COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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MEMORANDUM

TO: The Honorable Ralph S. Northam
Governor of Virginia

The Honorable Janet D. Howell
Chair, Senate Finance Committee

The Honorable Luke E. Torian
Chair, House Appropriations Committee

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

Dan Timberlake
Director, Department of Planning and Budget

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

SUBJECT: Prioritized Strategies to use HCBS reinvestment dollars

This report is submitted in compliance with the Virginia Acts of the Assembly –Chapter 1 Enactment Clause 1.E.3, which states:

The Department of Medical Assistance Services (DMAS) shall develop strategies, for consideration by the 2022 General Assembly, to re-invest general fund dollars freed-up by the enhanced federal match on home and community based services (HCBS). These strategies should enhance the Commonwealth's HCBS by creating capacity to meet the growing demand for HCBS and support structural changes needed to strengthen the HCBS systems. In addition, DMAS shall work with the Department of Behavioral Health and Developmental Services and the Centers for Medicaid and Medicare Services to identify any opportunities to use HCBS reinvestment dollars to divert individuals who are at risk of institutionalization in state facilities. DMAS shall prioritize those strategies that do not require significant on-going obligations or rely on rate increases. By October 1, 2021, DMAS shall report these strategies, including six year cost projections, to the Governor, the Chairs of the House Appropriations and Senate Finance and Appropriations Committees, and the Director, Department of Planning and Budget.

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

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

Prioritized Strategies to Use HCBS Reinvestment Dollars

A Report to the Virginia General Assembly

October 1, 2021

Report Mandate:

From the 2021 Special Session II Amendment to the Acts of Assembly 2021, Chapter 1, E.3 states, The Department of Medical Assistance Services (DMAS) shall develop strategies, for consideration by the 2022 General Assembly, to re-invest general fund dollars freed-up by the enhanced federal match on home and community based services (HCBS). These strategies should enhance the Commonwealth's HCBS by creating capacity to meet the growing demand for HCBS and support structural changes needed to strengthen the HCBS systems. In addition, DMAS shall work with the Department of Behavioral Health and Developmental Services and the Centers for Medicaid and Medicare Services to identify any opportunities to use HCBS reinvestment dollars to divert individuals who are at risk of institutionalization in state facilities. DMAS shall prioritize those strategies that do not require significant on-going obligations or rely on rate increases. By October 1, 2021, DMAS shall report these strategies, including six year cost projections, to the Governor, the Chairs of the House Appropriations and Senate Finance and Appropriations Committees, and the Director, Department of Planning and Budget.

Background

The Centers for Medicare and Medicaid Services (CMS) issued a State Medicaid Director letter on May 13, 2021 (SMD# 21-003). This letter provided guidance to states on implementing section 9817 of the American Rescue Plan Act of 2021 (ARP). Section 9817 provides a temporary increase of 10% to the federal medical assistance percentage (FMAP) for qualifying home and community-based services (HCBS) expenditures between April 1, 2021 and March 31, 2022. Total FMAP may not exceed 95% so Virginia will only receive an additional 5% on any expenditures attributable to Medicaid expansion populations. States must reinvest all savings (General and Special Funds) from the increased FMAP to "implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program." This reinvestment must take place between April 1, 2021 and March 31, 2024 and will be matched by the federal government at the prevailing FMAP when they are expended. Until all of the savings have been reinvested, states must meet maintenance of effort requirements including not reducing existing services or rates and not imposing stricter eligibility standards.

To receive this additional FMAP, states must submit and CMS must approve a spending plan and narrative for the proposed reinvestments. Virginia submitted an initial spending plan on June 11th and received partial approval from CMS on September 13, 2021.

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 for more than 1.8 million Virginians. Members have access to primary and specialty health services, inpatient care, dental, behavioral health as well as 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 more than 500,000 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.

This partial approval covers the two items approved by the General Assembly in savings. CMS has indicated that final approval will not be provided until Virginia submits an updated plan covering the remaining projected reinvestment funds.

