BHC Behavioral Health Commission

Commission meeting

September 8, 2026

Briefing

Enhancement of Medicaid behavioral health services

Abigail Cornwell, BHC Policy Analyst

Monitoring request

- BHC[1] directed staff to monitor the enhancement of Medicaid behavioral health services on an ongoing basis
- Includes periodic review of Project BRAVO[1]
  - First monitoring report in 2023
- 2026 report includes Behavioral Health Redesign due to concerns over design and implementation

[1]BHC – Behavioral Health Commission; Project BRAVO – Behavioral Health Redesign for Access, Value, and Outcomes

Research activities

- Interviews with DMAS[1], DBHDS[1], VDOE[1], CEP-Va[1], VAHP[1], CSBs[1] and VACSB[1], private providers, and VACBP[1]
- Analysis of Medicaid claims data, budget and utilization projections, and fidelity and outcome data
- Review of DMAS provider manual drafts and public comments, Mercer rate study and fiscal impact analyses, planning materials, annual reports on services, and research literature

[1]DMAS – Department of Medical Assistance Services; DBHDS – Department of Behavioral Health and Developmental Services; VDOE – Virginia Department of Education; CEP-Va – Center for Evidence-based Partnerships in Virginia; VAHP – Virginia Association of Health Plans; CSBs = Community Services Boards; VACSB – Virginia Association of Community Services Boards; VACBP – Virginia Association of Community-based Providers

In brief

- Access to behavioral health services improved under Project BRAVO but uptake remains low for some intensive outpatient services, and crisis services may be improperly used
- State lacks comprehensive metrics and reporting mechanisms for redesigned behavioral health services
- Behavioral Health Redesign (BHR) will replace four legacy services with evidence-based alternatives
- Additional time and resources are needed to implement BHR successfully and ensure effectiveness

