CardinalCare
Virginia's Medicaid Program

VIRGINIA'S MEDICAID PROGRAM
DMAS

The Department of Medical Assistance Services

Behavioral Health Redesign Stakeholder Summary Report

Contents

1. Background 1

2. Summary 2

- Standardization 3
- Lack of Transportation and Services 4
- Need for a Long-Term Maintenance Service 4
- Workforce 4
- Peer Supports 4
- Continuum of Care 5

3. Member Feedback 6

- In-Person Meeting Themes 6
- Member Survey Themes 7

4. Advocate Feedback 9

- Virtual Meeting Themes 9

5. MCO Feedback 12

- Service Authorizations and Medical Necessity Criteria 12
- Service Expansion and Evidence-Based Practices 12
- Workforce and Provider Oversight 13
- Operational and Training Needs 13

6. Provider Feedback 15

- Survey Themes 15
- Themes 20

Background

The Virginia Department of Medical Assistance Services (DMAS or Department) began work in July of 2024 to implement Virginia Medicaid Behavioral Health Services Redesign to enhance behavioral health services in Virginia Medicaid authorized in Item 288.XX of the 2023 Appropriations Act. As part of the initiative, DMAS engaged Mercer to assist with gathering stakeholder feedback to inform service definition development and rate setting.

DMAS recognizes the importance of including stakeholders who are a daily part of the mental health system to inform system change and rate setting decisions. Several stakeholder activities were conducted, including outreach to providers, advocacy groups, Medicaid members, and managed care organizations (MCOs). Because Medicaid members primarily provide feedback based on their personal experiences as recipients of health care services, their feedback focused more on the quality, accessibility, and effectiveness of the current services they receive. Their input will help shape policies, programs, and services to be more person-centered and help ensure acceptance and support. Provider input predominantly focused on service delivery and rate considerations, while MCOs provided information on implementation areas such as authorization and standardization criteria. Advocate group feedback included comments regarding quality, funding, and workforce concerns. All stakeholder information is summarized below for consideration.

Section 1

Summary

The purpose of this report is to summarize the information gathered through stakeholder engagement. This information will be used alongside best available evidence, models from other states, and direct planning with sister agencies to redesign legacy mental health rehabilitative services.

Stakeholder input was gathered through surveys and in person and virtual listening sessions, and informational webinars were also held to share information. Provider surveys also included detailed information about current staffing and practices for legacy services as well as evidence-based practices (EBPs) which will be used to inform the assumptions of the rate study, but is not presented in this report.

To target specific groups, several listening sessions were scheduled each with specific audiences. Three in-person member listening sessions were conducted: one in Richmond and the other two in Blacksburg. Two virtual sessions were also held for members, one in the afternoon and the other in the evening. Two 90-minute virtual listening sessions were held for advocates with one targeted to adults and the other to youth and their families. A three hour in-person session was conducted with the MCOs in Richmond.

In addition to listening sessions, there were three surveys conducted. A member survey was made available to obtain feedback from those who either could not attend a session or preferred to give feedback in writing. An additional Therapeutic Day Treatment (TDT) specific survey was provided to school personnel to provide feedback on TDT in the school setting. A provider survey requesting both feedback on reform topics as well as information regarding provider costs for rate setting was also collected.

Materials were prepared for each listening session's target population to describe the project and gather comments. In addition to providers being asked for cost information, three basic questions were asked across all stakeholders in both listening sessions and surveys to gather qualitative information regarding reform:

- What parts of the Community Mental Health Rehabilitation Services (CMHRS) are good and should be kept the same?
- What parts of the CMHRS should be changed?
- What concerns do you have about CMHRS that you want to make sure the Commonwealth considers?

Format	Number Completed
Surveys	
Adult Provider Survey	66

Format	Number Completed
Youth Provider Survey	61
Therapeutic Day Treatment Surveys for school personnel	42
Youth/Family Member Survey	48
Adult Member Survey	32
Listening Sessions	
Virtual Advocate sessions	2 sessions, 18 attendees
In person member sessions	2 sessions, 23 attendees
Virtual member sessions	2 sessions, 20 attendees
Provider conference sessions	4 sessions, 100+ attendees
Health plan session	1 session, 40 attendees

Across all stakeholder groups (members, providers, advocates, and MCOs), several key themes emerged that all groups identified as important for Virginia's behavioral health services redesign. The Department should consider the cross-cutting themes below as work moves forward with the Right Help Right Now Virginia Medicaid Behavioral Health Services Redesign. These cross-cutting themes are described first, and then the feedback from each stakeholder group is summarized.

