BHC Behavioral Health Commission

Enhancement of Medicaid behavioral health services

Implementation and performance monitoring

2026

Report document #594

Commonwealth of Virginia

Behavioral Health Commission

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Purpose

The Commission is established in the legislative branch of state government for the purpose of studying and making recommendations for the improvement of behavioral health services and the behavioral health service system in the Commonwealth to encourage the adoption of policies to increase the quality and availability of and ensure access to the full continuum of high-quality, effective, and efficient behavioral health services for all persons in the Commonwealth. In carrying out its purpose, the Commission shall provide ongoing oversight of behavioral health services and the behavioral health service system in the Commonwealth, including monitoring and evaluation of established programs, services, and delivery and payment structures and implementation of new services and initiatives in the Commonwealth and development of recommendations for improving such programs, services, structures, and implementation.

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1 Overview of Medicaid behavioral health enhancement

Virginia has undertaken a major multi-phase initiative to enhance the delivery of Medicaid-funded behavioral health services. The primary goals of the initiative are to increase service access, strengthen service quality, and improve service cost effectiveness. To fulfill these goals, Virginia plans to build a continuum of behavioral care in which each Medicaid member can receive the level of care needed in the most appropriate setting (Exhibit 1-1). The first phase of this enhancement was named Behavioral Health Redesign for Access, Value, and Outcomes (Project BRAVO). Planning for Project BRAVO started in 2019, and its services launched in 2021. It has addressed services for individuals in acute need, adding intensive community- and facility-based services and expanding the crisis services available. The second phase, Behavioral Health Redesign (BHR), will focus on rehabilitative services that Medicaid members rely on to stay in the community long-term. BHR is scheduled to take effect in July 2027. Additional phases were anticipated when enhancement efforts began but have not yet been designed or funded.

The Behavioral Health Commission (BHC) is tasked with conducting ongoing oversight of behavioral health services and programs, including this enhancement initiative. The primary purpose of this oversight is to ensure that the initiative is satisfying legislative intent, and this report provides a status update on the initiative's progress in meeting its goals.

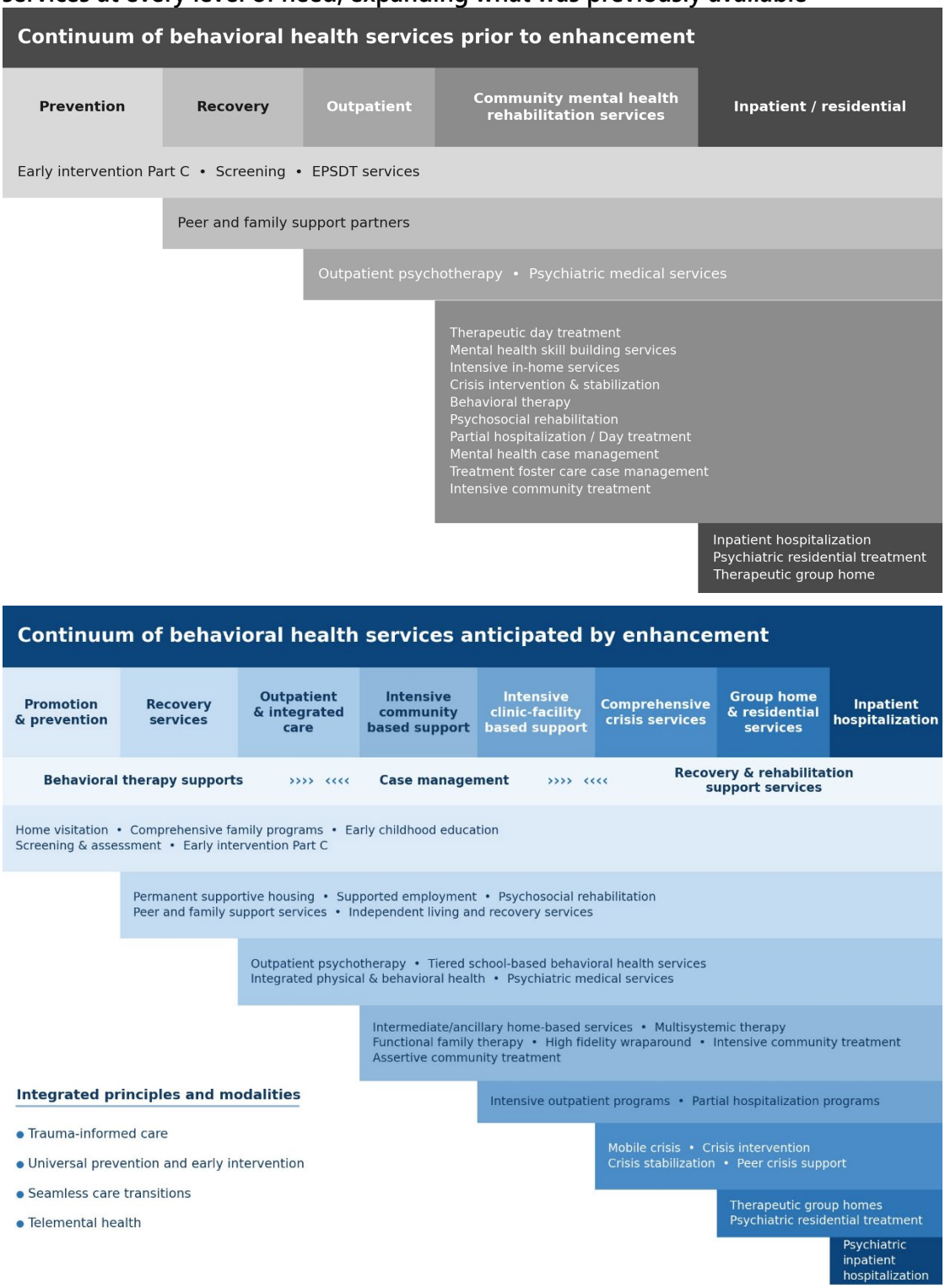
Goals of enhancement initiative are to improve access, quality, and cost-effectiveness

The ultimate goals of the initiative are to build a full continuum of services that (i) can provide access to services that meet all of the behavioral health needs of Medicaid members in the appropriate setting, (ii) have been demonstrated through research to be effective, and (iii) are cost effective.

Expanding access by increasing the array of covered services and attracting more providers

Prior to the enhancement initiative, Medicaid included few treatment options for members whose needs exceeded routine therapy but who had not yet reached a point of being at risk for hospitalization. The enhancements are intended to fill that gap by providing services at every level of intensity, so that members are able to access the services they need. As part of making needed services available, reimbursement rates for the new services need to be set at levels sufficiently high to attract an adequate number of providers to deliver them.

Exhibit 1-1
Enhancement of behavioral health services is intended to build a continuum of services at every level of need, expanding what was previously available



Source: BHC staff analysis of information from the Department of Medical Assistance Services

Improving quality by adopting services supported by evidence and producing good outcomes

Along with increasing access, the enhancement initiative involves replacing services of unknown effectiveness with services that research has shown produce positive outcomes. Most services Virginia covered before enhancement were not built on defined models, and there was a lack of evidence indicating that they achieved positive outcomes. Moreover, several services dated back to the 1990s and were written with broad requirements that left providers with substantial discretion in how they delivered services.

Adopting services built on research also makes it possible to measure whether they are working. The Department of Medical Assistance Services (DMAS) had planned to develop metrics and measures to track implementation and outcomes of the new services, according to early presentations on the enhancement initiative. Using research-based services helps identify what outcomes a service is supposed to achieve; it also informs the development of outcome measures to assess whether the treatment objectives of each service have been achieved. For example, a service demonstrated to reduce out-of-home placement can be evaluated on whether youths remain at home, and a service demonstrated to reduce hospitalization can be evaluated on whether individuals who receive it stay out of hospitals.

Enhancing cost-effectiveness by reducing unnecessary spending on ineffective services and achieving favorable outcomes faster

The final goal of the enhancement initiative is to increase cost effectiveness by directing Medicaid dollars toward services proven to work in the community rather than in hospitals. The intensive community-, clinic-, and facility-based services added through enhancement are designed as research-based alternatives to inpatient admission, so that people can receive treatment in the community whenever possible. DMAS projected that enhanced services would divert admissions from inpatient beds, shorten hospital stays, and reduce repeat admissions. Over time, Virginia plans to reinvest the savings from these enhanced community-based services into building out the remaining pieces of the continuum.

Project BRAVO enhanced intensive outpatient and crisis continuums for adults and children

The first phase of the enhancement initiative was Project BRAVO, which focused on enhancing the intensive outpatient and crisis continuums for adults and children. Project BRAVO services became available on a staggered schedule beginning on July 1, 2021. All services were available by December 1, 2021.

Project BRAVO added intensive community-based and clinic-based services and helped fund comprehensive crisis services

Project BRAVO added services in the middle of the continuum, where individuals need more support than routine outpatient therapy provides but less than a hospital. These services

were selected because they offer an alternative to inpatient admission or shorten the time an individual spends admitted.

DMAS focused on three groups of services under Project BRAVO.

(1) **Intensive outpatient/community-based services** deliver treatment in a person's home or elsewhere in the community. These services are designed to prevent an individual from being removed from home or admitted to a hospital.

(2) **Intensive clinic/facility-based services** provide structured treatment in a program setting for several hours a day or several days a week, while the individual lives in their home. These services offer more than routine outpatient therapy and less than inpatient care and serve individuals who need more than weekly counseling but do not require round-the-clock care.

(3) **Comprehensive crisis services** respond when an individual is in crisis and needs immediate attention. They are available at all hours and are designed to resolve the crisis in the least restrictive setting possible, so that an individual can avoid an emergency department visit or psychiatric hospitalization.

DMAS retired four legacy services across these three groups of services and replaced them with (i) five enhanced services and (ii) four brand-new services for which nothing comparable had previously existed in the Medicaid benefit (Table 1-1).

Together, the nine BRAVO services give Medicaid members options at several levels of intensity (Table 1-2). An individual can receive a few hours of structured treatment a week, a therapist in the home several times a week, a team available daily, or an immediate response at any hour.

Over $1.5 billion has been spent on Project BRAVO services since FY22

Virginia has spent more than $1.5 billion on Project BRAVO services since they became available. Spending grew each year, and crisis services accounted for most (85 percent) of that spending between FY22 and FY26 (Figure 1-1). Several Project BRAVO services replaced services Medicaid already covered, so a portion of this spending took the place of spending that would have occurred anyway. Still, Medicaid spending was significantly less for the legacy services replaced through Project BRAVO, totaling $128.1M in FY21, the last full year before the new services took effect (Figure 1-2).

Nearly 38,000 Medicaid members received at least one Project BRAVO service in FY26, up from about 21,000 in FY22. Since FY22, the number of members receiving at least one Project BRAVO service grew each year, and crisis services accounted for most of the growth (Figure 1-3). The largest increase in members receiving Project BRAVO services occurred between FY22 and FY23, in part because more people were receiving Medicaid during the public health emergency of COVID-19 and the mental health impacts of the pandemic increased the need for crisis services. Project BRAVO also reaches more members than the services it replaced; about 26,000 members received the legacy services in FY21, the last full year before the new services took effect (Figure 1-4).

Table 1-1
Nine services were enhanced and added to Virginia's Medicaid benefit under Project BRAVO, expanding the services available in three categories

BRAVO service	New or enhanced?	Legacy service (if enhanced)
Assertive community treatment (ACT)	Enhanced	Intensive community treatment
Multisystemic therapy (MST)	New	
Functional family therapy (FFT)	New	
Intensive outpatient programs for mental health (MH-IOP)	New	
Partial hospitalization programs for mental health (MH-PHP)	Enhanced	Day treatment Partial hospitalization
Mobile crisis response	Enhanced	Crisis stabilization Crisis intervention
23-hour crisis stabilization	New	
Residential crisis stabilization	Enhanced	Crisis stabilization Crisis intervention
Community stabilization	Enhanced	Crisis stabilization Crisis intervention

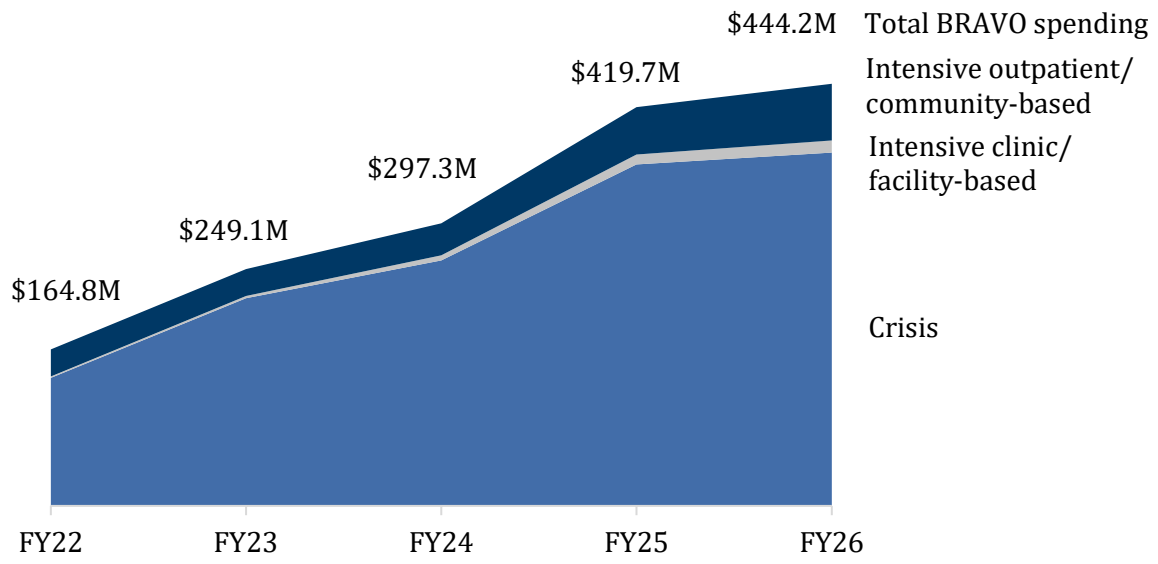
Source: BHC staff analysis of DMAS bulletins and interviews with DMAS staff

Table 1-2
Project BRAVO enhanced intensive services and crisis continuum for adults and children

Service	Who it serves	What it provides
Intensive outpatient/community-based support services Targeted, concentrated interventions for adults and children delivered in the home or community that provide more comprehensive care than can be provided in outpatient settings.		
ACT	Adults with serious mental illness	A team provides treatment, medication, and support wherever the person lives, as often as daily
MST	Youths ages 12 to 17 at risk of removal from home	A therapist works with the youth and family in the home several times a week over several months
FFT	Youths ages 11 to 18 at risk of institutionalization	A therapist works with the youth and family to change how the household functions
Intensive clinic/facility-based support services Intermediate level of care for individuals requiring a higher intensity of services than outpatient care, but lower intensity than residential or inpatient care.		
MH-IOP	Youths and adults needing more than routine outpatient care	Structured group and individual treatment several days a week while living at home
MH-PHP	Youths and adults at risk of or leaving psychiatric hospitalization	Daily treatment at an intensity like inpatient care, without an overnight stay
Comprehensive crisis services Services designed to prevent or de-escalate behavioral health crises and divert from inpatient services.		
Mobile crisis response	Youths and adults experiencing a behavioral health crisis	A team travels to the person and works to resolve the crisis on site, available at all hours
23-hour crisis stabilization	Youths and adults needing observation and assessment during a crisis	Up to 23 hours in a safe setting with evaluation and a determination of what care is needed next, provided in crisis receiving centers (CRCs)
Residential crisis stabilization	Youths and adults needing more time to stabilize during a crisis	A short residential stay with treatment and assessment, provided in crisis stabilization units (CSUs)
Community stabilization	Youths and adults who recently experienced a crisis	Short-term support and coordination while the person waits to begin ongoing treatment

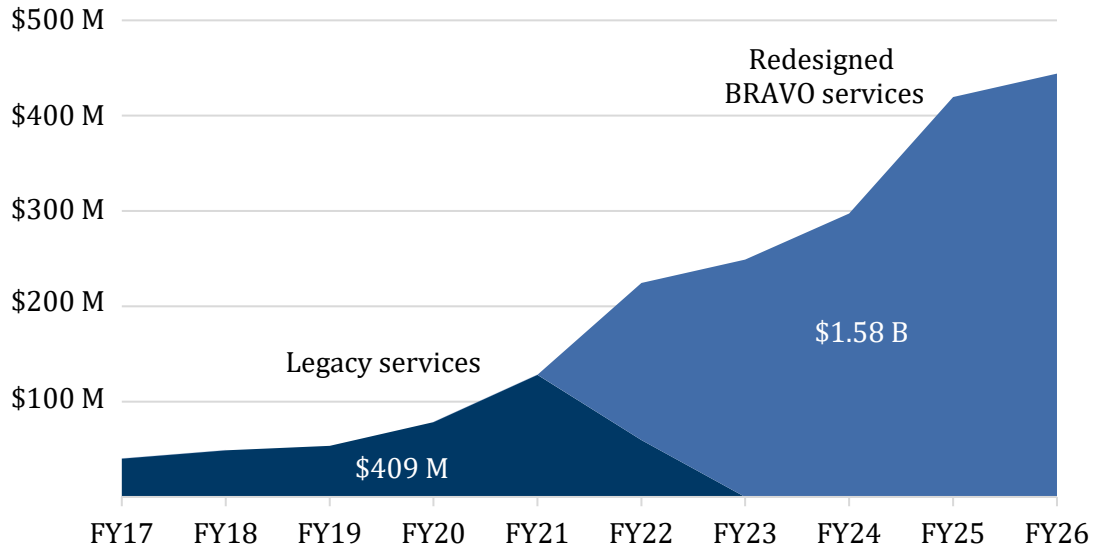
Source: BHC staff analysis of DMAS service manuals

Figure 1-1
Spending on Project BRAVO services has increased every year, driven primarily by crisis services



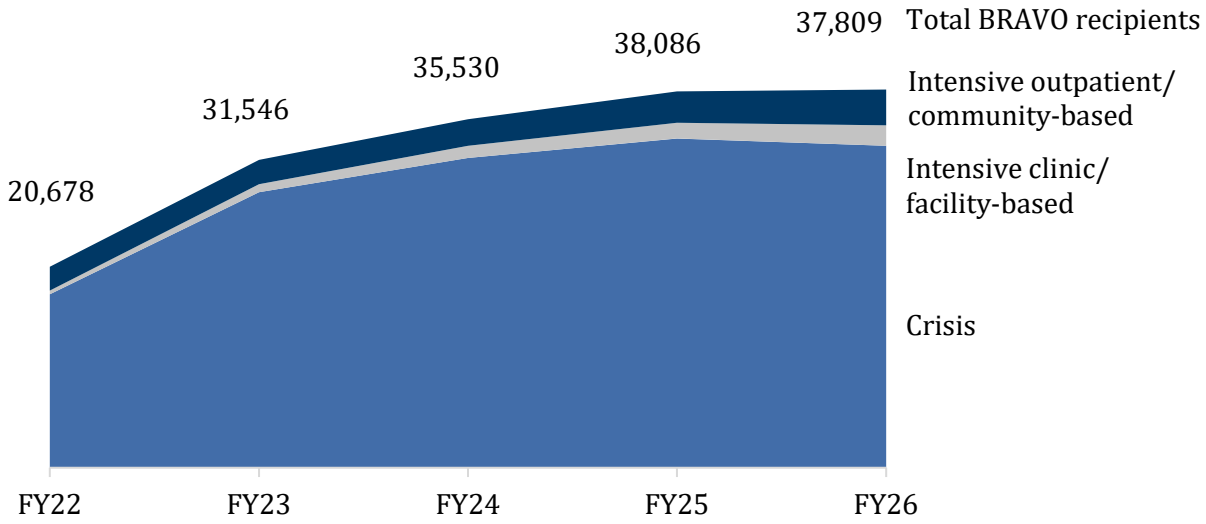
Source: BHC staff analysis of claims data, FY22-FY26, Department of Medical Assistance Services

Figure 1-2
Medicaid spending increased significantly after Project BRAVO services were implemented, totaling more than $1.5 billion between FY22 and FY26



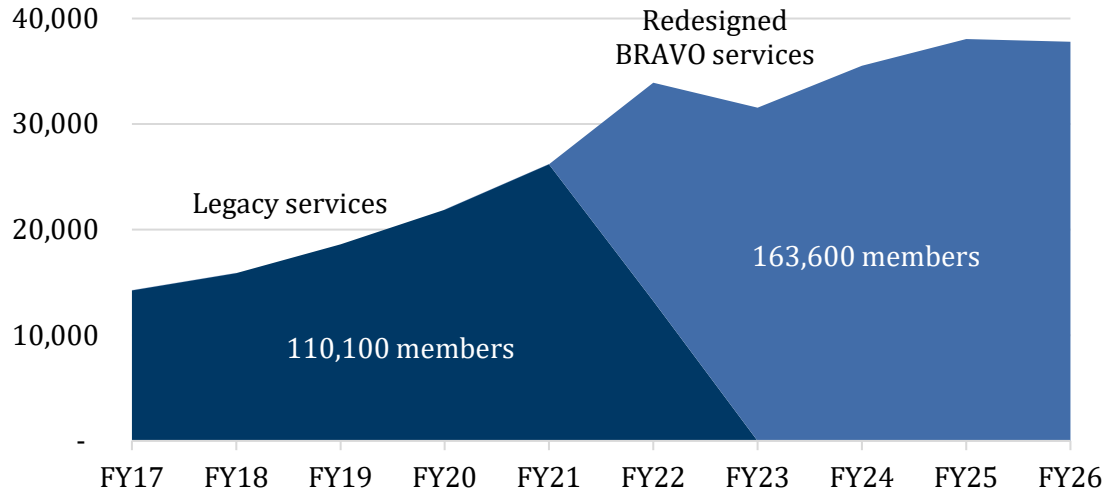
Source: BHC staff analysis of claims data, FY17-FY26, Department of Medical Assistance Services

Figure 1-3
Number of Medicaid members receiving Project BRAVO services has increased every year, driven primarily by crisis services



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

Figure 1-4
More Medicaid members receive Project BRAVO services than received the legacy services they replaced



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

BHR will be the second phase of the enhancement initiative, focused on rehabilitative services

Behavioral Health Redesign (BHR) is intended to enhance four of Virginia's oldest Medicaid rehabilitative behavioral health services, which help individuals build and maintain the skills needed to live in the community. A person receiving rehabilitative services might work on managing medication, keeping a job, maintaining a household, or sustaining relationships. Individuals often receive these services over long periods, and for some the service is what allows them to remain out of a hospital or an institution.

