February MCAC Meeting

February 28, 2024

Virtual Meeting

MCAC Agenda

1. **Welcome and Roll Call**

2. **New Member Introduction** (5 minutes)
    1. Rachelle Ellison
    2. Saleem Shah
    3. Tabitha Morris

3. **DHCF Updates and Q&A** (30 minutes)
    1. SPA, Waiver, Regulations
    2. Medicaid Renewal
    3. Quality Strategy
    4. Behavioral Health Integration

4. **Discussion** (50 minutes)
    1. Revisiting Business Transformation Technical Assistance Report and Recommendations
    2. Maternal Health Advisory Group

5. **Access Subcommittee Update** (5 minutes)

6. **Strategic Session Planning** (15 minutes)

7. **New Business** (10 minutes)

8. **Public Announcements** (5 minutes)

DHCF Update

State Plan Amendment/Waiver and Rulemaking Report (see attached)

Medicaid Renewal

Quality Strategy

Behavioral Health Integration Pause

Medicaid Renewal

Medicaid Beneficiaries are Finishing the Process of Renewing their Coverage for the First Time in 3+ Years

- After a pause between March 2020 and April 2023 because of the Continuous Enrollment provision and the public health emergency, the District restarted Medicaid eligibility **renewals beginning April 1, 2023.**
- Renewals were divided ~evenly over 12 months.
- The **first eight groups that have been required to renew coverage have had their eligibility expire already.**
- For those first contacted on April 1, 2023, and who need to submit a renewal in 2024, the District will ask for their renewals again on April 1, 2024.
- Medicaid Renewal is not over –the District still needs to accept and process the renewals of many beneficiaries, along with any extensions and the 3-month grace period.

DHCF is Pausing Terminations and Reinstating Eligibility for Children with SSI Program Codes

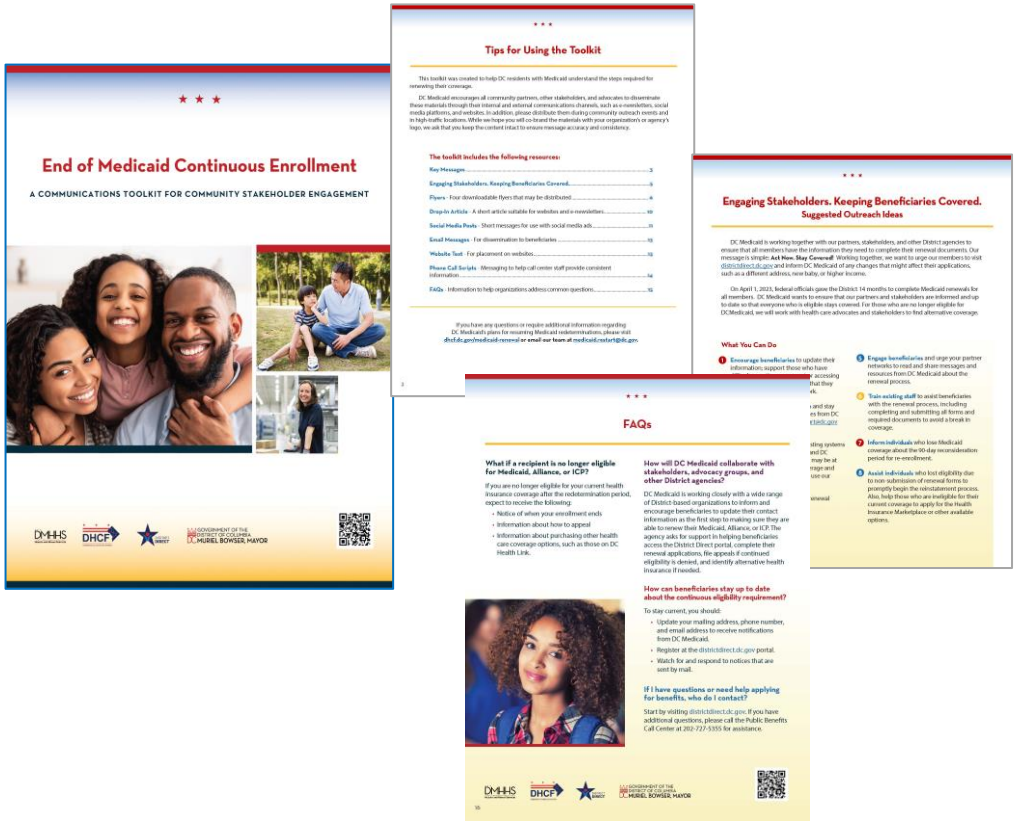
- **Effective January 31, 2024, DHCF: 1)** temporarily **paused** SSI Terminations for children under 21; **2)** is fully **reinstating** eligibility for approximately 130 improperly terminated SSI children (and any subsequently identified improper SSI terminations); and **3)** is temporarily **reinstating** the targeted population of high-need disabled children to minimize disruption in access to care while DHCF conducts further review of disenrollments.
  - Temporary pauses and reinstatements will be in place through April 30, 2024, or until eligibility system functionality is corrected, whichever is later.
- DHCF has requested priority follow-up with SSA to determine root causes for SDX transmissions/reason codes that differ from SSI eligibility status verified by direct calls to SSA.
  - If you or a client has had this experience, please let us know by emailing medicaid.renewal@dc.gov *(please note "SSA Issue" in the subject line).*
- DHCF is working on system updates to address all identified system functionality issues contributing to improper SSI disenrollments.
- DHCF's review of SSI terminations is ongoing. DHCF will share additional information about its findings and planned mitigating steps in future meetings.

DHCF Started a New Advertisement and Outreach Campaign Around Mail and "Act Now. Stay Covered!"

- **<u>DHCF started an advertising and outreach campaign on Feb. 5</u>**
- These ads emphasize that most beneficiaries will have received information by mail and create a sense of urgency to act
- "Act Now. Stay Covered!" is the new tagline, emphasizing steps to take to complete a renewal
- The ads will run primarily on transit, radio, television, and community newspapers

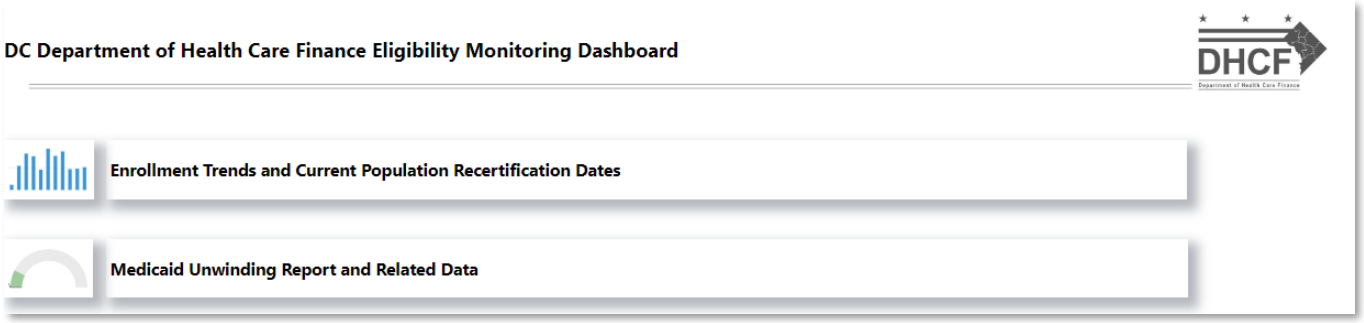
DHCF Updated its Stakeholder Toolkit and Fliers

- **<u>DHCF updated its Fliers and Stakeholder Toolkit for 2024</u>**
- The Toolkit is the best place to get District-approved messaging on Medicaid Renewal.
- Translations into 6 languages are forthcoming very shortly for the new version and are already available for previous versions.
- These are available to print on the Medicaid Renewal website - please display fliers any place they would reach people!

