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ABA Services	How does ABA fit in? It hasn't been mentioned yet today and I know you didn't mention all specific services, but I would love to be able to report the latest and greatest. My concern is that my providers tend to get antsy when it looks like their service is going away.	Behavior Therapy is not one of the services set for Enhancement at this time, though there are other factors that may drive some change to this service. Two of those factors include: 1) The current billing code used for Behavioral Therapy (H2033) is actually the code that should be used for Multi-Systemic Therapy according to CMS correct coding standards. Thus, the billing code will need to change, but to which code is not yet determined; 2) There are new CPT codes for ABA that were released in 2019 (https://www.autismspeaks.org/sites/default/files/ABA%20and%20Treatment%20Code%20Conversion%20Table.pdf) that DMAS should move towards implementing in order to be aligned with the national correct coding initiative (https://www.medicaid.gov/medicaid/program-integrity/national-correct-coding-initiative-medicaid/index.html). These codes provide one option for how to move away from use of the current, technically incorrect code.
BHE and Trauma Informed Care	What is the plan/conversation for dealing with systemic trauma and racism?	Developing meaningful and actionable plans for addressing the impacts of systemic trauma and racism necessarily involve significant effort, commitment, and stakeholder engagement. Close examination of the impacts of these factors for our members is important to leadership at both DMAS and DBHDS, and that process involves both work internal to the agencies in examining policies, procedures and practices as well consideration of new initiatives and how they can help to ameliorate the effects of racism. DMAS and DBHDS have reaffirmed their commitment toward ameliorating the effects of systemic trauma and racism. DMAS as an agency started this journey prior to 2020 with the establishment of its Diversity Council. DMAS and DBHDS haves continued through participation in the Commonwealth's COVID-19 Health Equity workgroups, and has its own Health Equity workgroup that is focusing on examination of how we can integrate equity metrics and themes into our current projects. DMAS and DBHDS have each been in recruitment for a Diversity, Equity and Inclusion officer for their agency. In terms of the BHE initiative, DMAS is planning to initiate nominations for a stakeholder workgroup in the second week of January that will focus on health equity related to the implementation of these new services. We are reviewing a

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		number of resources to support this work, including consideration of how data integration and use of guiding principles can drive equity (e.g. https://www.aisp.upenn.edu/centering-equity/ and https://www.rwjf.org/en/library/research/2020/05/health-equity-principles-for-state-and-local-leaders-in-responding-to-reopening-and-recovering-from-covid-19.html) We anticipate that a nomination survey for this workgroup will go out to stakeholders in January 2021.
BHE Providers	Do any of these services apply to private providers? Or do the CSB's get to initiate these services and we will catch up over time?	All services within Behavioral Health Enhancement are intended for implementation by public and private providers.
BHE Workgroups	Are there other Peer Recovery Specialist's on this workgroup who can provide lived experience and share stories?	Yes. We have had participation from VOCAL as one of the original stakeholder parties who nominated participants for the service specific workgroups, and all nominations were accepted. Voices for Virginia's Children, NAMI, and Mental Health America have also been included from the very beginning and made similar nominations. We are open to additional nominations and welcome Peer and Member voices, so please send those to enhancedbh@dmas.virginia.gov.
Billing	Do you have ideas about how the rates will be set for FFT and MST? We currently have a regional service that is underutilized - less than 50% due to the current cost that is charged for the service.	Rates have already been set for all six services through our stakeholder engagement and rate study process in 2019. The rates that were proposed based on that study and were used to inform our budget request are here: https://www.dmas.virginia.gov/files/links/5170/DMAS%20BH%20Enhancement%20Proposed%20Rates%20Summary%202019.pdf You can also find documents on how our actuary set these rates here: https://www.dmas.virginia.gov/#/behavioralenhancement
Billing	Can you please clarify if those rates are finalized?	We do not anticipate those rates to change, as they were approved and used to inform the budget process. We will send out formal communication about billing and rates in Spring of 2021.
Billing	Is it safe to assume, if the rates are pretty much set, then codes for each services area is set? Asking as plans gear up for configuration.	Billing Codes are in draft format and we do anticipate a few changes. The MCOs will be fully engaged in this process with our internal project teams.
Crisis Stabilization Services	Is it against any regulations to provide TEMPORARY PLACEMENT or TEMPORARY SHELTER for clients in a crisis....Non-residential services, however?	There is no prohibition against providers doing so, however, the reimbursement rate for Crisis Stabilization (H2019) is for clinical services rendered and not housing, and thus while providers may opt to provide such shelter it is not a billable part of the service. The DBHDS Office of Licensing is currently working on formal guidance related to the use of hotels by crisis stabilization providers. Moving forward, when BHE Crisis Services are implemented (Dec 2021), to include the following services, Mobile Crisis Services, Community Stabilization, 23-Hour

