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

Work Group 1: System Structure and Finance

Meeting Summary

June 5, 2018, Central State Hospital, Petersburg

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 third meeting of the 2018 interim on Tuesday, June 5, 2018, at Central State Hospital in Petersburg. Following opening remarks and an overview of the agenda, the Work Group received presentations on components of the Commonwealth's publicly funded mental health service system.

Presentation: Role of the Department of Medical Assistance Services (DMAS) in the Commonwealth's public mental health service system; Ann F. Bevan, Director, Division of Developmental Disabilities and Behavioral Health, Department of Medical Assistance Services

Ms. Bevan provided information on the number of individuals covered by the Commonwealth's Medicaid program and Children's Health Insurance Program (CHIP) and the types of behavioral health services covered by Medicaid. She stated that Medicaid is now the predominant payer for mental health services nationally and in the Commonwealth. Approximately 46 percent of Medicaid spending in the United States is for services for individuals with mental illness or substance use disorder.

Major Medicaid initiatives affecting behavioral health services include the transition to managed care through Commonwealth Coordinated Care Plus (CCC Plus) and implementation of Medallion 4.0, as well as implementation of Addiction and Recovery Treatment Services (ARTS) and transformation of children's residential treatment services. CCC Plus is a managed care program that provides an integrated delivery model that includes medical services, behavioral health services, and long-term services and supports for more than 210,000 Virginians. Care is coordinated by six managed care organizations, each serving a region of the Commonwealth. Phased implementation of CCC Plus began in August 2017, with full implementation achieved in January 2018. Currently, community mental health services are part of CCC Plus. Medallion 4.0 is a managed care program that will cover 760,000 Virginians, including infants, children, pregnant women, and parents. Medallion 4.0 will also include Early Intervention Services and community mental health and rehabilitation services. Care coordination will be provided by the same six managed care organizations participating in CCC Plus.

Another major initiative of DMAS is the transformation of the Medicaid community-based mental health delivery system. Ms. Bevan reported that during 2017, the Commonwealth partnered with the Farley Center, a nationally recognized expert on health care integration, to analyze Medicaid behavioral health spending at the provider and locality level. During 2018, the Farley Center is working with DMAS and stakeholders to create a plan for DMAS and other state agencies to transform the Commonwealth's existing mental health service delivery system

into a comprehensive evidence-based continuum of community-based mental health services with uniform standards and quality measures. To do this, the Farley Center is reviewing DMAS claims data; data about psychiatric freestanding hospitals, state funding of behavioral health facilities, and CSB locations and service areas from the Department of Behavioral Health and Developmental Services; and population health outcome data, including mortality rates and behavioral health outcomes, from the Department of Health.

Ms. Bevan also provided information about Medicaid funding of behavioral health services. She stated that to be eligible for federal funds, the state must develop a State Plan that must be approved by the Centers for Medicare and Medicaid Services; this plan forms a contract that sets out the populations covered, services provided, and other details of the Medicaid program. DMAS contracts with managed care organizations and a behavioral health services administrator to manage services provided, including credentialing and contracting with providers, authorizing services based on medical necessity, providing care coordination, and paying provider claims. Half of the cost of services provided to Medicaid enrollees is paid by the Commonwealth, while the other half is covered by federal funds.

A copy of the presentation can be found on the Joint Subcommittee's website at: http://dls.virginia.gov/groups/mhs/060518dmas.pdf.

Presentation: Overview of the Commonwealth's behavioral health service delivery system; Daniel Herr, Deputy Commissioner for Behavioral Health Services, Department of Behavioral Health and Developmental Services

Mr. Herr explained the elements of the public behavioral health service system operated by the Department of Behavioral Health and Developmental Services (DBHDS); types of CSBs; the relationship between CSBs, private providers, and DBHDS; financing of the public behavioral health service system; current behavioral health priorities; and challenges affecting the public behavioral health service system.

Mr. Herr began with an overview of the public behavioral health service system operated by DBHDS. The system is composed of three training centers for individuals with intellectual disability, eight adult mental health hospitals, one mental health hospital for children and adolescents, one medical center, one center for behavioral rehabilitation, 40 CSBs that have entered into performance contracts with DBHDS and that serve as the single point of entry into the publicly funded behavioral health and developmental disability service system, and 947 private providers of behavioral health and developmental disability services licensed by DBHDS. The State Board of Behavioral Health and Developmental Services works with DBHDS to promulgate public policies and regulations.

Mr. Herr then spoke about CSBs, noting that there are three types of CSBs: administration policy boards representing single jurisdictions, employees of which are local government employees; operating boards representing multiple jurisdictions, employees of which are employees of the CSB or one of its contractors; and policy-advisory boards that do not deliver services directly but rather act as advisory bodies for local government agencies providing services. CSBs are mandated by law to provide certain services, including emergency services, case management subject to availability of funds, and preadmission screening and discharge services. Beginning July 1, 2019, CSBs will be required to provide same-day access to mental health screening and referral and primary screening and referral. Beginning July 1, 2021, CSBs will be required to

provide crisis, outpatient, psychiatric rehabilitation, peer and family support, care coordination, and case management services as well as services for certain members of the armed forces and veterans. CSBs may provide additional services beyond those required by law.

