COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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April 11, 2023

MEMORANDUM

TO: The Honorable Tod Gilbert
Speaker, Virginia House of Delegates

The Honorable Richard Saslaw
Majority Leader, Senate of Virginia

Members of the Virginia General Assembly

FROM: Cheryl Roberts
Director, Virginia Department of Medical Assistance Services

SUBJECT: Initial Strategic Plan Report: Coordinated Specialty Care Workgroup

This report is submitted in compliance with Article 1 of Chapter 10 of Title 32.1 in a section numbered 32.1- 331.05 which creates the Coordinated Specialty Workgroup and states:

D. The work group shall meet to produce an initial five-year plan report to the General Assembly no later than November 1, 2022, and then provide annual updates to the five-year strategic plan beginning November 1, 2023.

Should you have any questions or need additional information, please feel free to contact me at (804) 664-2660

CR/WRF
Enclosure

Pc: The Honorable John Littel., Secretary of Health and Human Resources

Initial Strategic Plan Report: Coordinated Specialty Care Workgroup

A Report to the Virginia General Assembly

April 11, 2023

Report Mandate:

Article 1 of Chapter 10 of Title 32.1 in a section numbered 32.1- 331.05 states:

A. The Department shall establish a work group in coordination with the Department of Behavioral Health and Developmental Services to evaluate and make recommendations to improve approaches to early psychosis and mood disorder detection approaches, make program funding recommendations, and recommend a core set of standardized clinical and outcome measures. Early psychosis intervention includes services to youth and young adults who are determined to either be at a clinical high risk for psychosis or are experiencing a first episode of psychosis.

B. The work group shall include (i) a representative from the Bureau of Insurance; (ii) a representative from the Department of Health Professions; (iii) a representative from the Department of Behavioral Health and Developmental Services; (iv) a psychiatrist with working knowledge of first-episode psychosis and coordinated specialty care; (v) a mental health clinician with working knowledge of first-episode psychosis and coordinated specialty care; (vi) a support services specialist with experience in supported education and employment; (vii) a representative of a state, regional, or local mental health advocacy group as recommended by such group; (viii) an individual who has experienced psychosis or a family member of an individual who has experienced psychosis; and (ix) up to three representatives of health insurance issuers or managed care organizations operating in the Commonwealth as recommended by such issuers or organizations.

C. The work group shall develop a five-year strategic plan to accomplish the following objectives:

1. Enhance services to existing coordinated specialty care programs;

2. Expand early psychosis intervention in underserved areas of the Commonwealth;

3. Develop a strategy to identify and apply for funds from individual foundations and federal and state sources and disburse those funds; and

4. Develop a strategy to advance the goals and utilization of coordinated specialty care for Medicaid beneficiaries and individuals who are privately insured.

The strategic plan shall identify current coordinated specialty care programs in the Commonwealth and include information on how they are funded, how many individuals use the current programs, and the insurance status of the programs. As used in this section, "coordinated specialty care" means a team-based service provided to a person for treatment of first-episode psychosis that is composed of case management, family support and education, pharmacotherapy and medication management, individual and group psychotherapy, supported education and employment, coordination with primary care, and outreach and recruitment activities.

D. The work group shall meet to produce an initial five-year plan report to the General Assembly no later than November 1, 2022, and then provide annual updates to the five-year strategic plan beginning November 1, 2023.

About DMAS and Medicaid

The mission of the Virginia Medicaid agency is to improve the health and well-being of Virginians through access to high-quality health care coverage.

The Department of Medical Assistance Services (DMAS) administers Virginia's Medicaid and CHIP programs for over 2 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 600,000 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 an approximate 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% for newly eligible adults, generating cost savings that benefit the overall state budget.

Background

In 2015, eight CSBs began to implement coordinated specialty care (CSC) programming, including Alexandria CSB, Fairfax-Falls Church CSB, Henrico Area Mental Health and Developmental Services, Highlands CSB, Loudoun County CSB, Prince William County CSB, Rappahannock-Rapidan CSB, and Western Tidewater CSB. CSC is a team-based, collaborative, recovery-oriented approach to treating first episode psychosis (FEP). The goal of CSC is to identify and engage young individuals, usually between the ages of 16 to 30, and their caregivers in an individualized-specific treatment which includes low-dosage medications, cognitive and behavioral skills training, supported employment and education, case management, and family psychoeducation. Participants are empowered through shared decision-making to address their unique needs, preferences, and recovery goals.

