Medicaid Behavioral Health Transformation

Request for Information Summary

February 2021

Executive Summary

In September 2020, The Department of Health Care Finance (DHCF) and the Department of Behavioral Health (DBH) jointly published a Request for Information (RFI) to solicit information from consumer organizations, the provider community, health plans, and others regarding the pathway to integrate behavioral services more fully into the benefits offered through the District's Medicaid managed care program. A total of sixteen (16) responses were received to the twenty-one (21) questions posed in the RFI.

Most respondents were supportive of transforming behavioral health care in the District to achieve a whole-person, population-based, integrated Medicaid behavioral health system that is comprehensive, coordinated, high quality, culturally competent, and equitable. Several respondents offered potential edits to the principles for Medicaid behavioral health reform, as well as the definition of integrated care.

Respondents offered specific approaches and strategies to achieve these aims. These spanned the spectrum of support needed at various points of care such as the Substance Abuse and Mental Health Services Administration (SAMHSA) Framework for Integrated Care; Certified Community Behavioral Health Clinic Certification; The Collaborative Care Model; and the Centers for Medicare and Medicaid Services (CMS) Transforming Clinical Practice Initiative model, among others.

Respondents expressed consensus in several areas regarding:

- Continuing reimbursement and use of telehealth for behavioral health at the same rates as office visits. Several also suggested DHCF and DBH consider reimbursement for remote patient monitoring;
- The need to support targeted interventions for special needs populations (e.g., children, individuals with learning and developmental disabilities or autism spectrum disorder, those experiencing homelessness, veterans, LGBTQIA+ communities, deaf and hard of hearing);
- Support to ensure the continued implementation of a community-based approach (e.g., social services, peer specialists, etc.) informed by social determinants of health;
- Continued funding of current efforts focused on improving health equity, including support for strategies to address the findings of the *Health Equity Report for the District of Columbia 2018* (HER) released by DC Health, as well as more financial incentives for evidence-based models, and better integration of behavioral health across the entire health care ecosystem;
- Defining and measuring success of efforts to integrate care based on specific health outcomes.

Notable areas of feedback or ongoing discussion and consideration include the following:

- Disagreement regarding whether to require managed care organizations (MCOs) to include all DBH-certified providers in their contracts. Some respondents advocated for including all certified providers for the first 12 to 24 months after the carve-in planned for October 2021 (now planned for October 2022) to stabilize the provider network.

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- Several respondents favored universal contracting for critical providers and/or an "any willing provider" clause for behavioral health providers, as well as directed payment for behavioral health providers to hold provider rates equal or greater than current FFS rates. However, some suggested that this type of directed payment requirement only be in place for the first year or two of the carve-in.
- Restructuring or re-assessing rates for behavioral health services to ensure high-quality outcomes and providers' financial sustainability.

Several respondents suggested areas for enhanced investment to achieve integrated care, including:

- Requiring providers to exchange data in a standardized way, including potential investments in a shared analytic platform with capabilities to support standard and ad hoc reporting, predictive analytics, statistical tools, risk stratification, and trend analysis with data visualization tools; as well as general adoption of certified technology and assessments that complies with the CMS Interoperability final rule.
- Respondents indicated the need for support to align DBH-funded data systems, provider systems, and MCO requirements for billing.
- Using the framework provided by the National Council of Behavioral Health in their June 2020 report titled, "The Transition of Behavioral Health Services into Comprehensive Medicaid Managed Care."
- Adapting or implementing evidence-based models highlighted by the National Register of Health Service Psychologists' Integrated Healthcare Training Series.
- Supporting workforce development, including provider recruitment, education and cross-sector partnerships to support the behavioral health workforce.
- Investing in and using community health workers to deliver evidence-based interventions and a multi-disciplinary approach to reducing health disparities within the community.

DHCF synthesized responses to the Behavioral Health RFI, which are provided in the chart on page 6. The following is a narrative summary of these responses, organized by section of the RFI.

Background

In September 2020, DHCF and DBH received a total of sixteen (16) responses to the jointly published Request for Information (RFI) focused on Medicaid behavioral health transformation. The first two sections of the RFI provide an introduction and background. For this reason, the summary responses that follow are numbered starting with section 3.0, which included the first set of questions for respondents.

Foundation & Principles (3.0)

3.2 Principles for Medicaid Behavioral Health System in the District

DBH and DHCF identified the following six (6) principles to guide the design of a comprehensive integrated system of Medicaid behavioral health services:

- Embrace a Population Health Framework
  - Ensure access to a continuum of behavioral health services, including prevention, treatment, and recovery for the Medicaid population.
  - Improve coordination of physical and behavioral health services.
  - Promote evidence-based approaches to population health management.

- Provide Person-Centered Care
  - Facilitate access to care, including the ease of making an appointment and telehealth.
  - Patient engagement in care, including assistance with self-care, patient education, and access to personal health information.
  - Ensure accessibility of public information to inform provider choice such as provider directory information on office hours, services, credentials, and patient experience, and opportunities for ongoing, routine patient feedback.

- Ensure Parity
  - Promote access to behavioral health services comparable to that which occurs for physical health services.

- Improve Quality
  - Invest in a system that integrates, when needed, the treatment of mental health and substance use disorders.
  - Measure performance using Federal and District defined metrics.
  - Ensure clinical information systems support high-quality care, practice-based learning, and quality improvement.
  - Implement a data-driven continuous quality improvement plan for behavioral health services and coordination of physical and behavioral health services.

- Promote Health Equity
  - Ensure the availability of culturally competent services and healthy living access across all eight (8) wards.
  - Develop programs and services that address social determinants of health and enhance community supports to optimize care for higher-need consumers/clients
  - Implement strategies to reduce health and health care disparities.

