

DMAS Behavioral Health Services Redesign

DRAFT-Member Transition Plan

Implementation Date: July 1, 2027

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Section 1. Purpose and Scope

This plan establishes the operational steps that Virginia's Cardinal Care Managed Care Organizations (CCMCOs) and Acentra Health, the DMAS fee-for-service (FFS) service authorization contractor, will take to transition Medicaid members from the legacy Community Mental Health Rehabilitative Services (CMHRS) to the new Collaborative Behavioral Health Services (CBHS) effective July 1, 2027. It ensures continuity of care, uninterrupted service authorizations, and coordinated communication with members, legal representatives, and providers throughout the transition.

The Department of Medical Assistance Services (DMAS), with the Department of Behavioral Health and Developmental Services (DBHDS) and the Department of Health Professions (DHP), is replacing legacy CMHRS with Community Psychiatric Support and Treatment (CPST), Mental Health Clubhouse Services, and Coordinated Specialty Care (CSC). **The core operating principle of this plan is that no member experiences a gap in medically necessary services during the transition.**

1.1 How Members Are Identified and Availability Is Protected

Members in service on June 30, 2027, are identified in advance through claims and authorization data. Each CCMCO and Acentra Health can already identify every member with an active Intensive In-Home (IIH), Therapeutic Day Treatment (TDT), Mental Health Skill Building (MHSS), or Psychosocial Rehabilitation (PSR) authorization. That transition roster is produced ahead of go-live and refreshed as the date approaches.

The CBHS service is initially determined by the service crosswalk, not by a pre-go-live assessment. The Virginia CANS Lifetime assessment will **not** be completed before July 1, 2027. Each member's current authorization is transitioned to the mapped CBHS service, and the CANS Lifetime is completed after go-live (see Section 5). The crosswalk sets the initial service; the CANS later confirms or adjusts the level of need.

Availability on July 1, 2027, is protected through converted authorizations. Every member's existing authorization is converted to a new-service authorization based on the crosswalk mapping, so a valid authorization is in place on July 1 with no gap in care. Members continue with their current provider only if that provider is fully licensed, enrolled and credentialed for the service. If the current provider does not provide the identified transition service, the member is offered the choice of a new provider, or a transition to another appropriate service the current provider offers.

Section 2. Roles and Responsibilities

Successful transition depends on clearly delineated responsibilities across the entities managing member benefits and authorizations.

Entity	Primary Transition Responsibilities
DMAS	Sets policy, effective dates, and authorization parameters; issues provider bulletins/Medicaid memos; oversees CCMCO and Acentra performance; approves member notice templates and reading-level standards.

Entity	Primary Transition Responsibilities
Cardinal Care Managed Care Organizations (CCMCOs)	Manage transition for managed care—enrolled members: care coordination, authorization conversion, provider network readiness, member notices, and continuity-of-care protections.
Acentra Health (FFS)	Manages transition for fee-for-service members: converts service authorizations, communicates with FFS providers, and coordinates with DMAS on FFS member notices.
DBHDS	Coordinates CSC grant-to-Medicaid transition; supports provider licensing readiness for CBHS.
CSB Case Managers	Support members on their caseloads through the authorization transition; coordinate warm handoffs; help update the ISP and help members choose among CBHS (see Section 4.3).
Providers	Complete enrollment/credentialing for CBHS, reassess members after go-live, submit new authorization requests as a transitioned authorization's end date approaches, and support member communication and warm handoffs.

Section 3. Transition Timeline and Phases

The transition is organized into four phases anchored to the July 1, 2027, go-live date.

Phase	Window	Focus
Phase 1 – Readiness & Data	Present – Mar 2027	Identify affected members, confirm provider network readiness, finalize systems configuration and authorization logic.
Phase 2 – Notification	March – April 2027	Member and provider advance notices; care coordination outreach begins for high-acuity members.
Phase 3 – Authorization Transition	May – June 2027	Convert authorizations per the crosswalks; confirm warm handoffs.
Phase 4 – Go-Live & Stabilization	Jul 1 – Sep 30, 2027	CBHS active; CANS Lifetime completed post-go-live; monitor gaps, appeals, and claims; resolve exceptions.

Section 4. Care Coordination Approach

Care coordination is the backbone of the transition. Both CCMCOs and Acentra/DMAS apply a member-level coordination protocol, so every affected member is contacted, connected to the appropriate CBHS service before their CMHRS authorization ends, and supported through the post-go-live CANS assessment.

