COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

KAREN KIMSEY
DIRECTOR

SUITE 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804/786-7933
804/343-0634 (TDD)
www.dmas.virginia.gov

October 13, 2021

MEMORANDUM

TO: The Honorable Janet D. Howell
Chair, Senate Finance and Appropriations Committee

The Honorable Luke E. Torian
Chair, House Appropriations Committee

The Honorable Mark D. Sickles
Vice Chair, House Appropriations Committee

Daniel S. Timberlake
Director, Virginia Department of Planning and Budget

FROM: Karen Kimsey
Director, Virginia Department of Medical Assistance Services

SUBJECT: **Updated Report:** Special Report: Medicaid Behavioral Services Realignment

This report is being resubmitted at the request of the Department of Planning and Budget and RD743 of Chapter 854 of the 2019 Acts of Assembly, Item 303.YYY.3. Please note that the following narrative is unchanged from the original report but budget figures have been updated and are included on the last page.

Should you have any questions or need additional information, please feel free to contact me at (804) 786-8099.

KK
Enclosure

Pc: The Honorable Daniel Carey, M.D., Secretary of Health and Human Resources

KAREN KIMSEY
DIRECTOR

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

804-786-7933
www.dmas.virginia.gov

December 31, 2019

MEMORANDUM

TO: The Honorable Thomas K. Norment, Jr.
Co-Chairman, Senate Finance Committee

The Honorable Emmett W. Hanger, Jr.
Co-Chairman, Senate Finance Committee

The Honorable S. Chris Jones
Chairman, House Appropriations Committee

Daniel S. Timberlake
Director, Virginia Department of Planning and Budget

FROM: Karen Kimsey KK
Director, Department of Medical Assistance Services

SUBJECT: Special Report: Medicaid Behavioral Health Services Realignment

YYY.1. The Department of Medical Assistance Services shall work with the Department of Behavioral Health and Developmental Services and stakeholders to develop the continuum of evidence-based, trauma-informed, and cost-effective mental health services recommended by the University of Colorado Farley Center for Health Policy that will result in the best outcomes for Medicaid and FAMIS members. This continuum shall include community mental health rehabilitation services (including early intervention services) and integrated behavioral health in primary care and school settings.

2. The department shall develop the necessary waiver(s) and the State Plan amendments under Titles XIX and XXI of the Social Security Act to fulfill this item, including but not limited to, changes to the medical necessity criteria, services covered, provider qualifications, and reimbursement methodologies and rates for Community Mental Health and Rehabilitation Services. The department shall work with its contractors, the Department of Behavioral Health and Developmental Services, and appropriate stakeholders to develop service definitions, utilization review criteria, provider qualifications, and rates and reimbursement methodologies. The department shall also work with its actuary to model the fiscal impact of the proposed continuum.

3. Prior to the submission of any state plan amendment or waivers to implement these changes, the Department of Medical Assistance Services and Department of Behavioral Health and Developmental Services shall submit a plan detailing the changes in provider rates, new services added and any other programmatic or cost changes to the Chairmen of the House Appropriations and Senate Finance Committees. The departments shall submit this report no later than December 1, 2019.

Should you have any questions or need additional information, please feel free to contact me at (804) 786-8099.

KK/

Enclosure
pc: The Honorable Daniel Carey, MD, Secretary of Health and Human Resources

Special Report:
Medicaid Behavioral Health Services Realignment

A Report to the Virginia General Assembly

December 1, 2019

Report Mandate:

Item 303 (DMAS) Medicaid Program Services. HB1700 - Chapter 854

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Executive Summary

Medicaid is the largest payer of behavioral health (BH) services in the Commonwealth and spent $862 million on these services in 2017. BH services are an essential part of whole-person healthcare within the Medicaid program, as nearly 1/3 of members have a BH diagnosis. While BH services play a critical role in the wellness of members, the current array of services available through Virginia's State Plan is outdated, lacks integration of, and support for, evidence-based practices and has not manifested strong outcomes. Virginia's Medicaid-

About DMAS and Medicaid

DMAS's mission is to improve the health and well-being of Virginians through access to high-quality health care coverage.

DMAS administers Virginia's Medicaid and CHIP programs. Through the Medallion 4.0 and Commonwealth Coordinated Care (CCC) Plus managed care programs, more than 1.4 million Virginians access primary and specialty health services, inpatient care, behavioral health, and addiction and recovery treatment services. In addition, Medicaid long-term services and supports enable thousands of Virginians to remain in their homes or to access residential and nursing home care.

Medicaid members historically have included children, pregnant women, parents and caretakers, older adults, and individuals with disabilities. In 2019, Virginia expanded the Medicaid eligibility rules to make health care coverage available to close to 400,000 newly eligible, low-income adults.

Medicaid and CHIP (known in Virginia as Family Access to Medical Insurance Security, or FAMIS) are jointly funded by Virginia and the federal government under Title XIX and Title XXI of the Social Security Act. Virginia generally receives a dollar-for-dollar federal spending match in the Medicaid program. Medicaid expansion qualifies the Commonwealth for a federal funding match of no less than 90 percent for newly eligible adults, generating cost savings that benefit the overall state budget.

funded BH services are characterized by an overreliance on intensive treatment services and underdeveloped opportunities for prevention and early intervention. The current service system is not structured to effectively manage member needs, promote the implementation of gold-standard practices, support alleviation of the significant psychiatric bed crisis, or successfully align with other state investments to improve access to high quality services (e.g. STEP-VA, Families First Prevention Services Act (FFPSA) Implementation, Department of Juvenile Justice transformation, Department of Education school-based health services task force). Virginia currently ranks 40th in the country for mental health care access and 41st in terms of mental health workforce supply. To improve Virginia's BH system functioning and promote resiliency and recovery for Medicaid members, changes to the current service structure and adjustment to rates that support new services and promote fidelity to best practice standards are imperative initial steps.

The report summarizes an initial set of 6 critical services. First are the necessary services that are missing from the current Medicaid-funded behavioral health benefit - Partial Hospitalization and Intensive Outpatient. Next are alternatives/redesigns of existing services that drive fidelity to evidence-based models for our most vulnerable members with the most complex needs - Multisystemic Therapy, Functional Family Therapy, Comprehensive Crisis Services, and Assertive Community Treatment. The interagency vision of the comprehensive Behavioral Health Redesign proposal is to work alongside stakeholders on phased implementation that will transform the system's current focus on high-intensity, acute service delivery, to a robust service array that is cost-effective, trauma-informed and focused on prevention, early intervention and recovery. *The proposed phases of Redesign build upon each other but are not contingent upon each other.* Each new phase will move Virginia towards the goal of improved access to care and quality of services for the entire system. The six services will be the main components within the redesigned continuum. They are designed to reduce the psychiatric bed crisis, provide evidence-based services for members with the highest needs, and align with other integral BH initiatives such as STEP-VA and FFPSA.

Background

Mental health conditions are very common and frequently undertreated, both across the U.S. and within Virginia. Nationally, 46% of adults will experience a mental health or substance use disorder in their lifetime, and 28% of adolescents will experience a mental health or substance use disorder with distress or severe impairment.[1-2] In Virginia, 28% of Medicaid members had a behavioral health diagnosis in 2017.

Medicaid expansion also creates an urgent need to ensure that newly covered individuals can access high-quality, evidence-based behavioral health services. Based on the experience of states similar to Virginia, we can anticipate that many of the newly covered individuals will have untreated physical and BH conditions due to their lack of coverage. For example, in Ohio's expansion population they found that 32.7% of people screened positive for depression or anxiety.[3]

While the prevalence of mental health disorders is similar in Virginia compared to other states, access to BH care is more limited. Virginia ranks 40th in terms of access to BH care in the nation.[4] Virginia also ranks 41st in terms of availability of mental health providers. Mental Health Professional Shortage Areas (MHPSAs) are designated based on availability of psychiatrists as well as "core" mental health professionals; these include clinical psychologists, clinical social workers, psychiatric nurse specialists, and marriage and family therapists. Of the 133 localities in Virginia, 95 counties and 38 cities, 87 (65%) were designated by the Health Resources and Services Administration as Mental Health Professional Shortage Areas in 2018. Significant regional variation exists; the greatest workforce shortages are in the Southwest and Southside regions.