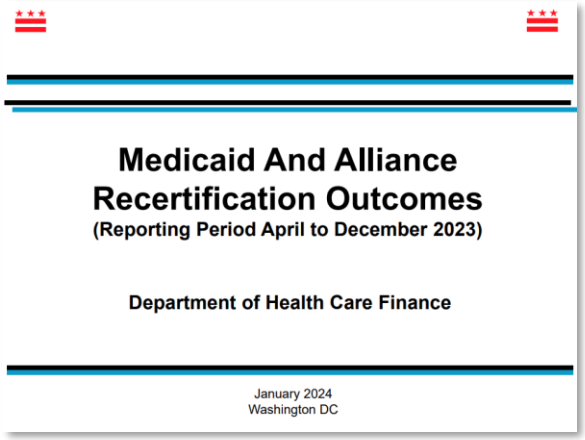


DC Medicaid Renewal Data is Publicly Available and Regularly Updated on the DHCF Website

- **Dashboard data** at https://dhcf.dc.gov/eligibilitydashboard is as of January 15. For an overview, see the 1/17/2024 community meeting materials.

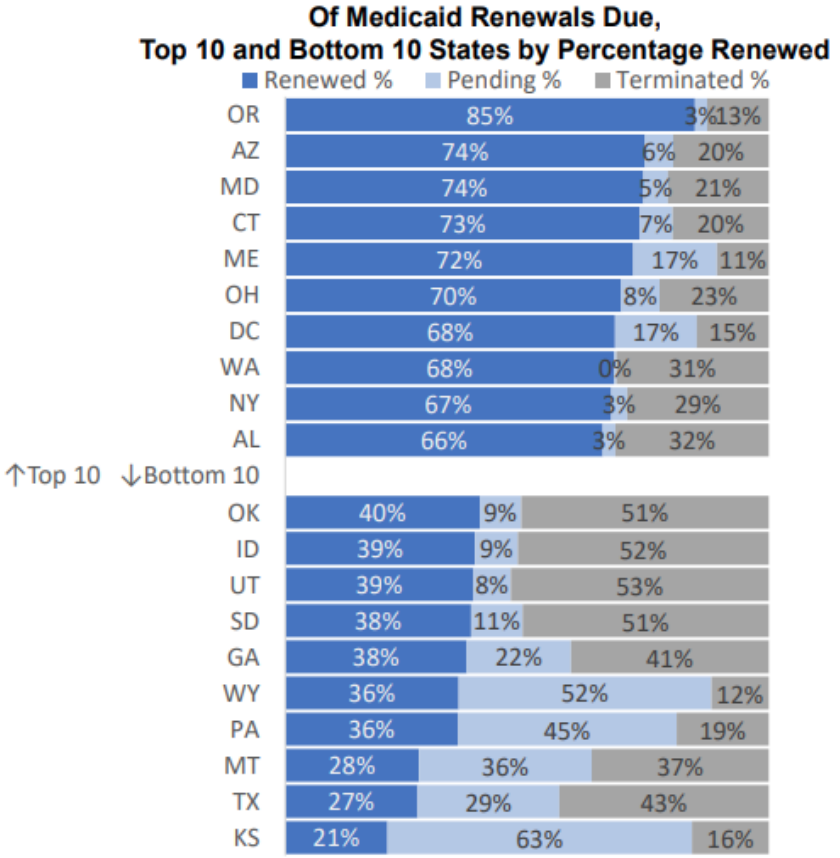


- DHCF recently released its **monthly report on Medicaid redeterminations** at https://dhcf.dc.gov/medicaid-renewal. The monthly reports summarize information from the dashboard but also provide additional detail on characteristics of beneficiaries whose coverage was renewed, those who have not responded, and pending renewal timing.



Redetermination Report Data: Renewal Rates in the District Remain High Relative to Many Other States

- DC currently has among the highest overall and passive renewal rates in the nation.
- For example, 68% of DC Medicaid beneficiaries due in May-November had renewed as of December 18 (before DC's latest dashboard update in January).
  - DC ranked 7th highest out of 46 states with data for the overall renewal rate (see chart at right).
  - DC also ranked 9th highest for the rate of passive renewals (data not shown).
  - A variety of factors contribute to variation across states, including differences in the groups being targeted for early renewals as well as differences in renewal policies and system capacity.



Redetermination Report Data: Many Enrollees Are Responding During The 90-Day Grace Period

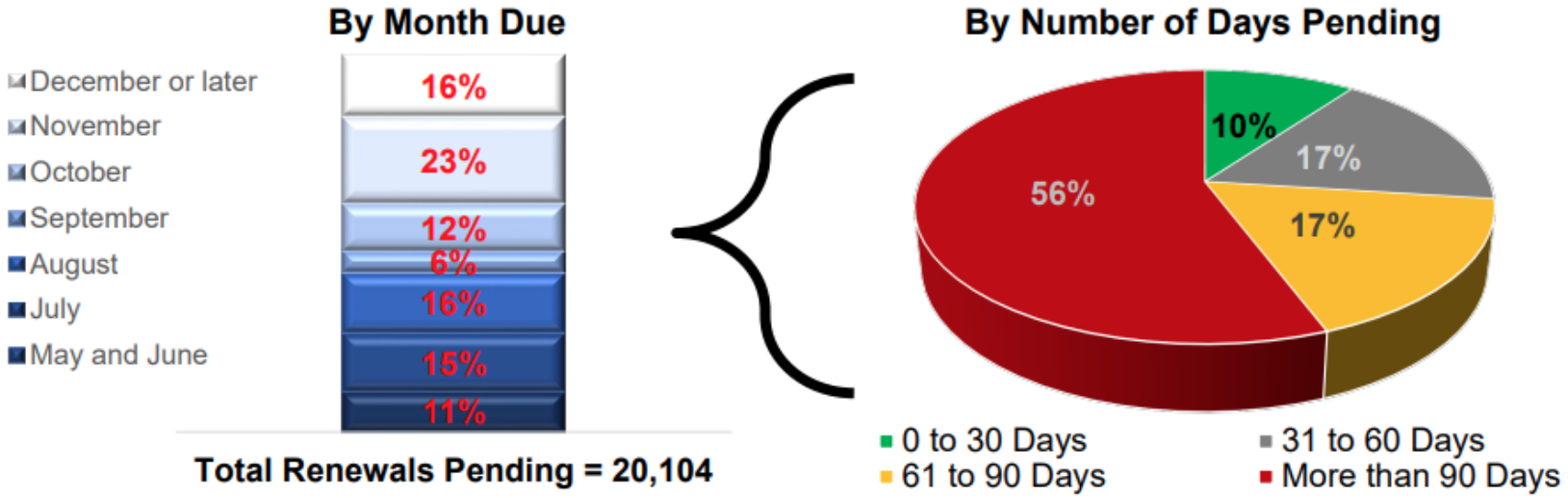
Medicaid Beneficiaries Who Responded During Their 90-Day Grace Period, by Month Due for Those Due in May – December

