

The membership of the West Virginia Behavioral Healthcare Providers Association believes that if we can work in partnership with the administration and the legislature to effect these five bold steps, we will have made great strides toward making the West Virginia behavioral health system what it has the potential to be – one of the best systems in the country.



West Virginia
Behavioral
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Providers
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A Vision for Value:

*The West Virginia Community
Behavioral Healthcare System*



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Executive Summary: The membership of the West Virginia Behavioral Healthcare Providers Association consists of twenty-one organizations that provide services throughout the state to individuals with behavioral health needs or concerns: those with developmental disabilities, those with mental health needs, and those having chemical dependencies.

The membership has significant concerns about the current behavioral health delivery system in the state. While once a national leader as a state in the de-institutionalization movement, we are now challenged to strengthen our community-based services. We believe that the current system of care is fragmented, under-resourced and fails to provide the essential services that individuals need to live successfully in their communities. The membership shares the sentiment of the Governor, his administration and the legislature that we all can, and ought to, do a significantly better job of treating, supporting and rehabilitating our state's most vulnerable citizens. To that end, we make the following recommendations for change:



Assure the stability of funding for behavioral health providers.

The deterioration of our previously balanced system of care accelerated in the year 2000 marked by the beginning of Medicaid managed care activities resulting in a \$31 million reduction in funding for community-based behavioral health care services. Concurrently, the state's forensics' population has quadrupled, now occupying 90 of our total statewide 240 public beds.

With few community-based outpatient alternatives available, and without the necessary continuum of community-based service options West Virginia once enjoyed, our two acute psychiatric hospitals have been constantly 'at capacity' resulting in the current annual \$10 million in unbudgeted diversionary payments for unused bedspace in private hospital facilities.

Without significant increases in rates of reimbursement in Medicaid since 1992, and in order to again begin stabilizing the system, we suggest a routine rate-indexing system for behavioral health services. Providers must be able with some certainty to maintain an adequate, competent workforce, keep pace with technological advances in the field and offer persons served state-of-the-art treatments and services. Providers cannot be expected to focus on these issues when rates are addressed every decade and a half.



Step 2

Implement a “No Wrong Door” approach for point of entry.

This allows our current provider system to triage, assess and refer individuals to needed resources within the community, without rejection and without an additional layer of service provision. We insist that every dollar that is available for behavioral health service systems be spent on service delivery and not be used to establish the elaborate, expensive technologies required by the proposed single point of access system. West Virginia’s demographics and geography require that consumers have access to the most convenient service delivery system possible and they receive all necessary evaluations, assessments and triaging at that point of service.



Step 3

Implement a new level of accountability in our state system

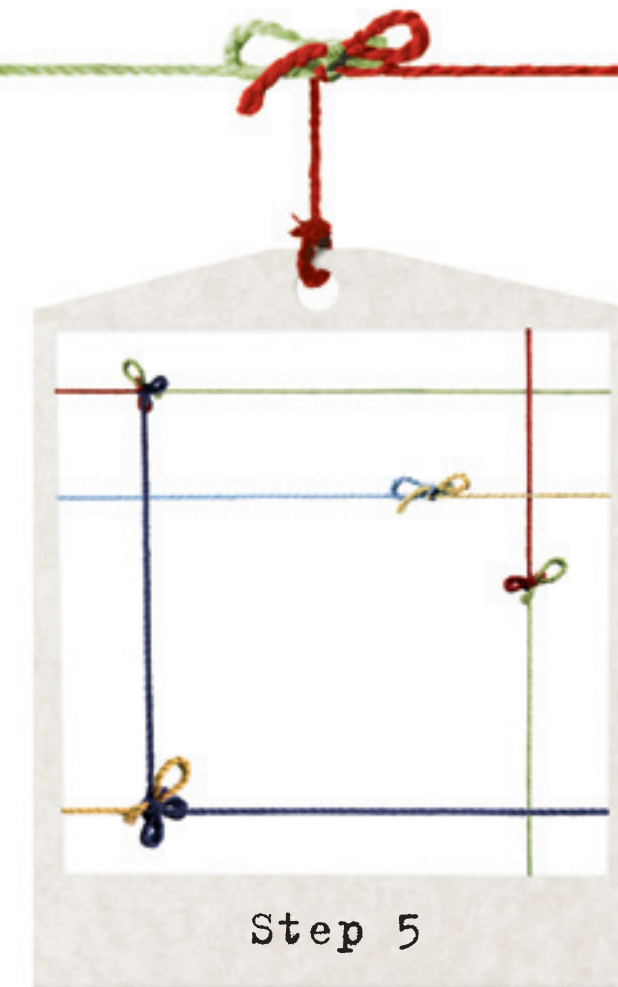
by developing a comprehensive state plan that facilitates partnerships among federal, state, local governments and providers. We must make the highest and best use of scarce resources within our system and these partnerships are essential to that. State and local governments must be more accountable for results, not only to the federal government but to persons and families in need, as well.

Additionally, it is essential that the system be accountable for the coordination of care. Persons served are invariably involved with more than one service system in addressing basic housing, employment, child welfare, justice, substance abuse and physical health problems.

Finally, we as providers understand the need to be held accountable, as well. Members want to be accountable for the funding they receive and want to demonstrate that persons served get better because of the services provided. To that end, we propose the implementation of a system-wide outcomes management process that will prompt the regular submission of indicators of effectiveness, efficiency, access and satisfaction to our funding authorities.



Streamline duplicative or inconsistent regulatory processes so that providers spend less time demonstrating compliance and regulators spend less time reviewing for compliance. We believe that over-regulation inhibits the effective use of various revenue streams and serves as a barrier to the ongoing use of best practices in the behavioral health system. Our objective is to identify policy changes that make the most of existing resources, increase our cost effectiveness and reduce burdensome regulatory structures. We recognize the need for oversight, but firmly believe that this can be accomplished by utilizing one standard and uniform set of measurements and one audit tool.



Implement a comprehensive array of services accessible to all citizens of the state. Our behavioral health system has been hindered by service gaps. Those gaps have caused cost shifting to other, more expensive systems, such as the use of state and diversion psychiatric hospitals, and have hindered the ability of our members to serve individuals in the most effective manner in the community, including the state hospital safety net function. The membership has created a menu of the services that we believe need to be made available to persons in need in our state.

We firmly believe that services for persons with severe psychiatric disabilities that were decimated by Medicaid cuts several years ago, need to be reinstated. These include 24/7, intensive residential services, psychosocial rehabilitation day programs and day treatment programs for adults and children. Cost shifting has been dramatic because of the demise of these programs and we believe that the reinstatement of these supports will have a significant impact on decreasing that cost shifting.