Access to BH services is particularly limited for lower acuity settings and services. A disproportionate amount of mental health expenditures are spent on inpatient and high acuity care, with approximately 50% of general funds supporting only 3% of the population served.[5] Feedback from stakeholders suggests that these service types may be overused, when a lower acuity service would suffice; however, there is limited availability of lower acuity services. Reasons for this may include the fact that lower acuity service reimbursement rates are not sufficient to support providers.

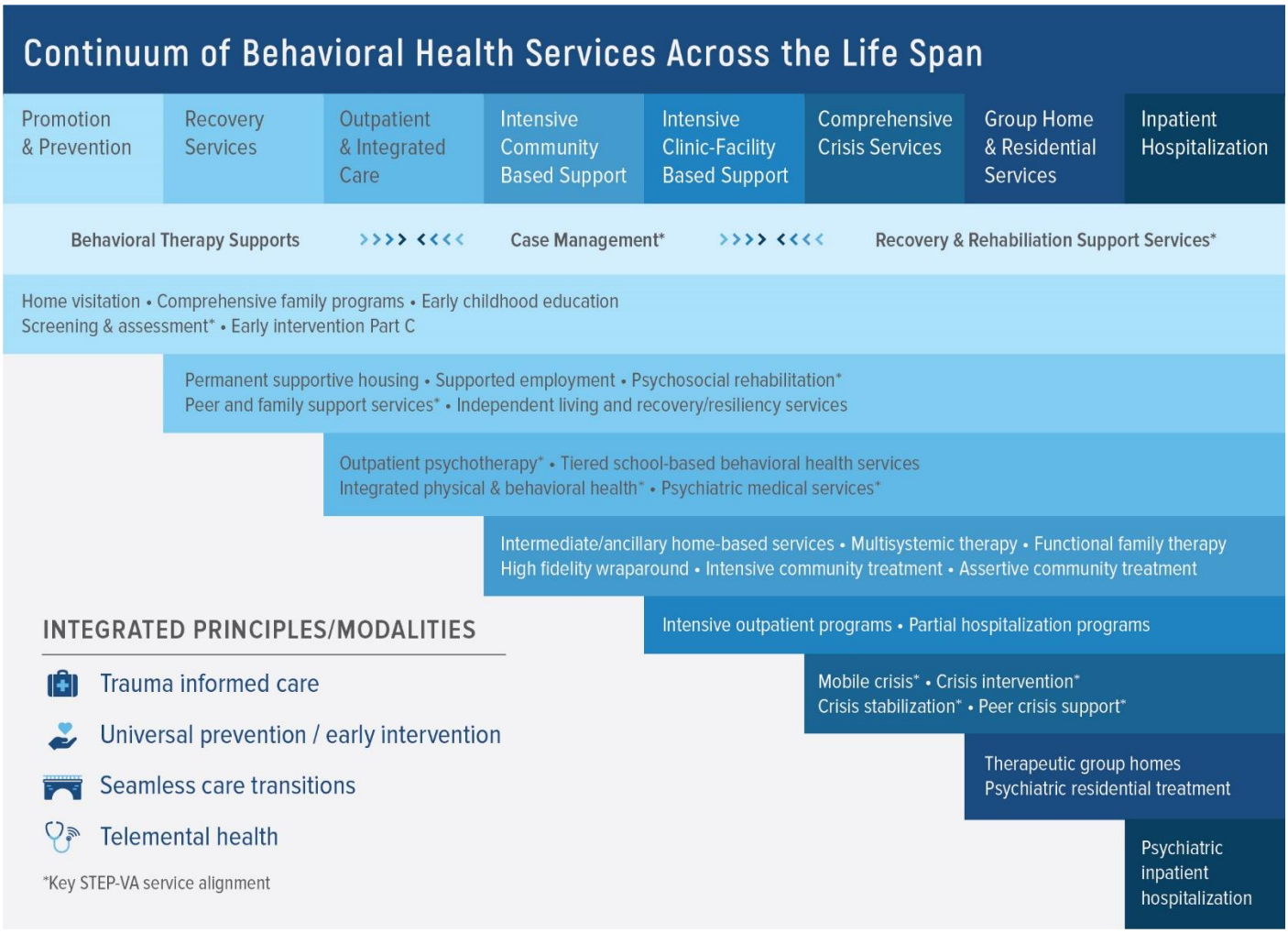
The overutilization of psychiatric inpatient beds for lack of a more appropriate level of care has contributed to the psychiatric bed crisis in Virginia. The Statewide Temporary Detention Order (TDO) Task Force, charged with examining the dramatic rise in admissions to state psychiatric hospitals under TDOs, noted that one of the factors contributing to the decreasing number of available private psychiatric hospital beds is the extended length of stay by patients for whom the hospital is unable to find a community placement due to significant care needs and instability. This is paralleled in state facilities, where the extraordinary barriers to discharge list (EBL) has remained steady at approximately 200 individuals.[6]

Lower acuity services are necessary to transition individuals out of the inpatient setting and to prevent the need for inpatient admission, when possible.

The majority of the uninsured individuals in state psychiatric facilities will be eligible for Medicaid expansion. Redesign of Medicaid BH services is an opportunity to build a delivery system with expanded community-based treatment settings that provide alternatives to TDOs and hospitalizations in psychiatric facilities.

In November, 2018, the Centers for Medicare and Medicaid Services (CMS) announced a new opportunity for states to apply for Medicaid 1115 demonstration waivers to support redesign of their mental health delivery systems.[6] This waiver would draw down new federal Medicaid matching funds for adult mental health residential treatment and inpatient treatment delivered by residential facilities and psychiatric hospitals with greater than 16 beds. This infusion of new federal Medicaid funds would allow DMAS to create a new adult mental health residential treatment benefit as part of the redesigned continuum that could prevent TDOs and help transition patients out of state and private psychiatric hospitals. DMAS will only be eligible to apply for this waiver once Virginia has demonstrated commitment to redesign and active implementation of a system focused on evidence-based practices and placements in least-restrictive and community-based settings.

DMAS and DBHDS are committed to redesigning behavioral health services in Virginia to create a more robust, integrated system. A survey of Virginia stakeholders conducted as part of the service redesign process indicated overwhelming agreement that additional and/or redesigned Medicaid-covered services are needed to meet the state's BH needs. The vision for redesigned BH care is that any person seeking care will have a direct pathway to obtain services reflecting their needs, regardless of their zip code or the setting where they present for care. Further, redesigned BH care in Virginia will be prevention and recovery focused, person-centered, trauma informed, and evidence based. Person-centered care includes availability of services at an appropriate level and setting of care to meet patient needs, as well as measurement of outcomes that matter to patients. This vision will result in building capacity for lower acuity services in natural environments like schools and primary care offices, and prevent unnecessary emergency department visits and hospitalizations. Previous research in Virginia has demonstrated a correlation between availability of outpatient behavioral health services and lower rates of inpatient hospitalization.[7]



