Virginia Department of Medical Assistance Services
SMI IMD 1115 Application (Draft)

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Section I. Summary

The Commonwealth of Virginia is seeking an 1115 demonstration waiver to receive FFP for services furnished to Medicaid members during short term stays for acute care in psychiatric hospitals or residential treatment facilities that qualify as Institutions for Mental Diseases (IMDs). Virginia anticipates that three types of facilities will be included under this waiver as IMDs: state-run freestanding psychiatric hospitals, private freestanding psychiatric hospitals, and Residential Crisis Stabilization Units.

As a part of this waiver, and as part of the Commonwealth's Right Help, Right Now initiative, Virginia is committed to improving access to community-based services so that the full continuum of care is available to meet the needs of Medicaid members with Serious Mental Illness (SMI).

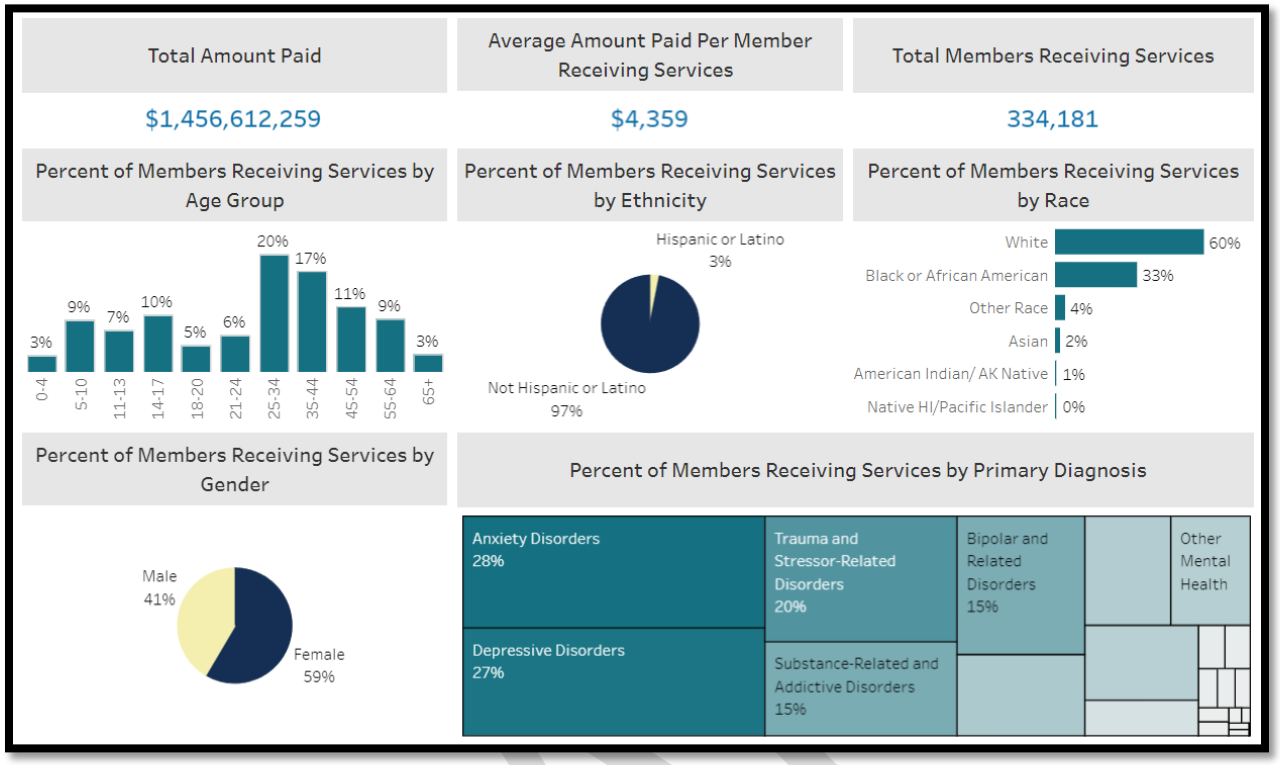
Virginia is actively working on implementation and evaluation planning for this waiver and will submit an implementation plan no later than 90 days following the approval of this waiver. Virginia acknowledges that it may not claim FFP until such time as CMS approves the implementation plan.

Section II. Program Overview

The Department of Medical Assistance Services (DMAS) is Virginia's State Medicaid Agency, which administers the Medicaid program, Cardinal Care. Cardinal Care provides health care to over two million Virginians. In 2024 alone, over 300,000 Cardinal Care members received behavioral health services, including over 4,000 members who received psychiatric residential treatment or residential crisis stabilization services.[1] Another 190,000 members received outpatient psychiatric treatment, and even more members received additional forms of community-based behavioral health services.

[1] https://www.dmas.virginia.gov/data-reporting/programs-services/behavioral-health/behavioral-health-service-utilization-and-expenditures/

Figure 1. Profile of Medicaid Members Receiving Behavioral Health Services in FY 2024[2]

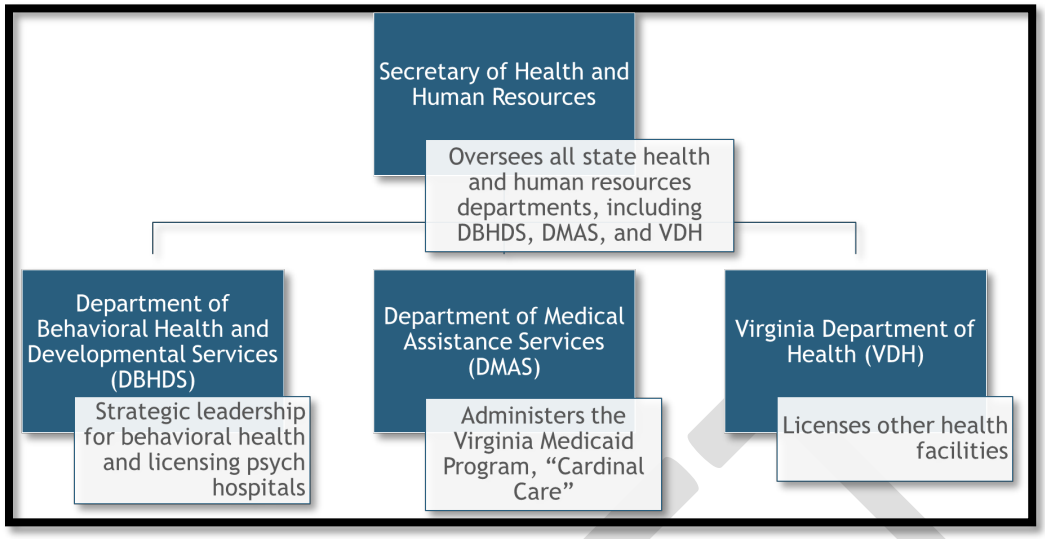


Supporting Cardinal Care members with behavioral health needs, particularly those diagnosed with serious mental illnesses, requires care and coordination across state agencies, as well as working closely with managed care organizations (MCOs), providers, advocacy organizations, families, and of course, the members themselves.

To implement this waiver, DMAS will collaborate closely with sister state agencies including the Department of Behavioral Health and Developmental Services, which provides strategic leadership and coordination for behavioral health services and supports statewide, and the Department of Health, which has a key role in ensuring participating IMD facilities meet the criteria for participation, including the necessary accreditation and licensing.

[2] https://www.dmas.virginia.gov/data-reporting/programs-services/behavioral-health/behavioral-health-service-utilization-and-expenditures/

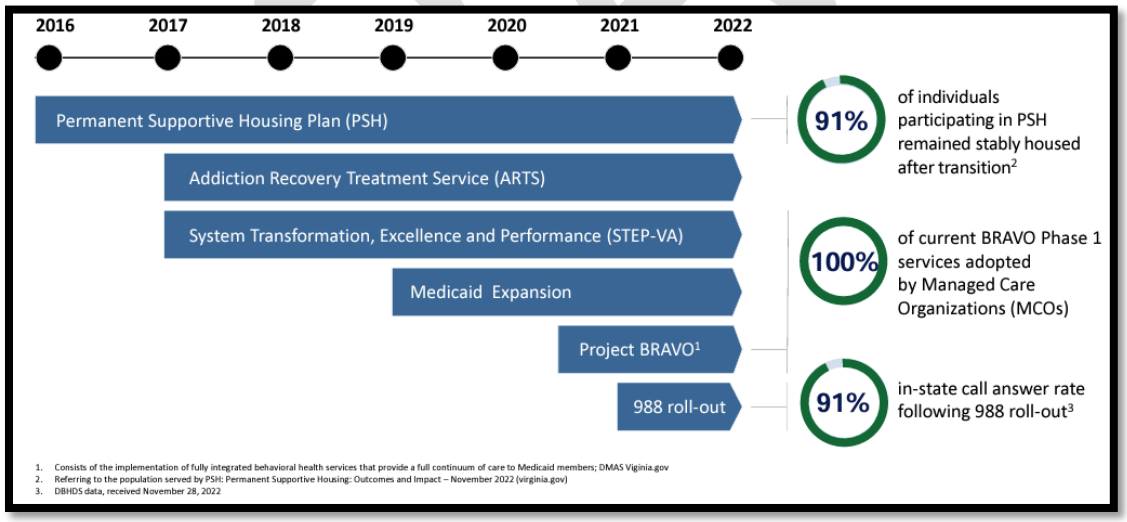
Figure 2. Key State Agencies for Waiver Implementation



Historical Narrative

Over the past decade, Virginia has demonstrated a cross-governmental commitment to continuous improvement of behavioral health services and supports for all Virginians through a series of policy and programmatic actions to expand coverage, benefits, and broader system transformation.

Figure 3. Timelines of Key Efforts Supporting Virginians' Behavioral Health



**In addition to the items listed above, MCO coverage of SUD for Medicaid members began in April 2017 and coverage for community-based mental health for Medicaid members began in January of 2018.*

GAP demonstration

On January 9, 2015, the Centers for Medicare and Medicaid Services (CMS) approved the Virginia Governor's Access Plan (GAP) demonstration. The GAP demonstration provided limited benefits to childless adults and non-custodial parents ages 21 through 64 with a diagnosis of serious mental illness (SMI) and household incomes at or below 100 percent of the Federal Poverty Level (FPL) using the Modified Adjusted Gross Income (MAGI) methodology. Prior to Virginia's 2019 expansion of Medicaid to 138 percent of FPL, these individuals would not have otherwise been eligible for Medicaid, the Children's Health Insurance Program (CHIP), or Medicare, and were uninsured.

Permanent Supportive Housing

The 2015 Virginia General Assembly appropriated an initial $2.1 million to the State Department of Behavioral Health and Disability Services (DBHDS) to "support rental subsidies and services to be administered by community services boards (CSBs) or private entities to provide stable, supportive housing for very low-income persons with serious mental illness." DBHDS adopted the evidence-based practice standards for Permanent Supportive Housing (PSH) from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) to define the program model, target population, and operating standards for Virginia's PSH program for adults with SMI. In the years since, this investment has grown substantially. As of Fiscal Year 2023[3], DBHDS reported that the Commonwealth had developed 2,951, or 40 percent of the approximately 7,220 PSH units needed. This includes:

- 2,762 PSH SMI units funded by state general funds appropriated to DBHDS,
- 120 Auxiliary Grant in Supportive Housing (AGSH) units, and
- 69 leveraged HUD Mainstream vouchers.

Nearly half (48 percent) of PSH participants were hospitalized in a state psychiatric facility at some point in their lifetimes. FY23 outcomes for the 1,921 individuals who were housed through this program between February 6, 2016, and June 30, 2023 included:

- Two hundred ninety-three (293) individuals were discharged from a state psychiatric hospital into DBHDS PSH, and overall, 393 individuals in PSH for at least twelve months had a state hospital admission in the year before move-in.
- 91.6 percent of individuals served in PSH remained stably housed for at least one year.
- Only 9.6 percent of those served since program inception have been discharged to an institutional setting or higher level of care.

It is important to note that this service is coordinated outside of the MCO delivery system and is not paid for through Medicaid; however, it is a good resource for members who can benefit from this support.

ARTS Delivery System Transformation 1115 Waiver

On December 15, 2016, CMS approved Virginia's first SUD 1115 Demonstration through December 31, 2019. The amendment included DMAS' new SUD benefit, referred to as the Addiction and Recovery Treatment Services (ARTS) benefit. The amendment also changed the name of Virginia's Demonstration to "The Virginia Governor's Access Plan (GAP) and Addiction and Recovery Treatment Services (ARTS) Delivery System Transformation (Project No. 11-W-00297/3)."

The amendment incorporated the following elements:

[3] https://rga.lis.virginia.gov/Published/2024/RD567

- expanded substance use disorder (SUD) benefits to all Virginia Medicaid recipients eligible under the state plan covering the full continuum of SUD treatment;
- introduced quality of care and programmatic features for the successful integration of SUD services into comprehensive managed care for all managed care enrollees;
- incorporated industry standard SUD treatment criteria into program standards;
- improved the quality and availability of evidenced-based treatment services for Opioid Use Disorder (OUD); and
- introduced policy, practice, and system reforms consistent with CMS State Medicaid Director Letter (SMDL) #15-003.

Virginia amended the Medicaid and CHIP state plans to cover the full continuum of community-based SUD care aligning with the American Society of Addiction Medicine (ASAM) Criteria. In addition, the 1115 SUD Demonstration allowed Virginia to cover SUD treatment in an Institution for Mental Diseases (IMD). On December 30, 2019, CMS approved a five-year extension of the demonstration to allow Virginia to maintain the ARTS benefit and associated authorities, as well as authority to provide eligibility to former foster care youth who aged out of foster care under the responsibility of another state and applied for Medicaid in Virginia. A further extension of this waiver is pending before CMS as of the date of this submittal.