4.1 Member Identification and Stratification

1. Generate a transition roster of all members with an active or recently active CMHRS authorization (IIH, TDT, MHSS, PSR) and all Medicaid members in DBHDS-funded CSC.
2. Stratify members by acuity, service intensity, and continuity risk, identifying these populations for each CMHRS service:
 - a. Members with high weekly utilization
 - i. IIHS: 7 or more units per week
 - ii. TDT: 13 or more units per week
 - iii. MHSS: 8 or more units per week

- iv. PSR: 13 or more units per week
 - b. Youth in foster care.
 - c. Members with a recent crisis episode — Mobile Crisis Response, Community Stabilization, 23-Hour or Residential Crisis Stabilization, or inpatient psychiatric hospitalization — in the past 90 calendar days.
 - d. Members with an ED visit or hospitalization in the past 90 calendar days.
3. Flag all TDT, PSR, and DBHDS-funded CSC members, whose default crosswalk placement requires Specialized Conversion (see Section 5).

4.2 Assignment of Care Coordinators / Transition Leads

1. CCMCOs identify all care coordinators assigned to any member receiving CMHRS.
2. CCMCOs assign a care coordinator to each member, unless one is already assigned. Acentra coordinates with DMAS and FFS providers to ensure a comparable point of contact for FFS members.
3. Establish a single accountable transition contact, per member, to prevent duplicated or conflicting outreach.

4.3 CCMCO–CSB Coordination Protocol

For any member who has both a CCMCO care coordinator and a CSB case manager (a “shared member”), this protocol ensures one lead, one plan, and no duplicated outreach. CSB Mental Health (Targeted) Case Management continues as a covered service, and for members receiving it the CSB case manager is often the most continuous relationship through the transition.

Roles. The CCMCO care coordinator **leads** each shared member's transition — owning the authorization, the roster, network/enrollment confirmation, and escalation. The CSB case manager **supports** the transition — providing the continuous member relationship, the clinical record, member-facing outreach, planning, and warm handoffs. For members without a CSB case manager, the CCMCO care coordinator is the sole lead. For FFS members, Acentra Health and DMAS perform the CCMCO care coordinator functions.

4.3.1 Division of Responsibilities

Transition activity	CCMCO Care Coordinator	CSB Case Manager
Overall lead for the member's transition	Lead	Support
Member/family outreach and explaining the change	Lead	Support (may deliver, given the existing relationship)
Explaining CBHS options and next steps	Lead	Support
Provider selection	Support (confirms network, enrollment, credentialing)	Lead (facilitates clinical handoff)
Creating the service authorization	Lead	Inform
Setting the transitional authorization end date	Lead (with provider and member)	Consult
CBHS service warm handoff	Support	Lead (facilitates clinical handoff)
Identifying members at risk of a service gap	Both identify	Both identify

Transition activity	CCMCO Care Coordinator	CSB Case Manager
Tracking unreached members against the roster	Lead	Support
Escalation and resolution	Lead	Support

4.3.2 Coordination Rules

1. **Single point of contact.** Each shared member has one named lead — the CCMCO care coordinator — recorded in both CCMCO and CSB systems; all transition outreach is coordinated through the lead.
2. **Reconcile the roster early.** During the readiness phase, the CCMCO and CSB reconcile member lists to identify shared members; members on neither party's radar are the priority gap to close.
3. **One shared plan.** The authorization decision and ISP update are documented once and visible to both parties (with consent), so the member is not asked the same questions twice.
4. **Warm handoffs.** The CSB case manager facilitates the clinical handoff (including records, with consent); the CCMCO confirms the receiving provider is enrolled and credentialed and the authorization is in place.
5. **Standing touchpoints and lead handoffs.** The CCMCO and CSB hold a standing check-in during the peak notification/authorization phase to reconcile the roster and review escalations. If a member's lead changes (e.g., disenrolls from CSB case management or changes plans), the transfer is documented and acknowledged.

Section 5. Service Authorization Transitions

Preventing authorization gaps is the highest operational and clinical priority. Because CBHS are not billable until July 1, 2027, the transition converts existing authorizations rather than completing new assessments beforehand. For every continuing member, the CCMCO or Acentra creates a valid authorization — for the mapped CBHS service or another behavioral health service that meets the member's needs — effective July 1, 2027. The provider does not submit an authorization request for the transition, and no member is reassessed before July 1 to keep services.

1. DBHDS Licensing, DMAS enrollment and CCMCO credentialing are a precondition for providing CBHS. A provider must be fully DMAS-enrolled and CCMCO-contracted/credentialed for the CBHS service for the transitioned authorization to be valid and billable.
2. To protect continuity, a cutoff date of [To Be Determined] (in advance of July 1, 2027) will be set: if a member's current provider is not fully enrolled and credentialed for the identified service by that date, the member is transitioned to a provider who is, with care coordinator support and member choice (Section 6.3).

