JLARC
JOINT LEGISLATIVE AUDIT AND REVIEW COMMISSION

December 13, 2022

CSB Behavioral Health Services

Behavioral Health Commission Briefing

Study resolution

- Review community services boards' (CSBs) behavioral health services, including:
  - funding and staffing
  - consumer outcomes
  - services for individuals experiencing behavioral health emergencies
  - service delivery structure

Commission resolution (December 2021)

Primary research activities

- Analyzed data on consumers, services, and outcomes
- Conducted surveys of CSB executive directors and staff
- Interviewed key stakeholders in Virginia and nationally
  - CSB leadership and staff
  - staff at DBHDS, other state agencies
  - directors of state psychiatric hospitals
  - representatives of jails, private hospitals, and consumers
  - national experts
- Reviewed national research and other states' approaches

In brief

A fundamental restructuring of the CSB system is not necessary, but improvements are needed.

Compared to a decade ago, CSBs are serving more Virginians with serious mental illness, and individuals with significant impairments tend to improve their functioning while receiving CSB services.

CSBs struggle to hire and retain staff, especially for emergency and crisis services, and turnover among CSB staff is high and increasing.

In brief

CSBs recommend psychiatric hospitalization for some individuals who do not need that level or type of care, and expanding residential crisis stabilization units (RCSUs) would help reduce inappropriate state psychiatric hospitalizations.

CSBs' Medicaid funding has declined; some CSBs are not consistently billing Medicaid or receiving reimbursements from MCOs.

DBHDS does not adequately oversee the performance of CSBs.

In this presentation

Background

Behavioral health trends and CSB consumer outcomes

Staffing for CSB behavioral health services

CSB emergency services

Medicaid funding for CSB behavioral health services

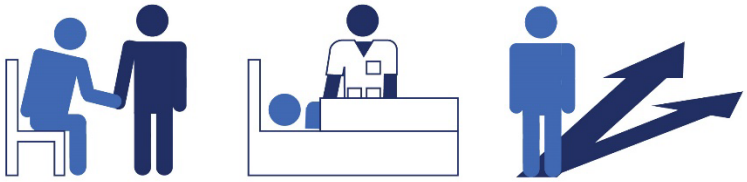
Oversight of CSB performance

CSBs are the public provider of community-based behavioral health services

- CSBs provide mental health and substance abuse services ("behavioral health services") to adults and youth with serious conditions
  - Primarily intended to serve individuals with significant functional impairments or who are at imminent risk
  - Services not restricted to individuals based on income, insurance status, or condition severity
- Private providers also deliver publicly funded services
  - 82% of Medicaid behavioral health spending in FY21 paid to private providers
  - CSBs also contract with private providers to deliver services

CSBs provide various services to Virginians with a mental illness or substance use disorder

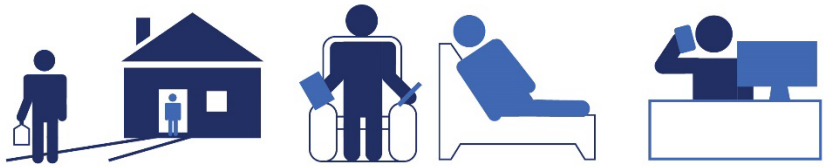
Emergency and crisis services



Support for individuals in crisis and facilitation of **state psychiatric hospital admissions** and **discharges**

- Pre-admission screenings
- Crisis intervention
- Residential crisis stabilization
- Discharge planning

Non-emergency services



Assessments, treatment, and monitoring for individuals with behavioral health conditions that significantly impair their functioning

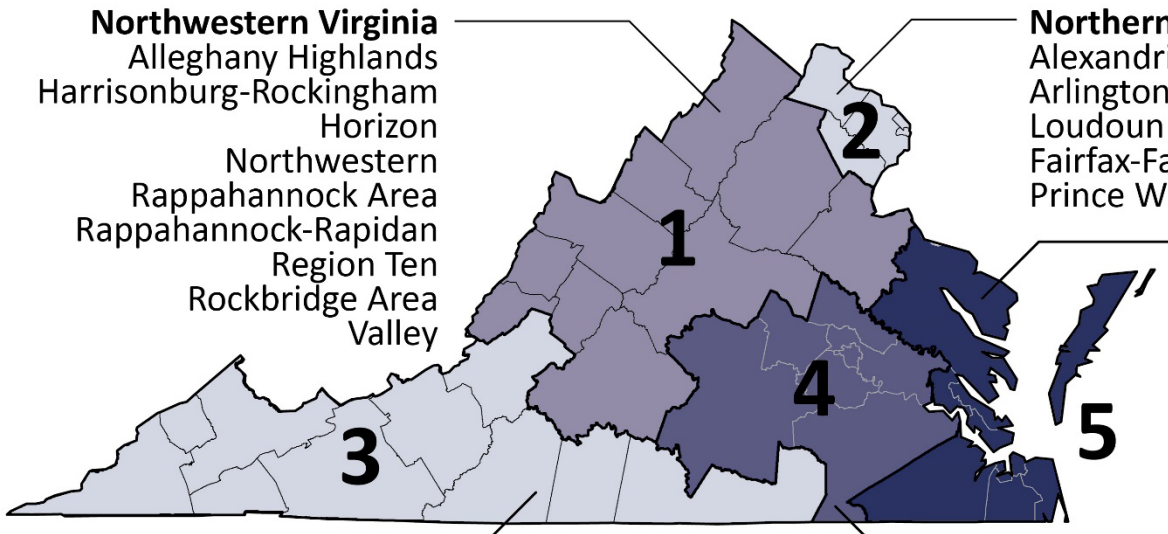
- Assessments and evaluations
- Outpatient services
- Residential treatment services
- Medical services
- Permanent supportive housing
- Case management
- Detoxification and MAT
- Day support services
- Employment services

Note: MAT = medication-assisted treatment. Some services are not provided by all CSBs.

CSBs are local entities and most are multi-jurisdictional

- State law requires every city or county to establish or join a CSB
  - Agents of local governments that established them
- Virginia currently has 40 CSBs
  - Most (29 CSBs) serve multiple localities
  - 17 serve at least four localities
- All CSBs participate in four or more regional programs with other CSBs

Virginia has 40 CSBs that are separated into five regions



Northwestern Virginia
Alleghany Highlands
Harrisonburg-Rockingham
Horizon
Northwestern
Rappahannock Area
Rappahannock-Rapidan
Region Ten
Rockbridge Area
Valley