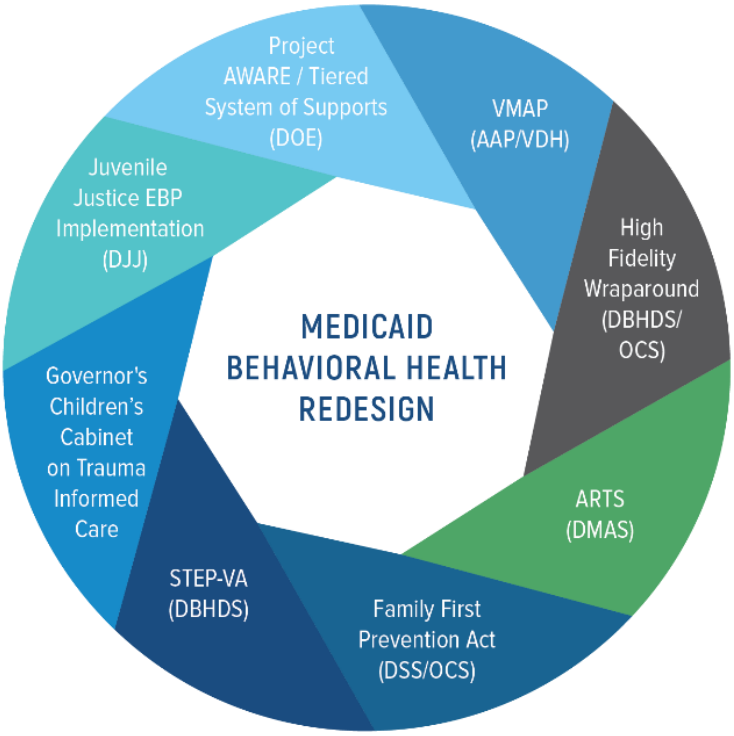
The above framework is based upon the model developed by the Institute of Medicine and adopted by the Substance Abuse and Mental Health Services Administration. It incorporates recommendations from the National Alliance for Mental Illness. The graded continuum of services provides a framework that distinguishes between promotion and prevention, treatment maintenance of recovery from mental health disorders, and shows how all components are interrelated. The continuum allows for a complete range of services and activities to meet all mental health needs, and supports collaboration and integration of BH services into the healthcare system across all health settings[8]

The recommendations in this report were developed through a multi-step process in partnership between DMAS, DBHDS, and the Eugene S. Farley, Jr. Health Policy Center at the University of Colorado Anschutz Medical Campus. The multi-step process to develop this continuum began with an evidence review to examine best practices for BH services from the peer-reviewed literature, agency and organization reports, case studies, and models from other states, as well as a service gap analysis to describe the current needs and capacity of Virginia's Medicaid program. The recommendations in this report represent the synthesis of best practices for services, cross-walked with current practices and identified service needs in Virginia. The report is available at: https://www.dmas.virginia.gov/#/behavioralredesign

Throughout this process, the Farley Health Policy Center, DBHDS, and DMAS worked together to ensure that the developed continuum accurately reflects the need for redesigned services. Diverse stakeholder input was collected through face-to-face meetings, outreach, and surveillance. The Behavioral Health Redesign Workgroup brought stakeholders together with agency leadership from DBHDS, DMAS, Virginia Department of Social Services (VDSS), Office of Children's Services (OCS), Virginia Department of Education (DOE), Virginia Department of Juvenile Justice (DJJ), and Virginia Department of Health (VDH). This Workgroup created a forum for regular communication and

meaningful input. The Workgroup members provided invaluable feedback by identifying gaps and bright spots in behavioral health services for Medicaid members. A broader set of stakeholders, including those participating in the Workgroup, had the opportunity to inform the continuum through a Stakeholder Survey. There were 203 survey respondents, representing over 60 different organizations or organization divisions. The input from the Workgroup and survey was instrumental in developing the overall categories and specific services recommended in the redesigned continuum.

The development of this continuum builds on ongoing and concurrent efforts to improve the BH care of Virginians (see below). Foundational initiatives like STEP-VA and the Addiction Recovery and Treatment Services (ARTS) benefit have laid the groundwork for broader BH redesign. This continuum aligns with and complements concurrent work for the FFPSA by including integration of the evidence-based practice models that will be implemented for overlapping populations and workforces. Other simultaneous efforts to improve behavioral health care in Virginia include the Governor's Cabinet's focus on trauma-informed care and the Department of Juvenile Justice transformation toward the use of evidence-based practices to maintain youth in the community rather than in correctional facilities. Medicaid expansion will also make behavioral health services available to a much broader population of low-income adults.



Summary of Services

Whereas DMAS and DBHDS worked with stakeholders to develop the 70-page Continuum Proposal and have a long-term vision for realizing a prevention-oriented and evidence-based continuum of care, there is also recognition that such a transformative change will necessarily take time. Further, the interagency team recognizes that workforce shortages and the complexity of the coordination necessary to assure continued alignment across Secretariats will require careful planning, monitoring and reporting out to stakeholders and the General Assembly. The interagency team includes clinician-researchers with experience in implementation science and systems transformation who are committed to a step-wise process wherein each phase of service redesign is non-contingent on further phases. This provide flexibility to address downstream effects of each phase and system needs as time moves forward. A commitment from Virginia to one

phase does not require commitment to future phases; it simply opens the door to continued efforts towards this vision of hope for a system that will serve our members with equity, integrity, and best practice medicine.

Partial Hospitalization Services

BH Partial Hospitalization Programs are standard, short-term, non-residential and medically-directed services for members who require intensive, highly coordinated, structured and inter-disciplinary ambulatory treatment within a stable environment that is of greater intensity than Intensive Outpatient or Psychosocial Rehabilitation. Partial Hospitalization Programs are appropriate for members who do not currently meet medical necessity for inpatient psychiatric hospitalization, but do require greater intensity of intervention than outpatient services can provide to support member safety, maintenance and recovery. Partial Hospitalization Program services shall be provided by an interdisciplinary team comprised of credentialed behavioral health professionals including a board-certified psychiatrist. Licensed Professional Counselors will also be team members for these programs. Partial Hospitalization Services are structured programs of skilled treatment services for adults, children and adolescents that are reasonably necessary for the diagnosis and active treatment of a member's mental health condition (e.g. SMI, MI and/or co-occurring SUD); they are reasonably expected to improve or maintain the member's symptoms and level of functioning, and reasonably expected to prevent relapse or hospitalization. The minimum number of service hours per week is 20 hours with at least 5 service hours per day of skilled treatment services. *This level of care is not currently available within the Medicaid service array and its absence contributes to barriers in diversion and step-down from more intensive levels of care such as psychiatric hospitalization and residential care.*

Partial Hospitalization Program components shall include the following as directed by the Individual Service Plan and based on the member's treatment needs identified in the Comprehensive Needs Assessment:

- Biopsychosocial Testing / Assessment (within the first program day and weekly thereafter);
- Individualized treatment planning (updated weekly);
- Family therapies involving member-defined family members, guardians, or significant other in the assessment, treatment, and continuing care of the member (at least once weekly);
- Medical, psychological, psychiatric, laboratory, and toxicology services, which are available by consult or referral (upon intake and as needed thereafter);
- Psychiatric and medical formal agreements to provide medical consult within 8 hours of the requested consult by telephone, or within 48 hours in person or via telemedicine. Referrals to external resources are allowed in this setting;
- Emergency services available 24-hours a day and seven days a week;
- Skilled treatment services with a planned format including individual and group psychotherapy (at least 4 hours per day, at least 3 days per week);
- Ongoing diagnostic services for the purpose of diagnosing those individuals for whom an extended or direct observation is necessary to determine functioning and interactions, to identify problem areas, and to formulate a treatment plan;
- Medication management (daily);
- Occupational, recreational therapy, and/or other therapies as relevant to the treatment goals;
- For children and adolescents, educational instruction and support (daily);
- Activity therapies but only those that are individualized and essential for the treatment of the patient's condition. The treatment plan must clearly justify the need for each particular therapy utilized and explain how it fits into the patient's treatment;
- Close coordination through referrals to higher and lower levels of care and supportive housing services.

