

**Joint Committee to Study Mental Health Services  
in the Commonwealth in the 21st Century  
Thursday, November 28, 2017  
Pocahontas Building  
Richmond, Virginia**

The Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century (the Joint Subcommittee) met on Thursday, November 28, 2017, at the Pocahontas Building in Richmond. Members present included Senator Deeds (chair), Delegate Bell (vice-chair), Senator Barker, Senator Cosgrove, Senator Hanger, Delegate Garrett, Delegate Ransone, and Delegate Watts.

**Update on the Work of the Farley Health Policy Center and the Department of Medical Assistance Services**

Dr. Ben Miller from the Farley Health Policy Center presented to the Joint Subcommittee on the work of the Farley Health Policy Center with the Department of Medical Assistance Services (DMAS) to advance mental health in Virginia. The presentation centered around the Medicaid-eligible population in the Commonwealth with an emphasis on the alignment and integration of the Commonwealth's mental health system, standards and accountability for the system, and multiple entry points for easy access to the system. Dr. Miller noted that Medicaid is the single largest payer in the United States for behavioral health services, including mental health and substance abuse services. Recent numbers show that Medicaid accounts for 26 percent of behavioral health spending nationally. In 2011, one in five Medicaid beneficiaries had behavioral health diagnoses but accounted for almost half of total Medicaid expenditures.

Dr. Miller and the Farley Health Policy Center analyzed Medicaid data from DMAS, the Department of Behavioral Health and Developmental Services (DBHDS), and the Department of Health. The average cost per Medicaid enrollee in Virginia was \$8,597, and there were a total of 1.37 million Medicaid recipients in Virginia during fiscal year 2017. Of those recipients, 386,305 individuals received behavioral health services.

Dr. Miller asserted that the alignment and integration of state agencies providing behavioral health and related services is paramount to a successful system in the Commonwealth, and he provided a map outlining the various regions of the Commonwealth measured by DMAS, DBHDS, and the Department of Health. Such regions are not uniform across the three agencies, which is a barrier to collecting accurate service and outcome data. Dr. Miller emphasized the importance of shared accountability and collaboration from the agencies.

Dr. Miller noted that, in fiscal year 2017, the Commonwealth spent \$ 862,339,335 on fees for behavioral health services. He further broke down such expenditures into categories of behavioral health services and noted that an increase in services provided in a certain category was not necessarily driven by patient needs or outcomes but was often driven instead by reimbursement rates. The lack of good measurements for quality of care and patient outcomes for Medicaid spending further exacerbated such problem.

Dr. Miller again stressed that a fundamental cultural change is needed in the Commonwealth to advance its behavioral health system. Such cultural change needs to be rooted in the alignment and integration of the Commonwealth's mental health system, standards and accountability measures for the system, and multiple entry points for easy access to the system.

### **Report on Financial Realignment**

Dr. Jack Barber, Interim Commissioner, DBHDS, provided an update on the financial realignment of Virginia's public behavioral health system. According to Dr. Barber, the basic intent of the financial realignment was to shift to the community service boards (CSBs) the funding that had previously gone directly to the state hospitals, so that the CSBs would pay for hospital bed days. Dr. Barber described the progress made toward implementing the financial realignment, which included implementing a community integration plan to prepare for the realignment. Some of the expected benefits of realignment are a reduction in the number of persons needing hospital-level care, a decrease in the amount of time persons wait on the extraordinary-barriers-to-discharge list, a reduction of state hospital utilization to the best practice rate of 85 percent, and the ability to avoid spending excessive amounts of money on more hospital beds, which are an impediment to building the capacity of community treatment. Dr. Barber stated that the expected timeframe to implement full realignment was four years.

### **Report on Forensic Discharge Planning**

Dr. Michael Schaefer, Assistant Commissioner, DBHDS, provided a report on forensic discharge planning. The report was mandated by Chapters 137 and 192 of the Acts of Assembly of 2017. Jail discharge planning for individuals with severe mental illness includes the screening for and assessment of psychiatric, medical, social services, employment, and residential needs as soon as possible after the individual's admission to jail. Discharge planning also includes the development of a discharge plan that prioritizes goals and objectives that reflect the assessed needs. It includes care coordination with community providers and community supervision agencies, including the exchange of treatment records, communication of treatment needs, and linkage of clients with available services and support options upon release. Traditionally, discharge planning has resulted in increased public safety measurements, improved quality of life for discharge planning participants, and a reduction in costs for jails. According to Dr. Schaefer, of those jails that responded to his survey, 75 percent reported insufficient staffing or other resources to provide a comprehensive discharge planning service. Dr. Schaefer recommended a three-phase approach to implement a comprehensive discharge planning system with jails across the Commonwealth, with the appropriate phases being implemented according to which jails have the highest percentage of severe mental illness.

### **Public Comment**

Following discussion of the recommendations, the Joint Subcommittee received two public comments, one from a psychiatric nurse on her experiences in the mental health field and the need for mental health reform in the Commonwealth and the other from a physician on the need for alternative treatments to be included in the Commonwealth's mental health reform.