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Virginia's Medicaid Program

Redesign of Medicaid Behavioral Health Rehabilitative Services

CSA Conference
October 15, 2025

DBHDS
Virginia Department of Behavioral Health and Developmental Services

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Transforming Behavioral Health Care for Virginians

DMAS

Today's Speakers

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Department of Medical Assistance Services

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Department of Medical Assistance Services

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Deputy Commissioner, Community Services
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Today's Agenda

1. Project Overview
2. Project Update
3. New Service Rates
4. New DRAFT Service Array Descriptions and Admission Criteria
5. Provider Readiness Survey and Training Plan
6. Next Steps

Project Overview

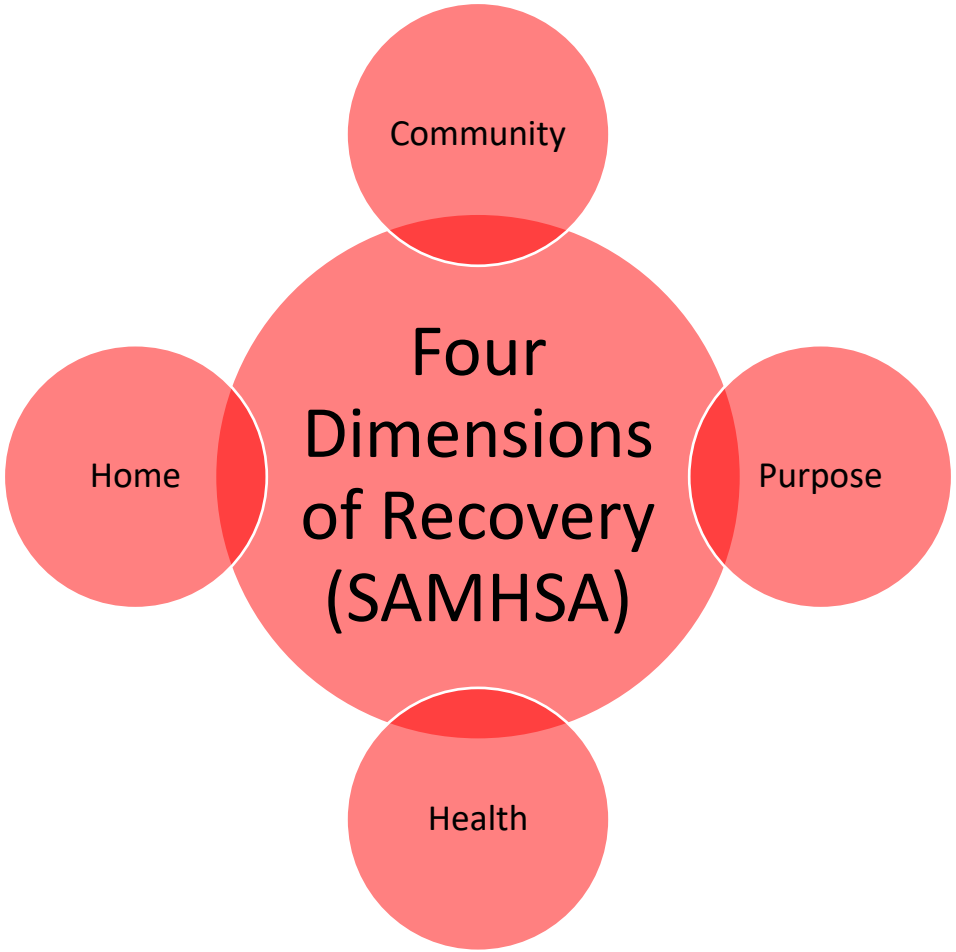
DMAS, in coordination with DBHDS, DHP and DMAS health plans, is employing an integrated and comprehensive approach to address rate, service, and workforce/provider roles for Medicaid over the next two years.

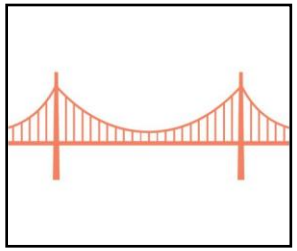
The project seeks to redesign DMAS' youth and adult legacy services: Intensive In-home Services (IIHS), Therapeutic Day Treatment (TDT), Mental Health Skill Building (MHSS), Psychosocial Rehabilitation (PSR), and Mental Health Case Management (MHCM).

The budget language authorizes DMAS to move forward with budget neutral changes to replace the legacy services with evidence-based, trauma-informed services.

XX. 1. Effective July 1, 2024, the Department of Medical Assistance Services (DMAS) shall have the authority to modify Medicaid behavioral health services such that: (1) legacy services that predate the current service delivery system, including Mental Health Skill Building, Psychosocial Rehabilitation, Intensive In Home Services, and Therapeutic Day Treatment are phased out; (2) legacy youth services are replaced with the implementation of tiered community based supports for youth and families with and at-risk for behavioral health disorders appropriate for delivery in homes and schools, (3) legacy services for adults are replaced with a comprehensive array of psychiatric rehabilitative services for adults with Serious Mental Illness (SMI), including community-based and center-based services such as independent living and resiliency supports, community support teams, and psychosocial rehabilitation services, (4) legacy Targeted Case Management- SMI and Targeted Case Management- Serious Emotional Disturbance (SED) are replaced with Tiered Case Management Services. All new and modified services shall be evidence based and trauma informed. To facilitate this transition, DMAS shall have the authority to implement programmatic changes to service definitions, prior authorization and utilization review criteria, provider qualifications, and reimbursement rates for the legacy and redesigned services identified in this paragraph. DMAS shall only proceed with the provisions of this paragraph if the authorized Medicaid behavioral health modifications and programmatic changes can be implemented in a budget neutral manner within appropriation provided in this Act for the identified legacy services. Moreover, any new or modified services shall be designed such that out-year costs are in line with the current legacy service spending projections. No new Medicaid behavioral health services or rates shall be implemented until corresponding legacy services have ended. Implementation of the redesigned services authorized in this paragraph shall be completed no later than June 30, 2026.