DBHDS provides oversight and accountability for services delivered by CSBs, including finance and program audits, licensing of services, enforcement of human rights protections, and technical assistance and clinical reviews. Additional oversight is provided by the federal Centers for Medicare and Medicaid Services, which require CSBs to be certified to receive Medicaid payments, as well as national accrediting bodies that accredit CSB services. The relationship between DBHDS and CSBs is governed by a performance contract that is negotiated by the parties each year. The performance contract includes information about the relationship between and responsibilities of the parties, provides a mechanism for funding community services, and communicates accountability requirements.

Mr. Herr also provided information on funding of behavioral health services in the Commonwealth. He noted that in FY 2017, funding for the publicly funded behavioral health service system in the Commonwealth totaled approximately $1.86 billion. Sixty-five percent of that amount, or $1,214 million, funded CSBs, while 29 percent, or $538 million, funded state facilities. The remainder went to support DBHDS Central Office. Funds received by CSBs include a mix of state general funds ($745million, or 40.1 percent of the total), local funds ($284 million, or 15.3 percent of the total), federal grants ($87 million, or 4.7 percent of the total), fees ($666 million, or 35.9 percent of the total), and other sources ($74 million, or 4 percent of the total). State funds for the publicly funded behavioral health services provided by CSBs flow from the General Assembly to DBHDS. DBHDS program staff develop plans for services and funding and issue Requests for Proposals to CSBs. Any CSB interested in providing the service must respond with a proposal package submitted to DBHDS. Proposals are reviewed by DBHDS staff. If a proposal is approved, the program and funding agreement is added to the CSB performance contract together with reporting requirements.

Mr. Herr reported that current DBHDS Behavioral Health Priorities include continued implementation of STEP-VA, including same-day access to services and primary health care screenings; implementation of the Service Process Quality Management (SPQM) system to collect data on and measure and improve clinical outcomes of services provided by CSBs; addressing the rising number of individuals admitted to state hospitals under temporary detention orders and the substantial impact of that increase on hospital census; financial realignment of the publicly funded behavioral health service system to reduce demands for inpatient treatment and improve availability of and access to community-based services; and implementation of Medicaid expansion. Challenges to the publicly funded behavioral health service system include the need for continued funding to implement STEP-VA; the need for funding to increase access to community services to reduce the need for inpatient treatment and facilitate discharge of individuals from state hospitals to reduce overall hospital census and reduce pressures on state facilities; the need for capital improvements at existing state facilities beginning with replacement of Central State Hospital; and workforce needs.

Presentation: Role of CSBs in the Commonwealth's publicly funded behavioral health system; Jennifer Faison, Executive Director, Virginia Association of Community Services Boards

Ms. Faison noted the three types of CSBs and the impacts of the form of a CSB on everything from staffing and compensation to flexibility and services provided. Regardless of form, CSBs partner with local agencies including law enforcement, emergency medical services agencies, schools, local government, and other state agencies to provide services in the community. CSBs also provide an infrastructure for other programs, including implementation of the CCC Plus program, and participate in other service systems, including the Children's Services Act program, community criminal justice boards, and interagency coordinating councils. The performance contract process, reporting requirements for different funding streams, and licensing are ways in which CSBs are held accountable for services provided. Looking forward, implementation of the SPQM program to collect and analyze data on outcomes will inform the performance contract process.

Ms. Faison reported that in 2017, CSBs in the Commonwealth served 218,120 individuals, including individuals with private insurance coverage, Medicaid coverage, or no coverage. For individuals receiving Medicaid, the Medicaid program provides a range of services but does not cover all services. In cases in which Medicaid recipients require services not covered by Medicaid, CSBs are often the only source of services available to the recipient. Similarly, for individuals without insurance coverage, CSBs are often the only source of services available. One tool that CSBs have adopted to address service needs is regional agreements. CSBs may enter into regional agreements to provide specific services or programs. In many cases, services provided through regional agreements are high-end, low-utilization services for which regional delivery is most efficient. Regional agreements provide CSBs with flexibility and the opportunity to provide the broadest range of services in the most efficient manner.

In closing, and in response to questions from the Work Group members, Ms. Faison reported that CSBs are not currently required to provide services to individuals in jails and that only eight CSBs are providing services to individuals with serious mental illness in jails at this time. Issues influencing the ability of CSBs to provide services to individuals in jails include lack of clear expectations for CSBs providing services in jails and lack of standards for populations to be served and services to be provided. Staff noted that the Joint Commission on Health Care is currently studying this issue and that more information should be available in the fall.

Next Meeting

Members of the Work Group discussed potential agenda items for upcoming meetings, including more detailed information about CSB services, the role of the State Board of Behavioral Health and Developmental Services, behavioral health workforce needs, and private provider perspectives.