Month Due	Beneficiaries with Response to a Non-Passive Renewal	Responded During Grace Period	Grace Period Percent of Response Total
May 2023	2,983	918	31%
June 2023	6,813	1,968	29%
July 2023	13,267	3,945	30%
August 2023	12,419	3,318	27%
September 2023	4,993	1,098	22%
October 2023	9,273	2,106	23%
November 2023	9,491	1,871	20%
December 2023	2,926	337	12%
Total	**62,165**	**15,561**	**25%**

- The 90-day grace period for all beneficiaries due in September or earlier has concluded.
- Responses for those due in October or later do not yet reflect their full 90-day grace period and will therefore continue to increase in the coming months.

Redetermination Report Data: Coverage is Maintained while Renewals are Pending

Percent of Medicaid Beneficiaries With A Pending Renewal, By Month Due And Length Of Time In Process



- The number of days pending is counted from the date the renewal was received (not the date it was due).
- During the period when a renewal is pending, coverage is extended until a determination is made.

The District has Multiple Ongoing Methods of External Outreach and Wants to Join your Meetings too!

- The District wants to join meetings of key stakeholders to explain Medicaid Renewal.
  - ✓ *DHCF staff would attend meetings hosted by your stakeholder group - or that you know about – send invites to us via email at Medicaid.restart@dc.gov.*
- The District created a website with information on Medicaid Renewal and the End of the Public Health Emergency that hosts the Unwinding Plan, Stakeholder Toolkit, meeting recordings and slides, etc.
- The District is hosting regular Community Stakeholder meetings such as this every other week - continuing every other Wednesday at 2:30p.m. and **next is on Wednesday, March 13, 2024**
  - ✓ *Please email Medicaid.renewal@dc.gov to join the meetings and related mailing list if not on it already*
- The District is holding monthly Beneficiary-Focused Meetings on 'How Do I Renew My DC Medicaid Health Insurance"– the 9th is **in March**.
- The District is continuing monthly Districtwide Trainings on Medicaid Renewal designed for stakeholders and anyone helping others with renewals – the 12th is **in March**.

For Official Government Use Only

Quality Strategy

Process Overview

- DHCF released a draft Quality Strategy for a public comment period of 31 days from 12/8/2023 – 1/8/2024.
- DHCF presented an overview of the Quality Strategy to MCAC on 12/20/2023.
- The Quality Team reviewed comments and updated the document where possible in January 2024.
- Revised Quality Strategy submitted to CMS on 1/31/2024.
- Comment themes were shared with Managed Care Plan leadership.
- The Quality Team working to post the final Quality Strategy on the DHCF website.

Breakdown of Submissions

Quality Strategy Commenters

- There were a total of eight (8) individual submissions
- Submissions ranged from individuals to organizations

Breakdown by Organization Type

- Primary Care/FQHC's
- Community advocate
- Health Insurance
- Behavioral Health
- Dental
- Legal

Comment Themes

- **Value-Based Purchasing Program**
  - Provide greater transparency and public reporting on VBP oversight and monitoring.
  - Provide more stringent oversight and guidance from DHCF on VBP requirements (e.g. which arrangements qualify, consider FQHCs and how they fit within VBP).
- **Behavioral Health**
  - Develop and test measures for Infant and Early Childhood Mental Health.
  - Measure the wait for non-acute behavioral health care in days.
- **Quality Measures**
  - Inclusion of Prenatal and Postpartum Depression Screening/Follow Up a part of Goal 3.1 (Improve Population).
  - Consider the inclusion of a patient experience measure for respectful care as it relates to maternal health.
  - Include objectives for Health Equity.

Comment Themes, continued

- **MCP Contract Modifications**
  - Require MCPs to obtain additional NCQA accreditations – Health Equity, Managed Behavioral Health Organization.
- **Performance Improvement Projects (PIPs)**
  - Add an Infant and Early Childhood Mental Health PIP.
  - Provide further clarity on the “follow up” visit for the behavioral health PIP.
- **Network Adequacy**
  - Format standardization for community resources.
  - Include an objective to track the number of credentialed dentists.
  - Expand the measures of “Timely Access” to mental health care with the goal of more accurately quantifying the capacity of behavioral health providers in the Medicaid network.

