Boards

The current governance structure in Missouri provides a limited governance role at the local level. There are several avenues for local governance as discussed below:

- Administrative Agent Boards: Each Administrative Agent is a nonprofit entity that has its own governing board. The composition is not defined by statute. While this provides flexibility, it also means that there is not consistency in the types of people who serve on these boards. In addition, these private boards do not require public input.

- Regional Advisory Councils: As permitted by statute, the Department of Mental Health appoints up to 20 community members to Regional Advisory Councils throughout the state (Missouri Revised Statutes 632.040). At least one-half of the members must be consumers and no more than one-fourth can be vendors. These bodies are solely advisory and do not have any governance authority.

- Missouri Coalition for Community Behavioral Healthcare: This organization is a coalition of community mental health providers. While it is not a local governing board defined in statute, it serves as an unofficial advisory body to the state. The Coalition serves as an active partner with the state in designing and implementing policies, and has played an advocacy role.

- Local Tax Governing Boards: According to the Department of Mental Health, 17 cities and counties have implemented voter-approved local taxes to fund mental health and substance abuse services for children and adults. These taxes are administered by governing boards that are separate from local government entities. They also are unaffiliated with the Administrative Agents. While these boards can fund programs run by the Administrative Agents, they are free to fund other eligible services. There are two types of taxes, the Community Mental Health Fund and the Children's Services Tax.

    - Community Mental Health Fund: This fund is a voter-approved property tax not to exceed 40 cents per each $100,000 of assessed valuation for mental health services. The local government agencies that created the tax appoint a total of nine board members. The Regional Advisory Council or other interested parties may nominate board members. At least one-third of the board members must be consumers or family members while no more than one-third can represent providers of mental health services. In addition, at least one member must be a licensed physician and at least half must not be providers of healthcare. Employees of entities that receive funds cannot serve on the board. The board can choose to directly provide mental health services or contract out for services [Missouri Revised Statutes (RSMO) 205.975 to 205.990].

- Children's Services Tax: This tax is a voter-approved sales tax not to exceed one-fourth of one cent for providing children's services. Funds can be used for various services, including temporary shelter, respite care, services to unwed mothers, outpatient chemical dependency and psychiatric treatment, counseling, community-based family intervention, crisis services, and screenings/evaluation. The local government that created the tax appoints nine board members. In certain jurisdictions, the board members must be the same members serving on the County Community Mental Health Fund board. The board is responsible for administering and expending the tax funds, and may contract with public and nonprofit agencies to provide eligible services. The law also includes a conflict of interest provision that prevents board members from having a financial interest in a grantee or being the employee of a grantee (RSMO 67.1775 and 210.861).

Some interviewees expressed concern that because the Administrative Agents are not public entities, they are not truly accountable to the community. In addition, there was some concern that the close advisory relationship between the Administrative Agents and the state leaves the public without substantive input and perpetuates the status quo. In contrast, other interviewees stated that the lack of a governmental structure at the local level makes the system nimble and facilitates implementation of changes. The communities that have adopted taxes to fund mental health have significant influence over decisions related to the provision of behavioral health services. Since only 17 communities have passed taxes, in effect the community has a limited role in governance of behavioral health services throughout most of Missouri.

Coordination Across Agencies

Missouri recently took proactive steps to improve coordination between agencies. Since 2013, the state has funded "Mental Health Liaisons" at each of the community mental health centers, although they could also be called criminal justice liaisons. These mental health professionals work with courts, law enforcement, and families to help individuals with mental illness receive proper treatment. There is widespread acknowledgement from the law enforcement community that the Mental Health Liaisons have made a positive impact in working across agencies.

Local funding for Behavioral Health

Local governments are not required to provide funding for behavioral health services. However, as discussed above, 17 local jurisdictions have implemented voter-approved sales and property taxes to fund mental health. Because not all agencies have a local tax, the level of service and the level of involvement of local government varies substantially throughout the state.

Incentives and Evaluation

The primary contract between the state and the Administrative Agents does not include incentives to save money across agencies or improve the quality of services. However, the state has started experimenting with incentives in certain programs such as Primary Care Health Homes and Disease Management 3700, which targets 3,700 high cost Medicaid clients who have impactable chronic medical conditions. For Primary Care Health Homes, the state makes incentive payments to primary care practice sites of up to 50 percent of the value of the reduction in total healthcare per member per month cost relative to prior year experience.[19] Savings are distributed on a sliding scale up to 50 percent of net savings based on performance relative to a set of clinical preventive and chronic care measures. For the Disease Management 3700 program, the state makes an incentive payment to providers preliminarily

calculated at $24 per member per month if providers meet the goal of reducing total healthcare spending enough to cover the cost of the additional behavioral healthcare services.[20] The Disease Management 3700 program also measures ongoing progress in improving physical and behavioral health indicators.[21]

Missouri has also put in place efforts for money to follow the patient from the hospital into community services. Through an inpatient redesign process, the state moved 100 voluntary by guardian inpatients to the community and used redirected inpatient state funds for enhanced services and residential supports to ensure the success of those placements and minimize any risk to public safety.

Information Technology

Missouri has a statewide data system called Customer Information Management, Outcomes and Reporting (CIMOR), which is viewed throughout the state as an effective system. There are ongoing efforts to improve the ability of CIMOR to demonstrate system-wide outcomes. However, local entities with mental health taxes do not have access to this system. The state also has a statewide dashboard with a user-friendly data tool.[22]

North Carolina

Overview of System

North Carolina currently has a regionally controlled behavioral health system and is transitioning to a system of regions that serve larger geographic areas and play a greater role in providing integrated care. The state agency responsible for oversight of the system is the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, in the Department of Health and Human Services. Medicaid-funded physical healthcare service delivery is currently coordinated by 14 nonprofit networks in a fee-for-service system while behavioral health services are managed under a separate capitated system through nine public agencies called Local Management Entities-Managed Care Organizations (LME-MCOs). North Carolina has 162 counties so these regions cover multiple counties. The LME-MCOs are currently responsible for: coordinating care; managing provider networks; ensuring access services and supports in the areas of mental health, substance abuse, and intellectual and developmental disabilities; and monitoring for fraud, waste, and abuse [North Carolina (NC) General Statute 122C-117]. The LME-MCOs administer Medicaid-reimbursed services as well as state and federally funded programs for people without insurance or the means to pay for services.

In March 2014, the North Carolina Department of Health and Human Services released a proposal to reform North Carolina's Medicaid program, which aims to strengthen Medicaid fiscally, increase efficiency for providers, and unite physical and behavioral healthcare.[23] Physical health services will be coordinated by provider-led Accountable Care Organizations through a fee-for-service model. The Accountable Care Organizations will share some of the financial risk with the state through an incentive formula that rewards organizations that meet spending benchmarks and quality performance standards and penalizes organizations with cost overruns.

Under the proposal, physical and behavioral health will remain separate systems and the number of LME-MCOs will decrease from nine to four. Two LME-MCOs recently agreed to merge and the goal is to complete the mergers by July 2016. The Accountable Care Organizations will be expected to enter into cooperative agreements with the LME-MCOs to ensure integrated care. In addition, some services will be transferred from the LME-MCOs to the Accountable Care Organizations.

While the proposed system aims to integrate physical and behavioral healthcare, silos between these two categories will remain. The state received input from consumers and families indicating they agree with whole-person integrated care, but are concerned that specialty behavioral healthcare could receive inadequate attention in a fully integrated system. Consumers warned that rapid implementation of fully integrated care could destabilize an already fragile system. Some stakeholders expressed an interest in maintaining a public role in the provision of behavioral health services so that accrued savings are reinvested in services rather than taken out of the system in the form of profits.

