BHC Behavioral Health Commission

Project BRAVO

Implementation and performance monitoring

2023

Commission draft

Commonwealth of Virginia
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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.

1 Overview of Project BRAVO and Behavioral Health Redesign

At the beginning of 2023, the Behavioral Health Commission (BHC) directed staff to monitor the implementation and performance of Behavioral Health Redesign for Access, Value, and Outcomes (Project BRAVO), the first phase of the Behavioral Health Redesign initiative. Launched in 2019, the multi-phase Behavioral Health Redesign initiative is intended to improve access to and the quality and cost effectiveness of Medicaid behavioral health services in Virginia. To achieve these improvements, the initiative facilitates the development of a complete continuum of evidence-based, trauma-informed, and recovery-oriented behavioral health services that yield positive outcomes for individuals receiving services. Project BRAVO includes nine essential behavioral health services selected to improve the well-being of adults and children in need of behavioral health services, and to reduce demand for inpatient psychiatric treatment.

To evaluate the implementation and performance of Project BRAVO, BHC staff examined the extent to which Project BRAVO has accomplished its goals and contributed to the strategic goals adopted by the Commission. Staff used a variety of research methods including interviews with program experts; data analysis; and reviews of the Code of Virginia, agency reports, and administrative manuals. Analysis was conducted using data for calendar year 2022 and the first quarter of calendar year 2023, the most recent period for which data and information about Project BRAVO was available.

Medicaid provides access to a broad array of health care services for eligible individuals

Medicaid is a joint federal-state safety net program that provides access to health care for eligible individuals. States operate their Medicaid programs consistent with federal law and receive significant federal funding to support the program. Medicaid requires states to provide a wide array of health care services for individuals who meet eligibility criteria, either through contracts with managed care organizations (MCOs) or on a fee-for-service basis. Virginia's Medicaid program provides access to health care for nearly two million individuals and represents a significant investment of state funds.

Medicaid is a partnership between states and the federal government

The Medicaid program is a partnership between the federal government and the states. States must operate Medicaid programs consistent with federal requirements. Federal law establishes the broad outlines and basic requirements of the Medicaid program, including requirements related to program eligibility, services to be provided, provider reimbursement methodologies, and processes and procedures for administration of the program. States may

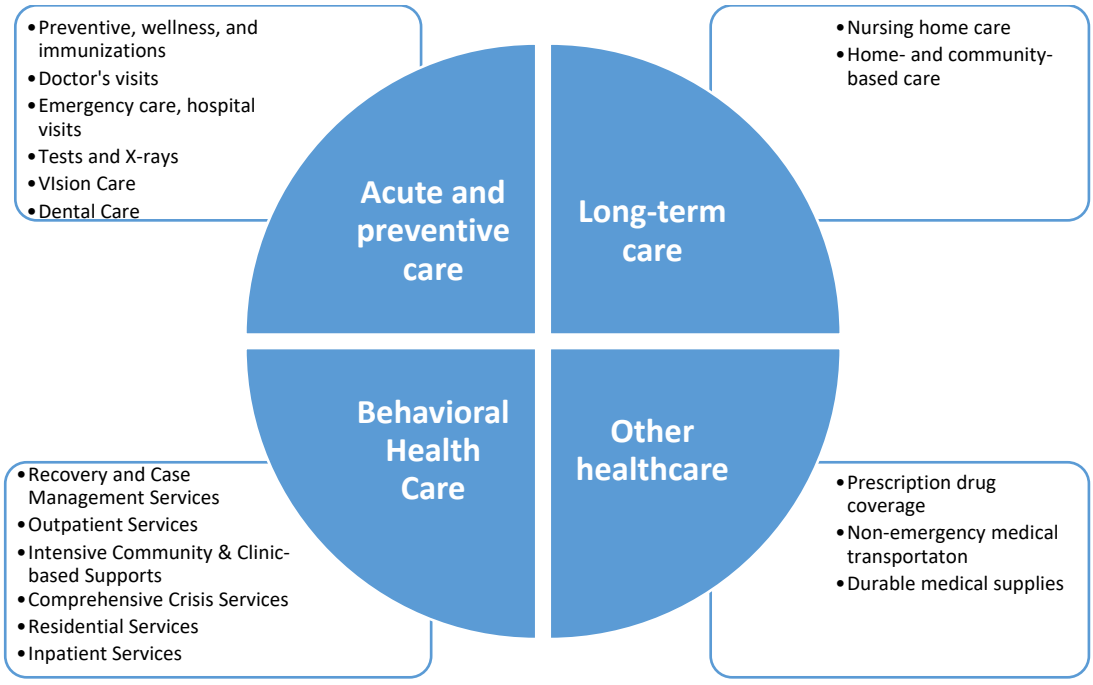
choose to expand eligibility and service offerings beyond the floor established by the federal government, but at a minimum, they must cover those individuals and services required by federal law.

In return for complying with federal requirements governing the Medicaid program, states receive significant federal funding to pay for the services provided. The amount of federal funding a state receives for its Medicaid program, known as the federal medical assistance percentage (FMAP), varies by state and depends on a number of factors, including the state's per capital income relative to the U.S. per capital income and the population receiving services. Virginia's FMAP rate is between 51 and 90 percent of the cost of providing services, depending on the service and the population served.

Medicaid provides access to a broad array of health care services for eligible individuals through managed care organizations

Federal law requires states to provide a broad array of health care services including a range of acute, long-term, and behavioral health services for individuals who are found eligible for Medicaid (Figure 1-1). In Virginia, one in eight adults is covered by the state's Medicaid program. To be eligible to receive services, individuals must meet specific household income criteria that range from 80% of the federal poverty level for blind and disabled seniors to 148% of the poverty level for households with children or pregnant women. Children receiving foster care or adoption assistance are also eligible.

Figure 1-1
Virginia's Medicaid Program Services



Source: BHC staff analysis of DMAS reports and provider manuals, information provided by DMAS

Most Medicaid services are provided through contracts with managed care organizations (MCOs), which are private health plans that receive fixed monthly premiums from the state in return for providing health care services to covered Medicaid recipients. Prior to October 1, 2023, Virginia had two managed care programs: Commonwealth Coordinated Care Plus (CCC Plus), which covered Medicaid members receiving long-term care services and supports, and Medallion 4.0, which covered all other Medicaid members. On October 1, 2023, CCC Plus and Medallion 4.0 were merged into a single Medicaid managed care program, Cardinal Care Managed Care.

Behavioral Health Redesign intended to enhance Medicaid behavioral health services

Launched in 2019 after several years of planning, the Behavioral Health Redesign initiative is intended to improve access to behavioral health services for Medicaid members by expanding the array of behavioral health services available, and to improve the quality and cost-effectiveness of these services through enhanced service design.

Behavioral Health Redesign to improve access to Medicaid behavioral health services

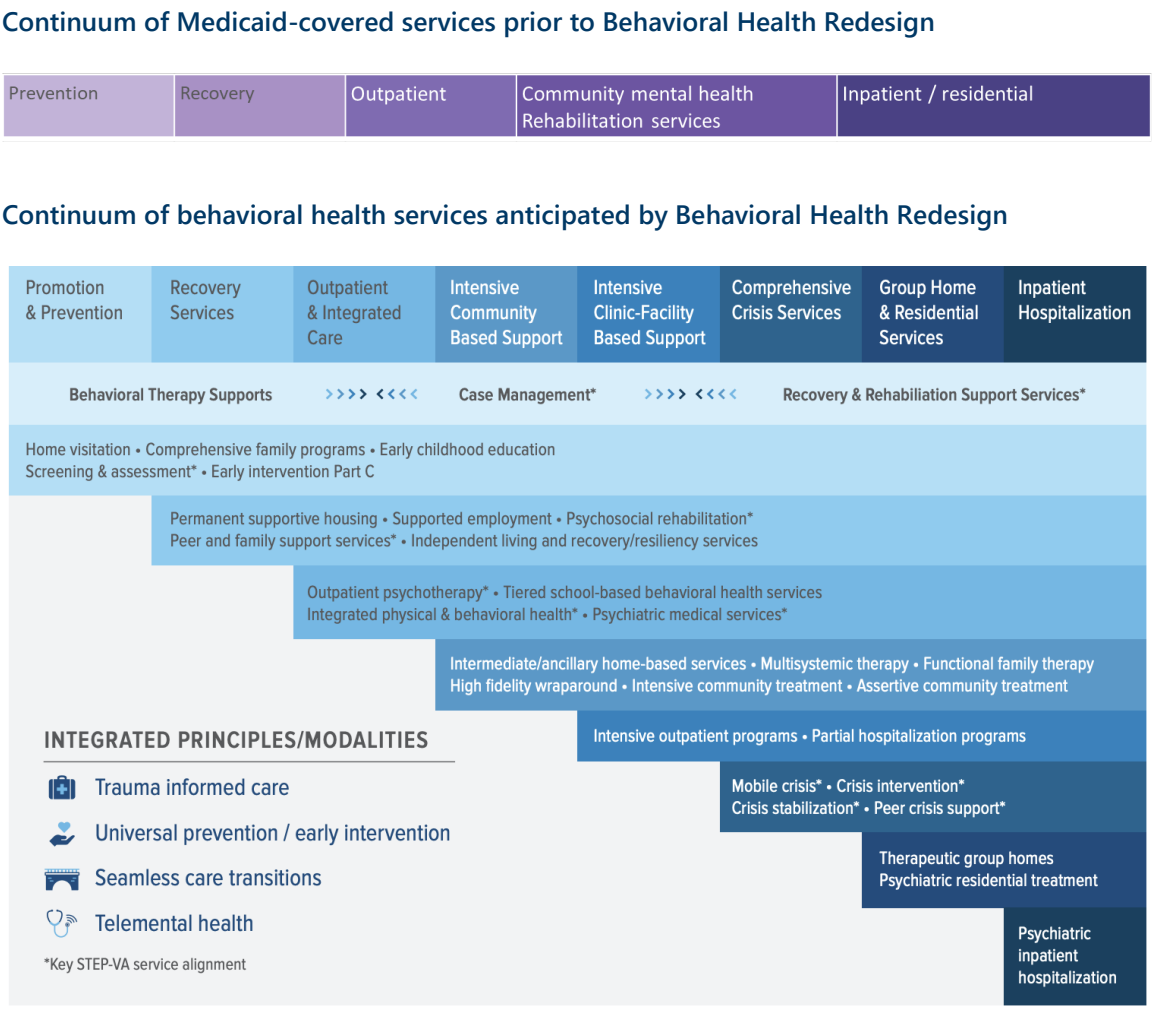
The Behavioral Health Redesign initiative is expected to ensure access to essential behavioral health services for Medicaid members by expanding the array of covered services and creating a comprehensive continuum of behavioral health services that can meet the range of behavioral health needs across the lifespan, from low- to high-acuity and increasing the number of behavioral health providers who participate in the Medicaid program.

