COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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November 1, 2024

MEMORANDUM

TO: The Honorable Don Scott
Speaker, Virginia House of Delegates

The Honorable Scott A. Surovell
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: Coordinate Specialty Care Workgroup

This report is submitted in compliance with Section 32.1-331.05. of the Code of Virginia which creates the Coordinated Specialty Care 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/wf
Enclosure

Pc: The Honorable Janet V. Kelly, Secretary of Health and Human Resources

Annual Strategic Plan Update: Coordinated Specialty Care

November 2024

Report Mandate:

Section 32.1-331.05 of the Code of Virginia 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.

Background

Coordinated Specialty Care (CSC) is a person-

centered, team-based comprehensive treatment and support service that is evidence based and recovery oriented. First-episode psychosis (FEP) is the early period after first psychotic symptoms due to a serious mental illness (SMI) and people usually experience this in their teens through mid-twenties. There is significant research[1] indicating that many people experiencing these symptoms do not receive treatment for a year or longer, and that untreated symptoms are a primary driver of negative outcomes like developing substance use disorder (SUD), experiencing homelessness, unemployment, or incarceration. By intervening early with person-centered care, low-dose antipsychotic treatments, shared decision making between professionals and the individual and family, CSC can change the trajectory of symptoms and individuals' lives.

Team-based approaches can be difficult to fund and require a cross-agency strategy, which is one reason an initial workgroup and this annual report was mandated to further refine and advance Virginia's approach to this life-changing service. In Virginia, CSC services provided at CSBs are funded through a combination of state general funds (GF) and federal mental health block grant (MH BG) funds. The federal MH BG funds require 10 percent to be set aside for services for individuals experiencing FEP. In FY2021, a total of $5,712,718 was dedicated to the provision of CSC in Virginia. 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 successful reduction in time to treatment by admitting individuals into CSC services soon after an individual's FEP.

There is not currently a license or certification for CSC in Virginia. But there are eleven programs operating with DBHDS support 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, with the final three programs being new: Blue Ridge Behavioral Health, Mount Rogers, and Arlington CSBs.

Medicaid Behavioral Health Service Redesign

As part of Governor Youngkin's *Right Help Right Now* plan to transform Virginia's behavioral health system and supported by the General Assembly in 2024, a budget amendment for $1,000,000 was funded for a rate study to move forward to redesign Virginia's legacy behavioral health services in Medicaid. The 2024 Appropriation Act language is as follows:

"Item 288.XX.1. Effective July 1, 2024, the Department of Medical Assistance Services (DMAS) shall have the authority to modify Medicaid behavioral health services such that: (1) legacy

[1] National Institute on Mental Health. Recovery after an Initial Schizophrenia Episode (RAISE). National Institute of Mental Health; 2022. **NIMH » Recovery After an Initial Schizophrenia Episode (RAISE) (nih.gov);** Heinssen R, Goldstein A, Azrin, S. Evidence based treatments for first episode psychosis: components of coordinated specialty care. National Institute on Mental Health; 2014.**evidence- based-treatments-for-first-episode-psychosis.pdf (nih.gov).**

services that predate the current service delivery system, including Mental Health Skill Building, Psychosocial Rehabilitation, Intensive In Home Services, and Therapeutic Day Treatment are phased out; (2) legacy youth services are replaced with the implementation of tiered community based supports for youth and families with and at-risk for behavioral health disorders appropriate for delivery in homes and schools, (3) legacy services for adults are replaced with a comprehensive array of psychiatric rehabilitative services for adults with Serious Mental Illness (SMI), including community-based and center-based services such as independent living and resiliency supports, community support teams, and psychosocial rehabilitation services, (4) legacy Targeted Case Management- SMI and Targeted Case Management- Serious Emotional Disturbance (SED) are replaced with Tiered Case Management Services. All new and modified services shall be evidence based and trauma informed. To facilitate this transition, DMAS shall have the authority to implement programmatic changes to service definitions, prior authorization and utilization review criteria, provider qualifications, and reimbursement rates for the legacy and redesigned services identified in this paragraph. DMAS shall only proceed with the provisions of this paragraph if the authorized Medicaid behavioral health modifications and programmatic changes can be implemented in a budget neutral manner within appropriation provided in this Act for the identified legacy services. Moreover, any new or modified services shall be designed such that out-year costs are in line with the current legacy service spending projections. No new Medicaid behavioral health services or rates shall be implemented until corresponding legacy services have ended. Implementation of the redesigned services authorized in this paragraph shall be completed no later than June 30, 2026. The Department of Medical Assistance Services shall have the authority to seek federal authorization through waiver and state plan amendments under Titles XIX and XXI of the Social Security Act, as necessary, to meet the requirements of this paragraph. The department shall have authority to implement the changes authorized in this paragraph upon federal approval and prior to the completion of any regulatory process."

CSC is one of only a few evidence-based models for early intervention for serious mental illness (SMI), thus, it is included as part of the rate study. As outlined in the above language, only budget neutral changes can move forward without additional authority from the General Assembly. Thus, the rate study will outline a continuum of replacement services and the projected utilization and ultimate cost of these replacement services. The budget neutral changes will move forward in the second year of the project. The specific services, projected utilization, and total state cost will be completed prior to June 2025 and information will be shared publicly regarding which services will move forward to implementation during year two of the project (FY26).

