Latest Trends in State Mental Health Agencies

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Carrie Slaton-Hodges, Oklahoma
Randall Burns, Alaska
Vera Hollen, NRI

NASMHPD Summer 2016 Commissioners Meeting
August 8, 2016
Introductions

• NRI
  o NASMHPD/NRI History
  o Federal Projects
    – Profiles, URS-MH/CLD, FEP and others
  o Performance and Quality Improvement
    – BHPMS, Data Integrity Reviews and others
  o New Initiatives
    – NASMHPD/NRI Joint Annual Conference – Fall, 2017
    – NRI Mental Health/Criminal Justice Research Center
    – Special State Projects: CO, OH, TX, WA and others

• Presentations and Presenters
Presentation Outline

- Trends in State Mental Health Agency (SMHA) Services and Financing
  - SMHA approaches in addressing state budget shortfalls
    - Oklahoma: Carrie Slaton-Hodges
    - Alaska: Randall Burns
- Use and Funding of State Psychiatric Hospital beds
- Innovative Uses of Technology To Address The Needs Of Justice-Involved Persons With Behavioral Health Issues
What we know about SMHA Services

Through 3 major Federal Projects, NRI compiles information that describes:

1. How SMHAs are organized and structured; and their major policy, service, and financing issues (State Profiles)
2. SMHA expenditures and revenues for mental health (SMHA Rev/Exp Study)
3. Who SMHAs serve: how many persons are served, by demographics, employment, living situation, service setting, etc. (URS/CLD)

Plus, NRI conducts special Studies for NASMHPD, States, SAMHSA, and Others: Olmstead, State Budget Shortfalls, Premature Mortality, Medicaid
SMHA Systems are organizing the delivery of high quality mental health services to more consumers than ever before:

- Minorities and children are served at high rates by SMHAs—relatively fewer Elderly served by SMHA system
- Large increase in the number of SMHA consumers with Medicaid paying for some or all of their care
- Almost all SMHA consumers are served in community settings. State hospitals serve 2% of clients, but at a high cost
- Competitive Employment rates for SMHA consumers increased after a large drop during the recent recession
- The number of consumers receiving EBPs, such as Assertive Community Treatment, Dual Diagnosis Treatment, Multi-Systemic Therapy, First Episode Psychosis (FEP)
- SMHA Budgets increased—but are still below pre-recession levels in inflation and population adjusted dollars (and FY 2017 is looking worse for many states).
7,448,380 consumers received mental health services from SMHA systems in 2015*

- 2.3% of the US population
- Range from 0.5% to 5.8% of state population

$41 billion of mental health expenditures was controlled by SMHAs in FY 2014 providing these services

- SMHA budgets ranged from $60 million to $6.8 billion

* Based on 58 states and territories reporting URS data on mental health consumers served by SMHA systems in 2015
SMHA MH Clients Served Per 1,000 State Population, 2015

Source: SMHA submissions to SAMHSA 2015 Uniform Reporting System, Table 2
Demographic Characteristics of Clients Served: 2015 URS

- Slightly more female (52%) than males (48%)
- Children were 28% of clients served (16% were children age 0 to 12, and 12% were adolescents age 13 to 17)
- Adults were 67% (10% were young adults age 18 to 24, and 57% were adults age 25 to 65)
- Older adults were 4.8% (age 65 and older)
- Majority of clients served were White (62%), followed by Black/African-Americans (20%)
Age and Gender Distribution of Clients Served in Community Settings: URS 2014

- **Age Distribution**
  - Age 0-17: 27.5%
  - Age 18-20: 4.5%
  - Age 21-64: 63.4%
  - Age 65 and Over: 4.5%
  - Age NA: 0.1%

- **Gender Distribution**
  - Male: 48%
  - Female: 51.90%
  - NA: 0.10%
Age and Gender Distribution of Clients Served in State Psychiatric Hospitals: URS 2014

- Male: 66%
- Female: 34%
- Gender NA: 0.0%

- Age 0-17: 7.5%
- Age 18-20: 4.3%
- Age 21-64: 83.1%
- Age 65 and Over: 5.1%
Utilization Rates (per 1,000 population), by Age and Gender: 2015 URS

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Female</th>
<th>Males</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 12</td>
<td>28</td>
<td>23</td>
<td>28</td>
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<tr>
<td>13 - 17</td>
<td>42</td>
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<tr>
<td>18 - 20</td>
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<tr>
<td>21 - 24</td>
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<td>23</td>
<td>22</td>
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<tr>
<td>25 - 44</td>
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<td>27</td>
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<td>45 - 64</td>
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<tr>
<td>65 - 74</td>
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<td>75+</td>
<td>7</td>
<td>5</td>
<td>9</td>
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<tr>
<td>All</td>
<td>24</td>
<td>23</td>
<td>23</td>
</tr>
</tbody>
</table>
Age Distribution of Mental Health Clients and U.S. Population: 2014

MH-CLD

Based on X states reporting
N(Total) = 4,885,207
Missing = 4,887

Age of Clients

Percentage

0.0% 0.2% 0.4% 0.6% 0.8% 1.0% 1.2% 1.4% 1.6%

1 3 5 7 9 11 13 15 17 19 21 23 25 27 29 31 33 35 37 39 41 43 45 47 49 51 53 55 57 59 61 63 65 67 69 71 73 75 77 79 81 83 85

male
female
Utilization Rates (per 1,000 population), by Gender and Race: 2015 URS

- American Indian/Alaska Native
- Asian
- Black or African American
- Native Hawaiian/Pacific Islander
- White
- More Than One Race
- Hispanic
- All

Utilization Rate per 1,000 Population

Males
Females
Total
Mental Health Diagnosis, Adults (18+) by Gender: 2015 MH-CLD

Consumers can have up to 3 diagnoses
N = 4,924,929
Total Number of Clients Served, by Age: 2004–2015 URS
Number and Characteristics of Individuals Served by SMHAs: 2015

• 98% of clients received **community-based mental health services**
  - 75% of FY 2014 SMHA Expenditures were for Community-Based Mental Health

