Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century

Work Group 1: System Structure and Finance

Meeting Summary

July 16, 2018, Catawba Hospital, Catawba

Work Group 1 (System Structure and Finance) (the Work Group) of the Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century (the Joint Subcommittee) held its fourth meeting of the 2018 interim on Monday, July 16, 2018, at Catawba Hospital in Catawba. Following opening remarks and an overview of the agenda, the Work Group received presentations on components of the Commonwealth's publicly funded mental health services system.

Presentation: Behavioral Health Delivery System Accountability & Oversight - Dr. Hughes Melton, Commissioner, Department of Behavioral Health and Developmental Services, and Daniel Herr, Deputy Commissioner for Behavioral Health Services, Department of Behavioral Health and Developmental Services

Dr. Hughes Melton, Commissioner, Department of Behavioral Health and Developmental Services, and Daniel Herr, Deputy Commissioner for Behavioral Health Services, Department of Behavioral Health and Developmental Services, provided information about oversight of the publicly funded behavioral health delivery system by the Department of Behavioral Health and Developmental Services (DBHDS), including the community services board (CSB) performance contracting process, licensing of private providers, and the role of the Board of Behavioral Health and Developmental Services. Dr. Melton and Mr. Herr also provided updates on efforts to advance the behavioral health system in the Commonwealth, financing of the publicly funded behavioral health system, and current state hospital censuses.

CSB Performance Contracts

Mr. Herr described the three types of CSBs authorized by statute and the services provided by CSBs, including mandated services and other services CSBs are authorized but not required to provide as part of the core of comprehensive behavioral health services. He also described the statutory basis of the CSB performance contract process. Pursuant to § 37.2-508 of the Code of Virginia, the performance contract governs the relationship between DBHDS and the CSBs, specifying the provision of state and federal funds for the delivery of mental health, developmental, and substance abuse services to CSBs by DBHDS and the conditions that a CSB must comply with related to the provision of such funds. The performance contract serves as the primary tool by which DBHDS exercises oversight and holds CSBs accountable for services provided. Section 37.2-504 authorizes CSBs to provide services pursuant to the performance contract and to enter into agreements with other CSBs for the provision of services on a regional basis where appropriate. Section 37.2-509 limits the allocation of state funds for salaries and operating costs of CSBs to 90 percent of the total amount of state and local matching funds available to the CSBs, creating the requirement that localities provide at least 10 percent of the funds available to a CSB for salaries and operating costs. However, language in § 37.2-509 does allow DBHDS to grant a waiver of this requirement in certain situations.

Mr. Herr stated that each CSB negotiates its performance contract with DBHDS each year. Each CSB's performance contract includes the contract itself, the language of which is the same for every CSB, setting out provisions and requirements that apply to all CSBs, plus a set of 12 exhibits, which are amended to address specific agreements and requirements between a single CSB and DBHDS. While some exhibits may be the same for each CSB, others may be different. Negotiation of the performance contract between DBHDS and the CSB generally occurs in the spring of each year and includes opportunity for public comment on the proposed agreement and review of the performance contract by the local governing bodies participating in the CSB prior to finalization.

Mr. Herr also described oversight and accountability of CSBs pursuant to the performance contract, including requirements for mid-year and end-of-fiscal-year reporting on funds and expenditures, compliance with federal block grant requirements, local matching fund requirements, requirements set out in the appropriation act, and information on costs of services and staffing by program area; analysis of monthly data on individuals served and services provided to measure outcomes and performance; review of audits from operating CSBs; and financial and operational reviews of CSBs identified as being at higher financial risk. He reported that changes have been made to the performance contract in recent years to enhance oversight and accountability. For the FY 2019 Performance Contract, these include requirements that CSBs attempt to contact and re-engage individuals admitted for services who have not received services for more than 100 days, requirements for same-day access to services, revisions to the DBHDS remediation process for noncompliance with performance contract requirements, imposition of additional performance measures, requirements for operating reserves of funds, and a new exhibit establishing state hospital census management admissions and discharge requirements.

Private Provider Licensing

Commissioner Melton described DBHDS's role in licensing private providers of behavioral health services. He stated that the Code of Virginia requires DBHDS to license private providers, conduct annual inspections of license services and investigate complaints about licensed providers, and modify or revoke licenses as appropriate. All new provider applications are reviewed by specialists located at the DBHDS Central Office. Licensing staff located in each of the five regional offices conduct inspections, investigate complaints against and incidents involving licensed providers, and make recommendations regarding the issuance or revocation of licenses. Regional licensing offices may also issue and monitor compliance with corrective action plans where appropriate.