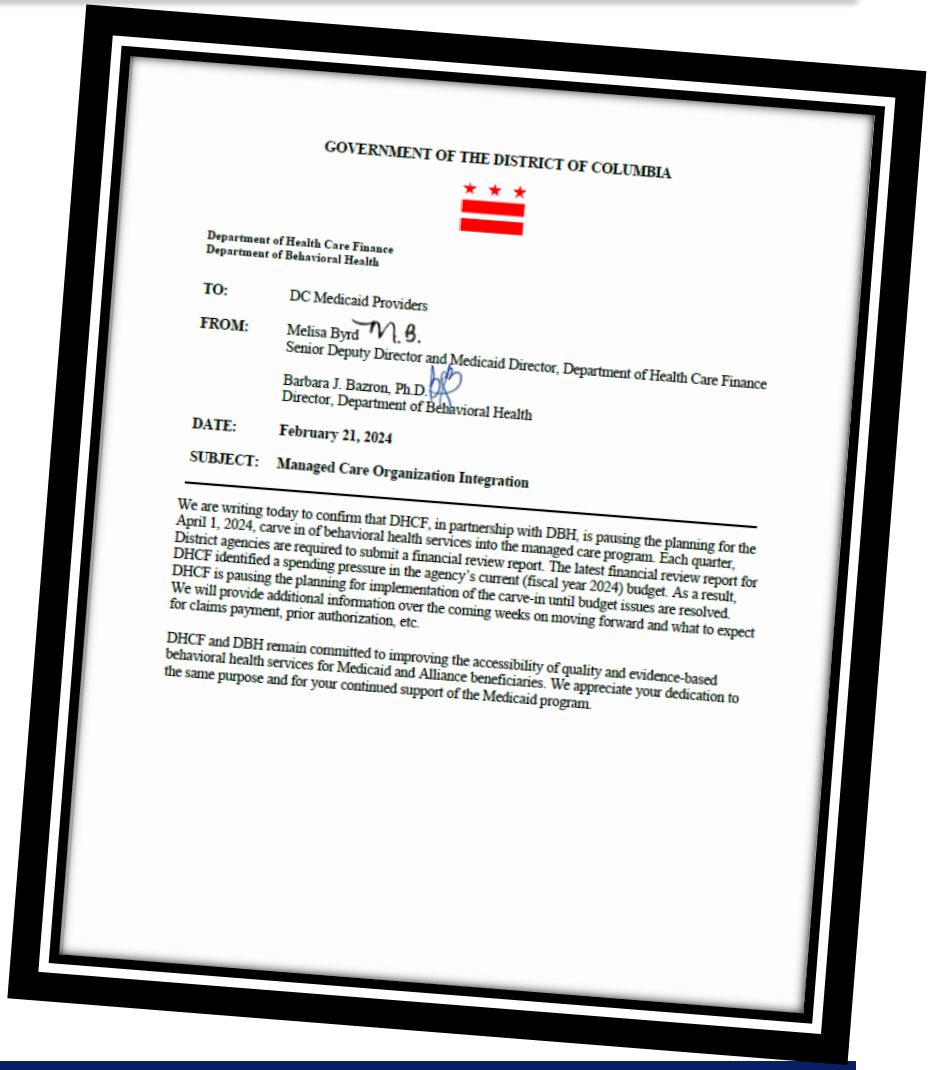
Quality Strategy Updates

Section of Quality Strategy	Updates/Change
Agency Organization	Added a statement highlighting the administration responsible for oversight of the MCP contract at DHCF.
Updates and Revisions	Added link in footnote to Annual Technical Report, which assesses effectiveness of the Quality Strategy.
Goals and Objectives	Added the NCQA Lead Screening measure to Goal 3 within the Goals and Objective Table of the Quality Strategy.
Goals and Objectives	Removed objective 2.8 from as it was a duplicate of goal 1.10 from Goal 1.
PIPs	Added statement to the PIP section clarifying inclusion and exclusion criteria for an individual's (enrollee) participation in multiple PIPs.
Table 3. Summary of PIP Topics	Added bullet points for the Comprehensive Diabetes Care PIP and a footnote detailing the timeline for the PIP.
Appointment Availability Table 5. Timely Access Standards	Added language specifying age ranges and clarifying categories for pediatric timeliness standards.
Medical Necessity	Added language clarifying Medical Necessity with respect to EPSDT guidelines.
Authorization of Services	Added bullet point to include an enrollee's right to have counsel or another representative in the Appeal and Fair Hearing process.

Behavioral Health Integration Pause

DHCF Sent Notice to Providers Regarding Behavioral Health Integration Status

On February 21, 2024, the DHCF and DBH sent a letter to providers pausing the planning of the April 1st carve-in of behavioral health services into the managed care program until FY2024 budget pressures have been resolved.



GOVERNMENT OF THE DISTRICT OF COLUMBIA

Department of Health Care Finance
Department of Behavioral Health

TO: DC Medicaid Providers

FROM: Melisa Byrd M.B.
Senior Deputy Director and Medicaid Director, Department of Health Care Finance

Barbara J. Bazron, Ph.D.
Director, Department of Behavioral Health

DATE: February 21, 2024

SUBJECT: Managed Care Organization Integration

We are writing today to confirm that DHCF, in partnership with DBH, is pausing the planning for the April 1, 2024, carve in of behavioral health services into the managed care program. Each quarter, District agencies are required to submit a financial review report. The latest financial review report for DHCF identified a spending pressure in the agency's current (fiscal year 2024) budget. As a result, DHCF is pausing the planning for implementation of the carve-in until budget issues are resolved. We will provide additional information over the coming weeks on moving forward and what to expect for claims payment, prior authorization, etc.

DHCF and DBH remain committed to improving the accessibility of quality and evidence-based behavioral health services for Medicaid and Alliance beneficiaries. We appreciate your dedication to the same purpose and for your continued support of the Medicaid program.

Discussion Topics

Revisiting Business Transformation Technical Assistance Report and Recommendations

Maternal Health Advisory Group

Medicaid Business Transformation DC: Next Steps on Technical Assistance Recommendations Report

Elizabeth Garrison
Health Care Reform and Innovation Administration, DHCF
Medical Care Advisory Committee
February 2024

Moving Forward:
Next Steps to Support District Providers

I. Recap of Business Transformation Grant and Key Recommendations **(5 min.)**

II. Review BT Technical Assistance Pilot **(5 min.)**

III. DHCF Approach to Technical Assistance with Integrated Care DC **(5 min.)**

IV. Open Discussion/Next Steps **(20 min.)**

Business Transformation Grant Overview

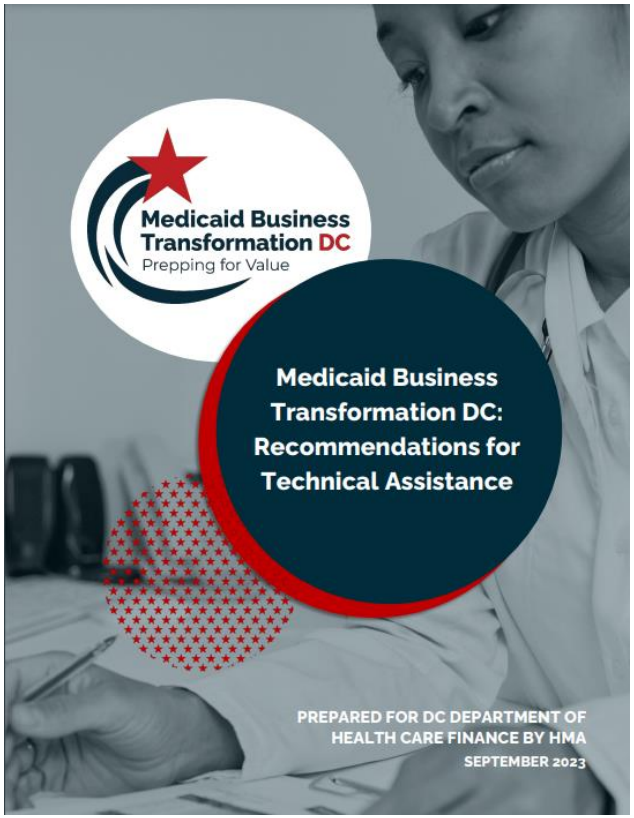
The goal of the Business Transformation grant was to support Medicaid provider practice transformation and facilitate integrated whole-person care by enhancing providers' ability to collaborate across entities and participate in value-based care arrangements.

DHCF's grantee Health Management Associates received funding to perform a landscape assessment of Medicaid providers' needs for legal analysis, financial consulting, and business development support.

