Mercer

Government Human Services Consulting

Analysis for Behavioral Health Redesign

Commonwealth of Virginia
Department of Medical Assistance Services

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Contents

Section 1
Introduction

The Virginia Department of Medical Assistance Services (DMAS or Department) began work in July of 2024 to implement Virginia Medicaid Behavioral Health Services Redesign and Virginia House Bill 30 enhancing behavioral health services in Virginia Medicaid. As part of the initiative, DMAS engaged Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, to assist with developing rate range recommendations for the services DMAS identified as part of the redesign. In this document, Mercer provides a summary of the analysis and outlines the results of the analysis.

Background

DMAS is undertaking a significant redesign of behavioral health services to replace outdated legacy programs with evidence-based, trauma-informed, community-based support for youth and adults.

The redesign aims to enhance access to care, promote recovery, and improve outcomes for individuals with behavioral health needs. Mercer is assisting in this analysis by evaluating the new service models and developing appropriate reimbursement rates. This collaboration will ensure that the redesigned services are financially sustainable and effectively meet the needs of Virginia's Medicaid population. The analysis is essential for establishing a robust framework that supports the implementation of these critical behavioral health services.

DMAS requested that Mercer conduct an analysis to develop rate range recommendations for the services listed in Table 1. This table provides a high-level overview of the services, while Appendix A includes a detailed breakdown of each service, categorized by professional type, setting (community vs center-based), and service delivery (individual vs group), as requested by DMAS for rate setting.

Table 1: Service Summary

Service
Community Psychiatric Support and Treatment (CPST)
Targeted Case Management (TCM)
Clubhouse
Coordinated Specialty Care (CSC)
Standardized Assessment for Level of Care Model
Evidence Based Practice (EBP) • Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) • Parent-Child Interaction Therapy (PCIT) • Cognitive Behavioral Intervention for Trauma in Schools (CBITS)
Rehabilitation Community Success Skill-Building
Rehabilitation Independent Living Skills
High Fidelity Wraparound (HFW)

Service
Crisis Therapeutic Home
Residential Rehabilitative Supports
Professional Resource Family Care (PRFC)

Overview

This report serves as a summary of the methodology used to develop the rate ranges for the behavioral health redesign for DMAS. In addition to walking through Mercer's rate development process, this report also includes details on data sources, assumption development, and the projected fiscal impact of the selected rates for the upcoming redesign.

Mercer initiated the rate analysis in January 2025 and completed the analysis and modeling work in April 2025. Over the course of four months, Mercer met regularly with DMAS to ensure alignment of the rate analysis process with DMAS's expectations. Both DMAS and Mercer implemented various strategies to disseminate information to stakeholders and gather feedback at multiple stages of the project. DMAS organized regular meetings with state agency stakeholders through an advisory council, an adult core group, and a youth core group. Mercer participated in these meetings to present project progress and to gather feedback with DMAS.

Mercer recognizes the legislative requirement that any changes to the behavioral health services must be implemented in a budget-neutral manner. To address this, Mercer developed preliminary rate ranges for each behavioral health service, establishing foundational estimates for the state fiscal year (SFY) 2027 budget request to the legislature. These established rate ranges will serve as a critical baseline for decision-making and strategic planning.

In alignment with the budget neutrality requirement, DMAS plans to adopt a phased approach to implement rate updates. This phased implementation will prioritize the replacement of legacy services with new services, ensuring that the most critical needs are addressed first. By systematically introducing these new services, DMAS can facilitate a smoother transition while maintaining fiscal responsibility. This approach not only supports the gradual enhancement of the behavioral health service array but also allows for the careful monitoring of fiscal impacts, ensuring that the overall budget remains balanced as new services are rolled out. Appendix C contains the full list of service rate ranges developed by Mercer to facilitate rate updates for the behavioral health redesign.

Section 2

Stakeholder Engagement

DMAS recognizes the importance of including stakeholders who are a daily part of the mental health system to inform system change and rate-setting decisions. Several stakeholder activities were conducted, including outreach to providers, advocacy groups, Medicaid members, and managed care organizations (MCOs). Because Medicaid members primarily provide feedback based on their personal experiences as recipients of health care services, their feedback focused more on the quality, accessibility, and effectiveness of the current services they receive. Their input will help shape policies, programs, and services to be more person-centered and help ensure acceptance and support. Provider input predominantly focused on service delivery and rate considerations, while MCOs provided information on implementation areas such as authorization and standardization criteria. Advocate group feedback included comments regarding quality, funding, and workforce concerns.

Mercer developed the Stakeholder Summary report, provided to DMAS on December 12, 2024, to summarize feedback from members, advocates, MCOs, and providers. Mercer took several approaches to reach stakeholders for feedback:

- Listening sessions:
  - Three in-person listening sessions for members: one in Richmond and the other two in Blacksburg
  - Two virtual sessions for members, one in the afternoon and the other in the evening
  - Two 90-minute virtual listening sessions for advocates with one targeted at adults and the other for youth and their families
- In-person session:
  - A three-hour in-person session with the MCOs in Richmond
- Surveys:
  - A member survey to obtain feedback from those who either could not attend a session or preferred to give feedback in writing
  - An additional Therapeutic Day Treatment (TDT) specific survey for school personnel to provide feedback on TDT in the school setting
  - A provider survey requesting both feedback on reform topics as well as information regarding provider costs for rate setting

Mercer's Stakeholder Summary report provides more details about the themes identified through stakeholder discussion, which included:

- Standardization of service definitions, medical necessity criteria, service authorizations, and discharge criteria

- Lack of transportation and services
- Need for long-term maintenance service
- Lack of adequate behavioral health workforce
- Desire to add peer support
- Need for a full continuum of care that includes preventative services

The information gathered from stakeholders factored into the service definitions and ultimately the rate development considerations. Mercer considered the information that providers submitted about their costs on the provider survey to inform assumptions for rate modeling, for example, related to staffing and employee benefits.