Medicaid Behavioral Health Services Redesign Priorities





Strengthen the evidence-based, trauma-informed service continuum for youth and adults

Promote earlier intervention and increase access through tiered service design

Design services for Virginia's managed care service delivery system and multipayer system

Integrate workforce priorities and workforce supports into service design and implementation

<u>Evidence Base Highlights</u>

- Mental health disorders are complex and include genetic, environmental, biological, and social factors
- Treatments include medication, therapy, and support services
- Duration of untreated mental illness is primary predictor of long-term functional impairment; recovery is a process
- Early, coordinated intervention during sensitive periods improves long-term outcomes
- Mental health treatment system is paradoxical if not constrained: over-treatment (mild) and under-recognition (severe)
- Financial incentives are often misaligned for both providers and payers

Medicaid Behavioral Health Redesign Timeline
July 2024-June 2026

Year 1

July 2024-June 2025

- Service research, stakeholder input, contractor support to develop service requirements
- Develop service definitions and requirements
- Develop FFS rates for each proposed new service
- Estimate utilization, cost and budget impact for redesigned services

Year 2

July 2025-June 2026

- Operationalize new services through licensure, regulatory, and policy manual changes
- Prepare providers to transition to new services
- Ensure MCO readiness to implement new services
- New Services Go Live
  Potential phased in approach of service implementation

Project Updates

We are here!

June, 2025

Fiscal impact study completed

Implementation plan developed

July, 2025

Phase 2 (Implementation) Launch!

Rates Posted

August, 2025

Provider Readiness Survey Completed

MAP Training Application

DMAS/DBHDS Regs and Policy Development

FFS/MCO Implementation Launch

September 2025

Informal public comment begins

Provider office hours begins

Provider Letter of Intent Developed

October 2025

Informal Public Comment continues

Provider Letter of Intent Due to DBHDS

DRAFT-Level of Need Approach for CPST

Level of Need	Other Services	Community Rehabilitative Services	CPST Tier	Units (15 mins)	Minimum Limit	Maximum Limit	Average hours/ week	Average hours/ month
1	Crisis, Peer Recovery Supports Medication Management, Outpatient therapy	Not eligible for CPST	-	-	-	-	-	-
2	Crisis, Peer Recovery Supports Medication Management, Outpatient therapy, IOP	CPST Clubhouse International, TCM (when in long term maintenance)	CPST Tier 1	12-27 units per 30 calendar days	3 hours per month	Up to 6.75 hours per month	1-1.5	4-6
3	Crisis*, Peer Recovery Supports, Medication Management, IOP, PHP	CPST Clubhouse International, TCM (when stepping down)	CPST Tier 1	28-35 units per 30 calendar days	7 hours per month	Up to 8.75 hours per month	1.75-2	7-8
4	Crisis*, Peer Recovery Supports Medication Management, PHP	Assertive Community Treatment; Multisystemic Family Therapy; Functional Family Therapy; Coordinated Specialty Care CPST; Clubhouse International, TCM (when appropriate)	CPST Tier 2	36-79 units per 30 calendar days	9 hours per month	Up to 19.75 hours per month	4-4.75	16-19
5	rCSU, Crisis*, Peer Recovery Supports Medication Management PRTF, TGH Youth		CPST Tier 2	80-95 units per 30 calendar days	20 hours per month	Up to 23.75 per month	5-5.75	20-23
6	Inpatient		CPST Tier 2	96-112 units per 30 calendar days	24 hours per month	Up to 28 hours per month	6-7	24-28

Final Budget Neutral Model for July, 2026 Implementation

Services Being Retired July 1, 2026	New Services July 1, 2026
• Intensive In-Home Services (H2012) • Therapeutic Day Treatment (H2016) • Mental Health Skill Building (H0046) • Psychosocial Rehabilitation (H2017)	• Standardized Assessment for Level of Need (LON) Placement • Community Psychiatric Support and Treatment (CPST) in community (youth and adult) and schools (youth)- Tier 1 and 2 • Coordinated Specialty Care for First Episode Psychosis • Clubhouse International Model of Psychosocial Rehabilitation

Cross Walk of Current Community Rehabilitative Mental Health Services (CMHRS) and New Service Array

Current Services	New Service Replacement
Mental Health Skill Building (H0046) Psychosocial Rehabilitation (H2017)	Community Psychiatric Support and Treatment (Adult) - Community
	Coordinated Specialty Care (CSC)
	Mental Health Clubhouse Services (Clubhouse International Model)
Intensive In-Home Services (H2012)	Community Psychiatric Support and Treatment (Youth) - Community
Therapeutic Day Treatment (H2016)	Community Psychiatric Support and Treatment (Youth) - School Setting
Mental Health Case Management (H0032)	Remaining Mental Health Case Management with policy changes

Rates for BH Redesign July 2026 Implementation

Setting and Professional - Individual	Rate Type	Rate
CPST — Licensed Mental Health Professional (LMHP), Community	Per 15 Minutes	$33.24
CPST — LMHP, School Setting	Per 15 Minutes	$25.81
CPST — Qualified Mental Health Professional (QMHP), Community	Per 15 Minutes	$25.66
CPST — QMHP, School Setting	Per 15 Minutes	$19.41
CPST — Behavioral Health Technician (BHT), Community	Per 15 Minutes	$20.49
CPST — BHT, School Setting	Per 15 Minutes	$14.69

Setting and Professional – Group; (Adult max of 10); (Youth max of 6)	Rate Type	Rate
CPST — LMHP, Community Youth Group	Per 15 Minutes	$8.31
CPST — LMHP, School Setting Youth Group	Per 15 Minutes	$6.45
CPST — LMHP, Community Adult Group	Per 15 Minutes	$5.54
CPST — QMHP, Community Youth Group	Per 15 Minutes	$6.41
CPST — QMHP, School Setting Youth Group	Per 15 Minutes	$4.85
CPST — QMHP, Community Adult Group	Per 15 Minutes	$4.28

Rates for July, 2026 Implementation- Cont'd.