Structure of Governing Board and Coordination Across Agencies

Each LME-MCO has a governing board of 11 to 21 members (NC General Statute 122C-118.1) Members are appointed by the boards of county commissioners within the area. Each board must include the following members:

- At least one county commissioner;
- The chair of the local Consumer and Family Advisory Committee;
- A family member and a consumer;
- An individual with healthcare expertise in the fields served by the LME-MCO;
- An individual with healthcare administration expertise;
- An individual with financial expertise;
- An individual with insurance expertise;
- An individual with social services expertise;
- An attorney with healthcare expertise;
- A member who represents the general public and who is not employed by or affiliated with the Department of Health and Human Services, as appointed by the Secretary; and
- The president of the LME-MCO Provider Council and an administrator of a hospital shall serve as nonvoting members.

One LME-MCO, Alliance Behavioral Healthcare, has an alternative board structure, which includes 19 members appointed by county commissions. Each county has a certain number of appointees based on population size. Appointees include three county commissioners, a consumer or family member, a member of the Consumer and Family Advisory Committee, an individual with provider expertise, and individuals with health and financial expertise. Contractors are ineligible to serve on the board.

Each board is responsible for appointing a director, approving budgets, and overseeing the work of the LME-MCO. The boards must have a finance committee, which is responsible for reviewing the financial strength of the program. (NC General Statute 122C-119). The finance committee meets six times per year and must include a minimum of three members, two of whom must have expertise in budgeting and fiscal control. Finance officers from participating counties serve as ex officio members.

The board structure of LME-MCOs is more structured than other states profiled in this report. It has evolved to place more emphasis on having professionals who have the ability to run a managed care organization. Several interviewees expressed concern that as the number of regions decreases and the geographic size increases, it may be more difficult for these boards to be responsive to local needs.

The current board structure includes a county commissioner, but does not emphasize the need to collaborate with other agencies, such as law enforcement. Law enforcement officials do not currently serve on the LME-MCO boards and their inclusion could help facilitate coordination.

Local Funding for Behavioral Health

In the past, a local match for mental health was required, but the requirement was removed due to the fiscal impact on counties. Some counties, such as Mecklenburg County, provide local funding to pay for services for uninsured consumers. However, not all counties have sufficient resources to augment funding for behavioral health. This creates disparities between counties and within regions in the types of services that can be offered.

Incentives and Evaluation

Under the current system, there are some incentives in the LME-MCO contract to pay for services in one area to save in another. The LME-MCO is responsible for the cost of Medicaid covered inpatient psychiatric treatment provided to Medicaid recipients. Because the LME-MCOs have a set contract amount per member, an incentive is created to minimize hospital stays and find less expensive options for treatment.[24] It also ensures that the money follows the patient from the hospital to other behavioral health services.

The current LME-MCO contract also includes performance measures in the areas of effectiveness of care, access/availability, patient and provider satisfaction, use of services, network capacity, enrollment, and health and safety.[25] While LME-MCOs must have plans to meet these measures, there are not currently any financial incentives associated with meeting the measures.

There are also efforts to integrate care to save money across different agencies. Community Care of North Carolina, which coordinates physical health services, is piloting a program with Alliance Behavioral Healthcare, an LME-MCO, to integrate physical and behavioral healthcare services and share the savings. The pilot project has shown that increased spending in behavioral health can provide savings in physical health. A legislative proposal is planned to expand the pilot program to other regions.

North Carolina's Medicaid reform proposal aims to place more emphasis on performance monitoring through outcome-based contracts. Contracts will require monitoring at the county level to identify issues within regions. The contracts will also include clearer expectations for coordinating physical healthcare needs as well as provisions for shared accountability for physical healthcare. There will be benchmarks for expected care management caseloads and minimum proportions of populations to be served, as well as incentive payments for collocated integrated care models.

Information Technology

North Carolina faces several challenges in the area of information technology. The state has worked to decrease the number of different information technology systems used by the LME-MCOs and there are currently two primary data systems used across the state. The use of different information technology systems continues to create challenges in obtaining uniform data and effectively tracking performance. More uniform information technology systems would also facilitate sharing data across LME-MCOs. Providers have also faced challenges bridging into NCTracks, the state's new Medicaid management information system. There are also challenges sharing data between physical and behavioral health providers. The pilot integrated health program at Alliance Behavioral Healthcare has implemented a technology sharing agreement to bridge this gap.

Ohio

Overview of System

Ohio has a long history and tradition of home rule and strong local control for behavioral health services. The mental health system is managed by the Department of Mental Health and Addiction Services, which is responsible for operation of six regional hospitals [Ohio Revised Code (ORC), 5119.14 and 5119.21]. The Department also oversees the community mental health boards, which consist of counties and groups of counties. The boards are the single authority for the mental health system in each community and receive a combination of Medicaid, state funds, and other grant funds.

Ohio currently has 53 community mental health boards of which 33 are single-county and 20 consist of multi-county boards. The boards do not provide direct services but contract with public, private and nonprofit providers (ORC 340.091). State law requires the boards to do the following within available resources: establish the essential elements of a community support system; provide mental health services; provide emergency and crisis intervention services; assist with vocational services; provide access to housing and residential treatment; assist families and consumers; and provide grievance and case management procedures (ORC 340.03 and 340.08).

In 2013, Ohio elected to expand Medicaid as part of the Affordable Care Act, and uses managed care organizations to provide physical health services. Certain behavioral health services are provided by the managed care organizations, but most behavioral health services are carved out and provided on a fee-for-service basis by the community mental health boards. The Department is discussing whether to move to managed care for behavioral health and whether to integrate behavioral and physical health systems. Ohio also implemented Medicaid health homes for people with severe and persistent mental illness to promote the integration of physical and behavioral healthcare.

Overlaying this system, the Ohio Association of County Behavioral Health Authorities has established standards for boards based on best practices and statutory requirements. The Association built a voluntary peer certification model and half of the boards are now certified.

Ohio has undergone many changes recently, including consolidating mental health and substance abuse services into one department, expanding Medicaid, and implementing new initiatives. The local control model has received positive reviews and has promoted active community involvement. However, there is some concern that the rapid pace of implementation of innovative measures and reforms are stressing the system, which has affected providers and other stakeholders in the system.

Structure of Governing Boards and Coordination across Agencies

All but two of the county-based boards are known as Alcohol, Drug Addiction and Mental Health Services Boards. Key duties include developing plans, addressing complaints, conducting evaluations, and contracting out for services (ORC 340-03). The Boards have the option of having either 14 or 18 members (ORC 340.02). Each board must include a clinician, consumer, and family member in the area of mental health as well as a clinician, consumer and family member in the area of addiction services. A single person with qualifications in both fields can serve as the clinician. Conflict of interest provisions prevent providers, county commissioners, and their families from serving on the boards.

For an 18-member board, the Department appoints eight members and the board of county commissioners designates ten members. For the 14-member boards, the Department appoints six

members and the counties name eight. For the multi-county boards, the county commissions appoint board members proportional to their populations with at least one appointee from each county. The Department ensures appropriate representation on the boards, and each board member is required to attend one annual in-service training session provided or approved by the Department (ORC 340-02).

State and local officials indicate a good process of communication exists within the state. The Department sponsors a Behavioral Health Leadership Group that meets quarterly to share information throughout the system. The Department also supports and seeks input from three roundtable groups that meet bi-monthly relating to prevention, addiction, and mental health issues.

