Category	Question	Answer
General	How will the potential federal level cuts to funding affect the BH redesign?	Currently, there is no impact.
	Are there any scheduled TA sessions?	DMAS will communicate with providers when provider office hours are scheduled. Our current plan, which is subject to change is to start provider office hours in September 2025.
	Are there any cross walks completed integrated with CPST and all other services along with DMAS, Licensure and MCO's?	We are working on a crosswalk and will make it available to providers as soon as it's finalized.
	Where is the DRAFT of the guidelines located?	There is not a draft of the current services available. A prior draft was posted for public comment in December, but there have been significant changes since that time. A draft is forthcoming, tentatively planned for September, 2025. The information provided in the slide deck for this webinar which has been posted along with this Q&A is the most up to date information available.
	How will you tease out the first incident cases versus an ASD in Crisis who is having a meltdown and needs more support and services? Once again, how will you keep inappropriately placing ASD in this process?	Comprehensive clinical assessment is a required component, including differential diagnosis. Individuals with ASD may be appropriate for redesigned mental health services if they have a co-occurring primary mental health diagnosis. If there is not a primary mental health diagnosis, CPST, Coordinated Specialty Care, or Clubhouse would not be authorized services.
Case Management Updates	With the redesign, will Mental Health Case Management services be allowed to be delivered in settings other than community service boards? For example, outpatient hospital-based programs, or office-based services? Will case management services be available for the private sector to provide?	Community Services Boards (CSBs) will remain the sole provider per § 37.2-500 (Purpose; community services board; services to be provided). CSBs may contract out the provision of these services for their catchment area if needed.
	When will the policy changes for mental health case management be shared?	DMAS' current plan, which is subject to change, is to share draft policy changes for the new services and Mental Health Case Management in September 2025.
	Will the restructure affect Treatment Foster Care case management authorizations?	No
	Is case management only going to be provided under CPST ?	No, Case Management will remain a separate service. Care coordination is a required component of CPST.

Category	Question	Answer
Case Management Updates (cont.)	Are child and youth case managers required to be complete MAP training?	This will not be an initial requirement. Case managers will be required to complete the foundational trainings (still in development, but for example, Person Centered Treatment Planning) but not the full MAP curriculum.
	We really need more information about the case management piece. Can you please consider doing service specific webinars? The information was confusing as so much time was spent on CPST. We need to know what we need to do to restructure. We are a CSB.	A draft service description will be provided as soon as feasible. CSBs were involved in the development process and we continue to coordinate with VACSB.
Provider Requirements/ Licensing	Are we going to have to apply for a new license?	Yes, DMAS and DBHDS are working toward development of new licenses for the new services and will provide information to providers as soon as we are able.
	How long and arduous will the process be for agencies to become licensed through DBHDS? It took years for initial licenses in the past.	Our tentative plan is to have required Letters of Intent due in October or November 2025. To ensure a smooth transition for our members to a provider licensed to provide the new services, agencies that meet the requirements and submit a completed application with all required documentation by the deadline (which has not been set) will be licensed prior to Go Live July 1, 2026 .
Assessment Changes	Is there going to be an adults CANS assessment developed for 21 and over adults.	Yes. Some stakeholders may be familiar with the Child and Adolescent Needs and Strengths (CANS) which is a multi-purpose tool developed for children's services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. There is a corresponding adult assessment called the Adult Needs and Strengths Assessment (ANSA). You may find each of these assessments here: https://praedfoundation.org/DMAS will require a version of the CANS or ANSA to be completed in collaboration with each youth or adult and a corresponding Level of Need (LON). DMAS is calling this assessment the Comprehensive Assessment of Needs and Strengths (CANS Lifetime) for both youth and adults.