Intensive Outpatient Services

Intensive Outpatient Services (IOP) are structured programs of skilled treatment services for children, adolescents and adults focused on maintaining and improving functional abilities through a time-limited, interdisciplinary approach to

treatment. This approach is based on a comprehensive, coordinated and individualized service plan that involves the use of multiple, concurrent services and treatment modalities. Treatment focuses on symptom reduction, crisis and safety planning, promoting stability and independent living in the community, recovery/relapse prevention and reducing the need for a more acute level of care. IOP services are provided by an interdisciplinary team of BH treatment professionals for minimum of 3 service hours per service day to achieve 9 to 19 hours of services per week for adults and 2 service hours per service day to achieve 6 to 19 hours of services per week for children and adolescents. Services can also be provided on the weekend. This service is provided to members who do not require the intensive level of care of inpatient, residential, or partial hospitalization services, but requires more intensive services than outpatient services and would benefit from the structure and safety available in a facility setting. *This level of care is not currently available within the Medicaid service array and its absence contributes to barriers in diversion and step-down from more intensive levels of care such as psychiatric hospitalization and residential care.*

The following service components shall be delivered and monitored weekly as directed by the member's Individual Service Plan (ISP) and based on the member's treatment needs identified in the Comprehensive Needs Assessment.

- Psychiatric and other individualized treatment planning;
- Individual, family and/or group counseling and or psychotherapy;
- Skill development and psychoeducational activities;
- Medication management;
- Psychological assessment / testing (as indicated in treatment plan).

Referrals to external resources are allowable in this setting, including:

- Requests for a psychiatric or a medical consultation shall be available within 24 hours of the requested consult by telephone and preferably within 72 hours of the requested consult in person or via telemedicine;
- 24-hour emergency services available seven days per week when the treatment program is not in session;
- Occupational and recreational therapies, as well as other therapies that may be directly related to the behavioral health goals (e.g. speech therapy for members with feeding disorders, physical therapy for members with complex medical and psychosocial needs).
- Medical, psychological, psychiatric, laboratory, and toxicology services, which are available through consultation or referral, as indicated in the member's ISP;
- Higher and Lower levels of care and supportive housing services.

Program of Assertive Community Treatment

Assertive community treatment (ACT) is comprised of intensive nonresidential treatment and rehabilitative mental health services provided according to the assertive community treatment model. Assertive community treatment provides a single, fixed point of responsibility for treatment, rehabilitation and support needs for clients with serious mental illness (SMI) whose needs have not been met by more traditional service delivery approaches. Services are offered 24 hours per day, seven days per week, in a community-based setting. The nature and intensity of ACT services are developed through the person-centered service planning process and adjusted through the process of daily team meetings. ACT integrates the principles of cultural competence, addressing the impact of discrimination/stigma into its service philosophy. ACT will provide services with consideration of linguistic preference. An essential aspect of ACT is recognizing the importance of family, community-based, and faith-based supports. Typically, recipients served by ACT have a serious and persistent psychiatric disorder and a treatment history that has been characterized by frequent use of psychiatric hospitalization and emergency rooms, involvement with the criminal justice system, alcohol/substance abuse, and lack of engagement in traditional outpatient services.

ACT teams must offer and have the capacity to provide the following services/activities and bill at a daily rate:

- Assertive engagement
- Assessment and Treatment Planning
- Socials skills and support
- Benefits and finance support

- Co-occurring SUD treatment
- Crisis assessment and intervention
- Employment services
- Family psychoeducation and support
- Housing access & support
- Medication education, assistance and support
- Mental health certified peer specialists services
- Physical health services
- Psychiatric Rehabilitation and Assistance with Activities of Daily Living
- Symptom management
- Empirically Supported Therapeutic Interventions & Psychotherapy
- Wellness self-management and prevention
- Other services based on client needs as identified in a client's assertive community treatment individual treatment plan

ACT team services shall be provided by a team of individuals who have strong clinical skills, professional qualifications, experience, and competency to provide a full breadth of biopsychosocial rehabilitation services. While all staff shall have some level of competency across disciplines, areas of staff expertise and specialization must be emphasized to fully benefit ACT service beneficiaries. Team members strive to offer evidence-based practices, which are clinical and rehabilitation services that have been demonstrated to be effective for beneficiaries with severe and persistent mental illness. Teams must have staff that provide tenancy supports to beneficiaries living independently in the community. Team staffing is dependent on the program size and the maximum beneficiary to team member ratio (psychiatric care providers and program assistants excluded from ratio calculation). Three program sizes may be implemented: small, mid-size, and large ACT teams.

Program Size:

a. Small teams serve a maximum of 50 beneficiaries, with 1 team member per 8 or fewer beneficiaries;
b. Mid-size teams serve 51-74 beneficiaries, with 1 team member per 9 or fewer beneficiaries; and
c. Large teams serve 75-120 beneficiaries, with 1 team member per 9 or fewer beneficiaries.

Teams in urban locations should implement mid-size to large teams. Teams in more rural locations will likely implement small or mid-size teams as large teams may be impractical in a sparsely populated area. Teams shall be expected to maintain an annual average not to exceed 50, 74, and 120 beneficiaries, respectively.

To ensure appropriate ACT team development, each new ACT team is recommended to titrate ACT intakes (example, 4–6 individuals per month) to gradually build up capacity to serve no more than 100–120 individuals (with a 1:9 ratio) and no more than 42–50 individuals (a 1:8 ratio) for smaller teams. Movement onto (admissions) and off of (discharges) the team may temporarily result in breaches of the maximum caseload. To provide the appropriate level of coverage and services across all beneficiaries, a low beneficiary to staff ratio must be maintained. For all staff listed, it is expected that the assignment to the team reflects practice in service to the team, including direct care to the individuals served.

ACT beneficiaries have varying needs and the ACT team is the sole provider of the services to address those needs. Therefore, a high level of service is required reflecting crisis response, maintenance, and rehabilitation and growth-oriented interventions. ACT is a flexible service provided in an individualized manner. As such, service frequency and intensity will vary across beneficiaries. However, when considering caseload averages, the team must see members, on average, 3 times per week and for at least two hours per week. It is expected that additional face-to-face and phone contacts are made with beneficiaries, their natural supports, and other providers on their behalf (example, inpatient hospital staff, landlord, residential staff).

Multisystemic Therapy

Multisystemic Therapy (MST) is an evidence-based, intensive family- and community-based treatment for youth ages 12-17 years old with significant problems with disruptive behavior, mood, and/or substance use. The multi-systemic approach views individuals as being nested within a complex network of interconnected systems that encompass individual, family, and extra-familial (peer, school, neighborhood) factors. Intervention may be necessary in any one or a combination of these systems. Critical features of MST include: (a) integration of empirically based treatment approaches to address a comprehensive range of risk factors across family, peer, school, and community contexts; (b) promotion of behavior change in the youth's natural environment, with the overriding goal of empowering caregivers; and (c) rigorous quality assurance mechanisms that focus on achieving outcomes through maintaining treatment fidelity and developing strategies to overcome barriers to behavior change. The major goal of MST is to empower parents with the skills and resources needed to independently address the difficulties that arise in raising teenagers and to empower youth to cope with family, peer, school, and neighborhood problems. Within a context of support and skill building, the therapist places developmentally appropriate demands on the adolescent and family for responsible behavior. Intervention strategies are integrated into a social ecological context and includes strategic family therapy, structural family therapy, behavioral parent training, and cognitive behavior therapies. Services are intensive, with intervention sessions being tailored to the Individual Service Plan and conducted from once per week to daily. Service intensity varies with the needs of the youth and family. Early in treatment, the therapist may meet with the family several times a week, but as treatment progresses, the intensity tapers. Close to treatment termination, the therapist may only contact the family as needed to assure that treatment gains have been maintained by the family. Throughout treatment, contacts may range from brief check-ins either by telephone or face-to-face, up to two-hour sessions addressing specific treatment issues such as substance misuse, family communication and problem solving. A 24 hour/7 day/week on-call schedule is utilized to provide round-the-clock availability of clinical services for families. The average duration of MST treatment is approximately 4 months.

