Commonwealth of Virginia
June 17, 2019

Report to the Governor and the General Assembly of Virginia

CSB Funding

2019

COMMISSION DRAFT

JLARC
JOINT LEGISLATIVE AUDIT AND REVIEW COMMISSION

JLARC Report 520
jlarc.virginia.gov

Commission Draft

This document is an exposure draft of the JLARC report, *CSB Funding*. This draft has been assembled for discussion and factual review. Do not publish or release any material contained in this document because it is subject to additional verification and editorial review.

Joint Legislative Audit and Review Commission
June 17, 2019

Contents

Summary: CSB Funding

WHAT WE FOUND

Clear policy goals should be established before adopting a new CSB funding model

DBHDS allocates most of the $356 million in discretionary funding to CSBs based on what CSBs received in previous years. This approach provides CSBs with budget stability but limits the state's ability to target resources to the needs of each community.

In contrast to DBHDS, other states' behavioral health systems and programs in Virginia use funding models designed to support specific goals. They use a combination of funding formulas, reimbursement models, and grants to identify service needs and allocate funding. Some of these models could be appropriate to support a consistent array of services across CSBs, while others could better enable CSBs to develop services that meet their communities' distinct needs. If a new funding model is adopted, Virginia should first identify its goals for the availability of services and then develop a funding model to support those goals.

WHY WE DID THIS STUDY

In 2018, the Joint Subcommittee on Mental Health Services in the Twenty-First Century requested that Joint Legislative Audit and Review Commission (JLARC) staff review the funding allocations to Virginia's community services boards (CSBs). The request directed JLARC staff to review current funding allocations to CSBs and alternative allocation methods used in other states and Virginia programs.

ABOUT CSB FUNDING ALLOCATIONS

Virginia's 40 CSBs are the public safety net provider for community-based mental health, substance use disorder, and developmental services, serving primarily indigent and Medicaid populations. Total CSB funding for all services was $1.28 billion in FY18. The Department of Behavioral Health and Developmental Services is responsible for distributing all non-Medicaid state and federal funds, which accounts for $420 million of total CSB funding.

Characteristics of funding models

	Alignment with need	Ease of implementation	Transparency	Budget stability
Funding formula	Medium	High	High	High
Reimbursement model	High	Low	High	Low
Grants	Medium	Medium	Low	Medium

SOURCE: JLARC analysis of interviews with staff from other state behavioral health systems and other programs in Virginia.

Virginia could better consider other funding sources when allocating CSB funding

Regardless of the funding model, Virginia can take steps to ensure that state funds are the "payment of last resort" by maximizing Medicaid revenue. DBHDS does not currently consider Medicaid revenue in determining how most state funds are allocated, even though Medicaid is the largest payer for CSB services in Virginia. Ensuring that

CSBs are maximizing Medicaid revenue and using that revenue to inform state funding allocations will help the state target general funds most effectively.

Accounting for local ability to pay would also help ensure state funds are the "payment of last resort" and that community needs are met. Local funding is the third-largest source of revenue for CSBs, but local match requirements do not account for local ability to pay. Basing local match requirements or state funding allocations on local ability to pay would reduce the financial burden on some CSB and local government budgets, while increasing the demand on others.

Changes to CSB funding allocations, whether a major shift in strategy or a change in how other funding sources are accounted for, should reflect the state's goals and be established with buy-in from stakeholders. Once an approach is established, increasing total appropriations to avoid reducing funding to any CSBs, or gradually phasing in the change, would mitigate the impact on CSB budgets and operations. The funding formula or reimbursement rates would also need to be updated regularly so that they continue to account for changing needs across the Commonwealth.

WHAT WE RECOMMEND

Legislative action

- Consider establishing goals for state funding allocations to CSBs that can direct the potential adoption of new funding models.

Executive action

- DBHDS should develop a method to account for Medicaid reimbursements to CSBs when allocating state funds to CSBs.
- DBHDS, in collaboration with the Department of Medical Assistance Services, should take steps to ensure that CSBs are maximizing Medicaid reimbursements for eligible consumers.

The complete list of recommendations and options is available on page iii.

Recommendations: CSB Funding

RECOMMENDATION 1

The Department of Behavioral Health and Developmental Services should develop a method to factor in the revenue that each community services board (CSB) should be able to collect through Medicaid and private insurance reimbursements when determining allocations of non-Medicaid state and federal funds to CSBs so that such funds can only be used to pay for services not fully reimbursed by Medicaid. (Chapter 3)

RECOMMENDATION 2

The Department of Behavioral Health and Developmental Services should work with the Department of Medical Assistance Services and the community services boards (CSBs) to analyze if CSBs are maximizing their Medicaid reimbursement for services, and if not, put processes in place to ensure CSBs are maximizing their Medicaid reimbursements. (Chapter 3)

OPTION 1

The General Assembly could consider including language in the Appropriation Act (i) establishing specific objectives for the extent to which funding that the Department of Behavioral Health and Developmental Services (DBHDS) allocates to community services boards (CSBs) should support consistent services statewide versus services that address each community's needs and (ii) directing DBHDS, in collaboration with the CSBs, to develop and submit a proposed funding allocation strategy to meet these objectives to the Joint Subcommittee on Mental Health Services in the Twenty-First Century. (Chapter 2)

1 Overview of CSB funding

In 2018, the Joint Subcommittee on Mental Health Services in the Twenty-First Century requested that Joint Legislative Audit and Review Commission (JLARC) staff review the funding allocations to Virginia's community services boards (CSBs). The request asked JLARC to research how state and federal pass-through funding is currently allocated and identify potential alternative approaches (Appendix A). JLARC staff analyzed data on CSB funding, interviewed staff from other states' behavioral health systems and Virginia programs, and reviewed documentation of alternative allocation methods. (See Appendix B for additional information on the research methods.)

CSB funding is complex and comes from various sources

There are 40 CSBs across Virginia that administer behavioral health and developmental services (sidebar). CSBs serve as the safety net provider for behavioral health services and are the points of entry for publicly funded developmental services. CSBs provide a variety of services based on their local needs and available funding. Some services, such as crisis intervention, are provided through regional collaborations. CSBs served nearly 220,000 consumers statewide in FY18, with about 128,000, or 58 percent, of these consumers covered by Medicaid. Most of the remaining consumers were uninsured.

Behavioral health services include mental health and substance use disorder services.

Developmental services support individuals with developmental disabilities to increase their independence.

CSBs' funding and operations are complex. CSBs serve two distinct populations (individuals needing behavioral health and developmental services) and receive funding from various sources—Medicaid, non-Medicaid state and federal funds, and localities—with different requirements attached to each of those funds. Each CSB serves between one to 10 localities that include a mix of urban, suburban, and rural communities, which affects operational costs. In addition, there are currently multiple initiatives that could change CSB funding and operations, including STEP-VA, Medicaid expansion, the expansion of community developmental services under a settlement with the U.S. Department of Justice, and a redesign of Medicaid behavioral health services.

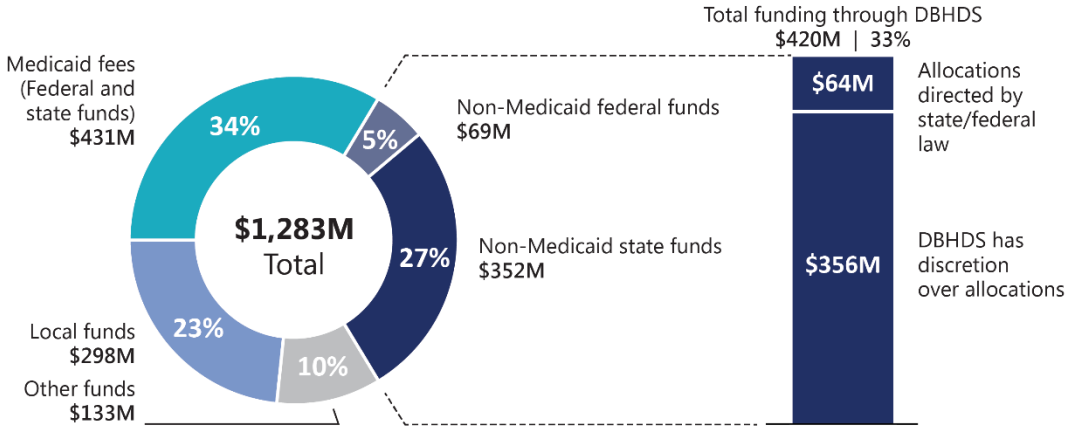
CSBs received a total of $1.28 billion in FY18, with Medicaid fees, state general funds, and local contributions making up the majority of funding. Funding is further divided into 131 unique budget lines that are used to track the sources and purposes of funding. (See Appendix C for a catalogue of all CSB funding sources.)

Of all funding received by CSBs, about one-third is distributed by DBHDS, including all non-Medicaid state and federal funds. DBHDS has discretion over most of this

funding, with the remaining funds being distributed according to state and federal laws. DBHDS allocates a majority directly to CSBs, with the remainder going to regional CSB leads who determine how to allocate funds within their respective regions (Figure 1-1).

DBHDS does not allocate the remaining two-thirds of CSB funding, which mostly is made up of Medicaid fees and local funding. Medicaid fees and local funding vary significantly among CSBs. CSBs with larger Medicaid-eligible populations are able to bill Medicaid for more services. Additionally, localities' ability and willingness to contribute funds vary. Local contributions range dramatically, making up between 2 percent and 87 percent of total state and local funding.

FIGURE 1-1
About one-third of CSB funding is allocated by DBHDS (FY18)



SOURCE: JLARC analysis of CSB funding data collected by DBHDS.
NOTE: Total state funding to CSBs was an estimated $567.5 million, including Medicaid and non-Medicaid general funds. Virginia typically pays for half the cost of Medicaid services, but services for Medicaid expansion recipients will be paid entirely with non-general funds. The majority of non-Medicaid state funding is allocated to mental health services ($256 million). About $51 million is used for substance use disorder services and $46 million for developmental disability services. Other funds include services fees and private insurance payments.