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		Observation, Residential Crisis Stabilization Unit, the per diem rates for residential Crisis Stabilization Unit will be inclusive of the cost of members staying overnight.
Licensing	What will the process be for providers to obtain the new licenses, where required?	DBHDS Office of Licensing (OL) will be providing guidance for obtaining new licenses where required. The OL has drafted an internal timeline and will be sending out a formal correspondence to all providers once finalized and no later than February 1st, 2021. OL currently plans to begin to accept service modification by April 1st, 2021 for the services beginning July 1st, 2021. These modifications will be prioritized above others.
Licensing	Will the 6-month wait time still apply in the licensing process if the intent is to incentivize providers to provide these services in the middle of the crisis, we don't have time to wait. 6 months could be dire to the populations we serve.	New providers applying for one of these services will be prioritized for initial review of applications. Providers will still need to meet all of the requirements outlined within the initial application review process. DBHDS will be offering a training on the initial application process to providers who are interested in applying for the July 2021 services. If the provider is already licensed to provide services, adding additional services can be completed through the service modification process, which does not include a waiting list. If the service modification is completed accurately, the process should not take more than 60 business days.
MCO Administration	I would be interested to know what measures will be in place to assure MCO accountability to authorize services that have been inclusive of so many statewide partners to develop a system of care that at the core will make a significant dent in public health indicators. Ultimately, if services are not authorized or authorization becomes so challenging as a methodology of reducing expenditures that it discourages the offering of services in the community, the entire project could fall apart.	There are numerous mechanisms by which the MCOs are held accountable to their contracts with DMAS. First, each plan must be National Committee for Quality Assurance (NCQA) accredited. There is also oversight through the Health Services Advisory Group (HSAG) who performed on-site reviews every three years. HSAG is a third party that is used for auditing networks, operations, credentialing, provider access, utilization review, claims processing, authorization process, quality improvement practices on the whole. DMAS also has program dedicated Compliance units with staff who examine appeals, claims payment, quality improvement and member/provider complaints. These units require monthly, quarterly and annual reporting from the plans and identify any issues and discrepancies. DMAS also requires that each plan go through the Managed Care Health Insurance Plan (MCHIP) certification process, which is overseen by the Virginia Department of Health. DMAS also requires Bureau of Insurance licensure of each plan, which requires that they meet national standards in terms of solvency, claims payment, profitability, and profit caps. DMAS conducts regularly scheduled meetings with MCOs on operations and performance, and the BH team leadership meetings bi-monthly with BH leads at each MCO.

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		DMAS has also initiated an MCO Resolutions Panel in accordance with budget language that mandates a venue wherein provider associations may bring forth concerns related to trend-level evidence (rather than individual member appeals) that indicates MCO actions around behavioral health services are violating their contracted standards.
Mobile Crisis	What does mobile crisis look like? In the event the individual needs to be removed from their environment immediately to de-escalate and eliminate the crisis. Where does the individual go if we are to avoid hospitalization?	If you are interested in a high level overview of how the different aspects of the crisis system are intended to work together, please visit https://crisisnow.com/ Mobile Crisis will be multifaceted including the build out of crisis intervention settings outside of hospital settings that may look much like "Urgent Care" settings wherein providers have the opportunity set up multiple services in one setting (e.g. Walk-In clinic/Mobile crisis teams, Community Stabilization Services, Residential Crisis and 23 hour beds).
Mobile Crisis	How will we ensure responders look like the people they are serving?	This question taps into the idea of culturally congruent healthcare service delivery, and the challenges and questions about the "active ingredients" in the delivery of behavioral health interventions that have been widely studied and discussed over the last 25 years, particularly since the advent of evidence-based practices. There are numerous variables that have been correlated with outcomes for people participating in behavioral health care that are related to both provider/therapist and intervention characteristics. Some work has shown that racial match (one way that responders might "look like" those they serve) has both positive and negative effects on some aspects of disclosure and engagement in traditional therapy (https://guilfordjournals.com/doi/abs/10.1521/jscp.2014.33.10.936) and some meta-analysis have shown no significant effect for racial matching on therapeutic outcomes (https://psycnet.apa.org/doiLanding?doi=10.1037%2Fa0025266). Translating these findings to the ways that we provide effective access to care for our members is an ongoing process. For example, in the area of CMHRS, providers bill using a group NPI and DMAS would have no means to know the demographics of the individual staff who are providing direct service to each member, making it challenging to do any analysis or ongoing monitoring of matching efforts and their outcomes. Thus, we may not have theoretical grounding or mechanism by which we can assure that a mobile crisis response team would have demographics that would match the member they serve, particularly in a crisis context where immediacy of response is paramount. What we can work to assure initially is that mobile crisis providers are trained in trauma informed care, cultural humility and effective interventions that can help us to reduce further traumatization through

