

To: All Stakeholders of the West Virginia Behavioral Health System

From: Bureau for Behavioral Health and Health Facilities (BHHF) and Public Consulting Group, Inc. (PCG)

RE: Stakeholder Comments to System Redesign Report

This document presents a summary of stakeholder comments received with regard to the draft report entitled “Proposed Redesign of West Virginia’s Behavioral Health Service System,” which was developed by Public Consulting Group, Inc. (PCG) and released on the Bureau for Behavioral Health and Health Facilities’ (BHHF) website during the last week of September, 2006. Comments on the draft report were collected for a two-week period ending October 10, 2006. In that time, BHHF received a total of 289 comments from a wide range of stakeholders, including consumers, providers, advocacy groups, and national organizations, among others.

Supportive Comments

The overwhelming majority of comments received were positive—stakeholders voiced their support of the redesign goals recommended in the PCG report. Comments were especially supportive of:

- Developing a service brokerage model that will result in increased choice and self-direction for consumers and a more streamlined access to needed services and supports.
- Improving communication, sharing of information, and dialogue between BHHF and providers of all supports and services.
- Increasing the focus on evidence-based practices and performance-based contracts.
- Developing a basic behavioral health service package that will be provided to all consumers throughout the state, funded in a fair and equitable way.
- Developing new and redesigning existing waivers to provide additional services and supports to Medicaid consumers.

While these comments were discussed in detail amongst PCG and BHHF, responses to these comments will not be issued. However, we would like to extend our appreciation to the stakeholders who took the time and effort to send commentary of this nature to us—these comments let us know that the vision for the redesigned behavioral health system in West Virginia was accurate and reflected the true needs of its stakeholders.

Comments Requiring a PCG / BHHF Response

Some comments expressing doubts and raising questions were also received by BHHF. These comments and questions were actively discussed amongst PCG and BHHF. After reviewing all of the comments, PCG and BHHF jointly decided that the best approach would be to generate the following list, which states each inquiry / unsure comment and includes a correlating response from PCG and BHHF. These comments and responses have been categorized into 12 main topics for ease in reading the list.

TOPIC: SINGLE POINT OF ENTRY / SERVICE BROKERAGE MODEL

- Comment 1: Development of Service Brokerage – Point of Entry (POE) Centers appears to be desirable but is not advised because:**
- costs associated with setting it up;
 - the distraction from and potential neglect of existing behavioral health centers (BHC) to be practicable;
 - it is not convenient to consumers/patients in a State where ease of transportation is always a limiting factor;
 - is the POE Center really “independent” serving a “navigator” function – or not?
 - it would seem more practical and more cost-effective to provide resources to fully fund and hold accountable the existing BHCs; and,
 - it is unrealistic to think that fully functioning BHCs would choose to relinquish this status and all the infrastructure, experiences, resources and services they have developed in order to become brokerage POE Centers.

Response: Details will be added to the narrative regarding the single point of entry process and service brokerage model that will address many of these issues; however, some of these comments are related to operational issues that the Steering Committee will need to address and make decisions on during the implementation phase of work.

- Comment 2: The proposed service brokerage model does not clearly address the patients who are referred to hospital ERs and how they fit into the single point of entry once they are here.**

Response: We will add details to the report regarding individuals who are referred to the ER prior to their entry into the redesigned service system.

- Comment 3: Competitive service models do not work in rural communities - no one to compete against. Refer to white paper on rural sociology website.**

Response: The State wants to create an environment in which consumer choice is maximized.

- Comment 4: Single Point of Entry Model would lead to:**

- **Higher costs.** A large number of new bureaucracies would be created with their concomitant personnel and overhead costs.
- **Barriers to service.** The more people clients have to talk to prior to receiving treatment, the more likely they are to give up the quest midway or not pursue it at all.
- **Duplication of services.** Prior authorizations for Medicaid populations are currently conducted by the ASO. The plan calls for a new bureaucracy to perform many of the same functions for the non-Medicaid population.
- **Fragmentation of services.** Economies of scale are an important advantage offered by the comprehensive CMHCs. Equally important are service coordination advantages which occur when needed services are available from the same organization under one roof.
- **Increased opportunity for malfeasance.** Cut off referrals to any direct service provider in the state for three months, or significantly reduce referrals for six months and that direct service provider will go under.