Service	Rate Type	Rate
Standardized Comprehensive Assessment of Needs and Strengths (CANS Lifetime)	Flat Rate	$323.42
Clubhouse International Model of Psychosocial Rehabilitation	Per Diem	$72.41
Coordinated Specialty Care for First Episode Psychosis	Monthly Rate	$2,308.00
Coordinated Specialty Care for First Episode Psychosis	Encounter Rate	$381.00
Mental Health Case Management for SMI and SED	Monthly Rate	$374.09

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New Services Array, Descriptions, and Rate Assumptions

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DRAFT-Community Psychiatric Support and Treatment (Home/Community) Service Description

Community Psychiatric Support and Treatment (CPST) is a multi-component, team-based service for adults and youth that recognizes the widespread impact of trauma and prioritizes safety, trustworthiness, and collaboration. CPST consists of assessment, counseling, therapeutic interventions, care coordination, crisis and functional supports, all delivered through a trauma-informed lens. In partnership with the individual, CPST services concentrate on strengths-based, goal-directed supports and solution focused interventions, which focus on restoring functional skills of daily living, building natural supports, and achieving identified person-centered goals and objectives as identified in the Individual Service Plan (ISP). These individualized, trauma-informed interventions are grounded in principles of safety, choice, collaboration, and cultural humility and are designed to assist the individual in achieving stability and functional improvement in daily living, family/caregiver and interpersonal relationships, and personal recovery and resilience. CPST services prioritize the individual's inherent strengths and ability to succeed in the community while recognizing that trauma responses are normal adaptations to abnormal circumstances. Services support individuals in identifying and accessing needed resources, demonstrating improvement in school, work, and family/caregiver functioning, and enhancing the family/caregiver's capacity to provide supportive environments that promote healing and successful community integration.

DRAFT-Community Psychiatric Support and Treatment (School Setting) Service Description

Community Psychiatric Support and Treatment (CPST) is a multi-component, team-based service for youth in a school setting that recognizes the widespread impact of trauma and prioritizes safety, trustworthiness, and collaboration. CPST consists of assessment, counseling, therapeutic interventions, care coordination and crisis and functional supports, all delivered through a trauma-informed lens. Services are delivered in collaboration with the youth, their family and the school, emphasizing goal-directed, solution-focused interventions aligned with the youth's Individual Service Plan (ISP) and, for youth with an Individualized Education Program (IEP), the youth's IEP. Interventions support the development of natural supports, promote emotional regulation, and help youth achieve identified person-centered goals related to their emotional, social, and personal growth. These individualized, trauma-informed interventions are grounded in principles of safety, choice, collaboration, and cultural humility and are designed to assist the individual in achieving stability and functional improvement in daily living, family/caregiver and interpersonal relationships, and personal recovery and resilience. CPST services prioritize the individual's inherent strengths and ability to succeed in a school setting while recognizing that trauma responses are normal adaptations to abnormal circumstances. Services support individuals in identifying and accessing needed resources, demonstrating improvement in school, and family/caregiver functioning, and enhancing the family/caregiver's capacity to provide supportive environments that promote healing and successful integration in to the identified school setting.

Proposed Medical Necessity Criteria- Community

Tier One CPST MNC

- **Tier One Diagnostic Criteria:**
- The individual meets criteria for a primary ICD diagnosis that correlates to a DSM diagnosis or,
- A provisional diagnosis as developed by an LMHP, when no definitive diagnosis has been made.
- **Tier One Functional Impairment Criteria:** The individual is unable to maintain an adequate level of functioning without CPST due to a mental illness as evidenced by **moderate** impairment in functioning in the following domains: Symptom Management; Social Relationships/Community Integration; Personal Care and Daily Living Skills; Personal Safety and Self-Regulation
- **Tier One Intensity Service Criteria:**
- Supporting the need for weekly intervention for no more than four to six hours per calendar month with a focus on skill building and community integration
- Supporting the need for behavioral interventions requiring environmental modification and real-time coaching

Tier Two CPST MNC

- **Tier Two Diagnostic Criteria:**
- The individual meets criteria for a primary ICD diagnosis that correlates to a DSM diagnosis and
- Individual meets criteria for an Early Serious Mental Illness, Serious Mental Illness or Serious Emotional Disturbance.
- **Tier Two Functional Impairment Criteria:** The individual is unable to maintain an adequate level of functioning without CPST due to a mental illness as evidenced by **significant** impairment in functioning in the following domains: Symptom Management; Social Relationships/Community Integration; Personal Care and Daily Living Skills; Personal Safety and Self-Regulation
- **Tier Two Intensity Service Criteria:**
- Supporting the need for weekly intervention that requires between seven and 28 hours per calendar month with a focus on skill building, community integration and crisis support
- Supporting the need for care coordination with multiple service providers (psychiatry, case management, crisis services)