Currently, just over 1,300 private providers providing more than 3,300 services at more than 9,100 locations are licensed by DBHDS. These providers provide a wide range of services for both adults and children. During FY 2017, a total of 6,301 inspections were conducted, including 1,441 inspections conducted as part of an investigation of a death or serious injury at or a complaint against a private provider.

Commissioner Melton stated that private providers are a key part of the behavioral health system. During FY 2017, the Department of Medical Assistance Services (DMAS) paid $636,151,356 to private providers of behavioral health services in the Commonwealth. Private providers received approximately 98.8 percent of Medicaid dollars spent for intensive in-home treatment, 76.7 percent of Medicaid dollars spent for therapeutic day treatment, 94.5 percent of

Medicaid dollars spent for mental health skill building, and 42.4 percent of Medicaid dollars spent for other behavioral health services.

Advancing the Behavioral Health System

Commissioner Melton reported that DMAS and DBHDS are partnering to implement a redesign of the public behavioral health system that addresses all Medicaid mental health services provided by both private and publicly funded providers. The effort will focus on ensuring an evidence-based, trauma-informed continuum of Medicaid-funded mental health services that supports and works together with STEP-VA. The Farley Center for Health Policy at the University of Colorado will support the agencies and stakeholders in developing a comprehensive system reform plan for Medicaid mental health services. The process of developing the plan will include preparation of an evidence brief focusing on best practices for Medicaid services across the lifespan; a service gap analysis for the Medicaid population; a recommendations report of individual and population level metrics and quality outcomes; a recommendations report on changes to DBHDS licensing requirements and regulations to produce a system that ensures quality and accountability for all individuals regardless of payment source or service provider; a stakeholder engagement report on the process and how data collected informed the synthesis of evidence, measures, and the strategic plan; and a recommendations report on the continuum of evidence-based, trauma-informed, preventive-focused Medicaid community mental health services, including early intervention services, school-based behavioral health services, and integrated primary care and behavioral health services, with additional recommendations related to requirements for provider qualifications and reimbursement rates.

State Board of Behavioral Health and Developmental Services

Mr. Herr described the organization and function of the State Board of Behavioral Health and Developmental Services (the Board). Chapter 2 (§ 37.2-200 et seq.) of Title 37.2 of the Code of Virginia sets out provisions governing the Board. The Board is created as a policy board, as defined in § 2.2-2100, charged with promulgating public policies or regulations. Section 37.2-203 sets out the powers and duties of the Board, including developing and establishing programmatic and fiscal policies governing operations of state hospitals, training centers, and CSBs; ensuring development of long-range programs and plans for mental health, developmental, and substance abuse services provided by DBHDS and CSBs; adopting regulations; monitoring activities of DBHDS, including budget and appropriations requests and compliance with policies; and other duties. Section 37.2-200 sets the membership of the Board, requiring representation of individuals receiving or who have received services, family members of individuals receiving or who have received services, local government officials, licensed psychiatrists, and citizens of the Commonwealth.

Behavioral Health System Financing

Mr. Herr provided an overview of public behavioral health system funding, noting that in FY 2017, a total of $1,857,011,440 was spent by the publicly operated behavioral health and developmental services system. A total of $1,214,342,810, or 65.4 percent, was spent to support CSBs; $538,328,152, or 29 percent, was spent to support state facilities; and $104,340,478, or 5.6 percent, was spent to support the DBHDS Central Office. Sources of funding included state general funds ($756,814,183, or 41 percent), fees ($671,986,289, or 36 percent), funds provided

by localities ($284,946,271, or 15 percent), federal funds ($91,220,954, or five percent), and other sources ($52,043,743, or three percent).

State Hospital Censuses

Commissioner Melton provided an update on state hospital censuses. He provided information about the census at each hospital, noting that six of the Commonwealth's eight hospitals were over capacity and the other two were at greater than 95 percent capacity. To mitigate the demand on state hospitals, DBHDS is working with the Virginia Hospital and Healthcare Association to develop short-term and long-term solutions to increase the percentage of individuals accepted by private hospitals, including ensuring adherence to doctor-to-doctor communication for individuals with medical issues; adopting procedures to escalate admissions denials to appropriate facility administrators as needed; and identifying trends in the reasons for denial by private hospitals and implementing targeted remedial measures. DBHDS has also established bed search expectations for CSBs, developed contracts with two private hospitals for admissions of individuals who would otherwise go to state hospitals, implemented a requirement that state-funded crisis stabilization programs admit individuals under a temporary detention order and operate at no less than 75 percent of capacity, and taken steps to ensure that emergency services workers consult with a developmental disability professional in cases involving individuals with a developmental disability in crisis prior to recommending issuance of a temporary detention order.

