Summary of Survey Results
Impact of Current Practices on Service Capacity
Therapeutic Day Treatment

Between August 21 and August 28, 2019 private providers of CMHRS were surveyed; the survey was distributed through VACBP, Caliber and VNPP. Similar information was requested from the Community Services Boards and collected by VACSB; those results are not reflected here, but would be available through VACSB. This summary was prepared by VNPP, Inc.

Respondents provide a variety of CMHRS and the majority provide services in multiple regions; a significant majority currently have contracts with all six of the CCCPlus/Medallion 4 Health Plans.

Recent contract terminations (to date, by Aetna, Anthem and Magellan) have impacted approximately 17% of the respondents; we asked what impact these terminations have had, specifically on the provider's ability to provide TDT services and honor their commitments to both the schools and the children/youth that they serve. The answers appear on page 2.

The more significant issue, which is happening concurrently, is the sharp increase in either denial of authorization requests or the reduction in units of service approved. The impact is described on page 4.

We also asked for specific information on the impact to the workforce:
40% of the providers are reducing non-licensed staff,
22% of the providers are reducing licensed staff,
36% report delays in starting services because of the slowness of service authorizations
18% of the providers have eliminated one or more service location(s), and
6% have already closed the service

We asked for other impacts and/or more detailed explanation of the impact. Those answers appear on page 8. It should be noted the approximately 30% of the respondents said they are the sole TDT provider in the school or district.

The impact of the severe cuts in TDT extends beyond that line of service, approximately 30% of the providers also report that have had to reduce or eliminate other services. The impact is described on page 9.

We will not argue that the service as currently described and utilized in Virginia is perfect, we will, however, argue that in the absence of an alternative this dramatic shift will put children at risk and service providers in an untenable position. An unsustainable business can not be a quality provider.

Please describe the projected impact of a contract cancellation on your business:

Responses:

- We kind of did from Aetna, however I was able to resolve the issue.

- It will impact the families we serve by once again taking away their choice of providers. It will further reiterate to them that poverty, class, and many times race ranks them as unworthy of things like choice, preferred options, and power to dictate the type of help and from whom they receive it. We provide services in rural areas such as Eastern Shore, Culpepper, Franklin, Emporia etc. where service providers are sparse thus leaving those we serve with limited options and again NO CHOICE of their own. It will impact the schools we are in because each provider went through a competitive process to win bids to provide services in specific school districts. If we are the only provider or one of a select few, then a good number of children in the schools we serve will be unable to receive care because the providers aren't able to accept their insurance. In order to get new "approved" providers in the schools buildings, school district would have to start the bidding process over again thus prolonging the time when a child can be properly served. The projected impact also includes the number of overall clients we serve, therefore we have had to make plans to reduce our workforce. This will place more responsibility and burden on staff we are able to keep and will greatly impact staff burnout rates and could potentially negatively affect clinical care. It will force us to eliminate offered employment benefits. These benefits are a part of what sets our agency apart from others. We take pride in how we treat our staff. We view it as a way to ensure quality care to those we serve because happy staff provide the best services. Lastly the economic impact will likely be devastating and our agency may not survive it.

- The impact is largely effecting client currently serviced or on waitlist. The client, case managers and client advocates were unaware of this creating chaos, damaging our reputation and integrity of the work we are doing.

- 1 - MCO reflective of 20% of our business. Cancellation is only with Medicaid Contract

- Guided Paths received a contract termination from Aetna with an effective termination date of 10/1/19. This impacted 20% of the company's clients and as a result is having a significant impact on business.

- I oversee more than one agency that does MHSB. Only one of them got a notice. Will impact 6 clients currently

- We will potentially lose up to 1/8th of our clientele as well as that revenue which is well over 250K.

- The cancellations will reduce our ability to serve 30% of our clients

- One contract so far. 20% of revenue line.

- Anthem provided us with a "without cause" termination letter. We responded for reconsideration as we are the sole provider of these services in several school divisions and rural counties in the eastern part of the state.

- This will affect roughly 340 clients and in terms of revenue this will cost 3 million dollars plus and leaves clients in some of our rural areas without providers and in schools where we are the sole providers puts a tremendous hardship on schools and clients with more clients being expelled etc.

TDT authorizations are being reduced in duration and/or number of units per day; describe the impact this will have on your business:

Responses:

- It impacts the type of care we provide. It limits our time in the school buildings which leaves the children we serve unsupported. It will jeopardize our contracts with the individual school districts because a part of our contractual obligations is to be present in the buildings. We are unable to pay staff to be in the schools during the day if the units are reduced. It leaves the children vulnerable and it leaves them without the supports we committed to provide.

