January 27, 2020

Following five years of partisan opposition, Virginia celebrated Medicaid Expansion that was approved by the Virginia General Assembly in an extended session in 2018. The new benefits that started January 1, 2019, provide essential healthcare for thousands of uninsured low-income Virginians. Some 330,000 newly enrolled citizens now receive services as of July 26, 2019 of the 400,000 believed to be eligible. The Department of Medical Assistance Services (DMAS) projects 360,000 to be enrolled by the end of 2019 and 375,000 enrolled by mid-2020. Despite these initiatives and advances, there remains much work to be done to adequately serve Virginia's Medicaid recipients, specifically, Virginia's most vulnerable and underserved populations.

Notwithstanding the excitement of the long- awaited and much- needed strides achieved with the final approval of Medicaid Expansion in 2018 toward an equitable system of access to healthcare for all Virginian's; it is of great concern that in 2019, DMAS, in partnership with Virginia's six managed care organizations (MCO's), has chosen to restrict access and freedom of choice to mental health and substance abuse services to Virginia's Medicaid recipients. We see this as an egregious affront of the intent of the Virginia legislatures underlying premise of Medicaid Expansion-quality and access to healthcare for all Virginians. To this end, we have three inherent policy concerns that Virginia's state agencies are currently leading:

1) Medicaid consolidation -eliminating private providers without cause 2) workforce shortage - refusing to put forth initiatives to address workforce shortage and 3) attacking the private community based mental and behavioral health model and retreating from community-based models. All of these issues are antithetical to a state seeking to expand behavioral health Medicaid services.

   Because of this, we are asking for the following consideration:

   As part of JLARC's on-going Medicaid study, Caliber Virginia is requesting a review/study of the impact Medicaid expansion and the behavioral redesign on access and continuity of services of Medicaid recipients, an analysis of workforce capacity and its impact on small and minority behavioral health providers to be added as a component of this study.

Background Information:

1. Virginia's 6 MCO's are terminating providers in Virginia and have no demonstrable evidence of value-based outcomes, but terminating indiscriminately in a time when Virginians are facing opioid and mental health epidemics, why? As a part of the ACA, the federal Network Standard Adequacy regulation in the 45 Code of Federal Regulations §156:230 describes federal requirements for all qualified health plans to maintain a provider network that is "sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay."

2. Expansion of Medicaid simply in word only, the DMAS is intentionally restricting the supply of providers and QMHPS to limit the demand. DMAS is aware of the shortage of QMHPs and has not taken ample steps to close the gaps of needs for that skillset. In fact, DMAS has raised the service level definition for service provision to eliminate opportunities for low income people to access services

While Medicaid expansion is creating an opportunity for thousands of people to enroll in healthcare coverage, it's also creating a demand for more behavioral health specialists, "says Sara Dunnigan, Governor Ralph Northam's Deputy Chief Workforce Development Advisor.

The work group will look into ways to entice more people to not only join the behavioral health workforce, but to also take jobs in rural areas where the shortage is often more pronounced. They'd tentatively like to come up with a set of final recommendations to introduce in Virginia's 2020 General Assembly session.

Every state is touched by the workforce shortage. Projections show that by 2025 the shortage will be astronomically worse; six vital mental health provider types (psychiatrists; clinical, counseling, and school psychologists; substance abuse and behavioral disorder counselors; mental health and substance abuse social workers; mental health counselors; school counselors) will have shortages of approximately 250,510 FTEs.4 An infusion of qualified behavioral health providers is needed to drive down avoidable hospitalization costs, reduce recidivism with justice-involved clients, address the substance use epidemic and increase access to timely, evidence-based care.

https://www.bhecon.org/wp-content/uploads/2016/09/BHECON-Behavioral-Health-Workforce-Fact-Sheet-2018.pdf

3. DMAS has publicly stated that's its re-design model is a replicant of both Arizona and North Carolina and both states are in dire need of providers, 3 -5 years post system redesign. Why are repeating their errors

Arizona and NC are 2 states that are 3-5 years out and reverting back to a multi/provider network

Data obtained by the Arizona Daily Star shows trends since 2015 that are worrisome.

Among the concerns:

An increase in mental-health transports by Tucson police. An increase in opioid overdoses and suicide.

More petitions for court-ordered mental-health evaluations, to determine if a person is a danger to one's self or others and requires court-ordered treatment.

