DECEMBER 2018

Virginia Medicaid Continuum of

BEHAVIORAL HEALTH SERVICES

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VIRGINIA'S MEDICAID PROGRAM
DMAS
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Virginia Department of
Behavioral Health &
Developmental Services

Acknowledgments

Suggested citation

Virginia Department of Medical Assistance Services, Virginia Department of Behavioral Health and Developmental Services, & the Farley Health Policy Center. *Virginia Medicaid Continuum of Behavioral Health Services.* December 2018.

Virginia Department of Medical Assistance Services

Virginia Department of Behavioral Health and Developmental Services

Farley Health Policy Center

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About us

DMAS plays a critical role in providing high quality, cost-effective health care coverage to low-income children, older adults, individuals with disabilities, and pregnant women in the Commonwealth, serving over 1.5 million individuals in 2017. Medicaid's role will grow with expansion of coverage to up to 400,000 low-income individuals starting in January, 2019. In Virginia and nationally, Medicaid is the largest payor for behavioral health services.

In collaboration with its federal, state, and local partners, the DBHDS provides technical assistance and develops, licenses, directs, funds, and monitors the delivery of comprehensive behavioral health services throughout the Commonwealth of Virginia. To ensure the delivery of coordinated services to the Medicaid, uninsured and under-insured populations, DBHDS is involved in the development and implementation of evaluation processes, data reporting standards, and measures used to analyze the delivery of behavioral health services. DBHDS also operates nine acute care state psychiatric facilities, including one for children. Locally governed Community Services Boards (CSBs) hold performance contracts with DBHDS for statefunded services; these are the primary point of entry into the state behavioral health system. In 2017, over 219,000 individuals received these state behavioral health services, the majority through CSBs and approximately 7,000 through state facilities.

The Farley Health Policy Center strives to advance policy that overcomes fragmented systems and addresses the wholeness of a person — physical, behavioral, and social health in the context of family, community, and the healthcare system. The FHPC works with state agencies and policymakers to understand and inform achievable policy actions to improve the integration of behavioral health across health and healthcare systems.

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Executive Summary

This purpose of this report is to outline recommendations to achieve the vision of improved behavioral health care for Virginia's Medicaid population. The recommendations included in this report reflect a comprehensive review of evidence-based practices (EBPs), an examination of current services and gaps in Medicaid-covered behavioral health services, and input from diverse stakeholders invested in better behavioral health care for all Virginians. The continuum of services refers to a spectrum of behavioral health care from promotion/ prevention to treatment to recovery, modeled on nationally accepted frameworks.

> Currently, Virginia's Medicaid-covered behavioral health services reflect a crisis-oriented approach to population needs, with an overreliance on intensive treatment services and underdeveloped opportunities for prevention and treatment in non-traditional mental health settings such as schools and primary care.

This reactionary approach is exemplified by the current inpatient psychiatric bed crisis. As the Statewide Temporary Detention Order (TDO) Task Force, charged with examining the dramatic rise in admissions to state psychiatric hospitals under TDOs, concluded, "The best long-term solution to psychiatric crises is strengthening the community-based system of mental health care."[1]

Lack of alignment, workforce shortages, and inadequate implementation and funding for evidence-based practices further compound the limited access to lower acuity, more cost effective levels of care. Nomenclature and definitions of services differ across agencies, which creates confusion. A shortage of licensed mental health professionals (LMHPs) and high utilization of unlicensed qualified mental health professionals (QMHPs) exacerbate geographic disparities in workforce and access to care. Workforce shortages are an issue regardless of payer source but magnified for the Medicaid population, because many licensed mental health professionals accept few or no Medicaid members due to low Medicaid reimbursement rates.[2] Despite the increasing attention to EBPs, sustainable funding does not exist to implement the supervision structure and supports necessary to achieve fidelity to these practices. As a result, care is expensive, fragmented, of variable quality, and difficult to access where and when it is needed.

The ongoing movement to better address behavioral health needs in Virginia is exemplified by foundational initiatives such as the System Transformation Excellence and Performance (STEP-VA), the Medicaid Addiction Recovery and Treatment Services program (ARTS), and the Governor's Children's Cabinet's focus on trauma-informed care. These initiatives have begun a shift towards better alignment of services, statewide consistency, and more comprehensive care. However, further system redesign is needed to fully address the current gaps and increasing needs anticipated after Medicaid expansion.

The behavioral health system redesign described in this report is based on key principles including trauma-informed care, universal promotion and prevention, and seamless care transitions across the continuum. Telemental health is incorporated as a key modality to increase access across all levels of care. Behavioral therapy and case management are embedded across all contexts as essential supports. Finally, the continuum is oriented around a recovery-oriented system framework with peer supports, permanent supportive housing, and supported employment embedded as critical services to obtain and maintain recovery.

The recommended continuum establishes or expands coverage for "upstream" service areas focused on promotion and prevention rather than crisis, as well as outpatient and integrated treatment, including school-based services and integrated behavioral health services in primary care. In parallel, recommendations are made for appropriate EBPs in intensive community-based and new intensive clinic/facility-based supports and narrowed target populations for higher intensity services including residential and inpatient.

To cover these service expansions, a variety of financial mechanisms are indicated. In several instances, upstream behavioral health services are not covered under current billing codes, and there are codes available to open up to support this work. To shift towards value-based payment, it is important to consider mechanisms beyond traditional fee-for-service codes as well. Global payment models such as risk-adjusted capitation incentivize and enable proactive population management. For cross-sector services such as school-based behavioral health there are multiple funding streams with shared purposes from different agencies and departments. Blending and braiding funds, with established shared authorities to determine their best use, allows for streamlined services that are tailored to an individual rather than fragmented service lines limited by funding source.

> The overall vision of behavioral health redesign is to rebalance Virginia's Medicaid mental health system away from high cost inpatient hospital and residential settings toward lower cost outpatient and prevention and promotion services and evidence-based community services while maintaining budget neutrality and not increasing the overall spending of the Medicaid program.

Redirection of funding toward a more robust array of outpatient services, integrated behavioral health services in primary care and schools, and intensive community-based and clinic-based supports should yield improved outcomes and reduce downstream costs of emergency department visits and hospitalizations to the Medicaid program. A new federal Medicaid 1115 waiver opportunity would allow the Commonwealth to draw down new federal Medicaid matching funds for adult residential and inpatient treatment but is contingent on moving forward first with behavioral health redesign and implementation of this continuum. A comprehensive financial analysis is needed to evaluate the cost of the new mental health services and rate increases for licensed mental health clinicians proposed for this continuum as well as the potential downstream cost savings from preventing utilization of higher cost, more intensive services and the potential infusion of new federal funds from the 1115 waiver.

Addressing workforce shortages will require multi-pronged efforts. Effective utilization of current workforce requires appropriate triage of patient care to reserve the limited behavioral health workforce to care for the most complex and highest acuity patients. For services and provider types where Medicaid reimbursement rates are significantly lower than other insurers, enhancing reimbursement rates can incentivize providers to accept additional Medicaid patients. Additional state-level strategies to grow the mental health workforce include scholarship and loan repayment programs for mental health providers committing to working in an underserved area of the Commonwealth and new certification and training programs for qualified mental health professionals.

A service redesign of this scale will require a multi-year, phased and strategic implementation with approval from the Administration and General Assembly. The additions and expansions of services will take time to be implemented, and any narrowing of scope of over-utilized services should be decreased in tandem with the development of new services to avoid creating a larger gap in service availability to meet patient needs. Department of Medical Assistance Services (DMAS) and Department of Behavioral Health and Developmental Services (DBHDS) should work with stakeholders to create an implementation plan that recognizes the support necessary to develop infrastructure for behavioral health services in new settings and train the workforce to deliver these new services with a realistic timeline for development of the new services, workforce training, and implementation.

The Need and Vision for Behavioral Health Redesign

Improving care for individuals with mental health conditions is a top priority in Virginia.

Mental health conditions are extremely common and frequently undertreated, both across the U.S. and within Virginia. Nationally, 46% of adults will experience a mental health or substance use disorder in their lifetime, and 28% of adolescents will experience a mental health or substance use disorder with distress or severe impairment.[3-4] In Virginia, 28% of Medicaid members had a behavioral health diagnosis in 2017.

IN VIRGINIA

28%

of Medicaid members had a behavioral health diagnosis in 2017

Medicaid expansion also creates an urgent need to ensure that newly covered individuals can access high-quality, evidence-based behavioral health services. Based on other similar states' experiences, many of the newly covered individuals will have significant chronic physical and behavioral health conditions that have previously been un-treated or under-treated due to their lack of coverage. For example, in Ohio's expansion population they have found that 32.7.% of people have screened positive for depression or anxiety.[5]

While the prevalence of mental health disorders is similar in Virginia compared to other states, access to behavioral health care is more limited.

> Virginia ranks 40th in terms of access to behavioral health care in the nation.[6] Virginia also ranks 41st in terms of availability of mental health providers, as measured by a ratio of population to providers.

Mental Health Professional Shortage Areas (MHPSAs) are designated based on availability of psychiatrists as well as "core" mental health professionals (clinical psychologists, clinical social workers, psychiatric nurse specialists, and marriage and family therapists). Of the 133 counties in Virginia, 87 (65%) were designated by the Health Resources and Services Administration as Mental Health Professional Shortage Areas in 2018. Significant regional variation exists, with the greatest workforce shortages in the Southwest and Southside regions.

Access to behavioral health services is particularly limited within lower acuity settings and services. A disproportionate amount of mental health expenditures are spent on inpatient and high acuity care with approximately 50% of general funds supporting only 3% of the population served.[7] Feedback from stakeholders suggests these service types may be overused when a lower acuity service could suffice; however, there is limited availability of lower acuity services. Reasons for this may include lower acuity services not being reimbursed or being reimbursed at rates insufficient for financial viability for providers.

The overutilization of psychiatric inpatient beds for lack of a more appropriate level of care has contributed to the psychiatric bed crisis in the Commonwealth. The Statewide Temporary Detention Order (TDO) Task Force, charged with examining the dramatic rise in admissions to state psychiatric hospitals under TDOs, notes one of the factors contributing to the decreasing number of available private psychiatric hospital beds is the extended length of stay by patients for whom the hospital is unable to find a community placement due to significant care needs and instability. This is paralleled in state facilities, where the extraordinary barriers to discharge list (EBL) has remained steady at around 200 individuals.[8] Lower acuity services are necessary to transition individuals out of the inpatient setting and to prevent the need for inpatient admission where possible.

The majority of the uninsured individuals in state psychiatric facilities will be eligible for Medicaid after expansion. Redesign of Medicaid behavioral health services is an opportunity to build a delivery system with expanded community-based treatment settings that provide alternatives to TDOs and hospitalizations in psychiatric facilities.

> Medicaid behavioral health redesign is critical to decreasing the census at state psychiatric hospitals and improving the outcomes for this very high risk and vulnerable population.

In November, 2018, the Centers for Medicare and Medicaid Services (CMS) announced a new opportunity for states to apply for Medicaid 1115 demonstration waivers to support redesign of their mental health delivery systems.[9] This waiver would draw down new federal Medicaid matching funds for adult mental health residential treatment and inpatient treatment delivered by residential facilities and psychiatric hospitals with greater than 16 beds. This infusion of new federal Medicaid funds would allow DMAS to create a new adult mental health residential treatment benefit as part of the redesigned continuum that could prevent TDOs and help transition patients out of state and private psychiatric hospitals.
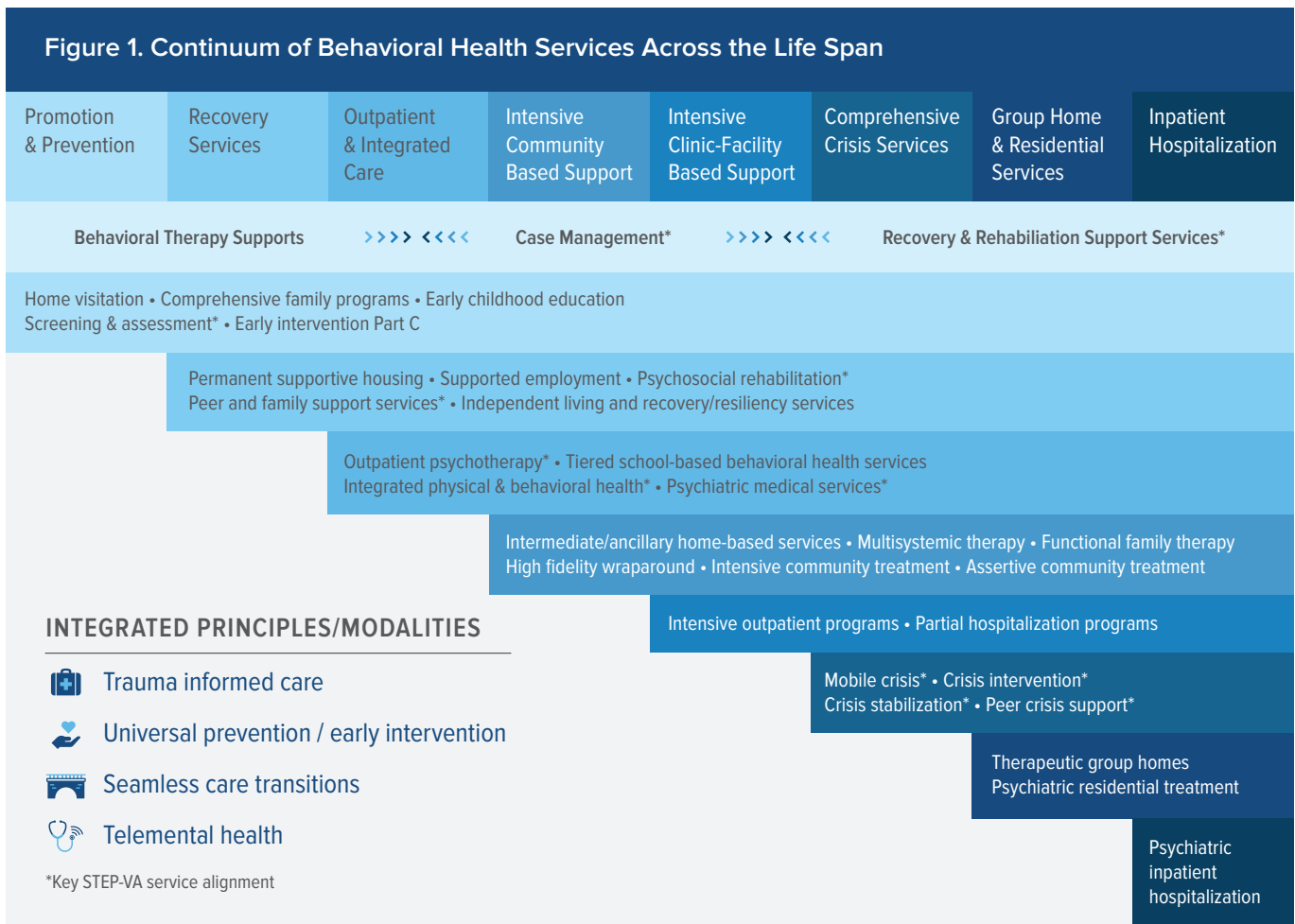
To successfully obtain this waiver, states must redesign their community-based mental health services and ensure that a continuum of evidence-based services is available including integration of behavioral health into schools and primary care practices to improve early identification and treatment of mental health conditions. States must also ensure that individuals with Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED) are provided appropriate levels of care to meet their needs including use of evidence-based assessment tools (such as the Level of Care Utilization System or *LOCUS* tool) that match individuals with standardized levels of care based on assessments of clinical need.

