Massa, Cody

From: Linda Macdonald <linda.macdonald@floridabha.org>
Sent: Friday, June 3, 2022 4:48 PM
To: solicitation.questions
Cc: Melanie Brown-Woofter
Subject: FBHA Response to RFI 014-21/22 Re-Procurement of SMMC Program
Attachments: FBHA Recs_Re-Procurement SMMC_ Final.docx

Good Afternoon,

Find attached Florida Behavioral Health Association (FBHA) recommendations in response to the Agency's RFI 014-21/22. Please let us know if you would like to meet to discuss our recommendations.

Sincerely,
Linda

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Florida Behavioral Health Association

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Florida Behavioral Health Association Recommendations for the Re-Procurement of Statewide Medicaid Managed Care (SMMC) Program

1. Adjust the Medicaid reimbursement rates for mental health and substance use services upward as the Medicaid rates no longer cover the cost of providing the service. The cost of service provision is impacted by several factors, including the increased demand for services, the reduced number of professionally trained staff available (which drives salaries upward) and increased overhead costs.
2. Seek state plan authority to implement the Community Certified Behavioral Health Clinic (CCBHC) model (that provides for prospective payments to the CCBHC providers) and direct the selected plans to contract with the CCBHC providers upon implementation in Florida.
    - When developing the evaluation criteria of the ITN, include higher scoring for plans that include mental health and substance use providers that have been awarded the CCBHC implementation grant and/or are working to obtain the CCBHC certification in the plan networks.
    - Currently Florida has 13 CCBHC grant awardees and another 33 providers submitted grant applications for CCBHC funding for implementation in the most recent funding opportunity which closed on May 17, 2022.
3. Review the plan's provider network adequacy to ensure sufficient behavioral health service availability for Medicaid recipients both in person and via telehealth.
    - Allow providers delivering services via telehealth to count toward available practitioners in the plan catchment areas, especially in rural areas or areas with limited behavioral health providers and transportation.
4. Revise physical location requirements as long as the provider's administrative headquarters has a registered address in Florida. Many providers practice telehealth statewide and do not have physical presence in all regions.
5. When developing the evaluation criteria of the ITN, include higher scoring for plans that include "in lieu of "services that support evidence-based practice (EBP) community-based services for families to keep children and adolescents out of residential or foster care. The traditional Medicaid covered service codes do not support EBP implementation. The EBPs below represent the models that DCF has approved for prevention services eligible under Title IV-E.
    - Parent-Child Interaction Therapy (PCIT)
    - Functional Family Therapy (FFT)
    - Brief Strategic Family Therapy (BSFT®)
    - Homebuilders
    - Parents as Teachers
    - Healthy Families America (HFA®)
6. Implement more progressive funding models for mental health and substance use services that support whole-person care. When developing the evaluation criteria of the ITN, include higher scoring for plans that include contracting utilizing the models below:

- Prospective Payment Models
    i. CCBHC model (includes the integration of primary care and Behavioral Health services).
    ii. Capitation rates for mental health, substance use services and integration of primary care and Behavioral health services.

- Value-based contracting (this includes the Behavioral Health Home models)

