State Demonstrations Group

DEC 1 9 2019

Melisa Byrd
Senior Deputy Director and State Medicaid Director
Department of Health Care Finance
One Judiciary Square 441 4th Street NW
Washington, DC 20001

Dear Ms. Byrd:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of the most recent revisions to the Serious Mental Illness (SMI) and Substance Use Disorder (SUD) Implementation Plans for Washington D.C.'s ("the District") approved section 1115(a) demonstration, titled "Behavioral Health Transformation" (BHT) (Project No. 11-W-00331/3). We have determined that, pending an updated mental health services assessment, the revised implementation plans are consistent with the requirements outlined in the BHT's Special Terms and Conditions (STC). Therefore, CMS is concurrently approving the SMI and SUD Implementation Plans. With this concurrent approval, the state may begin receiving federal financial participation as of the effective date of January 1, 2020, as listed in the STCs, for providing the services approved under the BHT demonstration. A copy of the approved SMI and SUD Implementation Plans are enclosed and, hereby, incorporated into the STCs as Attachments C and D, respectively.

If you have any questions, please do not hesitate to contact your project officer, Mr. Jack Nocito. Mr. Nocito can be reached at (410) 786-0199, or at Jack.Nocito@cms.hhs.gov.

We look forward to continuing work with your staff on the District's BHT section 1115(a) demonstration.

Sincerely,
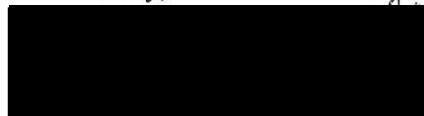
Angela D. Garner
Director
Division of System Reform Demonstrations

cc: Francis McCullough, Director, Division of Medicaid Field Operations East

ATTACHMENT C
Section 1115 SMI/SED Demonstration Implementation Plan

Overview: The implementation plan documents the state's approach to implementing SMI/SED demonstrations. It also helps establish what information the state will report in its quarterly and annual monitoring reports. The implementation plan does not usurp or replace standard CMS approval processes, such as advance planning documents, verification plans, or state plan amendments.

This template only covers SMI/SED demonstrations. The template has three sections. Section 1 is the uniform title page. Section 2 contains implementation questions that states should answer. The questions are organized around six SMI/SED reporting topics:

1. Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings
2. Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care
3. Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services
4. Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration
5. Financing Plan
6. Health IT Plan

State may submit additional supporting documents in Section 3.

Implementation Plan Instructions: This implementation plan should contain information detailing state strategies for meeting the specific expectations for each of the milestones included in the State Medicaid Director Letter (SMDL) on "Opportunities to Design Innovative Service Delivery Systems for Adults with [SMI] or Children with [SED]" over the course of the demonstration. Specifically, this implementation plan should:

1. Include summaries of how the state already meets any expectation/specific activities related to each milestone and any actions needed to be completed by the state to meet all of the expectations for each milestone, including the persons or entities responsible for completing these actions; and
2. Describe the timelines and activities the state will undertake to achieve the milestones.

The tables below are intended to help states organize the information needed to demonstrate they are addressing the milestones described in the SMDL. States are encouraged to consider the evidence-based models of care and best practice activities described in the first part of the SMDL in developing their demonstrations.

The state may not claim FFP for services provided to Medicaid beneficiaries residing in IMDs, including residential treatment facilities, until CMS has approved a state's implementation plan.

Memorandum of Understanding: The District's Department of Health Care Finance (Single State Medicaid Agency) has a Memorandum of Understanding (MOU) with the District's

Department of Behavioral Health (Mental Health Authority) delineating how the agencies work together to deliver covered behavioral health services to Medicaid eligible individuals. The current MOU is provided as Attachment A. Upon approval of this demonstration, the District will evaluate if the MOU needs to be amended.

State Point of Contact:
Melisa Byrd
Senior Deputy Director and State Medicaid Director
202-442-9075
melisa.byrd@dc.gov

1. Title page for the state's SMI/SED demonstration or SMI/SED components of the broader demonstration

State	*District of Columbia*
Demonstration name	*Behavioral Health Transformation Demonstration Program*
Approval date	*November 6, 2019*
Approval period	*January 1, 2020 through December 31, 2024*
Implementation date	*January 1, 2020*

2. Required implementation information, by SMI/SED milestone

Prompts	Summary
SMI/SED. Topic_1. Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings	
To ensure that beneficiaries receive high quality care in hospitals and residential settings, it is important to establish and maintain appropriate standards for these treatment settings through licensure and accreditation, monitoring and oversight processes, and program integrity requirements and processes. Individuals with SMI often have co-morbid physical health conditions and substance use disorders (SUDs) and should be screened and receive treatment for commonly co-occurring conditions particularly while residing in a treatment setting. Commonly co-occurring conditions can be very serious, including hypertension, diabetes, and substance use disorders, and can also interfere with effective treatment for their mental health condition. They should also be screened for suicidal risk. *Through these section 1115 SMI/SED demonstrations, FFP is only available for services provided to beneficiaries during short term stays for acute care in IMDs (See top of p. 12 in the State Medicaid Director Letter (SMDL). As part of their implementation plan, states should propose to CMS how they are defining a short term acute stay in an IMD for purposes of these demonstrations. This definition should include a length of stay (e.g., up to 60 days) that will enable the state to demonstrate that FFP is only being claimed for services provided to beneficiaries during short term stays for acute care and the statewide average length of stay meets the expectation of 30 days (stated at the bottom of p. 12 in the SMDL). States may not claim FFP for services provided to beneficiaries who require long lengths of stay beyond a short term stay for acute care as defined by the state. However, states should provide coverage of services during longer stays in these settings for those beneficiaries who need them, but with other sources of funding than FFP. States should avoid imposing a hard cap or limit on coverage of services provided to beneficiaries residing in IMDs which may not be in compliance with federal parity requirements.* *To meet this milestone, state Medicaid programs should take the following actions to ensure good quality of care in psychiatric hospitals and residential treatment settings.*	
Ensuring Quality of Care in Psychiatric Hospitals and Residential Treatment Settings	
1.a Assurance that participating hospitals and residential settings are licensed or otherwise authorized by the state primarily to provide mental health treatment; and that residential treatment facilities are accredited by a nationally recognized accreditation entity prior to participating in Medicaid	*Current State:* The Psychiatric Institute of Washington (PIW) is licensed by DC Health and is accredited by the Joint Commission. Saint Elizabeths Hospital is licensed by DC Health and certified as meeting the Medicare conditions of participation ([CMS FAQ, May 17, 2019](#)).
	Future State: If residential treatment providers wish to participate in the demonstration, the District will ensure they are licensed or otherwise authorized to primarily provide mental health treatment and accredited by a nationally recognized accreditation entity. If additional hospitals wish to participate, the District will ensure they are licensed and meet Medicare conditions of participation.
	Summary of Actions Needed: No action needed at present. If residential treatment providers wish to participate in the demonstration, the District will ensure they are licensed or otherwise authorized by the District to primarily provide

Prompts	Summary
	mental health treatment and accredited by a nationally recognized accreditation entity. If additional hospitals wish to participate in the demonstration, the District will ensure that they are licensed and meet Medicare conditions of participation.
1.b Oversight process (including unannounced visits) to ensure participating hospital and residential settings meet state's licensing or certification and accreditation requirements	*Current State:* As part of the licensure issuance and renewal process for hospitals (including psychiatric hospitals), DC Health performs licensure surveys annually and complaint investigations upon occurrence. DC Health's licensure surveys include unannounced visits to assess the facility's compliance with the statutes and rules governing the facility. Federal validation surveys are performed upon request from CMS to assess the accrediting organization's ability to ensure a hospital's compliance with CMS' health and safety standards.
	Future State: If residential treatment providers or additional hospitals wish to participate in the demonstration, the District will ensure the facilities meet applicable District licensing, certification, and accreditation requirements.
	Summary of Actions Needed: No action needed at present. If residential treatment providers or additional hospitals wish to participate in the demonstration, the District will ensure the facilities meet applicable District licensing, certification, and accreditation requirements.
1.c Utilization review process to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight on lengths of stay	*Current State:* The Department of Health Care Finance (DHCF) contracts with a quality improvement organization (QIO) to conduct utilization review to monitor appropriateness and quality of care provided to Medicaid fee for service (FFS) beneficiaries. Hospitalizations at specialty hospitals, including psychiatric hospitals, must be authorized by DHCF's QIO. The QIO also provides oversight on lengths of stay by conducting concurrent utilization reviews during hospitalizations at specialty hospitals to determine the clinical appropriateness of current and proposed levels of care. DHCF's current QIO uses InterQual Behavioral Health Criteria, an established evidence-based guideline used by many insurers, to make initial authorization and concurrent utilization review decisions.

