

GOVERNMENT OF THE DISTRICT OF COLUMBIA

Department of Health Care Finance

Department of Behavioral Health

Request for Information:

**Medicaid Behavioral Health Transformation in the District of Columbia:
A Roadmap to Integrated Care**

August 25, 2020

To All Interested Parties:

The Department of Health Care Finance (DHCF) and the Department of Behavioral Health (DBH) are jointly publishing a Request for Information (RFI) to solicit information from interested parties (e.g., consumer organizations, the provider community, etc.) regarding the pathway to integrate behavioral services more fully into the benefits offered by District's Medicaid managed care program. Overall, DHCF and DBH envision a three-phase approach to Medicaid behavioral health transformation that will result in a whole-person, population-based, integrated Medicaid behavioral health system that is comprehensive, coordinated, high quality, culturally competent,¹ and equitable.²

Phase I of the District's Medicaid behavioral health transformation efforts were initiated in 2019 with DHCF and DBH's collaboration and joint development of the 1115 Behavioral Health Transformation Waiver. Additionally, DHCF is continuing its progress of developing a more coordinated Medicaid system of care by transitioning approximately 19,000 individuals from fee-for-service (FFS) to the managed care program in October 2020, where primary and acute care health services will be administered for these individuals via their assigned/selected managed care organization (MCO). During this first phase, MCOs will be responsible for ensuring coordination among individuals' primary, acute, and behavioral health care needs.

¹ Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations, according to the Centers for Disease Control and Prevention.

² Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities, according to the U.S. Department of Health and Human Services, Office of Minority Health.

This model will allow the District Medicaid program to shift away from a fragmented approach of providing care to individuals most in need of behavioral health services, to ensuring that the total health outcomes of an individual are coordinated.

In Phase II, DHCF plans to include behavioral health services as covered benefits in the District's managed care contracts as of October 1, 2021 with the purpose of improving coordination and providing whole-person care. Phase III will focus on additional efforts to integrate physical and behavioral health for Medicaid beneficiaries in the District of Columbia.

This RFI is exploratory in nature and is designed to solicit feedback from all community members, stakeholders, and partners on Phase II and Phase III of the Medicaid behavioral health transformation activities. No award will be made as a result of this RFI. DHCF and DBH may share responses publicly in aggregate; however, individual responses and the names of the respondents will not be identified.

Submission Deadline: Monday, September 21, 2020 at 5:00 PM (ET)

Submission Format: Responses to this RFI should be submitted in a Microsoft Word attachment in 12 point font and must be limited to a maximum of 20 double-spaced, 8 ½" x 11" pages in total, excluding appendices. All responses must include organization name and contact information.

Respondents: DHCF and DBH are seeking feedback from consumers, consumer/client advocates, health plans, provider networks or associations, independent providers, hospital organizations, and other stakeholders interested in strategies that will result in a whole-person, population-based, integrated Medicaid behavioral health system that is comprehensive, coordinated, high quality, culturally competent, and equitable for Medicaid beneficiaries served by MCOs in the District.

Questions: Questions concerning this RFI must be received via email at healthinnovation@dc.gov no later than Tuesday, September 1, 2020 at 5:00 PM (ET). Please reference the transmittal number on all correspondence. Any questions received in response to the Behavioral Health Transformation RFI will be posted on DHCF's website as an addendum to this solicitation.

1.0 Introduction

The Department of Health Care Finance (DHCF) and the Department of Behavioral Health (DBH) are jointly publishing a Request for Information (RFI) to solicit information from interested parties (e.g., consumer organizations, the provider community, etc.) regarding the pathway to integrate behavioral services more fully into the benefits offered through the District Medicaid managed care program. DHCF plans to phase-in the integration of behavioral health services via Medicaid managed care organizations (MCOs) starting in October 2021 to improve coordination and provide high quality, culturally competent, whole-person care. Overall, DHCF and DBH envision a three-phase approach to behavioral health transformation that will result in a whole-person, population-based, integrated Medicaid behavioral health system that is comprehensive, coordinated, high quality, culturally competent, and equitable.