- **Past failure of model. This model was recommended by PCG in NC and it failed.**

Response: We acknowledge these comments and will add more description regarding this model to the report.

Regarding the comment on PCG's work in North Carolina, the Single Point of Entry model developed by PCG for the State has been regarded as a success. However, once we developed our recommendations for North Carolina, the State took a lengthier period of time than expected to develop required standards for its local offices, including funding standards. The standards required some of the small counties to work together. Issues regarding time, finances, and county collaboration were all challenges to implementing the recommendation of a Single Point of Entry in North Carolina, but have since been worked on and the system is now running well in the State. We stand behind our recommendation for a Single Point of Entry Model in North Carolina to better serve the system's consumers.

Comment 5: Include goal for publicizing single points of entry.

Response: We will review where this comment can fit into the report's goals and whether it can be made part of the strategic planning process. We will possibly add this in as part of the responsibilities of the redesign Steering Committee; however, this is part of the implementation process instead of the design process.

Comment 6: Case management should be a part of the service brokerage component.

Response: Description of Service Coordination will be reviewed.

Comment 7: One wonders how the service coordination agency may provide QA to assure quality services from those over whom the system navigator has absolutely no control except to withhold future referrals.

Response: See response to Comment 1; we will add more detail to this goal.

Comment 8: Is the Single Point of Entry service brokerage model successful in other States that are comparable to rural West Virginia?

Response: Yes, we have seen this model utilized well in the area of long-term care in other states (currently 32 states and the District of Columbia are using a single point of entry model for their long-term care system). Please see the following on-line links for further information:

http://www.mass.gov/gcmr/pdf/Single_Point_of_Entry_052001.pdf#search='single%20point%20of%20entry%20and%20national%20policy'

http://www.nashp.org/Files/NY_POE_Systems_for_LTC_State_Case_Studies.pdf#search='single%20point%20of%20entry%20and%20longterm'

<http://www.nashp.org/Files/SEPReport11.7.03.pdf#search='single%20point%20of%20entry%20and%20State%20Health%20Policy'>

Comment 9: The redesign is heavily based on “the Single Point of Entry service brokerage model.” However, it is difficult to understand exactly what constitutes that model in

RESPONSE TO STAKEHOLDER COMMENTS

the initial parts of the report. If the only way in to the system to get services that would be reimbursable for the provider is through a separate entity, then it appears that users of primary care centers would face a daunting route to those services. In a truly integrated model of behavioral health and primary care, the patient would be seen immediately at the primary care center by a behavioral health provider who would consult with the PCP to determine the best thing for the patient. It is not clear how the SPE model would allow for that.

Response: See response to Comment 1; se will clarify this further by adding details to the report.

Comment 10: The brokerage system as proposed fails to address the issue of crisis response and gate keeping. To separate the crisis and gate-keeping from service coordination is failing to recognize the effectiveness of combining intake functions with crisis services which when acting as a single point of entry into a provider can lead to a more clinically effective and cost efficient service system.

Response: See response to Comment 1; we will add further detail to the report regarding the brokerage system and crisis response.

Comment 11: Currently, Comps have significant responsibilities as found in Chapter 27 of the State Code. These requirements place additional liability and cost on Comps. The PCG report asserts the state must open up the system to other private behavioral health providers. However, there is no mention of those additional providers assuming Chapter 27 requirements.

Response: Changes to Chapter 27 of the State Code will most likely need consideration in order to implement the recommendations presented in this report.

TOPIC: STEERING COMMITTEE

Comment 1: What is the relationship of a proposed “Steering Committee” to the “Behavioral Health Commission Advisory Board”?

Response: The “Steering Committee” will be the “Behavioral Health Commission Advisory Board” plus other stakeholders as needed. We will reflect this in the report.

Comment 2: Include consumers on Steering Committee.

Response: We concur; consumers should be included on the Steering Committee.

Comment 3: What authority would the Steering Committee be given?

Response: None; the Steering Committee will be utilized for advisory purposes only. The Bureau will have the authority on all final redesign decisions.

Comment 4: We strongly encourage the inclusion of a psychiatric physician as part of the Steering Committee.

Response: We concur.

Comment 5: Add Consumers in the Transition Plan’s column titled “Parties Responsible”: the state cannot determine the needed and desired services for consumers without this inclusion.