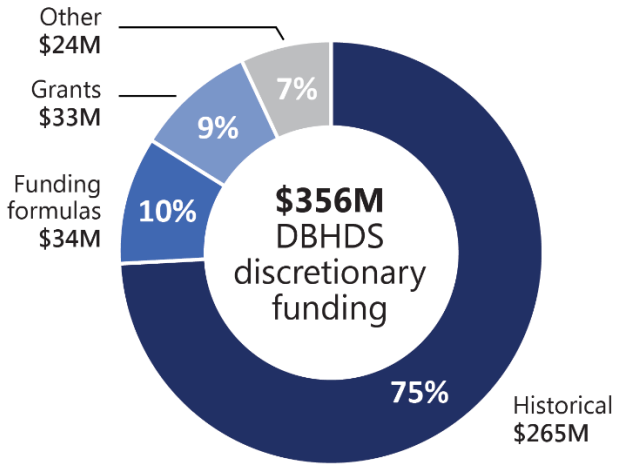
DBHDS distributes most CSB funding based on historical allocations rather than current needs

DBHDS does not use a consistent method to allocate funds to CSBs. Instead, DBHDS staff use different funding methods for the budget lines under the agency's discretion. When new state funding is appropriated, it typically supports a specific service or program. DBHDS then develops a funding model for that particular service. Over time, these services may be changed or eliminated, but DBHDS does not change the way in which the associated funding is allocated to CSBs.

DBHDS distributes most funding based on historical budgets, formulas, and grants

While there are almost as many allocation methodologies as there are budget lines, each methodology falls within one of four broad categories (Figure 1-2). (See Appendix C for a listing of all budget lines and their allocation method.) DBHDS most commonly bases funding on past allocations, which are rooted in decisions that are sometimes decades old.

FIGURE 1-2
DBHDS bases most of its discretionary funding to CSBs on historical budgets (FY18, $ millions)



SOURCE: JLARC analysis of CSB funding data provided to DBHDS and DBHDS description of funding methodologies.

Historical allocations maintain CSB budgets year over year

Nearly three-quarters of all discretionary funding is distributed to CSBs based on historical allocations. Most budget lines that use historical allocations were initially based on factors such as population, service need, and to a limited extent, local ability to pay. Starting in 1986, DBHDS allocated new appropriations using a funding formula also based on these factors. The agency stopped using this formula in the early 2000s and these allocations have remained largely unchanged since that time.

Local ability to pay measures a locality's ability to contribute funding to the CSB based on the potential tax base.

Formulas and grants direct funding according to operational and community needs

Ten percent of all discretionary funding is distributed to CSBs using funding formulas. This method helps DBHDS staff align funding with CSBs' need for services and update allocations as community needs change. For example, formulas for crisis stabilization services account for Medicaid reimbursements, geographical challenges to service delivery, and population. In addition, DBHDS uses formulas for substance use disorder prevention services and plans to use them for most STEP-VA services. While

funding formulas can account for the CSBs' needs, formulas are only as useful as their indicators.

Nine percent of all discretionary funding is distributed to CSBs using grants. Through grants, CSBs develop funding proposals that DBHDS reviews, ranks based on need and quality, and then funds based on available resources. Grants allow CSBs to request funding for their specific needs. Funding for intensive treatment services, like permanent supportive housing and opioid treatments, are typically allocated through a grant process.

Some funds are distributed according to a mix of factors

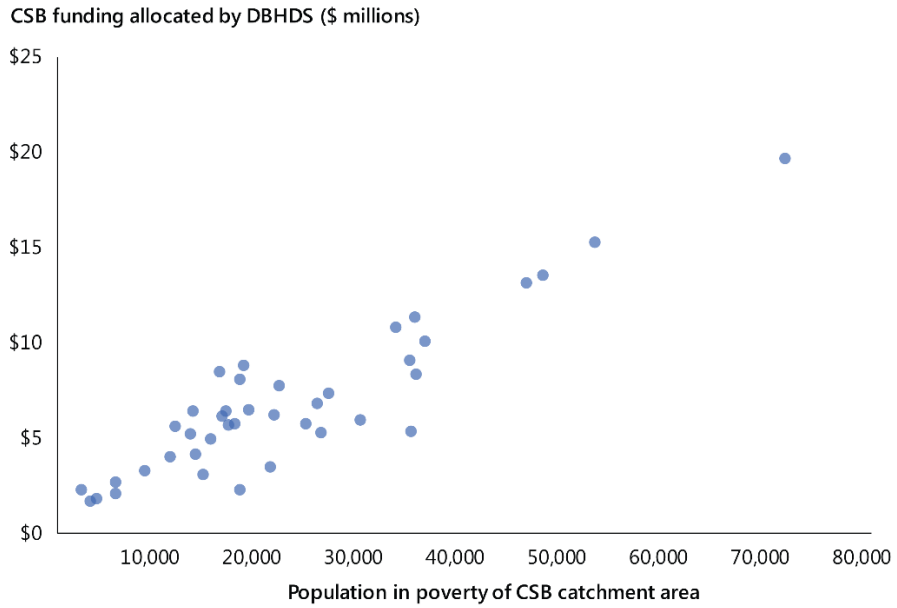
Other methods are used to allocate 7 percent of general funds to CSBs. These funds are awarded for special projects on a case-by-case basis and are typically distributed to cover the cost of patients who have transitioned into the community from state hospitals or training centers. Across all program areas, these budget lines include federal funds that are carried over to the next fiscal year and transfers from the DBHDS facilities' budgets or the DBHDS trust fund.

Despite lack of strategy, CSB funding generally aligns with population in poverty

CSBs are the safety net providers for public behavioral health services, primarily serving Medicaid and uninsured consumers. The alignment of DBHDS allocations with the population in poverty helps determine if allocations account for the population being served.

DBHDS allocations generally align with communities' population in poverty (Figure 1-3). CSBs primarily serve residents living in poverty, suggesting that CSB funding is likely going to communities that need their services the most. There is variation in funding per person in poverty across CSBs, and this is likely driven in part by the different services each CSB provides and the prevalence of behavioral health issues and developmental disabilities in the community. In the case of historical-based budgets, this per-person variation is likely driven by population and demographic shifts over time that were not captured in an outdated formula.

FIGURE 1-3
Funding generally aligns with CSBs' population in poverty



SOURCE: JLARC analysis of data from the 2017 American Community Survey 5-Year Estimate and DBHDS.
NOTE: CSB funding allocated by DBHDS includes funds that DBHDS has full discretion over and that are given directly to CSBs (does not include regional funds).

2 Alternative funding strategies

Before current funding strategies can be assessed and new strategies can be adopted, decisions must be made regarding funding and service delivery goals. Aligning funding methodologies with these goals will ensure the most effective use of state funding. The General Assembly and DBHDS should consider:

- What is the right balance between allocating funds to provide consistent, core services at all 40 CSBs versus meeting the unique needs of each community?
- Should state general funds always be used as "funds of last resort"?
- How should local funding contributions be factored into allocation decisions?

Depending on the answers to these questions, there are several strategies DBHDS can use to align funding with CSB needs. Other states and programs in Virginia did this by considering both the demand for services and resources available. Funding methods generally fall into one of three categories.

- **Funding formulas** use data to allocate funding based on estimated need for future services.
- **Reimbursement models** directly pay for services after they are provided.
- **Grants** award funds based on a provider's request, accounting for needs that are not considered in the other two methods.

JLARC reviewed the funding allocation methods of seven other states' behavioral health systems with structures similar to Virginia. The states' behavioral agencies, which provide funding to community providers, have similar roles to DBHDS.

Alternative methods use funding formulas or reimbursement models in conjunction with grants

Almost all of the models JLARC staff reviewed use a combination of at least two allocation methods. Funding formulas and reimbursement models primarily are used to fund core services, while grants are most commonly used to fund non-core services and projects (Table 2-1). CSBs' core services include case management, outpatient services, and eventually all services required by STEP-VA. Non-core services include supportive residential services and medication-assisted treatment.

TABLE 2-1
Funding formulas and reimbursement models are the primary allocation methods used by other states and programs

Primary allocation method	Services	Other states	Virginia programs
Funding formulas	Core and non-core services	MI, CO[a]	SOQ, Base adequacy, VDH, DSS, prior DBHDS model
Reimbursement models	Core and non-core services[b]	MD, GA, NC, CO	
Grants	Non-core	WV	

SOURCE: JLARC analysis of interviews with staff from other state behavioral health systems and Virginia programs.
NOTE:
[a] Colorado has three primary allocation methods. Two of their primary methods are reimbursement models—a fee-for-service model and a capacity model. The other primary method is a case-rate model, which is a funding formula.
[b] Other states using reimbursement models as their primary allocation method used them for services that were mostly offered by all community providers. Georgia also uses reimbursement models for non-core services.

Funding formulas estimate community needs

Funding formulas use data about a community's population to estimate the demand for services. These indicators typically include population measures, disease prevalence, and the number of clients served. These estimates are used to allocate funding before the services are provided. Virginia programs and two of the other states JLARC reviewed use funding formulas.

Michigan's community behavioral health system and Virginia's public K–12 education (Standards of Quality) use funding formulas. (See Appendix D for additional detail on alternative funding strategies.)

- **Michigan** allocates funding based on the percentage of the state's uninsured population, using data on population below 200 percent of the federal poverty level and the number of Medicaid recipients.
- **Standards of Quality (SOQ)** establishes a minimum cost per student to provide a basic public education using staffing and other cost models.

Funding formulas must include strong indicators of community need to be effective. Indicators should account for each population's service needs. For example, a CSB's population could be twice as big as another's, but require less funding because its population is largely insured or able to secure services elsewhere. A sufficient number of factors should be included to account for these variables, while keeping the formula as simple and understandable as possible for stakeholders.

Applying a new formula would redistribute funding across CSBs. For example, if the population in poverty were to be the sole indicator of need used in a funding formula, 22 CSBs would experience a decrease in funding, while 18 would see an increase. There was no discernible pattern to which types of CSBs would receive more or less funding

under this scenario (e.g. gains or losses were independent of geographical issues, current local contributions, or the number of uninsured consumers). To mitigate the impact of redistributing funding, other states and programs have increased total funding to avoid funding reductions or slowly phased in new allocation formulas. One strategy to achieve this would be to increase the total funding to all CSBs so that no CSBs actually see a decrease in funding. Another approach used by at least one other state is to slowly phase in the new funding model, enabling CSBs to gradually adjust to funding reductions or increases.

Several factors should be considered related to funding formulas for CSBs (Table 2-2).