Expanding array of Medicaid-funded behavioral health services by creating an enhanced continuum of care

The enhanced behavioral health continuum of care envisioned as part of the Behavioral Health Redesign initiative includes nine categories of services that build upon each other and incorporate foundational principles of trauma-informed and recovery-oriented care, universal promotion and prevention, and seamless care transitions across levels of care along the continuum of care to support individuals through transitions points (Figure 1-2). Certain modalities and services such as telemental health, behavioral therapy supports, and case management are included to expand access to mental health services and providers, optimize functioning and improve outcomes, and ensure that Medicaid members are able to access and fully benefit from the behavioral health services included in the continuum of care.

The framework of the enhanced behavioral health continuum of care is based on the Behavioral Health Continuum of Care model developed by the Institute of Medicine and adopted by the Substance Abuse and Mental Health Services Administration. The framework also incorporates recommendations provided by the National Alliance for Mental Health and was revised to reflect terminology used in Virginia.

Figure 1-2
Continuum of Medicaid-covered services prior to Behavioral Health Redesign vs. anticipated by Behavioral Health Redesign



Source: Virginia Department of Medical Assistance Services

The redesigned behavioral health service continuum of care envisioned by the Behavioral Health Redesign initiative seeks to address challenges created by a Medicaid service array that DMAS described as "outdated," "characterized by an over-reliance on intensive treatment services and underdeveloped opportunities for prevention and early intervention," and "not structured to effectively manage member needs, promote the implementation of gold-standard practices, support alleviation of the significant psychiatric bed crisis, or successfully align with other state investments to improve access to high quality services", according to a 2019 report entitled *Special Report: Medicaid Behavioral Health Services Realignment*.

At the time of that report, Virginia ranked 40th among the states in terms of access to behavioral health care. Across the behavioral health service system, access to services was particularly limited for lower acuity settings and services, resulting in a system that was crisis-oriented and over-reliant on expensive inpatient services. Lower-acuity services were insufficient to prevent crises, did not provide alternatives to hospitalization, or offer step-down options to reduce length of stay for individuals admitted to inpatient care, which contributed to a growing bed crisis at state psychiatric hospitals. Problems affecting the Commonwealth's behavioral health system were particularly acute for individuals enrolled in the Medicaid program due to low reimbursement rates that acted as disincentives for private providers to participate in the Medicaid program.

Increasing the availability of behavioral health service providers

Virginia ranked 41st nationally in terms of availability of mental health providers, according to the 2019 report. Systemwide workforce challenges limited the pool of providers available to provide behavioral health services. Additionally, low reimbursement rates for Medicaid behavioral health services further limited the pool of providers available to Medicaid members, thereby restricting access to necessary behavioral health services.

The Behavioral Health Redesign initiative includes several strategies to increase the availability of providers. Planning and preparation for the initiation of redesigned behavioral health services identified strategies to expand the behavioral health workforce to ensure an adequate supply of providers to meet existing needs. Strategies included workforce needs analyses; revisions to training, licensure, and regulatory requirements to align with redesigned services and reduced barriers to workforce expansion; and statewide workforce training to prepare for and support implementation of redesigned services.

To incentivize providers to participate in Medicaid, DMAS also sought to increase reimbursement rates for behavioral health services. Rate studies and fiscal impact analyses were conducted to determine the appropriate provider reimbursement rates needed to increase the provider pool.

Reducing emergency department visits and inpatient admissions

By developing services along the complete continuum and building a robust supply of providers for enhanced services, the Behavioral Health Redesign initiative is intended to improve individual outcomes while also reducing the downstream costs of emergency department visits and hospitalizations to the Medicaid program.

Within the redesigned continuum of care, robust promotion and prevention services are intended to build resilience and protect against more acute or severe behavioral health problems. Concurrently, high-quality outpatient services integrated into a variety of settings (e.g., primary care and schools) are intended to identify behavioral health needs early and link individuals to services quickly, preventing delays in services, unnecessary worsening of symptoms, and subsequent utilization of more intensive services. Intensive community-, clinic-, and facility-based supports are specifically designed to provide alternatives to inpatient admission, so that high-intensity services (e.g., crisis services and inpatient hospitalization) could be reserved for those with the highest level of need. Recovery and

rehabilitation support services are intended to provide long term support for individuals with chronic mental health disorders, allowing them to live, work, learn and fully participate in their communities.

Making lower-intensity alternatives available throughout the continuum of care are viewed as key to rebalancing the Commonwealth's Medicaid mental health system away from high-cost inpatient hospital and residential settings toward lower cost community-based services. Savings resulting from the shift in services is expected to allow for further investment in the behavioral health service system generally, promoting the continued development of services along the continuum of care.

Behavioral Health Redesign to improve the quality of Medicaid behavioral health services

The Behavioral Health Redesign initiative is also intended to improve the quality of Medicaid behavioral health services provided along the continuum of care. Redesigning services—including revised service definitions and components, medical necessity criteria, and provider qualifications for each service—is intended to lead to more consistent quality and to bring about meaningful improvement in the condition of individuals receiving Medicaid behavioral health services. Incorporating trauma-informed and recovery-oriented principles is designed to ensure that services are responsive to the needs of recipients. The selection and implementation of evidence-based practices is also intended to ensure that services are of high quality. Metrics and dashboards will be developed to track implementation progress and outcomes, resulting in more thorough oversight and evaluation of redesigned services.

Project BRAVO phase 1 of Behavioral Health Redesign

The Behavioral Health Redesign initiative is intended to be a multi-phase, multi-year process. Project BRAVO, the first phase of the Behavioral Health Redesign initiative, includes redesign and enhancement of nine Medicaid behavioral health services selected to reduce demand for inpatient behavioral health services. Subsequent phases were anticipated but have not been initiated. Planning and preparation for BRAVO began in 2019, and services were initiated in the second half of 2021.

Project BRAVO includes nine essential behavioral health services

Project BRAVO focuses on nine essential behavioral health services in the middle of the behavioral health continuum of care, where intensive community- and clinic/facility-based support services as well as comprehensive crisis services are needed (Table 1-1). Behavioral health services included in Project BRAVO were selected because they offer alternatives or opportunities to reduce the duration of inpatient admissions, and because they are likely to have the greatest impact on demand for inpatient psychiatric services and the state hospital census. Additionally, the services selected were already available in Virginia but were either not covered by Medicaid or were not sufficiently funded through Medicaid to meet demand. Because the services already existed, it was expected that the transition to the redesigned services would be efficient and effective.