Section 3

Key Process Steps

The rate study process involved several key steps. First, Mercer obtained and reviewed relevant service definitions, provider qualifications, and staffing requirements to ensure a clear understanding of each service. A summary of each service can be found in Appendix A. Next, Mercer considered the following key cost components incurred by providers to deliver each service.

- Wages for Direct Care Worker (DCW) and other program staff
- Employee-related expenses (ERE) (e.g., health insurance, other employee benefits, employer taxes) for DCW and other program staff
- Productivity (e.g., paid time off [PTO], staff training time, other non-billable staff time)
- Other service-related costs (e.g., supplies, mileage costs associated with service transportation, training)
- Administration/overhead

To inform the pricing assumptions for each cost component, Mercer obtained and analyzed various data sources. These data sources included publicly available market data to align with the Centers for Medicare & Medicaid Services (CMS) rate study expectations, experience working on similar services in other states to develop initial assumptions, and stakeholder feedback:

- Bureau of Labor Statistics (BLS) market data on wages, ERE, full-time (FT) staff and turnover percentages
- IRS data related to employer tax rates and mileage reimbursement rates
- Stakeholder feedback gathered during targeted discussions and through provider surveys

For each service, Mercer projected a modeled rate range specific to the SFY2027 rate study period (July 1, 2026, through June 30, 2027). The modeled rate ranges consist of a lower bound, medium bound, and upper bound rate, which provide a range of reasonable rates based on market conditions and stakeholder input.

Section 4

Cost Component Assumptions

Mercer analyzed the data sources and identified the assumptions for each service to generate the rate study modeled rate ranges. Mercer describes each key cost component below.

Wages

To develop the modeled wage ranges for DCW and other program staff integral to service delivery, Mercer reviewed the job categories available in the most recent, available Washington-Arlington-Alexandria, DC-VA-MD-WV BLS wage data publication (released in April 2024). Mercer compared job positions to the service definitions, provider qualifications, licensing requirements and staffing requirements for each service. Mercer used the 25th percentile BLS wage data to model the lower bound of the wage range, the median BLS wage data to model the medium wage, and the 75th percentile BLS wage data to model the upper bound of the wage range.

Mercer trends the BLS compensation data to the midpoint of the implementation period of the rates (i.e., January 1, 2027) to ensure that any anticipated wage growth between the BLS survey period and implementation period is appropriately considered in rate development. Mercer applied an annualized trend factor of 4.1%, based on recent years of wage increases for the specific BLS occupations used in the rate development process.

Mercer summarized the resulting SFY2027 modeled wage ranges for DCW and other program staff in Appendix B.

ERE

As part of the ERE cost component, Mercer included consideration for provider costs associated with worker's compensation insurance and employer taxes (FICA/FUTA/SUTA) for both FT and part-time (PT) staff. Mercer assumed the following additional benefits for FT staff.

- Health insurance (Medical, Dental, and Vision)
- Short- and long-term disability
- Life insurance
- Retirement benefits
- Workers' compensation
- Unemployment taxes (Federal and State)
- Federal Insurance Contribution Act tax (Social Security and Medicare Withholding)

It was important to recognize the distinction between private and governmental ERE, given that some services were exclusively associated with governmental sector employees, while others encompassed a combination of both private and governmental employees. To accurately reflect this, Mercer implemented a blended approach, applying a ratio weighted with 90% private ERE

and 10% governmental ERE for the majority of services. In contrast, for TCM, Rehabilitation Community Success Skill-Building and Rehabilitation Independent Living Skills Training, Mercer used 100% governmental ERE to ensure alignment with the specific needs and characteristics of that sector. This nuanced approach allows for a more precise representation of the costs associated with each service type, enhancing the overall accuracy of the ERE analysis.

ERE assumptions for rate services were based on BLS market data for Virginia private and public sector employers in comparable industries. Mercer met with DMAS to discuss findings for reasonability. The resulting private and governmental ERE are summarized in Appendix D.

Productivity

As part of the DCW's job, there are certain tasks that are considered non-billable (i.e., the DCW is being paid by the provider, but they are not delivering services that can be billed as a Medicaid unit of service). Some examples include PTO, time the DCW spends attending training sessions, and non-billable activities such as shift changes, treatment team meetings, and notes/documentation. For all services, Mercer included an assumption of 35 days of PTO for FT employees and nine days of PTO for PT employees in the rate study. For all services, Tables 2 and 3 summarize the assumptions included for the other productivity-related cost components. Mercer used stakeholder feedback to inform the training hours and staff turnover assumptions. Mercer estimated productivity assumptions by service based on service definitions and informed by stakeholder feedback.

Table 2: Training Hours and Staff Turnover Assumptions

Service	First Year Staff	Annually Thereafter	Staff Turnover Percentage
CPST — Licensed Medical Health Professional (LMHP)	160 hours per year	64 hours per year	28%
CPST — Qualified Medical Health Professional (QMHP)	80 hours per year	64 hours per year	28%
CPST — Behavioral Health Technician (BHT)	80 hours per year	64 hours per year	28%
Medication Aide	80 hours per year	64 hours per year	28%
Peer	582 hours per year	74 hours per year	28%
TCM		64 hours per year	
Clubhouse	33 hours per year	23 hours per year	28%
CSC	95 hours per year	55 hours per year	20%
TF-CBT	224 hours per year	75 hours per year	28%
PCIT	224 hours per year	68 hours per year	28%
CBITS	24 hours per year	4 hours per year	28%
Rehabilitation Community Success Skill-Building	Specialist: 283 hours per year Supervisor: 84 hours per year	Specialist: 144 hours per year Supervisor: 104 hours per year	20%