Managed care organizations (MCOs) contracted with DHCF are required to develop and maintain a Utilization Management Program. Stays in psychiatric hospitals and residential treatment settings are allowable for MCO beneficiaries under the "in lieu of services" provision of federal Medicaid Managed Care rules. MCOs contracted with DHCF conduct independent utilization reviews of those hospitalizations and inpatient stays, based on standards such as InterQual Behavioral Health Criteria and Milliman Care Guidelines, for their enrollees. |
| | *Future State:* Stays for FFS beneficiaries in psychiatric hospital settings will be authorized by DHCF's QIO. The QIO will also provide oversight on lengths of stay by conducting concurrent utilization reviews. (Timeline: 12-24 months) |

Prompts	Summary
	MCOs will continue to conduct independent utilization reviews of stays in psychiatric hospitals and residential treatment settings for their beneficiaries. If new residential treatment facilities wish to participate in the demonstration, the District will establish a utilization review process to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight on lengths of stay.
	Summary of Actions Needed: DHCF will develop and issue rulemaking and other policies as necessary. DHCF will also modify existing contracts as necessary.
1.d Compliance with program integrity requirements and state compliance assurance process	*Current State:* DHCF regulations outline provider requirements which assist in assuring program integrity and quality compliance, including fraud detection and investigation, the prevention of improper payments, and provider participation. During provider enrollment and re-enrollment, DHCF uses a contractor to ensure providers meet federal program integrity requirements.
	Future State: Already implemented.
	Summary of Actions Needed: No action needed.
1.e State requirement that psychiatric hospitals and residential settings screen beneficiaries for co-morbid physical health conditions, SUDs, and suicidal ideation, and facilitate access to treatment for those conditions	*Current State:* Upon admission, psychiatric hospitals conduct psychiatric and medical screenings. If the facility is unable to provide necessary health care services, they facilitate access to treatment for all admitted patients.
	Future State: The District will require psychiatric hospitals to conduct the required psychiatric and other medical screenings.
	Summary of Actions Needed: The District will develop and issue rulemaking and other policies as necessary. (Timeline: 12-18 months)
1.f Describe the state's approach to defining a 'short term stay for acute care in an IMD', as described above and as referenced in the SMDL (page 12).	The District is seeking FFP for treatment provided to Medicaid recipients in institutions for mental disease (IMDs). The District will aim for a statewide average length of stay of 30 days in inpatient and residential treatment settings. This proposed demonstration will cover short term (up to 60 days) stays for acute care. Reimbursement for long-term residential or inpatient (longer than 60 days), and forensic IMD stays are not being proposed under this demonstration. Short term stays are defined as those necessary to resolve the acute phase of a mental health crisis. Total length of stay will be determined by medical necessity and reviewed by DHCF or its assignee for clinical appropriateness.

Prompts	Summary
1.g Other state requirements/policies to ensure good quality of care in inpatient and residential treatment settings.	*Current State:* See responses to Sections 1.a, 1.b, 1.c, 1.d, 1.e, and 1.f.
	Future State: The requirements and policies described in Sections 1.a, 1.b, 1.c, 1.d, 1.e, and 1.f ensure good quality of care is provided in inpatient and residential treatment settings and the District will continue to provide oversight as necessary.
	Summary of Actions Needed: No action needed.

SMI/SED. Topic_2. Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care
Understanding the services needed to transition to and be successful in community-based mental health care requires partnerships between hospitals, residential providers, and community-based care providers. To meet this milestone, state Medicaid programs, must focus on improving care coordination and transitions to community-based care by taking the following actions.
Improving Care Coordination and Transitions to Community-based Care

Prompts	Summary
2.a Actions to ensure psychiatric hospitals and residential settings carry out intensive pre-discharge planning and include community-based providers in care transitions.	*Current State:* For services delivered by providers certified by the District's Department of Behavioral Health (DBH) and/or DBH-funded services, DBH imposes several discharge planning and care coordination requirements on psychiatric hospitals and community-based providers, including timeframes in which certain activities must occur. For consumers receiving Mental Health Rehabilitation Services (MHRS) benefits, hospitals must notify the consumer's core service agency (CSA) or assertive community treatment (ACT) provider, if applicable, of the admission. The DBH Access Helpline (AHL) is able to provide information about an individual's CSA/ACT provider to the hospital, if needed. For MHRS-eligible consumers who do not have a pre-existing relationship with a CSA or ACT provider, the DBH AHL will link an individual to a CSA in accordance with DBH's consumer choice policy.

When notified of an admission, CSA/ACT providers are expected to establish contact with the consumer and provide the hospital with relevant consumer information, such as psychosocial, treatment course, and medication history. The CSA/ACT provider is to maintain ongoing contact with the consumer and the hospital, which can include participation in the hospital's treatment team meetings and the discharge planning process.

MCOs contracted with DHCF are responsible for coordinating services for MCO beneficiaries between settings of care, including appropriate discharge planning for stays in psychiatric hospitals and residential treatment settings. MCOs are required to assist in the development of an appropriate discharge plan prior to an MCO beneficiary's hospital discharge or change in treatment setting and when possible, participate in discharge planning meetings. As part of clinical management, MCOs are responsible for collaborating with staff in other District agencies, community service organizations, and other providers to meet beneficiaries' health care needs. MCOs are also responsible for care coordination and case management for beneficiaries receiving services through DBH. In addition, MCO Care Coordination and Case Management programs are required to be tiered models, with at least one tier designed for |