TABLE 2-2
Factors to consider when using funding formulas

Factors to consider	Funding formula characteristics
Alignment with need	Estimates future demand
Ease of initial implementation	Collaboration required to develop formula
Ease of ongoing implementation	Easy to update and calculate annually
Transparency	Clear allocations based on formula
Budget stability	Rarely results in substantial changes year to year

SOURCE: JLARC analysis of interviews with staff from other state behavioral health systems and other programs in Virginia.

Reimbursement models compensate community providers for services

Reimbursement models are similar to fee-for-service models where the state behavioral health budget, including federal pass-through funds, is used to reimburse local providers for services provided or the number of consumers served. This is often used for core services that are also reimbursed through Medicaid or private insurance. The state behavioral health agencies in states using this model ensured that state funds were used as payments of last resort, and some states worked closely with their state Medicaid agencies to establish appropriate reimbursement rates.

Georgia, Maryland, and North Carolina's community behavioral health systems use reimbursement models. Some states cap the reimbursements community providers can receive, and others reimburse community providers for all eligible costs. A key distinction between these two models is that using a cap places the financial risk on community providers, whereas reimbursing providers for all costs leaves the financial risk to the state. (See Appendix D for additional detail on alternative funding strategies.)

- **Georgia** uses Medicaid rates to reimburse community providers. Medicaid rates were developed specifically to account for community provider costs.

- **Maryland** community providers bill the state Medicaid agency for all services and are reimbursed from the appropriate funds based on whether the consumer is a Medicaid recipient.
- **North Carolina** develops a separate rate for services provided by community providers and uses seven regional coordinating entities to manage billing and payment for both Medicaid and non-Medicaid consumers.

For these models to be effective, reimbursement rates need to adequately reflect the cost of services across different community providers. For example, rural areas may have higher costs for substance use disorder treatment services because of transportation costs, while urban areas may have higher costs for supportive housing services because of higher real estate costs. These factors need to be accounted for either through reimbursement rates or a different funding mechanism. The impact of using a reimbursement model on CSB funding allocations would vary significantly depending on the services provided and the reimbursement rates.

Several factors should be considered related to reimbursement models for CSBs (Table 2-3).

TABLE 2-3
Factors to consider when using reimbursement models

Factors to consider	Reimbursement model characteristics
Alignment with need	Pays for exact services provided
Ease of initial implementation	Rate development is technical and requires data collection
Ease of ongoing implementation	Billing and payment systems require staff and IT
Transparency	Funding is clearly based on established rates
Budget stability	Funding to CSBs varies with actual services provided

SOURCE: JLARC analysis of interviews with staff from other state behavioral health systems and other programs in Virginia.

Grants are commonly used to fund specific projects or services

Almost all of the programs JLARC reviewed used grants to fund specialty services or projects that were not covered through their primary allocation method. For example, Maryland uses grants to fund specialty services not accounted for through its reimbursement model. West Virginia is an exception because it uses grants as its primary allocation method to develop services that meet the various needs of its rural service areas. (See Appendix D for additional detail on alternative funding strategies.)

Several factors should be considered related to grant-based allocation strategies for CSBs (Table 2-4).

TABLE 2-4
Factors to consider when using a grant-based allocation strategy

Factors to consider	Grant-based allocation strategy characteristics
Alignment with need	Funding is provided based on specific requests
Ease of initial implementation	Defining grant process and timeline is simple
Ease of ongoing implementation	Grant writing and evaluation are time-consuming
Transparency	Grant scoring and allocations are subjective
Budget stability	Funding is prospective but grant awards change as needs change

SOURCE: JLARC analysis of interviews with staff from other state behavioral health systems and other programs in Virginia.

CSB funding should support Virginia's community behavioral health goals

DBHDS funding allocations to CSBs should reflect Virginia's goals for its community behavioral health and disability services. Those goals, however, have not been clearly stated for all services and initiatives. For example, the STEP-VA initiative has clearly defined goals related to access and availability, but Virginia has not defined goals to guide allocation of unrestricted funds. Virginia may wish to develop different goals for different groups of services. For example, Virginia could continue to pursue consistent access to the core services required under STEP-VA, but allocate other funds in a way that enables CSBs to develop services to meet their community needs.

The **STEP-VA** initiative is developing nine core services that all CSBs are expected to implement by FY21. The goal is to ensure all Virginians have access to a core set of high-quality, publicly funded behavioral health services.

One strategy would be to plan for a new allocation method once STEP-VA services are operational at all 40 CSBs. Funding supporting these nine core services could be allocated using a funding formula or reimbursement model, helping ensure all Virginians have access to these services. However, services that are not needed across all CSBs, such as inpatient substance use disorder or mental health permanent supportive housing, may be better funded through the use of grants or a different funding formula.

Virginia can determine allocation models by considering their advantages and disadvantages. Some models more precisely align funding with need, but might also be administratively burdensome (Table 2-5).

TABLE 2-5
Relative characteristics of the different funding models

	Alignment with need	Ease of implementation	Transparency	Budget stability
Funding formula	Medium	High	High	High
Reimbursement model	High	Low	High	Low
Grants	Medium	Medium	Low	Medium

SOURCE: JLARC analysis of interviews with staff from other state behavioral health systems and other programs in Virginia.
NOTE: Administrative complexity combines both initial and ongoing administrative requirements. Rankings are relative to the other funding strategies considered.

The General Assembly could start this process by articulating a goal, or set of goals, for discretionary funding. DBHDS could then develop a proposed allocation strategy to balance these goals and their impacts. The allocation strategy could identify both a funding allocation model as well as an implementation plan (e.g. the factors considered in the funding formula or in developing the reimbursement rates). DBHDS could submit a plan of the proposed changes to the Joint Subcommittee on Mental Health Services in the Twenty-First Century. The plan should include:

- the proposed allocation strategy,
- the impact of the proposed strategy on each CSB's funding,
- an explanation of how the proposed strategy supports the General Assembly's goals, and
- a process and timeline to develop the details and implement the proposed allocation strategy.

Should the General Assembly wish to change how state and federal funds are allocated to CSBs, the following option could be considered.

OPTION 1
The General Assembly could consider including language in the Appropriation Act (i) establishing specific objectives for the extent to which funding that the Department of Behavioral Health and Developmental Services (DBHDS) allocates to community services boards (CSBs) should support consistent services statewide versus services that address each community's needs and (ii) directing DBHDS, in collaboration with the CSBs, to develop and submit a proposed funding allocation strategy to meet these objectives to the Joint Subcommittee on Mental Health Services in the Twenty-First Century.

3 Other CSB funding sources

DBHDS should consider other funding sources when allocating CSB funding. The agency should do this regardless of whether or not Virginia changes its funding model. Medicaid reimbursements and local funding make up slightly more than half of total CSB funding, and this proportion could increase. Maximizing Medicaid reimbursement helps reserve state general funds for unmet need at CSBs, because federal funding pays for at least half the cost of services for Medicaid recipients. Factoring in local funding is a more complicated policy question, but there are several Virginia programs that factor local funding into allocation decisions.

Other states use "payer of last resort" strategy

DBHDS does not consider Medicaid or private insurance reimbursement in almost all of its funding allocations. That means that a CSB treating 70 percent Medicaid consumers can receive the same funding as one that serves fewer than 50 percent Medicaid-eligible consumers. Medicaid pays for many CSB services. While Medicaid fees are accounted for in some allocation decisions for developmental services, the majority of state and federal allocations do not factor in Medicaid reimbursements.

Other states that JLARC reviewed ensured non-Medicaid federal and state funds were used as the payments of last resort for community behavioral health services. The behavioral health authorities of other states developed their funding formulas or reimbursement models to account first for other funding sources, primarily Medicaid reimbursement and other insurance. State and federal funds are then used to pay for unmet needs in the system. DBHDS can ensure that non-Medicaid state and federal funds are used as payments of last resort whether Virginia keeps its current allocation model or develops a new one.

- **Funding formulas** can factor estimated revenue from other funding sources using Medicaid enrollment data or historical reimbursements.
- **Reimbursement models** can restrict payments to services that are not reimbursable through an alternative funding source, subtract revenues from alternative funding sources from the service costs to determine the state's reimbursement, and check claims for Medicaid eligibility.
- **Grants** can require CSBs to demonstrate need for services not funded through other sources.

Medicaid reimbursements will not always cover the full cost of providing services to Medicaid clients. Other states indicated that they still used state funds to cover some unreimbursed costs for Medicaid clients.

Medicaid expansion and the behavioral health realignment initiatives provide opportunities for Virginia to ensure non-Medicaid state and federal funds are payments of last resort for community behavioral health services. Medicaid expansion is projected

to increase CSB revenue from Medicaid consumers, and the Appropriation Act reduced state general funds for CSBs to offset the estimated increase in Medicaid revenues. While it will take time for CSB Medicaid revenue to be predictable, the reliance on non-Medicaid state and federal funding will decrease if CSBs optimize Medicaid revenue. Establishing a policy that non-Medicaid state and federal funding are to be used as payments of last resort will help identify opportunities to ensure these funds are used to address unmet community needs.

RECOMMENDATION 1

The Department of Behavioral Health and Developmental Services should develop a method to account for Medicaid and private insurance reimbursements that each CSB should be able to collect when allocating non-Medicaid state and federal funds.

Other states also take steps to ensure community providers maximize their ability to bill Medicaid for services. Colorado put controls in place to ensure state funds are used as a payment of last resort after it found that state general funds were used to pay for services for Medicaid-eligible clients. Maryland has community providers bill the state Medicaid agency for all services, whether or not the consumer is Medicaid eligible. The state Medicaid agency then reimburses providers for uninsured consumers using non-Medicaid state and federal funds, and for Medicaid consumers using Medicaid funds.

It is unclear whether all CSBs are maximizing their ability to obtain reimbursement for Medicaid-eligible services, but average Medicaid revenue for mental health services ranges from less than $1,000 per eligible consumer up to more than $4,000 for some CSBs. Medicaid expansion should provide some opportunities to ensure CSBs are maximizing Medicaid revenue. For example, CSBs are now receiving data on Medicaid-eligible individuals so they can identify all Medicaid-eligible consumers. DBHDS should continue to work with the Department of Medical Assistance Services and the CSBs to ensure CSBs are maximizing their ability to seek Medicaid reimbursement for services.

§ 37.2-509 of the Code of Virginia: Allocations (of state funds) to any community services board for operating expenses, including salaries and other costs, or the construction of facilities, shall not exceed 90 percent of the total amount of state and local matching funds provided for these expenses or such construction, unless a waiver is granted by the Department pursuant to policy adopted by the Board.