5.1 Definitions

Standard Conversion means transitioning a member's active IAH or MHSS authorization into the corresponding CBHS authorization using the Standard Conversion Crosswalk (Section 5.2) and standardized authorization parameters. It applies when the default crosswalk service is clinically appropriate, and requires no provider authorization request, no member reassessment,

and no individualized review before July 1, 2027. The CCMCO or Acentra creates the authorization directly from the crosswalk and the CPST Transitional Level of Need Process (Attachment 1).

Specialized Conversion means transitioning a member's active TDT, PSR authorization, or DBHDS-funded CSC services, into an appropriate CBHS or other Virginia Medicaid behavioral health service, using the Specialized Conversion Crosswalk (Section 5.3), the Other Mental Health Services Crosswalk (Section 5.4), and the full behavioral health continuum where the crosswalk service does not fully meet the member's needs. It applies to all TDT, PSR, and DBHDS-funded CSC members, and to any member whose placement is unclear, spans multiple destinations, or is flagged for individualized review (Section 4.1). The CCMCO or Acentra identifies the appropriate service, in collaboration with the member and creates the authorization, setting its end date per the rules in Section 5.5(4).

5.2 Standard Conversion Crosswalk

The following governs the default clinical mapping from each CMHRS service to its CBHS successor. Individualized member needs may result in a transition to another behavioral health service in the DMAS continuum.

CMHRS Service (ends 6/30/2027)	Population	CBHS (begins 7/1/2027)
Intensive In-Home (IIH)	Youth	CPST – Youth (Community)
Mental Health Skill Building (MHSS)	Adult	CPST – Adult (Community)

5.3 Specialized CBHS Conversion Crosswalk

CMHRS Service (ends 6/30/2027)	Population	CBHS (begins 7/1/2027)
Therapeutic Day Treatment (TDT)	Youth	CPST – Youth (School Setting) and/or CPST – Youth (Community)
Psychosocial Rehabilitation (PSR)	Adult	Mental Health Clubhouse Services and/or CPST – Adult (Community)
DBHDS-funded Coordinated Specialty Care (CSC)	Youth or Adult	Medicaid-funded Coordinated Specialty Care (CSC)

5.4 Other Mental Health Services Crosswalk

Specialized Conversion may place a member in another Virginia Medicaid behavioral health service. Standard authorization parameters for those services are:

Mental Health Service	Procedure Code	Standard Units	Standard Authorization Timeframe
Applied Behavior Analysis	97153 / 97154 / 97155 / 97156 / 97157 / 97158 / 0362T / 0373T	To Be Determined	To Be Determined
Assertive Community Treatment	H0040	To Be Determined	To Be Determined
Coordinated Specialty Care	H2040 / H2041	To Be Determined	To Be Determined
Functional Family Therapy	H0036	To Be Determined	To Be Determined
Mental Health Intensive Outpatient	S9480	To Be Determined	To Be Determined

Mental Health Service	Procedure Code	Standard Units	Standard Authorization Timeframe
Mental Health Partial Hospitalization	H0035	To Be Determined	To Be Determined
Multisystemic Therapy	H2033	To Be Determined	To Be Determined

5.5 Authorization Transition Principles

- 1. Member identification drives the transition.** The transition operates from the Section 4.1 roster — all members with an active or recently active CMHRS authorization (IIH, TDT, MHSS, PSR) and all DBHDS-funded CSC members. The roster is refreshed as go-live approaches to capture new, renewed, or recently ended authorizations.
- 2. Stratification determines the conversion method.** High-acuity or continuity-risk members (Section 4.1) are prioritized for early conversion. Members with a clear, clinically appropriate crosswalk placement receive Standard Conversion; members flagged for individualized review receive Specialized Conversion, which may identify another service in the DMAS continuum.
- 3. Standard Conversion — default for most IIH and MHSS.** The CCMCO or Acentra maps each active authorization to its CBHS service and creates the new authorization effective at go-live.
 - Standardized end dates: for any IIH or MHSS authorization ending between July 1 and September 30, 2027, the converted authorization ends September 30, 2027.
 - For IIH or MHSS authorizations with end dates past September 30, 2027, the original end date is honored.
- 4. Specialized Conversion — TDT, PSR, and DBHDS-funded CSC,** and any member for whom the crosswalk service does not fully meet their needs. The CCMCO or Acentra identifies the appropriate service and creates the authorization; the provider submits a new request only as the end date approaches.
 - TDT converted to CPST – School Setting: end date January 31, 2028.
 - TDT converted to CPST – Youth (Community) with an original end date between July 1 and September 30, 2027: converted to end September 30, 2027.
 - Youth enrolled in both IIH and TDT: the IIH authorization follows the Standard Conversion process in principle 3 above.
 - PSR converted to Clubhouse and/or CPST – Adult with an original end date between July 1 and September 30, 2027: converted to end September 30, 2027; original end dates past September 30, 2027, are honored.
 - New CSC authorizations, and any other Specialized Conversion authorizations, use the standardized timeframes in Section 5.4.
- 5. CPST unit amounts follow the Transitional LON Process.** All authorizations transitioned to CPST follow the CPST Transitional Level of Need Process (Attachment 1) to set units per 6-month authorization.
- 6. The CANS Lifetime is completed after go-live.** For CPST and CSC authorizations, the CANS Lifetime is completed by the end of the transitioned authorization, which is updated then if the assessment indicates a change.