Proposed Medical Necessity Criteria- School

Tier One CPST MNC

- **Tier One Diagnostic Criteria:**
- The individual meets criteria for a primary ICD diagnosis that correlates to a DSM diagnosis or,
- A provisional diagnosis as developed by an LMHP, when no definitive diagnosis has been made.
- **Tier One Functional Impairment Criteria:** The individual is unable to maintain an adequate level of functioning without CPST due to a mental illness as evidenced by **moderate** impairment in functioning in the following domains: Symptom Management; Academic/Educational Functioning; Social/Interpersonal Functioning; Emotional Regulation; Behavioral Functioning and Family/Caregiver Relationships
- **Tier One Intensity Service Criteria:**
- Evidence of needing specific service components (psychotherapy, crisis, care coordination etc.
- Supporting the need for weekly intervention for no more than four to six hours per calendar month with a focus on skill building and community integration
- Supporting the need for behavioral interventions requiring environmental modification and real-time coaching

Tier Two CPST MNC

- **Tier Two Diagnostic Criteria:**
- The individual meets criteria for a primary ICD diagnosis that correlates to a DSM diagnosis and
- Individual meets criteria for an Early Serious Mental Illness, Serious Mental Illness or Serious Emotional Disturbance .
- **Tier Two Functional Impairment Criteria:** The individual is unable to maintain an adequate level of functioning without CPST due to a mental illness as evidenced by **significant** impairment in functioning in the following domains: Symptom Management; Academic/Educational Functioning; Social/Interpersonal Functioning; Emotional Regulation; Behavioral Functioning and Family/Caregiver Relationships
- **Tier Two Intensity Service Criteria:**
- Evidence of needing specific service components (psychotherapy, crisis, care coordination etc.
- Supporting the need for weekly intervention that requires between seven and 28 hours per calendar month with a focus on skill building, community integration and crisis support
- Supporting the need for behavioral interventions requiring environmental modification and real-time coaching

Community Psychiatric Support and Treatment- Youth

Multicomponent Service

Two Tiers of Service Intensity

Collaborative Behavioral Health Service

CPST is a Multicomponent Service

- Standardized comprehensive assessment (CANS + diagnostic interview) drives person-centered treatment planning
- Treatment plans include a person-centered, clinically indicated combination of the following:
  - Psychotherapy
  - Crisis Support
  - Restorative Life Skills Training
  - Rehabilitative Skills Practice (Tier 2 only)
  - Care Coordination
- Youth approved for Tier 2 services may also receive repetition/practice of the skills being developed

Community Psychiatric Support and Treatment Service Components

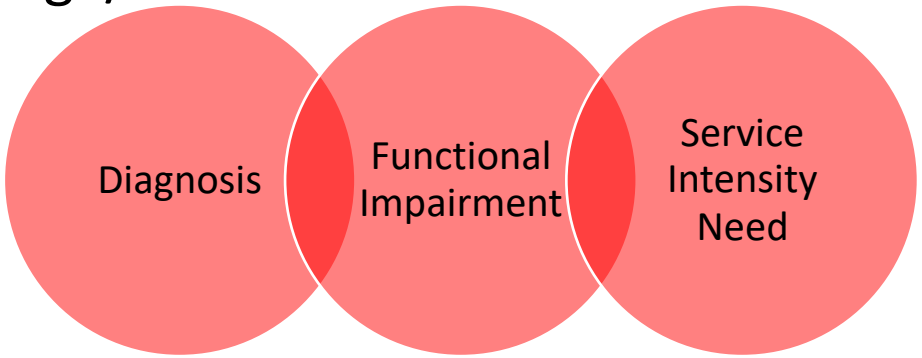
CPST Required Service Components		Allowable Staff Credentials
Standardized Comprehensive Assessment of Needs and Strengths (CANS Lifetime)	Required	The assessment shall be conducted by a LMHP, LMHP-R, LMHP-RP or LMHP-S. A QMHP can assist. LMHP is ultimately responsible.
Treatment Planning	Required	Treatment planning shall be conducted by a LMHP, LMHP-R, LMHP-RP or LMHP-S. A QMHP can assist. LMHP is ultimately responsible.
Crisis Support	Required	Crisis support must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S or QMHP.
Restorative Life Skills Training	Required	Restorative life skills training shall be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S or QMHP.
Care Coordination	Required	Care coordination must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S or QMHP.
Psychotherapy	based on clinical need	Psychotherapy must be provided by a LMHP, LMHP-S, LMHP-R or LMHP-RP acting within their scope of practice.
Rehabilitative Skills Practice (Tier 2 Only)	Required (Tier 2 Only)	Rehabilitation skills practice must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP, QMHP-T or BHT.

CPST Has Two Tiers of Service Intensity

- Both tiers are rehabilitative
- Both tiers are more intensive than outpatient therapy- taking a holistic approach and practicing skills being developed
- Tier 1 is between **3 and 8.75 hours** of service per month
- Tier 2 is between **9 and 28 hours** of service per month
- Tier 1 and Tier 2 have different medical necessity criteria

Service Intensity

- Outpatient therapy and/or medication management is first line treatment for most mental health problems
- Specific symptoms, along with functional impairment, support diagnosis of mental health disorder
- Youth would be referred to CPST (versus outpatient therapy and medication management) if, in addition to diagnosis and functional impairment, there is a need for a more intensive service with increased real-world skill building, care coordination, and crisis supports
- Eligibility for CPST does not change the model of change/evidence base for mental health diagnoses; it provides more intensive supports to achieve the same goals



Service Intensity and Evidence-Based Practices

CPST is not the only community-based youth service that is more intensive than outpatient therapy/medication management.

There are some specific services for youth in Medicaid that are evidence-based and clinically indicated for specific presenting problems and are more appropriate services to address those needs than CPST.