Service	First Year Staff	Annually Thereafter	Staff Turnover Percentage
Rehabilitation Independent Living Skills	Specialist: 168 hours per year Supervisor: 80 hours per year	Specialist: 24 hours per year Supervisor: 12 hours per year	20%
High Fidelity Wraparound (HFW)	Coaches: 250 hours per year Supervisor: 108 hours per year Wraparound Facilitator: 193 hours per year FSP: 90 hours per year Peer Supervisor (Embedded): 24 hours per year Peer Supervisor (FSO): 50 hours per year	Coaches: 80 hours per year Supervisor: 68 hours per year Wraparound Facilitator: 132 hours per year FSP: 38 hours per year Peer Supervisor (Embedded): 2 hours per year Peer Supervisor (FSO): 24 hours per year	30%
Crisis Therapeutic Home	272 hours per year	40 hours per year	30%
Tier 1 — Supervised Apartment Tier 2 — Group Home	80 hours per year 80 hours per year	64 hours per year 64 hours per year	28% 28%
Professional Resource Family Care (PRFC)		In-Home Skills Trainer: 44 hours per year Foster Parent: 28 hours per year Foster Care Recruiter: 40 hours per year Individual and Family Therapy: 44 hours per year Program Supervisor: 48 ours per year	

Table 3: Billable Time Assumptions

Service	Productivity Assumption for Direct Staff Delivering Services
CPST — LMHP — Community	69%
CPST — LMHP — Center-based	81%
CPST — QMHP — Community	69%
CPST — QMHP — Center-based	81%
CPST — BHT — Community	69%
CPST — BHT — Center-based	81%
Medication Aide — Center-based	81%
Peer — Community	69%
Peer — Center-based	81%
TCM — Community	56%
TCM — Center-based	75%
Clubhouse — Community	69%
Clubhouse — Center-based	81%
CSC	Does not apply for per member per month (PMPM) model
TF-CBT	69%
PCIT	58%
CBITS	58%
Rehabilitation Community Success Skill-Building	50%
Rehabilitation Independent Living Skills	59%
HFW	Does not apply for PMPM model
Crisis Therapeutic Home	Does not apply for per diem model
Tier 1 — Supervised Apartment Tier 2 — Group Home	Does not apply for per diem model
PRFC	Does not apply for per diem model

Other Assumptions

In addition to ERE and PTO, Mercer and DMAS identified the following other assumptions that contribute to service delivery.

- **FT and PT Staff Split:** Assumptions regarding FT and PT staffing percentages to appropriately apply ERE and PTO based on service staff mix.
- **Productivity — Absentee Factor:** An absentee factor represents the percentage of time that participants miss service appointments and for which the provider is still incurring costs.

- **Occupancy Factor (Residential Services):** To include consideration for days when the beneficiary is temporarily not in the residence and providers are unable to bill (e.g., due to medical or therapeutic leave), an occupancy factor was included in the rates. Similar to the absentee factor, this assumption acknowledges that providers continue to incur costs when they have empty residential beds.
- **Staffing Ratios:** Staffing ratios were assessed for the number of direct care workers to participants, the number of supervisors to DCWs, and the number of additional staff to participants such as directors or additional program aides. These assumptions vary by service and are typically based on program and licensing requirements outlined in the service definition or indicated by DMAS.
- **Participant Transportation and Staff Travel:** Expenses related to participant transportation, as required by the service definition, and staff travel expenses that are necessary as part of the service delivery model.
- **Service-Related Supplies:** Accounts for the cost of service-related materials or equipment that the provider would be required to have to deliver the service.
- **Training Costs:** Expenses related to training and certification requirements as outlined in the service definitions and regulations.
- **Administration:** Costs associated with general administrative expenses such as management, equipment and supplies, recruitment, information technology, human resources, billing, finance and accounting, legal, and other program-related costs necessary for program operations. Mercer included a 15% administrative/overhead cost load factor for most services, except for TF-CBT, PCIT, CBITS, CSC for First Episode Psychosis, and Rehabilitation Community Success Skill-Building at 18%.

Unit Definitions

Mercer developed Modeled Rate Ranges on a 15-minute basis and then applied a factor to convert each rate range to the applicable unit definition. Please see Table 4 for the unit definition and conversion factor for each service.

Table 4: Unit Definitions and Conversion Factors

Service	Unit Definition	Conversion Factor
CPST — LMHP	15 Minutes	Divided by four 15-minute units per hour
CPST — QMHP	15 Minutes	Divided by four 15-minute units per hour
CPST — BHT	15 Minutes	Divided by four 15-minute units per hour
Medication Aide	15 Minutes	Divided by four 15-minute units per hour
Peer	15 Minutes	Divided by four 15-minute units per hour
TCM	Monthly	Multiplied by Medium Touch annual units/12
Clubhouse	Per Diem	Small: 20 users*50% Occupancy*365.25 days Medium: 40 users*50% Occupancy*365.25 days Large: 100 users*50% Occupancy*365.25 days

Service	Unit Definition	Conversion Factor
CSC	PMPM Encounter	Monthly Cost/35 slots*95% Occupancy Total Expenses/Total Service Hours Per Year
EBP TF-CBT PCIT CBITS	 15 Minutes 15 Minutes 15 Minutes	 Divided by four 15-minute units per hour Divided by four 15-minute units per hour Divided by four 15-minute units per hour
Rehabilitation Community Success Skill-Building	15 Minutes	Divided by four 15-minute units per hour
Rehabilitation Independent Living Skills	15 Minutes	Divided by four 15-minute units per hour
HFW	PMPM	Monthly Cost/36 caseload
Crisis Therapeutic Home	Per Diem	6 beds*60% Occupancy*365 days
Residential Rehabilitative Supports Tier 1 — Supervised Apartment Tier 2 — Group Home	 Per Diem Per Diem	 4 beds*90% Occupancy*365 days 4,5, and 6 beds*90% Occupancy*365 days
PRFC	Per Diem	10 users*80% Occupancy*365 days

Individual versus Group Rates

While the majority of the rate study services are delivered via a one-to-one (1:1) staffing ratio, meaning that one DCW delivers services to one participant at a time, there are some services that require group rates. These include CPST— LMHP, CPST — QMHP, and CBITS. To establish appropriate group rates for these services, Mercer collaborated with DMAS to determine average group size assumptions. The rate ranges developed for the 1:1 staffing ratio were then adjusted by dividing them by the average group size for each service. Please see Table 5 for the average group size assumption for each service.