5.6 Authorization Steps (CCMCO and Acentra/FFS)

These steps apply to both entities — the CCMCO for managed care members and Acentra Health for fee-for-service members. FFS-specific actions are noted inline.

1. Configure claims and authorization systems for the CBHS service codes, units, and limits per DMAS policies.
2. Generate the transition roster (managed care roster for CCMCOs; FFS roster for Acentra) of members with an active or recently active CMHRS authorization and all DBHDS-funded CSC members and refresh it daily through go-live. *Acentra additionally coordinates with DMAS to reconcile members who move between FFS and managed care.*
3. Stratify the roster by acuity, service intensity, and continuity risk, and determine each member's conversion method — Standard where the crosswalk service is appropriate, Specialized where placement needs individualized review. Prioritize high-acuity and flagged members.
4. Identify each member's target service: apply the crosswalk for Standard Conversion; for Specialized Conversion, identify the appropriate service from the CBHS array or broader continuum. The CCMCO or Acentra creates the authorization — providers do not submit one for the transition.
5. Create the new-service authorizations for continuing members using the crosswalks in Sections 5.2, 5.3, and 5.4.
6. Communicate authorization decisions to members and providers with clear effective and end dates, including that a new authorization request will be needed from the provider as the end date approaches.
7. Apply managed care transition-of-care rules and appeal rights for any change in service type, amount, duration, or scope. *For FFS, coordinate member notices with DMAS and give providers a clear pathway and point of contact for submitting authorization requests when an end date approaches.*

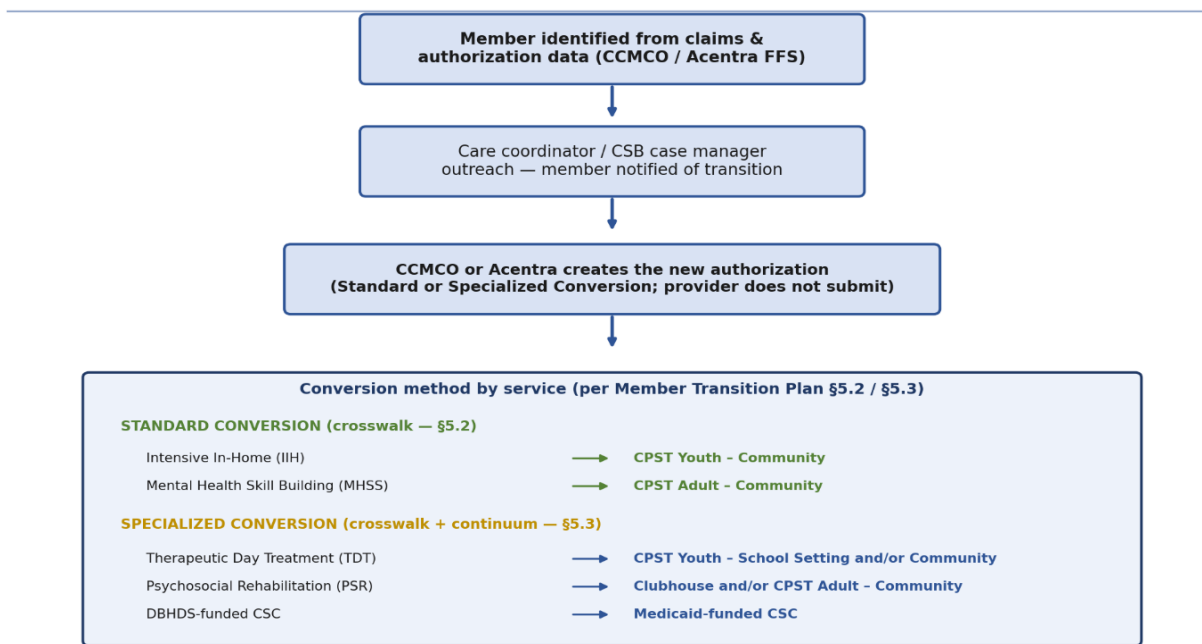
5.7 Member Journey Through the Transition

The diagram below shows how a member in service on June 30, 2027, moves through identification, notification, authorization transition, and provider selection to reach a CBHS service on July 1 without a gap in care, with the CANS Lifetime completed after go-live.