Table 1-1
Project BRAVO includes nine services in three categories

Service	Description
(1) Intensive community-based support services Targeted, concentrated interventions for adults and children delivered in the home or community settings that provide more comprehensive care than can be provided in outpatient settings to prevent or reduce the duration of inpatient admissions.	
▪ Multisystemic Therapy	Service for youth with serious antisocial behavior, psychiatric crisis, or serious emotional disturbance at risk of or returning from out-of-home placement and families with child welfare involvement
▪ Functional Family Therapy	Services for youth at risk of institutionalization and their families to address symptoms of SED and parenting/caregiving practices
▪ Assertive Community Treatment	Intensive, client centered, recovery-oriented, coordinated services for adults and children with severe and persistent mental illness to maintain connection to mental health services and improve social functioning and quality of life
(2) 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, to prevent or reduce the duration of inpatient admission.	
▪ Intensive Outpatient programs	Structured outpatient programs for youth and adults that provide more intensity than routine outpatient care to maintain and improve functional abilities and reduce the need for more acute levels of care
▪ Partial Hospitalization Programs	Short-term, time-limited, non-residential, ambulatory programs for youth and adults at risk of or transitioning from psychiatric hospitalization that provide services at a level of intensity similar to inpatient programs but not on a 24-hour basis
(3) Comprehensive crisis services Opportunities to prevent or de-escalate behavioral health crisis and divert from inpatient services.	
▪ Mobile Crisis Services	Rapid response services for individuals experiencing behavioral health crisis that are available 24/7/365 to provide de-escalation, assessment, stabilization, and linkages to appropriate services
▪ 23-hour crisis stabilization	Assessment, crisis intervention, stabilization, and clinical determination of level of care for individuals experiencing behavioral health crisis
▪ Residential crisis stabilization	Short-term residential psychiatric and SUD assessment and brief intervention services for individuals that may at risk of or transitioning from inpatient admission
▪ Community crisis stabilization	Short-term assessment, crisis intervention, and care coordination services delivered in the community for individuals who have recently experienced behavioral health crisis or who cannot access necessary services because of a gap in the availability of services

Source: BHC staff analysis of DMAS provider manuals

Virginia spent nearly $430 million on Project BRAVO in FY 22 and FY 23

DMAS has paid more than $429 million for Project BRAVO services since FY 2022. Six of the nine Project BRAVO services were initiated in December 2021, and FY 2022 spending reflects only partial-year spending for these services. All nine Project BRAVO services were available for the entirety of FY 2023. Project BRAVO spending in FY 23 represented 18 percent of all Medicaid spending on behavioral health services in Virginia during the same period ($1.4B).

Table 1-2
Total Spending, Project BRAVO Services (FY 2022 – FY 2023)

Service	FY 2022	FY 2023
Intensive Community-Based Support Services		
Multisystemic Therapy[1]	$1,055,456	$1,844,462
Functional Family Therapy[1]	313,187	592,338
Assertive Community Treatment	28,054,482	26,324,438
Intensive Clinic/Facility-Based Support Services		
Intensive Outpatient programs	305,932	837,627
Partial Hospitalization Programs	1,167,766	1,569,021
Comprehensive Crisis Services		
Mobile Crisis Services[1]	1,029,296	3,055,577
23-hour crisis stabilization[1]	121,746,963	111,015,235
Residential crisis stabilization[1]	12,727,506	99,380,768
Community stabilization[1]	$5,746,124	$12,047,666
Total	**$172,146,712**	**$256,667,132**

Source: BHC staff analysis of DMAS data dashboard
[1]Service was initiated in December 2021, halfway through FY22. FY22 therefore represents partial year spending.

It is important to note that Project BRAVO expenditures do not constitute entirely new spending. Several Project BRAVO services are a redesigned and enhanced version of behavioral health services that were previously covered by Medicaid. Spending on these new Project BRAVO services has therefore replaced spending on those previously existing services. Medicaid spending on those services was $128.4 million in FY21 and $57.8 million in the earlier part of FY22, as the services were transitioning to Project BRAVO redesigned services.

Subsequent phases of Behavioral Health Redesign have not been initiated

The Behavioral Health Redesign initiative was anticipated to be a multi-phase, multi-year process to allow sufficient time for planning and preparation for each round of services. Subsequent phases of the Behavioral Health Redesign initiative were expected to include

additional services. In a 2019 presentation, DMAS identified services for possible inclusion in three later phases of the initiative (Table 1-3).

In 2021, DMAS submitted a decision package requesting funding in the 2022 Appropriation Act to initiate the second phase of the Behavioral Health Redesign initiative. The request sought funding for a rate study for "prioritized services for Behavioral Health Enhancement" including "tiered school-based services, evidence-based models of outpatient and in-home services for youth, High Fidelity Wraparound Service for youth, Coordinated Specialty Care including Early Psychosis Intervention, Therapeutic Foster Care case management model, and Peer Recovery Support Services for the Addiction Recovery and Treatment Services program and mental health," The services described in the request did not align with the earlier vision of subsequent phases of the Behavioral Health Redesign initiative, but rather reflected shifting priorities in response to changing perceptions of the most significant needs for behavioral health services in Virginia. The funding request was not included in the Governor's proposed budget.

Table 1-3
Initial planned subsequent phases of Behavioral Health Redesign

Phase 2	Phase 3	Phase 4
Behavioral therapy	School-based behavioral health services	Psychosocial rehabilitation services
Home visitation	Independent living and recovery/resiliency services	Intermediate ancillary home-based services
Comprehensive family programs	Integrated primary care/ behavioral health care	Intensive community treatment
High fidelity wraparound	Outpatient psychotherapy	
Case management		

Source: BHC staff analysis of DMAS presentation

The following year, recognizing that while initial Project BRAVO implementation has brought in some critical services, [the] system was still lacking critical redesign of "community-based options" for Medicaid members, DMAS requested funds for a rate study "to evaluate costs related to continued, necessary enhancements of Medicaid Behavioral Health services" for children, transition aged youth (ages 18 to 21), and families. Specific services identified in the request included multi-tiered system of supports in schools, high fidelity wraparound service for youth, coordinated specialty care including early psychosis intervention, therapeutic foster care case management model, and a specific rate for the completion of the Uniform Pre-Admission Screening Assessment by community services boards. However, as in the previous year, funding for the request was not included in the Governor's prosed budget.

DMAS submitted a decision package requesting funding in the 2024 Appropriation Act to secure a contractor to provide comprehensive support in transforming DMAS's youth

behavioral health service continuum, including identifying service innovations and best practices in pre-crisis prevention services, crisis care, and post-crisis recovery and support, and developing tangible and achievable means to close capacity gaps. The transformed youth behavioral health service continuum is expected to include pre-crisis prevention services and post-crisis recovery services such as multi-tiered, school-based, behavioral health services; high-fidelity wraparound services; coordinated specialty care; specialty outpatient services; and care coordination. To close gaps in capacity, DMAS would establish residential crisis stabilization units for youth, develop a specific rate for the completion of the Uniform Pre-Admission Screening Assessment, redetermine policy and standards for intensive in-home services, Multisystemic Therapy and Functional Family Therapy, and rebase new behavioral health services implemented as part of Project BRAVO in 2022.

In 2023 DMAS also submitted a decision package requesting funding to "hire a contractor to provide comprehensive support in transforming DMAS's adult behavioral health service continuum, including the development of a Section 1115 waiver to address the supports and services needed by adults with serious mental illness." Services anticipated to be included in the waiver program include evidence-based pre-crisis prevention, crisis care, and post-crisis recovery and support services. The proposed redesign of existing Medicaid services into an array of evidence-based behavioral health services could represent an additional phase of the Behavioral Health Redesign initiative.

Deferred implementation of subsequent phases of the Behavioral Health Redesign initiative prevents the initiative from fully achieving its goals. The full continuum of redesigned Medicaid behavioral health services envisioned by the initiative will not exist until all phases of are implemented. Delays in initiation increased in provider reimbursement rates and other workforce improvement strategies will inhibit efforts to improve access to providers. Delays in redesign and enhancement of individual services may hamper efforts to improve quality, consistency, and cost effectiveness of Medicaid behavioral health services.

Behavioral Health Redesign and Project BRAVO build on and work together with other initiatives

The Behavioral Health Redesign initiative builds upon and is intended to work together with other efforts to improve Virginia's behavioral health service system, including the Medicaid Addiction Recovery and Treatment Services (ARTS) program, System Transformation Excellence and Performance for Virginia (STEP-VA), and services provided in accordance with the Families First Prevention Services Act (FFPSA). Taken together, the ARTS program, STEP-VA, and the FFPSA offer the opportunity to substantially reform and improve the Commonwealth's behavioral health services and system. The Behavioral Health Redesign initiative is intended to support these initiatives, provide long-term stability and sustainability, and bring about even greater benefits in terms of the availability, accessibility, affordability, and quality of behavioral health services in the Commonwealth. Project BRAVO represents the first steps toward achieving these outcomes. Subsequent phases of the Behavioral Health Redesign initiative are intended to continue the work initiated with Project BRAVO and are necessary to achieve the initiative's full potential.

ARTS program

The ARTS program, implemented in 2017, provided a model for the Behavioral Health Redesign initiative. The ARTS program carves community-based addiction services into MCOs and creates an evidence-based continuum of services for individuals in need of addiction services, with levels of care within the continuum based on a framework created by the American Society of Addiction Medicine. Additional components of the program include rate increases for evidence-based treatment services, a requirement that MCOs provide care coordination to service recipients, and a requirement that providers participate in education and training to ensure fidelity to evidence-based service models. The ARTS program has been successful in increasing access to substance use disorder treatment among Medicaid members, reducing total emergency department visits related to opioid use disorder and decreasing hospitalizations. The Behavioral Health Redesign initiative is intended to support and build upon these successes for mental health services, transforming the Commonwealth's broader behavioral health service system.