Table 5: Average Group Size

Service	Group Size Assumption
CPST — LMHP	1:4 — Group Youth, 1:6 — Group Adult
CPST — QMHP	1:4 — Group Youth, 1:6 — Group Adult[1]
CBITS	1:7 — Group Youth

[1] The Youth Group size assumption of 4 reflects DMAS's preferred design; however, the fiscal impact reflects a Youth Group Size of 6 to assist with achieving budget neutrality under the BH Redesign.

Rate Range Summary

Upon completion of rate study assumptions for each service, Mercer developed proprietary provider rate models to generate SFY2027 modeled rate ranges. Please refer to Appendix C for a summary of the rate ranges resulting from this study.

In the next section, Mercer discusses the fiscal impact of the DMAS selected medium rates.

Section 5

Fiscal Impact Analysis

Mercer conducted an analysis to estimate the fiscal impact at the medium rates from this study, as directed by DMAS. A fiscal impact analysis examines utilization by service, comparing current expenditures to projected expenditures using the same or estimated utilization under the proposed rate ranges. The difference between the current and projected expenditures is the fiscal impact. Unique to this analysis, DMAS will migrate users from legacy services, closing out those legacy services, and assign users to a new set of services.

Mercer modeled two approaches for this fiscal impact:

1. 1-to-1
2. Level of care (LOC)

The 1-to-1 approach assumes redesign utilization will mirror baseline utilization; however, redesign units use a different basis than baseline units due to a change in base service units, e.g., mapping from hourly to per 15-minute units.

The LOC approach assumes redesign utilization will differ from baseline utilization. Redesign utilization projections under the LOC approach rely on material changes to how DMAS manages behavioral health care. If changes to behavioral health care do not occur as expected, then the projections for the LOC approach will be inaccurate.

Development of Baseline Expenditures and Utilization

DMAS instructed Mercer to ensure the impact of new services replacing legacy services was budget neutral. Mercer worked with DMAS to identify the legacy services that will be replaced by new services. The following is the list of procedure codes representing legacy services that will be replaced as part of this redesign.

Table 6. Legacy Services to be Replaced by Redesign

Procedure Code	Description
H0023	Targeted Case Management
H0046	Mental Health Skill Building
H2012	Intensive In-home Services
H2016	Therapeutic Day Treatment
H2017	Psychosocial Rehabilitation
H0031	Intensive In-home Assessment
H0032	Assessment

Mercer also considered the utilization of existing services that will belong to the overall service package for individuals needing behavioral health rehabilitation services under the LOC

approach. These services are collectively referred to as BRAVO services. The following BRAVO services were included as part of the baseline estimate of expenditures for the LOC.

Table 7. BRAVO Services as part of LOC Approach

Procedure Code	Description
H0035	Mental Health Partial Hospitalization Program
H0036	Functional Family Therapy
H0040	Assertive Community Treatment
H2033	Multisystemic Therapy
S9480	Mental Health Intensive Outpatient

SFY2024 (July 1, 2023 through June 30, 2024) Community Behavioral Health claims were used for baseline data, with costs adjusted for wage inflation to align with the proposed SFY2027 redesign rates.

Based on these lists of procedure codes, Mercer's actuarial team used trended historical utilization and expenditures to serve as a baseline amount for comparison to the projected utilization and expenditures using proposed rates.

1-to-1 Approach

Through discussions with DMAS, Mercer initially translated existing utilization of legacy services to expected utilization of new services as a direct crosswalk, e.g., taking 1 hour of legacy service and calculating that hour under the new service. In most cases, redesign units were on a different basis than the baseline units due to a change in base service units, e.g., mapping from hourly units to per 15-minute units. For the legacy service H0046 Mental Health Skill Building, one unit of service could account for 1–2.99 hours of service; however, when aligned to the new service, Adult Community CPST Individual, DMAS assumed 1 hour of service or four 15-minute units. This illustrates the process of translating legacy service utilization into the framework of redesigned services. The baseline for comparison to the 1-to-1 approach includes the legacy services but excludes BRAVO services.

The 1-to-1 approach resulted in total projected expenditures of $147 million above the baseline. By comparison, the rate study modeled rate ranges are generally higher than legacy service rates. If DMAS does not implement policies to influence the utilization of adult and youth services under the proposed rates, the 1-to-1 approach suggests that expenditures will greatly increase.

Mercer determined that using a direct crosswalk of services would not yield a budget neutral result and would fail to adequately represent DMAS's intended policy. Instead, Mercer collaborated with DMAS to create a best estimate of utilization under the behavioral health redesign through the establishment of LOCs for adult and youth services.

DMAS LOC Structure

DMAS modeled its LOC structure after a similar approach used in Texas by the Meadows Mental Health Policy Institute.[2] Establishing the LOC structure allowed DMAS to apply its vision for how services will be utilized in the redesigned system. DMAS evaluated the types of services that would be required at each level, with the expectation that individuals would move between the LOCs, as appropriate for their needs. The LOCs ranged from 0 to 6, with 0 representing the lowest level and 6 representing the highest level. The behavioral health redesign impacts levels 2 through 6. A description of the LOC for adults is provided in Table 8, below.