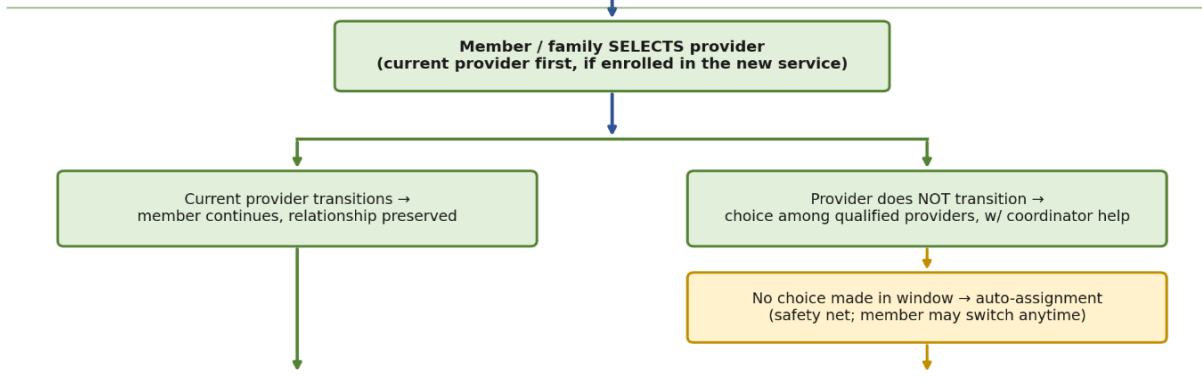
Member Journey Through the Transition

How a member in service on June 30, 2027 reaches a CBHS service on July 1 — with no gap in care

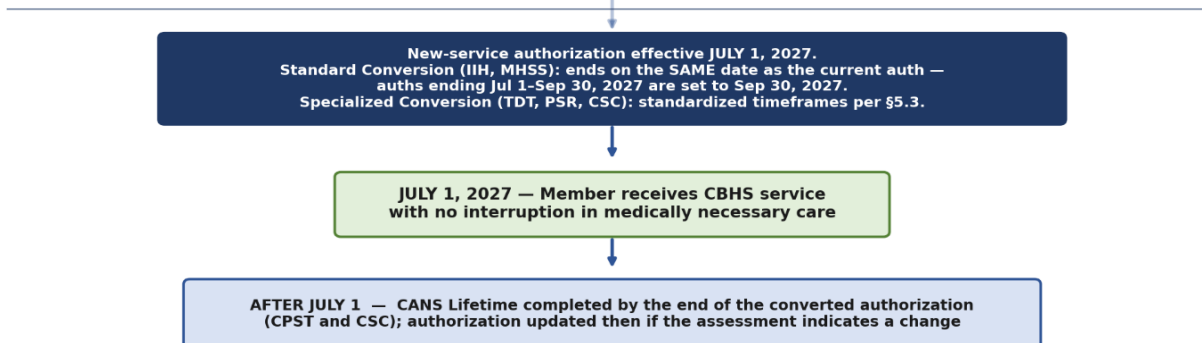
BEFORE JULY 1, 2027 — Notification & Authorization Transition



PROVIDER SELECTION — Member Choice Governs



AUTHORIZATION CONTINUITY — No Gap at the June 30 / July 1 Transition



Section 6. Member Communication and Provider Choice

Responsibility for member communication is divided by coverage: DMAS approves standardized notice content and reading-level/language standards; each CCMCO communicates with its enrolled members; and Acentra Health communicates with fee-for-service members, coordinating with DMAS. In this section, “the plan” and “the care coordinator” mean the CCMCO for managed care members and Acentra/DMAS for fee-for-service members.

6.1 Communication Principles

1. Write member notices in plain language at approximately a 5th-grade reading level.
2. Provide notices in the members’ preferred language and accessible formats, consistent with language-access and ADA requirements.
3. Reassure: most members continue receiving services, and coordinators are available to help.
4. Include appeal rights and continuity-of-care information where a service or provider is changing.

6.2 Member Notice Content

CCMCOs coordinate to develop the member notice template, which DMAS approves and provides to Acentra for FFS. Each CCMCO issues notices to its enrolled members; Acentra issues notices to FFS members in coordination with DMAS. Every notice includes:

1. What is changing and when (CMHRS service ending; CBHS service beginning July 1, 2027).
2. Which new service the member will receive and whether their provider stays the same.
3. Any action the member needs to take (often none) and how to reach their care coordinator.
4. Rights, including how to appeal and how continuity of care protects current services.
5. Contact information for the member's CCMCO member services line (or Acentra/FFS help line) and crisis resources.