- We are being told that we cannot provide 3 unit programming for after school. Our authorizations have been drastically reduced and it has caused a significant loss of revenue. The peer to peer reviews that have been completed, most by Optima with Dr. Ebenger have been provided feedback stating we are supposed to be providing our clients "free time" outside of billing and that she knows decreasing our programs will cause salaries and staffing issues, but that is not her problem, that is what needs to happen for the clients.

- From the business side, this has resulted in layoffs. Even with explaining to parents that this reduction in units is the MCO decision, the relationship between the organization and parent is strained. This has resulted in a strained relationship between the parents and the school as well. It is creating another gap that no one is 'picking up the tab' and clients slip through the cracks unless services are probono. Having to probono hours per day for a multitude of clients in numerous schools is just not possible. The business could exist for a while with one MCO giving partial authorizations, but not all MCOs. So therefore, the client with the partial units is getting a lesser quality of service. The principals are extremely unsettled with this. If more than one MCO begins partial units, then our business will not be able to continue for long. It is significant to note that a TDT program with clients that have fully approved authorizations is needed for the simple fact of being able to run a summer TDT program. For our program, a 'successful' summer program results in a $100K deficit, and that is with clients authorized for 3 units per day. The remainder of the year our 'profit' goes towards making up for that loss. This summer was a hard hit which has resulted in a loss for our organization greater than -100K. With partial authorizations, I don't see how we will make up for this loss when we are struggling to balance the bottom line during the school year months.

- Will greatly impact the overall financial health of the business, as well as day to day operations with TDT - will now expand caseloads of counselors, which could effect the quality of services to a number of TDT clients.

- Significant impact to the entire organization and department as a whole, in which increase caseloads for staff due to decreased units and will lead to decrease in quality services provided; layoffs for staff; and overall lack of access to services needed for clients.

- They are also denying MHSB PAs.

- More children may be authorized for IIH or outpatient.

- "We have already laid off approximately 50% of our TDT staff due to the reduction in revenue. Now that the authorizations are coming in, irregularly, our current staff is split between sites, and unable to optimize the units prescribed/available due to time constraints. This has resulted in providing what we consider to be a lower level of care as clinicians are not available for immediate concerns or crisis due to the fact that they are at multiple schools splitting time between multiple programs (like IIH). Realistically, if all of our pending auths, or the rest of the priority list, were to get approved today, we'd be approximately 90 days from being able to onboard, train, certify, and staff new QMHP's (given that we could find any as we were one of the main producers of QMHP's in this region).

- From a business perspective, we prioritized the 100 or so highest priority cases in our school district (collaboratively with the district, DSS, Juvenile Justice, etc.) and received initial authorizations for about 15 of those kids. The auth reduction/restriction process has given us a negative reputation in the community as an agency that overpromised and under-delivered.

- Finally, from a competitive marketplace perspective, the authorization reductions have given rise to unsavory providers contacting the school district and trying to poach the division based off of the fact that we haven't been able to get the divisions top priority kids in. We have been disallowed from doing what we said we would do, and historically what we've done. "

- Staff will have to carry larger caseloads.

- Clients who need TDT are not being served and are at risk of school failure and/or more restrictive placements or home bound instruction. Reduced units creates significant stress financially as TDT is not a profitable at less than 3 units per day. If units continue to shrink we cannot provide the service and remain fiscally sound.

- This action will negatively impact effective service delivery to our clients and schools. Clients will be suspended and fail to meet the required seat time in my districts.

- "Significant. More important than our business model, we are seeing a substantial impact on students and families. TDT is such a valuable service that has been proven successful in helping many students thrive in the school environment. The increase in outright denials for this service, as well as the reduction in duration and units per day, is creating a situation where students are not getting the attention they need to be successful in the school environment. Parents are up in arms because their children are being denied services that DMAS regulations and Commonwealth legislation say they are entitled to receive.

- Not only has TDT led to positive behavior change in identified students, but also this service has positively affected the entire school environment. Teachers can better focus on educating, and other students can better focus on learning, as TDT counselors can actively address behavioral challenges in disruptive students throughout the day. Many students who are clearly eligible for TDT according to the DMAS regulations are getting denied for this service due to MCO cost saving initiatives. Those attempts to save costs via this program will likely have significant

negative fiscal ramifications that will surface in other areas of the Commonwealth (public safety, social services, health care, hospitalizations, residential care, foster care, etc.).