Local Funding for Behavioral Health

Counties have the option of approving local property tax levies to supplement state sources. Interviews with stakeholders revealed that the boards have received significant support from the voters in approving property tax levies for addiction and mental health services, but that support is uneven and inconsistent depending on the wealth of the county or multi-county region. Thirteen of the poorest boards have no levies, such as those in Appalachian and other rural areas of the state. In contrast, wealthier counties have been successful, with eight new levies approved in the past eight years. Medicaid expansion has helped reduce inequities across the boards by providing significantly increased access to mental health services.

Medicaid expansion also freed up approximately $70 million in local dollars, which has been used to improve access to housing, and to provide vocational, prevention, and other support services. The Legislature also provided a $50 million general fund appropriation in each year of the past biennium that was targeted by the Department to help meet behavioral health prevention, treatment and recovery needs throughout the state.

Incentives and Evaluation

Ohio has implemented incentives to have money follow the person from the hospital to the community, but the results suggest mixed success. In 2012, the state implemented a program that provided a financial incentive to boards that reduced the use of forensic psychiatric hospital beds. These additional funds could then be used to provide alternative services. However, the program was discontinued in 2014. While some boards were able to gain additional funds by significantly reducing their bed days and admissions, overall hospital use increased statewide. State officials indicate the financial incentive likely was not sufficient to engage all the boards.

In contrast, Ohio has experienced success with an incentive program called “Recovery Requires a Community.” This program uses the federal Money Follows the Person grant to assist nursing home residents under age 60 with a primary mental health diagnosis to move into the community, at lower taxpayer expense.[26] The funding is used to help eliminate barriers to independent living, ranging from providing a rental subsidy to furnishing a service animal. Participation in the program has grown to 350 in its first year.

While Ohio does not currently use performance-based contracts to incentivize providing the best care at the lowest cost, the Department conducts studies to inform planning priorities, and to analyze disparities and the quality of care. It also collects substance abuse and mental health treatment data to monitor grants and measure system performance.

Information Technology

State officials report that its information technology and evaluation system is in transition from an older program established in 1997 (MACSIS) to the state's Medicaid reporting system, which is not yet an outcome-based reporting mechanism. There is a lack of consistency in reporting information and outcomes across boards. Outcomes are built into provider contracts, but they are not universally reported so it is difficult to determine which practices are more effective than others.

The Department also has a Patient Care System that collects, aggregates, and monitors all patient data at the regional state hospitals. This system provides the community boards with monthly reports they can use to monitor client movement and project what type of services will be needed.

Oregon

Overview of System

In 2012, Oregon implemented a new system for Medicaid that integrates physical, behavioral, and dental health through 16 Coordinated Care Organizations [Oregon Revised Statutes (ORS) 414.625]. These organizations are community-based comprehensive managed care organizations that operate under a risk-based contract with the state. Coordinated Care Organizations are focused on prevention and helping people manage health conditions to control costs. There is also an emphasis on person-centered care, where all care providers coordinate efforts to ensure service plans complement each other. Coordinated Care Organizations have "global budgets" that grow at a fixed rate. Global budgets provide one, integrated source of funds for all Medicaid-funded physical, behavioral, and dental health services. The state agencies responsible for oversight of the system are the Oregon Health Authority and the Addictions and Mental Health Division.

Counties play a dual role in the provision of behavioral healthcare services.[27] First, counties provide Medicaid behavioral health services through the Coordinated Care Organizations. In some cases the counties are risk accepting entities within the Coordinated Care Organizations. In others, the Coordinated Care Organization pays the county a per member per month amount that is adjusted quarterly. Secondly, counties also serve as Local Mental Health Authorities and are responsible for providing non-Medicaid services using state general funds, beer and wine taxes, federal block grants, and local funds. Coordinated Care Organizations and Local Mental Health Authorities are tasked with collaborating to ensure that people with and without Medicaid services receive coordinated care. There are currently discussions about integrating all behavioral health services into the Coordinated Care Organizations in the future.

Structure of Governing Boards and Coordination Across Agencies

Each Coordinated Care Organization has a governing body that includes the following members (ORS 414.625):

- Persons (organizations) who share in the financial risk of the organization (must constitute a majority of the governing body);
- The major components of the healthcare delivery system;
- At least two healthcare providers in active practice, including a physician or a nurse practitioner and a mental health or chemical dependency treatment provider;
- At least two members from the community at large; and

- At least one member of the community advisory council.

Each governing board is unique depending on the organizations that have joined the Coordinated Care Organization. For example, Health Share of Oregon contracts with seven risk accepting entities; four for physical health and three for behavioral health. The board has 20 members, including representatives of the four physical health risk accepting entities and representatives from the three risk accepting county health departments.[28] In contrast, the InterCommunity Health Network Coordinated Care Organization has only one risk accepting entity and three counties that provide mental health services but do not bear risk. The governing board includes the Chief Executive Officer of the risk accepting entity, two county commissioners, and one county administrative officer.[29] While having a board comprised of the providers of health services can create conflicts of interest, stakeholders argue that the governance structure effectively brings stakeholders together to collaborate.

Each Coordinated Care Organization must also have a Community Advisory Council (ORS 414.627). The majority of the council seats must be filled by consumers and it must include representatives of the community and government of each county served by the Coordinated Care Organization. The key roles of the Council are to oversee a community health assessment, adopt a community health improvement plan, and publish an annual report on the progress of the plan. Community Advisory Councils have experienced varying levels of effectiveness and have faced challenges maintaining consistent membership. The Councils have also had difficulty fulfilling their planning duties without staff support.

The Coordinated Care Organizations have the potential to foster collaboration across agencies. One interviewee indicated that collaborating early on with providers, community members, and advocacy groups helped to establish trust and to build a foundation for future success. Law enforcement has not been actively involved with the Coordinated Care Organizations and several stakeholders expressed an interested in increasing collaboration with the law enforcement community.

Local Funding for Behavioral Health

Some counties contribute funds for behavioral health but a match is not required.[30] This can create differences in the amount and types of services that are available across counties and within Coordinated Care Organizations. For example, Multnomah County contributes local property tax funding but the other two counties in Health Share of Oregon do not contribute local monies.

Incentives

Oregon's integrated Medicaid program includes performance measures to incentivize reducing costs while improving health outcomes.[31] Each Coordinated Care Organization receives a monetary incentive payment from the Quality Pool based on a combination of its reduced costs, and its measured performance or improvement in a calendar year.[32] In 2014, the maximum payment from the Quality Pool is three percent of the actual amounts paid to the organization in calendar year 2014.

Incentive pay is based on 17 measures, which include three related to behavioral health:[33]

- Mental and physical health assessment within 60 days for children in the custody of the Department of Human Services through foster care;
- Appropriate screening and intervention for alcohol and other substance abuse for adults; and
- Follow up care with a healthcare provider within seven days of being discharged from the hospital for a mental illness.

There are no specific requirements for the use of Quality Pool funds but Coordinated Care Organizations are required to offer incentive payment arrangements with providers that align with the Quality Pool program.[34] For example, Multnomah County indicates that Quality Pool funds are shared with nonprofit providers based on outcomes generated by each provider.

Oregon produces progress reports on the 17 outcome measures discussed above. For each outcome measure, current data is compared to 2011 baseline data and to benchmarks (goals) established by the state. A progress report released in February 2014 shows mixed results for the three outcome measures related to behavioral health: 1) data is not yet available on receipt of a mental and physical health assessment for children in foster care; 2) there was a slight increase statewide in screening and intervention for alcohol and substance abuse but the statewide average is only 0.7 percent; and 3) there was a slight increase statewide in the percentage of clients receiving follow up care within seven days after hospitalization for mental illness.[35] Several Coordinated Care Organizations exceeded the benchmark of 68 percent while others experienced decreases. Some interviewees criticized this outcome measure, asserting that seven days is too long to wait for follow up care.