6.3 Member and Family Choice of Provider

Member free choice of provider is the governing principle. Consistent with federal Medicaid and Virginia managed care requirements, members select their new provider — most often their current provider, if that provider enrolls in the CBHS service, preserving the therapeutic relationship.

1. Where the current provider does not transition or is not fully enrolled and credentialed for the identified service by the cutoff date (Section 5(2)), the member is offered a choice among available qualified providers with care coordinator support.
2. **Auto-assignment is a safety net, not the default.** It is used only when a member does not choose within the outreach window, so no one is without a provider on July 1, 2027. An auto-assigned member retains the right to change providers.

6.4 Member Communication Channels and Timing

Timing	Communication	Audience	Responsible Entity
March – May 2027	Advance member notice (mail + secure portal/app)	All affected members / guardians	CCMCO (its members); Acentra (FFS); DMAS approves template
March – Jun 2027	Care coordinator outreach call	High- and moderate-acuity members	CCMCO coordinators; Acentra for FFS
May – Jun 2027	Confirmation of new service, provider, and effective date	Continuing members	CCMCO / Acentra (by coverage)
Jul – Sep 2027	Follow-up on unreached members; stabilization check-ins	Members not yet confirmed	CCMCO / Acentra; DMAS monitors

Section 7. Provider Communication and Readiness

DMAS issues policy-level provider communication (Medicaid memos, bulletins, manuals, rates, and the transition-readiness framework) to all providers. Each CCMCO communicates with its network providers on enrollment, authorizations, and claims. Acentra communicates with FFS providers and executes service-authorization notices. DBHDS communicates CBHS licensing requirements. Together these entities coordinate so providers can enroll in CBHS, reassess members after go-live, and submit new authorization requests as end dates approach.

7.1 Provider Communication Principles

- DMAS publishes the authoritative facts** (effective dates, codes, rates, authorization requirements); CCMCOs and Acentra align all provider messaging to them.
- Use multiple channels.** DMAS owns statewide bulletins and Provider Open Office Hours; CCMCOs own network notices to their providers.
- Point providers to resources:** DMAS BH Redesign resources, provider manuals, rate sheet, readiness tools, FAQ, and DBHDS licensing resources.

7.2 Provider Transition Steps

Each step is assigned to the responsible entity and its timing. Where more than one entity is listed, each acts for its own population.

#	Provider Transition Step	Responsible Entity	Timing
1	Notify CMHRS/CSC providers of the service changes, timelines, and steps to become eligible to deliver CBHS.	DMAS (statewide bulletins) CCMCOs (network providers)	Present – Mar 2027
2	Confirm provider enrollment, credentialing, and licensing/accreditation for CBHS.	CCMCOs (network) DMAS/Gainwell (FFS enrollment) DBHDS (licensing)	Present – Mar 2027
3	Assess network adequacy for each CBHS service by region; recruit or contract to close gaps, especially CPST-Youth, Clubhouse, and CSC.	CCMCOs (their networks) DMAS (monitors)	Present – Mar 2027
4	Instruct providers on how transition authorizations work: the CCMCO or Acentra creates the authorization (providers do not submit for the transition); the provider is notified of the authorization and end date and submits a new request only as the end date approaches.	DMAS (drafts/approves content) CCMCOs (network) Acentra (FFS)	March – May 2027

#	Provider Transition Step	Responsible Entity	Timing
5	Communicate claims/billing changes (codes, units, rates) and any system testing windows.	DMAS (sets codes/rates, posts bulletin) CCMCOs & Acentra (systems/testing)	March – Jun 2027

7.3 Standards for Fair Referral Across the Provider Continuum

Where a CCMCO facilitates a referral or makes an auto-assignment, the following ensure fair referral across the continuum:

1. **Network adequacy** — CCMCOs maintain adequate networks for each CBHS service by geography and timely-access standards, enforceable through the DMAS Cardinal Care Managed Care contract.
2. **Non-discrimination and anti-steering** — members can reach any qualified participating provider; referrals may not be funneled to disadvantage otherwise-qualified providers.
3. **Uniform, state-set qualifications** — DBHDS licensure, the DMAS LMHP-directed CPST model, CANS-based level-of-need, and enrollment/credentialing are set by DBHDS and DMAS. DMAS enforces via the managed care contract and policy; DBHDS enforces licensing; CCMCOs apply these standards but do not define them.
4. **Free choice** — even where the CCMCO facilitates a referral, the member may decline it for another qualified provider.