DMAS already obtained a similar Medicaid waiver to obtain federal matching funds for adult substance use disorder residential and inpatient treatment after redesigning the substance use delivery system through the ARTS benefit and implementing the American Society of Addiction Medicine criteria to create standardized assessments and levels of care. This new waiver opportunity is also contingent upon the Commonwealth moving forward rapidly with behavioral health redesign. This waiver would have a significant impact because many of the uninsured with serious mental illness will be covered under Medicaid expansion and a large percentage of the Medicaid expansion population will have mental illness based on the experiences of other states.

DMAS and DBHDS are committed to redesigning behavioral health services in Virginia to create a more robust, integrated behavioral health system. A survey of Virginia stakeholders conducted as part of the service redesign process indicates overwhelming agreement that additional and/or redesigned Medicaid-covered services are needed to meet the state's behavioral health needs.

> The vision for redesigned behavioral health care is that any person seeking care will have a direct pathway to obtain services reflecting their needs, regardless of their zip code and the setting where they present for care.

Further, redesigned behavioral health care in Virginia will be prevention- and recovery-focused, person-centered, trauma-informed, and evidence-based. Person-centered care includes availability of services at an appropriate level and setting of care to meet patient needs as well as measurement of outcomes that matter to patients. This vision will result in building capacity and investment in lower acuity services in natural environments like schools and primary care offices and prevent unnecessary emergency department visits and hospitalization. Previous research in Virginia has demonstrated a correlation between availability of outpatient behavioral health services and lower rates of inpatient hospitalization.[10] See Figure 1 for a visual representation of an ideal continuum of behavioral health services for youth and adults.

Figure 1. Continuum of Behavioral Health Services Across the Life Span

Promotion & Prevention	Recovery Services	Outpatient & Integrated Care	Intensive Community Based Support	Intensive Clinic-Facility Based Support	Comprehensive Crisis Services	Group Home & Residential Services	Inpatient Hospitalization

Behavioral Therapy Supports ›››› ‹‹‹‹ Case Management* ›››› ‹‹‹‹ Recovery & Rehabiliation Support Services*

Home visitation • Comprehensive family programs • Early childhood education
Screening & assessment* • Early intervention Part C

Permanent supportive housing • Supported employment • Psychosocial rehabilitation*
Peer and family support services* • Independent living and recovery/resiliency services

Outpatient psychotherapy* • Tiered school-based behavioral health services
Integrated physical & behavioral health* • Psychiatric medical services*

Intermediate/ancillary home-based services • Multisystemic therapy • Functional family therapy
High fidelity wraparound • Intensive community treatment • Assertive community treatment

Intensive outpatient programs • Partial hospitalization programs

Mobile crisis* • Crisis intervention*
Crisis stabilization* • Peer crisis support*

Therapeutic group homes
Psychiatric residential treatment

Psychiatric inpatient hospitalization

INTEGRATED PRINCIPLES/MODALITIES

- Trauma informed care
- Universal prevention / early intervention
- Seamless care transitions
- Telemental health

*Key STEP-VA service alignment

Framework

The framework used for the visual representation of the continuum of behavioral health services in this report is rooted in the model developed by the Institute of Medicine and adopted by the Substance Abuse and Mental Health Services Administration as the Behavioral Health Continuum of Care Model and incorporates recommendations from the National Alliance for Mental Illness. Specific categorization and labeling have been adapted to match terminology used in Virginia. The graded continuum of services provides a framework that distinguishes between promotion and prevention, treatment, and recovery/maintenance of mental health disorders, and shows how all components are interrelated. The continuum allows for a complete range of services and activities to meet all mental health needs and supports collaboration and integration of behavioral health services into the healthcare system across settings and with other sectors that affect health.[11]

The Process for Developing a Continuum

The recommendations in this report were developed through a multi-step process in partnership between DMAS, DBHDS, and the Eugene S. Farley, Jr. Health Policy Center at the University of Colorado Anschutz Medical Campus. The multi-step process to develop this continuum began with an evidence review to examine best practices for behavioral health services from the peer-reviewed literature, agency and organization reports, case studies, and models from other states as well as a service gap analysis to describe the current needs and capacity of Virginia's Medicaid program. The recommendations in this report represent the synthesis of best practices for services, cross-walked with current practices and identified service needs in Virginia.

Throughout this process, the Farley Health Policy Center, DBHDS, and DMAS worked together to ensure that the developed continuum accurately reflects the need for redesigned services. Diverse stakeholder input was collected longitudinally through face-to-face meetings, outreach and surveillance to inform these recommendations.

> The Behavioral Health Redesign Workgroup brought stakeholders together with agency leadership from DBHDS, DMAS, Virginia Department of Social Services (VDSS), Office of Children's Services (OCS), Virginia Department of Education (DOE), Virginia Department of Juvenile Justice (DJJ), and Virginia Department of Health (VDH).

This Workgroup created a forum for regular communication and meaningful input. The Workgroup members provided invaluable feedback by identifying gaps and bright spots in behavioral health services for Medicaid members. A broader set of stakeholders, including but not limited to those participating in the Workgroup, had the opportunity to inform the continuum through a Stakeholder Survey. There were 203 survey respondents, representing over 60 different organizations or organization divisions. The input from the Workgroup and survey was instrumental in developing the overall categories and specific services recommended in the redesigned continuum.

A Foundation for Success

The development of this continuum builds on ongoing and concurrent efforts to improve the behavioral health care of Virginians (see Figure 2). Foundational initiatives like STEP-VA and the ARTS are laying the groundwork for broader behavioral health redesign. This continuum aligns with and complements concurrent work for the Families First Prevention Services Act (FFPSA). Other simultaneous efforts to improve behavioral health care in Virginia include the Governor's Cabinet's focus on trauma-informed care and the Department of Juvenile Justice transformation toward the use of evidence-based practices to maintain youth in the community rather than in correctional facilities. Medicaid expansion will also make behavioral health services available to a much broader population of low-income adults.

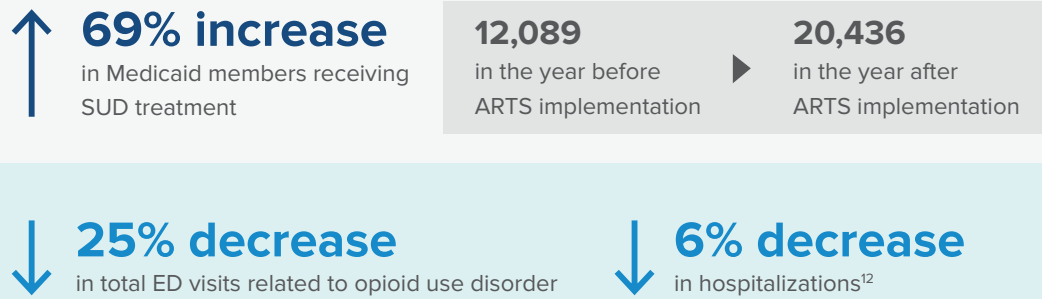**Figure 2. Interagency Alignment of Behavioral Health Initiatives**
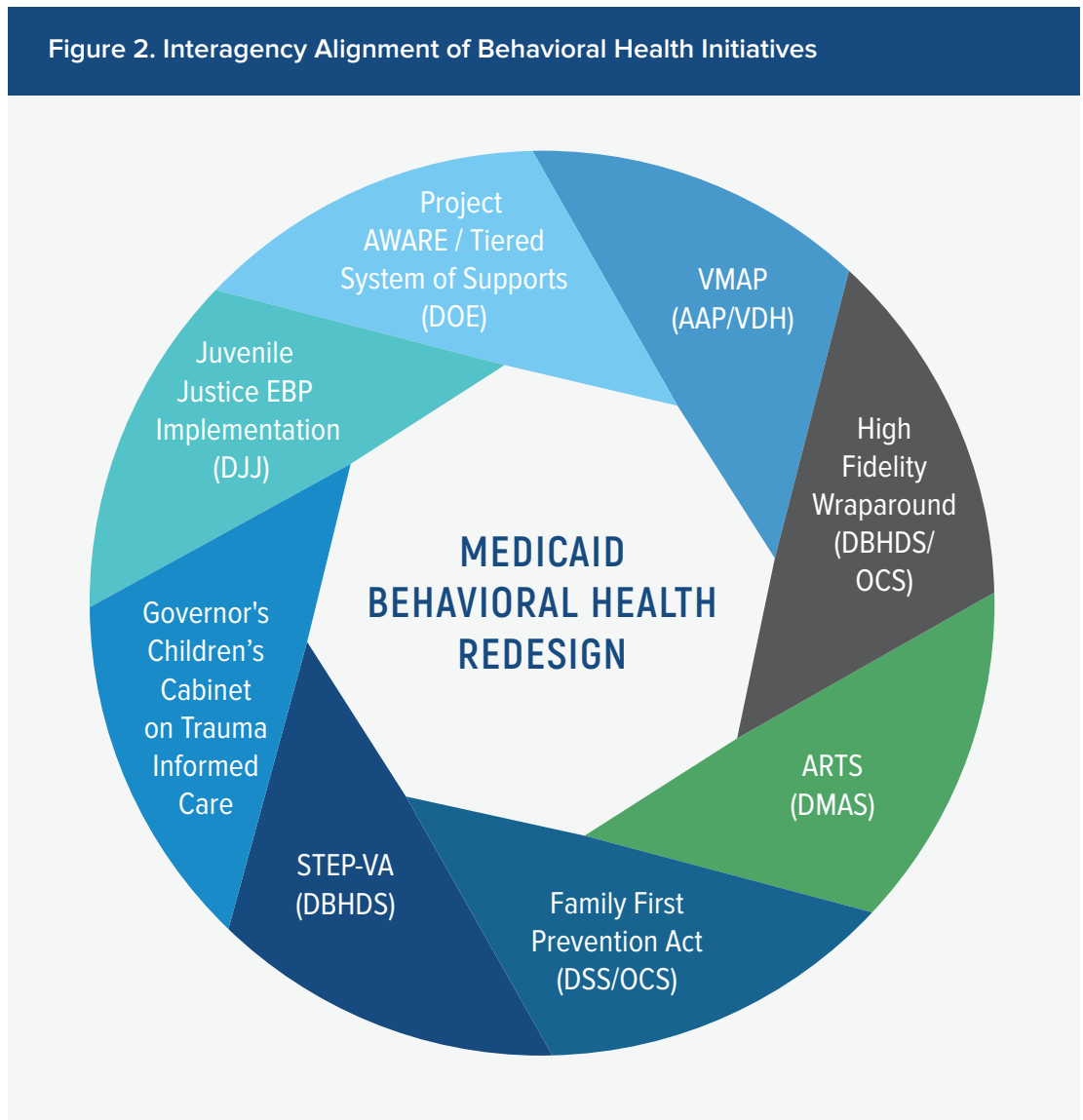
STEP-VA, which began in 2015, features a uniform set of required services, consistent quality measures, and improved oversight in all Virginia communities. STEP-VA is based on a national best practice model (Certified Community Behavioral Health Clinic or *CCBHC* model, delineated in the Excellence in Mental Health Act) that requires the development of a set of deliberately chosen services that make up a comprehensive, accessible system for those with serious behavioral health disorders. The broad goals of STEP-VA are to increase access, promote consistency of services, strengthen quality, and increase accountability throughout the CSB system. STEP-VA provides same-day access, strengthens the array of core services required to be available in every CSB's catchment area and promotes primary care and behavioral health integration. Aims of the program include decreased medical and psychiatric emergency department visits and hospitalizations, fewer state hospital beds and meeting a safe occupancy standard, decreased number of individuals with serious mental illness in jail for misdemeanors, decreased wait time for jail referrals, and high rates of adults with serious mental illness having seen their primary care provider within the past year.

> The first phase of STEP-VA was funded by a planning grant, DBHDS contributions, and funds from the General Assembly. New and modified supports are needed to sustain the changes accomplished through these initial funding sources. Recommendations in this continuum include service area additions and modifications and financial reimbursement that supports the comprehensive STEP-VA service array that creates long term sustainability for the CSB system.

The ARTS program carved community-based addiction services into Medicaid Managed Care Organizations (MCOs) and created an evidence-based continuum of services including inpatient, residential treatment, partial hospitalization, intensive outpatient, opioid treatment programs, case management, and peer recovery supports. DMAS and DBHDS used the national American Society of Addiction Medicine (ASAM) criteria as a framework for the levels of care in the continuum. Additional components of the program include rate increases for other evidence-based treatment services to average commercial rates, requirements for care coordination by the Managed Care plans, and provider education and training. An innovative care model supported by ARTS is the Preferred Office-Based Opioid Treatment (OBOT) provider that offers financial incentives for high quality clinics providing evidence-based Medication Assisted Treatment including medication, counseling, and care coordination to members with an opioid use disorder. The ARTS program is an example of better integration of behavioral and physical health services at a system level and streamlining services across health plans through standardization of credentialing, prior authorization, and billing requirements.

THE ARTS PROGRAM RESULTS

↑ **69% increase**
in Medicaid members receiving SUD treatment

12,089
in the year before ARTS implementation

▶

20,436
in the year after ARTS implementation

↓ **25% decrease**
in total ED visits related to opioid use disorder

↓ **6% decrease**
in hospitalizations[12]

The Families First Prevention Services Act (FFPSA), passed in 2018, alters federal funding for foster care to direct funds towards prevention of foster care placements. Under the Act, Title IV-E funds are eligible for use in prevention services such as mental health care, substance use disorder treatment, and in-home parenting skills training. These services must be evidence-based, with at least 50% of expenditures directed towards "well-supported" practices. Current planning work groups in Virginia are determining eligibility criteria, capacity, and training needs for use of evidence-based practices, and other state and local resources needed for implementation. There is significant overlap in those served through the Medicaid-funded system and youth at risk for child welfare involvement who will be served through FFPSA. Alignment between agencies will be vital in assuring that these two implementations support and do not compete with each other in terms of workforce, quality and outcome measures, evidence-based practice adoption and training and system infrastructure. This alignment and coordination is underway between leaders of redesign and FFPSA implementation.

Bright spots of Virginia's behavioral health system that were identified by multiple stakeholder groups include the Program of Assertive Community Treatment, the Virginia Mental Health Access Program, crisis intervention teams, peer support services, telepsychiatry, Mental Health First Aid, high fidelity wraparound services, Tiered Systems of Support for school-based services, REVIVE opioid overdose and naloxone education program, Medication Assisted Treatment, Multi-Systemic Therapy and Functional Family Therapy within the Department of Juvenile Justice, and expansion of trauma-informed care including trauma-focused cognitive-behavioral therapy. For some of these services or programs, stakeholders have voiced that improved reimbursement rates or attention to delivering the model with fidelity to its evidence-based principles and structure are needed to realize their optimal impact. These bright spots are recognized assets that can be retained and bolstered through this service and payment redesign.

Integrated Principles and Modalities Across the Continuum

Building a Trauma-Informed System

One of the principles of this redesign is mindfulness to the impact of trauma on all those participating in the care process, and a focus on building resilience and promoting recovery across the service delivery system. Trauma is extremely common, with more than half of the U.S. population reporting experiencing at least one trauma in their lifetime, with witnessing a trauma being the most common.[13] The opioid crisis in Virginia that resulted in 1230 overdose deaths in 2017 and affected countless more Virginians is a source of often chronically traumatic experiences for those struggling with addiction, their loved ones, and their community. Secondary traumatic stress amongst service providers is a valid and growing concern in the behavioral health field, and is connected to burnout and workforce turnover.

> Redesign seeks to implement system changes that will support early identification and intervention for trauma reactions and integrate trauma-focused evidence-based practices into every level of care in the continuum.

The development of the implementation plan for redesign will include thoughtful consideration of drivers for trauma within the system itself (e.g., repeated hospitalization, the impact of stigma, feeling loss of control in the treatment process) and means to support resilience and recovery within the member and provider experience.