• 2% of clients received services in **state psychiatric hospitals**
  - 23% of FY 2014 SMHA Expenditures were for state psychiatric hospital-inpatient services

• 4.5% of clients received services in **other psychiatric inpatient** settings (35 states reporting)
  
Note: Clients can be served in multiple settings during the year, thus percentages of consumers served are greater than 100%
Total Number of Clients Served, by Service Setting: 2004 to 2015 URS
2015 URS Summary Results

• 69% of SMHA consumers had Medicaid pay for some or all of their mental health services

• 22% of Adult mental health consumers were competitively employed during the year
  ○ 6.6% of consumers with a diagnosis of schizophrenia were competitively employed

• 3% of Adult mental health consumers were homeless
Medicaid Status of SMHA Consumers: URS 2015

7,329,568 consumers served by SMHAs in 2015
- 7,108,742 consumers (97%) had known Medicaid status
- 220,826 consumers (3%) were missing Medicaid status information

Note, this is the number of consumers receiving mental health services from SMHA systems that had Medicaid paying for some or all of their mental health services. It is not how much ($) Medicaid paid for these services.
Medicaid Status of SMHA Consumers: 2005–2015 URS

Number of SMHA Consumers, in Millions

- With Medicaid
- No Medicaid
- Medicaid Status Not Available

URS Report Year

Change in Medicaid Status of SMHA Consumers Since ACA

Since states began expanding Medicaid, the states that expanded Medicaid have seen an increase in the percent of their consumers served who have Medicaid paying for some or all of their mental health services:

• In the 24 states that Expanded Medicaid in 2014, they had an average increase of 10.3% in the number of consumers with Medicaid coverage.
• In the 4 states that Expanded Medicaid in 2015, they had an average increase of 7.5% in consumers with Medicaid.
• The 20 states that had not Expanded Medicaid had no change (0%).
  o 9 states had an increase in the number of clients with Medicaid, and 10 had a decrease—a net US average change of 0%.

Source: SAMHSA 2015 URS
Competitive Employment Status of Adult Clients: URS 2015 with Known Employment Status

Employed, 21.6%

Unemployed, 26.1%

Not in Labor Force, 52.2%

1,401,214 Adults with Employment Status Not Available
Percent of SMHA Adult (age 18 and over) Mental Health Consumers Competitively Employed: 2005–2015 URS

Total of Clients In 2015:
26% were unemployed
52% were not in labor force
Employment Status: By Diagnosis 2015, At Start of Reporting Period, Ages 18-64, 2015 MH-CLD
Employment Change from within 2015 MH-CLD from T1 to T2

Clients with a valid employment update flag: Age 18-64

- Total adults at T1: 1,000,000
- Employed at T1: 212,255
- Unemployed at T1: 269,980
- Not in labor force at T1: 506,206

<table>
<thead>
<tr>
<th>Employed at T2</th>
<th>Unemployed at T2</th>
<th>Not in labor force at T2</th>
</tr>
</thead>
<tbody>
<tr>
<td>86.9%</td>
<td>79.5%</td>
<td>90.8%</td>
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</tbody>
</table>

T1 = Admission for new clients and status at Start of Year for Continuing Clients
T2 = End of Year status for Continuing Clients and Status at Discharge for discontinued Clients
Living Situation of Adult Clients: 2015

- Private Residence: 65.1%
- Not Available: 16.1%
- Jail (Correctional Facility): 1.7%
- Foster Home: 0.7%
- Institutional Setting: 1.8%
- Residential Treatment Center: 0.2%
- Homeless (Shelter): 3.5%
- Residential Care: 3.9%
- Other: 6.9%
- Crisis Residence: 0.1%
People Living in Shelters/Homeless, by Race: 2015 URS

- Multi-Racial: 3.6%
- Hispanic/Latino: 1.9%
- White: 2.9%
- Native Hawaiian: 3.7%
- Black/African American: 5.2%
- Asian: 2.0%
- American Indian: 4.3%
- Total: 3.4%
Percent of Clients who were Homeless: URS 2005 to 2015

- Adults (18-64)
- Total SMHA Consumers
- Older Adults (65 and over)
- Children (0 to 17)

Year | States:
--- | ---
05 | 44 states
06 | 49 states
07 | 51 states
08 | 50 states
09 | 53 states
10 | 54 states
11 | 53 states
12 | 55 states
13 | 53 states
14 | 58 states
15 | 54 states
How States Finance their SMHA Services

Trends in SMHA-controlled Revenues and Expenditures for Mental Health Services: FY 1981 to FY 2014
MENTAL HEALTH SYSTEM
USA

"There's really only one question - do you have money?"
Trends in State Mental Health Agency Controlled Mental Health Spending, FY'81 to FY'14

SMHA-Controlled Expenditures (In Billions of Dollars)

Current Dollars

Constant Dollars

© 2016 National Association of State Mental Health Program Directors Research Institute
Trend in Per Capita State Mental Health Agency Controlled Mental Health Spending, FY'1981 to FY'2014

Based on 50 States Reporting

Per Capita SMHA-Controlled Mental Health Expenditures
Total FY 2014 SMHA-Controlled Per Capita Mental Health Expenditures
SMHA-Controlled Expenditures for State Psychiatric Hospital Inpatient and Community-Based Services as a Percent of Total Expenditures: FY'81 to FY'14

State Mental Hospital Inpatient

Community Mental Health

© 2016 National Association of State Mental Health Program Directors Research Institute
Funding Sources of State Mental Health Agencies for Mental Health Services: FY 2014

Total SMHA Revenues = $41.2 billion
Funding Sources for State Psychiatric Hospitals and Community MH: FY 2014

Community Mental Health

- Federal Medicaid: 35%
- State Medicaid Match: 24%
- State General Funds: 30%
- Medicare: 1%
- MH Block Grant: 1%
- First/Third Party: 1%
- Other Funds: 4%

Community MH Revenues = $29.9 billion

State Psychiatric Hospitals

- State Medicaid Match: 9%
- Federal Medicaid: 13%
- Medicare: 4%
- MH Block Grant: 0%
- All other Federal: 1%
- First/Third Party: 2%
- Other Funds: 2%
- Local: 1%

State Psychiatric Hospital Revenues = $10.4 billion
Medicaid Reimbursement Approaches for Mental Health Services, by State, 2015

- Combination (31)
- Fee for Service Only (13)
- Managed Care Only (4)
- No Response (3)
NRI has been working with NASADAD in an expanded set of Profiles to combine information on SMHA expenditures and financing with SSA expenditures and financing.