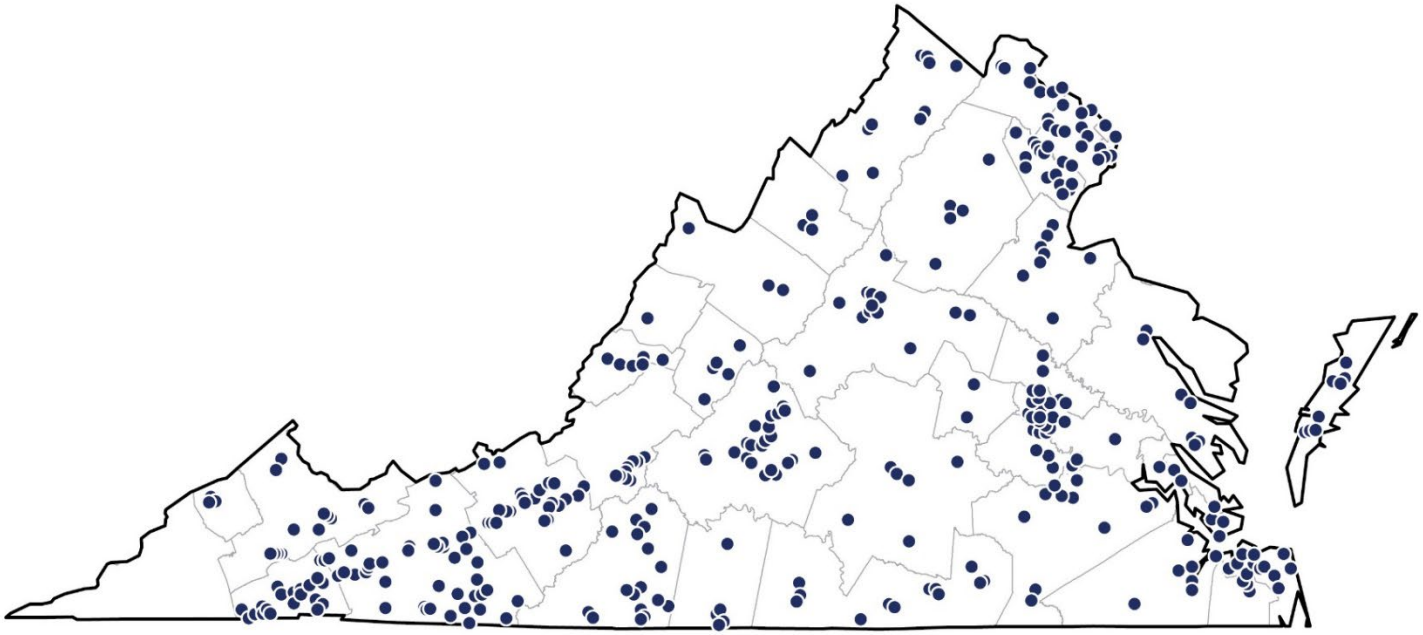
Northern Virginia
Alexandria
Arlington
Loudoun
Fairfax-Falls Church
Prince William

Eastern Virginia
Chesapeake
Colonial
Eastern Shore
Hampton-Newport News
Middle Peninsula-Northern
Neck
Norfolk
Portsmouth
Virginia Beach
Western Tidewater

Southwestern Virginia
Blue Ridge
Cumberland Mountain
Danville-Pittsylvania
Dickenson
Highlands
Mount Rogers
New River Valley
Piedmont
Planning District One
Southside

Central Virginia
Chesterfield
Crossroads
District 19
Goochland-Powhatan
Hanover
Henrico Area
Richmond

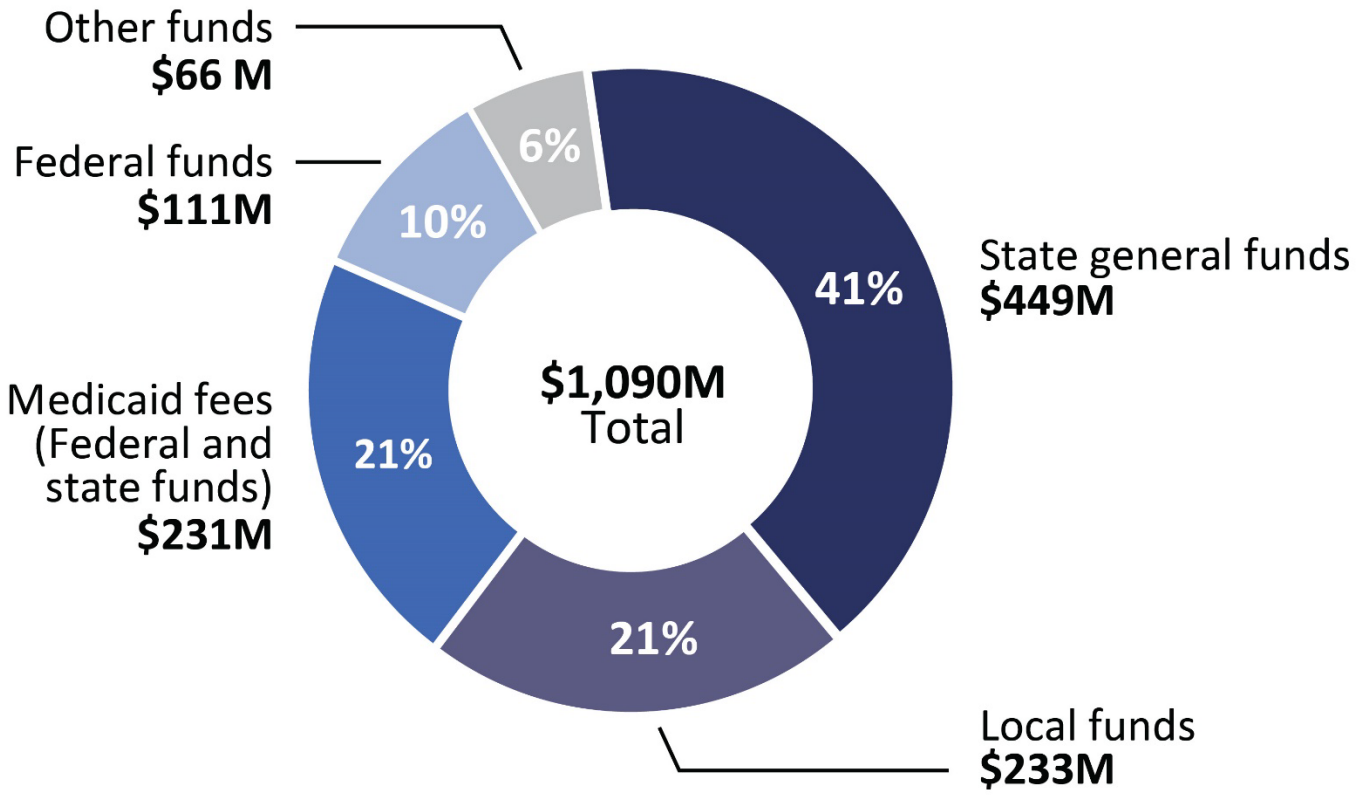
Across 40 CSBs, the number of behavioral health service locations ranges from two to 34



Licensed CSB behavioral health services locations

Note: Map includes only locations at which CSBs are licensed to provide behavioral health services. Some locations may be licensed to provide services that are not currently offered. Planning District 1 CSB (bottom-left corner) contracts with a private provider for all of its behavioral health services.

CSBs are primarily funded by state general funds, local funds, and Medicaid fees (FY22)



Note: Only includes funding for behavioral health services. CSBs also receive funding for developmental disability services. Funding for Medicaid fees comes from both federal and state funds—federal funds for Medicaid are matched by state general funds.