The six cross-cutting themes were:

- Standardization
- Lack of Transportation Services
- Need for a Long Term Maintenance Service
- Workforce Consideration
- Peer Supports
- Need for Comprehensive Continuum of Care

Standardization

Members, advocates, providers, and MCOs all noted a need for standardization of service definitions, medical necessity criteria, service authorizations and discharge criteria. Standardizing processes would also assist in related concerns expressed about administrative burden by making processes the same across all MCOs and reduce the volume of back-and-

forth requests for additional information needed for an authorization by providing clear criteria and standards.

Lack of Transportation and Services

Stakeholders noted that lack of transportation prevented members from accessing services and other community supports. Multiple stakeholders reported that non-emergency medical transportation was unreliable, often either not coming when scheduled or not returning for the member after appointments to take them home. The lack of transportation resulted in the isolation of members which can lead to decompensation. Stakeholders noted a lack of services in rural areas, leading to waiting lists and delays in people receiving treatment. Housing was also flagged to a lesser extent as a social determinant of health impacting members with behavioral health issues, with a lack of supportive housing or other resources for members with housing instability leading to decompensation and crises.

Stakeholder Engagement

Two in-person (Richmond and Blacksburg) member listening sessions — 23 attendees

Two virtual member listening sessions — 20 attendees

Member survey — 48 youth and 32 adult respondents

TDT survey — 42 respondents

Two advocate listening sessions — 18 attendees

Provider survey — 66 adult and 61 youth respondents

Need for a Long-Term Maintenance Service

Another common universal theme was that mental illness is often a lifelong condition requiring long term interventions and maintenance support. The need for a long-term maintenance service was expressed by several different groups, as was the need for fluidity in accessing other levels of care if a crisis occurs or new needs are identified for a member. A maintenance service should also include assistance with access to transportation.

Workforce

A lack of adequate behavioral health workforce was a common theme both in terms of number of staff available and in the quality of trained staff. There is a current shortage and concern that increased training requirements and potential increased documentation for new services may further limit the ability to hire staff. Other workforce concerns included lack of adequate funding for salaries and implementing Evidence Based Practices, lack of adequate experience to deal with high acuity cases, and lack of any services or supports in rural areas.

Stakeholders noted that having tiers in acuity could help balance the caseload of behavioral health providers, allowing more time for members with higher needs when balanced with a portion of the caseload having members with lower acuity.

Peer Supports

Peer supports were noted by all stakeholder groups to be a good addition to services. Peers allow for lived experience to be incorporated into treatment and can be useful to truly meet people where they are at with a personal knowledge of navigating treatment and unique

engagement skills. Peer supports could also be utilized to address specific populations, such as family peer support, transition age youth, and individuals engaged with the legal/carcel system.

Continuum of Care

Another theme across all stakeholder groups was the need for a full continuum of care that includes preventative services. Many stakeholders across the different groups noted that services seem to require people to fail first by being hospitalized or reach a crisis before being able to access care. The lack of options between inpatient and Assertive Community Treatment (ACT) levels of care and Psychosocial Rehabilitation (PSR) and Mental Health Skill-building Services (MHSS) also were noted to be areas of need. A continuum of community-based services in between the two as well as a preventative level of care to keep people from escalating into a crisis were suggestions to help improve the efficacy and stability of the current behavioral health array. Other areas of need identified include services for individuals with a dual diagnosis, such as substance use disorders (SUDs) or intellectual disabilities.

Section 2

Member Feedback

In-Person Meeting Themes

Transportation

Many adult members discussed concerns that Non-Emergency Medical Transportation (NEMT) is not dependable. NEMT providers either do not pick up members to attend appointments or do not return them home leaving them stranded. This lack of transportation can prevent adherence and maintenance activities such as a lack of medication adherence if the member does not have transportation to the pharmacy and medication management appointments. A new step-down service that includes transportation was requested. Several members also noted that public transportation was only available to them twice a day to go to a PSR program and therefore they had no flexibility in their hours for attendance.

Service Limits

Members expressed concern about services terminating before the individual has had all their needs met. Service authorizations appear to not be linked to member treatment, with the example being given of MHSS being universally denied by all MCOs after three years. There was discussion about mental illness being a lifelong condition and services sometimes needing to be increased or decreased depending on what is happening in the member's life. Members felt that the MCOs do not understand that progress happens differently for different people and if services are taken away too soon the member will lose any progress they have made. Commenters stated that members needed to be able to move between tiers easily and quickly to address major life events and to help prevent escalation of symptoms leading to crisis.