Category	Question	Answer
Assessment Changes (continued)	Is the CANS replacing the Comprehensive needs assessment for CPST and or for all services?	In addition to the CANS Lifetime assessment, providers are expected to include sensitive, reliable and valid clinical assessments such as symptom checklists appropriate to the population served on a more regular basis to inform treatment approaches and monitor progress. As part of the proposed Serious Mental Illness 1115 waiver, a statewide Level of Care (Level of Need) model is required. Currently, our plan is to implement the CANS for the redesigned services and continue to assess how the CANS should be integrated into other existing services.
	How will the CANS, DLA 20 and the CNA complement each other? Is the CNA being retired will the CANS replace it for our adult populations?	The CANS Lifetime assessment will replace the Comprehensive Needs Assessment (CNA) as the required standardized assessment for Community Psychiatric Support and Treatment, Clubhouse and Coordinated Specialty Care on July 1, 2026. We are planning a phased in approach to replace the CNA with the CANS Lifetime for most of our other services after July 1, 2026.
	Does the CANS replace/identify the tiered placement of services (billable units)?	The CANS and clinical assessment will identify a Level of Need (tentatively, Levels 1-6). CPST will be authorized by Tiers (tentatively, Level of Need Two and Three would be authorized Tier 1 CPST, and Level of Need Four through Six would be authorized for Tier 2 CPST, after being screened for referral for standalone EBPs including ACT, MST, FFT, and CSC). Level of Need 1 would not meet criteria for CPST authorization. More information about the Level of Need model is in development and will be shared with providers when it's available.
	Will DMAS/DBHDS be developing its own format and training for CANS-Lifetime, or will providers be expected to take standardized training for CANS and ANSA?	DMAS and DBHDS are developing CANS Lifetime training specific for Virginia. Information about how to participate in this training will be communicated as soon as it is available.
CPST Program/ Reimbursement Structure	Under the Rates list, for the Assessment, it states "Unit Rate (90 min), each (LMHP and QMHP). Can you explain more what is meant here? Can the LMHP be reimbursed for 90 minutes of the assessment and the QMHP for 90 minutes of supportive information gathering, thus billing 2 total units for the assessment?	The assumption that the rate study used to create the rate was 90 minutes of LMHP time and 90 minutes of QMHP time. The rate for the actual CANS Lifetime assessment is a flat rate of $323.46 per assessment, no matter how much time the LMHP and if needed QMHP time works on the assessment.

Category	Question	Answer
CPST Program/ Reimbursement Structure (continued)	What are the CPST Team (for Tier 1 and Tier 2) caseload limits?	Information on caseload limits are being finalized and will be shared with providers when it is available.
	Three part question: For the CPST services what will the actual required team make up? What are the hierarchy (position) layers with a CPST? Is CPST a carved-out section and a license needs to be applied?	The team based approach refers primarily to Virginia's newly codified definition of *collaborative behavioral health services*. Team make-up will vary based on licensure status, to meet the supervision and service component requirements. **CPST will be billed by the professional type who is working directly with the client at the time, not based on team composition overall.** There may be instances where multiple team members are present at the same time, and billing guidance will be forthcoming. A tentative framework is provided here for illustration purposes, but is subject to change. For Tier 1 services, teams could range from two to three individuals, with up to two individuals working directly with the client on a regular basis. The possible formations would be (1) a QMHP-type and a fully licensed supervisor who provides the assessment, therapy, planning, AND supervision on the case; (2) a QMHP-type, a license-eligible provider, and a fully licensed supervisor where the fully licensed supervisor does not interact directly with the client but supervises both the QMHP and the license-eligible providers' activities on the case; or (3) a license-eligible provider providing all components of CPST directly under the direction of a fully licensed supervisor. For Tier 2 services, the additional repetition/practice component and associated additional hours of service can be provided by a Behavioral Health Technician, a new role in Virginia's workforce. For Tier 2 services, teams could range from two to four individuals, with up to three individuals working directly with the client on a regular basis, depending on the licensure status of the individual providing the assessment, therapy, and planning components and whether a Behavioral Health Technician is part of the team.
	For the new CPST Community based services when there is a Team of an LMHP and QMHP etc. Are they both billing for their individual rates during that time of providing services?	Billing requirements and guidance have not yet been finalized. Although the CPST is a team-based service, most of the team work will happen at the agency level (weekly team meetings, supervision, etc.) and not with the individual. When the individual is participating in CPST services, they will generally participate with one staff person at a time, not with the entire team. There may be encounters with multiple team members, but this will likely not be the norm. DMAS will include billing guidance for these encounters in our draft policy.

