

## **Expert Advisory Panel on System Structure and Financing Work Plan for 2017-18\***

### **INTRODUCTION**

At the outset of its work in the spring of 2016, the Panel surveyed the basic structures for delivering publicly funded mental health services used by other states, finding that most states resemble Virginia's combination of locally controlled community services agencies and state oversight (as opposed to a unified state system or exclusive reliance on private providers). The Panel concluded that the most sensible approach is to build on and improve the existing structure rather than undertake a radical change. The Panel is convinced that local and regional public agencies under state oversight is still the best fit for the Commonwealth's needs, just as it was four decades ago. The weaknesses of the current system can be remedied, and there is no assurance that any other approach would produce better results than an improved version of the current structure.

The Panel also notes that fundamental alteration of the structure of the system would be highly disruptive and costly. The transition would require a massive expenditure of time and resources and would not, until many years down the road, allow the direct investment in services and supports that everyone knows are needed. Changing the structure would also erase the decades-long relationships that have developed between many of the CSBs and their local governments, as well as many other community partnerships and programs - especially among public entities. For example, ending CSB collaborations with jails, schools, courts, etc., which have been tailored to the local circumstances, would likely erase beneficial services, alienate important constituencies, and jeopardize local government funding and support.

Eight key needs have been identified for improving the statewide system of delivering publicly funded mental health services for both children and adults: (i) to assure access to a full array of core services (as envisioned and defined in STEP-VA) and specifically to assure that such services are available to individuals and families who cannot afford or qualify for insurance or who live in underserved areas of the state; (ii) to align the services provided and mechanisms of accountability across the systems and providers who are responsible for delivering services to Medicaid-covered individuals and to persons who lack insurance; (iii) to assure the timely, safe and effective provision of emergency mental health services to all residents of the Commonwealth; (iv) to develop an integrated data system that enables the collection, protection, and appropriate and timely sharing of data regarding consumers' involvement with the service system and the outcomes of that involvement; (v) to identify and utilize the most appropriate criteria and measures for monitoring outcomes and performance and collecting the relevant data across agencies for all publicly funded services; (vi) to strengthen the oversight and authority of state government in assuring that the goals of the system are being met by establishing the right incentives and taking remedial action if local providers, including CSBs, are unable to achieve desired outcomes; (vii) to facilitate local and regional cooperation among human service

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\* Presented on behalf of the Panel by Richard J. Bonnie, Chair, on June 12, 2017.

agencies and other stakeholder organizations in providing services to individuals with mental illness; (vii) to develop an effective system for educating, training and retaining a skilled workforce, and for using that workforce most effectively and efficiently through such means as building tele-health capacities and increasing the integration of behavioral health care with primary care.

## CURRENT PANEL ACTIVITIES

The General Assembly has affirmed its commitment to the core array of services envisioned in STEP-VA and has begun the challenging task of identifying the funds needed to finance these services. The Panel will also continue to monitor *federal developments on health care reform*, and specifically those that may affect the financing of mental health services for children and adults, including caps on Medicaid and/or elimination of opportunities to expand Medicaid coverage. In addition, several other *key transformation initiatives are underway*.

### *1. Fiscal Realignment of the Relationship between State Hospitals and CSBs*

The most important structural reform initiative currently under consideration is the *fiscal realignment of the relationship between state hospitals and CSBs*. On average, other states spend 75% of state mental health dollars on community services and the other 25% on state hospitals; by comparison, Virginia spends almost half of its mental health dollars (excluding Medicaid) on state hospitals. In addition, state hospital utilization consistently exceeds capacity. One of the many factors contributing to this imbalance is that the budgets of state hospitals and CSBs are completely independent, and the “system” as a whole lacks incentives to manage care efficiently and effectively.

By requiring CSBs to purchase services from the state hospitals, the realignment plan currently being developed would create incentives for CSBs to invest in cost-effective community alternatives that, if successful, would allow the downsizing of state hospitals and would help create a more efficient public mental health services system. The General Assembly directed the Secretary of Health and Human Resources to prepare a plan for implementing such a fiscal realignment, and the Panel is receiving periodic briefings on the development of the plan, which is due to the General Assembly on December 1, 2017. The Panel plans to concentrate its attention over the coming months on the implementation plan developed by HHR.

