

**GOVERNMENT OF THE DISTRICT OF COLUMBIA  
Department of Health Care Finance**



**Public Hearing on**

**B24-0092, the “Substance Use Prevention and Treatment Omnibus  
Amendment Act of 2021”**

**Testimony of**

**Melisa Byrd  
Senior Deputy Director/Medicaid Director**

**Before the  
Committee on Health  
Council of the District of Columbia  
The Honorable Vincent C. Gray, Chairperson**

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9:00 a.m.

WebEx Virtual Platform  
The John A. Wilson Building  
1350 Pennsylvania Avenue, NW  
Washington, DC 20004

Good morning, Chairperson Gray, and members of the Committee on Health. I am Melisa Byrd, Senior Deputy Director/Medicaid Director of the Department of Health Care Finance (DHCF). I am here today to provide testimony on behalf of DHCF on Bill 24-0092, the “Substance Use Prevention and Treatment Omnibus Amendment Act of 2021.”

As it pertains to DHCF, the stated purpose of this bill is twofold. First, the bill mandates DHCF to pay for substance use disorder (SUD) assessment and referral services under the Medicaid State Plan. Second, the bill mandates DHCF, in partnership with the Department of Behavioral Health (DBH), to develop a plan to provide care coordination for individuals experiencing SUDs and establish minimum criteria for care coordination plans.

Today, I will first describe the current structure of Medicaid coverage of SUD assessment and referral services and review the ways in which DHCF currently covers both these services and care coordination for individuals with SUD. I will then go over DHCF’s approach to monitor and implement innovative strategies to support beneficiaries with SUD.

### **SUD Assessment and Referral Services**

Currently, the District provides comprehensive SUD services—including assessment and referral—to individuals enrolled in the Medicaid program through the Adult Substance Abuse Rehabilitation Services (ASARS) State Plan Amendment and the Section 1115 Behavioral Health Transformation Demonstration Waiver (see Table 1). In October 2020, DBH published a final rulemaking that updated the section of the District of Columbia Municipal Regulations on Certification Standards for Substance Use Disorder Treatment and Recovery Providers (Title 22, Subtitle A, Chapter 63), which decentralized SUD assessment and referral services. Now, all DBH-certified providers are to provide assessment and referral services. In addition, all Medicaid

providers can conduct Screening, Brief Intervention, and Referral to Treatment (SBIRT) services. As such, the benefits proposed through Bill 24-0092 are already functionally available to individuals served by Medicaid.

**Table 1. Current Medicaid Coverage of SUD Services**

State Plan Amendment Authority Currently (SPA – Supplement 6 to Attachment 3.1-A)	1115 Waiver – current SUD Services
Assessment/Diagnostic and Treatment Planning	IMD Services (inpatient residential, mental health SUD for individuals ages 21-64)
Clinical Care Coordination	Clubhouse (adult psychosocial day rehabilitation services)
Crisis Intervention	Trauma-Targeted care (Trauma Systems Therapy and Trauma Recovery and Empowerment Model (TREM))
Substance Abuse Counseling*	Recovery Support Services (RSS)
Substance Abuse Psychotherapy**	Transition Planning Service
Substance Abuse Screening and Brief Intervention***	
Short-term Medically Monitored Intensive Withdrawal Management	
Medication Management	
Medication Assisted Treatment	

\* Supplement 1 to Attachment 3.1A and Supplement 6 to Attachment 3.1A

\*\* Physicians, Supplement 1 to Attachment 3.1A

\*\*\*All providers

### Care Coordination and Medicaid Health Home Programs

Effective January 1, 2011, Section 2703 of the Affordable Care Act allows states (under the State Plan option or through a Waiver) to establish and implement Health Home programs. The purpose of a Health Home is to provide the opportunity for States to address and receive additional Federal support for the enhanced integration and coordination of primary, acute, behavioral health, and long-term services and supports for persons with chronic conditions.

Under the authority of Section 1945 of the Social Security Act, the District established two Health Home Programs to address unmet care coordination needs. The first health home, My DC Health Home, was established via a partnership between DBH and DHCF but is managed by DBH. This Health Home launched in January 2016 and focuses on the consumers with a Serious Mental Illness (SMI).

The second health home, My Health GPS, launched July 2017, is managed by DHCF and focuses on beneficiaries with three or more chronic conditions, including individuals with SUD. The My Health GPS program has provided services to approximately 8,100 beneficiaries over the life of the program and 5,300 are currently enrolled. Of the approximately 5,300 currently enrolled, 18 percent have an SUD diagnosis.

Both the My DC and My Health GPS health homes are designed to be the central point for coordination and collaboration of the beneficiary's care through the utilization of an interdisciplinary team. This team is expected to provide individualized person-centered care management and care coordination and work to improve the beneficiaries experience in accessing and receiving services, improving the health of the population, and reducing per capita cost of care.

Health Homes are expected to provide six billable services focused on person-centered care coordination, including:

1. Comprehensive Care Management;
2. Care Coordination;
3. Health Promotion;
4. Comprehensive Transitional Care;
5. Individual and Family Support Services; and

## 6. Referral to Community and Social Support Services.

The new Section 106, Joint Medicaid Health Home Coordination Care Plan, of B24-0092 and its associated benefits are already a part of the District's Health Home programs I just described. For example, as part of the Comprehensive Care Management service, Health Home providers are required to create a person-centered plan of care. Health Home providers are required to connect beneficiaries to peer and recovery supports through Health Promotion. In the My Health GPS program, Comprehensive Transitional Care requires providers to support transitions from inpatient to other care settings.

