1987-2017 30 years

NRI

Analytics Improving Behavioral Health SM

Value Based Purchasing: The Role of State Mental Health Systems

Ted Lutterman

Senior Director of Government & Commercial Research

National Association of State Mental Health Program Directors Research Institute (NRI)

State Mental Health Authorities (SMHAs)

- The State Mental Health Authority (SMHA) is the state agency dedicated in charge of the provision of state mental health services.
- Typical responsibilities:
  - Operate psychiatric inpatient services for persons dangerous to themselves or others
  - Fund or operate a comprehensive array of community mental health services
  - Plan for mental health service development, address unmet need, set standards for services, license mental health providers, monitor quality and outcomes
- Coordinate financing and delivery of services with other state government agencies

Organization of State Mental Health Authorities (SMHAs)

- State Governments have been assuring the provision of mental health services for over 200 years
  - Virginia opened the first state hospital in 1773 (still operating today as Eastern State Hospital in Williamsburg, VA. Several early directors went on to sign The Declaration of Independence)

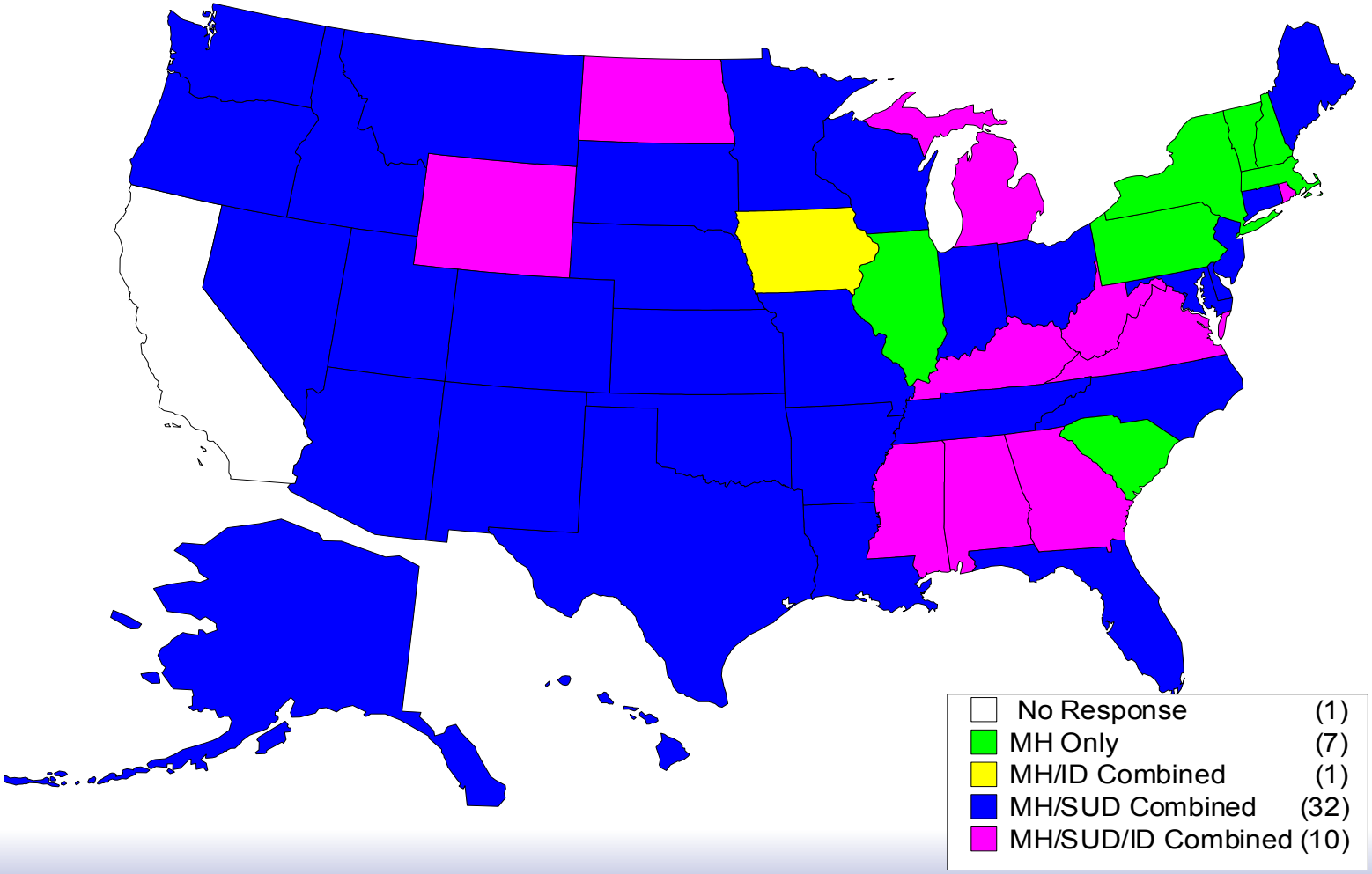
- By 1900, every state government was operating state psychiatric hospitals and beginning in the 1950s, states began to open or fund community-based mental health services
  - By 1955, over 550,000 individuals were residing in state and county psychiatric hospitals

Organization of SMHAs

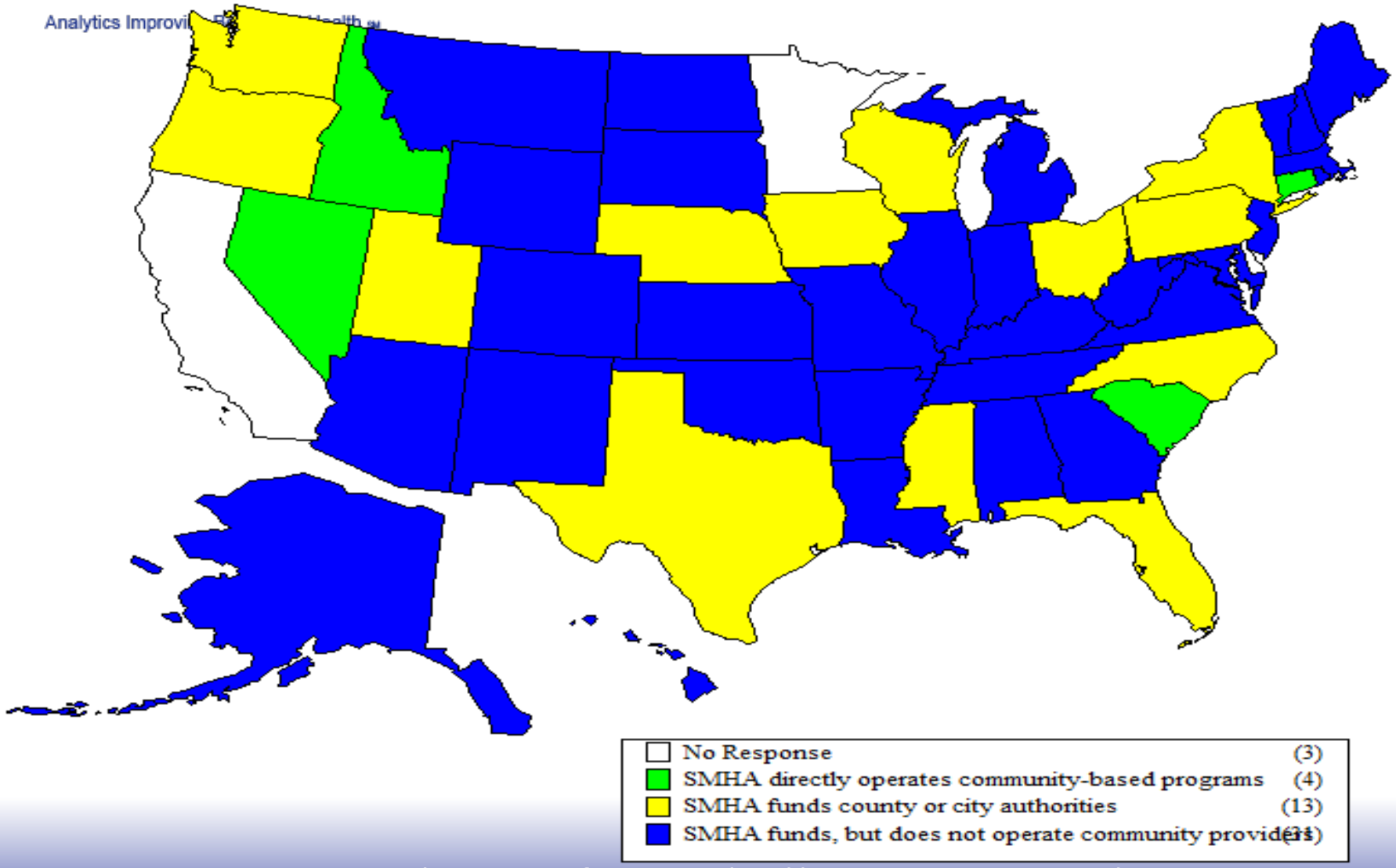
Until the 1970s, most SMHAs were combined independent State Departments of Mental Health and "Mental Retardation".

- In 2017, the majority SMHAs are now part of a larger Department of Health or Health and Human Services
  - In 12 states, the SMHA is a separate cabinet department
  - Most (28 states) have the SMHA located in the same umbrella department as the State Medicaid Agency
- Intellectual Disability Services have been moved away from the SMHA and Substance Abuse Combined in most states
  - 42 states have now **combined mental health and substance abuse services**
  - 11 state have combined responsibility for Intellectual Disabilities with the SMHA

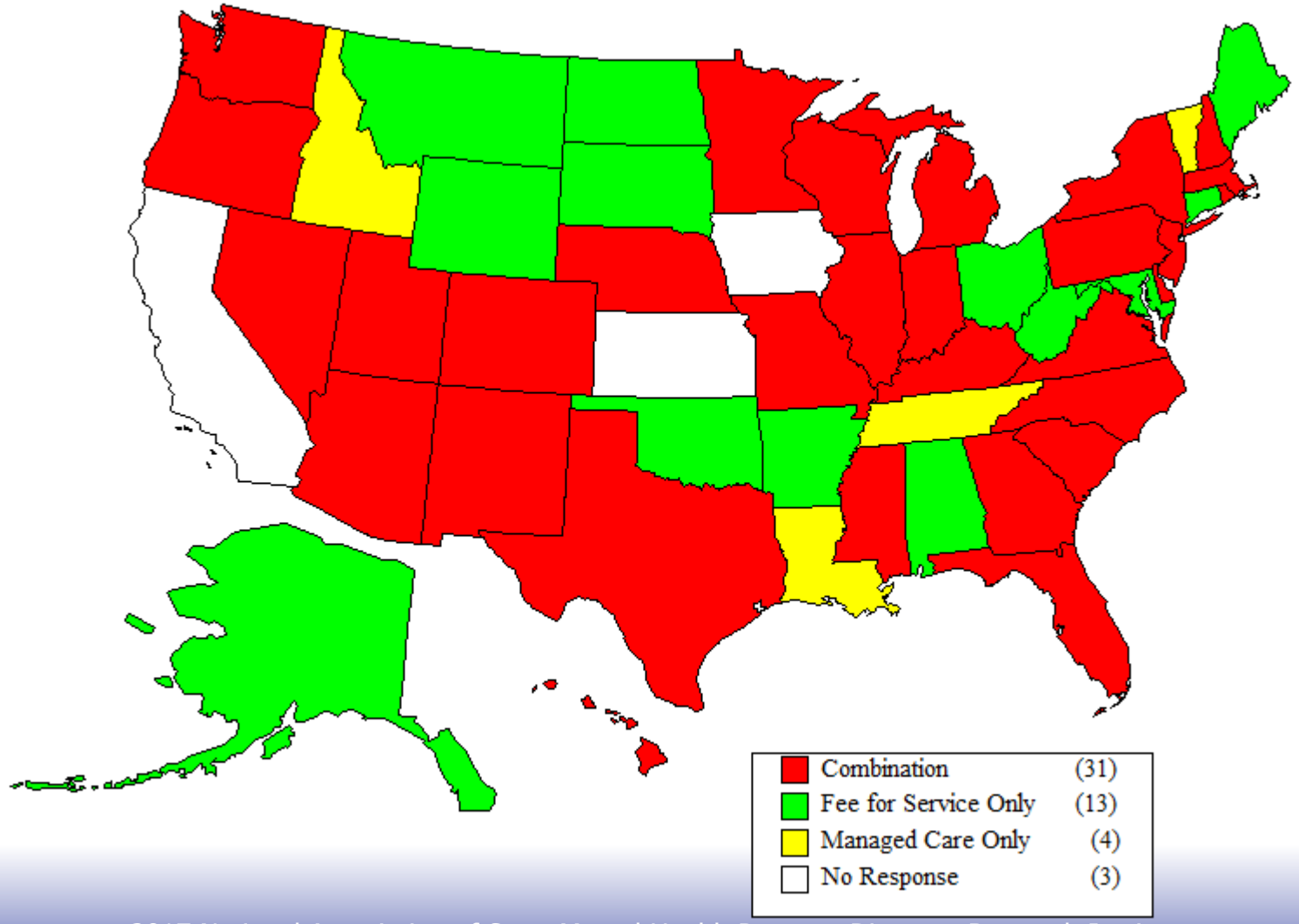
Organization of Mental Health, Substance Use Disorder, and Intellectual Disability Services in State Government, 2017



Primary Mechanism Used by SMHAs to Administer Community Mental Health Services: 2015



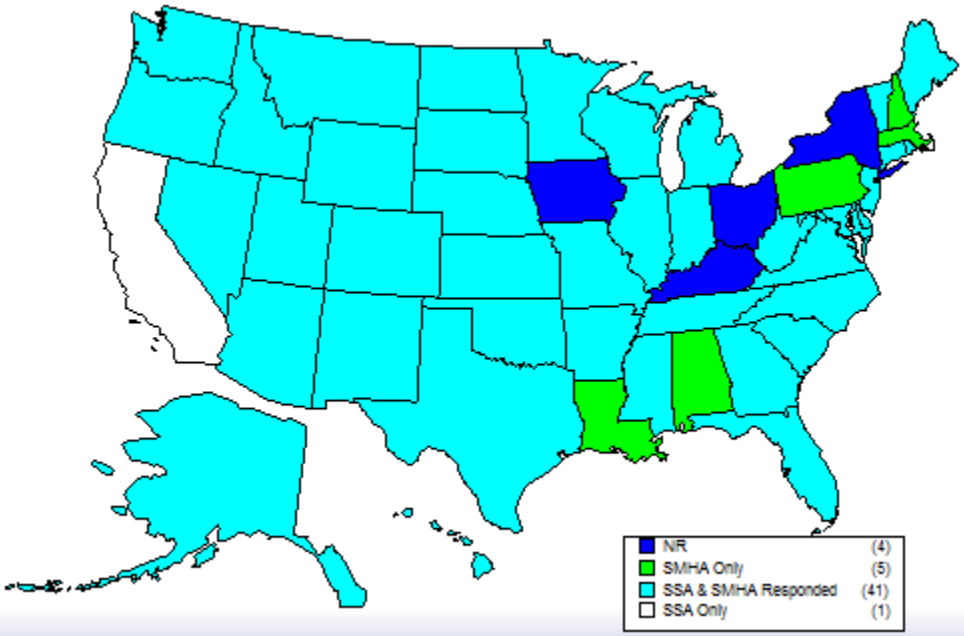
Medicaid Reimbursement Approaches for Mental Health Services, by State, 2015



SMHA and SSA Activities for Health Insurance Reform: 2015

NRI and NASADAD Compiled Information about SSA and SMHA Activities Related to Health Insurance Reform

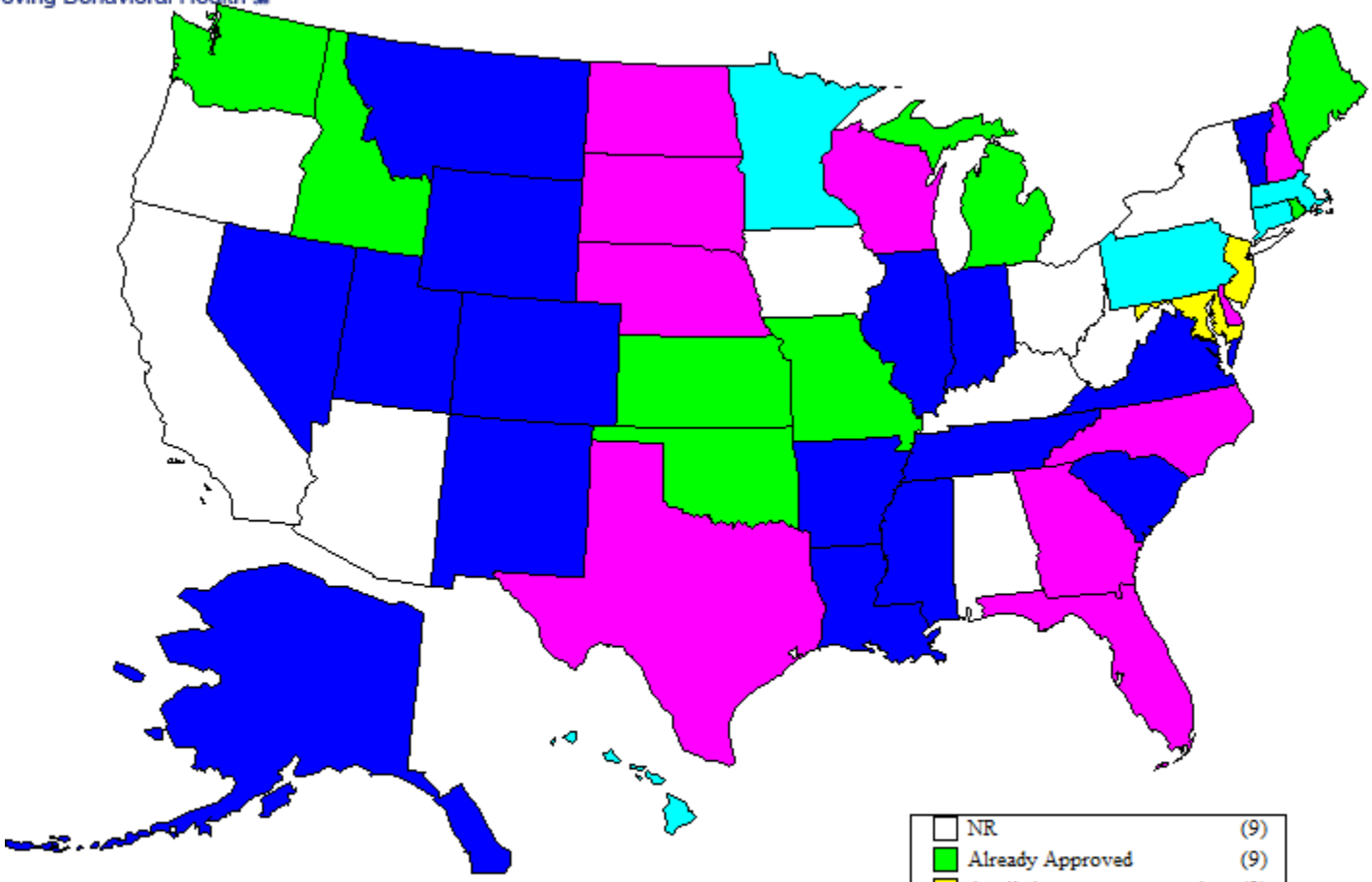
- 46 SMHAs Responded
- 42 SSAs Responded
  - 4 States No response



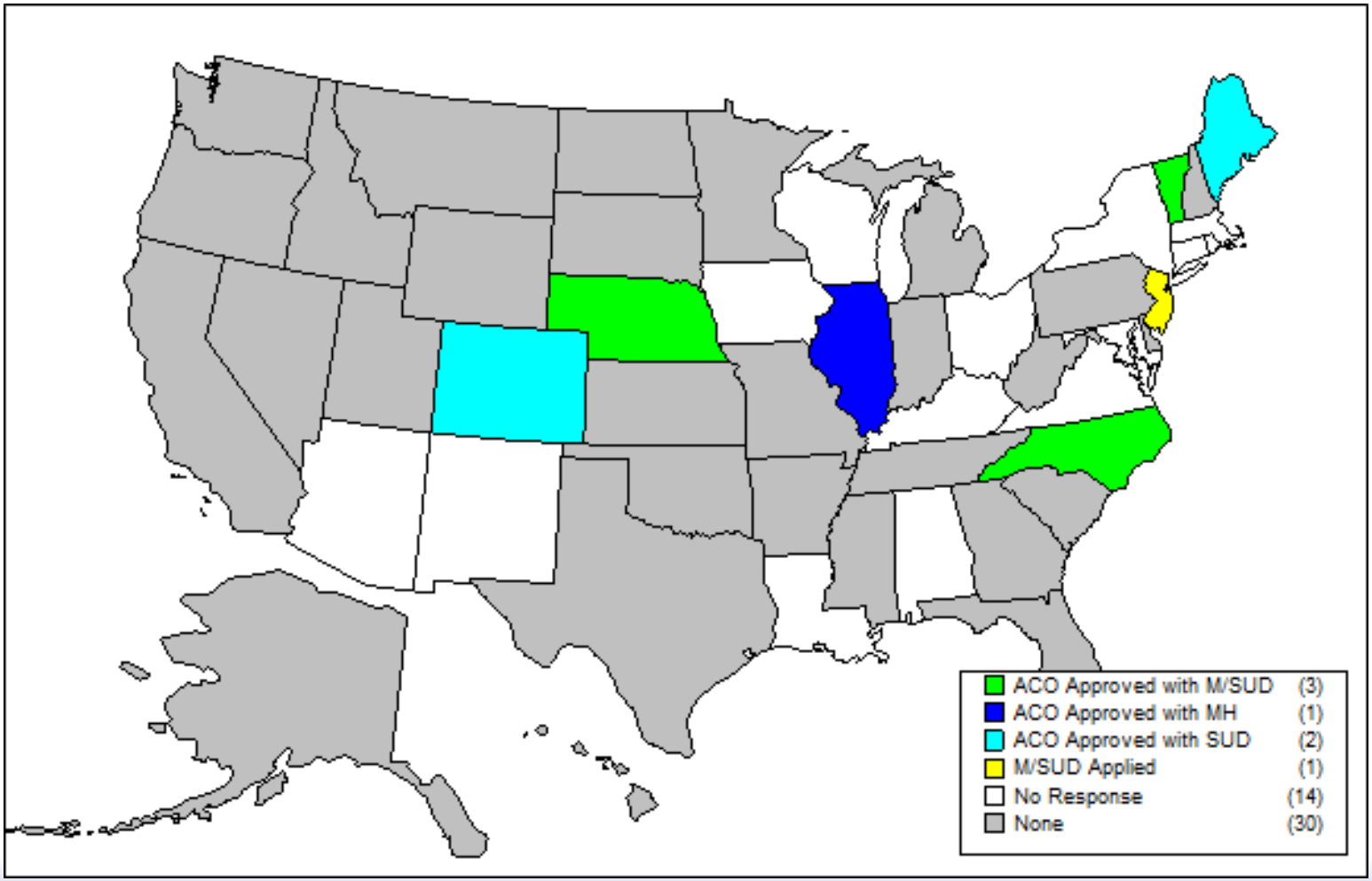
SMHAs and SSAs Working with Medicaid Behavioral Health Homes: 2015

- Most states are either already using or are applying to establish Medicaid Health Homes that integrate and coordinate the Behavioral Health Needs of consumers with their physical health care
  - ACA Section 2703 provides a State Option in Medicaid to offer a State Plan to establish Health Homes to coordinate care for people with Medicaid who have chronic conditions
  - Only 11 SSAs and 10 SMHA were NOT applying to use a Medicaid Health Home to provide behavioral health services

Use of Medicaid Health Homes to Provide MH Services: 2015



SSAs and SMHAs Working with Accountable Care Organizations (ACOs): 2015



Activities SSAs and SMHAs are Undertaking with Medicaid Directors and State Insurance Commissioners: 2015

	SSA		SMHA	
	Yes	No	Yes	No
Working with State Medicaid Agency on MH and SUD Benefits in Alternative Benefit Plan	26	10	24	13
All SUD and MH Providers Were Certified Medicaid Providers	13	23	21	16
If not, how many (and what percent of) providers are NOT Certified	52	33.4%	35	4.8%
Are all Private Practitioners and Individual Counselors/Clinicians Certified to Bill Medicaid for BH Services	5	27	8	23
Working with State Insurance Commissioner on MH and SUD Benefits in Benefit Plans	9	29	9	29
Working with State Insurance Commissioner on Enforcement of Parity Issues	6	32	6	32

Based on 42 SSAs and 45 SMHAs Reporting

Focus on Evidence-Based Practices

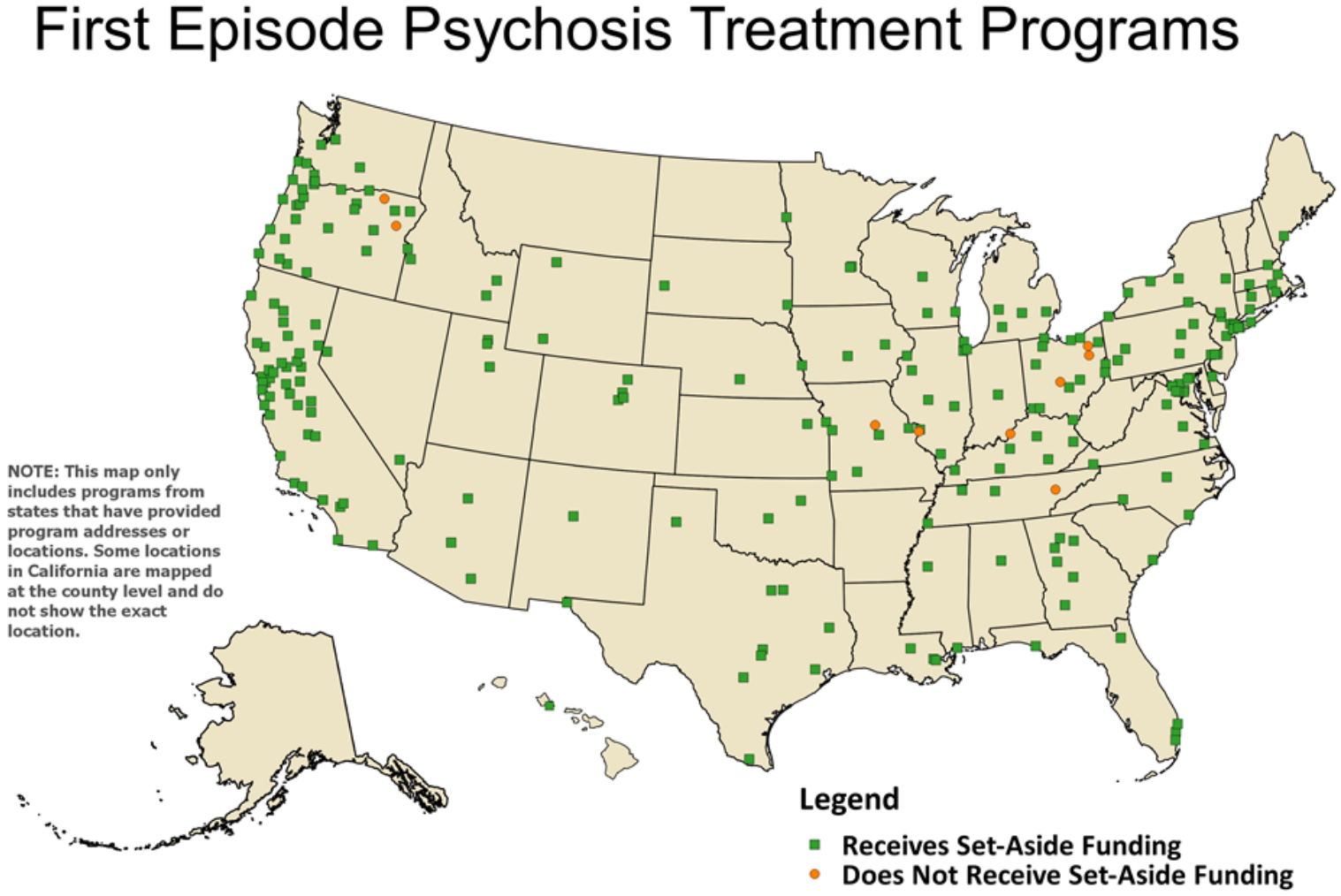
- States are continuing to focus on provision of Evidence-based Practices. Practices shown to increase outcomes and/or reduce costs
  - Assertive Community Treatment, Supported Housing, Supported Employment are available in most states,
    - But with still limited universal availability.
    - Often now covered by Medicaid through waivers and options
- Congress has increased funding for EBPs– For example, the Mental Health Block Grant Set-aside for Early Intervention for Psychosis
  - Congress provided $50 million additional funds for the set-aside

CSC Implementation

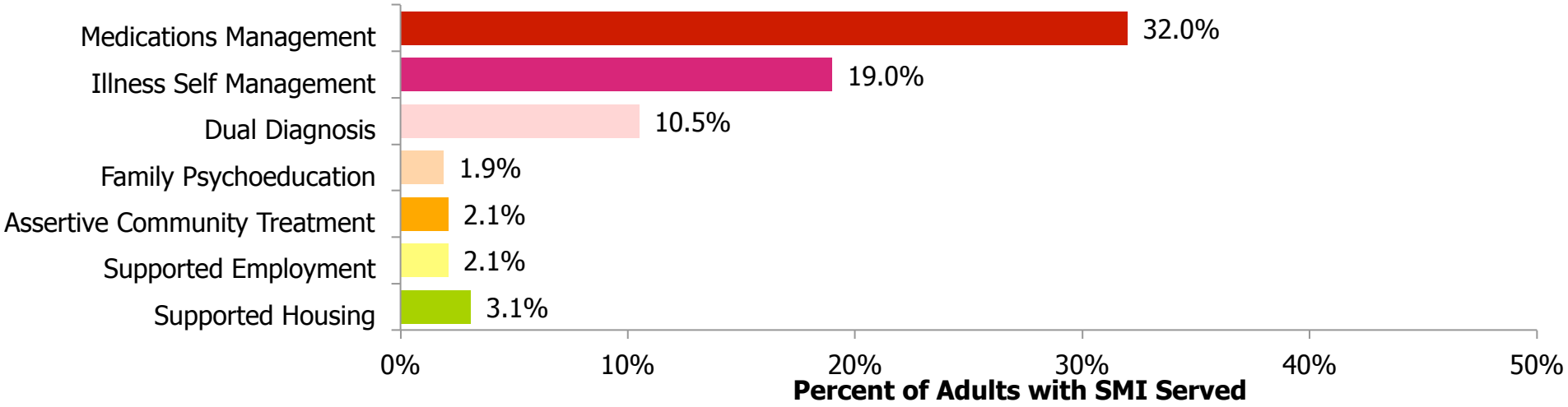
In 2017, states reported 261 CSC programs (251 funded by the MHBG set-aside and 10 that had other funding).