This RFI is the next phase of the work initiated with approval of the District's 1115 Medicaid Behavioral Health Transformation Waiver. Specifically, the RFI seeks input on the next two phases of Medicaid behavioral health transformation. First, the RFI seeks input on how to more fully integrate behavioral health services as covered benefits in the District's Medicaid managed care contracts as of October 1, 2021. Second, the RFI seeks input on strategies to integrate physical and behavioral health for Medicaid beneficiaries served by Medicaid MCOs.

This is a Request for Information. No award will be made as a result of this RFI.

1.1 RFI to Inform the Potential Design of Medicaid MCO Services for Behavioral Health

This RFI outlines the type of information being solicited from potential respondents and includes guidelines for the content and format of responses. The RFI includes a number of questions designed to solicit feedback on:

- The District's likely design of adding behavioral health services to the Medicaid managed care contracts; and
- The long-term trajectory and goals of a whole-person, population-based, integrated Medicaid behavioral health system that is comprehensive, coordinated, high quality, culturally competent, and equitable.

1.2 Process

Please submit responses by email to healthinnovation@dc.gov by Monday September 21, 2020 at 5:00 PM (ET). All responses must include organization name and contact information. All submissions should be submitted in a Microsoft Word attachment in 12 point font and must be limited to a maximum of 20 double-spaced, 8 ½" x 11" pages in total, excluding appendices.

Respondents need not reply to every question to participate in this process. DHCF and DBH may share responses publicly; however, individual responses and the names of the respondents will not be identified.

The structure of the RFI and page limit for responses are intended to minimize respondent burden and provide a structured response to facilitate the analysis and summary of responses. Concise responses are appreciated.

2.0 Background

2.1 Purpose of the Request for Information

This RFI is being issued to solicit specific information from consumers, consumer/client advocates, health plans, provider networks or associations, independent providers, hospital organizations, and other stakeholders with respect to the near-term and long-term strategic direction of behavioral health in the Medicaid program.

The District will use information received through this RFI, in conjunction with other available information, in order to refine elements of the District's approach, including benefit design, payment policy, and network requirements. Additionally, DHCF and DBH are interested in perspectives on an approach to creating a whole-person, population-based, integrated Medicaid behavioral health system that is comprehensive, coordinated, high quality, culturally competent, and equitable over the next several years.

DHCF and DBH are interested in perspectives on the development and implementation of adding behavioral health services as covered benefits in the Medicaid managed care contracts. This RFI is specifically seeking input on integrated behavioral health service design within the Medicaid managed care program, and addresses design considerations such as:

- system models;
- service array, including prevention and early intervention services, access to benefits, and care utilization, including treatment planning and care coordination;
- person-centered design and consumer education;
- program infrastructure, such as governance and data analytic capabilities;
- provider networks;
- payment models;
- quality measurement; and
- oversight.

2.2 Phased Approach for Medicaid Behavioral Health Reform

DHCF is committed to transitioning the District's Medicaid behavioral health system away from a fee-for-service (FFS), or volume-based payment approach, and towards value-based care. Behavioral health transformation is a critical component of overall system reform, and reflects the high priority to diagnose, treat, and provide support and recovery services for all District residents with behavioral health needs, as well as provide prevention and early intervention services. The shift towards a population health model of whole-person, integrated behavioral health services within the District's Medicaid managed care program signals a collaborative effort to deliver comprehensive, coordinated, high quality, culturally competent, and equitable care.

A significant undertaking of this nature must follow a phased approach to Medicaid behavioral health reform. This RFI seeks input on the proposed phases II and III by which the community can complete a transition to fully integrated care within Medicaid.

- The first phase, underway since January 2020, is the implementation of the 1115 waiver, support for behavioral health practice transformation, access and use of health information exchange, and the enrollment of approximately 19,000 FFS Medicaid enrollees in MCOs.
- Phase II will be implemented in the fall of 2021 and will incorporate a full continuum of behavioral health services in Medicaid managed care plans.
- Phase III, starting in the fall of 2022, will further advance a population health model and incorporate value-based payment methodologies.

The following sections describe key features and progress in designing a Medicaid behavioral health system that meets the goal of providing culturally competent, whole-person care; ensures the value and accountability of the Medicaid program; and strengthens DHCF's internal operating infrastructure in order to enhance health care quality, improve care and outcomes, and promote health equity for Medicaid beneficiaries.