7.4 Provider Communication Channels and Timing

Each entity communicates to its own population: DMAS for statewide policy and content, CCMCOs to their network providers, Acentra to FFS providers, and DBHDS for licensing.

Communication	DMAS	CCMCOs	Acentra (FFS)	DBHDS
Bulletins, Office Hours & readiness tools <i>Present – Mar 2027</i>	Issue bulletins and Medicaid memos; host Office Hours; publish readiness tools, manuals, rates	Distribute bulletins; provide network-specific readiness support	Distribute guidance to FFS providers	Publish CBHS licensing requirements
Enrollment & credentialing <i>Present – Mar 2027</i>	Set enrollment standards; oversee FFS enrollment	Contract and credential network providers for CBHS	Support FFS provider enrollment with DMAS	License providers for CBHS
Network adequacy <i>Present – Mar 2027</i>	Set standards; monitor compliance	Assess and close network gaps; recruit/contract	—	—
Transition instructions & roster <i>March – May 2027</i>	Draft/approve content; monitor readiness	Send instructions to network providers; coordinate member roster	Send instructions to FFS providers; coordinate FFS roster	—
How authorizations work <i>March – May 2027</i>	Draft, post bulletin, approve content	Instruct network providers on the authorization process	Instruct FFS providers on the same process	—
Notice of created authorizations <i>May – Jun 2027</i>	Monitor to ensure auths effective 7/1/2027	Notify network providers of created auths and end dates	Notify FFS providers of created auths and end dates	—
Claims/billing changes & testing <i>March – Jun 2027</i>	Set codes, units, rates; post billing bulletin	Communicate systems/claims guidance	—	—

Communication	DMAS	CCMCOs	Acentra (FFS)	DBHDS
Go-live support & feedback loop <i>Jul – Sep 2027</i>	Monitor performance; resolve escalations; FFS claims support	Go-live support and claims troubleshooting to network providers	Go-live service-auth support	Support licensing-related issues

Section 8. Monitoring, Oversight, and Escalation

DMAS monitors CCMCO and Acentra transition performance. Both track and report core continuity metrics and maintain an escalation pathway for members at risk of a service gap.

8.1 Key Metrics

- Percentage of affected members identified, contacted, and confirmed into a CBHS service.
- Percentage of continuing members with a transitioned CBHS authorization effective 7/1/2027 (target: no gaps).
- Number and status of members on continuity extensions.
- Post-go-live CANS Lifetime completion rates and warm-handoff completion rates.
- Appeals volume, claims denial rates, and crisis/hospitalization events among transitioning members.
- Network adequacy by CBHS service and region.

8.2 Enforcement and Referral-Pattern Oversight

Enforcement: DMAS is the primary enforcing agency — through managed care contract oversight, network-adequacy reporting, referral and encounter monitoring, grievance and appeal data, and audit. DBHDS enforces provider licensing and service-model fidelity; DHP oversees practitioner licensure. Members retain grievance and appeal rights, supported by external quality review and ombudsman functions.

Recommended safeguard: DMAS supports published, monitored referral-pattern reporting — requiring CCMCOs to report where auto-assignments and CCMCO-facilitated referrals go — so any concentration or steering is visible and correctable.

8.3 Escalation and Exception Handling

1. Maintain a rapid-response process for members at risk of a service gap, including expedited authorization and provider assignment.
2. Establish a joint CCMCO–Acentra–DMAS issue log and regular transition status meetings through stabilization.
3. Provide members and providers a clear escalation contact for unresolved transition problems.

Section 9. Summary of Coordinated Actions

The transition rests on advance identification of members and conversion of every current authorization to an appropriate CBHS or continuum service, with standardized or individualized end dates, so no member loses medically necessary services at the June 30–July 1 transition. The CANS Lifetime follows after go-live to confirm or adjust the level of need. Member choice of provider governs, with assignment used only as a safety net; referral fairness is protected by

network-adequacy, non-discrimination, and state-set qualification standards enforced primarily by DMAS.