In this presentation

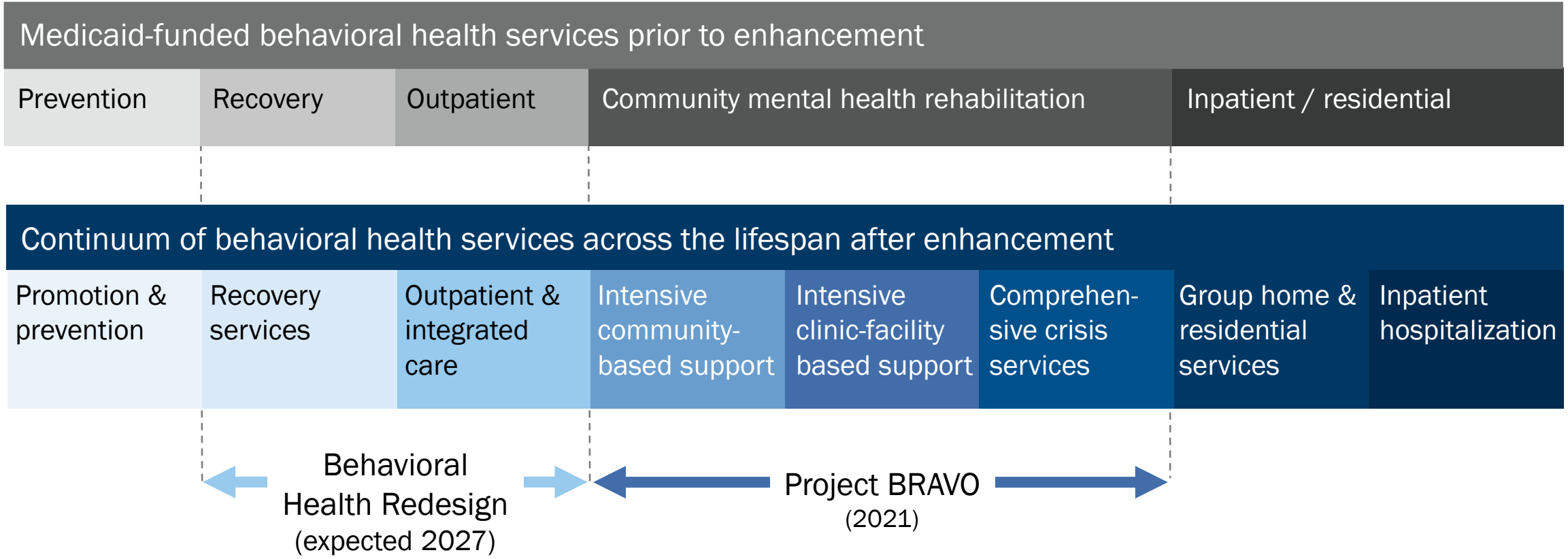
Background

Access to Project BRAVO services

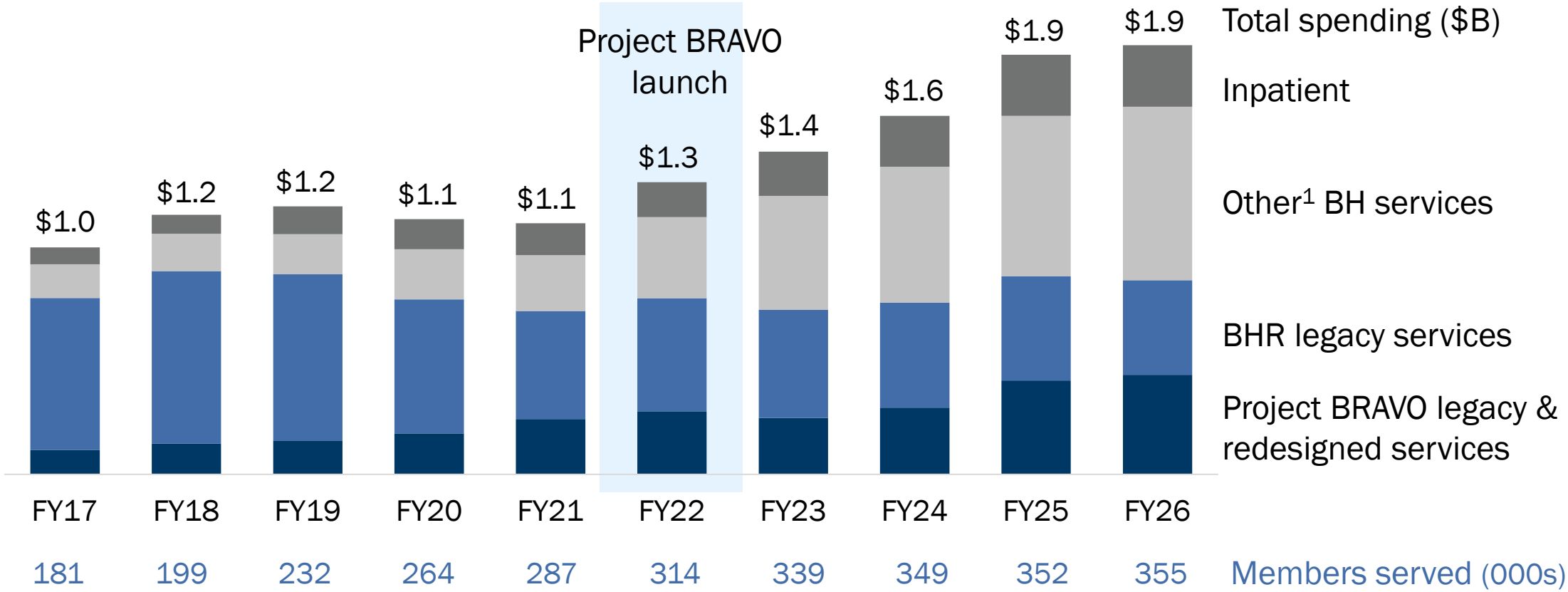
Quality of Project BRAVO services

Behavioral Health Redesign

Virginia is enhancing Medicaid behavioral health services in phases to improve access, quality, and cost-effectiveness



Medicaid spending on behavioral health services has increased since FY17, and reached $1.9 billion in FY26



[1]Other behavioral health services include Applied Behavior Analysis, outpatient psychiatric, outpatient psychotherapy, peer recovery support services, psychiatric residential treatment, and therapeutic group home

Source: BHC staff analysis of data from Behavioral Health Service Utilization and Expenditures dashboard, FY22-FY26, DMAS

In this presentation

Background

Access to Project BRAVO services

Quality of Project BRAVO services

Behavioral Health Redesign

Project BRAVO intended to increase access to behavioral health services for Medicaid members

- Expand the array of covered services to fill gaps in the continuum
- Attract enough providers to deliver the new services
  - Set rates high enough to draw providers into delivering the new services
  - Ensure individuals in all regions of the state could receive the services

Project BRAVO enhanced intensive outpatient and crisis services

Intensive outpatient

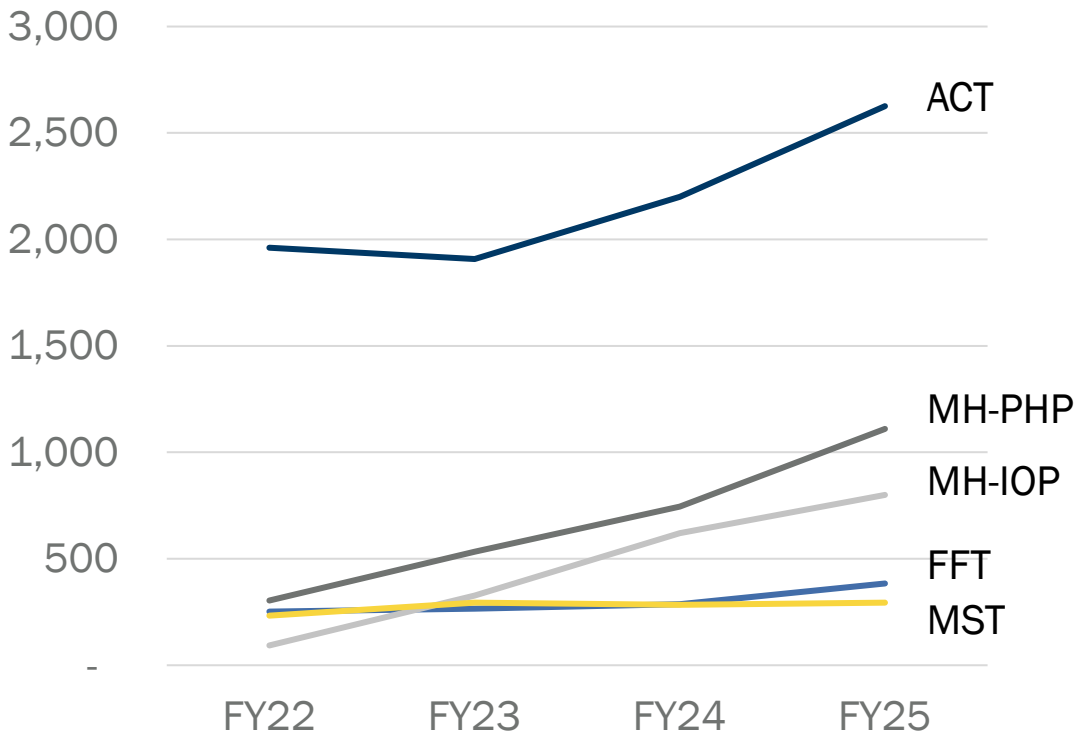
Intensive community-based support	Intensive clinic-/facility-based support	Comprehensive crisis services
• Multisystemic therapy (MST) • Functional family therapy (FFT) • Assertive community treatment (ACT)	• Intensive outpatient programs for mental health (MH-IOP) • Partial hospitalization programs for mental health (MH-PHP)	• Mobile crisis • Community stabilization • 23-hr crisis stabilization (CRC) • Crisis stabilization unit (CSU)