Presenting problem, eligibility for these services, and client/family preferences should all be taken into consideration and referrals should be made prior to enrolling an individual in CPST:

- Multisystemic Therapy (adolescents with delinquency, conduct issues, and/or substance use)
- Functional Family Therapy (adolescents with behavior problems and/or family conflict)
- Coordinated Specialty Care (transition age youth with psychotic symptoms)
- Addiction, Recovery, and Treatment Services (ARTS/ASAM Continuum-youth with substance use disorder)
- Applied Behavior Analysis (youth with Autism Spectrum Disorder)
- Specialty Outpatient, Intensive Outpatient, or Partial Hospitalization programs

Treatment Intensity Comparison

Treatment	Average Intensity (weekly)	Average Intensity (monthly)	Contact Details
Outpatient Therapy	< once a week	About 1.6 hrs per month	Typically clinic based
Tier 1 CPST	LON 2: average 1 hour per week LON 3: average 2 hours per week	LON 2: average 4 hours per month (up to six) LON 3: average 7.5 hours per month (up to eight)	Community Based; includes natural supports; includes first line crisis supports
Functional Family Therapy	2-2.5 hours per week	8-10 hours per month	Community or Clinic Based; includes natural supports; some crisis support
Multisystemic Therapy	4-6 hours per week	16-24 hours per month	Community Based; includes natural supports; includes first line crisis supports
Tier 2 CPST	LON 4: average 4 hours per week LON 5: average 5 hours per week LON 6: average 6 hours per week	LON 4: average 16 hours per month (up to 20) LON 5: average 20 hours per month (up to 24) LON 6: average 24 hours per month (up to 28)	Community Based; includes natural supports; includes first line crisis supports
Assertive Community Treatment	Base Fidelity: 50 - 84 minutes across 1.4-2.1 contacts per week High Fidelity: Average of 2 hours/week or more of face-to-face contact per client. Average of 3 or more face-to face contacts / week per client.	Base Fidelity: 3.3 – 5.6 hours per month across 5-8 contacts High Fidelity: at least 8 hours per month across at least 12 contacts	Community Based; includes natural supports; includes first line crisis supports
Intensive Outpatient Therapy	6-19 hours per week	24 – 76 hours per month	Clinic based or school setting
Partial Hospitalization Program	At least 20 hours per week	At least 80 hours per month Typical length of stay is 2-4 weeks.	Clinic based

CPST is Delivered as a Collaborative Behavioral Health Service

§ 54.1-3500. Definitions

"Collaborative behavioral health services" means

those supportive services that are provided by a registered behavioral health technician, registered behavioral health technician assistant, registered qualified mental health professional, or registered qualified mental health professional-trainee under the direction of and in collaboration with either a mental health professional licensed in the Commonwealth or a person under supervision as a prerequisite for licensure who has been approved by the Board of Counseling, Board of Psychology, or Board of Social Work.

CPST is Delivered as Collaborative Behavioral Health Service

- CPST policy sets a minimum standard for supervision activities, ratios, and clinical direction for all CPST providers to ensure that the service is delivered as a collaborative behavioral health service.
- How the team functions and who interacts face-to-face with the youth/family depends on individual's clinical needs, the professional types employed by the provider and the tier of service being provided.

DRAFT-Community Psychiatric Support and Treatment Teams – Collaborative Behavioral Health Services

Team	Supervisor	Staff Type	Staff Type
CPST Tier One Team #1	LMHP Clinical Supervisor	LMHP	[redacted]
CPST Tier One Team #2	LMHP Clinical Supervisor	LMHP-R, LMHP-S, LMHP-RP	
CPST Tier One Team #3	LMHP Clinical Supervisor (provides all service components that require an LMHP-type)	QMHP	
CPST Tier One Team #4	LMHP Clinical Supervisor	LMHP-R, LMHP-S, LMHP-RP	QMHP

DRAFT-Community Psychiatric Support and Treatment Teams – Collaborative Behavioral Health Services

Team	Supervisor	Staff Type	Staff Type	Staff Type
CPST Tier One Team #1	LMHP Clinical Supervisor	LMHP	[redacted]	
CPST Tier One Team #2	LMHP Clinical Supervisor	LMHP-R, LMHP-S, LMHP-RP		
CPST Tier Two Team #3	LMHP Clinical Supervisor (provides all service components that require an LMHP-type)	QMHP		
CPST Tier Two Team #4	LMHP Clinical Supervisor	LMHP-R, LMHP-S, LMHP-RP	QMHP	
CPST Tier Two Team #5	LMHP Clinical Supervisor	LMHP-R, LMHP-S, LMHP-RP (provides all service components that require an LMHP-Type or QMHP	BHT	
CPST Tier Two Team #6	LMHP Clinical Supervisor (provides all service components that require an LMHP-type)	QMHP	BHT	
CPST Tier Two Team #7	LMHP Clinical Supervisor	LMHP-R, LMHP-S, LMHP-RP	QMHP	BHT

Evidence-Based Practices (EBPs) in Tier 1 and 2 Community Based Rehabilitative Services

- Use of evidence-based principles, practices, and protocols will be required for all agencies providing Tier 1 and Tier 2 CPST
- Statewide training requirements will be set by profession level and adult vs. child serving agencies
  - All agencies: Comprehensive Assessment of Needs and Strengths (CANS- Lifetime) and associated person centered treatment planning training
  - For youth agencies: Managing and Adapting Practice (MAP) will be adopted as a statewide curriculum. PracticeWise training (MAP Clinician) will be required for at least one licensed clinician at each child serving agency. A Virginia specific version of MAP training (MAP Credentialed User) will be required for all staff providing CPST to youth.
  - For adult agencies: All staff, both licensed clinicians and all other staff, will be required to complete a Virginia-specific training curriculum. Additional requirements and options for adult clinicians (in addition to the statewide curriculum) are still under development.