Service Changes

Members expressed openness to a change in services and were hopeful that changes will lead to more services across a continuum. In rural areas, members noted it was harder to get services. Members also reported that telehealth is not always an option due to poor internet service or a lack of privacy to receive telehealth services. Members suggested that peer support be built into new services, but that transportation and training costs can be barriers for people seeking peer support certification. Members acknowledged that the current system lacks long term supports. Skills gained through MHSS or PSR continue to need maintenance supports to maintain stability in the community. Members requested more supports on the worksite including more access to vocational rehabilitation to assist in obtaining employment. Additionally, members requested another service as a step-down to ACT that is more intensive than MHSS to serve a larger continuum. Members requested that any new services address skill-building for communication and anger management as well as independent living skills.

Concerns

Members expressed concerns that they are penalized when doing well and are denied supports to either maintain wellness or prevent escalation to a crisis. Even when they are not struggling, termination of services can result in isolation which can lead to deterioration of mental health conditions. If services such as MHSS and PSR are eliminated and not replaced, members fear losing support and losing access to a non-judgmental party during a crisis. Rural members were concerned about losing transportation to grocery stores and for other basic needs. Members almost universally noted that they fear losing community access if current services are discontinued.

Member Feedback

"CMHRS have been paramount in helping me to adjust to a new normal following a tragic period in my life."

Resources

Several members expressed the need for more resources such as staff, space, literacy, speech assistance, and weekend programming. One member noted that more PSR groups would be helpful, but providers lack space or staff to conduct more programming. Members requested additional assistance for people with speech and literacy issues, such as someone requiring American Sign Language interpretation. Programming on weekends was also a deficit noted by many members, who pointed out that services that were reduced during the public health emergency have not returned to previous levels.

Member Survey Themes

Value of CMHRS

Members were divided between those who felt CMHRS services for both youth and adults are working well and those who felt that services are inadequate and not accessible. One member noted having to wait over three months for CMHRS service initiation due to a lack of provider availability. NEMT was also an area of need noted by many respondents.

Access

Member respondents noted strengths and areas of opportunity regarding CMHRS access. Members requested that DMAS not require hospitalization to be eligible for community rehabilitative services. Several members requested more access to in-home services, especially for members lacking transportation. Some members reported that wait lists lead to difficulty initiating services if a program has no immediate openings. Many members requested more education about available services. Members also expressed concerns that people are discharged too soon when making progress, making some members feel punished for doing well, and undermining member's goal completion.

Member Feedback

"It takes a very long time to receive case management, and my daughter still is on the waitlist for a therapist."

Workforce

Members were concerned about a lack of available staff and the training and education of staff. While many respondents expressed positive experiences with individual counseling and medication management, some parents

reported poor communication with their child's provider, especially for TDT. Several respondents reported that staff were not listening to their needs or were judging them. These staff needed improved customer service skills and more rapport building expertise. Members were concerned with a lack of counselors and other staff, leading to waiting lists and an inability to receive help in a timely manner.

Section 3

Advocate Feedback

Virtual Meeting Themes

Continuum of Care

Advocates in the adult and youth meetings requested a broader continuum of care, including more services for members stepping down from residential or inpatient treatment, for members engaged with the legal/carcel system, and for transition age youth. Services are needed to address the gap between inpatient and outpatient treatment, including transitional case management, intensive outpatient treatment, more home and community-based services to provide services to members in their environment, and increasing the range of services provided by different staffing levels. Additionally, advocates requested additional treatment and diversion options for members with Serious Mental Illness (SMI), Autism Spectrum Disorders, and Individuals with Intellectual/Developmental Disabilities engaged in the legal/carcel system. For transition age youth ages 18 to 26, advocates suggested adding services to address member's difficulty of moving from child to adult services.

Peer Supports

Advocates expressed a need for peer recovery support at all levels, including mental health, substance use, incarceration supports, youth supports, and community peer advocates. Advocates noted that peers with lived experience providing assistance offer judgment free support that can lead to resilience, especially for those who have been incarcerated.