In response to findings, HMA delivered a pilot technical assistance collaborative, value-based payment toolkit, and workshop on value-based care. All materials can be found at the Integrated Care DC website: https://www.integratedcaredc.com/medicaid-business-transformation-dc/.

Recap: Grantee's Landscape Analysis

1. Findings from a literature review of national value-based payment (VBP) best practices, published materials, and a scan of the District's healthcare reform landscape;
2. Results from focus groups, interviews, and a technical assistance (TA) survey with District organizations, agencies, and stakeholders on provider barriers and readiness to deliver value-based care; and
3. Policies and best practices for the District and DHCF that are drawn from leading edge states to advance value-based care and transform the healthcare delivery system.



Full report: https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/TA%20Recommendations%20Report_DC%20BTTA_Final.pdf

Recap: Key Recommendations for System Changes

1. Increase stakeholder engagement and communication in the design, development, and implementation of VBP models.
2. Develop clear definitions and a common methodology for measuring revenue growth tied to value-based care delivered to individuals covered by Medicaid managed care.
3. Align and limit quality measures and increase incentives across MCOs.
4. Enhance opportunities for integrated and complex care models through reimbursement and delivery models (health homes, CCBHCs).
5. Adopt regulations and guidance to advance provider-led entities (e.g., ACOs, CINs, IPAs) in the District.
6. Issue regulatory guidance related to the FQHC's ability to capitated reimbursement from the Medicaid MCOs as part of the wrap payment submission.

Recap: Key Findings from Landscape Assessment

Domain	District Reported Barriers
Business/ Operational	▪ Lack of knowledge about VBP (e.g., contracts, negotiation) ▪ Untimely MCO payment ▪ Silos within District (e.g., lack of natural incentives to work together) ▪ Resistance to change/culture shift (particularly in independent practices) ▪ Staffing (e.g., limited resources, workforce shortages) ▪ Technology ▪ Corporate/government distrust
Financial	▪ Variation in rates ▪ Lack of standardization in payment methodology ▪ Cash management
Legal	▪ Lack of understanding with contracts and negotiating better arrangements ▪ Concerns with workforce and managing DC requirements
Clinical	▪ Improved access to care ▪ Standardized workflows ▪ Sufficient staffing
Data	▪ Lack of actionable, user-friendly information ▪ Better data needed on claims/payments; current systems inadequately setup ▪ Limited data systems

National VBP Models

What is successful?

- Successful Models
  - Adopt consistent standards, clear benchmarks
  - Focus on population health and embed health equity and outcomes
  - Include a framework that is not based on a FFS chassis
  - Alignment of metrics across payers
- Providers and Payers
  - Enhance infrastructure and upfront investments to build APM competencies
  - Develop robust IT investments and model
  - Develop transparent payer-provider partnerships

Why is it successful?

- Develop consistent VBP programs including metrics and performance targets across payers to send an aligned definition of high-value care
- Encourage providers to address community health needs and provide targeted interventions that address social drivers of health
- Allow upfront investments to develop infrastructure and necessary resources for effective participation in VBP
- Incent payer/provider partnership opportunities that align goals, data and resources, and establishes shared accountability
- Identify outcome measures and their definitions at the District level

How can we be successful?

- Identify infrastructure investment needs and mechanisms for addressing them
- Develop processes for outcome measure indicator identification and definition
- Identify VBP strategies and provide technical support to operationalize clinical progression from FFS to more advanced payment models
- Provide technical support that assists providers with understanding contract requirements
- Provide training to enhance understanding of financial implications of contracts, reserves and other aspects

Recap: Key Recommendations for Technical Assistance

1. The District should continue offering no-cost TA along with providing upfront investments and resources to prepare healthcare organizations to deliver high-quality value-based care.
2. The TA approach should be flexible to meet a variety of provider needs. The approach should vary based on provider type, size, and complexity, and provide a range of TA options to improve readiness for value-based payment (VBP).
3. The District should develop additional guidance, criteria, benchmarks, and standards for managed care VBP programs that include both medical and behavioral health expenditures.
4. Based on other state experience, multiple years and significant technical support is necessary for transformation of provider business, legal, and financial operations, including support around:
    - Provider readiness for success with advanced payment models (APMs);
    - Multi-payer alignment of APMs, including reporting and claims requirements, reduces administrative burden on provider entities;
    - Provider collaboration and integration through creation of new business models, including accountable care organizations, clinically integrated networks, and provider-led entities.

Review of Business Transformation Grant TA Pilot

- In August and September 2023, the Business Transformation grant served 48 distinct provider entities with technical assistance, training, and resources.
- Although the timeframe was compressed, the grantee created a site page with recorded training and VBP toolkit materials on the Integrated care website to offer all materials for asynchronous learning that all District Medicaid providers can access at any time
- The Value-Based Payment Virtual Learning Collaborative included a day-long workshop with legal and finance tracks focusing on formation of community partnerships, financial modeling, revenue cycle operations, and clinical documentation in VBP arrangements

Business Transformation Grant:

- **131** individuals from 48 organizations joined at least one of 18 live webinars and 1 workshop
- **4** cohort learning tracks, including: VBP Foundations; Behavioral Health; FQHCs; and Legal and Contracting

DHCF's Approach to Integrated Care TA Furthers VBP

- Since 2021, DHCF has leveraged Integrated Care DC to deliver targeted TA, on-site coaching, and community learning to support clinical best-practices, technology, and processes to deliver whole-person care by:
  - Delivering patient-centered care across the care continuum;
  - Using data and population health analytics to improve care; and
  - Engaging leadership to support value-based care.
- FY24 learning opportunities focus on improving provider readiness for VBP, improving quality metrics and impacting care outcomes.
  - Cost of Care Learning Series.
  - CRISP DC Tools Learning Series.
  - Leadership Through Change Learning Collaborative.
  - *Coming Soon: Learning opportunities for VBP-participating practices in collaboration with MCPs.*