Prompts	Summary
	beneficiaries with the most complex needs and at the highest risk for poor health outcomes, such as individuals discharged from psychiatric hospitals and residential treatment settings. Care Coordination and Case Management activities in the highest tier are increased in frequency and/or intensity based on beneficiaries' particular needs. MCOs are required to assign a Registered Nurse or a Licensed Independent Clinical Social Worker as the primary case/care manager to oversee a multidisciplinary team for beneficiaries in the highest tier.
	Future State: In addition to DBH discharge planning and care coordination requirements and MCO care coordination requirements, this demonstration proposes to add Medicaid reimbursement for transition planning services provided by certain behavioral health providers for individuals with SMI/SED (and/or SUD) being discharged into their care from an inpatient, residential or other institutional setting. An individual's physical and mental health needs, as well as the need for non-clinical supports, are to be assessed during the discharge planning process. Enabling these behavioral health providers to be a part of plan development with the individual and the institution's treatment team promotes continuity of care and helps ensure that appropriate treatment services and supports are available and accessed after discharge. These transition services could be provided in person, remotely via telemedicine, and/or outside of the care delivery setting.
	Summary of Actions Needed: DHCF and DBH will develop and issue rulemaking and other policies as necessary for the new transition planning service. (Timeline: 12-18 months) DHCF will also modify existing contracts as necessary. At its discretion, DHCF can require MCOs to implement protocols and procedures for coordinating managed care services with the provision of other Medicaid services, including all behavioral health services. (Timeline: 12-18 months)
2.b Actions to ensure psychiatric hospitals and residential settings assess beneficiaries' housing situations and coordinate with housing services providers when needed and available.	*Current State:* DBH's discharge planning requirements include addressing benefits acquisition, transitional services, and housing, if applicable. As part of treatment plan development and updates, CSA and ACT providers also assess individuals for housing needs and coordinate with housing service providers, as appropriate and available.
	Future State: As noted in Section 2.a, this demonstration proposes to add Medicaid reimbursement for transition planning services provided by certain behavioral health providers for individuals with SMI/SED (and/or SUD) being discharged into their care from an inpatient residential, or other institutional setting. An individual's physical and mental health needs, as well as the need for non-clinical supports, including housing, are to be assessed during the discharge planning process.

Prompts	Summary
	Summary of Actions Needed: DHCF and DBH will develop and issue rulemaking and other policies as necessary for the new transition planning service. (Timeline: 12-18 months) DHCF will develop and issue rulemaking and other policies as necessary to ensure psychiatric hospitals and residential treatment settings assess beneficiaries' housing situations. (Timeline: 12-18 months)
2.c State requirement to ensure psychiatric hospitals and residential settings contact beneficiaries and community-based providers through most effective means possible, e.g., email, text, or phone call within 72 hours post discharge	*Current State:* As discussed in Section 2.a, for DBH-funded services, psychiatric hospitals must notify the consumer's CSA or ACT provider, if eligible, of an admission to their facility. CSA and ACT providers must participate in discharge plan development. The discharge plan must include an appointment with the CSA or ACT provider within seven days of discharge and a medication/somatic appointment for consumers on psychotropic medications within ten days of discharge. As discussed in Section 2.a, MCOs contracted with DHCF are responsible for coordinating services for MCO beneficiaries between settings of care. Following a discharge from a psychiatric hospital, MCOs are responsible for ensuring beneficiaries' timely and coordinated access to primary, specialty, and behavioral health care, including confirming that health care appointments have been kept.
	Future State: As noted in Section 2.a, this demonstration proposes to add Medicaid reimbursement for transition planning services provided by certain behavioral health providers for individuals with SMI/SED (and/or SUD) being discharged into their care from an inpatient, residential, or other institutional setting. The District will also require psychiatric hospitals and residential treatment settings to initiate contact within 72 hours of discharge with the beneficiary and community-based providers.
	Summary of Actions Needed: DHCF and DBH will develop and issue rulemaking and other policies as necessary for the new transition planning service. (Timeline: 12-18 months) The District will develop and issue rulemaking and other policies as necessary regarding the contact requirement within 72 hours post discharge for psychiatric hospitals and residential treatment settings. (Timeline: 12-18 months)
2.d Strategies to prevent or decrease lengths of stay in EDs	*Current State:* See Topic 3 for additional information on services that prevent the use of EDs, including non-hospital and non-residential crisis stabilization services.

Prompts	Summary
among beneficiaries with SMI or SED prior to admission	To receive full capitated payment, District MCOs must reduce preventable hospital admissions and low acuity emergency department visits, as well as reduce 30-day readmissions. These payments are based on outcomes largely derived from improved care coordination and transitional services.
	Future State: See Topic 3 for additional information on services that prevent the use of EDs, including non-hospital, non-residential crisis stabilization services.
	Summary of Actions Needed: See Topic 3 for additional information on services that prevent the use of EDs, including non-hospital, non-residential crisis stabilization services.
2.e Other State requirements/policies to improve care coordination and connections to community-based care	*Current State:* In addition to the discharge planning and care coordination requirements discussed in previous milestones, the Medicaid Health Home program is a key component of the District's care coordination strategy. The District currently operates two Health Home programs. My DC Health Home is administered by DBH. Through My DC Health Home, CSAs who are certified as health home providers deliver comprehensive care management services to Medicaid beneficiaries with SMI. The CSA collaborates with the consumer, the consumer's other health providers, and social services to develop and implement a comprehensive care plan. The My DC Health Home team is responsible for providing comprehensive transitional care and follow up, in addition to comprehensive care management and care coordination, health promotion, patient and family support, and referral to community and social support services. My DC Health Home providers must use health IT to support service linkages and communication across providers. They must also establish a continuous quality improvement program. The District's other Health Home program, My Health GPS, is administered by DHCF and focuses on the unmet care management needs of Medicaid beneficiaries with three or more chronic conditions. Behavioral health conditions, specifically SMI (and SUD), are included in the list of chronic conditions that determine eligibility for My Health GPS. The My Health GPS team is responsible for providing services akin to those provided through My DC Health Home, including providing comprehensive transitional care and follow up. My Health GPS providers are also responsible for facilitating linkages between physical and behavioral health services. My Health GPS providers are required to establish a continuous quality improvement program and to use health IT to support service linkages and communication across providers. District FQHCs are also incented to improve care coordination and transitions between levels of care. The FQHCs' payment methodology includes costs related to care coordination and part of the FQHCs' Alternative Payment Methodology (APM) includes a bonus payment for achieving benchmarks related to outcomes, access, and transitions

Prompts	Summary
	of care measures. The bonus payments are based on outcomes largely derived from improved care coordination and transitional services.
	Future State: The additional services being proposed under this demonstration will complement the District's existing Health Home programs by providing a framework in which health home beneficiaries with significant health needs will be able to receive support with care navigation. The Health Home programs are anticipated to grow over time and are a critical part of DHCF's investment to integrate the full array of primary, acute, behavioral health, and long-term services for Medicaid beneficiaries.
	Summary of Actions Needed: No action needed.

SMI/SED. Topic_3. Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services

Adults with SMI and children with SED need access to a continuum of care as these conditions are often episodic and the severity of symptoms can vary over time. Increased availability of crisis stabilization programs can help to divert Medicaid beneficiaries from unnecessary visits to EDs and admissions to inpatient facilities as well as criminal justice involvement. On-going treatment in outpatient settings can help address less acute symptoms and help beneficiaries with SMI or SED thrive in their communities. Strategies are also needed to help connect individuals who need inpatient or residential treatment with that level of care as soon as possible. To meet this milestone, state Medicaid programs should focus on improving access to a continuum of care by taking the following actions.