The legacy services being retired include mental health skill building and psychosocial rehabilitation (PSR) for adults, and intensive in-home services (IIH) and therapeutic day treatment (TDT) for children. Spending on legacy services totaled approximately $315 million in FY26. Over 31,000 Medicaid members received these services in FY26, nearly 60 percent of whom were adults.

Legacy services will be replaced by community psychiatric support and treatment (CPST) and Mental Health Clubhouse (Clubhouse). CPST can be delivered in either the community or school setting, and DMAS has developed separate service regulations for the two settings. Coordinated specialty care (CSC) is a service for people experiencing a first episode of psychosis. It is a brand-new service that will be added to the Medicaid benefit under BHR (Table 1-3).

Together, the three BHR services are intended to help an individual remain in the community long-term. An individual can receive help in the home, community, or school with the tasks of daily life, spend the day at a center working alongside staff toward a job, or receive team-based treatment after a first episode of psychosis (Table 1-4).

Table 1-3
BHR replaces four legacy services with two enhanced services, and adds one new service

Legacy service	BHR service
Mental health skill building Intensive in-home	Community psychiatric support and treatment (CPST)-community
Therapeutic day treatment	CPST-school
Psychosocial rehabilitation	CPST-community Mental Health Clubhouse (Clubhouse)
No legacy service, newly added under BHR	Coordinated specialty care (CSC)

Note: CPST can be offered in either a community setting or a school setting.
Source: BHC staff analysis of DMAS draft provider manuals, FY25-FY26

Table 1-4
Three BHR services are aimed at helping individuals maintain stability and function in their communities

Service	Who it serves	What it provides
CPST	Youths and adults with a mental health condition who need ongoing treatment and support to function in the community	Restorative skills training and practice, care coordination, crisis management, and support delivered in the home, school, or community
Clubhouse	Adults with serious mental illness	Center-based program where members and staff work side by side to run the program and prepare members for employment, education, and independent living
CSC	Youths & adults experiencing a first episode of psychosis, generally ages 15 to 30	Therapy, medication management, family education, and support returning to school or work

Source: BHC staff analysis of DMAS draft provider manuals, FY25-FY26

BHR creates new framework to determine level of need and amount of service

BHR will use a more structured approach to decide who qualifies for a service and how much of that service should be provided. Under BHR, a standardized assessment will produce a numeric level of need, and that number will establish both eligibility and the amount of service authorized. Under the legacy services, a licensed clinician qualitatively assessed an individual and determined the amount of service needed, with the managed care organization authorizing the request.

Providers will use an assessment called the Comprehensive Assessment of Needs and Strengths (CANS) Lifetime, which scores an individual across several domains and uses an algorithm to assign a level of need from zero to six. Level zero indicates a person who needs only crisis services and level six the most intensive ongoing support. Each level corresponds to a set of services an individual qualifies for and, for some services, the amount of service that can be authorized. Individuals assessed at levels four through six will receive the same services, but the number of hours of service an individual may receive increases at each level.

The framework currently applies to CPST; however, DMAS intends to extend this framework to other Medicaid behavioral health services as the state continues enhancement (Table 1-5). A level of need framework of this kind is a prerequisite for the federal 1115 waiver Virginia received in July 2026, and a standardized assessment, such as the CANS Lifetime, is a prerequisite for Certified Community Behavioral Health Clinic (CCBHC) certifications.

Table 1-5
Assessed level of need will determine which services adults and youths may receive

Level of need	Services available for adults	Services available for youths
0	Crisis only	Crisis only
1	Medication management, outpatient therapy	Medication management, outpatient therapy
2a	CPST Tier 1	CPST Tier 1
2b	CPST Tier 1, targeted case management, Clubhouse	CPST Tier 1, targeted case management
3	CPST Tier 1, targeted case management, Clubhouse, ACT, CSC	CPST Tier 1, targeted case management, MH-PHP, MH-IOP
4	CPST Tier 2 or MH-IOP, MH-PHP, Clubhouse, ACT, CSC	CPST Tier 2 or MH-PHP, MH-IOP, MST, FFT
5	CPST Tier 2 or MH-IOP, MH-PHP, Clubhouse, ACT, CSC	CPST Tier 2 or MH-PHP, MH-IOP, MST, FFT
6	CPST Tier 2 or MH-IOP, MH-PHP, Clubhouse, ACT, CSC,	CPST Tier 2 or MH-PHP, MH-IOP, MST, FFT

Note: The level of need framework had not been finalized as of September 2026 and may change prior to implementation.
Source: BHC staff analysis of Mercer analysis for Behavioral Health Redesign (2025) and interviews with DMAS staff

Implementation of new services and retirement of legacy services must coincide on July 1, 2027 under current law

The 2026 Appropriation Act sets July 1, 2027 as the date new BHR services must take effect and legacy services must end (Appendix B). The General Assembly originally set the date one year earlier and delayed it after DMAS, managed care organizations, community services boards, private providers, and school divisions asked for at least an additional year to prepare. The budget language also requires that legacy services be retired before the services replacing them begin.

Appropriation Act requires BHR to be implemented in budget neutral manner

The Appropriation Act also requires that redesigned services cost no more than the services they replace. DMAS contracted with Mercer to estimate what the new services would cost to deliver and to identify a combination of rates and utilization assumptions that would fit within that limit. The budget neutrality baseline was set at about $556.7 million, of which

about $357 million was for adult services and $200 million for youth services. Mercer built the baseline using projected expenditures for the services BHR replaces.

Multiple entities play a role in enhancing and administering Medicaid behavioral health services

Enhancing Medicaid behavioral health services requires the participation of several entities (Table 1-6). DMAS designs the new services and sets what Medicaid will pay for them. The Department of Behavioral Health and Developmental Services (DBHDS) then writes licensing regulations that align with DMAS service requirements and licenses the providers that will deliver services. The Department of Health Professions (DHP) sets the scope of practice and boundaries around which services different types of staff can provide. Managed care organizations (MCOs) build networks, operationalize authorization criteria, and reimburse providers. Providers deliver services to individuals. These include community services boards (CSBs)—the locality-based public agencies that serve as Virginia's behavioral health safety net and serve anyone who comes to them—and private providers, which are independent organizations that choose which services to offer and where to operate.

Table 1-6
Multiple entities play a role in enhancing and administering Medicaid behavioral health services

Entity	Role
DMAS	Defines which services Medicaid covers, sets the requirements providers must meet, sets rates, and contracts with managed care organizations
DBHDS	Licenses the providers that deliver behavioral health services and manages the public behavioral health system, including community services boards
DHP	Licenses individual practitioners and sets each profession's scope of practice, which determines what services different types of staff may deliver
MCOs	Build provider networks, authorize services, and pay providers; contract with DMAS to manage care for most Medicaid members
CSBs and private providers	Deliver services to Medicaid members

Source: BHC staff analysis of the Code of Virginia

2023 background report on Project BRAVO found that data was not yet available to evaluate Project BRAVO

The Commission first directed staff to monitor Project BRAVO in 2023, roughly a year after the services became available. The resulting report described the redesign's goals and design, examined early utilization, and identified what would be needed to evaluate whether Project BRAVO was working. However, data limitations prevented a full evaluation; claims data was limited and no outcome data existed for any service.

The report also found that subsequent phases of the redesign had not begun. Virginia had planned a multi-phase effort, and staff found that the continuum the initiative envisioned would not exist until later phases were implemented.

2 Access to Project BRAVO services

Behavioral Health Redesign for Access, Value, and Outcomes (Project BRAVO) was intended to expand access to behavioral health services for Medicaid members by filling critical gaps in the continuum of care and ensuring an adequate number of providers were available to deliver redesigned services. Under Project BRAVO, the Department of Medical Assistance Services (DMAS) added new intensive outpatient services to better serve individuals whose needs exceed routine outpatient therapy and who previously had to rely on inpatient admission or residential placement. New crisis services were also added as alternatives to emergency department visits and psychiatric hospitalization, supporting Virginia's investment in the development of a comprehensive crisis system. Access to intensive outpatient and crisis services has improved, although very unevenly. Utilization remains well below projections for several intensive outpatient services, in part due to low referrals and high barriers to entry for providers. Conversely, the utilization of crisis services has greatly exceeded projections, but some of that growth reflects improper use of mobile crisis response and community stabilization.

For Project BRAVO services to be accessed as intended, the General Assembly may wish to (1) help defray the cost of training for providers of intensive outpatient services, (2) strengthen the requirements providers must meet to deliver crisis services and the state's capacity to enforce them, and (3) improve the information available to identify improper use.

Access to intensive outpatient services has improved, but utilization remains low for some services

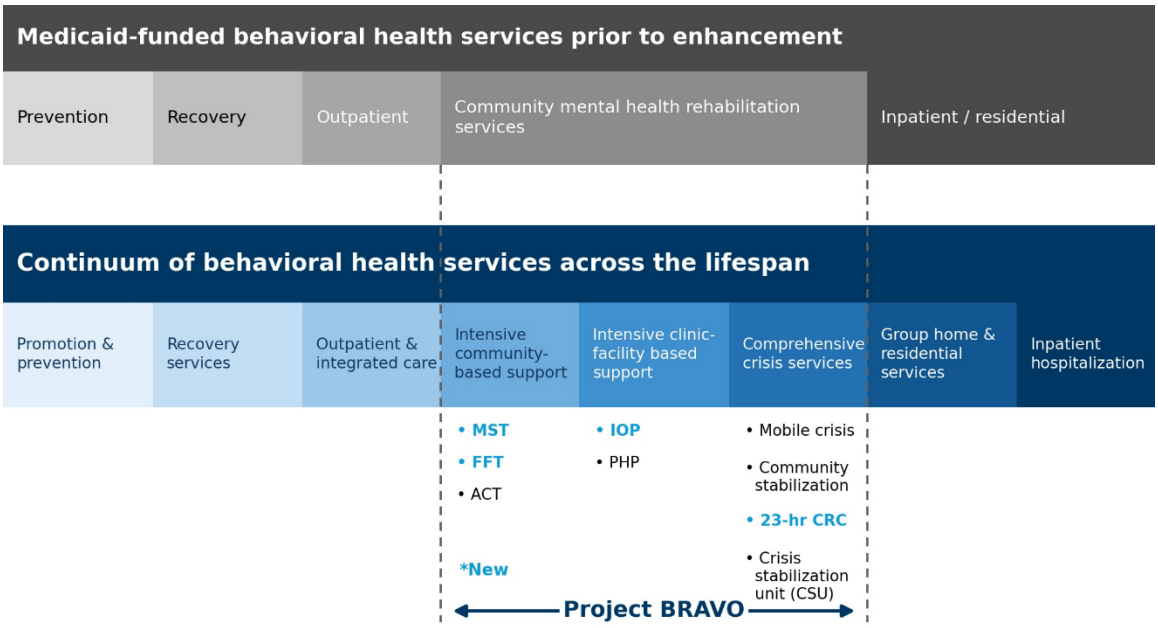
Project BRAVO added five intensive outpatient services to the continuum of Medicaid behavioral health benefits, helping to offer community-based alternatives for individuals whose needs exceed traditional outpatient services. Access to all new services has improved, but to varying degrees. More individuals have been receiving services since FY22, but utilization has lagged behind projections for multisystemic therapy (MST), functional family therapy (FFT), and intensive outpatient programs for mental health (MH-IOP); too few providers exist and other Medicaid services continue to attract members and providers. The retirement of legacy services under Behavioral Health Redesign (BHR) may increase utilization, though the extent of any increase is not known.

Broader continuum of intensive community-based services is available to Medicaid members

Project BRAVO extended coverage to intensive outpatient services, allowing more individuals to receive services in their communities (Exhibit 2-1). DMAS selected these specific offerings

after a gap analysis revealed that Virginia lacked care especially in the middle of the continuum. Previously, members whose needs exceeded routine outpatient therapy had few alternatives other than inpatient admission or residential placement.

Exhibit 2-1
Project BRAVO services added intensive outpatient and crisis services to help individuals remain in the community



Source: BHC staff analysis of information from the Department of Medical Assistance Services

Multisystemic therapy (MST) and functional family therapy (FFT) were brand-new services specifically for youths with high needs. Both services serve youths at risk of removal from their homes, and both send a provider into the family's home to work with the youths and caregivers together. Assertive community treatment (ACT) replaced intensive community treatment, a legacy service that had been part of Virginia's Medicaid benefit since the late 1990s. Project BRAVO fully aligned the service with the national ACT model by adopting the prescribed team composition and its fidelity measures. DMAS also changed reimbursement to a daily rate.

Partial hospitalization programs for mental health (MH-PHP) and intensive outpatient programs for mental health (MH-IOP) gave individuals a level of care that few providers had offered before Project BRAVO. Both services allow individuals to receive several hours of structured clinical treatment a day while continuing to live at home. Virginia's Medicaid benefit had included a day treatment and partial hospitalization service since the 1990s, but that service did not align with models supported by research. Project BRAVO replaced the legacy service with MH-PHP and MH-IOP, specifying the hours of treatment required each week, the components providers must deliver, and the staff who must deliver them.

Access to intensive outpatient and community-based care has increased under Project BRAVO but trails projections for some services

Access to intensive outpatient services has generally improved since the launch of Project BRAVO in FY22. More Medicaid members have been receiving these services, and the number of active providers has increased in most cases (Table 2-1). Still, uptake has been slow for MST and FFT; the number of available providers has remained about the same, and utilization has fallen well short of projections. Access appears to have improved in accordance with projections for ACT and MH-PHP but remains significantly below projections for MH-IOP.

Table 2-1
Access to intensive outpatient behavioral health services has improved for Medicaid members, but remains below projections for some services

	Most recent (FY25)			% change vs. 1st year BRAVO (FY22)			% variance vs. projected (FY25)	
Service	# Members	# Providers	$M Spent	# Members	# Providers	$M Spent	# Members	$M Spent
MST	294	16[1]	$2.8	+26%	0%[1]	+170%	(39%)	(79%)
FFT	384	12[1]	$1.3	+52%	+20%[1]	+299%	(19%)	(81%)
ACT	2,626	46	$46.0	+34%	+48%	+72%	32%	49%
MH-IOP	800	45	$3.0	+760%	+137%	+897%	(88%)	(95%)
MH-PHP	1,110	44	$7.1	+265%	+52%	+529%	81%	(22%)

[1]Based on data collected by Center for Evidence-based Partnerships in Virginia
Source: BHC staff analysis of claims data and budget assumptions, FY18-FY25, Department of Medical Assistance Services; data on teams who provided MST and FFT, FY22-FY25, Center for Evidence-based Partnerships in Virginia

Uptake of MST and FFT has been slow, and access remains short of what Project BRAVO envisioned

More youths are receiving MST and FFT than when the services launched in FY22, but utilization of both services remains well below the levels projected for FY25 (Table 2-1). Uptake has fallen short of expectations in part because a limited number of providers exist. According to data from the Center for Evidence-Based Partnerships in Virginia (CEP-Va) at Virginia Commonwealth University (VCU), the number of FFT providers serving Medicaid members increased by 20 percent since the launch of Project BRAVO, and the number of MST providers remained the same. Existing providers are serving a larger number of localities in Virginia. As of FY25, providers accepted referrals from an additional 33 localities for MST, and 57 localities for FFT compared to FY22. MST and FFT serve similar populations and address similar needs, so a locality with at least one team accepting referrals gives youths in

that locality access to this type of service. In FY25, 89 percent of localities had at least one MST or FFT team accepting referrals from youths living there, up from 80 percent in FY23.

Stakeholders report that additional youths could benefit from receiving these services, if additional providers were available. Both models require licensed supervisors and clinicians who provide only MST or FFT, and providers report difficulty recruiting and retaining amid the statewide shortage of licensed practitioners. Teams are also expensive to establish. For example, starting an MST team costs about $85,000 in the first year and $64,700 every year afterward for continued licensing and mandatory booster training. Starting an FFT team costs about $55,000 in the first year, $28,500 in the second, and $15,500 annually thereafter. Although Medicaid reimbursement rates incorporate the cost of training and licensing, these payments are distributed to providers incrementally over time, when they meet with youths. Providers must cover these regulatory and training costs upfront, resulting in a prolonged period to fully recoup their initial expenditures. Moreover, the assumptions for training and licensing costs included in rate development were significantly lower than actual costs. For example, start-up costs were assumed to be $38,500 for an MST team, compared to $85,000, and $39,000 for an FFT team, compared to $55,000. Additional disparities could also exist with licensing costs and ongoing training.

CEP-Va has helped cover the start-up costs of some MST and FFT teams using Title IV-E funds from the Virginia Department of Social Services as well as funding from the Virginia Department of Juvenile Justice. In FY26, CEP-Va helped train two MST and two FFT teams, and they have received applications from six additional FFT and three additional MST providers wanting to start a new team in FY27. However, CEP-Va's current budget is insufficient to cover the estimated cost of $565,000 to train all nine new teams in their first year, or to help sustain them in future years.

To help attract additional MST and FFT providers while building on Virginia's existing training efforts at VCU, the state could appropriate additional funding to CEP-Va to defray the up-front cost of training and certification for interested providers. VCU estimates the total cost of meeting provider demand for FFT and MST training at $590,000 per year. A portion of this amount could continue to be funded with Title IV-E funds, but state general funds would have to be added to meet the full need.

RECOMMENDATION 1

The General Assembly may wish to consider including funding in the 2027-2028 Appropriation Act for the Center for Evidence-Based Partnerships in Virginia (CEP-Va) to establish additional multisystemic therapy (MST) and functional family therapy (FFT) teams.

Even when providers are available, a relatively low number of youths are referred to MST and FFT. Instead, the entities that refer youths continue to use longstanding Medicaid services such as intensive in-home services and therapeutic day treatment because those are more familiar, more readily authorized, and they require less family participation.

Referrals to MST and FFT are expected to increase once Behavioral Health Redesign is implemented; youths will have to be assessed for MST and FFT and referred, if they meet criteria and an appropriate provider is available, before they can receive community psychiatric support and treatment (CPST). Intensive in-home services and therapeutic day treatment will also no longer be available. Although this creates an opportunity to direct more youths toward MST and FFT, there are currently no plans to help increase the availability of providers or to ensure that referral entities understand the benefits of these services. If qualifying youths are unable to access MST and FFT due to a lack of providers, they will default into CPST, which may not be the most appropriate service.

RECOMMENDATION 2

The Department of Medical Assistance Services, in conjunction with the Department of Behavioral Health and Developmental Services, should develop and communicate educational materials on the populations eligible for multisystemic therapy (MST) and functional family therapy (FFT), the benefits of these services, and how to make referrals to providers. These materials should be provided to (i) all entities responsible for referring youths to behavioral health services, including community services boards, managed care organizations, courts, and schools; and (ii) families no later than six months prior to the discontinuation of intensive in-home services and therapeutic day treatment.

Access to ACT has improved for Medicaid members, exceeding projections

Medicaid members have had greater access to ACT since Project BRAVO launched in FY22. The number of individuals receiving ACT increased by 34 percent (~660 individuals) between FY22 and FY25 and has also outpaced the number who received the legacy service that ACT replaced (intensive community treatment) (Table 2-1). More providers are also delivering ACT; the number of ACT teams operating in Virginia rose from 31 to 46 (48 percent) between FY22 and FY25. This increase is partly attributable to private providers, which have become a growing share of all ACT providers since FY22. The utilization of ACT had outpaced projections by over 30 percent as of FY25 (~640 members), leading to $15 million in additional spending in FY25.

Access to MH-PHP and MH-IOP has improved for Medicaid members, but utilization of MH-IOP is well below projections

The number of people receiving MH-PHP almost quadrupled between FY22 and FY25, and more youths and adults received MH-PHP in FY25 than received the legacy service it replaced (day treatment/partial hospitalization). The number of MH-PHP providers increased by over 50 percent between FY22 and FY25. Private providers accounted for nearly all that growth.

Private providers deliver most MH-PHP in Virginia, and only a few Community Services Boards (CSBs) billed for the service in FY25. Spending on MH-PHP totaled $7.1 million in FY25, 22 percent below what DMAS projected (Table 2-1).

The number of people receiving MH-IOP has grown about 34 percent a year on average since the service launched in FY22, but remains less than half of what DMAS projected when it designed Project BRAVO (Table 2-1). In FY25, 800 individuals received MH-IOP, at a cost of $3 million. Low utilization of MH-IOP appears to reflect competition from several legacy services in the Medicaid benefit, including mental health skill building. DMAS does not allow providers to bill MH-IOP at the same time as legacy services, and some providers have continued delivering the legacy services even though they hold a license for MH-IOP. The legacy services demand less of providers, requiring less clinical staffing and no accreditation, and a provider can deliver them to the same individual for years, while MH-IOP carries more requirements and is a short-term service. In FY25, at least 175 providers serving adults and 21 serving children held licenses for MH-IOP, but only 45 providers billed for the service. Stakeholders report that families often decline MH-IOP in order to keep receiving legacy services.

Utilization of MH-IOP may increase under BHR. The competing legacy services are scheduled to be retired, and state agency staff expect providers and families to shift toward MH-IOP, though the extent of that shift is not yet known.