And a rise in inpatient psychiatric hospital days for patients with mental illness at least one large behavioral-health agency.

Gov of AZ:" Turmoil over the past few years has hindered access to routine care for patients, who are more likely to spiral into crisis and require hospitalization if they are unable to reach a case manager, reschedule an appointment in a timely manner or get their medications refilled."

4. The scattered chaotic and nonlinear rollout and implementation of Medicaid expansion and Behavioral Health Redesign necessitates that the 2020 General Assembly; review/study impact Medicaid expansion and the behavioral redesign on access and continuity of services of Medicaid recipients and its impact on small and minority behavioral health providers.

Please review our article in Style Weekly for the Week of January 7th, 2020, in the link below: https://m.styleweekly.com/richmond/opinion-troubling-gaps/Content?oid=15506381

Medicaid Consolidation:

Paradoxically to the mental health professional workforce shortage, and in the midst of Virginia's Opioid crisis, it is deeply troubling that the will of Virginia's general assembly, DMAS and Virginia's MCO's instigated a consolidation of private community- based

behavioral and mental health providers on September 25, 2019. This consolidation resulted in the termination "without cause" of more than 50 of Virginia's licensed private and community based behavioral and mental health providers; all qualified by DMAS and DBHS (the preeminent authority for Medicaid recipient's behavioral health services in the commonwealth). **We strongly question at a time of expansion of services underneath the Medicaid umbrella why INDISCRIMINATELY terminate these qualified providers "without cause"** if the ultimate goal is to serve as many needy Virginians as possible? This element simply is not consistent with the need for services and the fundamental intent of the Virginia legislature.

Workforce Shortage:

Virginia's community-based mental health professionals who treat and support individuals living with mental illnesses and substance use are a key segment of the mental health workforce. Primarily funded through Medicaid, these professionals provide treatment and support at home or in the community rather than in a traditional clinic setting. Such settings are preferential for and conducive for a population that is often reluctant to seek treatment due to a combination of mental health challenges, frequent homelessness, unstable housing, and extreme poverty. Since 2011, in part because of Virginia's restructuring the professional qualifications of its mental health professionals, the mental health professional workforce serving this population has decreased by 23%. **Without additional workforce development initiatives, Virginia will continue to fail to deliver adequate access to treatment. As a result, access to treatment will remain elusive for Virginia's most vulnerable populations because there are simply not enough workers**.

(https://www.kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D).

(https://psychcentral.com/blog/mental-health-professionals-us-statistics-2017/)

Community Based Behavioral and Mental Health Service Model vs a Clinical Model

There are a number of effective private community-based mental and behavioral health treatment models for serving Virginians with mental illness and substance abuse disorders, Most of the services are delivered by a multidisciplinary team in the individual's home or wherever the client is most comfortable receiving services, by a multidisciplinary team of mental health professionals. Community based services continues to be effective for managing symptoms and reducing housing instability and psychiatric hospital admissions, as well as treating early psychosis has been a major step forward for the early treatment of serious mental illnesses in Virginia, with the potential to change the trajectory of illness.

Hiring and maintaining the mental health professionals necessary to do this kind of work, however, has been difficult. Community base work has a different set of challenges than clinic-based treatment. For example, community-based work entails a wider scope of care than traditional therapy in a clinic, ranging from engaging people who may not want treatment, teaching daily living skills, addressing social determinants, and teaching self-management of illness strategies.

Community-based mental health professionals must also negotiate nontypical challenges more directly than their clinic-based counterparts, such as providing care in high-crime neighborhoods (because of the lack of affordable housing in lower-crime areas) and working toward the care goals of stable housing or jail diversion. This work is often stymied by the multiple fragmented systems within which these professionals work. Not surprisingly, studies document higher rates of burnout for community -based mental health professionals compared to those who are clinic-based. (https://www.ncbi.nlm.nih.gov/m/pubmed/15742228/) This is compounded by extremely low Medicaid reimbursement levels, causing this important work to go significantly underpaid.

We are encouraged by the recent investments in Medicaid expansion, behavioral health redesign and behavioral and mental health services, and I thank you for the work you have done on that. Virginia's behavioral and mental health care system needs sustained, long-term support.