Crisis Services

Advocates noted that Mobile Crisis has been a good resource but requires additional staffing. Similar feedback was provided regarding crisis stabilization services, which help prevent inpatient stays but with limited access. Although Crisis Now is an adult model, advocates suggested creation of a specialized center for youth focused on families. The youth center could provide diversion or, if a youth has legal charges, a mechanism for law enforcement to work with families to divert the youth. Members also suggested home based crisis intervention to keep the family intact and provide crisis services with trained professionals coming into the home.

Technology

Advocates reported that remote access technology could be better leveraged to address shortages of behavioral health professionals including psychiatrists. Mental health intensive outpatient was also flagged as a service that has benefitted from virtual delivery due to difficulty hiring enough people to provide services in person.

Family Involvement

Advocates reported that providers need to better engage families with both adult and youth populations. Advocates also stated that it was particularly difficult to engage family members of adult members and to find appropriate resources or services to help caregivers manage behavioral health needs in rural areas. The youth advocacy group noted that parenting support

is especially important when youth return home from a residential placement, as outcomes are poor if the youth return to the same environment. Additionally, many parents have their own trauma, and youth may escalate to a degree where the parents experience burn out. Advocates noted parents are exhausted, leading to concerns of placement and adoption placement breakdown, especially for teenagers.

Advocates recommended family focused services including parent to parent support groups through National Alliance on Mental Illness of Virginia, Certified Community Behavioral Health Clinics, or partial hospitalization providing skill building and parent training. Youth advocates also suggested enhanced funding for peers to develop youth specialization. TDT or Intensive In-Home (IIH) services in conjunction with Intensive Care Coordination (ICC) services were also noted to be beneficial for integrating the family, supporting family engagement, alleviating barriers, promoting family voice and choice, and reducing the overwhelming feelings for parents as ICC provides one point of contact. All advocates requested respite to divert from hospitalizations and incorporating parents at an early stage to assist with proactive interventions. Advocates also asked for an information hub to inform families about what services they can access for their child.

Mental Health Skill Building

Adult advocates noted that members not meeting the main service authorization requirements (i.e., hospitalization and crisis), especially hospitalization, lead to members being denied services. Advocates would like to see services promoting members community integration and reducing home isolation, as well as offering members more one-on-one support and assistance in skill building such as building structured daily schedules to improve their quality of life.

Intensive In Home

Youth advocates requested in-home services for families, especially in rural areas where there are transportation barriers for members to access services. Intensive in home was noted to be a service that filled this need but as the service and evidence-based interventions have changed, providers have not been able to keep up with the changes. The quality of the service has declined, and the families are not receiving the specific interventions needed. Advocate feedback included possibly expanding the service, such as utilizing licensed providers for more evidence-based modalities that fit the needs of children with higher acuity.

Parent Advocate

"Remove the requirement to have a crisis or IP event in order to qualify for MHSS. It did not at all help further his mental health treatment or recovery. If anything, it has made it harder. I also have to wonder how many individuals do not survive the crisis?"

Therapeutic Day Treatment

Youth advocates felt that TDT services benefit children in the school system who need daily intervention in the classroom and eliminate transportation and guardian scheduling barriers. One advocate reported that TDT data demonstrates that TDT has decreased discipline and out of school suspensions where implemented. Advocates supported a tiered acuity approach, modifying the billing structure to be a tiered daily billed system not units, and standard authorization processes across MCOs. Additionally, advocates would like a more proactive service approach to TDT instead requiring the exhaustion of outpatient treatment. Advocates argued that prevention would lead to better outcomes such as decreased or shorter suspensions.

Advocates were concerned with TDT staffing and believed that licensed providers should be available to work with higher acuity children. In addition, advocates report that TDT has high caseloads and a substantial administrative burden for approval, peer review and appeals. Several advocates noted that TDT could be of benefit in addition to services on a youth's IEP instead of using it as a placeholder service until a child receives an IEP, which often occurs currently.

Case Management

Advocates noted that case management service was effective in linking youth to services when the family is not familiar with the system. In addition, advocates noted the importance of continuing case management when a child enters residential treatment to continue family interventions and to ensure a smooth transition for the child back to the community.

Evidence-Based Practices

Both adult and youth advocates supported continuing and enhancing the basic core Rehabilitative services. Advocates supported making Rehabilitative services more consistent with evidence-based standards. Advocates were concerned with the feasibility of implementing evidence-based services in rural areas as well as siloed programming between schools, Medicaid, and child welfare agencies. Advocates requested a basic psychoeducation literacy program including information on First Episode Psychosis.