Table 8. LOC Structure for Adults

Level	Description	Comments
0	Crisis only	
1	Medication management only	
2a	CPST 1	CPST 1 — 1 hour per month
2b	CPST 1, TCM, Clubhouse	CPST 1 — 1 hour per month Clubhouse — 2 visits per week
3	CPST 1, TCM, Clubhouse, ACT, CSC	CPST 1 — 4 hours per month Clubhouse — 3 visits per week
4	CPST 2 or ACT, CSC	Majority CPST 2
5	CPST 2 or ACT, CSC	Split CPST 2/ACT
6	CPST 2 or ACT, CSC	Majority ACT

In Table 9, a description for the LOC for youth is provided.

Table 9. LOC Structure for Youth

Level	Description	Comments
0	Crisis only	
1	Medication management only	
2a	CPST 1	CPST 1 — 4 hours per month CPST 1 — Center-based only
2b	CPST 1, TCM	CPST 1 — 4 hours per month CPST 1 — Center-based only
3	CPST 1, TCM, PHP, IOP	CPST 1 — 7.5 hours per month CPST 1 — Majority Center-based with some Community
4	CPST 2 or CSC, PHP, IOP, MST, FFT	CPST 2 —16 hours per month

[2] The Meadows Mental Health Policy Institute. (2025). Patients Served at Texas LMHAs and their Levels of Care -- FY 2023. Available by request to Jennifer Gonzalez, PhD, Senior Vice President of Population Health, at jgonzalez@mmhpi.org.

Level	Description	Comments
		Shift more toward Community
5	CPST 2 or CSC, MST, FFT	CPST 2 — 20 hours per month Shift more toward Community
6	CPST 2 or CSC, MST, FFT	CPST 2 — 24 hours per month

Mercer took the LOC structure provided by DMAS to model cost estimates for the redesigned system. For each level, DMAS provided Mercer with projections for the anticipated number of individuals served, separately, for the adult and youth models. DMAS also provided Mercer with the expected distribution of services within each level. For example, 95% of youth within level 3 would receive CPST, while 5% would receive IOP and PHP, and 75% of all youth at level 3 would receive TCM. These guidelines from DMAS allowed Mercer to project the expected annual cost of each level as a starting point to discuss a budget neutral LOC approach. DMAS and Mercer then engaged in discussions to refine the initial assumptions provided by DMAS. Mercer modeled three versions of the LOC approach, with the first two versions reflecting DMAS estimates and the third version adjusting DMAS estimates to reach budget neutrality.

LOC Baseline Utilization and Expenditures

For the total baseline cost used to create the fiscal impact for the LOC approach, Mercer considered the trended cost of legacy services, as well as the trended cost of BRAVO services included in the LOC structure. The baseline cost target was $356,664,429 for adult services and $200,011,690 for youth services, resulting in a combined total of $556,676,119.

LOC Fiscal Impact

Mercer modeled a LOC approach that achieved an overall budget neutral result. This budget neutrality was achieved through several key rate decisions reviewed and approved by DMAS:

- Removed differentiation between Youth Group and Adult Group CPST rates resulting in a group size of six for each
- Reduced the Clubhouse rate by assuming the large caseload rate, instead of the small caseload rate
- Assumed 95% funding of the medium CPST rate
- Assessment rates only reflect LMHP

In addition, adjustments to utilization assumptions contributed to budget neutrality:

- Adjusted distribution of individual and group CPST rates
  - For youth CPST, on average, 52% of CPST units are individual and 48% are group
  - For adult CPST, on average, 40% of CPST units are individual and 60% are group
- Adjusted distribution of LMHP, QMHP, and BHT CPST rates

  - For youth CPST, on average, 10% of CPST units are LMHP, 75% of CPST units are QMHP, and 15% of CPST units are BHT
  - For adult CPST, on average, 65% of CPST units are LMHP, 24% of CPST units are QMHP, and 11% of CPST units are BHT
    - Adult CPST has more LMHP units than youth CPST because adult CPST group rates only include LMHP while youth CPST group rates only include QMHP
- Reduced CPST utilization for LOCs 2 and 3
- Kept BRAVO and TCM utilization at baseline levels, i.e., maintain current utilization levels
- Set CSC to a small start at 220 individuals
- Set Clubhouse within LOC 2b to two visits per week
- Set Clubhouse within LOC 3 to three visits per week

Please refer to Appendix E for a list of rates used for the Budget Neutral LOC approach.

Ultimately, DMAS agreed that budget neutrality was achieved in terms of total costs across both adult and youth services. As shown in Table 10, reductions to the adult budget effectively help to offset the youth budget.

Table 10. Modeling Results of Budget Neutral LOC Approach

	Youth	Adult	Total
Members	28,960	42,500	
Per Person Cost	$8,435	$7,338	
Rehab Cost	$238,780,881	$303,794,427	$542,575,308
Assessment Cost	$5,489,658	$8,056,300	$13,545,958
Total Cost	$244,270,539	$311,850,727	$556,121,266
Baseline[3]	$200,011,690	$356,664,429	$556,676,119
Gap to Budget	$44,258,849	$(44,813,702)	$(554,852)

*Totals may differ due to rounding.

Please refer to Appendix F for estimates of projected annual utilization by LOC and service for the Budget Neutral LOC approach, for youth and adult.

Estimated Impact on Federal Medical Assistance Percentage

The LOC approach is budget neutral on a total computable basis (-$0.6 million). However, the reduction in adult expenditures and increase in youth expenditures results in a lower effective federal medical assistance percentage (FMAP) (adult includes the Expansion population, which

[3] The baseline data is SFY2024 experience, which occurred during the PHE redetermination. Adjustments have not been made to reflect the impact of the PHE redetermination on utilization. Overall, total projected SFY2027 Community Behavioral Health dollars in this analysis aligns with projected Community Behavioral dollars used in (SFY2026 rate setting).

has a 90% FMAP, higher than the standard Virginia FMAP). As a result, while the LOC approach is budget neutral overall, the State's share of the expenditures will increase.