- Promote Value, Efficiency, and Coordination
    - Pay for value, not for volume, of health care services.
    - Reward performance.

Respondents generally agreed with the six proposed principles for Medicaid behavioral health transformation (above), however, several respondents proposed the following additional concepts be added to the principles:

- Improving access to person-centered, community-based care.
- Providing or ensuring parity between physical and behavioral health.
- Improving care quality and timely access to services.
- Increasing network capacity to deliver a recovery-oriented system of care (ROSC).
- Promoting a trauma-informed care environment to support healing and recovery.
- Developing meaningful long-term health care provider-patient relationships.
- Improving engagement and referral practices.
- Improving ability to recruit and retain diverse and culturally competent staff.
- Sustainably addressing systemic racism.

3.3 Definition of Integrated Care

DHCF and DBH's preliminary working definition of integrated care is:

> "The systematic approach to provide person-centered care for a defined population that coordinates physical and behavioral healthcare through a team of primary care and behavioral health clinicians, working with the patients and families. Integrated care models ensure that mental health, substance abuse, primary care, and specialty services are coordinated and delivered in a manner that is most effective to caring for people with multiple healthcare needs and produces the best outcomes."

Respondent made suggestions to strengthen the definition, including:

- Incorporating health equity promotion, culturally competent care, social determinants of health (SDOH), peer support, and destigmatization of help-seeking.
- Replacing "clinicians" with "practitioners" because some providers delivering home-based services are credentialed, but not licensed (e.g., community support workers, peer specialists). Respondents suggested the word "clinician" should only be used exclusively for people with clinical licensure (e.g., Licensed Independent Clinical Social Workers, Licensed Practical Nurses, Registered Nurses).
- Replace "abuse" with "use disorder," as "abuse" is often seen as archaic and stigmatizing.
- Replace "patients and families" with "people served, families, and other natural and informal supports" in recognition of non-kinship ties.

Phase II: Incorporating Behavioral Health Services in Medicaid Managed Care (4.0)

4.1 Required Scope of Services

Respondents were asked whether, among the services *not* currently covered by Medicaid, there are services or benefits that should be prioritized for inclusion in Phase II, if funding allows. Respondents provided specific feedback on services they felt should be prioritized for Phase II through a carve-in to managed care contracts including:

- Certified Community Behavioral Health Centers, the Collaborative Care Model and Z codes.
- Psychiatric Residential Treatment Facility (PRTF) placements, and community supports.
- Support for social needs including housing, access to quality food, childcare, and employment training.

4.2 Relationship with MCOs and Network Participation Requirements

Respondents were asked about accountability structures for MCOs and other requirements that may be included in managed care contracts.

Several respondents advocated for a universal contracting requirement in the managed care contracts for critical providers. However, some respondents differed as to whether organizations such as Federally Qualified Health Centers (FQHCs) must be certified by DBH or could seek alternative national certifications that would confer deemed status. Several respondents recommended that the District set minimum payment rates for MCOs for behavioral health services and that these rates should at least match the current Medicaid fee-for-service schedule for an established period.

4.3 Hold Harmless and Program Transition Policies

Respondents were asked about policies needed to ensure continuity of care and to protect access for vulnerable beneficiaries as the District implements the carve-in of behavioral health services in the managed care program.

Some respondents shared specific concerns about the implementation of a carve-in, noting that the move to managed care could be good but may be administratively burdensome and introduce uncertainty that should be mitigated. Specific areas in which oversight, provider technical assistance, or training[1] were perceived to be needed include:

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[1] DHCF, in partnership with DBH, recently launched a new *Integrated Care Technical Assistance Program (ICTA)*, which will be delivered for free to providers by leading experts from Health Management Associates (HMA). The ICTA program was developed in direct response to Medicaid provider's requests for technical assistance on

- Assurances of prompt, timely payment moving into Phase II
- Management of expectations around cost and establishing risk corridors
- More support for timely access to services and efforts to be patient centered with extended hours, etc.
- The need to assess and monitor patient satisfaction
- Technology support for personalized treatment plans
- The need to support and address potential language barriers, including communication with deaf clients
- The need to address discontinuity in Medicaid eligibility and work across agencies, especially for returning citizens.

One respondent commented that they were concerned that MCOs subcontracting management of behavioral health services to Behavioral Health Service Organizations could reduce the effectiveness of or impede the goals of an integrated model of care. Another requested that key standards and expectations for behavioral health providers under the carve-in be shared with the community by January 2021 to ensure providers are ready in October 2021(now planned for October 2022).

Phase III: Further Steps to Integrate Behavioral Health in MCOs (5.0) and Infrastructure, Engagement, and Accountability (6.0)

Respondents were asked to provide examples of specific infrastructure investments, workflow, and practice management strategies, or other innovations that DHCF and DBH should consider implementing in the next five years to promote comprehensive, integrated care.

In response, respondents recommended continued funding of current equity efforts some of which are outlined in the DC Health Equity Report, such as the DC Mental Health Access in Pediatrics (DC MAP) program. Others asked for DHCF and DBH to require that all performance data analyses be stratified by race or ethnicity and including disparity-sensitive measures among performance metrics. Several respondents suggested the District mandate or require a standard set of SDOH assessments/screeners across the system.