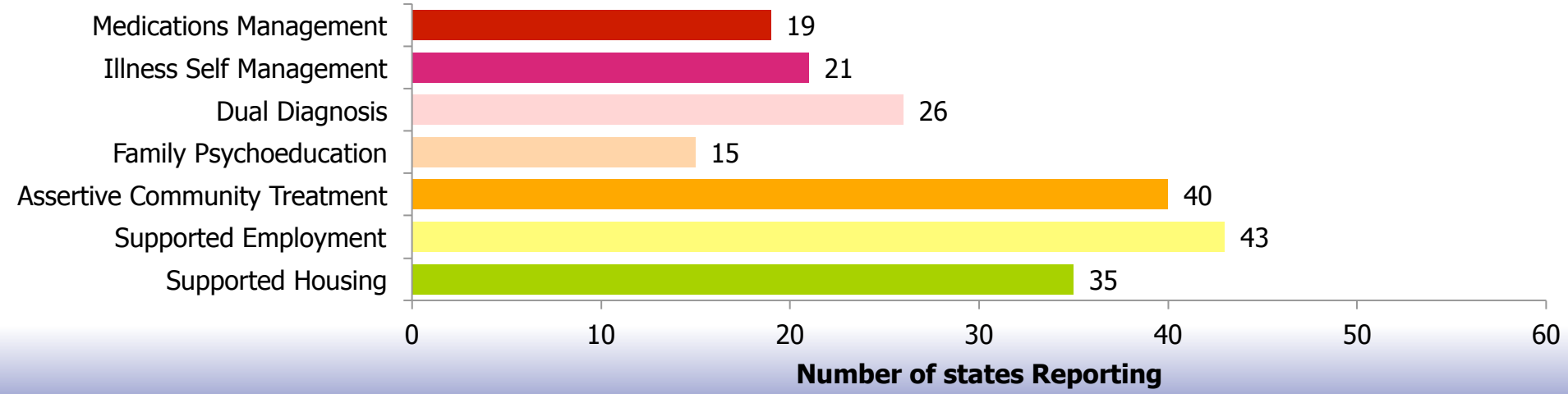
Number of CSC Programs by Implementation Phase and Funding Source		
FEP Treatment Program Implementation Phase	**Receiving Set Aside Funds**	**Total Number of Programs**
Exploration	4 programs	4 programs
Installation	33	33
Implementation	141	144
Program Sustainability	73	80
Total	**251**	**261**

Locations of Set-Aside Supported FEP Treatment Programs (CSC only)



Percent of Adults with SMI Receiving EBPs/ Number of States Reporting: 2016 URS





SMHAs and SSAs Are Experiencing Difficulties Getting Private Insurance to Pay for Evidence-Based Practices (EBPs): 2015

Number of SSAs and SMHAs experiencing difficulty getting private insurance to pay for EBP services

Evidence-Based Practices	Private Insurance			
	SSA		SMHA	
	Yes	No	Yes	No
Supported Housing	18	6	20	5
Supported Employment	17	6	18	4
Assertive Community Treatment	16	7	18	5
Peer Supports	16	4	16	3
Medication Assisted Treatments	17	8	8	8
Other	3	2	3	1

Based on 42 SSA s and 45 SMHAs Reporting


ENTRANCE
MENTAL HEALTH
TREATMENT
CENTER

1987-2017 30 years

NRI

Analytics Improving Behavioral Health SM

Available State Level Data on Clients Served and Outcomes of SMHA Services:

SAMHSA's Uniform Reporting System and National Outcome Measures (NOMs) and Mental Health Client Level Data (MH-CLD)

Provision of Mental Health Services (2016)

- 7.4 million individuals received services from SMHA systems in 2016
  - 2.3% of the US population received services from State Mental Health Agencies
- SMHA systems controlled the expenditures of over $43.5 billion to provide mental health services to these clients
  - $135.80 per resident in states

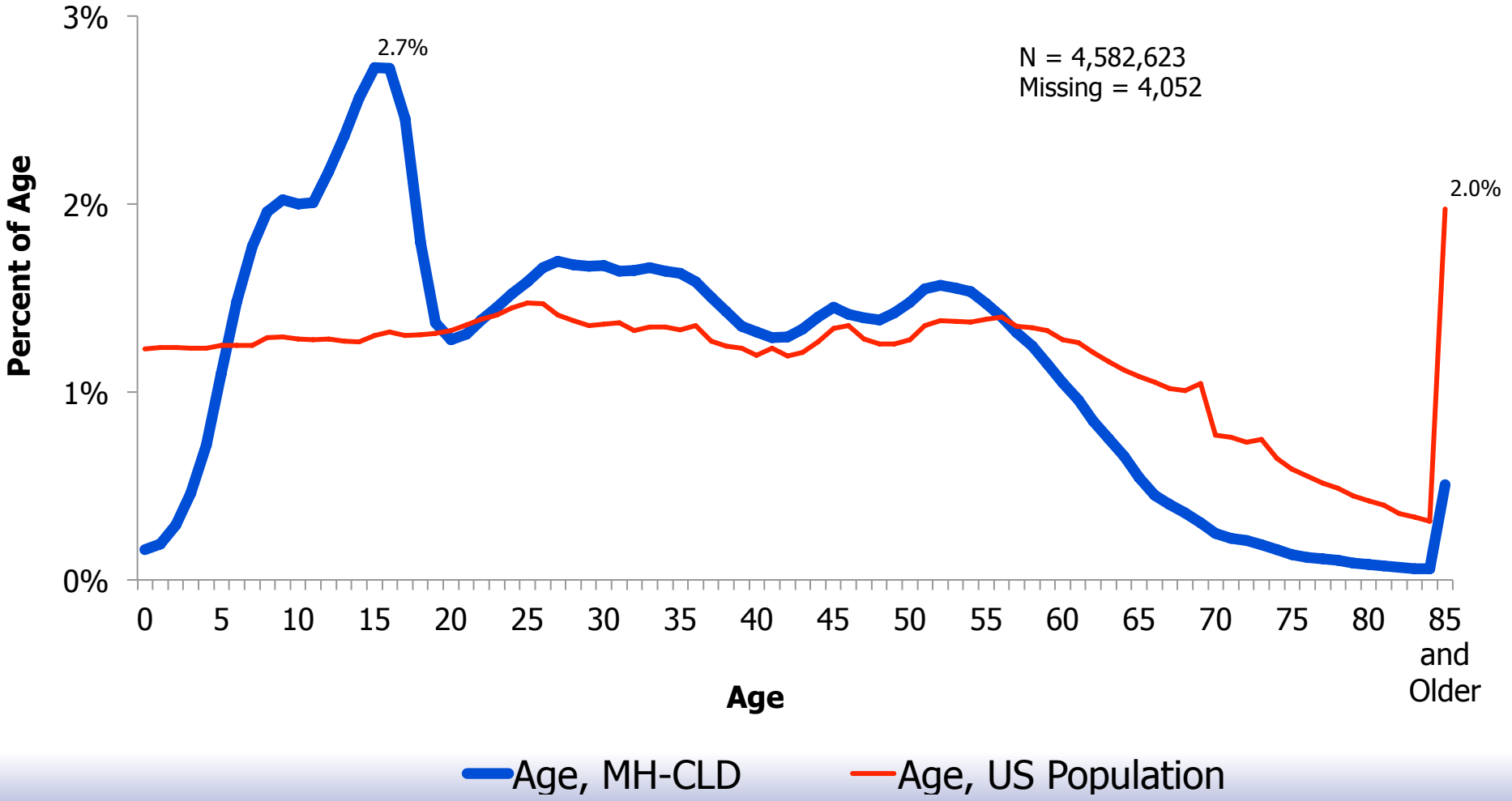
Percent of Clients Served, by Service Setting: 2016 URS

- 97% of clients received community-based mental health services
  - 22 per 1,000 population
- 1.8% of clients received services in state psychiatric hospitals
  - Range from less than 1% of clients (in 11 states) to 12% in (2 states) of total clients served
- 4.7% of clients received services in other psychiatric inpatient settings (35 states reporting)

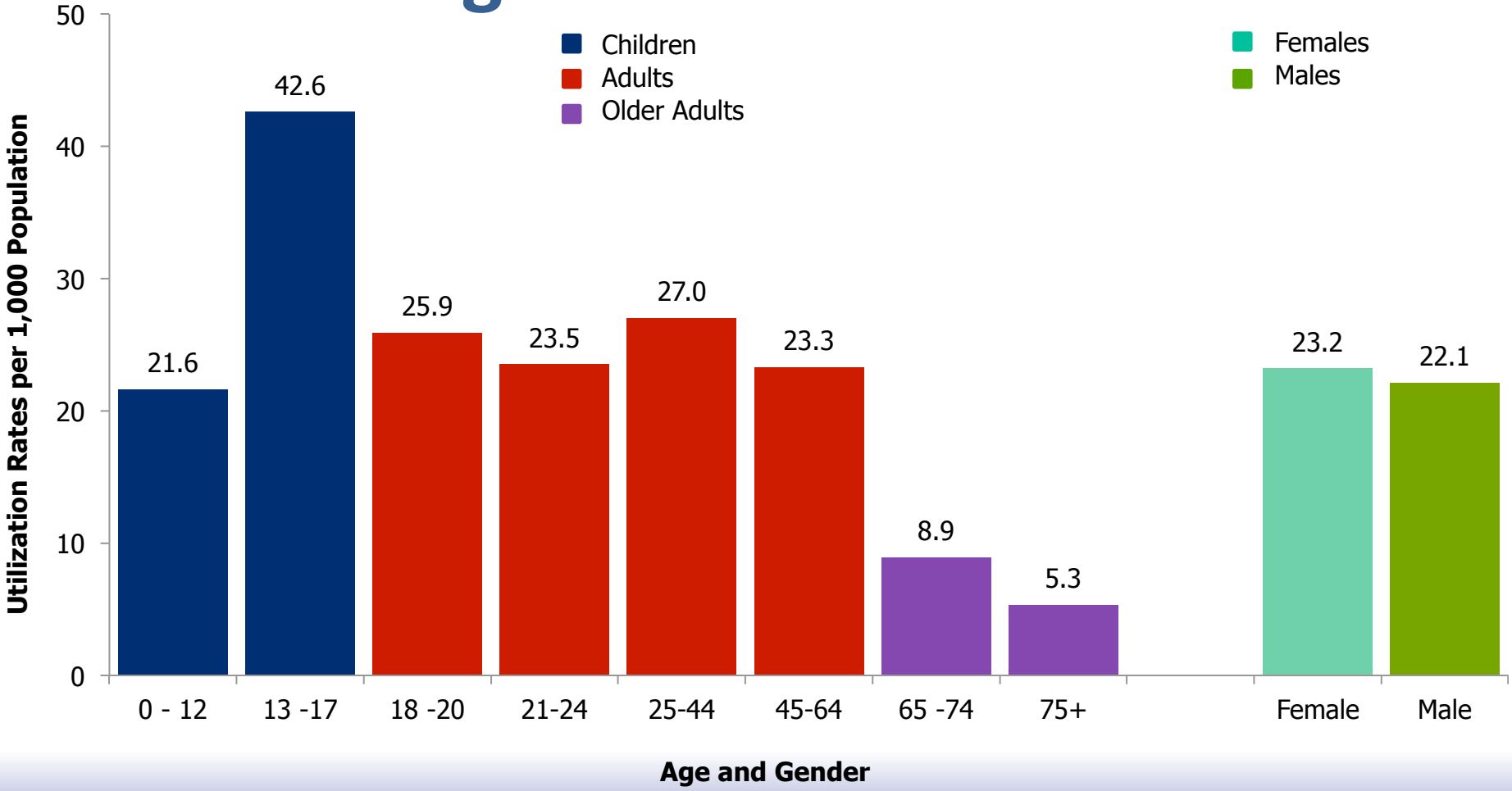
Characteristics of Mental Health Consumers Served by SMHAs (2016)

- Slightly more females (52%) than males (48%)
- Majority of clients served were White (61.6%), followed by Black or African-Americans (18.9%)
- 70% of SMHA clients had Medicaid pay for some or all of their mental health services
- 24.5% of adult mental health clients were competitively employed
- 5% of adult mental health clients were homeless
- 67% of all adults served had a serious mental illness and 69% of all children served had a serious emotional disturbance

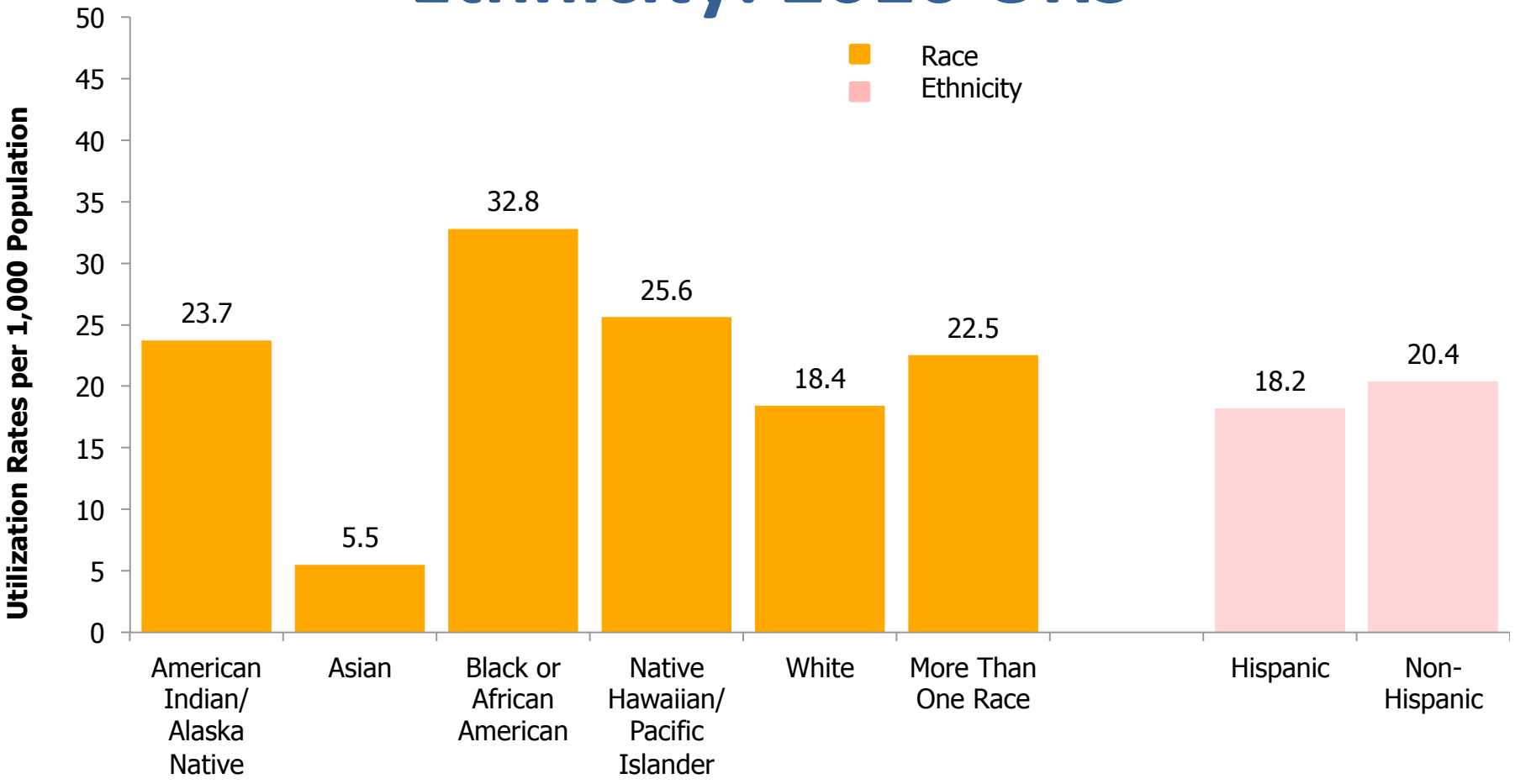
MH-CLD: Clients Served, by Age, 2016



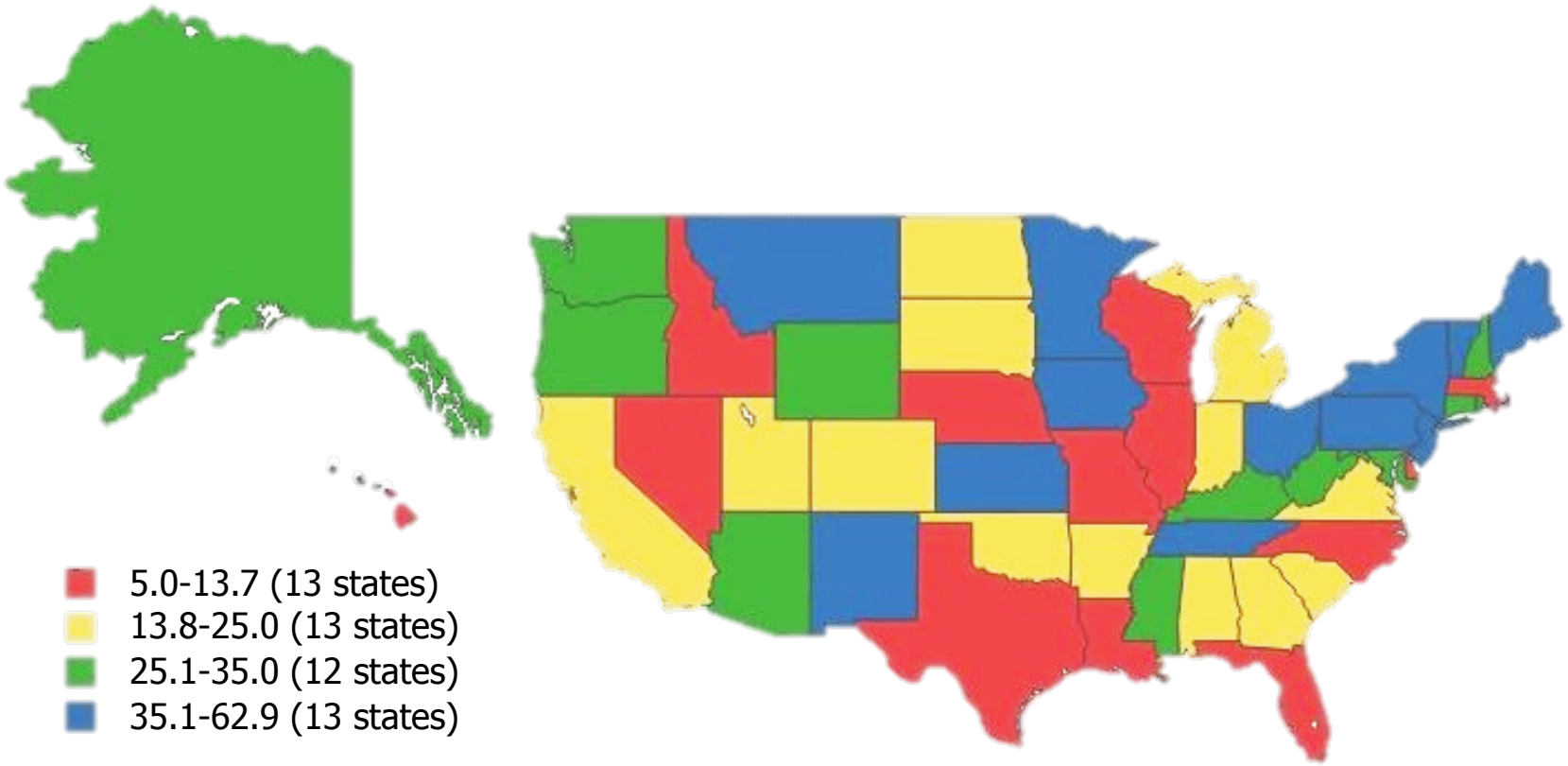
Utilization Rates (per 1,000 population) of Services, by Age and Gender: 2016



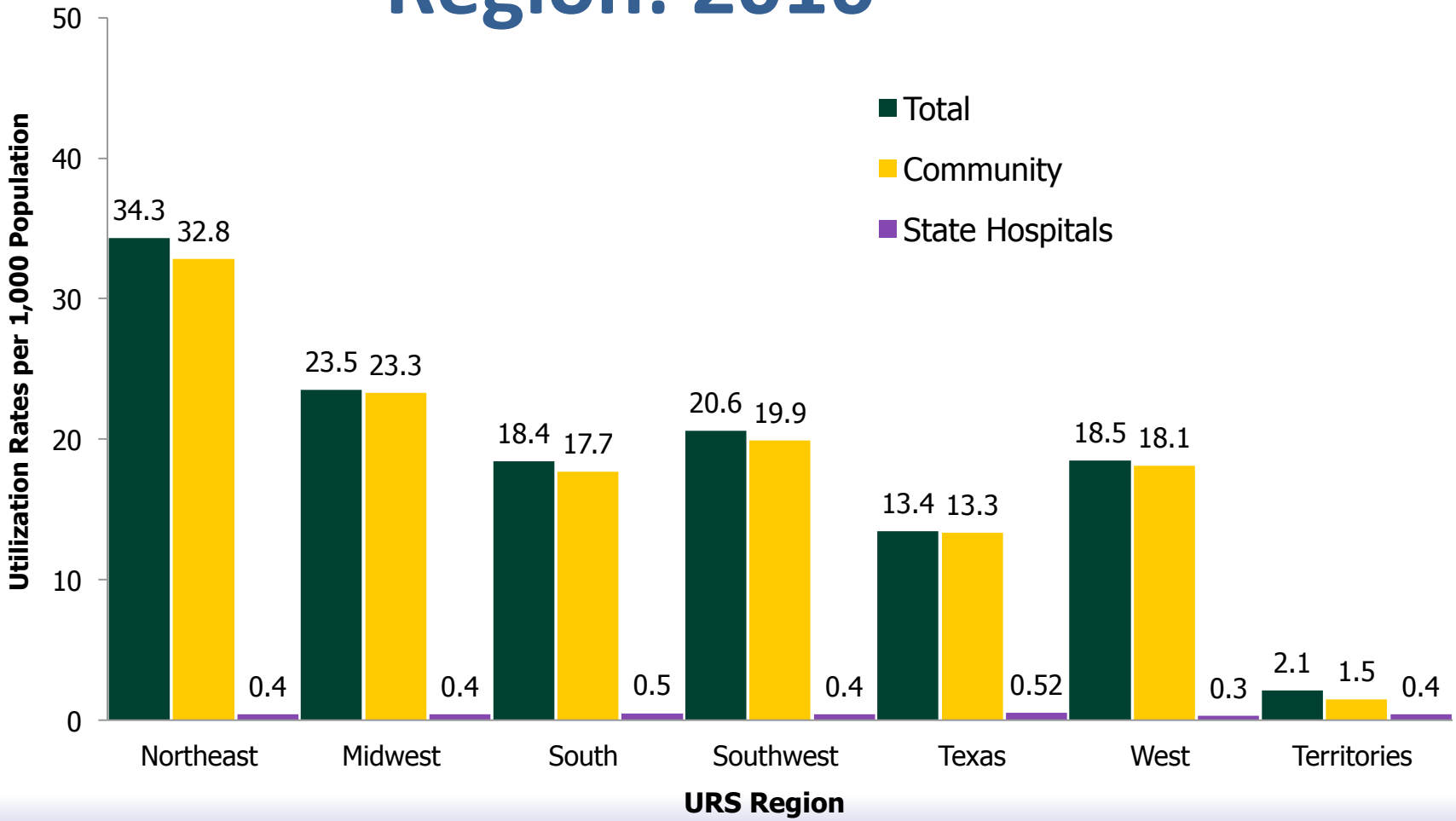
Utilization Rates (per 1,000 population), by Race and Ethnicity: 2016 URS



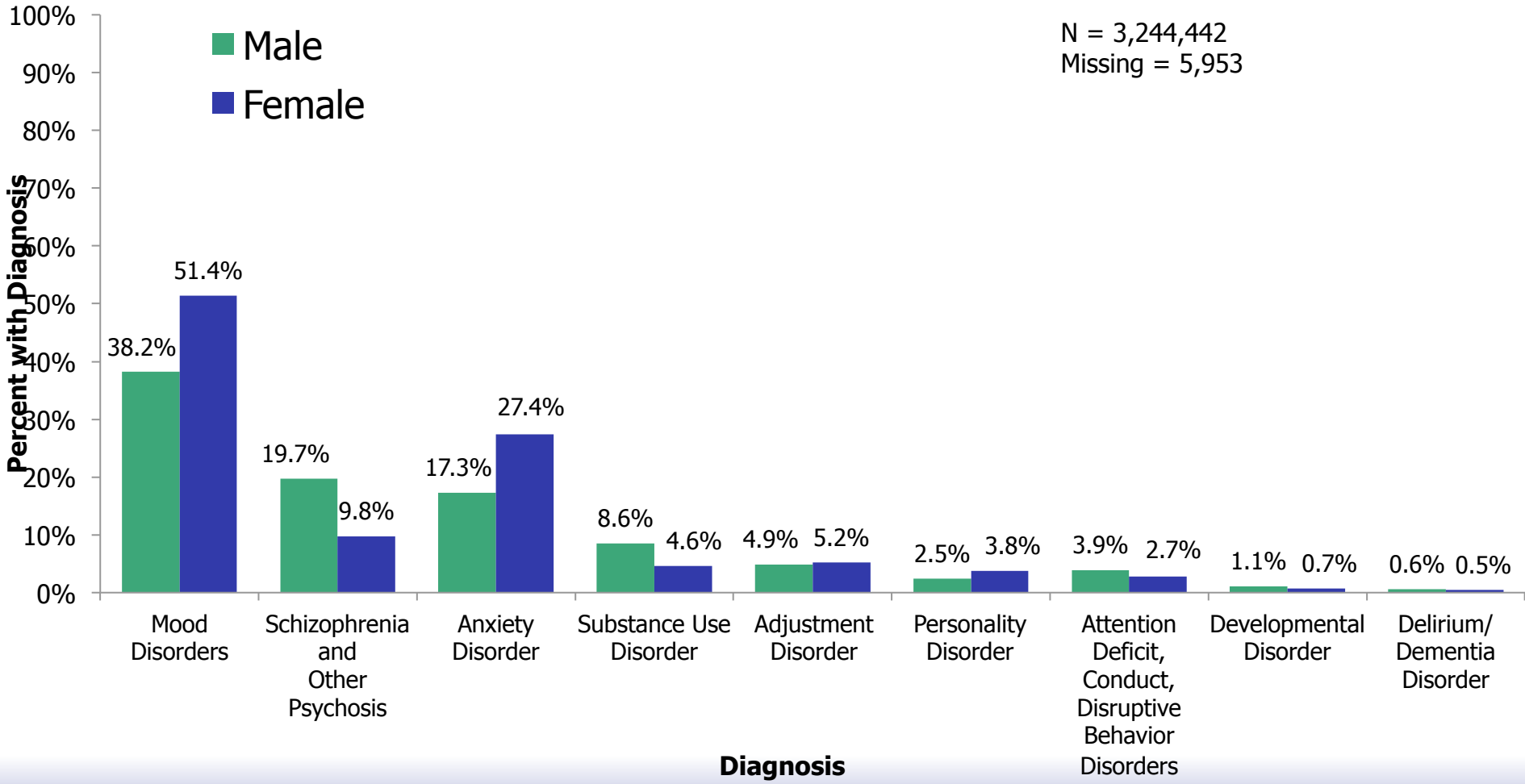
SMHA Clients Served per 1,000 State Population: 2016



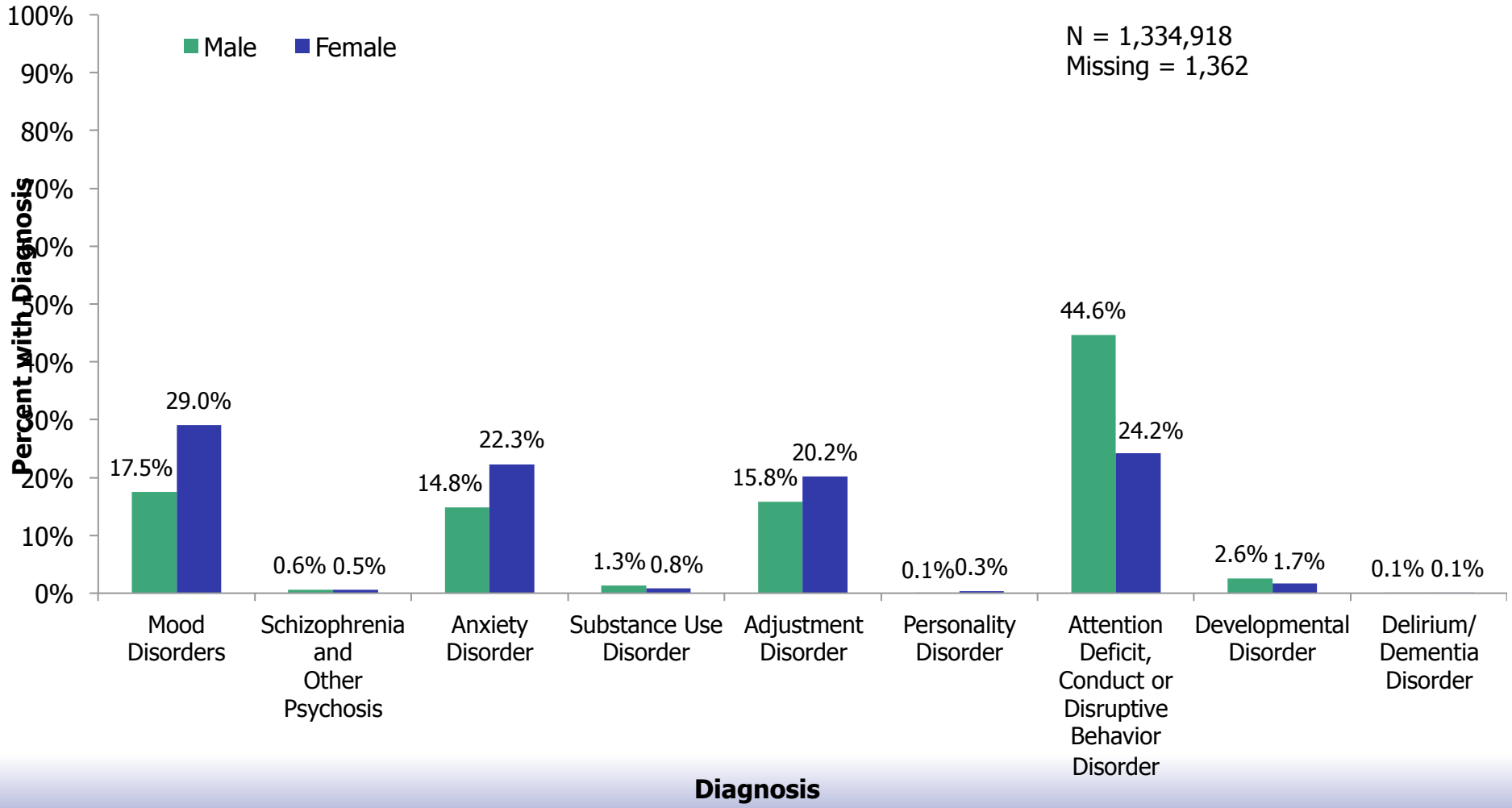
Utilization Rates (per 1,000 population) of Services, by Region: 2016



MH-CLD: Percent of Adults (Age 18 and Older), by Diagnosis, 2016

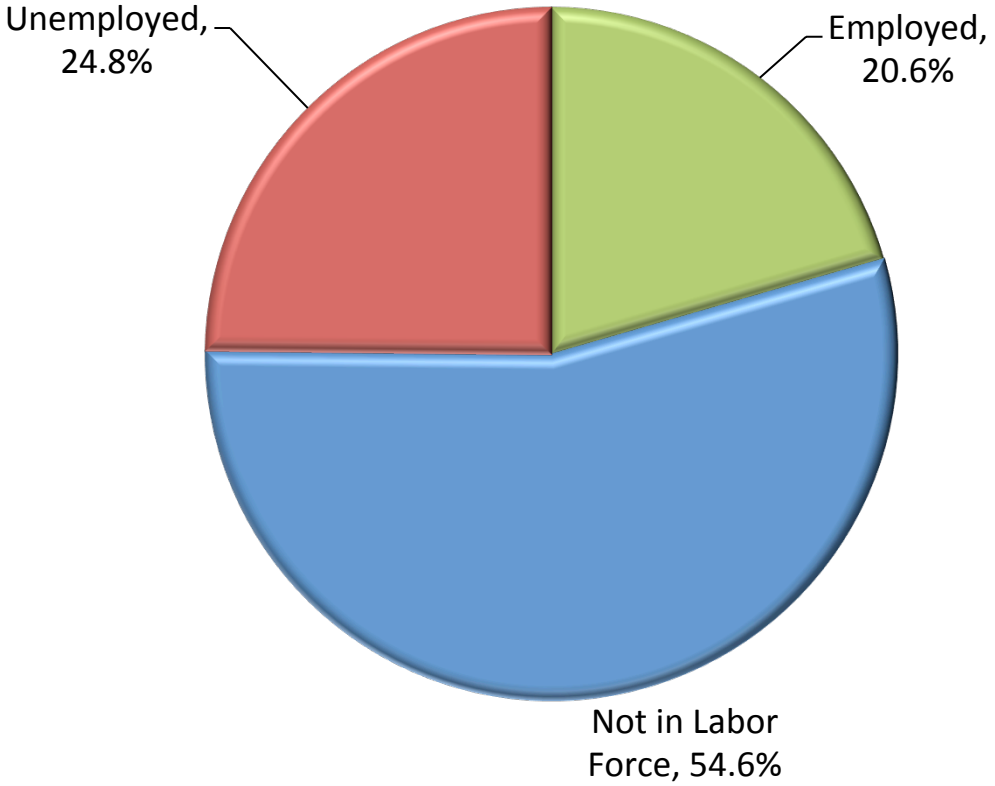


MH-CLD: Percent of Children (Age 0 to 17), by Diagnosis, 2016



Competitive Employment Status of Adult SMHA Clients: 2016 (58 States)