Example Treatment Plan Components - Youth

Presentation	Evidence-Based Intervention	Role of LMHP/LMHP-type	Role of QMHP	Role of BH Tech (Tier 2 Only)
Oppositional or Disruptive Behavior	Parent Management Training	Assessment, selection of parent management training approach, initial training, oversight of treatment plan	Psychoeducation and skill building in real world environment (e.g., Special Time; Time Out procedures) Crisis plan management and care coordination	Practice of Special Time skills Reinforcement of tracking tool usage
Traumatic Stress Symptoms	Trauma Focused Cognitive Behavioral Therapy	Assessment, initial training in relaxation, affective techniques, cognitive coping. Trauma narrative and sharing narrative done with clinician. Exposure hierarchy designed with clinician.	Relaxation, affective coping, cognitive coping skill building in real world environment; crisis plan management and care coordination; in vivo exposures as directed by clinician	Practice of relaxation techniques Reinforcement of tracking tool usage On going in vivo exposures following habituation

Example Treatment Plan Components - Adult

Presentation	Evidence Based Intervention	Role of Clinician	Role of QMHP	Role of BH Tech (Tier 2 Only)
Schizoaffective Disorder, with positive symptoms controlled by medication but significant ongoing negative symptoms and mood	CBT-p or behavioral activation, with focus on building daily home and self care habits	Assessment, selection of therapeutic approach (CBT-p, behavioral activation), initial intervention and building insight, oversight of treatment plan	Set up behavior activation (BA) tracking and identify triggers for antecedents; real world implementation of BA tasks; Crisis plan management and care coordination	Practice of BA tasks (e.g., going to grocery store; being in room while calling sister; helping plan daily chores), review tracking logs and use motivational interviewing skills to enhance practice
Bipolar disorder with partial response to medication	Illness Management and Recovery (IMR) and Cognitive Therapy related to significant issues of power/control/ Autonomy	Assessment, cognitive therapy, initial illness management and recovery overview with member.	Skills training aligned with IMR model (personal goal setting, self-advocacy, family psychoeducation), wellness habit development and tracking, sleep tracking and psychoeducation; crisis plan/relapse prevention	Practice of self-advocacy goals (e.g., rehearsing phone calls), sleep hygiene reinforcement and review of tracking

DRAFT-Clubhouse International Model of Psychosocial Rehabilitation Service Description

Clubhouse is a community-based program organized to support adults living with a serious mental illness. Clubhouse services assist individuals with behavioral health diagnoses to develop social networking, independent living, budgeting, self-care, and other skills that will assist them to live in the community.

Participants are known as Clubhouse members. Through what is referred to as the work-ordered day, the Clubhouse provides opportunities for member involvement and ownership in all areas of Clubhouse operation. Clubhouses are vibrant, dynamic communities where meaningful work opportunities drive the need for member participation, thereby creating an environment where empowerment, relationship-building, skill development and related competencies are gained. Members and staff work side-by-side in the program as colleagues. Comprehensive opportunities are provided within the Clubhouse, including supports and services related to employment, education, housing, community inclusion, wellness, community resources, advocacy, and recovery. In addition, members participate in the day-to-day decision making and governance of the program.

All programs must be accredited by Clubhouse International: https://clubhouse-intl.org/

DRAFT-Coordinated Specialty Care for First Episode Psychosis (CSC) Service Description

- Coordinated Specialty Care is an evidence-based, recovery-oriented, **team approach** to treating first-episode psychosis that promotes easy access to care and shared decision making among CSC team staff, the person experiencing psychosis, and family members.
- First-episode psychosis is generally regarded as the early period (up to five years) after the onset of psychotic symptoms.
- CSC provides comprehensive services that includes:
  - Psychotherapy (individual, group and family)
  - Evidence-based medication Management
  - Peer Recovery Support Services
  - Crisis Support
  - Caregiver outreach and skill building
  - Care Coordination/Case Management
  - Supported employment and education
- There are currently 11 CSC teams in Virginia, funded by DBHDS.
- All teams will be required to participate in fidelity monitoring.

Mental Health Case Management (H0023)- DRAFT- Service Description

Mental health case management (MHCM) is defined as a service to assist individuals, eligible under the State Plan who reside in a community setting, in gaining access to needed medical, social, educational, and other services. MHCM includes the assessment, development of a person-centered Individual Service Plan (ISP), referral to appropriate services, and monitoring of the services provided pursuant to the ISP. MHCM does not include the provision of direct clinical or treatment services.

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Provider Readiness Survey and Training

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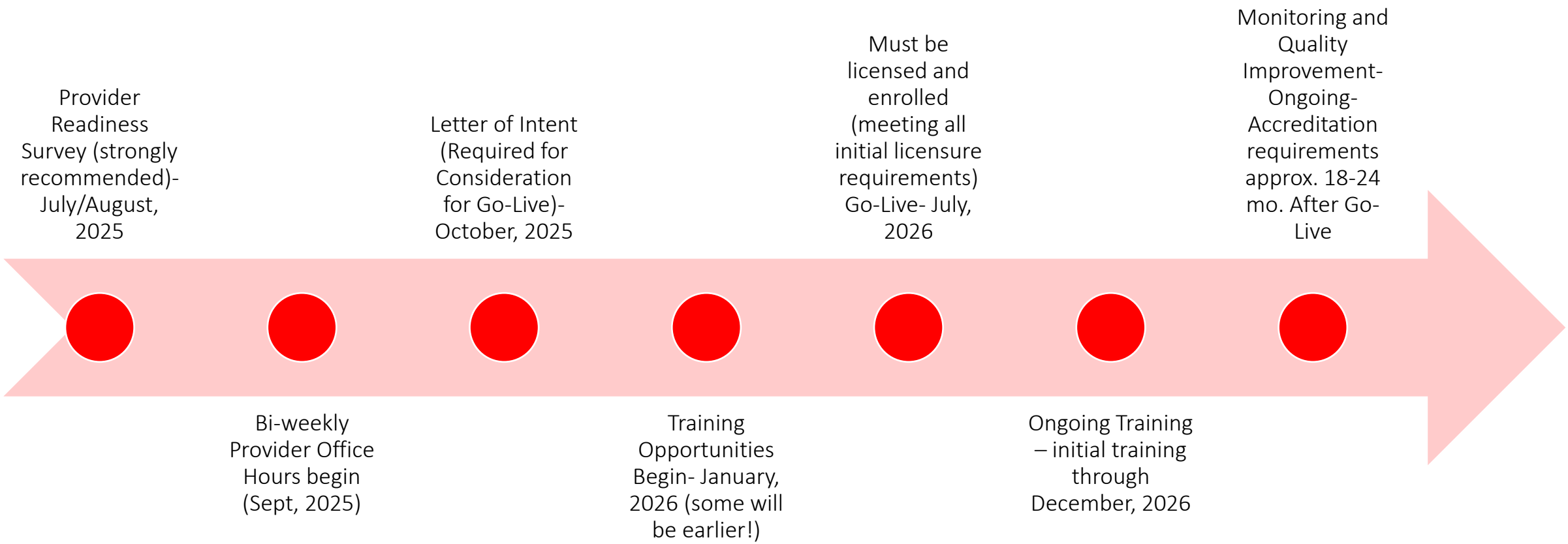
Provider Readiness