Finding

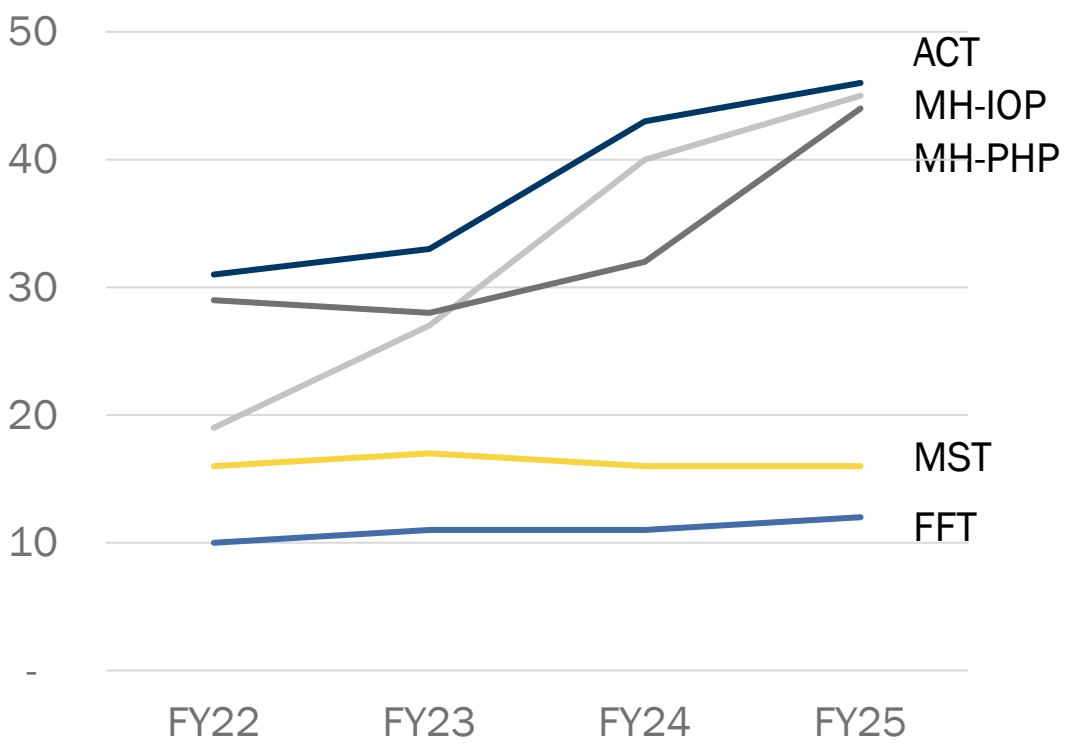
- Access to intensive outpatient services has improved under Project BRAVO, but utilization remains low for several services

Access to all intensive outpatient services has increased under Project BRAVO

Medicaid members

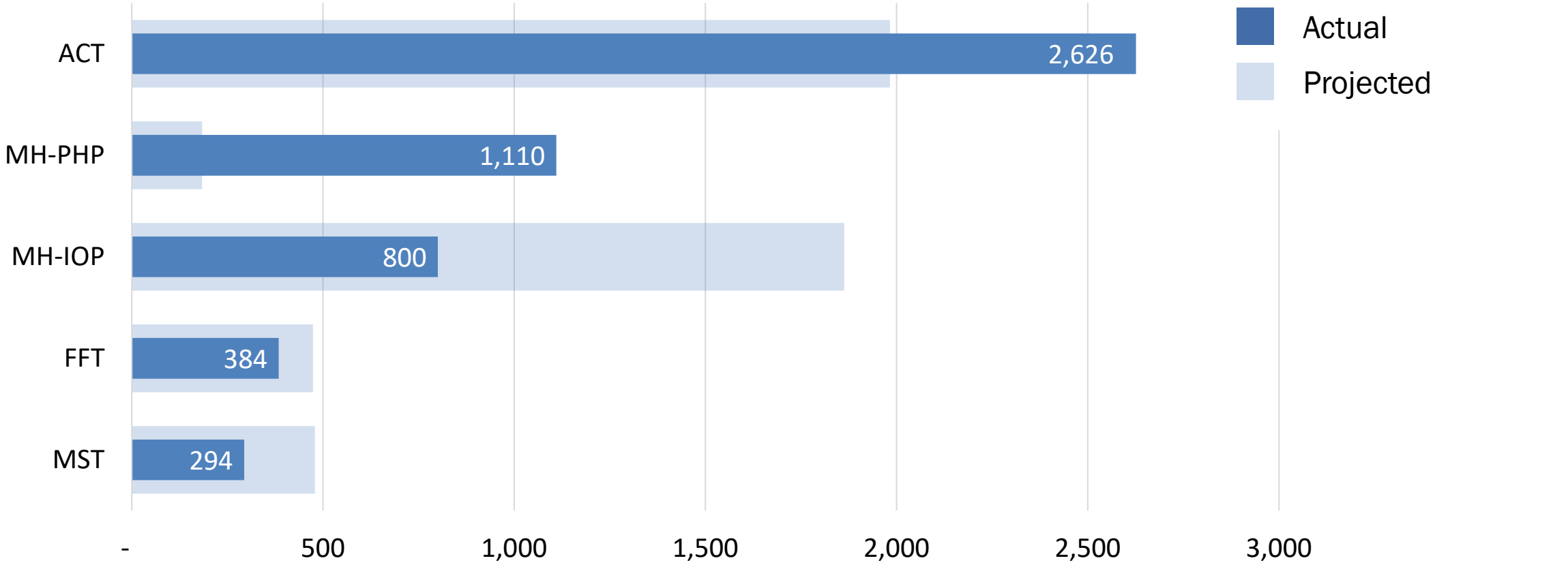


Providers



Source: BHC staff analysis of claims data; data from Behavioral Health Service Utilization and Expenditures dashboard, FY22-FY25, Department of Medical Assistance Services; data on MST and FFT teams, Center for Evidence-based Partnerships in Virginia, FY22-FY25

Number of members receiving services in FY25 trails projections for some services



Source: BHC staff analysis of claims data, budget assumptions, and data from Behavioral Health Service Utilization and Expenditures dashboard, FY22-FY25, Department of Medical Assistance Services

Uptake of certain services has been slow due to low provider participation and limited referrals