- Combines NRI data on SMHA-controlled Revenues and Expenditures with
- SSA reported Expenditures and Revenues submitted to SAMHSA as part of SAPT Block Grant Reporting

Combined SMHA and SSA systems controlled expenditures of $46.25 billion for behavioral health services in FY 2014
SSA and SMHA Per Capita Expenditures: FY 2014
Funding Sources of SSAs and SMHAs: FY 2014

- State Funds (not including Medicaid Match): 40% (SMHA), 45% (SSA)
- Medicaid (Federal & State Match): 49% (SMHA), 16% (SSA)
- SAMHSA Block Grants: 32% (SMHA), 1% (SSA)
- All Other Funding Sources: 10% (SMHA), 6% (SSA)
## SSA and SMHA Funding: FY2008 to FY2014

<table>
<thead>
<tr>
<th>Funding Source</th>
<th>FY 2008</th>
<th>FY 2014</th>
<th>FY 2008 to FY 2014 Change</th>
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<tbody>
<tr>
<td></td>
<td>SSA</td>
<td>SMHA</td>
<td>SSA</td>
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<tr>
<td>State Funds</td>
<td>$2,192,412,306</td>
<td>$16,061,413,401</td>
<td>$2,265,508,240</td>
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<tr>
<td>Medicaid</td>
<td>$624,689,826</td>
<td>$17,019,598,135</td>
<td>$824,183,569</td>
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<tr>
<td>SAMHSA Block Grants</td>
<td>$1,668,321,153</td>
<td>$405,537,084</td>
<td>$1,607,501,201</td>
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<td>Other Federal</td>
<td>$269,980,441</td>
<td>$1,204,671,508</td>
<td>$270,304,697</td>
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<td>Other Funds</td>
<td>$158,903,291</td>
<td>$2,629,975,240</td>
<td>$62,265,220</td>
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<tr>
<td>Total</td>
<td>$4,914,307,017</td>
<td>$37,321,195,368</td>
<td>$5,029,762,927</td>
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- State Funds have been flat for both SSAs and SMHAs
- Medicaid has been the major source of new funds for both SMHAs and SSAs, with SSAs having a larger percent increase (but starting at a much lower base)
Impact of the 2009-2011 Recession on SMHA Systems and Current State Budget Situations

• The recession that occurred during the late 2000s impacted state government budgets for many years.
  o The National Governor’s Association identified it as the worst prolonged reduction in state government revenues since the Great Depression of the 1930s

• NRI worked with NASMHPD to track the impact of state budget reductions on public mental health systems during the recession

• Unfortunately, a number of states are now experiencing new budget shortfalls and reduced state revenues
State Mental Health Systems were Affected By 2009 to 2012 State Budget Shortfalls

**From FY2009 to FY2012 SMHAs Had Total MH cuts of $4.35 Billion***

<table>
<thead>
<tr>
<th>Year</th>
<th>Total</th>
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<tbody>
<tr>
<td>FY 2009</td>
<td>$1,216,020,843</td>
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<tr>
<td>(39 states had MH Cuts out of 44 responding)</td>
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<tr>
<td>FY 2010</td>
<td>$1,019,325,136</td>
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<tr>
<td>(38 states had MH Cuts out of 45 Responding)</td>
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<tr>
<td>FY 2011</td>
<td>$1,270,618,291</td>
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<tr>
<td>(36 states had MH Cuts out of 47 responding)</td>
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<tr>
<td>FY 2012</td>
<td>$842,236,221</td>
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<tr>
<td>(31 states had MH Cuts out of 41 Responding)</td>
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</table>
• 12 States closed 15 state psychiatric hospitals

• 29 States closed over 4,400 beds
  o Over 9% of state psychiatric hospital bed capacity was closed
  o Acute civil status beds were most likely to be closed. Few forensic beds were closed.

Results based on 41 SMHAs Reporting Winter 2011-2012
"State General Fund Budgets Finally Surpass Pre-Recession Levels after Adjusting for Inflation"

*Fiscal 2017 spending is based on governors’ proposed budgets.
**For the first time, real aggregate spending levels in fiscal 2016 surpassed the pre-recession peak level of fiscal 2008, which was equivalent to $789 billion after adjusting for inflation.
Revenue Growth Slows in Fiscal 2016, According to Preliminary Figures

Brian Sigritz
July 29, 2016

NASBO recently conducted a short survey on year-end tax collections to help gain a better understanding of how states closed out fiscal 2016. As expected, revenue growth noticeably slowed for the recently concluded fiscal year. Twenty-eight states were able to provide preliminary data regarding fiscal 2016 tax collections. The survey results include:

- The median growth rate for total general fund tax collections in fiscal 2016 was 2.3 percent for the 28 reporting states.
- By comparison, the 50-state median growth rate in fiscal 2015 was 5.2 percent.
- Sales tax collections had the largest median growth rate in fiscal 2016 at 3.4 percent, while personal income tax grew 2.9 percent and corporate income tax declined at a median rate of 9.8 percent.
- 10 states saw revenues come in above their final projections for fiscal 2016, while 18 states were below.
- Overall, for the 28 states reporting data, total collections were 0.8 percent below final projections.

The preliminary year-end tax collections reported by the 28 states are mostly similar to estimated figures in the Spring 2016 Fiscal Survey of States, whose field survey was conducted from February through April. For example, the Spring Fiscal Survey reported that the estimated 50-state median growth rate for fiscal 2016 was 2.8 percent. However, some of the results from the new short survey on year-end tax collections seem to indicate slower than anticipated revenue growth since the time the Fiscal Survey was conducted. While the majority of states in the Spring Fiscal Survey reported revenue collections higher than, or on target with, their most recent revenue projection, a majority of states in the new short survey showed revenues below their most recent projection.