Response: See response to Comment 2.

Comment 6: Is the Steering Committee the same as the newly appointed State Comprehensive Behavioral Health Commission?

Response: See response to Comment 1.

TOPIC: BHHF's VISION AND MISSION STATEMENTS

Comment 1: Does BHHF currently have a Mission Statement?

Response: Yes, but the report recommends the development of system culture and resources to support it better. The current Mission Statement can be found on the Bureau's website.

Comment 2: Stakeholder role in the development of mission/vision statements is unclear.

Response: Stakeholder input will be requested once a draft of the mission and vision statements has been prepared; this is documented in the report.

TOPIC: PROVIDER RELATIONS

Comment 1: A better approach would be to encourage and enable better communication with the associations whose membership is already comprised of these private providers.

Response: We can include this as part of the goal.

Comment 2: Statement on page 17 that private providers appear to have no objection to being represented by the West Virginia Behavioral Healthcare Providers Association is totally wrong.

Response: Report will be modified to reflect this.

Comment 3: As currently constituted, the WV Behavioral Health Care Providers Association essentially functions as a lobbying group for BHCs. Why other providers are not involved, e.g. time commitment? No sense of shared interests?

Response: No matter the vehicle utilized, there should be provider collaboration amongst all. We will ensure that the report conveys this message.

TOPIC: STRATEGIC PLANNING PROCESS

Comment 1: BHHF is made responsible for the design of an actual strategic statewide plan for behavioral services (pg. 18). Isn't that what PCG was employed to do? How does this 3-5 year process relate to the 2006-2009 of this report?

Response: The Strategic Planning process is distinct from our redesign effort and the Steering Committee will be assisting with this process; we will clarify this recommendation to relate the difference more clearly.

Comment 2: The strategic planning process will create another group to develop recommendations.

Response: We will define "strategic planning" further, as this is the process that changes recommendations into reality.

RESPONSE TO STAKEHOLDER COMMENTS

TOPIC: TARGET POPULATIONS

Comment 1: The draft report states “... it is recommended that BHHF collaborate with the Steering Committee to develop and finalize a comprehensive list of the target populations that BHHF will serve.” To then present in the same report “a possible list of targeted populations to be served” seems unnecessary, if not inappropriate.

Response: The PCG list of target populations is posited for consideration and to facilitate discussion, but it is not intended to be where the discussion ends.

Comment 2: Traumatic Brain Injury needs to be priority.

Response: Acquired Brain Injury is a priority for the Bureau; we will change “Traumatic Brain Injury” to “Acquired Brain Injury” in the report.

Comment 3: I am curious as to what “serious mental illness” is going to include...if they are moving towards more behavioral health service in primary care clinics they may eliminate the mood disorders and leave the more chronic/severe population to the behavioral health providers. This would be devastating to us as the majority of clients fall into the mood disorder category.

Response: There needs to be some holistic healthcare provided at the primary care level; however, the Bureau needs to focus on behavioral health issues and the system’s consumers.

Comment 4: There is discussion regarding “target populations” but it does not seem clear that the consultants consider chronic disease patients with emotional disorders to be part of that target population.

Response: We will clarify the descriptions of the target populations listed in the report.

Comment 5: Developing a list for the Bureau’s target populations is unjust and seems to represent a frank commitment to a policy of rationing of care that is ethically unacceptable.

Response: By developing the list, we are identifying areas within the system that require additional resources. Target populations need to be identified so that dollars can be spent on those that are more in need—there are also safety net dollars available within the system for other individuals.

TOPIC: TRAINING / WORKFORCE DEVELOPMENT

Comment 1: Need to focus on training on how to collect data.

Response: We will add in our report that one key component of training should be on data collection methods.

Comment 2: More providers trained in serving people with TBI should be included in this group.

Response: We can make the report more specific with this added suggestion.

Comment 3: The report appears to contain a semblance of partiality for physicians, psychologists, and nurse practitioners over other provider categories, such as licensed clinical social workers, the largest behavioral health provider group in the country.

RESPONSE TO STAKEHOLDER COMMENTS

Response: We will clarify our recommendations, as the intent was to introduce innovative ways to serve more consumers of the system through workforce development strategies.