Information Technology

Facilitating data sharing to improve care is a major focus in Oregon. As part of their contract with the state, Coordinated Care Organizations must develop and implement strategies to increase implementation of electronic health records. These are electronic records of an individual's health-related information that conform to nationally recognized interoperability standards and that can be created, managed, and consulted by authorized clinicians and staff across more than one healthcare provider.[36] One of the incentive measures is the percentage of eligible providers within a Coordinated Care Organization's network and service area who qualified for a "meaningful use"[37] incentive payment during the measurement year through the Medicaid, Medicare, or Medicare Advantage Electronic Health Record Incentive Programs. The February performance report shows a substantial increase in the use of electronic health records in every Coordinated Care Organization. The percentage of providers meeting the criteria increased statewide from 28 percent in 2011 to 59 percent in 2013, which exceeds the benchmark of 49 percent. The benchmark is based on the 2014 federal benchmark for adoption of electronic health records under Medicaid.[38]

Like other states, Oregon faces challenges with multiple data systems. The Addictions and Mental Health Division recently implemented a new data system for counties to track outcomes for non-Medicaid services. While this system is different from what is being used for Medicaid, a data warehouse is being used to tie all the data together. A single data system would make data integration more seamless.

Virginia

Overview of System

Virginia has a long history of local governance for behavioral health with state oversight.[39] At the state level, the Board of Behavioral Health and Developmental Services serves as a policy making body and the Department of Behavioral Health and Developmental Services performs administration and oversight. Since 1968, local services have been provided by Community Services Boards, which are public agencies that are established by cities and counties.[40] The Department contracts with, funds, monitors, licenses, regulates, and provides leadership, guidance, and direction to the 40 Community Services Boards. These agencies are the single point of entry for mental health, substance abuse, and intellectual disability services to Virginians with Medicaid or those who are uninsured. Services can be provided by staff or

contract providers.

The Community Services Boards receive a combination of Medicaid, state, local, and federal funding. These agencies bill Medicaid on a fee-for-service basis. In contrast, Medicaid services for physical health are separate and are provided through managed care organizations. Some behavioral health services are available through managed care, but more intensive services such as case management are only available from the Community Services Boards. Overlaying this system, the state contracted with Magellan Behavioral Health of Virginia in December 2013 to serve as the Behavioral Health Services Administrator. This is a non-risk-bearing Administrative Service Organization contract to perform service authorization, claims payment, provider credentialing, and enrollment for behavioral health services. Magellan is also responsible for managed care for non-traditional behavioral health services that are not covered under Medicaid.

Community Services Boards are not responsible for providing a complete array of mental health services. The core of services provided "shall include emergency services and, subject to the availability of funds appropriated for them, case management services" (Code of Virginia 37.2-500).[41] Contract language established by the state also limits the responsibility of the Community Services Boards, stating that a Board "shall provide needed services to adults with serious mental illnesses, children with or at risk of serious emotional disturbance, and individuals with intellectual disability or substance use disorder to the greatest extent possible within the resources available to it for this purpose."[42] Private providers have started to fill this gap in services. While the majority of behavioral health services used to be provided by the Boards, Magellan reports that 70 percent of services are now furnished by private providers.

Since Virginia decided not to expand Medicaid at this time, the state recently applied for a Medicaid demonstration waiver to be implemented beginning January 1, 2015 called the Governor's Action Plan (GAP).[43] The goal of the waiver is to provide a targeted benefit package to 20,000 Virginians age 19 to 64 who: have income less than 100 percent of the federal poverty level; are not eligible for Medicaid or Medicare; and suffer from serious mental illness. Benefits will include a limited package of primary and specialty care; diagnostic, laboratory, pharmacy and behavioral health community services; and care coordination. Services will be provided through existing networks, which will include private providers and the Community Services Boards. The waiver will be funded 50/50 with state general funds and Medicaid. It is intended to be cost neutral by reducing improper emergency department visits, inpatient hospital utilization, interaction with the criminal justice system, and uncompensated healthcare costs.[44] There is some concern that the waiver will be used to supplant existing benefits provided by the Community Services Boards instead of expanding the population receiving benefits.

Structure of Governing Boards and Coordination Across Agencies

Four types of governing bodies are authorized in the Code of Virginia (37.2-100 & 37.2-600):

- Administrative Policy Community Services Boards (11): These boards are either city or county government departments or entities that utilize local government employees to deliver services. They provide services using either government staff or contracts with other organizations or providers. These boards set policy for and administer the provision of mental health, developmental, and substance abuse services. They also participate with local government to appoint, evaluate, and prescribe duties for the executive director.

- Operating Community Services Boards (27): These boards are typically multi-jurisdictional and have more authority than administrative policy boards. They employ their own staff but are not a

government department. These boards are responsible for direct provision of mental health, developmental, and substance abuse services. They also appoint the executive director.

- Policy Advisory Community Services Boards (1): These boards act as advisory committees to a government department. They are advisory in nature with no operational powers or duties. The policy advisory board participates in the selection and annual performance evaluation of the executive director.

- Behavioral Health Authorities (1): State statute authorizes Chesterfield County and the cities of Richmond and Virginia Beach to establish an authority but only Richmond has done so. The powers resemble operating boards but authorities have broader contracting authority, including the ability to contract with any federal agency, any local government agency, behavioral health providers, insurers, and managed care or healthcare networks.

All Community Services Boards have 6 to 18 members, one-third of which must be consumers or family members. For each board, the board of supervisors of each county and the council of each city must mutually agree on the size of the board and appoint members. One or more appointments may be nongovernmental service providers. Sheriffs or their designees shall also be appointed when practical. State law also prohibits employees of Community Services Boards or organizations that receive funding from sitting on boards. In addition, the boards cannot be composed of a majority of elected or appointed local government officials and there is a maximum of two officials from each city or county. These rules were put in place to prevent conflicts of interest and to prevent concentration of local government officials.

In practice, the effectiveness of boards varies across the state. Some interviewees opined that it is important for boards to have governing authority and advised against creating policy advisory boards since they place too much authority in the hands of the executive director. Other interviewees indicated that the boards are autonomous and not accountable to anyone, which makes it difficult to collaborate across agencies. In addition, law enforcement representatives indicated that few officers serve on the boards and that a greater role for law enforcement would be helpful in addressing issues that cross agencies. Interviewees also cited inconsistency in the effectiveness and strength of the consumer role on the boards.

Local funding for Behavioral Health

State law requires Community Services Boards to provide a local match of 10 percent of contract funds (Code of Virginia 37.2-509). However, the state can waive this requirement based on economic factors as permitted by a policy adopted by the Board of Behavioral Health and Developmental Services.[45] Cities and counties that want to reduce their local match must also notify the Community Services Board and the state. In practice, there are major disparities in the amount of local funding provided across the state. Local funding currently is provided by only eight localities. Fairfax Falls Church, the largest Community Services Board, contributes $48 million of the total $248 million contributed statewide.[46]

Incentives and Evaluation

Virginia requires each Community Services Board to enter into a performance contract (Code of Virginia 37.2-508).[47] While efforts are underway to strengthen these contracts, several interviewees reported that these contracts are not strong in practice and are used more for remediation than to incentivize behavior

to save money across agencies, provide quality services, or ensure money follows the patient.

Each Community Services Board must report its performance quarterly and identify and implement actions to improve performance on measures where it does not meet the benchmark. The state is currently developing a dashboard to display the performance measures online. Existing indicators include:

- Percentage of individuals who kept scheduled face-to-face (non-emergency) service visits within seven business days of discharge from the hospital;
- Percentage of individuals who saw a certified preadmission screening evaluator face-to-face to determine the need for involuntary hospitalization within one or two hours of initial contact;
- Percentage of adults whose case managers discussed integrated, community-based employment with them during their annual plan reviews in this quarter; and
- Percentage of adults with plans reviewed whose plans included employment-related or readiness goals.