Policy /Legislative Recommendations

As Virginia policy makers consider policy incentives to grow the community-based mental and behavioral health workforce, we support the following from the governor's budget:

1.) Increasing funding for behavioral health redesign

2.) Implementation of the VMAP program

3.) Funding to support the expansion of outpatient behavioral health services Virginia's Community Services Boards in order to fully implement the STEP VA plan.

4.) Increasing provider rates for psychiatric services

Caliber Virginia Recommendations to be added to the 2020 Legislative Agenda:

1) We need to expand the availability of outpatient mental health services in our state. We are hopeful that the $15 million for STEP VA outpatient services will remain in the budget for 2020, but we also request that the General Assembly fund the additional $21 million needed to fully implement STEP VA services.

2) We request that Virginia develops an administrative code, statute or regulation that prevents MCOs from having terminable at- will contracts.

The MCOs should not have the authority to create terminable at will contracts – the authority to create terminable at will contacts moves the MCOs from a vendor to an executing decision maker, which is exactly what 42 CFR 455.410 and case law, K.C. v. Shipman, state is in violation of the law.

3) We request that Virginia develop an appellate/regulatory governance board consisting of private community based behavioral and mental health providers and clients that will hold DMAS, DBHDS, DHP and all other agencies that provide governance and oversight to the state's licensed providers and Medicaid recipients. The governance board shall report directly to the general assembly committee of health and welfare institutions. The board would be made up of no more than nine providers: three small providers (under 20 employees), three medium providers (21 to 65 employees), and, three large providers (66 employees and above). The board shall also have two clients as members.

The board will be responsible for ensuring that state agencies abide by the intent of current laws and spirit of the laws created within the Virginia General Assembly.

Because there is no current system that holds DMAS and all other applicable entities accountable for their arbitrary behavior and policies, the aforementioned governing board will be a regulatory Board of Directors.

4) We request that Virginia develop student loan repayment programs for mental health professionals who practice in areas that are federally designated mental health workforce shortages areas. This effort would incentivize targeted professionals to locate in areas with limited access to treatment.

5) We request that Virginia improve Medicaid reimbursement rates for specific treatment models aimed at treating those with serious mental illnesses. In addition, Virginia needs to create a reimbursable administrative rate separate from the delivery of program services for all of the administrative documentation required by Virginia's regulatory agencies. Low reimbursement means providers that treat this population do not have the resources to hire enough professionals to treat those with the most significant conditions, thus limiting access to treatment. As a result, it can take someone with a serious mental illness many years to get the correct treatment; treatment lags result in

accumulating disability that can mean a lifetime of debilitating symptoms. Enhanced reimbursement would enable providers to hire more clinicians, thus increasing access to care.

6) We request that Virginia shift from fee-for-service Medicaid reimbursement to a value-based care payment model; a reimbursement methodology that challenges the "volume-based care" associated with fee-for-service and encourages healthcare providers to deliver the best quality care at the most reasonable cost, improving the overall value of care. A value-based care model enables mental health professionals to deliver care that results in the best health outcomes.

Antiquated state regulatory systems can stymie what mental health professionals are able to provide for clients. Modernizing these rules in ways that harness the community-based workforce, allowing for innovation, staffing flexibility, and the integration of mental health and substance use treatment with other medical care, combined with paying for positive health outcomes, would not only improve the quality of care delivered but also would reduce workforce burnout and turnover.

With the state's six psychiatric hospitals operating at 90% capacity or higher for the past three years, the state legislature has promised more funding for community based mental health services. Data from the federal Substance Abuse Mental Health Services Administration say Virginians receive less community care than most Americans. We hope policy makers will take action to support and implement these recommendations to grow the community-based mental health treatment workforce, and thereby improve access to treatment.

Thank you for your continued leadership and strong dedication to mental health and substance use disorder parity. We look forward to working with you to ensure the enactment of this important legislation.

Caliber Virginia, was established in 2006 to provide support, resources and information with a united, well-informed and engaged voice among the private community-based behavioral and mental health service providers of the Commonwealth.

Caliber Virginia is the collective voice of private minority community-based behavioral and mental health providers in Virginia. We champion community providers' causes and represent their interests at the Legislature, with the Administration, state agencies that contract with community providers, the media, and with other related advocacy organizations/associations at the local, state, and national levels. Caliber Virginia's respected voice protects private community-based service provider funding, advance new funding initiatives, support strategies for long-term change to the funding system, facilitates training and education programs for providers and advocate for policies that support the community provider system.