Mercer estimates the increase to state expenditures to be approximately $6 million. This estimate assumes that expenditures under the behavioral health redesign will follow the same distribution of dollars as baseline behavioral health expenditures for Expansion, CHIP, and all other populations. For this analysis, Mercer used the FMAPs for SFY2026 (90.00% for Expansion, 65.27% for CHIP, and 50.39% for all other). SFY2027 FMAPs are subject to change.

Estimated Cost of Other Rate Study Services, Not Included in the LOC Approach

Mercer modeled rates for additional services on behalf of DMAS that were not included in the LOC approach. These services require further discussion by DMAS for timing and feasibility of implementation. However, to assist with understanding the potential impact these services could have on DMAS budgets, Mercer provides estimates for service expenditures in the tables below.

DMAS chose the medium rates for these services to calculate all estimates. The rates can be found in Appendix C. DMAS also provided the estimates for the number of members and number of staff that Mercer used as a basis for the services in Table 11 and 12. Mercer referenced each service Assumption Log to align estimates on staffing ratios and units per month.

Table 11. Additional Services

Service	Unit	Rate	Members Served	Per Client Units Per Month	Est. Annual Cost
Coordinated Specialty Care (CSC)	PMPM	$2,308.00	261	N/A	$7,228,656
High Fidelity Wrap	PMPM	$2,178.76	301	N/A	$7,869,681
Pre and Post-tenancy Supports (Ind Living Skills Training)	Per 15 Minute	$33.32	2,444	20	$19,544,179
Supported Employment	Per 15 Minute	$47.72	178	20	$2,038,598

For the analysis in Table 12, DMAS did not have estimates for the number of members served. Instead, Mercer estimated annual costs based on DMAS estimates for staff. Mercer based staffing ratio assumptions on the Assumption Log for each service.

Table 12. Additional Services, Evidence-Based Practice

Service	Unit	Rate	Staff	Staffing Ratio	Per Client Units Per Month	Est. Annual Cost
TF-CBT	Per 15 Minute	$37.63	339	1:12	16	$14,695,569
PCIT	Per 15 Minute	$51.76	76	1:5	16	$3,776,410

Table 13 shows additional facility-based services, with an estimate of annual cost for one facility, and the estimated annual cost for five facilities. The assumption for five facilities was chosen for demonstration purposes.

Table 13. Additional Services, Facility-Based

Service	Size	Rate	Annual Per Facility Cost	Annual Cost of 5 Facilities
Supervised Apartments	4 beds	$314.37	$458,980	$2,294,901
Adult Group Homes	5 beds	$659.05	$1,202,766	$6,013,831
Professional Resource Family Care (PRFC)	10 members	$160.64	$586,336	$2,931,680
Crisis Therapeutic Group Homes	6 beds	$1,471.62	$3,222,848	$16,114,239

Estimates reported in Tables 11, 12, and 13 demonstrate the potential annual costs for these services given the assumptions provided to Mercer by DMAS.

Section 6
Limitations and Caveats

In preparing the assumptions and modeled rate ranges summarized in this document, Mercer considered publicly available market information, stakeholder feedback, and other information provided by DMAS. Mercer reviewed the data and information for consistency and reasonableness, but did not audit them. If the data or information is incomplete or inaccurate, the modeled rate ranges may need to be revised accordingly. Assumptions were developed based upon information available as of April 2025. Should additional information become available, the assumptions and modeled rate ranges may need to be updated accordingly.

All projection estimates are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a likely range of variability from the estimates. Any estimate or projection may not be used or relied upon by any other party or for any other purpose than for which it was issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use.

Assumptions and rates developed by Mercer are projections of future contingent events. Actual provider costs may differ from these projections. Mercer has developed these ranges on behalf of DMAS for purposes of the SFY2027 behavioral health redesign. Use of this information for any purpose beyond that stated may not be appropriate. This document should only be reviewed in its entirety.

Additional Actuarial Caveats and Notes

This report includes exhibits that cover the fiscal impact analysis for the SFY2027 Behavioral Health Redesign.

The fiscal impact analysis is prepared on behalf of the Commonwealth of Virginia and is intended to be relied upon by DMAS. It should be read in its entirety and has been prepared under the direction of Selina Gilbertson, FSA, MAAA, and Daniel Rondon, FSA, MAAA, who are members of the American Academy of Actuaries and meet its US Qualification Standard for issuing the statements of actuarial opinion herein.

To the best of Mercer’s knowledge, there are no conflicts of interest in performing this work.

The suppliers of data are solely responsible for its validity and completeness. We have reviewed the data and information for internal consistency and reasonableness, but we did not audit it. All estimates are based upon the information and data available at a point in time and are subject to unforeseen and random events, and actual experience will vary from estimates.

Mercer expressly disclaims responsibility, liability, or both for any reliance on this communication by third parties or the consequences of any unauthorized use.

Appendix A

Service Detail

Service	Setting	Service Delivery
CPST — LMHP	Community/Center-based	Individual & Adult/Youth Group
CPST — QMHP	Community/Center-based	Individual & Adult/Youth Group
CPST — BHT	Community/Center-based	Individual Only
Medication Aide	Center-based Only	Individual Only
Peer	Community/Center-based	Individual Only
Targeted Case Management (TCM)	Community Only	Caseload
Clubhouse	Community/Center-based	Group Only
Coordinated Specialty Care (CSC)	Community Only	Caseload
Evidence Based Practice (EBP)		
TF-CBT	Clinic-based	Individual Only
PCIT	Community/Clinic-based	Individual Only
CBITS	Clinic-based	Individual and Youth Group
Rehabilitation Community Success Skill-Building	Community Only	Individual Only
Rehabilitation Independent Living Skills	Community Only	Individual Only
High Fidelity Wraparound (HFW)	Community Only	Caseload
Crisis Therapeutic Home	Center-based Only	Bed Count
Residential Rehabilitative Supports		
Tier 1 — Supervised Apartment	Site-based Only	Bed Count
Tier 2 — Group Home	Site-based Only	Bed Count
Professional Resource Family Care (PRFC)	Community Only	Caseload