Access to crisis services has improved, but services are sometimes improperly used

Project BRAVO helped develop a more comprehensive crisis system, and more individuals now receive crisis services than at any point before. The utilization of crisis services has increased significantly to meet previously unaddressed needs, but an unknown portion is attributable to improper use. Spending and utilization have exceeded projections significantly, and stakeholders express concern that mobile crisis response and community stabilization are not consistently used as intended. DMAS, the Department of Behavioral Health and Developmental Services (DBHDS), and the General Assembly have taken action to curb improper use, but some of these restrictions may limit access for individuals who genuinely need these services, and additional steps are needed to ensure services are delivered adequately.

Comprehensive array of crisis services has become available to Medicaid members

Project BRAVO has helped create a more complete range of crisis services. The services added under Project BRAVO are key components of a comprehensive crisis system intended to respond at every stage of a behavioral health crisis, from the moment a person calls for help through the days after the immediate crisis passes. Virginia's Medicaid benefit previously covered two crisis services, crisis intervention and crisis stabilization, which addressed only parts of that sequence. In the absence of a comprehensive crisis system, individuals

experiencing a crisis often had no covered alternative to an emergency department visit or a psychiatric hospitalization.

Mobile crisis response (MCR) offers individuals a way to receive help when and where the crisis occurs. A mobile crisis team travels to the person's location, assesses the situation, and works to resolve it on site. Mobile crisis response is available 24 hours a day and can serve individuals who would otherwise go to an emergency department or psychiatric hospital setting.

23-hour crisis stabilization, delivered in crisis receiving centers (CRCs), and residential crisis stabilization, delivered in crisis stabilization units (CSUs), give individuals somewhere to go when a mobile crisis response is not enough. CRCs provide a safe setting where staff can observe and assess a person for up to 23 hours, conduct a psychiatric evaluation and medical testing, and direct the person to the appropriate next level of care. CSUs provide a short stay for individuals who need more time to stabilize but do not require inpatient psychiatric admission. Both services provide an alternative to hospitalization for individuals whose crises can be resolved in less restrictive settings.

Community stabilization is intended to support individuals during the period after a crisis. The service can include short-term assessments, crisis intervention, and care coordination for individuals who have recently experienced a crisis and are waiting to begin ongoing treatment. Community stabilization functions as a bridge for individuals between a mobile crisis response and their next service or as a step down from a higher level of care.

Access to crisis services has expanded significantly for Medicaid members, far exceeding projections

Access to crisis services has expanded significantly since the launch of Project BRAVO in FY22. The number of Medicaid members receiving crisis services has increased by 33 percent since FY22, surpassing 38,000 in FY25 (Table 2-2). In part because service utilization far exceeded initial forecasts, actual spending was more than $300 million above projections in FY25 alone, driven primarily by mobile crisis and community stabilization. The number of crisis providers also increased by 58 percent between FY22 and FY25.

Mobile crisis and community stabilization account for the majority of utilization and spending on crisis services

Utilization of crisis services has increased by 33 percent since services were launched in FY22, reaching approximately 38,000 Medicaid members in FY25. Mobile crisis and community stabilization have been the largest drivers of utilization, which nearly 25,000 and 15,000 Medicaid members accessed in FY25, respectively. The level of utilization of these two services is about 3.5 times higher than projected.

Spending on crisis services reached $360 million in FY25, 2.7 times more than when the services were launched in FY22. Similar to the trend in utilization, mobile crisis and community stabilization accounted for the vast majority (87 percent) of spending in FY25. The cost of crisis services also exceeded projections significantly every year since services were launched (Figure 2-1). Between FY22 and FY25, spending on crisis services totaled

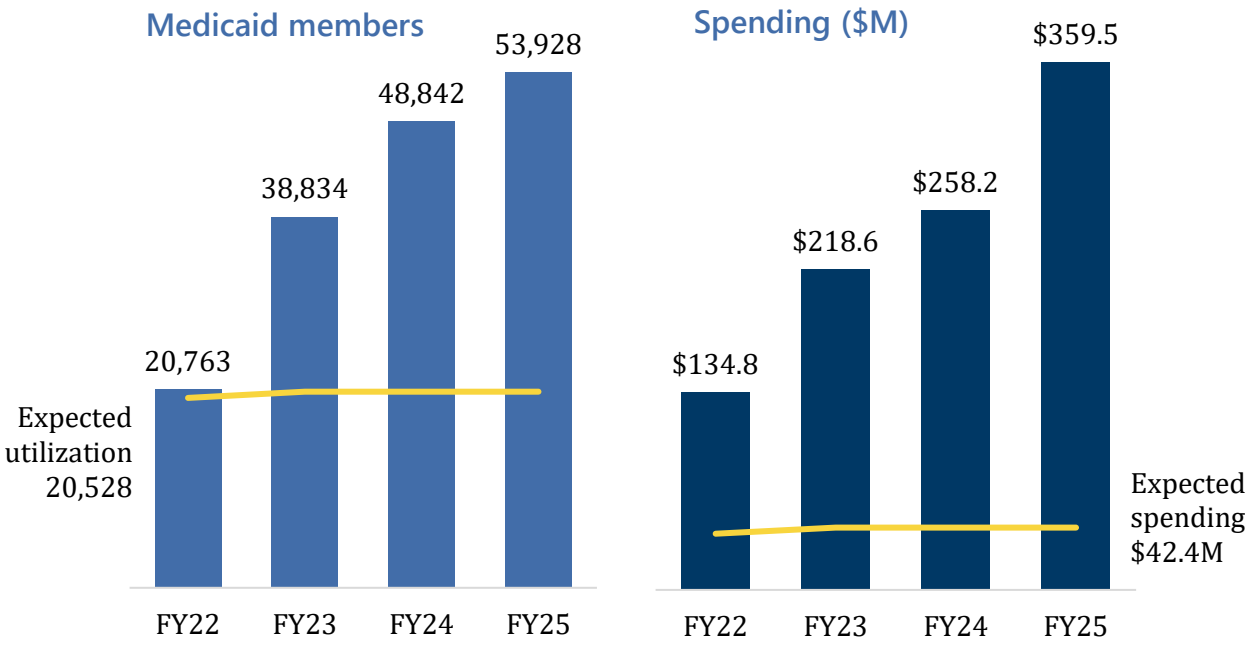
$971 million, nearly 5 times the amount projected of $165 million. Spending exceeded projections in part due to higher utilization. In addition, the actual cost of crisis services per individual has also been significantly higher than projected ($5,900 per member compared to $2,100 per member for FY25).

Table 2-2
Access to all crisis services has improved for Medicaid members

Service	Most recent (FY25)			% change vs. 1st year BRAVO (FY22)			% variance vs. projected (FY25)	
	# Members	# Providers	$M Spent	# Members	# Providers	$M Spent	# Members	$M Spent
Mobile crisis	24,556	286	$177	191%	249%	1238%	264%	1464%
Comm. stab.	14,641	326	$136	38%	44%	18%	243%	522%
CRC	10,064	146	$16	1296%	1227%	1673%	478%	1015%
CSU	4,667	60	$31	375%	161%	457%	360%	343%
Total crisis	**38,086**	**408**	**$360**	**33%**	**58%**	**167%**	**151%**	**766%**

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

Figure 2-1
Utilization of and spending on crisis services have significantly exceeded projections



Source: BHC staff analysis of claims data & projections, FY22-FY25, DMAS

Medicaid coverage helped attract private providers of crisis services, especially for mobile crisis and community stabilization

The launch of Project BRAVO was concurrent with large investments of state general funds that supported the development of numerous new mobile crisis teams, CRCs, and CSUs operated by CSBs. The availability of CRCs and CSUs increased primarily due to Virginia's heavy investment in building its public crisis system. As of August 2026, 205 residential crisis stabilization beds were available at CSUs, and 181 chairs were active in CRCs. Another 122 beds and 230 chairs remain under development. CRCs and CSUs cannot expand without physical capacity, so growth in these services depends, in part, on construction of facilities.

Medicaid coverage of crisis services also acted as an incentive for private providers to offer mobile crisis and community stabilization services. Private providers accounted for the majority of growth in providers and spending since Project BRAVO launched. In FY25, private providers were responsible for 92 percent of spending on crisis services, compared to 89 percent in FY22. Although private providers began operating throughout Virginia, they have been most heavily concentrated in DBHDS Region 4, the area around Richmond. Private providers located in the Central Region account for 62 percent of all private providers and 68 percent of all crisis spending.

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

Some of the growth in crisis service utilization and spending reflects improper use, particularly in mobile crisis response and community stabilization. All stakeholder groups interviewed for this study, including state agencies, managed care organizations (MCOs), and providers, raised concerns that some providers are improperly billing for mobile crisis response and community stabilization services that are either not needed or that are not delivered as intended.

Some providers are improperly delivering crisis services

Stakeholders reported that to maximize revenue, some providers coached Medicaid members to call 988 and request a mobile crisis dispatch, sometimes offering monetary incentives to do so. Certain providers also delivered mobile crisis response and community stabilization services to the same individuals multiple times. In some cases, providers also delivered a level of care well below what is intended for the service. For example, some mobile crisis providers were found to consistently complete calls for dispatch within less than 15 minutes. Similarly, some providers of community stabilization services were reported to give individuals gift cards for a meal and a one-night hotel stay, rather than linking them to community-based services intended to support them post crisis.

In some cases, providers may be using crisis services to meet needs that cannot be addressed with existing Medicaid benefits and supports, rather than strictly for their own financial gain. For example, providers have reportedly used community stabilization to pay for a hotel voucher or food for individuals who do not have a safe place to stay post crisis. In such cases, improper use reflects gaps in supports needed to stabilize individuals. Medicaid does not cover housing or employment supports in Virginia, and state agency staff identify both as

services critical to recovery and stabilization. Virginia pays for permanent supportive housing through general funds, but there is a shortage of housing options and limited slots in the program. Virginia also lacks a residential continuum for adults with serious mental illness. DBHDS currently funds about 100 group home beds, so high-acuity adults who need more than outpatient services have few care options and may turn to crisis services.

DMAS pursued a Medicaid benefit to cover these supports, and the Centers for Medicare and Medicaid Services (CMS) approved it in 2020; however, funding was not appropriated and the benefit was not implemented. DMAS's renewal application for the 1115 waiver, approved in August 2026, "sunsetted" the housing components of this benefit.

Strong reimbursement rates, lack of prior authorization controls, and expedited licensing left crisis services vulnerable to improper use

Multiple factors left crisis services vulnerable to improper use, including generous rates, limited controls, and an expedited licensing process. Reimbursement rates for crisis services were set to attract new providers who would be needed to meet the needs of individuals in crisis. Rates have been described as relatively generous, and barriers to entry are relatively low for mobile crisis and community stabilization, which do not require much up-front investment or infrastructure.

Crisis services are also especially vulnerable to improper use because the standard Medicaid controls designed to prevent improper utilization cannot be applied. Because a behavioral health crisis is treated as an emergency, providers do not have to seek prior authorization from MCOs before they respond. With few controls to limit improper use, the payment structure created misaligned incentives: each additional service unit generates high-rate revenue, yet nothing rewards resolving a crisis in fewer encounters or connecting individuals to ongoing, preventive treatment.

Licensing requirements help ensure that unqualified providers are not authorized to enter the field, and the licensing application process can be a useful window into providers' ability and willingness to deliver services as intended. However, the licensing standards in place when Project BRAVO launched were not strong enough to keep unsuitable providers from becoming licensed. The standards themselves set a low bar for entry, and the compressed implementation timeline and limited capacity to review applications did not allow sufficient time to adequately review providers seeking to enroll.

Multiple steps have been taken to curb improper use of crisis services

DMAS, DBHDS, and the General Assembly have taken multiple steps to identify and curb improper use since reports of potential fraud and abuse first surfaced. Providers suspected of delivering services improperly received on-site technical assistance to address potential confusion, and some have been referred to the authorities when fraud was suspected. Steps have also been taken to strengthen the provider pool, including revised memorandums of understanding (MOUs) between providers and regional crisis hubs. Lastly, limitations have been placed on the receipt of mobile crisis services, and community stabilization has been discontinued as a Medicaid-covered service.

- **Analysis of suspicious billing patterns**

  DBHDS analyzed dispatch data to identify providers whose billing patterns deviated from the norm, flagging responses recorded as arriving in under a minute, services completed in under 15 minutes, and repeat use by the same individuals (late 2024—early 2025). That analysis identified 21 outlier providers, which received a DBHDS site visit. This analysis is now shared with the regional crisis hubs responsible for dispatching mobile crisis response teams, to help them identify potentially improper provider activity.

  DMAS also continues to monitor utilization and shares this data with partner agencies.

- **Fraud referrals**

  DMAS and DBHDS sent referrals to the Office of the Attorney General (OAG) for suspected fraud, testified in trials, and are collaborating with the U.S. Attorney's Office and OAG on investigations.

- **Enhanced licensing practices and regulations**

  DBHDS has also identified changes that could be made to the licensing standards for providers of mobile crisis and community stabilization services and plans to continue revising standards.

- **Stronger MOUs**

  Region 4's regional hub used a competitive procurement process for FY26 and selected a smaller number of providers with which to enter into an MOU.

  DMAS also terminated providers who did not have an MOU with a regional hub.

- **Service limitations**

  The 2027-2028 Appropriation Act limits mobile crisis response to four hours and discontinues community stabilization effective July 1, 2026. DMAS projected the elimination would reduce spending by about $547,000 in general funds and $1.65 million in federal funds in FY27, and by $892,000 in general funds and $2.69 million in federal funds in FY28. The General Assembly removed these projected amounts from the amount appropriated to DMAS.

To further mitigate the improper use of crisis services, better information sharing is required between key stakeholders, including DMAS, DBHDS, CSBs, and MCOs. Enabling data sharing between these entities may require additional resources, technical solutions, and governance. Legal review may also be needed to ensure alignment with applicable federal and state data sharing restrictions. DMAS has indicated needing additional funding and at least two additional staff to build the type of information systems needed to share information and to analyze the information collected.

RECOMMENDATION 3

The Department of Medical Assistance Services (DMAS), in collaboration with the Department of Behavioral Health and Developmental Services (DBHDS), should improve the availability of information to identify improper use of crisis services by (i) providing managed care organizations with real-time access to crisis dispatch information, including data platform reference numbers and provider acceptance data, in a form that allows an organization to verify that a dispatch occurred and which provider responded; (ii) establishing a process through which managed care organizations share information about providers identified as delivering crisis services improperly, so that a provider identified by one organization can be identified by all; and (iii) linking crisis service data held separately by DMAS, DBHDS, managed care organizations, and community services boards by July 1, 2027.

RECOMMENDATION 4

The General Assembly may wish to consider appropriating additional funding and FTEs in the 2027-2028 Appropriation Act at the Department of Medical Assistance Services (DMAS) to build data sharing among DMAS, the Department of Behavioral Health and Developmental Services, managed care organizations, and community services boards, and to analyze the resulting data to identify improper use of crisis services.

DBHDS should issue revisions to licensing standards to reflect changes that have been identified as necessary.

RECOMMENDATION 5

The General Assembly may wish to consider directing the State Board of Behavioral Health and Developmental Services to promulgate regulations, pursuant to the Administrative Process Act, amending the licensing regulations governing crisis services to strengthen protections against improper use of those services by July 1, 2027.

State agencies and stakeholders have expressed concerns that discontinuing community stabilization will leave individuals without support during the period between a crisis and the start of ongoing treatment. Without this transitional support, individuals may experience gaps in care that increase the risk of further crisis, emergency department use, hospitalization, or loss of housing. Virginia's 1115 Medicaid waiver included a High Needs Support benefit that could have addressed a portion of this gap; however, this benefit was "sunsetted" as a part of the 2024 renewal application. BHC staff recommended examining how Medicaid could best cover the services and supports included in the High Needs Support benefit as part of is study of Permanent Supportive Housing in 2024. This recommendation was not included in the 2025-2026 Appropriation Act.

Under Behavioral Health Redesign, CPST will offer many of the same components and supports currently provided through community stabilization. However, authorization for

CPST services could take time, potentially leaving a gap for individuals who are experiencing or have recently experienced a behavioral health crisis. An expedited authorization pathway that allows individuals to transition directly from crisis services into CPST could help reduce delays in care for individuals in crisis.

3 Quality of Project BRAVO services

Behavioral Health Redesign for Access, Value, and Outcomes (Project BRAVO) was intended to raise the quality of Virginia's Medicaid behavioral health services by filling gaps in the continuum of care and replacing outdated practices with trauma-informed services shown to improve outcomes. New services implemented through Project BRAVO are supported by the research literature to varying degrees, but Virginia has not put into place a comprehensive accountability mechanism to ensure that services are being implemented according to best practice (fidelity) or that they are producing intended outcomes. Only three services, multisystemic therapy (MST), functional family therapy (FFT), and assertive community treatment (ACT), are monitored continuously for both fidelity and outcomes, and the individuals who receive them generally achieve positive outcomes. Although some information exists on the performance of the other six services, which accounted for 87 percent of spending on Project BRAVO in FY25, it is limited, inconsistent, and highly decentralized.

To help ensure that redesigned BRAVO services deliver on intended enhancements, the General Assembly may wish to (1) expand the capacity to assess whether providers deliver evidence-based services as designed, (2) direct the responsible agencies to develop performance and outcome measures for the services that lack them and comprehensively report on all services, and (3) expand the capacity of responsible agencies to collect and analyze data to populate performance and outcome measures.

Project BRAVO has enhanced the continuum of Medicaid behavioral health care with research-based services

The services added and enhanced through Project BRAVO are generally supported by research showing positive outcomes, including three evidence-based practices that follow a national model (Table 3-1). These services have strengthened the continuum of care for intensive outpatient care provided in the community and in clinics/facilities, and for crisis care.

Intensive outpatient services added under Project BRAVO are supported by research, and three follow defined national models

MST, FFT, and ACT are evidence-based practices. Each follows a single defined model that specifies how a provider must deliver the service, including who provides the service, how often a participant receives the service, and what each session includes. Research demonstrates that people who receive the service, as prescribed by the model, experience better outcomes than those who do not.

Research on partial hospitalization programs for mental health (MH-PHP) and intensive outpatient programs for mental health (MH-IOP) shows positive outcomes, but neither service follows a single defined model. No national body specifies the components or staffing MH-IOP or MH-PHP programs must include, so programs vary in how they deliver the services. Research on these services shows positive results, but the programs studied differ from one another, which limits what those findings say about the services as delivered elsewhere.

Mobile crisis, 23-hour crisis stabilization, and residential crisis stabilization services are based on the national Crisis Now framework

Mobile crisis response, 23-hour crisis stabilization, and residential crisis stabilization are based on the national Crisis Now framework. The Crisis Now framework consists of three components: 988 Lifeline and crisis call centers, mobile crisis, and 23-hour crisis stabilization and residential crisis stabilization (Exhibit 3-1). A growing body of research evidence suggests that the Crisis Now framework is an effective means of reducing reliance on jails and emergency departments for individuals experiencing behavioral health crises, and states that have implemented the framework have reported reduced psychiatric hospitalizations and emergency department use. Although it is a national framework, Crisis Now does not prescribe how services should be delivered, and implementation has varied significantly across the country.

Exhibit 3-1
Crisis Now consists of someone to call, someone to respond, and somewhere to go

Source: BHC staff analysis of the Crisis Now model

Community stabilization is not part of the Crisis Now model. It was carried over from Virginia's earlier community-based crisis services and was retained alongside the Crisis Now services to act as a bridge between the end of crisis services and the start of community-based care. Because community stabilization does not derive from a national model, little is known about what outcomes can be expected or how it is best delivered. Other states typically fold this kind of follow-up support into mobile crisis response rather than paying for it as a separate service.

Table 3-1
Services added under Project BRAVO are associated with improved outcomes in the research literature

Service	Outcomes identified in research	Strength of evidence
MST	Reductions in out-of-home placements, recidivism, delinquency, criminal behavior, and substance use; improved family functioning	High
FFT	Reductions in out-of-home placements, recidivism, delinquency, criminal behavior, and substance use; improved family functioning	High
ACT	Fewer psychiatric hospitalizations, greater housing stability, improved symptoms and quality of life	High
MH-PHP	Symptom improvements equivalent to inpatient care	Moderate
MH-IOP	Symptom improvements equivalent to inpatient and residential treatment for IOP for substance use (SUD-IOP); more limited evidence for IOP for mental health	Moderate for SUD-IOP, limited for MH-IOP
Mobile crisis response	Reduced psychiatric hospitalization and emergency department use	Limited
23-hour crisis stabilization	Reduced psychiatric hospitalization and emergency department use	Limited
Residential crisis stabilization	Reduced psychiatric hospitalization and emergency department use	Limited
Community stabilization	*No research identified*	None

Note: Strength of evidence reflects the research design supporting each service. “High” indicates multiple randomized controlled trials of programs delivering a defined model; “Moderate” indicates randomized and observational studies of programs that vary in how they deliver the service; “Limited” indicates results reported by states that implemented the service rather than findings from controlled trials.
Source: BHC staff analysis of research literature

Virginia lacks mechanism to assess the implementation and effectiveness of most Project BRAVO services

Although research supports the effectiveness of Project BRAVO services, Virginia lacks comprehensive, consistent data on actual service delivery and clinical impact. Currently, rigorous fidelity and outcome monitoring is limited to just three designated evidence-based practices (EBPs). For the majority of BRAVO services, a limited number of measures exist to capture performance on service delivery and outcomes. Existing measures are either not reported publicly or not easily consumable, and data is highly fragmented—scattered across multiple agencies and providers. This lack of centralized oversight deviates from the robust accountability structure originally envisioned during Project BRAVO's initial planning phases.