Respondents identified a range of strategies to provide financial incentives to adopt or implement evidence-based integrated models of behavioral health. Specific behavioral health models cited by respondents as worthy of consideration in Phase II and Phase III for alignment with the MCO contracts included:

- The Collaborative Care Model
- Transforming Child and Family Behavioral Health Model
- Behavioral Health Integration (BHI) Model

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integration of care and best practices for population health and is designed to be highly responsive to District provider's needs. See www.integratedcaredc.com

Longer-term models of integration, many building on national frameworks or local recommendations include:

- National Register of Health Service Psychologists' Integrated Healthcare Training Series.
- Massachusetts Child Psychiatry Access Program.

Next Steps

DHCF and DBH greatly appreciate the time and thoughtfulness provided by District stakeholders who responded to the Medicaid Behavioral Health RFI.

DHCF and DBH plan to hold a public stakeholder meeting as part of the Medicaid Medical Care Advisory Committee Delivery System Redesign subcommittee meeting on March 3, 2021 at 4pm. Additional integrated care resources, including technical assistance and training are available for Medicaid providers and interested community members at www.integratedcaredc.com .

For further information regarding this RFI, or interest in attending the stakeholder meeting on March 3, please email healthinnovation@dc.gov.

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Table 1: Summary of Behavioral Health RFI Responses (16 total) – September 2020

Question	Synopsis of Responses
1. Please provide a brief description of your organization and personal interest in this topic, or if you prefer, provide a link to your organization's website.	Respondents included: • Providers; • Managed Care Organizations (MCOs); • Community Health Centers; • Hospitals; • Associations; and • Advocacy Organizations
2. Do you agree that the principles above should serve as a foundation for Medicaid's behavioral health transformation efforts? Are there others you feel should be included? Deleted?	14 respondents agreed with the proposed, draft principles for Medicaid behavioral health transformation. Additional concepts stakeholders felt could be better incorporated into the principles included: • Person-centered; • Community-based; • Ensure parity; • Improve quality; • Normalize behavioral health and create a safe and trusting environment for families to convey their needs; • Support family-driven care; • Increase effective community engagement; • Ensure timely access to services; • Build meaningful long-term health care provider-patient relationships; • Improve engagement and referral practices; • Support diverse and culturally competent staff; • Address systemic racism; • Address the impact of trauma on health; • Cultural humility; and • Promote collaborative multi-organization coordination. Models or frameworks suggested as additional references included: • The Substance Abuse and Mental Health Administration (SAMHSA) "A Standard Framework for Levels of Integrated Health Care"; • DHCF's Medicaid Managed Care Quality Strategy; and • Principles and Values to Guide Child and Adolescent Public Behavioral Health Care System Transformation in the District of Columbia.
3. What do you see as the greatest opportunities to transform behavioral health care in the District to achieve a whole-person, population-	Seven (7) respondents provided a range of approaches to achieve the goals of Medicaid behavioral health transformation, including: • Developing an integrated approach, comprehensive continuum of care, enhanced care management, and decreased fragmentation in funding; • Establishing shared commitment and accountability to achieve health outcomes, with robust community, provider, and

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based, integrated Medicaid behavioral health system that is comprehensive, coordinated, high quality, culturally competent, and equitable? Please describe specific initiatives, interventions, and/or target populations.	consumer involvement in establishing outcomes; • Clarifying and streamlining DBH's role in the system of care to focus on policy and regulatory oversight; • Requiring MCOs to incorporate social determinants of health (SDOH); • Effectively integrating behavioral health services provided outside traditional health system settings; • Increasing assessment capacity for physical and behavioral health needs, metrics, and accountability; • Incorporating a cultural competence framework that includes intellectually and developmentally disabled populations; • Supporting workforce development, including provider recruitment, education, and cross-sector partnerships to support the behavioral health workforce; and • Providing a Certified Community Behavioral Health Clinic (CCBHC) Certification.
4. Please share your perspective on the benefits and potential challenges of using the managed care delivery system to achieve these goals.	13 respondents provided a range of perceived benefits and challenges of using the managed care program to achieve the specified goals of Medicaid behavioral health transformation: Perceived Benefits: • Potential to improve health outcomes • Potential to decrease costs • Opportunity for data-driven performance • Increased innovation Perceived Challenges: • Potential to under-fund behavioral health services • Clinical outcomes have not been defined to assess success of managed care carve-in • Need to reduce unnecessary hospital visits, incorporating SDOH • Facilitate provider negotiations and reimbursement • Ensure that relevant DC Code and Regulations are revised in a timely manner to support implementation • Ensure timely provider credentialing, service authorization, and claims payment • Lack of behavioral health care providers to care for the mental health of children and youth in DC, particularly for very young children (under 5 years), families whose first language is not English, and children with Autism Spectrum Disorder or developmental delays • Provide technical assistance to ensure that health and social providers (e.g., provider training) operate in a coordinated manner • Support for payment-related challenges to the managed care delivery system
5. Please share your perspective on the benefits and potential challenges of requiring MCOs to include DBH-certified providers of Medicaid services in their network of behavioral health services. Please provide	13 respondents provided a variety of perspectives on requiring MCOs to include DBH certified providers in their contracting, including those in strong favor of the option to ensure adequate access to specialty providers and stabilize the provider network during this transition, for at least for the first 12-24 months following October 2021(now planned for October 2022). Others felt that national certifications and network standards could achieve similar goals and that deemed status for certain providers types using these approaches was appropriate. A range of perceived benefits and challenges of requiring MCOs to include DBH-certified providers of Medicaid services in their network of behavioral health services were received, including:

feedback on specifications, standards, and time frame of any provision.	**Perceived Needs or Benefits:** • MCOs are capable of monitoring whole person care. • Current mental health parity reporting requirements can address network adequacy. • Implementing an alternative payment methodology by January 2021 to allow for enough time to incorporate changes before October 2021(now planned for October 2022) for directed payment to providers will help to meet the requirement for CCBHC certification. • Universal contracting would allow DHCF to offer any licensed and credentialed provider a contract. • A coordinating center with links to MCOs and all DBH-certified providers is best positioned to conduct ongoing, comprehensive provider needs assessment and then deliver tailored training and TA in response. **Perceived Needs or Challenges:** • Reconciling DHCF and DBH payment structures. • Requiring evaluations of current Core Service program. • While the DBH certification process serves as an additional layer of vetting and oversight, it does not always make clear what staffing and capabilities are available for community-based providers. • Many providers lack the electronic medical record (EMR) systems and claims processing systems needed to submit electronic claims for the services and check member eligibility. • Hiring Board Certified Behavior Analysts and Register Behavior Technicians. • Coordinating center that links MCOs and DBH-certified providers. • Providers must have capacity to negotiate MCO contracts, efficiently submit, be paid, and reconcile accurate claims, effectively utilize health information in electronic health records, and be fully integrated into the District's Health Information Exchange (HIE).
6. Do you agree with this definition? Please suggest any edits to this working definition: *"The systematic approach to provide person-centered care for a defined population that coordinates physical and behavioral healthcare through a team of primary care and behavioral health clinicians, working with the patients and families. Integrated care models ensure that mental health, substance abuse, primary care, and specialty services*	10 respondents agreed with this definition, one (1) "partially agreed" with this definition. To strengthen this definition, respondents suggested incorporating: • Health equity promotion; • Culturally competent care; • SDOH; • Peer support; • Destigmatization of help-seeking; and • Broadened definition of integrated care team to include a culturally responsive, team-based approach that includes a variety of practitioners (see below). Several respondents suggested replacing "clinicians" with "practitioners" because many people delivering home based services are credentialed but not licensed (e.g., community support workers, peer specialists). The word "clinician" should only be used for people with clinical licensure (LICSWs, LPCs, RNs, etc). One (1) respondent suggested changing references to "patient" or "client" to "enrollees", "beneficiaries", or "persons served."

are coordinated and delivered in a manner that is most effective to caring for people with multiple healthcare needs and produces the best outcomes."	One (1) respondent suggested incorporating concepts from the Standard Framework for Levels of Integrated Healthcare as well as an Organizational Assessment Toolkit developed by the SAMHA-HRSA Center for Integrated Healthcare Solutions.
7. What do you believe are the most critical payment and/or delivery system features of an effective, integrated system of care to support the goals of Medicaid behavioral health transformation?	12 respondents addressed this question, several of whom specifically recommended value-based payments (VBP). Recommendations for Payment Features included: • Streamlining payment of all behavioral health services. • Supporting providers with the transition from fee-for service (FFS) to managed care to facilitate readiness to shift focus from volume to value. • Requiring or encouraging MCOs to enter into VBP agreements with providers, bundled payments, shared savings/risk, rewards, global or capitated payment, strengthen request for proposal (RFP) requirements, and contract terms in areas related to VBP. • Reevaluating rate setting for specialty services to ensure they cover the cost of delivering the service. • Providing payment for prevention and early intervention services, payment for same-day services, increased utilization of "non-traditional" providers, and expansion the My Health GPS program. • Providing an enhanced rate for the deaf population such as automated clearing house (ACH) payments on a weekly basis. • Gradually phasing in changes to payment terms to help provider organizations who are not yet ready to move to VBP. • Using directed payments to support more complex integrated care options, such as CCBHCs. Recommendations for Delivery System Features included: • Accessing information across different electronic platforms, rapid response for individuals who are utilizing hospitals, and effective responses to deter repeat visits. Use of community members, especially peers (not necessarily certified), is essential. • Ensuring claims audits are consistent with current regulations.
8. Are there requirements or approaches to assessment and referral that should be considered to ensure population-level behavioral health screening and assessment for all Medicaid beneficiaries by October 1, 2021?	12 respondents provided requirements or approaches to assessment and referral that should be considered to ensure population-level behavioral health screening and assessment for all Medicaid beneficiaries. These recommendations included: • Supporting a "no wrong door" approach to enable an expanded array of services for providers to utilize best practices, protocols, policies, and procedures to guide the assessment, referral, and care transitions process. • Mandating that providers use a standard set of behavioral health/substance use disorder assessments and adhere to the latest CMS Interoperability and Patient Access Final Rule's technical authentication standards. • Following guidance from the U.S. Preventive Services Task Force regarding frequency of screenings in different health care settings triggered by request of beneficiaries, or symptoms of functional decompensation identified during brief screenings (e.g., PHQ-9). • Fully recognizing and funding outreach and harm reduction services in DBH's current system of care. This may include sobering centers, needle exchanges, and/or residential and outpatient programs • Requesting that any new efforts regarding screening and referral be built on a solid, collaborative foundation.
9. Of the services not	11 respondents provided recommendations on services and benefits that should be prioritized for Phase II inclusion. These