State revenue growth slowed in fiscal 2016 for a number of reasons including the impact of low oil and natural gas prices on energy-producing states, the weaker stock market performance in calendar year 2015, and modest national economic growth. It is likely that the slow revenue growth will continue into fiscal 2017, with the median projected growth rate being 3.1 percent. In the fall, NASBO will release a new Fiscal Survey of States with updated figures for both fiscal 2016 and fiscal 2017.
ND state legislators met at the state capital to solve more a more than $300 million revenue shortfall

By Catherine Ross on Aug 2, 2016 at 7:16 p.m.

Board OKs reductions that will limit mental health care access

by Jaclyn Cosgrove  •  Published: April 28, 2016  •  Updated: Apr 29, 2016

Advocates fear looming cuts to behavioral health services

By Justin Horwath
The New Mexican | Posted: Saturday, January 30, 2016 10:00 pm
Oklahoma Department of Mental Health and Substance Abuse Services

Carrie Slatton-Hodges, Deputy Commissioner

Oklahoma’s System to Address Brain Health: Impacting Our State’s Future

National Association of State Mental Health Program Directors
Aug. 8, 2016
Oklahoma Has Some of the Highest Rates for Mental Illness and Substance Use Disorders

- ODMHSAS is responsible for Oklahoma’s public behavioral health system, an array of treatment services, a statewide prevention network, certification, policy and other related programs/initiatives along with administration and oversight of the State’s behavioral health Medicaid program.

- The department serves approximately **195,000 Oklahomans** annually (this includes Medicaid eligible clients).

- Oklahoma *consistently ranks as having among the highest rates of mental illness in the country* and disproportionately high rates of negative consequences/factors related to substance abuse.

- Various reports rank Oklahoma *between 46-49th per capita for mental health spending, at $53.05 per capita*, compared to a national average of $120.56.
Recovery Does Happen When People Access Appropriate Care

- ODMHSAS funds and operates a statewide network of behavioral health treatment services that includes:
  - Funding more than 300 contracted community behavioral health providers that act as the statewide safety net for services, in addition to state-operated services.
  - Operating/managing Oklahoma’s Behavioral Health Medicaid System (1,262 Medicaid contracted providers; 394 agencies and 868 independents).
  - Overseeing/managing a statewide network of court diversion services ... programs that have won national awards and are constantly in the news.

- The department provides outpatient services, urgent and crisis care, hospital care, an array of substance abuse treatment options, court related services and jail diversion, services that impact children and families in the DHS system, services that support the education system, forensic services, prevention services, certification and training, specialized housing needs, transitional care ... EVERYTHING THAT IS ESSENTIAL TO RECOVERY!
Factors that limit publicly assisted services...including stagnant investment

- Lack of investment has resulted in the implementation of a **tiered service delivery system** based on acuity/available resources.
- The department is committed to the delivery of **evidence-based services/programs** (better care and better utilization of funding).
- ODMHSAS has also done an excellent job of **competing for and winning competitive grants for innovative programs**.

*In FY-2012 ODMHSAS was transferred responsibility for the Medicaid Behavioral Program along with the corresponding funding from the OHCA. The transfer was a lateral transfer between the two agencies and does not represent an increase in Behavioral Health spending.*
Lack of Needed Investment Means that the Door to Services is Narrow

• The primary source of funding is $324 million in state appropriations that includes Oklahoma’s behavioral health Medicaid program match (Oklahoma is one of 19 states that is not a Medicaid expansion state).

• This funding is far short of what is required to meet treatment need (these services have never been funded to meet demand), and in fact is significantly reduced from where we were just one year ago.

• ODMHSAS state appropriations have been cut by $23 million since January 2016 (over 73,000 Oklahomans impacted and significant provider billing loss).
Action Taken to Determine How to Best Distribute Cuts

• The department follows a thorough decision-making process regarding such challenges and seeks to reduce the negative impact of service changes; the goal is to impact the fewest number of seriously ill clients as possible.

• Often, this means choices that are the least terrible of nothing but terrible choices.

• It is important to be engaged with system partners when making these tough decisions:
  - Mental Health Planning Committee meetings;
  - Behavioral Health Advisory Committee meetings;
  - Meetings with Community Mental Health Center and Substance Abuse Center facility directors;
  - Meetings with community providers and Medicaid contractors, and others of interest.
And, the Door is Narrowing Even More!
ODMHSAS Was Forced to Cut Services in FY16/17

First Revenue Failure
- $4.4 million – Cuts to ODMHSAS Administration/Operations
- $1.5 million – Cuts to Mental Health Court Expansion
- $1.3 million – Cut to Safety Net Services
- $1 million – Postponed SOC Expansion
- $400,000 – Cuts to Prevention Services

Second Revenue Failure
- $7 million – Cut to Private Community-Based Providers
- $4.1 million – Delay of Final Reimbursement Claims for Contracted Providers
- $1.8 million – Rate Cuts for Private Providers (FY17 - $10.5 million)
  - 3% cut to acute inpatient reimbursement rate ($22,333)
  - 15% cut to psychiatric residential treatment services rate ($875,000)
  - 10% cut to reimbursement rate for an LBHP Under Supervision ($537,419)
  - 30% cut to individual LBH services ($346,802)
- $1.3 million – Capped Delivery of Psychotherapy Services (FY17 - $15.6 million)
- $48,000 – Cuts to Treatment Plan Updates (FY17 - $580,000)
How Alaska Addressed a $5.8 Million Reduction in Behavioral Health Treatment Grants:
A NASMHPD Presentation – August, 2016

Randall P. Burns, Director, Division of Behavioral Health
Alaska Department of Health & Social Services
How the Reduction Came to Be

• The total amount of the Reduction ($5.8 Million) to the Division’s behavioral health grants line was contained in Governor Walker’s original FY17 Budget Proposal

• The reduction was in Undesignated General Funds (UGF), a true reduction in state spending

• The reduction for FY17 – and additional commitments up to five years out – was proposed during the previous (CY2015) legislative session as an enticement to the Republican-led Legislature to adopt the Medicaid Expansion provisions of the ACA beginning in FY16
How the Reduction Came to Be

• Despite the enticements, the Legislature refused to pass Medicaid Expansion beginning in FY16

• This was but one of many efforts put forth by the Governor to respond to Alaska’s deep financial troubles, including proposals to the Legislature for an income tax, a cap on the Alaska Permanent Fund Dividend, savings from reductions to/increases in oil company rebates/taxes, etc.