No compelling evidence of need to fundamentally change CSB system structure

- Different state approaches to structuring community-based behavioral health services, but VA not atypical
  - 48 states have decentralized systems that involve local governments and/or private providers, like Virginia
  - Larger states, including Virginia, tend to involve local governments in service delivery
- National experts report no structure inherently superior
- Improvements to current system would
  - help ensure system is as efficient and effective as possible
  - enable state to pursue long-term changes that some officials may view as advantageous

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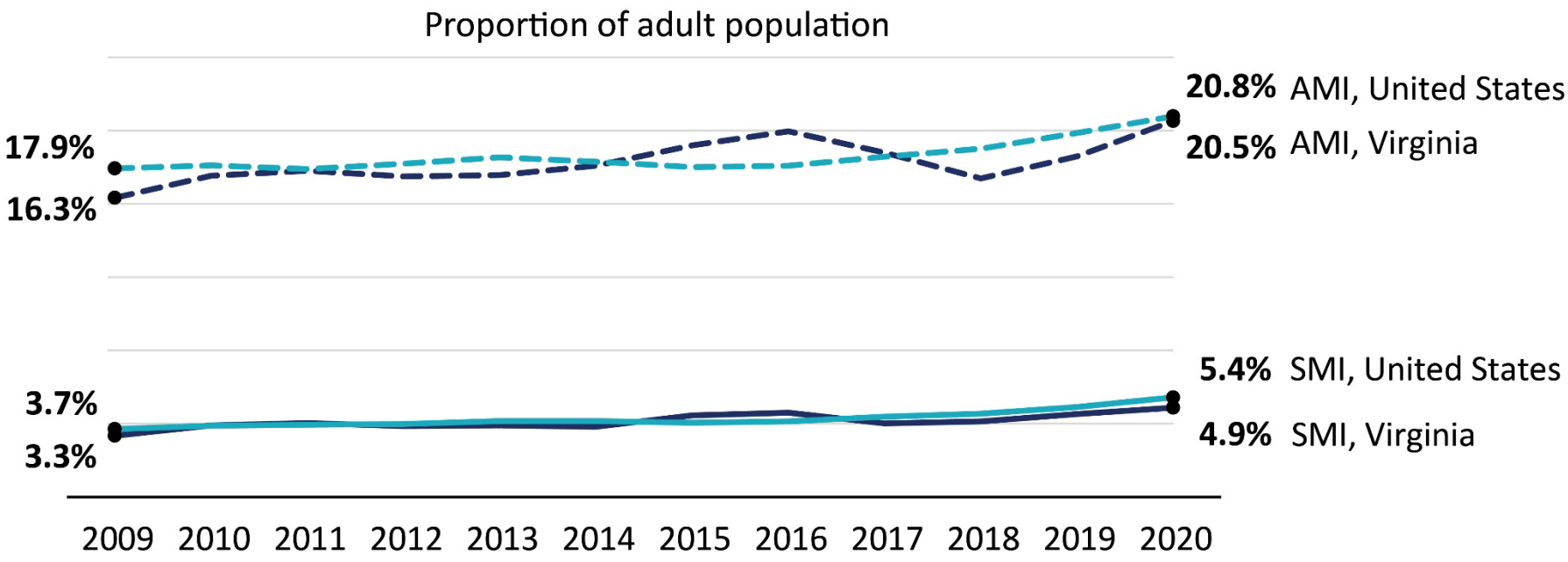
Oversight of CSB performance

CSB behavioral health services should primarily serve individuals with functional impairments

- CSBs should primarily serve individuals experiencing a mental illness or substance use disorder that significantly impairs their normal functioning
  - Conditions may affect an individual's ability to work, maintain healthy relationships, care for themselves
- When a mental illness significantly impairs an individual's functioning, it is considered a "serious mental illness"

Prevalence of mental illness is increasing in Virginia and nationally



AMI = “any mental illness”; SMI = “serious mental illness” (i.e., that significantly impairs functioning)

CSBs serving more consumers with a serious mental illness than they were a decade ago

- In FY22, CSBs served 20% more individuals with a serious mental illness than in FY12
- At most CSBs, consumers with a serious mental illness represent the majority of recipients of mental health services
- Individuals with serious mental illness generally require more intensive and longer lasting services

Finding

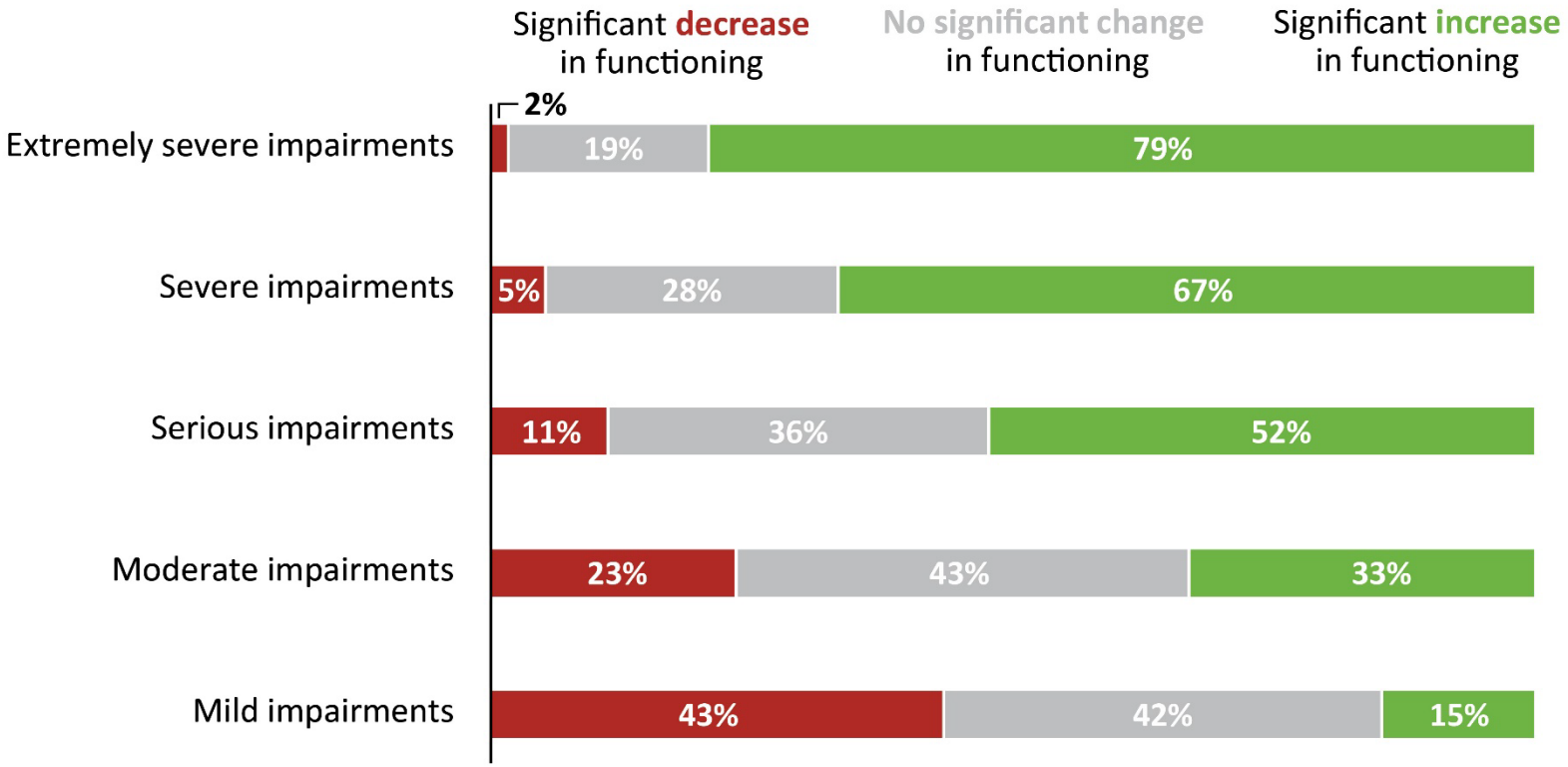
CSB consumers with the most severe impairments typically improve their functioning while receiving CSB behavioral health services.