National purveyors monitor MST and FFT

MST and FFT have fidelity and outcome measurement built into the models. A provider cannot deliver either service without certification from the national purveyors that own the model, the Multisystemic Therapy Institute or FFT LLC. The national purveyors require teams to collect fidelity and outcome data as a condition of certification. The Department of Medical Assistance Services (DMAS) requires Medicaid providers to meet the model's requirements. In Virginia, the Center for Evidence-Based Partnerships in Virginia (CEP-Va), part of Virginia Commonwealth University, has produced comprehensive quarterly reports on fidelity and outcomes for MST and FFT since 2021.

The purveyors monitor adherence continuously through several instruments and provide support to the teams they certify. Fidelity measures for MST and FFT include caregiver questionnaires administered every four weeks, supervisor measures administered every two months, and reviews of each program's overall implementation conducted twice a year. Additionally, each MST team works with an assigned expert who holds weekly consultation calls with the team, delivers quarterly on-site booster trainings, and develops the team's supervisor. FFT teams follow a similar structure, with weekly consultation from a national consultant during a team's first year and less frequent consultation as the team matures. Both models require teams to complete ongoing training to maintain certification.

When teams struggle to meet fidelity benchmarks, national purveyors develop improvement plans and may assist teams in improving fidelity. For example, an MST assigned expert may assist with staff recruitment, developing strategies to increase referrals, or restructuring how a program is funded. A team that does not improve risks losing the certification it needs to deliver the service.

DBHDS established fidelity monitoring and tracks three outcomes for ACT, but has only assessed fidelity for a subset of teams

Virginia adopted the Tool for Measurement of Assertive Community Treatment (TMACT) to assess the fidelity of ACT teams, and the Department of Behavioral Health and Developmental Services (DBHDS) contracts with the Institute for Best Practices at the University of North Carolina (UNC) to conduct fidelity assessments. ACT has no national purveyor, because the

model is publicly available, and no organization certifies teams or collects fidelity and outcome data.

Fidelity information is available for one-third of providers

UNC has assessed the fidelity of 35 percent (30 of 85) of ACT providers since FY24. UNC can assess roughly ten teams a year, whereas Virginia had more than 85 ACT teams at the beginning of FY27. The TMACT is designed to be repeated over time, because a single assessment captures a team at one point in time and the tool's value comes from tracking whether a team improves or declines. DBHDS schedules a follow-up review 12 to 18 months after each evaluation regardless of a team's score; however as of FY26, no teams have received a follow-up review. Sustaining the TMACT assessment cycle for all of Virginia's ACT teams requires more capacity than UNC has. DBHDS has begun training some staff to conduct TMACT reviews to increase capacity and keep up with the expanding number of ACT teams; however, DBHDS needs additional staff dedicated to TMACT reviews to assess the growing number of ACT teams in Virginia.

Virginia therefore does not know whether most ACT teams deliver the service according to the model. A team that departs from the model may not produce the positive outcomes found in research, and Virginia is not positioned to know when teams depart from the model or if they should direct support to teams that are struggling. Payment is affected as well. DMAS pays a higher rate to teams rated high fidelity, so a team delivering the model at high fidelity is paid at base fidelity until an assessment can be conducted. DBHDS selects teams for review at random. A team may also arrange and pay for a review with a DBHDS-approved evaluator before being selected, which allows a team with the resources to do so to obtain the higher rate sooner than a team with fewer resources.

RECOMMENDATION 6

The General Assembly may wish to consider appropriating $565,760 and four FTEs in the 2027-2028 Appropriation Act to the Department of Behavioral Health and Developmental Services to expand capacity to conduct fidelity assessments of assertive community treatment teams.

Managed care organizations (MCOs) determining which rate to pay an ACT team and individuals seeking a team have no way to tell which teams have been assessed for fidelity. MCOs use fidelity ratings to identify high-fidelity teams that qualify for the higher reimbursement rate, and individuals and families use fidelity ratings as indicators of effective ACT teams when choosing their provider. Both consult the EBP Finder, an online tool listing the providers that may deliver ACT and showing each team's fidelity rating. The EBP Finder lists every team as either base fidelity or high fidelity, and it assigns base fidelity to teams that have never been assessed. A base rating therefore does not distinguish a team that was reviewed and met the standard from a team that has not been assessed.

RECOMMENDATION 7

The Department of Behavioral Health and Developmental Services should require that the Evidence-Based Practice Finder indicate whether each assertive community treatment (ACT) team has undergone a fidelity assessment, and the date of the most recent assessment.

Virginia tracks three outcome measures for a subset of ACT recipients

DBHDS reports annually on the cost of each ACT team, the cost per individual served, and hospitalizations and incarcerations for a subset of ACT recipients. Each measure compares hospitalization and incarceration in the two years before an individual entered ACT with hospitalization and incarceration in the two years after, and each report shows these outcomes for the individuals who entered ACT two years prior. Outcomes for an individual are measured once and not continually, so someone who entered ACT in FY18 and remains enrolled today has no outcome data more recent than FY21. The measures also exclude individuals served by private providers, which operate about a third of Virginia's ACT teams, because private providers are not required to report outcome data to DBHDS. The research supporting ACT identifies positive outcomes in housing stability, symptoms, and quality of life alongside reduced hospitalization, but Virginia does not measure these outcomes.

The FY25 report shows outcomes for 384 individuals who entered ACT in FY22. For these individuals, state hospital bed days decreased by 54 percent (estimated $17.4 million in avoided cost) and local psychiatric bed days were 35 percent lower compared to the two years prior to entering ACT. Across cohorts admitted between FY16 and FY22, DBHDS estimates $84.5 million in avoided state hospital costs. DBHDS did not evaluate incarceration outcomes in the annual reports because confinement data from the Local Inmate Data System was unavailable.

No information available to gauge the quality of MH-IOP and MH-PHP as delivered in Virginia

No national body defines what the components of a MH-IOP or MH-PHP must include, so no national fidelity monitoring tool exists for either service. DMAS provider manuals set specific requirements for both services, including minimum hours per week, required service components per day, staffing composition, and physician direction; however, there is no process in place to identify how closely services are provided to match DMAS requirements. No other stakeholders were able to identify information on how these services are delivered or outcomes for individuals who receive them. Greater insights into MH-IOP and MH-PHP could be accomplished by developing fidelity and outcome measures.

DBHDS tracks some measures of service delivery and outcomes for crisis services

DBHDS collects several measures of service delivery that provide some insight into how the crisis system operates, including mobile crisis response times and admission rates to crisis receiving centers and crisis stabilization units. Although the Crisis Now framework does not

prescribe specific fidelity measures, certain operational standards are viewed as indicators of quality, such as responding to a mobile crisis call within 60 minutes.

DBHDS uses discharge to community as a key outcome measure for most crisis services, including mobile crisis response, 23-hour stabilization (CRCs), and residential crisis stabilization (CSUs). However, performance on the outcome measure has not been reported publicly. In FY26, 63 percent of individuals who received mobile crisis were discharged into the community. During the first nine months of FY26, 70 percent of individuals who were admitted to a CRC and 90 percent of individuals who were admitted to a CSU were discharged to the community, based on DBHDS calculations. When BRAVO was proposed, DMAS projected that the new crisis services would divert admissions from inpatient beds, shorten hospital stays, and reduce repeat admissions; however, data has not been analyzed or reported to determine if these outcomes have been achieved.

Virginia lacks comprehensive metrics and reporting structure to assess the implementation and outcomes of most Project BRAVO services

The information available to determine whether Project BRAVO services are producing intended outcomes in a cost-effective manner is incomplete, decentralized, and not readily available. Virginia could begin measuring the quality and outcomes of all its redesigned behavioral health services by directing agencies to define and report on specific measures, requiring the MCOs and private providers who hold the underlying data to report it, and funding the personnel capacity and data systems needed to analyze what is collected.

DBHDS has a quality management structure that could support this effort for Project BRAVO services, as well as other behavioral health services that may be redesigned in the future, but it lack capacity to expand beyond their current work. The Office of Clinical Quality Management employs quality specialists who review services, provide technical assistance to providers, and verify that services meet regulatory requirements. Fifteen of those staff support developmental disability services, a structure DBHDS built following its settlement agreement with the U.S. Department of Justice. Only three staff support behavioral health services. DBHDS reports that establishing a comparable structure on the behavioral health side would allow it to assess whether behavioral health services are delivered as intended and to report publicly on outcomes.

RECOMMENDATION 8

The Department of Medical Assistance Services (DMAS), in conjunction with the Department of Behavioral Health and Developmental Services, should develop measures of service delivery and outcomes for the redesigned behavioral health services that lack them, including intensive outpatient programs, partial hospitalization programs, the four crisis services, and any additional behavioral health services that have been redesigned at the time of the report. DMAS should report the proposed measures, the data required to populate them, the steps and timeline needed to begin reporting, a proposed reporting structure, and any associated infrastructure costs to the Behavioral Health Commission by November 1, 2027.

RECOMMENDATION 9

The General Assembly may wish to consider including $1 million and seven FTEs in the 2027-2028 Appropriation Act for the Department of Behavioral Health and Developmental Services Office of Clinical Quality Management to support developing, tracking, and reporting on measures of service delivery and outcomes for all redesigned behavioral health services. The Office will be responsible for reporting comprehensively on Virginia's behavioral health services, including all Project BRAVO services and services redesigned in future phases of Medicaid behavioral health enhancement. Reporting should begin by December 1, 2028.

MST and FFT have yielded positive results in Virginia

Virginia has insight into fidelity and outcome data of MST and FFT teams because of the Family First Prevention Services Act, which directs states to report on the evidence-based services they use to prevent youths from entering foster care, including MST and FFT. The Virginia Department of Social Services contracts with the Center for Evidence-Based Partnerships at Virginia Commonwealth University (CEP-Va) to produce these reports. The national purveyors collect fidelity data from Virginia providers and send it to CEP-Va. CEP-Va publishes quarterly reports on how closely Virginia teams adhere to each model and reports three outcome measures for each service: (1) whether youths remained in the community or at home, (2) whether youths were in school or working, and (3) whether youths avoided new law violations or arrests. The reports include outcomes for all youths who receive MST and FFT. On average, about 60 percent of youths who receive these services are enrolled in Medicaid.

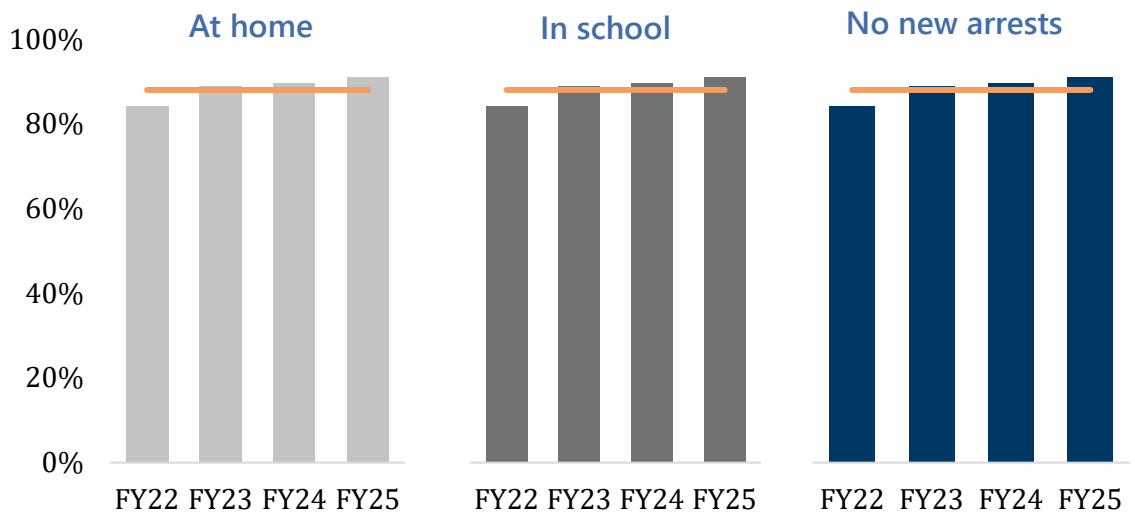
MST achieved targeted positive outcomes

Youths who received MST in Virginia appear to be achieving the outcomes the model is designed to produce. In FY25, 91 percent of youths who had completed MST were living at home at the time of discharge, 90 percent were attending school or working, and 90 percent had no new arrests (Figure 3-1). All three of these outcome measures met or exceeded their performance targets, and 83 percent of youths achieved all three outcomes in FY25.

FFT achieved positive outcomes, but below targeted level

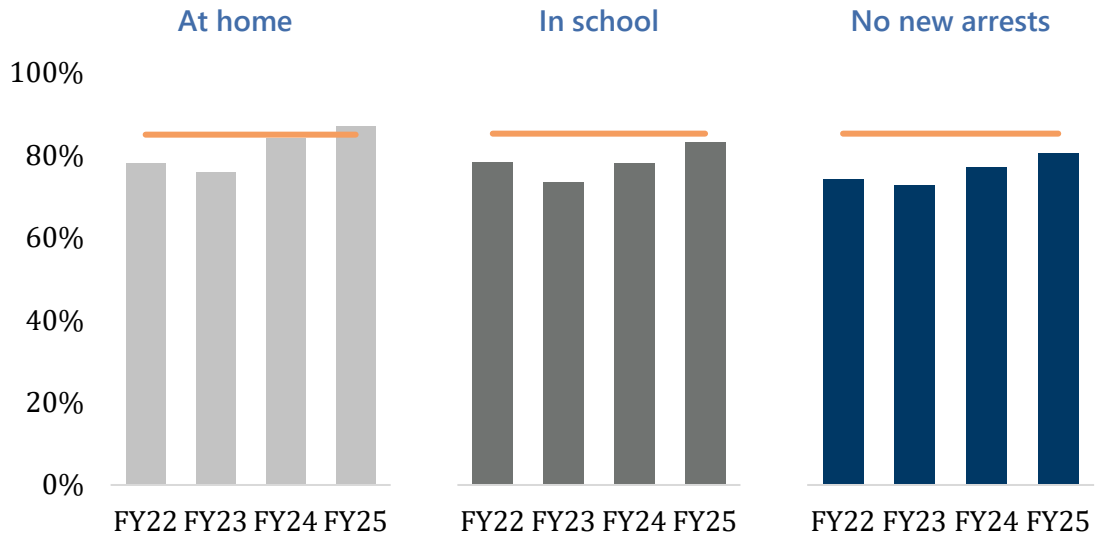
Most youths who received FFT in Virginia also achieved positive outcomes, but teams did not meet performance targets on two measures. In FY25, 87 percent of youths who received FFT remained in the community, exceeding the program's target of 85 percent; 83 percent were attending school, and 80 percent had no new law violations, falling below the 85 percent target for these measures (Figure 3-2). Still, the proportion of youths who attend school and who experienced no new law violations has been improving over time. Seventy-four percent of youths achieved all three outcomes in FY25.

Figure 3-1
Outcomes for youths who received MST improved between FY22 and FY25, and exceeded benchmarks in FY25



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

Figure 3-2: Outcomes for youths who received FFT improved between FY22 and FY25, but two outcomes remain below benchmark in FY25



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

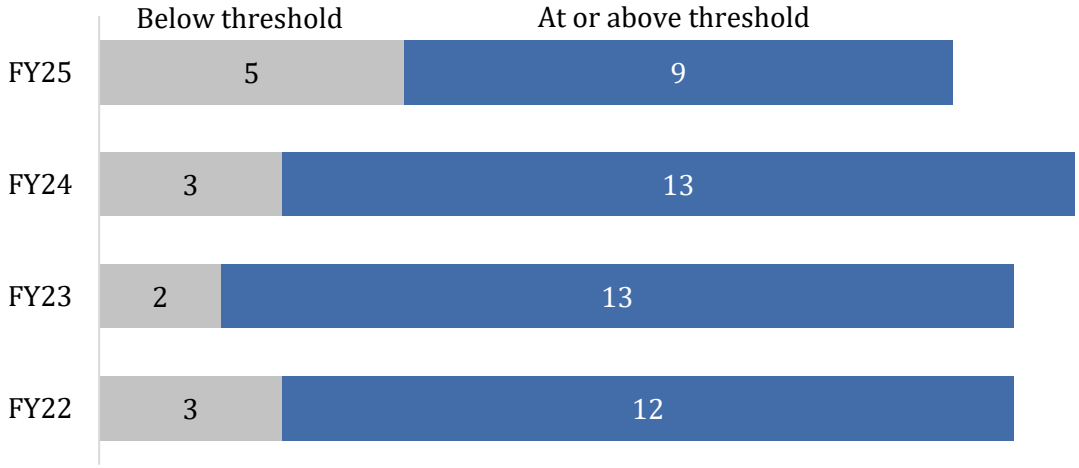
MST and FFT provider teams face difficulty meeting all fidelity standards

MST and FFT provider teams have had difficulty meeting all fidelity measures prescribed by the models. Fidelity measures assess how closely a team's practice aligns with an evidence-based model and can help explain performance on outcome measures. Each model establishes a specific threshold that a team must meet to be considered adherent.

For MST, adherence is measured through the Therapist Adherence Measure-Revised (TAM-R)—a questionnaire completed by caregivers that rates how well the therapist is following the model. MST teams meet the adherence threshold with an average score of 0.61 or higher. For FFT, supervisors rate each clinician during weekly case reviews on how completely and how skillfully they apply the model. FFT teams meet the threshold with an average score of 3.0 or higher on a 6-point scale. Both models also treat team staffing as a component of fidelity, setting targets for the number of active therapists per team and for the caseload each therapist carries.

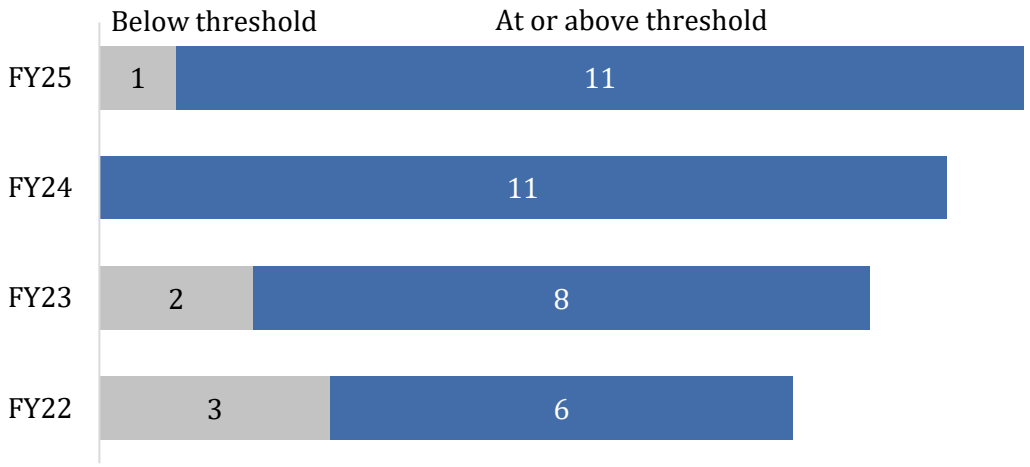
Fidelity outcomes were mixed in FY25**:** nine of 15 MST teams met the threshold, a decline from FY23 (Figure 3-3). Conversely, FFT teams saw progress, with 11 of 12 FFT teams meeting the threshold in FY25, up from FY23 (Figure 3-4).

Figure 3-3
Nine of 15 (60 percent of) MST teams met the fidelity threshold in FY25, a decline from prior years



Note: Fidelity is calculated from closed cases. One team had no closed cases in FY22 or FY25 and is excluded from the figure in those years.
Source: BHC staff analysis of fidelity data on MST teams in Virginia, FY22-FY25, Center for Evidence-based Partnerships in Virginia

Figure 3-4
11 out of 12 teams met the fidelity threshold in FY25, progressing from prior years



Source: BHC staff analysis of fidelity data on FFT teams in Virginia, FY22-FY25, Center for Evidence-based Partnerships in Virginia

Staffing is the main obstacle to meeting fidelity. Virginia has a shortage of licensed practitioners, which makes it difficult for MST and FFT teams to hire and retain therapists. Non-licensed practitioners, such as qualified mental health professionals, can fill some roles on a MST or FFT team; however, only licensed staff can conduct assessments and treatment planning. Each team must have a full-time supervisor who is a licensed mental health professional.

Low referral volume further precludes FFT teams from meeting fidelity thresholds. The model requires therapists to carry at least five active cases and targets an average of 10 to 12. As described in Chapter 2, the volume of youths receiving FFT has been relatively low, partly due to limited referrals. Caseloads per therapist across FFT teams in Virginia have generally fallen short of the optimal range, particularly during 2023 and 2024, when referrals did not keep pace with teams adding more therapists.

Many of the recommendations made to improve access to FFT and MST may also improve fidelity. Actions that expand the clinical workforce available to MST and FFT teams or that increase the number of youths referred to them would help improve fidelity. The number of youths referred to MST or FFT may increase under Behavioral Health Redesign (BHR). BHR retires the legacy services that referring entities have continued to use in place of MST and FFT, and the Community Psychiatric Support and Treatment (CPST) provider manual requires that individuals be assessed for and referred to MST and FFT before CPST may be authorized. Youths who would previously have entered a legacy service would therefore be considered for MST or FFT first, which could raise caseloads toward the range the models require.

4 Design and implementation of Behavioral Health Redesign

Behavioral Health Redesign (BHR) will help Medicaid members receive enhanced services that are based on evidence and research. However, proposed reimbursement rates may be insufficient to attract enough providers of these new services and concerns remain about the number of hours that individuals will be allowed to receive. Several important steps appear unlikely to be completed in time to ensure that redesigned services will be sufficiently available and provided as intended if BHR launches on July 1, 2027. Without additional resources, the Department of Behavioral Health and Developmental Services (DBHDS) will not be able to license the expected number of providers prior to launch; providers will begin delivering services prior to receiving the prescribed initial training, which is not yet available for all services; requirements for delivering redesigned services in schools are still in flux and expected to change significantly; and the platform for the assessment determining who qualifies for certain services has not been developed, necessitating a manual process. Moreover, Virginia currently lacks an accountability system to ensure individuals are served adequately during the transition, new services produce positive outcomes, and redesigned services are truly budget neutral.

