

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

## Work Group 1: System Structure and Finance

### Meeting Summary

August 7, 2018, Southwestern Virginia Mental Health Institute, Marion

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) met on Tuesday, August 7, 2018, at Southwestern Virginia Mental Health Institute in Marion. Following opening remarks and an overview of the agenda, the Work Group received presentations on alternate human service delivery models.

### **Other State Behavioral Health Systems - Coy Jones, Senior Consultant, Public Consulting Group**

Coy Jones, Senior Consultant, Public Consulting Group, provided information about the organization of other states' public behavioral health systems. He began the presentation with an overview of persisting issues in mental health, noting prevalence rates of mental illness in the United States, the individual and societal health and financial impacts of mental illness, and treatment rates for adults and youth with mental illness.

Mr. Jones then addressed structural differences among the varying state mental health service delivery systems. He noted that behavioral health delivery systems involve complex combinations of public and private services, providers, and financing. Funding for public mental health services is provided through a mix of local, state, and federal appropriations as well as the Medicaid and Medicare programs. Legal and programmatic requirements are generally established at the state level, though federal and local requirements also influence the organization and operation of public mental health service systems. Mr. Jones identified six key variables in the structuring and financing of behavioral health systems that create a framework for comparing state mental health service systems:

1. *Distance of the state mental health agency from the governor in the state government hierarchy.* In seven states, the state mental health agency is one step below the governor in the hierarchy of state government, and the head of the state mental health agency reports directly to the governor. In 23 states, including Virginia, one intermediary stands between the head of the state mental health agency and the governor. In Virginia, the intermediary is the Secretary of Health and Human Resources. In 16 states, two intermediaries stand between the head of the state mental health agency and the governor, and in two states, three or more intermediaries stand between the head of the state mental health agency and the governor. The number of intermediaries between the head of the state mental health agency and the governor impacts agency decision-making authority and state spending on mental health services. In states where there are fewer intermediaries between the state mental health agency and the governor, state spending on mental health services tends to be higher per capita than in states where there are more intermediaries between the state mental health agency and the governor.

2. *Location of the state mental health agency within state government.* In some states, like Virginia, the state mental health agency is an independent agency, while in other states the state mental health agency is part of a larger agency. In states in which the state mental health agency is not an independent agency, the state mental health agency may be part of a larger human services agency or may be combined into a single agency with the state's health, Medicaid, or social services programs. The location of the state mental health agency within state government has an impact on agency decision-making authority and state spending on mental health services. In states where the state mental health agency is an independent agency, state spending on mental health services tends to be higher per capita than in states where the state mental health agency is part of a larger agency.
3. *Relationship of the state mental health agency with the state Medicaid agency.* In some states, the state mental health agency is completely separate from the state Medicaid agency, while in other states, the state mental health agency is part of a larger agency that includes the state Medicaid program and is responsible for setting rates for mental health services provided through the Medicaid program and administering Medicaid benefits for mental health services. In yet other states, the state Medicaid agency delegates oversight of Medicaid mental health services to the state mental health agency but retains authority to set rates for mental health services. The relationship between the state mental health agency and the state Medicaid agency directly affects expenditures for mental health services. States with a close organizational relationship between the state mental health agency and the state Medicaid agency are generally better equipped to coordinate Medicaid-financed community mental health services with the rest of the public mental health services system. Additionally, states that have centralized authority over Medicaid mental health services may experience greater cost containment and increased consistency and standardization of services.
4. *Structure of the public mental health service delivery system.* State mental health service delivery systems generally take one of three forms: state-operated, with the state mental health service agency serving as the direct service provider for community services; locally operated, with localities serving as the direct service provider for community services; or state-contracted, with private organizations serving as direct service providers for community services, pursuant to contracts with the state mental health agency. Locally operated systems tend to have the lowest administrative costs and the highest per capita expenditures. State-operated systems tend to have the highest administrative costs and lowest per capita expenditures and tend to rely more on state general funds and less on Medicaid and other reimbursements to fund the cost of providing services. State-operated systems also tend to provide more consistent services, while locally operated systems tend to be less consistent. However, states with a locally operated system tend to do a better job of leveraging local funds, maximizing the amount of funding for public mental health services more effectively than state-operated systems. Virginia is an example of a state with a locally operated public mental health service system.
5. *Relationship of the state mental health agency with state hospitals for people with mental illness.* In most states, the state mental health agency is responsible for the operation of state mental hospitals. However, in a few states, authority over the state's mental

hospitals is located with a different agency, often the state agency responsible for licensing and regulating medical hospitals.