	recommendations included:
currently covered by Medicaid, are there services or benefits that should be prioritized for inclusion in Phase II, if funding allows? Please clearly identify any priority of the recommended services.	- Focusing on services that are targeted toward the most complex and highest-need enrollees, including: - Assertive Community Treatment (ACT); - Cognitive Behavioral Intervention (CBI); - Psychiatric Residential Treatment Facility (PRTF) placements; - Community Supports; - Outreach and harm reduction services; and - Individuals with traumatic brain injury, who may be misdiagnosed with serious mental illness. - Supporting or subsidizing social needs, including: - Housing, particularly for individuals with substance use disorders (SUDs) and returning citizens; - Access to quality food; - Childcare; and - Employment training. - Reviewing local dollar spending, much of which helps support several critical services that promote continuity of care, including: - Treatment team meetings (i.e., different staff meeting with same client); - Discharge planning from hospitals and nursing facilities; - Outreach, engagement, and linkage to services (care coordination), including for Qualified Medicaid Beneficiaries (QMB); and - Release planning/returning citizen programs from the corrections facilities. - Ensuring knowledge of existing community resources to assist in linking members to community organizations to address the conditions of the SDOH, including: - Community-Based Social Services; - Self-Help Referral Connections; - Substance Misuse Treatment Support Services in and School; and - Family Support Services. Other responses: Assessment, Diagnostic and Treatment Services for Children with Autism including neuropsychological assessment and ABA therapy. Remote patient monitoring. The CCBHC model to enable Collaborative Care Codes. Pay for work creating linkages to social and supportive services, including possible adoption of the Z code framework for such activities.
10. Which of these [MCO network participation] requirements, if any, should DBH and DHCF consider in order to promote a whole-	Overall, of the 12 respondents that answered this question, six (6) did not support a requirement that all MCO contracted providers providing behavioral health services should be DBH-certified; and four (4) supported this requirement. The range of perspectives on certification requirements are broadly reflected below: DHCF should require MCOs to implement universal contracting with all DBH-certified providers.

person, population-based, integrated Medicaid behavioral health system that is comprehensive, coordinated, high quality, culturally competent, and equitable?	• MCOs should be required to contract with any critical behavioral health provider licensed and willing to accept their contract terms. • MCOs may contract with any provider who is DBH certified or accredited by a recognized organization such as The Joint Commission, CARF International, or CCBHC. Additional comments regarding whether to require MCOs to contract with DBH-certified providers included: • A desire to increase number of physicians and clinicians providing behavioral health services in MCO provider network overall. • Providing temporary directed payments that are not less than those offered under the Medicaid fee schedule, or providing other rate setting provisions to support carve-in of behavioral health providers. • Releasing MCOs from the contracting requirement after the first year if some of the providers cause them to not to be able to meet their contractual obligations to the District. Additional comments regarding behavioral health requirements in the MCO contract included: • Reporting on behavioral health quality metrics and tie these metrics to payment for all providers. • Including SDOH services and allow behavioral health providers to set their own rates regarding these additional services. • Adopting the cultural competence model developed by SAMHSA. • Requiring DBH, DHCF, and MCO investments to increase capacity for trauma-informed organizations, policies, and care.
11. Are there additional requirements DBH and DHCF should consider to promote a whole-person, population-based, integrated Medicaid behavioral health system that is comprehensive, coordinated, high quality, culturally competent, and equitable? Are there limitations that should be placed on any of these requirements, and if so, what would such limitations look like?	10 respondents responded with additional requirements for the MCO contracts to improve behavioral health integration, including: • Continuing to use the Medicaid Fee Schedule for the rate setting of behavioral health services as they transition to Medicaid managed care. • Requiring an extensive transition period during which no changes are required to either a beneficiary's provider or level of care without beneficiary agreement. • Requiring performance measures to define success. In addition, respondents offered the following recommendations for ensuring continuity of care: • Understand the communities being served. • Protect patient privacy and extend information sharing. • Require providers to report on health needs of population and how they are partnering with the communities. • Support SAMHSA CFR 42 Part 2. • Implement community health assessments into the continuum of care. • Work with the MCOs to establish a standard format and process for collecting data from providers. • Provide financial support to frontline staff to support reliable internet access and quality software and hardware. • Ensure that the quality, skills, and expertise of those conducting prior authorizations and utilization review at least match that of the recommending clinician. • Address children's behavioral health needs through changes to DC's Medicaid Program. • Support the exchange of information among community organizations, MCOs, and providers regarding SDOH and include reporting on SDOH in value-based programs. Support the work of DC PACT to build out an SDOH referral and screening process through the Community Resource Information Exchange Technical Solution (CoRIE) project.

12. What policies are needed to ensure continuity of care and beneficiary protections in a manner that does not unnecessarily jeopardize the success of program implementation?	Seven (7) respondents provided additional policy recommendations in the context of continuity of care. The recommendations included:
	• Incorporating policies that ensure a strong Continuity of Care continuum, such as:
	  o Developing a plan for providing clear and understandable education to service recipients about benefit packages;
	  o Using a one-stop-shop model that facilitates access to multiple disciplines at a single point-of-care, which better serves members under value-based care models;
	  o Requiring MCOs to honor DBH authorizations and prior authorizations for a reasonable period of time after October 1, 2021 for any services moving from FFS to the MCOs;
	  o Delineating which services fall under a 90-day continuity of care policy and which fall under a 180-day continuity of care policy;
	  o Assessing network adequacy at all the different levels of care; and
	  o Assessing the beneficiaries' level of satisfaction with a provider, correlated to their health outcomes.
	• Ensuring effective Transitions of Care, including:
	  o Demonstrating that on-call services are adequately provided and that beneficiaries can reach a live staff person;
	  o Placing clear parameters and definitions around continuity of care to avoid unmanaged increases in utilization during the transition period;
	  o Ensuring accessible patient information data is available to all providers;
	  o Providing the opportunity for patients and providers to ask and get responses to questions;
	  o Clearly articulating and implementing authorization and reimbursement policies;
	  o Providing adequate provider administrative infrastructures to manage increased administrative demands from multiple managed care plans; and
	  o Using and credentialing non-licensed providers.