In 2019, DBHDS issued a report on the first three years of available data for CSC programs in the Commonwealth (2015-2018). Preliminary data indicated that CSBs were successful in reducing the duration of untreated psychosis by admitting individuals into CSC services soon after an individual’s FEP.

An additional report was published in 2021 and included a summary of current services, funding and programmatic issues to address treatment and care of this population, as well as planned efforts and recommendations to expand and improve care for this population. Program challenges identified in the report include lack of trained workforce, availability of complementary community-based services, and sustainability of CSC programs.

Key recommendations from the 2021 report:

1. Continue state funding for the existing eight CSBs providing CSC and allocate ongoing state general funds for the three CSC programs at CSBs.

2. Work toward sustainable funding for CSC, including providing funding to DMAS for a rate study to develop a bundled reimbursement mechanism for CSC and consideration of the development of commercial rates.

3. Support training and technical assistance for CSC, including investing in or routine fidelity monitoring, training, and technical assistance from industry experts, such as ONTrackNY and NAVIGATE.

4. Invest in data collection and reporting mechanisms to monitor CSC outcomes.

5. Join the Early Psychosis Intervention Network (EPINET) and the EPINET National Data Coordinating Center (ENDCC) to connect to national standards.

Establishment of Coordinated Specialty Care Workgroup

In keeping with the mandate, DMAS established a workgroup inclusive of those parties previously invited to participate in the development of the report written by DBHDS in 2021 as well as additional parties mandated in the budget language.

This workgroup includes the following individuals, who met for the first time on September 26, 2022, to review the budget language and strategic plan.

Required Membership Category	Workgroup Member (Role/Organization)
Bureau of Insurance	Brant Lyons James Young

Department of Health Professions	Jaime Hoyle (Executive Director, Boards of Counseling, Psychology and Social Work)
Department of Behavioral Health and Developmental Services	Jeffrey Vanarnam Margaret Steele Lisa Jobe-Shields Alexis Aplasca Josie Mace
A psychiatrist with working knowledge of first-episode psychosis and coordinated specialty care	Andrea Watkins (Medical Director, Anthem)
A mental health clinician with working knowledge of first-episode psychosis and coordinated specialty care	Amanda Scott Davis (Turning Point Program, Fairfax Falls Church) Valerie Coley (Henrico CSB) Amber Harris (Highlands CSB) Sophia Lenk
A support services specialist with experience in supported education and employment	Crystal Edmonds (Fairfaix Falls Church CSB)
An individual who has experienced psychosis or a family member of an individual who has experienced psychosis	Jennifer Spangler (Advocate)
Up to three representatives of health insurance issuers or managed care organizations operating in the Commonwealth as recommended by such issuers or organizations.	Theodora Appiah (Molina Healthcare) Anne Catlett (Anthem) Andrea Watkins (Anthem)
Department of Medical Assistance Services	Alyssa Ward (Behavioral Health Clinical Director) Laura Reed Ashley Airington
Additional Member	Jennifer Faison (Virginia Association of Community Services Boards)
Additional Member	Mindy Carlin (Virginia Association of Community Based Providers)
Additional Member, sponsor of budget amendment	Delegate Patrick Hope (Virginia General Assembly)
Additional Member	Thomas Schuplin (Private Consultant, CSC)
Additional Member	Bruce Cruser (Mental Health America of Virginia)
Additional Member	Mary Beth Walsh (Director of Programs, National Alliance for Mental Health)

<u>Current funding for CSC in the Commonwealth</u>

CSC services provided at CSBs are funded through a combination of state general fund (GF) and federal mental health block grant (MH BG) funds (see Table 1). The federal MH BG funds require 10 percent set aside for services for individuals experiencing FEP. In FY23, $5,712,718 was dedicated to the provision of CSC in Virginia. Some of the composite services involved in the delivery of CSC may be billed to Medicaid (e.g. Case Management, Individual/Group Psychotherapy, Peer Recovery Support Services, Medication Management) though there is no existing service that is defined with the full components of CSC as a single service.