Universal Prevention & Promotion

The redesigned continuum includes a level of care specified as prevention and promotion and at the same time recognizes that the principle of prevention applies across the continuum through a focus on early identification of problems and improved access to the care process. The services summarized in the prevention section of this document are defined as those traditionally occurring during the perinatal period for families and in early childhood for children in order to manage risk around adverse childhood experiences and social determinants of health (SDOH). Screening and detection for risk factors for SDOH and mental health problems are vital techniques within prevention and early intervention. These practices will be vital in building school-based and integrated care services in the redesigned system. One of the primary goals for the redesigned system and for STEP-VA is improving access to care to allow for earlier intervention for mental health problems. Early intervention pursues prevention of more intense, chronic problems tied to societal costs far beyond system dollars. The Centers for Disease Control and Prevention's Healthy People 2020 plan has emphasized the role of screening and addressing social determinants of health as a central means to improve population health and advance health equity.[14]

Service gap analyses performed as part of this project have indicated significant disparities in the Commonwealth in terms of geographic access to care. As the redesigned continuum takes shape through implementation planning, a careful focus on addressing the social determinants of health is warranted. Implementation plans should consider use of The National Public Health Performance Standards (NPHPS or the Standards) available through the Association of State and Territorial Health Officials (ASTHO) in conceptualizing how prevention is included across the service array in our public health system.

Transitioning Across the Continuum

"Continuum of care" refers to a treatment system in which clients enter treatment at a level appropriate to their needs and then step to more intensive treatment or down to less intense treatment as needed. This document describes a comprehensive array of services; however, each service should not be thought of as discrete levels of care, but rather as points in a continuum of treatment. Clinicians and administrators should, "envision admitting a client into the continuum *through* their program rather than admitting the client *to* their program." This early focus on moving the client along the continuum prompts clinicians to continually look ahead to the next step in the client's treatment and integrates transition planning into the treatment plan.[15]

Evidence-based transitional support strategies are organized into three categories: pre-discharge, post-discharge, and bridging services.[16]

- Pre-discharge services that have been shown to significantly reduce hospital readmissions include psychoeducation services that are adapted from the "Symptom management module" of the Social and Independent Living Skills series, which focuses on relapse prevention.[17] This patient education helps individuals manage their disorder warning signs and develop problem-solving skills and emergency plans. Structured needs assessments have also been shown to improve patient outcomes and reduce hospital admissions.[18] As specific patient-centered needs are identified, case managers and patient navigators are better equipped to connect patients to appropriate community services. Pre-discharge medication reconciliation and education are considered a best practice and should continue to be a staple of pre-discharge services. Although necessary, the acquisition of a follow-up appointment with outpatient mental health care is not sufficient for successful transitions in care.[16,19]

- Post discharge services that have been found to have significantly positive impacts on patient care include follow-up telephone outreach, home visits, and case management to facilitate timely outpatient follow up.[18,20-22] Post-discharge structured needs assessments demonstrate significant improvements in patient care, mirroring their effectiveness when applied pre-discharge.

- Bridging tools at the time of a transition of care include timely communication between pre-discharge and post-discharge providers. Patient introduction to outpatient mental health providers prior to discharge has also been found to significantly reduce hospitalizations.[16]

This continuum not only describes the service array, it also incorporates the applicability and needs that change across a lifespan. The redesign acknowledges inter-sectoral transitions such as coordination of services and needs from early childhood interventions administered by DBHDS into the school environment under the DOE, transitions between public and private entities such as the state psychiatric facilities into the community, and age related transitions such as those experienced by transitional aged youth moving from the child and adolescent system of care into the adult mental health services, and the specific needs of the geriatric population. An examination of all the transition points are needed to identify and remove barriers to effective and early treatment initiation, communication, care coordination, and information and data sharing.

Leveraging Telemental Health Across the System

Due to the significant workforce shortages in urban and rural underserved areas of the Commonwealth and barriers to accessing mental health care, telemental health is an important modality to ensuring timely access to care regardless of where an individual lives. The Joint Commission on Health Care (JCHC) defines telemental health as, "the use of electronic information and telecommunications technologies to support behavioral health services at a distance." This includes clinical care, patient and professional health-related education, public health and administration. A variety of modalities can be used to deliver these services, including live interactive videoconferencing, remote monitoring and mobile applications. Providers of telemental health include, but are not limited to psychiatrists, psychologists, social workers, psychiatric nurse practitioners, and licensed professional counselors.[23]

> Redesign will leverage telemental health at every level of care in the new continuum to ensure access to licensed mental health clinicians, who can enhance the professional development and service provision of qualified mental health professionals through more easily accessible support and supervision.

The ARTS program serves as a model of how telehealth can be leveraged to meet requirements for consults with and/or supervision by a credentialed addiction treatment provider at all levels of care.

Redesign will also incorporate relevant recommendations on telemental health from the JCHC including building on the Project ECHO program,[24] which supports sharing of knowledge, collaboration, and increased capacity of primary care providers in appropriately managing patients with mental illness and substance use disorder. The Virginia Department of Health (VDH) already employs Project ECHO's collaborative practice model that links expert specialist teams at academic "hubs" who provide consults on patient cases via videoconferencing with primary care clinicians in local communities to increase training in addiction treatment.

Redesign will also help ensure the sustainability of the Virginia Mental Health Access Program (VMAP), a statewide program to expand primary care capabilities to provide mental health care to children and adolescents. The program includes four services across five regions of the state: 1) primary care provider education and training on screening, diagnosis, and management of mental health disorders using Project ECHO; 2) primary care provider telephonic/video access to child and adolescent psychiatrists, psychologists, and/or social workers for consults; 3) tele-mental health services; and 4) care coordinators to help identify regional mental health services. The Virginia Chapter of the American Academy of Pediatrics is working with VDH, DBHDS, DMAS, Department of Education, Secretary of Health and Human Resources, Children's Cabinet, and Governor's Office to fully implement this program.

Behavioral Therapy Supports Across the Continuum

Applied Behavior Analysis (ABA) is a therapy approach based on learning and behavioral principles that helps to increase language and communication skills; improve attention, focus, social skills, and skills in academic domains; and decrease problem behavior. ABA is considered a strong evidence-based practice (EBP) for the treatment of Autism Spectrum Disorder (ASD) and other neurocognitive disorders. Many studies have concluded the effectiveness of ABA on positive improvements in intellectual functioning, language development, daily living skills and social functioning.[25-26] Behavioral Therapy is expected to increase appropriate social - communicative interactions and pivotal responses within a social framework, increase adaptive functioning, and produce beneficial changes in pivotal responses that result in more widespread behavioral change across a number of other non-targeted behaviors.

> Research on ABA beyond the treatment of ASD focuses on the use of behavioral techniques, such as behavior analysis to treat depressive disorders and ABA in psychotherapy for trauma,[27-29] but has inherent limitations in generalizability due to the currently narrow scope and methodology of the evidence base.

As the evidence base grows for ABA, systems should stay abreast of this science and evolve to allow for use of ABA and other Behavioral Therapy interventions as indicated.

Behavior therapy interventions are recommended to be allowable *across settings and levels of care* in the continuum for youth with ASD and other neurocognitive disorders, as evidence has indicated that these types of supports show strong effectiveness when used in natural environments. Research and practice-based evidence indicate that behavior therapy approaches such as ABA should necessarily integrate caregivers and family members into the care process to facilitate modeling and practice. This involvement is essential to empower these natural supports to reinforce and eventually assume primary responsibility for the maintenance of progress in managing the problem behaviors. Additionally, as people participating in these services move temporarily into different levels or settings of care, it is important that behavioral therapy interventions remain intact to maintain treatment progress. For example, availability of ABA within inpatient and residential settings would expand the capacity for individuals with ASD and/or developmental disabilities to receive valuable, integrated care in these higher acuity settings. Additionally, if an ABA provider is able to follow the person he/she serves across that person's journey in the system of care, he/she can support continuity and effective transitions between settings. Within the development of the new continuum, it is recommended that DMAS and DBHDS work with stakeholders to determine and establish regulations around this service that are informed by evidence and the need for comprehensive treatment planning in the population served by behavioral therapy interventions.

Case Management Services

DESCRIPTION AND RATIONALE

Case management aims to assist individuals in gaining access to needed medical, social, educational, and other services with the primary goal of optimizing the functioning of people who have complex needs by coordinating the provision of quality treatment and support services in the most efficient and effective manner. Case management services should remain with the individual regardless of where they are receiving services along the continuum. Case management can range in intensity and duration, depending on setting, companion services, and need. Case management typically includes assessment and periodic re-assessment of service need; development of a care plan that prioritizes the referrals and linkages needed and the specific goals and actions to address the medical, social, educational, and other services; referral and related activities to obtain needed services; and monitoring and follow up to ensure the person is receiving the recommended services. Case management is not a distinct level of care within a behavioral health service array; rather, it is an enhanced service that impacts the effectiveness and outcomes of specific services.

Case management is a component of specific services including Assertive Community Treatment, High Fidelity Wraparound, Coordinated Specialty Care, the team-based model of care in Virginia for individuals with first-episode psychosis, and Comprehensive School Based Case Management. These services are described in more detail in the section titled "Intensive Community Based Services."

> Case management applied within these services has an established interdisciplinary team and adheres to high fidelity principles and models that result in reduced number of admissions, reduced hospital days per month, medication treatment adherence, and improved social functioning including markers such as employment and education.[100]

Intensive Case Management differs from the above type of services such that it is provided by a single case manager, rather than an interdisciplinary team. The ICM case manager collaborates with a team as indicated based on a person's individual needs. ICM is intended for target populations: those with serious mental illness (SMI) and children with serious emotional disturbance (SED) but for whom the functional disabilities are less serious, including children with SED in or at risk for foster care, substance use disorders, and developmental disorders including recipients of Early Intervention/Part C services. Services target development of individual skills and support, rehabilitation, service coordination, and establishment of community linkages.

Regardless of service type, clinical case management is comprised of core activities, including patient engagement, assessment and planning, linkage with resources, consultation with families, collaboration with medical professionals, patient education, crisis planning, and termination of services to minimal or no case management.[30]

RECOMMENDED SERVICE MODEL

Case management that is encompassed within specific intensive community-based services is discussed in detail in the section titled "Intensive Community Based Services". With respect to Mental Health Intensive Case Management and Treatment Foster Care Case Management, that is provided by a single case manager, the provider qualifications of this service include qualified mental health professionals. Case managers who specialize in specific patient populations may need additional training in that area. Service delivery should adhere to evidence-based models of care. Research literature reports a wide range of outcomes for effective case management, which indicates the importance of establishing patient-centered, attainable, and measurable goals when members receive this service. As the implementation of FFPSA is developed, further examination of the role of Treatment Foster Care Case Management may be needed as evidence more strongly support Therapeutic Foster Care, a model of care in which foster parents receive training to provide the supports needed for children in foster care with SED. Support for the workforce is also necessary to ensure effectiveness, as field work exposes case managers not only to the individual's functional and symptom disability, but also to environmental stresses and triggers. Support and training of the workforce reduces staff turnover and burnout while providing professional development. Mental Health Case Management is currently a service provided solely by the Community Services Board and is a key component of STEP-VA. Redesign will assist STEP-VA by establishing consistency and measurable effectiveness of the service, while increasing access to the community interventions needed to make Intensive Case Management successful.

Recovery and Rehabilitation Support Services

Recovery is a process in which people are able to live, work, learn, and fully participate in their communities. Also referred to as maintenance, recovery interventions provide long-term support for individuals with chronic mental health disorders. Mental health rehabilitation is support intended to help people develop social, emotional, and cognitive skills that they need to feel satisfied with their lives and have as little professional involvement as necessary. For people living with serious and chronic mental illness in a recovery or maintenance phase, there is risk that disease course, physical health complexity, and/or life stressors can lead to an exacerbation of their mental health challenges. While medically-defined "recovery" from serious mental illness is possible in some cases, recent person-centered definitions of recovery have emerged that focus on progress towards personalized goals and improvements in functioning.[31-32]

In the redesigned continuum of care, rehabilitative services are conceptualized within recovery as they are appropriate interventions to quickly address the drivers of some loss of functioning and bring a person's skills back to where they were at their point of maintenance without having to escalate to higher levels of acute care.

> Both recovery and rehabilitation services support individuals' abilities to live productive lives in their community and decrease disability associated with mental illness.

Given this role, recovery services are relevant across the entire continuum of community mental health services. In the stakeholder survey, 43% of respondents reported the current array of recovery services does not meet needs and 20% suggested redesign of the current array of services would meet needs.

Evidence-based recovery and rehabilitation services in the continuum will include *Independent Living and Recovery Services, Peer Support Services, Psychosocial Rehabilitation, Permanent Supportive Housing, and Supported Employment*. The services previously conceptualized in the Medicaid-funded system as Mental Health Skill Building is recommended to be shifted into the category of Independent Living and Recovery Services to reflect their function in the care process in terms of rehabilitation after set-backs/exacerbations in symptoms. Substantial changes are recommended to the current *Psychosocial Rehabilitation* service to meet the needs of people living with serious mental illness whose symptom or impairment levels indicate the need for more intensive, structured supports. Strong evidence exists for recovery-based services for patients with serious mental illness (SMI), schizophrenia, and other psychotic disorders. In populations with serious mental illness, studies demonstrate improved cognitive functioning, improved social and daily living skills, reduced symptomatology, improved illness management, and reduced relapses.[33-36] Strong effectiveness is observed with social skills training, social cognitive training, cognitive remediation, and cognitive-behavioral therapy approaches, as well as when these services are delivered as part of an integrated program such as Illness Management and Recovery

(which has been implemented by peers as well as professionals and as an element of Assertive Community Treatment) and Integrated Psychological Therapy (a small group intervention focused on neurocognitive, social cognitive, social skills, and problem solving skill training).[37-38] Implementation planning for these services will include agency and stakeholder collaboration to determine best-fit EBPs for use in the redesigned system.

INDEPENDENT LIVING AND RECOVERY SERVICES

Independent Living and Recovery Services is a direct service in the redesigned continuum that helps adults with serious mental illness enhance their capacity to successfully accomplish a task or goal. Previously conceptualized as Mental Health Skill Building Services, this new conceptualization recognizes that for those with SMI, recovery is a long-term process with evolving needs based on life circumstances, stressors, fluctuations in disease course, and physical health complications.

> Strength-based supports for long-term recovery are important for managing risk for escalation in level of care.

Evidence-based skill building interventions within this service should be based on psychoeducational and cognitive-behavioral approaches and assist individuals with developing competencies in self-help, self-care, adaptation to new challenges, or socialization. The goals of this service are to assist in illness self-management, medication management, and management of physical health; improve life skills (for example, activities of daily living and community living skills such as transportation, financial management, shopping, and cooking); and improve cognitive and intellectual skills (for example, learning and organizational skills, attention, and memory), interpersonal and intrapersonal skills, self-help and advocacy skills, and skills in functional areas such as employment and education.[63] These services would integrate use of EBPs (e.g., Illness Management & Recovery) for skill-building that could be delivered in community settings by peer supports, QMHPs or LMHPs. To retain key workforce partners, the QMHPs who currently deliver Mental Health Skill Building will receive substantial training and support to transition to providers of the Independent Living and Recovery Services.

PEER SUPPORT SERVICES

The provision of Peer Support Services facilitates recovery from both serious mental health conditions and substance use disorders. CMS considers peer support services "an evidence-based mental health model of care,"[39-40] and both the Substance Abuse Mental Health Services Administration (SAMHSA) and the National Association of State Mental Health Program Directors endorse the use of peer providers as part of a recovery-based treatment for individuals with mental health diagnoses and substance use disorders.[41-42]

> Peer support services assist the individual to develop and maintain a path to recovery, resiliency, and wellness. Specific peer support service activities emphasize the acquisition, development, and enhancement of recovery, resiliency, and wellness. Services are designed to promote empowerment, self-determination, understanding, and coping skills through mentoring and service coordination supports, as well as to assist individuals in achieving positive coping mechanisms for the stressors and barriers encountered when recovering from their illness or disorder.