Access to Continuum of Care Including Crisis Stabilization

Prompts	Summary
3.a The state's strategy to conduct annual assessments of the availability of mental health providers including psychiatrists, other practitioners, outpatient, community mental health centers, intensive outpatient/partial hospitalization, residential, inpatient, crisis stabilization services, and FQHCs offering mental health services across the state, updating the initial assessment of the availability of mental health	*Current State:* As part of the demonstration application, the District conducted an assessment of the availability of mental health services to provide a baseline understanding of current rates of utilization, provider participation, and Medicaid enrollment against which to measure as the demonstration is implemented. The assessment includes information on the number of District providers of mental health services and a brief overview of the District's population with SMI/SED. DHCF was unable to compare DHCF's network to the total number of providers in the District for several categories of providers who treat mental illness, including psychiatrists or other practitioners who are authorized to prescribe, other types of practitioners authorized to treat mental illness, and intensive outpatient/partial hospitalization providers. The District's assessment of the availability of mental health providers is available in Attachment 2 of the demonstration application. Additional information on the District behavioral health system is available in the District of Columbia Uniform Application fiscal year 2018/2019 – State Behavioral Health Assessment and Plan Substance Abuse Prevention and

Prompts	Summary
services submitted with the state's demonstration application. The content of annual assessments should be reported in the state's annual demonstration monitoring reports. These reports should include which providers have waitlists and what are average wait times to get an appointment	Treatment Block Grant,[1] DHCF's *2016 Access Monitoring Review Plan*,[2] and DC Health's *2014 Community Health Needs Assessment*.[3] MCOs contracted with DHCF are required to publish a Provider Directory. The Provider Directory must identify providers that are not accepting new patients. MCOs are required to revise the Provider Directory quarterly to ensure that the information is accurate. DHCF also maintains a Provider Lookup database which contains all providers with an open DC Medicaid provider number. Additionally, DHCF has worked with our DC HIE partner, CRISP DC, to implement a provider directory, including DIRECT addresses and other practice information as available.
	Future State: The District will update the initial assessment of the availability of mental health services in the annual demonstration monitoring reports as required by CMS. DHCF will work with our contractor to implement a mechanism within the Provider Lookup database to capture information about which providers are accepting new patients. However, DHCF will be reliant on providers to maintain their patient acceptance status. DHCF will also continue to develop the DC HIE provider directory and work to incorporate information on providers who are accepting new patients in the MCO and FFS programs, consistent with requirements in the Cures Act (sec. 5006), section 1902(a)(83) and 42 CFR 438.10(h)(1)(vi).
	Summary of Actions Needed: DHCF will work with other District agencies to continually improve the data for future assessments. DHCF will work with our contractor to implement a mechanism within the Provider Lookup database to capture information about which providers are accepting new patients. (Timeline: 18-24 months) DHCF will also continue to develop the DC HIE provider directory and work to incorporate information on providers who are accepting new patients in the MCO and FFS programs, consistent with requirements in the Cures Act (sec. 5006), section 1902(a)(83) and 42 CFR 438.10(h)(1)(vi). (Timeline: 18-24 months)
	Current State: See Topic 5 for additional information on the District's financing plan.

---

[1] https://dbh.dc.gov/page/behavioral-health-services-block-grants
[2] https://dhcf.dc.gov/page/read-dhcf%E2%80%99s-first-access-monitoring-review-plan-ffs-medicaid-program
[3] https://dchealth.dc.gov/page/dc-community-health-needs-assessment

Prompts	Summary
3.b Financing plan – See additional guidance in Topic 5	
	Future State: See Topic 5 for additional information on the District's financing plan.
	Summary of Actions Needed: See Topic 5 for additional information on the District's financing plan.
3.c Strategies to improve state tracking of availability of inpatient and crisis stabilization beds	*Current State:* DBH does not currently systematically track the availability of inpatient and crisis stabilization beds.
	Future State: DBH plans to more systematically track open inpatient and crisis stabilization beds to facilitate more timely referrals.
	Summary of Actions Needed: The District plans to broadly assess and potentially redesign the electronic health records systems and practices of DBH, MHRS providers, SUD provider, and Saint Elizabeths Hospital. As part of that work, the District will consider how to best improve tracking of bed availability. For additional information, see Topic 6. (Timeline: 18-24 months)
3.d State requirement that providers use a widely recognized, publicly available patient assessment tool to determine appropriate level of care and length of stay	*Current State:* The District's State Plan defines the scope of behavioral health services provided by MCOs contracted with DHCF. MCOs are responsible for adopting and disseminating clinical practice guidelines for the provision of behavioral health services. Practice guidelines are required to be based on valid and reliable scientific clinical evidence or drawn from provider consensus and the results of peer-reviewed studies. Practice guidelines are to be readily available to all contracted providers and made available upon request to enrollees and potential enrollees. MCOs are to utilize the application of practice guidelines to assist practitioners and enrollees make decisions about appropriate utilization of behavioral health services.
	MCOs are also responsible for developing, adopting, and maintaining written medical necessity criteria. MCOs must communicate their medical necessity criteria, along with any practice guidelines or other criteria they use in making medical necessity determinations, to their network providers. MCOs must make medical necessity criteria available upon request to whomever and whatever entity may request it. Additionally, MCOs are responsible for developing or selecting screening tools for identification of behavioral health problems in primary care settings and are to submit the tools for DHCF review and approval prior to implementing or utilizing the screening tools. As part of provider training, MCOs must include training on the manifestations of mental illness, use of screening tools to identify such problems, and how to make appropriate referrals for treatment services.
	Rehabilitative services for Medicaid beneficiaries who need services due to mental illness or SED are carved out of DHCF's MCO contracts and provided through the DBH's MHRS program. DBH requires MHRS providers to use the Level of Care Utilization System (LOCUS) level of care assessment tool to ensure that services to adults are

Prompts	Summary
	individualized, clinically appropriate, and least restrictive. The LOCUS assists in determining the appropriate level of care and treatment interventions are based on individualized clinical assessments. LOCUS evaluations must be used at intake, during treatment plan development, when a consumer is in crisis, and when a level of care change is needed. Consumers in continuing treatment must have LOCUS evaluations every 180 days. DBH's Access Helpline (AHL) also uses completed LOCUS evaluations as part of its authorization and re-authorization decisions. For individuals ages 6 to 20, DBH requires providers to use the Child and Adolescent Functional Assessment Scale (CAFAS) to guide treatment planning and provide information on the effectiveness of services. For children ages 3 to 5, DBH requires providers to use the Preschool and Early Childhood Functional Assessment Scale (PECFAS) to guide treatment planning and provide information on the effectiveness of services. The CAFAS or PECFAS must first be completed within 30 days of an intake or by the fourth visit, whichever comes first. It must then be repeated every 90 days to monitor progress or improvement over time. Any significant events affecting the child's or youth's functioning that may impact service intensity or treatment plan needs, or discharge from treatment, require completion of the CAFAS or PECFAS as well. As noted in Section 1.c, hospitalizations at specialty hospitals, including psychiatric hospitals, must be authorized by DHCF's QIO. The QIO also provides oversight on lengths of stay by conducting concurrent utilization reviews during hospitalizations at specialty hospitals to determine the clinical appropriateness of current and proposed levels of care. DHCF's current QIO base their prior authorization determinations and concurrent utilization reviews on the InterQual Behavioral Health Criteria.
	Future State: DHCF will promulgate a policy directing contracted MCOs to require their providers to utilize a standard patient assessment tool to determine appropriate level of care and length of stay. MHRS providers will continue to use the LOCUS, CAFAS, and PECFAS assessment tools and DHCF's QIO will continue to provide oversight to determine the clinical appropriateness of current and proposed levels of care at inpatient and residential settings by utilizing a standard patient assessment tool.
	Summary of Actions Needed: DHCF will develop and issue rulemaking and other policies as necessary to standardize the use of a patient assessment tool. DHCF will also modify existing contracts as necessary. (Timeline: 18-24 months)
3.e Other state requirements/policies to improve access to a full continuum of care including crisis stabilization	*Current State:* MCOs contracted with DHCF are responsible for ensuring that services for the assessment and stabilization of psychiatric crises are available 24-hours, seven days a week, including weekends and holidays. Phone based assessment must be provided within 15 minutes of request and, when medically necessary, intervention or face-to-face assessment is to be provided within 90 minutes of completion of the phone assessment. The MCOs are

Prompts	Summary
	responsible for ensuring these services are provided by providers with appropriate expertise in mental health, including on-call access to a psychiatrist.

See Section 5.a for additional information on the District's currently available non-hospital, non-residential crisis stabilization services.