Table 1. Individuals served and funding for Coordinated Specialty Care

Community Services Board	Individuals Served FY23 YTD	Total Individuals Served Since Start of CSC	FY23 Mental Health Block Grant Funds	FY23 State Funds
Fairfax – Falls Church	39	190	397,203	572,428
Western Tidewater	45	120	179,452	467,798
Highlands	21	113	177,673	463,215
Alexandria	17	160	220,040	572,416
Loudoun	37	134	190,809	497,074
Henrico	32	173	182,726	476,237
Prince William	23	277	192,381	501,123
Rappahannock-Rapidan	19	50	172,434	449,709
TOTAL	**233**	**1,017**	**1,712,718**	**4,000,000**

In addition to the eight CSBs, there are three new teams being formed at Blue Ridge Behavioral Health, Mount Rogers, and Arlington CSBs. Neither Mount Rogers nor Blue Ridge currently have any participants in the program. Arlington has served 7 participants total-to-date.

The following table provides a timeline of the actions towards the implementation of CSC.

Timeline	Actions Undertaken
2014	DBHDS released an RFP to the Virginia CSB system to solicit applications for funding to develop and implement evidence-supported early intervention and treatment models designed to address the behavioral health needs of young adults.
2015	Eight CSBs began implementation of CSC programming
2019	DMAS and DBHDS collaborated on an official “behavioral health redesign” proposal and “Continuum” vision document, which included reference to CSC. Presented to stakeholders and published to DMAS’s website.

2019	DBHDS reported early impacts of the first three years of funding Coordinated Specialty Care.
November 2021	DBHDS reported via Item 320.MM of Chapter 552 of the 2021 Acts of Assembly an update on CSC services funded by GF and Mental Health Block Grant.
September 2022	DMAS initiates CSC workgroup in cooperation with DBHDS to develop a 5-year strategic plan.

Coordinated Specialty Care 5 Year Strategic Plan

The draft strategic plan is presented below and organized by the mandated task categories of this plan, with specific steps that correspond to these categories provided within each year.

	Enhance Services for Existing CSC Programs	Expand Early Psychosis Intervention to Underserved Areas	Develop Foundation, Federal and State Funding Strategy	Develop Private Insurance Funding Strategy
Year 1 (*FY23)*				
Explore existing mechanisms for payment of CSC components through Medicaid and provide training to CSBs on how this would be done. Establish plan for engaging training and support from ONTrackNY and/or NAVIGATE. Establish recommendations for detection of early psychosis. Establish required commitment and necessary sustainment resources plan for enhanced data collection and outcomes analysis base on agreed upon core set of measures (WebCAB through EPINET).	X			
DBHDS has expanded support to 3 new CSC teams. Conduct assessment of underserved areas for strategic team development.		X		
DMAS submitted budget package decision to conduct a rate study on CSC Wait to see if CSC rate study ends up in Final Budget, remaining plan based on assumption that this occurs, at it is the necessary step to movement forward for Medicaid.			X	
Year 2 (*FY24)*				

Roll out training and support to existing and new CSC providers through DBHDS. Put recommendations to action for detection of early psychosis. Roll out enhanced data collection and analysis for DBHDS to existing CSC CSB providers for DBHDS.	X			
DBHDS to explore additional funding sources including foundation funding that could support expansion to underserved areas.		X		
If authority in budget, rate study to begin with workgroup of stakeholders participating in service design and cost assumptions. DMAS to develop budget cost estimates for implementation. DMAS to submit budget decision package for authority and funding to implement CSC service within Medicaid.			X	
	Enhance Services for Existing CSC Programs	**Expand Early Psychosis Intervention to Underserved Areas**	**Develop Foundation, Federal and State Funding Strategy**	**Develop Private Insurance Funding Strategy**
Year 3 (*FY25)*				
Continued training and support for CSC providers.	X			
Integrate CSC into BH dashboards to support utilization management across localities in VA. Establish data collection and analysis methods for CSC across agencies		X		
If DMAS receives authority for funding and implementation, begin process of state plan amendment, policy manual development, regulation development, system changes for MCO/FFS delivery systems.			X	
Year 4 (*FY26)*				
Continued training and support for CSC providers.	X			
Explore means to use Medicaid funding to expand services to underserved areas, engage MCOs in network adequacy assurance and value-based payment strategies.		X		
If the above occur, first full year of Medicaid service implementation.			X	
Explore private insurance coverage.				X
Year 5 (*FY27)*				
Continued training and support for CSC providers.	X			
Implement strategies to leverage Medicaid in expanding access.		X		

Develop Medicaid report on first full year of implementation with outcomes analysis.			X	
Begin processes to operationalize any adopted suggestions for private insurance coverage.				X