13. Are there other transition policies that can be implemented to support program implementation, such as supports for providers, care coordination staff, or others?	Six (6) respondents provided transition policy recommendations to support program implementation, including: • Building incentives that promotes successful, well-integrated, comprehensive health outcomes into the reimbursement system. • Ensuring there is alignment between DC Code and municipal regulations, which some respondents commented do not anticipate a fully managed care environment. • Resolving disagreements among various parties about appropriate Level of Care in order to align District government, MCO, and provider expectation. • Creating a new Member Access Center that would deliver comprehensive provider support including technical assistance and training relative to member assessment and other aspects of member care and treatment. • Allowing nurses and other licensed professionals to approve plans of care since they will likely be assisting in developing them. Also, any criteria being used for authorizations or re-authorizations should be transparent. • Emphasizing managed care concepts and practices, including contract negotiation, quality metrics, utilization management, coding, claims submission, payment reconciliation, and auditing, as well as population health management, data sharing, and HIE, VBP and practice transformation, and trauma-informed care.
14. Are there specific requirements related to electronic health information systems that DHCF and DBH	Nine (9) respondents proposed specific requirements DHCF and DBH should consider related to electronic health information systems. Ideas and suggested requirements included: • Supporting a District-wide care coordination platform and SDOH referral system using a standard screening tool. • Making an electronic provider directory accessible.

should consider?	- Implementing a psychiatric Bed Board to help efficiently locate inpatient and crisis beds. - Identifying new software tools to perform the functions of iCAMS and DataWITS that would better meet the documentation, billing, and privacy needs of all users. - Supporting significant investments for providers who currently only participate in DBH's iCAMS system to purchase their own electronic health record (EHR). - Providing or reimbursing for software and mobile applications that provide enrollees with recovery support services. - Enabling patients to create a profile, load medical records regardless of EHR source, store and manage their information using a simple and clean smartphone application or website. - Providing access to the internet as a public benefit and improve access to phones and data plans, especially for those who are experiencing homelessness and are transient. Requirements for standardizing specific standards in the HIE were also provided, including: - Standardizing electronic referral for all health care stakeholders. - Producing a Continuity of Care Document (CCD) summary clinical document for exchange. The agencies should consider open format file types instead of proprietary formatting to allow for data transfer between systems. DHCF would need to provide content-specific technical support. - Ensuring future software is HIPPA compliant. - Ensuring interoperability across multiple EHRs such as Cerner, Epic, Medictech, Athenahealth, Allscripts and CMS Blue Button, to allow clinicians to get the information they need, when they need it. - Requiring all DBH-contracted providers and other service providers procure behavioral health EHRs that are capable of exchanging member data in compliance with the CMS final rule (Stage 2 EHR).
15. Are there specific population health analytic capabilities that DHCF and DBH should require of providers and/or MCOs?	Nine (9) respondents addressed the question regarding specific population health analytic capabilities. Three (3) respondents specifically mentioned that all providers should be required to exchange data in a standardized way such as the DC Health Information Exchange (DC HIE) or mentioned CRISP, the District's Designated HIE Partner, specifically. Additional recommendations for population health analytic capabilities, included requiring: - Providers to use Z codes for SDOH, coupled with demographics to provide a more complete picture of what is available to Medicaid beneficiaries. - Current MHRS rates to take [population health] analysis and systems needed into consideration. - DHCF and DBH to have the capacity to collect and analyze electronic clinical quality measures (eCQMs) data. - The development a roadmap for establishing a longitudinal continuity of care history of enrollee data that will support comprehensive population health analytics. - Claims and clinical data to be available for populations to identify high risk beneficiaries and support personalized treatment plans. - The promotion the adoption of certified technology that complies with the CMS Interoperability final rule and HL7 FHIR 4.0, recognized as the industry's data interoperability standard. - Incentives or providers to adopt, upgrade, and implement certified EHR technology that allows them to chart electronically, code accurately, submit electronic claims to MCOs and share data across the District's designated HIE, CRISP. - Each payor to provide its provider network with the tools to assess member populations using standardized evidence-based assessments. The resulting partnership should be based on an incentivized payment for high risk patients that are identified by

	the payor.
	• Behavioral health providers to submit data for the nine quality measures that are identified as part of the CCBHCs initiative. These analytics should be reported back to providers and readily available, potentially using a web-based system accessible to all providers and near real-time updated.
	
	Additional suggested capabilities or resources include developing a shared analytic platform, which could include capabilities such as:
	    ○ Support for standard and ad hoc reporting
	    ○ Predictive analytics
	    ○ Statistical tools
	    ○ Risk stratification, and
	    ○ Trend analysis with data visualization tools

16. Are there specific health IT supports or technical requirements related to telehealth services that DBH and DHCF should consider?	10 respondents commented on the continued use of telehealth and audio-health and reimbursement at same rates as office visits, as well as ensuring broadband access for all District residents. Telehealth-related recommendations from respondents included: • Working with the Mid-Atlantic Telehealth Resource Center, Connect DC, MCOs, and providers to improve telehealth through broadband access and build on recent initiatives. • Considering the integration of health care plans or questionnaires within the telehealth services that promote patient engagement and active participation, thus reinforcing accountability and enhancing compliance with prescribed treatment plans. • Adopting separate modifier codes for 'audio telehealth' versus 'audio-visual telehealth' to help further develop understanding of the use of audio telehealth through claims analysis without need for clinical documentation review. • Supporting reimbursement of remote-patient monitoring (RPM) by adding RPM codes to the Medicaid Fee Schedule to enable deployment of remote monitoring solutions for residents who suffer from co-occurring chronic conditions, behavioral health conditions, and SUD. Recommended supports and technical requirements included: • Organizing all health information in one place for providers; and sharing a consolidated report of the health information with family, health care professionals, and payers, including automated alerts when possible. • Ensuring a full view of patients' health electronic medical record for doctors, accessible on any device; and receiving alerts for appointments, health changes, referrals, billing, and more. • Ensuring patients have full control/access to all health records from all doctors and the ability to share information with any members of their health team; and providing patients with the ability to access educational resources and be alerted about changes to their health. • Using artificial intelligence to detect health changes, provide alerts to prevent duplication, manage medications and treatments, and connect patients to clinical trials and Internet of Things (IOT) devices.
17. In support of DHCF and DBH's system improvement goals, are there health or supportive services that DHCF should prioritize	The following health or supportive services were recommended by 10 respondents: • Following the Recovery-oriented Systems of Care (ROSC) Framework. • Using the SAMHSA Standard Framework for Levels of Integrated Healthcare to help drive improvement in care coordination of enrollees with physical and behavioral health needs. • Using the CCBHC model. DHCF works with MCOs to consider setting baseline bundled payment rate, while also allowing