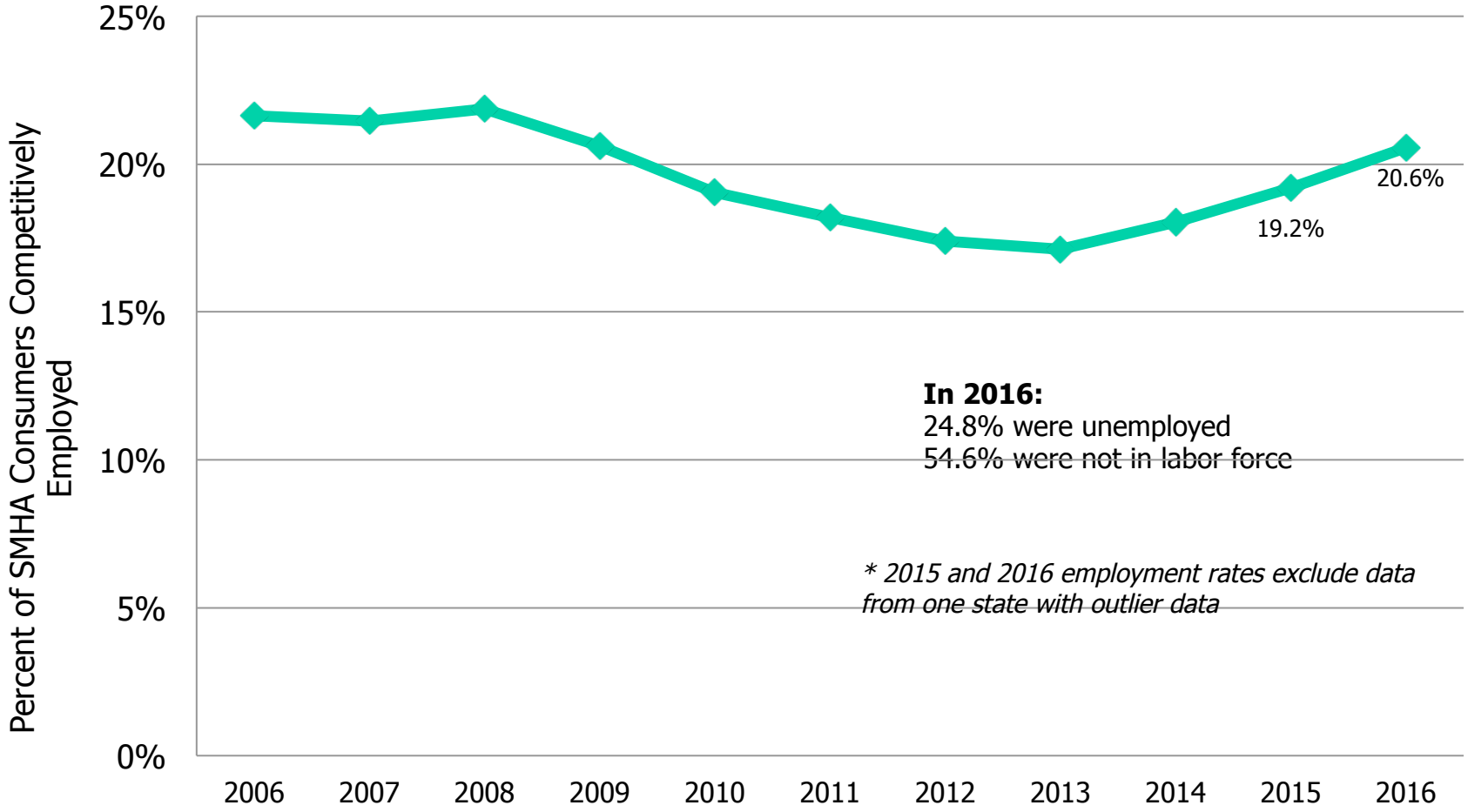
Clients with known employment status



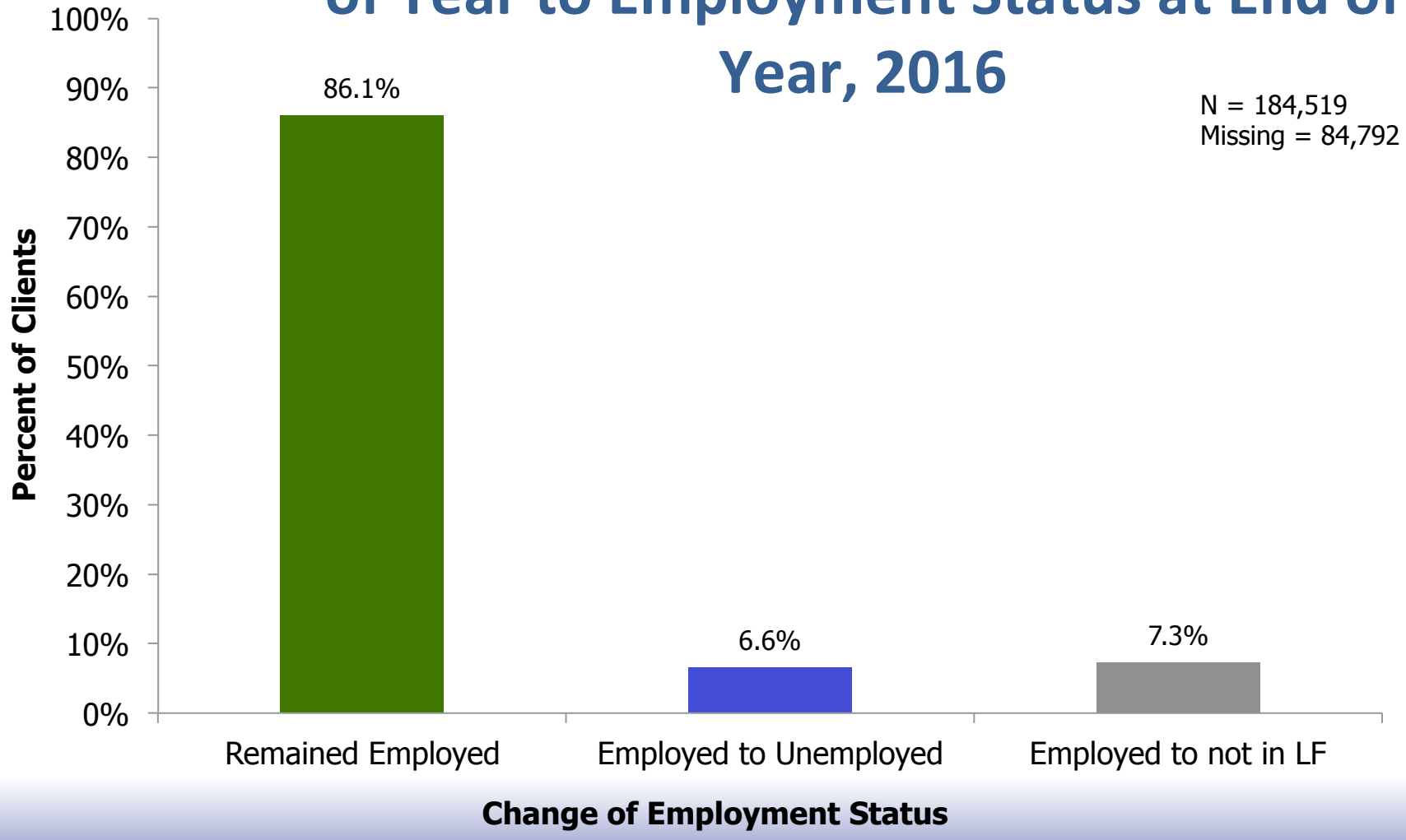
*Employment status was not available for 25.5% of adults

** employment rates exclude data from one state with outlier data*

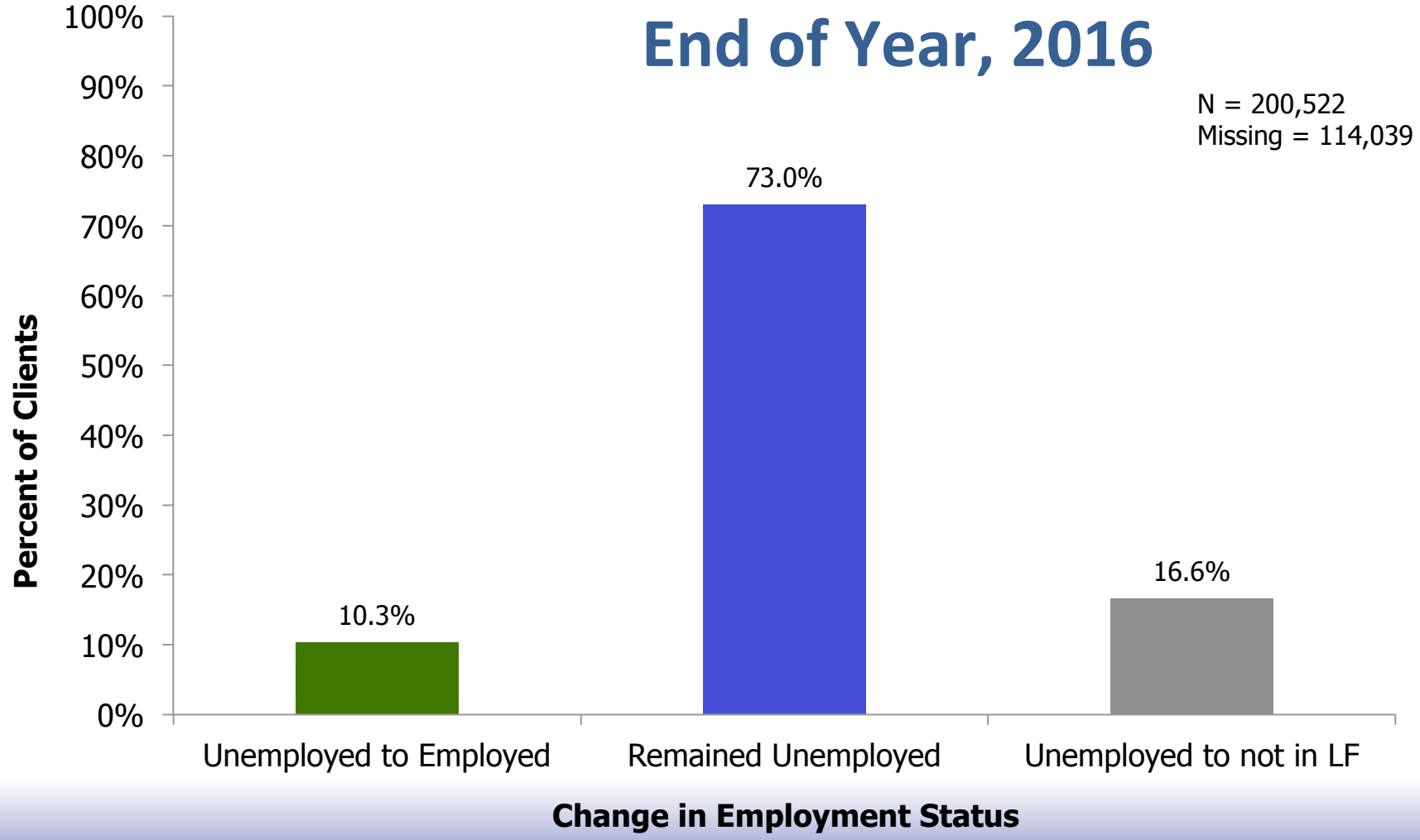
Percent of SMHA Adult (age 18 and over) Mental Health Clients Competitively Employed: 2006 to 2016

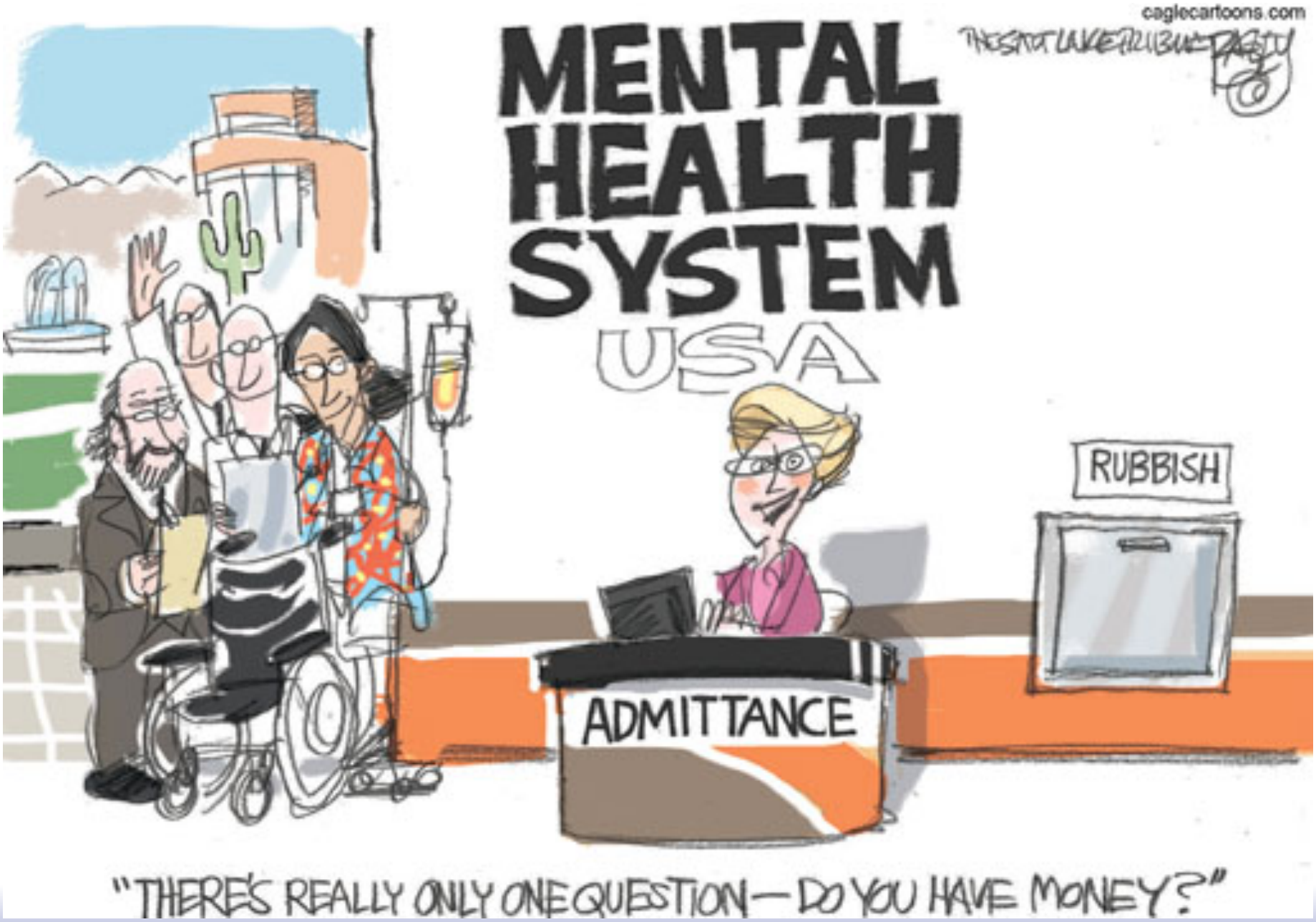


MH-CLD: Change in Employment Status for Clients that were Employed At Start of Year to Employment Status at End of Year, 2016



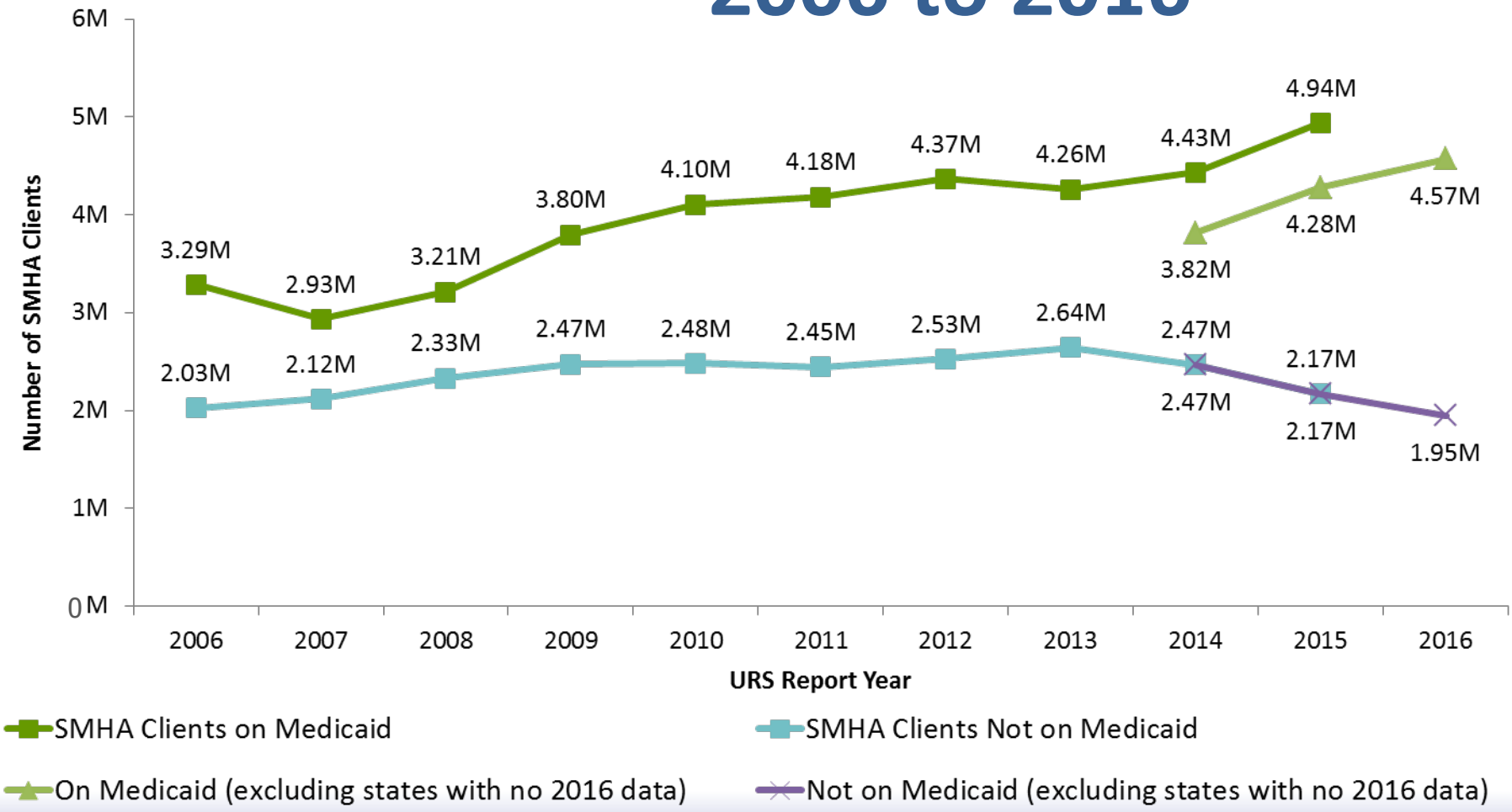
MH-CLD: Change in Employment Status for Clients that were Unemployed at Start of Year to Employment Status at End of Year, 2016



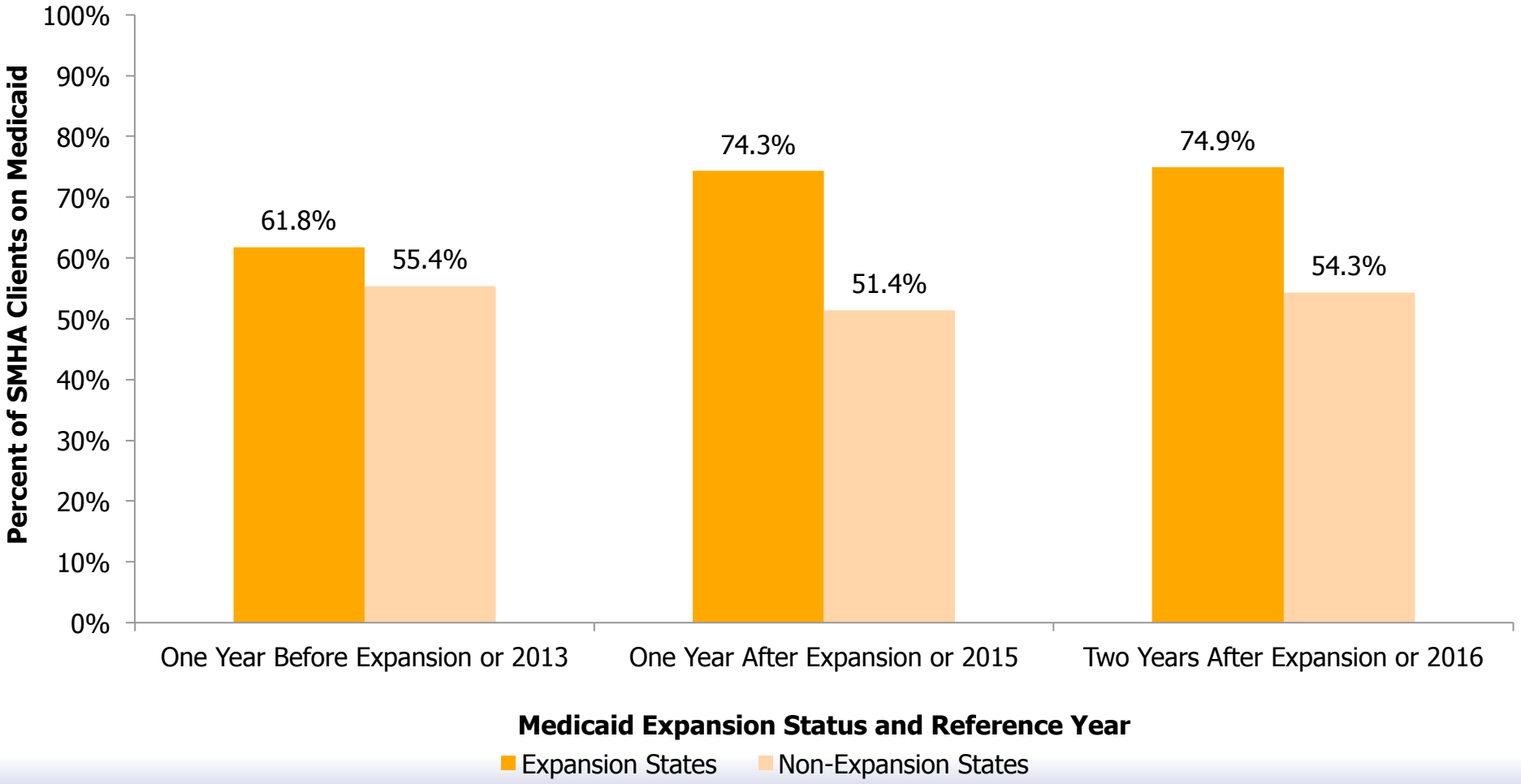

caglecartoons.com
MENTAL HEALTH SYSTEM
USA
RUBBISH
ADMITTANCE
"THERE'S REALLY ONLY ONE QUESTION—DO YOU HAVE MONEY?"

The Effect of Medicaid Expansion on SMHA Client Numbers and Utilization Rates: 1 and 2 Years Later

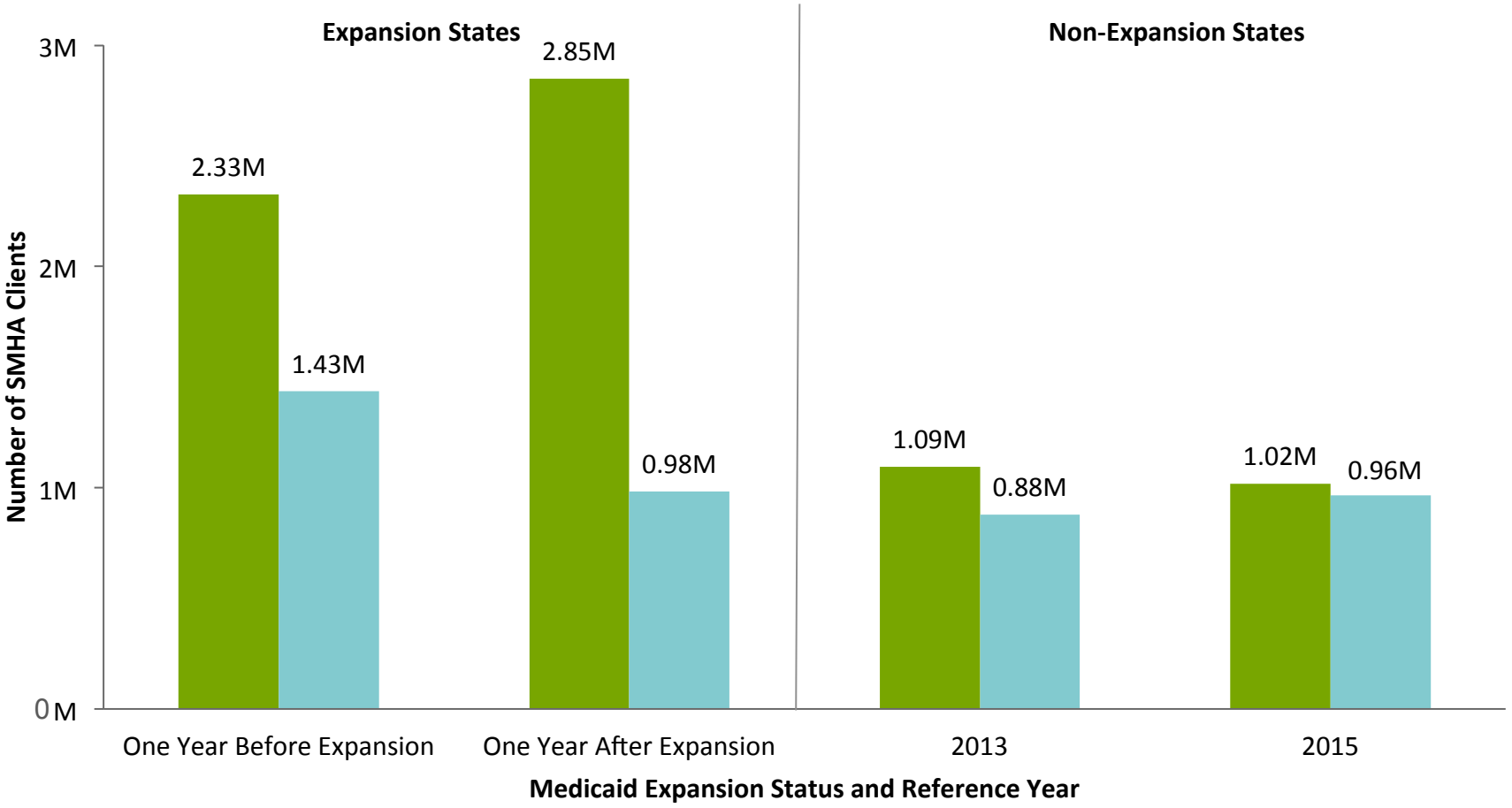
Number of SMHA Clients on Medicaid and Not on Medicaid: 2006 to 2016



Percent of SMHA Clients with Medicaid, in Expansion and Non-Expansion States, Before and After Expansion (or 2014)



Number of SMHA Clients on Medicaid and Not on Medicaid, in Expansion and Non-Expansion States



1987-2017 30 years

NRI

Analytics Improving Behavioral Health SM

What do State Mental Health Agencies Spend to Provide Mental Health Service and What Sources Fund these Services?

