November 22, 2019

Following five years of partisan opposition, Virginia celebrated Medicaid Expansion - approved by the Virginia General Assembly in an extended session in 2018. The new benefits that started Jan. 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. The Department of Medical Assistance Services (DMAS) projects 360,000 to be enrolled by year-end and 375,000 enrolled by mid-2020, of the over 400,000 believed to be eligible. And yet there is still much work to be done to adequately serve Virginia's Medicaid recipients, i.e. 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-finally moving the Commonwealth toward an equitable system of access to healthcare for all Virginian's; of great concern is that in 2019, DMAS, in partnership with Virginia's six 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 undermining 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 3 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 - retreating from community-based models. All of these items are antithetical to a state looking to expand behavioral health Medicaid services,

<u>Medicaid Consolidation:</u>

Paradoxically to the mental health professional workforce shortage, and in the midst of Virginia's Opioid crisis, its deeply troubling, if not usurping the will of Virginia's general assembly ,that starting September 25, 2019, DMAS and Virginia's MCO's instigated a consolidation of private community based behavioral and mental health providers. This consolidation resulted in the termination of 50 plus of Virginia's licensed and qualified by DMAS and DBHS (the preeminent authority for Medicaid recipient's behavioral health services in the commonwealth) private community based mental and behavioral health providers "without cause". **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 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, which is essential for a population that is often reluctant to seek treatment due to a combination of mental health symptoms, 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 adequately deliver access to treatment , remaining 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 in the individual's home or where the person is most comfortable receiving services, by a multidisciplinary team of mental health professionals. Community based services continues to be very 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 based, work has a different set of challenges than clinic-based treatment. For instance, community-based work has 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 illness self-management 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 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.

## Policy /Legislative Recommendations

As Virginia policy makers consider policy incentives to grow the community-based mental and behavioral health workforce, we recommend that:

1) Virginia develop an administrative code or 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.

2) Virginia develop an appellate/regulatory council consisting of private community based behavioral and mental health providers and clients that will hold DMAS, DBHDS, DHP and all other agencies that provides 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 9 providers 3 small under 20 employees 3 medium providers 21 to 65 employees 3 large providers 66 and above. The board shall also have 2 clients.

The board will be responsible for ensuring state agencies abide by the intent of current laws and spirit of the laws created within the general assembly.

There is no current system designed to hold DMAS and all other applicable entities accountable for their arbitrary behavior.

3) Virginia should 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.

4) Virginia should 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 right treatment, and treatment lags result in accumulating disability that can mean a lifetime of debilitating symptoms. Enhanced reimbursement would enable providers to hire more clinicians, thus growing access to care.

5) Virginia should 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 stymie what mental health professionals are able to do 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 get 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.