Item E.3. of Chapter 1, directs DMAS, working with DBHDS, to develop strategies to reinvest those remaining savings. This report provides options for the General Assembly and Governor to allocate those state reinvestment dollars that meet the CMS requirements and E.3's direction to focus on strategies that will strengthen HCBS systems, divert individuals who are at risk of institutionalization in state facilities, and minimize on-going obligations or further rate increases. DMAS will update our spending plan and narrative to reflect actions taken during the 2022 General Assembly and seek final approval from CMS. The General Assembly may want to include additional rate increases to account for any funds not otherwise specified. Additional funds may be used to increase rates for providers and for start-up funds for the Section 1115 High Needs Supports waiver services.

Current Landscape of Home and Community Based Services (HCBS)

The central purpose of Home and Community Based Services (HCBS), including community mental health and rehabilitation services, is to support individuals in their pursuit of recovery and whole person wellness in the context of the their natural supports. Inherent in this purpose is to create a strong backbone for the system of care that holds the individuals that make up that system steady, preventing crisis and intervening early to avoid unnecessary institutionalization in hospitals, residential facilities and jails. Current HCBS waiver services support 50,000 members to live in their community; specifically 15,312 members within the DD/IDD Waiver and 40,476 members in the CCC Plus Waiver. Community mental health and rehabilitative services support an estimated 105,149 individuals to remain living in the context of their families, natural supports, and communities.

While Virginia has a large HCBS provider network overall, this critical backbone of our system has longstanding fractures that the pandemic conditions have further exacerbated. Our current system simply does not provide the kind of coordinated, solid support necessary to serve its purpose. These fractures have compounded over time, and the most painful symptom has surfaced as our state psychiatric bed crisis. These facilities are operating well above safe capacity, with average daily census above 95% and geriatric bed capacity well above 100%. The pandemic only further intensified the workforce issues involved in the bed crisis, which led to unprecedented efforts by our Commonwealth to address this pain point, including the temporary closure in July 2021 to admission at five of these hospitals and the allocation of significant funds appropriated during Special Session 2021 to attempt financial incentives to bolster their workforce. Ultimately, these recent efforts are reactions to this acute crisis for our system. To work towards meaningful healing of our fractured system of care, our Commonwealth must focus intensive efforts on the backbone—home and community based services. The long-term goal for the Commonwealth is to significantly reduce the reliance on institutional care and both the human and monetary costs of these services. To reach this goal, it is imperative that we strengthen the public and private provider network of community-based providers by enhancing both the quality and reimbursement of services and the coordinating system structures that hold the services together in a strong continuum of care.

Continuum of Care Initiatives

Over the last few years, DMAS and DBHDS have been working through collaborative efforts with Community Service Boards and private provider stakeholders to envision, propose and implement plans towards a strong, coordinated continuum of care. Several existing initiatives are in direct pursuit of this goal and the long-term solution to dependency on institutional care. These initiatives include Step Virginia, Project Bravo, and a Comprehensive Crisis Continuum.

STEP-VA

The numerous fractures in our system have impacted the foundation, the Community Services Boards (CSBs). The CSBs play a critical role in our system as they provide an important universal door into the larger network at the locality level, and the Code of Virginia mandates their exclusive delivery of certain services such as targeted case management, state hospital discharge planning, and emergency services. In 2017, the General Assembly enacted Chapter 6072 to expand the core services of CSB to include same day access, primary care screening, crisis services, outpatient services, psychiatric rehabilitation services, peer support and family services, veteran support services, care coordination, and case management. These nine services are collectively part of a multi-year initiative called System Transformation, Excellence and Performance (STEP-VA), which focuses on the foundation of our public mental health safety net provided by the CSBs. To date, the General Assembly

has funded or partially funded six steps (same day access, primary care screening, outpatient services, crisis services, peer support and family services, and veteran support services). STEP-VA is foundational to increasing access to public services and creating consistency across localities, and creating the training and infrastructure necessary to ensure a complete continuum of evidence-based community based services that are effective in reducing behavioral health crises and diverting or preventing individuals from more costly levels of care, including inpatient admissions to state hospitals. Contextually, it is important to note that while STEP-VA represents a foundational commitment to strengthening our system of care, the Community Service Boards are just one of the discs in the backbone of our system. Roughly 80% of Virginia's Medicaid members participate in behavioral health services with private providers; thus, additional investments are necessary to expand the goals of STEP-VA across the full system to reach the full population of those participating in the system.