Presentation: Variations in Service and Funding Across Community Services Boards - Kevin Farley, Institute for Law, Psychiatry, and Public Policy, University of Virginia

Kevin Farley, Institute for Law, Psychiatry, and Public Policy, University of Virginia, presented information on variations in services and funding across CSBs. He reported significant variation in CSB services and funding levels across the Commonwealth. Reasons for variations in services include differences in CSB funding, workforce availability, and community needs. Reasons for variations in funding include differences related to local government budgets, Medicaid penetration rates, CSB type and structure, and allocations of base funding to CSBs. Mr. Farley noted that the information presented was based on FY 2017 data and that changes are underway to address some of the issues identified.

Mr. Farley then presented an overview of the types of CSBs and information about which CSBs fall into each category. He provided data on CSB funding by source, reporting that total CSB funding in FY 2017 included approximately $432.4 million, or 37 percent, from Medicaid funds; $321.4 million, or 27 percent, from state general funds; $287 million, or 24 percent, from local funds; $61.1 million, or five percent, from federal funds; and $84 million, or seven percent, from other funds. CSB funding for mental health services totaled $664.5 million, with approximately $237.1 million, or 35.7 percent, from state general funds; $210.5 million, or 31.7 percent, from Medicaid funds; $148.1 million, or 22.3 percent, from local funds; $17.4 million, or 2.6 percent, from federal funds; and $51.4 million, or 7.7 percent, from other sources. Mr. Farley also described the variation in CSB funding and funding for mental health services delivered by CSBs in the Commonwealth, including variation in the sources of funding, for each CSB in the Commonwealth. These figures indicate that local funding is a key determinant of variation in CSB funding. Increased levels of local funding allow for greater flexibility for CSBs, as well as

greater buy-in from localities. Conversely, CSBs that receive a greater portion of funds from Medicaid experience less flexibility as a result of the restrictions of the Medicaid program.

Mr. Farley then described variations in CSB services in the Commonwealth, noting that DBHDS collected data on 50 discrete services provided by CSBs, which were grouped into one of four categories: mental health, developmental services, substance use disorder services, or emergency and ancillary services. The median number of services offered was 25. The four CSBs with the highest number, or broadest array, of services were Fairfax-Falls Church (40), Arlington (37), Virginia Beach (33), and Region 10 (32). The three CSBs offering the lowest number, or narrowest array of services, were Portsmouth (18), Rockbridge (18), and Northwestern (17). With regard to mental health services specifically, the highest number of services were provided by Arlington (16), Fairfax-Falls Church (15), and Region 10 (14) while the lowest number were provided by Dickenson, Eastern Shore, and Goochland-Powhatan, each of which provided seven types of mental health services. Every CSB in the Commonwealth provided outpatient and case management services. Mr. Farley also provided data on developmental, substance use disorder, and emergency and ancillary services provided by CSBs in the Commonwealth.

Mr. Farley also provided information about other factors affecting CSB services, including variations in the estimated percentage of the adult population with serious mental illness by region and variations in staffing capacity and workforce across CSBs.

Presentation: Private Provider Perspectives - Ray Ratke, President, Board of Directors, Virginia Network of Private Providers

Ray Ratke, President, Board of Directors, Virginia Network of Private Providers, spoke on the private provider perspective on the public behavioral health services system. He stated that approximately 86 percent of Medicaid spending on community-based behavioral health services is for services provided by private providers. As a key part of the public behavioral health system, private providers want to make a positive impact on the lives of the people and communities served. Specific challenges for private providers in the publicly funded behavioral health system include a need to develop partnerships with and coordination among system components; the realities of a market-based approach to service delivery rather than a system of care approach; demands created by an increased focus on outcomes and value-based contracting and the need to develop appropriate infrastructure to meet those demands; changes to regulations and regulatory processes that result in unforeseen or unintended consequences for private providers and result in inconsistencies and inefficiencies; workforce issues including recruitment and retention; and the need to focus on prevention and early intervention and develop strategies to ensure access to prevention and early intervention services.

Discussion

Following the presentations, members discussed information received during the meeting. Key issues identified included the need to address variation in local funding for CSBs and incentivizing localities to do more.

Next Meeting

The next meeting of Work Group 1 (System Structure and Finance) of the Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century will be held on Tuesday, August 7, 2018, at Southwestern Virginia Mental Health Institute in Marion.