To support a successful transition, the General Assembly may wish to consider (1) directing an increase to the proposed reimbursement rates for BHR services; (2) potentially delaying the implementation date of BHR by one year; (3) funding provider training; (4) supporting additional positions to conduct licensing, quality management, and analysis; and (5) establishing an accountability system to assess implementation, access, outcomes, and budget neutrality.

Redesigned services are grounded in evidence

The legacy services that will be replaced through BHR were not built on defined models, and no body of research establishes what outcomes they produce. Redesigned services, in contrast, draw on external models with established evidence and research. In addition, providers will be required to track and meet fidelity measures for Clubhouse and coordinated specialty care (CSC). Because Community Psychiatric Support and Treatment (CPST) is not a national model, it lacks established fidelity measures.

CPST is modeled on framework used in other states, and requires consideration of evidence-based practices

CPST is intended to replace most legacy community mental health services. The new service will offer targeted clinical support, skill building, and care coordination to people living in the community, delivered at two levels of intensity depending on an individual's assessed needs. CPST draws on a framework developed by the Meadows Mental Health Policy Institute and

used in other states, under which a standardized assessment will help determine service intensity. In Virginia, providers will use the Comprehensive Assessment of Needs and Strengths (CANS) Lifetime assessment to assign each individual a level of need, which will determine eligibility and service intensity. DMAS policy, as laid out in draft provider manuals, requires evidence-based practice training for staff, and directs providers to consider evidence-based practices, including multi-systemic therapy (MST) and functional family therapy (FFT), before authorizing CPST. CPST can be delivered in the community or school, and DMAS policy establishes service requirements for each setting.

Clubhouse is an evidence-based practice with a defined model and demonstrated positive outcomes

Clubhouse is a center-based program where adults with serious mental illness spend their days working alongside staff to build skills for employment, education, and independent living. Clubhouse follows a defined model maintained by Clubhouse International, which sets standards covering how a clubhouse program is run, how it is staffed, when it operates, and how participants and staff work together. Research on the Clubhouse model finds that members are more likely to gain and keep employment, spend less time in psychiatric hospitals, and report better quality of life. Studies also find improvements in educational outcomes and social relationships. Clubhouse providers will be required to obtain and maintain Clubhouse International accreditation, which verifies that a provider operates according to the model's standards.

CSC is research-based with demonstrated outcomes for people experiencing first-episode psychosis

Coordinated specialty care (CSC) is a team-based program for people experiencing their first episode of psychosis (often young adults), which combines therapy, medication management, family education, and help returning to school or work. Research on CSC finds substantial improvements in outcomes: people who receive it are more likely to return to school or work, are hospitalized less often, and experience greater improvement in symptoms and quality of life than people who receive other services. The evidence is strongest for people who begin the service soon after their first symptoms appear. Because of the effects CSC has shown to have on outcomes, it is the standard of care for early psychosis according to the American Psychiatric Association, the National Institute of Mental Health, and the Substance Abuse and Mental Health Services Administration (SAMHSA). CSC providers will be required to undergo fidelity reviews, and those who receive a poor fidelity rating may lose eligibility for reimbursement.

Revisions to service requirements have alleviated some concerns

Many of the initial concerns raised by stakeholders about potential shortcomings of new BHR services have been addressed through revised requirements. DMAS issued multiple revisions to service requirements after receiving public comments, many of which responded directly to concerns raised by providers (Table 4-1). Drafts of service requirements have been revised

twice for CPST services delivered in the community, and once each for Clubhouse and CSC. However, no revisions have been made to the original draft requirements governing CPST services offered in schools, despite significant public comments.

Despite meaningful progress toward addressing public comments, some concerns remain that new services may fall short of their potential. Some providers indicate that CPST offers fewer hours of care than legacy services, which could be insufficient to maintain stability for certain individuals and lead to increased reliance on crisis services, emergency departments, and inpatient care. Requirements for Clubhouse services may also be difficult to implement in line with national standards.

Table 4-1
DMAS revised draft service requirements for CPST-community, Clubhouse, and CSC in response to major concerns

Service	Major concerns raised	Change in most recent draft
CPST-community	Service hours too low	Raises service hours across all levels of need, allowing 8.5 to 28 hours per month
	Referral required to specialized service that may be unavailable	Allows enrollment in CPST when the specialized service is not available or when person prefers CPST
	Assessment required within 30 days, possibly duplicating assessments	Accepts an assessment completed within the past year, including by another provider
Clubhouse	Improvement required for continued participation, contrary to national model	Allows participant to remain in service if holding steady or maintaining work and social connections
	Staffing and documentation requirements unworkable at the proposed rate	One staff per 20 members, no clinical license required for director, weekly rather than daily notes
	Participants not allowed to receive ACT or other services concurrently	Removes ACT and several other services from the exclusion list
CSC	Flat cap of 30 people per team, regardless of team size	Ties caseload to staffing, requires one staff member per 20 people
	Level of need assessment and second eligibility test required	Removes second eligibility test
	Participants not allowed to receive a variety of other services concurrently	Removes several services from exclusion list, allows people receiving CSC to receive substance use treatment, MH-PHP, MH-IOP, and other services concurrently

Source: BHC staff analysis of DMAS draft provider manuals and public comments

CPST-community enrollment will be easier but hours could be insufficient, despite increase

Revised draft service requirements have made it easier to enroll individuals in CPST. Providers are required to assess and refer individuals to a more specialized, evidence-based service such as MST, FFT, or ACT before enrolling them in CPST. This previously raised concerns given the limited and uneven availability of these services, discussed in Chapter 2 of this report. The most recent draft allows enrollment directly in CPST when a more specialized service is not practical or if the person prefers CPST. Providers may also now use an assessment completed within the past year to evaluate individuals for CPST, including one done by another provider, rather than repeating assessments.

The number of service hours available under CPST has increased since the initial draft service requirements were issued, in response to provider concerns about the ability to adequately serve individuals eligible for the service. The most recent requirements allow approximately eight and a half hours of CPST per month for a person with the lowest level of need and 28 hours a month for a person with the highest level of need.

Despite the increase, the maximum number of hours allowable under CPST remains well below that allowable for legacy services. For example, individuals can be authorized to receive intensive in-home services for eight to 15 hours per week, and therapeutic day treatment for up to 25 hours a week during the school year. However, there is little information about how much time providers spend with clients, and it is unknown how many fewer hours individuals will receive under CPST. Concerned stakeholders reported that individuals accustomed to seeing a provider several times a week may deteriorate if they have access to the provider only a few times a month, and may lose stability. These individuals may then turn to more intensive and costly services including crisis services, emergency department visits, and more inpatient admissions.

The number of service hours allowable under CPST does not appear to have any basis in research or the experience of other states. Rather, it was selected primarily to achieve budget neutrality. According to DMAS, individuals are likely to need fewer hours of services under CPST because it is a more active treatment approach than the services it replaces. Whether the allowable hours are sufficient will not be known until individuals begin receiving CPST. To ensure the new service yields positive outcomes and does not lead to higher utilization of more intensive services, DMAS should monitor outcomes for individuals receiving CPST and revisit service hours limits after implementation if necessary.

RECOMMENDATION 10

The General Assembly may wish to consider including language in the 2027-2028 Appropriation Act directing the Department of Medical Assistance Services (DMAS) to assess whether the allowable number of service hours is sufficient to meet the needs of Medicaid members who receive Community Psychiatric Support and Treatment (CPST) services, and report findings from its assessment and any recommended changes to the Behavioral Health Commission annually beginning December 1, 2028. The assessment should include, at a minimum, (i) average hours authorized, reported by CPST tier and level of need; (ii) the percentage of CPST recipients who reach the monthly service limit for their level of need; and (iii) the frequency of emergency department visits, inpatient admissions, and crisis service use among individuals receiving CPST. DMAS should identify any additional measures and data collection required to fully assess the sufficiency of CPST hour authorizations.

Clubhouse service requirements may be challenging to implement in line with national model

Clubhouse providers are required to meet the standards of Clubhouse International, the organization that maintains the model. Revisions to the first draft of the service requirements resolved several instances of conflict between state requirements and the national standards; participants will be allowed to remain in the program if they are holding steady, keeping a job, or maintaining social connections, and they will be able to return after an absence.

However, the most recent draft requirements still contain aspects that may be difficult to implement in line with the national model, according to providers. The model requires that all space be shared between members and staff, but providers report that they cannot meet service requirements for documentation and supervision without private staff space. DMAS staff do not believe this is a valid concern. Providers also assert that the service requirements for licensed professional oversight of service plans are more applicable to clinical services, whereas the Clubhouse International model treats the service as non-clinical. The requirement of licensed professional oversight cannot be removed from Clubhouse service requirements because it is required by the Centers for Medicare and Medicaid Services (CMS) as a condition of federal Medicaid funding. These differences could impact the ability of Clubhouse programs in Virginia to achieve positive outcomes, because the evidence supporting Clubhouse comes from programs operating exactly as the model specifies.

Revised service requirements also added reimbursement for activities that the model requires and reduced some administrative requirements. Clubhouse programs can now be reimbursed for job training and staff support at a participant's workplace, and staff can complete weekly summaries for each participant instead of providing daily notes. Participants will also be able to receive other services concurrently with Clubhouse, such as ACT.

CSC providers have more flexibility in staffing and enrollment has been streamlined

Revised service requirements allow CSC teams to serve more people. The first draft capped the number of people that could be served by a CSC team at 30, regardless of how many staff the team had. The most recent draft better aligns the service requirements with the CSC fidelity instrument; allows larger teams to serve more people by requiring one staff member per 20 people; and removes a secondary eligibility test, making enrollment more expeditious.

BHR rates may not be sufficient to attract and sustain enough providers for CPST and Clubhouse

Reimbursement rates established for new BHR services have been constrained by budget neutrality, and they may be insufficient to attract enough providers to deliver them. Providers have reported that the rates set for CPST and Clubhouse will not cover the cost of delivering these services, especially for smaller providers that lack economies of scale. This could result in provider shortages, compromise access to the right level of care, and shift costs toward more intensive services.

Proposed reimbursement rates are set to achieve budget neutrality

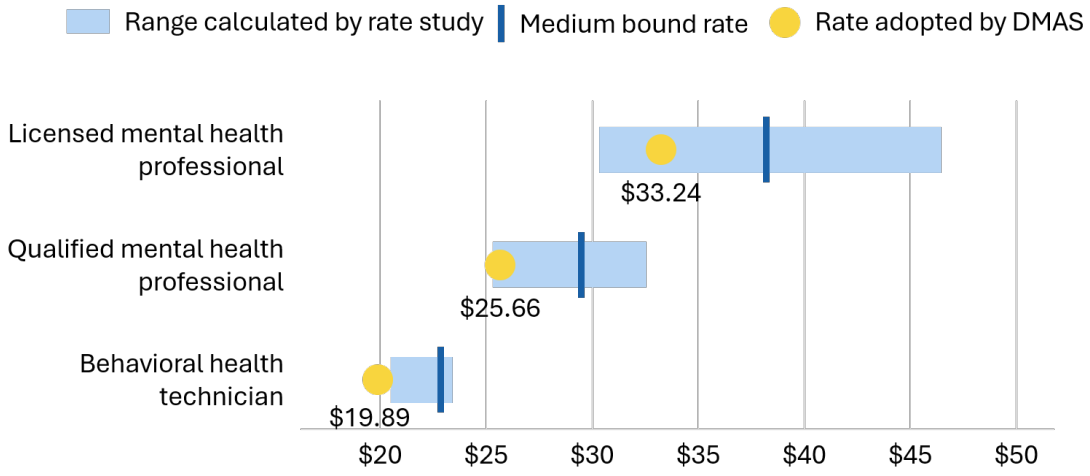
The proposed reimbursement rates for BHR services were selected from a range of recommended rates calculated by Mercer—a consulting firm hired by DMAS to conduct rate studies. Mercer estimated the cost of delivering new services and helped DMAS identify a combination of rates and utilization assumptions that would achieve budget neutrality, in accordance with the Appropriation Act. Budget neutrality, as defined by DMAS, requires that the projected cost of redesigned services not exceed spending on legacy services, including state and federal funding. Mercer recommended paying every service at its medium bound rate, but those rates would have cost more than the legacy services; therefore, Mercer proposed a budget neutral alternative that funded CPST at 95 percent of the medium-bound rate, lowered the Clubhouse rate, and made some programmatic changes to Clubhouse. DMAS was concerned about the changes made to Clubhouse and opted instead to decline these changes, and to fund CPST at 87 percent of the medium bound rate to achieve budget neutrality.

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

DMAS has acknowledged that CPST rates are lower than it would like in order to attract providers, and providers report that the rates do not cover what the service costs to deliver. Providers will need more licensed practitioners than are currently required for legacy services, particularly in supervisory roles. CPST also requires more activities including documentation, supervision, and training, which providers report are not supported by the rates and are not separately reimbursable.

CPST rates differ based on the qualifications of the person who delivers the service, with the highest rate for licensed mental health professionals, a lower rate for qualified mental health professionals (QMHPs), and the lowest for behavioral health technicians (BHTs). When developing the rates, it was assumed that QMHPs and BHTs would deliver about 90 percent of youth CPST and 35 percent of adult CPST. Rates for QMHPs and BHTs are significantly lower than the medium-bound rates proposed by the rate study: QMHP rates are close to the bottom of the range, and the BHT rate falls below the bottom of the range (Exhibit 4-1).

Exhibit 4-1
CPST rate falls near bottom of the range for QMHPs, and below the range calculated for the rate study for BHTs



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

Providers have reported that low CPST rates may prevent them from offering the service, and there may be too few CPST providers to serve all individuals transitioning from legacy services. A majority of community services boards (CSBs) interviewed for this study indicated they do not plan to provide CPST. Rural areas have less provider choice and often rely primarily on CSBs for behavioral health services. Several rural CSBs interviewed for this study indicated that they will not provide CPST; therefore, some rural areas could be left without any CPST provider. Some private providers report that they intend to try providing CPST but are unsure whether the service will be financially viable. Small providers are least likely to be able to offer CPST. Providers will need to serve 40 to 50 individuals a year for the service to be viable, according to DMAS, and many providers delivering the legacy services today serve just three to five Medicaid members.

Raising CPST rates appears necessary to ensure Medicaid members can access CPST services. Funding rates at 95 percent of the medium bound, as initially proposed by Mercer, would increase costs by approximately $30 million, if applied to all provider types. Alternatively, the rates increase could be targeted at the practitioner types with the lowest rates, QMHPs and BHTs. Although increasing rates could undermine budget neutrality, the redesign may not prove budget neutral even without the increased rates. Budget neutrality holds only if a set

of untested assumptions about how services will be used proves correct, and Mercer's modeling showed spending exceeding the baseline by $147 million if utilization mirrors the legacy services. Also, the increased rates will not have a direct or immediate impact on the Medicaid budget because of the state's use of managed care organizations (MCOs). Virginia pays MCOs capitated rates, a fixed monthly amount per member, to manage Medicaid services. MCOs pay providers to provide the services, usually at the rates established by DMAS. DMAS calculates capitation rates using what MCOs spend in prior years, and capitated rates will likely have to be increased in future years if MCO costs of BHR services exceed projections.

OPTION 1

The General Assembly may wish to consider including language in the 2027-2028 Appropriation Act directing the Department of Medical Assistance Services to increase reimbursement rates for Community Psychiatric Support and Treatment (CPST) to 95 percent of the medium bound rates for all practitioner types.

Clubhouse rate may be too low for providers to offer the service

Providers report that it will be difficult to operate a Clubhouse program at the rate DMAS set. DMAS set the Clubhouse rate at $72.41 per day, higher than the rate of Mercer's budget neutral proposal. This rate is below what Virginia currently pays for psychosocial rehabilitation, the service Clubhouse replaces. Providers may bill psychosocial rehabilitation up to three units a day, totaling $89.97, and report that many psychosocial rehabilitation programs operate at a loss under the current rate.

Clubhouse costs more to deliver than psychosocial rehabilitation and the rate does not account for these additional costs, according to providers. The most recent draft of Clubhouse service requirements directs Clubhouse programs to acquire and maintain Clubhouse International Accreditation. Clubhouse International awards accreditation for either one or three years, and staff training must be repeated with staff turnover. DMAS estimates training costs between $7,000 and $11,000 per site and has no funding available to help providers cover the cost.

Providers that cannot operate a Clubhouse at this rate will not offer the service. If too few psychosocial rehabilitation providers convert to Clubhouse or too few new providers start a Clubhouse program, Virginia will not have enough Clubhouse programs to support individuals who need this service.

RECOMMENDATION 11

The General Assembly may wish to consider including $440,000 in the 2027-2028 Appropriation Act for the Department of Behavioral Health and Developmental Services to establish a grant program supporting the training of Mental Health Clubhouse sites.

More time and resources may be needed to successfully implement BHR

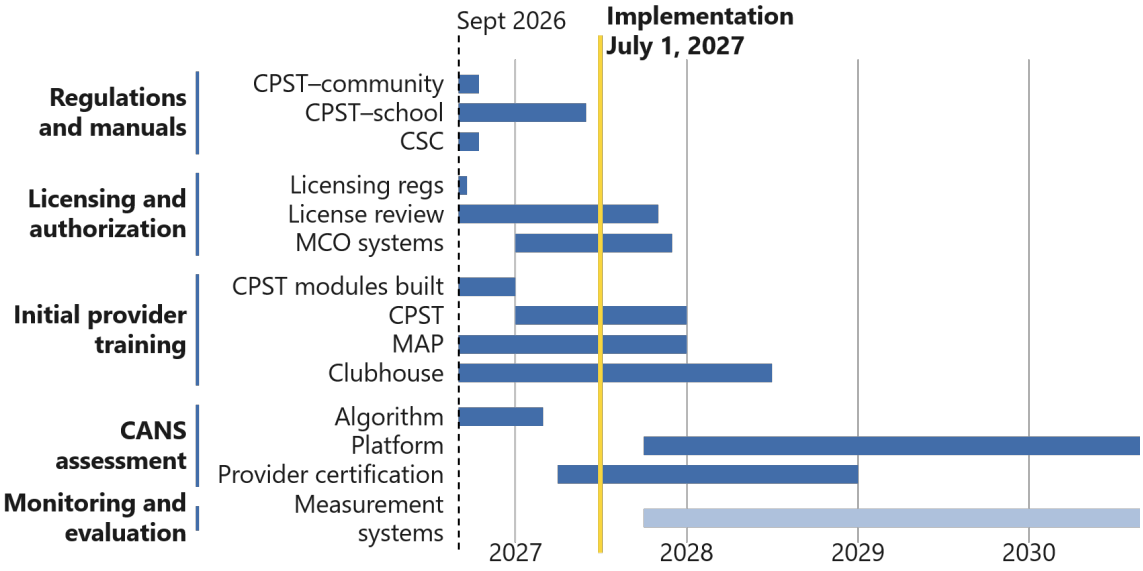
Although the deadline to implement Behavioral Health Redesign was extended by one year, additional time appears needed to ensure Medicaid members have adequate access to redesigned services that are provided as intended. The 2026 Appropriation Act delayed BHR by one year until July 1, 2027, after DMAS, the Department of Behavioral Health and Developmental Services (DBHDS), MCOs, CSBs, private providers, and school divisions asked for additional time to prepare and implement BHR. Several of the steps required to implement BHR successfully likely still cannot be completed in time to adhere to the current deadline (Exhibit 4-2). In particular, service requirements for school-based CPST are unlikely to be finalized in time to allow schools and providers to be ready for the transition. Without additional resources, DBHDS will not be able to license the expected number of providers prior to launch. MCOs may not have adequate time to build authorization systems, and many providers will begin delivering services prior to receiving the prescribed initial training, which is not yet available for all services. The platform that providers will use to complete the CANS Lifetime assessment has also not been developed. Additional time and staffing would allow more of this work to be completed before legacy services are discontinued. The General Assembly could delay implementation again, at a minimum for school-based CPST and Clubhouse services, and permit a phased transition so providers come online as they become ready.

School-based CPST service requirements have not yet been revised

The service requirements for most BHR services will be completed before launch; however, the requirements for CPST-school lag behind. Requirements for CPST services delivered in schools were first released in September 2025 and have not yet been revised to address public comments, although significant changes are expected. For CPST-community, each of the two rounds of comments and revision took roughly three months.

The Virginia Department of Education (VDOE) reports that it does not have a clear picture of how to prepare for the transition and that school divisions do not have a good grasp on the scope of upcoming changes, with some administrators unaware of the transition entirely. Providers currently delivering therapeutic day treatment (TDT) in schools report the same uncertainty. Some schools are unaware that TDT will end, which means schools relying on TDT may lose the service without warning. VDOE has prepared guidance that explains what CPST is and what divisions will need to do (e.g., identifying students who will qualify and establishing agreements with CPST providers), and reports that it is waiting for a final implementation date before distributing it. The lack of clarity around the school-based services delivered under CPST could compromise provider readiness and availability, and in turn undermine access to services for students.

Exhibit 4-2
Many steps of BHR implementation are unlikely to be completed by July 1, 2027



Note: Estimates based on current resources; timelines may change if additional resources are allocated.
Source: BHC staff estimates based on DMAS draft provider manuals and DBHDS licensing regulations, DBHDS Office of Licensing staffing estimate, and interviews with DMAS, DBHDS, DBHDS Office of Licensing, MCOs, and CEP-Va

Capacity constraints and regulatory mismatch could impede state's ability to adequately vet new providers of BHR services

DBHDS needs additional capacity to adequately review the large volume of provider applications anticipated, and to regulate these new providers on an ongoing basis. The DBHDS Office of Licensing expects to receive over 1,000 new applications, double the number it receives in a typical year. Additionally, BHR providers will receive two inspections a year during their first three years, and will hold conditional licenses that expire at the same time, meaning renewals and inspections will need to occur for all providers at the same time. The Office currently employs 46 licensing specialists who are responsible for reviewing initial applications, conducting annual renewals and on-site inspections, and investigating incidents and complaints. The Office reports these staff are at capacity under their current workload, and additional staff are needed to review BHR applications and sustain increased inspections without setting back the licensing work the Office already performs.