Family support partners is a strength and team-based service whereby the caregiver must be directed exclusively toward the benefit of the Medicaid-eligible youth. Services are expected to improve outcomes for youth with complex needs who are involved with multiple systems and increase the youth and family's confidence and capacity to manage their own services and supports while promoting recovery and healthy relationships.

Experiences of peer support providers as consumers of mental health and substance use services should be embedded in all aspects of the continuum of care. Peer Support Services are delivered by trained and certified peers who have been successful in the recovery process and can extend the reach of treatment beyond the clinical setting into an individual's community and natural environment to support and assist an individual with staying engaged in the recovery process.

Effective July 1, 2017, DMAS expanded the Medicaid benefit to allow for credentialing and reimbursement of Peer Support and Family Support Partner Services. This is in response to a legislative mandate to implement peer support services to eligible children and adults who have mental health conditions or substance use disorders. Peer support services target individuals 21 years or older with mental health or substance use disorders or co-occurring mental health and substance use disorders. Family Support Partners may be provided to eligible individuals under the age of 21 who have a mental health or substance use disorder or co-occurring mental health and substance use disorders, which are the focus of the support with their families or caregivers.

Virginia should embed peer recovery supports across the redesigned continuum of care as a core component of the service delivery. In Virginia, Certified Peer Recovery Specialists (CPRS) have the qualifications, education, and experience established by DBHDS and show certification in good standing by U.S. Department of Veteran's Affairs, NAADAC, a member board of the International Certification, and Reciprocity Consortium (IC&RC), or any other certifying body or state certification with standards comparable to or higher than those specified by the DBHDS.

Stakeholders describe peer support services as a current bright spot in behavioral health services. However, they also stated that the reimbursement rate for peer support services does not cover the costs of the service provider's time. In the envisioned continuum, reimbursement rates are commensurate with costs of providing evidence-based services. DMAS and DBHDS should also evaluate the barriers for peer support services currently covered under the Medicaid benefit and solutions to increase the peer workforce and improve service delivery. These solutions could include reviewing the reimbursement rate for peers to ensure that the full costs including supervision are factored into the rate.

PSYCHOSOCIAL REHABILITATION

This continuum recommends substantial changes to the current Psychosocial Rehabilitation service to meet the needs of people living with serious mental illness whose symptom or impairment levels indicate the need for more intensive, structured supports than available through Independent Living and Recovery Services.

> This change is based on the concept that recovery for individuals with SMI is a long-term process with evolving needs based on life circumstances, stressors and fluctuations in disease course and physical health complications.

This revised service should provide a consistent, structured environment for conducting targeted, evidence-based exercises and coaching to restore an individual's ability to manage mental illness. This service should include education to teach the individual about mental illness, substance use, and appropriate medication to avoid complication and relapse and opportunities to learn and use independent living skills and enhance social and interpersonal skills within a consistent program structure and environment. Integrated Psychological Therapy is an example of an EBP that would fall in this category of service.

PERMANENT SUPPORTIVE HOUSING

SAMHSA describes Permanent Supportive Housing (PSH) as "decent, safe, and affordable community-based housing that provides tenants with the rights of tenancy under state and local landlord tenant laws and is linked to voluntary and flexible supports and services designed to meet tenants' needs and preferences."[43] PSH combines affordable housing and flexible, voluntary supportive services to address treatment, rehabilitative, and

recovery support needs of participants with serious mental illness, co-occurring disorders, and complex medical needs so that they can live stably in their communities. Permanent supportive housing is based on the premise that stable housing is a foundation for pursuing other health and social service goals and that housing is intricately linked to health care for vulnerable individuals. As such, applicants for housing are accepted regardless of use of substances, participation in services, or completion of treatment, though they are encouraged to engage in treatment.[44]

Virginia currently has a unique interagency partnership that helps to address the housing needs of citizens. The core partnership consists of Virginia Housing and Development Authority (VHDA), the Department of Housing and Community Development (DHCD), DMAS, DBHDS, and DARS. The partnership has worked towards a collaborative, comprehensive PSH plan.

DBHDS is in the process of building capacity for permanent supportive housing, launched by the onset of general fund dollars for permanent supportive housing allocated by the General Assembly beginning in 2015.

> Through FY 2020, $14 million in funds have been awarded for permanent supportive housing for people with serious mental illness and an additional $1.5 million specifically targeting pregnant or parenting women with substance use disorders.

DBHDS' PSH program requirements are designed to ensure fidelity to national evidence-based practice standards, and programs target individuals who are currently experiencing homelessness or are unstably housed and are frequent users of institutional, crisis, or emergency services.

Funds cover long-term rental assistance, housing transition and tenancy sustaining services, some case management/peer services, and the administration of rental assistance. Clinical services are provided through existing funds (i.e., state general funds, Medicaid, federal grants, local funds).

> Currently about 700 people with SMI are housed through the DBHDS PSH program, which contracts with CSBs and private organizations throughout the state. It is anticipated that new funds will house approximately 400 more people.

Additional housing supports for homeless individuals with serious mental illness are in place through the Projects for Assistance in Transition from Homelessness (PATH), with services provided by CSBs or their subcontractors and funded by federal PATH dollars and local matching funds. Services include street outreach, shelter in-reach, case management, connection to services, and assistance with accessing housing.[45]

Permanent supportive housing has been shown to improve health outcomes, save costs, and promote community integration of individuals who would otherwise need an institutional level of care.[44] In Philadelphia, through three Pathways to Housing PSH programs, 89% of 1,200 individuals remained in housing after eight years without using crisis services. Initial costs increased, followed by decreased costs after housing was well-established. Addressing housing along with other social determinants has led to $15 million annually in savings, which only includes assessment of behavioral health expenditures.[46] In Illinois, a permanent supportive housing program evaluation that included costs of services from Medicaid, mental health hospitals, prisons and county jails, and substance use treatment centers found expenditure decreases of $5,000 per person, leading to an overall savings of $854,477 after two years for 177 participants.[47] Frequent Users Systems Engagement in Connecticut targets high utilizers of social services through partnerships across agencies. After one year, the first 120 individuals housed had a 73% reduction in jail days.[48]

There is strong evidence for permanent supportive housing from long-standing Virginia PSH programs as well. Over a period of 20 months, Virginia Supportive Housing's A Place to Start program found a decrease in emergency room visits by 61%, a decrease in inpatient psychiatric hospitalizations by 62%, and decline in emergency room costs of 66%. Providing permanent supportive housing to 50 high needs homeless individuals with serious mental illness in Richmond using an Assertive Community Treatment model paired with long-term rental assistance saved the community $320,000 over the 20-month period in reduced utilization of emergency response systems.[49]

INITIAL OUTCOMES OF THE DBHDS PSH PROGRAM

700
people housed

93%
have maintained stable housing

94%
reduction in state hospital bed days

74%
reduction in local hospital inpatient bed days

48%
reduction in jail stays

The redesigned continuum should include a robust Medicaid housing supports benefit that helps individuals with mental illness and/or substance use disorder obtain and maintain stable housing.

DMAS already included a proposal for Medicaid housing supports developed with DBHDS, DHCD, and VHDA in an 1115 Medicaid Demonstration Waiver that was submitted to CMS on November 20, 2018, that would enhance the continuum if approved and funded.[50]

With this waiver, Virginia is seeking authority to pilot a housing support benefit that would provide Medicaid coverage of housing transition and sustaining services for Medicaid-covered adults (ages 18 or older) in the currently eligible or expansion populations who have a Serious Mental Illness, Substance Use Disorder, or serious and complex medical condition. Individuals must have at least one of the following risk factors:

1 chronic homelessness;

2 history of frequent or lengthy stays in an institutional setting, institution-like setting, assisted living facility, or residential setting;

3 frequent Emergency Department visits or hospitalizations;

4 history of involvement with the criminal justice system; or

5 frequent turnover or loss of housing as a result of a behavioral health symptom.

The Medicaid benefit would cover housing supports services that are determined to be necessary for an individual to obtain and reside in an independent community setting and are tailored to the goal of maintaining an individual's personal health and welfare in a home and community-based setting. These would include:

- **Individual Housing Transition Services**, inclusive of community transition services, that provide housing supports and linkages for individuals with disabilities and long term services and supports needs who are experiencing chronic homelessness.
- **Housing and Tenancy Sustaining Services** that are provided to individuals who are already residing in housing in the community, for the purpose of maintaining tenancy.

These services, if approved by CMS and funded by the General Assembly, will be phased in across the six Medicaid Managed Care regions of the Commonwealth.

DMAS should work with DBHDS, DHCD, VHDA, and the Medicaid MCOs to coordinate the Medicaid housing supports benefit with other state and federal funding sources with the goal of ensuring that the greatest number of individuals with SMI and SUD receive PSH with wrap-around Medicaid support services that enable them to obtain and maintain stable housing.

SUPPORTED EMPLOYMENT

Supported employment refers to paid, competitive employment with integrated and ongoing supports. Individual Placement and Support is an evidence-based supported employment practice characterized by rapid job search, good job fit, and supports to maintain employment that focus on preparation for competitive employment, time-unlimited supports, and tailoring to individual needs, talents and preferences.[51]

Clubhouses are evidence-based programs that include employment services. These community-based centers for individuals with mental illness are structured around a work-ordered day, with members working alongside staff to operate the Clubhouse. Employment services include supported employment, transitional employment, and independent employment.[51]

Individual Placement and Support and Clubhouse programs have also been adapted to include supported education for young adults. Existing tools to assess fidelity include the Individual Placement and Support Fidelity Scale. Clubhouses are accredited by Clubhouse International for meeting evidence-based quality standards.

The rate of unemployment among people receiving state behavioral health services is three times that of the general population.[51] Most vocational rehabilitation programs are not tailored to individuals with serious mental illness.[52]

IN INDIVIDUAL PLACEMENT AND SUPPORT PROGRAMS

60%
of individuals with serious mental illness will succeed in working

VS

24%
of individuals not in a supported employment program

Some evidence suggests that Individual Placement and Support is associated with better symptom control, quality of life, self-esteem, and social functioning. Specific components of Individual Placement and Support are associated with positive outcomes including integration of vocational and mental health services, rapid job search, eligibility based on client choice, competitive employment, time-unlimited support (though needs vary by individual), and zero-exclusion criterion (services for all clients regardless of substance use or criminal justice history).[53]

The redesigned continuum should also include a robust Medicaid employment supports benefit for the individuals with mental illness or substance use disorder. As modeled in other states, financial incentives may be provided for Clubhouses, an intensive psychosocial treatment for individuals with serious mental illness, who are certified by Clubhouse International with a proven employment track record as evidenced by employment outcomes. Employment specialists should also achieve competencies reflective of national best practice in supported employment, such as those developed by the Association of Community Rehabilitation Educators (ACRE) and the Association of Persons Supporting Employment First (APSE).

DMAS already included a proposal for Medicaid employment supports developed with DBHDS, the Chief Workforce Development Advisor, and the Department of Aging and Rehabilitative Services (DARS) in the 1115 waiver application submitted to CMS. In the waiver, Virginia also requests authority to pilot an employment support benefit that would provide Medicaid coverage of housing transition and sustaining services for Medicaid-covered adults (ages 18 or older) in the currently eligible or expansion populations who have a Serious Mental Illness, Substance Use Disorder, or serious and complex medical condition.

Individuals must have at least one of the following risk factors:

1 unable to be gainfully employed for at least 90 consecutive days due to a mental or physical impairment;

2 an inability to obtain or maintain employment resulting from age, physical/sensory disability, or moderate to severe brain injury;

3 more than one instance of inpatient or outpatient SUD in the past two years; or

4 at risk of deterioration of mental illness and/or SUD.

The Medicaid benefit would cover employment support services that are determined to be necessary for an individual to obtain and maintain employment in the community. They could include any of the following components:

- **Educational Services** including subsidies for industry certification or subsidies for industry licensure
- **Pre-Employment Services** including pre-vocational/job-related discovery or assessment; person-centered employment planning; individualized job development and placement; job carving; benefits education and planning; and transportation
- **Employment Sustaining Services** including career advancement services; negotiation with employers; job analysis; job coaching; benefits education and planning; transportation; asset development; and follow-along support

These services, if approved by CMS and funded by the General Assembly, will also be phased in across the six Medicaid Managed Care regions of the Commonwealth. DMAS should work with DMAS, DARS, and the Chief Workforce Development Officer to coordinate the Medicaid employment supports benefit with other state and federal funding sources while bolstering existing evidence-based programs such as certified Clubhouses and stimulating the development of new programs to help individuals with SMI and SUD obtain and maintain stable employment.

A Redesigned Continuum of Behavioral Health Services

Early Childhood Promotion and Prevention Services

Promotion and Prevention services build resilience within mental well-being and protect against the development of more acute or severe problems; they are the equivalent of "seat belts" for the behavioral health system that prevent future accidents. Promotion and prevention services are applicable across the lifespan as mental health issues can arise at any point in people's lives.

4%

of Virginia Medicaid spending on behavioral health services is directed towards promotion and prevention

In the stakeholder survey, 47% of respondents reported that the current array of Medicaid-funded services in this category does not meet the needs of members, and an additional 19% reported the service array is inadequate to meet needs and requires redesign.

Description and Rationale

When applied to the sensitive milestones of early childhood and the perinatal period, promotion and prevention services include home visitation, comprehensive family programs, and early childhood education and intervention.

HOME VISITATION PROGRAMS

Home visitation programs deliver family support and child development services in natural environments and include EBPs such as Nurse Family Partnership, Healthy Families America, and Parents as Teachers. In the Nurse Family Partnership, registered nurses or paraprofessionals with the same length of training work one-on-one with first-time mothers starting in early pregnancy through the child's second birthday with aims to improve prenatal health while reducing child maltreatment and injury-related healthcare visits.[54]

COMPREHENSIVE FAMILY PROGRAMS

teach caregivers skills to bolster family resilience in managing trauma, preventing abuse, and managing emerging disruptive behaviors in young children. These programs include EBPs such as Healthy Families and The Incredible Years. Healthy Families America (HFA) is the signature program of Prevent Child Abuse America. It is rooted in attachment theory and is a highly family- and strength-centered approach to assessment of adverse childhood events and risk for maltreatment, home visitation support, and ongoing monitoring of maternal depression and childhood developmental milestones during the first 5 years of life. Incredible Years-Parents is a group-based parenting program that strengthens parents' skills to promote their children's social, emotional, and academic competence.[54]

EARLY CHILDHOOD EDUCATION PROGRAMS

Early Childhood Education programs, such as Early Intervention Part C, Head Start/Early Head Start, provide early learning, health, and family well-being services to vulnerable young children. Head Start preschool programs primarily serve 3- and 4-year-old children. Early Head Start serves infants, toddlers, and pregnant women. Early Intervention / Part C serves infants and toddlers through age 2 with developmental disabilities and delays.

Virginia stakeholders identified that home visitation and comprehensive family programs are key service areas for Medicaid support. Home visitation programs increase school readiness, enhance parents' ability to support children's development, improve child health and development, and improve family economic self-sufficiency. Comprehensive family programs improve parent-child relationships, increase children's prosocial behavior, and decrease child maltreatment.[55] Early childhood education programs such as Head Start/Early Head Start improve school readiness, enhance cognitive and language development, lead to positive parenting styles, and significantly reduce children's risk of falling in at-risk ranges of developmental functioning.[56-57]

Economic benefits from early childhood prevention programs can be found in school, social welfare, workforce, and criminal justice domains.