Category	Question	Answer
CPST Program/ Reimbursement Structure (continued)	What is meant by the assessment and the ISP ultimately being the "responsibility" of the LMHP? Can QMHPs write and submit an ISP as long as an LMHP signs and approves it? Or must it be submitted under the LMHP in the EHR?	Treatment planning and thus developing the goals and objectives and corresponding interventions on an ISP is only in the scope of practice for an LMHP in Virginia. A QMHP cannot develop an Individual Service Plan (ISP) as per their scope of practice. The LMHP is responsible for the development, and ultimately the implementation of the ISP. The QMHP, under the collaborative behavioral health services framework, can assist with components of the assessment, including the CANS, and implement components of the ISP. CPST service components have been aligned with current Virginia scope of practice, with QMHPs being allowed to implement components such as restorative live skills training, crisis support, care coordination and rehabilitation skills practice. The actual documenting in the EHR of the developed plan can be completed by any team member, however, all team members that are working with the individual will sign the ISP including the LMHP supervisor.
CPST General Questions	How will you bill for someone with Autism Spectrum Disorder (ASD) who does not have a Mental Health DX but is sent to these processes?	Community Psychiatric Support and Treatment will require a primary mental health diagnosis. During the standardized comprehensive assessment of needs and strengths, a level of need will be identified and correlating services for that level of need. If an individual has Autism Spectrum Disorder and no co-occurring primary mental health diagnosis, the individual would not meet criteria for CPST and would be referred to services that would need their needs with the diagnosis of Autism Spectrum Disorder.
	Can Outpatient, Case Management and individual Therapy be provided outside of CPST?	Yes
	Are the MAP trainings posted on the DBHDS website?	Information regarding the Managing and Adapting (MAP) trainings via DBHDS is forth coming in the Fall 2025.
	For CPST, is a client required to receive all 7 or 8 of the services (depending on the tier)? Or can they only choose or be recommended for certain services, based on client preference and ability level? For example, if they are not a good candidate for psychotherapy, do they have to receive psychotherapy through CPST?	There will be a specific set of covered service components that are required for CPST. Psychotherapy will not be a required service component of CPST, unless it is an identified treatment need in the CANS Lifetime Assessment. Additionally, statewide training will include supports to develop competencies for approaches to psychotherapy with individuals with the conditions treated by CPST.

Category	Question	Answer
CPST General Questions (continued)	Which of the CPST components can be provided in a group setting?	Tentative plan is for Psychotherapy and Restorative Life Skills Training to be available in a group format, this is subject to change.
	Are authorizations and registrations required for the CPST services?	Yes, preservice and concurrent authorizations will be required for CPST.
Clubhouse General Questions	What is the length of the day for Clubhouse services? The rate states it is per diem but the length of the day is not established.	Rate study rates were developed based on Clubhouses operating 5 days a week, 8am-3pm, with one weeknight or weekend activity per week. Policy has not been finalized at this time but will be generally in line with the rate assumptions.
	How is per diem defined for PSR?	Five days a week, five hours a day was assumed in the rate study. Membership and attendance at Clubhouse activities is voluntary and Clubhouses are open to members during operating hours; whether or not they are present for any specified amount of time. Billing guidance regarding when the per diem is billable is still in development.
Redesign Impact on Legacy Services	Is there a specific date when IIH will no longer be covered by Medicaid?	IIH will no longer be covered by Medicaid when the new redesign services go live on 7/1/2026.
	If a provider is only licensed for intensive in Home under the new guidelines, will they be able to provide TDT and mental health skill building?	Therapeutic Day Treatment and Mental Health Skill Building will no longer be covered as of July 1, 2026. There will not be a new Intensive In Home license under the new guidelines.
	Psychiatrists reimbursement rates - are those changing?	No
	Our agency is currently licensed with DBHDS for Skill Building, but we provide therapy/ counseling independent of being licensed for therapy as all of our staff are independently licensed. Will we have to be licensed for therapy to provide these services.?	A DBHDS license for Community Psychiatric Support and Treatment, Clubhouse and or Coordinated Specialty Care will be required to provide any of the new services. All agencies will have to have a full-time independently licensed LMHP on staff to become licensed to provide CPST or Coordinated Specialty Care.