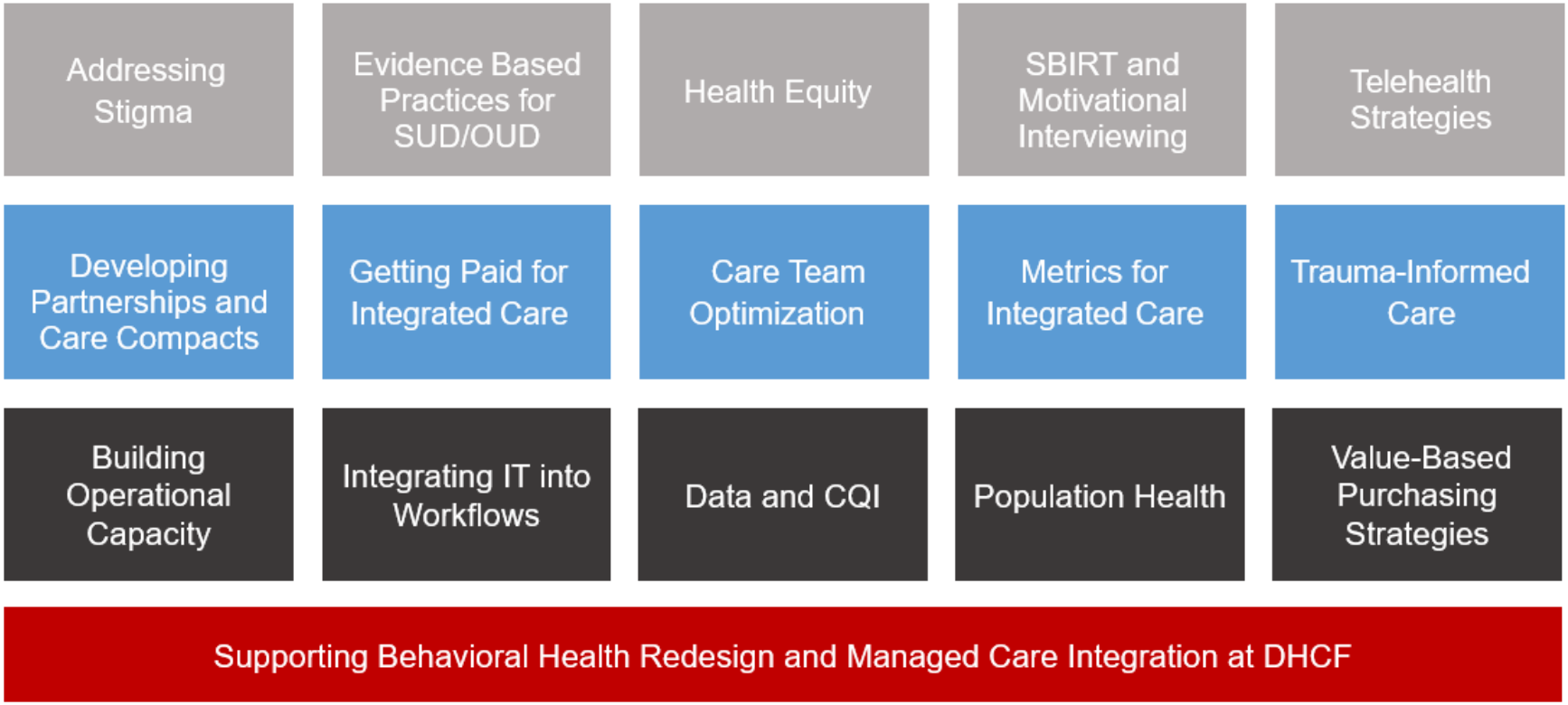
Integrated Care DC:

- **567** individuals from 165 organizations joined at least one of 61 live webinars
- **125** individuals from 60 organizations attended the MCP panel at a Managed Care Readiness Workshop
- **50** sites across a wide array of provider types engaged in practice-level coaching

Integrated Care DC Program Overview

- Integrated Care DC enhances Medicaid providers' capacity to deliver whole-person care for the physical, behavioral health, substance use disorder, and social needs of beneficiaries.
- The technical assistance program is managed by the DC Department of Health Care Finance (DHCF) in partnership with the DC Department of Behavioral Health (DBH).
- Open to all DC Medicaid providers, including physical health, behavioral health, specialty, and other provider types

Integrated Care DC Training and TA Focus Areas



Discussion

- What technical assistance and resources would be helpful in FY24 to support the implementation of new managed care value-based payment initiatives?
- As DC Medicaid moves forward with value-based care and 1115 waiver health-related social needs services, what strategies can DHCF implement to support provider collaboration and integrated care networks? What infrastructure and technical assistance supports are needed in FY25 and FY26?
- What are the challenges that providers are experiencing in engaging with Integrated Care DC and other TA resources? How can we get more engagement and provide the right support to build capacity to deliver high-quality whole person care?

Maternal Health Advisory Group

Maternal Health Advisory Group

- DHCF convened an 18-member Maternal Health Advisory Group composed of District agencies and stakeholders with experience in maternal health, to inform the expansion of postpartum coverage and maternal health services.
- The Advisory Group met between January and July 2022 to take public input on the service array, financial impact, and coverage.
- Accomplishments:
  - Advised on training, public outreach, program support, and other items related to implementation of new maternal health coverage and benefits.
  - While the Advisory Group did not issue formal recommendations as a body, input from group members and discussion at meetings shaped the Doula Services State Plan Amendment and related guidance in several ways.
    - The District's decision to reimburse differently for perinatal and postpartum doula visits came from input from the Maternal Health Advisory Group.
    - Input from the Maternal Health Advisory Group helped determine the total number of doula visits that DHCF would reimburse.
- The Advisory Group was reconvened in June 2023 to hear from VA Medicaid on their Doula program and develop ideas for outreach for enrollment (i.e., Doula Champion) and assistance with credentialing.

Implementation of Postpartum Coverage and Doula/Midwifery Services

- Postpartum coverage 1 year after the end of pregnancy was successfully implemented on April 1, 2022
- Doula services were successfully authorized on October 1, 2022, and doula registration as DHCF providers has been open since October 3, 2022
- Due to a delay in the development of local doula certification standards and the absence of national standards, DHCF adopted temporary standards for registration of doulas for its programs
- Doula registration into DHCF health programs has been slow- only 4 doulas are registered and none have billed
  - The District is working to address this through outreach to doulas
- DHCF believes that final local certification standards will help doulas understand why and how to register with DHCF
  - Local trainings run through DC Health could include trainings on registration and billing

Implementation of Postpartum Coverage and Doula/Midwifery Services (cont.)

- Due to a delay in the development of local certified professional midwife licensure standards and the absence of national standards, DHCF has not yet implemented services for certified professional midwives
  - The latest action from DC Health was to combine the CPM and Doula licensure boards.
- DHCF already covers services for nurse midwives

DHCF Convened a Perinatal Mental Health Task Force in 2023

- The Perinatal Mental Health Task Force was convened in January 2023
- The Task Force brought together diverse stakeholders, including government representatives from behavioral health, Medicaid, public health, and the Council. The task force was further enriched by members representing various fields including medicine, mental health, nursing, midwifery, doula services, community-based organizations, health centers, and managed care plans.
- The Task Force met 9 times between January and September 2023. Meeting notices were posted on the Department of Health Care Finance website. Public comments were taken and considered at every meeting.
- The work of the Task Force was divided into four workgroups:
  - Navigation and Access;
  - Resources and Data;
  - Screening, Referral, and Workforce Development; and
  - Public Awareness and Systems Capacity.
- Each workgroup met multiple times to gather information, share resources, and develop and finalize recommendations to address unmet maternal mental health needs in the District.