- Participation of MST and FFT providers has not increased significantly since Project BRAVO launched
  - Teams are costly to start and hard to staff amid licensed workforce shortage
  - CEP-Va helps cover start-up and training costs, but has limited capacity
- Referrals often made to legacy services rather than MST, FFT, and MH-IOP
  - Legacy services are more familiar, more readily authorized, and easier to provide
  - Legacy services will be retired under BHR, which may increase referrals to redesigned services

Recommendations

- The **General Assembly** may wish to include funding in the 2027-2028 Appropriation Act for CEP-Va at VCU to establish additional MST and FFT teams
- **DMAS**, with **DBHDS,** should develop and communicate materials on MST and FFT eligibility, benefits, and referrals to all entities responsible for referring youth to these services and to families at least six months prior to legacy services being discontinued

Project BRAVO added Medicaid coverage for crisis services, complementing the state's investment in building the crisis system

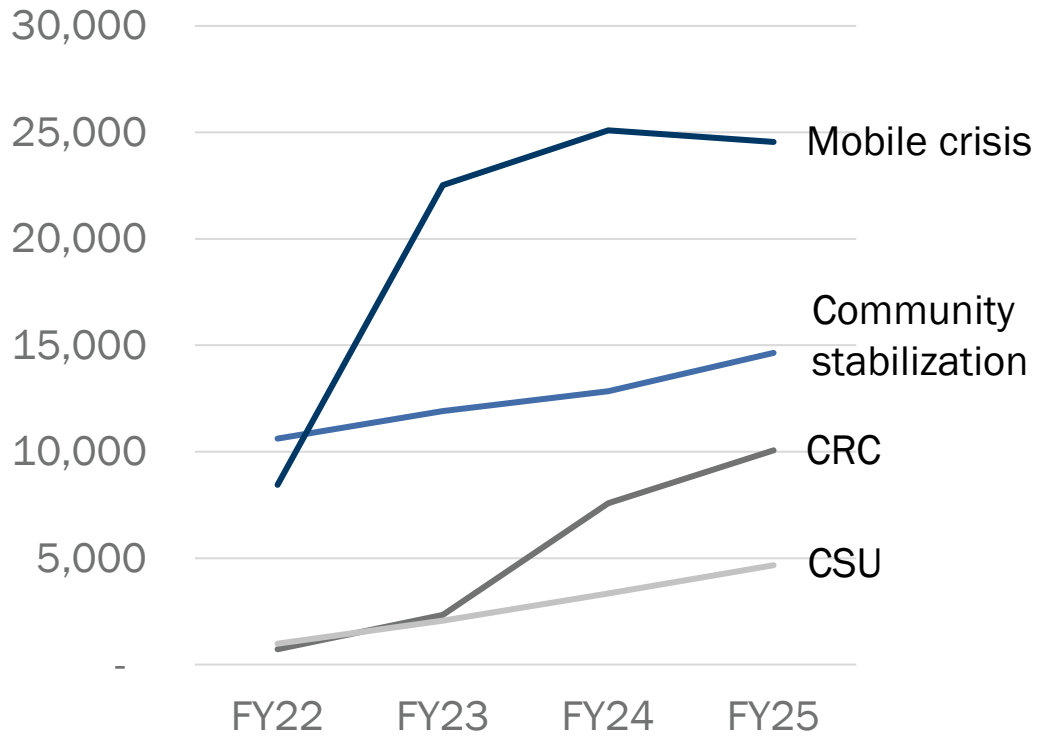
- Project BRAVO added Medicaid reimbursement for a comprehensive set of crisis services
  - Previously covered only two crisis services: crisis intervention and crisis stabilization
- State general fund investment helped build the public crisis infrastructure (mobile crisis teams, CRCs, and CSUs at CSBs)
- Project BRAVO offered sustainable funding for services and drew in private providers

Finding

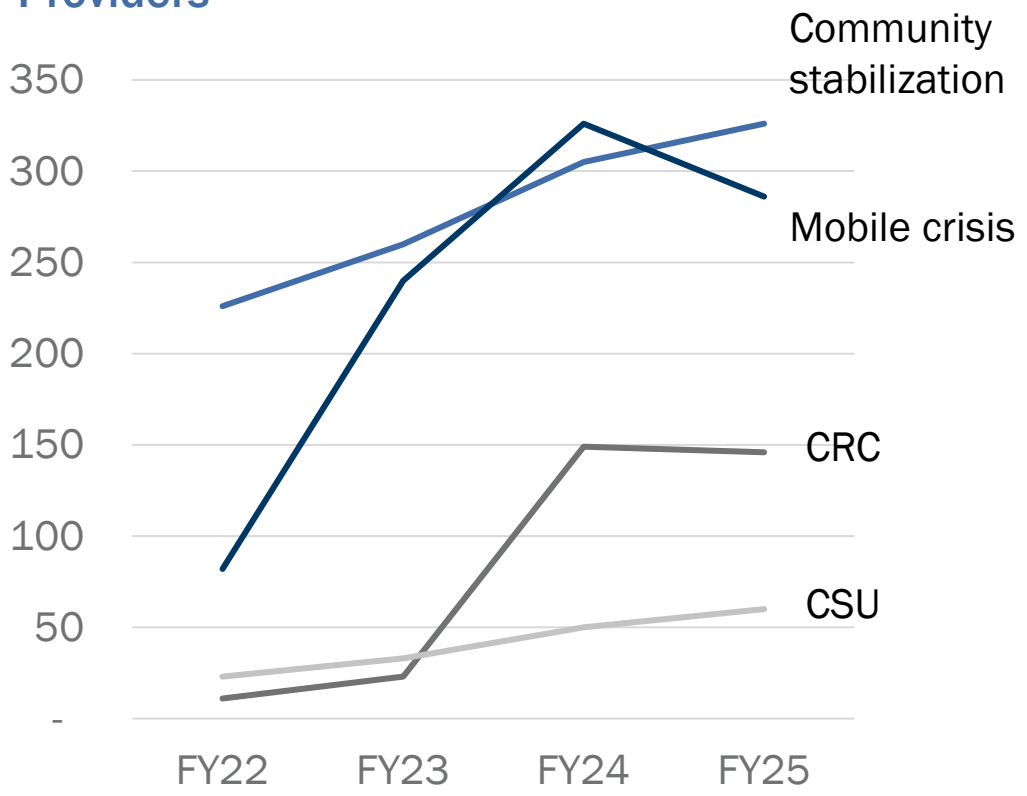
- Access to crisis services has improved, but some growth reflects improper use