Action Area	DMAS	CCMCOs	Acentra (FFS)	DBHDS
Member identification	Define roster and stratification standards; oversee completeness	Stratify managed care roster by acuity/risk	Identify FFS members with active CMHRS auths	Identify DBHDS-funded CSC members
Care coordination	Set coordination expectations; issue CCMCO–CSB protocol with DBHDS	Assign coordinators; warm handoffs; post-go-live CANS support; lead CCMCO–CSB coordination	Coordinate FFS contact/CANS support with DMAS & providers	Support CSB case manager role; co-issue protocol
Authorization	Set conversion policy, codes, rates, end-date rules	Transition auths via Standard/Specialized Conversion; apply standardized end dates	Transition/process FFS auths; apply standardized end dates	Coordinate CSC grant-to-Medicaid transition
Member communication	Approve notice templates, reading-level & language standards	Plain-language notices; coordinator outreach; provider choice	Coordinate FFS member notices with DMAS	—
Provider communication	Issue bulletins/memos, manuals, rates, Office Hours	Network readiness; auth instructions; provider/member notices	FFS provider auth instructions & submission pathway	Communicate CBHS licensing requirements
Monitoring	Oversee performance; enforce network-adequacy & referral standards	Report continuity & referral-pattern metrics; escalate gaps	Report FFS metrics; escalate gaps	Enforce licensing regulations

Attachment 1. CPST Transitional Level of Need Assignment

Assigning a CPST Tier and Level of Need without a provider-completed CANS.

1. Purpose

CPST authorizations are built from a **Level of Need (LON)**, which sets the CPST tier (Tier 1 = LON 2–3; Tier 2 = LON 4–6), the authorization timeframe, and the units authorized. LON is normally produced by the Virginia CANS Lifetime. Because the CANS is completed **after** July 1, 2027, providers are not required to complete a CANS to enable Standard or Specialized conversion. This attachment gives the CCMCO or Acentra an interim, data-driven method to assign a Transitional LON so CPST authorizations can be converted and effective on July 1, 2027, with the CANS confirming or adjusting the LON after go-live.

Core principle: The Transitional LON is an administrative bridge from data the plan already holds, set conservatively so no member is under-served. It is not a clinical determination. The CANS Lifetime remains the clinical source of truth and reconciles the LON at the first continued-stay request after July 1, 2027.

2. How Level of Need Drives the CPST Authorization

Per the CPST service definitions, LON maps to tier, timeframe, and units as follows — the structure the Transitional LON must generate:

Level of Need	Tier	SA Timeframe	Units per SA	Approx. hours/week
2/3 (provisional dx)	Tier 1	3 months	102	~2 hrs/wk
2	Tier 1	6 months	204	~2 hrs/wk
3	Tier 1	6 months	300	~3 hrs/wk
4	Tier 2	6 months	480	~5 hrs/wk
5	Tier 2	6 months	576	~6 hrs/wk
6	Tier 2	6 months	768	~7 hrs/wk

Note: *The CANS Lifetime scoring algorithm is still to be determined. Until it is finalized, the unit bands in Section 4 are approximate, published by DMAS so all CCMCOs and Acentra assign the Transitional LON consistently.*

3. The Transitional LON Assignment Process

The process is summarized below and depicted in the flowchart in Section 5. All four CMHRS services default to Tier 2 (start LON 4); the Transitional LON is then set from utilization and reconciled by the post-go-live CANS.

1. Set a default LON by service. IIH, TDT, MHSS, and PSR all default to Tier 2 (start LON 4).
2. Set the Transitional LON from existing utilization — map authorized/delivered units per week onto the bands in Section 4; a crisis, ED, or inpatient stay within 90 calendar days raises the LON by one level.
3. Apply conservative guardrails: never assign below LON 4; round up between bands; honor recent higher intensity.
4. Issue a converted authorization, governed by the authorization principles in Section 5 of the Member Transition Plan.

5. Reconcile with the post-go-live CANS: once completed, the authorization is governed by the policies in the Mental Health Services Manual.

4. Draft Utilization-to-Transitional-LON Conversion Table

A proposed draft to be finalized and published by DMAS for consistent assignment across all CCMCOs and Acentra. Unit bands assume a 5-day service week; the acuity rule applies on top of the unit band.

Current CMHRS service	Delivered / authorized units per week	Starting tier	Transitional LON
IIH (youth)	To Be Determined	Tier 2	LON 4
IIH (youth)	To Be Determined	Tier 2	LON 5
IIH (youth)	To Be Determined	Tier 2	LON 6
TDT (youth)	To Be Determined	Tier 2	LON 4
TDT (youth)	To Be Determined	Tier 2	LON 5
TDT (youth)	To Be Determined	Tier 2	LON 6
MHSS (adult)	To Be Determined	Tier 2	LON 4
MHSS (adult)	To Be Determined	Tier 2	LON 5
MHSS (adult)	To Be Determined	Tier 2	LON 6
PSR (adult)	To Be Determined	Tier 2	LON 4
PSR (adult)	To Be Determined	Tier 2	LON 5
PSR (adult)	To Be Determined	Tier 2	LON 6

Acuity rule (every row): a crisis episode, ED visit, or inpatient psychiatric stay in the last 90 days raises the Transitional LON by one level. Assignments round up between bands and never fall below LON 4.