COST-BENEFIT ANALYSES SHOW A RANGE OF SAVINGS	RETURN ON INVESTMENT TO SOCIETY
$1,400 - $240,000	**$1.80 - $17.01**
per child	per $1 invested
With greatest savings from services delivered to disadvantage children and families	

Programs that include longer follow up, require a larger investment (over $40,000 per child), and focus on home visiting or parent education yield the largest economic returns. Services that combine early childhood intervention and education also yield significant economic returns.[58] In Virginia, an MCO pilot of home visitation and case management services for high-risk pregnant women and infants saved an average of $2,287 per pregnancy.[59]

Recommended Service Model

Given the significant dearth of current Medicaid funding for promotion and prevention services, the redesigned continuum recommends significantly expanded funding and capacity for the delivery of these services across the lifespan. Alignment of services across agencies and organizations will be key to leveraging resources for maximal impact in the early childhood and perinatal period. Multiple federal sources of funding exist for complementary aims, including IDEA Part C Early Intervention funds, the Families First Prevention Services Act (FFPSA) of 2018, time-limited (for 1 year) Title IV-E funding, and the

federally-funded Maternal, Infant and Early Childhood Home Visiting program. The Virginia Children's Services Act of 1993 created a blended funding pool to meet health-related social needs of at-risk youth and families from multiple funding streams from the Department of Social Services (DSS), Department of Juvenile Justice (DJJ), Department of Education (DOE), and DBHDS, administered by the Office of Children's Services (OCS). Funding redesign would benefit from strategic braiding of these various funds for coverage of aligned prevention programs offered more widely across the Commonwealth.

The system would benefit from adoption of home visiting programs aligned with those selected for FFSPA implementation and consideration of means to better fund and provide coordination of resources for current implementations of home visiting programs operated through Virginia Department of Health and coordinated by Early Impact Virginia (Resource Mothers for pregnant teens; Maternal, Infant and Early Childhood Home Visiting Program for pregnant women, families, and at-risk parents of children birth to age 5; and Healthy Start Loving Steps for African American and Hispanic families at risk of life stressors) and similarly, Healthy Child Care Virginia and Project Seed which are aimed at supporting early childcare providers.

> Funding redesign should consider use of Targeted Case Management to allow Medicaid to reimburse for home visiting services.

Virginia could adapt the Kentucky Medicaid model that reimburses CPT codes billed for assessments, home visits by nurses and social workers, and home visits by paraprofessionals employed by the Kentucky Department of Health in the Health Access Nurturing Development Services (HANDS) home visiting program. Implementation of the prevention programs should consider use of interdisciplinary team-based approaches that include, LMHPs, QMHPs, and peer recovery supports for caregivers all working within their scope of practice.

Outpatient and Integrated Care

Outpatient and Integrated Care refers to treatment services for a broad population with a high symptom level or diagnosable mental, emotional, or behavioral health problem, inclusive of mild to moderate needs. Services within Outpatient and Integrated Care include traditional outpatient psychotherapy and medication management, integrated behavioral health and primary care, and school-based mental health services.

APPROXIMATELY

4%

of Virginia Medicaid behavioral health spending goes to outpatient services

In the stakeholder survey, 74% of respondents reported the current array of treatment services does not meet needs or requires redesign to do so.

OUTPATIENT SERVICES – PSYCHOTHERAPY AND MEDICATION MANAGEMENT

Description and Rationale

Outpatient services such as psychotherapy and medication management are essential for individuals with mild, moderate, and severe behavioral health conditions. A robust and diverse research base exists for traditional outpatient psychotherapies with variation in the strength of evidence across diagnostic problem area and intended age group. Available repositories for traditional EBPs include the Substance Abuse and Mental Health Services Administration, the American Psychological Association, PracticeWise, and resources from the Virginia Commission on Youth (see Appendix B). Systems are also available to support the implementation of evidence-based practices, such as Managing and Adapting Practice.

> Evidence-based psychotherapies may be delivered in a variety of settings, including home, schools, and other community settings; through clinicians on high fidelity wraparound teams; residential treatment settings; and inpatient settings.

These services are most commonly delivered by Licensed Mental Health Professionals (LMHPs), both masters and doctoral-level, or by a Qualified Mental Health Professional (QMHP) under the supervision of a LMHP. Outpatient EBPs have also been implemented with peer supports or unlicensed team members supplementing with additional community-based support for practicing skills and translation to the family and home environments.

Recommended Service Model

To build a full continuum of care, it is essential that Virginia expand the capacity and accessibility of outpatient services. This is aligned with one of the goals of STEP-VA, and redesign seeks to support that goal through funding support across diverse delivery settings. The system would benefit from the implementation of outpatient services that include trauma-focused EBPs that are aligned with those to be selected for use within FFSPA as well as those that seek to address the most common mental health problem areas for Virginians across the lifespan. The selection of those EBPs should be driven by data regarding the demographics and problems areas served by Medicaid, and the menu of practices will be established as part of implementation planning alongside stakeholders.

> Redesigned outpatient care would also benefit from integration of the Managing and Adapting Practice (MAP) System to guide evidence-based practice adaptations.

MAP includes use of a meta-analytic database of evidence-based interventions distilled to the practice element level, a set of decision-guidance frameworks for creating and delivering modular treatment plans to address multiple mental health problems in one course of care, and a clinical dashboard system for monitoring individual treatment progress.

MAP is applicable across a diverse service array and can be applied with standard EBPs or modularized versions that are adapted to address complex mental health co-morbidities. MAP has been implemented in a variety of other service systems and states with strong outcomes.[60-61]

> The current Virginia Medicaid reimbursement rates for licensed mental health professionals (LMHPs) who can deliver these evidence-based interventions such as MAP in outpatient settings are significantly lower than Medicare and commercial insurers.

As a result, the Joint Legislative Audit and Review Commission (JLARC) noted that Medicaid members have more difficulty accessing care, such as outpatient mental health, given the low percentage of LMHPs who treat Medicaid patients.[2] Including higher reimbursement for LMHPs across the continuum to address geographic disparities is critical to ensure that Medicaid members have access to outpatient services. Rate increases should apply to services such as psychiatric evaluations; medication management; individual, family, and group therapies for mental health conditions and substance use disorders; and psychological testing. Enhanced rates for EBP implementation have been explored in several systems including the Philadelphia Medicaid-funded system and should be explored as an option to promote uptake and fidelity in Virginia.[62-63]

SCHOOL-BASED SERVICES

Description and Rationale

School-based behavioral health services are "any program, intervention, or strategy applied in a school setting that was specifically designed to influence students' emotional, behavioral, and/or social functioning."[64]

> These services are essential because children spend the majority of their time in school and often first present with behavioral and emotional symptoms in schools. Schools need the trained mental health clinicians and evidence-based programs to address children's mental health needs at the time they present to prevent delays in treatment and the unnecessary worsening of symptoms and suffering of children.

Within a continuum of services to be provided within school settings, the Multi-Tiered System of Supports (MTSS) offers a framework for integrating youth, schools, families, and communities in providing services that meet student needs in the right setting, with the right services, and with the best qualified personnel.

The Virginia Tiered Systems of Supports is based on this framework and provides supports tailored to the specific needs of students including:[64]

TIER 1

Universal Supports for all (80-90% of students): Provides interventions that decrease behavior problems and improve academic success to the entire school. These interventions may include trauma and mental health screening; violence prevention; problem solving; empathy skill building curricula; trauma-informed mental health training for parents, caregivers, and school staff; and suicide prevention training.

TIER 2

Targeted Intervention for some (5-10% of students): Provides targeted services to students who demonstrate emergent mental, emotional, or behavioral problems or risk factors. Targeted services include case management and referrals to community supports, evidence-based group intervention to address specific mental health conditions, and school crisis team participation.
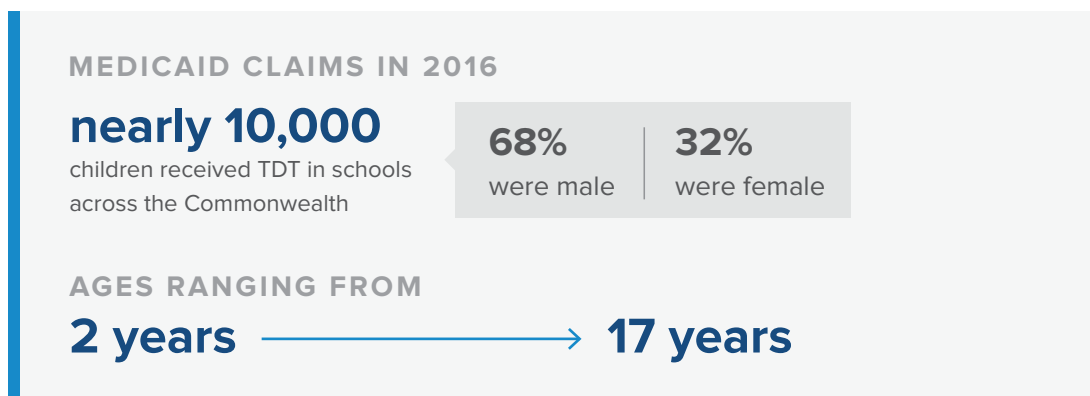
TIER 3

Intensive Intervention for few (1-5% of students): Provides more intensive, individualized interventions for highest risk students experiencing mental health challenges. School personnel collaborate with mental health providers and families to provide a coordinated system of care. The focus is promotion, prevention, and intervention to reduce symptoms. Services are most successful when they are collaboratively provided as either intensive school interventions with community support or intensive community interventions with school support.

School-based health centers (SBHCs) are primary care clinics located on elementary, middle, and high school campuses. Most SBHCs provide a combination of primary care, mental health care, substance abuse counseling, case management, dental health, nutrition education, health education, and health promotion. These centers emphasize prevention and early intervention, and usually operate as a partnership between the school district and a community health organization, such as a Federally Qualified Health Center (FQHC), health system, or the local health department.

Universal school-based strategies promote mental health well-being and prevent mental health problems. For example, Positive Action, a universal elementary and middle school-based intervention, reduces grade retention, suspensions, and absenteeism; improves reading and math proficiency; increases socio-emotional and character development; lowers self-reported substance use, violence, and bullying; increases peer and school self-esteem; and lowers depression and anxiety.[54]

Availability of lower acuity in addition to intermediate and higher acuity services in school-based settings expands access to a broader population of youth with behavioral health needs. Children and adolescents with access to mental health services in school (through school-based health centers) are 10 times more likely to seek care for mental health or substance abuse than those who do not.[65] A systematic review of the economic cost and benefits of school-based health centers demonstrated the economic benefit exceeds the intervention cost, with the benefit-cost ratio ranging from $1.38-$3.05 return for every $1 invested. Additionally, school-based health centers led to a net savings to Medicaid, ranging from $30-$969 per visit.[66] Project AWARE schools in Virginia have observed an increase in students served by school-based mental health professionals; increase in the number of students who were referred to community-based behavioral health services actually receiving services; and decreases in office discipline referrals, in-school suspensions, and out of school suspensions.[67]

Medicaid reimbursed school-based behavioral health supports in Virginia are primarily through the current Therapeutic Day Treatment services within the CMHRS service array.

MEDICAID CLAIMS IN 2016

nearly 10,000
children received TDT in schools across the Commonwealth

68%
were male

32%
were female

AGES RANGING FROM

2 years ⟶ **17 years**

The average age of initial authorization for TDT was six years and the average age of all recipients of TDT was ten years.

> The average length of stay for this service was reported as 405 days, with children receiving an average of 39 units per month, which equates to as high as 30 hours per week of treatment.

Overwhelmingly, the primary diagnoses for children in this service are Attention Deficit Hyperactivity Disorder (ADHD) and Oppositional Defiant Disorder (ODD). Additionally, there is no current requirement in the regulations that children receiving this service also are assessed for needs under IDEA. There is not outcome related data available for this service resulting in variable delivery and quality of the service. There is a strong evidence base and range of treatments and interventions for this targeted demographic of children and diagnoses that commonly present at this age. Specifically, ADHD is the most researched child mental health condition in the past 20 years, and the evidence around the treatment and interventions for this condition and its co-morbidities are not present in the current TDT treatment model with respect to level of intensity and duration, treatment interventions, medications, and family-child interventions.

Recommended Service Model

Due to the overwhelming evidence of the effectiveness of school-based services and imperative to deliver services in the settings where children primarily present with mental health issues, the redesigned continuum should significantly expand Medicaid funding for all school-based behavioral health services. Currently, DMAS uses an Administrative Claiming process to draw down 45% matching federal funds while the localities pay 55% of the costs for direct services in a Medicaid-covered student's Individualized Education Program. The DMAS-DBHDS team will continue to work with DOE to identify the best strategy to provide behavioral health services to youth in school settings that also best supports the learning environment.

To expand access to school-based services, DMAS should follow the Massachusetts School-Based Health Centers model and remove the requirement that the service be in the Individualized Education Plan (IEP) to be reimbursed by Medicaid. DMAS should also add additional covered services and behavioral health provider types who can deliver these services in schools. School-based behavioral health centers should serve as the foundational structure in a coordinated, tiered system of supports to ensure that the interventions delivered are individualized and evidence based.

DMAS should also request State General Funds as matching funds instead of requiring localities to pay 55% of the costs, to remove the financial burden from cash-strapped school districts with limited resources. This would allow Medicaid and FAMIS to fully reimburse the following services in schools that are currently covered but require local matching funds:

- Evidence-based practices delivered by Licensed Mental Health Professionals, including licensed professional counselors, licensed psychiatrists, licensed psychologists, licensed educational psychologists, licensed clinical social workers, licensed marriage and family therapists, and licensed school psychologists
- Grade-level physical, mental, and behavioral health screenings provided by licensed professional nurses and registered nurses

If schools receive full Medicaid funding for these services, they will have the resources to hire additional behavioral health clinicians as staff and expand the services they provide.

To fully support the DOE's Virginia Tiered System of Supports and robust evidence-based services available to all Medicaid and FAMIS covered children in schools, DMAS should also add coverage of the following school-based services:

- Evidence-based practices delivered to Medicaid and FAMIS members within all three tiers of the Virginia Tiered System of Supports with requirements for fidelity and use of standard definitions
- Applied Behavior Analysis services for individuals with an autism spectrum disorder and other neurocognitive developmental disorders by licensed Applied Behavior Analysts, licensed Assistant Applied Behavior Analysts, and autism specialists

DMAS, DBHDS, and VDH should also work with FQHCs, CSBs, health systems, private providers and local health departments to encourage the development of school-based health centers that are co-located on school campuses and staffed by primary care and behavioral health clinicians who address the comprehensive prevention and treatment needs of children and adolescents.

In addition, the new continuum should ensure that the school-based mental health clinicians offer extended therapeutic afterschool programs to youth who need more intensive interventions. Youth with moderate to serious behavioral health needs will also need support during the summer through therapeutic summer programs. Evidence-based extended therapeutic afterschool and summer programs are comprised of core components, and the service intensity is equivalent to an Intensive Outpatient Program (further described below), with the primary distinction of being in a school setting. This allows improved coordination and communication and access to this level of service acuity.

Finally, schools should be supported in leveraging telehealth to access appropriate evidence-based services and licensed behavioral health providers including psychiatrists and psychologists while ensuring linkage and collaboration with students' primary care providers and caregivers who have challenges in coming to the school for involvement in care. Schools should be recognized by DMAS as originating sites for telehealth and receive the Medicaid originating site facility fee to fund the necessary equipment and staff time.

When schools receive full Medicaid funding for the full array of prevention and treatment services, they will have the resources to hire additional behavioral health clinicians as staff and expand the services provided on-site by school staff. They will also be able to develop partnerships with FQHCs, CSBs, health systems, private providers and health departments to open school-based health centers that can provide a robust array of services.

> This robust array of fully-funded school-based prevention and treatment services will decrease the need for Therapeutic Day Treatment provided by private providers not employed by the schools and allow schools to transition away from Therapeutic Day Treatment (TDT) and towards evidence-based services for students with serious emotional disorders in school.