RECOMMENDATION 2

The Department of Behavioral Health and Developmental Services should work with the Department of Medical Assistance Services and the community services boards (CSBs) to analyze whether CSBs are maximizing their Medicaid reimbursement for services, and if not, put processes in place to do so.

Local match requirements do not account for ability to pay, and some localities do not meet requirement

Under statute, the proportion of all CSB funds that come from the state is capped at 90 percent (sidebar). This means that CSBs must provide the other 10 percent, which typically comes from their local governments. None of the other seven states JLARC

reviewed requires a local match for community behavioral health services. However, it is a common approach in other Virginia programs. Virginia's local health departments, local school divisions, and local DSS offices are all required to provide matching funds.

CSBs that serve localities with stronger economies do not receive less state funding on a per-person basis. In some cases, a CSB serving localities with significant revenue capacity receives twice as much DBHDS funding per capita as CSBs with limited revenue capacity. Accounting for CSBs' ability to secure local funds would help ensure non-Medicaid state and federal funds are used to meet community needs that are not fully paid for by another revenue source.

Michigan requires a 10 percent local match for the cost of inpatient services in state hospitals. Staff in Michigan indicated the goal of this requirement is to incentivize local providers to provide services necessary to keep consumers in the community.

Other Virginia models account for local ability to pay in various ways

The SOQ, VDH, and historical DBHDS allocation methods all account in different ways for a locality's ability to contribute funding. They use different data to estimate local revenue capacity and then factor that in their funding formulas (Table 3-1).

Funding strategies can use local ability to pay to either 1) change the percentage of funds each CSB is required to provide (local match requirement) or 2) change the amount of state funding a CSB receives while keeping the match requirements the same. Both the SOQ and VDH allocation methods use local ability to pay to determine each locality's match requirements.

Rather than redistributing funding, the historical DBHDS formula used local ability to pay to increase state funding for CSBs with lower revenue capacity. (This was before DBHDS moved primarily to allocations based on historical budgets.) However, the 10 percent local match requirement remained the same, requiring these localities to increase their match in total dollars to meet higher state funding levels.

Table 3-1
Virginia programs account for local ability to pay in various ways

Model	Local match requirement	Statewide local match	Local ability to pay indicators	Used to determine
SOQ	20% to 80%	45%	True value of real property Adjusted gross income Taxable retail[a]	Local match requirements
VDH	18% to 45%	37%	Potential local revenues for major tax instruments[b] Sales Tax revenues Other local tax revenues	Local match requirement
Historical DBHDS formula	10%	10%	Total per capita value of real property Total per capita personal income	State allocations to localities

SOURCE: JLARC analysis of local ability to pay models included interviews with VDH staff, the former DBHDS staff member who developed the DBHDS funding formula, and a review of documentation on the three Virginia programs.
NOTE: The average local match for VDH varies each year depending on the relative size of each local health department's budget.
[a]Each SOQ local ability to pay indicator accounts for the different populations of localities by expressing each indicator on a per capita basis (weighted 1/3) and a per pupil basis (weighted 2/3).
[b]Examples of major tax instruments include real estate property and motor vehicles. The value of these instruments are then multiplied by the state's average tax rate.

If DBHDS were to use a local ability to pay measure to determine local match requirements, and total state funding stayed the same, CSBs in regions with greater revenue capacity would receive less state funding and would need to obtain more local funding to make up for this reduction. On the other hand, CSBs serving localities with lower revenue capacity would receive an increase in state funds and a reduction in required local funding contributions.

JLARC estimated how funding would change if each CSB's required match varied based on its ability to pay, and the state kept the aggregate local contribution at the current 10 percent funding level. Using revenue capacity data from the Commission on Local Government, the required CSB local match would vary between 6 percent and 19 percent. These changes would lower the local match requirement for more than half of CSBs (23), while seven CSBs' match requirements would stay nearly the same. The remaining 10 CSBs would have an increased local match requirement because of their localities' higher revenue capacity. These 10 CSBs would see reductions in their state funding if DBHDS replaced state funds with the increased local match.

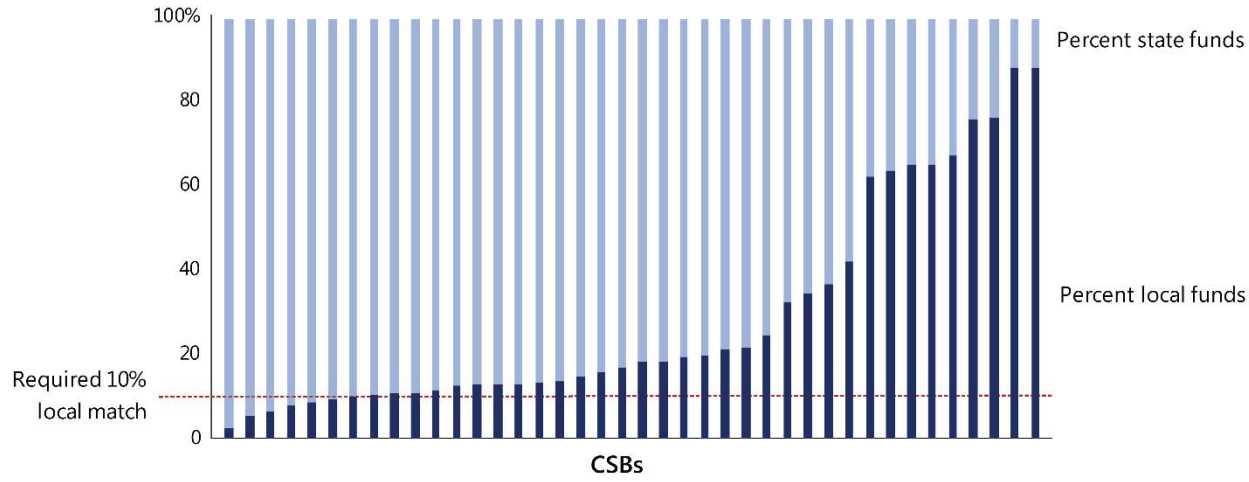
DBHDS does not include regional funds when calculating local match requirements for CSBs. If regional funds were included, more CSBs would not meet the 10 percent match requirement by a collective total of $4.4 million.

Some CSBs are not able to obtain local funding to meet matching requirements

While CSBs are required to obtain the 10 percent local match from their localities, six CSBs were unable to obtain the necessary funding from their localities in FY18. DBHDS waives the local match requirement when CSBs are not able to obtain enough

local funding to meet the 10 percent requirement, as authorized in statute, instead of reducing state funding proportionally to reflect the local match. These waivers, coupled with substantial local funding above the required match provided to some CSBs, result in local matches ranging from 3 percent to 88 percent across the state (Figure 3-1).

FIGURE 3-1
Local funding to CSBs varies substantially

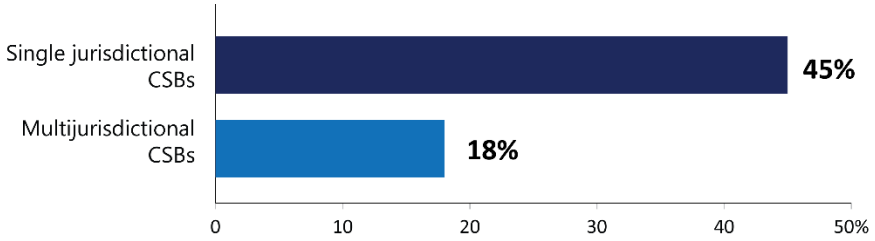


SOURCE: JLARC analysis of CSB funding data collected by DBHDS.
NOTE: Calculations of local match do not include regional funds.

The state takes a different approach when funding local health departments. VDH reduces state funding if localities do not provide the required local match. If DBHDS did not provide waivers to CSBs when localities failed to provide required matching funds, the six CSBs would have lost $11.8 million in state general funds because of their inability to obtain $1.3 million in local funds (FY18). VDH staff indicated that sometimes localities increase their funding to maximize their state allocation, while other localities are unable to increase their match and are left with less funding even though they typically have a greater need. Local health departments typically serve one locality, providing a more direct incentive for localities to meet the local match requirement.

Securing local funding tends to be more challenging for CSBs that serve multiple localities. The average local match for multijurisdictional CSBs was 18 percent in FY18, compared with 45 percent for single jurisdictional CSBs (Figure 3-2). All six CSBs that were unable to meet local match requirements serve multiple localities. Localities in multijurisdictional CSBs tend to have lower revenue capacity, but CSBs also must build relationships and request funding from each locality separately. In addition, these CSBs must develop a way to divide how much each locality is responsible for contributing.

FIGURE 3-2
Average local match of multijurisdictional CSBs is significantly lower than single jurisdictional CSBs



SOURCE: JLARC analysis of CSB funding data collected by DBHDS.
NOTE: Data includes all state funding to CSBs, including regional funding.

Unless measures are taken to improve accountability for local match requirements, any efforts to redistribute funds or account for local ability to pay may not result in actual changes to local funding. One strategy to increase accountability would be amending the statute to place the requirement on the localities rather than the CSBs. This may provide additional incentive for localities, particularly those served by multijurisdictional CSBs, to appropriate funding for their share of the local match. Another strategy would be to limit the use of waivers to extreme cases to increase the accountability of local match requirements. VDH and DOE do not provide waivers to localities that are unable to meet their match and instead reduce their state funding. (All school divisions have met or exceeded their match requirement in recent years.)

Implementation of any strategy should include several key factors

Four key elements should be incorporated into any plan to develop and implement a new funding allocation model for CSBs. Several factors should guide the development of allocations and the sustainability of new funding methodologies over time. All of these issues are relevant to any change, whether it is a minor adjustment to how Medicaid funding is considered or a major change to local matching requirements.

Goal-driven

The allocation methods should reflect the state's goal for specific services. Funding formulas or reimbursement models are most appropriate to promote consistent services across CSBs, while grants are best at developing specialty services to meet the needs of different CSBs. For example, once STEP-VA's nine core services are fully implemented across all 40 CSBs, DBHDS could develop an allocation method that continues to ensure access to these quality services across all CSBs. However, services needed only by some communities, such as inpatient substance use disorder or permanent supportive housing services, may be better funded through an alternative method that focuses on CSBs' various needs.