Functional Family Therapy

Functional Family Therapy (FFT) is a family intervention program for dysfunctional youth with disruptive, externalizing problems. FFT has been applied to a wide range of problem youth and their families in various multi-ethnic, multicultural contexts. Target populations range from at-risk pre-adolescents to youth with moderate to severe problems such as conduct disorder, violent acting-out, and substance abuse. While FFT targets youth aged 11-18, younger siblings of referred adolescents often become part of the intervention process. Intervention ranges from, on average, 12 to 14 one-hour sessions. The number of sessions may be as few as 8 sessions for mild cases and up to 30 sessions for more difficult situations. In most programs, sessions are spread over a 3-month period. FFT has been conducted both in clinic settings as an outpatient therapy and as a home-based model.

The FFT clinical model offers clear identification of specific phases which organizes the intervention in a coherent manner, thereby allowing clinicians to maintain focus in the context of considerable family and individual disruption. Each phase includes specific goals, assessment foci, specific techniques of intervention, and therapist skills necessary for success. FFT directly addresses youth behavior problems by systematically targeting risk and protective factors at multiple levels in the youth's ecology. Systemic and cognitive-behavioral interventions are included to change/replace maladaptive emotional, behavioral, and psychological processes within the individual, the family, and with relevant extra-family systems.

Comprehensive Crisis Services

Crisis Hotline:

The role of the crisis hotline is to:

- Assess the caller's needs
- Provide supportive advocacy
- Brief crisis de-escalation as needed
- Offer information and appropriate referrals to community services using warm handoffs when possible
- Assist with safety planning and brainstorming available options
- Complete a risk assessment

- Dispatch appropriate mobile crisis supports or contact other services

Services are delivered over the phone, chat boxes, or text and serve to stabilize the crisis or link the person to the appropriate supports and resources.

Crisis Intervention (Initial response, up to 72 hours following initial contact):

Crisis Intervention is brief focused assessment that reviews precipitating events leading to the crisis, history of crisis, mental status exam and disposition. Crisis intervention includes the mobilization of resources to defuse the crisis, restore safety, implement interventions that minimize the potential for psychological trauma, prevent further deterioration of functioning, link to other supports and services and to avert hospitalization.

Services are delivered in the community, home, school, or desired secured environment and are face-to-face with the individual and/or family providing appropriate crisis intervention strategies, even if the time spent during the initial up to 72 hours is not continuous. The person in crisis must be present for all or some of the services. Crisis intervention services shall be available 24 hours a day, seven days a week, wherever the need presents.

Community-Based Crisis Stabilization (Crisis Avoidance, Following the up-to 72-hour intervention):

Crisis stabilization services are community based mobile services for the development, monitoring, coordinating and implementing of an individualized crisis prevention plan, to ensure the stabilization of the crisis following the initial service delivered through crisis intervention.

Crisis stabilization services shall be available 24 hours a day, seven days a week, wherever the need presents, including, but not limited to, the individual's home, other living arrangement or other location in the community. Crisis stabilization services shall not be rendered in an acute care hospital setting or residential treatment facility, although an initial referral to a mobile response agency may be made prior to the individual's discharge from the facility. Crisis stabilization service can be provided intermittently dependent on the individual or support systems need up to 45 days post the initial crisis intervention.

Crisis stabilization services include:

- Effectively responding to or preventing identified precursors or triggers that risk a person's ability to remain in the community and cycle in out of crisis;
- Assisting a person and/or their support system with identifying signs of psychiatric and personal crises;
- Practicing de-escalation strategies;
- Developing a crisis prevention plan;
    - Assessing and developing a step by step plan to utilize before a crisis
    - Developing a step by step plan to stabilize future crisis situations utilizing trauma informed and least restrictive treatment philosophies
- Seeking other supports to restore stability;
- And, where appropriate developing strategies to take medication appropriately.

The individualized crisis prevention plan shall include a transition/discharge plan that links the individual to clinical and behavioral services, formal and informal community supports, and linkages with appropriate system partners after the crisis stabilization services are finished as appropriate.

Crisis stabilization services function to provide a short-term linkage and referral between persons in crisis and the appropriate/additional behavioral health and/or ID/DD services and supports, while reducing the rate of hospitalization, incarceration, out of home placement and unnecessary emergency room visits. This service includes post crisis follow-up to ensure linkage with recommended services. It is expected that 90% of calls during any time frame are responded to in the community within 1 hour from the mobile team being dispatched.

24-Hour Crisis Stabilization:

24-Hour Crisis Stabilization provides short-term, 24/7, facility-based, walk-in psychiatric/substance related crisis evaluation and brief intervention services to support an individual who is experiencing an abrupt and substantial change in behavior. These services also include screening and referral for appropriate outpatient services and community resources. While these services are provided in a facility based program, utilization of these services do not require an inpatient admission to the facility.

Interventions used to de-escalate a crisis situation may include assessment of crisis; active listening and empathic responses to help relieve emotional distress; effective verbal and behavioral responses to warning signs of crisis related behavior; assistance to, and involvement/ participation of the individual (to the extent he/she is capable) in active problem solving, planning, and interventions; referral to appropriate levels of care for adults experiencing crisis situations which may include a crisis stabilization unit or other services deemed necessary to effectively manage the crisis; to mobilize natural support systems; and to arrange transportation when needed to access appropriate levels of care.

Crisis Stabilization Unit:
This is a residential alternative to or diversion from inpatient hospitalization, offering psychiatric stabilization and/or withdrawal management services, when appropriate. Crisis Stabilization can serve as a stepdown from a psychiatric admission, if the person meets admission criteria. Crisis Stabilization Unit length of stays last between seven to 15 days and do not include room and board. Services may include:

- Psychiatric, diagnostic, and medical assessments;
- Crisis assessment, support and intervention;
- Medication administration, management and monitoring;
- Psychiatric/Behavioral Health Treatment;
- Nursing Assessment and Care;
- Psychosocial and psychoeducational individual and group support;
- Brief individual, group and/or family counseling; and
- Linkage to other services as needed.

Detoxification Crisis Stabilization Units provide medically monitored residential services for the purpose of providing psychiatric stabilization and substance withdrawal management services on a short-term basis. Additional Services may include Medically Monitored Residential Substance Withdrawal Management (at ASAM Level 3.7-WM). These services are in addition to the services provided in crisis stabilization unit that is not specific to detoxification.

Rate Assumptions Summaries by Service:

Partial Hospitalization Services
Rates are based on median wage assumptions for multidisciplinary teams of credentialed mental health professionals (including certified peer support specialists, family support partners, qualified mental health professionals, licensed clinical social workers, clinical psychologists, nurse practitioners, and psychiatrists). The per diem rate for hospital and community-based PHP is consistent the Medicare rate for partial hospitalization programs, with services of LCSWs, QMHPs, and certified peer specialists/family support partners built into the per diem rate, and the services of clinical psychologists, psychiatrists, and nurse practitioners billed separately. Additional details regarding assumptions are provided in Appendix.

Intensive Outpatient Services
IOP are assumed to be clinician-directed, and staffed by a multi-disciplinary team of credentialed mental health professionals (including a part-time psychiatrist). Median wage assumptions were utilized. It was assumed that IOP operations would include yearly training in evidence-based practices. A separate set of assumptions was constructed for

IOP with inclusion of recreation and/or occupational therapy (4 hours per week on site at program), which resulted in a slightly different per diem rate. Details of assumptions are provided in Appendix.

Program of Assertive Community Treatment

A total of six rates based on team size (small, medium, and large) and fidelity (base and high fidelity) were modeled. Small teams, designed to serve up to 50 clients, were assumed at base fidelity as including 7.40 FTEs across multidisciplinary providers. Medium teams at base fidelity included 9.6 FTEs, and large teams at base fidelity included 11.7 FTEs. High fidelity assumptions included additional .5 FTE additional general staff and .5 FTE additional nursing staff at each team size (yielding 8.40, 10.6, and 12.7 FTEs for small, medium, and large teams). Yearly travel assumptions were based on data provided by teams currently providing ACT across the state of Virginia, and yearly training costs were assumed (see details in Appendix). Primary differences between this redesigned service and rate regard unit of service (moving to a per diem rate) and provision of small, medium, and large teams which will allow for sustainable teams to meet the needs of areas across the state with varying populations and population densities.