STEP-VA

The STEP-VA initiative is intended to improve access and quality for behavioral health service provided by CSBs. Key strategies include expanding the core of required services at CSBs to standardize available services across Virginia and establishing effective performance measures and benchmarks to monitor service outcomes. The redesign of services and rate increases associated with the Behavioral Health Redesign initiative are intended to help improve the availability of services required by STEP-VA and to create long-term sustainability for the community services board system. Crisis services and the emphasis on creation of a complete continuum of crisis care incorporated in both Project BRAVO and STEP-VA exemplifies the synergy between Project BRAVO and STEP-VA, both of which build on a model developed by National Association of State Mental Health Program Directors in collaboration with other stakeholders, also known as the Crisis Now Model.

Families First Prevention Services Act

The Families First Prevention Services Act (FFPSA) of 2018 revised federal foster care funding provisions to direct services toward prevention of foster care placements, making funds available for use in prevention services such as mental health care, substance use disorder treatment, and in-home parenting skills training. Services funded with federal FFPSA funding were required to be evidence based, and funding was intended to support training and other supports necessary to ensure high-quality services. The Behavioral Health Redesign initiative allowed agencies charged with implementing the FFPSA the opportunity to maximize the effectiveness of workforce initiatives, quality and outcome measures, evidence-based practice adoption, and training and system infrastructure. Two services included in Project BRAVO – MST and FFT – are included in the array of services offered under FFPSA.

Behavioral Health Redesign and Project BRAVO are aligned with BHC goals

The Behavioral Health Redesign initiative is intended to expand access and improve quality for Medicaid behavioral health services. The services included in Project BRAVO were selected to reduce demand for inpatient psychiatric beds and mitigate the inpatient bed crisis. These goals align with the strategic goals adopted by the Behavioral Health Commission (BHC) in 2023 to most significantly improve the behavioral health system in Virginia (Table 1-4). The Behavioral Health Redesign initiative is an important strategy for meeting the goal of improving access to publicly funded behavioral health services and its success is imperative to realizing the BHC's vision of ensuring that all Virginians can access the services they need, when and where they need them.

Table 1-4
Vision and strategic goals of the Behavioral Health Commission

Vision
Virginia has a full continuum of high-quality, effective, and efficient behavioral health services accessible to all persons in the Commonwealth.

Strategic Goal	Description
1. **Complete continuum of care**	Individuals can receive the most appropriate services for their needs because an adequate supply of services is available along the entire continuum of behavioral health care and prevention.
2. **Timely access to services statewide**	Individuals can receive the services they need when and where they need them.
3. **Cost-efficient care for everyone**	Sufficient funding is available for the state and providers to build and operate services and patients can afford the services they need.
4. **Effective and efficient services**	Behavioral health services are high-quality and effective, and provided efficiently.
5. **Lower inappropriate criminal justice involvement**	Individuals with behavioral health disorders are not unnecessarily involved in the criminal justice system, and those who are involved with the criminal justice system receive appropriate treatment that also mitigates recidivism.

Source: BHC staff analysis

2 Performance of Project BRAVO

Project BRAVO, the first phase of the Behavioral Health Redesign initiative, is intended to improve access, quality, and cost-effectiveness for nine Medicaid behavioral health services. Because the full array of redesigned services has only been available since December 1, 2022, there is limited data available to assess the impact of Project BRAVO at this time. Initial data suggests mixed results regarding the utilization of Project BRAVO services, which can be viewed as a proxy for access. More comprehensive data about the utilization of Project BRAVO services collected over a longer period and information about the outcomes of redesigned services is necessary to provide a more complete picture of the impact of Project BRAVO.

Early utilization trends for Project BRAVO services suggest mixed impact on access to date

Initial trends in the utilization of Project BRAVO services vary among services and do not paint a clear picture of the program's impact on access to the redesigned Medicaid behavioral services to date. The utilization of intensive outpatient program (IOP) services, partial hospitalization program (PHP) services, and most crisis services clearly increased between Q1 2022 and Q1 2023, suggesting that access to these services improved. Conversely, the number of individuals receiving community crisis services decreased by nearly half during the same period.

Decreased utilization of some Medicaid behavioral health services included in Project BRAVO may be the result of increased access to and utilization of other, more appropriate behavioral health services made available as a result of the initiative. The redesign and enhancement of Medicaid behavioral health services undertaken through Project BRAVO made new behavioral health services available to Medicaid members, filling gaps in the continuum of care and providing alternatives to existing services. Accessing and using those new services may reduce the need for other, less appropriate behavioral health services. For example, higher utilization of crisis services such as mobile crisis, 23-hour crisis, and residential crisis stabilization services as well as intensive clinic- and facility-based services such as IOP and PHP may have reduced the demand for (and utilization of) community stabilization, a service that can be used to mitigate service gaps for individuals transitioning between levels of care.

Changes in utilization of services may also reflect changes in program requirements. For example, a prior authorization requirement was added to community stabilization in September of 2022, which likely contributed to the reduction in the number of Medicaid members using this service between 2022 Q1 and 2023 Q1.

Data and information about utilization and performance of Project BRAVO services is limited

Due to the recent start date of the nine redesigned services included in Project BRAVO, there is limited longitudinal information that could help identify trends in access to these services. The first three services redesigned and enhanced as part of Project BRAVO – Assertive Community Treatment, Intensive Outpatient Program services, and Partial Hospitalization Program services – became available on July 1, 2021. The remaining six services became available on December 1, 2021. 2022 Q1 is therefore the first quarter for which data about all nine services included in Project BRAVO is available.

Utilization data, which indicates the number of Medicaid members receiving services and the amount of each service that Medicaid members receive, is available for five quarters beginning with 2022 Q1. However, data about provider participation, which is an important indicator of access, could not be accessed for this report because this data is not currently collected on encounter claims. Similarly, data about outcomes of Project BRAVO services is not currently available for evaluation. These data limitation preclude a full evaluation of the impact of Project BRAVO on access to and the quality and cost-effectiveness of the nine Medicaid behavioral health services included in the first phase of the Behavioral Health Redesign initiative at this time.

Utilization data can provide some insight into the impact of Project BRAVO on access to services, as characterized by the number of individuals receiving the service and how much of the service they receive. Although utilization is not a perfect proxy for access, it can be assumed that a service has to be accessible in order to be used. Therefore, an increase in the number of individuals using a service indicates an increase in access, as does an increase in the amount of services they receive. However, utilization data does not provide any insight into whether the number of people receiving a service is consistent with actual need. Additionally, it is difficult to make generalizations about changes in utilization for a service when the number of individuals served is low, because even small changes in the number of people receiving the service can have a big impact on the overall trend.

Ultimately, utilization data alone cannot be used to determine whether increased utilization and access for Project BRAVO services are attributable to the initiative itself, or to other, external factors such as increases in overall Medicaid enrollment or improved transportation. To draw conclusions about the impact of the Project BRAVO initiative in Virginia however, more longitudinal data will be required, as will better information regarding the availability of service providers and their location, changes in waiting times for services, and other relevant data.

Multisystemic Therapy utilization decreased moderately overall, and initial uptake of appears low

Multisystemic Therapy (MST) is an evidence-based, intensive family treatment practice used with:

- youth with serious antisocial behavior,
- juvenile offenders,
- youth with psychiatric crisis or severe emotional disorders, and
- families with child welfare involvement who are at risk of out-of-home placement or who are returning to home from a higher level of care.

The service is provided in the home or other community-based settings, and it is intended to be a short-term and rehabilitative service with a usual duration of approximately four months. A single unit of MST for which a claim may be filed is 15 minutes. MST has been shown to produce positive outcomes in several areas including conduct, delinquency and criminal behavior, externalizing and problematic behavior, internalizing behavior, positive social/prosocial behavior, illicit drug use, and violence. MST has also been shown to produce short- and long-term reductions in out-of-home placements.