The Task Force's Recommendations Have Been Categorized into Four Domains Covering Access, Continuity of Care, Accountability, and Workforce

Enhancing Navigation and Care Coordination to Improve Access to Perinatal Mental Health Care

Investment in the Continuum of Care of Perinatal Mental Health Services

System Accountability through Data Collection, Public Reporting and Boards

Development of Workforce to Address Shortages and Wait Times

Proposed Charter

Purpose:

Building upon the work of the Perinatal Mental Health Task Force and the Maternal Health Advisory Group, the District of Columbia Department of Healthcare Finance (DHCF) is establishing an advisory group to provide ongoing input and guidance on improving maternal health outcomes for all birthing people and families enrolled in DHCF's programs.

Objectives:

1. Develop a maternal health framework and identify gaps, challenges, and opportunities for improvement that aligns with other District-wide advisory groups/committees/taskforces.
2. Review and analyze current Medicaid policies and programs related to maternal health.
3. Assess the impact of existing policies on the physical and mental well-being of pregnant individuals.
4. Provide evidence-based recommendations to enhance Medicaid services to better support maternal physical and mental health.
5. Collaborate with healthcare professionals, community organizations, and stakeholders to gather diverse perspectives and input.

Tasks:

1. Develop specific solutions to better recruit and retain doula providers in the Medicaid program.
2. Develop an implementation plan for the PMHTF recommendations, prioritizing those under the agency's purview.
3. Provide input on the Transforming Maternal Health (TMaH) Model proposed by CMS, focusing on its alignment with Medicaid goals and strategies to reduce disparities in access and treatment.
4. Collaborate with participating state Medicaid agencies (SMAs) to develop a whole-person approach to pregnancy, childbirth, and postpartum care, addressing physical, mental health, and social needs to improve outcomes and experiences for mothers and newborns while reducing program expenditures.

Next Steps

Maternal Health Advisory Group will meet virtually on Tuesday, March 5th from 11 am to 12:30 pm.

Contact DaShawn Groves for the calendar invite: dashawn.groves@dc.gov

Question for MCAC:

- How do we best align the two groups that make recommendations to DHCF?
- Is there a member who is interested in being a liaison between the two entities?

Appendix

Key Findings: Stakeholder Assessment

Business Operations

- VBP foundations
- Building relationships with MCOs
- Evaluating payment models
- Change management
- Staffing for success
- Coaching the workforce to meet District requirements
- Stakeholder engagement and provider partnerships
- Developing clinical advisory boards and governance models that advance VBP
- Maximizing incentive payments
- Development of continuous quality improvement (CQI) strategies
- Assessing readiness for participation in VBP

Financial

- Cash management
- Coding, claims and reimbursement
- Billing and authorizations
- Actuarial analysis
- Determining and tracking the cost of care
- Implement strategies to identify sufficient reserves for risk-bearing arrangements
- Implement processes for quality and TCOC/shared-savings payments made six to nine months after the measurement period ends
- Maintaining financial sustainability

Legal

- Understanding VBP contracts
- Negotiating arrangements
- Forming independent physician associations (IPAs), clinically integrated networks (CINs)
- Merger and acquisition support

Clinical

- Understanding population health
- Measurement-based care
- Adopting validated screenings for physical and behavioral health conditions and social determinants of health
- Standardized clinical workflows
- Evidence based care pathways and workflows
- Clinical practice guidelines
- Team based care
- Managing complex/high need individuals
- Developing meaningful outcome and process measures that target health disparities and improve health equity

Data

- EHR support
- Population health management tools
- Tools to drive decisions, track quality measures, and monitor outcomes
- Best practices for collecting data
- Data analytics
- Collaboration with MCOs to identify gaps and opportunities
- Development of data-sharing agreements
- Using CRISP DC and eHealth to support providers

Stakeholder & Market Assessment Methods

Brief Stakeholder Assessment:
A 30-minute survey was sent to more than 200 healthcare organizations with 26 organizations (13%) responding.

Brief Stakeholder Assessment Respondents

26 organizations responded to the brief assessment survey.

Nine organizations represent Wards 7 and 8

Organization Types	
Behavioral Health	12
Primary Care	2
Home Health	4
Nursing Home	2
Hospital	1
Other	5*

Other Includes: Homeless Services; Primary Care and Addiction Medicine; SUD; BH and Primary Care and Housing; Permanent Supportive Housing

Organization Size*	
< 100	2
< 200	4
< 300	6
<500	3
+1000+	11

Organization size is defined as number of unduplicated patients served on an annual basis.

Market Assessment:
A review of District and national VBP published reports and literature to inform findings and recommendations.

10 Focus Groups:
Six sessions for specific provider types (Behavioral Health, Home Health, Residential Treatment Providers) and four sessions with a mixed group of providers.

12 Stakeholder interviews:
Key informants representing providers, MCOs, District agencies, and provider associations.

Legal Analysis for the Establishment of a CIN, IPA or ACO in the District:
Adam Falcone, JD, Feldesman Tucker Leifer Fidell
Researched regulatory gaps or barriers for establishing provider networks.

Performance Period Technical Assistance PILOT

Cohort	Live Webinars	Short-Takes & Tools
VBP Foundations	• VBP 101 (the "basics") • Data-Driven Insights to Advance Behavioral Health Quality • Allocation of Value-based Payment Incentive Payments to Optimize Performance • Clinical and Programmatic Implications of VBP • VBP 101- Teaching to the Tools	• Risk Mitigation and Risk Reserves • How to Negotiate Your Share with Payers • What's Your Value Proposition? • Mergers & Acquisition • ACO Foundations
Behavioral Health	• Promise and Perils of VBP • Measurement Based Care for VBP • Getting to an Advanced APM as a BH Provider • Managing Complex Populations	• VBP Terminology 101 • Attribution • VBP Levels • Risk Adjustment • Primary Care Integration • VBP Readiness Tool
FQHCs	• Clinically Integrated Networks: Build, Buy or Stay on the Sidelines • Value-based Payment: Is it disrupting health care for the better? • Role of a Capitated Alternative Payment Model • Value-based Payment: Is it disrupting health care for the better? Role of a Clinically Integrated Network	• Term Sheet for Contracting
Legal and Contracting	• Strategies for Negotiating Managed Care Contracts • Understanding Key Terms in Managed Care Contracts • Where Quality Meets Legal • Key Considerations for Value Based Payment Arrangements	• Managing Expectations Related to the BH Carve-In • Privacy Requirements and Care Coordination: Leveraging the functionality of CRISP to Build Your Clinic's VBP Capacity • Understanding Your Clinic's Current Strengths and Potential In the Context of D.C.'s Medicaid MCOs' Legal Obligations to DHCF • Evaluating D.C.'s Medicaid Provider Ecosystem for Partnership Opportunities to Strengthen Your Clinic's Negotiating Position • RAG Status Tool For VBP • RAG tool for quality measures and contracts • Resources for gaining a better understanding of how your organization fits into the District's goals and priorities for Medicaid Managed Care • Health Care Provider Checklist for Entering into Managed Care Contracts