Stakeholder support

Staff from other states' behavioral health systems and Virginia programs have stressed that stakeholder support, particularly from community providers like CSBs, is a crucial element in developing a successful long-term funding strategy. Most states established this support through needs assessments and work groups. The needs assessments helped determine what factors (size, geography, population demographics, etc.) were most important to consider in determining costs and needs. Work groups discussed whether the potential allocation methods would meet the needs of community providers. These work groups built support from community providers by engaging them in the development of new funding methods and, as a result, providers were better prepared to adapt to the new funding methods.

Gradual phase-in

All other states phased in their new allocation methods to protect community providers from significant losses in funding. The transition period helps community providers adjust their budgets and operations. Changes include expanding operations, adjusting to reductions, or establishing new processes to bill for services.

There are many options to phase in a new model. Historically, DBHDS did this by applying new allocation methodologies only to new funds. This eased the transition but took a long time to redistribute funding. Michigan implemented a new funding formula for its behavioral health system but chose a quicker transitional approach, moving toward the new target allocations over a five-year period. This resulted in providers seeing gradual changes to their total funding, allowing providers to better adjust to any decreases in funding.

For states that adopted reimbursement models, these new methods were first used for specific services and then expanded to other services as community providers became accustomed to billing the behavioral health authority. This helped ensure that the behavioral health authority was able to assist those who had difficulty using the system.

Ongoing management and updates

Regularly updating funding formulas and reimbursement rates is critical to ensure funding allocations reflect the state's goals over time. As community economic conditions and needs evolve, historical calculations may not accurately account for localities' current needs. Over time, this results in funding disparities, undermining the goal of any model. If formulas and reimbursement rates are not updated regularly using current data, formula changes are likely to be significant when updates are eventually made. Updating allocations frequently allows for incremental changes rather than significant, one-time shifts in funding that can disrupt CSB operations.

Appendix A: Study mandate

SENATE OF VIRGINIA

R. CREIGH DEEDS
25TH SENATORIAL DISTRICT
ALL OF ALLEGHANY, BATH, HIGHLAND, NELSON, AND ROCKBRIDGE COUNTIES; ALL OF THE CITIES OF BUENA VISTA, CHARLOTTESVILLE, COVINGTON, AND LEXINGTON; AND PART OF ALBEMARLE COUNTY
P.O. BOX 5462
CHARLOTTESVILLE, VIRGINIA 22905

COMMITTEE ASSIGNMENTS:
COURTS OF JUSTICE
PRIVILEGES AND ELECTIONS
TRANSPORTATION

December 5, 2018

The Honorable Thomas K. Norment, Jr., Chair
Joint Legislative Audit and Review Commission
P.O. Box 6205
Williamsburg, VA 23188

Dear Senator Norment:

I am writing on behalf of the Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century (the Joint Subcommittee) to request that the Joint Legislative Audit and Review Commission study the Commonwealth's current model for funding the state share of community services board operating expenses for the delivery of publicly funded behavioral health services.

The Joint Subcommittee was established during the 2014 Session of the General Assembly to review the laws of the Commonwealth governing the provision of behavioral health services, assess the system of publicly funded behavioral health services, identify gaps in services and the types of facilities and services needed to meet the behavioral health care needs of the Commonwealth in the twenty-first century, and recommend statutory or regulatory changes necessary to improve access to services, the quality of services, and outcomes for individuals in need of services. Since 2014, the Joint Subcommittee has conducted a thorough review of the Commonwealth's publicly funded behavioral health services system and recommended a number of changes to that system designed to improve access to and the quality of publicly funded behavioral health services. Among these recommendations was implementation of STEP-VA, a behavioral health services delivery model designed to ensure the availability of and access to a comprehensive array of high-quality publicly funded behavioral health services for all Virginians.

The General Assembly approved STEP-VA during the 2017 Session. Chapters 607 and 683 of the Acts of Assembly of 2017 amended the Code of Virginia to require community services boards to provide, by July 1, 2019, same-day mental health screening services and outpatient primary care screening and monitoring services. Chapters 607 and 683 also required community services boards to provide, by July 1, 2021, (i) crisis services for individuals with mental health

P.O. DRAWER D, HOT SPRINGS, VIRGINIA 24445

or substance use disorders, (ii) outpatient mental health and substance abuse services, (iii) psychiatric rehabilitation services, (iv) peer support and family support services, (v) mental health services for members of the armed forces located 50 miles or more from a military treatment facility and veterans located 40 miles or more from a Veterans Health Administration medical facility, (vi) care coordination services, and (vii) case management services.

Implementation of STEP-VA will impose additional costs on both the state and localities. Currently, the Code of Virginia limits the state share of funding for community services board operating expenses to 90 percent of the total amount of funds allocated for such expenses. Localities must provide at least 10 percent of the total amount of funds allocated for operating expenses, unless a waiver is granted by the Department of Behavioral Health and Developmental Services; localities granted such a waiver may pay less than 10 percent of the total amount of funds allocated for community services board operating funds. The amount of state funding provided to a community services board each year is determined upon consideration of (a) the total amounts of state-controlled funds appropriated for community services board operating expenses; (b) previous allocations of state-controlled funds for each community services board; (c) requirements or conditions attached to appropriations of state-controlled funds by the General Assembly, the Governor, or federal granting authorities; (d) community services board input about the uses of and methodologies for allocating existing and new state-controlled funds; and (e) other relevant and appropriate conditions. The methodology for determining the state share of funding for community services board operating expenses does not take into account the characteristics of the community services board catchment area, including population, average income levels, Medicaid penetration rates, or ability of the locality to raise revenue.

Variability in the existing funding formula, together with differences in the amount of local contributions for community services board operating expenses, affects the availability of behavioral health services for individuals in need and the success of STEP-VA. The Joint Subcommittee believes that ensuring appropriate allocation of funds for implementation of STEP-VA is of fundamental importance in ensuring consistent access to high-quality behavioral health services for all adults and children in the Commonwealth. Therefore, the Joint Subcommittee requests that the Joint Legislative Audit and Review Commission study the current model for funding the state share of community services board operating expenses. Specifically, the Joint Subcommittee requests that the Joint Legislative Audit and Review Commission:

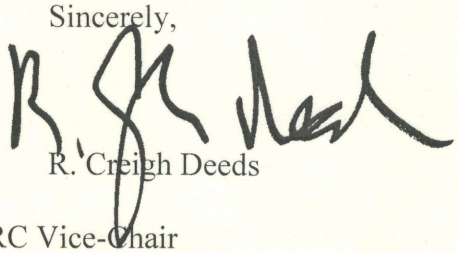
1. Prepare an inventory of sources of funding for community services boards that identifies each federal, state, and local source of funding for each community services board in the Commonwealth and the amount of funds from each source received by each community services board;

2. Describe the criteria used to determine the amount of funds provided to each community services board for the primary funding streams identified in the inventory of sources of funding;

3. Identify alternative models for funding publicly funded behavioral health services, including the models and formulas for funding (i) publicly funded behavioral health services in other states and (ii) other public services such as health, social, education, and other services in the Commonwealth. Such information should include information about the criteria used to determine how funds are allocated; and
4. Evaluate the potential impact of adoption of alternative models of funding publicly funded behavioral health services in the Commonwealth, together with recommendations for the appropriate criteria to be considered in determining the proper allocation of funds under each model evaluated.

Thank you for considering undertaking this study.

Sincerely,



R. Creigh Deeds

cc: Delegate R. Steven Landes, JLARC Vice-Chair
Hal E. Greer, JLARC Director

Appendix B: Research methods

JLARC staff conducted three primary research activities to answer the questions posed in the study request:

- analyzed revenue and expense data reported by each CSB to DBHDS;
- interviewed DBHDS program and budget staff; and
- conducted a survey of all 40 CSB executive directors.

This attachment provides a brief explanation of methods used to answer each question.

Catalog of CSB funding and current allocation methods

JLARC staff analyzed funding data reported by each CSB to DBHDS. The data included all state, federal and local funding; Medicaid fees; private insurance fees; retained earnings; and other sources of funding that each CSB received during FY18. JLARC staff then conducted three structured interviews with DBHDS budget and program staff for mental health, substance abuse, and developmental services to understand how the allocations of each state and federal budget line were determined. These interviews helped categorize the state and federal funding into the four allocation methods.

Most of the budget lines are now allocated based on historical funding, and JLARC staff wanted to understand the original allocation method for these budget lines. JLARC reviewed DBHDS documents and research literature on the agency's funding formula developed in the 1980s. JLARC also interviewed the former DBHDS director of program evaluation, who held that job when the funding formula was developed. This interview helped JLARC staff understand why the funding model was developed, how long it was used for, the funding sources it was used for, and the role CSBs played in the development and implementation of the formula.

To determine if current DBHDS allocations were aligned with particular characteristics of CSBs, JLARC staff conducted quantitative analysis of a variety of factors. The factors considered included:

- total population,
- population below the poverty line,
- local funding for CSBs in FY18,
- local ability to pay (as measured by the SOQ composite index and the Commission on Local Government revenue capacity data),
- number of clients served,
- units of service provided, and
- number of clients served by insurance type (Medicaid, private, uninsured).

Alternative allocation methods

JLARC reviewed documents and conducted interviews with staff from seven others states' behavioral health authorities. These states had a community behavioral health system structured similarly to Virginia's. They include

- Colorado,

- Georgia,
- Louisiana,
- Maryland,
- Michigan,
- North Carolina, and
- West Virginia.

These interviews addressed the structure of the other states' behavioral health systems, their methods of allocating state funding across community providers, and the advantages and disadvantages of their current allocation method.

JLARC also reviewed documents or conducted interviews with other programs in Virginia to better understand their funding allocation methods and how they accounted for local ability to pay. These other programs included

- cooperative budgets for local health departments (VDH);
- standards of quality for local school divisions (DOE);
- higher education base adequacy funding (SCHEV) and
- multiple programs for local departments of social services (DSS).

In addition to interviews with staff from these programs, JLARC interviewed seven CSB executive directors and conducted a survey of all 40 CSB executive directors to better understand their financial operations. These interviews and survey responses helped inform JLARC's understanding of how alternative funding methods would affect CSB operations.