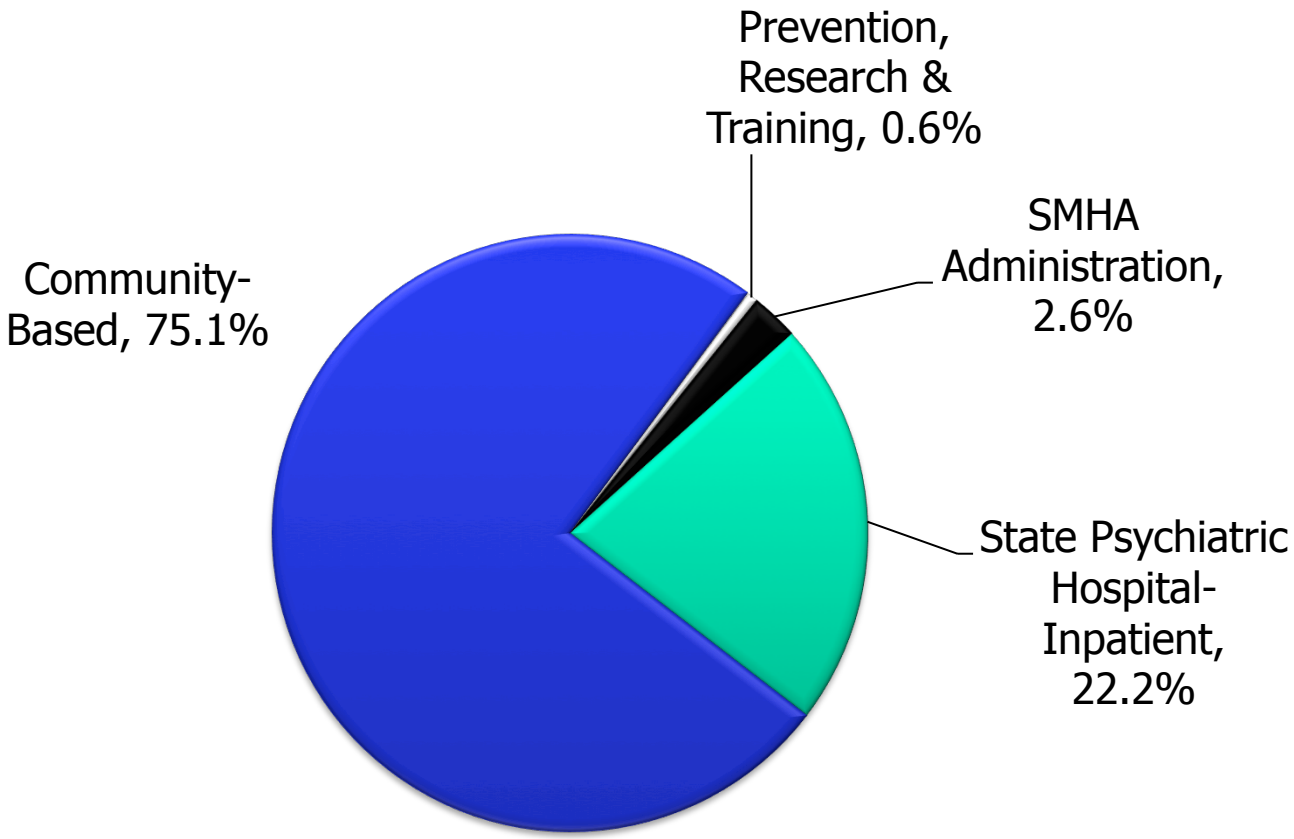
SMHA financing data From State Fiscal Year 1981 to Fiscal Year 2015

SMHA-Controlled Mental Health Expenditures

SMHA-Controlled Mental Health Expenditures are those expenditures that the State Mental Health Agency either directly funds, or requires local mental health providers to expend as part of their funding allocations

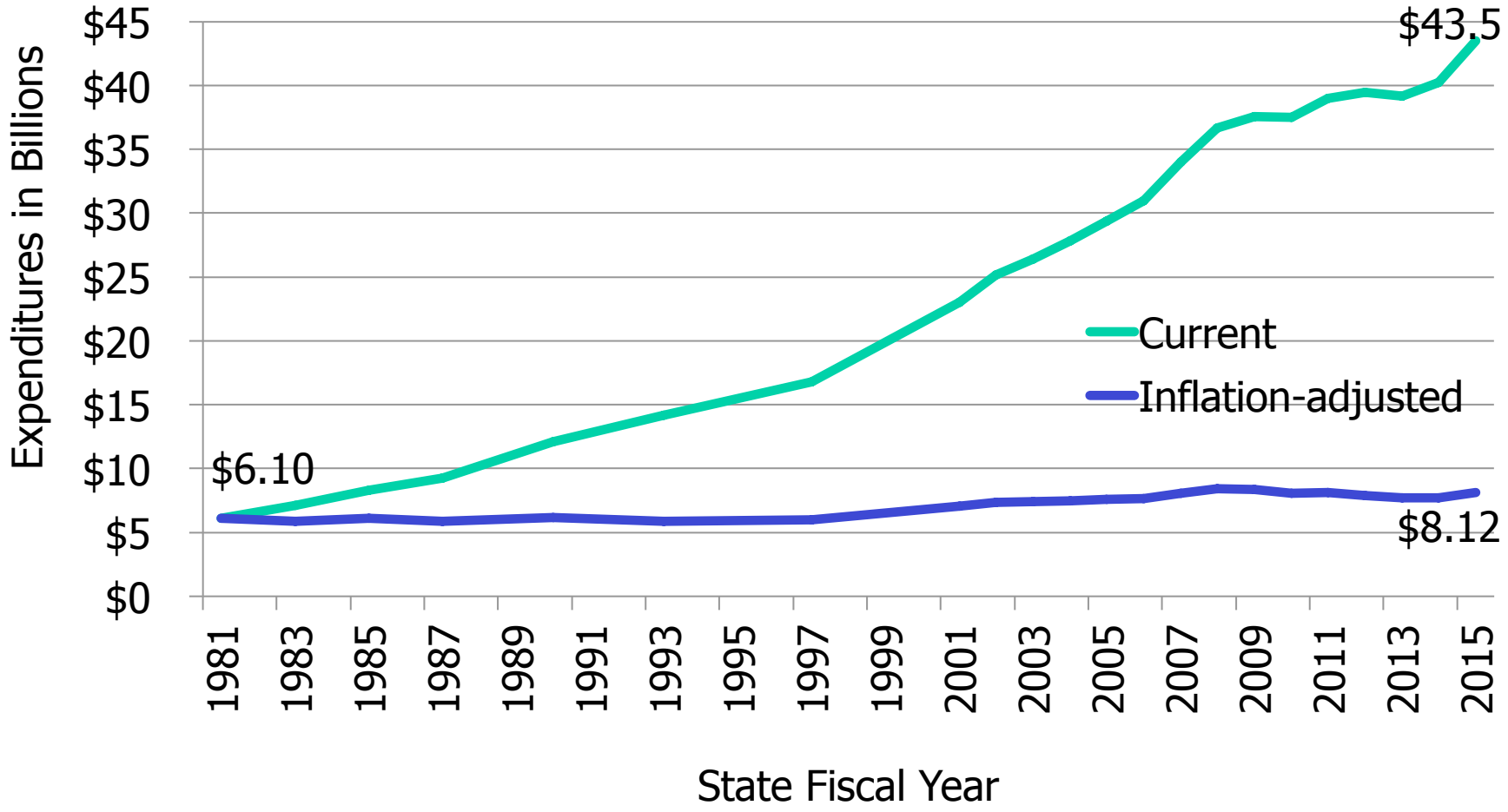
SMHA-Controlled Expenditures should match the expenditures with the clients and programs reported in a state's MH Block Grant Application and in its URS reporting of clients and services

SMHA Controlled Expenditures for Mental Health, By Type of Program, FY 2015



U.S. Total SMHA Expenditures = $43.8 Billion

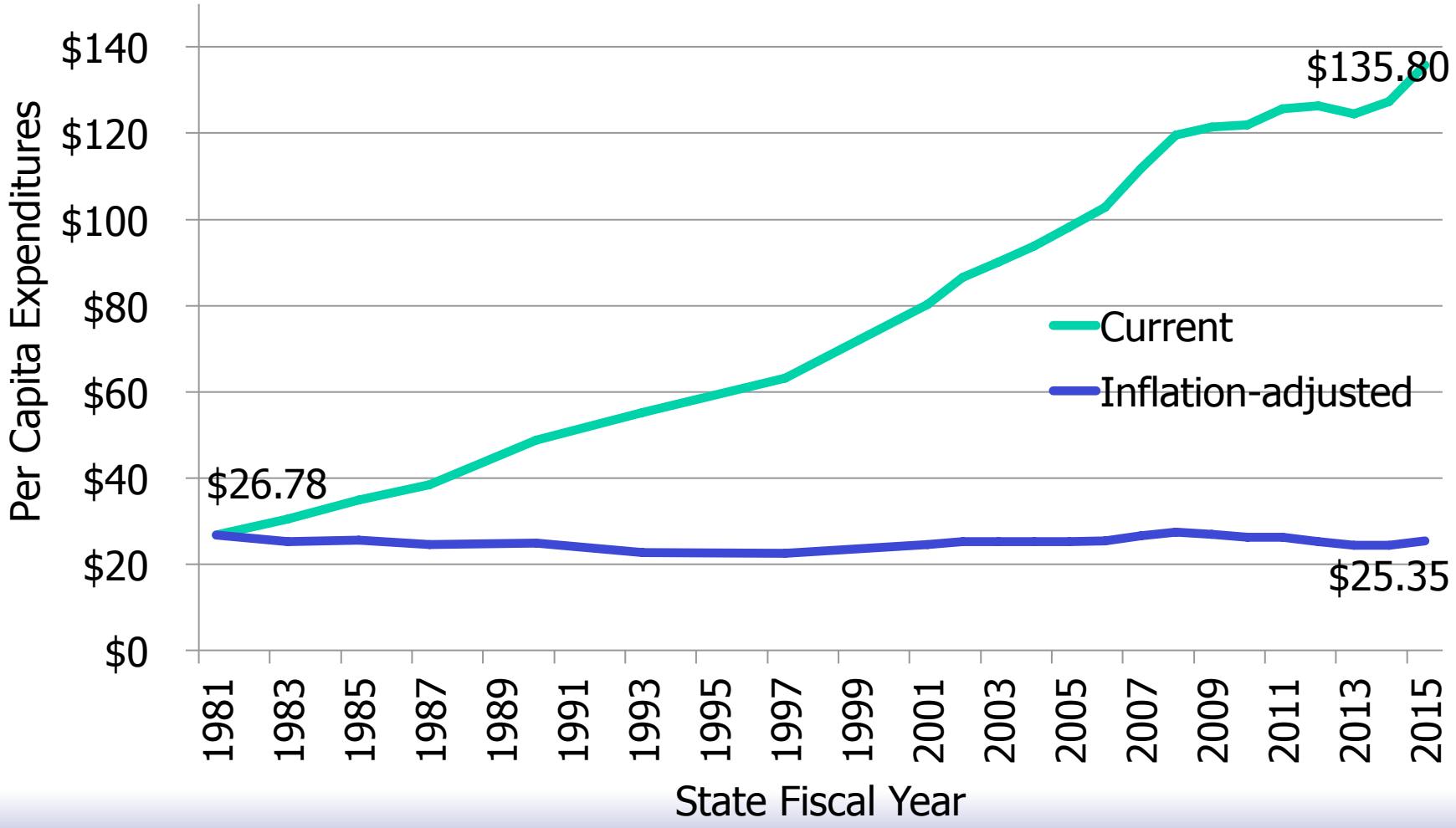
Trends in SMHA-Controlled Mental health Spending (Current and Inflation Adjusted), FY 1981 to FY 2015



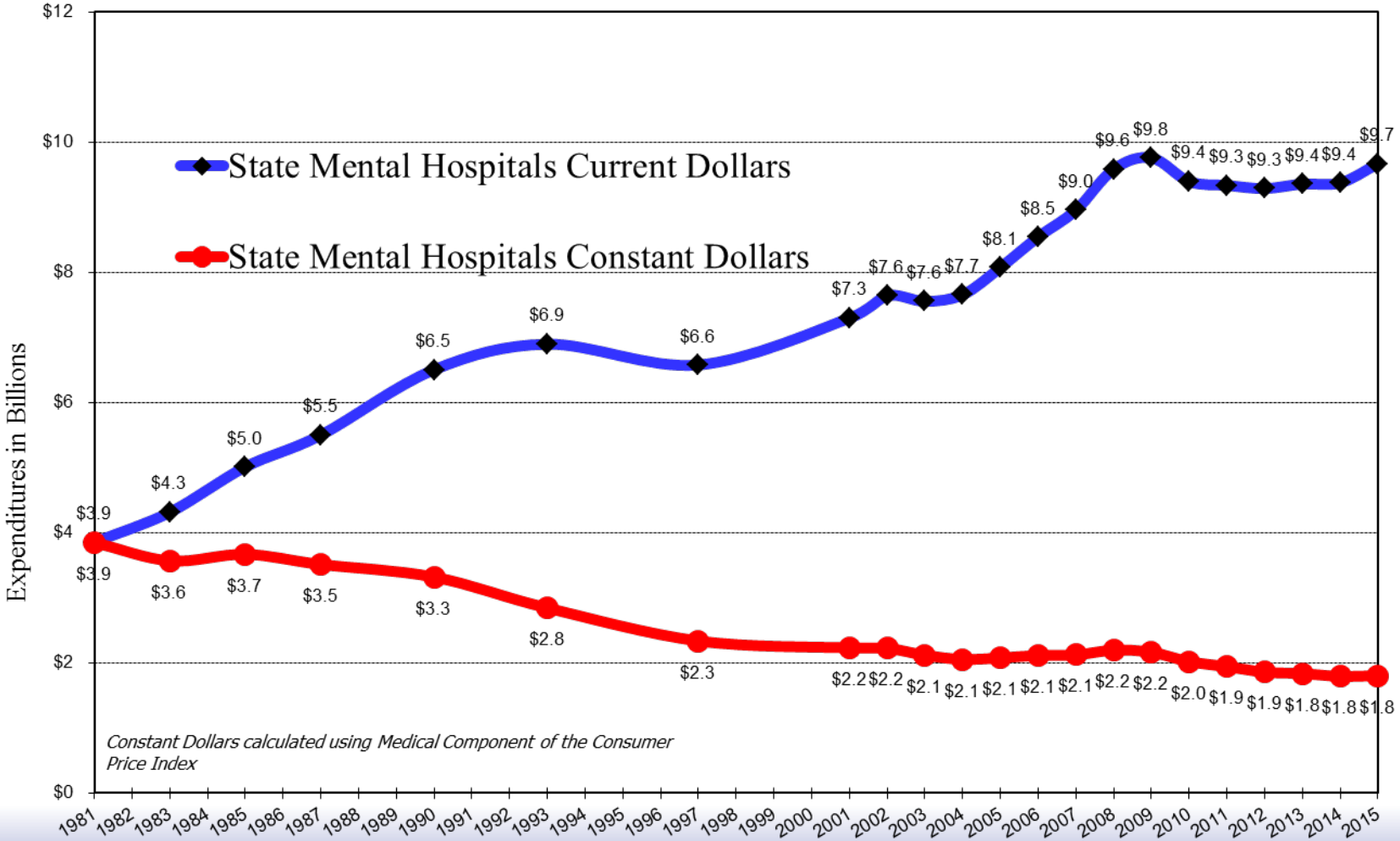
Source: NRI—State Mental Health Agency Revenues and Expenditures Study, 2015

Per Capita SMHA Expenditures for Mental Health: FY 1981 to 2015,

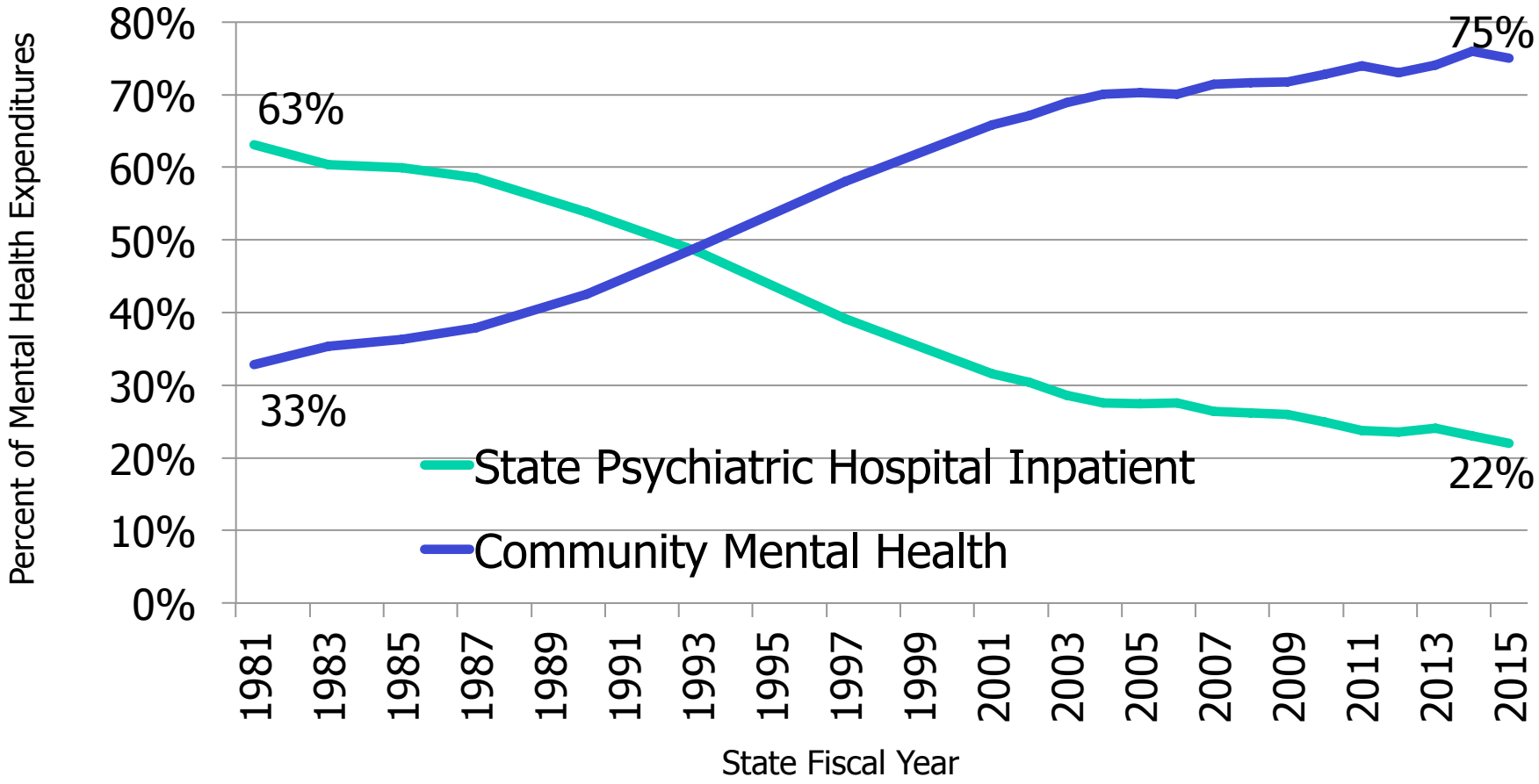
in Current and Constant "1981" Inflation Adjusted Dollars



SMHA Controlled Expenditures for State Psychiatric Hospital Inpatient Services, FY 81 - FY 15 in Current and Constant "1981" Dollars

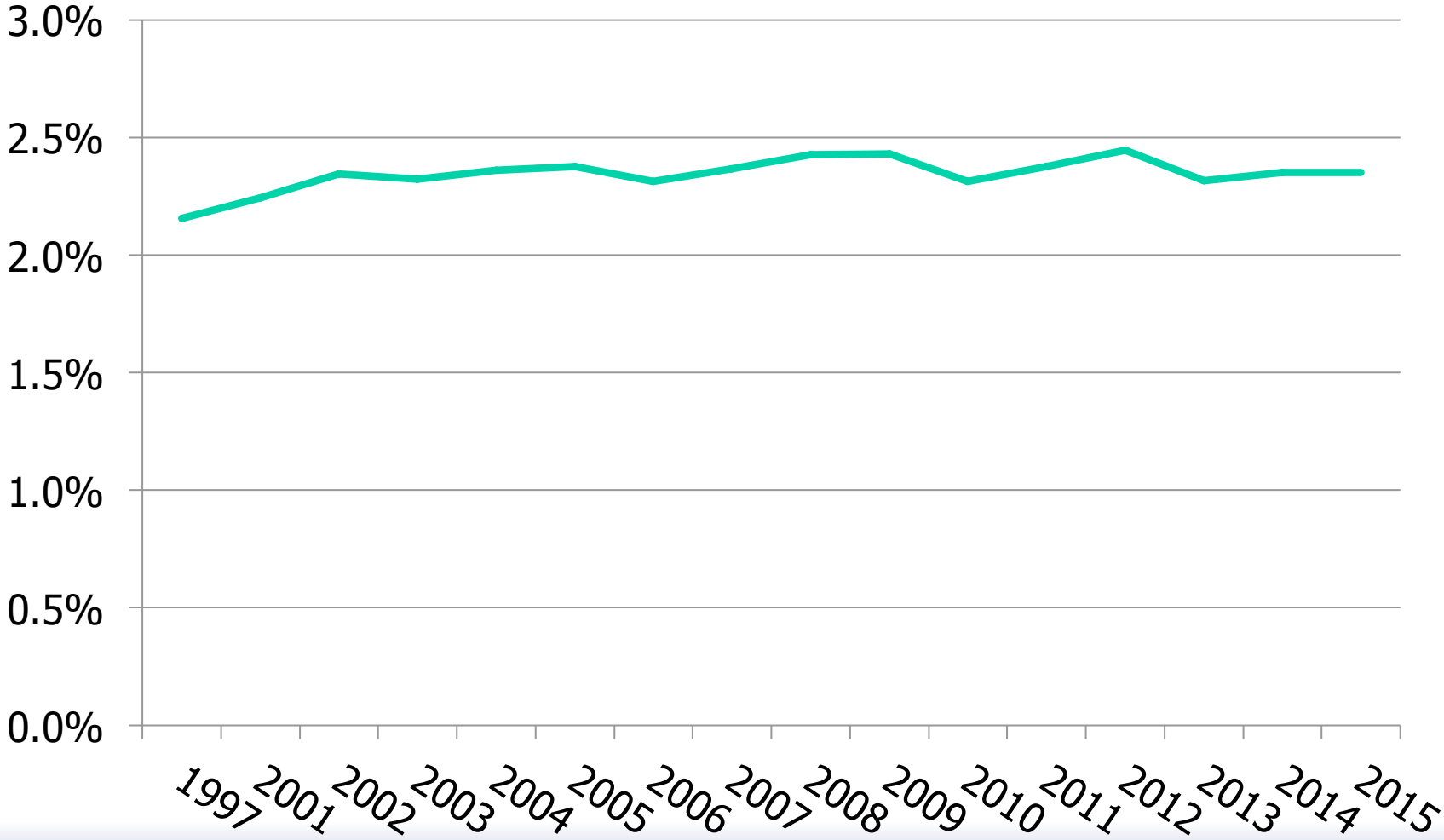


State Mental Health Agency Controlled Expenditures for State Psychiatric Hospital Inpatient and Community-Based Services as a Percent of Total Expenditures: FY'81 to FY'15

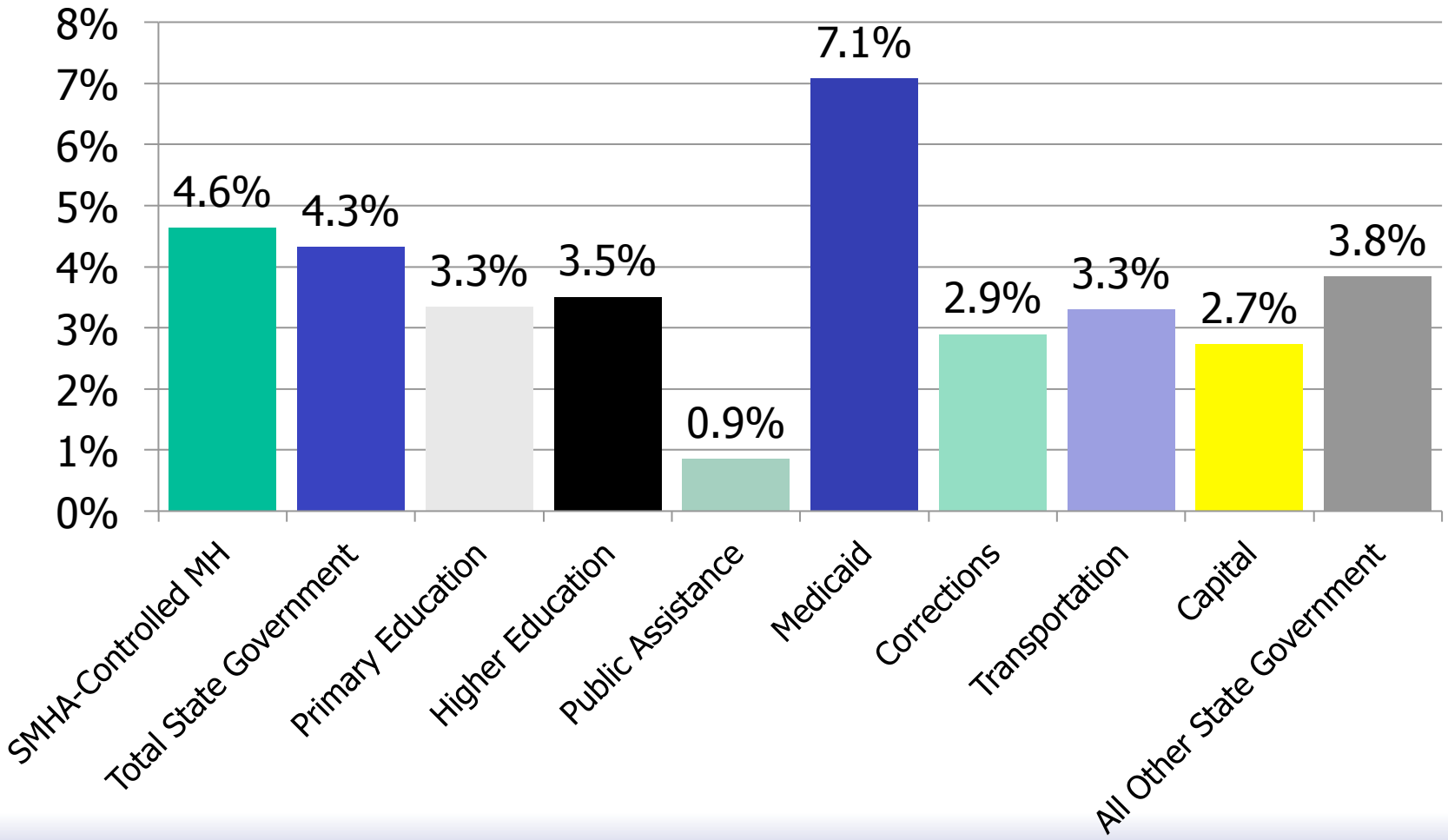


Source: NRI—State Mental Health Agency Revenues and Expenditures Study, 2015

Total SMHA Controlled Mental Health Expenditures as a Percent of Total State Government Expenditures: FY‘1997 to FY'2015

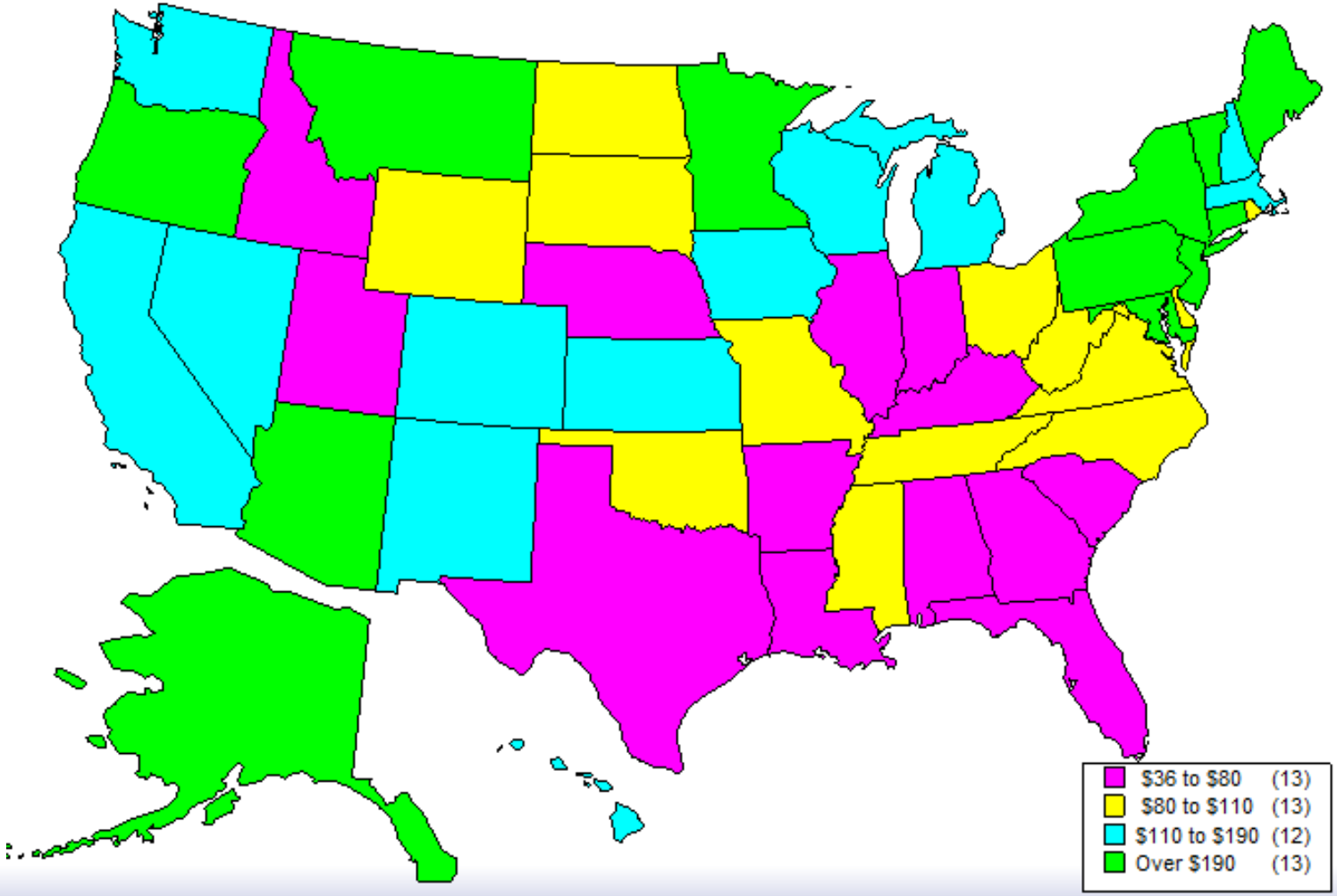


Average Annual Change in Expenditures for Major Government Agencies: FY 2001 to FY 2015