Comment 4: The proposal (pg. 40) to consider “licensing Ph.D. psychologists with pharmacy training” should not be given serious consideration for a number of reasons: 1) no data; 2) only two states have licensed psychologists for that purpose; and, 3) a new behavioral health plan for West Virginia does not need to become embroiled in sure-to-follow controversy.

Response: We will revise this recommendation in order to re-focus the capability of this activity providing access to individuals and assisting in some of the State’s challenging workforce development issues. The Steering Committee will be working on this issue.

TOPIC: EVIDENCE-BASED PRACTICES

Comment 1: The phrase, “inventive uses of evidence-based practices” is an oxymoron.

Response: We will remove the word “inventive.”

Comment 2: Include training and orientation on Evidence Based Practices to providers.

Response: Will be added to the report.

Comment 3: Psychiatric Day Treatment is not an evidence based practice.

Response: PCG recommends both evidence-based practices and practices that are not evidence-based as part of our suggestions to the Bureau for its redesign.

TOPIC: ESTABLISHING A BASIC BEHAVIORAL HEALTH PACKAGE

Comment 1: Include action steps for facilitating change to WV State Code.

Response: We do not believe that the Code is affected by establishing a package of basic services to be provided.

Comment 2: Implement a ticket or voucher system for accessing services.

Response: This is something the Bureau can consider as an operational issue when implementing the redesign activities.

Comment 3: What does the development of a family-centered behavioral health service focused on “resiliency” mean?

Response: We will insert a definition for resiliency in the report.

TOPIC: INTERACTION OF PRIMARY AND BEHAVIORAL HEALTHCARE

Comment 1: Improving the interaction of primary care and healthcare service providers. This issue is already well established and an integral part of providing services in the private sector. The proposed model is not suitable for what is done in the private psychiatric sector. Incorporation of Evidenced Based Practices fails to address as to who would be delivering these services in the private sector.

Response: We heard that the interaction between primary and behavioral health providers was a weakness within the behavioral health system in interviews conducted with stakeholders.

RESPONSE TO STAKEHOLDER COMMENTS

We need more detail as to why the proposed model is not suitable for the private sector. We can add further detail into the report about delivering evidence-based practices.

TOPIC: JAIL DIVERSION STRATEGIES

Comment 1: A step-down forensic bed appears to be a good idea at first blush; however, this population is called “forensic” for a reason.

Response: We will clarify the definition of forensic step-down unit in our report.

Comment 2: The work on this goal [jail diversion strategies] should not wait for FY 2009.

Response: The Bureau is working on this goal currently, so this goal will be moved to an earlier Fiscal Year within the report.

TOPIC: REPORT METHODOLOGY

Comment 1: Throughout the report it is mentioned that decisions were made based upon data gathered from the focus meetings in this area. Any decisions made were made based upon data from the community level with no input from the hospital-based provider. With the formation of this committee who will be decide who the key stakeholders are in WV?

Response: Focus groups were advertised in newspapers and individuals from certain target groups were individually invited to attend these sessions. All redesign decisions will stem from Steering Committee recommendations but will be made by the Bureau.

TOPIC: OTHER COMMENTS

Comment 1: The information here on the office of Ombudsman is insufficient.

Response: We will add detail to the report that states the Ombudsman has and will try to be more visible.

Comment 2: Write new Waivers for TBI population.

Response: We will consider making this goal more specific.

Comment 3: BHHF should be sensitive to the needs of service providers whether in facilities or BHCs and aggressive in providing what they need to do their jobs of caring for clients/patients.

Response: We concur; we are attempting to include all providers in the redesign process.

Comment 4: There are patients/clients for whom community alternatives are neither feasible nor realistic.

Response: It is hard to approximate a number of individuals for whom community alternatives are not feasible or realistic when a framework of necessary community supports and services is not in existence.

Comment 5: Transportation and stigma are issues within the behavioral health system.

Response: BHHF acknowledges this—therefore the issues of transportation and stigma will be addressed within the report in more detail.

Comment 6: The proposed changes are too vague. As a consumer, how can I give you feedback if I don't know what your report is really saying will happen to my services in the future?

Response: We will add detail to the report so that it is more clear and understandable for consumers.

Comment 7: All recommendations point toward maximizing resources as an outcome, not improving the lives of individuals experiencing disabilities.