Project BRAVO

Project BRAVO stands for Behavioral Health Redesign for Access, Value and Outcomes and is an initiative that seeks to expand upon and carry forward the spirit of enhancement of STEP-VA within the CSBs to the full spectrum of behavioral health providers and services in our system. Project BRAVO's broad goal is to develop a continuum of evidence-based, trauma-informed, prevention-focused and person-centered Medicaid behavioral health services that will reduce reliance on high acuity care such as inpatient hospitalization. On November 18, 2020, the amended and reenacted 2020 Virginia Acts of Assembly, Chapter 56, Item 313 YYY (2020 Appropriations Act) authorized the Department of Medical Assistance Services (DMAS) to implement programmatic changes and develop new service definitions, prior authorization and utilization review criteria, provider qualifications, and reimbursement rates for specified mental health services. In accordance with the 2020 Acts of Assembly, DMAS phased in the first set of enhanced BRAVO services: Assertive Community Treatment (ACT), Mental Health Partial Hospitalization Program (MH-PHP) and Mental Health Intensive Outpatient (MH-IOP) on July 1, 2021. The second set of BRAVO services: Multisystemic Therapy (MST), Functional Family Therapy (FFT), Mobile Crisis Response, Community Stabilization, 23-hour Crisis Stabilization and Residential Crisis Stabilization Unit services will be implemented December 1, 2021. Project BRAVO is both the vision and of these two strategic phases of services seeking to reduce reliance on psychiatric inpatient hospitalization. The guiding principles of BRAVO will inform future DMAS budget decision packages as we continue with the enhancement of behavioral health services as an agency priority.

Comprehensive Crisis Continuum

The interagency development of the vision and operationalized plan for a unified, comprehensive crisis system for the Commonwealth is a key example of the intersection of STEP-VA and Project BRAVO. Crisis Services assist individuals currently experiencing or having recently experienced a behavioral health crisis, and evidence has shown that a robust, high functioning crisis system is the lynchpin in strong, coordinated systems that avoid reliance on hospitalization. Crisis NOW is a national model implemented in several states with strong outcomes and includes the use of crisis hotline to triage and coordinate dispatch of mobile crisis services. These initial responders provide assessment, brief intervention, and referral to other providers as needed. Community stabilization services are short-term bridges to longer-term care and are important for inclusion in services that have fractured community-based services, as there are often delays or waitlists for the appropriate services to avoid hospitalization. 23-hour crisis stabilization provides individuals in crisis with up to 23 hours of supervised care to de-escalate the severity of their crisis or need for hospitalization. Short-term crisis residential stabilization services provide continuous 24-hour observation and supervision for individuals who are in crisis but do not require inpatient services. In Virginia, the current crisis services are one of the most fractured vertebrae in the backbone of our system due to their vague definition, problematic reimbursement structure, and lack of equity in access across geographic regions of the state. While STEP-VA works to bolster and support infrastructure for mobile crisis teams in the public system. Project BRAVO provides the re-definition of the overall services available for provision across CSBs and private providers and enhances the reimbursement rate and structure. The two agencies are working together to integrate these enhancements alongside the implementation of 988 and the Marcus Alert system in what may be the most complex and critical behavioral health implementation in Virginia's history. The cross-agency transformation of our crisis system holds promise to revolutionize and create equitable access to behavioral health care for every Virginian, regardless of their source or lack of healthcare coverage. This will take time and sustained stakeholder engagement, but has the potential to make the largest impact so far on use of emergency rooms for behavioral health care entry points and over-reliance on psychiatric hospitalization. Also importantly, it has the most potential to reduce the costs presently

associated with these higher levels of care, thus hopefully shifting those resources to further development of our backbone of community-based services.