STEP-VA

In 2018, Virginia launched the Behavioral Health System Transformation Excellence and Performance, known as STEP-VA.[4] STEP-VA focused on building out a set of core services, referred to as STEPs. The goal for STEP-VA is to have consistent delivery and access to care across all 40 Community Services Boards (CSBs) throughout the Commonwealth.

CSBs serve as the primary point of entry into Virginia's public mental health system and are a primary provider of targeted case management services to individuals with Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED). CSBs are enrolled as Medicaid providers and make up approximately 14 percent of the behavioral health provider network.

Based on the Certified Community Behavioral Health Clinic (CCBHC) model, a national best-practices model for behavioral health services, STEP-VA created a roadmap to consistent, comprehensive, high-quality community-based services for those facing mental health and substance use issues.

The nine core components of STEP-VA are:

- **Same Day Access** – creates a way for Virginians to engage in an initial assessment for intake and treatment services the same day they contact their local CSB.
- **Primary Care Screening** – collects key data to identify health risks and coordinate with medical care providers for individuals with SMI and SED.
- **Crisis Services** – builds out a comprehensive crisis system situated to provide the right service at the right time to individuals nearing crisis, experiencing crisis, or stabilizing after a crisis.
- **Outpatient Services** – considered the core of behavioral health services, this includes both mental health and substance use therapy for adults and children, as well as psychiatry services.
- **Peer and Family Services** – incorporates certified professionals with lived experience into the full array of behavioral health services.

[4] https://dbhds.virginia.gov/wp-content/uploads/2024/02/Final-One-Pager-STEP-VA.pdf

- **Service Members, Veterans, and their Families (SMVF)** – requires that all clinical staff of CSBs have SMVF training, in addition to identifying Virginians with a connection to military service, at entry to public mental health services, and offers referrals to appropriate services and resources.
- **Psychiatric Rehabilitation** – services that build or rebuild the skills and supports necessary for successful life in the community for individuals with SMI and SED.
- **Care Coordination** – person-centered, holistic care planning that connects resources and services across the continuum of care for all individuals served by the CSBs.
- **Case Management** – a comprehensive service that coordinates and links key resources and care planning for individuals with SMI and SED.

Table 1. Annual Funding for STEP-VA service components, FY18-FY24 (in millions)

Annual Funding for STEP-VA service components

Core services	FY18	FY19	FY20	FY21	FY22	FY23	FY24	FY18-24 Total
Same-day access	$4.9	$10.8	$10.8	$10.8	$10.8	$10.8	$12.0	$70.9
Primary care	-	3.7	7.4	7.4	7.4	7.4	8.2	41.7
BH crisis svcs.	-	-	9.8	9.8	31.2	38.4	39.1	128.3
Outpatient BH svcs.	-	-	15.0	15.0	21.9	21.9	24.3	98.2
Peer/family support	-	-	-	-	5.3	5.3	5.3	16.0
Veterans' BH	-	-	-	-	3.8	3.8	3.8	11.5
Psychiatric rehab.	-	-	-	-	-	2.2	3.8	6.0
Care coordination	-	-	-	-	-	6.5	6.5	13.0
Case management	-	-	-	-	-	3.2	4.1	7.3
Cross-step admin	-	-	-	-	4.9	11.9	10.9	27.8
IT infrastructure	-	-	-	-	-	2.6	5.2	7.8
	$4.9	$14.5	$43.0	$43.0	$85.4	$114.1	$123.1	$428.4

SOURCE: BHC staff analysis of data from annual appropriations acts and DBHDS reports

Mental Health Access Program[5]

Also in 2018, Virginia launched the Mental Health Access Program (VMAP). VMAP is a statewide initiative that increases access and improves mental, behavioral, and emotional health and development by providing education, consultation, and care navigation to medical providers of infants, children, adolescents, young adults, and pregnant & postpartum people. VMAP's provider education effort builds PCP knowledge and comfort in screening, diagnosing, and treating pediatric mental health conditions. Since its inception, VMAP has engaged 1,140 providers through 46 training offerings and additional webinars and discussion forums. Three out of four (75%) providers participating in education were physicians. Nurse practitioners made up 19% of participants.

Project BRAVO: Enhanced Behavioral Health Services for Medicaid

From 2019-2021, DMAS brought online nine new behavioral health services as part of Medicaid benefits.[6] These services were intended to continue to build out the continuum of behavioral health care available to Virginia Medicaid members, with the goal of strengthening crisis response, prevention and early intervention to help members avoid inpatient admissions and find support in the community after a hospital stay. This included:

[5] https://vmap.org/wp-content/uploads/2024/07/VMAP_Impact-Report-2023_DIGITAL-2.pdf
[6] Virginia-Launches-Enhanced-Behavioral-Health-Services-for-Medicaid-Members-1.pdf

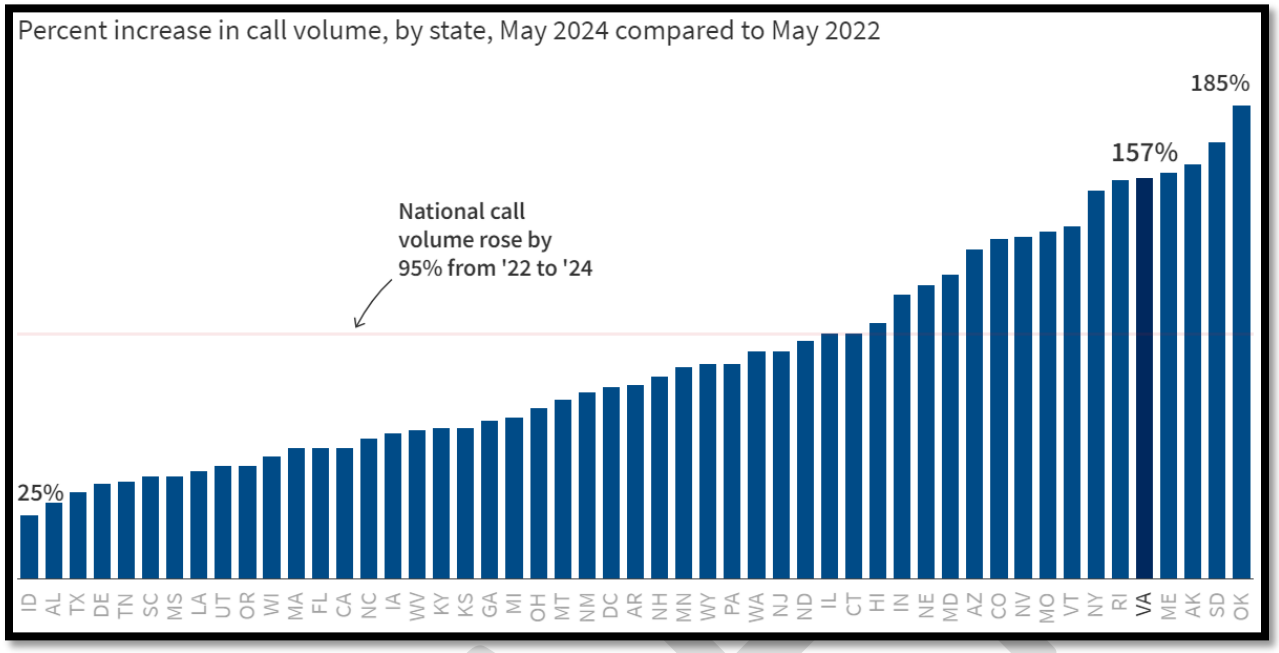
- **Clinic based intensive outpatient:** Adults and youth receive short-term, focused therapy and counseling both individually and with members of their support system two to three times weekly.
- **Partial hospitalization:** Adults and youth receive intensive services during daytime hours for five or six days per week while continuing to live in their homes.
- **Assertive Community Treatment:** Adults with serious mental illness receive care through a single team that works closely together to support the individual and is available 24/7.
- **Multi-systemic Therapy:** Intensive family and community-based treatment for youth ages 11-18 with significant disruptive behaviors and substance use disorders.
- **Functional Family Therapy:** Short-term treatment for youth ages 11-18 with significant disruptive behaviors who have received referrals from juvenile justice, behavioral health, school, or child welfare systems.
- **Mobile Crisis Response:** 24/7 rapid response, assessment and early intervention for individuals experiencing a behavioral health crisis.
- **Community Stabilization:** Short-term support for individuals who recently required crisis services or who need assistance to avoid escalation to more intensive treatment models.
- **23-Hour Crisis Stabilization:** Up to 23 hours of crisis stabilization services in a community-based setting for individuals experiencing an acute behavioral health emergency.
- **Residential Crisis Stabilization Unit:** Short-term, 24/7 residential evaluation and intervention for psychiatric and substance use crises. This new service enables some individuals to avoid inpatient admission and offers stepdown support for others who require hospitalization.

988 Launch

On July 16, 2022, the federally mandated behavioral health crisis number, 988, became available to all landline and cell phone users at no charge. As noted by the Kaiser Family Foundation[7], call volumes have increased in all states in 2024 compared to initial volume. Call volumes in Virginia rose 157%, the fifth highest rate nationally, due in part to efforts by the Commonwealth and stakeholders to build awareness among the public about the new resource. As it adjusts to this higher level of demand, the Commonwealth has benefitted from being the first state in the nation to pass a telecom fee to provide funding sustainability for the service, collecting $0.08 or $0.12 monthly from consumers, depending on their wireless plan. Virginia also passed legislation in 2023 requiring private insurance to cover crisis services. In December, 2023, Virginia began dispatching the Cardinal Care mobile crisis response service via 9-8-8 call center infrastructure to achieve a coordinated crisis approach consistent with the Crisis Now Model. Any Virginian can call 9-8-8 and, if found to be appropriate, mobile crisis will be dispatched, and for Medicaid members, 9-8-8 is the access point for receiving the mobile crisis response service. This policy change is related to the relatively higher increase in volume Virginia has experienced from 2022 to 2024 and demonstrates Virginia's commitment to an all-payer approach that is payer-agnostic for Virginians experiencing behavioral health crises.

[7] https://www.kff.org/mental-health/issue-brief/988-suicide-crisis-lifeline-two-years-after-launch/

Figure 4. 988 Call Volume % increase since launch



Current State

The investments that the Commonwealth has made to date have strengthened the behavioral health system, expanded the continuum of care, and supported improved access to critical services for Virginians with metal health needs, including Medicaid members with Serious Mental Illnesses. However, similar to the United States as a whole, Viriginia continues to grapple with an expanding mental health crisis and ever-growing demand for services.

Prevalence of Mental Health Conditions in Virginia

In April of 2024, the Substance Abuse and Mental Health Services Administration released Volume 7 of the Behavioral Health Barometer, which is designed to serve as a series of snapshots of behavioral health in the United States at the national, regional, and state level. This Volume covered behavioral health indicators as measured in the 2021-2022 National Surveys on Drug Use and Health. This Report showed a continued increase in the prevalence of behavioral health issues compared to a decade earlier, both in Virginia and nationwide. In addition, the Kaiser Family Foundation's State Fact Sheet on Mental Health in Virginia showed that the mental health crisis in Virginia still bears many similar traits to the broader nationwide crisis:[8]

- From February 1 to 13, 2023, 32.0% of adults in Virginia reported symptoms of anxiety and/or depressive disorder, compared to 32.3% of adults in the U.S.
- In May 2022, among adults in Virginia who reported experiencing symptoms of anxiety and/or depressive disorder, 28.1% reported needing counseling or therapy but not receiving it in the past four weeks, compared to the U.S. average of 28.2%.