Provider Readiness Survey

- Survey completed by 158 providers by deadline
  - 31 CSBs
  - 127 private providers
- Providers completing survey represented about 1/3 of current providers (based on # served and claim history)
- More than half of PSR provider responded
- Respondents from smaller agencies were less likely to respond
  - Example: For intensive in home, 30% of providers serving 20-49 and 50+ members per year completed the survey but 17% of providers serving 0-8 and 8-19 members per year completed the survey

Services currently provided by respondents:

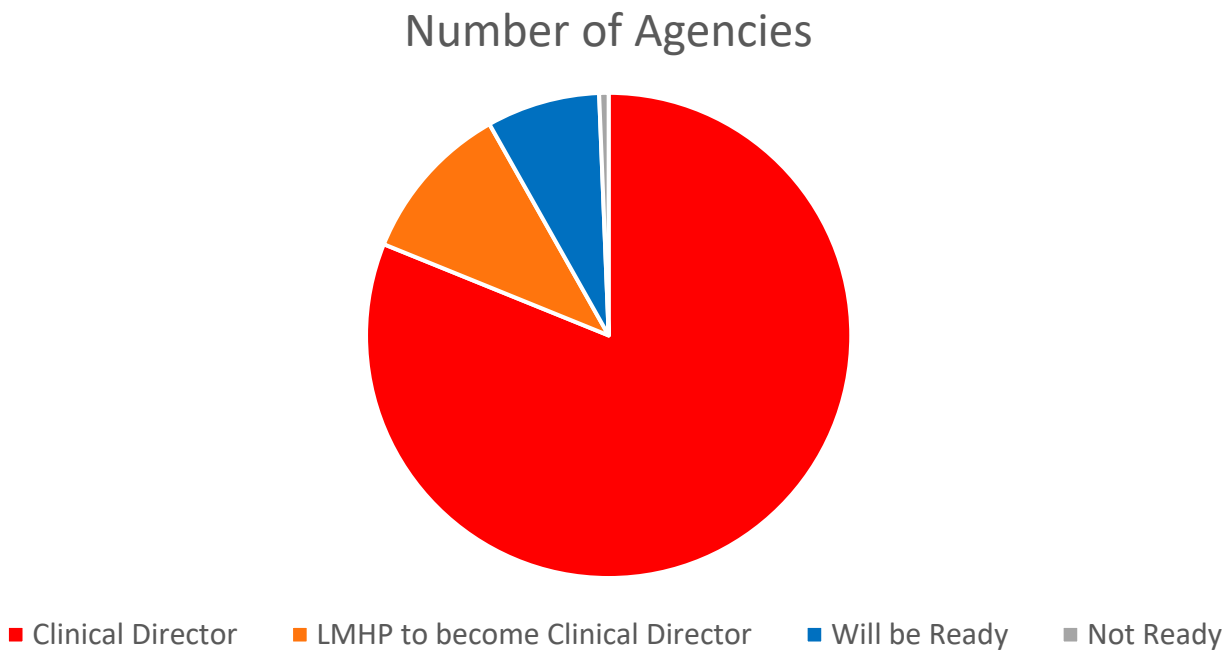
Current Service	Number
Intensive In-Home	93
Therapeutic Day Treatment	13
Mental Health Skill Building	127
Psychosocial Rehabilitation	42

Services providers are interested in providing:

New Service	Provider Count
CPST Youth Community	127
CPST Youth School	69
CSC	51
CPST-Adult	142
Clubhouse	68

Clinical Director and Accreditation Readiness

CPST Agencies will be required to have a fully licensed, full time LMHP clinical director. Which statement describes your agency's readiness?



25% (39 agencies) of survey respondents are currently accredited. Most accreditations reported were through CARF.