These major initiatives are foundational to creating capacity to repair our fractured system and strengthen the core of community based services. However, additional strategies would enhance the Commonwealth's ability to increase access to services, protect the workforce that has suffered significant attrition and burnout over the course of the pandemic, and safeguard provider financial stability and build the infrastructure required for oversight and quality management.

In May 2021, the Center for Medicare and Medicaid Services (CMS) provided guidance to states regarding specific approaches state Medicaid agencies could use to achieve these goals including implementing new services, payments, leave benefits, and specialized payments for providers. While these potentially represent significant and ongoing costs to implement, the CMS guidance also noted that investments that are more one-time in nature could also be made. For example, strengthening or developing cross-system partnerships, training, eligibility systems, employing cross-system data integration efforts, expanding use of technology and telehealth, and providing access to additional equipment or devices.

Vision to Strengthen the HCBS Systems

Many of the recommendations will serve to strengthen the Commonwealth's current HCBS system. They will also continue to build a system robust enough to consistently divert individuals from state facilities and other inpatient levels of care. Recommendations were developed to ensure the community based system infrastructure is built for accountability, outcomes, and performance through training and IT systems. Without these elements, long-term, sustainable diversion and reduction in utilization of inpatient care at state hospitals and community hospitals will not occur.

Recommendations are categorized into four areas based on CMS guidance.

1. **Access to HCBS and Support Services**

Efforts include initiatives to provide funding to providers who need additional financial support to ensure the impact of COVID does not prevent them from sustaining their services and ensuring access to Medicaid members. Funding could also be targeted to incentivize additional capacity building for underutilized services, such as waiver and HCBS behavioral health supports.

2. **Initiatives to Promote High Quality Care**

Examples of such initiatives include efforts to improve care coordination and member experience with HCBS services.

3. **Technology and HCBS Infrastructure**

Funds used for these purposes would include capital investments needed for developing and improving interagency systems, such as identifying critical incidents and social needs.

4. **Workforce Development**

Initiatives in this area may include items such as trainings for providers, especially for those working with members using HBCS services and requiring additional behavioral health support. Other initiatives would include recruitment and retention activities to ensure Virginia maintain a high-quality HCBS workforce.

Recommendations

DMAS in collaboration with DBHDS have identified a number of priorities that would strengthen the HCBS system and ensure sustained access to community-based services during the ongoing COVID-19 pandemic. Sustaining and strengthening the HCBS system will assist in diversion of individuals from state facilities and other inpatient levels of care.

1. Access to HCBS and support services

The recruitment and retention of Licensed Mental Health Providers (LMHPs, including residents and supervisees) into our behavioral health system workforce is a critical priority at this time. Virginia was ranked in 2020 by Mental Health America as 41st in the country for licensed mental health workforce supply, and the paucity of providers has been exacerbated by the pandemic. The enhanced services implemented through Project BRAVO intentionally rely on licensed workers to assure high quality and service delivery oversight. The evidence-based practices implemented in ACT, MST, FFT and the team-based comprehensive crisis, MH-PHP and MH-IOP have already identified staffing as a significant barrier to starting and sustaining these programs under the strain of the current workforce crisis. An important context here is that according to analysis cross-walking the Department of Health Professionals and Medicaid provider data reveals that less than half of existing LMHPs participate in the public behavioral health system, and thus our network of CSBs and private providers participating in Medicaid are not accessing the full workforce. Increased payment to these highest quality providers is a central strategy to recruit and retain them into jobs that typically pay far less than these providers can make in commercial

or (increasingly common) cash-only private practice settings.