Access to crisis services has increased significantly since Project BRAVO launched

Medicaid members

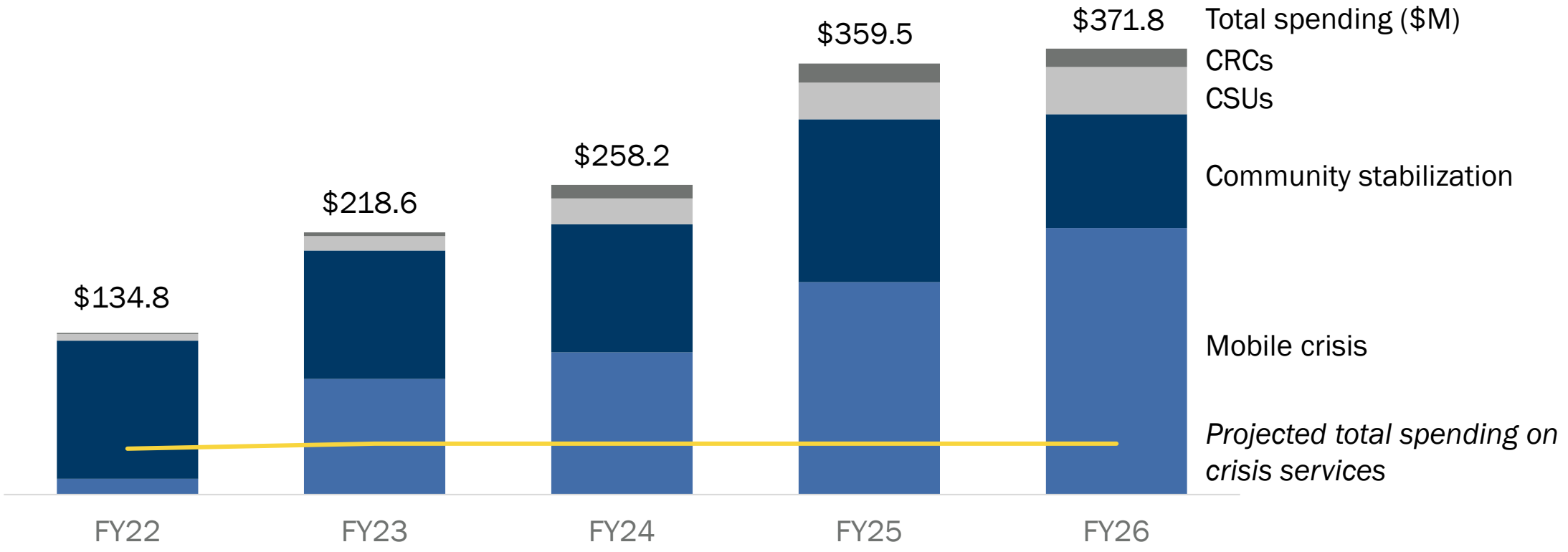


Providers



Source: BHC staff analysis of claims data, budget assumptions, and data from Behavioral Health Service Utilization and Expenditures dashboard, FY22-FY26, Department of Medical Assistance Services

Spending on crisis services has far exceeded projections, driven primarily by spending on mobile crisis and community stabilization



Source: BHC staff analysis of claims data and projections, FY22-FY25, Department of Medical Assistance Services

Improper use of crisis services has driven some of the increase in utilization and spending

- Some providers appear to deliver crisis services to maximize revenue
  - Reports of coaching members to request a mobile crisis dispatch, sub-15-minute responses, repeat billing, and gift cards or hotel stays in place of care coordination
- Some improper use reflects gaps in other supports
  - Providers report using community stabilization to cover food or shelter for individuals with no safe place to go after a crisis
  - Medicaid does not cover housing or employment supports, and Virginia has limited residential opportunities for adults with serious mental illness

Strong rates, no prior authorization, and expedited licensing left mobile crisis and community stabilization vulnerable to improper use

- Rates were set high to attract providers
- Standard prior-authorization controls do not apply to emergency service
- Licensing standards in effect at launch set a low bar for entry
- Limited capacity and tight implementation timeline did not allow sufficient time to adequately review providers seeking to enroll

DMAS and DBHDS have taken steps to curb improper use of crisis services, but gaps remain

- Analyzed billing patterns to identify suspicious activity
- Referred cases of suspected fraud to the authorities and participated in federal trials
- Strengthened MOUs[1] with crisis providers and ended agreements with providers suspected of improper use
- General Assembly limited mobile crisis to four hours and discontinued community stabilization in 2027-2028 Appropriation Act

[1]MOU – memorandum of understanding

Recommendations

- **General Assembly** may wish to direct the State Board of Behavioral Health and Developmental Services to amend licensing regulations for crisis services to strengthen protections against improper use
- **DMAS** and **DBHDS** should improve information available to identify improper crisis use (real-time dispatch data, cross-MCO[1] sharing, linked data)
- **General Assembly** may wish to appropriate additional funding and FTEs to DMAS to build data sharing and analyze data to identify improper use

[1]MCO – managed care organization

In this presentation

Overview

Access to Project BRAVO services

Quality of Project BRAVO services

Behavioral Health Redesign

Project BRAVO intended to improve quality of Medicaid behavioral health services

- Replace outdated services with research-based, trauma-informed services shown to produce good outcomes
- Research-based services make quality measurable by identifying the outcomes that should be achieved and how to measure them
- Measurable outcomes enable legislators to direct spending toward what works and correct course when a service falls short

Finding

- There is no comprehensive mechanism in place to ensure that Project BRAVO services are delivered as intended or produce good outcomes

Comprehensive evaluation and reporting mechanism needed to ensure success of enhancement efforts