Advocates supported several recent Virginia initiatives including mental health first aid initiative in schools, Multisystemic Therapy, Functional Family Therapy, and Parent Child Interaction Therapy (PCIT). PCIT was noted to have expensive training and too few trained providers. Advocates also supported other evidence-based practices including Structural Family Therapy, Coordinated Specialty Care for First Episode Psychosis, and Seeking Safety. Advocates pointed out that Seeking Safety is not covered by Medicaid and is currently paid for by the Children's Services Act. Some of the outcomes of Seeking Safety noted were reductions in truancy and referrals to specialty care.

Staffing

Adult and youth advocates saw workforce shortages as major system barriers, with an underfunded and scarce workforce, leading to too few licensed individuals and multi-disciplinary teams, to meet the needs of the population. Although Virginia has had some legislative increases in reimbursement, the increased fees did not increase wages enough to encourage professionals who have left the public health care sector to return. Additionally, more youth are being placed out-of-state because in-state per diem rates are too low to support residential care for the most acute youth. Advocates were also concerned that members in residential care did not receive treatment from experienced, licensed professionals, which could be detrimental to those youth.

Housing

Adult advocates requested Rehabilitative supports for home-based living or supervised housing. While Virginia has transitional housing available, some individuals require additional supports to live more independently.

Section 4

MCO Feedback

Service Authorizations and Medical Necessity Criteria

The MCO representatives requested that DMAS maintain service authorization requirements but implement more detailed Medical Necessity Criteria to improve standardization across managed care plans, and to reduce administrative burden and variability in processes. MCOs noted reauthorizations and discharges are pain points due to the lack of clear continued stay criteria. Crisis services not having authorization requirements were noted concerns. MCOs reported that lack of clear reauthorization and discharge criteria as well as recovery outcome expectations, have led to members being in the wrong level of care and can lead to regression and even the death of the member.

MCO staff reported a need to improve the quality of ISPs and inquired whether the redesign project would allow for changes to be made to improve the ISPs developed by providers and reviewed by the plans. Common quality concerns noted were goals not being specific, measurable, achievable, relevant, and time-bound (SMART), information being cut and pasted from past ISPs, or the ISPs of other members. MCOs are also seeing a larger percentage of ISPs generated through Artificial Intelligence.

Additionally, MCOs requested that the redesign project take steps to limit the number of requests for additional information MCOs make to providers, and that only clinical staff be allowed to attend peer-to-peer meetings (not non-clinical provider agency owners).

Service Expansion and Evidence-Based Practices

MCO staff noted that services previously expanded such as ACT are working well due to clear medical necessity criteria and high-quality expectations. In addition, other mental health services such as medication management and therapy are available in integrated settings such as primary care offices and schools. MCO staff request that redesign include a full continuum of community-based services be available to help members stabilize in the community. MCO staff felt that services should be designated to a specific population with specific needs for staff training. MCOs requested elimination of the current paradigm requiring a person to fail in lower-level services before accessing the correct level of care, because it leads to higher acuity and cycling through crisis services. New services should have measurements demonstrating good clinical outcomes as well as language requiring a higher level of care, different services, or transition to a different provider if interventions are not effective.

MCOs discussed the multiple needs that PSR addresses in adult populations: skills training, socialization, and long-term support services. MCOs also noted that IIH and TDT addressed needs in the youth population if done well by qualified providers (although there was some debate around whether or not there truly are good outcome measures to determine effectiveness). MCOs were concerned that IIH required the child to be at risk of out of home placement, resulting in late initiation of the service and ineffectiveness. MCOs believed that PSR and MHSS medical necessity criteria overlapped, making it difficult to differentiate between the two services. Similar to IIH, the MCO staff felt that the hospitalization prerequisites for the service lead to late service initiation. MCOs supported a tiered service approach to allow fluidity

in need at different levels of care. Additionally, MCOs opined that privatizing case management could open the service to more intensive services and reduce current large caseloads.

MCOs noted that access to 988 was an area of strength in service delivery for Virginia's behavioral health system, despite difficulty in reconciling billing. Enhanced collaboration in areas such as 988 has shown where silos exist and where relationships can be built between MCOs, DMAS, other partners to improve the behavioral health service system.

Workforce and Provider Oversight

MCOs agreed that services offered by trained, competent providers lead to good outcomes. More providers are available in urban areas such as Richmond, which does allow more access to services in the community where people live and work, allowing more access to step down services from higher levels of care.