The Panel recognizes that, despite its potential advantages, the envisioned realignment is complex, and may have possible downside consequences. In addition, any transition will require additional funding for CSBs, prior to any cost savings being realized from the anticipated reduction in the state hospital census, so that CSBs have in place the services needed to effectively serve individuals locally in lieu of state hospital placement. Even if such a transition proves to be economically feasible, it will require gradual implementation, and there will be trades-offs, including impacts on state hospital employment. The Panel was advised last year that a similar transition in Ohio took a decade.

Another issue to consider in thinking about realignment is the fact that emergency services, including crisis assessments and intensive interventions, are provided to every person in Virginia who needs them, without regard to the person's insurance status or type of provider. Thus, bed utilization by everyone, regardless of insurance or provider, affects the availability of beds to everyone else. Any monitoring system must include both voluntary and involuntary use of all hospital beds and other intensive alternatives to hospitalization. Indeed, reducing the need for use of these "deep-end" modalities, not only state hospital beds, must be a system-wide criterion of success.

## ***2. Alignment of Services for Medicaid-Insured and Uninsured Clients***

In addition to monitoring the proposed fiscal realignment, the Panel also plans to monitor the *efforts now being undertaken by a DMAS-DBHDS Task Force to align the mental health services provided to uninsured CSB clients with those provided to Medicaid-covered clients under the managed care initiative currently underway*. The transition to managed care will have enormous impact on the ways in which services are delivered (by CSBs and private providers) to Medicaid-covered clients, and will also facilitate the development and use of outcome-oriented performance measures for all clients, regardless of funding source. DBHDS and DMAS will need to work closely to assure that the performance criteria encompass measures that are important to the General Assembly as well as those that bear on federal requirements.

## ***3. Integrated Data System***

One of the challenges in knitting together a "single system" for serving the Commonwealth's most vulnerable citizens, regardless of funding stream, will be to integrate the data systems in a way that will allow attention to cross-overs between the Medicaid system and the system financed by other public funds. In addition, key decisions must be made about what data is important, including not only information about the individuals being served, in order to determine their service needs and outcomes, but also information about the costs of services in achieving those outcomes.

## ***4. Developing Criteria and Measures of Outcomes of Publicly-Funded Services***

A key component of the system transformation already underway is the development of outcome and performance measures for CSBs and other providers of publicly funded services. HHR, DBHDS and DMAS are already involved in reviewing and developing with the CSBs the most meaningful outcome and performance measures and the most effective data platform on which to enter and share that information. It will be important to monitor this process and to ensure that the measures that used fairly reflect both the effectiveness of services and their costs system-wide. The Panel plans to engage in a continuing conversation with HHR, DBHDS and DMAS as the transformation process unfolds, with the expectation that it will lead to the drafting of statutory language on this critically important topic.

## ***5. Behavioral Health Integration and Primary Care***

The challenge of reforming the system of publicly financed mental health services has to be addressed within the larger context of other recent initiatives relating to health service

delivery. One particularly relevant development is the rapid movement toward integration of behavioral health into primary care. Much has occurred in Virginia over the last few years, and the movement is reflected in the legislation enacted in 2017 requiring CSBs to provide primary care screening as a core service under the first step of STEP-VA. The Panel will continue to monitor policy and funding developments relating to behavioral health care integration.

#### **NEW PANEL INITIATIVES IN 2017-18 RELATING TO SYSTEM STRUCTURE AND GOVERNANCE**

As these changes unfold over the remainder of 2017, the Panel will also begin to explore two pivotal issues bearing on system structure and governance that are likely to occupy its attention throughout 2018:

- Authorities and Responsibilities of State Agencies in Delivery of Mental Health Services
- Roles, Needs and Responsibilities of Local Governments

##### ***1. Authorities and Responsibilities of State Agencies in Delivering Mental Health Services***

Several state agencies play central roles in the delivery of mental health services, ranging from licensure of private providers to direct delivery of services to residents of state-operated psychiatric hospitals and to incarcerated prisoners. The SJ 47 study focuses on improving and expanding publicly funded services delivered to persons residing in the community, with a particular, though not exclusive, emphasis on those delivered by CSBs. Several state agencies have responsibilities for overseeing, supporting and/or regulating community mental health services and the providers who deliver them. Although the most important of these agencies are DBHDS and DMAS, other state agencies (such as OCS and DCJS) have relevant authorities and responsibilities. In the upcoming phase of the SJ 47 inquiry, the Panel will focus on the authorities and responsibilities of DBHDS [and DMAS], deferring consideration of the roles of other state agencies until 2019.