The transition from TDT to comprehensive school-based services will occur over time as the current TDT workforce receives ample training and support shifting towards more evidence-based intervention and service delivery.

INTEGRATED BEHAVIORAL HEALTH AND PRIMARY CARE

Description and Rationale

Integrated behavioral health and primary care is the care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization.[68]

Integrating behavioral health and primary care leads to coordinated, comprehensive care and is important to meet the needs of the members with mild to moderate behavioral health needs who are most commonly seen in primary care. Integrated care reduces barriers to access by treating individuals with early behavioral health symptoms immediately when they present, which prevents delays in treatment and worsening of symptoms. It also decreases referrals of individuals with mild to moderate illness to specialty mental health settings, which creates more capacity to serve patients with more severe mental health problems.

Integration of primary care into behavioral health setting is also important to meet the primary care needs of the population with Serious Mental Illness. This is a key component of the STEP-VA program. A number of CSBs have already established fully integrated primary care clinics, and primary care screenings will be implemented in all CSBs. Increasing access to primary care in the settings where individuals with SMI seek care is critical because of the high prevalence of chronic physical disease among individual with SMI, which results in premature mortality and significant decreases in life expectancy.[69]

Integrated behavioral health models include the Primary Care Behavioral Health model, Collaborative Care model, Certified Community Behavioral Health Clinics, or a hybrid approach (see Appendix A for additional model definitions). Coordinating care between primary care and external behavioral health services is also an important component of integrated care. Advanced behavioral health training for primary care providers through programs such as Project ECHO[44] can maximize their capacity to take care of patients' mental health needs.

INTEGRATION OF SERVICES IMPROVES OUTCOMES

66% of youth
have a better behavioral health outcome if received integrated care[70]

COLLABORATIVE CARE IN COMPARISON TO USUAL CARE

31% of adults
with depression have improved outcomes

41% of adults
with anxiety have improved outcomes[71]

> Integrated behavioral health has also been shown to reduce health care costs; typical cost savings from practices using the collaborative care model range from 5%-10% of total health care costs over a 2- to 4-year period.[72]

This evidence is particularly robust for adults with depression. In a study of safety-net primary care clinics, broad application of behavioral health interventions (i.e., including services such as counseling for weight loss, insomnia, medication adherence, etc. in addition to targeted mental health conditions like depression) led to an estimated $500,000 decrease in costs from decreased inpatient utilization, or a net savings of $66,667 per year after accounting for behavioral health clinician salary.[73] In a payment pilot providing three practices with an annual calculated amount to cover the costs of integrated care, net savings to public payers totaled over $1 million after 18 months, or a $2:1 return on investment.[74] Youth with serious behavioral health disorders who received integrated care for one year had a 32% reduction in emergency room costs and 74% reduction in psychiatric inpatient service costs.[75]

Members with comorbid chronic physical and behavioral health conditions are some of Virginia Medicaid's most expensive members,[76] offering the opportunity for significant cost reductions by improving care management and outcomes. While only one in five Medicaid beneficiaries had behavioral health diagnoses in 2011, those with comorbidities of physical and behavioral health conditions accounted for almost half of all Medicaid expenditures, with more than $131 billion spent on their Medicaid-covered services. Integrated behavioral health and primary care models are critical to meet the behavioral and physical health needs and control the costs of this complex population.

Recommended Service Model

The redesigned continuum will need to create strong incentives for primary care providers to implement integrated behavioral health care models to meet the needs of the large number of Medicaid members with behavioral health conditions who present in primary care. DMAS and DBHDS should develop value-based payment (VBP) models that promote the integration of behavioral health (BH) and primary care through financial incentives for integrated practices that achieve better cost and quality of care outcomes for Medicaid members. Common features of integration that should be incentivized include:[77-78]

- **Coordination** – Integration of on-site care managers into care team, which involves actions such as warm-hand offs or email and phone support to patients

- **Co-location** – Access to a BH specialist available on-site in the primary care practice as a member of a care team

- **Consultation** – Prompt access to BH specialist to engage patient needs, including brief focused therapy, co-consultation visits with both the primary care and BH providers present, or timely telehealth consultations

- **Integrated Care** – Co-located BH specialist is part of a broader, interactive team addressing the patient's physical and behavioral health needs, care coordination, follow-up, and facilitation of access to necessary care outside the team (Primary Care Behavioral Health model).

To ensure fidelity to evidence-based models and flexibility to meet the unique needs of different practice settings, DMAS and DBHDS should develop a limited menu of qualifying VBP options for integrated primary care and behavioral health models tailored for practices of varying levels of size and sophistication. Features specified by DMAS should include measures of accountability (e.g., emergency department utilization), characteristics of integration (e.g., co-consultations with both primary care and behavioral health providers), and structure of financial incentives.

The redesigned continuum could also include VBP models such as Medicaid behavioral health homes that offer enhanced reimbursement to support integrated primary care. This would provide a sustainable funding mechanism for the CSBs and other private providers that have hired primary care clinicians while creating a payment model to incentivize additional private and public behavioral health providers to provide integrated primary care.

> Telemental health is a core component of integrated behavioral health and primary care because it facilitates psychiatry and psychology consults for primary care providers and patients.

DMAS should add coverage of the Behavioral Health Care Coordination codes to promote integrated BH in primary care. These codes are used by Medicare and New York Medicaid to allow primary care clinicians to bill for monthly services provided using the Psychiatric Collaborative Care Model, an approach that enhances "usual" primary care by adding two key services, care management for patients receiving behavioral health treatment and regular psychiatric inter-specialty consultation to the primary care team, particularly regarding patients whose conditions are not improving.

The Virginia Mental Health Access Program (VMAP) is also an essential program in the redesigned continuum to support integrated behavioral health in pediatric primary care clinics through a robust consultation and care coordination model. Medicaid reimbursement of the Behavioral Health Care Coordination codes would also help ensure the sustainability of this important program.

Intensive Community-Based Support

Description and Rationale

Intensive community-based support services are intended to provide targeted, concentrated interventions for people in their home or other community settings to address mental health problems that require more comprehensive care than is offered in outpatient service alone. Intensive community supports are at the same time vital services for people transitioning from high-acuity settings like residential centers, group homes, and hospitals who would still benefit from more than traditional outpatient follow up. Intensive community-based support services help stabilize emotion dysregulation and decrease disruptive behaviors to prevent out-of-home placements. These services play an important role in integrating family, friends, and community members in the treatment and recovery process and in allowing for skills rehearsal in people's real life environments. Intensive home-based therapy aimed at reducing out-of-home placements is associated with decreased placement costs, decreased hospitalization, decreased incarceration, and decreased out-of-home placement.[54,79] Stakeholders have endorsed the need for greater use of evidence-based practices within Intensive Community-Based Support service delivery, training, and skill development for qualified mental health providers (QMHPs), and consistency in implementation and in expectations of providers.

Recommended Service Model

The delivery of intensive, community-based services within the new continuum will include a selection of evidence-based programs relevant to community settings to allow for treatment focus and intensity level that are suited to the needs of each person across the lifespan. This service category will include a new, Intermediate or Ancillary Home-Based Service (youth/adults), Multisystemic Therapy (youth), Functional Family Therapy (youth), High Fidelity Wraparound (youth), Intensive Community Treatment (youth/adults), and Assertive Community Treatment (adults). While not included in this initial recommendation, redesign will consider the best way to fund Therapeutic Foster Care to support the FFSPA implementation moving forward and integrate necessary service categories as planning evolves. There is a robust research base for the diagnoses most frequently experienced by people participating in this level of care, and redesign seeks to bring that strong evidence into action in our behavioral health system.

INTERMEDIATE OR ANCILLARY HOME-BASED SERVICE

It is recommended that the redesign of community-based services include an additional, intermediate level of home-based intervention. This service would support access to intermediate levels of mental health intervention or ancillary home-based support for those persons whose level or type of symptoms would benefit from:

1 more intensity than the traditional weekly hour of outpatient therapy affords and/or

2 ability to conduct intervention and/or behavioral rehearsal/activation of skills learned either with the licensed clinician or with an unlicensed professional in the home or community environment.

This type of service would also be of benefit in supporting transitions between levels of care. One example of this would be if a family is participating in an evidence-based Parent Management Training in a group at a school-based clinic (e.g., Incredible Years), an LMHP or QMHP could come to the home 2-4 hours per week to support the caregiver in practicing and problem solving adaptation of the skills in real-world situations in the natural environment. Another example would be a transitional aged youth patient participating in exposure and response prevention for Obsessive Compulsive Disorder in an integrated care or traditional outpatient program who would benefit from home-based rehearsal of the very challenging demands of skill rehearsal in their daily lives in order to speed treatment progress and generalization of the habituation response outside of the therapy room. A final example would be an adult struggling with hoarding and participating in cognitive-behavioral outpatient care who would benefit from support in the actual home where the hoarding behaviors occur in order to monitor, assess, and facilitate treatment progress.

MULTI-SYSTEMIC THERAPY

Multi-Systemic Therapy (MST) is an evidence-based program based on a social-ecological theoretical framework that was originally designed for youth with serious antisocial behavior and juvenile offenders but has since been shown to be effective with others including with families with child welfare involvement, youth in psychiatric crisis (suicidal ideation, psychosis), youth with severe emotional disorders, and youth with comorbid physical health problems.[80]

> MST strives to promote behavior change using the strengths of the systems with which the youth is involved (e.g., family, peers, school, neighborhood) to facilitate change.

Intervention strategies include strategic/structural family therapy, behavioral parent training, and cognitive behavioral therapies. The usual duration of MST treatment is approximately four months, with at least one weekly home visit. MST has been shown to produce positive outcomes within areas of conduct, delinquency and criminal behavior, externalizing and problematic behavior, illicit drug use, internalizing behavior, positive social/prosocial behavior and violence, as well as produce short and long-term reductions in out-of-home placements for juvenile offenders.[54]

FUNCTIONAL FAMILY THERAPY

Functional Family Therapy (FFT) is a short-term (approximately 30 hours) family-based therapeutic intervention for youth at risk for institutionalization and their families. It is applied in five phases (engagement, motivation, relational assessment, behavior change, and generalization) and designed to improve within-family attributions, family communication, and supportiveness while decreasing intense negativity and dysfunctional patterns of behavior.[54,81]

> Program outcomes observed with FFT include reductions in delinquency, criminal behavior, and illicit drug use.

Additionally, FFT has resulted in decreases in recidivism and out-of-home placement and improvements in family interaction patterns.[54,79]

HIGH FIDELITY WRAPAROUND

High Fidelity Wraparound (HFW) is a process led by a facilitator where multiple systems come together with the child and family to create a highly individualized plan to address complex emotional needs. The process is team-based care and keeps the youth and family at the center of service planning. HFW is a process that seeks to prevent out-of-home placements or can provide a transition from out-of-home placements by coordinating a single plan of care and wrapping other needed services including natural and peer support. Other services may be received under the HFW process include evidence-based programs such as MST, Trauma-Focused Cognitive Behavioral Therapy, or Parent-Child Interaction Therapy.[82]

The National Wraparound Implementation Center describes four phases to implement wraparound services with high fidelity.

PHASE 1
Engagement and team preparation to establish trust and a shared vision among the family and wraparound team;

PHASE 2
Initial care plan development following a high-quality planning process and incorporating the youth and family input;

PHASE 3
Implementation of initial wraparound, continuous review of progress and successes, and continued building of team cohesiveness and mutual respect;

PHASE 4
Transition plans are made out from formal wraparound to a mix of formal and natural supports in the community (including transitions to services and supports in the adult system if appropriate).[83]

A moderate level of evidence exists for high fidelity wraparound services, with some variation in the literature. Outcomes observed for high fidelity wraparound services include better behavioral, functional, and child welfare outcomes.[84] When implemented with fidelity, wraparound services can help overcome barriers to accessing effective services and supports for youth with complex needs and/or multiple agency involvement.

INTENSIVE COMMUNITY TREATMENT

Intensive Community Treatment (ICT) is a team-based, client-centered, intensive mental health service that adheres to evidence-based practice designed to serve individuals with severe mental illness. ICT services include psychiatric assessment, counseling, medication management, and care coordination activities through a designated multidisciplinary team of mental health professionals. ICT is part of the current service array; however, it is limited in population and scope. The model of service provision has effective indications in other existing interdisciplinary, team-based care in the Commonwealth. Programs that provide early intervention for severe mental illness, such as schizophrenia and bipolar disorder, are needed to reduce long term morbidity associated with these conditions, such as repeat psychiatric hospitalizations, decreased incidence of co-occurring conditions, and recurrence of severe episodes of symptom exacerbation. One such example is Coordinated Specialty Care (CSC), an evidence-based, standardized treatment for first episode psychosis, which is currently provided by eight CSBs to transitional age youth, ages 16-25 years, who have emerging serious mental illness.

First episode of psychosis is often an indicator of the emergence of serious mental illness such as schizophrenia, and evidence indicates that high intensity interventions provided at this stage of illness change the long term trajectory of the disorder towards reaching recovery goals effectively. People can and do experience recovery; yet, treatment at this stage is often inadequate.

> Statistics indicate that 70% of people who seek mental health care drop out after their first or second visit,[85] indicating that patient engagement is not achieved and results in significant negative consequences. Inadequate and delayed treatment of schizophrenia costs the U.S. economy an estimated $155.7 billion a year in direct health care costs, unemployment, and lost productivity of caregivers.[86]

Virginia uses a combination of Mental Health Block Grant set-aside funds and state funds to support CSC programs. States with strong CSC program implementation such as Oregon and New York have achieved statewide expansion through a combination of annual allocation of state funds, SAMHSA funding, commercial insurance, and Medicaid coverage. For the Commonwealth to achieve statewide expansion, Medicaid support is needed. This impact of evidence-based, high intensity treatments for early stages of SMI will result in decreasing the overall burden on inpatient psychiatric facilities.

ASSERTIVE COMMUNITY TREATMENT

Assertive Community Treatment (ACT) is an intensive, client-centered, recovery-oriented evidence-based practice designed to serve individuals with severe and persistent mental illnesses who have not benefited from traditional outpatient treatment.[87] ACT enables individuals experiencing severe symptoms and impairments to live and receive psychosocial rehabilitation in the community. Unlike ICT, ACT teams specifically serve individuals who have experienced severe and persistent psychosocial dysfunction, repeated hospitalizations or crises, or involvement in the criminal justice system. ACT is mainly indicated for people who have transferred out of an inpatient setting but would benefit from a similar level of care and are able to be served in a less restrictive environment and experience a higher quality of life.

> ACT effectively meets the needs of individuals with severe and persistent mental illness who are discharged from state psychiatric facilities and overall reduces hospitalization by 20%.[88-89]

The main goals of ACT are to: 1) keep mentally ill people in contact with services in the community; 2) reduce hospital admissions and inpatient costs among this population and; 3) improve social functioning and quality of life for this population.[90] Comprehensive evidence for ACT strongly supports it as a widely implemented community-supported treatment model.

Several systematic reviews have documented its effectiveness in keeping those with serious mental illness (SMI) adaptively functioning in the community, out of the hospital, and not engaging in criminal behavior. ACT has a strong theoretical foundation and defined model that team members and program structure adhere to. The practice components of ACT are:

- Multidisciplinary staffing including full-time psychiatrist

- Team-based approach with shared caseloads

- Integrated mental and physical health services

- Low client-staff ratios

- Contacts for clients in the community

- Multiple weekly client meetings

- Assertive outreach, such as delivering medications

- Focus on symptom management and everyday adaptive problems in functioning

- Ready to access in times of crisis (24/7)

- Individualized services, including: individual assessment and treatment planning; case management; crisis intervention; individual supportive therapy; medication prescription and monitoring and delivery; substance abuse services; work-related services; support for activities of daily living (ADLs); social, interpersonal relationship skill building; education, support, and consultation to client family and support; and coordination of hospital admissions and discharges.