[8] https://www.kff.org/statedata/mental-health-and-substance-use-state-fact-sheets/virginia/

Figure 5. Major Depressive Episode in the Past Year, Aged 18 and older[9]

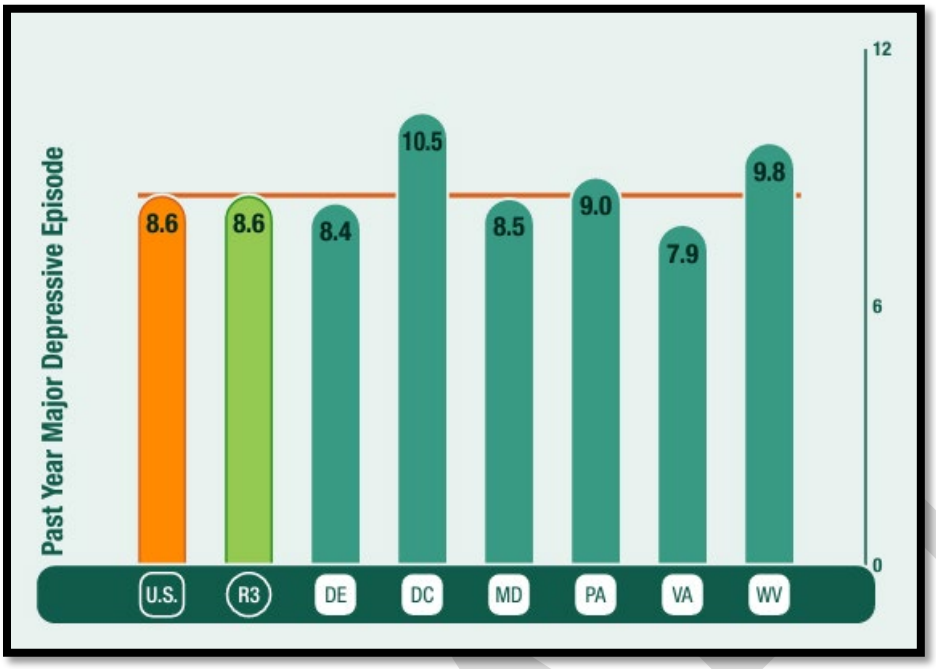
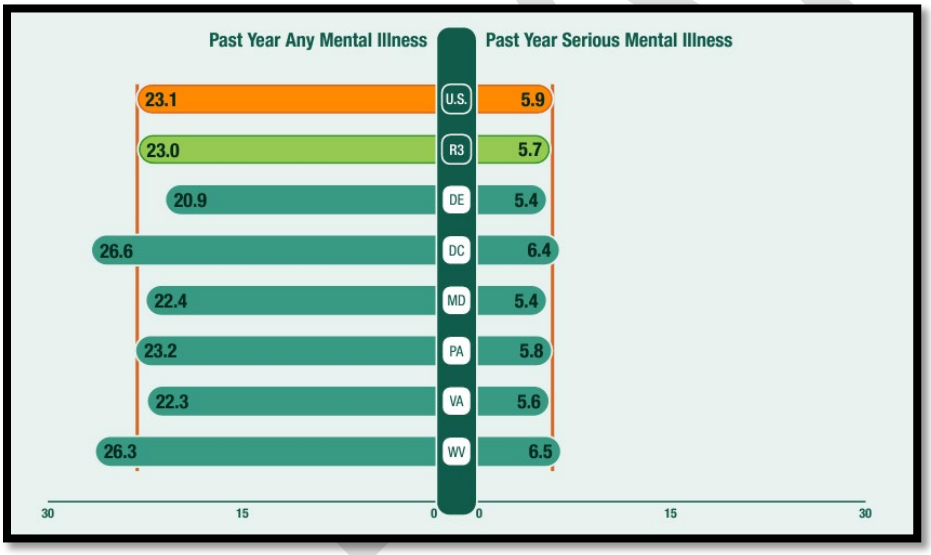


Figure 6. Mental Illness in the Past Year, Aged 18 and Older



Current Array and Access to Behavioral Health Services in Medicaid

As described, Virginia has made significant investments in and improvements to behavioral healthcare for Medicaid members over the last decade. Below is the current state of behavioral health services in the Medicaid benefit and access to these services across the Commonwealth, for adults (18+) and youth from state fiscal year 2023.

[9] https://www.samhsa.gov/data/sites/default/files/reports/rpt45297/2022-nsduh-barometer-region-3.pdf

Table 2. Behavioral Health Services Provided, 2023

Behavioral Health Services	Number of Adults Served State Fiscal Year 2023	Number of Youth Served State Fiscal Year 2023
Outpatient Therapies and Recovery Supports		
Outpatient Psychiatric Services	158,633	41,097
Outpatient Psychotherapy	118,736	61,339
Case Management (Targeted-SMI)	25,716	17,812
Peer Recovery Supports (MH)	216	32
Applied Behavior Analysis (ABA)	191	7,220
Any Outpatient Therapy/Recovery Supports	224,156	92,551
Crisis Services		
Mobile Crisis Response	19,285	4,067
Community Stabilization	10,935	12,08
23-Hour Crisis Stabilization	2,363	12
Residential Crisis Stabilization	1,770	349
Any Crisis Service	24,225	4,829
Intensive Clinic Based Supports		
Mental Health Intensive Outpatient (MH-IOP)	234	94
Mental Health Partial Hospitalization Program (MH-PHP)	376	156
Any Intensive Clinic Based Support	571	244
Intensive Community Supports		
Assertive Community Treatment	1,992	0
Mental Health Skill Building	17,369	109
Psychosocial Rehabilitation	3,682	0
Multisystemic Therapy	0	298
Functional Family Therapy	31	242
Therapeutic Day Treatment	10	5,514
Intensive In Home Services	330	11,448
Any Intensive Community Based Support	21,496	15,714
Residential and Group Home		
Psychiatric Residential Treatment Facility	38	1,037
Therapeutic Group Home	-	703
Any Residential/Group Home	38	1,539
Inpatient Treatment		
Inpatient	18,495	4,683

Total Any Service	240,647	98,524

Addiction, Recovery, and Treatment Services	Number of Members Served State Fiscal Year 2023
ASAM 0.5	2,344
ASAM 1.0	86,162
ASAM 2.1	6,373
ASAM 2.5	4,210
ASAM 3.1	1,755
ASAM 3.3/3.5	6,604
ASAM 3.7	3,497
ASAM 4.0	81
Peer Recovery Support Services (SUD)	2,331
SUD Case Management	4,799
Office Based Addiction Treatment and Opioid Treatment Programs	38,283
Total Members Receiving any ARTS service	**158,407**

Right Help, Right Now

In response to the ongoing and evolving mental health crisis, Governor Youngkin launched the Right Help, Right Now initiative in December 2022. The vision for Right Help, Right Now is that by 2025, all Virginians will:

- Be able to access behavioral health care when they need it;
- Have prevention and management services personalized to their needs, particularly for children and youth;
- Know who to call, who will help, and where to go when in crisis; and
- Have paths to reentry and stabilization when transitioning from crisis.

The goal of Right Help Right Now is to support Virginians before, during, and after a behavioral health crisis occurs. This strategy is focused on six pillars for transforming the behavioral health system:

1. **Offer same-day care for behavioral health crises.** Virginia is making a historic effort to offer Virginians access to same-day care for their behavioral health needs by implementing the best-in-class Crisis Now model, fully-funding mobile crisis teams, and building out the new 9-8-8 crisis hotline.
2. **Relieve law enforcement burdens and reduce criminalization of mental health**. Virginia aims to relieve the burden on law enforcement so they can keep us safe and reduce the criminalization of mental health by streamlining the discharge of temporary detention orders, allowing attending physicians to discharge temporary detention orders, and funding in-hospital monitoring alternatives to law enforcement.

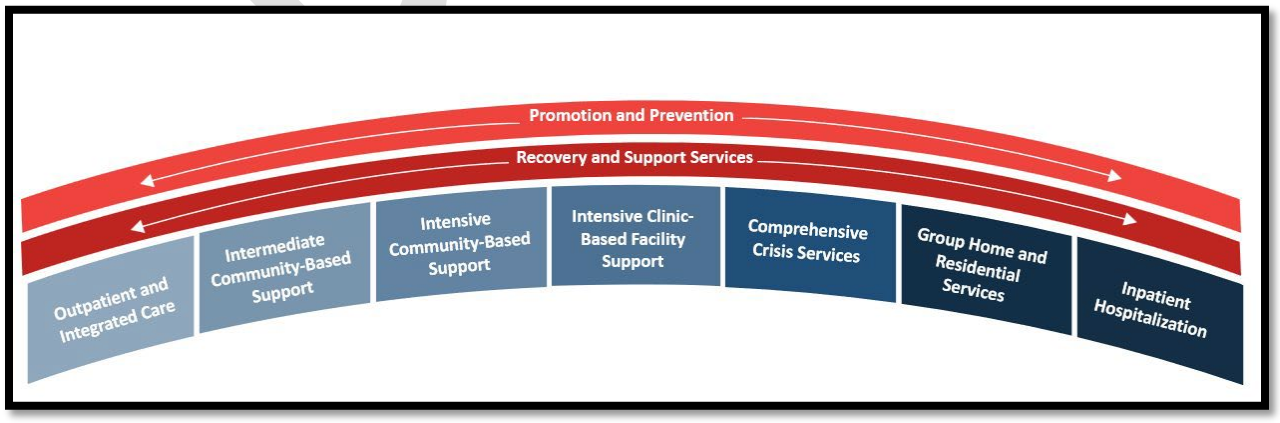
3. **Expand capacity to serve people.** Virginia aims to ensure that we can serve people by expanding capacity throughout the behavioral health system, including pre-crisis prevention services, crisis services, and post-crisis recovery and support by expanding the use of community-based care, increasing access to telebehavioral health, and increasing school-based support for students.
4. **Target support for substance use disorders and overdoses**. Virginia will engage directly on substance use disorders and overdose by developing better mobile treatment and crisis response, invest additional funding to wage war on fentanyl overdoses, and reduce barriers to recovery and re-entry.
5. **Strengthen behavioral health workforce.** Virginia is creating a pipeline of professionals who can help people by expanding recruitment strategies, supporting targeted increases in rates and compensation, and providing funds to educate new psychiatrists, psychiatric nurse practitioners, and other behavioral health workers.
6. **Identify innovations to close capacity gaps.** Virginia is pursuing best-in-class solutions and identify innovations to close capacity gaps by streamlining administrative requirements, better-aligning the behavioral health provider network, and developing outcome-based payment strategies and incorporating behavioral health innovations in rebid of the Medicaid managed care contract.

Vision for Improvement

This waiver is intended to build on Virginia's commitment to improved behavioral health outcomes articulated in Governor Youngkin's Right Help, Right Now Initiative. The vision is to have the full continuum of care to meet member needs, which requires an emphasis on coordination and step-down transitions.

The Commonwealth wants to leverage this opportunity to pull together related initiatives in a cohesive way. Virginia's investment in the community-based behavioral health system over the last decade allows the Commonwealth to be ready for this opportunity—however, the waiver is needed to address system fragmentation and gaps in care coordination across included and excluded settings. It has been a legislative priority with significant investment over the past ten years, ranging from the expansion of Medicaid, the focus on managed care and carving in behavioral health services to improve and integrate care, the ARTS waiver in support of individuals needing care in IMDs for SUDs, and finally the in-progress behavioral health services redesign.

Figure 7. Proposed Medicaid Behavioral HealthCare Continuum ("Right Help, Right Now")

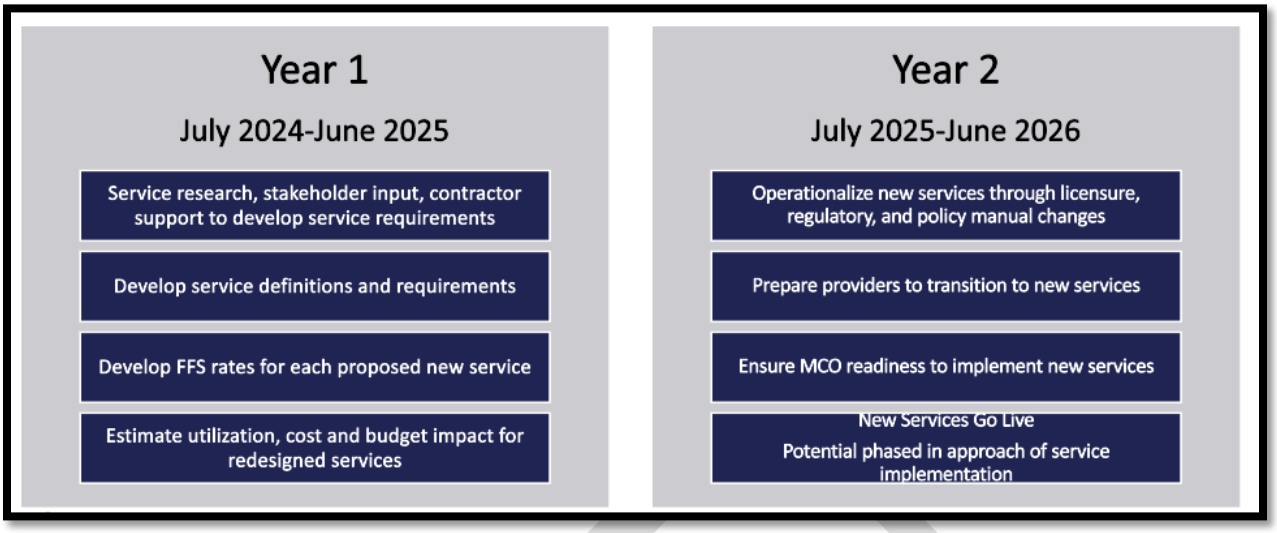


While the new authority and FFP claiming opportunity in this waiver is focused on short-term acute stays in residential and inpatient facilities that qualify as IMDs, the Commonwealth appreciates and shares CMS's emphasis on building services and access across the entire continuum of care, particularly crisis stabilization and community-based supports. The Commonwealth is building on the success of the first year of the Right Help, Right Now effort to continue to expand the crisis continuum infrastructure to achieve the target state by the end of Year 3.