To be successful, the transformation initiatives already begun (e.g., STEP-VA) and under development (e.g., fiscal realignment of financing of state hospitals and community services) will require that DBHDS (i) adopt performance criteria and measures that reflect outcomes of services for individuals and families, costs of care, hospital utilization, etc., (ii) intensify its data collection, reporting and monitoring, and (iii) provide more active oversight, support and management of the system of care. One important question for the SJ 47 Study is whether DBHDS has the capacity to carry out these essential functions and, if not, what changes may be needed, including additional resources or statutory authority. Additional questions include whether CSBs, as presently organized, have the capacity and local support to carry out their responsibilities under STEP-VA, fiscal realignment and other system transformation initiatives. The Panel plans to undertake a comprehensive study of DBHDS oversight of publicly funded services for individuals with behavioral health needs. Specific issues of interest to be considered include:

- Review of current methods for DBHDS monitoring of system-level and CSB outcomes and performance (including incentives and rewards for superior performance, consequences of inadequate performance, etc) and of potential alternative approaches that might enhance effectiveness of DBHDS oversight
- Review of DBHDS capacity to manage change in support of transformation initiatives and to implement quality improvement based on enhanced monitoring and oversight processes (e.g., organization and staffing, data infrastructure, statutory authority, etc.)
- Whether DBHDS oversight might be explicitly adjusted in relation to the strength of local or regional oversight and governance
- How DBHDS regulatory authority (e.g., licensing) can most effectively and usefully complement DMAS authority in the shared effort to assure quality of mental health services delivered to Medicaid-covered clients by private providers
- Whether DBHDS’s Behavioral Health and ID/DD responsibilities and operations should be disaggregated, or whether the budgets for each should be separated without administrative separation, so that these distinct areas, and the funding for each, can be more clearly recognized.

## ***2. Roles, Needs and Responsibilities of Local Governments and Regional Collaborations***

As noted earlier, the active involvement by many local governments in the services provided by the CSBs – including, in some localities, very significant financial support – and the various interagency agreements and collaborations between CSBs and local law enforcement, schools, social services agencies and other public and private entities – were key considerations in the decision to maintain but reform the current structure of public mental health services. That said, the degree of local government involvement, particularly financial involvement, has varied dramatically across the state, with a clear divide between the more affluent urban and suburban communities and the often cash-strapped rural regions. In addition, DBHDS has encouraged and incentivized regional cooperation and collaboration through a number of measures, including, for example, region-based funding to support local inpatient psychiatric care for uninsured individuals who are in mental health crisis.

In looking at how best to utilize and improve this existing structure, the Panel will review the following:

- The nature and variation in local governance and local investment in public mental health and substance abuse treatment services across the state
- The collaboration of CSBs with other local or regional human service agencies
- The regional collaboration among CSBs within their Health Planning Regions (HPRs) \*

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• The Commonwealth’s regional configuration in mental health services has become confusing in recent years. The original regional configuration in mental health services was congruent with the five Health Planning Regions (HPRs) rooted in federal health planning. A more recent configuration of Partnership Planning Regions (PPRs) within DBHDS refers generally to the seven catchment areas of the seven DBHDS adult psychiatric hospitals. The children’s MH services system, as well as the SUD and ID/DD systems, still use the 5-region HPR configuration, while the geriatric service map is differs from all of the others. Unless otherwise specified, the Panel will use “regions” to refer to the HPRs.

- The ways in which additional local funding (above the 10% match of state funds required by statute) are used to improve community-based services and outcomes
- Feasibility of consolidation of some CSBs without disrupting access to services
- Models within Virginia of regional collaboration and interagency collaboration that might be replicated
- The experience of other states with a similar structure (e.g., Oregon)