NASMHPD RESEARCH INSTITUTE

State Profile Highlights

New Information from the National Association of State Mental Health Program Directors Research Institute, Inc (NRI)

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State Mental Health Agency Operation and Funding of Community-Based Mental Health Services: 1999Update

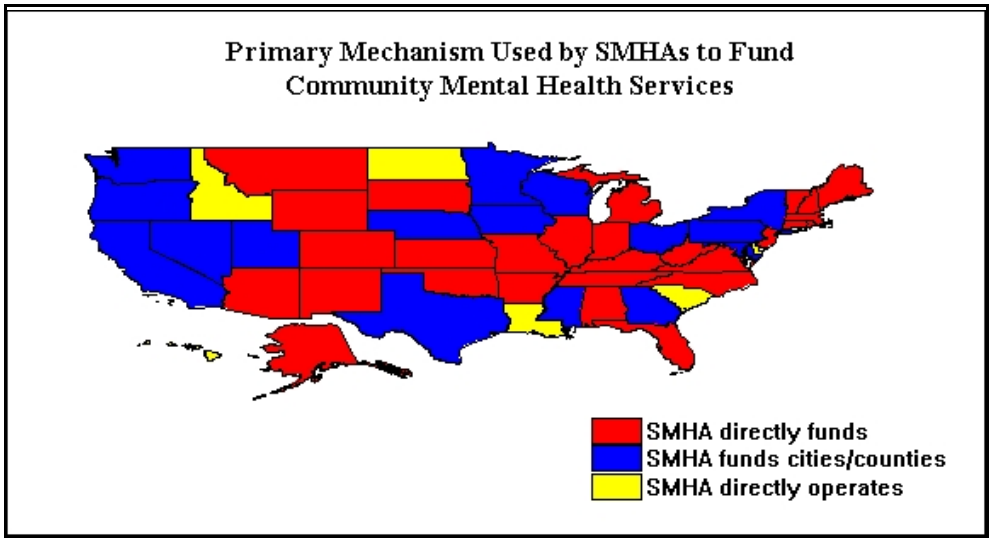
Major Findings:

- **35 States provide community mental health services by directly contracting with local community mental health programs.**
- **Most large population states provide community mental health services through direct contracts or through city, county, or multi-county mental health authorities, and most smaller population States directly operate community programs.**
- **The most commonly used methods to fund community services include: block grants (30 SMHAs); contracts (27 SMHAs); and program grants (26 SMHAs).**
- **33 States have community mental health programs perform gatekeeping functions to control admissions to state psychiatric hospitals.**
- **The community-based services in many States that have Medicaid managed care waivers for mental health are provided by private organizations, unlike in 1997, when most community services were provided through contracts with community mental health agencies.**

Overview: Collectively, the State and Territorial Mental Health Agencies (SMHAs) expend over half of their mental health budgets on community-based mental health services (over $9 billion in FY '97) and provide community mental health services to millions of individuals each year. However, the methods used by states to organize, finance, and deliver community mental health services vary widely from state to state. This report highlights the major methods used by SMHAs to organize the operation and funding of their community mental health systems.

Organizing and Financing Community- Based Services: Three major methods are used by SMHAs to provide community mental health services:

- SMHAs directly contract with local (usually not-for-profit) community-based mental health providers;
- SMHAs fund local governments (city, county, or multi-county) mental health authorities, which in turn, operate and contract for community mental health services; and
- Mental health services are provided in communities by SMHAs using their own state employees.



In many states, a combination of these mechanisms is used. Larger populated States tend to use local governments to organize the delivery of community mental health services, while smaller states often directly operate the community mental health system with their own employees. (See Figures 1 and 2). Of the States directly operating community-based services, 7 reported that they are involved with privatizing the SMHA-operated community mental health providers (DC, DE, IA, MS, NJ, OH, & SD).

Figure 2: Methods SMHAs use to Provide Community Mental Health Services

	SMHA Directly Contracts with Community providers	SMHA Funds City/County/Multi-County Mental Health Authorities	SMHA Operates Community Mental Health Services with State Employees
Mechanism is used for at least a portion of the system	35 SMHAs/ Average State Pop= 3,966,306	18 SMHAs/ Average State Pop= 8,270,393	13 SMHAs/ Average State Pop= 4,657,042
Primary mechanism used	29 SMHAs/ Average State Pop=4,230,021	16 SMHAs/ Average State Pop= 8,621,127	6 SMHAs/ Average State Pop= 2,013,695

Contracting for Community-Based Services: SMHAs use a variety of contracting mechanisms to finance community-based mental health services including, but not limited to:

- Block grants 30 States
- Contracts 27
- Program grants 26
- Fee for service 22
- Performance contracts 21
- Interagency plans or agreements 16
- Per capita allocation 14
- Retroactive reimbursement for services provided 10

Licensing/Rate Setting of Community Mental Health Providers: In addition to contracting for community mental health services, SMHAs frequently set reimbursement rates for services in community programs. Thirteen States set reimbursement rates for community programs (CO, FL, MA, MO, NE, NV, NH, NC, OK, RI, SC, SD, & VT), while SMHAs license community mental health services in 8 States (AL, IA, MA. PA. RI, SD, TN, & VA).

Controlling State Psychiatric Hospital Utilization: 33 SMHAs have community programs perform a gatekeeping function over admissions to state psychiatric hospitals, including predischarge planning (33 States); preadmission screening (30 States); and hospital-community liaison activities (30 States). Virtually all states (38 of 43) report that community programs operate crisis programs to reduce the number of admissions to state psychiatric hospitals.

The Role of Community Mental Health Providers Under Managed Care: 8 out of 43 States reported having a 1115 Medicaid waiver for mental health (AZ, DE, MN, OK, OR, RI, TN, & VT) and 13 States reported having a 1915b Medicaid waiver for mental health (CA, CT, CO, FL, IA, IN, MA, NM, OK, PA, TX, UT, & WA). A total of only 6 states with waivers reported that the participation of any community mental health agencies is mandated as "essential community providers". In 1997, almost 1/3 of the states that had managed care waivers funded community mental health agencies as contractors to deliver Medicaid managed mental health care. In 1999, the majority of the managed behavioral health care organizations in States with waivers are private organizations. This is the case in 7 out of 8 states with 1115 waivers and 6 out of 13 states with 1915b waivers.

Discussion: The methods SMHAs use to organize and fund community mental health services are continually evolving. Many SMHAs are contracting directly with community providers. Very few SMHAs operate community services directly, and most of the states that are involved in managed behavioral health care are utilizing private organizations to deliver these services. The NASMHPD Research Institute continues to monitor these changes through its State Profiles Database.

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