6. *Level of integration of public mental health services with other behavioral health and human services.* Many states have expanded the scope of the state mental health agency to include other behavioral health services. Nearly all states have consolidated mental health and substance use disorder services in a single agency. Ten states, including Virginia, have consolidated mental health, substance use disorder, and intellectual/developmental disability services in a single agency.

Mr. Jones reported that in recent years, a number of states have adopted reforms to their public mental health service system that change some of the variables identified. Key reforms include integration of mental health and other human services, primarily physical health services; regionalization, as several states with locally operated systems are implementing regional approaches to the organization and financing of mental health services to address disparities among localities; and localization, with some states shifting responsibility for community services to local governments. The impact and outcome of these reforms will vary depending on the unique characteristics of the state and the population served.

At the end of his presentation, Mr. Jones provided information on public sector funding for behavioral health services. He stated that public mental health service systems are generally funded through a mix of local, state, and federal funds. State funding often consists of general and other funds for the state mental health agency and the state share of Medicaid. Local funds may include local matching requirements or other requirements for services provided or coordinated by the state mental health agency. Federal funds include funds provided through government insurance programs like Medicaid and Medicare and federal grants for services for certain populations or treatment of substance use disorders. States may also use Medicaid waivers as a tool to finance services to certain populations.

### **State/Local Cooperative Service Delivery Systems in the Commonwealth: The Virginia Department of Health & Local Departments of Health - Bob Hicks, Deputy Commissioner for Community Health Services, Virginia Department of Health**

Bob Hicks, Deputy Commissioner for Community Health Services, Virginia Department of Health, provided an overview of the relationship between the Virginia Department of Health and local departments of health. He stated that the Code of Virginia requires each county and city to establish and maintain a local department of health headed by a local health director, who is to be a physician licensed to practice medicine in the Commonwealth. Local departments of health may be operated and funded cooperatively by the state and locality; operated and funded solely by the locality as an independent agency; or operated and funded solely by the state. Currently 93 counties and 36 cities have established local departments of health operated and funded cooperatively by the state and locality, and two counties and two cities have established local departments of health operated and funded solely by the locality. No counties or cities are served by local departments of health operated and funded solely by the state. Local departments of health are organized into 35 community health districts. Districts may consist of as few as one or as many as 10 localities. Each locality in a health district must operate at least one service delivery site.

Local health departments are required to provide services in 10 core service areas: administration, chronic disease, communicable disease, dental, environmental health, family planning, immunization, maternal and child health, nutrition, and personal care services. However, the specific array of services provided by local health departments may vary, even among local health departments within the same district, in response to local needs and local resources. Delivery of services by a local health department is governed by a local government agreement entered into by the locality and the state. At the state level, the Office of Community Health Services is responsible for development and enforcement of local government agreements. Services delivered within each locality may be delivered by the health district directly, by individual providers who have entered into agreements for the delivery of services with the health district, or through collaboration between the health district and individual providers.

Funding for local health departments includes state and local funds. The cooperative funding model adopted by the General Assembly calls for a local match of state funds. The local match rate varies by localities, with a maximum rate of 45 percent and a minimum rate of 18 percent. The amount of each locality's match depends on the locality's revenue generation capacity.

**State/Local Cooperative Service Delivery Systems in the Commonwealth: The Virginia Department of Social Services and Local Departments of Social Services - Angela Moore, Director, Regional Operations and Local Support, Virginia Department of Social Services**

Angela Moore, Director, Regional Operations and Local Support, Virginia Department of Social Services, provided an overview of the relationship between the Department of Social Services (the Department) and local departments of social services. She described the relationship as a state-supervised and locally administered system, with the Department and the State Board of Social Services responsible for oversight and guidance of the 120 local departments of social services in the Commonwealth. Local departments of social services are administered by a local director of social services, who may be removed at the will of the Commissioner of Social Services, and overseen by local boards of social services established by local governments. Local boards may be administrative, directing the activities of the local director and assisting with programmatic and personnel issues, or advisory, monitoring local social services programs and representing the interests of citizens served by the local department.

Funding for local department activities includes a mix of state and local funds. Pursuant to the Code of Virginia, the governing body of each locality must appropriate funds sufficient to provide for the payment of public assistance and provision of social services within the locality. Localities are then reimbursed for such expenditures by the Department from federal funds provided to the state for various social services programs and such funds appropriated to the Department by the General Assembly for such purpose. The amount of local spending reimbursed by the Department varies on the basis of the type of service provided. Administrative costs are reimbursed at a rate of 50 percent.

**Children's Mental Health Services in the Commonwealth - Margaret Nimmo Holland, Executive Director, Voices for Virginia's Children**

Due to time constraints, the presentation on children's mental health services was postponed to the September meeting.

**Next Meeting**

The Work Group will hold its next meeting on September 5 in Richmond.