2.3 Current Medicaid Behavioral Health System of Care

In FY18, an estimated 20 percent (55,919) of all District Medicaid beneficiaries had a diagnosis of a serious mental illness (SMI)/serious emotional disturbance (SED) or a substance use disorder (SUD). Moreover, roughly one-third of adults being treated for SMI in the District's public health system also have a co-occurring SUD. Individuals with SMI or SUD have high rates of tobacco use, physical inactivity, and co-morbid physical illness. The District, like many states, is also in the midst of responding to the opioid epidemic and the COVID-19 pandemic. The challenges of addressing these public health emergencies simultaneously adds to the urgency of rethinking how Medicaid, the major system of health coverage for low-income District

residents, ensures access, improves quality, and enhances the value of the care intended to meet the behavioral health needs of Medicaid beneficiaries.

The District's Medicaid behavioral health delivery system is currently divided, with oversight, services, and payment varying across the fee for service and managed care programs. MCOs contract with health professionals and provider organizations for low-acuity behavioral health services such as assessment, counseling, and medication administration and management. Most of the intensive services and supports for Medicaid beneficiaries with SMI/SED, SUD, and co-occurring conditions are carved-out of MCO contracts and delivered through FFS providers operating under the regulatory oversight and certification of DBH.

Both DHCF and DBH policy goals and priorities support quality of care, access, and consumer choice, but due to the ways coverage, benefits, programs, and providers overlap between DHCF and DBH, Medicaid providers and beneficiaries may not be aware of the full range of available benefits and coverage requirements. Moving forward, the District seeks to develop a more cohesive delivery system that effectively shares information, aligns financial incentives, increases accountability, and achieves the principles described in Section 3.0.

It is important to understand the District's robust commitment to value-based payment (VBP) and its role in supporting the more cohesive system envisioned by DHCF. As of 2020, DHCF's VBP programs are aligned around three key performance measures, which are also highly relevant for individuals with behavioral health issues:

- Potentially preventable hospital admissions;
- Low acuity non-emergent visits to hospital emergency rooms; and
- Hospital readmissions within 30 days of previous admissions.

The VBP programs currently exist across both the FFS and managed care programs. DHCF expects VBP arrangements in the managed care program to increase over the next two to five years.

3.0 Foundation & Principles

The following section outlines a set of questions to guide the District's approach to developing whole-person, population-based, integrated Medicaid behavioral health system that is comprehensive, coordinated, high quality, culturally competent, and equitable.

3.1 Behavioral Health Landscape

In order to better understand the health care landscape, it is helpful to understand the existing organizational structures and affiliations among provider groups in our community.

For organizations that deliver services to Medicaid beneficiaries, DHCF requests an overview of your organization.

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.

3.2 Principles for Medicaid's Behavioral Health System in the District

A key objective of this RFI is to understand the opportunities for Medicaid and DBH to develop a whole-person, population-based, integrated Medicaid behavioral health system that is comprehensive, coordinated, high quality, culturally competent, and equitable.

This effort must align with DBH and DHCF's missions and vision statements, as well as both agencies' strategic priorities. Given that by October 2020, 82% of Medicaid beneficiaries will be served by MCOs with dedicated care management activities, this RFI seeks input on strategies to integrate physical and behavioral health for Medicaid beneficiaries served in the Medicaid managed care program.

In January 2020, DHCF submitted to the Centers for Medicare & Medicaid Services (CMS) the District's Medicaid Managed Care Quality Strategy,³ which outlines DHCF's key priorities for improving health outcomes by providing comprehensive, cost-effective, and quality healthcare services to District residents. The quality strategy outlines specific objectives and associated metrics DHCF will focus on for measuring MCO performance, including addressing physical and behavioral health comorbidities and improving comprehensive behavioral health services.

DBH and DHCF have identified the following 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.

³ DC Department of Health Care Finance Medicaid Managed Care Quality Strategy, submitted to CMS January 2020. <https://dhcf.dc.gov/managed-care-quality-strategy>

- 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.

DBH and DHCF hope to use these principles to guide the development of a comprehensive, integrated system of Medicaid behavioral health services.