Response: We recommend the maximization of resources so that more people can be served by the system in order to reach improved outcomes.

Comment 8: The State should create a goal for evaluating the effectiveness of Medicaid Redesign in West Virginia.

Response: We acknowledge this comment; the Steering Committee will monitor the potential effects of Medicaid Redesign on the system redesign efforts.

Comment 9: Is there really an over-reliance on behavioral health? And, if there is, is it really because of discontinuous dialogue between primary care and behavioral health?

Response: Stakeholder interviews indicated this to be the case; we will review the report to ensure the language used in this section is clear.

TOPIC: FINANCIAL COMMENTS

Comment 1: What's the meaning of proposing to increase the "provider hospital tax"? I would not recommend financing system improvements by means of increasing taxes on providers –there is already an onerous State tax on providers.

Response: This recommendation is related to increasing provider taxes to develop a larger pool of funding to disburse to the facilities for behavioral health services. Provider taxes has proven to be a formidable financing tool in many states. Provider taxes are being reviewed by CMS and federal authorities to determine the appropriateness of these expenses.

Comment 2: It is difficult to get patients to the state hospital when we do not have beds. Applications for commitment are either denied or dismissed during the hearing. However, this does not release this hospital from the liability of discharging patients to the street. The hospital liability is different than those of the mental health centers. The homeless shelters, crisis units, PI shelters, etc. can refuse to accept patients – we do not have that option once they are in the ER. It may seem that by not placing patients on diversion status by the "voluntary" option that we are protecting the rights of the patients. However, since this does not apply to the patients sent to the state hospital, it seems more likely this is just shifting the financial burden of treatment from the state to the private hospitals willing to offer inpatient treatment.

Response: The issues addressed in this comment should be alleviated once a stronger system of community care is developed. We understand and agree with this comment, but do not see a reason to update the report.

Comment 3: The current system for number of allowed days for psychiatric inpatients is not realistic. Patients, who present with psychiatric emergencies, are placed on

medications that need supervision and who do not have resources outside the hospital to supervise them cannot be stabilized within 3 days. When we are unable to discharge patients due to the lack of community support and services we are denied payment for services due to the current criteria. This would be a workable system if there were community supports able to offer a step-down program. ARH has provided care for the mentally ill for over 30 years. We have an investment in treating mentally ill patients and have an obligation to our community. However, we think it is time that our concerns and opinions be addressed along with those of the mental health centers. It is unfortunate that our opinions and concerns were not included in this report.

Response: This comment is asking for more of an institutional review in the report. We have clarified the report to state that the recommendation is to make significant improvements to the community care system, which will release much of the financial and service capacity pressure currently felt by the institutional providers.

Comment 4: The recommendation to use BHHF funds to create additional funds for “State match” fails to recognize the importance of non-medical-model services and supports to people who do not have a Medicaid benefit. It is a good idea to “transition” Targeted Case Management (TCM) to a monthly billing rate. It is ludicrous to document / bill for 15-minute periods. As important as this task is, BHHF and BMS should look seriously at other models of TCM in other states.

Response: We recommend both medical and support models (Medicaid and non-Medicaid) in depth. We will ensure that we highlight and restate this in the report.

Comment 5: The State currently uses grants to fund basic, or core, services. The problem with this may not be that “grants” do not promote good policy or service outcomes. It may be that existing policy does not promote good service outcomes.

Response: This is why we have recommended a “Service Brokerage Entity,” which will handle all assessments on behalf of community providers. No change is necessary in the report.

Comment 6: There needs to be more explanation of the logic that grant funding cannot produce good outcomes for consumers. The report recommends taking \$10M from BHHF, diverting some remaining resources to ACT, and then adding personnel costs to the fiscal part of the Bureau. What funding will be left for services to consumers? In spite of the fact that this report suggests more reliance on Medicaid and recommends Disease Management approaches and recommends an administrative structure to gate-keep admission to services, there are several places in which there are comments that a “medical model” is not being recommended.

Response: The example provided on pgs. 22-23 of the report is a hypothetical used to illustrate how “revenue maximization” may occur. \$10M is was used to highlight the opportunities associated with revenue maximization. PCG will update with a simple statement – the new service package will cover Medicaid and non-Medicaid services, medical and support services, to ensure that the new behavioral health system is truly providing a comprehensive package of behavioral health services to West Virginia.