The Virginia Association of Community Services Board is working with the state to create financial incentives for implementation in FY 2016 to reward Boards that exceeded criteria or goals. These incentives would be provided using a small amount of one-time state funds. Examples of criteria or goals may include eliminating waiting lists for substance abuse outpatient services, producing the largest improvement on a performance measure, or achieving the highest percentage on a performance measure.[48]

Virginia is developing incentives to decrease state hospital utilization. The Virginia Association of Community Services Boards is working with the state to analyze temporary detention order bed utilization to develop baseline data. Fiscal incentives and disincentives could be implemented based on this data in FY 2016. The Community Services Boards are required to establish systems to manage state hospital utilization through discharge protocols, extraordinary barriers to discharge lists, and other regional management procedures.

Information Technology

Virginia has developed a collaborative process for addressing information technology issues. The contract with the Community Services Boards requires the state to work with the Data Management Committee of the Virginia Association of Community Services Boards on developing data reporting requirements.[49] The Data Management Committee also works with the state to streamline and reduce the number of data portals for reporting information.

Virginia has faced challenges with an online psychiatric bed registry launched in March 2014, which has been unable to provide real-time data to emergency services personnel as intended.[50] This system is statutorily required to provide current information about the number of beds available at each public and private inpatient psychiatric facility and residential crisis stabilization unit (Code of Virginia 37.2-308.1). However, some facilities have only been able to update the system once daily. Other facilities are now updating information four times per day. Further technological improvements would likely be necessary to automate updates from each public and private entity.

Washington

Overview of System

Washington's mental health system has traditionally had a strong role for local governance. However, the state is transitioning toward integrated care for Medicaid and the local governance role will change dramatically over the next few years. In 2014, the Washington Legislature adopted a phased timeline to integrate physical and behavioral health services by 2020.[51] Currently, mental health services are provided in silos. Regional Support Networks provide mental health services to people who have severe mental illness through risk-bearing managed care contracts.[52] There are currently eleven Regional Support Networks, which are generally single counties or county partnerships that administer services through managed care.[53] These Networks also provide services with state funding and federal grant funding. In contrast, substance abuse services are furnished through state and county contracts on a fee-for-service basis. The state also contracts with managed care organizations to provide physical health services. These managed care organizations also provide mental health services to enrollees who are not severely mentally ill. State oversight of the system is provided by the Division of Behavioral Health and Recovery, Department of Social and Health Services and the Health Care Authority.

In November 2014, the Health Care Authority established ten Regional Service Areas that will be used for Medicaid behavioral and physical healthcare purchasing in 2016.[54] These areas will be counties or groups of counties with sufficient beneficiaries to support full financial risk managed care contracting. The boundaries of some Regional Service Areas are different from the boundaries of the current Regional Support Networks. In 2016, each Regional Service Area has two options: (1) become an early adopter that provides a single benefit package of mental health, substance abuse, and physical health services to Medicaid beneficiaries through a minimum of two managed care plans in each region; or (2) transform the Regional Support Network into a Behavioral Health Organization that integrates mental health and substance abuse into a managed care contract and continue to provide physical health services through a separate managed care contract. By 2020, the legislation requires all Regional Service Areas to offer integrated care for physical and behavioral health. To entice Regional Service Areas to become early adopters, the legislation provides an incentive of ten percent of the savings realized by the state for up to six years.

Structure of Governing Boards and Coordination Across Agencies

State law is silent on what the governing boards of Regional Support Networks and Behavioral Health Organizations should look like. Single county regions, such as King County, do not have a governing board specific to behavioral health. Instead, the county governing board is responsible for oversight. King County also has an advisory board whereby consumers and family members must comprise 51 percent of the board membership. Multi-county Regional Support Networks have the flexibility to define their governing board through an interagency agreement. For example, the North Sound Regional Support Network governing board includes nine members who are county elected officials or their designees. The number of representatives from each county varies from one to four depending on the population of the county. In contrast, Grays Harbor Regional Support Network is developing a multi-county Behavioral Health Organization where each county will have one vote on the governing board. Each Regional Support Network/ Behavioral Health Organization must also have a mental health advisory board which broadly represents the demographic character of the region and includes representatives of consumers and families, law enforcement, and county elected officials.

Once integration is accomplished, counties will have a smaller role in governance. The state plans to put

in place an Accountable Community of Health in each region. These entities will not act as governing bodies, but will operate as regionally based, voluntary collaboratives working to align actions across agencies to achieve healthy communities and populations. The Accountable Communities of Health will be comprised of public-private partnership organizations bringing together social service providers, risk-bearing entities, counties, public health and tribes. Several interviewees expressed concern about the long term role of the county in the Accountable Communities of Health and about effective oversight in the absence of a governing authority. There is also concern about how non-Medicaid funded behavioral health services will fit into the new integrated behavioral health model.

The existing governance structure has generated mixed results in coordinating with stakeholder groups such as law enforcement and consumers. Law enforcement officials have initiated collaboration with some Regional Support Networks. However, under the current governance structure, stakeholder groups are only on advisory committees and not on the governing board. The Accountable Community of Health model aims to address this issue by bringing all stakeholders together to focus on outcomes.

Local funding for Behavioral Health

A local match is required for behavioral health, but monitoring and oversight of this requirement is limited. In addition, in 2005, the Washington Legislature adopted a provision allowing counties to impose a sales tax of one-tenth of one percent for mental health.[55] These funds can be used for operation or delivery of chemical dependency or mental health treatment programs and services and for the operation or delivery of therapeutic court programs and services. Services include treatment, case management, and housing that are a component of a coordinated chemical dependency or mental health treatment program or service. While these funds are intended to be supplemental, provisions were added to allow counties to use this money to supplant existing funds during certain time periods.

Several equity issues were raised regarding this tax. First, only certain counties have adopted this tax, so the same resources are not available in every county.[56] Second, since the taxes are county based and most Regional Support Networks have multiple counties, these funds are only available for part of the region and are controlled by the county government and not the Regional Support Network.

Incentives and Evaluation

In 2006, Washington adopted a statute to incentivize providing less costly and more effective alternatives to in-patient hospital treatment. Each Regional Support Network has an allocation of hospital beds that is adjusted every three years (Washington Revised Statutes 71.24.310). If the region exceeds its allocation, it must pay additional funds to the state. Half of the funds paid to the state are used for the state hospital system and the remainder goes to the regions that did not exceed their hospital bed allocation. Washington Revised Statutes 71.24.016 includes language encouraging regional support networks to provide alternatives to hospital treatment within existing funds.

In practice, it appears as though this formula worked well in the first few years but not as well since the number of state hospital beds was cut. The regions are generally at the maximum level of beds and the state has come under legal attack for “boarding” patients in emergency rooms while they await a space in a psychiatric hospital.

Washington is also developing performance measures that state agencies will use to inform and set benchmarks for purchasing decisions for health services. State Legislation created the Performance Measures Coordinating Committee, which is charged with recommending standard statewide measures of

health performance by January 1, 2015.[57] A draft list of 53 measures in three core areas has been circulated for public comment: population measures, clinical measures, and healthcare cost. [58] The Committee established the following criteria for selecting measures:

- The number of measures must be manageable;
- Data is readily available to facilitate timely implementation;
- Preferences are given to measures endorsed by the National Quality Forum;
- Measures track areas with significant impact on health outcomes and costs; and
- Measures are aligned with Medicaid performance measures.