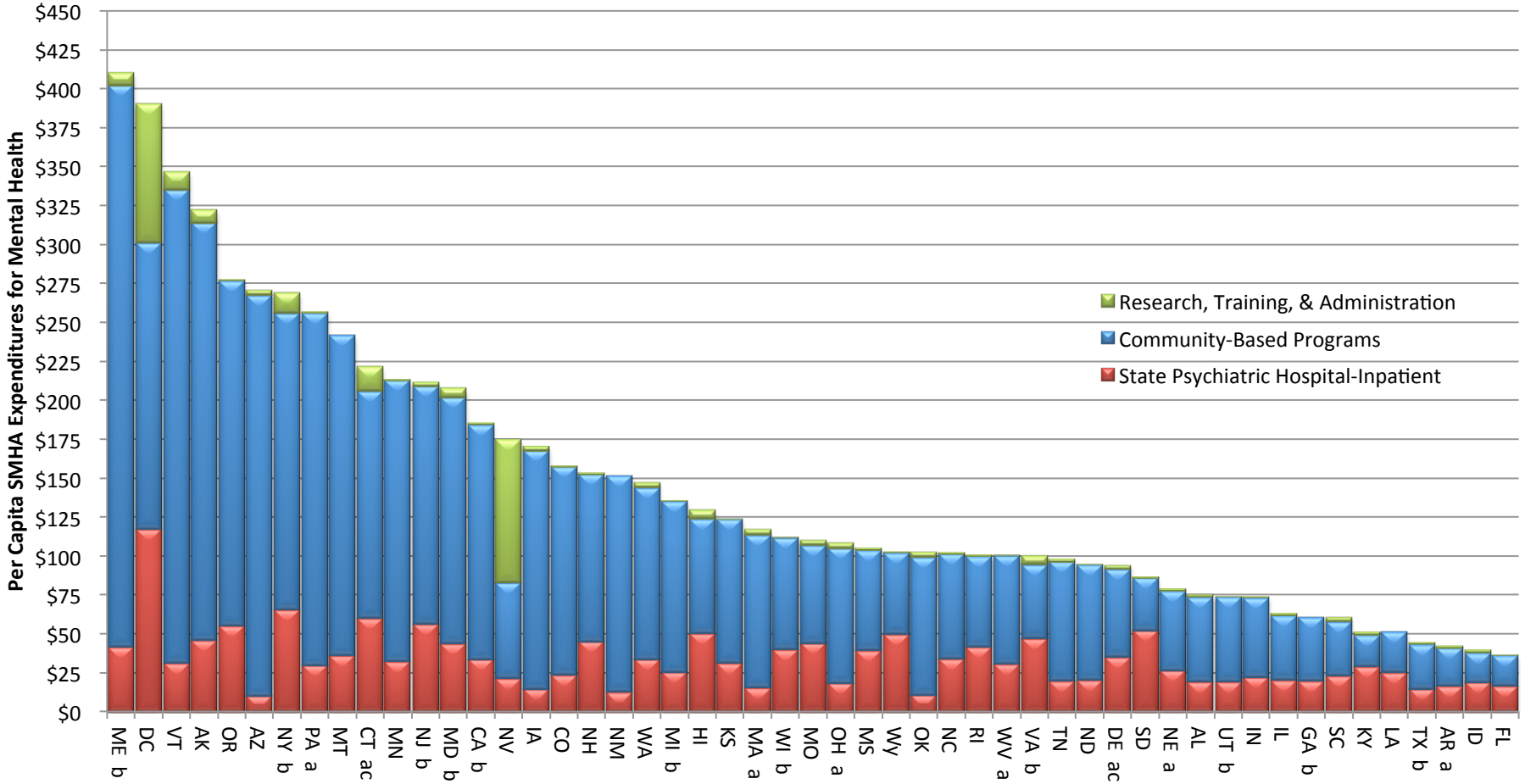


Data from National Association of State Budget Officers and NRI

Total FY'2015 SMHA-Controlled Per Capita Mental Health Expenditures

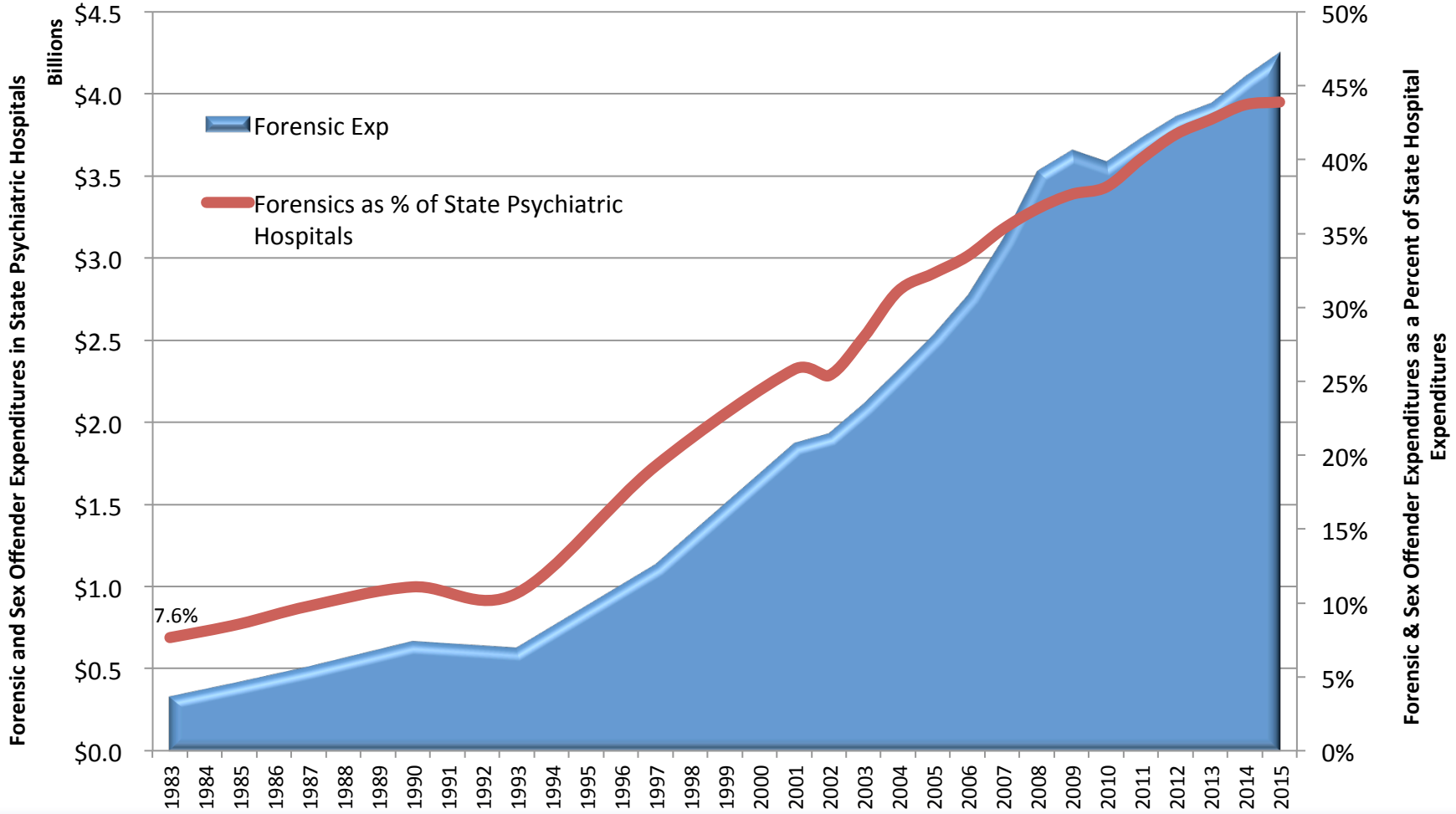


Fiscal Year 2015 SMHA-Controlled Per Capita Expenditures

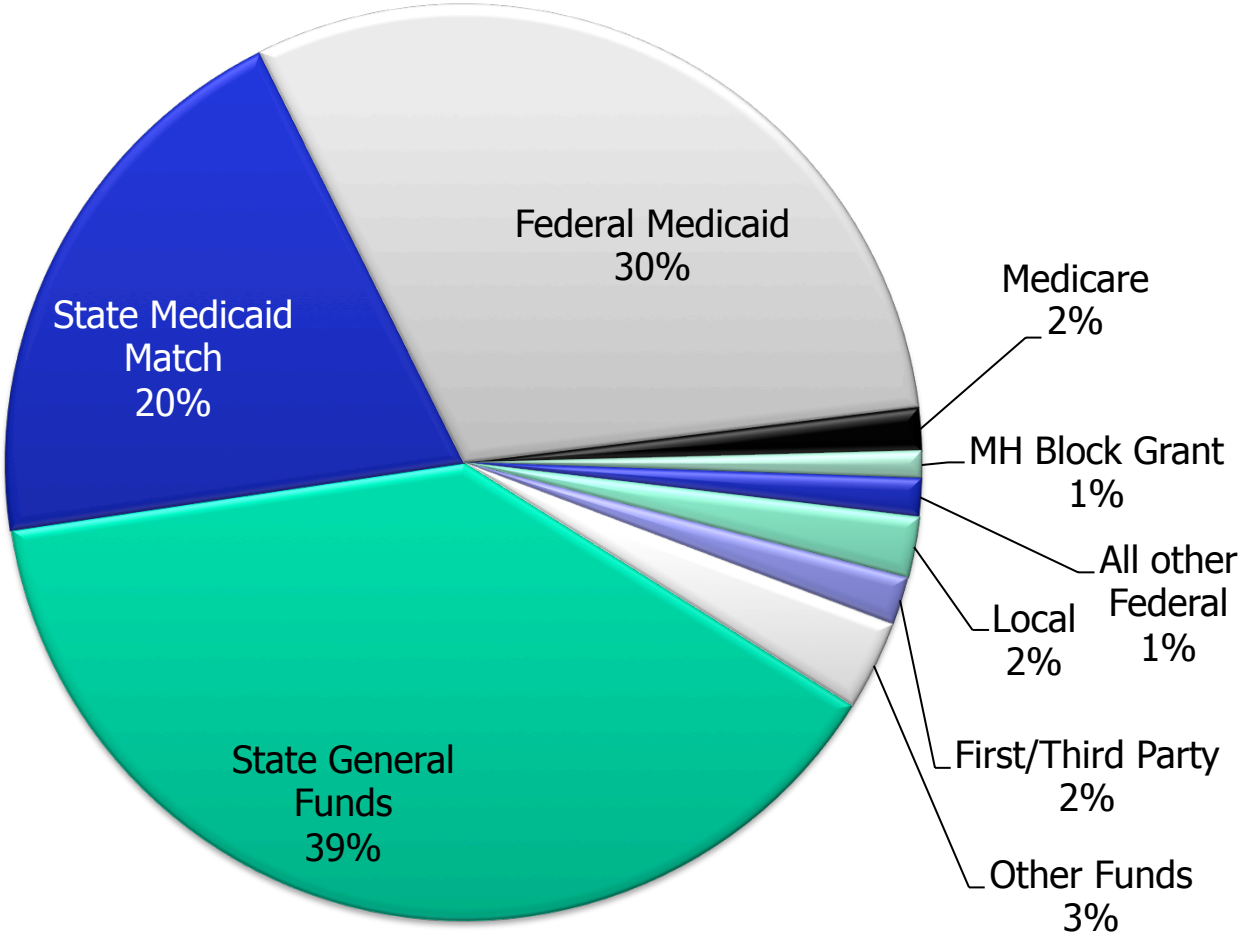


a = Medicaid Revenues for Community Programs are not included in SMHA-Controlled Expenditures
b = SMHA-Controlled Expenditures include funds for mental health services in jails or prisons.
c = Children's Mental Health Expenditures are not included in SMHA-Controlled Expenditures

SMHA-Controlled Forensic and Sex Offender Mental Health Expenditures and as a Percentage of State Psychiatric Hospital Expenditures, FY'83 to FY'15

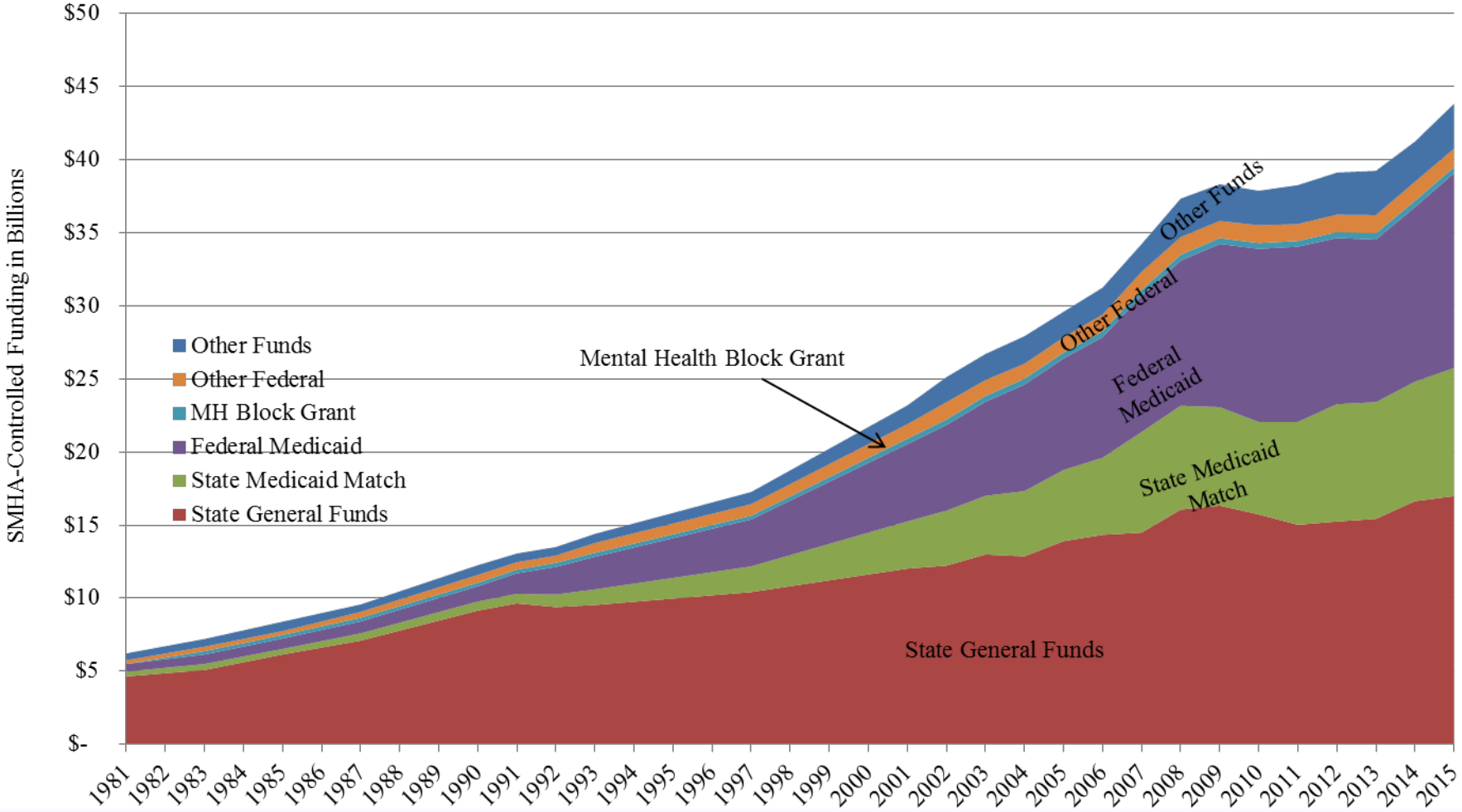


SMHA Revenues, By Source: FY 2015

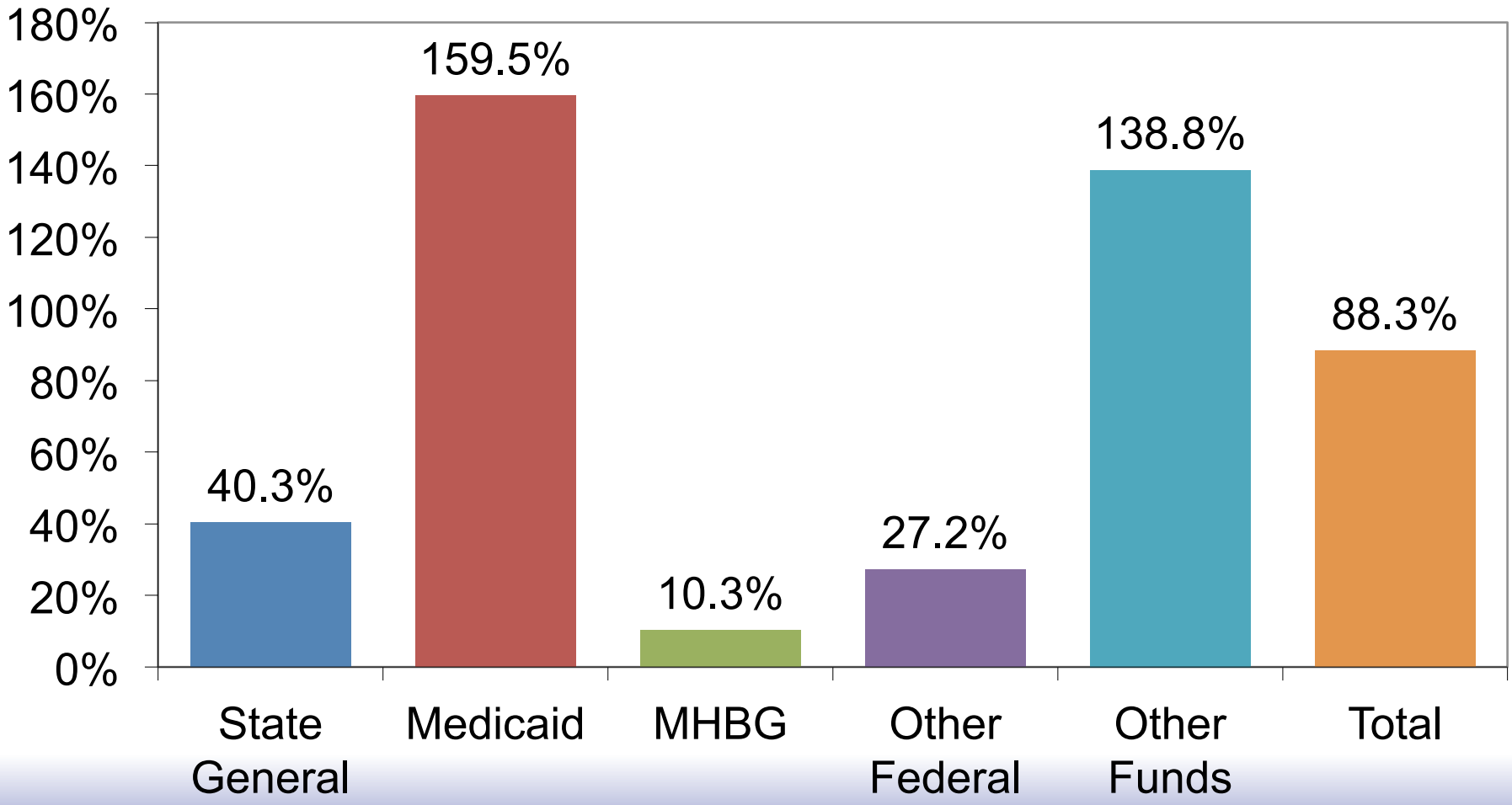


Funding Sources for SMHA Services: FY1981 to FY2015

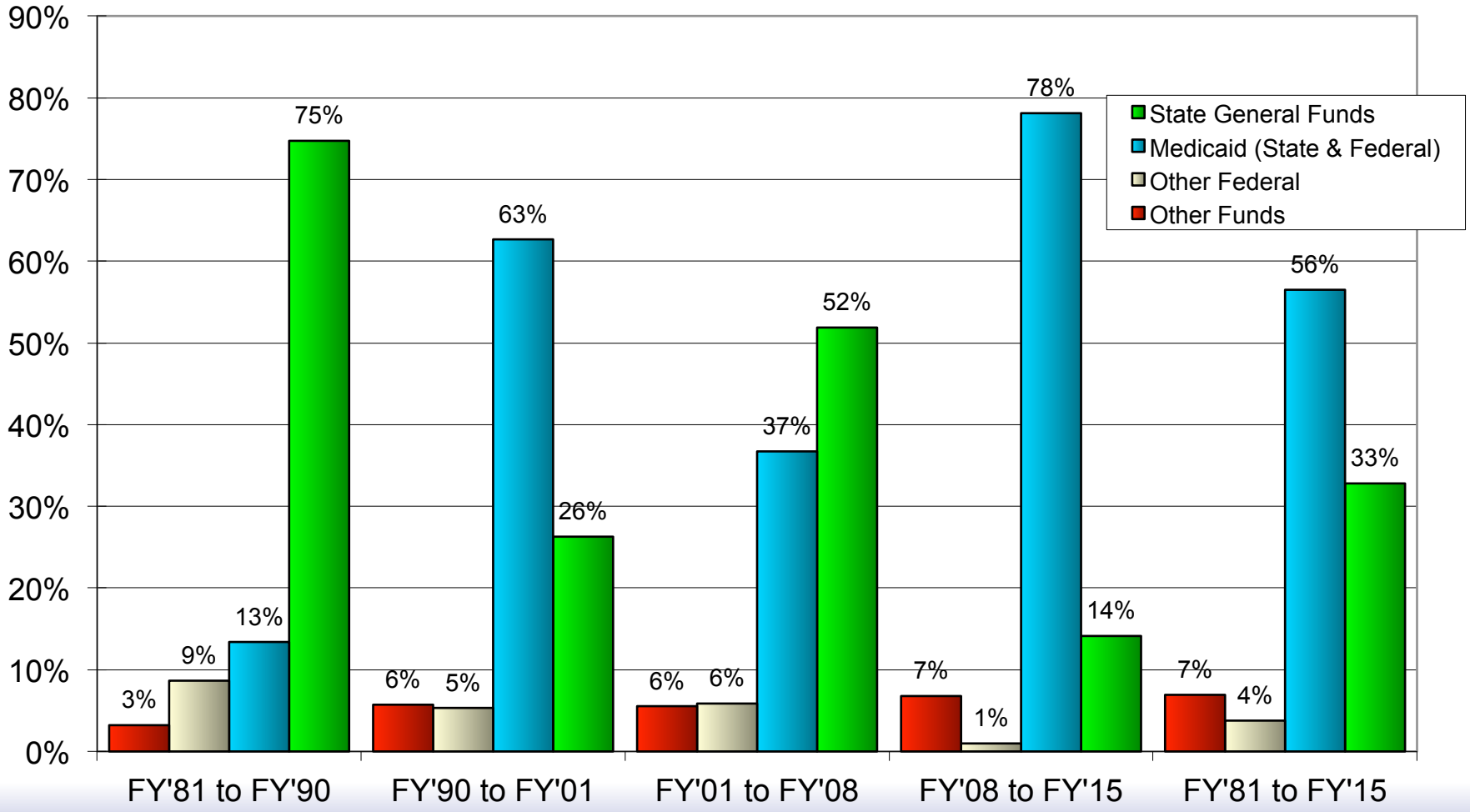
Analytics Improving Behavioral Health



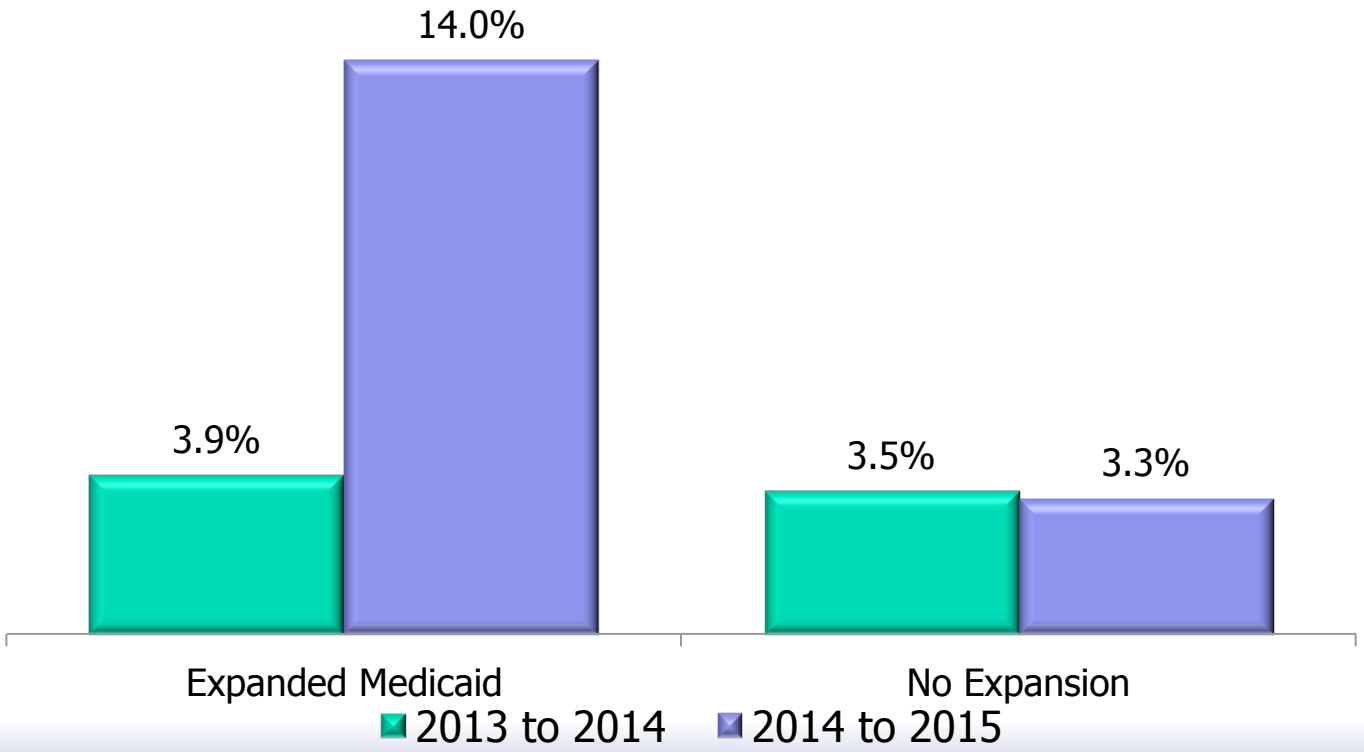
Percent Change in SMHA-Controlled Revenues, FY'01 to FY'15



Sources of New SMHA Funds, by Decade, FY'81 to FY'15



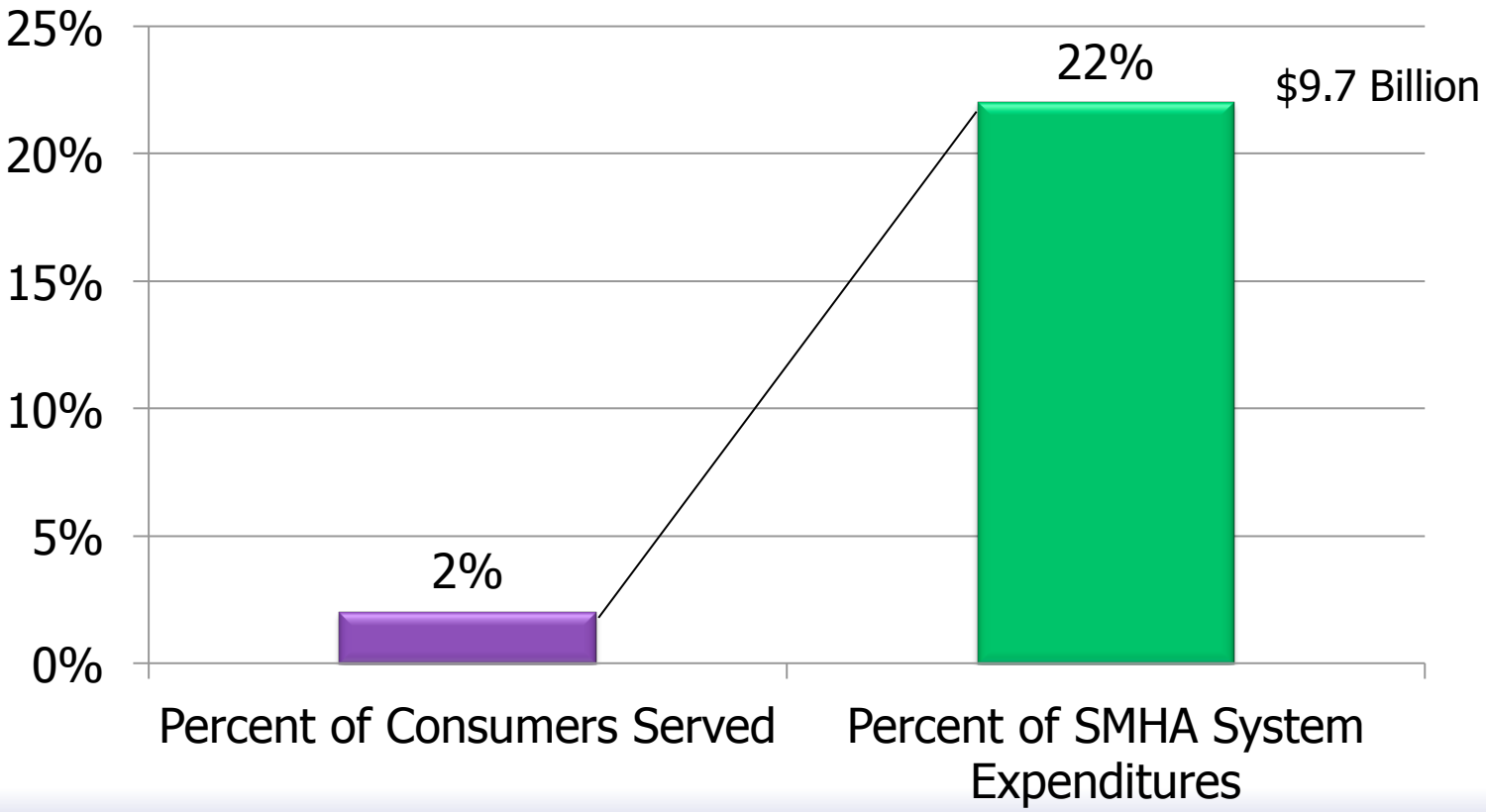
Percent Change in Medicaid Funding of Mental Health Services Provided by SMHA System, FY 2013 to FY 2015 For Medicaid Expansion and Non-Expansion States



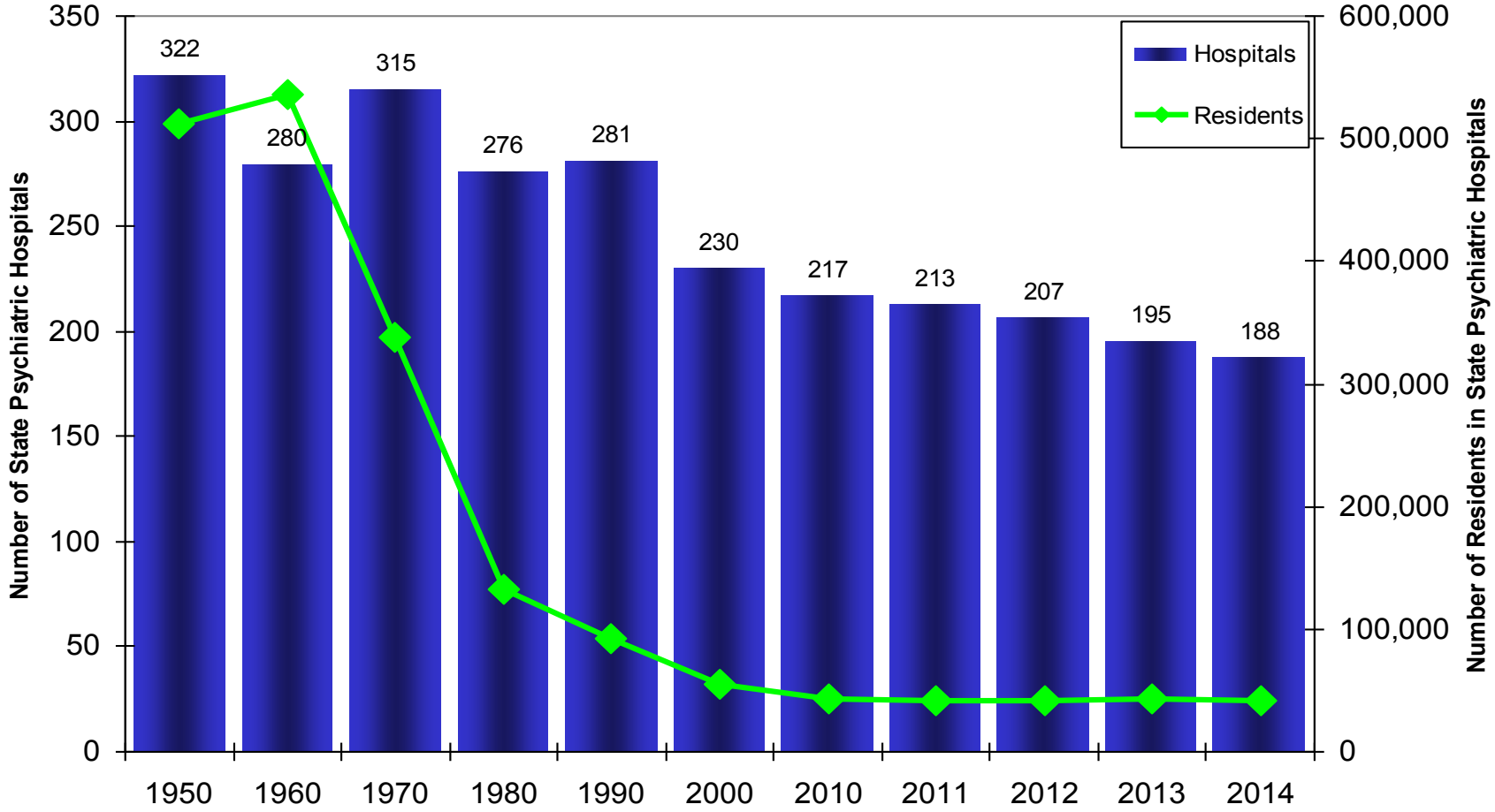
Focus on the most expensive Mental Health Services

Trends in Psychiatric Inpatient Services

Patients in State Psychiatric Hospitals Share of SMHA Systems: FY 2015



Number of State Psychiatric Hospitals & Resident Patients at the End of Year: 1950 to 2014



Sources: CMHS Additions and Resident Patients at End of Year, State and County Mental Hospitals, by Age and Diagnosis, by State, United States, 2002, and 2015 State MH Agency Profiles System