Additionally, no providers are currently certified by DBH to provide intensive day treatment services. District stakeholders have identified some regulatory requirements related to operations as the primary barrier to certification. |
| | *Future State:* MCOs contracted with DHCF will continue to be responsible for ensuring crisis stabilization services are available 24-hours, seven days a week.

See Section 5 for additional information on the District's plan to increase non-hospital, non-residential crisis stabilization services.

Under modified regulatory requirements, DBH successfully certifies providers to offer intensive day treatment services in the District. |
| | *Summary of Actions Needed:* See Section 5 for additional information on the District's plan to increase non-hospital, non-residential crisis stabilization services.

DBH will issue updated certification regulations for intensive day treatment services to address barriers identified by stakeholders and maintain high-quality care. (Timeline: 18-24 months) |
SMI/SED. Topic_4. Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration	
Critical strategies for improving care for individuals with SMI or SED include earlier identification of serious mental health conditions and focused efforts to engage individuals with these conditions in treatment sooner. To meet this milestone, state Medicaid programs must focus on improving mental health care by taking the following actions.	
Earlier Identification and Engagement in Treatment	
4.a Strategies for identifying and engaging beneficiaries with or at risk of SMI or SED in treatment sooner, including through supported employment and supported education programs	*Current State:* Clinically appropriate behavioral health services are available to all Medicaid beneficiaries through Free-standing mental health clinics (FSMHCs) and FQHCs. FSMHCs and FQHCs provide diagnostic assessment and treatment services on an outpatient basis and serve as easily accessible providers for those with behavioral health needs.

As discussed in Section 3.d, as part of provider training for all their network providers, MCOs contracted with DHCF include training on the manifestations of mental illness, use of screening tools to identify such problems, and how to |

Prompts	Summary

	make appropriate referrals for treatment services. Furthermore, MCOs are responsible for providing at least annual training for all primary care providers in their networks about proactively identifying behavioral health service needs at the earliest point in time and offering beneficiaries referrals to behavioral health services when clinically appropriate.
	
	DBH undertakes many activities and supports numerous initiatives to identify and engage District residents with or at risk of SMI or SED in treatment sooner, including:
	• The Access Helpline (AHL), which is operational 24-hours, seven days a week and is staffed by behavioral health professionals. AHL can refer callers to immediate help, including by activating mobile crisis teams;
	• The Comprehensive Psychiatric Emergency Program (CPEP), which is a 24-hour, seven day a week facility that provides multi-disciplinary, emergency psychiatric services to assess and stabilize consumers, including through extended observation care. It serves individuals aged 18 and over who present either voluntarily or involuntarily;
	• DBH contracts with two other community providers to provide a total of 15 additional crisis stabilization beds for consumers who do not require inpatient treatment;
	• The DBH Community Response Team (CRT), which recently merged DBH's Mobile Crisis, Homeless Outreach, and Pre-Arrest Diversion Pilot programs into a single program. CRT is DBH's integrated, multidisciplinary approach to improve behavioral health outcomes in the District with a focus on expanded, proactive service offerings and tailored responses to behavioral health support needs. The CRT model includes teams of licensed clinicians, community behavioral health specialists, and individuals with lived experience. Unlike the previous programs, the CRT operates 24-hours, seven days a week. Features of the CRT designed to identify and engage beneficiaries with or at risk of SMI or SED in treatment sooner include:
	  o Providing behavioral health support to address individual and community crises, community education, trauma informed care, de-escalation techniques, and grief assessment and referral;
	  o Conducting mental health and substance use screening, assessment, and referral to treatment and other social services as a part of crisis response or individual wellness checks and outreach;
	  o Coordinating care for individuals in response to a crisis or other outreach during hospitalization, discharge, and enrollment with a community-based provider. This may include:
	    ▪ Case planning and consultation for treatment of individuals who are difficult to engage,
	    ▪ Support with criminal justice system navigation. These locally-funded activities may include linking individuals to behavioral health services and supports and other resources (e.g. transportation), while they are being prosecuted or after they have been released from custody. The goal is to facilitate compliance specific to criminal justice related involvement, such as ensuring individuals attend court dates,
	    ▪ Community behavioral health engagement through peer counseling, psychoeducation, supportive counseling, and
	    ▪ Assistance with securing documents required to engage in services;

Prompts	Summary
	- o Establishing a presence within communities to enhance community engagement and knowledge of the services provided by the CRT; - o Coordinated community response with the Metropolitan Police Department (MPD), the Department of Human Services (DHS), and other District agencies; - o Inclement weather support and connection to emergency resources; and - o Targeted outreach efforts to areas identified as having a service need ("hot spots"); - DBH-supported Peer-Operated Centers, which are community Drop-in Centers that provide mutual support, self-help, advocacy, education, information, and referral services. Their primary goal is to assist people with psychiatric illnesses, who may also have co-occurring SUD and/or other medical conditions, to regain control of their lives and of their recovery process. The Drop-in Centers promote an environment that is conducive to self-directed recovery, based on consumer experience, knowledge and input; and - Several other DBH locally-funded initiatives target criminal-justice involved individuals to identify treatment needs and facilitate referrals to care. This includes DBH staff: - o Providing screenings and mental health assessments for those in pre-trial status and making referrals for mental health services, and - o Screening incarcerated individuals awaiting release from jail for needed mental health services and coordinating release planning activities for those linked with community-based providers. Additionally, the Crisis Intervention Officer (CIO) program is a DBH partnership program with MPD to train approximately 125 officers each year to support people with mental illness who come to the attention of law enforcement but do not meet the threshold for arrest. CIOs are trained to recognize the signs of mental illness, determine the most appropriate response, and use de-escalation techniques that build on their skills and training. Other law enforcement agencies in the District such as the Capital Police, Protective Services Division, and the Transit Police also participate in the training. In addition to these specially-trained officers, every MPD officer must receive mental health training to learn appropriate techniques to use when responding to calls-for-service involving residents with mental illness. DBH also provides therapeutic supported employment services as a part of Mental Health Rehabilitation Services (MHRS) benefits. DBH also supports numerous initiatives specific to children and adolescents as detailed in Section 4.c.
	Future State: As part of this demonstration, the District seeks to create a new reimbursement methodology for CPEP and CRT mobile crisis and outreach services to more appropriately account for and value the services provided.

Prompts	Summary
	As part of this demonstration, the District also seeks to provide vocational supported employment services to adults with SMI.
	Summary of Actions Needed: Expenditure authority is requested under this demonstration to establish a new reimbursement methodology for CPEP and the CRT mobile crisis and outreach services to Medicaid beneficiaries to appropriately account for and value them. The District will develop and issue rulemaking and other policies as necessary to establish vocational supported employment services for adults with SMI. (Timeline: 18-24 months)
4.b Plan for increasing integration of behavioral health care in non-specialty settings to improve early identification of SED/SMI and linkages to treatment	*Current State:* As discussed in Sections 3.d and 4.b, as part of provider training for all their network providers, MCOs contracted with DHCF are to include training on the manifestations of mental illness, use of screening tools to identify such problems, and how to make appropriate referrals for treatment services. Furthermore, MCOs are responsible for providing at least annual training for all primary care providers in their networks about proactively identifying behavioral health service needs at the earliest point in time and offering beneficiaries referrals to behavioral health services when clinically appropriate. The District's FQHC APM permits FQHC providers to bill separately for physical health and behavioral health services provided on the same day thereby incenting FQHC providers to address the totality of a beneficiary's health needs during the same visit and permitting beneficiaries to receive dental, behavioral health, and primary care services in one, integrated setting. For children and adolescents, DBH supports the DC Mental Health Access Project (DC MAP), which aims to improve mental health integration within pediatric primary care. Staffed collaboratively by a team of mental health clinicians (psychiatrists, psychologists, social workers, and a care coordinator) from Children's National Health System and MedStar Georgetown University Hospital, DC MAP provides free mental health phone consultation for primary care clinicians in the District. In addition to phone consultations, referrals, face-to-face consultations, education, and training are offered to support primary care clinicians' ability to address behavioral health concerns of their patients. DC MAP also oversees the implementation of developmental and behavioral health screening for children by participating pediatricians in the District at well-child visits, as well as a caregiver survey.
	Future State: DBH, as part of its strategic planning, will identify ways to continue to promote physical and behavioral health integration. For children and adolescents specifically, DC MAP funding has been secured through, at least, fiscal year 2020.