Comment 7: Identify source of payment for individual services.

Response: PCG will note in the report that there is a funding stream attached to each service.

Comment 8: Bundled Crisis Rate would encourage providers to only provide services to certain individuals, and does not allow the flexibility needed to access these services on a as needed basis.

Response: Unbundled rates for less intense levels of crisis can be developed, but more stringent utilization management must also occur. PCG has addressed this in the report within Goal #4 by recognizing the need for capacity to provide crisis services.

Comment 9: It is recommended that there be a fee for services rather than grants. It would seem with quality control focusing on functional outcomes that a grant system might be better in that it could save money and there would be more creativity and energy in finding the procedures that would work for each individual to achieve outcome goals.

Response: West Virginia does not have the structure yet in its service system to handle payments based on outcomes. No change to report.

Comment 10: Is the proposed redesign an expensive proposition?

Response: The system is likely going to cost more than it currently does; however, it is not necessary to highlight this fact, as it is a product of the desired outcomes. Addressing this in the report may make readers perceive that this is a restriction of the redesign when in actuality, it is not.

Comment 11: Grants should be applied for to strengthen community based services.

Response: BHBF currently manages several grants for MH and SA services; this is a strength of the current system. No change to the system.

Comment 12: There is no consideration of the differences in reimbursement and revenue enhancement possibilities between FQHC and other behavioral health providers. It should be noted that over 50 schools in West Virginia have FQHC health clinics in them operated by regular FQHC community health centers. Many of these provide mental health services to children. They are supposed to be paid the same cost-based rate, but are often not reimbursed for behavioral health services.

Response: We are aware of the differences in rates within school systems, especially for psychology services. In a perfect market with unlimited funding and where supply and demand were known, BMS would consider the qualifications of all FQHC behavioral health providers. BMS could budget, plan, and set policy for these providers. Unfortunately, the WV system is broken right now, and dollars spent should be focused on the service brokerage model. WV will continue to consider the inclusion of excluded FQHC providers in this model, but not at this time.

Comment 13: BMS refuses to reimburse FQHCs for certain licensed providers such as Licensed Professional Counselors arguing that their interpretation of federal rules prohibit such reimbursement. Similarly licensed providers in other states do generate reimbursements for their FQHC employers. Looking at ways to make the rules work for West Virginia rather than looking for ways to discourage behavioral healthcare in primary care settings would be a step forward.

Response: Please see response to Comment 12.

Comment 14: When implementing “a fiscal approach to funding behavioral health services” there must be a recognition of the high potential for providing services through FQHCs.

Response: Please see response to Comment 12.

Comment 15: One wonders if Arizona’s increase in reimbursement rates actually addressed, in anyway, the problem of retention.

Response: Increased rates would make providers more fiscally solvent and stable; this could result in increased retention. No change necessary in the report.

Comment 16: Slight mention of the vast hole in services for individuals with psychiatric disabilities in the WV system – the lack of psychiatric rehabilitation services in the state. There is no mention in the report of a funding system that promotes stability of supports for persons served. We would also suggest a recommendation that an outside entity study the amount of cost-shifting that occurs in the state mental health system.

Response: Supports are addresses in detail in the report. Also, an integrated funding report is being completed for the Behavioral Health Commission.

Comment 17: TCM to a monthly billing rate – does this contradict a latter statement in which they say move TCM to a fee for services reimbursement rate?

Response: No, per month TCM billing would still be on a FFS basis, a fee schedule, policies, and procedures for billing the monthly amount would be established.

Comment 18: On page 33, the report reads “...providers shift the costs to BHHF for Medicaid payment shortfalls...” What is this about? I don’t think we do this. If it is isolated violators...why not address the violators?

Response: This comment was providing recognition that Medicaid rates may be low. The report’s language can be revised.

Comment 19: The last paragraph on page 37 states “...we recommend that case management be reimbursed through a fee for service procedure code basis.” This seems to contradict statements on page 23.

Response: Please see response to Comment 18.

Comment 20: The report suggests moving up to \$10 million from BHHF funding to Medicaid, to serve as “match” for additional Medicaid funding to enable rate increases. The report seems to ignore the fact that many people served in the behavioral health system are not Medicaid-eligible.

Response: Please see response to Comment 7.