Appendix B

SFY2027 Modeled Wage Ranges

Service[4]	Lower Bound	Medium	Upper Bound
LMHP	$32.10	$42.20	$50.33
QMHP	$25.57	$30.60	$37.34
BHT	$18.23	$20.87	$22.90
Medication Aide	$20.53	$23.08	$25.68
Peer	$18.23	$20.87	$22.90
Administrative Director	$27.57	$33.23	$41.67
Clinical Director	$34.81	$53.10	$93.91
Medical Director	$88.63	$99.44	$109.27
Case Manager	$23.78	$28.23	$33.47
IPS Specialist	$23.47	$28.82	$35.66
Housing specialist	$23.47	$28.82	$35.66
Registered Nurse	$45.07	$54.60	$60.79
LPN	$33.74	$36.43	$41.78

[4] Presents wage ranges for the direct service provider and supervisor wage ranges.

Appendix C

SFY2027 Modeled Rate Ranges

Service	Rate Type[5]	Lower Bound	Medium	Upper Bound
Clubhouse — Small, Center-based	Per Diem	$62.27	$72.41	$85.31
Clubhouse – Medium, Center-based	Per Diem	$41.92	$49.15	$58.36
Clubhouse – Large, Center-based	Per Diem	$34.26	$39.64	$45.67
CPST — LMHP, Community	Per 15 Minutes	$30.31	$38.21	$46.48
CPST — LMHP, Center-based	Per 15 Minutes	$22.99	$29.67	$36.68
CPST — QMHP, Community	Per 15 Minutes	$25.31	$29.49	$32.55
CPST — QMHP, Center-based	Per 15 Minutes	$18.77	$22.31	$25.43
CPST — BHT, Community	Per 15 Minutes	$20.49	$22.86	$23.41
CPST — BHT, Center-based	Per 15 Minutes	$14.69	$16.69	$17.70
Medication Aide, Center-based	Per 15 Minutes	$16.87	$18.78	$19.71
Peer, Community	Per 15 Minutes	$22.84	$25.39	$25.82
Peer, Center-based	Per 15 Minutes	$16.44	$18.60	$19.55
CPST — LMHP, Community Adult Group	Per 15 Minutes	$5.05	$6.37	$7.75
CPST — LMHP, Center-based Adult Group	Per 15 Minutes	$3.83	$4.95	$6.11
CPST — QMHP, Community Adult Group	Per 15 Minutes	$4.22	$4.92	$5.42
CPST — QMHP, Center-based Adult Group	Per 15 Minutes	$3.13	$3.72	$4.24
CPST — LMHP, Community Youth Group	Per 15 Minutes	$7.58	$9.55	$11.62
CPST — LMHP, Center-based Youth Group	Per 15 Minutes	$5.75	$7.42	$9.17

[5] The Rate Type column provides the unit for each service, i.e., 15-minute, hour, or per diem.

Service	Rate Type[5]	Lower Bound	Medium	Upper Bound
CPST — QMHP, Community Youth Group	Per 15 Minutes	$6.33	$7.37	$8.14
CPST — QMHP, Center-based Youth Group	Per 15 Minutes	$4.69	$5.58	$6.36
Crisis Therapeutic Home	Per Diem	$1,280.32	$1,471.62	$1,698.03
CSC	PMPM Encounter		$2,183.00 $357.00	
TF-CBT	Per 15 Minutes	$29.05	$37.63	$46.93
PCIT	Per 15 Minutes	$40.14	$51.76	$65.68
PCIT, Community (BSFT)	Per 15 Minutes	$57.59	$72.86	$86.59
CBITS	Per 15 Minutes	$31.24	$38.41	$47.93
TF-CBT — Outpatient	Per 15 Minutes	$26.85	$34.92	$43.66
PCIT — Outpatient	Per 15 Minutes	$37.26	$48.18	$61.26
PCIT, Community (BSFT) — Outpatient	Per 15 Minutes	$53.80	$68.15	$81.07
CBITS — Youth Group	Per 15 Minutes	$4.46	$5.49	$6.85
High Fidelity Wraparound — Embedded Peers	PMPM	$1,829.34	$2,056.59	$2,318.19
High Fidelity Wraparound — WFO	PMPM	$1,317.11	$1,499.29	$1,726.26
High Fidelity Wraparound — FSO	PMPM	$617.87	$679.47	$736.25
Professional Resource Family Care (PRFC)	Per Diem	$130.43	$160.64	$211.32
Residential Rehabilitative Supports — Supervised Apartments	Per Diem	$276.80	$314.37	$347.50
Residential Rehabilitative Supports — Group Home (4 beds)	Per Diem	$718.60	$823.82	$929.65
Residential Rehabilitative Supports — Group Home (5 beds)		$574.88	$659.05	$743.72
Residential Rehabilitative Supports — Group Home (6 beds)		$479.07	$549.21	$619.77

Service	Rate Type[5]	Lower Bound	Medium	Upper Bound
Targeted Case Management, Community	Monthly	$329.79	$374.09	$428.48
Rehabilitation Community Success Skill-Building	Per 15 Minutes	$41.08	$47.72	$56.41
Rehabilitation Independent Living Skills Training	Per 15 Minutes	$28.76	$33.32	$39.19
Standardized Assessment for Level of Care Model	Unit			
Licensed component			$189.56	
QMHP component			$133.86	

Appendix D

SFY2027 ERE Components

Private Workers[6]

Component	Type	Value	Base Taxable Wage	Not Applicable to Part Time Employees
Health Insurance	Monthly Premium	$491.27		X
Federal Unemployment Tax Act (FUTA)	% of Taxable Wage	0.60%	$7,000.00	
State Unemployment Insurance Taxes	% of Taxable Wage	2.50%	$8,000.00	
Worker's Compensation	% of Taxable Wage	2.65%		
Social Security Withholding	% of Taxable Wage	6.20%	$168,600.00	
Medicare Withholding	% of Taxable Wage	1.45%		
STD, LTD, Life Insurance	% of Taxable Wage	0.60%		X
Retirement Benefits	% of Taxable Wage	3.00%		X
Bonuses	% of Taxable Wage	0.00%		
Overtime	% of Taxable Wage	0.00%		

[6] Blends 90% private ERE to 10% governmental ERE. Applies to all services except TCM, Rehabilitation Community Success Skill-Building and Rehabilitation Independent Living Skills Training.