MCOs expressed an interest in improving provider oversight as part of the redesign project.

The MCO staff discussed potential improvements to the provider oversight process. For example, identifying high performing providers as gold star providers and then tiering authorization and medical record reviews to focus attention on poor performers. MCO staff requested support for provider oversight efforts when poor performing providers are vocal to legislators and other leaders.

Social Determinants of Health

MCO staff felt that Social Determinants of Health (SDoH) such as housing and transportation are an area of opportunity to help members stabilize and improve in treatment, especially in rural areas. SDoH are easier to address in more urban areas as individuals step down from higher levels of care. Poor response times from NEMT in rural areas leads to an overutilization of MHSS services to fill gaps. Individuals lacking housing may be housed in hotel rooms temporarily and continue cycling through crisis services due to a lack of proper discharge planning and care coordination between the provider and the MCO. Care coordination may not be person-centered, and the member may not have a long-term stabilization plan.

Operational and Training Needs

MCO staff discussed several operational and training needs for system redesign. Providers and State Fair Hearing Officers would benefit from training on authorization and Medical Necessity Criteria

MCOs will need time to make operational changes to move toward more evidence-based services. The Department noted that the timeframe will probably be nine to 12 months. There will need to be updates to provider contracts, claim systems, and authorization systems. Ideally providers will not be grandfathered but will have to reapply for licensure. It was also noted it would be easier to roll services out in stages instead of all at once. Readiness, assessment and evaluation will need to be part of the implementation plan both for credentialing and network as well as authorizations and claims.

Changes in rates were noted as a key incentive for providers to move toward system change. Rate and unit updates were noted as important needed changes as the current intervals for units are awkward and difficult to compute.

Other broader potential operational changes were also explored. Monitoring could be streamlined by one MCO reviewing a provider's policies and procedures and sharing that information with other MCOs so that the other MCOs would only have to review their own member records. MCOs have quarterly program integrity meetings. MCOs could use those meetings, or other meetings to improve synergy in provider oversight for poor performers in several MCO networks, as well as by identifying more global potential trainings and other interventions needed. The MCOs would like to have a provider certification process to ensure knowledge of all services, not just evidence-based practices (EBPs) like Tool for Measurement of ACT or a specific assessment like Child and Adolescent Needs and Strengths (CANS).

Section 5

Provider Feedback

Survey Themes

Psychosocial Rehabilitation

For the current CMHRS including psychosocial rehabilitation, providers are concerned that services will be eliminated, leaving gaps in services, and members without services. Providers would like PSR to be a maintenance service for members who would deteriorate without routine, daily supports. Providers request that PSR have more flexibility to allow the service for as long as needed with hourly billing, that QMHPs be permitted to hold supervisory roles, and that redundant documentation requirements be simplified. Providers would like an ongoing monitoring and evaluation of services to assess effectiveness, outcomes and areas of improvement. Providers are concerned services will become so narrowly defined there will be no flexibility and existing providers of intensive services will be prevented from providing the newly proposed services.

Mental Health Skill Building

Mental Health Skill Building providers would like to see the hospitalization requirement eliminated to allow prevention of hospitalization as an enrollment criteria; an increase in time allowed per unit, number of units authorized, and reimbursement rates; clearly defined services and requirements, ensuring standardization across agencies; services offered to youth; increase in caseload size; inclusion of peer services; and no authorization requirements.

Targeted Case Management

TCM providers believe case management should not need a prior authorization, and some providers requested clear eligibility and continued stay criteria. Some private providers would like to become TCM providers, while other providers expressed concern that it would not be a good idea to allow private providers to offer TCM.

Therapeutic Day Treatment

TDT providers requested that the current model, unit structure, and rates be modified to meet the needs of the students being served; school-based services should be expanded and allowed on a tiered-based model; and parent coaching should be reimbursed as a required part of the service.

Regarding transforming PSR services specifically, consumers may lose their daytime structured activity. We serve many adults for whom other daytime structured activity options (work, school, volunteering, drop-in programming) are not a suitable option due to a variety of internal and external barriers. Many of the folks in our PSR programs need/want a highly structured activity that is more supportive and structured than a drop-in center, but they are not able to commit to fuller community integration through work/school/volunteering.

Additionally, many consumers in our PSR programs will lose their primary source of socialization/social contact if PSR is discontinued without a similar alternative in place.

Many of the folks we serve have difficulty in other social settings and/or initiating socialization with peers due to symptom barriers.