In addition to building out capacity statewide on behalf of all Virginians, the Commonwealth will be focusing in the next two years on continuing to evolve the Medicaid behavioral health benefit design to meet the changing landscape and utilize innovative, evidence-based practices to enhance the quality of care and improve outcomes. DMAS, in coordination with DBHDS, DHP and DMAS health plans, is employing an integrated and comprehensive approach to address service offerings, rates, and workforce/provider roles for Medicaid over the next two years. The project seeks to redesign DMAS' youth and adult legacy services: Intensive In-home, Therapeutic Day Treatment, Mental Health Skill Building, Psychosocial Rehabilitation, and Targeted Case Management. The budget language provided by the Commonwealth General Assembly authorizes DMAS to move forward with budget neutral changes to replace the legacy services with evidence-based, trauma-informed services, as shown below:

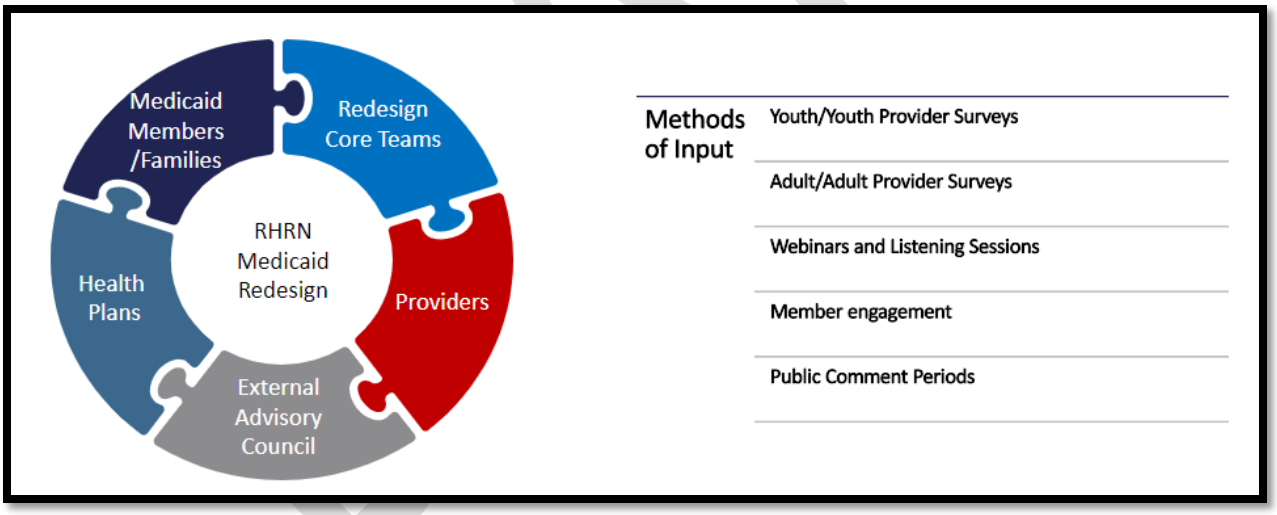
> *Effective July 1, 2024, the Department of Medical Assistance Services (DMAS) shall have the authority to modify Medicaid behavioral health services such that: (1) legacy services that predate the current service delivery system, including Mental Health Skill Building, Psychosocial Rehabilitation, 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.*

Figure 8. Medicaid Behavioral Health Services Redesign Timeline[10]



Co-creation with stakeholders is foundational for meaningful transformation. DMAS has developed and is currently engaging in a multi-modal approach to gather input and feedback from the full complement of organizations and individuals who have a stake in this effort's success.

Figure 9. Behavioral Health Services Redesign Stakeholder Engagement Model



In addition, DMAS is working with MCOs and providers to continue to improve care quality and outcomes for members with behavioral health needs, including those diagnosed with SMI. Examples of efforts planned or underway for adult services include:

- Replacing outdated medical necessity criteria with national standardized level of care assessment tools
- Replacing components of mental health skill building with specific evidence-based models

[10] RHRN webinar, July 29, 2024

- Investing in Coordinated Specialty Care
- Supporting inclusion of intermediate and intensive levels of care for community-based psychiatric rehabilitative services to fill the gap between skill building, case management and ACT
- Leveraging alternative payment models for case management entities and specialty provider types to ensure conflict free case management
- Integrating measurement-based care
- Developing differential collaborative behavioral health service requirements (e.g., caseload, supervision) for licensed practitioners, QMHPs, BH technicians, and moderate and intensive care levels following the implementation of new Department of Health Professions (DHP) state practice act regulations for non-licensed mental health providers

Section III. Demonstration Goals and Milestones

Waiver Demonstration Goals

Virginia is committed to the goal outlined by CMS in the 2018 SMD letter, reiterated below.

Table 3. Waiver Demonstration Goals

(1) Reduced ED Utilization
Reduced utilization and lengths of stay in emergency departments among Medicaid members with SMI or SED while awaiting mental health treatment in specialized settings.
(2) Reduced Preventable Readmissions
Reduced preventable readmissions to acute care hospitals and residential settings
(3) Improved Availability of Crisis Stabilization Services
Improved availability of crisis stabilization services, including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals, and residential treatment settings throughout the state;
(4) Improved Access to Community Based Services
Improved access to community-based services to address the chronic mental healthcare needs of members with SMI or SED, including through increased integration of primary and behavioral health care; and
(5) Improved Care Coordination
Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

Broadly, the forward-looking work to achieve these waiver goals and complete the milestones by year two of the demonstration falls into three categories:

- **Accreditation and Certification.** Ensuring all necessary accreditation and certification standards are met for participating providers, which includes the accreditation process for Residential Crisis Stabilization Units (RCSUs), as well as the DBHDS-led certification process for state-owned freestanding psychiatric facilities and RCSUs.
- **"Right Help, Right Now" Ongoing Implementation**. Continuing to implement the "Right Help, Right Now" initiative to improve behavioral healthcare access and quality statewide, including the continued modernization of Medicaid benefits, infrastructure, and systems.

- **MCO Best Practices**. Assessing MCO best practices associated with the goals and milestones of this waiver to disseminate, replicate, and – as appropriate – require on a statewide basis to support Medicaid members with SMI diagnoses. Many of these potential best practices are referenced below and are based on ongoing discussions with MCOs.

Milestone Area 1. Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings

Virginia is committed to ensuring patients receive high quality care in psychiatric hospitals and residential settings and has a number of efforts both in place and underway as part of an approach of continual improvement. As detailed in the SMD letter, the Commonwealth will submit an implementation plan following the approval of the waiver application which will detail the timeline for achieving the forward-looking initiatives and activities detailed under the milestones, with anticipated completion no later than the end of the second year of the waiver.

Accreditation and Licensing (Milestone #1.a)

Table 4. IMD facility types and relevant accreditation and certification requirements

IMD Facility Type	Accreditation	Certification
Freestanding Psychiatric Hospitals	Joint Commission. All facilities planned for inclusion under waiver are accredited.	All facilities planned for inclusion under the waiver will be certified by the Commonwealth to be in compliance with 42 CFR Part 482. Process to be detailed in waiver implementation plan.
Residential Crisis Stabilization Units	All facilities planned for inclusion will become accredited by either CARF or the Joint Commission prior to claiming FFP for services provided under this waiver. Proposed timeline and process to be detailed in waiver implementation plan.	All facilities planned for inclusion under the waiver will be certified by the Commonwealth to be in compliance with 42 CFR Part 482. Process to be detailed in waiver implementation plan.

As noted in a report for the Joint Legislative Audit and Review Commission, "as of October 2023, all of Virginia's state psychiatric hospitals are accredited by the Joint Commission." Furthermore, all private psychiatric institutions are accredited by the Joint Commission and licensed by the State Department of Behavioral Health and Disability Services (DBHDS).

In addition, Residential Crisis Stabilization Units (RCSUs) which have more than 16 beds are considered residential treatment IMD facilities consistent with this waiver and will be accredited by either CARF or the Joint Commission prior to claiming FFP for waiver services provided in that facility.

Facility Oversight and Auditing Processes (Milestone 1.b)

The Department of Behavioral Health and Developmental Services oversees the licensing for behavioral health providers and specifies in regulation that "The Department shall conduct an announced or unannounced onsite review of all new providers and services to determine compliance with this chapter

["Rules and Regulations for Licensing Providers"]. The Department shall conduct unannounced onsite reviews of licensed providers and each service at any time and at least annually to determine compliance with these regulations."[11]

In addition, those facilities, including psychiatric hospitals, which are accredited by the Joint Commission are subject to unannounced visits by the Commission. Beyond that, MCOs also conduct annual visits to provider networks, including these facilities, and those visits may be both scheduled and unscheduled. MCOs also conduct trend analyses and validate denial information between what has been submitted between EMR and claims information and provide onsite clinical education to ensure residential psychiatric facilities are following ASAM. DMAS and MCOs also collaborate if there are crosscutting issues with a provider. As a part of this waiver, DMAS will partner with the MCOs to continue to strengthen reporting and oversight and, where appropriate, further standardize site visit requirements across the MCOs and IMD provider types.

Utilization Review (Milestone 1.c)

As articulated in Virginia code, "All Medicaid services are subject to utilization review and audit. Absence of any of the required documentation may result in denial or retraction of any reimbursement. DMAS shall monitor, consistent with state law, the utilization of all inpatient freestanding psychiatric hospital services. All inpatient hospital stays shall be preauthorized prior to reimbursement for these services. Services rendered without such prior authorization shall not be covered."[12]

MCOs are charged with the utilization review process and have teams in place that conduct utilization management activities, as well as collaborating with care coordination teams when they see indications, such as potentially unnecessary ED or inpatient utilization, where a member could be better served by being connected to crisis stabilization services and community-based supports.

The implementation of this waiver will support continued strengthening of the utilization management process and associated DMAS oversight, particularly for Medicaid members currently receiving services in IMDs outside of managed care and/or Medicaid reimbursement.

Program Integrity (Milestone 1.d)

If the state licensing team has reason to expect waste, abuse, or suspicious activity over the course of a visit it has a process in place to alert the DMAS Program Integrity Division which is then tasked with assessment and appropriate follow up. MCOs also monitor claims and utilization data for escalation to their program integrity teams and at the state program integrity office. The state has also fulfilled the provider enrollment and screening requirements specified in the 21st Century Cures Act, including state screening of all Medicaid providers upon enrollment, monthly abbreviated screenings, and full revalidation screenings at least every 5 years.[13]

MCOs also do front-end and back-end auditing via over- and underutilization reports, looking at units and days being requested to look for patterns of movement, such as lateral facility moves rather than step down moves. Such instances can result in the facility being investigated by the Specialized Investigation Unit (SIU) and trigger a payment review and site audit. Similarly, any time that an MCO identifies a quality issue or deviation from typical patterns, it may conduct a quality review and ask for a corrective

[11] https://law.lis.virginia.gov/admincode/title12/agency35/chapter105/section70/
[12] https://law.lis.virginia.gov/admincode/title12/agency30/chapter60/section25/
[13] https://vamedicaid.dmas.virginia.gov/sites/default/files/2023-12/MHS%20-%20Chapter%202%20%28updated%2012.27.23%29_Final.pdf

action plan. One MCO reported using exploratory data and algorithms to identify facilities that may be "flying under the radar" but are still committing potentially inaccurate or suspicious billing practices.

One particular strength is the communication and information sharing between the MCOs and the state. Any suspicious activities get reported into the state, typically within 48 hours, and are shared as warranted with the Medicaid Fraud Control Unit for follow-up and potential law enforcement action.

Screening for SUD and other co-morbidities (Milestone 1.e)

All IMD facilities are required to screen and treat substance use disorders for patients presenting with an SMI diagnosis. Virginia has been implementing the ARTS waiver for SUD treatment in IMDs since receiving approval in 2016. In the ARTS waiver, Virginia hypothesized that the demonstration would increase the percentage of members with SUD who receive treatment for co-morbid conditions, which remains a priority for evaluation in the Commonwealth's pending extension application.

The Commonwealth is committed to continual improvement in this area to ensure member needs are addressed in an integrated and comprehensive manner. Virginia Commonwealth University (VCU), which is overseeing quality review and evaluation for the SUD 1115 IMD waiver, is focusing in particular on how co-morbid SUD/SMI conditions are addressed in ARTS facilities, with the goal of developing lessons and best practices for ARTS IMD facilities that can also be implemented in IMD facilities receiving FFP under this waiver. This initiative will be expanded into the SMI waiver as more information is available as a result of the SUD 1115 Waiver.

Milestone 2. Improving Care Coordination and Transitions to Community-Based Care

Pre-Discharge Care Coordination from IMDs to community-based outpatient services (Milestone 2.a)

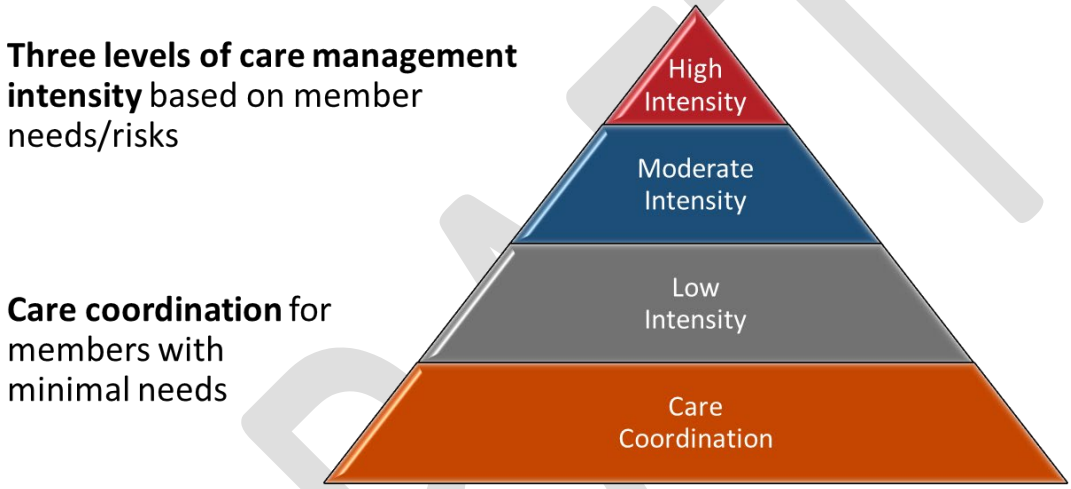
State psychiatric hospitals and Community Services Boards (CSBs) are required to coordinate the discharge plan for all patients exiting the care of those hospitals, including Medicaid members. Specifically, effective January 1, 2025, CSBs must develop a discharge plan in conjunction with state hospitals reflecting individual's preferences, including all necessary services and identifying agencies providing them. While this initiative is a required activity it does not guarantee engagement with DMAS contracted MCO's. DMAS MCO's have taken steps to find inpatient discharges to better support successful member transitions back into the community.