- Enhancement initiative envisioned accountability framework during planning phases
- Limited resources have been directed toward developing comprehensive evaluation and reporting structure
  - Unknown benefits to service recipients and the state
  - Delays in identifying issues with access, service delivery, and spending
  - Limited data for legislative oversight
- Current challenges with Project BRAVO services will also apply to future enhancement phases

Current efforts to measure service delivery and outcomes are incomplete and decentralized

Service	Fidelity/ service delivery measured?	Outcomes measured?	Responsible entity
MST	✓	✓	National purveyor, CEP-Va
FFT	✓	✓	National purveyor, CEP-Va
ACT	○	○	University of North Carolina, DBHDS
MH-IOP	✗	✗	
MH-PHP	✗	✗	
Mobile crisis	○	○	DBHDS
Community stab.	✗	✗	
CRCs	✗	○	DBHDS
CSUs	✗	○	DBHDS

✓ Fully measured

○ Partially measured

✗ Not measured

Source: BHC analysis of provider manuals, DMAS; data on fidelity and outcomes for MST and FFT, FY22-FY25, CEP-Va; ACT annual reports and data on outcomes for crisis services, DBHDS

Recommendations

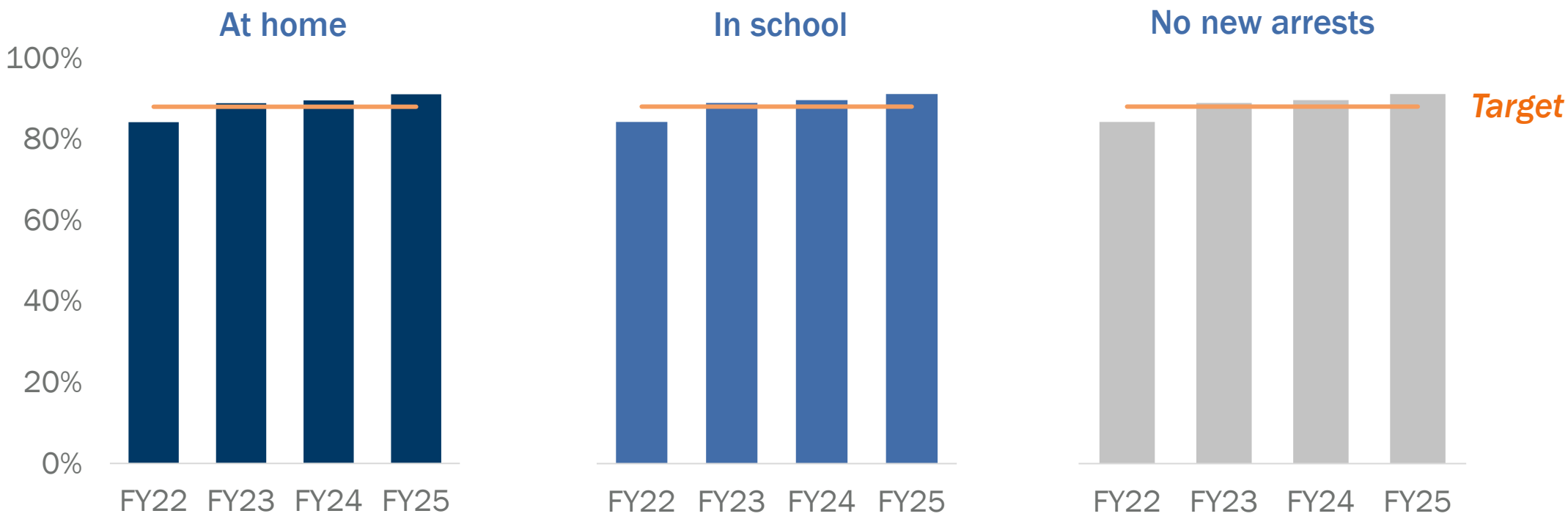
- **General Assembly** may wish to require comprehensive evaluation and reporting on all redesigned behavioral health services
  - **DMAS** and **DBHDS** should develop comprehensive service delivery and outcome measures for all redesigned services and report to BHC on proposed measures and reporting structure by November 1, 2027
  - **General Assembly** may wish to appropriate $1M and seven FTEs for DBHDS Office of Clinical Quality Management to conduct ongoing analysis and reporting

- **General Assembly** may wish to appropriate $565,000 and 4 DBHDS FTEs to expand ACT fidelity assessment capacity

Findings

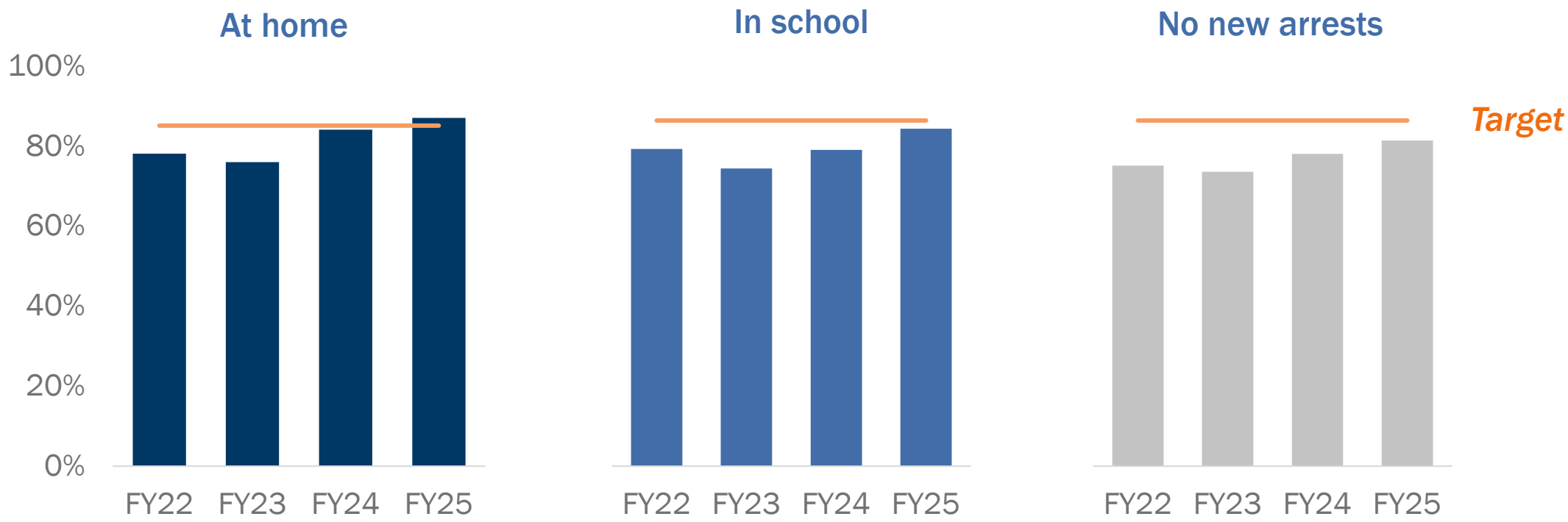
- Most youths who received MST and FFT experience positive outcomes
- Outcome measures available for ACT and crisis services suggest positive results