Multisystemic Therapy

As MST adheres to a highly structured national model, there was less flexibility regarding assumptions. Data from Virginia teams provided by Department of Juvenile Justice (DJJ) were utilized for assumptions. All staffing assumptions were based on the requirements of the model, including staff and supervision ratios, training requirements, and travel time estimates were based on DJJ data. Results of rate study yielded four rates, all billed as 15 minute units. These four rates represent Bachelor's level and Master's level, each for New teams and Established teams. Key differences in the four models include pay differential between Bachelor's and Master's providers, productivity estimates for New and Established teams, and training costs for New and Established teams.

Functional Family Therapy

Rate development process for FFT was similar to MST; FFT also has specific standards that must be adhered to, and data from DJJ guided specific assumptions about pay rates and travel time. Analysis yielded four rates representing Bachelor's and Master's providers for New and Established teams, all to be billed in 15 minute units. Similar to FFT, slight differences can be seen in these rates, representing the different levels of provider qualifications as well as variation in the productivity and training cost estimates for New and Established teams.

Comprehensive Crisis Services

Assumptions for rate development were based on the Crisis Now model and associated estimation tools, as well as an ongoing DBHDS workgroup on Mobile Crisis that has been working over the last year and the Behavioral Health Redesign stakeholder workgroup which formed this fall. For Crisis Intervention, 5 rates were developed, based on mobile response billed in 15-minute intervals across four provider levels for teams of two and one provision for a single responder. Call center off-set is built into each of these rates, as well as travel time estimates. Travel time estimates were based on data from two other states that was then compared across the geographical regions of Virginia and with REACH data to best estimate average travel times. Similarly, Community Based Crisis Stabilization analysis yielded four rates, two representing teams of two and two representing single responders. Results of 24-hour observation models yielded one per diem rate which includes assumptions regarding the cost of security and 22.65 FTEs in the staffing model across multidisciplinary providers. Finally, Crisis Stabilization Unit (CSU) model yielded one per diem rate including security also staffed by a total of 22.65 FTEs across provider types.

The following table summarizes the proposed changes in rates and clarifies which rates would be new:

BH Redesign Rate Changes Summary				
Redesign Service Name/Standard Service Level	**Current CMHRS/Virginia Developed Service Name**	**Current Rate and Unit Value**	**Redesign Rate and Unit Value**	**Difference**

Assertive Community Treatment (ACT)	Intensive Community Treatment	Urban $153 Rural $139	Hour	Team Size	Base Fidelity	High Fidelity	Per Day	New unit value and program alignment will yield increased billing activity to average $19k per member instead of the current $8.8K per member
				Small	$195.20	$245.29		
				Medium	$169.33	$206.64		
				Large	$158.90	$190.08		
Multi-Systemic Treatment (MST)	N/A	Non-Covered		New Teams 15 minutes		Established Teams 15 Minutes		New
				Masters	$55.03	Masters	$49.96	
				Bachelors	$51.00	Bachelors	$46.03	
Functional Family Therapy (FFT)	N/A	Non-Covered		New Teams 15 minutes		Established Teams 15 Minutes		New
				Masters	$44.17	Masters	$37.28	
				Bachelors	$40.73	Bachelors	$34.11	
Intensive Outpatient	N/A	Non-Covered		IOP	$141.51	Per Day		New
				Specialty	$142.96			
Partial Hospitalization	Day Treatment/Partial Hospitalization	$74.56	2 Units (up to 6.99 hours)	Agency	$121.62	Per Day		Agency 63% Increase
				Hospital	$222.76			Hospital New
Crisis Services								
Crisis Intervention (Mobile)	Crisis Intervention	Urban $30.71 Rural $18.61	15 Minutes	Staff Ratio/Type	Rate	15 Minutes		Mobile Crisis 103%-381% rate increase. Requires two staff for most encounters
				2:1 LMHP/Peer	$108.01			
				2:1 LMHP/MA	$117.27			
				2:1 MA/MA	$110.46			
				2:1 MA/Peer	$101.20			
				1:1 LMHP	$63.18			
Crisis Stabilization (Mobile/Crisis Avoidance)	Crisis Stabilization	Rural $81 Urban $89	One Hour	Staff Ratio/Type	Rate	15 Minutes		160%-339% rate increase. Service requires two staff for most encounters
				2:1 LMHP/Peer	$66.54			
				2:1 LMHP/MA	$76.29			
				1:1 MA	$35.76			
				1:1 LMHP	$42.93			
23 Hour Temporary Observation	N/A	Non-Covered		$817.83		Per Day		New
Crisis Stabilization Unit (Residential)	Crisis Stabilization Unit (Not Reimbursed by DMAS)	Non-Covered		$684.48		Per Day		New

Fiscal Impact Assumptions and Cost Analysis

Partial Hospitalization Services

Assumptions for initial fiscal impact were based on 12 Virginia hospitals with partial hospitalization programs participating in Medicaid and eight Community Mental Health Centers (CMHCs) with partial hospitalization programs participating in Medicaid. Average lengths of stay in these settings were included in assumptions (35.6 days for hospital PHP; 65.5 days for CMHC PHP). Total participation of 30 members per program was assumed, and it was assumed that one unit of billable service in addition to the per diem would be billed per participant per day. This yields an assumed service *capacity* of 240 in CMHC PHP for year 1 and 360 for hospital based PHP for year 1, and an assumed utilization of 200 participants in year 1. Growth was assumed as an additional 133 individuals served each year, ultimately growing to 600 participants served between FY 22 and FY 24. Additional details regarding assumptions are provided in the Appendix.

Intensive Outpatient Services

Assumptions for fiscal impact are based on the eight Virginia CMHCs with programs similar to PHP participating in Medicaid which could potentially provide IOP services. There are also ten additional Virginia facilities which provide group programs with similarities to PHP or IOP programming which would potentially be providers of IOP. It was assumed that each program could accommodate 30 participants at a time, indicating that 540 participants would be served across these 18 programs (and assumptions were based on 90% Medicaid eligibility). It was assumed that individuals would be served three days per week. It was assumed that only one program would be implemented in the first year, and that growth would mirror ARTs IOP program growth (currently 137 IOP programs) yielding 2,040 individuals served in 68 programs between FY 22 and FY 23.

Program of Assertive Community Treatment

ACT utilization information from DBHDS was utilized to evaluate fiscal impact. The current ACT census is 2,229, of which 1,683 are Medicaid eligible (75.5%). The current Medicaid cost-per-user on ACT is $8,800, but using the selected DMAS rate and an average assumed utilization of 91 units per user, the projected costs of the ACT teams are $14,460 (large), $15,409 (medium) and $17,763 (small). There are five small “ICT” teams (assumed to serve 150 individuals), approximately five teams where boards have lost staff and only serve 70 individuals (assumed to serve 325 individuals), and 20 large teams (assumed to serve 1,754 individuals). Additional capacity can be added with current teams (total of 396 additional clients) in year one; and we assume that between 5% and 10% of teams will begin achieving high-fidelity in FY 22 and FY 23 respectively (but all teams will start with base fidelity). The budget model adds 396 total individuals in FY22 (see notes above on increases by team size to reach full capacity). It is assumed that there is one large and one medium team achieving high fidelity in FY23 and an additional large and medium team also achieve high fidelity in each of FY24 and FY25.

As teams achieve high fidelity, the number of hospitalizations, emergency room visits, and incarcerations of individuals with serious mental illness are expected to decrease, in line with recent report to the General Assembly regarding evaluated hospital reductions among a group of individuals prior to being served by ACT and during ACT service. Cost offsets are expected in these areas, not from decreases in other Medicaid billing at this time.

Multisystemic Therapy

The 10 current teams serve 465 individuals, and each individual is projected to receive an average of 152 units. These units are estimated to be delivered by a Bachelor’s Level practitioner 25% of the time (38 units) and by a Master’s Level practitioner the remaining 75% of the time (114 units). Estimated costs-per-user based on these assumptions results in an average cost-per-user of about $7,400, which is consistent with national averages between $7,300 and $7,800.