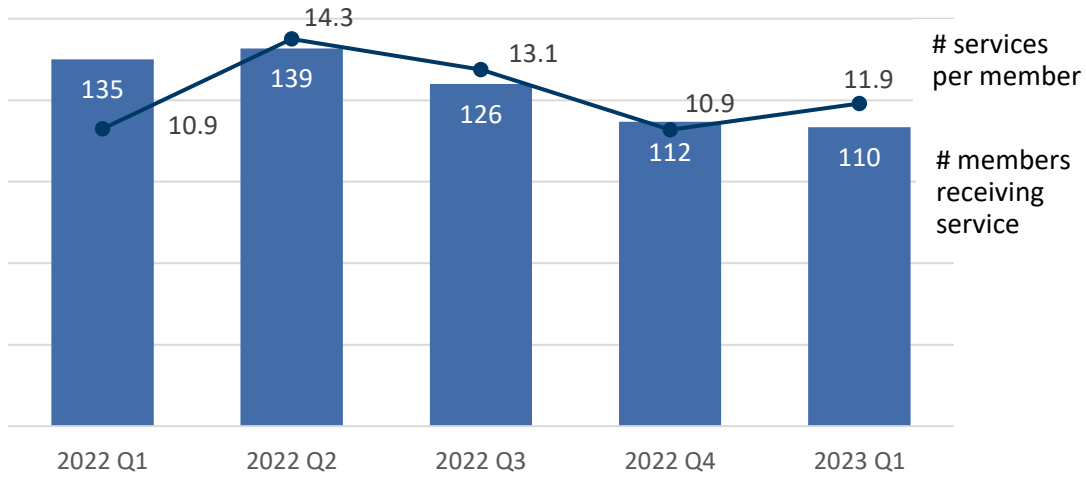
MST was added to the Medicaid behavioral health continuum of care as a result of Project BRAVO and first became available on December 1, 2021. Between 2022 Q1 and 2023 Q1, the total number of Medicaid members receiving MST dropped by 18.5 percent, from 135 members to 110 members, and the number of claims filed also decreased by 11.6 percent. According to DMAS, the number of members utilizing this service is relatively low and may indicate that initial uptake of this new service was limited. The reduction in both the number of Medicaid members served and the number of claims for service suggests a decrease in access overall (Table 2-1). Although fewer people received the service, the amount of MST each Medicaid member received was higher in 2023 Q1 than in 2022 Q1, on average, indicating that individual utilization went up.

Table 2-1
Fewer Medicaid members using Multisystemic Therapy overall, but those receiving the service are using it more, on average

	2022 Q1	2023 Q1	Change Q1 2023 vs. 2022
# members served	135	110	-18.5%
# claims for service	1,478	1,307	-11.6%
Average # claims/member	11.0	11.9	8.5%

Source: BHC staff analysis of data provided by DMAS

Figure 2-1
Fewer members receiving Multisystemic Therapy since start of Project BRAVO, but average services per member increased slightly



Source: BHC staff analysis of data provided DMAS

Functional Family Therapy utilization declined slightly overall, and initial uptake appears low

Functional Family Therapy (FFT) is an evidence-based, short-term, family-based therapeutic intervention for youth who are at risk for institutionalization and their families. The service is designed to address symptoms of serious emotional disturbance in youth and the parenting/caregiving practices and caregiver challenges that affect the ability of the youth and caregiver to function as a family. FFT is provided primarily in the home, and services are organized around the whole family as a unit, rather than the individual. The service can serve as a diversion or step-down from higher levels of care. FFT is generally provided over the course of 12 to 14 one-hour sessions, with an average duration of three months. A single unit of FFT for which a claim may be filed is 15 minutes. Outcomes for FFT include reduced out-of-home placements and recidivism, improved family interaction patterns, and reduced delinquency, criminal behavior, and illicit drug use.

FFT was added to the Medicaid behavioral health continuum of care as a result of Project BRAVO and first became available on December 1, 2021. Between 2022 Q1 and 2023 Q1, the total number of Medicaid members receiving FFT dropped by 9.6 percent (from 115 members to 104 members). According to DMAS, the number of members utilizing this service is relatively low and may indicate that initial uptake of this new service was limited. The reduction in the number of Medicaid members served suggests a decrease in access overall (Table 2-2). During the same time period, the average amount of FFT received by Medicaid

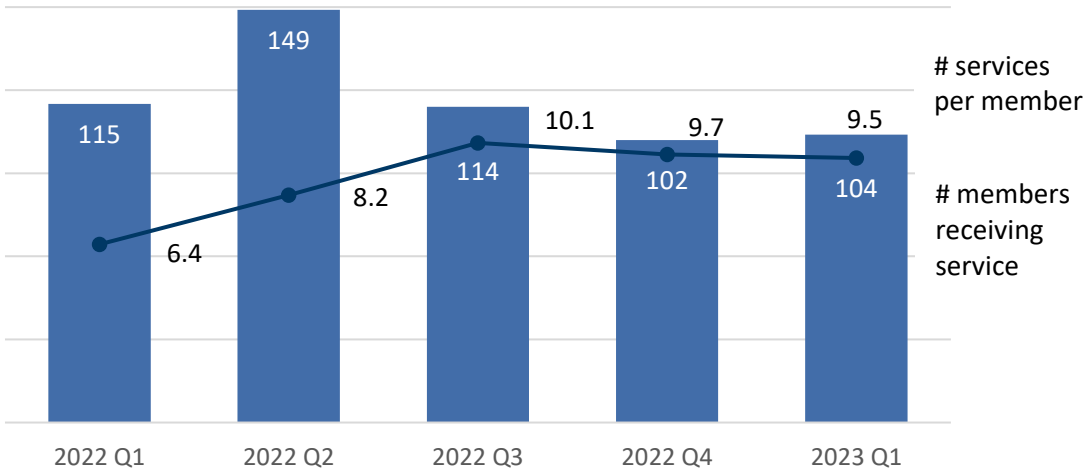
members who participated in the service increased by nearly 50 percent, suggesting an increase in individual utilization.

Table 2-2
Fewer Medicaid members using Functional Family Therapy overall, but those still receiving the service are using it more, on average

	2022 Q1	2023 Q1	Change Q1 2023 vs. 2022
# members served	115	104	-9.6%
# claims for service	740	1,151	34.2%
Average # claims/member	6.4	9.6	48.7%

Source: BHC staff analysis of data provided by DMAS

Figure 2-2
Fewer members receiving Functional Family Therapy since start of Project BRAVO, but average services per member increased



Source: BHC staff analysis of data provided DMAS

Assertive community treatment utilization decreased slightly overall

Assertive community treatment (ACT) is an intensive, client-centered, recovery-oriented evidence-based practice designed to serve adults and children who have experienced severe and persistent psychosocial dysfunction, repeated hospitalizations or behavioral health crisis, or involvement in the criminal justice system and who have not benefited from

traditional outpatient treatment. The service is mainly indicated for individuals who are stepping down from an inpatient setting to a less restrictive environment but require a similar level of care to that provided in inpatient settings.

ACT is a coordinated set of services offered by a group of medical, behavioral health, and peer recovery support providers and rehabilitation professionals in the community that allow individuals experiencing severe symptoms and impairments to live and receive long-term treatment, rehabilitation, and support services in the community. The main goals of ACT are to (i) keep mentally ill people in contact with services in the community, (ii) reduce hospital admissions and inpatient costs, and (iii) improve social functioning and quality of life. Evidence shows that ACT is effective in keeping individuals with serious mental illness adaptively functioning in the community, out of the hospital, and not engaging in criminal behavior. The service frequency and average duration of ACT varies across beneficiaries. A single unit of ACT for which a claim may be filed is one calendar day, with at least 15 minutes of face-to-face covered services provided to the individual receiving services by a qualified ACT team member on that calendar day.

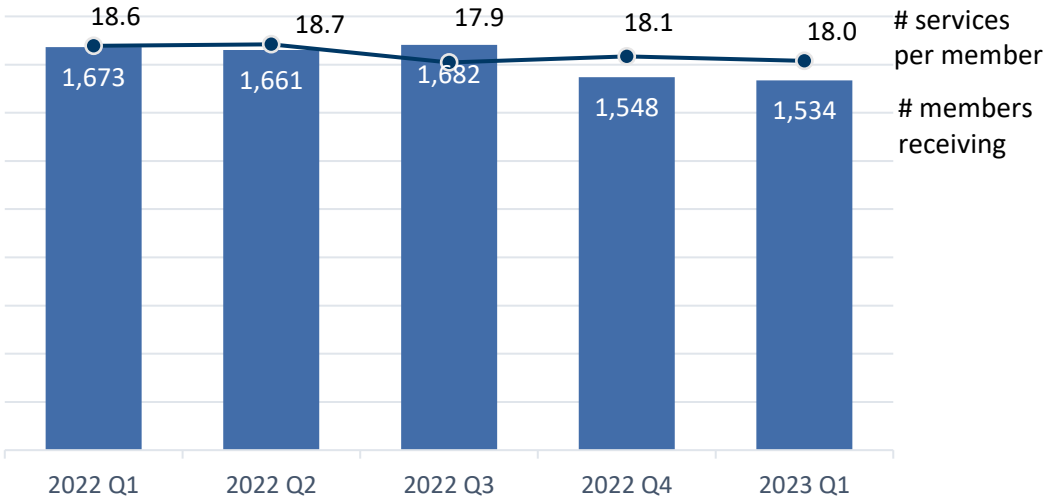
Intensive Community Treatment (ICT) services were covered by Medicaid prior to the Behavioral Health Redesign initiative. These services were replaced by redesigned and enhanced Assertive Community Treatment (ACT) services as part of Project BRAVO. ACT services became available on July 1, 2021. Between 2022 Q1 and 2023 Q1, the total number of Medicaid members receiving ACT dropped by 8.3 percent (from 1,673 members to 1,534 members) and the total number of claims filed decreased by 11.7 percent. This reduction in both the number of Medicaid members served and the number of claims for service suggests a decrease in utilization which may indicate a reduction in access overall (Table 2-3). During the same time, the amount of ACT that each Medicaid member received also decreased 3.68 percent, indicating that individual utilization fell as well.