DLA-20 measures consumers' level of functional impairment

Level of impairment	Problems present…	Problems disrupt a person's life…	% of CSB consumers (FY19 to FY22)
Extremely severe impairments	Almost all of the time	Every day	0.4%
Severe impairments	Most of the time	Most days	6%
Serious impairments	At least half of the time	Frequently	25%
Moderate impairments	Less than half the time	Occasionally	40%
Mild impairments	A little of the time	Rarely	25%
No significant impairments			6%

Majority of CSB consumers with most impaired functioning improved while receiving services

After at least six months, proportion of CSB consumers in each functioning group experiencing…



A significant change in functioning is a score change ±0.4 points. Figure excludes about 6% of CSB consumers who had no significant impairments when their first DLA-20 assessment was completed.

Recommendation

The General Assembly may wish to consider requiring DBHDS to report annually on CSB performance in improving consumer functioning levels to the State Board of Behavioral Health and Developmental Services and to the Behavioral Health Commission.

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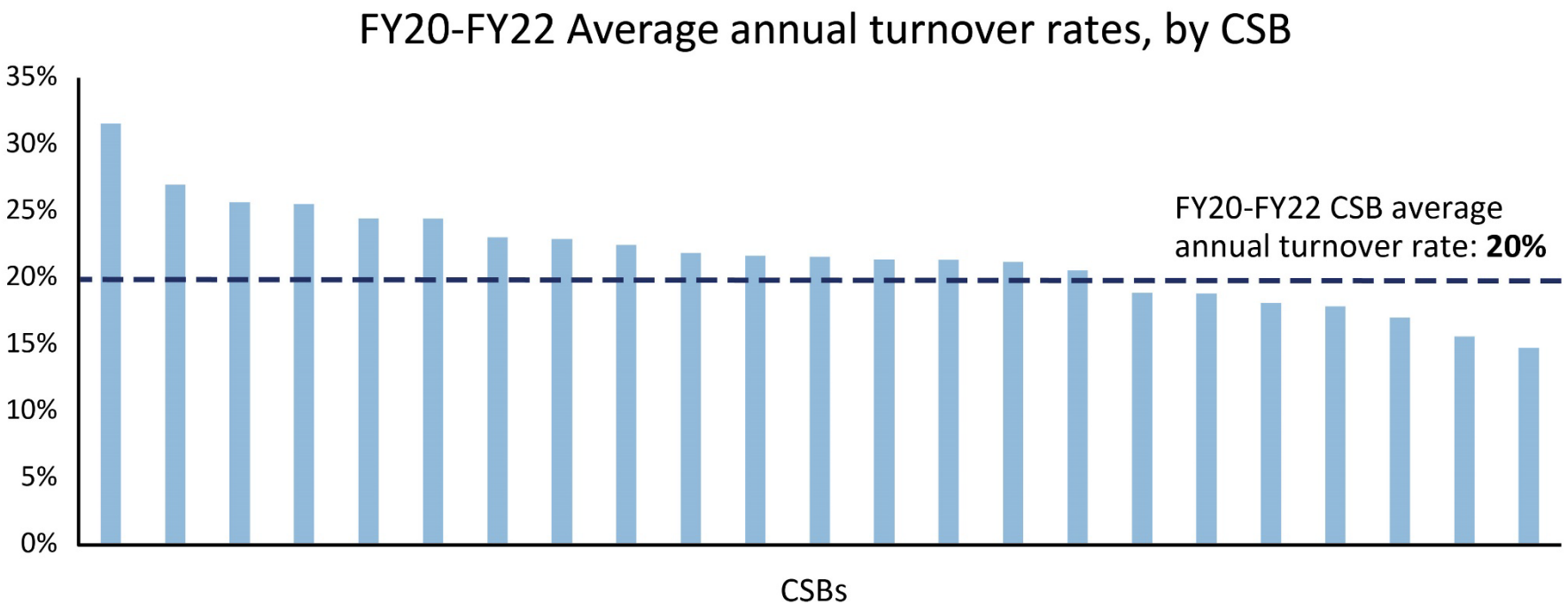
Finding

Turnover among CSB behavioral health staff is high and increasing, and CSBs struggle to hire new staff.

CSBs struggle to retain and hire staff, especially for emergency and crisis services

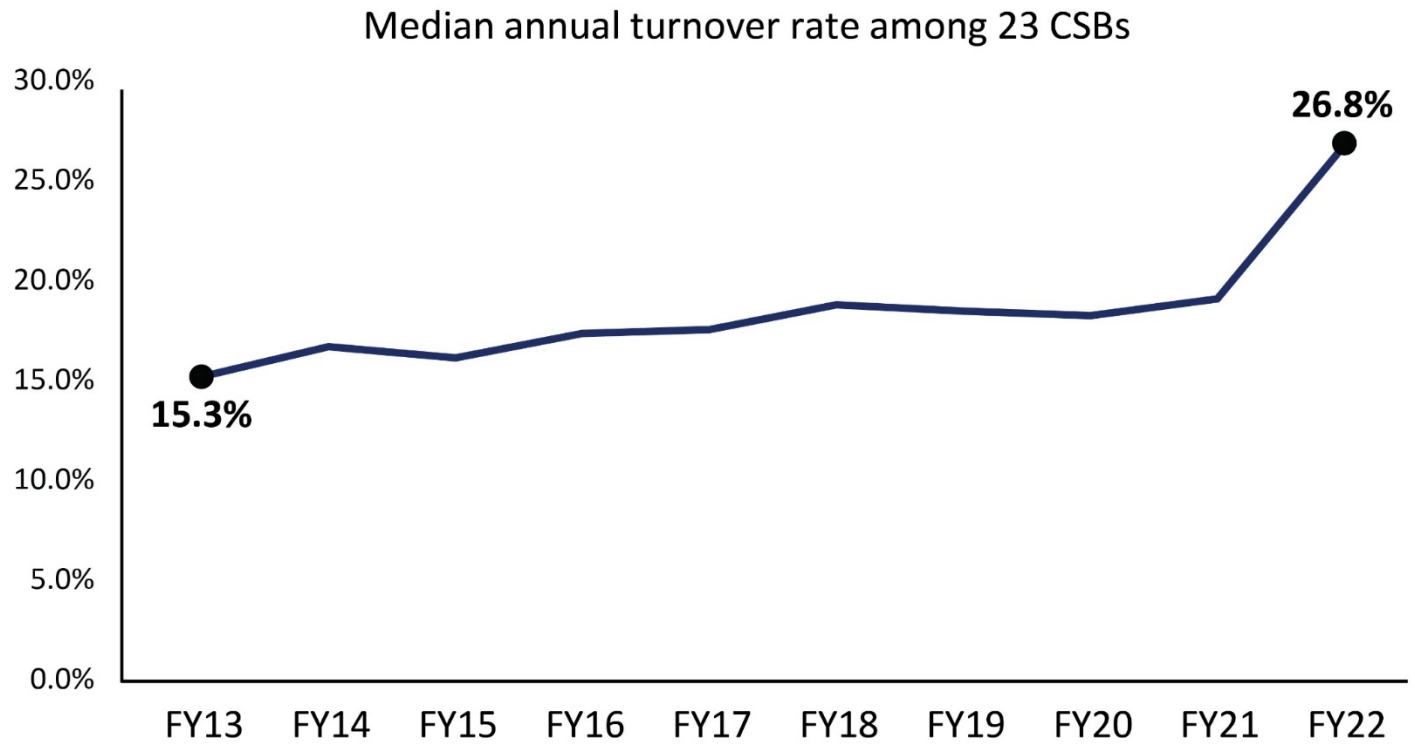
- 19 of 40 CSB directors reported substantial difficulty retaining qualified behavioral health staff during past 12 months
  - Emergency and crisis services positions most difficult types of positions to keep filled
- In survey, 91 of 283 CSB emergency services staff (32%) reported they were considering leaving in next 12 months
- 90% of CSBs directors (36 of 40) also reported substantial challenges recruiting qualified staff