The state identified several barriers to implementing the performance measures, including lack of structured access to clinical data for robust statewide measurement and reporting.[59] For behavioral health, the state also cited the lack of vetted measures and availability of data. There is some concern that the time and effort required for gathering and reporting data could take away from the provision of services. Other concerns include the absence of incentives to encourage for-profit companies to reinvest savings in additional services.

Information Technology

Each Regional Support Network has its own technology platform, which has created barriers to the collection of uniform data needed for the performance contracts. In addition, the state has separate reporting systems for Medicaid and chemical dependency. Funding has not yet been provided to fully integrate these systems.

Part 4: Key Decision Points

As stakeholders in Nevada deliberate on what a new and effective mental health governance structure should look like, several key issues should be considered as discussed below. These decisions can be grouped into several categories: overall structure, governing board structure, funding, and outcomes/information technology.

Overall Structure

1. What should be the role of the state in community mental health? Nevada has a unique structure in which the Department of Health and Human Services is both the overseer and the provider of community mental health services for children and adults. In many other states, the only services directly operated by the state are psychiatric hospitals. Nevada should consider having the state assume more of an oversight role for community mental health services, which could include elements such as setting policy, establishing benchmarks and performance standards, administering contracts, and collecting and publicizing performance data. This could also include fiscal oversight to ensure that the maximum amount of Medicaid and federal grant funding are received. However, transferring responsibility for providing services from the state to local providers can result in a loss of standardization, consistency, and accountability. States should take an active role in ensuring that behavioral health needs are met, especially in underserved areas.

2. Should Nevada be divided into regions to provide services? While many states manage behavioral healthcare regionally, Nevada's geography and population patterns make it difficult to divide the state into regions. Clark and Washoe Counties could each be a region on their own, but the low population density in rural counties makes it difficult to develop a region that is small enough to be responsive to local needs and large enough to run a fiscally viable health program. Other states have found that a sufficient number of people are needed in a region to enable a government entity or private organization to take on the risk required in managed care contracts. In a regional model, the state will also need to develop an equitable formula for allocating funding that takes into account issues such as different service needs and economies of scale.

3. What type of entity should manage services? Nevada will need to decide whether to devolve authority to local governments or private organizations (for-profit and nonprofit). There is perceived benefit from having public agencies maintain responsibility for the mental health system, thereby ensuring an adequate safety net. However, it may be difficult for Nevada's counties to take on the role of managing behavioral health services since there is not a culture of local control or an infrastructure in place to take on this role. There is also concern that private entities will not adequately serve the most challenging consumers in an effort to contain costs. This issue can be addressed by designing incentives to reward private organizations for serving the most costly consumers.

   Some have argued that counties are not sophisticated or knowledgeable enough to administer a complex behavioral health system and it is best to rely on experienced nonprofit or for-profit organizations. However, states should be cautious with allowing contractors to exert too much control in the contracting process. The state should consider several key issues under either model:

a. Will there be increased costs to create a new public or private regional bureaucracy?
b. Do local governments or private organizations have the capacity to take on a substantial new responsibility or create new agencies?
c. How can the state ensure the least disruption of service for consumers? Behavioral health consumers may face challenges adapting to new service providers.
d. How would state facilities be utilized by the new agencies? Will the state lease these facilities to the new providers?

4. What are the human resources implications of changing the entity providing services? The Silver State would need to decide how to handle personnel issues for state staff that would like to transfer to the new agencies, such as salary levels, retirement credit, sick time, and vacation time. The state would also need to consider the impact on state staff if the new agencies are public vs. private. In North Carolina, many people lost their retirement or moved out of state when public agencies were required to divest their services and contract with external providers.

   Nevada should also ensure that the new structure does not exacerbate existing mental health provider shortages. Loan forgiveness programs can be effective tools to recruit and retain staff and the state should ensure that the new entities qualify as approved sites under the National Health Service Corps loan forgiveness program and other loan programs.[60]

5. Should there be a pilot project before moving to the whole state? Some states, such as Arizona, implemented a pilot project for changes in the service delivery structure prior to expanding to the whole state. Washington is also recruiting "early adopters" to implement its new governance model. A pilot program could help the state determine all the elements that should be in a contract before the new model is implemented statewide.

6. How should physical and behavioral health services be integrated? To address co-occurring disorders, many states have recently placed a high priority on integrating physical and behavioral health services. States have approached this goal in a variety of ways. In most states, behavioral health has traditionally operated in a silo separate from physical health. Under Medicaid, 24 states "carve out" some or all of their behavioral health benefits.[61] Oregon is the state farthest along on the integration continuum, with physical and mental health all under one global budget. In contrast, Arizona is implementing an approach that will maintain behavioral health as a specialty health plan but will add in physical health for adults with severe mental illness. Other consumers will continue to receive physical healthcare in a separate system.

   Research finds that "carve-outs" can be inadequate in addressing full-person health needs, even when the carved out plan provides both physical and behavioral health services.[62] Other research argues that carve-outs have been successful in lowering costs and maintaining or improving access.[63] Maintaining separate behavioral health and physical health plans also requires guidelines for when a person should be in one system versus the other. The experience of the states profiled in this report indicates there can be variability in how these guidelines are implemented. These guidelines also can create an incentive for providers to move more expensive consumers into the other plan.

Structure of Governing Boards

7. How should governing boards be organized to facilitate coordination across agencies? Governing boards are organized in many different ways in other states. Several decision points will need to be considered:
    a. Should the state emulate the structure of the existing regional Children's Behavioral Health Consortia? Three regional consortia are required in statute (Clark County, Washoe County, and rural counties). There is also a statewide consortium that coordinates the activities of the three boards.
    b. Should the local governing boards have operating authority or policy advisory authority? The Children's Behavioral Health Consortia are advisory. Our comparison of various models suggests that boards can be more effective if they have policymaking authority.
    c. What types of people should be on governing boards and should this be defined in statute? Some of the states included in our analysis have very specific membership requirements while Washington allows counties to decide board composition through interagency agreements. In Nevada, the members of the Children's Behavioral Health Consortia are specified in statute and include representatives of other agencies to take a holistic approach to behavioral health. If Nevada creates something similar to Oregon's Coordinated Care Organizations, the board members could include the managed care organizations, counties, individuals with specific areas of expertise, and consumers/family members. However, this type of model can lead to conflicts of interest. Other models require appointees to not have a financial interest in the services being provided. The state also should consider whether law enforcement officials should be on the governing boards since they have direct interaction with mental health issues. It is also important to ensure that boards include people with knowledge of behavioral healthcare and issues.
    d. How should the unique needs of rural communities be addressed? Given that rural regions will likely include several counties, it will be important to work out issues such as how many appointees will represent each county, where the board will meet, and how the board will ensure it receives input from the entire region.
    e. Should the state also establish local advisory councils to provide a voice for the community within each county or region? Local advisory councils can help ensure services are responsive to local needs, but our research shows they have varying levels of effectiveness. The state also will need to consider what financial and personnel resources will be necessary for an effective advisory council structure.

8. What is the appropriate role for providers on governing boards? Several of the states we profiled (Missouri, Ohio, and Virginia) specifically exclude providers from governing boards while Oregon includes them. While having providers on governing boards could lead to conflicts of interest, they also have a lot of important knowledge and need to be involved in the governance system to ensure the provision of high quality services. Some states, such as Missouri, include providers on advisory boards to address these concerns.

Funding

9. What funding sources should be part of the system? Most behavioral health reform efforts have focused on Medicaid since it is typically the largest portion of funding and most likely to apply to persons with severe mental illness. However, states also use state General Funds and federal grants for behavioral health services. Arizona is combining all of these funding sources together

to be administered by its regional entities. Oregon implemented its new system using only Medicaid but is examining the inclusion of state and federal funding sources traditionally administered by counties. In Nevada, some services are jointly funded with state and federal funds. It may be difficult to continue providing these services if state and federal funds are not administered together.