Prompts	Summary
	Summary of Actions Needed: DBH strategic planning activities will continue. DC MAP activities to increase behavioral and/or developmental screenings for children and youth during pediatrician visits will also continue.
4.c Establishment of specialized settings and services, including crisis stabilization, for young people experiencing SED/SMI	*Current State:* All Medicaid enrollees under 22 years of age are to be provided Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services without limitation. EPSDT services include periodic and inter-periodic assessments that consist of mental health (and substance use) screenings as required by the District's Periodicity schedule. Primary care physicians screening for mental health conditions are required to use a validated, brief mental health screen approved by DBH. Medicaid enrollees who screen positive for referral to mental health services are to receive timely access to an appointment for further assessment and treatment by a mental health provider. All Medicaid enrollees under 22 years of age also have access to Psychiatric Residential Treatment Facilities (PRTFs) outside of the District.

In addition to services available through Medicaid, DBH supports several specialized services for District children and adolescents, including crisis stabilization. These include:
- The Children and Adolescent Mobile Psychiatric Service (ChAMPS), in which a community-based provider provides on-site, immediate help to children facing a behavioral or mental health crisis whether in the home, school, or community. The goal of ChAMPS is to stabilize the young person and avert inpatient hospitalizations or placement disruptions for children involved in the foster care system. The ChAMPS teams also make follow up visits and connect families to needed support services;
- Evidence-based practices as part of the treatment process that include: Child Parent Psychotherapy for Family Violence; Trauma Systems Therapy (TST); Parent Child Interaction Therapy; Functional Family Therapy (FFT); Trauma Focused Cognitive Behavioral Therapy; Multi-Systemic Therapy; Multi-Systemic Therapy for Youth with Problem Sexual Behavior; and Adolescent Community Reinforcement Approach (ACRA);
- For Transition Age Youth (TAYs) and young adults (YAs), initiatives and service provision related to: reducing stigma around mental health; First Episode Psychosis; supportive independent housing; supported employment; the evidence-supported Transition to Independence Process (TIP);
- DC Social, Emotional and Early Development (DC SEED) Project to address the highly specific, largely unmet needs of infants and young children (birth to 6 years old) who are at high imminent risk for or diagnosed with an SED. Major grant activities include developing early childhood competency in the provider network; evidence-based practice training, coaching, and ongoing consultation; strengthening of early childhood community partnerships; infusing early childhood component in existing services and supports; and establishment of a centralized early childhood telephonic referral and intake process;
- High Fidelity Wraparound (HFW), which is an evidenced-based practice for children and youth with complex emotional and mental health needs who are at risk of out-of-home placement, a more restrictive school setting, or have had multiple inpatient placements; and |

Prompts	Summary
	• Professional training for providers who work with TAY population on better ways to connect and work with young adults. Despite the multitude of specialized services for children and adolescents available through Medicaid and DBH, the District's provider network is somewhat fragmented and can result in siloed care for young people with co-occurring disorders.
	Future State: All Medicaid enrollees under 22 years of age will continue to be provided EPSDT services without limitation and have access to PRTFs. DBH will continue to provide an array of specialized services for young people experiencing SED/SMI. Additionally, as a part of this demonstration, the District seeks to increase access to and utilization of trauma-informed services, including TST, by changing the reimbursement methodology to encourage more providers to become certified to deliver the therapy. To reduce system fragmentation, DBH also plans to provide and support community-wide training and implementation of evidence-based treatment models to address co-occurring disorders and support evidence-based treatment and recovery models for youth and young adults. DBH also plans to develop an action plan to address selected recommendations made in several reports and studies on the District's child and adolescent public behavioral health treatment system. This may include identifying opportunities to expand Medicaid coverage of specialized treatment services tailored to children and adolescents.
	Summary of Actions Needed: The District will develop and issue rulemaking and other policies as necessary regarding the enhanced reimbursement methodology for TST. (Timeline: 12-18 months) DBH is working to secure funding through SAMHSA's Mental Health and Substance Abuse Prevention and Treatment Block Grants to promote improved transitions and integration of care for TAYs and YAs with co-occurring conditions. A DBH workgroup is currently reviewing the findings and recommendations of the reports on the District's child and adolescent public behavioral health system and their work will inform the development of an action plan. (Timeline: 18-24 months)
4.d Other state strategies to increase earlier	*Current State:* See responses to Sections 4.a, 4.b, and 4.c.

Prompts	Summary
identification/engagement, integration, and specialized programs for young people	*Future State:* Due to the breadth of covered services and activities described in Sections 4.a, 4.b, and 4.c, strategies to increase earlier identification/engagement, integration, and specialized programs for young people have already been implemented and are ongoing.
	Summary of Actions Needed: No action needed.

SMI/SED. Topic_5. Financing Plan	
State Medicaid programs should detail plans to support improved availability of non-hospital, non-residential mental health services including crisis stabilization and on-going community-based care. The financing plan should describe state efforts to increase access to community-based mental health providers for Medicaid beneficiaries throughout the state, including through changes to reimbursement and financing policies that address gaps in access to community-based providers identified in the state's assessment of current availability of mental health services included in the state's application.	
5.a Increase availability of non-hospital, non-residential crisis stabilization services, including services made available through crisis call centers, mobile crisis units, observation/assessment centers, with a coordinated community crisis response that involves collaboration with trained law enforcement and other first responders.	*Current State:* As discussed in Sections 4.a and 4.c, there are ongoing efforts in the District to assess community needs and increase the availability of non-hospital, non-residential crisis stabilization services. Examples of relevant initiatives include:
	• The Access Helpline (AHL), which is operational 24-hours, seven days a week and is staffed by behavioral health professionals. AHL can refer callers to immediate help, including by activating mobile crisis teams;
	• The Comprehensive Psychiatric Emergency Program (CPEP), which is a 24-hour, seven day a week facility that provides multi-disciplinary, emergency psychiatric services to assess and stabilize consumers, including through extended observation care. It serves individuals aged 18 and over who present either voluntarily or involuntarily;
	• DBH's Community Response Team (CRT), which recently merged DBH's Mobile Crisis, Homeless Outreach, and Pre-Arrest Diversion Pilot Programs into a single program. CRT is DBH's integrated, multidisciplinary approach to improve behavioral health outcomes in the District with a focus on expanded, proactive service offerings and tailored responses to behavioral health support needs. The CRT model includes teams of licensed clinicians, community behavioral health specialists, and individuals with lived experience and, unlike the previous programs, the CRT operates 24-hours, seven days a week;
	• The Crisis Intervention Officer (CIO) program, which is a partnership with MPD to train approximately 125 officers each year to support people with mental illness who come to the attention of law enforcement but do not meet the threshold for arrest; and
	• The Children and Adolescent Mobile Psychiatric Service (ChAMPS), in which a community-based provider provides on-site, immediate help to children facing a behavioral or mental health crisis whether in the home, school, or community.
	Future State: As part of this demonstration, the District seeks to create a new reimbursement methodology for CPEP and for CRT mobile crisis and outreach services to more appropriately account for and value the services provided. The