adding to the Medicaid behavioral health service array to promote integrated care? Are there approaches to care coordination that DHCF and DBH should adopt to promote integrated care across continuum of services?	for providers to directly negotiate with MCOs for additional quality bonus payment tied to selected measures. • Providing residential support services and coaching. • Enabling Psychiatric Collaborative Care Management (PCCM) through CPT Codes 99492- 99494, included in the District's Medicaid fee schedule that integrates non-traditional behavioral health practitioners into primary care and hospital-based settings. • Using Dialectical Behavioral Therapy (DBT), including time spent both in groups and for phone coaching. Recommendation to increase availability of outpatient services and trained DBT clinicians. • Using Health Behavior Assessment and Intervention (HBAI)

18. Are there specific strategies DHCF and DBH should employ to meet the needs of special populations, including children or youth with special health care needs, children in foster care, individuals with developmental disabilities, or individuals with co-occurring mental health and substance use diagnoses, among others?	12 respondents provided very strong support for targeted interventions to serve special needs populations. Providing screening and referral services offered across the continuum of care was mentioned by several respondents.
	
	Recommendations for Foster Care Enrollees included:
	• Providing clear pathways to accessing care for children in the DC foster system across the District, Maryland, and any other applicable jurisdiction.
	• Developing collaborative cross-sector outcomes measures to help track the overall success of managing foster care enrollees, including safety outcome rates, foster care removal rates, and school readiness measures.
	• Ensuring health workforce plans include recruiting and retaining adequate clinicians with appropriate trauma-informed training to provide health care for children in foster care.
	• Providing automatic behavioral health services for any child who enters foster care.
	
	Recommendations for Individuals with Social Support Needs (to address social determinants of health) included:
	• Connecting enrollees who have special needs with nonmedical services. Proposed examples include:
	  o The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) tool, which can be used by providers to collect SDOH core measures
	  o National standards for systems of care for Children and Youth with Special Health Care Needs (CYSHCN), including screening, assessment, referral, eligibility, enrollment, and access to care.
	
	Recommendations for Children, Youth, Families included:
	• Working with MCOs and providers to help establish specialty networks like the autism specialty care network of providers, who are experienced in delivering whole-person care beginning with early intervention, diagnosis assessment, and treatment.
	• Reviewing the unique challenges in the current Medicaid behavioral health systems of care for children, youth, and families.
	• Supporting the needs of pediatric patients with acute psychiatric needs, including Intensive Outpatient Supports (IOP/PHP); Crisis Stabilization Unit; and bridging clinics for youth who are being discharged from inpatient psychiatric units.
	• Serving youth at risk or diagnosed with SUD
	• Keeping special populations carved outs and handling these individuals like the Home and Community Based Waiver for the Intellectually Disabled.
	• Working with the infant and early childhood mental health (IECMH) technical assistance working group to implement IECMH strategies.
	• Continuing to work with community-based organizations and other stakeholders to increase access to Perinatal Mood & Anxiety Disorder (PMAD) screenings and easily accessible integrated care treatment options in OB/GYN and pediatric

primary care settings resources as well as inclusion of the new 2020 perinatal HEDIS measures in quality of care metrics and reporting, which cover prenatal and postpartum depression screening and follow-up.

Recommendations for Individuals with Autism included:
- Implementing an Autism Spectrum Disorder (ASD) Medicaid benefit for children At-Risk or Diagnosed with ASD.
- Developing and enforcing strategies to achieve parity and network adequacy specific to the medical needs of patients with Autism.
- Collaborating with the newly formed DC Autism Collaborative.
- Increasing number of providers trained to work with ASD.

Recommendations for Individuals with SUDs included:
- Providing a greater variety of recovery supports, including:
  - Services for specific segments of the SUD population (e.g., veterans, men/women, men and women, LGBTQ+ populations, mothers with children),
  - Services of different types, (e.g., peer groups, community centers, housing first models, one-on-one mentorship or coaching programs), and
  - Services with different policies or approaches (e.g., sober and non-sober living, 12-step, SMART Recovery, faith-based or secular).

19. Are there particular value-based or accountable care models DHCF should consider?	11 respondents answered this question. Five (5) respondents specifically advocated for the Collaborative Care Model and/or CCBHC Model.