State Psychiatric Hospitals Treat Different Caseloads than 40 Years Ago

In 1970

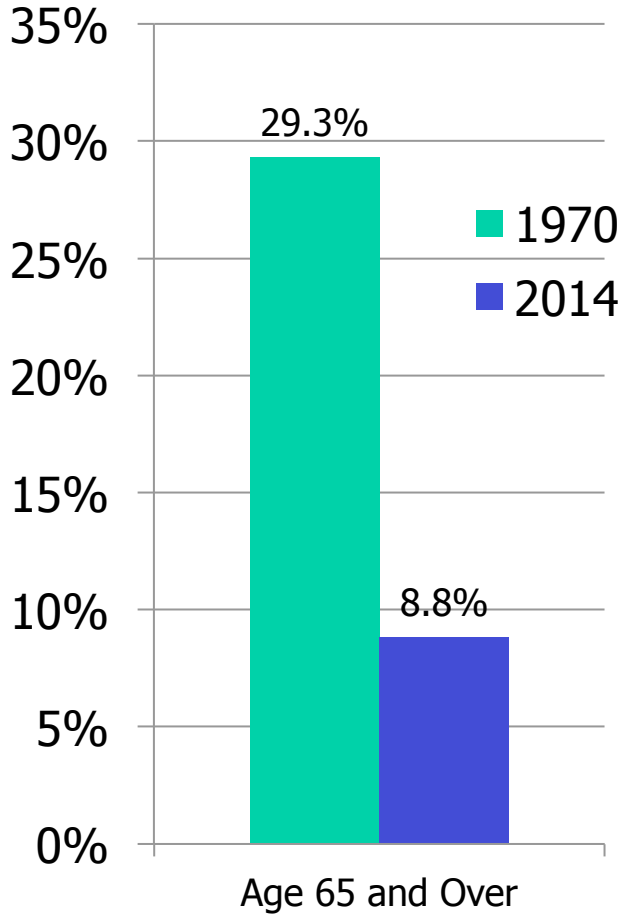
- 29.3% (99,087) Patients were age 65 and Over
- 24% (81,621) had an Organic Brain Syndrome
  - (45,811 of whom were Older Adults)
- 9% (31,884) had Mental Retardation.
- 7% (18,098) had an Alcohol or Drug Disorder (1973 data)

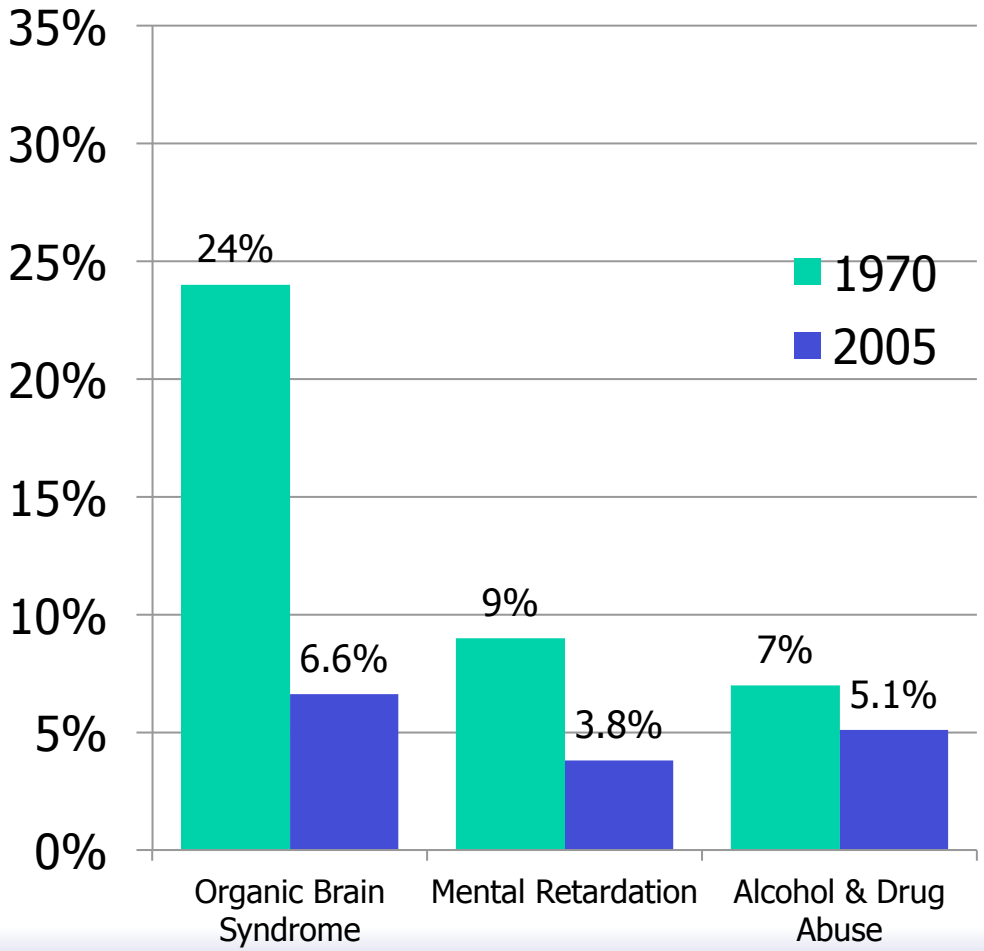
In 2014, only 8.8% of patients were age 65 and over

In 2014 diagnosis was no longer collected by SAMHSA

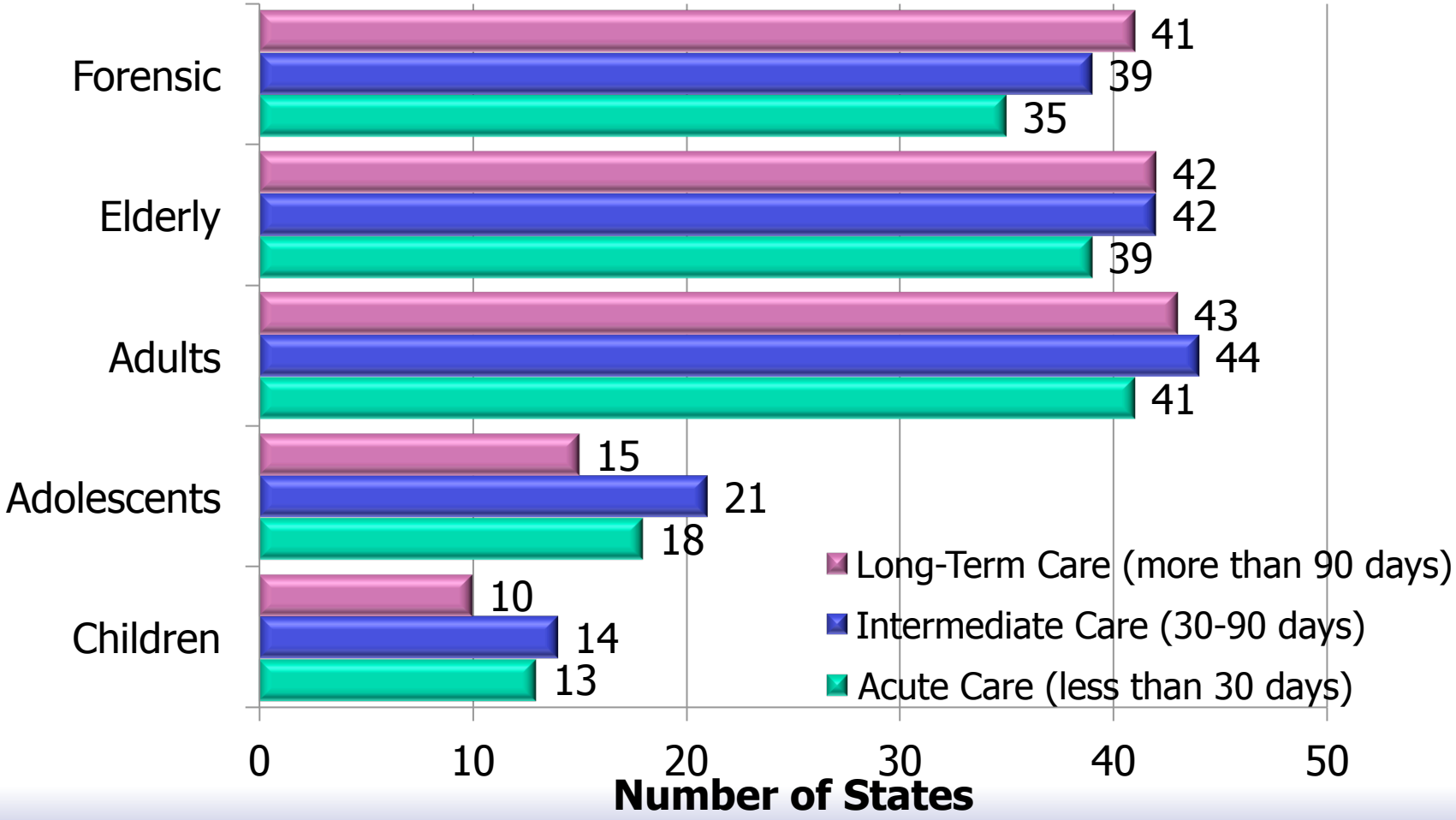
In 2005: only 3.8% of patients had a Mental Retardation and
3.6% had an Organic Brain disorder
5.1% had an Alcohol or Drug Disorder

State Psychiatric Hospitals Treat Different Caseloads than 40 Years Ago

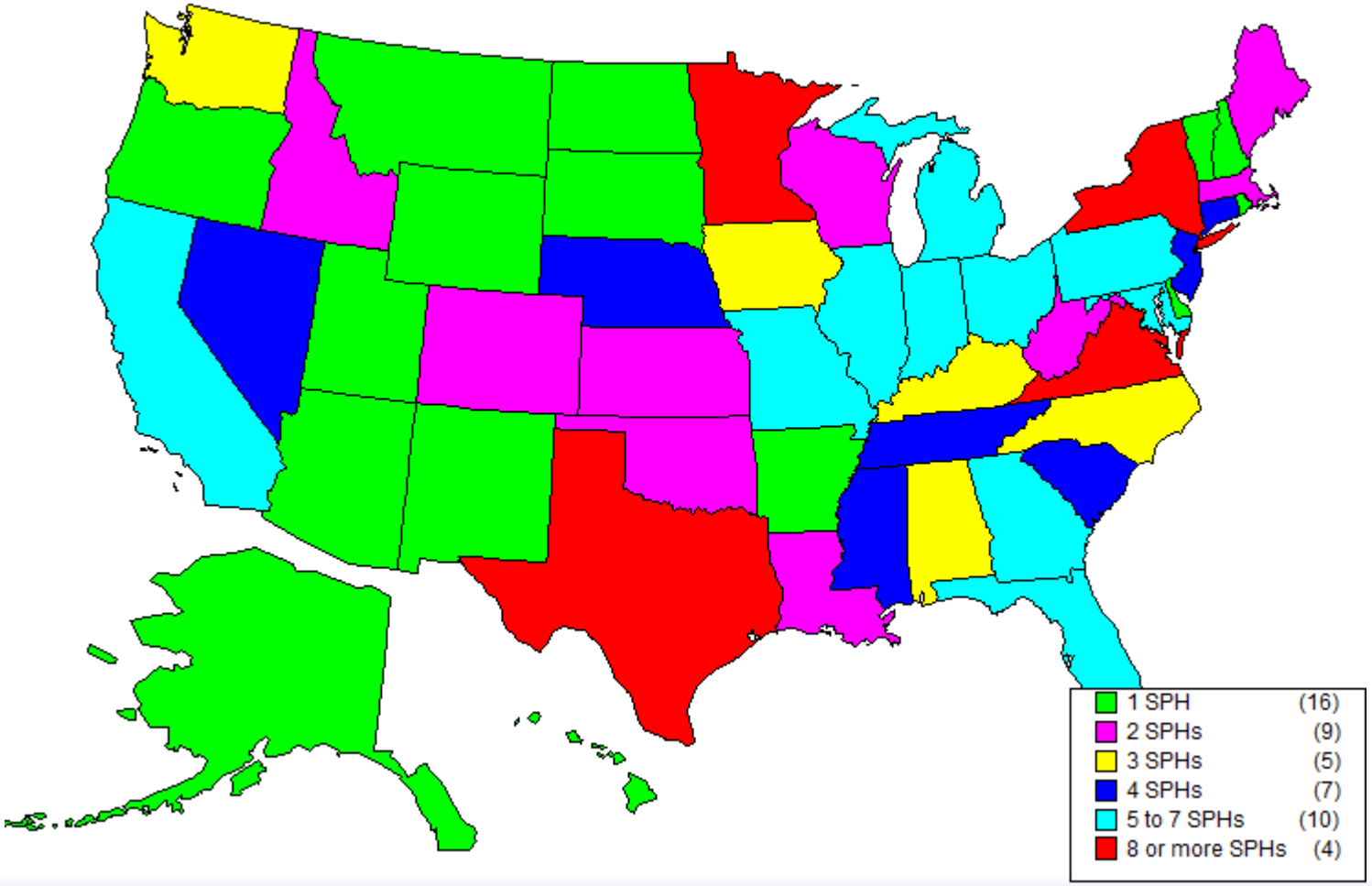




Intended Use of State Psychiatric Hospitals: 2015



Number of State Psychiatric Hospitals, 2015



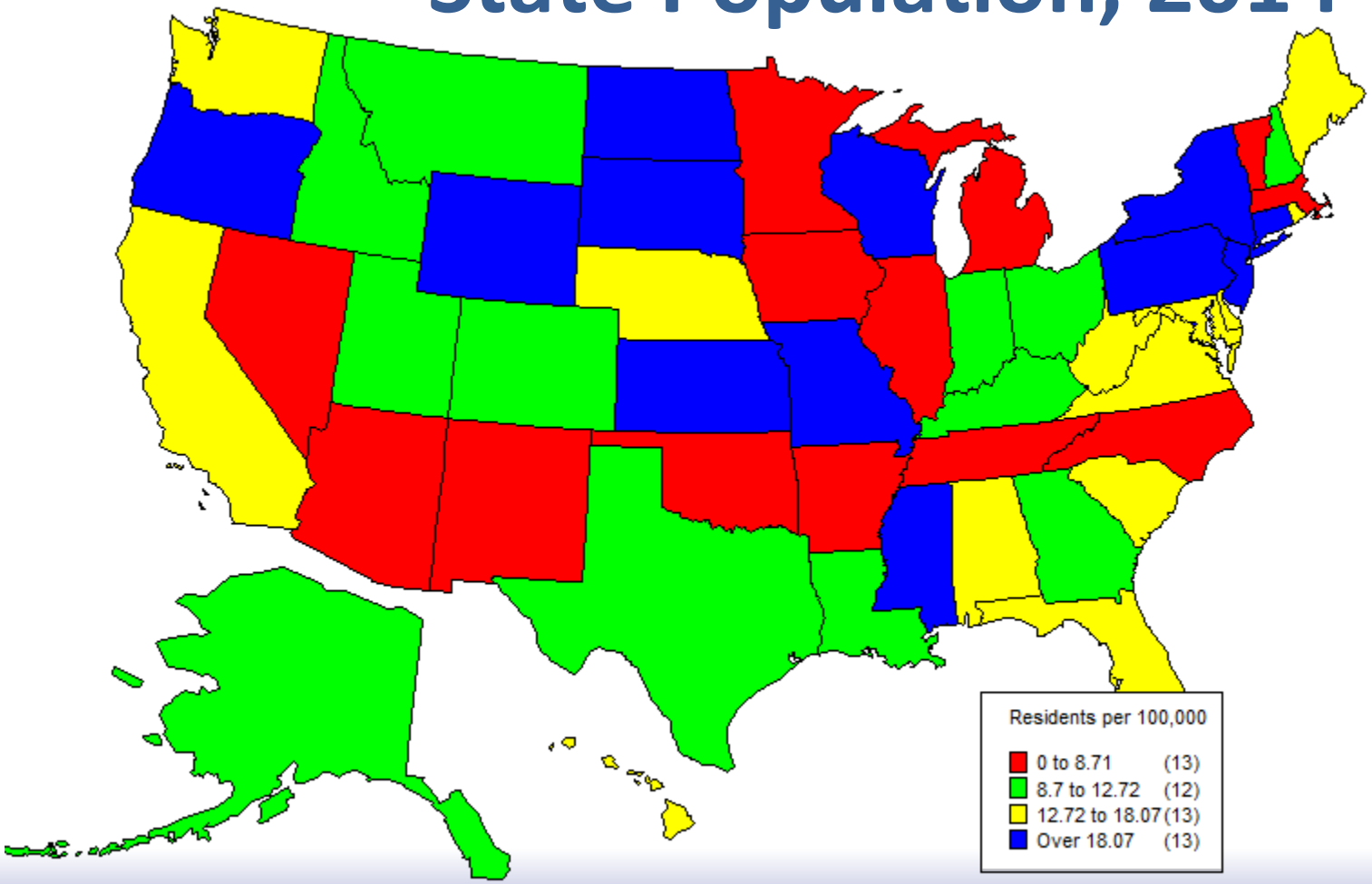
Source: NRI 2015 State Mental Health Agency Profiling System

1987-2017 30 years

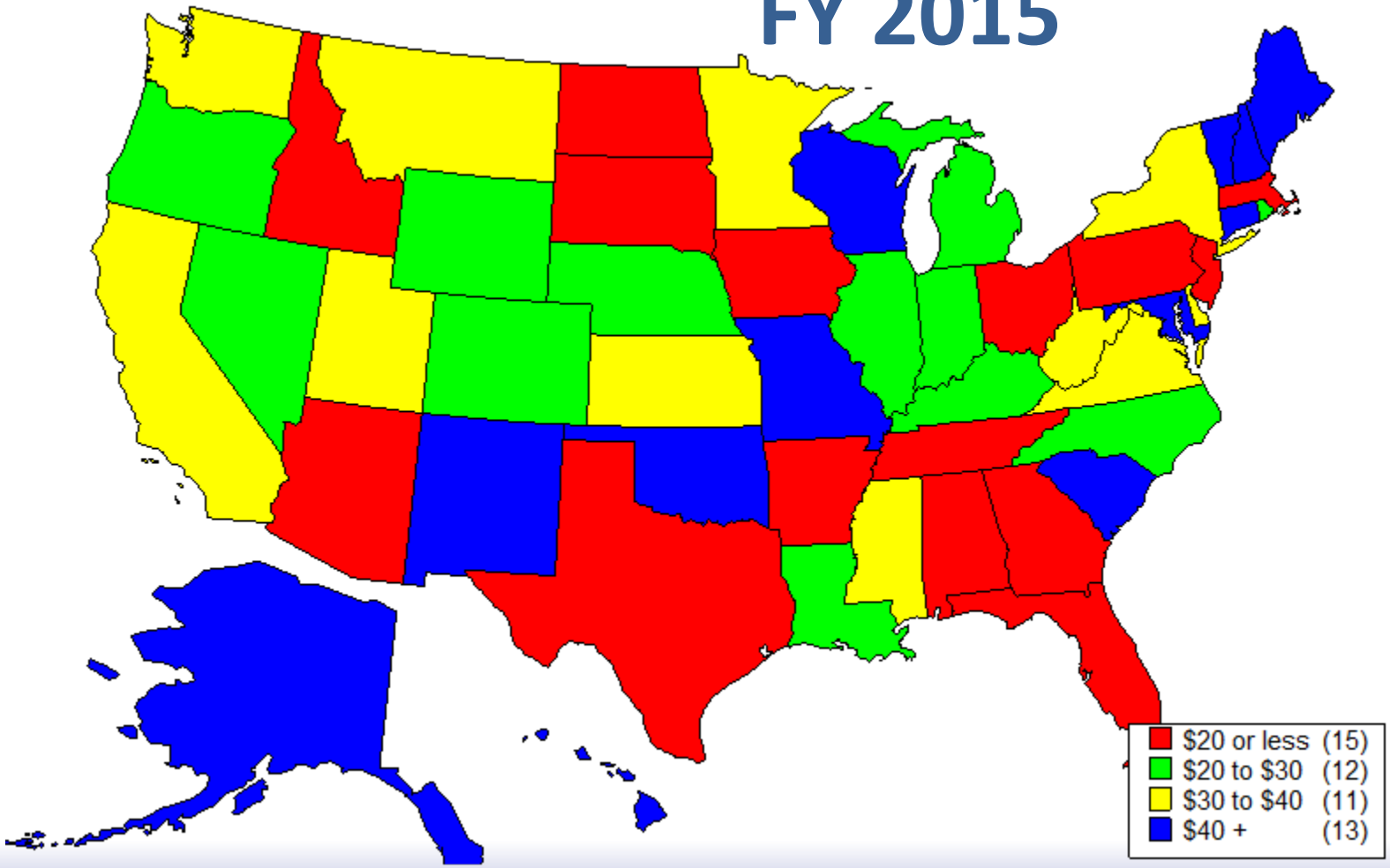
NRI

Analytics Improving Behavioral Health SM

State Psychiatric Hospital Inpatients Per 100,000 State Population, 2014



Per Capita Expenditures for State Psychiatric Hospitals: FY 2015



1987-2017 30 years NRI
Analytics Improving Behavioral Health SM

Psychiatric bed shortages are frequently in the news and a focus of courts, advocates, providers, and states

Recent News Headlines

"Mental health problems strain ERs"

Rutland Herald (VT), July 15, 2017

"Amid shortage of psychiatric beds, mentally ill face long waits for treatment"

PBS News Hour, August 2, 2016

"Nation's psychiatric bed count falls to record low"

Washington Post, July 1, 2016

"Psychiatric beds disappear despite growing demand"

USA Today, May 12, 2014

"A dearth of psychiatric hospital beds for California patients in crisis"

NPR, April 14, 2016

Recent International Headlines

Ireland: "Shortage of beds in child mental health service, Seanad told"

Irish Times, July 6, 2017

Great Britain: "Patients sent 500 miles to Scotland due to hospital bed shortage"

Wiltshire Times, June 29, 2017

Canada: "London bed crisis: A shortage of beds for people needing mental health care defies easy answers"

London Free Press, March 31, 2017

Australia: "Bed shortage across South Australia sees 15 mentally ill patients locked out of hospital and cared for in jail"

The Advertiser (Adelaide), July 11, 2016

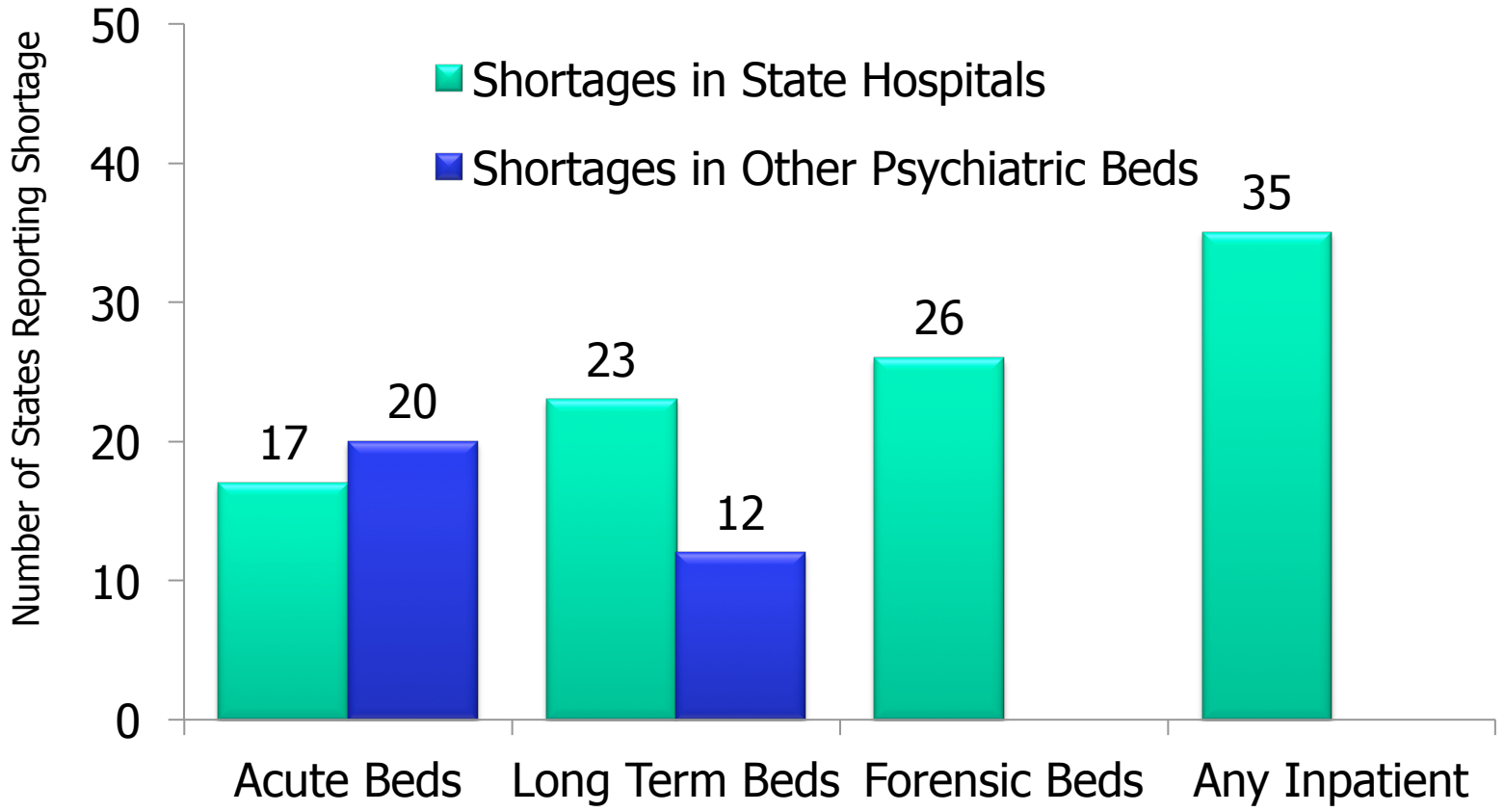
The Decrease of Psychiatric Inpatient Capacity is Frequently Blamed for:

- Increased Homelessness
- Increased individuals with MI in Jails and Prisons
- Boarding and Increased use of Emergency Departments
- Increases in Violent Crimes
- Increased Suicide

  - Note—these are not just recent claims—

    Thirty-three years ago--in 1984 the NY Times listed the closure of state hospitals as a cause of homelessness and incarnation of individuals with MI

In 2015, NRI asked SMHA if they were Experiencing Bed Shortages in State Psychiatric Hospitals

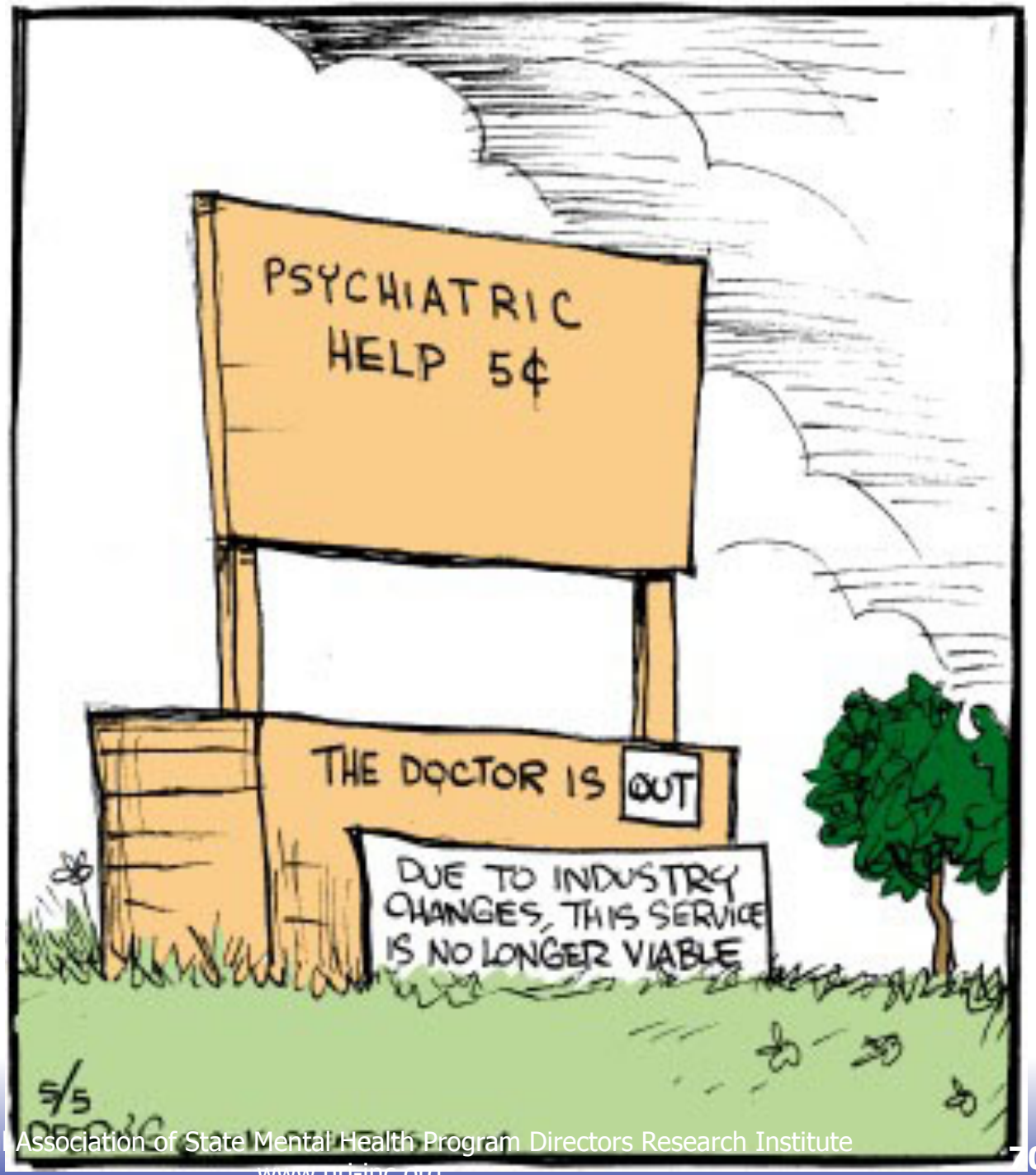


Source: NRI 2015 State MH Profiles

1987-2017 30 years

NRI

Analytics Improving Behavioral Health SM



State Policies to Address Shortages are not Reopening State Hospital Beds

States reported on a variety of policies to address shortages including:

- Expand and promote the use of crisis centers to divert individuals away from inpatient psychiatric beds
- Work with local hospitals (private psychiatric and general hospitals) to open mental health beds
- Increased use of Assertive Community Treatment and other community supports to avoid hospitalization
- Focus on transition from hospitals to the community to reduce re-hospitalization and permit more rapid discharge of clients ready for community integration
- Only 3 states reported plans to open new SH Beds

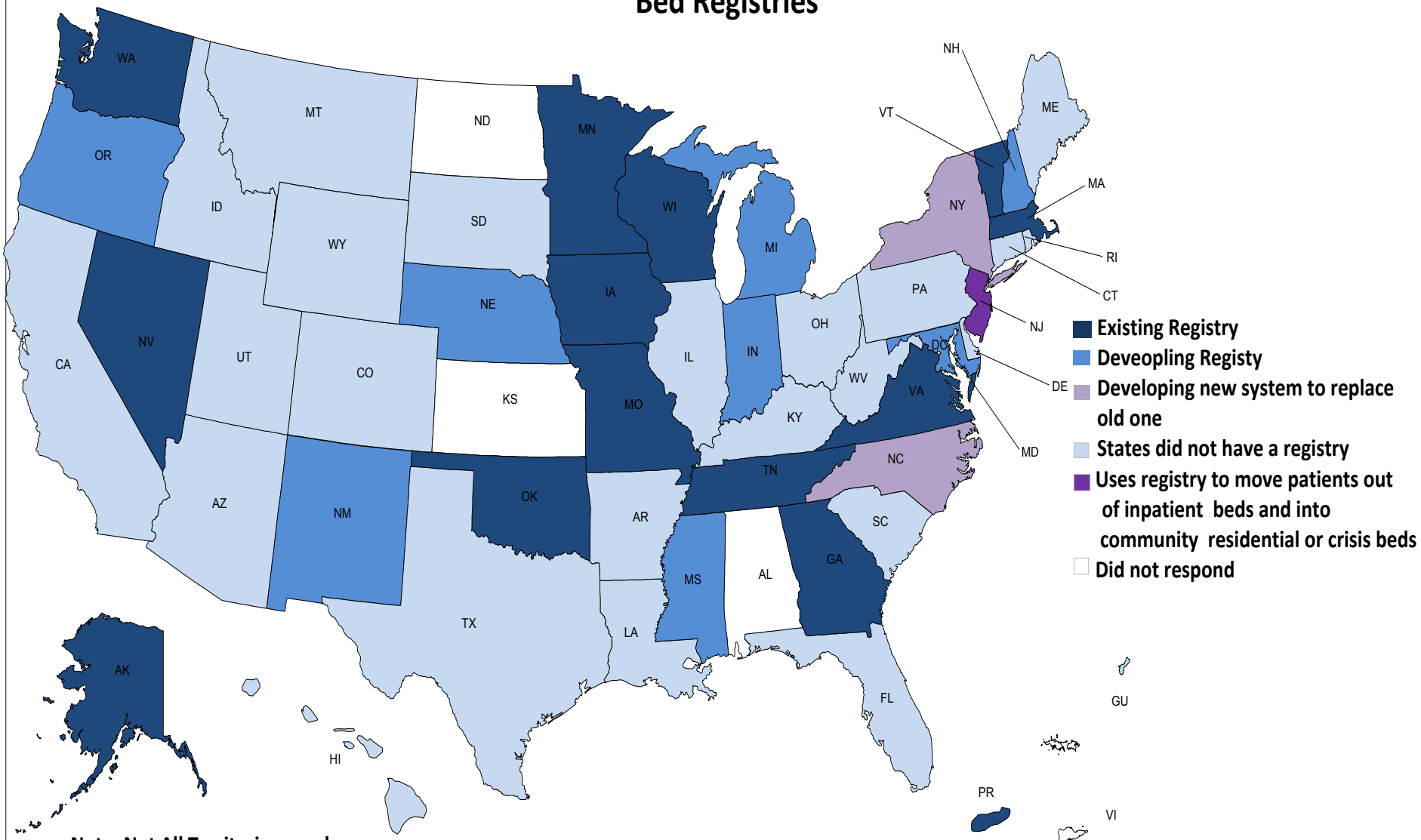
Source: NRI 2015 State MH Profiles

Bed Registries: Part of SMHA Efforts to Use Psychiatric Inpatient Beds More Efficiently

16 States are operating psychiatric **BED REGISTRIES**

- 11 states update the registry periodically (e.g. every morning, when new information is available, several times a day, etc.) as opposed to using real-time tracking.
- 15 states track the availability of beds within multiple types of facilities.
  - 13 States: State psychiatric hospital beds,
  - 13 States: General hospital psychiatric beds,
  - 12 States: Private psychiatric beds (12states)
- Participation in the Registry is Voluntary in 9 states

States Responding to Questionnaire on Psychiatric Bed Registries



Note: Not All Territories are shown.
DC did not have an existing registry.