MST achieved targeted positive outcomes



Note: Data includes all youths who received MST. Sixty percent, on average, were enrolled in Medicaid. N=190-281.
Source: BHC staff analysis of outcome data on youths who received MST, FY22-FY25, Center for Evidence-based Partnerships in Virginia

FFT achieved positive outcomes, but below targeted level



Note: Data includes all youths who received FFT. Sixty percent, on average, were enrolled in Medicaid. N=368-452.
Source: BHC staff analysis of outcome data on youths who received FFT, FY22-FY25, Center for Evidence-based Partnerships in Virginia

Outcome measures collected for ACT and crisis services suggest positive results

- ACT recipients[1] experienced reductions in hospitalization in most recent ACT report
  - State hospital bed days down by 54%
  - Local psychiatric bed days down by 35%
- Majority of individuals who used crisis services were discharged into the community in FY25
  - 63% of individuals who received mobile crisis
  - 70% of individuals in CRC
  - 90% individuals in CSU

[1]Includes 384 individuals who began receiving ACT from a CSB-based team in FY 2022, comparing psychiatric bed days two years before and two years after admission (state hospital n=384; local psychiatric n=267)
Source: BHC analysis of data from Report on Assertive Community Treatment, November 2025, Department of Behavioral Health and Developmental Services; data on crisis outcomes, FY25, from Department of Developmental Services

In this presentation

Background

Access to Project BRAVO services

Quality of Project BRAVO services

Behavioral Health Redesign

Behavioral Health Redesign will enhance rehabilitative services and replace four legacy services with new services

Legacy service	BHR service
Mental health skill building	CPST[1]-community
Intensive in-home	
Therapeutic day-treatment	CPST[1]-school
Psychosocial rehabilitation	CPST[1]-community Mental Health Clubhouse
No legacy service, newly added under BHR	Coordinated Specialty Care (CSC)

[1]CPST – Community psychiatric support and treatment
Source: BHC staff analysis of DMAS draft provider manuals, FY25-FY26

Appropriation Act requires new services to be budget neutral and implemented by July 1, 2027

- CPST, Clubhouse, and CSC cannot cost more than the legacy services they replace
  - Baseline=$557M ($357M adults, $200M youths)
- DMAS contracted with Mercer to estimate the cost to deliver new services and to develop reimbursement rates and service hours at budget-neutral levels
- Initial implementation date of July 1, 2026 was delayed by one year to give agencies more time to prepare

Providers express concerns that CPST hours could be insufficient to meet needs

- CPST hour limits were selected to achieve budget neutrality
  - Not based on research or other states' experience
- CPST hour limits are lower than allowable hours for legacy services
  - Concerns about stability during transition
- Individuals may need fewer CPST hours than under legacy services because CPST is a more active treatment approach

Recommendation

- General Assembly may wish to direct DMAS to assess whether CPST service hours are sufficient to meet members' needs and report on findings two years after implementation of Behavioral Health Redesign

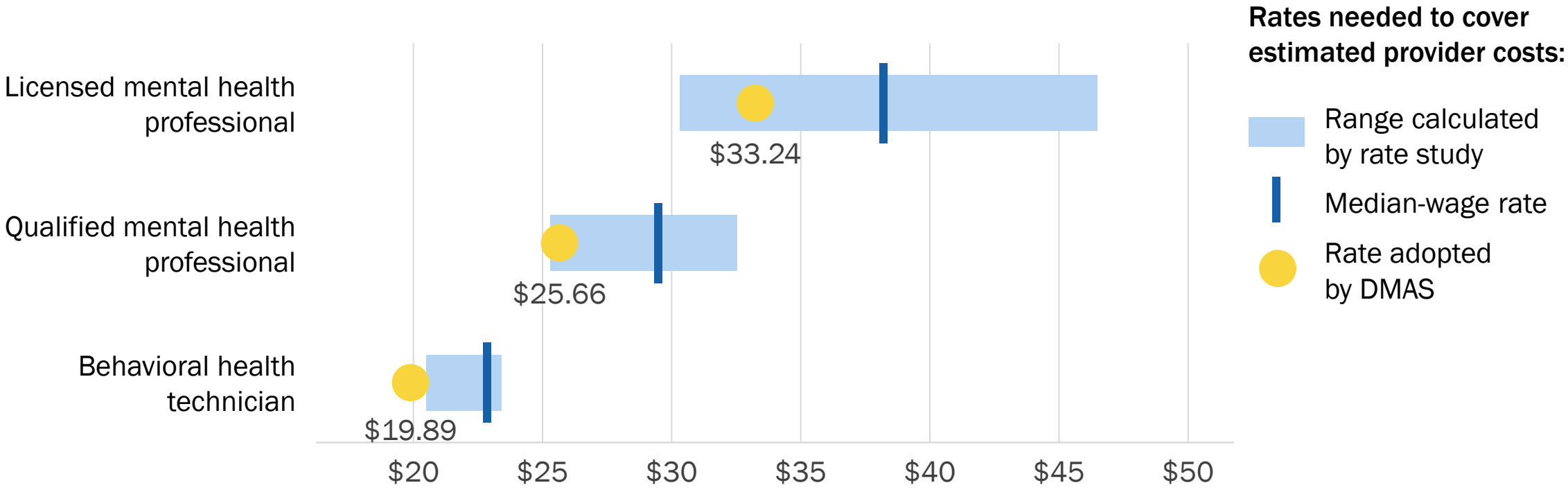
Finding

- BHR rates may not be sufficient to attract and sustain enough providers of CPST and Clubhouse services