Providers of Developmental Disabilities waivers' residential and day services have been especially hard hit by the pandemic in terms of their ability to retain Direct Support Professionals (DSPs), the front-line staff who provide the day-to-day services in group homes, individuals' own homes, and various types of day programs. Across the commonwealth, as is the case nationally, providers of these services are experiencing a workforce crisis, as many DSPs have quit rather than risk their own or their families' health by potentially exposing themselves to COVID in their ongoing face-to-face service provision. In Virginia, this has led a number of waiver providers to close their doors or consolidate service sites. Providing retention bonuses to those providers experiencing 40% or greater turnover for DSPs who have stayed the course and remained in employment for at least one year may provide a further incentive for these workers to continue to steadily support individuals with developmental disabilities.

2. Initiatives to Promote High Quality Care.

a. **Superutilizer public-private hospital partnership.** Funds to initiate targeted interventions to reduce patient over utilization of emergency rooms and state hospital utilization through a partnership with a contractor, VA College of Emergency Physicians, VHHA, and DBHDS. Funding would support a contract to establish complex care teams serving 1,000 patients. A private contractor will employ 5 teams across the Commonwealth, each targeting an enrollment of approximately 200 individuals/year who have been identified as "High Utilizers" or complex individuals. The contractor will operate a collaborative program that focuses on the following five areas of proven success with complex cases: 1) Direct Patient Engagement; 2) Community Resource Coordination; 3) Customized Care Plan Development; 4) Community Multi-Disciplinary Team Development; and 5) Community Controlled Substance Monitoring. The majority of the work will be field-based. The contractor will coordinate efforts with existing programs and coordination efforts across the Commonwealth.

b. **Technical Assistance for School-Based Services Redesign**. Payment to contractor for TA related to Free Care and School-Based Services Enhancement in anticipation of Commonwealth's emerging need.

3. Technology and HCBS Infrastructure.

a. **Consultant for cross-agency administrative review.** DBHDS and DMAS would issue a request for proposal for contracting with a consultation firm to review the various methods the Commonwealth in Virginia currently uses to assure compliance and quality improvement and to identify strategies and assist the agencies with implementation of systemic operational changes that would enhance the Commonwealths ability to implement quality management strategies in its public service delivery systems. Virginia currently reviews providers through DMAS quality management review and provider integrity as well through DBHDS licensing, quality services reviews, and support coordinator quality reviews. Additionally, some providers independently seek accreditation for their services to show additional commitment to best practice delivery of services. In addition to the reviews, the advent of 6 MCOs into the system has created additional requirements on providers for authorization of services in addition to the requirements related to registration and fee for service expectations. Consultative expertise could assess the provider burden when delivering services in the current service delivery system to identify ways to increase efficiencies in service delivery by assessing and changing or reducing current processes/paperwork and make recommendations for implementing a set of new service delivery rules including provider licensure and accreditation processes that would significantly reduce the current administrative burden on providers while assuring effective quality of care oversight for the individuals supported through the public system of care. This reduction in administrative burden would assure that our most valuable asset, the staff charged with providing supports and services, are in fact minimizing time on paperwork and process and maximizing time in service delivery.

b. **Invest in an adaptable and user-friendly Learning Management System.** DBHDS and DMAS are seeking to standardize training expectations across services to ensure continuity in care and to assure services are delivered according to best practice standards. Expectations are currently in place for Developmental Services around direct support professional and supervisor training and expectations are launching around Project

BRAVO, specifically related to the continuum of crisis services for mobile (children and adult) as well as the call center (clinical and technological). The learning management system would contain training that is both virtual and instructor led in nature. The system would be able to track requirements, registration and completion of courses. The system would allow for DMAS, DBHDS and subcontractors of both agencies to review training completed for staff of providers who are responsible for delivering services where standardized training is required and offer providers an easy way to track and demonstrate compliance.