Based on information available at Department of Medical Assistant Services (DMAS), it was assumed that 82% of individuals receiving MST are Medicaid eligible. To estimate future financial impact, the following assumptions guided the analysis. A team can have up to four therapists with caseloads of up to six children for each therapist and the supervisor

supervising two teams at most (i.e., one supervisor may oversee up to eight therapists and 48 children receiving services). There is one team of 48 children and one team with 72 children that would be considered "full" with current staffing. Currently, based on the size of remaining teams (ranging from six to 94 children), they could serve an additional 50 children at full capacity with no changes to staffing. An estimate of 25% is expected across FY 22 and FY 23; thus, 12% more children served were assumed in FY 22 and in FY 23.

Functional Family Therapy

Data regarding current team capacity and utilization assumptions were based on DJJ data. The current four teams are projected to provide an average of 99 units to each individual. These units are estimated to be delivered by a Bachelor's Level practitioner 25% of the time (24 units) and by a Master's Level practitioner the remaining 75% of the time (75 units). Estimated costs-per-user based on these assumptions results in an average cost-per-user of about $3.600, which is consistent with national averages. Based on information from DMAS, it is assumed that 82% of individuals receiving FFT are Medicaid eligible. To estimate increases in utilization over time, the following assumptions were used. Teams can be up to eight staff with caseloads of up to 12 children per therapist and the supervisor serving one-half caseload. Therefore, each team can serve up to 102 children. Based on current team sizes, it is estimated that an additional 80 children could be served with no changes to staffing. A 25% increase is expected to occur (with resources from DBHDS utilized for training and start-up costs for new teams), thus, the budget model adds 12% more children in FY22 and FY23.

Comprehensive Crisis Services

The following assumptions were based on current crisis calls in CSB system. Today, there are 300,000 crisis calls. 90,000 individuals walk into hospitals/crisis assessment centers and are screened by the 40 Community Service Boards (CSBs) using current Crisis intervention codes. Only 1–2% of calls are answered by mobile crisis teams today. Currently, 54,000 individuals (60%) are discharged to home, and about 25,000 individuals are hospitalized today of these calls. Following the call and disposition, 11,000 remain on a caseload and 13% are Medicaid clients.

Estimated Utilization

	Calls	**Mobile Teams**	**CSB walk-ins**	**Total**
Crisis Calls	300,000			
Mobile Teams		45,000		45,000
Walk into one of 40 CSB (bill traditional CI)			45,000	45,000
Discharged Home		27,000	27,000	
23-hour Response		4,050	7,550	11,600
CSU (average 10 days)		1,700	5,068	6,768
Community-Based Stabilization (139 units)		4,050	550	4,600
Hospitalized		9,900	9,900	19,800

For Mobile Crisis Intervention, four-hour episodes were assumed (16 units), and across provider types the following assumptions were made: 5,000 individuals will be served by a sole licensed practitioner; 40,000 individuals will be served by a team of two practitioners; 70% of individuals will be served by 2:1 teams of two Master's level practitioners; 10% of individuals will be served by 2:1 teams of Licensed/Peer; 10% of individuals by 2:1 Licensed/MA teams; and 10% of individuals by 2:1 MA/Peer team.

For Community-Based Crisis Stabilization, three hour episodes three times per week for the first week followed by three hous per week for four hours thereafter yields an assumed 139 units per crisis stabilization episode. It was assumed that 4,500 individuals will be served by a single practitioner; 90% of individuals will be served by a MA level practitioner; 10% of individuals will be served by a licensed practitioner; 100 individuals will be served by a two-person team; 90% of individuals will be served by a Licensed/Peer team; and 10% of individuals will be served by a Licensed/MA team.

The budget model assumes that walk-in CSBs under the current Crisis Intervention dropping by 50% from a current user level of 90,000 individuals (15% Medicaid eligible). The budget model has the new Crisis Intervention model starting at 10% of the ultimate projection and growing to 45,000 total users in two years. CSU already in place, so no change is assumed in the budget model. The budget model begins with 23-hour crisis starting at 2,900 users with a pilot in FY21 and increasing to 11,600 users in two years.

Cost Analysis

While the general funds estimated cost to DMAS's budget is $8.2 million, the costs do not reflect offsetting to the state, which would be achieved by 1) providing a federal match for services that are currently using general funds only and 2) diversion of members to more appropriate efficient care settings. These offsetting general fund savings are described below.

Direct Multisystemic Therapy (MST) and Functional Family Therapy (FFT) is currently paid for Medicaid enrolled members by DJJ using general funds only. It is estimated that 361 members using MST in the first year will have an impact on both Intensive In-Home (IIH) in Medicaid and MST payment in DJJ with a portion of members from each service and funding stream being reimbursed in the future by Medicaid using general funds and appropriate federal funds financial participation rates.

- **361 IIH cases would yield a transfer of $8,741 average cost per year to the MST program which assumes a $7,400 cost per member. This would potentially reduce Medicaid costs by $494,931 annually.**
- **361 MST cases that transfer from DJJ to Medicaid would potentially yield a reduction in DJJ costs by $2,671,400 annually.**

It is estimated that 378 members using FFT in the first year which will have an impact on both Intensive In-Home in Medicaid and FFT payment in DJJ with a portion of members from each service and funding stream being reimbursed in the future by Medicaid using general funds and appropriate federal funds financial participation rates.

- **378 IIH cases would yield a transfer of $8,741 average cost per year to the FFT program which assumes a $3,600 cost per member. This would potentially reduce Medicaid costs by $1,943,298 annually.**
- **378 MST cases that transfer from DJJ to Medicaid would potentially yield a reduction in DJJ costs by $1,360,800.**

Community Service Boards (CSBs) have historically relied on the general funds from DBHDS to fund crisis services in settings not covered by DMAS and to serve members who are not enrolled in the Medicaid program. Currently, DMAS spends $26 million per year on crisis intervention and crisis stabilization services. The current services do not include reimbursement options for all of the components of an evidence based crisis services system, and the current system lacks the two key services that can be used to prevent an inpatient admission from occurring. By adding reimbursement for both a new 23 hour temporary observation service and the currently available residential crisis stabilization unit services, DMAS will be able to better sustain the CSB crisis service system which can divert admissions from inpatient beds.

Current estimates show a gradual decrease in the numbers of members who will require a crisis services assessment. This change will be yielded by more robust provision of Assertive Community Treatment (ACT), Partial Hospitalization (PHP) and Intensive Outpatient (IOP) services in the community. By using the community based services and referring members for aftercare in the ACT, IOP and PHP programs, the usage of the crisis system will be lessened over time resulting in fewer crisis services assessments, hospital admissions and TDO's. Similar to the ARTS program

implementation, the use of hospital services will decrease because of the availability of partial hospitalization and intensive outpatient services in the community setting. By having effective services available to support aftercare the length of stay in hospital settings can be reduced along with the reduced number of admissions and repeated admissions. The savings yielded by the ARTS program can be replicated by another evidence based continuum of care.
DMAS utilization data shows that only 15% of crisis intervention services are billed to Medicaid where 39% of the proposed crisis stabilization services will be billed to Medicaid. The higher percentage of Medicaid billing in the stabilization service will yield greater savings in general funds when the service is rendered by a CSB.

The cost was calculated through a rate study and fiscal impact analysis conducted by DMAS's actuarial contractor with significant support and coordination from DMAS and DBHDS Behavioral Health clinical experts and Finance teams. Additionally, this request assumes savings for crisis services which is contingent on the approval of DBHDS' decision package request for STEP-VA.

As noted previously, this projection is solely for phase one of the redesigned continuum of services. The proposed phases of redesign build upon each other but are not contingent upon each other. Funding or regulatory authority provided for the first phase stands alone. While certain services are new and certain services will replace existing versions of the service options there will be some temporary overlap with existing Community Mental Health Rehabilitation Services.