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?

3. What do you see as the greatest opportunities to transform 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? Please describe specific initiatives, interventions, and/or target populations.
4. Please share your perspective on the benefits and potential challenges of using the managed care delivery system to achieve these goals.
5. Please share your perspective on the benefits and potential challenges of requiring MCOs to include DBH-certified providers⁴ of Medicaid services in their network of behavioral health services. Please provide feedback on specifications, standards, and time frame of any provision.

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.

6. Do you agree with this definition? Please suggest any edits to this working definition.
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?

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

The following sections outline a set of questions to guide the development and implementation of adding behavioral health services as covered benefits in Medicaid managed care. CMS defines many requirements of MCO contracts and DHCF must adhere to certain specifications

⁴ The [DC Department of Behavioral Health](#) certifies providers to deliver services that support individual recovery with qualified, culturally competent staff in a safe environment. Providers must comply with local and federal rules and regulations.

to meet those federal criteria. However, the District has some areas of flexibility, including benefits, network participation requirements, and others. DHCF seeks stakeholder comments on these areas.

The scope of these questions is intended primarily to inform Phase II transformation efforts, which focus on integrating behavioral services more fully into the benefits offered by District Medicaid MCOs.

4.1 Required Scope of Services

DBH and DHCF have reviewed the current array of Medicaid-reimbursable BH services, provided in Tables 1 and 2 in the attachments following this RFI.

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?
9. Of the services not 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.

4.2 Relationship with MCOs and Network Participation Requirements

Managed Care Organizations are held accountable for the total cost of care for a cohort of beneficiaries; however, these accountability structures can vary for behavioral health care. States can set the parameters for provider certification, provider payment, and other components of managed care programs. The following are examples of requirements that have been used in contracts from other states:

- All MCO-contracted behavioral health providers must be certified by the DBH.
- Medicaid MCOs must contract with any willing, DBH-certified behavioral health provider.
- Medicaid MCOs must provide temporary directed payments⁵ or other rate setting provisions to support the carve-in of behavioral health services. Requirement to support quality of care via the provision of information regarding community organizations that can address social determinants of health (e.g., housing, employment, food security, and transportation).

⁵ For further information, see: <https://www.medicaid.gov/medicaid/managed-care/guidance/state-directed-payments/index.html>

10. Which of these requirements, if any, should DBH and DHCF consider in order to promote a whole-person, population-based, integrated Medicaid behavioral health system that is comprehensive, coordinated, high quality, culturally competent, and equitable?
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?

4.3 Hold Harmless and Program Transition Policies

It is important to ensure continuity of care and to protect access to services for vulnerable beneficiaries as the District implements the carve-in of behavioral health services in the managed care program. There are specific actions DHCF can take to support continuity of care. One example is a “hold harmless” policy. Policies such as “hold harmless” service authorizations require the managed care organization to maintain services at a person’s current level for up to 90 or 180 days. During this period of time no changes to services may be made (e.g., no changes to provider or service level, etc).

At the time a transition to carve in services is implemented:

12. What policies are needed to ensure continuity of care and beneficiary protections in a manner that does not jeopardize the success of program implementation?
13. Are there other transition policies that can be implemented to support program implementation, such as supports for providers, care coordination staff, or others?

4.4 IT System Considerations

In 2018, DHCF published [the District of Columbia’s State Medicaid Health IT Plan \(SMHP\)](#). The SMHP outlines specific use cases and future directions for health IT investments in the District. As described in the SMHP, the majority of DBH contracted providers utilize three different health IT systems:

- Their own behavioral health electronic health records for clinical documentation;
- A DBH-provided system named iCAMS (Integrated Care Applications Management System), for tracking and billing of mental health rehabilitative services; and

- The District Automated Treatment Accounting System Web Infrastructure Technology System (DATA WITS), for tracking, management, and billing of SUD services.

While connectivity among behavioral health providers in the District has improved over the past few years, including the connection of many behavioral health providers and all institutions of mental disease to the DC Health Information Exchange, behavioral health data exchange is often manual, and frequently occurs by fax. Data storage across various systems, including iCAMS, SADO, DataWITS, eClinicalWorks (eCW), and others that store similar information, results in redundancy. However, providers in the District recognize the importance of exchanging behavioral health data to improve care coordination and communication. To facilitate this exchange, DHCF seeks guidance on specific strategies to support care integration.