Table 2-3
Fewer Medicaid members using assertive community treatment overall and those still receiving the service are using less of it, on average

	2022 Q1	2023 Q1	Change Q1 2023 vs. 2022
# members served	1,673	1,534	-8.3%
# claims for service	31,188	27,545	-11.7%
Average # claims/member	18.6	18.0	-3.7%

Source: BHC staff analysis of data provided by DMAS

Figure 2-3
Fewer members receiving assertive community treatment since start of Project BRAVO and average services per member decreased



Source: BHC staff analysis of data provided by DMAS

Intensive outpatient program utilization tripled since Project BRAVO rollout, but initial uptake appears low

Intensive outpatient programs (IOPs) are highly structured, evidence-based, outpatient programs for youth and adults that allow participants to remain integrated in the community while providing more intensity than routine outpatient care. IOPs are generally provided in a clinic setting but services may be provided in schools when an appropriate school-based clinic setting is available. The programs focus on maintaining and improving functional abilities through an interdisciplinary approach to treatment and reducing the need for more acute levels of care. IOPs may serve as an alternative to or step-down from higher-intensity inpatient services. Patients participate in 9 to 19 hours of services per week for adults and 6 to 19 hours of services per week for children and adolescents, spread over 3 to 5 days. The typical length of participation in IOP services is 90 days. A single unit of IOP for which a claim may be filed is a one-day session with a minimum of two service components per session.

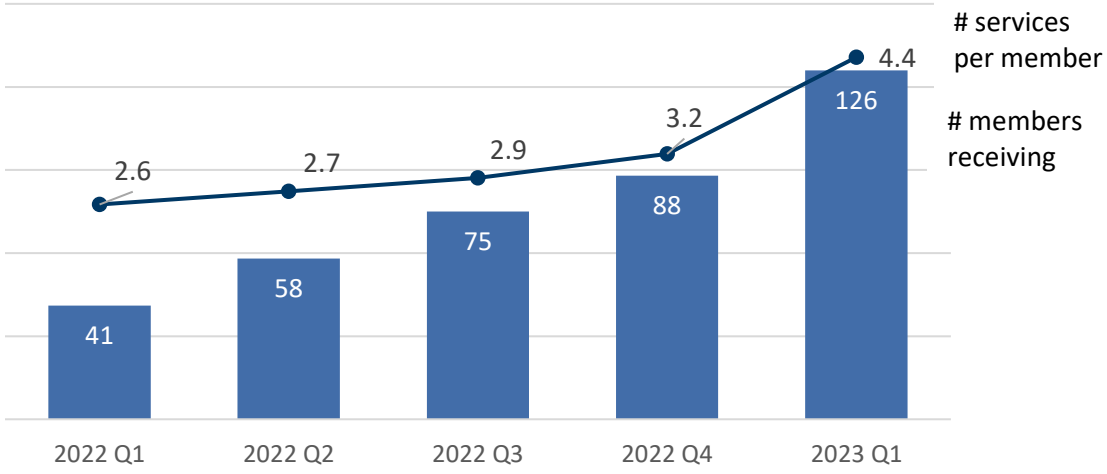
IOP was added to the Medicaid behavioral health continuum of care as a result of Project BRAVO and first became available on July 1, 2021. Between 2022 Q1 and 2023 Q1, the total number of Medicaid members receiving IOP services more than tripled (from 41 members to 126 members), and the number of claims filed increased more than five-fold. According to DMAS, the number of members utilizing this service is relatively low and may indicate that initial uptake of this new service was limited. The increase in both the number of Medicaid members served and the number of claims for service suggests an increase in access overall (Table 2-4). Additionally, the amount of IOP services each Medicaid member received was higher in 2023 Q1 than in 2022 Q1, on average, indicating that individual utilization went up.

Table 2-4
More Medicaid members using intensive outpatient program services overall and those receiving the service are using more of it, on average

	2022 Q1	2023 Q1	Change Q1 2023 vs. 2022
# members served	41	126	207.3%
# claims for service	106	549	417.9%
Average # claims/member	2.6	4.4	68.5%

Source: BHC staff analysis of data provided by DMAS

Figure 2-4
More members receiving intensive outpatient program services since start of Project BRAVO and average services per member increased



Source: BHC staff analysis of data provided by DMAS

Partial hospital program utilization nearly doubled since Q1 2022, but initial uptake appears low

Partial hospitalization programs (PHPs) are short-term, time-limited, non-residential, ambulatory programs that deliver services for youth and adults at a level of intensity similar to inpatient programs but not on a 24-hour basis, allowing program participants to maintain linkages to the community. PHPs are intended to stabilize an individual's psychiatric condition, and are appropriate for individuals at risk of psychiatric hospitalization or transitioning from psychiatric hospitalization to the community who have experienced acute and severe dysfunction in multiple areas of daily life as a result of a behavioral health disorder, but who are stable enough to be unsupervised for periods of time, able to remain

safe to themselves and others, and able to participate and benefit from intensive, structured therapies. PHPs may occur in hospital- or community-based settings and are appropriate when the individual requires at least 5 hours of clinical services per day, over several days in a week, for a total of at least 20 hours per week. The average length of stay in PHPs is usually between four and six weeks. A single unit of PHP for which a claim may be filed is a one-day session with a minimum of four hours of covered service components per session.

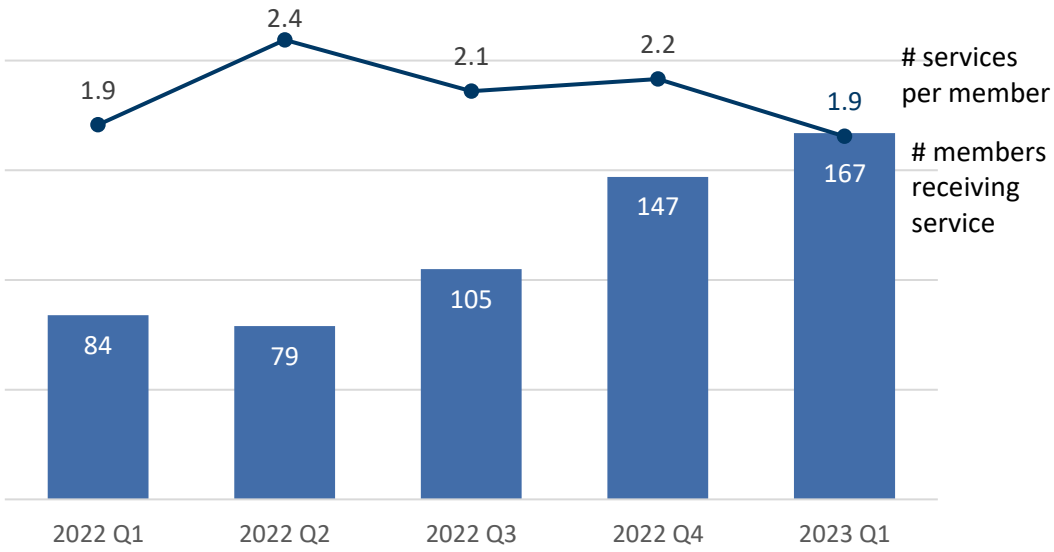
Day Treatment/Partial Hospitalization Program services were covered by Medicaid prior to the Behavioral Health Redesign initiative. These services were replaced by redesigned and enhanced Partial Hospitalization Program (PHP) services as part of Project BRAVO. PHP services became available on July 1, 2021. Between 2022 Q1 and 2023 Q1, the total number of Medicaid members receiving PHP services nearly doubled (from 84 members to 167 members), as did the number of claims filed. According to DMAS, the number of members utilizing this service is relatively low and may indicate that initial uptake of this new service was limited. The increase in both the number of Medicaid members served and the number of claims for service suggests an increase in access overall (Table 2-5). The amount of PHP services each Medicaid member received was slightly lower in 2023 Q1 than in 2022 Q1 (-3.1 percent), on average, indicating that individual utilization went down slightly.

Table 2-5
More Medicaid members using partial hospitalization program services overall but those receiving the service are using less of it, on average

	2022 Q1	2023 Q1	Change Q1 2023 vs. 2022
# members served	84	167	98.8%
# claims for service	163	314	92.6%
Average # claims/member	1.9	1.9	-3.1%

Source: BHC staff analysis of data provided by DMAS

Figure 2-5
More members receiving partial hospitalization program services since start of Project BRAVO, but average services per member decreased



Source: BHC staff analysis of data provided by DMAS

Mobile crisis services utilization doubled since Q1 2022

Mobile crisis services are available 24 hours a day, seven days a week to provide rapid response, assessment, and early intervention for individuals experiencing a behavioral health crisis. Services are deployed in real time to the location of the individual experiencing the crisis to de-escalate the crisis and prevent harm to the individual or others, assist in the prevention of acute exacerbation of the individual's symptoms, develop and implement an immediate plan to maintain safety, and provide coordination of care and links to appropriate treatment services to meet the individual's behavioral health needs. Mobile crisis services are provided in the environment in which the individual is comfortable to facilitate engagement, stabilization, and resolution of the crisis. Mobile crisis services include assessments, crisis intervention, health literacy counseling, individual and family therapy, peer recovery support services, treatment planning, preadmission screenings, and care coordination. A single unit of mobile crisis services for which a claim may be filed is 15 minutes.