Sensitivity analysis

JLARC conducted quantitative analyses to understand how CSB funding would change if DBHDS were to allocate funding using common indicators from other state models. Data from the American Community Survey (ACS) 2017 was used to calculate the population below the poverty line within each service area. JLARC then calculated the statewide funding for CSBs per person below the poverty line, using only non-regional funds that DBHDS has discretion over. This was then multiplied by the population below the poverty line for each service area to determine the new funding allocations if this were the primary criteria used. The DBHDS funds that were distributed regionally or that DBHDS did not have full discretion in allocating were then added to the calculated CSB allocations. Actual FY18 DBHDS allocations were then compared to these new hypothetical allocations.

JLARC staff used the Commission on Local Government's revenue capacity scores to assess how changing local match requirements would affect CSB allocations and total funding. DBHDS Little CARS data for FY18 was used to determine the current required local match of each locality, regardless of waivers that may have been awarded. JLARC then calculated a weighted average revenue capacity score for the localities in each CSB's service area, as a proxy for the service area's revenue capacity. These scores were then adjusted across CSBs until the statewide local match equaled 10 percent, but keeping the same relative difference between each CSB's revenue capacity score. New local match requirements, and the associated changes in state funding, were compared to actual FY18 state funding and local match requirement.

Appendix C: Catalog of CSB funding allocation methods

This is a catalog of all funding sources for mental health services (Table C-1), substance use disorder services (Table C-2), and developmental services (Table C-3).

TABLE C-1
Mental health services funding

Program	Source	Budget line	FY18 funding	#CSBs	Allocation method
MH	State	State funds	$66,391,456	40	Historical [a]
MH	State	Regional Discharge Assistance Program (regional)	28,718,393	9	Partial discretion [b]
MH	State	Other merged regional funds	21,682,819	23	Historical [c]
MH	State	Program of Assertive Community Treatment (PACT)	17,878,943	24	Historical [d]
MH	State	Crisis stabilization (regional)	14,966,994	20	Historical [e]
MH	State	Pharmacy - medication supports	13,917,687	40	Historical
MH	State	Law reform	12,122,120	40	Historical
MH	State	Crisis Intervention Teams (CIT) - assessment sites	10,921,180	32	Partial discretion
MH	State	Crisis response and child psychiatry (regional)	8,573,594	6	Partial discretion [f]
MH	State	Acute care (regional)	8,214,298	8	Historical [g]
MH	State	STEP-VA	7,960,651	18	Funding formula/other [h]
MH	State	Permanent supportive housing	7,629,505	14	Grant [i]
MH	State	Transfers from DBHDS facilities (regional)	6,065,938	14	Other [j]
MH	State	Child and adolescent services initiative	5,648,128	39	No discretion [k]
MH	State	Young adult SMI (serious mental illness)	4,000,000	8	Historical
MH	State	Recovery (regional)	3,217,455	16	Historical
MH	State	Children's outpatient services	2,780,645	40	Other [l]
MH	State	Jail diversion services	2,595,748	15	Historical
MH	State	Juvenile detention	2,401,656	23	Partial discretion [m]

Program	Source	Budget line	FY18 funding	#CSBs	Allocation method
MH	State	Expanded community capacity (regional)	$1,960,944	1	No discretion [n]
MH	State	Demo project – Linking Systems of Care for Children and Youth	1,771,180	4	Grant [o]
MH	State	State children's services	892,904	37	Historical
MH	State	Geriatric psychiatry services	880,000	1	Historical [p]
MH	State	Program of Assertive Community Treatment (PACT) - forensic enhancement	800,000	4	Historical
MH	State	Permanent Supportive Housing (PSH) – Cooperative Agreements to Benefit Homeless Individuals (CABHI)	700,000	2	Grant [q]
MH	State	First aid and suicide prevention (regional)	625,000	6	Grant [r]
MH	State	Expand tele-psychiatry capacity	620,000	32	Historical
MH	State	State regional deaf services	552,500	6	Historical
MH	State	Geriatric services	522,500	1	Historical [s]
MH	State	Transfers from DBHDS facilities - regional transfers	420,000	1	Other
MH	State	Not Guilty by Reason of Insanity (NGRI) Funds	314,137	38	Historical
MH	State	Adult outpatient competency restoration services	210,324	30	Funding formula [t]
MH	State	Regional Residential Discharge Assistance Program (DAP)	183,634	1	Funding formula
MH	State	Docket Pilot Justice and Mental Health Collaboration Program (JMHCP) match	96,702	2	Historical
MH	State	Total regional transfers	92,149	17	Other
MH	State	Expanded Community Capacity Regional transfers	—	5	Historical
MH	State	Crisis Response & Child Psychiatry Regional transfers	—	24	Grant
MH	State	Crisis stabilization - regional transfers	—	9	Historical
MH	State	First Aid and Suicide Prevention Regional transfers	—	25	Grant
MH	State	Acute care regional transfers	(122,518)	17	Historical
MH	State	Regional Discharge Assistance Program Regional transfers	(584,074)	32	Funding formula
MH	**State**	**Subtotal**	**$255,622,592**		
MH	Federal	SMI (serious mental illness) block grant	3,202,424	39	Funding formula [u]
MH	Federal	SED (serious emotional disturbance) child & adolescent block grant	2,852,061	40	Historical

Program	Source	Budget line	FY18 funding	#CSBs	Allocation method
MH	Federal	Other federal - CSB	$2,181,528	14	No discretion [v]
MH	Federal	Block grant - young adult SMI	1,293,174	8	Historical [w]
MH	Federal	Projects for Assistance in Transition from Homelessness (PATH)	1,285,830	13	Historical
MH	Federal	Block grant geriatrics	1,000,000	2	No discretion
MH	Federal	Cooperative Agreements to Benefit Homeless Individuals	764,419	4	Grant
MH	Federal	Assertive Community Treatment Grants (SMI block grant)	368,052	2	Historical [x]
MH	Federal	Other federal - DBHDS	259,550	2	Other
MH	Federal	Block grant - peer services	187,456	2	Historical
MH	Federal	Retained earnings	178,936	7	Other
MH	Federal	Pre-Trial Diversion Initiative	106,042	2	Historical
MH	Federal	SMI South West Virginia Behavioral Health board block grant	75,000	1	Grant
MH	**Federal**	**Subtotal**	**$13,754,472**		
MH	Fees	Medicaid fees	197,946,399.67	40	
MH	Fees	Fees: other	46,647,740	40	
MH	Fees	Transfer fees in/(out)	174,014	7	
MH	**Fees**	**Subtotal**	**$244,768,153.67**		
MH	Local	Local government appropriations	158,209,149	40	
MH	Local	In-kind contributions	427,347	5	
MH	Local	Philanthropic cash contributions	379,277	15	
MH	Local	Local interest revenue	146,408	6	
MH	**Local**	**Subtotal**	**$159,162,181**		
MH	Retain	State retained earnings- regional programs	15,000,047	39	
MH	Retain	State retained earnings	10,597,425	34	
MH	Retain	Other funds	7,758,208	27	
MH	Retain	Other retained earnings	7,111,669	12	

Program	Source	Budget line description	FY18 funding
MH	**Retain**	**Subtotal**	**$40,467,349**
MH		**Total**	**$713,774,747.67**

SOURCE: JLARC analysis of CSB funding data provided to DBHDS and DBHDS description of funding methodologies.
NOTE:
[a] Historical formula based on population and service areas' local ability to pay. Current DBHDS staff are unsure of specifics of original funding strategy.
[b] Social health factors are used to determine regions with the greatest need. Funds are used to support individuals who do not have another means of paying for services. Allocations are built on a case-by-case basis.
[c] Merger of multiple funding sources in 2012. Current DBHDS staff are unsure if new allocations were adjusted in 2012 or if old allocations were just summed together for each CSB. Since then allocations have remained the same.
[d] Allocations are established as new PACT teams are created at a CSB. Allocation amounts do not change after funds are initially distributed.
[e] Based on historical allocations from approximately FY06. Current DBHDS staff are unsure of specifics of initial allocation method.
[f] DBHDS used grant processes to distribute funding. Rankings of proposals were used to determine amounts distributed to each CSB.
[g] Current DBHDS staff are unsure of how these funds were originally allocated.
[h] All CSBs were provided equal funding for Step 1, same-day access. Additional awards are based on funding formulas. These formulas are based on the health opportunity index, workforce shortages, and population.
[i] DBHDS used grant processes to distribute funding. Rankings of proposals were used to determine amounts distributed to each CSB.
[j] Funds are allocated for specific projects. They primarily support populations that were in DBHDS facilities and now require support in a community setting. They also are used to support CSBs in times of a bed census crisis. This is a variable amount that depends on both facility revenues and expenditures. Allocations are made based on the specific needs of communities.
[k] Allocations are based on a historical funding formula. DBHDS are unsure of original funding strategy.
[l] Funds are distributed equally across CSBs.
[m] Used a competitive grant when funding was first distributed. In 2008 funding was distributed to any CSB providing the service. This is now historically allocated as the allocations have not changed since 2008.
[n] Allocated to CSBs in Region 5. The allocations have not changed.
[o] RFP process used.
[p] Funding distributed to one CSB for a specific program. This allocation has not changed.
[q] These are state matching funds for the CABHI grant recipients.
[r] CSBs provide DBHDS a plan of how they will use funding to support the region. Sometimes the fiscal agents distribute funds across CSBs in their region and other times they run the services centrally for the region. All CSB proposals must be data-driven and justified. DBHDS provides ongoing surveillance.
[s] Funding is distributed to one CSB for a specific program. This allocation has not changed.
[t] Allocations based on programmatic discretion.
[u] Allocations are based on population-based formula. The federal government chooses the populations that should be included.
[v] CSBs apply directly to the federal government for these funds.
[w] These funds were distributed via RFA (request for applications) in FY15. Changes after FY15 were based on population sizes of CSB service areas. FY19 allocations were based on historical data from prior two years.
[x] Federal government used to fund PACT teams. When this money was no longer available, state funds were used to replace it. The two CSBs that received the federal funding are now distributing the same amounts that were initially determined.