Even if additional licensing resources are secured, licensing regulations may not be aligned with DMAS' final service requirements, which are still evolving. For licenses to take effect on July 1, 2027, the Office of Licensing must begin accepting applications in September 2026. However, DMAS service requirements were still in draft form as of late August.

Under the current timeline, providers will be licensed based on regulations that may not completely match service requirements. For example, if newer drafts change requirements governing staff credentials, caseload ratios, supervision structure, required service

components, and hours of operation, licensing regulations will need to be adjusted to ensure providers can comply with these requirements. DBHDS has drafted licensing regulations based on drafts of DMAS service requirements; however, as DMAS continues to make changes to the service requirements, changes to licensing regulations will ultimately be needed. DBHDS has already withdrawn its licensing regulations once to align them with the most recent DMAS draft, but they cannot accommodate additional changes in response to DMAS revisions and final service requirements, because they must finalize licensing regulations before applications are accepted in September 2026. The licensing regulations governing BHR at launch will therefore be emergency regulations that may not match the final service requirements. Virginia can correct this mismatch only through the permanent regulatory process, which takes effect after implementation. DBHDS faced the same situation during Project BRAVO and had to return to the crisis regulations afterward to bring them into alignment.

Additional resources are needed not only to respond to the large influx of new providers, but also to strengthen the application review process and adequately vet potential providers. About four years ago, when new Project BRAVO services were launched, DBHDS streamlined its process by discontinuing applicant interviews and narrowing the scope of policy review. Under the streamlined process, the office relied largely on applicants attesting that they met the requirements rather than verifying that they did. DBHDS reports that these changes, combined with a compressed timeline to implement Project BRAVO, contributed to the influx of mobile crisis providers, some of which have been improperly delivering the service. The Office of Licensing has since determined that applicant interviews and full policy review need to resume to keep lower-quality providers out of the system. Restoring these parts of the licensing process adds roughly nine hours of work to each application.

RECOMMENDATION 12

The General Assembly may wish to consider appropriating $850,000 and eight FTEs in the 2027-2028 Appropriation Act for the Department of Behavioral Health and Developmental Services Office of Licensing to add eight additional licensing specialist positions.

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

State agencies, MCOs, and provider associations all report concerns that too few providers will be ready when BHR is currently scheduled to launch and legacy services are discontinued. BHR adds training requirements that legacy services did not have, which should strengthen the quality of services individuals receive. However, under the current timeline providers are unlikely to have been consistently trained in key aspects of service delivery prior to launch. Project BRAVO did not require training for mobile crisis response and community stabilization, and these services have been delivered inconsistently across the Commonwealth since implementation, according to stakeholders interviewed for this report.

Providers must receive training in multiple areas to comply with service requirements as currently drafted, including initial trainings and ongoing trainings conducted while providers offer the service. Relatively few providers have completed the initial trainings, and some training is not yet available, raising concerns about the feasibility of providers being fully trained on BHR services by the current launch deadline. The state is offering a grace period and will allow providers to deliver services before they have fulfilled training requirements. However, this creates a significant risk that services will not be delivered as intended.

For CPST, initial training includes online modules required for all CPST staff. DBHDS, CEP-Va, and other academic partners developed modules for CPST training, with DMAS funding the development of these modules to make them free to providers. These modules are not yet available to providers. They are expected to be released by the end of 2026, which leaves six months for all CPST providers to complete the modules.

Providers have also not received initial training in the assessment tool that determines eligibility for CPST and the authorized amount of services. DMAS has selected the tool, CANS Lifetime, but is still testing the algorithm that translates the assessment into a level of need. DMAS has tested the CANS Lifetime and the algorithm with about 30 clinicians, but has not finalized it. Staff who administer CANS Lifetime need initial training and certification by the Praed Foundation, which owns the tool. No providers have yet received CANS Lifetime training, and DBHDS needs funding to develop state trainers to provide this training. They estimate that $300,000 will enable them to train 12 state trainers and about 7,000 providers on the CANS Lifetime but have not identified a source of funding to support this.

Agencies serving youths must also have a clinician credentialed in Managing and Adapting Practice (MAP) to offer CPST. This process involves a training curriculum, six months of consultation, and a portfolio review. Ideally, providers would complete the training curriculum prior to launch and use the first six months of providing CPST to complete the consultation and portfolio review. DBHDS has funded MAP training for 200 youth clinicians and is funding a smaller number for the equivalent adult training. More time and resources are needed to train a sufficient number of providers prior to launch, and DBHDS reports that an additional year and additional resources would allow more providers to complete the training curriculum prior to providing CPST.

Clubhouse providers must train all staff as required by Clubhouse International. Each newly enrolled Clubhouse must send a team, including at least one member, to an authorized Clubhouse International training base within the first 12 to 18 months of operation, and staff must continue to participate in training to maintain accreditation. Few Virginia programs will complete training before the implementation date. Clubhouse International conducts training at a limited number of authorized training bases, none of them in Virginia, and those bases have limited capacity to train programs across the country. Clubhouse International training is also expensive for providers and may prohibit some providers from offering the service. DMAS estimates that training costs between $7,000 and $11,000 per site and reports that it has not identified funding to help providers cover the cost.

RECOMMENDATION 13

The General Assembly may wish to consider appropriating one-time funding in the 2027-2028 Appropriation Act to the Department of Behavioral Health and Developmental Services to establish a grant program to pay for training costs that providers must incur to deliver Behavioral Health Redesign services, including Managing and Adapting Practice (MAP), transdiagnostic cognitive behavioral therapy, and training on the Comprehensive Assessment of Needs and Strengths (CANS) Lifetime assessment tool.

Many providers report they will not be ready to deliver services by the implementation deadline. DMAS estimated 330 providers needed for adult CPST in community settings, 109 providers needed for CPST in school settings, and 74 providers needed for Clubhouse. Those estimates assume each provider serves 50 individuals a year, and the number of providers actually needed will depend on how many individuals each provider can serve. Fewer than half (47 percent) of providers interested in adult CPST, less than 65 percent of providers interested in CPST in school settings, and less than a quarter of providers interested in Clubhouse considered themselves likely to be ready to deliver these services in July 2026, according to a provider readiness survey administered by DMAS in November 2025. These figures likely overstate providers and readiness, as stakeholders report some providers may have responded to the survey in order to stay informed about the redesign rather than because they intended to deliver the service. This survey was also conducted based on the first draft of service requirements; now that the requirements have been revised, many providers interviewed for this study report that they are unlikely to be ready by July 2027.

Providers vary in how much they know about BHR, and the burden of learning about redesign has fallen on them. DBHDS reports that providers who have participated in the preparation sessions DMAS offers are further along than those who have not. Those sessions require providers to find them, attend them, and interpret draft service requirements that continue to change. Providers that lack administrative staff to track regulatory developments and small providers are the least likely to understand the transition. Providers that do not understand the requirements will not be ready to meet them. Some will submit applications that do not comply and lose time in correction cycles that the licensing schedule leaves little room for, and others will not apply at all.

Assessment tool for service eligibility and intensity likely to be administered manually

The assessment that will determine eligibility and service amounts is not ready for providers to use. Providers will use the CANS Lifetime to establish each individual's level of need. The CANS Lifetime is available publicly; however, DMAS needs to finalize the algorithm that translates assessment responses into a level of need and build a platform that providers will use to conduct the assessment and submit the results to MCOs for service authorization. DMAS has drafted specifications for the platform but does not expect the platform to be ready before implementation and reports it needs contract staff or a dedicated team to build the platform. At implementation, providers instead will complete the assessment within their own records systems and submit it to MCOs as a spreadsheet with each authorization request.

Without a central platform, DMAS cannot easily use the assessment results to comprehensively assess the outcomes of service recipients. The CANS Lifetime measures functioning across every domain of an individual's life, and it is the most comprehensive information Virginia will collect about the people receiving these services. Assessments stored in individual provider systems cannot be easily compiled, compared, or analyzed by the state. MCOs could be required to report back to DMAS the assessments submitted by providers for authorization purposes; this option would be labor-intensive and may require additional work on the part of providers. Having access to assessment information when BHR launches would also allow the state to establish a baseline at implementation, against which future outcomes can be measured.

Guidance delays and compressed timelines could undermine MCOs' ability to authorize BHR services consistently

DMAS has not finalized the sections of the provider manuals that define the new services, establish requirements, and include the medical necessity criteria that will determine who qualifies for each service. MCOs use the service requirements established in the provider manuals to build their authorization systems. There is concern that the time between finalization of service requirements and implementation may not be long enough for MCOs and providers to prepare. Providers have expressed concern that they cannot determine what they must do to deliver a service without finalized provider manuals.

MCOs must contract with providers to provide BHR services, verify that each provider is licensed and qualified, write authorization criteria, and update their systems to include the new services and pay claims. MCOs are engaged in the transition, but report that they cannot complete these steps until DMAS issues the guidance they are waiting for, including final service requirements and medical necessity criteria expected in fall 2026. That leaves roughly six months to build systems DMAS previously estimated would take nine to 12 months, and MCOs may authorize services inconsistently at launch as a result.

Families may lack awareness and understanding of upcoming BHR transition and its impact

Individuals receiving services and their families may also be unprepared for the transition. Providers interviewed for this study expressed concerns that the people they serve are not well informed about the upcoming changes, the nature of the new services, or the process for accessing them. Under the redesign, all individuals receiving therapeutic day treatment, intensive in-home services, mental health skill building, or psychosocial rehabilitation will either transition to a different service or stop receiving services entirely. Most of these individuals will also have to undergo a new assessment to determine their eligibility. Because families who do not understand the transition cannot proactively inquire about alternative options, individuals whose existing providers do not convert to the new model risk learning that their services have ended only when they terminate.

RECOMMENDATION 14

The Department of Medical Assistance Services, in conjunction with the Department of Behavioral Health and Developmental Services and the Virginia Department of Education, should develop and carry out a communication plan for the transition to Behavioral Health Redesign services, directed at individuals receiving legacy services and their families and school divisions. The plan should be carried out beginning no later than six months before implementation of Behavioral Health Redesign.

OPTION 2

The General Assembly may wish to consider including language in the 2027-2028 Appropriation Act delaying implementation of Behavioral Health Redesign services by one additional year, to July 1, 2028, and permitting a six-month phased implementation of redesigned services, allowing legacy services to continue while providers become licensed, trained, and able to deliver the services replacing them.

OPTION 3

The General Assembly may wish to consider including language in the 2027-2028 Appropriation Act delaying implementation of school-based Community Psychiatric Support and Treatment (CPST-school) and Mental Health Clubhouse, and retirement of therapeutic day treatment and psychosocial rehabilitation, by one additional year, to July 1, 2028, and permitting a six-month phased implementation of legacy services, allowing them to continue while providers become licensed, trained, and able to deliver the services replacing them.

BHR lacks an accountability system to ensure success

In light of the number of Medicaid members impacted by BHR and projected spending, Virginia must proactively develop an accountability system to ensure the state is positioned to realize the anticipated benefits of redesigned behavioral health services. No entity has been directly designated as responsible for monitoring the implementation and effectiveness of Behavioral Health Redesign. The Appropriation Act requires DMAS to implement redesigned services in a budget neutral manner but does not direct the agency to report on how implementation proceeds, what happens to the individuals who receive the new services, or whether redesigned efforts are in fact budget neutral. The agency most closely involved in the development of BHR and its implementation, DMAS, has no formal plans to conduct any assessments. Mercer's contract ended at the end of FY26, so the actuaries who built the model will not be available to test it against implementation. The Behavioral Health Division at DMAS, which has been tasked with the design and implementation of BHR, has not received any additional resources to either plan for the initiative, or to conduct assessments after launch. DBHDS has begun considering evaluating the effectiveness of new services as part of its quality management program, but would need additional resources to undertake this effort, as described in more detail in Chapter 3. Without ongoing assessments, the state will face the same information gaps that exist with Project BRAVO, which have led to delays in identifying cost overruns, access gaps, and unknown outcomes.

Recommendations 8 and 9 in Chapter 3 contemplate a comprehensive reporting structure on service delivery and outcomes for all redesigned behavioral health services, including those launched as part of BHR. If implemented, these recommendations would satisfy the need for ongoing information about the way services are delivered, and the outcomes of individuals who receive BHR services.

In addition to service delivery and outcome measures, DMAS should identify proposed measures to assess the implementation of BHR, specifically with respect to access and budget neutrality. The measures of access should capture, at a minimum: (i) how many individuals moved from each legacy service to a new service, (ii) how many individuals stopped receiving services entirely, (iii) how many providers were licensed and enrolled to deliver each new service by the implementation date, (iv) the number of individuals receiving each BHR service annually, (v) the number of providers delivering each BHR service annually, (vi) the availability of BHR services by region, and (vii) any factors that limit access to BHR services. The report should also identify the factors affecting whether spending remains within the baseline, including utilization compared with the assumptions used in the fiscal impact analysis. Because Virginia delivers these services through managed care, the report should include both the amounts managed care organizations report spending on Behavioral Health Redesign services and the behavioral health component of the capitation rates DMAS pays MCOs.

RECOMMENDATION 15

The General Assembly may wish to consider including language in the 2027-2028 Appropriation Act directing the Department of Medical Assistance Services (DMAS) to identify measures that will be used to evaluate the implementation of Behavioral Health Redesign services. These measures should reflect, for each redesigned service, (i) access adequacy, and (ii) spending compared with the budget neutral baseline established in the 2025 Mercer rate study. DMAS should report to the Behavioral Health Commission on the measures it proposes to track by November 1, 2027. Actual performance on each proposed measure should be reported annually to the Behavioral Health Commission beginning on July 1, 2028.

DMAS reports that it does not have the staff to conduct this kind of analysis. The agency employs no behavioral health analysts, and the single staff member most familiar with behavioral health data also supports every Medicaid waiver, nursing facilities, and developmental disability services. Additional reporting and analysis requirements would necessitate at least one dedicated staffing resource.

RECOMMENDATION 16

The General Assembly may wish to consider including $150,000 and one FTE in the 2027-2028 Appropriation Act for the Department of Medical Assistance Services to add an analyst position to the Behavioral Health Division. This position would be responsible for helping to develop, track, and report on access adequacy and cost-effectiveness measures for redesigned behavioral health services.

Recommendations and options: Enhancement of Medicaid behavioral health services

BHC staff typically offer recommendations or options to address findings identified in its reports. Staff will usually propose options, rather than recommendations, when (i) the action proposed is a policy judgment best made by the General Assembly or other elected officials; (ii) the evidence indicates that addressing a report finding could be beneficial but the impact may not be significant; or (iii) there are multiple ways to address a finding, and there is insufficient evidence to determine the single best way to address the finding.

Recommendations

RECOMMENDATION 1

The General Assembly may wish to consider including funding in the 2027-2028 Appropriation Act for the Center for Evidence-Based Partnerships in Virginia (CEP-Va) to establish additional multisystemic therapy (MST) and functional family therapy (FFT) teams.

RECOMMENDATION 2

The Department of Medical Assistance Services, in conjunction with the Department of Behavioral Health and Developmental Services, should develop and communicate educational materials on the populations eligible for multisystemic therapy (MST) and functional family therapy (FFT), the benefits of these services, and how to make referrals to providers. These materials should be provided to (i) all entities responsible for referring youths to behavioral health services, including community services boards, managed care organizations, courts, and schools; and (ii) families no later than six months prior to the discontinuation of intensive in-home services and therapeutic day treatment.

RECOMMENDATION 3

The Department of Medical Assistance Services (DMAS), in collaboration with the Department of Behavioral Health and Developmental Services (DBHDS), should improve the availability of information to identify improper use of crisis services by (i) providing managed care organizations with real-time access to crisis dispatch information, including data platform reference numbers and provider acceptance data, in a form that allows an organization to verify that a dispatch occurred and which provider responded; (ii) establishing a process through which managed care organizations share information about providers identified as delivering crisis services improperly, so that a provider identified by one organization can be identified by all; and (iii) linking crisis service data held separately by DMAS, DBHDS, managed care organizations, and community services boards by July 1, 2027.

RECOMMENDATION 4

The General Assembly may wish to consider appropriating additional funding and FTEs in the 2027-2028 Appropriation Act at the Department of Medical Assistance Services (DMAS) to build data sharing among DMAS, the Department of Behavioral Health and Developmental Services, managed care organizations, and community services boards, and to analyze the resulting data to identify improper use of crisis services.

RECOMMENDATION 5

The General Assembly may wish to consider directing the State Board of Behavioral Health and Developmental Services to promulgate regulations, pursuant to the Administrative Process Act, amending the licensing regulations governing crisis services to strengthen protections against improper use of those services by July 1, 2027.

RECOMMENDATION 6

The General Assembly may wish to consider appropriating $565,760 and four FTEs in the 2027-2028 Appropriation Act to the Department of Behavioral Health and Developmental Services to expand capacity to conduct fidelity assessments of assertive community treatment teams.

RECOMMENDATION 7

The Department of Behavioral Health and Developmental Services should require that the Evidence-Based Practice Finder indicate whether each assertive community treatment (ACT) team has undergone a fidelity assessment, and the date of the most recent assessment.

RECOMMENDATION 8

The Department of Medical Assistance Services (DMAS), in conjunction with the Department of Behavioral Health and Developmental Services, should develop measures of service delivery and outcomes for the redesigned behavioral health services that lack them, including intensive outpatient programs, partial hospitalization programs, the four crisis services, and any additional behavioral health services that have been redesigned at the time of the report. DMAS should report the proposed measures, the data required to populate them, the steps and timeline needed to begin reporting, a proposed reporting structure, and any associated infrastructure costs to the Behavioral Health Commission by November 1, 2027.

RECOMMENDATION 9

The General Assembly may wish to consider including $1 million and seven FTEs in the 2027-2028 Appropriation Act for the Department of Behavioral Health and Developmental Services Office of Clinical Quality Management to support developing, tracking, and reporting on measures of service delivery and outcomes for all redesigned behavioral health services. The Office will be responsible for reporting comprehensively on Virginia's behavioral health services, including all Project BRAVO services and services redesigned in future phases of Medicaid behavioral health enhancement. Reporting should begin by December 1, 2028.

RECOMMENDATION 10

The General Assembly may wish to consider including language in the 2027-2028 Appropriation Act directing the Department of Medical Assistance Services (DMAS) to assess whether the allowable number of service hours is sufficient to meet the needs of Medicaid members who receive Community Psychiatric Support and Treatment (CPST) services, and report findings from its assessment and any recommended changes to the Behavioral Health Commission annually beginning December 1, 2028. The assessment should include, at a minimum, (i) average hours authorized, reported by CPST tier and level of need; (ii) the percentage of CPST recipients who reach the monthly service limit for their level of need; and (iii) the frequency of emergency department visits, inpatient admissions, and crisis service use among individuals receiving CPST. DMAS should identify any additional measures and data collection required to fully assess the sufficiency of CPST hour authorizations.

RECOMMENDATION 11

The General Assembly may wish to consider including $440,000 in the 2027-2028 Appropriation Act for the Department of Behavioral Health and Developmental Services to establish a grant program supporting the training of Mental Health Clubhouse sites.

RECOMMENDATION 12

The General Assembly may wish to consider appropriating $850,000 and eight FTEs in the 2027-2028 Appropriation Act for the Department of Behavioral Health and Developmental Services Office of Licensing to add eight additional licensing specialist positions.

RECOMMENDATION 13

The General Assembly may wish to consider appropriating one-time funding in the 2027-2028 Appropriation Act to the Department of Behavioral Health and Developmental Services to establish a grant program to pay for training costs that providers must incur to deliver Behavioral Health Redesign services, including Managing and Adapting Practice (MAP), transdiagnostic cognitive behavioral therapy, and training on the Comprehensive Assessment of Needs and Strengths (CANS) Lifetime assessment tool.

RECOMMENDATION 14

The Department of Medical Assistance Services, in conjunction with the Department of Behavioral Health and Developmental Services and the Virginia Department of Education, should develop and carry out a communication plan for the transition to Behavioral Health Redesign services, directed at individuals receiving legacy services and their families and school divisions. The plan should be carried out beginning no later than six months before implementation of Behavioral Health Redesign.

RECOMMENDATION 15

The General Assembly may wish to consider including language in the 2027-2028 Appropriation Act directing the Department of Medical Assistance Services (DMAS) to identify measures that will be used to evaluate the implementation of Behavioral Health Redesign services. These measures should reflect, for each redesigned service, (i) access adequacy, and (ii) spending compared with the budget neutral baseline established in the 2025 Mercer rate study. DMAS should report to the Behavioral Health Commission on the measures it proposes to track by November 1, 2027. Actual performance on each proposed measure should be reported annually to the Behavioral Health Commission beginning on July 1, 2028.

RECOMMENDATION 16

The General Assembly may wish to consider including $150,000 and one FTE in the 2027-2028 Appropriation Act for the Department of Medical Assistance Services to add an analyst position to the Behavioral Health Division. This position would be responsible for helping to develop, track, and report on access adequacy and cost-effectiveness measures for redesigned behavioral health services.

Options

OPTION 1

The General Assembly may wish to consider including language in the 2027-2028 Appropriation Act directing the Department of Medical Assistance Services to increase reimbursement rates for Community Psychiatric Support and Treatment (CPST) to 95 percent of the medium bound rates for all practitioner types.

OPTION 2

The General Assembly may wish to consider including language in the 2027-2028 Appropriation Act delaying implementation of Behavioral Health Redesign services by one additional year, to July 1, 2028, and permitting a six-month phased implementation of redesigned services, allowing legacy services to continue while providers become licensed, trained, and able to deliver the services replacing them.