- 14.** Are there specific requirements related to electronic health information systems that DHCF and DBH should consider?
- 15.** Are there specific population health analytic capabilities that DHCF and DBH should require of providers and/or MCOs?
- 16.** Are there specific health IT supports or technical requirements related to telehealth services that DBH and DHCF should consider?

5.0 Phase III: Further Steps to Integrate Behavioral Health in MCOs

As discussed earlier, the District's Medicaid program has a robust framework for value-based purchasing and is actively engaged in practice transformation efforts to achieve integrated care. As DHCF and DBH consider phase III efforts to support integrated care in the Medicaid behavioral health system, the agencies seek input on the District's strategic direction and approach in the next five years. Specifically, DHCF and DBH welcome input on potential new services; strategies to support the needs of special populations; and value-based payment models that the agencies should contemplate.

Examples of evidence-based approaches, promising state and local approaches, and innovations that respondents believe are appropriate to meet the needs of District residents are particularly useful.

- 17.** In support of DHCF and DBH's system improvement goals, are there health or supportive services that DHCF should prioritize 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?

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?
19. Are there particular value-based or accountable care models DHCF should consider?

6.0 Infrastructure, Engagement, and Accountability

The need for infrastructure and practice transformation to support health system transformation has been discussed extensively in the [final report from Mayor Muriel Bowser's Commission on Healthcare Systems and Transformation](#), the District's [State Innovation Model \(SIM\) Plan: Better Health Together](#), and [State Medicaid Health IT Plan: Improving Care Through Innovation](#), [the DC Behavioral Health Strategic Plan](#), and [the LIVE.LONG.DC Opioid Strategic Plan](#), among others. Effective strategies or methodologies for utilization review and program oversight, specifically including telehealth services should be considered. The following components of health system infrastructure build upon the foundational elements of health system transformation outlined in the District's SIM plan:

- Consumer education, awareness and engagement
- Health IT and data analytics
- Workforce development
- Performance Metrics

DHCF and DBH welcome feedback on approaches to build the infrastructure needed to support person-centered care in a whole-person, population-based, integrated Medicaid behavioral health system that is comprehensive, coordinated, high quality, culturally competent, and equitable.

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.

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?

Attachments

In April 2011, SAMHSA proposed a behavioral health “Continuum of Care” across nine domains. Table 1 populates this continuum with currently Medicaid reimbursable behavioral health services. Table 2 reflects the current Medicaid reimbursable services by benefit (i.e., MHRS, ASARS, FSMHC, etc.).

Table 1: Medicaid Behavioral Health Services by SAMHSA Continuum of Care Domains

| HEALTHCARE HOME AND PHYSICAL HEALTH | PREVENTION (INCLUDING PROMOTION) | ENGAGEMENT SERVICES | OUTPATIENT SERVICES | MEDICATION SERVICES | COMMUNITY SUPPORT (RE-HABILITATIVE) | OTHER SUPPORTS (HABILITATIVE) | INTENSIVE SUPPORT SERVICES | OUT-OF-HOME RESIDENTIAL SERVICES | ACUTE INTENSIVE SERVICES | RECOVERY SUPPORTS |
|--|---|--|---|--|--|--------------------------------------|--------------------------------------|---|---|----------------------------------|
| Clinical Care Coordination (ASARS) | SBIRT (State Plan) | Transition planning (1115) | TREM & TST (1115) | Medication/Somatic Treatment (Individual and Group) (MHRS) | Clubhouse (1115) | | Assertive Community Treatment (MHRS) | Psychiatric stabilization program (1115) | CPEP (1115) | Recovery Support Services (1115) |
| Care Coordination, Case Management & Transportation for Enrollees receiving services through DBH (MCO) | | Diagnostic Assessment (MHRS) | Substance Use Disorder Counseling/Therapy (ASARS) | Medication Management (ASARS) | Supported Employment (MH and SUD) (1115) | | Intensive Day Treatment (MHRS) | Patient Psychiatric Residential Treatment Facility (PPRTF) for enrollees <22 years of age (MCO) | Youth Mobile Crisis Intervention (1115) | |
| Comprehensive Care Management (HH 1 & 2) | | Diagnostic Assessment and Plan of Care (ASARS) | Psychiatric diagnostic evaluation (FQHC) | Prescription Visits (FSMHC) | Rehabilitation Day Services (MHRS) | | | | Adult Mobile Crisis and Outreach (1115) | |