Table C-2
Substance use disorder services funding

Program	Source	Budget line	FY18 funding	#CSBs	Allocation method
SUD	State	State funds	$40,729,324	40	Historical [a]
SUD	State	Substance Abuse Residential Purchase of Services (SARPOS)	1,654,230	40	Grants
SUD	State	Women (Includes Project LINK at four CSBs) (restricted)	1,379,866	40	Historical [b]
SUD	State	Jail services/juvenile detention	1,253,626	11	Historical [c]
SUD	State	HIV/AIDS	1,190,132	11	Historical [d]
SUD	State	Region V residential	731,921	9	Historical [e]
SUD	State	Peer support recovery	719,263	8	Grants
SUD	State	Community detoxification (regional)	700,748	10	Grants
SUD	State	Recovery	600,000	5	Historical
SUD	State	MAT - Medically Assisted Treatment	579,549	6	Grants
SUD	State	Facility reinvestment (regional)	525,524	2	Historical
SUD	State	Transfers from DBHDS facilities (regional)	326,000	4	Other [f]
SUD	State	Recovery employment	300,000	1	Historical [g]
SUD	State	Facility reinvestment regional transfers	—	1	Historical
SUD	**State**	**Subtotal**	**$50,690,183**		
SUD	Federal	Alcohol/drug treatment block grant	20,417,639	40	Historical [h]
SUD	Federal	Prevention block grant	6,599,455	40	Historical/ Funding formula [i]
SUD	Federal	Federal Opioid Prevention, Treatment and Recovery (OPT-R) - treatment	5,500,445	25	Grants
SUD	Federal	Women block grant (Includes Project LINK at 6 CSBs)	4,715,501	40	Historical [j]
SUD	Federal	Other federal-CSB	2,987,721	11	No discretion [k]
SUD	Federal	Substance Abuse Residential Purchase of Services (SARPOS) block grant	2,514,740	40	Grants [l]
SUD	Federal	Federal Opioid Prevention, Treatment and Recovery (OPT-R) - prevention	2,511,749	36	Grants
SUD	Federal	Federal retained earnings	1,668,244	36	Other
SUD	Federal	Federal Opioid Prevention, Treatment and Recovery (OPT-R) - recovery	1,280,134	12	Grants

Program	Source	Budget line	FY18 funding	#CSBs	Allocation method
SUD	Federal	Strategic prevention	$1,085,662	9	Funding formula [m]
SUD	Federal	Prevention - Family Wellness block grant	774,338	8	Historical [n]
SUD	Federal	Project LINK/ Pregnant and Postpartum Women (PPW)	748,698	9	Grants
SUD	Federal	Cooperative Agreements to Benefit Homeless Individuals (CABHI)	745,447	4	Grants [o]
SUD	Federal	New Directions block grant	700,000	1	Historical
SUD	Federal	Co-occurring block grant	675,000	22	Grants
SUD	Federal	Young Adult Substance Abuse Treatment (YSAT) – implementation	571,588	4	Grants
SUD	Federal	Recovery grant	500,000	3	Grants [p]
SUD	Federal	Jail services block grant	443,792	3	Historical
SUD	Federal	Medically Assisted Treatment (MAT) block grant	370,676	3	Grants
SUD	**Federal**	**Subtotal**	**$54,810,829**		
SUD	Fees	Fees: other	12,239,133	39	
SUD	Fees	Medicaid fees	8,710,380	38	
SUD	Fees	Transfer fees in/(out)	153,964	7	
SUD	**Fees**	**Subtotal**	**$21,103,477**		
SUD	Local	Local government appropriations	32,424,281	32	
SUD	Local	Philanthropic cash contributions	67,529	8	
SUD	Local	In-kind contributions	39,546	3	
SUD	Local	Local interest revenue	13,037	4	
SUD	**Local**	**Subtotal**	**$32,544,393**		
SUD	Retain	Other funds	2,857,650	23	
SUD	Retain	Other retained earnings	1,253,587	6	
SUD	Retain	State retained earnings - regional programs	1,015,652	2	
SUD	Retain	State retained earnings	949,115	17	

Program		FY18 funding
SUD	**Total**	**$162,224,886**

SOURCE: JLARC analysis of CSB funding data provided to DBHDS and DBHDS description of funding methodologies.
NOTE:
[a] Original allocations were based on a population formula. Current DBHDS staff are unsure of the specifics of the original funding strategy. As new funding was introduced afterwards, allocations were made for special projects. These funds do not change and allocations are now static.
[b] Allocations based on historical, population-driven formula. This has not been updated.
[c] Allocations were initially made for specific projects. Current DBHDS staff are unsure if the projects that these funds are allocated for still exist.
[d] Funding was initially distributed through the Substance Abuse Prevention and Treatment Block Grant. When Virginia lost the federal block grant, state funds were used to replace them. The allocations remained the same from the initial allocations of the grant.
[e] All CSBs in Region 5 receive this funding, and the allocations have not changed.
[f] Funds are allocated for specific projects. They primarily support populations that were in a DBHDS facilities and now require support in a community setting.
[g] Based on Piedmont Community Services budget request. The allocation is now historical.
[h] Initially a population-driven formula. However, it has not been updated.
[i] These are historical for the most part. DBHDS staff are now using a preventative framework model. This has been phased into the allocation method over the past three years. They plan to use needs assessment data and recommendations from the VCU funding model to reallocate funding.
[j] Allocations based on historical, population-driven formula. This has not been updated.
[k] CSBs apply directly to the federal government for these funds.
[l] Allocations are made to support CSBs that are providing a service with uncovered costs. This is done through a grant process.
[m] Epidemiological data is used to identify the high end of need for areas with prescription drug and heroin overdoses. Account for population statistics as well when determining allocations.
[n] Allocations were initially made to 15 CSBs based on an 18-year-old funding model. Now only eight CSBs receive this funding. The eight CSBs get their original allocations from the old funding model but then the funds from the other seven CSBs were distributed across the eight based on capacity.
[o] Grants are awarded based on a needs assessment that places CSBs into three tiers. The highest tier suggests the CSB has the highest need and receives the most funding.
[p] RFP process used.

Table C-3
Developmental services funding

Program	Source	Budget line	FY18 funding	#CSBs	Allocation method
DV	State	Crisis stabilization (regional)	$13,168,208	17	Funding formula [a]
DV	State	State funds	9,456,700	39	Historical [b]
DV	State	Crisis stabilization - children	8,883,792	5	Funding formula [c]
DV	State	Transfers from DBHDS facilities (regional)	8,770,215	14	Other [d]
DV	State	Trust fund	3,450,000	6	Other [e]
DV	State	The Omnibus Budget Reconciliation Act (OBRA) funds	1,700,305	34	Grants [f]
DV	State	Guardianship funding	175,000	1	Grants
DV	State	Crisis stabilization regional transfers	5,630	1	Funding formula [g]
DV	State	Crisis stabilization - children regional transfers	—	1	Funding formula
DV	**State**	**Subtotal**	**$ 45,609,850**		
DV	Fees	Other Medicaid fees	119,975,727	30	
DV	Fees	Medicaid Intermediate Care Facilities (ICF)/IDD (intellectual or developmental disabilities) fees	104,586,187	27	
DV	Fees	Fees: other	14,857,581.25	39	
DV	Fees	Transfer fees in/(out)	(327,978)	5	
DV	**Fees**	**Subtotal**	**$239,091,517.25**		
DV	Local	Local government appropriations	106,161,778	32	
DV	Local	In-kind contributions	207,468	3	
DV	Local	Local interest revenue	75,639	4	
DV	Local	Philanthropic cash contribution	33,889	12	
DV	**Local**	**Subtotal**	**$106,478,774**		
DV	Retain	State retained earnings- regional programs	6,897,487	14	
DV	Retain	Other funds	2,987,364	21	
DV	Retain	Workshop sales	928,764	6	

Program	Source	Budget line	FY18 funding	#CSBs	Allocation method
DV	Retain	Other Retained Earnings	$905,708	7	
DV	Retain	State Retained Earnings	878,584	9	
DV	**Retain**	**Subtotal**	**$12,597,907**		
DV		**Total**	**$403,778,048.25**		

SOURCE: JLARC analysis of CSB funding data provided to DBHDS and DBHDS description of funding methodologies.
NOTE:
[a] Funding is adjusted based on Medicaid reimbursement, geography, population, staff utilization and delivery. These allocations are actively managed and updated based on the factors indicated. Five CSBs receive the majority of the funding to provide services for their region. The remaining 12 CSBs that were allocated funds received funds for a unique event.
[b] Based on a formula that was developed between 20 and 30 years ago. Old allocations remain the same. If new money is added to this budget line those funds are allocated on a case-by-case basis.
[c] These are allocated in the same manner as developmental services Crisis Stabilization (Regional).
[d] Funds are allocated for specific projects. They primarily fund training centers to support the developmental services population.
[e] These funds are made up of revenues from the sale of land from old facilities. These funds are used for special projects. Allocations are based on the facility revenues, facility expenditures and the needs of communities.
[f] Funds are allocated based on requests for specific individuals. These funds are provided to support consumers who need nursing services but there is not a facility accessible.
[g] Regional CSB distributed DV Crisis Stabilization (Fiscal Agent) funds to a CSB within the region.

Appendix D: Alternative allocation methods

JLARC reviewed allocation methods for seven other states (Table D-1) and four Virginia programs (Table D-2). These illustrate the variety of ways that funding formulas, reimbursement models, and grants can be used to accomplish the goals of each state or program.

TABLE D-1
Other state allocation methods for community behavioral health services

State	Allocation method	Description of methods	Goals
Colorado	• Reimbursement model • Funding formula	• Fee-for-service model: Providers are reimbursed retrospectively for the units of service provided. Reimbursement rates are calculated from base unit costs from audited financial reports. • Capacity model: providers are reimbursed for their total operating costs for certain services that are not reimbursed by another payer. Funding is not tied to a specific service provided but covers total operational costs minus reimbursements from other payers. • Case rate model: Providers are paid a set "case rate" for the estimated number of indigent clients they will serve in the coming year. Case rates are based on historical utilization and costs.	• Ensure the state is the payer of last resort • Improve the understanding of specific services and costs
Georgia	• Reimbursement model	• Providers are reimbursed for services provided with federal and state general funds. This model is used to cover services that are not reimbursable through private insurance or Medicaid. The reimbursement rates are identical to Medicaid reimbursement rates. • A base funding allocation is also distributed to CSBs for administrative and other costs not covered through the reimbursement model.	• Move toward a performance-based payment system • Ensure CSBs are competitive with other providers
Maryland	• Reimbursement model • Grants	• Community providers send bills for both Medicaid and uninsured patients to a contractor for the state Medicaid agency. For services not reimbursable through Medicaid, state general and other funds are used to reimburse for services. The Medicaid and uninsured reimbursement rates are identical. • Grants are used for a small proportion of funding.	• Provide access to the appropriate treatment plan for all residents

State	Allocation method	Description of methods	Goals
Michigan	• Funding formula	• Determine the population 200% below the federal poverty level that are uninsured. The majority of the funding is based on this factor. • Base funding amount is also distributed across community providers to cover additional cost associated with administrative, jail diversion, and other costs not accounted for through the funding formula.	• Consistent services across the state • Clear methodology • Incentivize efficiency of community provider operations
North Carolina	• Reimbursement model	• Local management entities—managed care organizations (LME-MCOs)—reimburse providers on a fee-for-service basis for Medicaid and uninsured consumers. For consumers not covered through Medicaid or private insurance, the LME-MCOs use state general fund appropriations. • The behavioral health authority's allocation to each LME-MCO is historically driven.	• Move toward full integrated care management • Transition to real outcome measures for funding allocations • Incentivize local providers to optimize Medicaid revenues and reduce reliance on state dollars
West Virginia	• Grants	• Allocate funding across community providers based on grant proposals	• Meeting the needs of each service area

SOURCE: JLARC analysis of interviews with staff and literature review of other state behavioral health systems.