- The authorization reductions have a ""big-picture"" impact that goes beyond the individual student who is being denied the service they need. Less authorizations and less units mean less personnel. We already have a significant shortage in the behavioral health workforce of the Commonwealth. As a result of these recent authorization reductions, qualified professionals are suddenly leaving the field. We (as a provider) have had more TDT staff quit in the last week than we had all of last year. Having less students to serve, less time to spend in the school, and less overall reimbursement, means less work and less income for staff. So, staff are seeking other employment (often outside our field). This is incredibly dangerous for the short-term and long-term solvency of school-based behavioral health in Virginia (which has been deemed to be crucial).

- Drastically changing the delivery of this service before the behavioral health redesign initiative has even attempted to deeply explore school-based services could exacerbate the workforce shortage that already exists. Then, when the new model of school-based services is rolled out, there will be far less personnel available to deliver the designated new approach. We would be behind before we even got started.

- The impact of these authorization reductions on students, families, schools, staff, providers, and the community as a whole is quite significant.

- Prolongs treatment for those in need.

- Reduced to 3 months 1-2 units per day and less

- Currently 35% of TDT authorizations are on reduced units. The impact of the unit reductions has resulted in organizational changes including increased client ratios and staffing reductions.

- Reduction in units has cause us to reduce salaries and reduce Paid Time Off.

- same thing for IIH and ABA under MCO's

- Due to denials and decrease in number of units approved, our agency had to close our TDT program in one county and laid off 16 employees from 10 elementary schools. We are currently in jeopardy of closing the remaining 5 TDT program locations that we have due to denials and significant reduction in units (1 unit) and amount of time approved (1 or 2 months).

- It is forcing us to increase the number of clients a QMHP has on their caseload which increases the amount of paperwork their required to do and will impact the therapeutic services provided since they will have so many clients to see.

- This will mean a 40% reduction in revenue and loss of current business structure. Schools and students will have significantly limited access to therapeutic supports. Schools have lost TDT resources and staffing reductions due to inability to plan for resource distribution.

- We are having to lay off half of our TDT staff in one of our regions and looking at layoffs in other regions. In the region with the large layoff, we had 177 clients in May and we have only 49 in August. Some of those are partial auths.

- This will have a profound impact as this 1/3 of our business.

- There is an increased administrative cost to shift from a 6 month re-evaluation and re-authorization cycle to a 2 or 3 month cycle. The number of units are drastically reduced as if mental illness is curable if the pressure is placed on the provider.

- This will hit our bottom line dollar extremely hard we are looking at between 3 and 4 million, more importantly it impact the quality of care clients get as well as additional hardship on schools, ultimately will most likely lead to us shutting down schools and a reduction in workforce up to 40%.

Describe what other steps you have taken in response to the reduced authorizations for TDT:

Responses:

- ervices have not been totally eliminated as of yet. But that is the direction in which it is going. We are trying to pro bono as much as we can because there are children in crisis and a WEEK waiting list in our area for crisis services. We can't NOT serve a child when we are the only service available at times like this. We are doing all of this pro bono work in hopes that DMAS will 'onboard' one MCO in particular who has denied children and/or given partial units to children who are in extreme need. We can't continue this much pro bono work for much longer.

- We've also de-prioritized available TDT units. We've had to shift to a financial model in which clinicians split their time between schools or between programs. That sometimes leads to using 2 units per day instead of the 3 that were approved for a specific child, or weighing out the value of 3-5 hours of IIH vs. 2 units of TDT.

- Increase caseload sizes

- Referral to outpatient or other appropriate services.

- We are working to get clients to move to other insurance with large success rate.

- We are waiting to see the full scope before making the final judgement.

- Reducing staff in the rural areas that limit overall access to services.

Describe the impact on other services:

Responses:

- The reduction in TDT has meant a reduction in clinical staff because of reduced receivables. Therefore, the other services that also require licensed or licensed eligible staff have to be downsized so that the remaining clinical staff remain in ratio of allowable clinical staff to qmhp staff numbers.

- We have lost substantial money operating TDT services over the last 2 years which has resulted in our not being able to provide as much of other services that are also not sustainable on their own such as outpatient. Also, the impact of having to dedicate increased staff time for TDT accounts receivable takes away from our ability to manage other services efficiently.

- Yes, and not yet. What I mean is that if this continues into the future then we likely won't be able to exist to provide the much needed OT in our area. For now, reductions in TDT impact the ability to even be able to provide a summer TDT program since much of our profit goes back into the company to make up for the loss we (and I am sure most all TDT providers) incur in having a TDT summer program each year. On a different note, the 'ability' to provide services is impacted now because the quality of services is simply not possible with TDT for one unit a day when a child is on the brink of needing crisis services, which is the case for many of our clients.