• Given the substantive savings that would accrue to the State from the adoption of Medicaid Expansion, Governor Walker last summer (2015) gave notice to the Legislature of his intent to move forward with Medicaid Expansion under his Executive Authority

• Alaska began enrolling adults eligible under Expansion for Medicaid coverage on September 1st

• The Legislature filed suit against the Governor’s actions shortly thereafter
Reduction Complexities

The present system of awarding funds via individual grants makes finding a way to fairly distribute the reductions very complex:

- Alaska does not award its grants to a BH agency, it distributes funding via individual grants that prescribe service delivery expectations/requirements across almost twenty (20) distinct provider types (SMI adults, SED children, SED children and parents, SUD detox, SUD residential for adults, SUD residential treatment for women with children, SUD IOP, etc.)

- Therefore, most agencies have multiple grants that cover a range of BH services that the agency may provide to residents within its community or region

- Further, there are up to six (6) possible funding sources from which DBH makes each individual grant award (with – in many cases – at least two of those six sources funding an individual grant)

- All these “parts within parts” makes finding a way to fairly balance the grant reductions very complex
Issue: Reductions = Expansion

• To some degree, the rationale for the reductions to the grants line was based on the understanding that under Medicaid Expansion, many formerly un- or under-resourced clients would now be eligible for Medicaid reimbursement.

• Therefore, the State could reduce the grants line because that formerly total UGF program could now be, replaced, in part, by Medicaid dollars that were eligible for 100%/then 90% federal match for the adult Medicaid Expansion population.

• In CY2015, AK DHSS estimated that it could replace up to $7 Million in grant funding with the funding that would come into the Behavioral Health Medicaid System via the now eligible adult Expansion population.
Medicaid in Alaska Dashboard

**MEDICAID IN ALASKA**

Through June 30, 2016

19,057
Lives covered by Medicaid expansion

Demographics of Medicaid expansion enrollees

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<th>Age Group</th>
<th>19-34</th>
<th>35-44</th>
<th>45-54</th>
<th>55-64</th>
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<tr>
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<td>6,950</td>
<td>2,989</td>
<td>4,613</td>
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<tr>
<td>Enrollee count</td>
<td>Male 10,682</td>
<td>Female 8,375</td>
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</table>

Medicaid expansion began on Sept. 1, 2015 in Alaska.

Medicaid expansion claims paid to date

Total $149,545,745

Medicaid provides health benefits to many Alaskans.

100% federally funded through CY16 and will transition to 90% in 2020 and beyond.

All Medicaid enrollees by category

- Expansion: 12%
- Disabled: 21%
- Disabled Adult: 10%
- Parent/Caretaker: 5%
- Children: 50%
- Seniors: 5%

Disabled Children: 2%
Medicaid in Alaska Dashboard

Alaskans across the state benefit from Medicaid.

**Medicaid enrollees by region**

- **Northern**
  - All Medicaid: 8,612
  - Expansion only: 691

- **Southwest**
  - All Medicaid: 17,939
  - Expansion only: 1,517

- **Interior**
  - All Medicaid: 16,793
  - Expansion only: 1,985

- **Anchorage/Mat-Su**
  - All Medicaid: 76,532
  - Expansion only: 9,994

- **Southeast**
  - All Medicaid: 14,838
  - Expansion only: 2,474

- **Out of state**
  - All Medicaid: 392
  - Expansion only: 19

*Temporarily absent or in an out of state medical institution.

**Demographics of all Medicaid enrollees**

<table>
<thead>
<tr>
<th>Age Group</th>
<th>18 or less</th>
<th>19-34</th>
<th>35-44</th>
<th>45-54</th>
<th>55-64</th>
<th>65+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrollee count</td>
<td>74,493</td>
<td>31,169</td>
<td>13,504</td>
<td>11,984</td>
<td>11,119</td>
<td>9,603</td>
</tr>
</tbody>
</table>

**Gender**

- Male: 71,609
- Female: 80,263

**Total Lives covered by all Medicaid**: 151,872
What 9 months of data told us

• Enrollment began September 1, 2015, under Alaska’s Medicaid Expansion Program

• DHSS expected 21,000 Alaskans to sign up for Medicaid in the first year of Expansion

• At the end of May, 2016, following 9 months of experience under Expansion, just under $7 Million in Medicaid Expansion Population payments were made for BH services

• So, BH Providers had indeed brought in more than the amount of the grants reduction ($5.8M), but the distribution of that “new” money was far from evenly distributed across all BH grantees who had access to the Medicaid Expansion population
Medicaid Expansion and Grantees

• There are 82 agencies presently receiving behavioral health grants from the Division

• Of those, only 39 actually had taken in any behavioral health related Expansion dollars in the 9 months between 9/1/15 and 5/31/16, totaling $6,997,523.

• Of that total, $3,908,746 came from 9 tribal organizations, with two of them bringing in 56% of that total amount ($1,436,413 and $769,264, respectively).

• Another $1,940,870 in BH Expansion dollars came from 8 non-tribal grantee agencies: 3 larger “comprehensive” BH centers ($582,543) and 5 SUD residential/IOP/OTP treatment programs ($1,940,870)

• The remaining $1,147,907 in Expansion revenue was spread across 22 grantees, all taking in less than $100,000 each
How to distribute the reductions

• Based on the behavioral health Medicaid Expansion data over the first 9 months, any suggestion that the entire $5.8M in Division grant reductions could be fairly distributed by spreading that reduction across only those grantees who were able to access the Expansion population was clearly not going to be possible.

• Therefore, we had to determine how best to attempt to spread the reductions in a way that did not penalize any agency program too significantly.