TABLE D-2
Other Virginia program allocation methods

Virginia program	Allocation method	Description of methods	Goals
Local health Departments	• Funding formula	• Total budget for each local health department is adjusted through a cooperative budgeting process between the state and the local governments. • The total budget is split between state and local funds based on historical local ability to pay indicators. These indicators are: Potential local revenues for major tax instruments, sales tax revenues, and other local tax revenues. The local tax base is then multiplied by the statewide average tax rate to determine the revenue capacity of a locality.	• Ensure local governments are at least partially accountable for the local departments of health • Balance funding across state local health departments • Equal access to needed services

Virginia Program	Allocation method	Description of methods	Goals
SOQ Model	• Funding formula	• The board of education and General Assembly share responsibility for formulating the standards of quality for public schools. They estimate the funding needed per pupil to achieve the standards of quality. Then each school's funding is determined based on the number of students enrolled. • The composite index is used to determine the proportion of the funding that the state and localities will be required to provide.	• Ensure a minimum level of quality support and instruction is available for all students
Base Adequacy Model	• Funding formula	• Use a formula to determine the funding needs to support academic operations and missions of public higher education. The formula is driven by the number of students enrolled in a school, the amount of faculty needed to support students and any other additional costs needed to operate a university or college. The formula uses updated enrollment data each year but the underlying cost per student calculations have not been updated.	• Provide an objective and commonly accepted measure for institutional funding
Historical DBHDS Model	• Funding formula	• The formula accounts for the following measures for each CSB: population, the percentage of population in poverty, disease prevalence measures for each program area, and the ability to pay. • A formula is calculated for each program area. Population, poverty, local ability to pay measures are used across all formulas. The measures for prevalence vary by program.	• Assure equitable allocations to each CSB of state funds.

SOURCE: JLARC analysis of interviews with staff and literature review of other Virginia programs.

Appendix E: Agency responses

As part of an extensive validation process, the state agencies and other entities that are subject to a JLARC assessment are given the opportunity to comment on an exposure draft of the report. JLARC staff sent an exposure draft of this report to the Virginia Department of Behavioral Health and Developmental Services and the Secretary of Health and Human Resources.

Appropriate corrections resulting from technical and substantive comments are incorporated in this version of the report. This appendix includes response letters from the

- Department of Behavioral Health and Developmental Services and the
- Secretary of Health and Human Resources.

COMMONWEALTH of VIRGINIA

DEPARTMENT OF
BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

S. HUGHES MELTON, MD, MBA
FAAFP, FABAM
COMMISSIONER

Post Office Box 1797
Richmond, VA 23218-1797

Telephone (804) 786-3921
Fax (804) 371-6638
www.dbhds.virginia.gov

June 10, 2019

Mr. Hal Greer, Director
Joint Legislative Audit and Review Commission
919 East Main Street
Richmond, Virginia 23219

Dear Mr. Greer:

Thank you for the opportunity to review the exposure draft of the JLARC report on *Review of CSB Funding.* We appreciate the Commission's and the Joint Subcommittee to Study Mental Health Services in the 21st Century goal of understanding current funding for Community Services Boards (CSBs) and how we can take steps to ensure, through appropriate allocation of funds, consistent access to high quality behavioral health services for all adults and children in Virginia. We are committed to working with you and the General Assembly to continue to improve the access and quality of behavioral health services in the Commonwealth.

We have a few general comments. First, as you note in the report there is an enormous amount of complexity in the CSB operational environment today. CSBs are at the forefront of several major changes to improve access to and quality of services for Virginians with behavioral health conditions. These include implementation of STEP-VA and Medicaid Behavioral Health Redesign. In addition, Medicaid expansion is just underway and CSB's must continue to work with DBHDS to address the remaining elements of the Department of Justice Settlement Agreement. Any changes to the current funding methodologies must be considered in the context of these large, overlapping system changes.

Second, the report does not include information about what DBHDS is already doing to drive more accountability and to more appropriately fund CSBs based on their current capacity as well as need. This information is critical in formulating any future funding methodologies:

- DBHDS will be undertaking a major overhaul of CSB Performance Contract for FY21/22. The Performance Contract is the vehicle used to hold CSBs accountable for services delivery, funding, and data collection;

- DBHDS has initiated through an independent contractor two projects to better assess community needs and CSB capacity to meet those needs. The first project is with Virginia Commonwealth University (VCU) to develop a behavioral health equity index. Virginia will be the first state to have such an index when the project finishes in the fall 2019. The second project is a community behavioral health needs assessment. The contractor is conducting site visits in July along with stakeholder interviews. There will be an interim report in November

and a final report by March 2020. This needs assessment will help inform further implementation of several DBHDS initiatives, including STEP-VA; and

- In FY19, DBHDS and CSBs began use of SPQM, a national recognized tool that will permit CSBs and DBHDS to collect and analyze data from the DLA-20 tool to assess access to, and quality of, care across the entire system.

Third, DBHDS and CSBs would benefit from enhanced ability to exchange information, assess performance, and monitor fiscal health and standing of CSBs. However, DBHDS has limited resources to complete these tasks. Its infrastructure and resources to conduct monitoring and oversight are limited. When new programs are implemented, there is no administrative set aside to provide oversight from Central Office. In contrast, DBHDS federal grant programs provide a 5% set aside for oversight and administration. Resources for appropriate oversight and infrastructure to conduct this oversight must be considered for any future funding formula changes.

Finally, the report notes that DBHDS should develop a method to factor in potential Medicaid revenue. DBHDS has included such a factor in its calculation of the recent General Fund reductions associated with Medicaid expansion. DBHDS will continue to examine how to distribute other funds using some factor to determine potential Medicaid and private insurance revenue. Currently, what CSBs should receive in terms of those eligible for Medicaid reimbursed services and what they actually receive under managed care frameworks can be vastly different. In addition, it is important to note that CSBs are public entities that provide services to the uninsured; and there will be a certain portion of the population that will remain uninsured after Medicaid expansion.

As noted previously, CSBs are non-state entities who must work with both local and state partners to provide locally driven resources for individuals in need. They must provide many of these services regardless of whether the individual receives Medicaid or has private insurance. CSB's exist in either an urban or rural community, they are multi-jurisdictional or single jurisdiction, and they operate using a web of federal, state, and local funds. This operating complexity is their baseline from which they are now undertaking Medicaid expansion, STEP-VA, and Medicaid Behavioral Health Redesign. Given the multiple complexities and system changes underway, the General Assembly should carefully consider the appropriate time to address CSB funding formulas or reimbursements. It may be more useful to revisit funding formula changes in 3 years when these system initiatives are more established and reflect standard day to day operation for CSBs.

Thank you for the opportunity to comment on this report. We look forward to continuing our advancement of our behavioral health system through better access, quality, and outcomes for Virginians.

Sincerely,

S. Hughes Melton, MD, MBA

COMMONWEALTH of VIRGINIA

Office of the Governor

Daniel Carey, MD
Secretary of Health and Human Resources

June 12, 2019

Hal E. Greer, Director
Joint Legislative Audit and Review Commission
919 East Main Street, Suite 2101
Richmond, VA 23219

Re: Draft JLARC report, review of *CSB Funding*

Dear Mr. Greer:

Thank you for the opportunity to review a draft of the JLARC report, *CSB Funding*. This letter will confirm that I have reviewed the relevant report. I discussed my feedback with the Department of Behavioral Health and Developmental Services (DBHDS) and my feedback is reflected in their response.

Please let me know if my office may be of further assistance.

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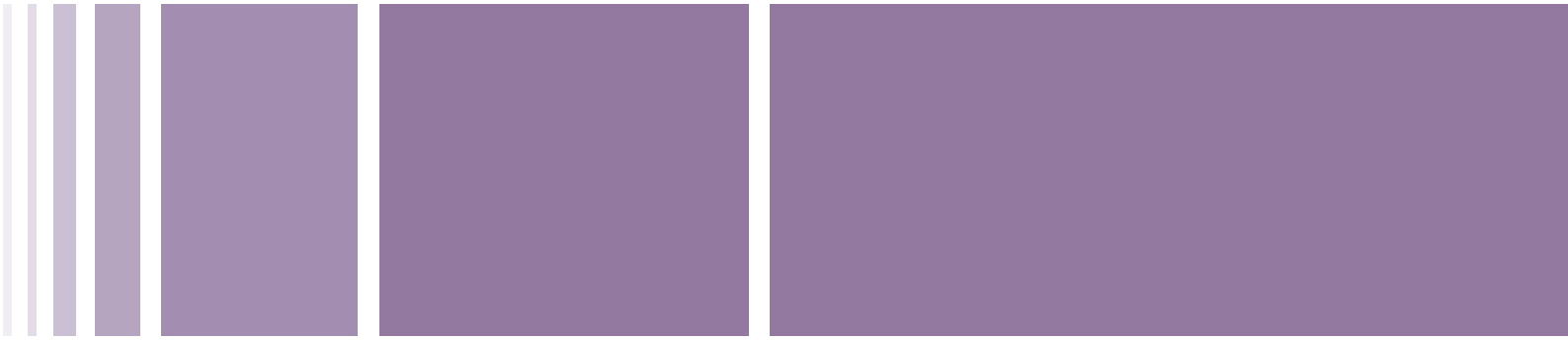

JLARC.VIRGINIA.GOV
919 East Main Street Suite 2101 Richmond, VA 23219