Managed Care Organizations are heavily involved in pre-discharge coordination. The Cardinal Care Contract between DMAS and the MCOs specifies with regards to transitional care management that "the Contractor must maintain and submit policies and procedures that reflect how the Contractor will meet the Contract requirements with regards to Transitional Care Management and timely discharge planning, including coordinating with nursing facilities and facility-based care coordinators, care managers, and/or case managers, how discharge plans will be documented, how the Member will be involved, and how discharge planning will be triggered."[14] The contract also requires that MCOs "implement procedures to ensure continuity of care and to coordinate all appropriate services the Contractor provides or anticipates providing to the Member… Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays."

[14] https://www.dmas.virginia.gov/media/cyod1lnw/cardinal-care-managed-care-fy2025-contract.pdf

MCOs are also contractually required to provide members with SMI with Care Management / Care Coordination as a "Mandatory Priority" population under the current MCO contract. As part of the 2021 Appropriations Act, DMAS was directed to merge its two managed care programs, Medallion 4.0 and Commonwealth Coordinated Care Plus (CCC Plus), in a manner that links seamlessly with the fee-for-service program. DMAS's strategy to achieve these legislative directives was implemented in phases, including the initial phase to rebrand as Cardinal Care in January 2023, while working closely with the Center for Medicare and Medicaid Services (CMS) to consolidate the two managed care waivers and contracts into Cardinal Care Managed Care (CCMC). CCMC improves continuity for members who will no longer need to transition between two managed care programs as support needs change. The single, unified care management model is represented in the following graphic:

Figure 10. Care management and coordination framework



Driving improved health outcomes, as demonstrated by quality measures and clinical efficiencies, the responsive model of care provides access to higher intensity care management services across populations, based on the member's evolving needs and health risk and uses data effectively to target appropriate and timely interventions to drive the right care at the right time. There are three levels of care management based on member needs/risk and care coordination is available for members with minimal needs and care planning assessments. Among other activities, Care Management involves requirements to ensure Care Managers establish a schedule of contacts to regularly monitor and address a member's needs in a timely way on an ongoing basis to ensure needs are addressed after triggering events and when individual care plans must be amended due to significant care needs or triggering events.

MCOs utilize a variety of approaches to support pre-discharge planning, including as a means of reducing readmission rates and follow up after care.

- Care managers doing non-mandated in-person visits to psychiatric hospitals and residential treatment facilities prior to patient discharge to develop trusted relationships and develop discharge plans in collaboration with facilities, patients, and families. This is in addition to mandated in-person visits triggered by an Inpatient stay, which requires the MCO to assess needs and revise the individual care plan/health risk assessment.

- Getting appropriate follow-up appointments scheduled prior to release whenever possible, including outpatient behavioral health, primary care, and community supports for health-related social needs.
- Connecting members to Community Services Boards to help members get connected to care. CSBs also work proactively with MCOs if there are members or step-down services where timely connections have been challenging. MCOs then engage to work with providers to expedite those connections.
- Educating members about available benefits and supports.
- Coordinating transportation to appointments.
- Connecting members to certified peer specialists for ongoing support.
- Utilization Management (UM) team, care transitions team, care managers team work collaboratively on members with frequent admissions or who are
- Placing onsite navigators in facilities to work with provider discharge planners to ensure discharges to providers are in-network, have authorizations, and receive support

A number of MCOs also noted that they were intentional in having one central point of contact conduct outreach to the member to prevent confusion and any duplication or fragmentation in connections to these outpatient services and supports.

As part of this waiver, the Commonwealth intends to continue to improve pre-discharge care coordination through building on the best practices identified by MCOs, assessing their effectiveness as part of ongoing monitoring and waiver evaluation, and replicating them broadly across Medicaid. In particular, the Commonwealth intends to improve its analytical and corresponding oversight capabilities through enhancements to the care management systems currently in development. A number of MCOs noted that they are leveraging closed-loop referral systems to so that referring providers and care managers have visibility into whether follow-up appointments were kept across both clinical and community supports and can intervene as needed on an accelerated timeline. The Commonwealth is interested in assessing what opportunities exist for enhancing interoperability and broader utilization. The Commonwealth also plans to assess the applicability of the requirements for pediatric discharge planning from PRTFs for additional best practices that could be effectively adapted for the adult population.

Assess Need and Connect Members to Housing Services (Milestone 2.b)

The Commonwealth appreciates the criticality of connecting members with SMI who are experiencing housing instability to services and resources that can provide housing supports and other critical housing-related services. The Commonwealth has been working both to increase the availability of housing options for adults with Serious Mental Illnesses through the Permanent Supportive Housing initiative managed by DBHDS as well as partnering with MCOs to support members in accessing those housing options following a stay in an IMD or other residential facility for behavioral health care. It is important to note that the majority of PSH administrative agencies across the Commonwealth are CSBs, which are also an entity with responsibilities associated with discharge planning for Virginians with SMI.

MCOs screen members for their housing needs as part of discharge planning and work closely with partners across the housing ecosystem (e.g., housing specialists, shelters, coordination care agencies that support housing) to connect those who are homeless or have unsuitable or unstable housing with community providers that coordinate housing services where available.

Connecting members to housing resources also helps to drive down ED utilization. Several MCOs reported that members with a SMI diagnoses and housing instability often present at the ED as a means of temporarily accessing shelter and food. MCOs will continue to engage CSBs and other stakeholders

across the housing continuum to understand and proactively address member housing needs in the most appropriate setting possible. To that end, MCOs also have dedicated social workers who are trained as housing specialists to proactively support members as soon as a need is identified and have invested in grants and partnerships to support housing supply and resources.

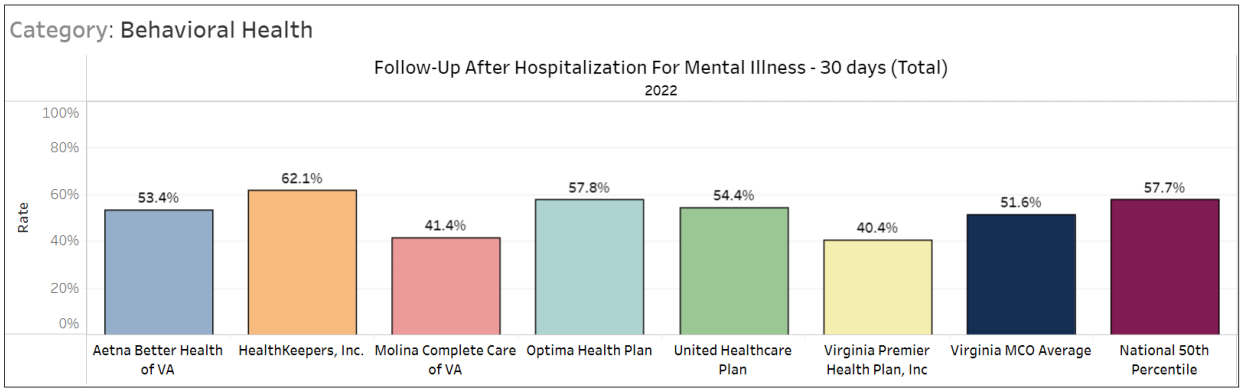
Contact between Community Providers and Members within 72 hours (Milestone 2.c)

The current MCO contract specifies that MCOs [the Contractor] must "implement procedures to ensure continuity of care and to coordinate all appropriate services the Contractor provides or anticipates providing to the Member."

MCOs reported that their standard protocol was to connect with the member within three business days post-discharge. While not explicit in the MCO contract, this is part of the clinical Transition of Care standards, which MCOs report on via HEDIS. MCOs also reported that they often had certified peer specialists reach out in that timeframe to build a relationship and support the member in successfully engaging in their ongoing care plan. MCOs may have more immediate internal standards, including outreach within 24 hours post discharge to continue to support members in transitioning successfully to the next provider, from medication adherence or adjustment to transportation to appointments.

DMAS tracks the performance of both the Follow Up After Hospitalization and After Emergency Department visits measures (7 and 30 days) on the DMAS website via the Managed Care HEDIS dashboard.[15] The dashboard is updated annually and displays three years of trended performance by MCO for the measures, as well as a comparison to the National 50th Percentile. Tracking performance this way allows DMAS to monitor individual MCO performance, how an MCO compares within the context of Virginia Medicaid MCOs, as well as how they compare on a national level. These measures also are highlighted as Agency priorities for performance in the 2023-2025 DMAS Quality Strategy, as they support Goal #5 "Providing Whole Person Care for Vulnerable Populations", under Objective 5.4 "Improve Behavioral Health and Developmental Services for Members".

Figure 11. Virginia HEDIS dashboard: Follow-Up After Hospitalization for Mental Illness (2022)[16]



As part of this waiver planning and implementation, Virginia will be refining additional strategies to impact these numbers. Planned strategies include ongoing implementation and oversight of the Cardinal Care model of care as well as ongoing implementation of legislation which clarified roles and responsibilities for discharge planning across CSBs and hospitals.

[15] https://www.dmas.virginia.gov/data-reporting/cardinal-care/hedis-dashboard/
[16] https://www.dmas.virginia.gov/data-reporting/cardinal-care/hedis-dashboard/

Strategies to Mitigate ED use among members with SMI (Milestone 2.d)

DMAS implemented a number of new services with potential to mitigate ED use among members with SMI, including Assertive Community Treatment (ACT), the mental health partial hospitalization program, mental health intensive outpatient program, and crisis response services. Among them was a Peer Recovery Support Services benefit in 2017 for individuals with mental health and SUD conditions to help reduce emergency department visits as well as to improve transitions of care. Yet, there is room for improvement in terms of ensuring all Virginians have access to these critical services.

The Commonwealth has a number of Peer and SUD bridge pilots in process to continue to test the efficacy of different interventions. DMAS also intends to explore the feasibility of working with MCOs to implement and / or expand value-based payment structures to reward interventions that successfully support positive member outcomes and reduce unnecessary ED use, particularly among members with significant behavioral health needs. More information on this effort and associated timelines will be included in the implementation plan.

As a result of the MCO contract requirements to identify and support all member care transitions the health plans have developed robust care management strategies that both utilize the emergency department data feed and other UM systems in the MCO's arsenal to identify when members require level of care transition supports and other triggering events that may yield enhanced care management supports. MCOs have implemented several strategies to improve care transitions and reduce ED utilization. Transition of care coordinators work directly with members prior to ED discharge to ensure follow-up appointments are scheduled within 72 hours. Additionally, MCOs are increasing follow-up opportunities by extending clinic hours and enhancing telehealth capabilities.

One MCO noted that it is supporting the top five facilities for readmissions and top five most common diagnoses to deliver targeted case management. This includes providing educational resources on appropriate care settings—urgent care vs. primary care vs. ED—aimed at reducing unnecessary ED visits. MCO staff are also placed on-site in EDs, collaborating with behavioral health (BH) discharge planners to improve care coordination.

To further support high-utilization populations, MCOs are expanding efforts to place navigators in high-utilizing residential facilities, all while ensuring full compliance with Emergency Medical Treatment & Labor Act (EMTALA) regulations. Opportunities for virtual care are being explored through expanded nurse advice lines and telehealth services. On the pediatric side, telehealth clinics are being integrated within schools through a pilot school liaison program. This initiative provides schools with additional tools and resources to support students, identify gaps in care, and deploy mobile health buses to address those gaps and engage families more effectively.

Strategies for Data Sharing between Providers for Care Coordination (Milestone 2.e)

DMAS has leveraged several data sharing platforms to improve care coordination between providers, as well as MCOs. The Commonwealth's health information exchange (HIE), ConnectVirginia, forms the backbone of this data sharing capability. For example, the Emergency Department Care Coordination (EDCC) platform enables managed care organizations to receive real time reports for members who have presented to the emergency room with a behavioral health or SUD event, and to be able to engage the member more readily upon discharge.

The EDCC was established by the Virginia General Assembly as a response to the overutilization of emergency departments seen throughout the country. Currently, 106 hospital EDs are live and participating on the network. All health plans (3.4 million lives), multiple clinics, accountable care

organization (ACOs), managed care entities (MCEs), community services boards (CSBs), federally qualified health centers (FQHCs) and skilled nurse facilities have already been onboarded or are in the process of onboarding.

MCOs noted that the care notes function in the EDCC had enabled providers and care coordinators to specify other settings where the member had accessed care, enabling the ED provider to connect the member to a setting where they have previously had a successful encounter, and provide more clinically appropriate and member centric care than a prolonged ED visit or a hospital admission.

Additional platforms used by MCOs and providers to coordinate care include "Find Help", "Unite US", "PointClickCare," and "Community Connector." Find Help and Unite US provide closed-loop referral systems for social services, and Community Connector helps care managers identify resources to support members' health related social needs. A number of MCOs have also collaborated with the Roanoke Department of Social Services to launch a pilot platform "Care Forward" which enables individualized matching between member needs and organizations, even individual volunteers, who are able to meet them. The MCOs have visibility into the process and also engage to meet individual member needs. The Commonwealth looks forward to seeing the results of this pilot and potential opportunities to build on successes and lessons learned.