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		institutionalization or incarceration. Finally, we also see responsibility on the part of mobile crisis providers to assure they employ a diverse workforce to support options in who responds to crisis when they are dispatched.
MST Service Definition	Under billing guidance for each program, costs for certification, training, and documentation "are included." Does this mean that the costs for those tasks are included in the rate that is billed for direct client care or that "the time spent performing these tasks" are billable?	This means that the rate was developed by taking into account how much trainings, certification and documentation cost. These are not billable activities but are used to develop the rate so that the rate can sustain those activities for the agency.
MST Service Definition	Will the medical criteria for this service be consistent with IIH MNC, linked to required referral from DJJ, or developed independently of either of these entities?	The BHE team is developing the medical necessity criteria for MST based on materials provided by the treatment developers alongside examples from other states that have already implemented MST within Medicaid programs. The BHE team is designing these medical necessity criteria in the context of Intensive In home criteria, with a mindfulness that there are a subset of youth who may traditionally meet criteria for Intensive In Home but would now have the option of MST or FFT instead. The medical necessity criteria will stand separate from the criteria for intensive in home, as MST is more restrictive and based on the subset of youth that would be appropriate for this service. Participation in MST through Medicaid will be based on those medical necessity criteria and will not require a referral from DJJ.
Policy Administration	We are held accountable at multiple levels! What forms of accountability are going to be in place to hold the MCOs and DMAS accountable to ensure both parties are ensuring applications of public policy...as everything that is written is not always consistently applied?	There are numerous mechanisms by which the MCOs are held accountable to their contracts with DMAS. First, each plan must be National Committee for Quality Assurance (NCQA) accredited. There is also oversight through the Health Services Advisory Group (HSAG) who performed on-site reviews every three years. HSAG is a third party that is used for auditing networks, operations, credentialing, provider access, utilization review, claims processing, authorization process, quality improvement practices on the whole. DMAS also has program dedicated Compliance units with staff who examine appeals, claims payment, quality improvement and member/provider complaints. These units require monthly, quarterly and annual reporting from the plans and identify any issues and discrepancies. DMAS conducts regularly scheduled meetings with MCOs on operations and performance, and the BH team leadership meetings bi-monthly with BH leads at each MCO. DMAS also requires that each plan go through the Managed Care Health Insurance Plan (MCHIP) certification process, which is overseen by the Virginia Department of Health. DMAS also requires Bureau of Insurance licensure of each plan, which requires that they meet national standards in terms of solvency, claims payment, profitability, and profit caps.