Having structured opportunities for socialization is an important coping skill and also aids in learning and practicing social skills they need for further community integration.

Without PSR many of our consumers will not have another opportunity for any kind of social contact with peers.

Intensive In Home

IIH providers requested that the service be standardized, more tightly regulated, and have increased rates; IIH providers requested that concurrent outpatient therapy should not be a requirement, but parent coaching should be required. IIH providers also requested that QMHP Master's Level clinicians should provide the service and less intense level of need should qualify to prevent out of home placement.

Additional Services

Many providers also requested that DMAS consider additional services including SMI Housing Case Management, EBPs, expanded crisis intervention services, Supportive Employment, enhanced opportunities for individuals with lived experience to participate in the design and evaluation of services, an integrated approach for co-occurring disorders, and increased access and expanded list of all Medicaid funded services, including multi-tiered assessment and services across all levels of acuity. Providers requested that current crisis services be maintained, flexible service delivery continued, annual assessments and quarterly progress

updates be continued, and that the Commonwealth maintain a consistent array of long-term supports and CMHRS.

Rate and Financial Considerations

Providers requested an increase in reimbursement rates to make workloads more tiered, allowing checks and balances to ensure quality of care. Providers requested reformed reimbursement structures enabling scalability, 15-minute service units, consideration of braided funding models or varied/different rates for different types of services and more resources for private mental health providers.

Providers are concerned with budget cuts and funding sustainability to cover the true cost of providing services. Providers are also concerned that managed care plans and funding will change from one administration to another. Providers report that they are unable to retain skilled practitioners with low reimbursement rates and are concerned about lack of a set schedule to review the sustainability of Rehabilitative service rates in a high inflation economy. Providers reported that changes to staff qualifications could introduce additional financial burdens for training and supervising, in addition the need for increased wages and better compensated. Providers are concerned that service tiering and new requirements may have non-billable aspects. Providers would like mileage, time required for travel, and language interpretation services to be reimbursed.

Structural Concerns

Providers expressed needing revamped and streamlined documentation and prior authorization processes, as well as standard processes and longer authorization time periods across all MCOs. Providers requested that communication and coordination among oversight agencies be improved, and that workforce recruitment and retention be enhanced. Providers requested an increase in the overall access to mental health services, including expanding telehealth, transportation, and the service array for members at all levels of support. Providers suggest that DMAS initiate public awareness campaigns to reduce stigma and improve community understanding of the services. Providers requested that DMAS implement robust metrics and tracking for effectiveness and accountability, along with ways to monitor, assess and evaluate members to address needs and prevent higher levels of care. Providers supported a standardized, validated assessment tool to be conducted by licensed professionals for all members and not just conducted by community service boards. Providers requested that standard of training curriculums be developed.

Providers requested more consistency in the MCO authorization process with standardized guidelines and centralized reporting mechanisms. Providers would like simplified documentation processes and paperwork requirements with reduced administrative burden. Providers requested that the length of authorizations and number of hours per authorization, or units, be reconsidered to include more services. Providers are concerned that redesign changes will make it more difficult for members to be eligible for the Rehabilitative services. Specifically, regarding the assessment for youth services, some responding providers noted they would prefer to continue using the DLA-20 as the assessment/outcome tool instead of the CANS.

Workforce

Providers reported that the current workforce lacks qualified staff. Changes in the Rehabilitative services could result in gaps in services if there is a change in types of services. Providers are concerned about maintaining high standards for quality of services including staff qualifications

and training. Providers are specifically concerned about licensing, including the Virginia Department of Behavioral Health and Developmental Services and DMAS not being on the same page regarding licensing. Continuing to raise the bar in terms of staff credentialing makes it difficult to provide these services in some areas of the state. Providers are concerned that a suggestion to license practitioners on the bachelor level license such as social work would be onerous. Providers mentioned liability concerns when a licensed professional counselor determines a youth needs services and meets criteria, but an MCO denies the service. Providers suggested creating service definitions and requirements that allow licensed medical health professional to focus on clinical tasks and QMHPs to hold supervisory roles and provide non-clinical services. Providers report staff are dissatisfied with having to take six separate MCO trainings as they are duplicative and should be consolidated into one.