As noted above, Virginia is committed to continuing to improve data sharing between the Commonwealth, MCOs, providers, and members, and their families to further enhance care coordination. Among other efforts, the Commonwealth plans to enhance inter-agency data sharing between DBHDS (Behavioral Health) and DMAS (Medicaid), focusing on facility admissions and involuntary commitments to share more admission information with health plans from public/state hospitals. One specific improvement will enable real-time reporting to MCOs when a member is involuntarily committed to a state hospital, which will play a critical part in ensuring those members receive all appropriate care coordination services and discharge planning.

Milestone 3. Increasing Access to Continuum of Care Including Crisis Stabilization Services

Annual Assessments of Availability of Mental Health Services (Milestone 3.a)

The Commonwealth currently has a multitude of ways to map and monitor the availability of mental health services in the Commonwealth. The 2023 report[17] of the Governor's "Right Help, Right Now" initiative provides a view of the Commonwealth's mental health services, with a particular focus on crisis services, as well as articulating the future actions to continue to expand services to mee the needs of Virginians.

Given the Commonwealth's recent efforts to invest in crisis stabilization services, DBHDS has developed mapping capabilities for crisis team engagement, which is possible due to Virginia's transition to centralized dispatch of mobile crisis across all payers of mobile crisis beginning in December 2023. In addition, the Virginia Crisis Connect Data Platform connects registered providers and enables them to access case information and make service requests including crisis stabilization units, crisis therapeutic homes, emergency services, community-based stabilization, mobile crisis, and preventative services.

[17] https://ij.org/wp-content/uploads/2024/03/1-Year-Update-RHRN-FINAL-complete-Feb2024-TEXT-SEARCHABLE-1.pdf

DMAS policy requires that all Medicaid providers use the platform. Therefore, in addition to being a tool actively used to connect members to needed care, it serves as a valuable repository of data about how providers are referring, and members are receiving services across a range of behavioral health settings.

In addition, the Commonwealth leverages the network adequacy requirements for behavioral health services specified in the MCO contracts to monitor the behavioral health providers throughout the Commonwealth who serve Medicaid members, including Multisystemic Therapy, Functional Family Therapy, and Assertive Community Treatment providers. Access to mental health services is defined as: "The Contractor's MHS network must ensure sufficient Member access to high quality service providers with demonstrated ability to provide evidence-based treatment services that consist of person centered, culturally competent and trauma-informed care using a network of high quality, credentialed, and knowledgeable providers in each level of care within the access to care and quality of care standards as defined by the Department. The Department will periodically review and monitor the Contractor's network adequacy for MHS, based on its network submission per Section 7.1.8, "Assurances That Access Standards Are Being Met."

To ensure that network adequacy and accessibility is maintained, the MCO contract requires that MCOs establish a system to monitor its provider network to ensure that the access standards set forth in this Contract are met, must monitor regularly to determine compliance, take corrective action when there is a failure to comply, and must provide a monthly report by provider taxonomy code that demonstrates to the Department that these access standards are being continuously monitored by the Contractor and that standards have been met. In accordance with 42 CFR §438.358(b)(1)(iv), the External Quality Review Organization (EQRO) will validate network adequacy during the preceding twelve (12) months to comply with the requirements set forth in 42 CFR §438.68 and within the MCO contract. A summary of member impacts related to any provider terminations are reported to the legislature each year

DMAS works with the MCOs to ensure that their delivery systems provide adequate numbers of facilities, accessible locations, and qualified personnel for the provision of covered services, including emergency services provided 24 hours a day, 7 days a week. The MCOs' provider networks are required to meet or exceed federal network adequacy standards as detailed at 42 CFR §438.68. The MCOs are also required to have sufficient types and numbers of traditional and specialty providers in their networks to meet the historical need and also add providers to meet increased member needs in specific geographic areas.

DMAS assesses network adequacy by evaluating a number of factors, including number of providers, mix of provider types, hours of operation, ratio of providers not accepting new patients, accommodations for individuals with physical disabilities (wheelchair access), barriers to communication (translation services), and geographic proximity to beneficiaries (providers to members or members to providers). The MCOs also provide emergency, urgent, and nonemergency transportation services to ensure that members have necessary access to and from providers of covered medical, behavioral health, dental, LTSS, and rehabilitative medical services and supports needed in a manner that ensures the member's health, safety, and welfare as required by 42 CFR §440.170(a) and 12 Virginia Administrative Code (VAC) 30-50-530.

DMAS is currently working to redesign network adequacy reporting for Behavioral Health to ensure that specialized services are captured by the methodology. With the implementation of the 21st Century Cures Act, improved network data is now available at the State level, in addition to the networks reported by each MCO. Comprehensive reporting for availability of Mental Health Services across the Commonwealth is expected to be finalized by the end of calendar year 2025, including an ongoing review methodology and strategic plan. As part of waiver implementation, Virginia may explore more granular, service and special population-level detail for network adequacy standards specific to behavioral health.

In accordance with 42 CFR §438.68, DMAS uses its EQRO to perform validation of MCO network adequacy. The analysis will evaluate each MCO's ability to:

- Collect, capture, and monitor valid network adequacy data
- Evaluate the adequacy of the provider network using sound analytic methods
- Produce accurate results to support MCO network adequacy monitoring
- Provide DMAS with accurate network adequacy indicator rates for each required standard
- Provide a calculated validation rating for each network adequacy indicator for each MCO

The contracts between DMAS and the MCOs detail Virginia's Medicaid standards for access to care, and as outlined in Subpart D of the Final Rule.

DMAS' standards are at least as stringent as those specified in 42 CFR §438.206–§438.210.

The MCOs are required to implement the following standards for access to care:

- Availability of services (42 CFR §438.206)
- Assurances of adequate capacity and services (42 CFR §438.207)
- Coordination and continuity of care (42 CFR §438.208)
- Coverage and authorization of services (42 CFR §438.210)

The DMAS EQRO, HSAG will conduct the Validation of Network Adequacy activity beginning in calendar year 2024. In preparation for the task, HSAG identified that to assess appointment availability, DMAS established minimum standards to ensure members' needs were sufficiently met. DMAS monitors the MCO's compliance with these standards through regular reporting requirements outlined in the DMAS Managed Care Technical Manual. In addition, DMAS requires the MCOs to conduct various activities to assess the adequacy of their networks as well as maintain provider and beneficiary data sets that allow monitoring of their networks' adequacy.

To develop overarching annual assessments of the availability mental health services, DMAS will collaborate with DBHDS, the Department of Health (VDH), and the MCOs to compile all relevant data across service and facility types to develop a comprehensive picture of access and actionable insights with targeted steps to continue to increase access and service availability for members with behavioral health needs, and in particular those with SMI diagnoses.

CMS-approved financing plan[18] to increase availability of non-hospital, non-residential crisis stabilization (Milestone 3.b)

The Commonwealth has invested over $1.36 billion in behavioral health care as part of the Right Help, Right Now initiative. Specific investments in non-hospital, non-residential crisis stabilization include, but are not limited to:

- 10% increase to Medicaid reimbursement rates for Community-Based Behavioral Health Services (effective January 2024)
- $165 million in increased funding to support a comprehensive crisis services system, including Crisis Receiving Centers and Crisis Stabilization Units.
- $20 million to expand mobile crisis units.
- $20 million for the expansion of the Virginia Mental Health Access Program

[18] by end of the five-year demonstration

- $30 million to increase STEP-VA services funding and conduct a needs assessment

These investments are yielding improvements in access to services. Current DMAS data indicates that over 300 unique mobile crisis providers have delivered care to Medicaid members. Community-based crisis care allows lower acuity psychiatric patients to be diverted from the emergency room, improving care, decreasing costs, and alleviating law enforcement burden. There are currently 190 active 24-hour Crisis Receiving Centers and Crisis Stabilization Units serving Medicaid members, with plans for additional growth underway. Assertive Community Treatment (ACT) is an evidence-based practice proven to reduce hospitalizations and incarcerations, increase housing stability, and improve quality of life for people with the most severe symptoms of mental illness. ACT now serves 2175 members as of FY 2024, an increase of almost 40% from 2019 utilization data with increases near the 10% mark each year.

Based on the impact of these investments to date, the results of the annual assessments, and the evaluation efforts under the ARTS waiver and this wavier, the Commonwealth looks forward to providing CMS with a proposed financing plan to further increase the availability of non-hospital, non-residential crisis stabilization services, subject to the unmet need and funding availability.

Track inpatient and crisis stabilization beds and connect patients in need (Milestone 3.c)

The Facility Referral module in Virginia Crisis Connect has the ability to both monitor the sending and acceptance of referrals by hospital and the ability to track bed inventory across systems. This module is fully functional, live, and actively receiving enhancements based on user-experience by CSB Emergency Services staff and admissions staff at both private and state facilities. The Commonwealth is in the midst of full implementation of the module; CSB Emergency Services is in a pilot phase of sending referrals to the State facilities, the state bed inventory is being prepared for automated update, and private hospital admission staff are participating in user trainings. Full implementation by all three user-types is anticipated by the end of calendar year 2024. Private hospitals will have the ability and will be expected to manually update their bed inventory, which is a functionality independent of receiving and accepting or rejecting referrals by CSB Emergency Services staff.

Patient Assessment Tool for Level of Care and Length of Stay (Milestone 3.d)

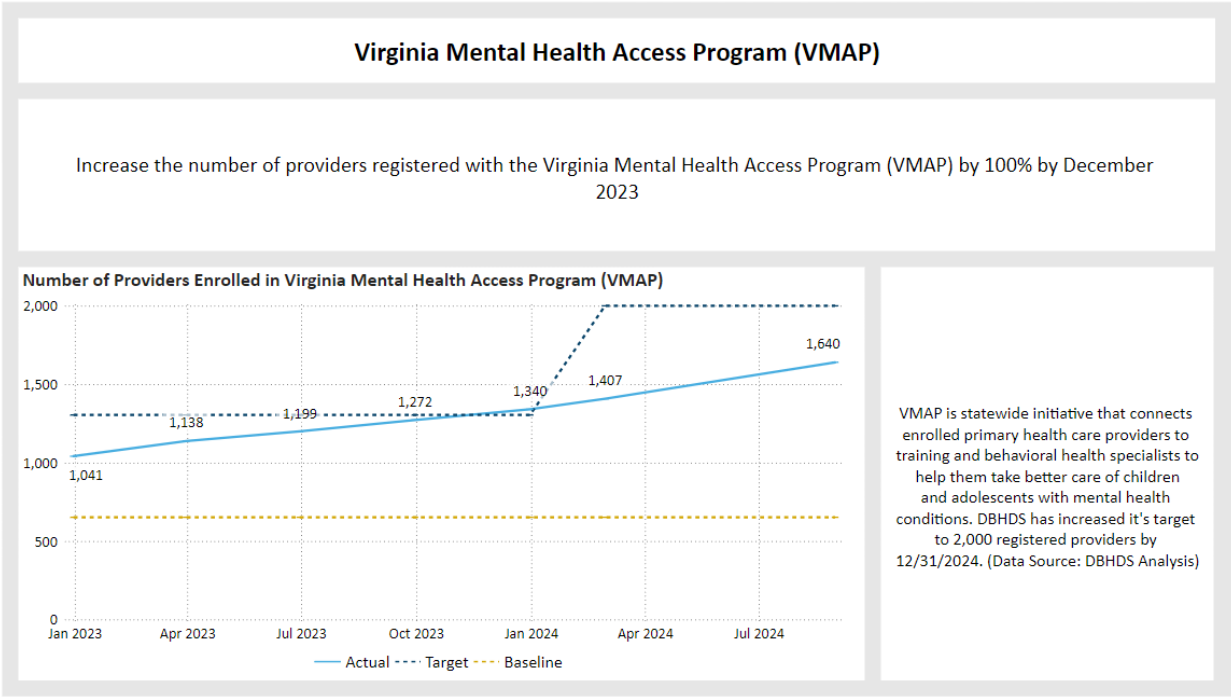
Virginia is actively working to implement a standardized patient assessment tool by July 2026. This was articulated as Strategy 2.B. of the Right Help, Right Now initiative. Currently, Virginia is looking at tools being leveraged in other states and their relative merits, along with cost implications. Once a tool is selected, algorithms will be developed to link standardized assessment results to a Virginia-specific level of care model so that members can be tracked across levels of care. This is a cornerstone to the replacement of the legacy community mental health rehabilitative services with trauma-informed, evidence-based services that are recovery oriented. The specific approach and timing for go-live will be detailed in the implementation plan. Currently, DMAS is in the process of gathering stakeholder input through a provider survey and listening sessions across the Commonwealth to inform the decision making and planning process.

Milestone 4. Earlier Identification and Engagement in Treatment Including through Increased Integration

Strategies to engage people with serious mental health conditions in treatment sooner (Milestone 4.a)

Virginia has released an Annual Strategic Plan for Coordinated Specialty Care[19] that focuses on engaging people, especially youth and young adults, in treatment sooner and evaluating options for implementing this service more robustly within the Medicaid benefit. In addition, the behavioral health redesign project is focusing on enhancing behavioral health preventative services, with a focus on building out a tiered system of community-based services, which will enhance the continuum of care and complement the services authorized under this waiver.

Figure 12. DBHDS Strategic Plan: VMAP



Increase behavioral health integration in non-specialty care settings, including school and primary care practices (Milestone 4.b)

In January 2024, Virginia implemented the Collaborative Care Model (CoCM) in Medicaid through a State Plan amendment. CoCM is an evidence-based model of integrated care designed to treat common behavioral health conditions such as depression, anxiety, post-traumatic stress disorder (PTSD) and alcohol or substance use disorders in medical settings.