10. Should there be a local match? As shown in Attachment A, 25 states use local funding to provide behavioral health services but only 15 states require a local match. A match requirement creates an incentive for local governments to ensure that funds are spent efficiently and effectively and to encourage collaboration with other agencies. Virginia and Washington require a local match, but this requirement is often either waived or not enforced.

    Several of the states we studied have an option for cities and counties to approve a local tax specifically for mental health, including Missouri, Ohio, and Washington. However, not all jurisdictions are successful in adopting these taxes. Local governments also sometimes contribute general funds for behavioral health but these funds usually come only from large or prosperous counties. Because not all jurisdictions have taxes in place, there are disparities between counties and within regions. Nevada also could create a new local tax that must be levied by all counties.

11. How should Medicaid-funded behavioral health services be administered? Medicaid has several payment models, which determine the amount of risk an entity takes. A summary of these models is included in Appendix B. Fee-for-service models do not carry risk but can result in high costs. In contrast, managed care and accountable care organization models carry risk by providing a set amount of funding per person enrolled, but can create incentives to discriminate against heavy users or provide low reimbursement rates for providers. In addition, managed care models can be difficult to implement in rural areas because there are not enough enrollees to spread the risk. Nevada may also wish to consider changing its current model where the state serves as a provider in the managed care system that it oversees.

12. What funding will be available to transition to a new governance structure? Nevada will likely need additional funding to develop and implement a new governance structure for mental health. Federal funding may be available if behavioral health transformation is planned within the context of overall physical health. Two of the states included in our analysis, Oregon and Washington, have received federal funding from the State Innovation Models Initiative to help plan and implement their new physical and mental health governance systems.[64] Virginia also recently applied for funding under this grant to create a healthcare transformation plan. In addition, Oregon is receiving approximately $1.9 billion in federal funds over five years through a waiver called Designated State Health Programs, which is only received if certain goals are met.[65]

Outcomes and Information Technology

13. How can the state create incentives to achieve positive outcomes with the least expensive, most appropriate care? This is perhaps the most difficult and complex set of decisions the state will need to make. Contracts can be structured in several ways to incentivize the desired behavior:
    a. Should incentives be structured as rewards or penalties? The state will need to decide the right balance between positive and negative incentives. For example, Oregon uses positive incentives by returning a portion of savings generated in return for positive

outcomes. In contrast, Washington has used negative incentives to require regions to pay for hospital bed costs that exceed an allocation. Regions are rewarded for underutilizing their allocations.

b. Should the state set up formulas and requirements to discourage hospital use? Several of the states we profiled have developed incentives to control hospital use. For example, some states use local entities to control hospital admissions or require the local entity to pay for hospital costs. Some hospital incentive formulas have met with limited success. In Washington, it appears that the incentive program described above has not been successful. While regions generally stay within their allocations, there has been a simultaneous reduction in the number of state hospital beds and insufficient investment in alternative care within the community. This has led to a boarding crisis of psychiatric patients in emergency rooms that has been the subject of a state Supreme Court case.[66] Ohio also had an incentive program that rewarded agencies for reducing hospital use, but there was not an overall reduction in hospital use and the program was discontinued after two years.
c. Should the state set aside funds or create programs to ensure that funds follow consumers when they leave a psychiatric hospital? For example, Connecticut has a grant program to help people transition out of the hospital into other services. Pennsylvania has a program that allows money previously used for state hospital psychiatric treatment to be used for persons discharged to the community.
d. Should the state develop performance incentives that reward agencies for reducing costs only if they also improve outcomes? Most incentives in behavioral healthcare merely reward reducing costs, which creates an incentive to reduce services and provider rates. Some states are experimenting with performance contracts that reward savings and positive outcomes. Oregon has a formula that provides financial incentives for agencies that meet performance benchmarks while North Carolina is developing an incentive program with greater rewards for simultaneously achieving quality goals and savings.
e. How should the state encourage innovation? Nevada can also incentivize implementation of innovative service delivery models that reduce costs and improve outcomes. For example, in light of the shortage of psychiatrists, entities may experiment with greater use of lower cost, collaborative teams of mental health professionals such as social workers or licensed clinical counselors.
f. Which outcomes should the state track? Decision makers need to pick outcomes wisely to incentivize desired behavior. In the beginning, Nevada may want to define only a few outcomes that are easy to understand and measure, such as days in the hospital, days homeless, or days in jail. Decision makers should avoid having too many outcomes, setting low standards, or measuring treatment episodes as opposed to improvement in health status.

14. <u>How can the behavioral health system provide supportive housing services?</u> The Behavioral Health and Wellness Council has identified supportive and low cost housing as a critical unmet need for persons with behavioral health issues. The state should consider how it can more effectively coordinate with existing housing authorities and how it can leverage resources to meet housing needs. For example, Ohio used state funds freed up by the Medicaid expansion to provide supportive housing services. Nevada can also explore how it can build capacity by providing training for people who would like to operate supportive housing services.

15. What information technology changes are needed to implement a new governance system?
    Nevada will need to build an information technology infrastructure that meets its oversight needs as well as the needs of providers. The state currently has two behavioral health information technology systems, one in the Division of Public and Behavioral Health and second in the Division of Children and Families. Our comparative analysis suggests that there are advantages of using a single, unified information technology system to standardize the data being collected and to move towards more outcome-based contracts. Standardization will be especially critical if the new system includes many public or private providers. To provide integrated physical and behavioral healthcare, the state also should consider how to incentivize providers to create electronic health records that can be shared across providers. Oregon has achieved success in this area by including electronic health records in its performance contracts.

Conclusion

This review of behavioral health governance models around the country illustrates that Nevada is not alone in its struggle to develop and implement a governance model that will result in quality outcomes for persons facing behavioral health challenges. The state is relatively unique on many fronts, including the structure of its mental health system, the population distribution across the state, and the state and local government tax structure. However, each state reviewed in this report offers lessons that can be utilized by Nevada to build a quality behavioral health governance system.

The four guiding principles presented in this report furnish an overall framework for decision makers to use in designing a new governance structure: providing the best care at the lowest cost; encouraging savings across programs and agencies; ensuring that money follows the client from the hospital to the community; and holding providers accountable for positive outcomes. Each decision the state considers should be evaluated against the guiding principles.

The 15 decision points included in this report can be used to create high quality contracts that reflect the guiding principles. Each presents tradeoffs the state will need to make as it develops a new mental health governance structure. Lessons learned by the states we reviewed can help inform decision makers about which strategies have been more successful than others and which structures are needed to incentivize the desired outcomes.

While putting in place sound, well-reasoned policies will be integral to establishing a quality mental health structure, the importance of leadership, commitment and collaboration are equally important. The Governor's Behavioral Health and Wellness Council has helped initiate much needed reforms, and it will take the collective effort of state agencies, providers, social services, consumers, and families to build a system that meets the needs of Nevadans.