Crisis intervention services for adults and youth were covered by Medicaid prior to the Behavioral Health Redesign initiative. These services were replaced by redesigned and enhanced mobile crisis services as part of Project BRAVO, which became available on December 1, 2021. Between 2022 Q1 and 2023 Q1, the total number of Medicaid members receiving mobile crisis services more than doubled (from 3,985 members to 8,149 members), and the number of claims filed increased by 140 percent. This increase in both the number of Medicaid members served and the number of claims for service suggests an increase in access overall (Table 2-6). Additionally, the amount of mobile crisis services each Medicaid member

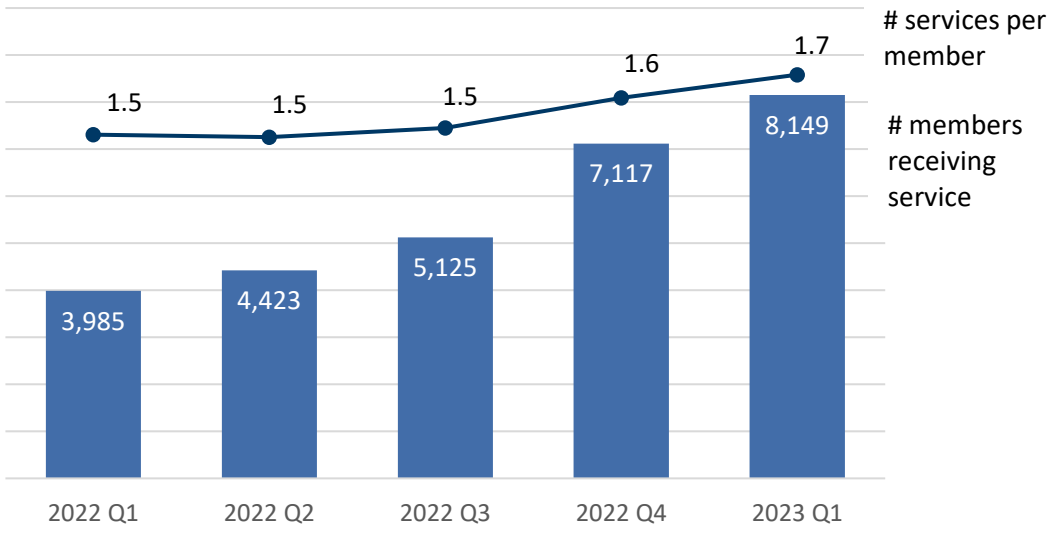
received was higher in 2023 Q1 than in 2022 Q1, on average, indicating that individual utilization went up.

Table 2-6
More Medicaid members using mobile crisis services overall and those receiving the service are using more of it, on average

	2022 Q1	2023 Q1	Change Q1 2023 vs. 2022
# members served	3,985	8,149	104.5%
# claims for service	5,822	13,988	140.3%
Average # claims/member	1.5	1.7	17.5%

Source: BHC staff analysis of data provided by DMAS

Figure 2-6
More members receiving mobile crisis services since start of Project BRAVO and average services per member increased



Source: BHC staff analysis of data provided by DMAS

23-Hour crisis stabilization utilization doubled since 2022 Q 1

23-hour stabilization services provide ongoing assessment, crisis intervention, and clinical determination for level of care for individuals who are experiencing a behavioral health crisis and who need a safe environment for observation and assessment prior to determination of the next level of care. 23-hour stabilization is appropriate for individuals experiencing significant dysregulation, disordered thought processes, substance use and intoxication

resulting in behavioral health crisis, environmentally de-stabilizing events, and other behavioral health crisis that require multidisciplinary crisis intervention and observation to stabilize the immediate crisis and determine the next appropriate step in the plan for care. Services are provided for up to 23 hours in a community- or center-based crisis stabilization setting, which may be an outpatient hospital setting. 23-hour stabilization services are intended to determine the best treatment options for a person experiencing a behavioral health crisis while also preventing unnecessary inpatient hospitalizations. 23-hour crisis stabilization services may include assessment; care coordination; crisis intervention; health literacy counseling; individual, group and family therapy; peer recovery support services; skills restoration; and treatment planning. A single unit of 23-hour crisis stabilization for which a claim may be filed is 23 hours, reimbursed as a per diem.

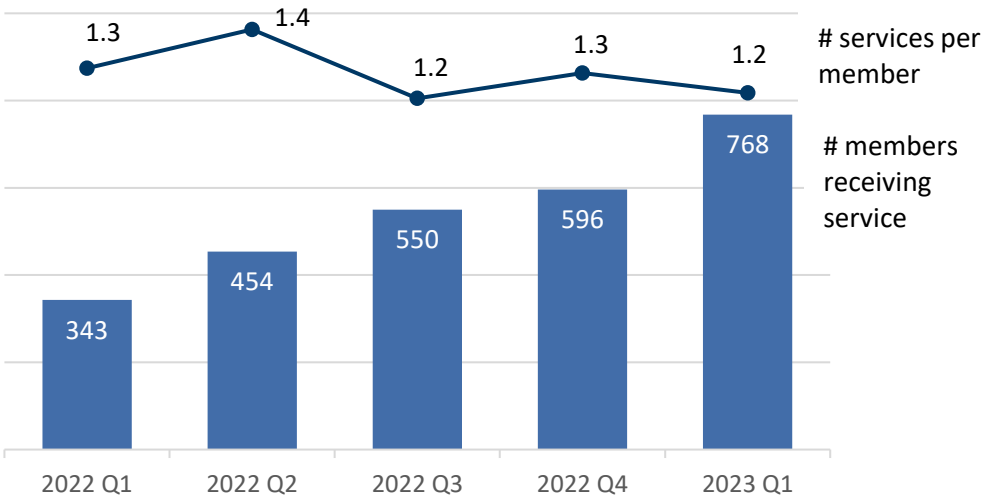
23-hour crisis stabilization services were added to the Medicaid behavioral health continuum of care as a result of Project BRAVO, and first became available on December 1, 2021. Between 2022 Q1 and 2023 Q1, the total number of Medicaid members receiving 23-hour crisis stabilization services rose by 123.9 percent (from 343 members to 768 members), and the number of claims filed also increased by 109.4 percent. This increase in both the number of Medicaid members served and the number of claims for service suggests an increase in access overall (Table 2-7). During the same period, the amount of 23-hour crisis stabilization services each Medicaid member received decreased, on average, indicating that individual utilization went down.

Table 2-7
More Medicaid members using 23-hour crisis stabilization services overall but those receiving the service are using less of it, on average

	2022 Q1	2023 Q1	Change Q1 2023 vs. 2022
# members served	343	768	123.9%
# claims for service	436	913	109.4%
Average # claims/member	1.3	1.2	-6.5%

Source: BHC staff analysis of data provided by DMAS

Figure 2-7
More members receiving 23-hour crisis stabilization services since start of Project BRAVO but average services per member decreased



Source: BHC staff analysis of data provided by DMAS

Residential crisis stabilization unit utilization increased since 2022 Q1 but average number of claims per member served decreased

Residential crisis stabilization units (RCSUs) provide short-term residential psychiatric and substance use related assessment and brief intervention services for individuals experiencing changes in behavior as a result of impairment or decompensation in function that may result in the need for a higher level of care; individuals transitioning from a higher level of care who require continued monitoring, stabilization and mobilization of resources; and individuals who need a safe environment for assessment, stabilization, and prevention of further escalation or decompensation. RCSUs may also provide medically monitored residential services for psychiatric stabilization and substance withdrawal management on a short-term basis. Service components of RCSU services include assessment; care coordination; crisis intervention; health literacy counseling; individual, group and family therapy; peer recovery support services; skills restoration; and treatment planning. Services are provided in a non-hospital, community-based crisis stabilization residential unit with no more than 16 beds. A single unit of RCSU services for which a claim may be filed is one calendar day, reimbursable as a per diem. The goals of RCSUs are stabilization of the individual in a community-based setting, reduction of acute symptoms and identification and mobilization of available resources including support networks.