To implement an evidence-based practice such as CSC in Medicaid, state infrastructure for fidelity oversight, or a license aligned with a high-quality/high-fidelity implementation of the practice is required to ensure that the practice is being provided as intended. Virginia implemented three team-based, evidence-based services as part of Project BRAVO in 2021: Assertive Community Treatment (ACT), Multisystemic Therapy (MST), and Functional Family Therapy (FFT). For each practice, multiple funding agencies have worked with VCU Center for Evidence Based Partnerships (CEP-Va) to build shared infrastructure for fidelity monitoring, and such activity will also be required for CSC.

Update on State Fiscal Year 2024 Strategic Plan Goals

There were eight goals set for State Fiscal Year 2024 in the five-year strategic plan[2]. An update on each is provided below.

SFY2024 Goal	Lead Agency	Status Update for September 2024
Review workgroup membership, stakeholder meeting attendance, and seek commitment from representative group to serve as workgroup moving forward through period of strategic plan.	DMAS	This is planned for integration into Medicaid Behavioral Health Service Redesign. Service specific workgroups are not being implemented, rather CSC is being integrated into the Adult redesign with input from Youth redesign.
DMAS submit budget package to conduct a rate study on CSC.	DMAS	The 2024 Appropriation Act includes replacing Medicaid legacy services with evidence-based, trauma-informed services and funding for a rate study.
DBHDS to identify funding (mental health block grant or other source) to ensure that the three additional teams have ongoing funding in line with the eight existing teams once their start-up funds are no longer available.	DBHDS	DBHDS is setting an additional 2% of the MHBG to support operations of the three new teams. Each receives $160,799. They do not, however, receive any SGF as do the other eight.

[2] Full report can be accessed here: **Initial Strategic Plan Report: Coordinated Specialty Care Workgroup – April 11, 2023 (virginia.gov)**

SFY2024 Goal	Lead Agency	Status Update for September 2024
Explore supplemental funding approaches in addition to rate study, including Early Periodic Screening, Diagnostic and Treatment (EPSDT) benefit for individuals under 21 years of age, ILOS provision in managed care, and feasibility of Certified Community Behavioral Health Clinic (CCBHC) model as an approach for sites implementing CCBHC who also offer CSC.	DMAS	This goal was not pursued at a state level. Individual managed care health plans have reported funding CSC, including start-up funds for one program.
Reach 100% participation in WebCAB for EPINET and publish public-facing report on Virginia CSC.	DBHDS	This goal has been met. Virginia has onboarded all 11 teams to complete a Virginia battery of WebCAB through EPINET. DBHDS is receiving data from all 11 programs quarterly
If rate study moves forward, include the following considerations as part of the program and rate development process: -early detection -expansion to underserved areas/analysis of underserved areas	Shared	The rate study has just begun and CSC was included as a goal. These steps have not been taken but are planned as part of the policy and rate development process which will occur July 2024-June 2025.
If rate study moves forward, workgroup should update the strategic plan for years 3-5 based on the expected timeline.	Shared	The group members will be engaged as part of the rate study completion. If CSC moves forward to implementation following the rate study, the group will be reconvened Spring 2025 to rewrite the strategic plan.
Conduct assessment of underserved areas for strategic team development.		No progress (no dedicated staff time/effort)

Strategic Plan Updates for SFY 2025

Updated Goal for SFY 2025	Lead Agency	Description
Conduct rate study in coordination with DBHDS to determine policies, rate structure. Consider early detection and expansion to underserved areas.	DMAS	As part of service redesign rate study, CSC will be evaluated by contractor and agencies. This includes developing service definitions and rate structure. Only budget neutral changes can move forward following the rate study without additional General Assembly action.
Determine roles and responsibilities, as well as funding needs, for fidelity oversight for CSC.	Shared	For specific Evidence Based Practices such as CSC, the Commonwealth needs cross agency planning and coordination for the oversight of fidelity to the model. Costs of fidelity review can be built into the rate model for providers to purchase the review activities, but additional infrastructure such as through VCU Center for Evidence Based Partnerships is needed across EBPs.
Reach 100% participation in WebCAB for EPINET and publish public facing report on Virginia CSC.	DBHDS	DBHDS has identified some additional data needs that are going unmet. They are working with their research and evaluation team to explore the potential option of developing a dashboard that would enhance capacity, DBHDS will continue to participate in the EPINET space
Following results of rate study, workgroup should re-write the strategic plan for years 3-5 based on the expected timeline.	Shared	Updated goal for SFY 2025.

Summary and Next Steps

In summary, goals from years 1-3 of the strategic plan are currently moving forward in a preliminary manner through the behavioral health service redesign rate study. The results of this rate study will provide a rate structure, service policies, provider qualifications, estimated utilization, and total state cost for CSC implemented for Virginia Medicaid. DMAS, in partnership with DBHDS, will work to move forward service changes that are budget neutral into implementation during state fiscal year 2026, which may include CSC, depending on the overall results of the rate study across services.

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.