• After weeks of debate, we determined to essentially “split the baby”.
Splitting the Baby:

SFY 2017 Behavioral Health Treatment & Recovery Grants
Quick Reference Guide to the Grant Reduction Allocation Process

• The SFY 2017 Division of Behavioral Health (DBH) Comprehensive Behavioral Health Treatment grant awards were reduced by $5,779,653 in compliance with the SFY17 budget actions by the Office of the Governor and the Legislature and in response to the State’s adoption of Medicaid Expansion under the ACA.

• The SFY 2017 grant funding reductions were allocated utilizing a two-step process:
  - Step 1: Apply a “System Proportional Reduction”
  - Step 2: Apply a “Medicaid Expansion Reduction”

• Grant amounts funded with General Fund (GF), General Fund/Mental Health (GF/MH), or Alcohol & Other Drug Abuse Treatment and Prevention Fund (ADTP) dollars were subject to (i.e., eligible for) reduction, unless they were excluded from reduction under “Grant Types Held Harmless” (see descriptions below).

• Grant amounts funded through Interagency Receipts (IA), Federal grants, RSAs (Reimbursable Service Agreements), and the Alaska Mental Health Trust Authority Authorized Receipts (MHTAAR) were held harmless from both reduction steps.
Step 1 Reductions

- **Step 1: System Proportional Reduction:**

  - Actual Amount Reduced was $3,066,237 of the $5,779,653 (Step 1 accounts for 53% of the total DBH reduction)
  
  - In addition to the grant amounts funded through IA Receipts, Federal grants, Reimbursable Service Agreements, and MHTAAR, the following grant “types” were held harmless from (i.e., not eligible for) a Step 1 Reduction:
    - $100 grants (allow providers to bill Medicaid)
    - Psychiatric Emergency Services
  
  - Agency grant funds eligible for the Step 1 reduction process were reduced based on the proportion they comprised of the total Step 1 eligible grant funds **across all agencies**. This proportion was applied to the total System Proportional Reduction to determine the amount of reduction to each grant.
Step 2 Reductions

- **Step 2: Medicaid Expansion Reduction:**
  - Actual Amount Reduced was $2,713,416 of the $5,779,653 (Step 2 accounts for 47% of the total DBH reduction)

- In addition to the grant amounts funded through IA, Federal grants, RSAs, and MHTAAR, the following grant “types” were held harmless from (i.e., not eligible for) a Step 2 Reduction:
  - 1) $100 grants; 2) Psychiatric Emergency Services; 3) Severely Emotionally Disturbed Youth; 4) Non-Direct Services; 5) Peer & Consumer Support Services; 6) Supported Employment; 7) Adult Residential Substance Abuse Treatment and Detox Services [due to the Medicaid IMD Exclusion]; and 8) Grants with a Total Award amount of $75,000 or less

- Agency grant funds eligible for the Step 2 reduction process were reduced based on the Agency proportion of the total Medicaid expansion payments received across all agencies. This proportion was applied to the total targeted Medicaid Expansion Reduction to determine the amount of reduction to each agency. *If an agency had more than one grant, the cut was spread proportionally across the agency’s grants that had funds eligible for the Step 2 reduction.* Agencies that received Medicaid expansion payments but did not have grant funds eligible for the Step 2 reduction process were excluded from receiving a Medicaid Expansion Reduction.
Communications Plan

Behavioral Health Grant Reductions in the FY17 Budget

COMMUNICATION PLAN

August 5, 2016

ISSUE STATEMENT:
The Division of Behavioral Health (DBH) received a $5,779,653 reduction to its $61,041,539 Comprehensive Behavioral Health Treatment and Recovery budget component for FY 2017 (equal to an overall 9.5% reduction to that component). This reduction reflects the State’s efforts to begin shifting from a reliance on grants funded by General Fund (GF) dollars to program funding via Medicaid dollars. This becomes more possible as additional clients gain access to health coverage through Medicaid Expansion under the Affordable Care Act (ACA).

The funds targeted for the reduction include GF, General Fund Mental Health (GF/MH) and Alcohol & Drug Abuse Treatment & Prevention (ADTP) dollars.

The total reduction was made applying the following two scenarios:

- The first was a proportional reduction to all eligible grants, with the intent of maintaining continuity of services and applying a consistent allocation formula to the majority of grants funded by the Treatment and Recovery component.
- The second was an additional reduction to those behavioral health agencies that have been able to benefit from access to new revenue via Medicaid Expansion payments received between September, 2015 and the end of May, 2016.

The reduction to the grantees will – on average – equal 9.5% of the grants agencies received in FY2016. However, where agencies have been very successful in implementing services benefitting the new Medicaid Expansion population, the reductions may be significantly larger.

LEAD AGENCY: Division of Behavioral Health
CONTRIBUTING STAFF: Brita Bishop, Amy Burke, Linda Brazak, Kathleen Carls, Stacy Toner, Darla Madden
SPOKESPERSON: Randall Burns
PUBLIC INFORMATION CONTACT: Sarana Schell
ADVANCE NOTICE LIST: Assistant Commissioner, Deputy Commissioners, Commissioner, Legislators, Governor

MEDIA RESPONSE:
☐ Statement Only  ☒ Available for Press Calls/Interviews  ☐ Press Release  ☐ Press Availability/Conference

Official Media Statement: Official Media Statement: “The Alaska Department of Health and Social Services is allocating reductions to Division of Behavioral Health treatment and recovery grantees that total $5.8 Million. This is a 9.5% reduction to the budget component that funds the Division’s various mental health and substance abuse treatment programs. This reduction is in compliance with the SFY17 budget actions by the Office of the Governor and the Legislature and in response to the State’s adoption of Medicaid Expansion under the ACA.”
Reaction to the Process

• Only one appeal!

• General appreciation expressed for the time, effort, and thought applied to the process

• No comment, as yet, from the tribal community

• No calls from Legislators

• No calls to the Department Commissioner’s Office
Thank You!