Crisis stabilization services for adults and youth were covered by Medicaid prior to the Behavioral Health Redesign initiative. These services were replaced by redesigned and enhanced RCSU services as part of Project BRAVO. RCSU services became available on December 1, 2021. Between 2022 Q1 and 2023 Q1, the total number of Medicaid members receiving RCSU services rose by 35 percent (from 465 members to 627 members), and the

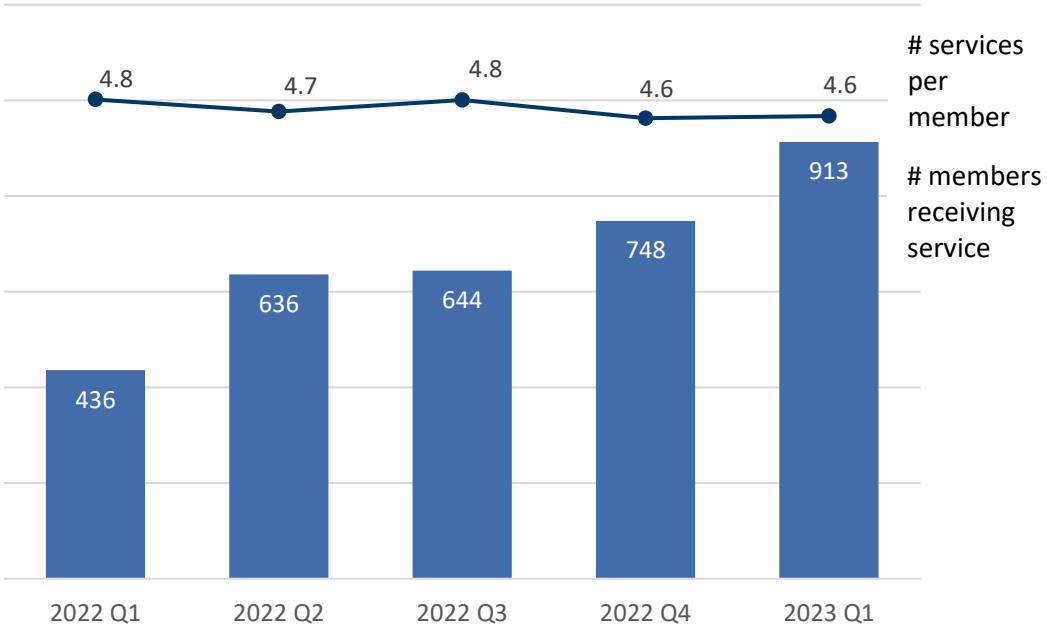
number of claims filed also increased by 30.2 percent. This increase in both the number of Medicaid members served and the number of claims for service suggests an increase in access overall (Table 2-8). During the same period, the amount of RCSU services each Medicaid member received decreased, on average, indicating that individual utilization went down.

Table 2-8
More Medicaid members using residential crisis stabilization unit services overall but those receiving the service are using less of it, on average

	2022 Q1	2023 Q1	Change Q1 2023 vs. 2022
# members served	465	627	34.8%
# claims for service	2,236	2,912	30.2%
Average # claims/member	4.8	4.6	-3.4%

Source: BHC staff analysis of data provided by DMAS

Figure 2-8
More members receiving residential crisis stabilization unit services since start of Project BRAVO but average services per member decreased



Source: BHC staff analysis of data provided by DMAS

Community stabilization utilization decreased since 2022 Q1

Community stabilization services are short-term assessment, crisis intervention, and care coordination services for individuals who have recently experienced a behavioral health crisis or to serve as a bridge to service to provide support for individuals transitioning between levels of care when there is a gap in the availability of services. Components of community stabilization include brief therapeutic and skill building interventions, engagement of natural supports, interventions to integrate natural supports in the de-escalation and stabilization of crisis, and coordination of follow-up services. Community stabilization services also include advocacy and networking to provide links and referrals to appropriate community-based services and assisting the individual and their natural support system in accessing other benefits or assistance programs for which they may be eligible. Community stabilization services are delivered in the individual's natural environment. A single unit of community stabilization for which a claim may be filed is 15 minutes.

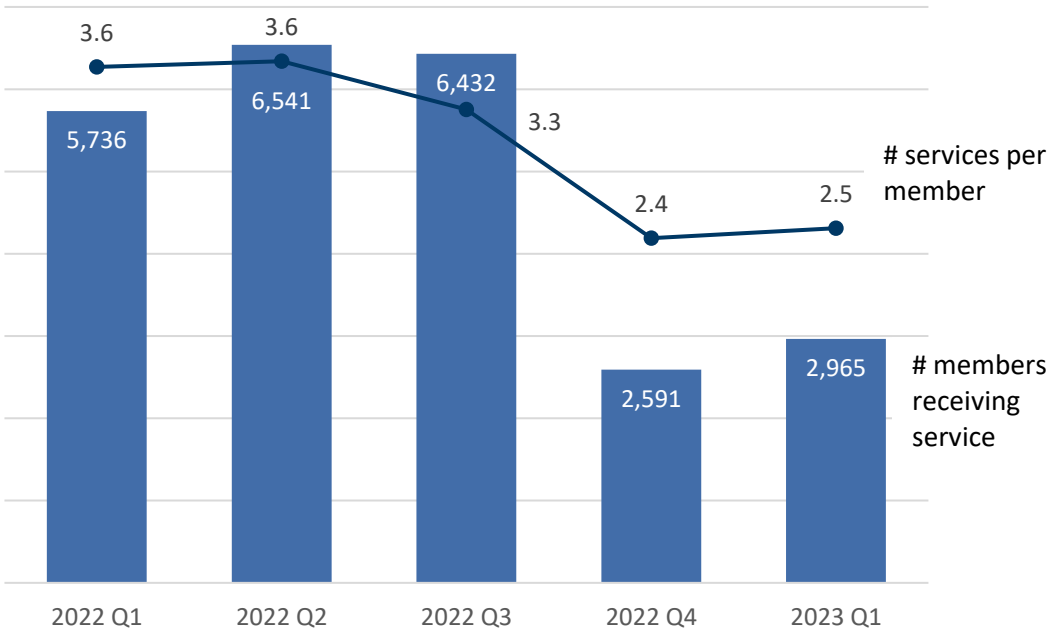
Community stabilization services for adults and youth were covered by Medicaid prior to the Behavioral Health Redesign initiative. These services were replaced by redesigned and enhanced community stabilization services as part of Project BRAVO. The redesigned and enhanced community stabilization services became available on December 1, 2021. Between 2022 Q1 and 2023 Q1, the total number of Medicaid members receiving community stabilization services fell by nearly half (from 5,736 members to 2,965 members), and the number of claims filed also decreased by 65 percent. The decline in the number of Medicaid members receiving community stabilization services may in part be due to addition of a service authorization requirement for this service implemented in September of 2022. The decrease in both the number of Medicaid members served and the number of claims for service suggests a decrease in access overall (Table 2-9). Additionally, the amount of community stabilization services each Medicaid member received was lower in 2023 Q1 than in 2022 Q1, on average, indicating that individual utilization went down.

Table 2-9
Fewer Medicaid members using community crisis stabilization services overall and those receiving the service are using less of it, on average

	2022 Q1	2023 Q1	Change Q1 2023 vs. 2022
# members served	5,736	2,965	-48.3%
# claims for service	20,553	7/305	-64.5%
Average # claims/member	3.6	2.5	-31.2%

Source: BHC staff analysis of data provided by DMAS

Figure 2-9
Fewer members receiving community crisis stabilization unit services since start of Project BRAVO and average services per member decreased



Source: BHC staff analysis of data provided by DMAS

Extent to which Project BRAVO has improved the quality of Medicaid behavioral health services is unknown

The Behavioral Health Redesign initiative is intended to improve the quality of Medicaid behavioral health services through multiple strategies, including enhancing the design of services offered as part of a redesigned continuum of care, incorporating trauma-informed and recovery-oriented principles of care to ensure that services are responsive to the needs of recipients, and emphasizing the use of evidence-based practices to ensure that services are of high quality. Enhanced metrics and dashboards were intended to facilitate oversight and ensure that Medicaid behavioral health services achieve desired outcomes. Data regarding outcomes of Medicaid behavioral health services included in Project BRAVO is not currently available because existing data systems do not capture this data. Absent data regarding outcomes, it is not possible to evaluate the impact of Project BRAVO on the quality of services.

Cost effectiveness of Project BRAVO services cannot be determined

The Behavioral Health Redesign initiative was intended to improve the cost-effectiveness of Medicaid behavioral health services but the extent to which Project BRAVO has accomplished

this goal cannot be assessed at this time. There has been no apparent trend in the average cost of Project BRAVO services since the initiative's relatively recent onset. The average cost per Medicaid member for all Project BRAVO services fell by 20.8 percent (from $5,253 to $4,160) between 2022 Q1 and 2023 Q1. During the same time, the average cost per Medicaid member increased for three Project BRAVO services, decreased for four others, and remained steady for two (See table 2-10 for more information). Further, it is not possible to determine whether services that have become less costly have also remained equally effective, due to the lack of outcomes data.

Table 2-10
Trend in average spending per Medicaid member varies among Project BRAVO services

	2022 Q1	2023 Q1	Change Q1 2023 vs. 2022
Multisystemic therapy	$ 2,989	$ 3959	32.5%
Functional family therapy	994	1,434	44.4%
Assertive community treatment	4,238	4,247	0.2%
Intensive outpatient programs	2,456	2,117	-13.8%
Partial hospitalization programs	3,215	3,227	0.4%
Mobile crisis services	1,303	3,709	184.7%
23-hour crisis stabilization	1,166	1,084	-7.1%
Residential crisis stabilization	5,135	4,921	-4.2%
Community crisis stabilization	8,734	6,234	-28.6%
All Project BRAVO Services	**$5,253**	**$4,160**	**-20.8%**

Source: BHC staff analysis of data provided by DMAS,

Chapter 2: Performance of Project BRAVO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