In this model, psychiatric collaborative care services are provided under the direction of an individual's treating physician (includes nurse practitioners and physician assistants). The treating physician can be the individual's adult or pediatric primary care provider or a specialty provider such as a nephrologist, OB/GYN, cardiologist or oncologist.

[19] https://rga.lis.virginia.gov/Published/2024/RD524/PDF

Specifically, these are the CPT codes which are now covered across Medicaid health plans and FFS:

Table 5: Covered CPT Codes

Code	Short Description
99492	Initial psychiatric collaborative care management – first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional
99493	Subsequent psychiatric collaborative care management - first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant and directed by the treating physician or other qualified health care professional
99494	Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant and directed by the treating physician or other qualified health care professional

Also in 2024, Virginia was the seventeenth state to receive CMS approval for a state plan amendment to expand its School Based Services program in a number of ways, including the implementation of the reversal of the free care rule. Virginia's approach emphasized access to behavioral health by:

- Existing services currently allowed (for cost reporting) for students with an IEP will be allowed for all general education students (Speech, OT, PT, Audiology, Behavioral Health, Nursing, Personal Care, Physician/PA/NP services).
- Adds licensed school counselors and substance use treatment practitioners, and licensed behavior analysts and assistant behavior analysts to the list of professionals whose time spent providing services may be eligible for reimbursement.
- Allows schools to include the costs associated with adaptive behavior therapy and substance use treatment services in cost settlement.

Establishment of specialized settings and services, including crisis stabilization services, focused on the needs of young people with serious mental illnesses (Milestone 4.c)

Virginia's approach to improving the availability and accessibility of specialized behavioral health settings acknowledges the critical importance of early intervention and connecting young people with serious mental illnesses to care to support stabilization and long-term treatment and management to support their overall wellbeing.

Regarding crisis stabilization services specifically, 23-hour crisis stabilization and residential crisis stabilization were added to Cardinal Care in 2021 (Project BRAVO). These services are accessible to youth and adults, including transition age youth and young people with or at risk for serious mental illness. Across initial years of implementation, utilization of these services for ages 14-24 is as follows:

Figure 13: Transition Age Youth (14-24) service in crisis stabilization

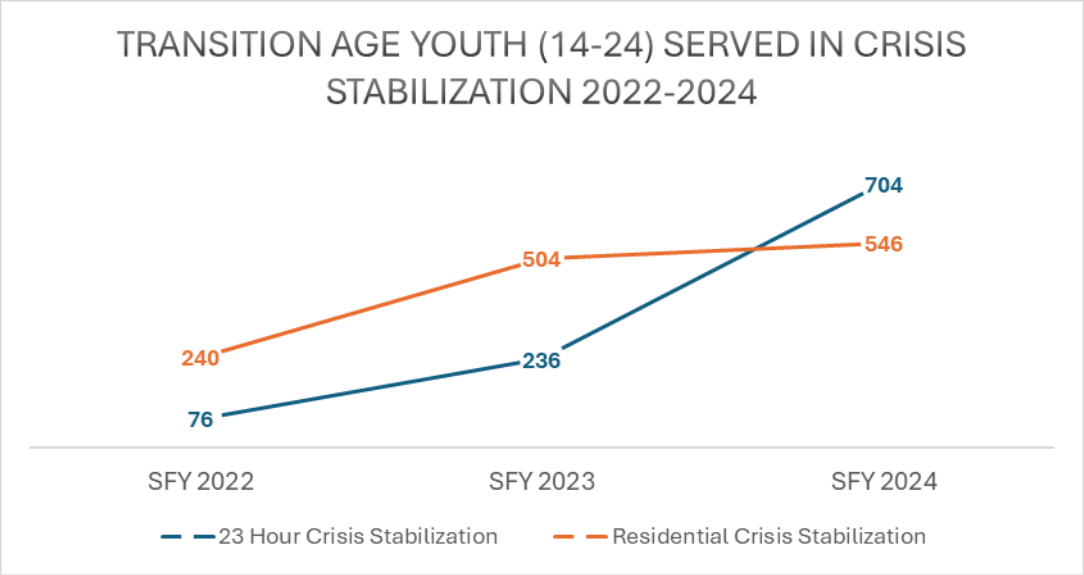


Table 6. Costs per member served (ages 14-24) remained relatively stable

	SFY 2022 Cost Per Member Served (14-24)	2023 Cost Per Member Served (14-24)	2024 Cost Per Member Served (14-24)
23 Hour Crisis Stabilization	$1,356	$1,294	$1,201
Residential Crisis Stabilization	$5,743	$5,905	$5,719

Across these services for ages 14-24, primary diagnoses were Depressive Disorders, Bipolar and Related Disorders, and Schizophrenia Spectrum Disorders.

As part of the ongoing behavioral health redesign, the Commonwealth is focusing specifically on specialized settings and services for youth, including:

- Embedding multiple/flexible evidence-based practices within home, school, and clinic-based services (TF-CBT, PCIT, BSFT, MAP).
- Inclusion of an Intermediate level of care and integrated services into youth centered locations and homes.
- Supporting and complementing DMAS rehabilitative services with Medicaid in School program under a Multitiered Systems of Support framework.
- Use of structured/semi structured screening and assessment approach with a standardized tool.

Section IV. Research Hypotheses and Evaluation Plan

The Commonwealth's Independent Evaluator will work with CMS to amend the Demonstration evaluation design. Below are proposed hypotheses for this initiative. The specific evaluation methodology will be submitted with the updated Evaluation Design upon approval of the amendment, and the Commonwealth is committed to assuring the necessary resources will be available to effectively support implementation of a robust monitoring protocol.

DMAS has experience with analytics and evaluations for members with SMI diagnoses through the 2015 GAP demonstration waiver, and with IMD services through the 2017 ARTS waiver. DMAS will develop a detailed evaluation plan that leans on those analytical capabilities and lessons learned. In particular, DMAS plans to leverage the data protocols developed for the ARTS waiver and adapt the relevant metrics for diagnostic and service codes that are applicable to members served in IMDs with SMI diagnoses, which is in line with the SMI/SED Evaluation guidance released by CMS. DMAS also plans to explore the feasibility of a qualitative survey with mental health wellness scales for a statistically significant sample of members served under the waiver.

Note that where evaluation questions and metrics reference sub-populations, this is intended to include race/ethnicity data, age group, and geographic distribution. Within geography, the Commonwealth is particularly interested in understanding any differences between rural and urban populations. The Commonwealth is also interested in looking at data by SMI diagnosis to understand if the efforts associated with this demonstration have disparate impacts by condition. The prevalence of co-morbidities and SUD diagnoses may also be considered. The Commonwealth will work with its independent evaluation to assess the feasibility and anticipated strength of actionable insights associated with these demographics and subpopulations.

Hypotheses, measures, and data sources are described below, and will be further described in the evaluation plan which is currently under development along with the accompanying detailed logic model. Regarding methodologies, we will make our best effort to identify comparison groups, for example, a comparison state, as well as time series designs and difference-in-differences regression models. All of these approaches have been successfully implemented in our ARTS (SUD 1115 waiver) evaluation. Descriptive statistics and analysis of patterns among subpopulations will also be used, particularly for survey and qualitative data associated with exploratory hypotheses.

Research Hypotheses

Table 7. Research Questions and Evaluation

Hypothesis	Evaluation Questions	Evaluation Parameters
Goal 1. Reduced utilization and lengths of stay in emergency departments among Medicaid members with SMI or SED while awaiting mental health treatment in specialized settings.		
The demonstration will result in reductions in utilization and length of stays in EDs among Medicaid members with SMI, with a more pronounced impact on avoidable ED visits. The impact may be more pronounced for certain demographic characteristics and/or diagnoses.	• How much of an effect does the demonstration have on ED utilization among members who access residential treatment in IMDs under this waiver? • To what extent is there an impact on avoidable ED admissions among members who access residential treatment in IMDs under this waiver? • Does the demonstration have a secondary impact on reducing involuntary temporary	• Follow-up after Emergency Department Visit for Mental Illness (Adjusted HEDIS measure) • Mental Health Services Utilization – Emergency Department (SMI diagnosis) • Avoidable ED visits (SMI diagnosis) • Involuntary psychiatric detention (SMI diagnosis)

	psychiatric detention?	
Goal 2. Reduced preventable readmissions to acute care hospitals and residential settings.		
There will be a measurable reduction in preventable readmissions due to the services and length of stay permissible under this waiver.	• Does the demonstration result in reduced preventable readmissions for members who receiving services in an IMD under this waiver? • To what extent is there a correlation between members with a SMI diagnosis receiving the clinically assessed Level of Care (LOC) and preventable readmissions?	• 30-day all cause readmission rate following psychiatric hospitalization • Members assessed for SMI services using standardized level of care screening tool • Members receiving level of care services consistent with LOC assessment
Goal 3. Improved availability of crisis stabilization services, including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals, and residential treatment settings throughout the Commonwealth.		
Expanding the continuum of care and continuing to emphasize crisis stabilization will make these services more accessible to members when they need them.	• What populations are more likely to have increased usage of crisis stabilization services? • To what extent do different types of non-residential crisis stabilization services see increased utilization following the implementation of the waiver? • To what extent are members with a SMI diagnosis more likely to be connected to CSBs for service coordination?	• Utilization on non-residential crisis stabilization services (by type and sub-population) • Members connected to CSBs as part of discharge planning from IMDs, including residential crisis stabilization units (by sub-population and diagnosis)
Goal 4. Improved access to community-based services to address the chronic mental healthcare needs of members with SMI or SED, including through increased integration of primary and behavioral health care.		
The demonstration will improve access to community-based services through improved integration of care.	• Does the demonstration result in improved access to community-based services for members with a SMI diagnosis? • Are there disparate impacts on specific service utilization or specific member populations? • To what extent are members	• Utilization of mental health services (outpatient) for services including Outpatient Therapy and Psychiatric Services, Peer Recovery Supports, Intensive Clinic Based Supports, and Intensive Community Based Supports • Rate of MCOs conducting ICT meetings for members with

	with a SMI diagnosis receiving integrated care? • Does improved access to community-based services result in a reduction in the time between first episode psychosis and connection to care for youth and young adults?	SMI diagnosis • Time between first episode psychosis and connection to care (focus on youth and young adults ages 16-30) via EPINET
Goal 5. Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.		
The demonstration will result in an increase in members who receive care for SMI at an IMD establishing care in the community following their stay.	• To what extent are members exiting IMDs after acute stays for SMI diagnoses more likely to receive care coordination supports? • To what extent are members connected to CSBs following stays at an IMD?	• Follow-up after hospitalization for mental illness. (7 and 30 days) • Members connected to CSBs as part of discharge planning from IMDs, including residential crisis stabilization units (by sub-population and diagnosis)

Data Sources

The following data sources will be considered in designing the evaluation plan the waiver:

1. Medicaid claims and encounter data (administrative data)
2. Medicaid enrollment and provider availability data (administrative data)
3. Medicare claims data for people dually eligible for Medicaid and Medicare
4. State hospital data and involuntary commitment data from Department of Behavioral Health and Developmental Services (DBHDS)
5. Beneficiary and provider surveys and/or qualitative data

In addition to the independent evaluation, DMAS will provide quarterly and annual reporting specific to this amendment and in accordance with a CMS-approved Monitoring Protocol to be submitted following approval.

Section V. Eligibility, Benefits, Cost Sharing, and Delivery System

Demonstration Eligibility

All Virginia Medicaid enrollees eligible for a mandatory or optional eligibility group approved for full Medicaid coverage and between the ages of 21-64 will be eligible for acute inpatient stays in an IMD under the waiver, as described in the table below. Only the eligibility groups outlined in next will not be eligible for stays in an IMD under this waiver, as they receive limited Medicaid benefits only.

Table 8. Eligible (All Full Benefit Medicaid Enrollees)

Category	Members Ages 21-64 Eligible for Demonstration Services in IMD
Low Income Adults and Children	Yes
Expansion Adults	Yes
Aged, Blind, and Disabled	Yes
Pregnant Women	Yes
FAMIS MOMS and FAMIS Prenatal	Yes
Former Foster Youth (1115)	Yes

Table 9. Not Eligible (Limited Benefit Groups)

Aid	Category	CFR	Social Security Act
023		42 CFR 435.123	1902(a)(10)(E)(i) and 1905(p)(1)
043	Blind QMB	42 CFR 435.123	1902(a)(10)(E)(i) and 1905(p)(1)
053	SLMB	42 CFR 435.124	1902(a)(10)(E)(iii) and 1905(p)(3)(A)(ii)
055	QDWI	42 CFR 435.126	1902(a)(10)(E)(ii) and 1905(s)
056	QI	42 CFR 435.125	1902(a)(10)(E)(iv) and 1905(p)(3)(A)(ii)
063	Disabled/ESRD QMB	42 CFR 435.123	1902(a)(10)(E)(i) and 1905(p)(1)
080	Plan First	42 CFR 435.214	1902(a)(10)(A)(ii)(XXI) and 1902(ii) and clause (XVI) in the matter following section 1902(a)(10)(G)
108	MAGI Adult Incarcerated	42 CFR 435.1009 - limits on FFP for incarcerated individuals 42 CFR 435.1010 - defines inmate of a public institution	
109	Other Medicaid Incarcerated	42 CFR 435.1009 - limits on FFP for incarcerated individuals 42 CFR 435.1010 - defines inmate of a public institution	
112	MAGI Adult Emergency Services	42 CFR 435.139	
113	Other Medicaid Emergency Services	42 CFR 435.139	
Note: ***(QMB) Qualified Medicaid Beneficiary; (SLMB) Special Low Income Medicaid Beneficiary; (QI) Qualified Individual; (QDWI) Qualified Disabled & Working Individuals***			

Enrollment

This 1115 waiver is not anticipated to impact Virginia Medicaid enrollment over the course of the five-year waiver demonstration.