At least 16 CSBs have lost an average of 20 to 30 percent of staff per year recently



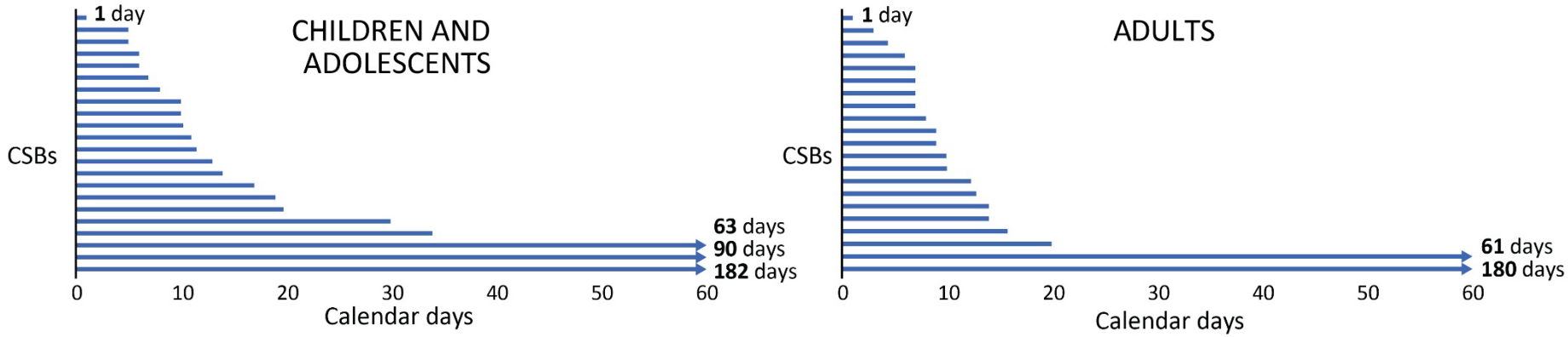
Note: Turnover rates include all full-time staff at 23 CSBs for which data is available.

Turnover rates among CSB staff have increased over the past decade



Note: Annual turnover rates include all full-time staff at 23 CSBs for which data is available. Data is different than previous slide because turnover rates are aggregated and only reflective of one fiscal year.

Example: Average wait times for mental health individual outpatient therapy among CSBs



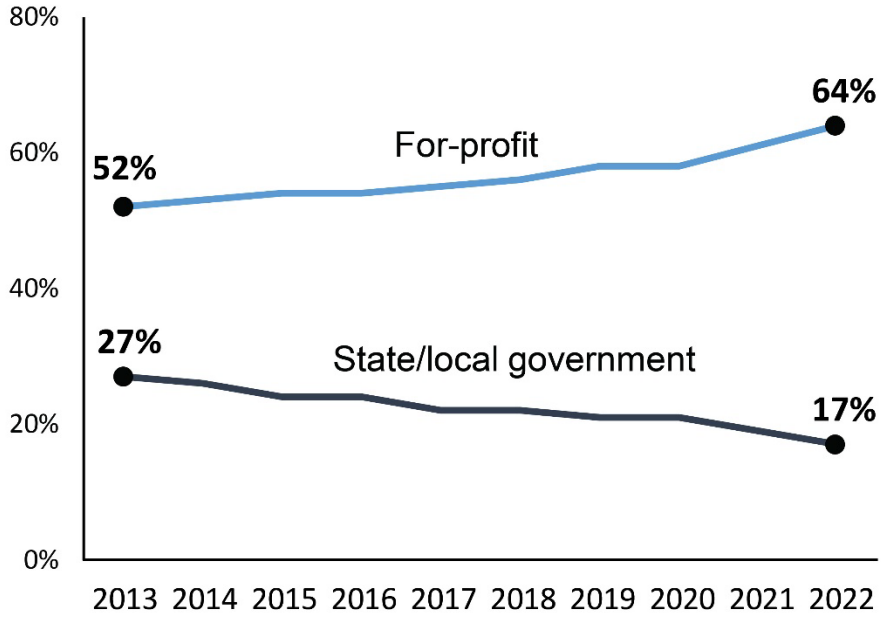
Note: Figure shows average days between referral for service and first offered appointment among consumers referred in June 2022. Includes only CSBs that maintain wait times information for mental health outpatient therapy and responded to a JLARC data request. Wait times for other services shown on page 31 of report.

Finding

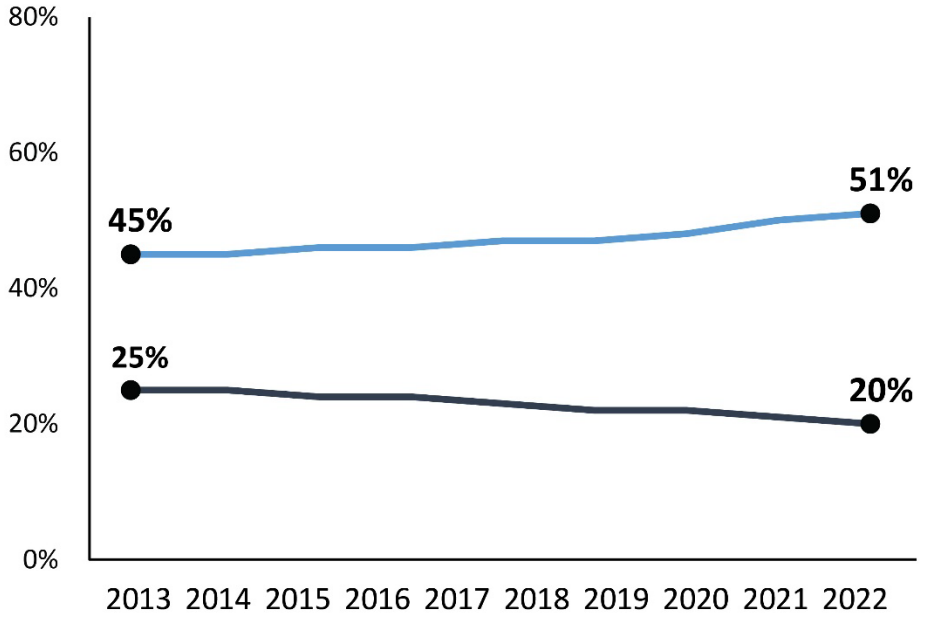
Uncompetitive salaries are a key reason for CSB staffing challenges.