OPTION 3

The General Assembly may wish to consider including language in the 2027-2028 Appropriation Act delaying implementation of school-based Community Psychiatric Support and Treatment (CPST-school) and Mental Health Clubhouse, and retirement of therapeutic day treatment and psychosocial rehabilitation, by one additional year, to July 1, 2028, and permitting a six-month phased implementation of legacy services, allowing them to continue while providers become licensed, trained, and able to deliver the services replacing them.

Appendix A: Research activities and methods

Key research activities performed for this study included:

- Semi-structured interviews with leadership and staff of: state agencies, managed care organizations, providers, provider associations, and academic partners;
- Analysis of claims data;
- Analysis of fidelity and outcome data;
- Review of service regulations, provider manuals, and licensing regulations;
- Review of previous reports on Project BRAVO and Medicaid behavioral health services;
- Review of national literature and evidence-based practice guidance; and
- Review of state documentation, such as those related to laws, regulations, and policies relevant to the provision of Medicaid behavioral health services in Virginia.

Interviews

Structured interviews were a key research method for this report. BHC staff conducted approximately 20 interviews with leadership and staff across the state agencies, associations, providers, and organizations that design, deliver, oversee, and pay for Medicaid behavioral health services. Interviews were semi-structured and organized around the study's issues, with separate discussions reserved for Project BRAVO and for Behavioral Health Redesign (BHR) where the two raised distinct questions. Key interviewees included:

- Leadership and staff of DMAS;
- Leadership and staff of DBHDS;
- Leadership and staff of theVirginia Department of Education (VDOE);
- Leadership and staff of the Center for Evidence-Based Partnerships in Virginia at Virginia Commonwealth University (CEP-Va);
- Provider associations, CSBs, and private providers; and
- Leadership of the Virginia Association of Health Plans (VAHP).

Leadership and staff of DMAS

BHC staff conducted several interviews with DMAS leadership and staff. Separate discussions addressed Project BRAVO and Behavioral Health Redesign. Interviews related to Project BRAVO were intended to gain an understanding of service design, service utilization, spending, provider participation, and the claims data available for monitoring. Interviews regarding BHR focused on service design, eligibility and level-of-need framework, the implementation timeline, and provider readiness.

Leadership and staff of DBHDS

BHC staff conducted several interviews with DBHDS leadership and staff. The interviews were designed to understand DBHDS's oversight functions of Project BRAVO services, including licensing, quality management, and fidelity monitoring. Interviews also focused on DBHDS's role in implementing BHR, including licensing and development of evaluation systems.

Leadership and staff of VDOE

BHC staff interviewed leadership and staff of VDOE. Interviews were designed to understand the role of schools in BHR, school readiness for the transition, and delivery of CPST-school.

Leadership and staff of CEP-Va

BHC staff conducted several interviews with leadership and staff of CEP-Va, who monitor fidelity and outcomes for several evidence-based services, including MST and FFT. Interviews focused on understanding the fidelity and outcome data available for MST and FFT. Interviews were also designed to understand CEP-Va's role in BHR, including developing provider training and monitoring systems for BHR services.

Provider associations and providers

BHC staff interviewed leadership and several members of the Virginia Association of Community Services Boards (VACSB), and leadership and several members of the Virginia Association of Community-Based Providers (VACBP). Interviews were designed to understand provider participation in Project BRAVO, rates, workforce, licensing, and authorization. Interviews also focused on provider perspectives on BHR services and implementation.

Leadership of VAHP

BHC staff interviewed representatives of Medicaid managed care organizations (MCOs). Interviews were designed to understand MCO authorization practices and service utilization of Project BRAVO services. The interview also focused on MCOs' role in the BHR transition and their perceived readiness. VAHP leadership also facilitated the distribution and completion of a structured questionnaire to individual MCOs.

Data collection and analysis

BHC staff analyzed several types of data for this study. DMAS provided Medicaid summary-level claims data for Project BRAVO services for FY22 through FY25 and for the legacy services they replaced for FY17 through FY21. CEP-Va and DBHDS provided fidelity and outcome data for MST, FFT, ACT, and crisis services. DMAS provided the results of its provider readiness surveys conducted for BHR.

Claims data

BHC staff analyzed summary-level claims data provided by DMAS to measure, for each BRAVO service, (1) the number of individuals who received the service, (2) the number of providers delivering the service, (3) spending, and (4) the annual percentage change in (1)-(3). BHC staff analyzed each measure statewide and by DMAS region, by population of adults and children, and by provider type (CSB or private provider). BHC staff grouped the BRAVO services into intensive outpatient/community-based services (MST, FFT, and ACT), intensive clinic/facility-based services (MH-IOP and MH-PHP), and crisis services (mobile crisis response, community stabilization, 23-hour crisis stabilization, and residential crisis stabilization).

A coding transition disrupted the FY22 claims data for MST and FFT, so BHC staff substituted two data sources for those services in FY22. The H2033 procedure code overlapped Behavioral Health Therapy and MST in the FY22 claims, so BHC staff drew FY22 MST spending from the behavioral health dashboard rather than from claims. BHC staff drew FY22 provider counts for MST and FFT from CEP-Va rather than from claims.

BHC staff compared actual utilization and spending against the projections DMAS used when BRAVO was funded. The baseline for expected values was the FY21 Project BRAVO budget projection in the Project BRAVO decision package (prepared in 2019). Service-level projections were not available for the individual crisis services, so BHC staff performed the crisis comparison at the group level.

Fidelity and outcome data

BHC staff analyzed the fidelity and outcome data that CEP-Va collects for MST and FFT. CEP-Va provided consolidated fidelity and outcome data for MST and FFT covering July 2021 through September 2025. BHC staff analyzed team fidelity to assess whether providers deliver the models as designed, examining the trend in fidelity scores by FY, the share of teams meeting the fidelity threshold, and the teams that fell below it.

BHC staff analyzed the outcomes CEP-Va reports for youths who complete or end treatment, including treatment completion and the three shared outcomes of living at home, attending school or working, and having no new arrests. For both MST and FFT, BHC staff compared Virginia's reported outcomes against the national purveyors' benchmark for each outcome, to show where Virginia's results fall relative to well-functioning programs.

BHC staff also analyzed the locations of MST and FFT teams to assess access, mapping each service separately and mapping the localities served by both, because the two services deliver similar treatment to similar populations.

Reimbursement rates adopted for CPST

DMAS contracted with Mercer to develop rates for the new BHR services. BHC staff analyzed how the rates DMAS adopted for the new BHR services compare to the rate ranges Mercer's rate study calculated. The rate study published a lower bound, medium bound, and upper bound for each service, and published these bounds for each practitioner type for CPST (Table A-1). The DMAS rate and fiscal impact summary states that DMAS funded CPST at 87

percent of the medium bound rate. BHC staff applied 87 percent to each medium bound rate to produce the adopted rate shown for each practitioner type. To validate the method, BHC staff applied 95 percent to the same medium bound rates and reproduced the rate study's separately published 95 percent values.

Table A-1
CPST community-setting rate ranges and adopted rates

Practitioner	Lower bound	Medium bound	Upper bound	Calculated adopted rate
LMHP	$30.31	$38.31	$46.48	$33.24
QMHP	$25.31	$29.49	$32.55	$25.66
BHT	$20.49	$22.41	$23.86	$19.89

Note: Adopted rates reflect 87 percent of the medium bound rate; rates are per 15 minutes of service delivered in a community setting.
Source: BHC staff analysis of Mercer rate and fiscal impact summary, Department of Medical Assistance Services, 2025

Implementation timeline

BHC staff constructed a BHR implementation timeline showing the major milestones required before the redesign can begin. DMAS has published target dates for some milestones but not for others, so BHC staff estimated the completion time for each remaining milestone by combining three sources: interviews with DMAS, DBHDS, and provider stakeholders about the work each milestone entails and the pace of progress to date; CMS guidance on the steps and approvals a change of this kind requires; and DMAS and DBHDS planning documents describing the sequence and dependencies among milestones. The estimates reflect the resources currently committed to the transition. Milestones could be completed sooner if the state adds staff, funding, or contractor capacity; or later if a step takes longer than the current pace suggests.

Provider distribution

BHC staff mapped the number of providers of each service by locality using choropleth maps created in Datawrapper. BHC staff joined provider counts to all 133 Virginia localities using five-digit FIPS codes, assigned localities to the six DMAS regions using the DMAS Regions by Locality and FIPS document, and classified provider counts using a six-class natural-breaks scheme with a shared legend across the adult and child maps for each service.

Data limitations

The data available for this study limited what could be measured. No systematic outcome data exist for most BRAVO services, so the analysis measures utilization, spending, and provider participation rather than outcomes. Currently available data does not capture

network adequacy or whether individuals receive care at the appropriate level of intensity. BHC staff noted these limitations wherever they bear on a finding.

Review of documents and literature

BHC staff reviewed numerous documents and the research literature pertaining to Project BRAVO, BHR, and Medicaid behavioral health services, including:

- The Appropriation Act language and budget documents that funded Project BRAVO and BHR;
- DMAS provider manuals, including draft sections for CPST, Clubhouse, and CSC;
- Public comments submitted on all draft provider manuals;
- DBHDS current and pending licensing regulations;
- Mercer rate and fiscal impact study for BHR (May 30, 2025);
- DMAS BHR provider readiness survey results;
- DBHDS annual ACT reports;
- CEP-VA quarterly reports on MST and FFT;
- Prior reports on Project BRAVO and Medicaid behavioral health services;
- National literature and evidence-based practice guidance; and
- Virginia laws, regulations, and policies governing Medicaid behavioral health services.

Appendix A: Research activities and methods

Appendix B: Budget language directing Behavioral Health Redesign

Item 291.TT.1 of Appropriation Act, 2026

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 July 1, 2027.

The Department of Medical Assistance Services shall have the authority to seek federal authorization through waiver and state plan amendments under Titles XIX and XXI of the Social Security Act, as necessary, to meet the requirements of this paragraph. The department shall have authority to implement the changes authorized in this paragraph upon federal approval and prior to the completion of any regulatory process.

Appendix B: Budget language directing Behavioral Health Redesign

Appendix C: Project BRAVO service profiles

Appendix C presents a one-page profile for each of the nine Project BRAVO services. Each profile describes the service and summarizes its performance on access, quality, and cost using the data available for this study.

Multisystemic therapy (MST)

What is MST?

MST is an intensive treatment for youth ages 12 to 17 whose behavior places them at risk of being removed from home. A therapist works with the youth and the family together, in the home and in the community, several times a week over three to five months. The therapist is available 24-7, and the team works with everyone involved in the youth's life, including school staff and, where relevant, probation officers.

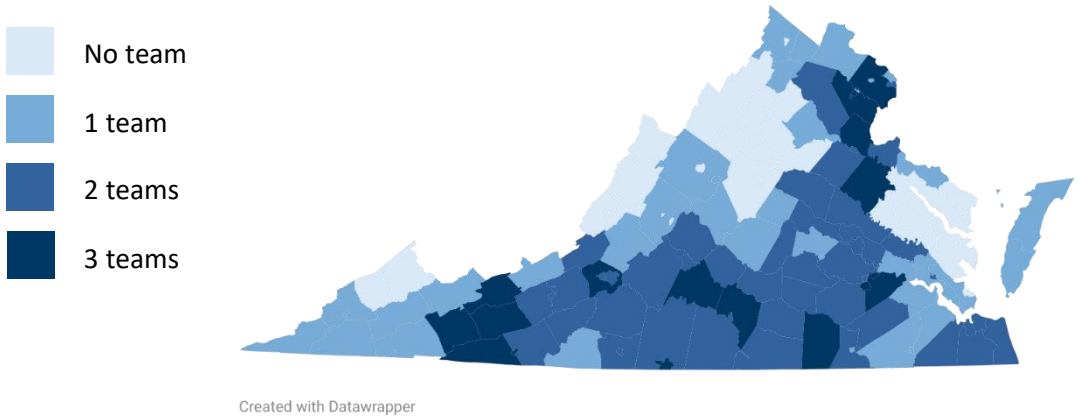
Who receives MST and what does MST cost under Medicaid?

Uptake of MST has been slow. The number of youths in Medicaid receiving MST has held roughly steady since FY22 and remains below what Project BRAVO projected.

294 Youths served *FY25, up 26% since FY22*	**16** Teams operating *FY25, same as in FY22*

$2.8 M Spent in FY25	**$8.4 M** Spent FY22–FY25	**$9,693** Average spent per youth *FY25*

Exhibit C-1
MST teams operated in 105 (77 percent of) localities in Virginia in FY25



Note: Providers serving more than one locality are counted in each locality they serve, so statewide totals on this map exceed the number of unique providers.

What does Virginia know about how well MST works?

Virginia knows more about MST than about most Project BRAVO services, because the organization that owns the model requires teams to collect fidelity and outcome data as a condition of certification. The information available pertains to all MST recipients, not just Medicaid members.

Is the service delivered as designed?	Are the people who receive it better off?
Measured Adherence is measured through a questionnaire caregivers complete during treatment. A team meets the threshold at an average score of 0.61 or higher. 9 of 15 teams met the threshold set by the model in FY25.	**Measured** CEP-Va reports three outcomes: whether youth remained at home, were in school or working, and avoided new arrests. In FY25, 91% of youth were living at home, 90% were in school or working, and 90% had no new arrests. All measures met the targets set by the model in FY25.

Source: BHC analysis of DMAS claims data, VCU CEP-Va quarterly fidelity and outcome reports, and interviews with DMAS, DBHDS, and VCU CEP-Va

Functional family therapy (FFT)

What is FFT?

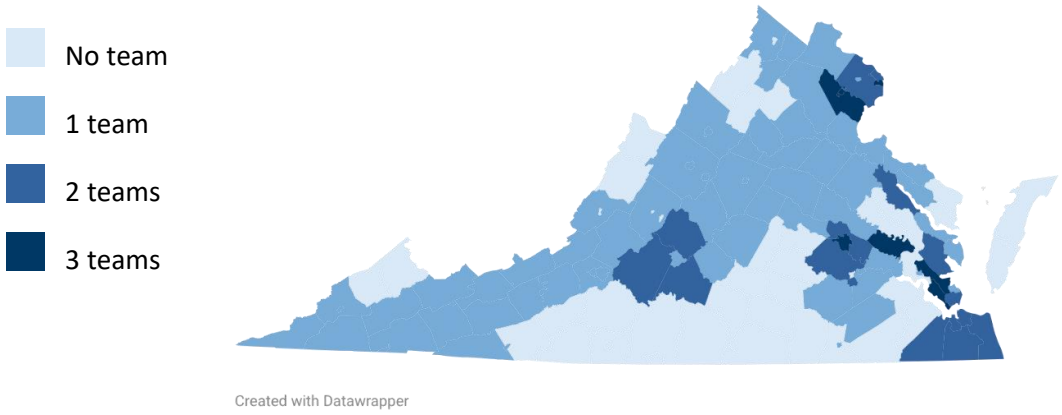
FFT is a short-term treatment for youth ages 11 to 18 who are at risk of being placed outside the home. A therapist works with the youth and family together, usually in the home, over roughly three to five months, focusing on how family members communicate and solve problems with one another. The service is designed to change patterns in the household rather than to treat the youth alone.

Who receives FFT and what does FFT cost under Medicaid?

Uptake of FFT has been slow. More youths receive FFT than when the service launched, but utilization remains below what Project BRAVO projected.

384 Youths served *FY25, up 63% since FY22*		**12** Teams operating *FY25, up from 9 in FY22*
$1.3 M Spent in FY25	**$3.1 M** Spent FY22–FY25	**$3,361** Average spent per youth *FY25*

Exhibit C-2
FFT teams operated in 91 (68 percent of) localities in Virginia in FY25



Note: Teams serving more than one locality are counted in each locality they serve, so statewide totals on this map exceed the number of unique teams.

What does Virginia know about how well FFT works?

Virginia knows more about FFT than about most Project BRAVO services, because the organization that owns the model requires teams to collect fidelity and outcome data as a condition of certification. The information available pertains to all FFT recipients, not just Medicaid members.

Is the service delivered as designed?	Are the people who receive it better off?
Measured Supervisors rate each clinician during weekly case reviews on how completely and how skillfully they apply the model. A team meets the threshold at an average score of 3.0 or higher on a 6-point scale. 11 of 12 teams met the threshold set by the model in FY25.	**Measured** CEP-Va reports three outcomes: whether youth remained in the community, attended school, and avoided new law violations. In FY25, 87% of youth remained in the community, 83% attended school, and 80% had no new law violations. Only one measure met the model's target of 85%.

Source: BHC analysis of DMAS claims data, VCU CEP-Va quarterly fidelity and outcome reports, and interviews with DMAS, DBHDS, and VCU CEP-Va

Assertive community treatment (ACT)

What is ACT?

ACT delivers treatment and support to adults with serious mental illness wherever they live, through a team of clinicians, nurses, and peer specialists. The team treats the person in the community, providing psychiatric care and medication, therapy, and help with housing, employment, benefits, and daily tasks. ACT is intended to keep adults who would otherwise cycle through psychiatric hospitals and jails living in their communities.

Who receives ACT and what does ACT cost under Medicaid?

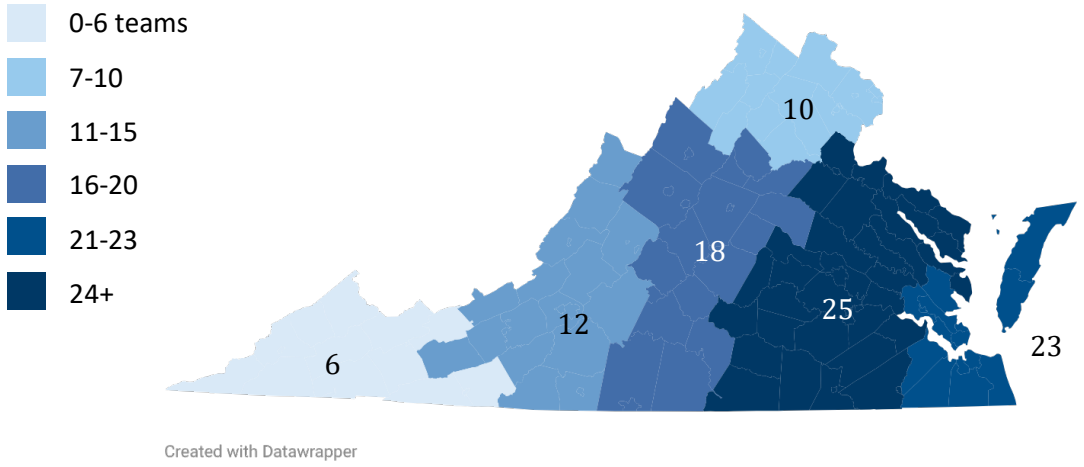
Access to ACT has improved. More adults receive ACT, relative to the number of adults who received the legacy service replaced by ACT. Providers have also added more teams.

2,626 Individuals served *FY25, up 34% since FY22*	**60** Teams operating *FY25, up from 31 in FY22*

$46.0 M Spent in FY25	**$128.9 M** Spent FY22–FY25	**$17,507** Average spent per person *FY25*

Exhibit C-3

60 ACT teams operated in Virginia in FY25, concentrated in the Central and Tidewater regions



Note: Providers serving more than one region are counted in each region they serve, so statewide totals on this map exceed the number of unique providers.

What does Virginia know about how well ACT works?

Virginia has some insight into whether ACT teams deliver the model as designed or whether the adults who receive it improve. The information available is not specific to Medicaid recipients.

Is the service delivered as designed?	Are the people who receive it better off?
Partly measured	**Partly measured**
Fidelity is measured with the TMACT, administered by the University of North Carolina under contract with DBHDS. 30 out of 60 teams have been assessed as of FY26. All teams were assessed at base fidelity. Teams should be assessed annually.	DBHDS reports one outcome, hospitalization, for individuals newly admitted to ACT at a CSB who are served by CSBs. Hospitalization decreased significantly (54% decrease in state hospital bed days and 35% decrease in local psychiatric bed days in FY25) within that group.

Source: BHC staff analysis of DMAS claims data, DBHDS annual ACT reports, and interviews with DMAS, DBHDS, and VCU CEP-Va

Intensive outpatient program for mental health (MH-IOP)

What is MH-IOP?

MH-IOP provides structured group and individual treatment several days a week to youth and adults who need more than weekly counseling but do not require hospitalization. Participants attend a program for several hours at a time while continuing to live at home and, for youth, attend school. MH-IOP is intended to serve people whose condition is too serious for routine outpatient therapy.

Who receives MH-IOP and what does MH-IOP cost under Medicaid?

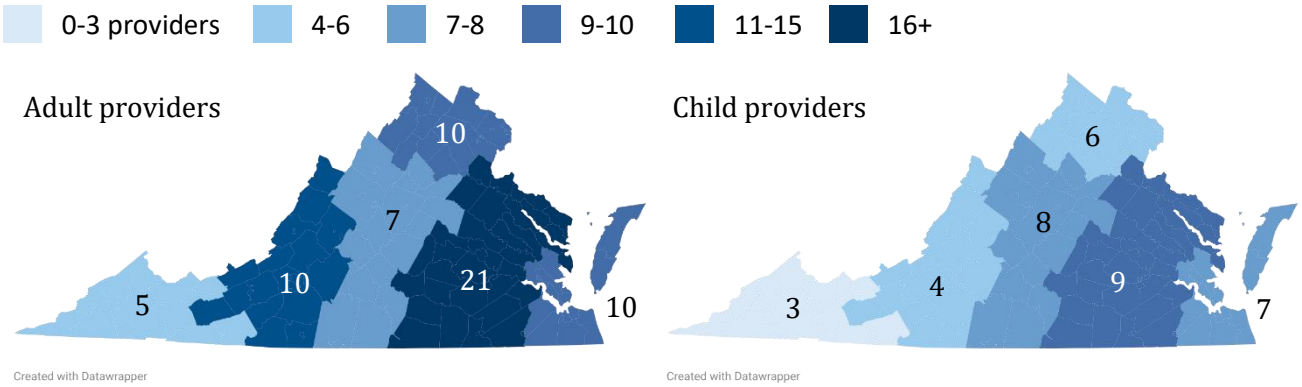
Few individuals receive MH-IOP. Utilization has grown since the service launched but remains less than half of what Project BRAVO projected.