CPST rates may be too low to attract and sustain enough providers, and may preclude small providers from offering the service

- Providers report rates do not cover cost of services and may preclude them from offering services
- Majority of CSBs interviewed do not plan to offer CPST
  - Communities served by only CSBs could be left with no CPST provider
- Small providers least likely to be able to financially sustain CPST
  - Viability requires serving 40 to 50 individuals a year

CPST reimbursement rates set below Mercer recommendation for all practitioner types to achieve budget neutrality



Note: Rates are per 15 minutes of service delivered in a community setting.
Source: BHC staff analysis of Mercer rate study and rate and fiscal impact summary, Department of Medical Assistance Services, 2025

Option

- The General Assembly may wish to consider directing DMAS to increase reimbursement rates for Community Psychiatric Support and Treatment (CPST) to 95 percent of the median-wage rates for all practitioner types.
  - Estimated cost is $30M, including federal and state dollars
  - Could target practitioner types with lowest rates

Clubhouse expensive to start-up, and rate may not be sufficient to cover ongoing costs

- Clubhouse rate set at $72.41 per day
  - Less than rate for legacy service, but expected to be more costly to deliver
- Clubhouse programs are expensive to start
  - Estimated start-up cost of $7,000 to $11,000 per site
  - No funding source has been identified to help providers cover upfront costs

Recommendation

- General Assembly may wish to appropriate $440,000 for a Clubhouse training grant program administered by DBHDS

BHR services are scheduled to be implemented by July 1, 2027

- Appropriation Act states that BHR services must be implemented by July 1, 2027
  - Date was delayed one year after stakeholders requested more time to prepare
- Budget language requires legacy services to be retired before BHR services begin

Finding

- More time and resources may be needed to successfully implement BHR

School-based CPST service requirements have not yet been revised

- Provider manuals for all BHR services are not finalized, and CPST-school lags behind
  - First released in September 2025 and received many public comments
- Significant changes to the service requirements are expected
- VDOE and school-based providers do not have a good grasp on the scope of the upcoming changes
- Concern that CPST-school providers will not be ready or available when TDT is retired and students could be left without services

Without additional resources, BHR providers may not be adequately vetted under current timeline

- DBHDS Office of Licensing expects over 1,000 new applications, triple the workload in a typical year
- DBHDS is strengthening the review process, which adds about nine hours of work per application
- After initially licensing, demand for oversight will remain high
  - BHR providers receive two inspections a year for their first three years
  - Initial, conditional licenses will expire, requiring review for longer-term license

Recommendation

- General Assembly may wish to consider adding $845,000 and 8 additional FTEs as DBHDS licensing specialists

Not enough providers can be trained and ready to deliver the new services before planned launch

- Providers should ideally receive initial training prior to providing new services
  - Training before launch is especially important for Clubhouse
- Many providers will not be trained when legacy services end, according to state agencies and provider associations
- State is allowing a grace period to deliver services before training is complete
  - Risks services not being provided as intended

Some training is not yet available, and few providers have completed what is available

Required upfront training	Available?	Funding
CPST		
Service modules	No	Fully funded by DMAS
CANS[1] Lifetime assessment	No	Not funded
MAP framework (youths)	Yes – 200 trained	Partially funded by DBHDS
Clubhouse program		
Clubhouse International	Yes *Out of state training*	Not funded

[1]CANS – Comprehensive Assessment of Needs and Strengths
Source: BHC staff analysis of draft provider manuals; interviews with DMAS, DBHDS, CEP-Va

Recommendation

- General Assembly may wish to consider appropriating one-time funding for provider training grants

Assessment tool for service eligibility and intensity likely to be administered manually, limiting access to data

- CANS[1] Lifetime could provide comprehensive information about who needs services and whether they improve
- No firm plans to build platform for providers to complete the assessment and state to collect data
- At launch, the state will not be able to readily access CANS data
  - Assessments will be collected within provider's record systems and submitted to MCOs as a spreadsheet with each authorization request

[1]CANS – Comprehensive Assessment of Needs and Strengths

Options

- General Assembly may wish to consider delaying implementation by one additional year to July 1, 2028 and allowing phased implementation of redesigned services for *either*
  (1) all Behavioral Health Redesign services, or
  (2) CPST-school and Clubhouse services

Finding

- BHR lacks an accountability system to ensure success

Accountability system is necessary to ensure the state realizes the anticipated benefits of redesigned behavioral health services

- Behavioral health redesign is expected to affect 70,000+ individuals and $550M+ in annual spending
- Accountability system would show
  - whether members have adequate access to services following implementation
  - what happens to individuals who receive the new services
  - whether redesigned efforts are budget neutral
- No entity is designated to monitor implementation, effectiveness, or budget neutrality
  - Effectiveness could be assessed by DBHDS Office of Clinical Quality Management
  - Implementation and budget neutrality could be evaluated by DMAS

Recommendation

- General Assembly may wish to
  - Direct DMAS to identify measures to evaluate access adequacy and spending against the budget-neutral baseline; report by November 1, 2027, and annually after
  - Appropriate $150,000 and 1 FTE for DMAS to add an analyst position to the Behavioral Health Division to assess access adequacy and spending for redesigned services

Take-aways

- Access to Project BRAVO services has improved for most services
- Improper use has driven some of the increased utilization of crisis services
- More time and resources are needed to successfully implement Behavioral Health Redesign, at a minimum for CPST in schools and Clubhouse
- Virginia needs comprehensive metrics and reporting structure to ensure the state realizes the anticipated benefits of redesigned behavioral health services

Staff for this report

Abigail Cornwell, Assistant Policy Analyst