Bed Registries

- Several states indicated difficulties maintaining "real-time" information about all available psychiatric beds—leading to frustration and lower utility.
  - Making sure information about available beds is current and accurate is critical.
- New Jersey has developed a different Bed Registry– NJ's registry focuses on Community Beds available for patients ready to leave hospitals.
  - By community providers and hospitals find safe community placements for patients ready for discharge, NJ's system frees up hospital beds more quickly thus increasing capacity without increasing inpatient beds.

Total Psychiatric Bed Capacity in 2014

Discussion of psychiatric bed capacity frequently focuses only on state psychiatric hospitals.

- The reduction of state psychiatric hospitals from over 550,000 patients in the 1950s to 40,000 patients today.
- Discussion of current inpatient capacity rarely addresses:
  - all beds available from different types of organizations
  - or the changed roles of state psychiatric hospitals

The paper developed for NASMHPD's TA Coalition Project (funded by SAMHSA) estimates of total current capacity and discusses some of the changes from historical bed usage.

Number and Rate per 100,000 Psychiatric Inpatients and Other 24-Hour Residential Treatment Patients On April 30, 2014

Year/Setting	Patients in Inpatients Beds (last Day of Year)	Inpatients Per 100,000 Population	Patients in Other 24-Hours Residential Treatment Beds	Other 24 Hour Residents Per 100,000 Population	Total Inpatient & Other 24 Hour Patients	Total Rate per 100,000 Population
State & County Psych Hospitals	37,209	11.7	2,698	0.8	39,907	12.6
Private Psychiatric Hospitals	24,804	7.8	3,657	1.0	28,461	9.0
General Hospital with Separate Psych Units	30,864	9.7	589	0.2	31,453	9.9
VA Medical Centers	3,124	1.0	3,886	1.2	7,010	2.2
RTCs	1,851	0.6	41,079	12.9	42,930	13.5
Other MH Providers	3,499	1.1	16,940	5.3	20,439	6.4
Total	**101,351**	**31.9**	**68,849**	**21.7**	**170,200**	**53.6**

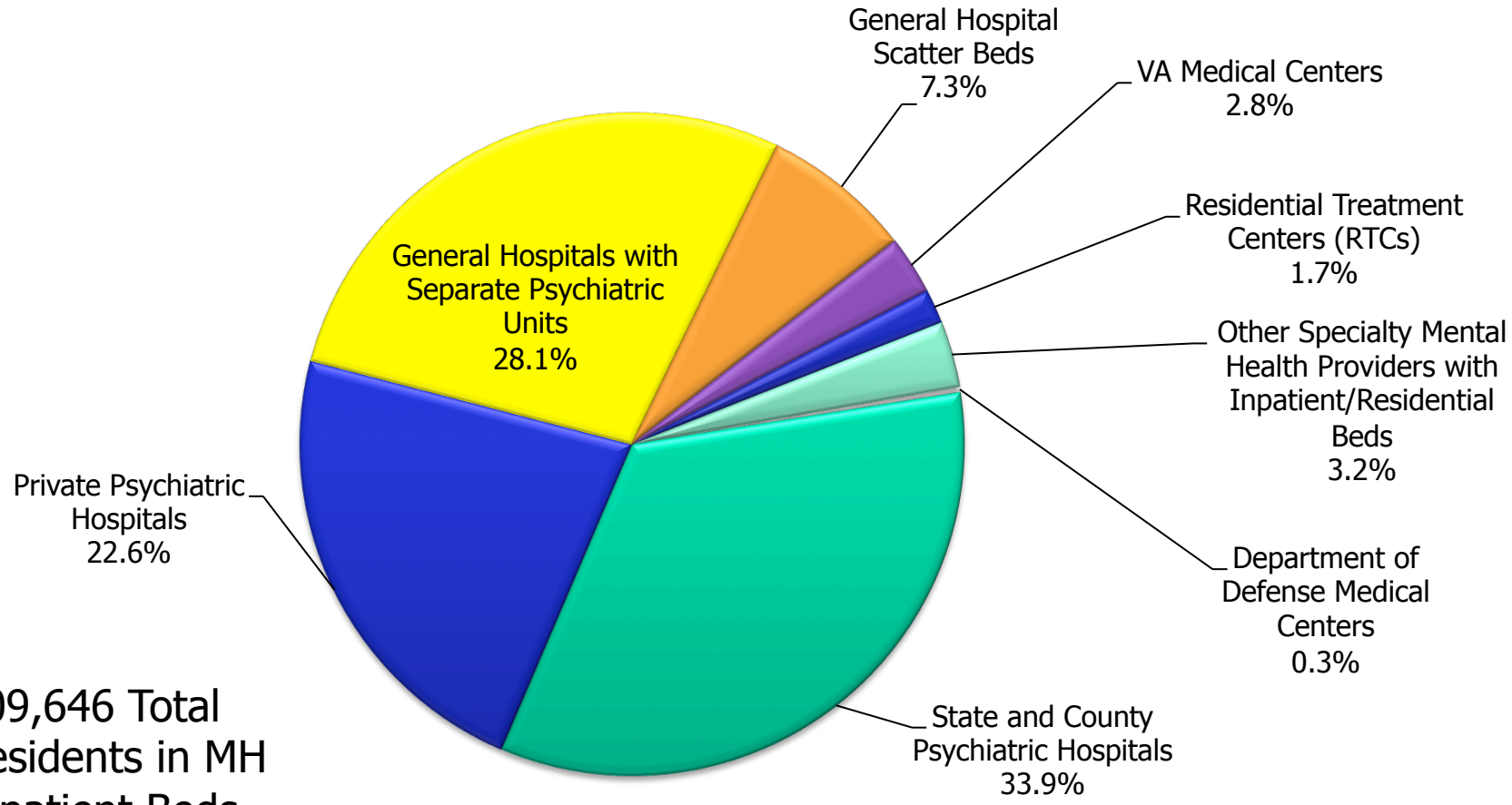
Source: SAMHSA N-MHSS, 2014, Tables 2.3 and 2.5

Total Number and Rate per 100,000 Psychiatric Inpatients and Other 24-Hour Residential Treatment Patients in 2014

Year/Setting	Psychiatric Inpatients (last Day of Year)	Inpatients Per 100,000 Population	Other 24 Hours Residential Clients	Other 24 Hour Residents Per 100,000 Population	Total Inpatient & Other 24 Hour Patients	Total Rate per 100,000 Population
State & County Psych Hospitals	37,209	11.7	2,698	0.8	39,907	12.6
Other MH Organizations	64,142	20.2	66,151	20.8	130,293	41.0
Total in MH Orgs	**101,351**	**31.9**	**68,849**	**21.7**	**170,200**	**53.6**
Beds in Non-Specialty Units	**8,295**	**2.6**			**8,295**	**2.6**
Nursing Home*			**183,534**	**57.8**	**183,534**	**57.8**
Total MH Org & Non-MH Orgs	**109,646**	**34.5**	**252,383**	**79.5**	**362,029**	**114.0**

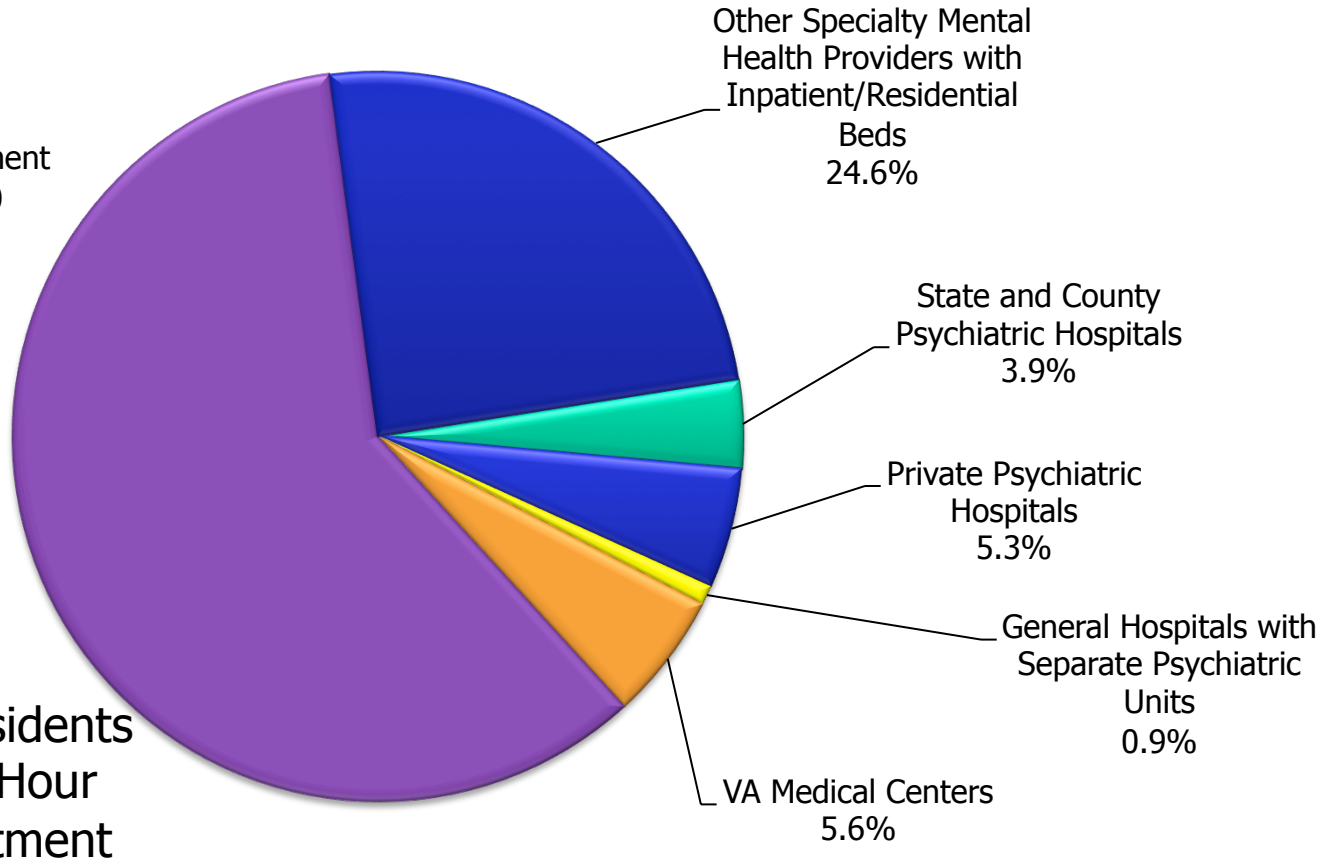
* Nursing home data for residents with a diagnosis of Schizophrenia and Bipolar diagnoses

Organizational Location of Mental Health Inpatients, 2014



109,646 Total Residents in MH Inpatient Beds

Organizational Location of Mental Health Residents in Other 24-Hour Residential Treatment, 2014



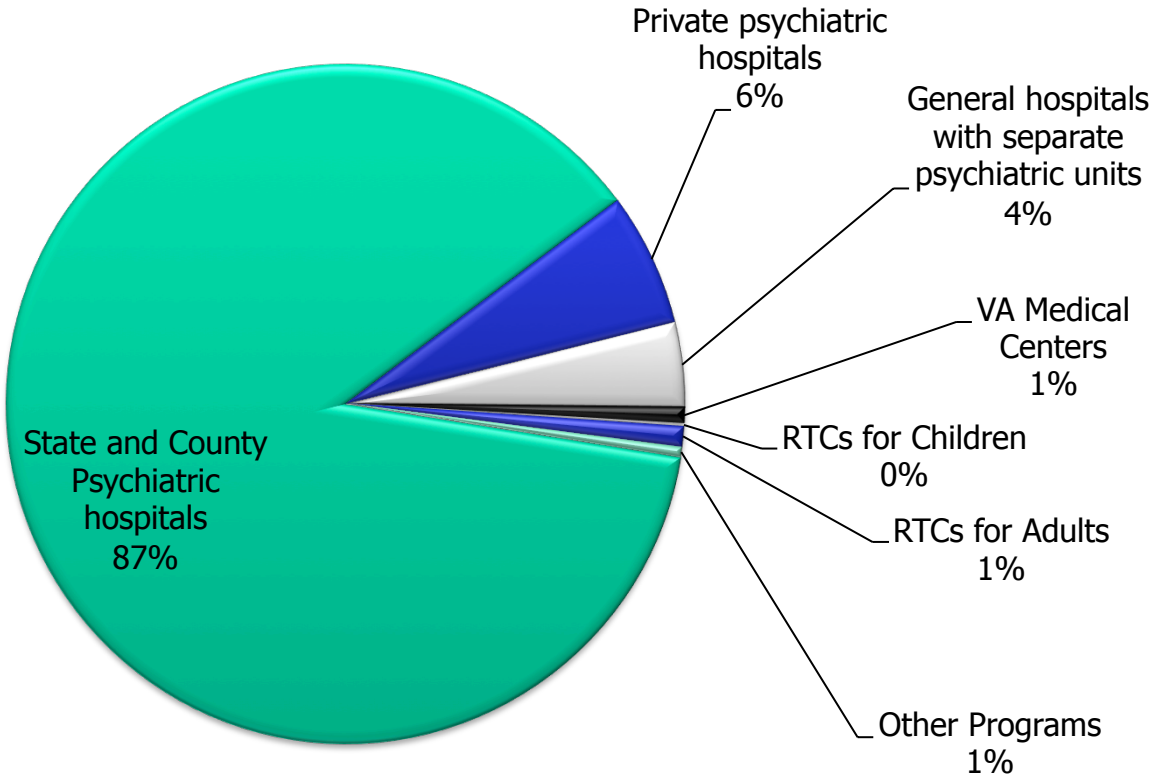
68,849 Total Residents in MH Other 24-Hour Residential Treatment Beds

Legal Status of Mental Health Inpatients, 2014

	Voluntary Clients		Involuntary-non Forensic		Involuntary Forensic	
	Number	Percent	Number	Percent	Number	Percent
State and County Psychiatric hospitals	6,523	18%	13,640	37%	17,046	46%
Private psychiatric hospitals	15,691	63%	7,876	32%	1,237	5%
General hospitals with separate psychiatric units	18,801	61%	11,278	37%	785	3%
VA Medical Centers	2,501	80%	476	15%	147	5%
RTCs for Children	370	81%	60	13%	28	6%
RTCs for Adults	578	55%	289	27%	189	18%
Other Programs	2,545	66%	1,197	31%	94	2%
Total	47,009	46%	34,816	34%	19,526	19%

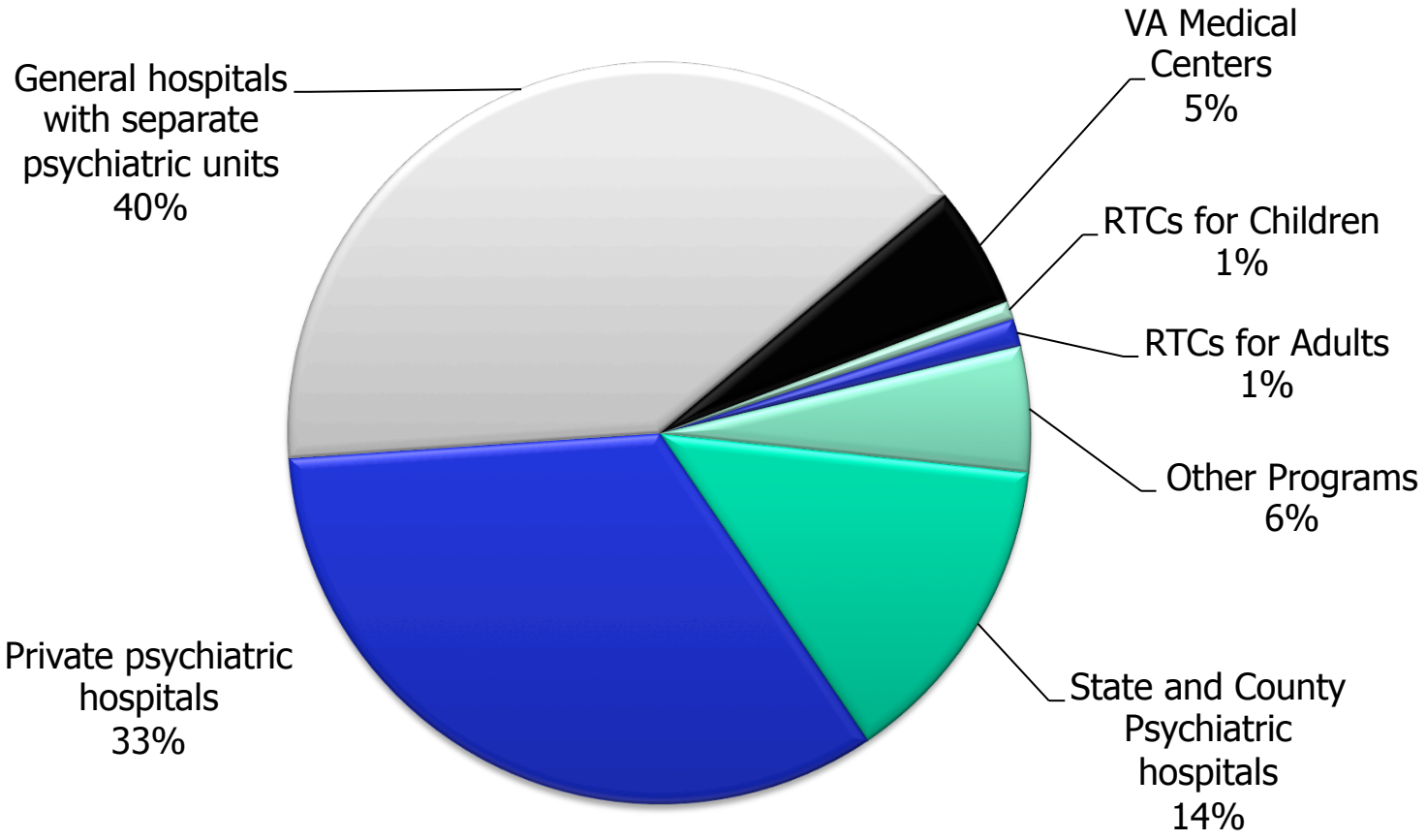
Source: SAMHSA N-MHSS, 2014

Percent of Involuntary-Forensic Inpatients, by Type of Organization, 2014



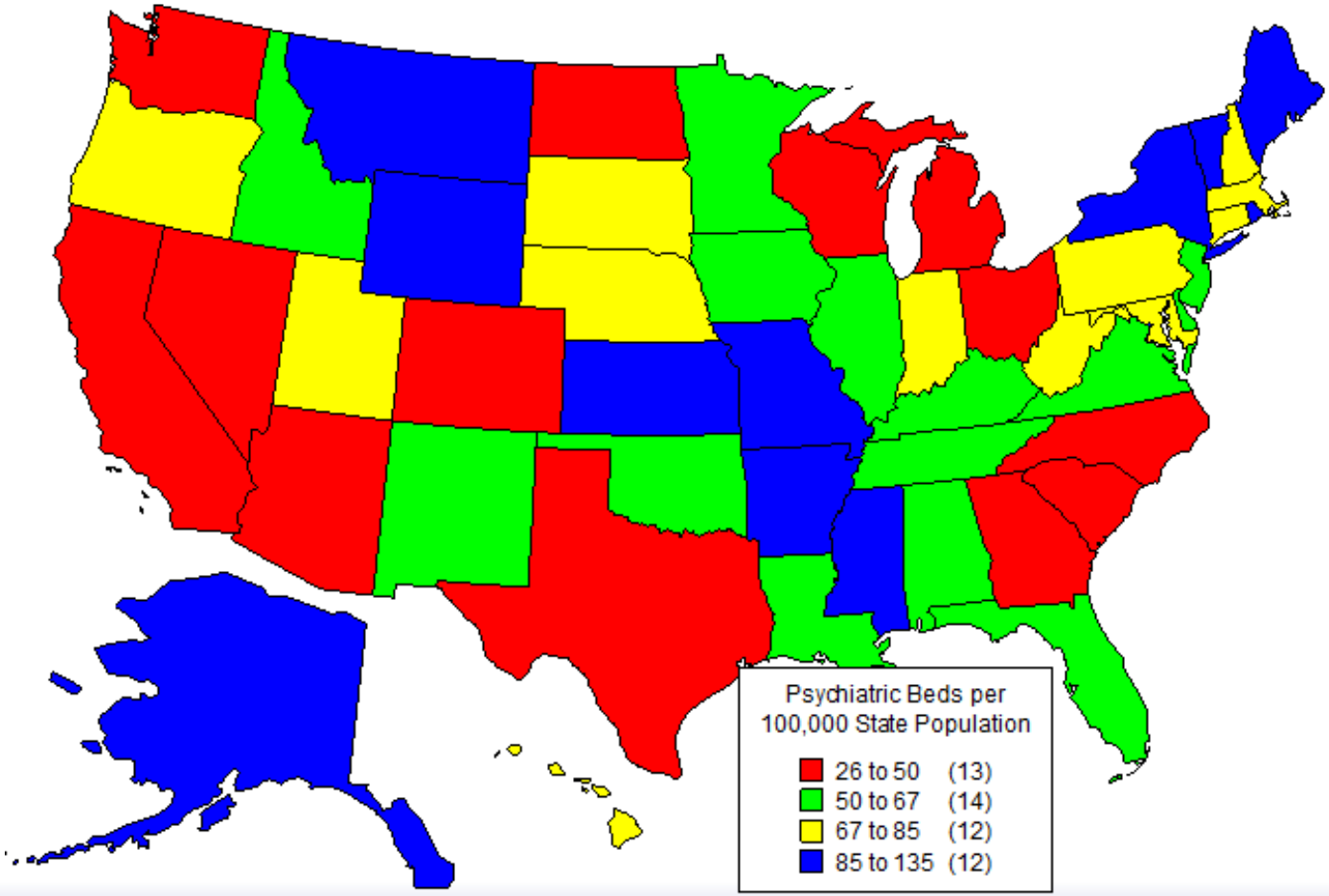
Source: SAMHSA N-MHSS, 2014

Percent of Voluntary Inpatients, by Type of Organization, 2014



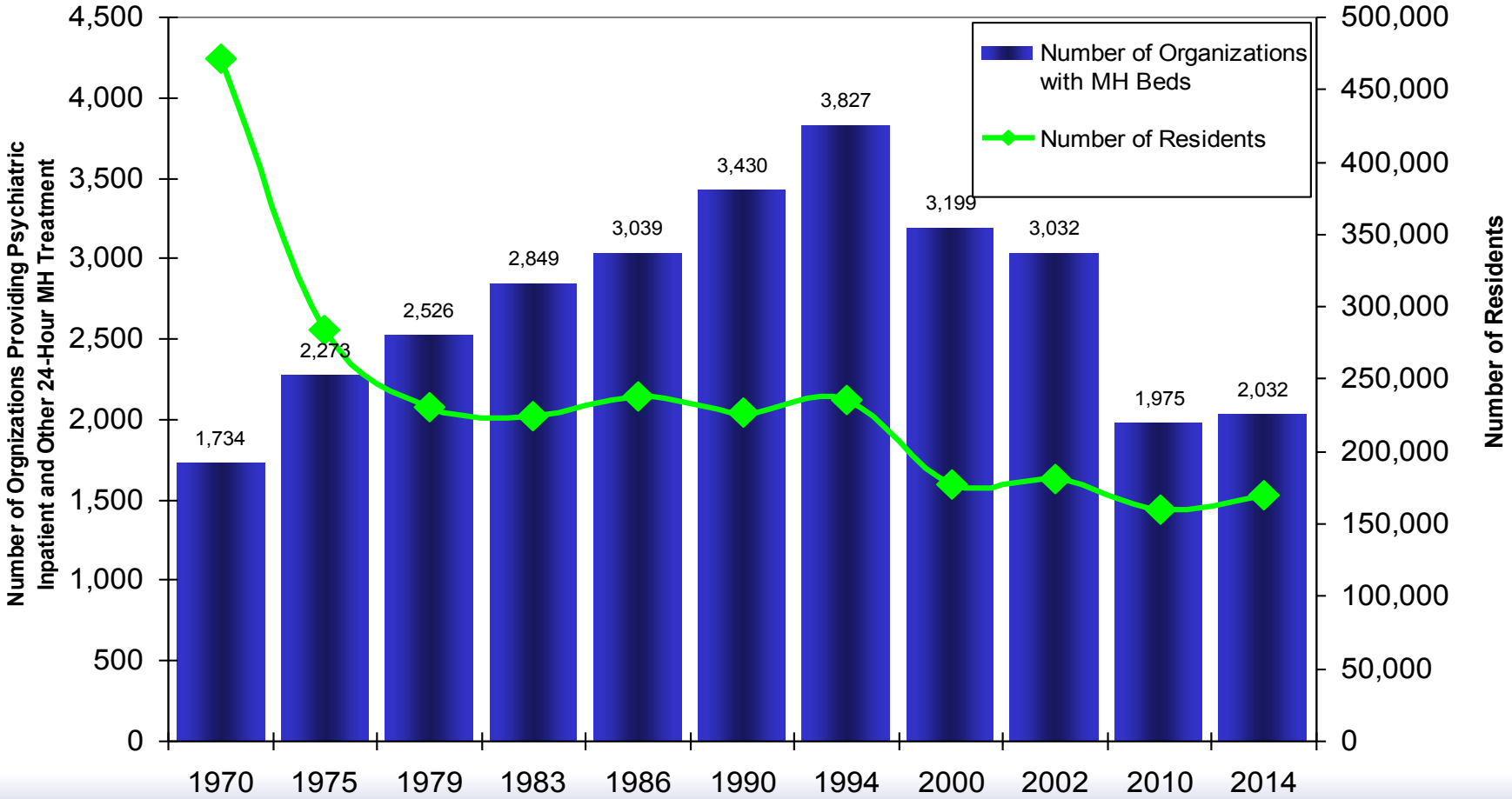
Source: SAMHSA N-MHSS, 2014

Total MH Inpatient and Other 24-Hour Residential Treatment Beds per 100,000 Population, By State, 2014



Source: SAMHSA N-MHSS, 2014

Number of Organizations Providing Inpatient and Other 24-hour Residential Treatment and Patients at the End of Year: 1970 to 2014



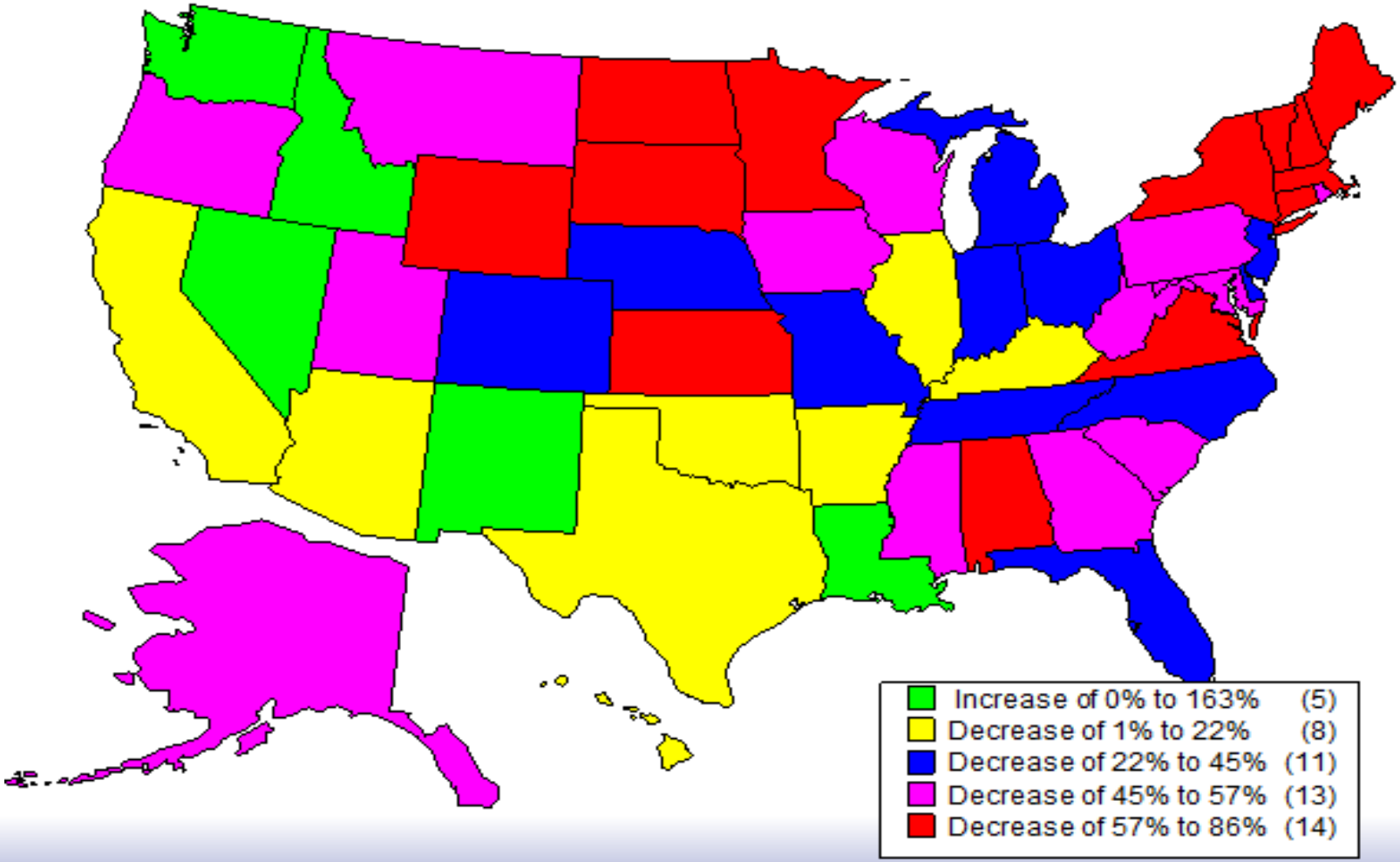
Sources: NIMH, SAMHSA IMHO, 2010 and 2014 NMHSS