Performance Period Technical Assistance PILOT

VBP Toolkit Resource

VBP Toolkit Elements
Achieving Total Cost of Care
Building a Positive Payer-Provider Partnership
Contracting for Value Based Payment
Creating a VBP Presentation for Payers
Developing Your Value Based Payment Value Proposition
Forming Strategic Partnership Agreements and Care Compacts
Promoting Value Based Purchasing to the Behavioral Health Workforce
Quality Measurement for Behavioral Health Providers
Succeeding in Advanced Alternative Payment Models
Technology Infrastructure to Support VBP
Understanding Your Population
VBP Milestone Grid
VBP Readiness Assessment
VBP Terms and Definitions

Virtual VBP Learning Collaborative

Legal Track	Financial Track
Forming Community Partnerships to Participate in VBP Arrangements - Part 1	Revenue Cycle Operational Excellence: A Foundation for Value-Based Payments
	Evaluating Payment Models and Financial Modeling
Forming Community Partnerships to Participate in VBP Arrangements - Part 2	Clinical Documentation and CDPS+Rx Coding Guidelines for Value-Based Payment Optimization

+ An FQHC-specific VBP workshop

All recordings and materials are posted on the Integrated Care DC – Business Transformation webpage:
www.integratedcaredc.com/medicaid-business-transformation-dc/

Performance Period Technical Assistance PILOT

Three TA Priorities Across Each Domain Identified through the Brief Assessment

	Clinical	Business	Legal	Financial
1	Developing clinical/operational workflows	Establishing systems to track utilization, quality and costs	Forming accountable care organizations (ACOs), direct contracting, clinically integrated networks (CINs), independent practice associations (IPAs)	Developing financial modeling for value-based care investments
2	Adopting reimbursement/billing for integrated models of care	Conducting continuous quality improvement, measurement, outcomes	Establishing contracts with providers	Adopting value based-revenue cycle management
3	Establishing key performance indicators to monitor the effectiveness of new care models	Training and support for staff to run data reports	Structuring agreements and contracts	Designing financial measures for population health using clinical and demographic factors

Policy Recommendations

	Key Findings from Exemplar State	District Policy Recommendations
Design/ Implementation	▪ Readiness assessments are important in understanding the type of arrangement that providers can best operate with managed care organizations (MCOs). ▪ Clarity of roles is crucial to determining which party is responsible for administration versus healthcare delivery (e.g., MCO or provider). ▪ Stakeholder engagement is critical. Important to also include healthcare advocates to reduce concerns regarding access and equity. ▪ Harder for states to build APMs without any upfront provider level investments or technical assistance.	▪ Develop clear definitions and a common methodology for measuring revenue growth tied to value-based care delivered to individuals covered by Medicaid managed care in the District. (RI, MA, NC, IL, TN) ▪ Identify measurable goals (milestones) for the MCOs that participate with DHCF to achieve its strategic plan goals. (RI, MA, OH) ▪ Assign accountability for reaching the goal in the described timeline with financial implications for performance. (NY, OR) ▪ Develop attribution assignment and reassignment policies to assure members are appropriately assigned to their treating clinician. (IL) ▪ Develop processes that ensure timely and accurate exchange of information between payers and providers. (IL, TN)

Policy Recommendations

	Key Findings from Exemplar State	District Policy Recommendations
Advancing to more APMs	▪ Important to develop model "on ramps" to advance progress providers from pay for reporting and pay for performance models to advanced APMs ▪ More advanced total cost of care (TCOC) models have the greatest potential for rewards but are still new and slower to progress given their complexity. ▪ The more advanced models, like those in New York, Pennsylvania, and Massachusetts, received federal funding/investments. ▪ Many advanced capitated models revert back to FFS. (CA) ▪ Very few aligned all-payer models (MD, VT). ▪ Mandatory models vary state-to-state and while they may be more impactful, may face opposition or force participation prior to readiness. (Only Maryland, New York, and Pennsylvania have some level of participation requirements for MCOs.) ▪ States and CMS are beginning to invest in payer alignment to reduce provider burden and increase impact of models (TN, OH) ▪ State and federal restrictions may challenge movement toward higher levels of accountability.	▪ Make upfront investments to: ○ Ensure that the financial incentives for achieving success under an APM yield a positive return on investment (RI, VT,PA, MA) ○ Incentivize providers who enter value-based payment arrangements with an MCO (RI, VT) ▪ Adopt regulations to Advance Provider Led Entities: ○ Encourage the creation of CINs, ACOs, IPAs through regulations and regulations. (RI, VT) ▪ Enhance the My Health GPS initiative (health home), as a valuable tool for providers to succeed in LAN 3 or 4 APM for complex populations (VT, RI)

Policy Recommendations

	Key Findings from Exemplar State	District Policy Recommendations
Evaluation & Quality	▪ Current evidence is limited. ▪ State initiatives often implemented alongside other initiatives which impact evaluation. ▪ Vermont, Pennsylvania, and Maryland had federal funding for formal evaluations while other states had limited funds available for formal evaluations. ▪ COVID-19 skewed many findings for states that started VBP models before 2020. (VT)	▪ Quality: To transition providers from LAN Category 2 to LAN category 3: ○ Focus on reducing potentially avoidable emergency department visits, hospitalizations, and rehospitalizations (RI, MA, PA) ○ Align and limit quality measures and incentive across MCOs. (RI, MA, PA)

Recommendations For Next Steps

1. Develop clear definitions and a common methodology for measuring revenue growth tied to value-based care delivered to individuals covered by Medicaid-managed care in the District;
1. Identify measurable goals (milestones) for the MCOs that participate with DHCF to achieve its strategic plan goals;
2. Assign accountability for reaching the goal in the described timeline with financial implications for performance;
3. Develop attribution assignment and reassignment policies to assure members are appropriately assigned to their treating clinician;
4. Make upfront population health investments available to providers who agree to value-based payment arrangements with an MCO;
5. Align quality measures and incentive across MCOs;
6. Limit quality metrics to a manageable number of measures across payers so providers can focus their quality improvement work;
7. To transition providers from LAN Category 2 to LAN Category 3, focus on reducing potentially avoidable emergency department visits, hospitalizations, and rehospitalizations;
8. Develop processes that ensure timely and accurate exchange of information between payers and providers;
9. Ensure that the financial incentives for achieving success under an APM yield a positive return on investment;
10. Encourage the creation of CINs, ACOs, and IPAs;
11. Consider leveraging the previous My Health GPS initiative as a valuable tool for providers to succeed in LAN 3 or 4 APM.

Business Transformation Grant Partner organizations

INTEGRATED CARE DC
A learning community for District of Columbia Medicaid providers

DCPCA
DISTRICT OF COLUMBIA
PRIMARY CARE ASSOCIATION

MSDC
MEDICAL SOCIETY OF THE
DISTRICT OF COLUMBIA

DISTRICT OF COLUMBIA
BEHAVIORAL HEALTH ASSOCIATION

FELDESMAN + TUCKER + LEIFER + FIDELL LLP

Medicaid Business Transformation DC
Prepping for Value