7. We recognize that care coordination and case management are vital, but inefficiency is created when multiple levels of care coordination are deployed for the same population (i.e. managed care plans, managing entities, community agencies and service providers all engaging in case management without coordination).
    - Enhance care coordination definitions to ensure roles are clear and to eliminate duplication if the member already has a community case manager or care coordinator.
8. Require the plans reimburse providers for care coordination services:
    - When developing the evaluation criteria of the ITN, include HIGHER scoring for plans that include contracting with providers for case management and care coordination.
    - When developing the evaluation criteria of the ITN, include LOWER scoring for plans that include a call center model of case managers and/ or care coordinators for the severe mentally ill, and clients identified as 'high utilizers' of crisis services, i.e. that the case manager is situated in a call center or at home and conducts all coordination services via telephonic or telehealth.
9. With suicide and overdose rates increasing, together with costs rising and staffing shortages, it is more important than ever to prioritize access to care through covered services and reduce administrative burden on care providers, such as:
    - Increase standard initial authorization for mental health crisis stabilization admissions (standard across ALL plans) to an automatic five days, rolling to Monday if falls on a weekend. Require notification of admission via a portal and requests only for continued stay after initial 5 days.
    - Create uniformity across the plans in terms of processes and workflows.
        i. Standardizing processes across plans such as requests for pre-authorization or continued stay for CSU/Inpatient mental health and substance abuse.
        ii. Training on information required for prior authorization and claims processing by each plan or streamline to a standard format.
        iii. Method for submissions – preference is for submission via an online portal rather than phone calls or faxing.
        iv. Require the plans to share claims denial data with AHCA to allow the Agency to be able monitor/audit denial practices.
10. Require the plans to pay for a portion of mobile response teams utilizing a true blended funding model since many of the individuals served are Medicaid recipients.
    - Require the plans to pay capitated payments for Mobile Crisis Response Team (MCRT) based on managed care covered population in a region with a baseline minimum payment guaranteed

for each provider of MCRT services that are available 24/7. Note: Since this is an emergency service that must be available 24/7, managed care plans paying fee-for-service per individual is not reasonable. The payment should not be tied to the number or volume of services as the team has to be in place 24/7 regardless of service volume.

- The plan's MCRT contracted services should be for providers who operate a 24/7 MCRT, and who operate and are designated as Public Receiving Providers for CSUs.
- Prohibit the plans from setting staffing standards for MCRT services offered 24/7 that differ from those required by DCF.

11. Eliminate the IMD 15-day coverage cap per month for inpatient crisis stabilization services which is currently in place.
12. To Improve mental health outcomes for children and adolescents and align quality metrics and outcomes with the Florida State Health Improvement Plan, we suggest including:
    - Health plan measures that align with the goals and objectives under the Mental Well-being and Substance Abuse Prevention priority area in the 2022-2026 State Health Improvement Plan. For example, measures related to hospitalizations and/or emergency department visits for adults and children who have diagnosed mental health and/or substance use disorders and increasing the percentage of individuals (pregnant women, youth, or other specific populations) who have been screened and/or received brief intervention and referral for alcohol and/or substance abuse.
    - Considering including the CCBHC Required Reporting Measure (listed on the next page) in plan reporting to align with the SHIP, and demonstrate improvement in mental health and substance use outcomes.

CCBHC REQUIRED MEASURES

	Measures to be reported by the CCBHC
1.	Number/percent of new clients with initial evaluation provided within 10 business days, and mean number of days until initial evaluation for new clients
2.	Preventive Care and Screening: Adult Body Mass Index (BMI) Screening and Follow-Up
3.	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
4.	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention
5.	Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling
6.	Child and adolescent major depressive disorder (MDD): Suicide Risk Assessment
7.	Adult major depressive disorder (MDD): Suicide risk assessment
8.	Screening for Clinical Depression and Follow-Up Plan
9.	Depression Remission at 12 months
	Measures to be reported by the State
10.	Residential Status at Admission or Start of the Reporting Period Compared to Residential Status at Discharge or End of the Reporting Period
11.	Follow-Up After Discharge from the Emergency Department for Mental Health
12.	Follow-Up After Emergency Department for Alcohol or Other Dependence
13.	Plan All-Cause Readmission Rate
14.	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who Are Using Antipsychotic Medications
15.	Adherence to Antipsychotic Medications for Individuals with Schizophrenia
16.	Follow-Up After Hospitalization for Mental Illness, ages 21+
17.	Follow-Up After Hospitalization for Mental Illness, ages 6 to 21
18.	Follow-up care for children prescribed ADHD medication
19.	Antidepressant Medication Management
20.	Initiation and engagement of alcohol and other drug dependence treatment
21.	Patient/Family experience of care survey