DMAS estimates that providing these services will require $14,242,555 in total funding ($210,565 in GF) in FY 2022. Note that the total funding of $14,242,555 includes both medical and administrative costs and the table below reflects medical costs only.

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DMAS Behavioral Health Redesign
Phase I Budget Projections

REVISED		Estimated Expenditures					Percent Change				
Service	**Level**	**FY 2022**	**FY 2023**	**FY 2024**	**FY 2025**	**FY 2026**	**FY 2022**	**FY 2023**	**FY 2024**	**FY 2025**	**FY 2026**
Assertive Community Treatment	Base - Small	$2,007,242	$3,357,245	$3,357,245	$3,357,245	$3,357,245	N/A	67.3%	0.0%	0.0%	0.0%
	Base - Medium	$3,775,212	$4,360,755	$3,497,850	$2,619,535	$1,741,220	N/A	15.5%	-19.8%	-25.1%	-33.5%
	Base - Large	$19,144,908	$21,834,449	$20,749,957	$19,651,004	$18,566,512	N/A	14.0%	-5.0%	-5.3%	-5.5%
	High Fidelity - Small	$0	$0	$0	$0	$0	N/A	0.0%	0.0%	0.0%	0.0%
	High Fidelity - Medium	$0	$0	$1,071,842	$2,124,879	$3,196,721	N/A	0.0%	0.0%	98.2%	50.4%
	High Fidelity - Large	$0	$0	$1,314,593	$2,611,889	$3,926,483	N/A	0.0%	0.0%	98.7%	50.3%
Multi-Systemic Therapy	Established - Bachelor's	$666,422	$746,883	$837,838	$837,838	$837,838	N/A	12.1%	12.2%	0.0%	0.0%
	Established - Master's	$2,169,963	$2,431,953	$2,728,116	$2,728,116	$2,728,116	N/A	12.1%	12.2%	0.0%	0.0%
	New - Bachelor's	$0	$0	$0	$0	$0	N/A	0.0%	0.0%	0.0%	0.0%
	New - Master's	$0	$0	$0	$0	$0	N/A	0.0%	0.0%	0.0%	0.0%
Functional Family Therapy	Established - Bachelor's	$309,446	$346,285	$388,035	$388,035	$388,035	N/A	11.9%	12.1%	0.0%	0.0%
	Established - Master's	$1,056,888	$1,182,708	$1,325,304	$1,325,304	$1,325,304	N/A	11.9%	12.1%	0.0%	0.0%
	New - Bachelor's	$0	$0	$0	$0	$0	N/A	0.0%	0.0%	0.0%	0.0%
	New - Master's	$0	$0	$0	$0	$0	N/A	0.0%	0.0%	0.0%	0.0%
Intensive Outpatient	Standard	$203,774	$7,225,501	$14,238,736	$14,238,736	$14,238,736	N/A	3445.8%	97.1%	0.0%	0.0%
	Specialty with OT/Recreational Therapy	$25,733	$814,872	$1,595,434	$1,595,434	$1,595,434	N/A	3066.7%	95.8%	0.0%	0.0%
Partial Hospitalization		$908,412	$1,518,984	$2,129,556	$2,740,128	$2,740,128	N/A	67.2%	40.2%	28.7%	0.0%
Crisis Intervention	2:1 (Licensed/Peer)	$103,690	$673,982	$1,036,896	$1,036,896	$1,036,896	N/A	550.0%	53.8%	0.0%	0.0%
	2:1 (Licensed/MA)	$112,579	$731,765	$1,125,792	$1,125,792	$1,125,792	N/A	550.0%	53.8%	0.0%	0.0%
	2:1 (MA/MA)	$742,291	$4,824,893	$7,422,912	$7,422,912	$7,422,912	N/A	550.0%	53.8%	0.0%	0.0%
	2:1 (MA/Peer)	$97,152	$631,488	$971,520	$971,520	$971,520	N/A	550.0%	53.8%	0.0%	0.0%
	1:1 (Licensed)	$75,816	$493,309	$758,160	$758,160	$758,160	N/A	550.7%	53.7%	0.0%	0.0%
Community-Based Crisis Stabilization	2:1 (Licensed/Peer)	$323,717	$323,717	$323,717	$323,717	$323,717	N/A	0.0%	0.0%	0.0%	0.0%
	2:1 (Licensed/MA)	$42,417	$42,417	$42,417	$42,417	$42,417	N/A	0.0%	0.0%	0.0%	0.0%
	1:1 (MA)	$18,943,109	$18,943,109	$18,943,109	$18,943,109	$18,943,109	N/A	0.0%	0.0%	0.0%	0.0%
	1:1 (Licensed)	$2,524,155	$2,524,155	$2,524,155	$2,524,155	$2,524,155	N/A	0.0%	0.0%	0.0%	0.0%
23-Hour Observation		$355,756	$889,799	$1,423,024	$1,423,024	$1,423,024	N/A	150.1%	59.9%	0.0%	0.0%
CSU		$6,947,472	$6,947,472	$6,947,472	$6,947,472	$6,947,472	N/A	0.0%	0.0%	0.0%	0.0%
Total		**$60,536,154**	**$80,845,741**	**$94,753,680**	**$95,737,318**	**$96,160,946**	**N/A**	**33.5%**	**17.2%**	**1.0%**	**0.4%**

		GIB FY22			Revised Implementation FY22 Estimate*			
Services	**Date**	**TOTAL**	**GF**	**NGF**	**New Implementation Date**	**TOTAL**	**GF**	**NGF**
Assertive Community Treatment	July 1, 2021	$ 29,552,449	$12,493,298	**$17,059,151**	July 1, 2021	$ 24,927,362	$ 7,939,365	**$ 16,987,997**
Intensive Outpatient	July 1, 2021	$ 3,178,836	$1,343,853	**$1,834,983**	July 1, 2021	$ 229,507	$ 73,098	**$ 156,409**
Partial Hospitalization	July 1, 2021	$ 1,528,993	$646,382	**$882,611**	July 1, 2021	$ 908,412	$ 289,329	**$ 619,083**
Multi-Systemic Therapy	July 1, 2021	$ 229,507	$97,024	**$132,483**	December 1, 2021	$ 1,654,558	$ 526,977	**$ 1,127,581**
Functional Family Therapy	July 1, 2021	$ 908,412	$384,031	**$524,381**	December 1, 2021	$ 797,028	$ 253,853	**$ 543,175**
Crisis Intervention	July 1, 2021	$ 1,131,528	$478,353	**$653,175**	December 1, 2021	$ 2,643,843	$ 842,064	**$ 1,801,779**
Community-Based Crisis Stabilization	July 1, 2021	$ 21,833,399	$9,230,069	**$12,603,329**	December 1, 2021	$ 20,144,105	$ 6,415,898	**$ 13,728,208**
23-Hour Observation	July 1, 2021	$ 355,756	$150,396	**$205,360**	December 1, 2021	$ 207,524	$ 66,097	**$ 141,428**
CSU	July 1, 2021	$ 6,947,472	$2,937,044	**$4,010,428**	December 1, 2021	$ 4,052,692	$ 1,290,782	**$ 2,761,910**
	Total BHE Costs	**$ 65,666,352**	**$ 27,760,450**	**$ 37,905,901**	**Total BHE Costs**	**$ 55,565,031**	**$ 17,697,463**	**$ 37,867,569**
	Current Program Costs	**$ 41,322,476**	**$ 17,486,897**	**$ 23,835,579**	**Current Program Costs**	**$ 41,322,476**	**$ 17,486,897**	**$ 23,835,579**
	Approved Requested Funding	**$ 24,343,876**	**$ 10,273,553**	**$ 14,070,322**	**Revised Requested Funding**	**$ 14,242,555**	**$ 210,565**	**$ 14,031,990**
					Estimated Savings	**$ (10,101,320)**	**$ (10,062,988)**	**$ (38,332)**

**Note: Adopted budget and Revised estimate do not consider "ramp-up"*