State and Local Government Workers[7]

Component	Type	Value	Base Taxable Wage	Not Applicable to Part Time Employees
Health Insurance	Monthly Premium	$1,300.77		X
Federal Unemployment Tax Act (FUTA)	% of Taxable Wage	0.60%	$7,000.00	
State Unemployment Insurance Taxes	% of Taxable Wage	2.50%	$8,000.00	
Worker's Compensation	% of Taxable Wage	2.65%		
Social Security Withholding	% of Taxable Wage	6.20%	$168,600.00	
Medicare Withholding	% of Taxable Wage	1.45%		
STD, LTD, Life Insurance	% of Taxable Wage	0.60%		X
Retirement Benefits	% of Taxable Wage	13.30%		X
Bonuses	% of Taxable Wage	0.00%		
Overtime	% of Taxable Wage	0.00%		

[7] 100% governmental ERE. Applies to TCM, Rehabilitation Community Success Skill-Building and Rehabilitation Independent Living Skills Training.

Appendix E

SFY 2027 Rates Used for Fiscal Impact — Budget Neutral Model[8]

Youth Rates

Service Name	Unit of Service	Rate Used in Budget Neutral Model
Targeted Case Management, Community — Medium Touch	Monthly	$374.09
CPST — LMHP, Community	Per 15 Minutes	$36.30
CPST — LMHP, Center-based	Per 15 Minutes	$28.19
CPST — QMHP, Community	Per 15 Minutes	$28.02
CPST — QMHP, Center-based	Per 15 Minutes	$21.19
CPST — BHT, Community	Per 15 Minutes	$21.72
CPST — BHT, Center-based	Per 15 Minutes	$15.86
CPST — QMHP, Community Youth Group	Per 15 Minutes	$4.67
CPST — QMHP, Center-based Youth Group	Per 15 Minutes	$3.53
Clubhouse — Large, Center-based	Per Diem	$39.64
Mental Health Intensive Outpatient (IOP)	Per Diem	$250.00
Mental Health Partial Hospitalization Program (MH-PHP)	Per Diem	$500.00
Multisystemic Therapy (Bachelor Established Team)	Per 15 Minutes	$56.96

[8] Rates for CPST in the Budget Neutral Model are assumed at a level equivalent to 95% of the Medium rates presented in Appendix C.

Service Name	Unit of Service	Rate Used in Budget Neutral Model
Multisystemic Therapy (Master Established Team)	Per 15 Minutes	$61.83
Functional Family Therapy (Bachelor Established Team)	Per 15 Minutes	$42.21
Functional Family Therapy (Master Established Team)	Per 15 Minutes	$46.13
Assessment — CPST — LMHP, Center-based (1.6 hours)	Per Member	$189.56
Assessment — CPST — QMHP, Center-based (1.5 hours)	Per Member	$133.86

Adult Rates

Service Name	Unit of Service	Rate Used in Budget Neutral Model
Targeted Case Management, Community — Medium Touch	Monthly	$374.09
CPST — LMHP, Community	Per 15 Minutes	$36.30
CPST — QMHP, Community	Per 15 Minutes	$28.02
CPST — BHT, Community	Per 15 Minutes	$21.72
CPST — LMHP, Center-based Adult Group	Per 15 Minutes	$4.70
Clubhouse — Large, Center-based	Per Diem	$39.64
Assertive Community Treatment (Small Team)	Per Diem	$241.56
CSC-FEP (Caseload: 30)	Per Month	$2,308.00
Assessment — CPST — LMHP, Center-based (1.6 hours)	Per Member	$189.56
Assessment — CPST — QMHP, Center-based (1.5 hours)	Per Member	$133.86

Appendix F

Estimated Annual Utilization by LOC by Service — Budget Neutral Model

Youth LOC

LOC	Service	Est. Annual Cost per Person	Est. Annual Utilization
2	CPST	$854	1,536,000
2	TCM	$4,489	26,640
3	CPST	$18,030	4,315,680
3	IOP/PHP	$78,000	2,304
3	TCM	$4,489	60,000
4	CPST	$45,160	5,985,792
4	IOP/PHP	$78,000	1,152
4	MST/FFT	$8,529	32,000
4	TCM	$4,489	40,080
5	CPST	$43,751	547,200
5	MST/FFT	$8,529	11,200
6	CPST	$52,502	299,520
6	MST/FFT	$8,529	9,600
Assessment	Assessment	$190	28,960
Total		**$8,435**	**12,896,128**

Adult LOC

LOC	Service	Annual Cost per Person	Annual Utilization
2	CPST	$693	432,000
2	Clubhouse	$9,514	336,000
2	TCM	$4,489	33,360
3	CPST	$2,773	2,536,512
3	Clubhouse	$5,708	345,600
3	ACT	$21,740	31,050
3	CSC	$27,696	528
3	TCM	$4,489	133,440
4	CPST	$10,366	9,301,248
4	ACT	$21,740	31,050
4	CSC	$27,696	528
5	CPST	$10,366	321,792
5	ACT	$21,740	46,350
5	CSC	$27,696	792
6	CPST	$10,366	6,912
6	ACT	$21,740	38,250
6	CSC	$27,696	792
Assessment	Assessment	$190	42,500
Total		**$7,338**	**13,638,704**

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