c. **Health Information Exchange w/ CSBs and Private Providers of Behavioral and Mental Health Services.** Collaborate with an IT platform such as Virginia Health Information (VHI) to include the continuum of behavioral health providers in Virginia's Health Information Exchange. Inclusion of these providers will allow maintenance of a single patient record across multiple service providers. This will aim to include all state facilities, CSB's, and private hospitals. Currently multiple EHR's are used that do not interface or have real-time, transactional data exchange capability. This compromises the quality of patient care due to lost continuity of treatment and the inability to identify disparate patient records being for a single individual. Improved patient data and ability to share records is a critical need for both the quality of patient of outcomes, reducing bed census demands in state facilities, and improving Quality Improvement programs across behavioral and mental health providers. Exact cost of this initiative will depend on full scope as determined feasible by DMAS, DBHDS, and VHI. Some interoperability and privacy constraints will need to be considered; however, DMAS and DBHDS believe that inclusion of these providers in the current HIE framework will improve care coordination and quality of care.

d. **Crisis System Technical Assistance.** Virginia is on the front end of a national movement to reform comprehensive behavioral health crisis policy and payment structure, with the additional opportunities of integrating the 988 call center using the cell phone tax. Other states have worked to braid funds, and there is potential for using the tax dollars identified as the matching funds for Medicaid Administrative dollars to support sustainability and cost of the 988 infrastructure. Technical assistance from a contractor familiar with the process of operationalizing these types of braided funds for crisis would allow for an expedient proposal that would strengthen the Commonwealth's movement towards an accessible, coordinated system of crisis care to reduce reliance on psychiatric hospitalization. This braiding would lessen the impact on general fund dollars.

e. **Outcomes System for BH Enhanced Services.** Funding for development and implementation of an online outcomes submission system for providers to submit clinical outcomes for Medicaid members participating in Enhanced BH Services through BRAVO to support evaluation of implementation and overall service system performance.

4. Workforce Development

a. **Medication Administration Training Curriculum Update.** The current Medicaid Administration Training curriculum for HCBS providers and their direct support professionals is 15-20 years old. Funds would retain an entity to update the curriculum to meet today's standards and ensure it is appropriately offered/taught through the current training delivery model.

b. **Evidenced Based Practices (EBP) Training Support.** Due to the reduction in re-allotted workforce training funds through Special Session, the enhanced services have had a limited opportunity to optimize their intended use of evidence-based practices. These funds would allow for a more robust training effort for LMHPs and QMHPs in partial hospitalization and intensive outpatient services, as well as additional training for ACT, MST and FFT teams to focus specifically on specialty co-occurring treatment of mental health and substance use disorders.

Six (6) Year Cost Estimates

Item E.3. Six Year Cost Estimates							
	2022	2023	2024*	2025	2026	2027	6 Year Total
Access to HCBS and Support Services							
Support payments for behavioral health providers	$0	$25,000,000	$0	$0	$0	$0	$25,000,000
Initiatives to Promote High Quality Care							
Superutilizer public-private hospital partnership	$0	$3,400,000	$0	$0	$0	$0	$3,400,000
Technical Assistance for School-Based Services Redesign	$0	$500,000	$0	$0	$0	$0	$500,000
Technology and HCBS Infrastructure							
Consultant for cross-agency administrative review	$0	$2,500,000	$0	$0	$0	$0	$2,500,000
Invest in an adaptable and user-friendly Learning Management System	$0	$5,000,000	$5,000,000	$1,000,000	$1,000,000	$1,000,000	$13,000,000
Health Information Exchange Improvements	$0	$5,000,000	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$9,000,000
Crisis System Technical Assistance	$0	$250,000	$0	$0	$0	$0	$250,000
Outcomes System for BH Enhanced Services	$0	$1,000,000	$3,000,000	$250,000	$250,000	$250,000	$4,750,000
Workforce Development							
Medication Administration Training Curriculum Update	$0	$500,000	$0	$0	$0	$0	$500,000
Evidenced Based Practices (EBP) Training Support	$0	$500,000	$0	$0	$0	$0	$500,000
Total	$0	$43,650,000	$13,000,000	$2,250,000	$2,250,000	$2,250,000	$63,400,000

* Funding through Q3 of SFY 2024 will be counted towards Virginia's reinvestment requirement under Sec 9817 of ARP.