Virginia currently operates 30 teams (25 Programs of Assertive Community Treatment or *PACT*, five Intensive Community Treatment) out of 27 of 40 CSBs. In order to achieve statewide expansion and availability of this highly effective, evidence-based service at every CSB in the Commonwealth, funding strategies through Medicaid need to be further explored. This is a service that can directly impact state psychiatric hospital census without resulting in lower levels of institutionalized or congregate care such as residential facilities and group homes. Mental health advocates describe this service as a "hospital without walls."

Intensive Clinic/Facility-Based Support

Intensive Clinic/Facility-Based Support services provide an intermediate level of care to individuals requiring a higher intensity of services than usual outpatient care in a less restrictive environment than residential treatment or inpatient hospitalization. These services include intensive outpatient treatment and partial hospitalization for children, adolescents, and adults. Both intensive outpatient and partial hospitalization provide alternatives to members at risk of psychiatric hospitalizations or residential placement and prevent institutionalization. They are also important to provide intensive supports to adults and youth transitioning from a psychiatric hospitalization or residential placement back to the community who need intensive group support for stabilization.

INTENSIVE OUTPATIENT PROGRAMS

Intensive Outpatient Programs (IOPs) are structured, outpatient programs that allow individuals to remain integrated within their daily lives by attending school or work, yet provide more intensity than routine outpatient care. Therapy and counseling are highly emphasized to attain or support progression towards symptom and functional improvement. The number of hours that patients participate in IOP vary depending on individual needs, but typically range from 6-30 hours per week, spread over 3 to 5 days.[91] With respect to substance abuse IOP for adults, ASAM defines IOP as 9 hours per week.

The length of treatment at this level of care is often cited as 90 days as programs focus on maintaining existing social functioning. However, IOPs offer increased flexibility with respect to the intensity and duration of services and may be an entry point for behavioral health treatment, a stepdown level of care from higher acuity services, or a step-up level of care when routine outpatient treatment is unsuccessful.

> The components of IOP treatment include increased intensity of individual, group, and family therapy, educational programming, development or strengthening of social supports, increased participation in positive recreational activities, and medication management.

Medication management should be available but less emphasized in IOP, and most patients maintain their own established psychiatric provider. Evidence exists that intensive outpatient programs are effective in combination with an assertive outreach component.[92-93] Patients with strong family and/or social supports also are well-suited for this level of care. Youth programs may be based in school, clinical, or hospital settings.[88,89]

IOPs are a critical component for behavioral health treatment and have good evidence for specific conditions such as eating disorders, Avoidant Restrictive Feeding Intake Disorder, Obsessive Compulsive Disorder, hoarding, and somatic disorders such as conversion disorder, and individuals with co-morbid physical and mental health conditions. IOPs for individuals with medical non-adherence due to the presence of co-morbid psychiatric conditions, such as diabetes and depression, sickle cell disorder and chronic pain, and co-occurring mental health and substance used disorders, are needed throughout the Commonwealth. Repeated hospitalizations due to treatment non-adherence for chronic health conditions are significant drivers of health care spending, and the rates of co-morbid mental health disorders compound this.

> In the U.S., patients with diabetes represent about 9% of the population, but account for approximately 25% of hospitalizations, with the prevalence of depression in adults with uncontrolled diabetes estimated to be 30%.[94-96] Less restrictive options that include early intervention services are needed to address the needs of individuals with medically complex and behavioral health needs.

Recommended Model

As the redesign is recovery focused and aims to meet the treatment needs of individuals in the least restrictive environment, the redesigned continuum should include a new Mental Health Intensive Outpatient Program (IOP) service for children, adolescents, and adults. The IOP should include options for intensive outpatient programming as aligned by evidence base for specific disorders such as those listed above.

> The ARTS program increased the evidence-based practices, provider qualifications, units, and reimbursement rates for the IOP service for members with Substance Use Disorder (SUD) based on the national American Society of Addiction Medicine (ASAM) criteria. As a result, the number of IOPs treating Medicaid members with SUD increased from 49 prior to the ARTS program to 136 programs that are ARTS IOPs and meet ASAM criteria.

Aligning the new Mental Health IOP service with the existing provider qualifications, units, and reimbursement rates for ARTS IOP services for adults and adolescents would allow clinics and hospitals to expand their existing ARTS IOP programs to add Mental Health IOP programs that can more effectively treat adults and adolescents with co-occurring SUD and mental illness. This would also allow rapid expansion of IOP programs due to the existing ARTS IOP program infrastructure and workforce employed by these programs.

The Mental Health IOP service definition should incorporate national evidence-based best practices. This includes integrated modalities of treatment to effectively treat co-occurring disorders and the use of certified or qualified mental health professionals to provide the various interventions needed for therapeutic, psychosocial support, and the use of educational consultants for children and adolescents to increase and support community linkage.

PARTIAL HOSPITALIZATION PROGRAMS

Description and Rationale

Partial hospitalization programs (PHPs) refer to time-limited, non-residential, ambulatory programs that deliver services on a level of intensity similar to inpatient programs but not on a 24-hour basis. Components of treatment may include therapeutic milieu; nursing services; psychiatric evaluation; medication management; and individual, group, and family therapy.[97-98]

> PHPs work best as part of a community continuum of mental health services. The focus remains on ensuring community linkage and close adherence to the daily life experiences of the patient.

To be an appropriate candidate for partial hospitalization, patients typically experience a mental health disorder that results in acute and severe dysfunction in multiple areas of daily life, yet should be stable enough to be medically unsupervised for periods of time, including overnight at home; able to remain safe to themselves and others; and able to participate and benefit from intensive, structured therapies. Patients discharged from PHP either step up to inpatient hospitalization if their acuity and safety concerns escalate, or step down to less intensive services in the community.

The American Association of Partial Hospitalization developed a set of standards for partial hospitalization programs that include the following requirements: minimum of 20 hours per week over a minimum of 5 days per week, use of a highly structured clinical program that emphasizes goal-directed interventions, and takes place within a stable therapeutic milieu. At least 65% of scheduled program hours should involve treatments that are targeted to the patients' presenting problems. Staffing is multidisciplinary, and there is a minimum staff to patient ratio of 1:4. Psychiatrists provide supervision and input tailored to patient needs and are available 24 hours a day.[99-100] The average length of stays at this level of care is 4-6 weeks. These youth programs may be based in clinic or hospital settings.[101-102] Adult programs can be based in clinic or hospital settings.

The effectiveness of the inclusion of partial hospitalizations within a continuum of behavioral services are evidenced through outcomes. Outcomes associated with partial hospitalization include prevention of full hospitalization, shorter treatment duration, and more rapid improvement in mental state for individuals with serious mental illness. Greater improvements in social functioning and higher patient and family satisfaction have also been associated with partial hospitalization compared to full hospitalization.[103] Partial hospitalization programs for children and youth are associated with improved outcomes in several domains: academic and behavioral improvement; reduction in or delay of psychiatric hospital placement; return to less restrictive school placements; and decreased symptom severity.[102,104-105] Evidence supports partial hospitalization for individuals with psychotic disorders, anxiety disorders, mood disorders, borderline personality disorder, and eating disorders.[106-108]

> Partial hospitalization is a cost-effective form of treatment and has shown to be less expensive than full hospitalization. Estimates range from partial hospitalization saving 20% of total costs per patient to being two-thirds the cost of full inpatient hospitalization.[106,109]

The costs of partial hospitalization are offset by a resulting long-term decreases in inpatient and emergency department utilization.[103,110] Partial hospitalization is also more cost effective and less expensive than full hospitalization for pediatric populations.[101]

Recommended Model

The redesigned continuum should include a new Partial Hospitalization Program (PHP) service for children, adolescents, and adults. The provider qualifications, units, and reimbursement rates for this service should fully align with the criteria for the ARTS Partial Hospitalization Program. A new Mental Health PHP service for children should be added to the continuum.

> The ARTS program created a new PHP service for adult and adolescent members with Substance Use Disorder (SUD) with evidence-based practices, provider qualifications, and units based on the American Society of Addiction Medicine. As a result, the number of PHPs treating Medicaid members with SUD increased from 0 prior to the ARTS program to 24 programs that are ARTS PHPs and meet ASAM criteria.

Aligning the new Mental Health PHP service with the existing ARTS PHP provider qualifications, units, and reimbursement rates will allow clinics and hospitals to quickly expand their existing ARTS PHP programs to add Mental Health PHP programs that can more effectively treat adults and youth with co-occurring SUD and mental illness.

The Mental Health PHP service definition should incorporate the national evidence-based best practices noted above. Ability to participate in group therapy is a key component of effective treatment at the IOP and PHP level of care. PHP, as compared to IOP, requires increased availability of psychiatry medical services. A stable and accessible home environment also increases success to community transition, therefore PHP programs are typically within one hour of an individual's residence.[111]

The current Medicaid-reimbursed Day Treatment service is rarely utilized because it is not structured or reimbursed at rates that allow for intensive treatment. It will be phased out and replaced by Partial Hospitalization Programs.

Comprehensive Crisis Services

Description and Rationale

Crisis Services assist individuals currently experiencing or having recently experienced a mental health crisis. These services include 23-hour crisis stabilization, short-term crisis residential stabilization services, mobile crisis services, 24/7 crisis hotlines, warm lines, and peer crisis services. 23-hour crisis stabilization provides individuals in crisis with up to 23 hours of supervised care to de-escalate the severity of their crisis or need for hospitalization. Short-term crisis residential stabilization services provide continuous 24-hour observation and supervision for individuals who are in crisis but do not require inpatient services. Mobile crisis services provide a rapid response to crisis, with assessment and definitive treatment conducted in the community, outside of a health care facility. 24/7 crisis hotlines are direct services delivered via telephone that provides a person in crisis with immediate support and referrals. This support includes problem-solving and coping skills. Warm lines are direct services delivered via telephone by trained mental health peers and those also in recovery.

> All of these services have a strong level of evidence and are associated with positive health and cost-effectiveness outcomes.

More limited evidence suggests improved symptom ratings with peer crisis services, which are services delivered by individuals with personal experience with mental illness in supportive community settings.[112]

Recommended Service Model

It is also recommended that current rates and regulations for crisis intervention and mobile services be assessed as increased access to outpatient services may have implications for the community need for mobile crisis services. Some people who have not yet entered services on the continuum may have their initial contact of support be through the form of a crisis service. STEP-VA is also committed to assuring access for comprehensive crisis services and will incorporate crisis services, including crisis stabilization and mobile crisis services, as part of the spectrum of care provided by CSBs.

> Within the Medicaid-funded behavioral health system, it is recommended to maintain crisis stabilization services and assure that their regulations reflect the new service additions and redesigns for recovery, rehabilitation and community-based services.

It is also recommended that current rates and regulations for crisis intervention and mobile services be assessed as increased access to outpatient services may have implications for the community need for mobile crisis services. Redesign within crisis services should also consider the role for peer supports in provision of these services. In considering the evaluation of access of crisis services outside of emergency rooms, redesign implementation planning should consider other states' approaches to comprehensive crisis for Medicaid-covered individuals across the lifespan (e.g., Masshealth Emergency Services Program / Mobile Crisis Intervention).

Group Home and Residential Services

Group home and residential treatment facilities provide 24-hour structure and mental health and substance use disorder treatment to individuals with serious emotional and behavioral health needs or individuals with substance use disorders who meet the ASAM multidimensional assessment criteria for this level of care. This level of care may be within community settings or hospital-based. Specialized group home and residential treatment services, such as those for substance use disorders, eating disorders, developmental disorders, and sexual offenders, are also recognized within this level of care due to the attention and adherence to evidence-based treatment modalities that are effective for specific disorders, but are limited throughout the Commonwealth.

In July, 2017, DMAS in collaboration with Magellan of Virginia (BHSA), implemented the Independent Assessment, Certification, and Coordination Team (IACCT), a locality-based, standardized approach to assess a child's comprehensive behavioral health needs. The IACCT is comprised of the child and family, clinical providers, educators, primary care physicians, care coordinators, and case managers who collaborate and assist with meeting the child and family's needs through an array of treatment options ranging from outpatient therapies to residential treatment. All individuals under age 21 years who are seeking group home or residential level of care have a single point of entry through the IACCT

of their locality. In collaboration with the local Family Assessment and Planning Team (FAPT), a child may enter these levels of care with educational funding through FAPT, the Department of Education, or scholarships with Medicaid funding all medically necessary treatment provided. Aligning the initial point of entry and funding streams for group home and residential treatment services is critical; however, this has not yet been achieved in the Commonwealth and poses significant challenges related to optimizing resources, access and consistency, establishing goals, and impacting long term outcomes.

> Research indicates that positive outcomes for children with severe behavioral and emotional disturbance and their families result from operationalizing values consistent with community-based system of care approaches in all settings.[113] Residential-specific research shows improved outcomes with shorter lengths of stay, increased family involvement, and stability and support in the post-residential environment.[114]

One example of an evidence-based framework is The Building Bridges Initiative which aims to achieve positive long term outcomes including reducing average length of stay, maintaining community tenure post-discharge, supporting families, reducing psychiatric symptomatology, and improving psychosocial functioning.[113] In addition to aligning the assessment process and funding streams, recommended models include short term residential treatment, enhanced reimbursement for high-fidelity, evidence-based, treatment programs, and removal of barriers that prevent community services from being initiated within group homes or residential facilities to promote transition of skills from facility to community.

Medicaid behavioral health redesign presents an opportunity to incorporate the evidence-based treatment modalities offered in multiple settings that are currently limited in adolescent and pediatric group home and residential settings.

> Effective treatment at this level of care can have a significant impact on reduction of the reliance on state psychiatric facilities to meet the needs of children and families with complex behavioral health needs.

Group home and residential services are within the continuum of services but specific redesign recommendations are beyond the scope of this document. It is recommended that more specific attention is given to evaluate this service due to the complex funding streams. DMAS and DBHDS should work with the Office of Children's Services and Department of Social Services to establish agreed upon evidence-based treatments and outcomes that align with the overall redesign as well as efforts of the FFPSA. DMAS should also work with the Medicaid MCOs to transition this carved out service into Medicaid Managed Care, which would allow the MCOs to provide comprehensive care coordination across all levels of services.

In addition, the redesigned continuum should add a new adult mental health residential treatment service that is carved into Medicaid Managed Care. This level of care would create an alternative to hospitalization and an important step-down option for individuals leaving private and state psychiatric hospitals. The provider qualifications and reimbursement structure for this benefit could be modeled after the ARTS Residential Treatment Service for individuals with Substance Use Disorder with the services including a number of the evidence-based practices described throughout this continuum. Moving forward quickly with the implementation of behavioral health redesign would position DMAS to successfully apply for and obtain the new Medicaid 1115 waiver that would draw down new federal Medicaid matching funds for adult mental health residential and inpatient treatment.

> After DMAS obtained the ARTS waiver and expanded coverage of SUD residential treatment from pregnant women to the entire Medicaid population with a SUD, the number of residential treatment providers participating in Medicaid increased from 4 to 94.

If Medicaid adds coverage of mental health adult residential treatment, many of the existing residential mental health providers in the Commonwealth that are accepting commercially insured individuals would likely accept Medicaid members, and the ARTS residential providers could quickly increase capacity by adding mental health programs.

Inpatient Hospitalization

Inpatient psychiatric hospitalization is not a focus of this redesign although is a key aspect of an overall continuum of mental health services. Individuals who require inpatient level of care, whether voluntary or involuntarily committed, like all behavioral health services, are best served in the community in which they reside and receive natural supports. The State Hospital Census Crisis is a significant driver for change of the mental health service array.