Randall P. Burns
Director
Division of Behavioral Health
Alaska Department of Health & Social Services
3601 C Street, Suite 878
Anchorage, AK 99503

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Trends in State Psychiatric Hospitals
Amid Shortage of Psychiatric Beds, Mentally Ill Face Long Waits for Treatment

August 02, 2016 | By Michael Ollove

Corrections deputies prepare to enter a cell in the psychiatric unit of the Pierce County Jail in Tacoma, Washington. A federal court last month held Washington state in contempt for holding mentally ill inmates without evaluating or treating them.
Number of State Psychiatric Hospitals, 2015

Source: NRI 2015 State Mental Health Agency Profiling System
State Psychiatric Hospital Residents Per 100,000 State Population, 2014

Residents per 100,000
- 0 to 8.71 (13)
- 8.7 to 12.72 (12)
- 12.72 to 18.07 (13)
- Over 18.07 (13)
Number of State Psychiatric Hospitals & Resident Patients at the End of Year: 1950 to 2015

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 Hospital Admissions and Residents: 2008 to 2015

The number of Residents in state psychiatric hospitals on the first day of each year declined by 5,965 from 2008 to 2015 (13% decrease).

Source: SAMHSA Uniform Reporting System: 2008 to 2015

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SMHA Controlled Expenditures for State Psychiatric Hospital Inpatient Services, FY 1981 - FY 2010 in Current & Constant "1981" Dollars

Expenditures in Billions

- State Mental Hospitals Current Dollars
- State Mental Hospitals Constant Dollars

Constant Dollars calculated using Medical Component of the Consumer Price Index

© 2016 National Association of State Mental Health Program Directors Research Institute
Intended Use of State Psychiatric Hospitals: 2015

- **Forensic**
  - Long-Term Care (more than 90 days): 41
  - Intermediate Care (30-90 days): 39
  - Acute Care (less than 30 days): 35

- **Elderly**
  - Long-Term Care (more than 90 days): 42
  - Intermediate Care (30-90 days): 42
  - Acute Care (less than 30 days): 39

- **Adults**
  - Long-Term Care (more than 90 days): 44
  - Intermediate Care (30-90 days): 43
  - Acute Care (less than 30 days): 41

- **Adolescents**
  - Long-Term Care (more than 90 days): 15
  - Intermediate Care (30-90 days): 21
  - Acute Care (less than 30 days): 18

- **Children**
  - Long-Term Care (more than 90 days): 10
  - Intermediate Care (30-90 days): 14
  - Acute Care (less than 30 days): 13
### State Psychiatric Hospital Utilization by Patient Day: 2005 to 2014

<table>
<thead>
<tr>
<th>Year</th>
<th>Forensic Patients</th>
<th>Sex Offenders</th>
<th>Children</th>
<th>Adults</th>
<th>Total Patient Days</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Patient Days</td>
<td>Patient Days</td>
<td>Patient Days</td>
<td>Patient Days</td>
<td>Percent</td>
</tr>
<tr>
<td>2005</td>
<td>5,653,891</td>
<td>995,444</td>
<td>715,098</td>
<td>9,984,066</td>
<td>58%</td>
</tr>
<tr>
<td>2006</td>
<td>5,531,851</td>
<td>1,102,346</td>
<td>671,758</td>
<td>10,109,656</td>
<td>58%</td>
</tr>
<tr>
<td>2007</td>
<td>5,742,751</td>
<td>1,243,028</td>
<td>652,735</td>
<td>9,752,858</td>
<td>56%</td>
</tr>
<tr>
<td>2008</td>
<td>5,895,691</td>
<td>1,369,403</td>
<td>648,843</td>
<td>9,605,169</td>
<td>55%</td>
</tr>
<tr>
<td>2009</td>
<td>5,905,327</td>
<td>1,490,156</td>
<td>617,698</td>
<td>9,197,320</td>
<td>53%</td>
</tr>
<tr>
<td>2010</td>
<td>5,956,987</td>
<td>1,440,118</td>
<td>550,311</td>
<td>8,722,005</td>
<td>52%</td>
</tr>
<tr>
<td>2011</td>
<td>5,601,736</td>
<td>1,494,353</td>
<td>533,711</td>
<td>7,992,605</td>
<td>51%</td>
</tr>
<tr>
<td>2012</td>
<td>5,627,805</td>
<td>1,574,339</td>
<td>521,884</td>
<td>7,650,164</td>
<td>50%</td>
</tr>
<tr>
<td>2013</td>
<td>5,267,956</td>
<td>1,366,919</td>
<td>491,567</td>
<td>6,584,330</td>
<td>48%</td>
</tr>
<tr>
<td>2014</td>
<td>5,725,286</td>
<td>1,587,424</td>
<td>471,802</td>
<td>6,813,699</td>
<td>47%</td>
</tr>
</tbody>
</table>
Average and Median State Psychiatric Hospital Inpatient Expenditures per Patient Day, by Patient Type: FY 2014

- Civil Status Children and Adolescents: $894
- Civil Status Adults: $812
- Forensic Patients: $766
- Sex Offenders: $687
- Total State Psychiatric Hospital: $767

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SMHA-Controlled Forensic and Sex Offender Mental Health Expenditures As a Percentage of State Psychiatric Hospital Expenditures, FY'83 to FY'14
State Hospital Admission Legal Status: 2015 SHR Data Set

- Voluntary-Others: 4.9%
- Involuntary-Civil: 69.8%
- Involuntary-Criminal: 24.1%
- Involuntary-Civil-Sexual: 0.8%
- Involuntary-Juvenile Justice: 0.5%

N=90,228 admissions with known legal status (94%); Not Reported = 5,550 (6%)
Total N = 95,778 discharges in 2015
Days Until Readmission

2015 SHR Data Set, First discharge records only
Clients Discharged due to Death or for Acute Medical Care are Excluded

- N=78,108 discharges during year
- 290 discharges excluded due to death
- 731 discharges for Acute Medical Treatment excluded

30 Days 6.1% Readmitted

180 Days 14.4% Readmitted
Days Until State Hospital Readmission
Patients with Schizophrenia and
with Schizophrenia and a Substance Abuse Problem
2015 SHR Data Set

N=78,108 discharges during year
• 290 discharges excluded due to death
• 731 discharges for Acute Medical Treatment excluded

First discharge records only
Clients Discharged due for Acute Medical Care or Death Excluded
Estimating the Total Psychiatric Inpatient Capacity

SAMHSA periodically surveys private psychiatric hospitals and general hospitals with separate psychiatric units. Currently 2010 is the most recent data available, but 2014 information should be available soon.