| HEALTHCARE HOME AND PHYSICAL HEALTH | PREVENTION (INCLUDING PROMOTION) | ENGAGEMENT SERVICES | OUTPATIENT SERVICES | MEDICATION SERVICES | COMMUNITY SUPPORT (RE-HABILITATIVE) | OTHER SUPPORTS (HABILITATIVE) | INTENSIVE SUPPORT SERVICES | OUT-OF-HOME RESIDENTIAL SERVICES | ACUTE INTENSIVE SERVICES | RECOVERY SUPPORTS |
|---|----------------------------------|---|--|--|-------------------------------------|-------------------------------|----------------------------|----------------------------------|--|-------------------|
| Care Coordination (HH 1 & 2) | | Diagnostic Evaluation (FSMHC) | Community Based Intervention (MHRS) | Medication Assisted Treatment (ASARS) | Community Support (MHRS) | | | | Crisis/ Emergency Services (MHRS) | |
| Comprehensive Transitional Care (HH 1 & 2) | | Psychiatric Diagnostic Evaluation (FSMHC) | Child-Parent Psychotherapy (MHRS) | Medication/ Somatic Treatment (MCO) | Case Management (MCO) | | | | Crisis Intervention (ASARS) | |
| Health Promotion (HH 1 & 2) | | Comprehensive Psychological Testing (FSMHC) | Trauma-Focused Cognitive Behavioral Therapy (MHRS) | Psychiatric diagnostic evaluation with medical services (FQHC) | Transitional care management (FQHC) | | | | Mobile crisis/ ER Services (excl. beneficiaries actively receiving svcs in a DBH certified entity) (MCO) | |
| Individual and Family Support Services (HH 1 & 2) | | Behavioral health outreach service (1115) | Functional Family Therapy (MHRS) | | Advance care planning (FQHC) | | | | Medically Monitored Inpatient Withdrawal Management (ASARS) | |

| HEALTHCARE HOME AND PHYSICAL HEALTH | PREVENTION (INCLUDING PROMOTION) | ENGAGEMENT SERVICES | OUTPATIENT SERVICES | MEDICATION SERVICES | COMMUNITY SUPPORT (RE-HABILITATIVE) | OTHER SUPPORTS (HABILITATIVE) | INTENSIVE SUPPORT SERVICES | OUT-OF-HOME RESIDENTIAL SERVICES | ACUTE INTENSIVE SERVICES | RECOVERY SUPPORTS |
|--|----------------------------------|---|--|---------------------|-------------------------------------|-------------------------------|----------------------------|----------------------------------|--|-------------------|
| Referral to Community and Social Support Services (HH 1 & 2) | | Diagnostic and Assessment Services (MCO) | Individual counseling (MCO) | | | | | | Inpatient hospitalization and emergency department services (MCO) | |
| | | Education on Access to Mental Health Services (MCO) | Group counseling (MCO) | | | | | | Inpatient psychiatric facility services for individuals under age 21 (MCO) | |
| | | Psychological testing (FQHC) | Family counseling (MCO) | | | | | | Inpatient detoxification (MCO) | |
| | | | Pediatric Mental Health Services (MCO) | | | | | | | |
| | | | Behavioral Health Service to Students in School Settings (MCO) | | | | | | | |
| | | | Psychotherapy (FQHC) | | | | | | | |

| HEALTHCARE HOME AND PHYSICAL HEALTH | PREVENTION (INCLUDING PROMOTION) | ENGAGEMENT SERVICES | OUTPATIENT SERVICES | MEDICATION SERVICES | COMMUNITY SUPPORT (RE-HABILITATIVE) | OTHER SUPPORTS (HABILITATIVE) | INTENSIVE SUPPORT SERVICES | OUT-OF-HOME RESIDENTIAL SERVICES | ACUTE INTENSIVE SERVICES | RECOVERY SUPPORTS |
|-------------------------------------|----------------------------------|---------------------|---------------------|---------------------|-------------------------------------|-------------------------------|----------------------------|----------------------------------|--------------------------|-------------------|
|-------------------------------------|----------------------------------|---------------------|---------------------|---------------------|-------------------------------------|-------------------------------|----------------------------|----------------------------------|--------------------------|-------------------|