OVER THE PAST 5 YEARS

55% increase
in state psychiatric hospital admissions[115]

State facilities are now consistently operating at 95% capacity or higher. It is considered best practice to maintain capacity at 85% or lower.[116] At any point in time, approximately 200 individuals in the state hospitals are clinically ready for discharge but remain hospitalized due to lack of housing and needed services.[8] A robust array of housing, including permanent supportive housing, and a comprehensive continuum of community services is needed to provide meaningful options for community integration for individuals transitioning from inpatient treatment. Several evidence-based practices noted throughout the continuum are applicable in the inpatient setting, and it is recommended to better understand barriers that preclude the ability to provide enhanced services in the inpatient setting.

Conclusion

Virginia has a strong foundation for Medicaid behavioral health redesign due to the unprecedented interagency alignment of transformation initiatives including STEP-VA, the Medicaid ARTS program, Family First Prevention Act, Juvenile Justice EBP Implementation, Virginia Mental Health Access Program, High Fidelity Wraparound, and Project AWARE/ Tiered System of School Supports. The redesigned continuum draws upon the successful implementation of evidence-based practices by other agencies and embeds these practices across multiple levels of care and settings.

> Medicaid behavioral health redesign would provide sustainable Medicaid funding for critical initiatives such as STEP-VA by paying for the essential services in each step for the currently eligible and Medicaid expansion population.

DMAS and DBHDS built upon this strong foundation by convening the Behavioral Health Redesign Workgroup with leaders from multiple agencies as well as stakeholders from providers, Medicaid MCOs, and advocates who identified gaps and bright spots in behavioral health services for the Medicaid population. The input from the Workgroup and over 200 responses to the Farley Center's survey of stakeholders was incorporated into the integrated principles and specific services recommended in this continuum.

The redesigned continuum integrates core principles of building a trauma-informed system, supporting universal promotion and prevention, seamless transitions across levels of care, and a recovery-oriented framework. Key modalities and services are available across the continuum including telemental health, behavioral therapy supports, case management, and a recovery-oriented framework. Evidence-based recovery and rehabilitation services in the continuum include *Independent Living and Recovery Services, Peer Support Services, Psychosocial Rehabilitation, Permanent Supportive Housing, and Supported Employment*.

> The continuum incorporates evidence-based practices across an array of services that will provide the appropriate intensity to meet an individual's needs ranging from promotion and prevention to outpatient and integrated care.

Intensive community-based supports and intensive clinic/facility-based supports are structured to provide alternatives to hospitalizations. These services such as *Intermediate Community-Based Services, Multisystemic Therapy, Functional Family Therapy, High Fidelity Wraparound, ICT and PACT Team Support, Intensive Outpatient* and *Partial Hospitalization* will help keep individuals in the community and help with transitioning individuals out of residential and inpatient settings.

High intensity services such as *Comprehensive Crisis Services, Group Home and Residential Services*, and *Inpatient Hospitalization* will be targeted toward the highest need population. The continuum includes a new *Adult Mental Health Residential Treatment Service* that could be funded through a new Medicaid 1115 waiver that would draw down new federal Medicaid matching funds for residential and inpatient treatment. The waiver is contingent on Virginia first moving forward quickly with implementing behavioral health redesign.

DMAS successfully worked with other agencies and stakeholders to design and develop the ARTS benefit and waiver and transform the Medicaid SUD delivery system into an evidence-based continuum. DMAS and DBHDS should use the same approach by continuing to engage the Behavioral Health Redesign Workgroup in designing each service in the continuum, developing a plan for comprehensive workforce training, and implementing the continuum. This Workgroup would also advise on development of an 1115 waiver application to CMS including identifying and adapting evidence-based assessment tools that use clinical assessments to match individuals with SMI and SED to standardized levels of care based on their clinical need. Finally, the Workgroup would also advise on streamlining the credentialing, service authorization, and billing requirements for the new services to decrease administrative burden and achieve efficiencies for providers and MCOs.

The 1115 waiver could draw significant new federal funds to help pay for new services such as adult residential treatment. Even with this additional funding, DMAS will need to perform a comprehensive financial analysis of the cost of the new mental health services proposed for the continuum.

> The overall vision of behavioral health redesign is to rebalance Virginia's Medicaid mental health system away from high cost inpatient hospital and residential settings toward lower cost comprehensive outpatient and prevention and promotion services and evidence-based community services. Redirection of funding toward a more robust array of outpatient services, integrated behavioral health services in primary care and schools, and intensive community-based and clinic-based supports will yield improved outcomes and reduce downstream costs of ED visits and hospitalizations to the Medicaid program.

DMAS was already directed by the General Assembly to include a Medicaid housing and employment supports benefit in the COMPASS 1115 waiver, and will need to request additional General Funds in the next biennial budget to implement these supports.

> DMAS and DBHDS will strive to work within a framework of budget neutrality to ensure that the cost of any new behavioral health services and rate increases will be balanced by new federal dollars, savings from state funds currently spent on state psychiatric hospitals, transitioning away from high cost, non-evidence-based services, and downstream cost savings.

DMAS shall report to the Administration and General Assembly if any additional General Funds will be required to increase the reimbursement rates for Licensed Mental Health Professionals or implement any of the recommended behavioral health services in this continuum.

Implementation of this redesigned continuum by 2020 would position Virginia to dramatically improve outcomes for Medicaid-covered adults and children. Since Medicaid is the primary payor for behavioral health in Virginia, leveraging the redesign of the Medicaid benefit and reimbursement structure could drive improvement of the entire mental health delivery system for all Virginians.

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Appendix A. Acronyms Used and Additional Definitions

AAP - American Academy of Pediatrics

ABA - applied behavior analysis

ACRE - Association of Community Rehabilitation Educators

ACT - Assertive Community Treatment

ADHD - attention deficit hyperactivity disorder

APSE - Association of Persons Supporting Employment First

ARTS - Addiction Recovery and Treatment Services

ASAM - American Society of Addiction Medicine

ASD - autism spectrum disorder

ASTHO - Association of State and Territorial Health Officials

BHSA - behavioral health services administrator

CCBHC - Certified Community Behavioral Health Clinic

CMS - Centers for Medicare and Medicaid Services

CPRS - certified peer recovery specialists

CPT - Current Procedural Terminology

CSB - Community Service Board

CSC - coordinated specialty care

DARS - Department of Aging and Rehabilitative Services

DBHDS - Department of Behavioral Health and Developmental Services

DHCD - Department of Housing and Community Development

DJJ - Department of Juvenile Justice

DMAS - Department of Medical Assistance Services

DOE - Department of Education

DSS - Department of Social Services

EBP - evidence-based practice

FAMIS - Family Access to Medical Insurance Security

FAPT - family assessment and planning team

FFPSA - Families First Prevention Services Act

FFT - Functional Family Therapy

FQHC - Federally-Qualified Health Center

HANDS - Health Access Nurturing Development Services

HFA - Health Families America

HFW - high fidelity wraparound

IACCT - independent assessment, certification, and coordination team

IC&RC - International Certification and Reciprocity Consortium

ICM - Intensive Case Management

ICT - intensive community treatment

IDEA - Individuals with Disabilities Education Act

IEP - Individualized Education Program

IOP - intensive outpatient program

JCHC - Joint Commission on Health Care

JLARC- Joint Legislative Audit and Review Commission

LMHP - licensed mental health professional

MAP - Managing and Adapting Practice

MCO - Managed Care Organization

MHPSA - mental health professional shortage area

MST - Multi-Systemic Therapy

NPHPS - National Public Health Performance Standards

OCS - Office of Children's Services

ODD - oppositional defiant disorder

PATH - Projects for Assistance in Transition from Homelessness

PHP - partial hospitalization program

PSH- permanent supportive housing

QMHP - qualified mental health professional

QMHP - Qualified Mental Health Provider

SAMHSA - Substance Abuse and Mental Health Services Administration

SDOH - social determinants of health

SED - serious emotional disturbance

SMI - serious mental illness

STEP-VA - System Transformation Excellence and Performance Virginia

SUD - substance use disorder

TDO - temporary detention order

TDT - therapeutic day treatment

VBP - value-based payment

VDH- Virginia Department of Health

VHDA - Virginia Housing and Development Authority

VMAP - Virginia Mental Health Access Program

ADDITIONAL DEFINITIONS

Behavioral and mental health care — Behavioral and mental health care refers to a broad array of services and treatments to help people with mental illness and those at particular risk of developing them to suffer less emotional pain and disability and live healthier, longer, more productive lives.[68] For the purposes of this report, this definition is expanded to include health promotion and prevention as described in the Institute of Medicine's continuum of mental health care. This review focuses on behavioral health services to address mental health problems, excluding substance use. Through the development and implementation of Virginia's Medicaid Addiction and Recovery Treatment Services (ARTS) program, evidence to inform best practices from the American Society of Addiction Medicine was already incorporated across the entire continuum of addiction treatment services. In this report, the term behavioral health is used broadly to refer to services and systems of care, while mental health is used to refer to symptoms, conditions, and providers.

Level of care — refers to the intensity of a treatment, intervention, or program.

Setting of care — refers to the location(s) in which a treatment, intervention, or program is delivered.

Evidence-based practice — Across the continuum, practices and interventions were selected from the highest level of evidence available, applying David Sackett's definition for evidence-based practice: "the conscientious, explicit and judicious use of current best evidence in making decisions about the care of the individual patient. It means integrating individual clinical expertise with the best available external clinical evidence from systematic research."[117]

Specific Models of Integrated Care — The Primary Care Behavioral Health Model (PCBH): The PCBH model is a specific type of integrated care that incorporates into the primary care team a behavioral health consultant (BHC) to extend and support the primary care provider and team to manage behavioral health problems and biopsychosocially influenced health conditions. The BHC works as a generalist and an educator who providers high volume services that are accessible, team-based and a routine part of primary care.[118]

Distinguishing features of the PCBH model include:

- **Generalist:** The BHC serves patients of any age and with any biopsychosocially influenced health condition, including mental health and substance use problems, chronic ideas, preventive care needs, social and sub-diagnostic problems, and medically unexplained problems.

- **Accessibility:** BHC aims to see patients on the same day the primary care provider requests their services; BHC engages in warm handoffs, case discussions, and consultations. BHC uses shorter appointment blocks than in traditional mental health settings to see a higher patient volume.

- **Team-based:** BHC is viewed by patients, providers, and staff as a routine care team member.

- **Educator:** BHC works with the primary care team to make them more skilled, comfortable, and efficient in working with biopsychosocial issues of patients.

The Collaborative Care Model: Collaborative Care is a specific type of integrated care that treats common mental health conditions such as depression and anxiety that require systematic follow-up due to their persistent nature. Based in the Chronic Care Model, Collaborative Care focuses on defined patient populations tracked in a registry, measurement-based practice and treatment to a specified target. Trained primary care providers and embedded behavioral health professionals provide evidence-based medication or psychosocial treatments, supported by regular psychiatric case consultation and treatment adjustment for patients who are not improving as expected.[119]

Distinguishing features of the Collaborative Care model include:

- **Population-focused:** Collaborative Care team is responsible for a defined population of patients.

- **Team-based:** The multidisciplinary team includes the primary care provider, a consulting psychiatrist, and a behavioral health-trained care manager with each empowered to work at the top level of their training.

- **Measurement-guided:** Care team uses systematic, disease-specific, patient-reported outcome measures to drive clinical decision-making.

- **Evidence-based:** Care team adapts scientifically proven treatment within an individual clinical context to achieve improved health outcomes.

Certified Community Behavioral Health Clinics (CCBHCs): CCBHCs provide a comprehensive range of mental health and substance use disorder services to individuals with behavioral health needs including serious mental illness, serious emotional disturbance, chronic addiction and substance use disorders, and mild or moderate mental illness. This model was defined in the Excellence in Mental Health Act. CCBHCs receive an enhanced Medicaid reimbursement rate to cover their expanded services.

Distinguishing features of the CCBHC model include:

- **Comprehensive:** CCBHCs must include 24/7 crisis services, immediate screening and risk assessment including for both behavioral health and primary care needs, targeted case management, psychiatric rehabilitation services, outpatient mental health and substance use services, peer support and family supports, person-centered treatment planning, and intensive community-based mental health care for members of the armed forces and veterans.

- **Accessibility:** Criteria for CCBHCs include a reduced wait time for services. CCBHCs can receive payment for care outside of the clinic, including through mobile crisis teams, home visits, outreach workers, and emergency or jail diversion programs.

- **Coordinated:** Expanded care coordination links care with other health care providers, social service providers and law enforcement.[120]

Appendix B. Additional Resources and Tools

Promotion and Prevention

1   Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities, National Research Council and Institute of Medicine Report, https://www.nap.edu/catalog/12480/preventing-mental-emotional-and- behavioral-disorders-among-young-people-progress

2   Repositories of evidence-based programs and practices:

  – Blueprints for Healthy Youth Development, Center for the Study and Prevention of Violence, University of Colorado Boulder Institute of Behavioral Science http://www.blueprintsprograms.com/

  – Evidence-Based Practices Resource Center, Substance Abuse and Mental Health Services Administration, https://www.samhsa.gov/ebp-resource-center

3   Financing mechanisms:

  – National Academy for State Health Policy brief, Medicaid Financing of Home Visiting Services for Women, Children, and Their Families[59]

  – National Center for Children in Poverty report, Using Medicaid to Help Young Children and Parents Access Mental Health Services[121]

  – Child and Family Policy Center report, A Sourcebook on Medicaid's Role in Early Childhood: Advancing High Performing Medical Homes and Improving Lifelong Health. Child and Family Policy Center[122]

Outpatient and Integrated Care

1   Repositories of evidence-based psychotherapeutic modalities:

  – Substance Abuse and Mental Health Services Administration: Treatments for Mental Disorders, https://www.samhsa.gov/ treatment/mental-disorders

  – American Psychological Association Society of Clinical Psychology, Division 12 Psychological Treatments, https://www.div12.org/psychological-treatments/

  – Report of the Virginia Commission on Youth: Collection of Evidence-based Practices for Children and Adolescents with Mental Health Treatment Needs - Reference Chart of Evidence-Based Practices[123]

  – PracticeWise Evidence-Based Service Database for Youth, https://www.practicewise.com/

2   Additional information on use of the Prospective Payment System for CCBHCs:

   –   Substance Abuse and Mental Health Services Administration Prospective Payment System (PPS) Reference Guide, https://www.samhsa.gov/section-223/certification-resource-guides/prospective-payment-system

   –   National Council for Behavioral Health, Getting Paid as a CCBHC (see under "What do I have to do to be ready for PPS and cost reporting?", https://www.thenationalcouncil.org/topics-a-z/getting-paid-ccbhc/

Permanent Supportive Housing

1   US Interagency Council on Homelessness Supportive Housing Opportunities Planner – spreadsheet with inputs (number chronically homeless, number housing units) and outputs (number housed)

2   US Department of Housing and Urban Development Toolkit – section on Developing a Medicaid Supportive Housing Benefit includes sample language from other states to use in waiver applications and a decision point table

3   SAMHSA Permanent Supportive Housing Evidence-based Practices KIT

4   State Health and Value Strategies handouts – includes links in best practices document[124]

5   Information sharing resources:

   –   The Administration for Children and Families toolkits

   –   The Council of Large Public Housing Authorities data sharing templates for housing and education sectors

   –   Other examples of data sharing across sectors: Data Across Sectors for Health (DASH), All in: Data for Community Health, National Neighborhood Indicators Partnership (Urban Institute), KIDS COUNT

Supported Employment

1   SAMHSA Supported Employment Evidence-Based Practices KIT[125]

Transitions

1   Additional resources for transitional age youth:

   a.   Got Transition, The National Alliance to Advance Adolescent Health, www.gottransition.org

   b.   California Evidence-Based Clearinghouse for Child Welfare, cebc4cw.org