1987-2017 30 years

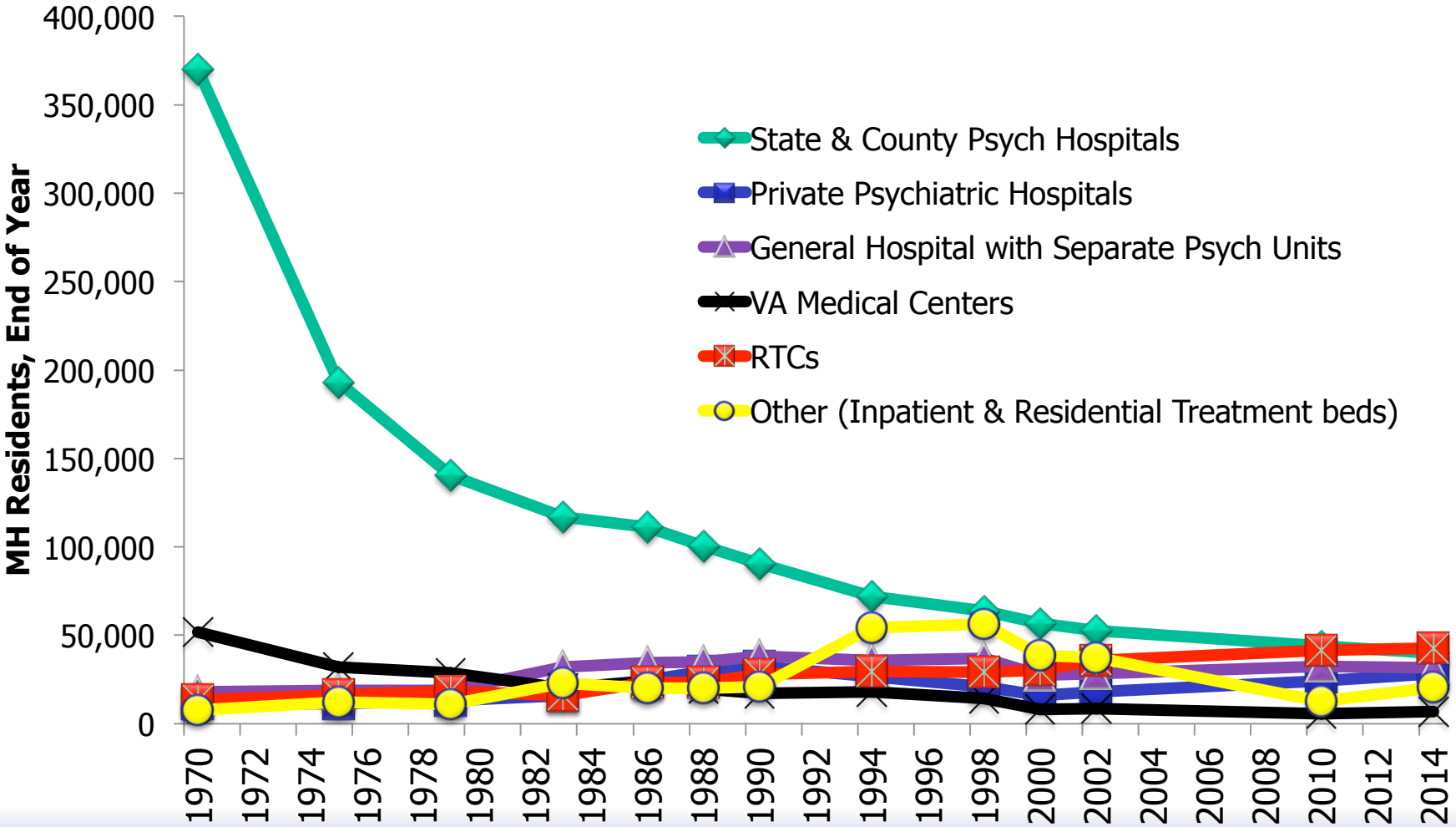
NRI

Analytics Improving Behavioral Health SM

Percent Change in Mental Health Residents Per 100,000 Population, by State, 1982 to 2014

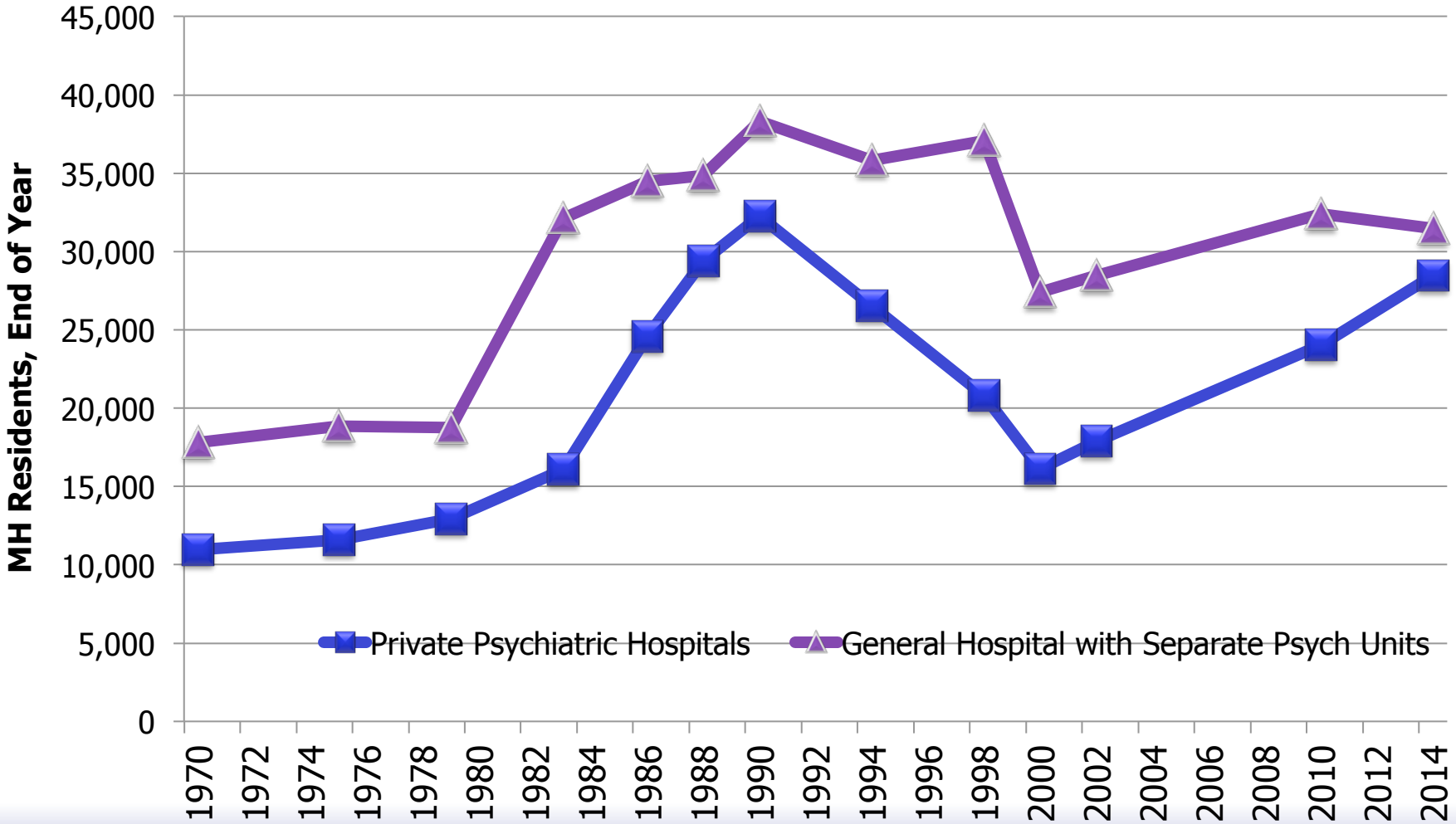


Inpatient and Other 24-Hour Treatment Residents at End of Year, 1970 to 2014, by Major Psychiatric Setting



Patients in Inpatient and Other 24 Hour Residential Units at End of Year, 1970 to 2014

Removing State Hospitals, VA Medical Center, and Other MH Providers



Use of Medicaid to Fund Public Mental Health Services

Medicaid is now the largest single payer for all Mental Health Services: $45 billion in 2014 (25% of all mental health service funding in the US)*

In FY 2015, Medicaid Represented the largest payor for SMHA Services:

- 50% of Total SMHA Controlled Funds)
- 61% of SMHA-controlled Community Mental Health Funding
- 22% Of State Psychiatric Hospital Funds

** Source for Total US spending for MH from SAMHSA National Spending Estimates, 2016*

Medicaid Waivers Used to Provide MH Services

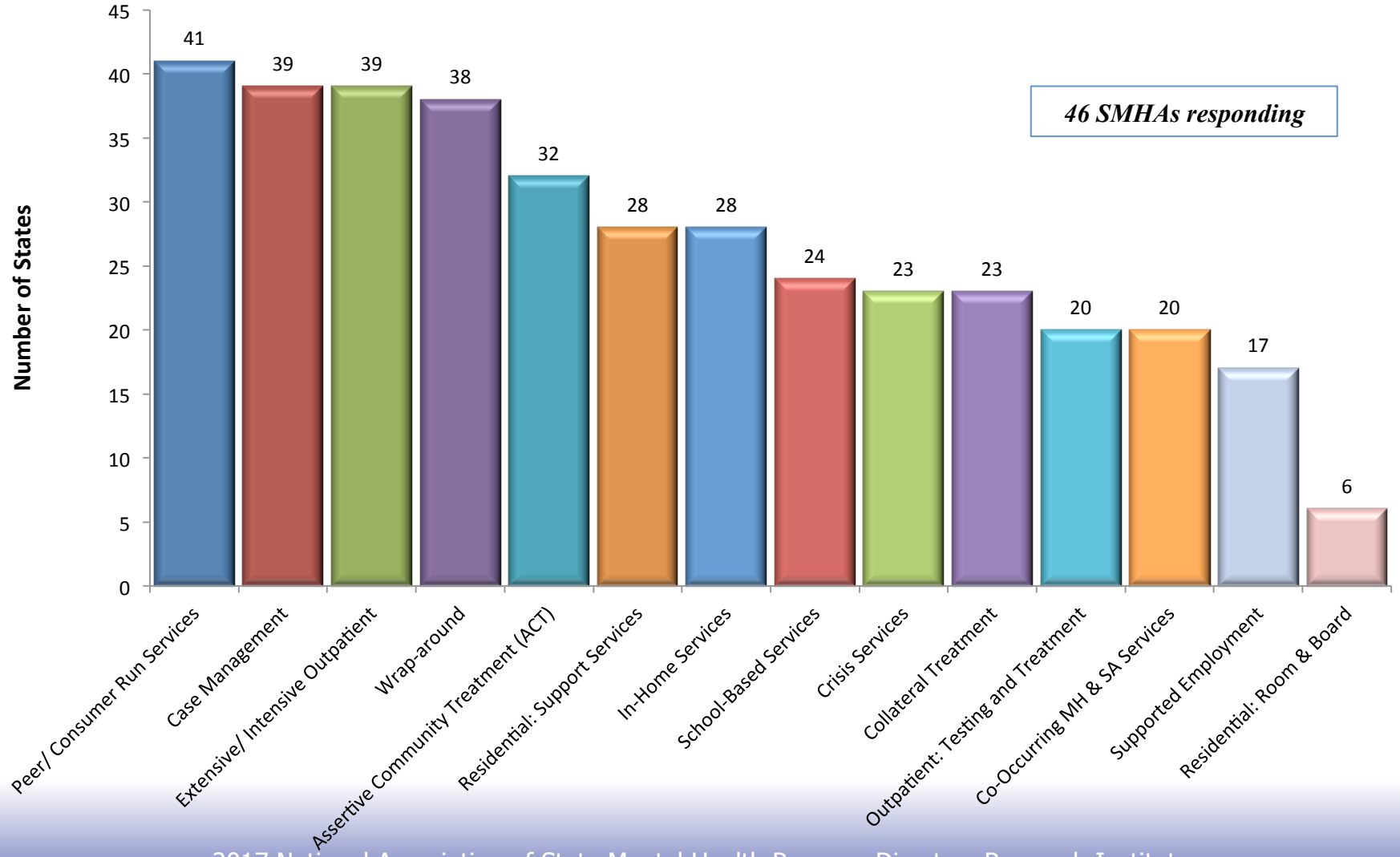
States use combinations of Waivers and Options to fund MH

- 19 States: 1115 Research and Demonstration Waiver:
- 15 States: 1915(B) Waiver
- 14 States: 1915(c) Home and Community-Based Waiver
- 10 States 1915(I) Home & Community Based State Option
  - 5 states applying for 1915(i) Option

SMHA Role in paying State Medicaid Match for MH Services

- 25 States The SMHA is responsible for the Match for MH Services in State-Operated providers
- 31 States The SMHA is responsible for the Match for MH Services in SMHA-funded providers

What Services Do SMHAs Use the Medicaid to Fund: 2015



Number of States Using Various Sources of Funding for Community Mental Health Services: FY 2015

Funding Sources	Inpatient Hospital	Residential: Room & Board	Residential: Support Services	Outpatient: Testing and Treatment	Extensive/ Intensive Outpatient	Collateral Treatment	Case Management	Crisis Services	Assertive Community Treatment (ACT)	Supported Employment	School-Based Services	Wrap-around	In-Home	Peer/ Consumer Run Services	Co-Occurring MH & SA Services
State general fund	37	37	40	41	37	28	40	44	35	35	29	32	30	37	23
State special funds	7	7	8	10	7	3	5	9	6	3	4	4	5	4	4
State Medicaid match	30	7	26	34	32	16	32	32	25	13	26	20	24	17	14
Medicaid (federal)	22	6	28	41	39	23	39	38	32	17	23	24	28	20	20
Clinic option	5	0	1	16	13	6	5	9	5	1	4	2	2	0	7
Rehabilitation option	2	3	18	25	25	11	16	23	20	7	13	10	19	13	12
Targeted case management	0	0	1	1	2	1	21	2	3	1	0	3	3	2	0
1915(i) option	0	0	2	2	3	0	1	3	1	3	0	0	2	2	0
1115 waiver	9	0	4	8	9	4	8	7	6	6	1	3	4	4	0
1915(b) waiver	5	0	5	9	7	4	7	7	6	4	4	6	7	4	3
1915(c) waiver (HCB)	1	1	6	1	1	1	6	2	0	3	3	5	6	0	4
EPSDT	6	2	5	9	8	5	5	5	1	1	7	6	7	1	1
Other Medicaid	10	0	0	4	4	1	0	2	1	0	2	1	1	0	1
Medicare	23	1	2	16	9	0	0	4	3	0	0	0	1	0	4
Veteran's Affairs	5	1	3	6	4	3	4	3	3	3	2	1	2	1	1
SAMHSA MH Block Grant	1	6	16	27	22	10	22	19	14	14	20	20	13	29	10
Social Services Block Grant	1	4	6	5	4	4	8	5	3	4	3	4	3	2	3
Housing and Urban Development	0	9	3	1	0	1	3	1	1	1	0	2	2	1	1
Other federal	1	2	6	2	4	2	5	3	0	4	1	3	1	3	4
Local government	12	11	13	16	13	9	14	15	13	10	9	9	10	11	8
First party	17	15	13	21	18	13	17	15	10	7	5	9	10	7	5
Third party	23	8	9	25	20	9	12	15	11	6	6	7	9	6	10
Charity	3	3	3	5	3	2	3	2	1	2	1	2	1	2	0
Other funds	1	0	0	1	1	1	1	1	0	2	2	1	1	1	1

1987-2017 30 years

NRI

Analytics Improving Behavioral Health SM

NRI Report: State Behavioral Health Authorities' Use of Performance Measurement Systems, 2016

https://www.nasmhpd.org/content/tac-assessment-working-paper-state-behavioral-health-authorities-use-performance-measurement

SBHAs' Use of Performance Measurement Systems 2016

- To learn how state behavioral health authorities (SBHAs) are using Performance Measurement Systems, NRI staff requested information from all 50 states and Washington, D.C. during the Summer of 2016:
  - If the SBHA has had, has, or is planning to implement a performance measurement system.
  - Which settings and populations are covered by the system.
  - If provider payments are tied to performance.
  - Which outcome domains are included in the system (e.g., strength-based, recovery/resilience, consumer perception of care, family involvement, client symptoms, client functioning, change in employment, and change in living situation).

- Interviewed six SBHAs for more in-depth information (IN, MD, OK, OH, OR, anonymous state)

SBHAs' Use of Performance Measurement Systems

- Information contained in the report:
  - Evolution on Performance Measurement in Public Behavioral Health Systems.
  - Information about SBHA Performance Measurement Systems, including:
    - Impetus for establishing a system
    - Considerations in building a performance measurement system
    - Settings covered in SBHA performance measurement systems
    - Populations included in SBHA performance measurement systems
    - Elements of SBHA performance measurement systems
    - Use of pay for performance
  - Reducing the Burden and Promoting a Culture of Performance Measurement, including narratives of state experiences.
  - Lessons learned from previous state performance measurement initiatives.
  - Sustainability of performance measurement systems.
  - Challenges and successes in establishing a performance measurement system.

SBHAs' Use of Performance Measurement Systems

- 41 SBHAs responded to our request for information
- Status of SBHA performance measurement systems (there may be duplication across states):
  - Currently have a Performance Measurement System: 31 SBHAs
  - Planning New Performance Measurement System: 4 SBHAs
  - No Performance Measurement System: 8 SBHAs
- Impetus for establishing a performance measurement system:
  - To meet federal reporting requirements.
  - Identified need by SBHA leadership for quality improvement monitoring, to provide a means to demonstrate success, and to respond to stakeholder requests for information (including the state legislature).
  - Only one SBHA's performance measurement system was required by the state legislature.

SBHAs' Use of Performance Measurement Systems

- SBHAs primarily collect data for community settings (30) and state hospitals (20), with several also collecting data for their MCOs (7).

- SBHAs using Pay for Performance:
  - Currently use Pay for Performance: 7 SBHAs
  - Planning to Move to Pay for Performance: 2 SBHAs

1987-2017 30 years

NRI

Analytics Improving Behavioral Health SM

Indiana Performance Measurement System

2016 Presented at

NASMHPD Commissioners' Meet-me-call

by Wendy Harrold, M.S. in Health Informatics

Indiana Division of Mental Health and Addiction

Indiana's Public Mental Health & Addiction System

- In Indiana, the public mental health and addiction system is comprised of 25 community mental health centers and 9 contracted providers.
- Criteria to be served: At or below 200% of poverty, an eligible mental illness diagnosis or substance-related diagnosis and functional impairment
- Last state fiscal year, the system served more than 162,000 individuals in the community.

Indiana Pay for Performance

- We started paying for performance in state fiscal year 2008.
- Currently, we hold back 10% of their contracted funds for performance. We run the data monthly and pay every quarter.
- We are contemplating increasing the percentage of funds held back for performance pay.
- We utilize the CANS/ANSA to measure outcomes (changes in symptoms, functioning, strengths)

Indiana's Assessment Tools

- CANS – Child and Adolescent Needs and Strengths - Indiana utilizes 2 CANS Tools
  - **Birth to 5 years** (Contains 59 required questions and 41 extension module questions)
  - **5 – 17 years** (Contains 66 required questions and 97 extension module questions) * Can be used up to 22 years old if developmentally appropriate
- ANSA – Adult Needs and Strengths Assessment
  - **For 18 year olds and older** (Contains 57 required questions and 70 extension module questions)

Indiana Example of the Monthly Scorecard

SFY: 2017 **Reported Time from 07/01/2016 to 9/30/2016**
Provider Local #999 **Example Provider**

Source Data Generated on 11/15/2016

Category	Numerator / Denominator	Numerator / Denominator	Pct. of Target Met	Numerator / Denominator	Numerator/ Denominator	Pct. of Target Met	Numerator / Denominator	Numerator/ Denominator	Pct. of Target Met	Numerator / Denominator	Numerator/ Denominator	Pct. of Target Met
Quarter 1	**July 2016**			**August 2016**			**September 2016**			**Quarter 1 of SFY 2017**		
Category	**Numerator / Denominator**	**Numerator / Denominator**	**Pct. of Target Met**	**Numerator / Denominator**	**Numerator/ Denominator**	**Pct. of Target Met**	**Numerator / Denominator**	**Numerator/ Denominator**	**Pct. of Target Met**	**Numerator / Denominator**	**Numerator/ Denominator**	**Pct. of Target Met**
Adults Served - SMI	3114 / 2990	104.15%	100.00%	3283 / 2990	109.80%	100.00%	3094 / 2990	103.48%	100.00%	3164 / 2990	105.82%	100.00%
Reassessments - NOMS - SMI	430 / 612	70.26%	87.83%	582 / 767	75.88%	94.85%	403 / 573	70.33%	87.91%	1415 / 1952	72.49%	90.61%
Reassessment - ANSA - SMI	443 / 523	84.70%	100.00%	550 / 643	85.54%	100.00%	493 / 577	85.44%	100.00%	1486 / 1743	85.26%	100.00%
Improvement in One Domain - SMI	218 / 458	47.60%	100.00%	308 / 574	53.66%	100.00%	280 / 517	54.16%	100.00%	806 / 1549	52.03%	100.00%
Improvement in One Domain for closed episodes -	54 / 70	77.14%	100.00%	108 / 132	81.82%	100.00%	44 / 62	70.97%	100.00%	206 / 264	78.03%	100.00%
Strength Development – SMI	126 / 457	27.57%	100.00%	169 / 572	29.55%	100.00%	169 / 516	32.75%	100.00%	464 / 1545	30.03%	100.00%
Community Integration - SMI	133 / 458	29.04%	100.00%	186 / 574	32.40%	100.00%	168 / 517	32.50%	100.00%	487 / 1549	31.44%	100.00%
Adults Served - CA	745 / 632	117.88%	100.00%	766 / 632	121.20%	100.00%	793 / 632	125.47%	100.00%	768 / 632	121.52%	100.00%
Reassessments - NOMS - CA	103 / 122	84.43%	100.00%	124 / 140	88.57%	100.00%	125 / 143	87.41%	100.00%	352 / 405	86.91%	100.00%
Reassessments - ANSA - CA	102 / 113	90.27%	100.00%	114 / 124	91.94%	100.00%	127 / 134	94.78%	100.00%	343 / 371	92.45%	100.00%
Improvement in One Domain - CA	70 / 103	67.96%	100.00%	72 / 117	61.54%	100.00%	83 / 128	64.84%	100.00%	225 / 348	64.66%	100.00%
Improvement in One Domain for closed episodes - CA	13 / 15	86.67%	100.00%	26 / 31	83.87%	100.00%	9 / 11	81.82%	100.00%	48 / 57	84.21%	100.00%
Strength Development - CA	37 / 103	35.92%	100.00%	42 / 117	35.90%	100.00%	49 / 128	38.28%	100.00%	128 / 348	36.78%	100.00%
Community Integration - CA	42 / 103	40.78%	100.00%	49 / 117	41.88%	100.00%	48 / 128	37.50%	100.00%	139 / 348	39.94%	100.00%
Youth Served - SED and CA	708 / 719	98.47%	98.47%	723 / 719	100.56%	100.00%	699 / 719	97.22%	97.22%	710 / 719	98.75%	98.75%
Reassessments - NOMS - Youth	66 / 85	77.65%	97.06%	104 / 120	86.67%	100.00%	97 / 108	89.81%	100.00%	267 / 313	85.30%	100.00%
Reassessment - CANS - SED	70 / 76	92.11%	100.00%	107 / 110	97.27%	100.00%	96 / 98	97.96%	100.00%	273 / 284	96.13%	100.00%
Improvement in One Domain (Youth 5-17)	51 / 61	83.61%	100.00%	71 / 97	73.20%	100.00%	64 / 80	80.00%	100.00%	186 / 238	78.15%	100.00%
Improvement in One Domain (Youth 0-5)	0 / 0	0.00%	0.00%	1 / 1	100.00%	100.00%	6 / 6	100.00%	100.00%	7 / 7	100.00%	100.00%
Improvement in One Domain for closed episodes –	36 / 41	87.80%	100.00%	47 / 58	81.03%	100.00%	19 / 21	90.48%	100.00%	102 / 120	85.00%	100.00%
Strength Development – Youth 5-17	24 / 61	39.34%	100.00%	39 / 98	39.80%	100.00%	33 / 86	38.37%	100.00%	96 / 245	39.18%	100.00%

Oklahoma Enhanced Tier Payment System

The Enhanced Tier Payment System (ETPS) is an *innovative* payment structure developed to enhance the recovery *outcomes* of customers in the mental health and substance abuse system.

Community Mental Health Centers (CMHCs) have the opportunity to earn money directly related to individual levels of performance on twelve measures.

Oklahoma Measures

1. Outpatient Crisis Service Follow-up within 8 Days
2. Inpatient/Crisis Unit Follow-up within 7 Days
3. Reduction in Drug Use
4. Engagement: Four Services within 45 Days of Admission
5. Medication Visit within 14 Days of Admission
6. Access to Treatment - Adults
7. Improvement in CAR (Client Assessment Record) Score: Interpersonal Domain
8. Improvement in CAR Score: Medical/Physical Domain
9. Improvement in CAR Score: Self Care/Basic Needs Domain
10. Inpatient/Crisis Unit Community Tenure of 180 Days
11. Peer Support: % of Clients Who Receive a Peer Support Service
12. Access to Treatment - Children

Current Data System - Oklahoma

- Fee-for-service based payment
  - Provider submit DMH and Medicaid claims together
- Demographic information collect at admission, discharge, level of care change and at treatment plan update (usually six months).
  - Information include age, race, sex, living situation, TEDS data elements, assessment scores, etc.

Oklahoma Community Mental Health Centers

- 14 CMHCs
  - 4 State Operate
  - 10 Private, Not for Provider
- Each owns their own data system
- Data submitted via FTP and/or Web service to central repositories
  - CDC to one location
  - Claims to another

Oklahoma: How much is each CMHC able to earn each quarter?

- Based on the number of unduplicated clients served in the past four months

- Agency X serves 1,000 person
- Statewide, 15,000 persons are served

- 1,000 / 15,000 = 6.6% of all money

Oklahoma: Example of earnings by quarter

- Agency X served 6.6% of the clients
- Amount available for all measures is $11,000,000
- Amount available for each measure is $916,667
- Agency Score in 100% Range, they earn:
  6.6% * $916,667 = $60,500 per measure

Oklahoma How much money is there?

- It varies from quarter to quarter.

- 1st Quarter FY16: $10,728,875
- 2nd Quarter FY16: $11,820,908
- 3rd Quarter FY16: $11,025,662
- 4th Quarter FY16: $11,071,700

- FY16 Total = $44,647,145

Oklahoma ETPS Summary

- What it did?
  - Improved access to services, follow up, engagement
  - Paid for what we agreed is important
  - Provider increased the number served
    - Jan 2009 = 23,500 / Jun 2016 = 32,280
    - 37.3% increase in customers served from January 2009 through June 2016
- Why it worked?
  - Consensus and transparency built in
  - Had data system to support process

Performance Measurement and Outcomes in 2017

- 1990s, Medicaid began moving to Managed Care to control growth in costs
  - Behavioral Health Services were usually "Carved-Out" to specialized "Behavioral Health Managed Care Organizations (BH-MCOs), with separate contracts to provide Mental Health and Substance Abuse services
  - With Carve-outs specializing in Behavioral Health, most SMHAs worked with State Medicaid agencies to establish MCO contract requirements, including reporting Performance and Outcome Measures.
  - SMHAs could readily identify BH-MCO patients and services for SAMHSA and other reporting

Performance Measurement and Outcomes in 2017 (p2)

State Medicaid Agencies are increasingly shifting from "Carve-out" Behavioral Health Managed Care organizations and instead are including Behavioral Health within Integrated Managed Care networks

Carve-In Integrated Managed Care has Implications for SBHAs

- In some states Medicaid is writing the Integrated managed care contracts without requiring the collection and reporting of data needed by the SMHA for SAMHSA reporting.
- Medicaid integrated MC contracts tend to focus on minimum data required for Claims Processing
- Integrated MCOs may bring in new providers without experience collecting Behavioral Health measures

Performance Measurement and Outcomes in 2017 (p3)

Several SMHAs in States with new Medicaid Integrated Managed Care Systems are struggling to:

- Identify "MH system clients" for reporting (due to new providers)
- Collect Outcomes needed for SAMHSA and SMHA Outcome Systems (claims records do not include homelessness, employment status, arrests, etc.)

Options States are assessing

- Require Parallel data system to collect BH Outcomes (parallel to the claims records)
- Link Claims data with information from other sources (Criminal Justice, Employment, etc.)
- Use new ICD-10 Social Determinants of Health Codes

ICD-10 Social Determinants of Health: Employment codes:

Z56	Problems related to employment and unemployment
Z56.0	Unemployment, unspecified
Z56.1	Change of job
Z56.2	Threat of job loss
Z56.3	Stressful work schedule
Z56.4	Discord with boss and workmates
Z56.5	Uncongenial work environment
Z56.6	Other physical and mental strain related to work
Z56.8	Other problems related to employment
Z56.81	Sexual harassment on the job
Z56.82	Military deployment status
Z56.89	Other problems related to employment

ICD-10 Social Determinants of Health: Living Situation Codes:

Z59	Problems related to housing and economic circumstances
Z59.0	Homelessness
Z59.1	Inadequate housing
Z59.2	Discord with neighbors, lodgers and landlord
Z59.3	Problems related to living in residential institution
Z59.4	Lack of adequate food and safe drinking water
Z59.5	Extreme poverty
Z59.6	Low income
Z59.7	Insufficient social insurance and welfare support
Z59.8	Other problems related to housing and economic circumstances
Z59.9	Problem related to housing and economic circumstances, unspecified

Future of SMHA Value Based Purchasing

- Most SMHAs are operating a Performance Measurement System for state-funded programs, but few are tying dollars to performance
- A few SMHAs are expanding Performance Contracting of State-funded services beyond counting services toward performance
- SMHAs are focusing on provision of Evidence-Based Practices—measuring fidelity and some Outcome measurement

BUT, State Performance Contracting initiatives are unique to each state

Future of SMHA Value Based Purchasing

States are expanding beyond a focus on the SMHA-funded services to look at combined Medicaid and State-funded services

State-funded mental health services are a shrinking portion of the public MH System. Medicaid's role is continuing to grow.

- States that expanded Medicaid have both new clients with Medicaid and clients that used to be state-funded now receiving Medicaid
- Medicaid is increasingly shifting to Integrated "Carve-In" Managed Care models
  - Need to make the case for Behavioral Health Measures in Integrated Delivery Systems

"What did you take away from the meeting?"

For Additional Information…

Contact:

Ted Lutterman

Director of Government and Commercial Research

NASMHPD Research Institute, Inc.

3141 Fairview Park Drive, Suite 650

Falls Church, Virginia 22042

703-738-8164

Ted.Lutterman@nri-inc.org

http://www.nri-inc.org