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		DMAS is monitored by regulatory authorities such as CMS, JLARC and internal audit groups such as APA. DMAS works closely with the MCOs to ensure that their policies and procedures related to the authorization of services is consistent with DMAS standards. DMAS will continue to follow-up on any areas of concern and research the root cause of the issues and provide MCO education, provider education, etc. Every implementation with the MCOs includes close monitoring to ensure policies are consistently applied within the scope of the regulations and contracts. DMAS has also initiated an MCO Resolutions Panel in accordance with budget language that mandates a venue wherein provider associations may bring forth concerns related to trend-level evidence (rather than individual member appeals) that indicates MCO actions around behavioral health services are violating their contracted standards.
Racial Equity and Service Delivery	I think the issue for us is provider equity and equality with the services we provide and the individuals that we serve through these services. When we say racial equity, is this also in consideration of our BH business community, which I believe has a nexus to the people that we serve? Are there plans to address inequities with respects to minority providers and the impacts our disparities have on marginalized communities?	DMAS is committed to assuring equitable access to high-quality care for all of its members, and the providers who contract with our Behavioral Health Service Administrator vendor (Magellan of Virginia), our Managed Care Organization contractors, and DMAS itself are an important part of achieving that mission. We understand that some providers have concerns about equity in business opportunities. DMAS is working closely with the Managed Care Organizations to address health inequity and disparities. Managed Care Organizations are required to provide annual reports on health disparities on members and providers. In 2021, DMAS would like to focus our data analysis efforts on provider inequities by identifying patterns and trends. The BHE health equity workgroup would be an ideal avenue to discuss the analysis and strategies to address the issue. DMAS and DBHDS recognize that this is a larger systemic issue and are addressing this at a higher interagency level.
Racial Equity and Service Delivery	What is the plan for addressing racial inequality in service delivery, provider selection, etc.?	DMAS is planning to initiate nominations for a stakeholder workgroup in the second week of January that will be focused on health equity related to the implementation of these new services. We are reviewing a number of resources to support this work, including consideration of how data integration and use of guiding principles can drive equity (e.g. https://www.aisp.upenn.edu/centering-equity/ and https://www.rwjf.org/en/library/research/2020/05/health-equity-principles-for-state-and-local-leaders-in-responding-to-reopening-and-recovering-from-covid-19.html)

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Racial Equity Workgroup	Are you able to talk a bit more about the Racial Equity Workgroup and what the objectives are?	The objectives of this group will be formulated by the group, though our broad goal in forming the group is to assure that we seek to make decisions based on principles of health equity, such as those outlined by the Robert Wood Johnson Foundation (https://www.rwjf.org/en/library/features/achieving-health-equity.html) and the Casey Foundation (https://www.aecf.org/resources/tools-for-thought-a-race-for-results-case-study/#key-takeaway). For example, some basic objectives of this group could including 1) defining the ways by which DMAS seeks to dis-aggregate data or operationalize variables to monitor impacts on demographic categories for members; 2) support cultural congruence of materials provided to members regarding new services; 3) reviewing and exploring existing language and terminology used in manuals or other documents to assure they are culturally inclusive; 4) reviewing data analysis in ongoing implementation to examine trends relevant to equity.
Racial Equity Workgroup	What is the timing for establishment of the Racial Equity Workgroup?	We aim to send out a nomination survey in the second week of January and convene the group following the close of the General Assembly.
School Services	With the adjusted timeline, when do you anticipate that school services will be discussed?	At this time, given the COVID-19 pandemic and the priorities and resources of the Commonwealth, DMAS is fully focused on the implementation of the currently approved services. DMAS shares concern with our sister agencies that serve youth as well as our stakeholders in regards to the mental health needs of Virginia's youth in the wake of the pandemic and impacts on schools. We have indication through stakeholders that taking action to support school services, and perhaps enhance them through changes to Medicaid-covered services may be the subject of proposed legislation and DMAS will act in accordance with direction from the General Assembly in regards to next steps.
School Services	Any consideration to moving up school based services in the phases	This question may refer to questions from early presentations on BHE wherein we discussed hypothetical, future phases of BHE. Any discussion of service enhancement beyond our current funding and direction from the Administration and General Assembly is purely hypothetical and any future proposals will be based on the evolving needs of the Commonwealth and our Behavioral Health System. As we have learned in this last year, major changes in our priorities can happen nearly overnight, as they did with COVID-19. DMAS stands ready to adjust and align with where our resources and efforts should be directed based on those priorities.
Service Definitions	Will service definitions be revised to clarify allowances for telehealth?	Yes. DMAS is currently working on its proposal for long-term telehealth policy changes and as these are approved, they will be reflected in the enhanced services.

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Telehealth	Will there be ongoing telehealth flexibilities beyond COVID-19?	DMAS is currently working on its proposal for long-term telehealth policy changes and as these are approved, they will be reflected in the enhanced services.
Workgroups	When is the work group looking at integrated care expected to start work?	At this time, given the COVID-19 pandemic and the priorities and resources of the Commonwealth, DMAS is fully focused on the implementation of the currently approved services. We believe that focused work on integrated care efforts is critical to the overall functioning our system, and a good example of the positive outcomes associated is the Virginia Mental Health Access Program (https://www.vmap.org/). Some efforts towards improving integrated care may be possible without changes to rates or services, though efforts in this domain will not be possible until after the currently approved services are implemented in 2021 given the competing demands on our team.