Prompts	Summary
	demonstration also proposes adding coverage for psychiatric crisis stabilization services as a treatment alternative to psychiatric inpatient hospitalizations.
	Summary of Actions Needed: DHCF and DBH will work with District stakeholders to assess a long-term sustainable plan to increase availability of non-hospital, non-residential crisis stabilization services for Medicaid beneficiaries throughout the District. These efforts will build upon information provided in the District's assessment of the current availability of mental health services included in our demonstration application and will incorporate an assessment of services made available through crisis call centers, mobile crisis units, and observation/assessment centers, with a coordinated community crisis response that involves collaboration with trained law enforcement and other first responders. This assessment will also include a review of changes to reimbursement and financing policies that address gaps in access to community-based providers as identified in the District's assessment of current availability of mental health services. (Timeline: 18-24 months)
5.b Increase availability of on-going community-based services, e.g., outpatient, community mental health centers, partial hospitalization/day treatment, assertive community treatment, and services in integrated care settings such as the Certified Community Behavioral Health Clinic model.	*Current State:* District residents can access community-based mental health services through several types of providers. Core service agencies (CSAs) serve as the main entry point for accessing the Mental Health Rehabilitation Services (MHRS) benefits, which include diagnostic assessment, medication/somatic treatment, counseling, day/rehab services, and community support. Free-standing mental health clinics (FSMHCs) also provide diagnostic assessment, medication/somatic treatment, and counseling services. As of July 2019, there are 51 CSAs and as of June 2019 there are 29 FSMHCs, 15 of which are also certified as a CSA.

There are additional providers certified by DBH which deliver specialty mental health services such as Assertive Community Treatment (ACT), Community Based Intervention (CBI) for youth and children, and trauma-informed services, like Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and Child-Parent Psychotherapy. However, no providers are currently certified by DBH to provide intensive day treatment services. District stakeholders have identified regulatory requirements related to operations as the primary barrier to certification.

In addition to CSAs, DHCF beneficiaries have access to 360 Medicaid-enrolled psychiatrists and advanced practice registered nurses with a behavioral health focus, 175 of whom billed DHCF in the past year. As indicated in the mental health services assessment, the District acknowledges that there is less than one psychiatrist/prescriber enrolled in Medicaid per 100 Medicaid beneficiaries with SMI.

DHCF beneficiaries also have access to community-based services through federally qualified health centers. In fiscal year 2018, 41 FQHC locations billed for behavioral health treatment provided to DHCF beneficiaries. |

Prompts	Summary
	Future State: Under modified regulatory requirements, DBH is planning to certify providers to offer intensive day treatment services in the District.

As part of this demonstration, the District proposes to fund services offered in a peer-partnered facility, "Clubhouse," targeting support services for adults with SMI to assist them with social networking, independent living, budgeting, self-care, and other skills to enable community living.

The District also seeks to add vocational services to currently provided supported therapeutic employment services for individuals with SMI. These additional services will connect individuals with training and skills to promote and maintain employment.

The demonstration proposes to reimburse for behavioral health services provided to individuals with SMI/SED or SUD by psychologists and other licensed behavioral health providers practicing independently, either in a separate practice or hospital setting.

The demonstration also proposes to reclassify two trauma-informed services for children, adolescents, and adults—the Trauma Recovery and Empowerment Model (TREM) and Trauma Systems Therapy (TST)—and change the reimbursement methodology. Currently, these services are provided and billed under the MHRS Counseling service definition. Creating a separate service definition for TREM and TST will allow for better tracking of service utilization. Increasing the reimbursement rates to be on par with other trauma-informed services is intended to promote additional service availability. |
| | *Summary of Actions Needed:* DHCF and DBH will work with District stakeholders to assess a long-term sustainable plan to increase availability of on-going community-based services and services in integrated care settings for Medicaid beneficiaries throughout the District. This assessment will include a review of potential changes to reimbursement and financing policies that address gaps in access to community-based providers identified in the District's assessment of current availability of mental health services, specifically to increase the number of psychiatrists/prescribers enrolled in Medicaid. (Timeline: 18-24 months)

DBH will issue updated certification regulations for intensive day treatment services to address barriers identified by stakeholders and maintain high-quality care. (Timeline: 18-24 months)

DBH and DHCF will develop and issue rulemaking and other policies as necessary regarding the proposed waiver services that increase access to community-based services. (Timeline: 12-18 months) |

Prompts	Summary
SMI/SED. Topic_6. Health IT Plan	
As outlined in State Medicaid Director Letter (SMDL) #18-011, "[s]tates seeking approval of an SMI/SED demonstration … will be expected to submit a Health IT Plan ("HIT Plan") that describes the state's ability to leverage health IT, advance health information exchange(s), and ensure health IT interoperability in support of the demonstration's goals."[4] The HIT Plan should also describe, among other items, the: • *Role of providers in cultivating referral networks and engaging with patients, families and caregivers as early as possible in treatment; and* • *Coordination of services among treatment team members, clinical supervision, medication and medication management, psychotherapy, case management, coordination with primary care, family/caregiver support and education, and supported employment and supported education.* *Please complete* all *Statements of Assurance below—and the sections of the Health IT Planning Template that are relevant to your state's demonstration proposal.*	
Statements of Assurance	
Statement 1: Please provide an assurance that the state has a sufficient health IT infrastructure/ecosystem at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration. If this is not yet the case, please describe how this will be achieved and over what time period.	Yes. As outlined in the District's State Medicaid Health IT Plan (SMHP),[5] the District has a high level of electronic health record (EHR) adoption and health information exchange (HIE) needed to achieve the goals of the demonstration. DHCF and DBH are committed to leveraging health IT to facilitate integration of physical and behavioral health. Technology enables consistent data capture via certified EHRs so that providers can communicate with each other to access medical records for patients who have seen other providers. Data exchange based on structured information is critical to electronic care planning, care coordination, and integrating physical and behavioral health. DHCF and DBH agree that provider access to certified EHR technology is an important step towards a common infrastructure to exchange information, as permitted by patient consent. In addition, having a certified EHR is a requirement to participate in city-wide HIE via secure messaging and can facilitate access to complete clinical information for patients. Today, 89% of District providers utilize EHRs and there are several DHCF-funded programs in place to assist providers in exchanging referral information electronically. DHCF's Medicaid EHR Inventive Program (MEIP) has paid out over $33 million from nearly 500 payments to eligible hospitals and providers since 2013. However, behavioral health providers are not eligible for MEIP incentive payments. Behavioral health provider use of EHR technology, specifically, reflects a mix of technology adoption, from those behavioral health providers who have implemented certified EHRs to a suite of DBH systems that have been implemented at Saint Elizabeths Hospital and among MHRS and District SUD providers.

---

[4] See SMDL #18-011, "Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance." Available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf.

[5] https://dhcf.dc.gov/hitroadmap

Prompts	Summary

	Based on a landscape assessment of EHRs in use across the District, DHCF identified at least 17 different EHR vendor-based systems in use within the District. DBH and DBH-certified providers use three separate EHR systems to document clinical care and to coordinate billing and reporting:
	• iCAMS: Supports mental health programs and the providers who administer those services.
	   o iCAMS is an implementation of Credible's behavioral health EHR.
	• Avatar: Provides comprehensive management for inpatient hospitalizations at Saint Elizabeths Hospital.
	   o Avatar is a product of Netsmart's behavioral health EHR.
	• DATA/WITS: Supports services for clients with SUD and the DBH-contracted providers who support them.
	   o DATA/WITS is an EHR solution developed and currently maintained by FEi Systems.
	A subset of behavioral health providers also have stand-alone, certified EHRs.
	