Family psycho-therapy (FQHC)

Individual psycho-physiological therapy (FQHC)

Counseling risk factor reduction and behavior change intervention (FQHC)

Services of a Licensed Behavioral Health Practitioner (1115)

Table 2: Medicaid Reimbursable Behavioral Health Services by Benefit Type (e.g. MHRS)

| 1115 Waiver | MHRS | ASARS | Health Homes | FSMHC | MCO^{1,2} |
|-----------------------------------|---|---|--|-------------------------------------|--|
| Clubhouse | Diagnostic Assessment | Diagnostic Assessment and Plan of Care | Comprehensive Care Management | Diagnostic Evaluation | Care Coordination, Case Management and Transportation for Enrollees receiving services through DBH |
| Recovery Support Services | Medication/Somatic Treatment (Individual and Group) | Clinical Care Coordination | Care Coordination | Psychiatric Diagnostic Evaluation | Diagnostic and Assessment Services |
| Supported Employment (MH and SUD) | Mental Health Therapy (Individual and Group) | Crisis Intervention | Comprehensive Transitional Care | Comprehensive Psychological Testing | Individual counseling |
| TREM & TST | Community Support (Individual and Group) | Substance Use Disorder (“SUD”) Counseling/Therapy | Health Promotion | Individual Psychotherapy | Group counseling |
| CPEP | Crisis/Emergency Services | Medically Monitored Inpatient Withdrawal Management (Adult; Adolescent – approved on a case-by-case basis, if | Individual and Family Support Services | Family therapy | Family counseling |

¹ From DHCF’s 1/31/2020 MCO solicitation

² “Except for services as defined Rehabilitation Behavioral Health Services as described in section C.5.28.10 Table B, the Contractor shall provide mental health and Substance Use Disorder Services in every classification in which medical/surgical services are provided.”

| 1115 Waiver | MHRS | ASARS | Health Homes | FSMHC | MCO ^{1,2} |
|---------------------------------------|---------------------------------------|---------------------------------------|---|---------------------|--|
| | | determined to be medically necessary) | | | |
| Mobile crisis for youth | Rehabilitation Day Services | Medication Management | Referral to Community and Social Support Services | Group therapy | FQHC BH services |
| | Intensive Day Treatment (“IDT”) | Medication Assisted Treatment | | Prescription Visits | Medication/Somatic Treatment |
| Mobile crisis and outreach for adults | Community Based Intervention (“CBI”) | | | Family conferences | Mobile crisis/Emergency Services (excluding beneficiaries actively receiving services in a DBH certified entity) |
| Psychiatric stabilization beds | Assertive Community Treatment (“ACT”) | | | | Inpatient hospitalization and emergency department services |
| Transition planning | Child-Parent Psychotherapy (“CPP”) | | | | Case Management |

| 1115 Waiver | MHRS | ASARS | Health Homes | FSMHC | MCO ^{1,2} |
|-------------|--|-------|--------------|-------|--|
| | Trauma-Focused Cognitive Behavioral Therapy (“TF-CBT”) | | | | Inpatient psychiatric facility services for individuals under age 21 |
| | Functional Family Therapy (“FFT”) | | | | Pregnancy-related services, including treatment for any mental condition that could complicate the pregnancy |
| | | | | | Patient Psychiatric Residential Treatment Facility (PPRTF) for enrollees < 22 years of age |
| | | | | | Education on Access to Mental Health Services |
| | | | | | Pediatric Mental Health Services |
| | | | | | Inpatient detoxification |
| | | | | | Outpatient Alcohol and Drug Abuse Treatment |
| | | | | | Behavioral Health Service to Students in School Settings |