Category	Question	Answer
Redesign Impact on BRAVO and ARTS	How will the CPST be different from ACT? Will there be overlap? Can you describe when individual should be referred to ACT versus CPST for adults?	CPST and ACT are separate services with distinct medical necessity criteria. However, there is some overlap concerning the types of interventions that may be provided within each of these services. ACT requires additional team members above what CPST requires, including a prescriber, nurses, vocational specialists, etc. The differentiation of which service may be the best fit for the individual will be determined with the individual during the CANS Lifetime assessment and corresponding Level of Need (LON) determination. As a general rule, if an individual meets the medical necessity criteria for ACT and ACT is available to the individual, the individual would receive ACT and not CPST. But, there are many presentations where an individual may need an ACT-like service but does not meet the criteria for ACT. These individuals may meet criteria for CPST. Relatedly, an individual may be referred to Tier 1 CPST as a step-down from ACT.
	How are we going to factor in an SUD IOP? Are the ARTS regulations going to be revised to support this change?	Behavioral Health Redesign does not authorize any changes to ARTS regulations.
Managed Care Administration	How are yall going to keep MCOs from limiting their coverage areas and ending contracts with providers without reason thus limiting options of behavioral care for individuals. What information will have to be shared documentation wise with MCOs for authorizations and changes in billing	MCOs will be required to have adequate networks of providers across Virginia. MCOs are not required to contract with any willing provider but will be required to demonstrate that they have an adequate network to meet the needs of each community based on population, drive time/distance, and other factors such as wait times for appointments. Standards specific to these services have not been developed at this time.
	Will the credentialing process and authorization process with the MCOs be streamlined and will there be any sort of consistency among the MCOs as there seems to be huge discrepancies currently?	MCOs, DBHDS, and DMAS will be working together closely for initial licensure (DBHDS), enrollment (DMAS), and credentialing (MCOs). Although we will not be formally making any changes to each MCO's credentialing process, we believe the coordinated approach will decrease burden on providers. Regarding authorization, the standardized assessment, Level of Need model, and tiered nature of the service and associated hours of service per tier should lead to decreased burden between providers and MCOs. Please send specific ideas for streamlining to enhancedbh@dmas.virginia.gov for our consideration.

Category	Question	Answer
DOE/CSA Impacts	For the CPST in the school setting- what has been DOE's engagement? Is there a requirement for schools to allow this model in their schools? Or will it be school choice?	DOE was involved in the rate study planning meetings that occurred over the past state fiscal year. A local education agency stakeholder specific survey was also conducted during the research period. DMAS will engage DOE this year with reviewing any policy that is written regarding CPST-school setting and discussing communication strategies to assist school divisions with making the decisions regarding mental health services provision. Each school division functions independently at the local level with state department support and guidance. Many local school districts operate their own School Based Medicaid Service programs, which can include behavioral health services. These services are distinct from the rehabilitative mental health services (such as TDT historically and CPST in the future) offered through managed care health plans and Fee-for-Service Medicaid. More information about these programs can be found here: https://www.doe.virginia.gov/programs-services/student-services/specialized-student-support-services/school-health-services/medicaid-schools
	Will OCS align their procedures and requirements for CSA with these new services? For example, TDT, IIHS and MHSS are specifically noted in the manual and CSA has to ensure DMAS eligibility is met for youth who do not have Medicaid but CSA is buying the service.	OCS is working closely with DMAS on this project and will communicate updates to providers as they are available.
	Will providers who perform a CANs assessment that Medicaid funds enter the score in CANVAS? and will CSA be able to use that CANS for our required submissions to OCS? Can CSA case managers use that CANS to meet OCS requirements?	These details have not been finalized. We are working closely with OCS and the managed care health plans to determine options and a plan for CANS data entry and transmission.
	Will DMAS sponsor a training for CSA coordinators about the new services and requirements? Will DMAS perhaps provide a workshop at the annual CSA conference about these changes?	We do not have formal plans (i.e., dates) for this at this time but agree this is an important component of the implementation and typically present at the annual CSA conference.