CSBs increasingly compete with private sector to recruit and retain qualified staff

Share of Virginia LPCs working in each sector



Share of Virginia LCSWs working in each sector



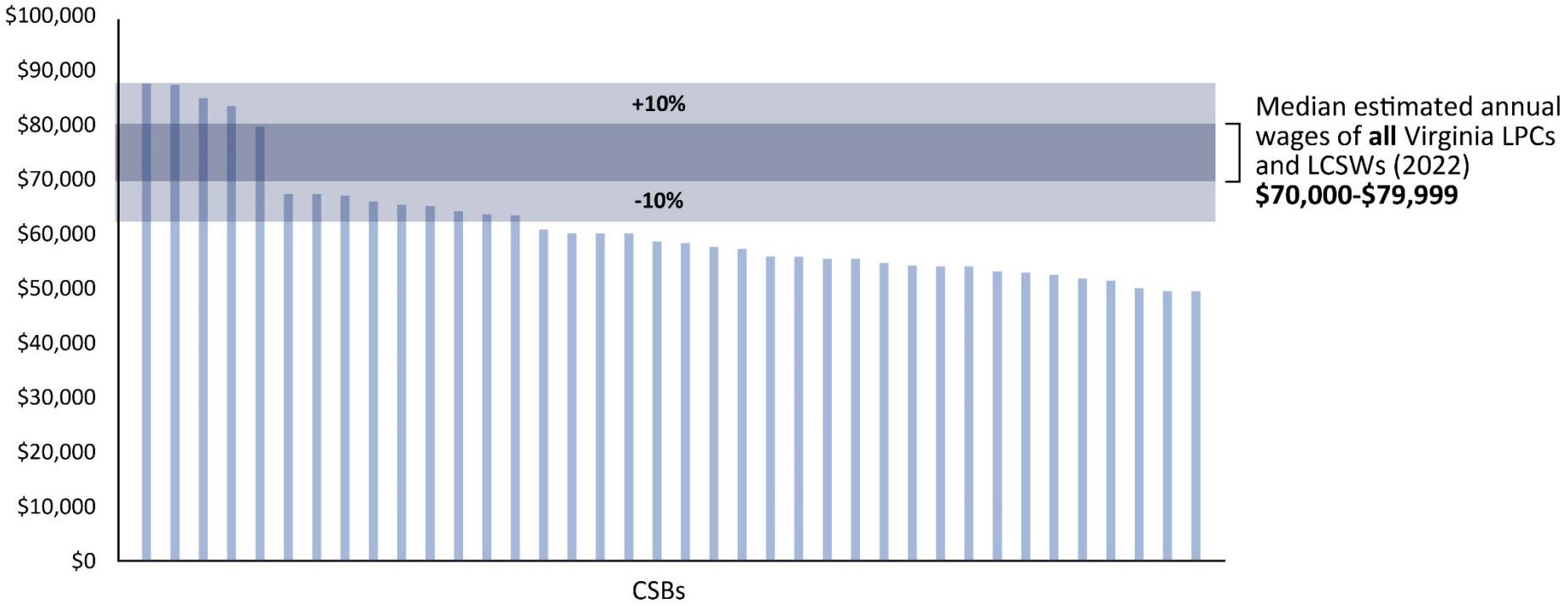
Note: LPCs = licensed professional counselors, LCSWs = licensed clinical social workers. Figures do not sum to 100 because not all types of establishments are shown, including nonprofit entities and the federal government.

CSB executive directors and staff report compensation as a top reason for staff turnover

- 58% of CSB executive directors reported “higher pay offered by private providers” as top reason for retention challenges
- 59% of CSB emergency services staff who were considering leaving their job were planning to leave because “other employers offered better compensation”

Majority of CSBs pay licensed behavioral health clinicians less than competitive salaries

Average annual wages of CSB licensed clinicians, counselors, and therapists (e.g., LCSWs and LPCs) (as of March 2022)



Note: There is no statutory or policy guidance about what Virginia considers "comparable" compensation, but JLARC staff considered between 90 percent and 110 percent of the market median to be a competitive range.

Recommendations

The General Assembly may wish to consider

- including funding in the Appropriation Act for a salary increase for direct care staff at CSBs; and
- requiring DBHDS to report annually on turnover, vacancy rates, and salaries across CSBs to monitor workforce challenges.

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State oversight of CSB performance

CSB emergency services staff play critical role in state psychiatric hospital utilization

- CSBs required to evaluate whether individuals who may be experiencing a behavioral health crisis need to be admitted to an inpatient psychiatric facility
  - Called a “preadmission screening”
  - Can recommend temporary detention order (TDO) for individuals unwilling or unable to be admitted voluntarily
- CSBs also required to find appropriate facility for individuals who need inpatient treatment

State psychiatric hospitals operating at or near capacity

- Reduced capacity and high demand for state psychiatric hospital beds contributing to waitlists
  - Daily average of 33 adults, 10 children were on state hospital waitlist between Sep 2021 and July 2022
- Individuals being detained in emergency departments for long periods without receiving needed psychiatric treatment
- Individuals being released from emergency departments without receiving psychiatric treatment, despite recently being determined to be a threat to themselves or others

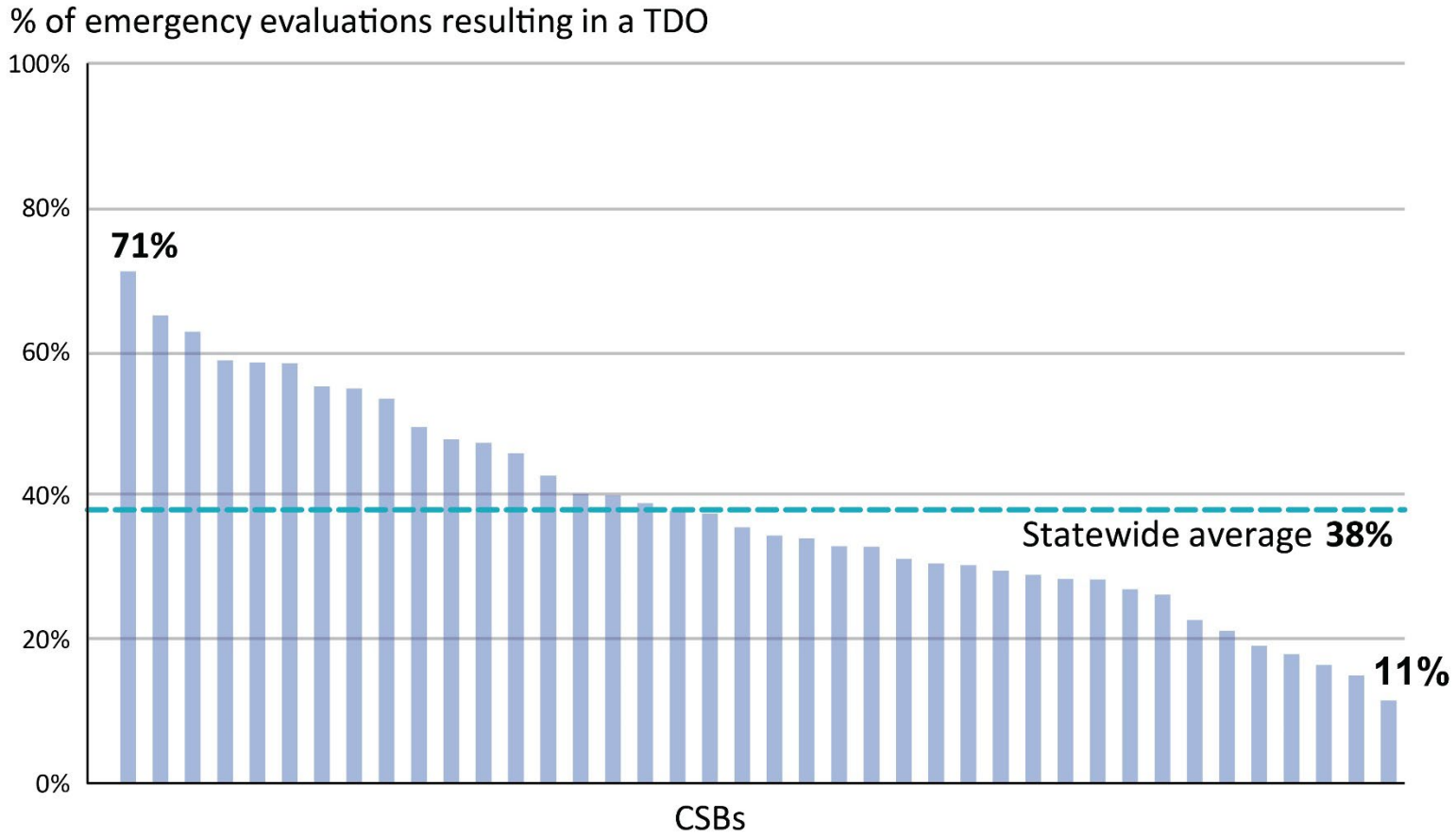
Finding

CSBs recommend state hospital TDO admissions for some individuals who do not need that level or type of care.