Comments and recommendations regarding a range of VBP models included:
- Providing flexibility, creativity, relationship building, and a commitment to reaching shared objectives for providers and MCOs when establishing behavioral health-focused VBP models need. Recommend keeping the contractual requirements that are in place today with the MCOs.
- Promoting VBP opportunities around addiction support and recovery services that cover the full continuum of levels of care as identified by the American Society of Addiction Medicine, including an opioid treatment program bundle. Consider the Patient-Centered Opioid Addiction Treatment Payment (P-COAT) model.
- Focusing VBPs on utilizing SDOH information and incentivizing closed-loop referrals to community-based organizations (CBOs) and health service organizations.
- Using the Health Homes (HH) model to target unique high-risk Medicaid users or implement a HH in a more generic primary care setting.
- Building upon the primary care medical home (PCMH) model.
- Promoting and incentivizing behavioral health providers who are further along in their efforts to integrate behavioral and physical health by co-locating mental health, addiction, primary care, pharmacy, and laboratory services, and operating as a team with a whole-person focus and shared practice model.
- Exploring the opportunity to create and implement Certified CCBHCs in DC.
- Encouraging the District to adopt specific targets for managed care value-based purchasing of behavioral health services, including targets for HCP LAN Level 3 and 4 arrangements for behavioral health.
- Visiting the National Council for Behavioral Health through the Care Transitions Network program website funded by CMS |

	for tools to implement.
20. Please provide specific examples of infrastructure investments, workflow and practice improvement strategies, or other innovations that DHCF and DBH should consider implementing in the next five years to promote comprehensive, integrated care? Where possible, please provide relevant examples of evidence-based models and/or promising state and local approaches.	11 respondents offered a range of perspectives on infrastructure investments, workflow and practice improvement strategies, or other innovations that DHCF and DBH should consider in the next 5 years. Recommendations for Practice Improvement Strategies and Workforce included: • Supporting small medical offices. For example, CRISP's model of providing IT support to small practices to integrate them into their systems is a model for behavioral health that DHCF and DBH must consider moving forward. • Funding Quality Improvement Learning Collaboratives for Pediatric Primary Care. • Increasing or establishing funds to support behavioral health training of high school, undergraduate, and graduate level students to increase interest and preparedness for working in an integrated care setting. • Improving screening and referral management for social service supports to reduce care fragmentation and enhance the consent management processes. Recommendations for Rates and Certification included: • Ensuring MHRS rates and Medicaid rates are the same for behavioral health services. The system of Core Service Agencies, sub-providers, and specialty providers should be eliminated and replaced with just DBH-certified providers. • Using deemed status instead of DBH certification. • Auditing by MCOs and DHCF, not DBH. References to other strategic plan recommendations or national that should be reviewed and considered included: • DC National Alliance for Mentally Ill (NAMI) • District State Innovation Model (SIM) plan • The 2020 report completed by the National Council on Behavioral Health • The CMS Transforming Clinical Practice Initiative (TCPI) model • The Center for Healthcare Integration's Organizational Assessment Toolkit – and each of its four component assessments.
21. Please provide specific examples of evidence-based models or interventions that DHCF and DBH should consider implementing in the next five years to promote comprehensive, integrated care? Are there specific strategies that should be considered to ensure the Medicaid behavioral health system improves health equity for all District residents?	Several respondents recommended continued funding for current health equity efforts, as well as more financial incentives for evidence-based models. The following specific models of integrated behavioral health were recommended for further review and potential reimbursement: • Psychiatric Collaborative Care Model (PCCM), with regular population health management services from consulting psychiatrists incorporated into primary care-based mental health or addiction services • Health Behavior Assessment and Intervention (HBAI) CPT codes • Behavioral Health Integration (BHI) Model to address mental health, substance abuse, or both • DC Mental Health Access in Pediatrics (DC MAP) program • Primary Care Behavioral Health Model • Evidence-based models highlighted by the National Register of Health Service Psychologists' Integrated Healthcare Training Series • Evidence-based models highlighted in the Transforming Child and Family Behavioral Health in DC • The Transition of Behavioral Health Services into Comprehensive Medicaid Managed Care (June 2020) National Council of

February 2021

Behavioral Health
- ASAP-MCPAP Consultation line: The Massachusetts Child Psychiatry Access Program (MCPAP) and Adolescent Substance Use and Addiction Program at Boston Children's Hospital (ASAP)

Additional comments on interventions and evidence-based models to promote comprehensive care included:
- Assessments and Outcomes
  - Using meaningful assessments that realistically capture necessary information and REPLACE others that are currently mandated (like the LOCUS).
  - Objectively measuring overall outcomes and rewarding those agencies that perform above the standard (probably financial).
- Workforce
  - Advancing the use of Peer Support Services. Peer Recovery Specialists will provide direct peer-to-peer support services to enrollees with mental illness, SUDs, or co-occurring disorders.
  - Further supporting workforce development and billing of services independent of setting or provider type to allow any health system to have a mechanism for funding these positions and integrating this helpful service into their workflow.
- Addressing Health Disparities
  - Mirroring the recommendations of the *Health Equity Report for the District of Columbia 2018*. More intensive interventions on the highest-needs census tracts are needed to demonstrate an equity approach to place-based care and population health.
  - Requiring all performance data analyses to be stratified by race or ethnicity and including disparity-sensitive measures among performance metrics. District should emulate states that deliberately include members in the design and evaluation of the value-based payment system.
  - Developing partnerships and supportive interventions with community organizations (such as the DC Housing Authority) and utilizing Community Health Workers to deliver evidence-based interventions and a multi-disciplinary approach to reducing health disparities within the community.
  - Addressing adverse childhood events (ACEs).
- Payment Models
  - Working with MCOs to consider setting a baseline bundled payment rate for one or more condition-specific populations, while also allowing for providers to directly negotiate with MCOs for additional quality bonus payment tied to selected measures.
  - Considering VBP programs that focus on the behavioral health needs of children and families, including bundled payments and episodes of care.