DHCF has partnered with DBH in a shared commitment to support whole-person, integrated care via care coordination. We recognize that effective care coordination and population health management strategies can require substantial changes to a providers' business practices and clinical workflows to improve health outcomes. For this reason, DHCF has worked with health home providers to revise and improve agency policies to address administrative burdens and to increase provider capacity through technical assistance. From May 2018 to April 2020, DHCF supported training and technical assistance for providers participating in the My Health GPS program. Building on this successful model, in the fall of 2020, DHCF announced a new five-year contract for the Integrated Care TA (ICTA) program, which is explicitly designed to support Medicaid provider's ability to transform their practice to deliver integrated physical and behavioral health, available to providers serving both of the District's Health homes. The first two years of this program are supported by the Centers for Medicare and Medicaid Services' (CMS) SUD Provider Capacity Grant the District received in FY20, and emphasize best practice strategies to improve care coordination among physical and behavioral health providers to integrate care for individuals with substance use disorder.

## **Medicaid Reform and Behavioral Health Transformation**

The District is in year two of a five-year reform plan for the Medicaid program. Creating a system that supports whole person care is our goal and changes to our behavioral health system are integral to achieving that goal. In looking at our behavioral health system and services for the Medicaid program, DHCF recognizes that there are: (1) key gaps in the Medicaid behavioral health service array, and (2) complex and overlapping oversight make it harder to manage services in a holistic way that is integrated with other medical treatment.

We began expanding the service array in January 2020, with the implementation of the combined SMI-SUD BH Transformation Demonstration, which leveraged federal CMS guidance on IMD waivers. The 10 waiver services are implemented and have shifted to on-going operations, monitoring, and evaluation of their services. Our focus now is the integration of the more intensive mental health and SUD services into the Medicaid managed care program. This work is not standalone—but complements on-going efforts to assess the current system, expand health information exchange and health information technology, and build behavioral health service capacity.

DHCF's recently released *Substance Use Disorder Community Need and Service Capacity Assessment*,<sup>1</sup> developed in close collaboration with DBH and authored by the DC Primary Care Association and John Snow International, documents the breadth of services in the District's SUD network and the sizeable number of clients served by service type. Nonetheless, the report

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<sup>1</sup>[https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page\\_content/attachments/DC%20SUD%20Community%20Need%20and%20Service%20Capacity%20Assessment%20Final%20%20%283%29.pdf](https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/DC%20SUD%20Community%20Need%20and%20Service%20Capacity%20Assessment%20Final%20%20%283%29.pdf)

identifies opportunities to improve, indicating that DC residents with SUD are not always able to access the services they need, when and where they want them.

DHCF is pursuing a number of strategies to address recommendations in the report, including: developing infrastructure to allow consent-based sharing of substance use treatment information via health information exchange; development of a community resource inventory and referral system, the Community Resource Information Exchange (CoRIE) to support SUD providers in linking individuals to community-based organizations that address social determinants of health; and providing technical assistance on integrating care with evidence-based substance use disorder screening, assessment, and treatment approaches.

The consent management tool will enable SUD and physical health providers to exchange information on a shared patient with appropriate federal consent. The District designated Health Information Exchange (HIE) partner, Chesapeake Regional Information System for our Patients DC (CRISP DC), has also built a comprehensive provider directory with eReferral capabilities using the DIRECT messaging standard. CRISP's e-Referral tool is "an online referral system" supporting users who do not have an existing system. Currently, the tool is in use by pilot/test sites as part of the CoRIE Project to facilitate electronic closed-loop referrals from healthcare providers to community-based organizations.

The DC HIE Provider Directory was launched on September 1, 2019 and includes contact information from 12 national sources and 20 DC/Local Data sources. The provider directory currently includes more than 31,000 contacts and is being refined with assistance from the DC Hospital Association.

Additionally, DHCF and DBH recently launched a Behavioral Health Integration Stakeholder Advisory Group with 40 members representing consumers, caregivers, consumer

organizations, providers offering behavioral health services across the continuum of care, provider organizations, Medicaid Managed Care Organizations and relevant subcontractors, and representatives from DBH and DHCF, and other District agencies to provide input on key decisions relating to transforming behavioral health services.

In the near future DHCF will also be releasing a Behavioral Health Rate Study and Development request for proposals (RFP) to conduct a comprehensive behavioral health rate study, to develop recommendations for reimbursement rates, and to provide consultation services to support the integration of behavioral health services into the Medicaid managed care program.

## **Conclusion**

DHCF and DBH are working closely in coordination 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. The District, through Mayor Bowser's leadership and commitment to improving SUD services, is undertaking efforts to improve health outcomes for individuals with SUD.

Many of the proposed services provided for in Bill 24-0092 are currently covered through the Medicaid program. DHCF remains committed to work in partnership with DBH to promote whole-person, high-quality care for individuals with SUD to ensure the opportunity for long-term recovery and improved health outcomes.

Thank you for the opportunity to testify today. This concludes my testimony. I am pleased to address your questions.