Some individuals in state psychiatric hospitals would be better served elsewhere

- State hospital staff estimated that 20% to 50% of their civil TDO admissions did not need to be at their facility
- Among surveyed CSB emergency services staff:
  - 21% estimated that at least half of the adults they recommended for psychiatric hospitalization would have been better served in a less restrictive setting
  - 36% estimated that at least half of the children and adolescents they recommended for psychiatric hospitalization would have been better served elsewhere
- Very short stays by many patients also indicate lower level of psychiatric care would be more appropriate

TDO rates variation indicates inconsistencies in screening practices and TDO recommendations



Note: Includes only civil TDOs and excludes forensic TDOs.

Gaps in training for CSB staff likely contribute to some inappropriate hospitalizations

- 40% of surveyed CSB preadmission screening clinicians felt that additional training would be beneficial. Clinicians most commonly reported a need for more training on:
  - developing recommendations for consumer services and placements;
  - understanding basic medical conditions
  - interpreting lab results
- 33% of surveyed clinicians reported not receiving formal training on preadmission screening within the last three years

DBHDS oversight of CSB emergency services insufficient to ensure effective screenings

- DBHDS has access to some information needed to conduct targeted oversight
  - Preadmission screening forms for individuals placed at state psychiatric hospitals
  - Data on emergency services activities (e.g., # of evaluations and TDOs executed by CSB)
- Lacks formal process to effectively monitor CSBs' preadmission screening activities and recommendations
- Initiated additional oversight activities in July 2022, but process still under development

Finding

A lack of alternative placements contributes to inappropriate state hospital TDO admissions.

CSB crisis services include assessment, non-residential treatment, and residential treatment

- CSB crisis services vary and may include
  - crisis intervention team assessment centers (CITACS) (assessments)
  - mobile crisis services (assessments/basic treatment)
  - 23-hour crisis stabilization services (non-residential observation and treatment)
  - Residential crisis stabilization units (RCSUs) (residential treatment)
- Between FY12 and FY22, most new state funding for CSB crisis services was for CITACs and mobile crisis

RCSUs would more directly help alleviate state hospital admissions than other crisis services

- RCSUs can be equipped to provide short-term residential psychiatric treatment for individuals under a civil TDO
  - Can also provide “step-down” option from state hospitals
- Virginia likely needs roughly twice as many RCSU beds as currently available
  - Most needed for children and adolescents and in Southside
  - Some RCSUs not operational or under capacity because of CSB staffing challenges
- Estimated state costs to establish a RCSU: $2M to $5M
- Stays in RCSUs may be paid for through Medicaid

Recommendations

The General Assembly may wish to consider including funding in the Appropriation Act to

- help CSBs hire additional staff for RCSUs whose bed capacity is not fully utilized because of a lack of staff; and
- support the development and ongoing operations of additional RCSUs for children and adolescents and for underserved areas of the state.

Finding

State's psychiatric bed registry wastes limited time and staff resources.

Current bed search process is unnecessarily cumbersome

- DBHDS's bed registry is intended to help improve the efficiency of the bed search process but lacks real-time, useful information about the psychiatric beds available
  - No improvement over prior process
  - CSB staff still call and fax individual hospitals directly
- 92% of surveyed CSB emergency services staff reported the bed registry was not at all useful or not being used as part of their bed search process
- Current process wastes limited time and staff resources, which could be deployed for other purposes

Other state models would improve the efficiency and transparency of bed search process

- At least nine other states have developed electronic referral systems that allow
  - authorized users to submit HIPAA-compliant electronic referrals to facilities; and
  - facilities to respond to referrals directly through the portal
- Other systems allow for monitoring of which facilities are responding in a timely manner and accepting patients
- In near term, state should contract for system to securely upload documents to inpatient facilities and suspend requirement that the bed registry be used

Recommendations

DBHDS should contract with a vendor to implement a secure online portal for CSBs to upload and share patient documents with inpatient psychiatric facilities.

The General Assembly may wish to consider repealing the requirement for participation in the bed registry.

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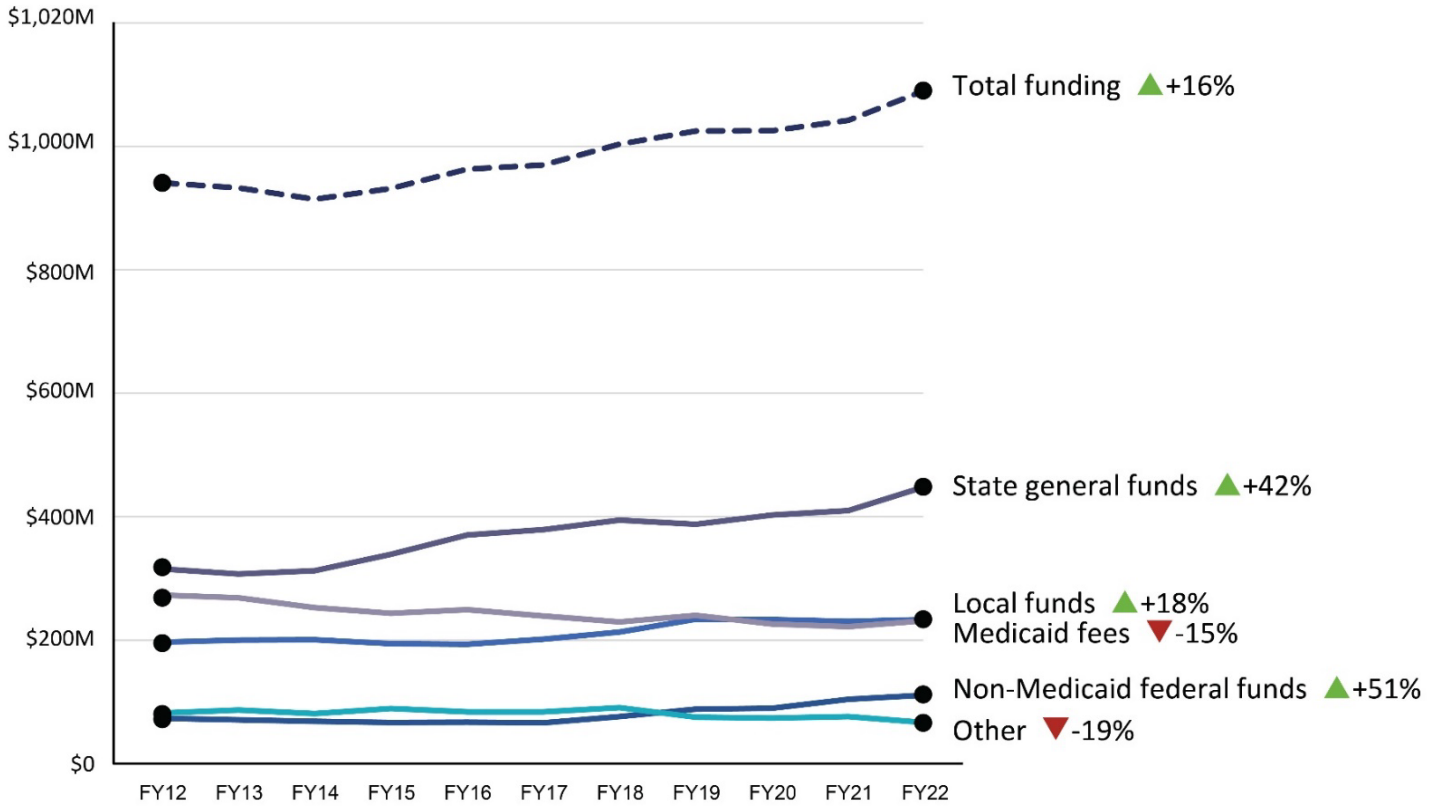
State oversight of CSB performance

State and local funding for the CSB system has increased, but Medicaid funding has decreased



Note: Figure is adjusted for inflation using Medical CPI and includes funding for behavioral health services only. Funding for Medicaid fees comes from both federal and state funds—federal funds for Medicaid are matched by state general funds.