Benefits

As described above, Virginia offers a wide range of Medicaid covered behavioral health benefits. Through this waiver application, the Commonwealth will expand the settings which are eligible for reimbursement for clinically appropriate short term stays for acute psychiatric care via psychiatric inpatient treatment and residential crisis stabilization, to include IMDs. Beneficiaries served in IMDs under this waiver will have access to the same full set of Medicaid benefits that they would if served in settings other than an IMD, and will be subject to the same medical necessity requirements. In accordance with CMS requirements, the Commonwealth will not reimburse for stays of more than 60 consecutive days and will maintain an average length of stay of 30 days or less across all applicable settings for eligible members.

Cost Sharing

All cost-sharing for services provided through this waiver will be consistent with the Medicaid State Plan applicable to an enrollee's specific eligibility category. No modifications are proposed through this waiver.

Delivery System

The Commonwealth seeks a waiver of IMD exclusion for all Medicaid members ages 21-64 regardless of delivery system. Virginia does anticipate that current coverage of acute inpatient stays in IMDs, which is currently provided under the In Lieu of Services provision of managed care will instead be covered via traditional capitation and FFS methods. This change will impact the contractual and financial relationship between the Commonwealth and the managed care plans, but not the delivery system for the care itself. Additionally, temporary detention and involuntary commitments are currently carved out of managed care capitation rates, and would be carved in under this waiver, which is anticipated to have a minimal impact on overall capitation rates. No additional modifications to current Virginia Medicaid FFS or managed care arrangements are proposed through this waiver application.

Enrolled free standing psychiatric hospitals which currently provide TDO only services or services under ILOS provision include the following facilities. State hospitals that provide these services are not being considered for the initial demonstration application.

Virginia Facilities:

Dominion Hospital

Keystone Newport News

North Spring Behavioral Healthcare

Poplar Springs Hospital

Potomac Ridge Behavioral Health System

Riverside Behavioral Health Center

The Pines at Kempsville

Virginia Beach Psychiatric Center

Out of State:

Creekside Behavioral Health, Kingsport, TN

All are already part of the delivery system and contracted with health plans (for ILOS) and Medicaid (for state funded TDO) to provide these services, but their agreements are expected to change with the implementation of the proposed waiver program.

Regarding crisis stabilization units with more than 16 beds, there are multiple projects planned in larger population centers in Virginia. Specifically, projects aim to co-locate youth and adult crisis stabilization services under multiple wings within a single facility (16 adult residential crisis beds and 16 youth residential crisis beds). One example is a facility being designed in Prince William County which would provide adult services to include urgent care for behavioral health crises, sixteen 23-hour crisis stabilization recliners and sixteen crisis stabilization beds as well as youth services to include urgent care for behavioral health crises, sixteen 23-hour crisis stabilization recliners, and sixteen crisis stabilization beds. Similarly, ARTS facilities with 16+ beds of detox and inpatient SUD treatment capacity may consider adding residential crisis beds to serve MH and co-occurring populations.

Payment Rates for Services

Payment methodologies will be consistent with those approved in the Medicaid state plan. To the extent that new facility rates are required for Residential Crisis Stabilization Units (RCSUs), including room and board, the Commonwealth will follow all applicable laws and regulations for rate development and approval prior to claiming.

Table 10. Service Payment Rates

Service	Current Rate (subject to change for future dates)
Psychiatric Inpatient Treatment	1 unit = 1 day Rates are based on individual considerations and updated annually. Rates are facility specific with an average reimbursement rate of $1159 per day. Rates are updated annually. Current rates are posted to the DMAS website: See "Free Standing Psychiatric Rates" here: Hospital Rates (virginia.gov)
Residential Crisis Stabilization	1 unit = 1 day Current rate of $847.04

Waiver Implementation

The waiver will be implemented statewide, with a requested date of no later than July 2026, but following the approval of the waiver, subsequent implementation plan, and receiving authority for implementation from the Virginia General Assembly, which previously provided authority for this waiver application's

submission in Item 28.XX.2 of the *2024 Appropriation Act*. The Commonwealth also proposes to cover services delivered by IMD facilities in contiguous states within 50 miles of Virginia, provided that the facilities comply with the terms of the waiver. The Commonwealth requests a five-year waiver approval for this demonstration amendment.

Section VI. Demonstration Financing and Budget Neutrality

Maintenance of Effort

In accordance with the November 13, 2018, CMS State Medicaid Director Letter, the Commonwealth understands this waiver request is subject to maintenance of effort (MOE) requirement to ensure the authority for more flexible inpatient treatment does not reduce the availability of outpatient treatment for these conditions. The following table details the SFY 2023 outpatient community-based behavioral health expenditures.

Table 11. Expenditures on Outpatient Community-Based Behavioral Health Services

Medicaid Program	Total	Federal	State – General Revenue	State – Other Funds
Outpatient Community-based Mental Health	$915,517,935.95	$640,765,990.59	$274,751,945.36	

Virginia is dedicated to maintaining access to community-based services and intends for services authorized within this waiver to complement, not replace, these outpatient services. However, the Commonwealth offers the following caveats as considerations for measuring maintenance of effort based strictly on total expenditures.

- Changes in enrollment patterns relative to underlying economic conditions may impact the total number of enrolled Medicaid members needing these supports.
- If the state transitions to more value-based reimbursement, costs may decline slightly without any loss of access or quality.
- County and local funding does not necessarily fall under the purview of the state

Budget Neutrality

Historical data and member month and expenditure projections are presented here and indicate that this amendment is projected to demonstrate federal budget neutrality. The services relevant for the historical and projected spending include (1) free standing psychiatric hospital costs for inpatient stays, (2) acute care hospital costs for inpatient psychiatric stays, and (3) emergency department costs for psychiatric care. Services provided in waiver covered settings are not limited to a specific population, but to estimate the number of members utilizing these services, expenditures for adults 21-64 for inpatient psychiatric stay in either a freestanding psychiatric hospital or acute care hospital and emergency department visit for behavioral health diagnoses were considered as historical and projected waiver expenditures.

Five years of historical spending for adults ages 21-64 across inpatient stays in freestanding psychiatric hospitals, psychiatric inpatient stays in acute care hospitals, and psychiatric ED visits is provided here:

	2019	2020	2021	2022	2023	Five Years
Total Medicaid Expenditure ($)	190,830,262	208,285,204	227,686,239	234,873,783	305,268,016	1,166,943,504
Eligible Member Months	601,920	629,088	661,668	694,308	819,780	
PMPM	$317.04	$331.09	$344.11	$338.28	$372.38	
Trend Rates		**Annual Change**				**5 Year Average**
Total Expenditure		9.15%	9.31%	3.16%	29.97%	12.46%
Eligible Member Months		4.51%	5.18%	4.93%	18.07%	8.03%
PMPM		4.43%	3.93%	-1.69%	10.08%	4.10%

Using historical growth patterns above, the below tables outline without waiver (WOW) projections and with waiver (WW) projections. Without the waiver, a state-general funded "temporary detention order" fund (TDO fund) would continue to pay for involuntary IMD stays for adults 21-64 when the member is not eligible for the Medicaid benefit and when the member is served in a state facility which is excluded from this demonstration. Differences in spending projections under without waiver (WOW) and with waiver (WW) conditions include the following. First, it is expected that a portion of inpatient stays funded from the TDO fund (state general fund only) will shift to include federal financial participation (FFP). There is increased federal cost due to a shift from TDO fund to Medicaid (including some members in Base Medicaid and others in Expansion Population), as well as cost savings associated with hypothesized decreases in emergency room (ED) visits, inpatient readmissions and psychiatric care provided in EDs. Specifically we project a .5% decreased growth rate in PMPM across these three services under waiver conditions. These decreases in spending would offset the increased FFP associated with TDO fund cost shifts, achieving a budget neutral comparison (with slight savings)across the WOW and WW conditions.

Without Waiver Projections (Demonstration Years 1-5)

	Base Year DY 00	Trend Rate	DY1	DY2	DY3	DY4	DY5	Total
Eligible Member Months	885,608	8.0%	956,723	1,033,548	1,116,541	1,206,200	1,303,057	
PMPM Cost	$387.65	4.1%	$403.54	$420.09	$437.31	$455.24	$473.90	
Total Expenditure ($)			386,075,870	434,182,973	488,274,709	549,110,328	617,518,939	$2,475,162,819

With Waiver Projections (Demonstration Years 1-5):

	Base Year DY 00	Trend Rate	DY1	DY2	DY3	DY4	DY5	Total

Eligible Member Months	885,608	8.0%	956,723	1,033,548	1,116,541	1,206,200	1,303,057	
PMPM Cost	$387.65	3.6%	$401.61	$416.07	$431.05	$446.57	$462.65	
Total Expenditure ($)			384,229,395	430,028,112	481,285,160	538,652,577	602,859,543	$2,437,054,787

Section VII. Waiver and Expenditure Authorities

The Commonwealth requests expenditure authority under Section 1115 for otherwise covered services furnished to otherwise eligible individuals for short term stays for acute care in a psychiatric hospital that qualifies as an IMD.

Waiver/ Expenditure Authority	Use for Waiver/Expenditure Authority	Currently Approved Waiver Request?
Limitations on FFP § 435.1009 Institutionalized individuals.	Expenditures not otherwise eligible for federal financial participation may be claimed for services for individuals who are short-term residents in facilities that would otherwise meet the definition of an Institute of Mental Disease (IMD) for the treatment of SMI.	No (currently approved for SUD; this amendment requests approval for SMI)

Section VIII. Public Notice

Public facing information regarding the waiver is located here: 1115 Demonstration Waiver | Virginia Medicaid

The 30-day public comment period for the demonstration is from November 8, 2024 to December 11, 2024. All comments must be received by 11:59 p.m. (Eastern Time) on December 11, 2024.

Copies of the demonstration application are available for public review and comment on the Demonstration page of the DMAS website at: www.dmas.virginia.gov (Go to the "About Us" tab and click on "1115 Demonstration Waiver.")

Public comments may be submitted via the Virginia Regulatory Town Hall public comment page at this link: https://townhall.virginia.gov/L/Forums.cfm (Scroll down to the Department of Medical Assistance Services and click on "View and Enter Comments.")

Comments may also be submitted by e-mail to lisa.jobe-shields@dmas.virginia.gov or by regular mail or in person at the address below:

Virginia Department of Medical Assistance Services

Building and Transforming Coverage, Services, and Supports for a Healthier Virginia Demonstration Amendment

Attn: Lisa Jobe-Shields

600 East Broad Street Richmond, VA 23219

Two public hearings will be held to seek public input on the demonstration application. These meetings satisfy the requirements of 42 CFR 431.408 (a)((3)(iv).

The details of the hearings are as follows:

Public Hearing #1: 1115 Serious Mental Illness Waiver Amendment- Public Meeting

Monday, November 18, 2024

12:00 pm – 1:00 pm

Fairfield Area Library

1401 N Laburnum Ave, Henrico, VA 23223

FA Meeting Room

Virtual Attendance: https://teams.microsoft.com/l/meetup-join/19%3ameeting_YjZiNjE0MjMtNGM5Ny00MWQ3LThhMzEtMWI4NzIyZmQwNjAz%40thread.v2/0?context=%7b%22Tid%22%3a%22620ae5a9-4ec1-4fa0-8641-5d9f386c7309%22%2c%22Oid%22%3a%22061182d3-e09a-4db3-bbc4-ab2f201489e9%22%7d

Meeting ID: 219 946 597 390

Passcode: 7BGtSB

Join by phone:

+1 434-230-0065, 577708503#

Phone conference ID: 577 708 503#

Lisa Jobe-Shields, Behavioral Health Division Director, will provide an overview of the Demonstration amendment application to individuals who are invited to attend in-person, by teleconference, and by webinar. This meeting will be recorded.

Public Hearing #2: Board of Medical Assistance Services Meeting Tuesday, December 10, 2024

10:00 am – 12:00 pm

In person attendance: Conference Rooms 102 A&B, 600 East Broad Street, Richmond, Virginia 23219

Virtual attendance: https://covaconf.webex.com/weblink/register/rba760d03940653afe731b1cffd21c2 e1

Join by phone

+1-517-466-2023 US Toll
+1-866-692-4530 US Toll Free

Access code: 2422 342 9589

Lisa Jobe-Shields, Behavioral Health Division Director, will provide an overview of the Demonstration amendment application during the Board of Medical Assistance Services public meeting. Individuals can also access this public meeting by teleconference and webinar. This meeting will be recorded and transcribed.

After considering public comments about the proposed demonstration amendment application, DMAS will make final decisions about the demonstration and submit a revised application to CMS. The summary of comments, as well as copies of written comments received, will be posted for public viewing on the DMAS website along with the demonstration extension application when it is submitted to CMS.

Documentation and Issues Raised

Will be completed at the end of the public comment period prior to submission to CMS.

State Consideration

Will be completed at the end of the public comment period.

Section IX. Appendices

Authorizing language for 1115 application

Budget neutrality backup tables