Appendix A: State Mental Health Agency Organizational Structure Summary: 2013

Appendix B: Medicaid Models

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State Mental Health Agency Organizational Structure Summary: 2013

State	Primary mechanism to provide community-based health services	Extent to which county or city authorities administer mental health services	Some counties merge together to form multi-county mental health authorities?	Local government contribution to pay for mental health services?	Local contributions required by the state?	Board or Council charged with direct oversight of the state mental health authority	Expanding Medicaid
Alabama	State funded but not operated	Not at all					
Alaska	State funded but not operated	Not at all					
Arizona	State funded but not operated	Statewide					Yes
Arkansas	State funded but not operated						Yes
California	State funds county/city to fund or operate services	Statewide	Yes	Yes	Yes		Yes
Colorado	State funded but not operated	Not at all					Yes
Connecticut- Adult		Not at all				Yes	Yes
Connecticut- Children	State funded but not operated	Not at all					Yes
Delaware	State funded but not operated	Not at all					Yes
District of Columbia	State funded but not operated	Not at all					Yes
Florida	State funded but not operated	Only in select parts of the state	Yes	Yes	No		
Georgia	State funded but not operated	Only in select parts of the state	No	Yes	No	Yes	
Hawaii	State funded but not operated	Not at all					Yes
Idaho	State operated	Not at all					
Illinois	State funded but not operated	Only in select parts of the state	No	Yes	No		Yes
Indiana	State funded but not operated	Not at all					
Iowa	State funds county/city to fund or operate services	Statewide	Yes	Yes	Yes		Yes
Kansas	State funded but not operated	Not at all	No	No			
Kentucky	State funded but not operated	Not at all					Yes
Louisiana	State funded but not operated	Not at all				Yes	
Maine	State funded but not operated	Not at all				Yes	
Maryland	State funded but not operated	Statewide	Yes	Yes	No		Yes
Massachusetts	State funded but not operated	Not at all				Yes	Yes
Michigan	State funds county/city to fund or operate services	Statewide	Yes	Yes	Yes		Yes
Minnesota	State funds county/city to fund or operate services	Statewide	Yes	Yes	Yes		Yes
Mississippi	State funded but not operated	Only in select parts of the state	Yes	Yes	Yes	Yes	
Missouri	State funded but not operated	Only in select parts of the state	No	Yes	No	Yes	
Montana	State funded but not operated	Statewide	Yes	Yes	Yes	Yes	
Nebraska	State funds county/city to fund or operate services	Statewide	Yes	Yes	Yes		
Nevada	State operated	Not at all				Yes	Yes
New Hampshire	State funded but not operated	Not at all					Yes
New Jersey	State funded but not operated	Not at all					Yes
New Mexico	State funded but not operated	Not at all				Yes	Yes
New York	State funds county/city to fund or operate services	Statewide	Yes	Yes	Yes		Yes

State	Primary mechanism to provide community-based health services	Extent to which county or city authorities administer mental health services	Some counties merge together to form multi-county mental health authorities?	Local government contribution to pay for mental health services?	Local contributions required by the state?	Board or Council charged with direct oversight of the state mental health authority	Expanding Medicaid
North Carolina	State funds county/city to fund or operate services	Statewide	Yes	Yes	No	Yes	
North Dakota	State operated	Not at all					Yes
Ohio	State funds county/city to fund or operate services	Statewide	Yes	Yes	No		Yes
Oklahoma	State funded but not operated	Not at all				Yes	
Oregon	State funds county/city to fund or operate services	Only in select parts of the state	Yes	Yes	No		Yes
Pennsylvania	State funds county/city to fund or operate services	Statewide	Yes	Yes	Yes		Yes
Rhode Island	State funded but not operated	Not at all					Yes
South Carolina	State operated	Not at all				Yes	
South Dakota	State funded but not operated	Not at all					
Tennessee	State funded but not operated	Not at all					
Texas	State funds county/city to fund or operate services	Statewide	Yes	Yes	Yes		
Utah	State funds county/city to fund or operate services	Statewide	Yes	Yes	Yes		
Vermont	State funded but not operated	Not at all				Yes	Yes
Virginia	State funds county/city to fund or operate services	Statewide	Yes	Yes	Yes		
Washington	State funds county/city to fund or operate services	Statewide	Yes	Yes	Yes		Yes
West Virginia	State funded but not operated	Not at all					Yes
Wisconsin	State funds county/city to fund or operate services	Statewide	Yes	Yes	Yes		
Wyoming	State funded but not operated	Only in select parts of the state	No	Yes	Yes		

Source: NRI Analytics Improving Behavioral Health, State Mental Health Agency Profiling System: 2013 , http://www.nri-incdata.org/

Category	Option	Description	Advantages	Disadvantages/ Challenges
Medicaid Payment Models	Accountable Care Organization (ACO)	1. Provider-led collaborations with a strong base of primary care, which may include physicians, hospitals, and other health service providers. 2. Accountable for improving health outcomes and quality of care while slowing the growth of overall costs for a defined population of patients. 3. Payments increase with measurable improvements in care, outcomes, and cost trends.	1. Can provide more flexibility in deciding how to spend resources. 2. Can help coordinate care of people who have not had access to reliable primary and preventive care and other vulnerable patient populations. 3. Can improve beneficiaries' health through improved quality care and coordination. 4. Can reduce state costs for health.	1. Can result in reductions in quality and access to care for vulnerable beneficiaries, particularly those with high costs, given stronger financial incentives for providers to reduce utilization. 2. Low payment rates in Medicaid can make it difficult to reduce costs. 3. State saves only the state portion of Medicaid 4. Too much new accountability for costs or quality improvement may deter participation or risk quality problems.
	Administrative Service Organization (ASO)	Contract to administer, or manage, claims and benefits for a fixed administrative fee while bearing little or no risk for the cost of delivering care. ASOs may also contract to provide other functions, such as provider and member services, data reporting, provider network development, care coordination and disease management services.	1. Can control costs by managing claims and benefits 2. Can aggregate data and provide it to state for decisionmaking	1. Contractor does not assume risk making it more difficult to control costs
	Fee for Service	A plan or Primary Care Case Management (PCCM) is paid for providing services to enrollees solely through fee-for-service payments plus in most cases, a case management fee.	1. Can be preferred by providers because of higher reimbursement 2. May be the only alternative in areas with limited population	1. Difficult to monitor which providers are billing for services 2. Difficult to control which services are billed, can lead to billing for unnecessary services 3. Costs can rapidly increase
	Managed Care Organization (MCO)	Patient care is paid on a capitation basis. This means MCOs are paid a monthly premium for each enrolled beneficiary in exchange for assuming the financial risk for providing comprehensive Medicaid benefits or a defined set of benefits. Contracts can be full-risk or partial risk, where some services are reimbursed on a fee-for-service basis.	1. Increases the predictability of state expenditures 2. Can provide the opportunity to coordinate care for high cost clients	1. Quality and accessibility of care may be reduced due to fixed funding 2. Cap on funding can result in low provider reimbursement rates and unwillingness of providers to take Medicaid patients 3. Service regions must have a sufficiently large Medicaid population to absorb the risk

Category	Option	Description	Advantages	Disadvantages/ Challenges
Provider Based Managed Care Strategies	Health Homes	Health homes involve the integration and coordination of primary, acute, mental and behavioral health, and long-term services and supports. Services include comprehensive care management; care coordination and health promotion; comprehensive transitional care, including appropriate follow-up, from inpatient to other settings; patient and family support; referral to community and social support services, if relevant; and use of health information technology to link services, as feasible and appropriate	1. Emphasizes integrated health care 2. Can include financial incentives to help ensure that providers will deliver health home services effectively and efficiently 3. Emphasizes quality measures	Challenges in health homes implemented: 1. Determining who incurs costs and who benefits from the return on investments 2. Inadequacy of data systems to meet provider needs, including electronic health records 3. Difficulty in providing sufficient, time, training, and funding to fully implementing the model
	Primary Care Case Management (PCCM)	A program where the State contracts directly with primary care providers who agree to be responsible for the provision and/or coordination of medical services to Medicaid recipients under their care. Currently, most PCCM programs pay the primary care physician a monthly case management fee in addition to reimbursing services on a fee-for-service basis.	1. Emphasizes coordination of care	1. Used primarily in fee for services models, which can make it more difficult to control costs

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