Declines in Medicaid funding are counter to state expectations and CSB consumer trends

- When Medicaid eligibility was expanded in 2019, state assumed CSBs would receive more Medicaid funding
  - State general funds to CSBs were reduced
- % of CSB consumers enrolled in Medicaid has increased, consistent with predictions, but Medicaid funding for CSB behavioral health services has declined
  - 25 of 40 CSBs received less Medicaid funding in FY22 than in FY12
  - 21 of 40 CSBs provided behavioral health services to more Medicaid-enrolled consumers and received less Medicaid funding in FY22 than in FY12

Finding

Not all CSBs are maximizing collection of Medicaid reimbursements, and challenges working with managed care organizations contribute to Medicaid collection issues.

CSBs are required to maximize Medicaid reimbursements, but some are not

- CSBs are expected to maximize their collection of payments for Medicaid-eligible services
  - Expectation in Appropriation Act and performance contracts
  - When a CSB does not collect Medicaid payments for eligible services, other funds, including non-Medicaid state general funds, must be used to cover the costs
- Two factors that contribute to CSBs' inability to maximize collection of Medicaid payments are
  - CSBs not billing <u>at all</u> for some Medicaid-eligible services
  - CSBs not <u>successfully</u> billing for Medicaid-eligible services

CSBs are not consistently billing for all Medicaid-eligible services

- Some CSBs report 10 times as much Medicaid funding per Medicaid enrollee as others, suggesting inconsistent billing practices
- Some CSBs are opting to not bill Medicaid because of the complexity
- DBHDS does not monitor whether CSBs are billing consistently and using state general funds as last resort
- JLARC report on CSB funding (2019) identified this problem and recommended DBHDS take steps to improve CSBs' billing

Recommendation

The General Assembly may wish to consider directing DBHDS to work with the Department of Medical Assistance Services to develop and implement a process to ensure CSBs are billing for all Medicaid-eligible behavioral health services they provide.

CSBs report challenges receiving timely and accurate payments for Medicaid-eligible services

- Previous DBHDS reports to the General Assembly found large differences between CSB billings and collections
- CSBs attribute issues to increased complexity associated with integrating behavioral health services into Medicaid managed care contracts
  - Must work with six managed care organizations (MCOs)
- Reported issues include
  - delays in approving providers to bill for services and
  - differences in authorization and billing requirements and processes

State should standardize MCO processes and requirements as much as possible

- Some variation across MCOs will exist, but standardizing processes and requirements would improve the effectiveness and efficiency of CSBs' Medicaid collection
- Other states have taken steps to align requirements across MCOs
  - Example: Centralized provider credentialing programs in Mississippi, North Carolina, and Ohio
- Would also help reduce administrative burden of CSB direct care staff

Recommendation

The General Assembly may wish to include language in the Appropriation Act directing the Department of Medical Assistance Services to (i) work with the MCOs to standardize, to the maximum extent practicable, policies, procedures, and requirements that CSBs must follow to receive reimbursement for the cost of services they provide and (ii) report on improvements made to MCO policies, procedures, and requirements to the Behavioral Health Commission.

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State oversight of CSB performance

State oversight of CSB performance and service quality has been insufficient

- Numerous prior studies have found that the CSB system has not been held accountable for effective and efficient services that deliver positive outcomes for consumers
- Creating accountability through state oversight is generally more challenging in state-supervised, locally administered systems
- Accountability particularly difficult without
  - clear direction/expectations
  - relevant and actionable information on performance
  - effective accountability mechanisms

Finding

CSB system lacks clear performance expectations and effective accountability.

State has not established clear purpose or goals for CSBs

- State law does not articulate a clear purpose for the behavioral health services delivered through CSBs
  - Current expectations are too general to effectively guide policymaking, funding decisions, or oversight of CSBs
  - CSBs left to implement numerous and evolving state initiatives without an overarching statement of purpose or broader goals to guide them
  - Clear purpose in state law would provide stability and framework for accountability
- Other states have more explicit purpose of their community behavioral health systems

Note: Example purpose, goals, and objectives provided in the report.

Recommendation

The General Assembly may wish to consider

- articulating the purpose of CSBs services within the state's system of community-based behavioral health services and
- requiring the DHBDS to develop clear goals and objectives for CSBs that align with and advance the articulated purpose, and include them in the performance contracts.

Finding

Oversight of CSB performance is hindered by inadequate performance contracts and data systems.

DBHDS's performance contracts are inadequate for holding CSBs accountable

- State law requires DBHDS to enter into a performance contract with each CSB to receive state funding
- Contracts contain performance measures, but few are useful
- DBHDS currently revising performance contracts but primarily to streamline parts of it
- Comprehensive re-evaluation by DBHDS of contracts is necessary, including improvements to performance measures

DBHDS data systems undermine performance monitoring and add administrative burdens

- Behavioral health data systems operated by DBHDS and CSBs are not compatible
  - Complicates reporting and data analysis and creates issues with data reliability and validity
  - Adds to administrative burden of direct care staff
- Currently, each CSB submits data to DBHDS through at least 10 different data systems
- DBHDS implementing new data exchange system to simplify reporting, improve data quality and timeliness
  - Initiative is very complex and warrants ongoing monitoring

DBHDS will need to devote more attention to CSB performance

- State law currently allows, but does not require, DBHDS to conduct ongoing performance monitoring
- Until recently, only one staff position was devoted full time to managing performance contracts for all 40 CSBs
- Previous state-level reports dating back to the 1970s have also identified significant gaps in DBHDS's monitoring efforts
- Enforcement measures rarely used including when instances of substantial non-compliance are known

Recommendation

The General Assembly may wish to consider

- requiring DBHDS to conduct ongoing monitoring of CSB performance and
- directing DBHDS to develop and implement clear and comprehensive requirements and processes for monitoring CSB performance.

Key findings

A fundamental restructuring of the CSB system is not necessary, but improvements are needed

Compared to a decade ago, CSBs are serving more Virginians with serious mental illness, and individuals with significant impairments tend to improve their functioning while receiving CSB services.

CSBs struggle to hire and retain staff, especially for emergency and crisis services, and turnover among CSB staff is high and increasing.

Key findings (continued)

CSBs recommend psychiatric hospitalization for some individuals who do not need that level or type of care, and expanding residential crisis stabilization units (RCSUs) would help reduce inappropriate state psychiatric hospitalizations.

CSBs' Medicaid funding has declined; some CSBs are not consistently billing Medicaid or receiving reimbursements from MCOs.

DBHDS does not adequately oversee the performance of CSBs.

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