NRI combined 2012 URS data on State Psychiatric Hospitals with data on private psychiatric hospitals and non-Federal general hospitals with separate psychiatric units (from SAMHSA’s 2010 National Mental Health Services Survey (N-MHSS))

<table>
<thead>
<tr>
<th>Type of Psychiatric Facility</th>
<th>Number of Facilities</th>
<th>Number of Beds/Residents</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Psychiatric Hospitals (2012)</td>
<td>195</td>
<td>41,821</td>
</tr>
<tr>
<td>Non-Federal General Hospitals with Separate Psychiatric Units</td>
<td>1,157</td>
<td>35,351</td>
</tr>
<tr>
<td>(2010)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private Psychiatric Hospitals (2010)</td>
<td>374</td>
<td>24,919</td>
</tr>
<tr>
<td>Total Psychiatric Inpatient Capacity</td>
<td>1,726</td>
<td>102,091</td>
</tr>
</tbody>
</table>
Trend in All Psychiatric Beds: By Type of Hospital, 1970 to 2015

- State Hospitals
- Private Psychiatric Hospitals
- VA Psychiatric Services
- General Hospitals
- Total Psych Beds

Number of Public and Private Psychiatric Beds per 100,000 State Population: 2010 estimate

State Psychiatric Hospital data are residents in state hospitals on the first day of 2012. Private psychiatric bed counts represent separate psychiatric units in general hospitals and private psychiatric hospitals from SAMHSA's 2010 Survey.
Residents in State Psychiatric Hospitals, Jails, and Prisons, 1950 to 2014
The Vital Role of State Psychiatric Hospitals

Editors:
Joe Parks, M.D.
Alan Q. Radke, M.D., M.P.H.

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July 2014

National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council
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Key Messages

• State psychiatric hospitals are a vital part of the continuum of care and should be recovery-oriented and integrated with a robust set of community services.

• All people served in state psychiatric hospitals should be considered to be in the process of recovery.

• Changing the culture and environment of state psychiatric hospitals are keys to providing effective care. Cultures should be recovery-oriented; trauma-informed; culturally and linguistically competent; and address health and wellness.

• Peer support services are an integral part of assisting with people’s recovery process and should be made available to all service recipients in state psychiatric hospitals. Peer support specialists should be made an equal member of the treatment team.
• Service recipients should be served in the most integrated and least restrictive environment possible.

• A state psychiatric hospital is not a person’s home. State psychiatric hospitals should be focused on service recipients returning to the community quickly when they no longer meet inpatient criteria.

• State psychiatric hospital staff, in partnership with the service recipient, should work directly with community providers on a discharge plan that includes what community services would be most helpful for the service recipient.
Key Messages (cont.)

• For forensic service recipients, sex offenders, and in many states involuntarily committed service recipients, decisions for admission and discharge are made by courts and not by the state psychiatric hospital.

• State psychiatric hospitals include people with mental illness, people with criminal behavior driven by mental illness, and people with criminal and predatory behavior with no mental illness. These populations should be served in discrete locations.

• It is the duty of the state psychiatric hospital to make reasonable efforts to create environments in which service recipients and staff are as safe as possible. Addressing safety needs should be trauma-informed.

• Leadership and a well-trained, professional and paraprofessional workforce are paramount in ensuring quality
PSYCHIATRIC HELP 5¢

THE DOCTOR IS OUT

DUE TO INDUSTRY CHANGES, THIS SERVICE IS NO LONGER VIABLE

5/5 DEERING © 2016 CREATORS.COM
Innovative Uses of Technology to Address the Needs of Justice-Involved Persons with Behavioral Health Issues
• Paper for the NASMHPD Technical Assistance Coalition (TAC)
• Funded by SAMHSA
• Available on NASMHPD’s website after SAMHSA clearance
• Conceptualized with the help of NASMHPD’S Forensic Committee. Special thanks to:
  Betsy Neighbors, Ph.D., ABPP (Nevada)
  Juliet Britton, J.D (Oregon)
  Li-Wen Grace Lee (New York)
• Authored by Vera Hollen, Glorimar Ortiz, Lucille Schacht
Sequential Intercept for Change: Criminal Justice-Mental Health Partnerships

Adapted from Monitz & Griffin 2006
## Camden New Jersey ARISE person-level linked datasets

<table>
<thead>
<tr>
<th>Data Set:</th>
<th>Type of information:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Camden Coalition</td>
<td>Static hospital claims data from area hospitals</td>
</tr>
<tr>
<td>Camden County Policy Department</td>
<td>Arrest, calls for service, overdose, and crime incident data</td>
</tr>
<tr>
<td>New Jersey State Prison</td>
<td>Inmate data</td>
</tr>
<tr>
<td>Camden County Schools</td>
<td>Student attendance and demographic information</td>
</tr>
<tr>
<td>CamConnect</td>
<td>Identifies addresses that are vacant (used as a proxy for homelessness)</td>
</tr>
<tr>
<td>South Jersey Perinatal Cooperative</td>
<td>Data on pregnant women</td>
</tr>
</tbody>
</table>
Bed Registries

Virginia

Oregon

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Person-level Data Linkages

Maryland DataLink Process Flow Diagram

- Daily “Booking” File
- ValueOptions FileConnect
- ValueOptions Data Warehouse
- Maryland Medicaid
- Eligibility & Pharmacy Claims Files
- Department of Public Safety and Correctional Services (DPSCS)
- Identity Defendant
- Append Defendant identifying data to input file
- ValueOptions FileConnect
- Generate Pharmacy Extract
- Generate Authorization Extract
- Pharmacy Match Extract File
- Authorization Match Extract File
- Local Detention Center
- Core Service Agency

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Video Technology - Nevada
For Additional Information

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