Access

Providers have concerns regarding service needs and access. Providers would like accessibility for all individuals in need, especially for underserved areas. Providers would like expanded telehealth services and more early intervention and prevention services. Providers requested less administrative burden through an easier referral process. Providers are concerned with the lack of supports for long-term independent living for SMI through ACT/FACT teams and other services related to the housing crisis. Providers would like to focus on long-term care options to prevent cycles of rehospitalization. Providers see a need to improve collaboration between CMHRS and other health services such as PCP, SUD, social services. Providers reported that Virginia needs more services that are culturally competent and sensitive to diverse backgrounds, tailored to meet individual needs. Providers requested more effective crisis services and programs aimed to reduce stigma and provide support to members and families. Providers requested a better notification and communication system when there is a change in insurance, crisis changes or authorization changes. Providers also pointed to needs for improved coordination between Emergency Rooms and CMHRS service providers. Providers reported gaps in services that need to be filled for those not meeting the criteria for the current services. Providers believe the clubhouse model needs to be incorporated into new regulations.

Targeted Case Management

Several providers noted concerns with privatization of targeted case management (TCM). Providers flagged specific concerns with financial instability if services were removed from Community Services Boards (CSBs) resulting in fragmentation in continuity of care and a lack of oversight across the many private providers leading to decreased service quality provision and monitoring. Providers pointed out that existing legislation requires that CSBs are the only point of entry into case management and that a fair rate for CSBs should be established to allow for hiring adequate numbers of qualified staff. CSBs were noted to have regulatory and funding structures to minimize fraud, waste, and abuse.

Providers also commented on supervision and noted concerns with requiring licensed TCM supervisors. Providers suggested that current TCM supervisors who are QMHP-A and C be allowed to maintain their positions and be grandfathered into their role.

Transition to EBPs

Providers are concerned that a transition to EBPs would increase cost, decrease access, and require a long implementation period. Regarding cost, providers expressed concern that smaller providers may not be able to afford transitioning to evidence-based services. Moving to EBPs with the required initiation and scaling of services may hinder Virginia’s ability to meet urgent

mental health needs and further strain limited workforce resources. Providers suggested providing financial incentives to establish new services and to encourage proactive providers to be early adopters of evidence-based models. In addition, providers recommended that the EBP drive the requirements, as extra requirements not a part of the EBP may inflate cost.

Providers are concerned that redesign could result in decreasing the services available, such as IIH and TDT having decreased access among youth. Providers noted overemphasis on highly structured programs like MST or PCIT may make services inaccessible to many families in need and flexibility is needed while still ensuring quality assurance to keep services accessible. Providers expressed concern if services are required to be provided solely in the home because parents may decline services for youth and staff often do not want to go into homes. Providers are concerned that schools may resist allowing students out of class to participate in intensive programs and services outside of the regular school day limits participants to those who have transportation other than the school bus. Providers also noted that many populations, minority groups, and age groups may not be addressed by EBPs. The higher cost of EBPs, combined with legislative requirements that redesign changes be cost neutral for current non evidence-based services, may also decrease access as fewer services can be provided if the per unit cost increases.

Providers noted they will need time to adopt new service requirements. Providers noted that service provision gaps in the transition period could result in members not receiving services and providers not being able to make payroll. Providers with staff who have worked in other states already employing EBPs reported the change in data collection and management practices as well as the learning curve can be challenging.

Section 6 TDT Survey

Themes

Access

TDT survey respondents noted that it was very helpful to have onsite assistance for high need services and school representatives would like to see the service retained. The service is not available in all schools but where it is offered it helps to keep students engaged in their education due to the integration of the service in the school setting. Feedback also reflected that the service helps to ensure the well-being and resulted in better academic outcomes for the students engaged. Some parents also responded, noting that the communication with the service provider is very helpful, although there was some concern that the same communication is not always happening with the teachers and school staff.

Parent Comments

"The communication that I receive about my children weekly and sometimes daily is great."

"We are very lucky to have a very involved counselor who understands and communicates with us."

Administrative Burden

Similar to providers comments, TDT survey respondents noted the current administrative burden of obtaining authorizations from MCOs. Respondents noted that the hours authorized are often too low, and the time spent to pursue an authorization and maintain documentation takes away from time being spent with the student. TDT respondents recommended that the outpatient counseling component be removed, and a parent coaching component be added.

Workforce

TDT survey respondents noted that the service is not offered in all schools due to workforce shortages, in part due to low reimbursement rates. In some cases, providers are split between schools, leading to service availability gaps. Many respondents also noted a concern that the service is only available to Medicaid students and would like to find a way to make TDT accessible to all students who need it.