800 Individuals served *FY25, up 760% since FY22*	**45** Providers delivering *FY25, up from 19 in FY22*

$3.0 M Spent in FY25	**$6.0 M** Spent FY22–FY25	**$3,770** Average spent per person *FY25*

Exhibit C-4

45 providers delivered MH-IOP in Virginia in FY25, concentrated in the Central region



Note: Providers serving more than one region are counted in each region they serve, so statewide totals on this map exceed the number of unique providers.

What does Virginia know about how well MH-IOP works?

Virginia does not measure the quality of MH-IOP as delivered or the outcomes of people who receive the service.

Is the service delivered as designed?	Are the people who receive it better off?
Not measured No national body defines the components this service must include, so no fidelity measure exists for it. No measures of service delivery have been adopted. DMAS provider manuals set requirements for hours, service components, staffing, and physician direction, but neither DMAS nor DBHDS report whether providers meet them.	**Not measured** No entity measures outcomes for individuals who receive MH-IOP.

Source: BHC analysis of DMAS claims data and interviews with DMAS, DBHDS, managed care organizations, and provider associations

Partial hospitalization program for mental health (MH-PHP)

What is MH-PHP?

MH-PHP provides treatment at an intensity similar to inpatient care without an overnight stay. Participants attend a program most of the day, several days a week, receiving therapy, medication management, and psychiatric care while returning home at night. MH-PHP serves youth and adults who are at risk of psychiatric hospitalization or who are leaving a hospital and need continued intensive treatment.

Who receives MH-PHP and what does MH-PHP cost under Medicaid?

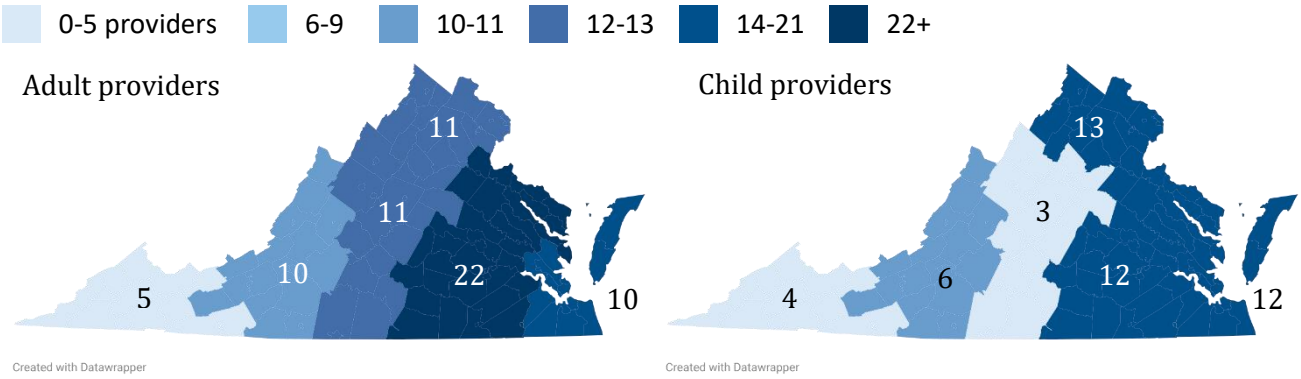
Access to MH-PHP has improved substantially. Nearly four times as many individuals receive PHP as when the service launched, and more providers deliver it.

1,110 Individuals served *FY25, up 265% since FY22*	**44** Providers delivering *FY25, up from 29 providers in FY22*

$7.1 M Spent in FY25	**$13.4 M** Spent FY22–FY25	**$6,396** Average spent per person *FY25*

Exhibit C-5

44 providers delivered MH-PHP in Virginia in FY25, concentrated in the Northern/Winchester, Western/Charlottesville, and Central regions



Note: Providers serving more than one region are counted in each region they serve, so statewide totals on this map exceed the number of unique providers.

What does Virginia know about how well MH-PHP works?

Virginia does not measure the quality of MH-PHP as delivered or the outcomes of the people who receive the service.

Is the service delivered as designed?	Are the people who receive it better off?
Not measured	**Not measured**
No national body defines the components this service must include, so no fidelity measure exists for it. No measures of service delivery have been adopted. DMAS provider manuals set requirements for hours, service components, and staffing, but neither DMAS nor DBHDS report whether providers meet them.	No entity measures outcomes for individuals who receive MH-PHP.

Source: BHC analysis of DMAS claims data and interviews with DMAS, DBHDS, managed care organizations, and provider associations

Mobile crisis response (MCR)

What is MCR?

MCR sends a team to a person experiencing a behavioral health crisis, wherever the crisis is happening, at any hour. The team assesses the situation, works to resolve it on site, and connects the person to further care if needed. The service is intended to prevent emergency department visits, psychiatric hospitalization, and law enforcement involvement.

Who receives MCR and what does it cost under Medicaid?

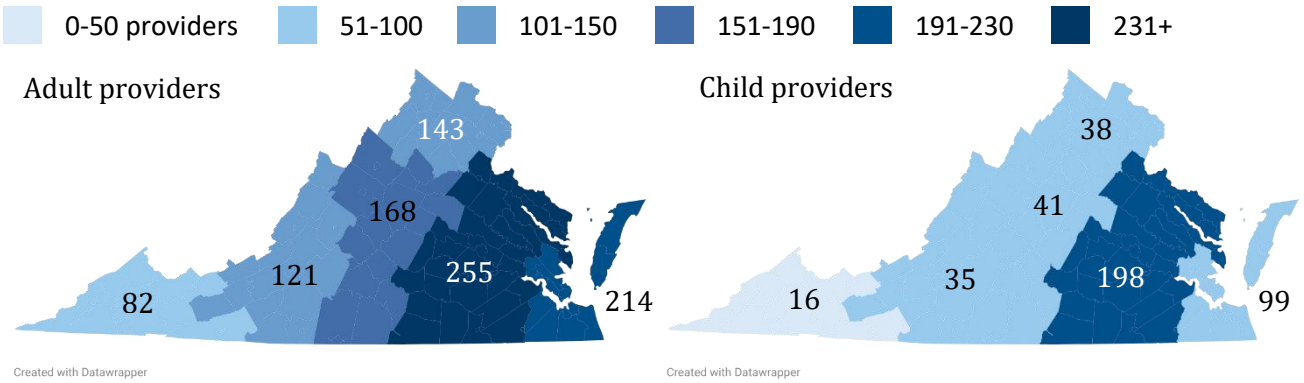
More individuals receive MCR than received the services it replaced, and far more providers deliver it than projected.

24,556 Individuals served *FY25, up 191% since FY22*	**286** Providers delivering *FY25, up 82 providers in FY22*

$177.0 M Spent in FY25	**$405.1 M** Spent FY22–FY25	**$7,208** Average spent per person *FY25*

Exhibit C-6

286 providers delivered MCR in Virginia in FY25, concentrated in the Central region



Note: Providers serving more than one region are counted in each region they serve, so statewide totals on this map exceed the number of unique providers.

What does Virginia know about how well MCR works?

Virginia measures some elements of service delivery and outcomes of MCR. The information available pertains to all MCR recipients, not just Medicaid members.

Is the service delivered as designed?	Are the people who receive it better off?
Partially measured	**Partially measured**
The Crisis Now model has no fidelity measure. DBHDS collects some operational measures that may be used to assess service delivery, such as response time. In FY26 average response time was 41 minutes. Stakeholder groups interviewed for this study raised concerns about improper use of this service.	DBHDS reports one outcome, resolved in community, for individuals who receive MCR. In FY26, 73.1% of MCR cases were resolved in the community. When Project BRAVO was proposed, DMAS projected that crisis services would divert inpatient admissions, shorten hospital stays, and reduce repeat admissions. No analysis has examined whether those results occurred.

Source: BHC analysis of DMAS claims data and interviews with DMAS, DBHDS, managed care organizations, and provider associations

Community stabilization

What is community stabilization?

Community stabilization provides short-term support to a person in the days after a behavioral health crisis, before ongoing treatment begins. Staff provide assessment, crisis intervention, and care coordination, and help connect the person to the services they need next. Unlike Virginia's other crisis services, community stabilization is not part of the national Crisis Now model; it carried over from Virginia's earlier crisis services.

Who receives community stabilization and what does it cost under Medicaid?

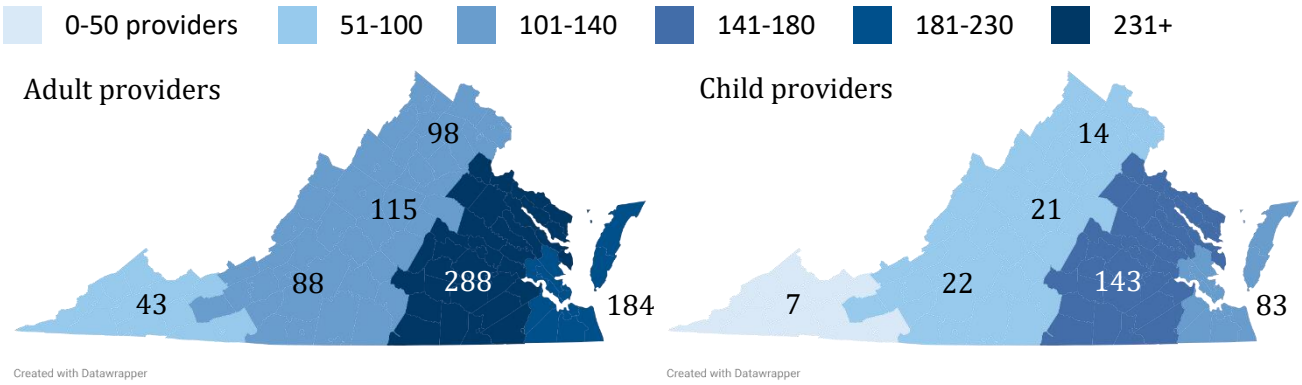
More individuals receive community stabilization, relative to the number of adults who received the legacy service replaced by community stabilization. The Appropriation Act discontinues the service effective July 1, 2026, pending CMS approval.

14,641 Individuals served *FY25, up 38% since FY22*	**326** Providers delivering *FY25, up from 226 providers in FY22*

$135.8 M Spent in FY25	**$464.7 M** Spent FY22–FY25	**$9,275** Average spent per person *FY25*

Exhibit C-7

326 providers delivered community stabilization in Virginia in FY25, concentrated in the Central region



Note: Providers serving more than one region are counted in each region they serve, so statewide totals on this map exceed the number of unique providers.

What does Virginia know about well how community stabilization works?

Virginia does not measure the quality or outcomes of community stabilization.

Is the service delivered as designed?	Are the people who receive it better off?
Not measured Community stabilization does not derive from a national model, so no evidence indicates what outcomes it should produce or how providers should best deliver it. No measures of service delivery have been adopted. Stakeholder groups interviewed for this study raised concerns about improper use of this service.	**Not measured** No entity measures outcomes for individuals who receive community stabilization.

Source: BHC analysis of DMAS claims data and interviews with DMAS, DBHDS, managed care organizations, and provider associations

23-Hour crisis stabilization

What is 23-hour crisis stabilization?

23-hour crisis stabilization provides a safe place where a person in crisis can be observed and assessed for up to a day. Staff conduct a psychiatric evaluation and medical testing and determine what care the person needs next. The service is delivered in crisis receiving centers and is intended as an alternative to an emergency department visit or a psychiatric hospital admission.

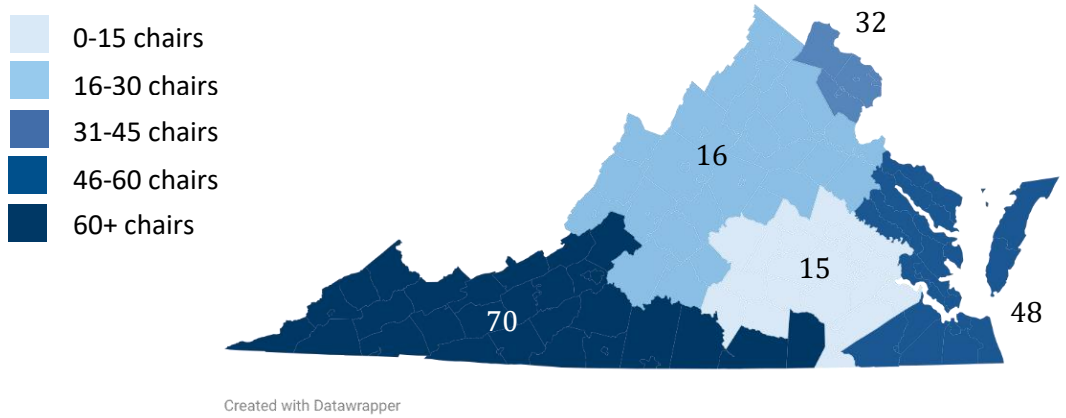
Who receives 23-hour crisis stabilization and what does it cost under Medicaid?

Virginia has added crisis receiving center capacity since Project BRAVO launched, and more individuals receive the service than was projected.

10,064 Individuals served *FY25, up 1,296% since FY22*	**181** Active CRC chairs *FY26, 230 additional chairs in development*

$15.9 M Spent in FY25	**$31.2 M** Spent FY22–FY25	**$1,577** Average spent per person *FY25*

Exhibit C-8
181 active CRC chairs in Virginia in FY26, concentrated in Region 3



What does Virginia know about how well 23-hour crisis stabilization works?

Virginia does not measure service delivery for 23-hour crisis stabilization, and measures one outcome for individuals who receive the service. Available information pertains to all recipients of 23-hour crisis stabilization, not just Medicaid members.

Is the service delivered as designed?	Are the people who receive it better off?
Not measured The Crisis Now model has no fidelity measure. No measures of service delivery have been adopted.	**Partially measured** DBHDS reports one outcome, discharge to community, for individuals who receive 23-hour crisis stabilization. In FY26, 70.2% of individuals in CRCs were discharged to community. When Project BRAVO was proposed, DMAS projected that crisis services would divert inpatient admissions, shorten hospital stays, and reduce repeat admissions. No analysis has examined whether those results occurred.

Source: BHC analysis of DMAS claims data; data from DBHDS strategic plan dashboard; and interviews with DMAS, DBHDS, managed care organizations, and provider associations

Residential crisis stabilization (RCSU)

What is residential crisis stabilization?

Residential crisis stabilization provides a short overnight stay for a person who needs more time to stabilize than a mobile response or a day of observation allows, but who does not require psychiatric hospitalization. Staff provide treatment, medication management, and assessment during the stay. The service is delivered in crisis stabilization units.

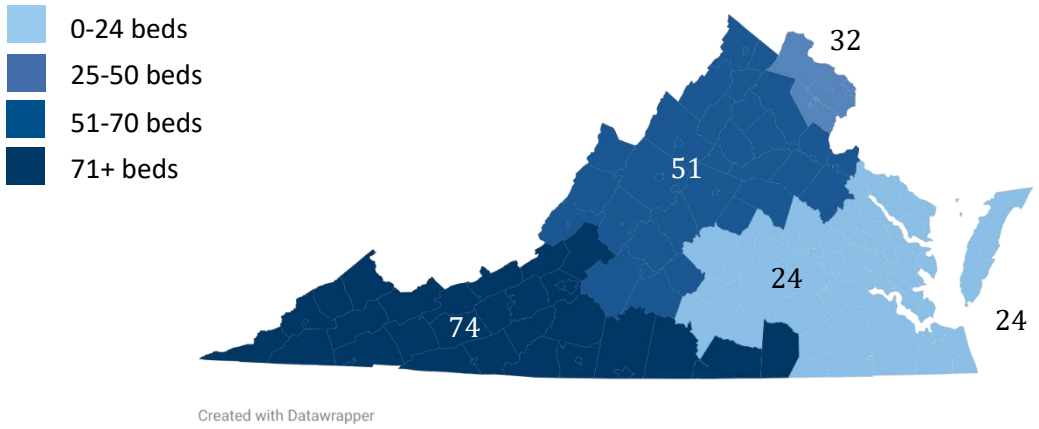
Who receives residential crisis stabilization and what does it cost under Medicaid?

Virginia has added crisis stabilization unit capacity since Project BRAVO launched, and more individuals receive the service than projected.

4,667 Individuals served *FY25, up 375% since FY22*	**161** Active beds *FY26, 205 additional beds in development*

$30.8 M Spent in FY25	**$70.0 M** Spent FY22–FY25	**$6,593** Average spent per person *FY25*

Exhibit C-9
161 active CSU beds in Virginia in FY26, concentrated in Region 3



What does Virginia know about how well residential crisis stabilization works?

Virginia does not measure service delivery for residential crisis stabilization, and measures one outcome for individuals who receive the service. Available information pertains to all recipients of residential crisis stabilization, not just Medicaid members.

Is the service delivered as designed?	Are the people who receive it better off?
Not measured The Crisis Now model has no fidelity measure. No measures of service delivery have been adopted.	**Partially measured** DBHDS reports one outcome, discharge to community, for individuals who receive residential crisis stabilization. In FY26, 90.6% of individuals in CSUs were discharged to community. When Project BRAVO was proposed, DMAS projected that crisis services would divert inpatient admissions, shorten hospital stays, and reduce repeat admissions. No analysis has examined whether those results occurred.

Source: BHC analysis of DMAS claims data; data from DBHDS strategic plan dashboard; and interviews with DMAS, DBHDS, managed care organizations, and provider associations

Appendix D: Acronyms and important terms

ACT: Assertive community treatment; new service added under Project BRAVO

BHC: Behavioral Health Commission

BHR: Behavioral Health Redesign; second phase of Medicaid behavioral health enhancement

BHT: behavioral health technician

Budget neutrality: expected cost of services added under BHR should not exceed the cost of legacy services they replace; baseline established by Mercer

CANS Lifetime: Comprehensive Assessment of Needs and Strengths Lifetimes; used by providers to assign each individual a level of need, and determine eligibility and service intensity of CPST

CCBHC: Certified Community Behavioral Health Clinic; federally certified clinic model offering comprehensive services to all who seek care, reimbursed through a prospective payment system

CEP-Va: Center for Evidence-Based Partnerships in Virginia at Virginia Commonwealth University; partners with DMAS and DBHDS to monitor some EBPs and develop CPST training

Clubhouse: Mental Health Clubhouse; new service added under BHR

Clubhouse International: organization that establishes standards for Clubhouse programs, runs training centers, and accredits providers of Clubhouse

CMS: Centers for Medicare and Medicaid Services; federal agency that partners with states to jointly fund and regulate Medicaid

CPST: community psychiatric support and treatment; new service added under BHR

CRC: crisis receiving center; used interchangeably with 23-hour crisis stabilization

Crisis Now: framework for mental health crisis system that includes (1) crisis call centers, (2) mobile crisis teams, and (3) crisis stabilization facilities

CSB: community services boards

CSC: coordinated specialty care; new service added under BHR

CSU: crisis stabilization unit; used interchangeably with residential crisis stabilization

DBHDS: Department of Behavioral Health and Developmental Services

DHP: Department of Health Professions

DMAS: Department of Medical Assistance Services

EBP: evidence-based practice; a treatment, intervention, or service backed by rigorous scientific research and clinical data proving it achieves positive outcomes

FFT: Functional family therapy; new service added under Project BRAVO

Fidelity: how accurately and faithfully a specific evidence-based intervention/service is delivered compared to its design/model

FTE: full-time equivalent

FY: state fiscal year; July 1 – June 30

IIH: intensive in-home; legacy service replaced under BHR

Legacy services: services redesigned and replaced under Medicaid behavioral health enhancement

LMHP: licensed mental health professional

MAP: Managing and Adapting Practice; training required for all youth CPST providers

MCO: managed care organization

MCR: mobile crisis response; new service added under Project BRAVO

Medicaid: joint federal and state program that provides free or low-cost health insurance to eligible individuals

Medicaid behavioral health enhancement: multi-phase initiative to enhance the delivery of Medicaid-funded behavioral services in Virginia with the goals of increasing service access, strengthening service quality, and improving service cost effectiveness

Mercer: consulting firm contracted to develop rates and conduct fiscal impact analysis for new BHR services

MH-IOP: Intensive outpatient program for mental health; new service added under Project BRAVO

MH-PHP: Partial hospitalization program for mental health; new service added under Project BRAVO

MHSB: mental health skill building; legacy service replaced under BHR

MOU: memorandum of understanding

MST: Multisystemic therapy; new service added under Project BRAVO

Project BRAVO: Behavioral Health Redesign for Access, Value, and Outcomes; first phase of Medicaid behavioral health enhancement

PSR: psychosocial rehabilitation; legacy service replaced under BHR

QMHP: qualified mental health professional

SAMHSA: Substance Abuse and Mental Health Services Administration; federal agency that sets behavioral health standards and identifies evidence-based practices

Service authorization: approval process used by MCOs to confirm that a requested behavioral health service is medically necessary before the service can be delivered and reimbursed

SMI: serious mental illness

SUD: substance use disorder

TAM-R: Therapist Adherence Measure-Revised; tool used to assess fidelity of MST teams

TDT: therapeutic day treatment; legacy service replaced under BHR

TMACT: Tool for Measurement of Assertive Community Treatment; tool adopted by DBHDS to assess fidelity of ACT teams in Virginia

UNC: University of North Carolina; for purposes of this report refers specifically to the Institute for Best Practices at the university

VCU: Virginia Commonwealth University

VDOE: Virginia Department of Education

Appendix D: Acronyms and important terms

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BHC Behavioral Health Commission