Provider Readiness to Provide Services

- DBHDS sponsored Managing and Adapting Practice (MAP) training will begin in October; over 90 applications received currently
- CSB Case Management Workgroup
- Provider Office Hours started in September, will tentatively occur every two weeks through the Spring
- Accreditation: we are working with CARF, one of the accrediting bodies to identify the programs that would best fit

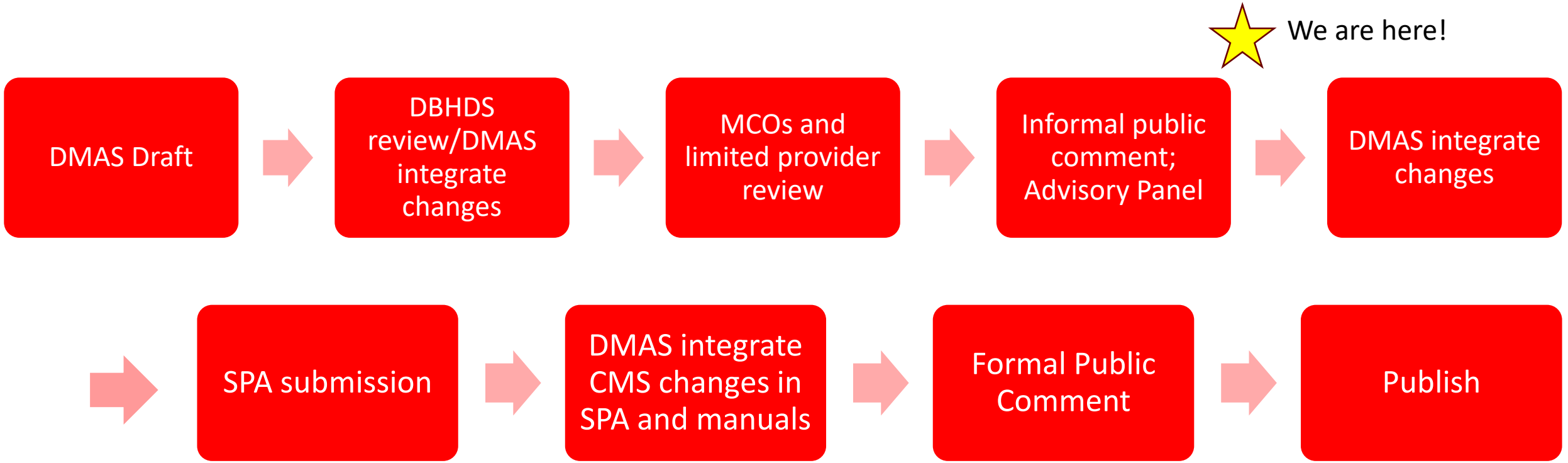
Provider Readiness DBHDS Licensing

- DBHDS is collaborating with DMAS to draft regulatory amendments to the licensing regulations to create a CPST license under the emergency authority granted under FY25-FY26 Budget Item 293 B.
- Goal for Board approval by September, after which they will be public while completing Executive Branch review.
- Along with drafting regulations, DBHDS will also:
  - Develop provider training and education
  - Develop license application review standards and processes
  - Disseminate provider communication on the status of these changes
  - Begin issuing new licenses before July 2026

Policy and Licensing Updates

- DBHDS Licensing Regulations- Draft of CPST was submitted and reviewed at DBHDS Board meeting on Sept 23rd
  - DBHDS Board approval in September, would be public and undergoing executive branch review
  - DBHDS Board review and posting of Coordinated Specialty Care and Clubhouse in December
- DMAS policy manuals- Goal is to post for informal public comment in September/October; followed by submission of SPA to CMS; followed by formal posting in Spring
- Meeting with a group of community-based providers to hear feedback about draft policies.

Policy Review Process



FFS/MCO Implementation

- All service codes have been assigned, systems changes are currently being drafted
- MCOs are currently providing feedback on drafts, technical specifications
- MCOs began conducting review and subsequent outreach to youth providers started in September
  - IIH and TDT providers cross referenced with survey respondents and claims history, by region
  - Need to retain all/increase providers in multiple regions
- Contractor System Testing: January-March, with readiness reviews in late Spring.

Additional Outreach/Engagement

- Recorded information videos by DMAS/DBHDS teams are posted on DMAS Youtube Channel
- Working with Clubhouse International on Clubhouse policy draft.
- Working with Praed Foundation on the development of CANS Lifetime Assessment
- DMAS/DOE and are working on strategic communication to school admin and school-based MH staff about CPST-School and TDT ending.
- DMAS joined an OCS led workgroup (Sept 19th) on redesign to provide support for CSA planning/implementation.
- Presenting at:
  - VACSB: Oct 1st
  - VNPP: Oct 15th
  - CSA Conference: Oct 15th
  - VACBP: Oct 28th

Upcoming Milestones

- FAQ from public webinar is posted and will be updated as provider office hours continue.
- CPST-Community was posted for informal public comment on 09/05/25 and closed on 09/21/25
- Mental Health Case Management (H0032) is currently up for informal public comment and will close 10/13/25.
- Others will be staggered as they are ready through October 2025.
- Managing and Adapting Practice (MAP) first training cohort trainings will be in October, November, December, and January.
- Provider Office Hours will be held twice monthly starting in September
  - Open office hours for all providers will start in October, info is posted to the DMAS redesign website: Medicaid Behavioral Health Services Redesign
- Short general information videos will be recorded and released to the public via the DMAS Youtube channel in the coming months.

Next Steps

- Letter of Intent (short survey) to provide a new service will be posted in October, please fill this out.
- Provide public comment when policies are posted.
- Be on the look-out for Managing and Adapting Practice (MAP) therapist trainings offered by DBHDS and VCU Center for Evidence-Based Partnerships.
  - MAP direct services training will be offered in Early Fall
  - CANS, MAP Qualified User, and all Adult Rehabilitative Training opportunities will be publicized by early Fall and training will be offered January 2026- December 2026
- Provider Office Hours for pre-implementation, will run starting Sept 2025-July 2026: link will be posted to our website Medicaid Behavioral Health Services Redesign
- More information about post July 2026 provider support will be provided closer to July 2026.

CardinalCare
Virginia's Medicaid Program

Thank you for your participation.

DBHDS
Virginia Department of Behavioral Health and Developmental Services

RIGHT HELP. RIGHT NOW.
Transforming Behavioral Health Care for Virginians

DMAS