- The financial stability of the organization within other departments

- "From a LMHP perspective- our LPC's are spending the majority of their time doing new intakes (as there's no shortage of referrals) and then preliminarily scheduling a peer review for when the auth gets denied as that has been the only way we've been successful at getting authorizations for some of these kiddos. Our LMHP staff is also putting out fires right now for kids that are waiting for approvals so services can start. Our LMHPs are also trying to assuage principals and superintendents who are acculturated to having at least one dedicated QMHP per school to now settling for less. In some of our schools, it would not be uncommon to have 2-3 Q's cycling through when the referral base necessitated, now we're cycling 1 Q through 2-3 schools and maintaining that spreadsheet and notifying all parties concerned is taking up a considerable amount of time for our Clinical Supervisors. This steals time from them when they were supposed to be providing outpatient services to the TDT kids (and the kids for whom OP was suggested in lieu of TDT), working on agency accreditation, obtaining more trauma-informed certifications, getting certified in ACT (as a good theoretical blend between CBT and ABA), and implementing new quality controls in our current programs to make better clinicians. From a Q perspective- we've cross trained some of our Q's as Registered Behavior Technicians (RBTs) as well. Due to the utter unpredictability of authorizations coming through, the clinicians who can work in other programs suffer the fate of getting a late night text with tomorrow's work assignment. This puts staffing patterns in flux and caps the amount of services each child gets, regardless of what they're prescribed or approved for.

From a financial position, this has wreaked havoc on our agency. We had plans to expand two different services into new regions this fall, services that were unique to the region, and services that have a significant (read externally supported by a school division, department of social services, or a Community Services Board) need. These aren't growth plans for the sake of profit, these are programs that other people have come to us asking for. We've been sought out to help in some areas because of the work that we do. Parts of our service region are sorely lacking in specialized crisis stabilization services (targeted population, theoretical framework, offering adequate step down services) and so we have our Crisis Stabilization Service Modification form ready to go. Due to constrained finances, and having to amend our staffing pattern, we're not pursuing this. Similarly, we were contacted by a Community Services Board that needed help with OBOT/MAT services and they were willing to contract with us to provide these services in house. They were going to give us a free group room and assist us with the tele-health application to manage doctor visits with our psychiatrist...its exactly the kind of model that DMAS has kept saying they want.

Our current process has forced us to shortchange the clinical care for (in this case) kids who desperately need services. We had an elementary student last week try to stab the principal with two different pairs of scissors (not the rounded tip kind!). This kid was waiting for over a week for authorizations and we weren't providing TDT services to them at the time of the stabbing attempt because services hadn't been approved. When this gets brought up, the MCO's say ""send me the client number and we'll look into it."" They don't, or at least they don't follow up with the provider once they have. Even if they did, and they correctly reversed their decision (or made a decision) it doesn't matter - this elementary student is now indefinitely suspended from school while they await their expulsion hearing. They made it exactly 9 days into the school year before getting kicked out.

At the end of the day, we can run a skeleton crew in TDT and do this service for less money with an acceptable margin. That's not hard, its just math. What we're not willing to do is provide substandard care for our clients because we are regulated to do so. For this reason, we've set a date of September 20 to decide whether or not to close our TDT program. The moment the provider community is regulated to do bad work is the moment when you lose good providers from the system (that's why they're good) and you open the door for the bad actors to run roughshod. As of today, it's our position that they can have TDT. "

- Workforce. With the authorization reductions, we are seeing a significant impact on our behavioral health workforce. As clinicians leave the organization due to these TDT authorization reductions (as their base income is dramatically affected), they are thus not available to provide valuable assistance on Intensive In-Home or Crisis Stabilization cases after school. For those TDT staff who are Residents in Counseling or Supervisees in Social Work that leave the organization, the result is less staff being available to conduct community-based assessments and out-patient services - thus, drastically affecting client access to behavioral health services in the Commonwealth.

- Our Outpatient Mental Health Counseling referrals have drastically decreased due TDT no longer being provided in many locations in our area. Since counseling was a requirement of TDT, we had significant referrals for individuals receiving TDT. Now that these individuals are not

receiving TDT, many parents and guardians are either not following through with the service or pulling them out all together.

- We are reducing and eliminating IIH services in certain regions. It was not cost-effective to provide on its own, but TDT was able to financially support the staffing and other overhead costs.

- TDT services supported cost sharing of smaller programs needed in the community.

- Many of the staff in the school buildings also provide other services as a supplement. Without the support of the school interventions the other services are being reduced as well.

- Some staff provided IIHS to go along with TDT, we have had to cut back because of the availability of staffing in rural areas