	As a result of this diversity in technology and implementation, DHCF is investing heavily in HIE services to achieve interoperability needed to ensure District resident's health information is available whenever and wherever needed. All four of the Medicaid MCOs in the District are participating in HIE, as are all of the District's acute care hospitals, and approximately 40 percent of ambulatory providers submitting 100 or more claims per year. In fiscal year 2019, DHCF awarded a competitively-bid five-year grant to CRISP DC to implement five core HIE capabilities: clinical patient lookup; simple and secure digital messaging; population health management analytics; specialized registry submission; and electronic clinical quality measurement (eCQMs).

Statement 2: Please confirm that your state's SMI/SED Health IT Plan is aligned with the state's broader State Medicaid Health IT Plan and, if applicable, the state's Behavioral Health IT Plan. If this is not yet the case, please describe how this will be achieved and over what time period.	Yes. The District's State Medicaid Health IT Plan (SMHP) was approved by CMS on January 23, 2019. The report addresses information needs of the behavioral health system in the District. In addition, DBH has identified strategies to align investments with the District's SMHP.
Statement 3: Please confirm that the state intends to assess the applicability of standards referenced in the Interoperability	Yes, the District intends to assess the applicability of the Interoperability Standards Advisory and 45 CFR 170 Part B and incorporate the relevant standards where applicable.

Prompts	Summary
Standards Advisory (ISA)[6] and 45 CFR 170 Subpart B and, based on that assessment, intends to include them as appropriate in subsequent iterations of the state's Medicaid Managed Care contracts. The ISA outlines relevant standards including but not limited to the following areas: referrals, care plans, consent, privacy and security, data transport and encryption, notification, analytics and identity management.	
To assist states in their health IT efforts, CMS released SMDL #16-003 which outlines enhanced federal funding opportunities available to states "for state expenditures on activities to promote health information exchange (HIE) and encourage the adoption of certified Electronic Health Record (EHR) technology by certain Medicaid providers." For more on the availability of this "HITECH funding," please contact your CMS Regional Operations Group contact. [7]	
Enhanced administrative match may also be available under MITA 3.0 to help states establish crisis call centers to connect beneficiaries with mental health treatment and to develop technologies to link mobile crisis units to beneficiaries coping with serious mental health conditions. States may also coordinate access to outreach, referral, and assessment services—for behavioral health care--through an established "No Wrong Door System."[8]	
Closed Loop Referrals and e-Referrals (Section 1)	
1.1 Closed loop referrals and e-referrals from physician/mental health provider to physician/ mental health provider	*Current State:* The District's State Medicaid Health IT Plan (SMHP) includes *improving transitions of care* as a major use case for developing and implementing HIT and HIE for Medicaid providers. E-referrals to and from primary care and mental health providers are necessary to improve transitions of care and ensure every member of a care team is informed about a patient's past medical history and care plan.
	Among the investments outlined in the District's SMHP and Advanced Planning Document (APD) funding requests to CMS is a project to spread and scale the use of DIRECT secure messaging to facilitate e-referrals. This will be

---

[6] Available at https://www.healthit.gov/isa/.

[7] See SMDL #16-003, "Availability of HITECH Administrative Matching Funds to Help Professionals and Hospitals Eligible for Medicaid EHR Incentive Payments Connect to Other Medicaid Providers." Available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd16003.pdf.

[8] Guidance for Administrative Claiming through the "No Wrong Door System" is available at https://www.medicaid.gov/medicaid/finance/admin-claiming/no-wrong-door/index.html.

accomplished through a recently awarded grant to CRISP DC, a regional HIE serving the District, Maryland and West Virginia. Currently, more than 8,200 people from 85 organizations utilize CRISP DC to access health information from outside of their own organization EHR. 109 providers or practice organizations have active DIRECT accounts in the District, including most of the FQHCs. CRISP DC provides free DIRECT accounts to any District Medicaid provider through the recently awarded Core HIE Capabilities for Providers grant funded by DHCF (fiscal year 2019 to fiscal year 2023). DHCF's grant allows CRISP DC to support five core HIE capabilities for providers over the next five years, including patient lookup of encounters and clinical data, electronic clinical quality measures, panel analytics and secure messaging.

The DHCF Core HIE Capabilities grant is also supporting CRISP DC's outreach efforts among behavioral health providers. These efforts will to implement changes to the DC Mental Health Information Act (DC Code § 7–1203), which requires that behavioral health providers offer notice to their patients that they participate in HIE to exchange mental health information. District policies also require providers to give patients the opportunity to opt out of HIE services, including Direct messaging and e-Referral, if they so choose.

To inform providers about changes to the DC Mental Health Information Act, CRISP DC and the DC Behavioral Health Association are also in the process of forming a workgroup to advise CRISP DC on implementing HIE for behavioral health providers.

In addition, DHCF has partnered with the DC Hospital Association and the DC Primary Care Association to form an "e-Referral collaborative" of hospitals, health systems, FQHCs and HIEs with the goal of implementing DIRECT-based referrals in 2019. DHCF is funding technical assistance for these organizations and supporting the cost of DIRECT accounts if necessary. This technical assistance is contracted through fiscal year 2021.

Future State: In fiscal year 2019 DHCF is implementing a new three-year HIE Connectivity grant to provide technical assistance to connect nearly all Medicaid providers to HIE by 2022. As one component of the Connectivity grant, behavioral health providers have been assigned priority for technical assistance in order to support e-referrals and better care integration across physical and behavioral health services.

In fiscal year 2020 the Connectivity grantee will continue to support provider adoption and use of EHR technology for e-referrals, emphasizing the role of Saint Elizabeths Hospital and the community-based mental health providers to facilitate transitions of care.

Summary of Actions Needed: Support CRISP DC Direct implementation; sustain collaborations with DCPCA/DCHA and District HIEs via the e-referral collaborative. Ensure that acute care hospitals, IMDs, community-based behavioral

	health providers (e.g. MHRS providers, free-standing mental health clinics), and primary care providers are incorporated into these discussions and have access to relevant technologies. (Timeline: 18-24 months)
	DBH and DHCF will collaborate to assess opportunities to support DBH-certified providers' adoption and use of certified EHR technology, which enables direct messaging among physical and mental health providers. (Timeline: 18-24 months)
1.2 Closed loop referrals and e-referrals from institution/ hospital/clinic to physician/ mental health provider	*Current State:* In addition to the work described in Section 1.1, DHCF has funded the Association to improve discharge planning from a major hospital in the District using HIE and Direct. The focus of the Discharge Innovations grant is not behavioral health, but includes at least one CSA, McClendon Center, who will participate in developing best practices to facilitate follow-up by community providers after hospital discharge.

The grantee is using CRISP DC to transmit structured discharge information to the next level of care, paving the way to standardize that process for all e-referrals and transitions in the District. This work is contracted through fiscal year 2019. |
| | *Future State:* The Core HIE Capabilities grantee (CRISP DC) is required to implement a secure messaging and referral system in fiscal year 2020. As this project matures, CRISP DC will measure and track improvement in e-referrals between institutions (hospital/clinical) to mental health providers. |
| | *Summary of Actions Needed:* Implement projects described in Section 1.1 and ongoing work with the DC Hospital Association. (Timeline: 18-24 months) |
| 1.3 Closed loop referrals and e-referrals from physician/mental health provider to community-based supports | *Current State:* The District offers a wide array of community-based supports and is working within and across agencies to build coordinated systems that facilitate e-referral from physician and mental health providers to community-based supports.

Eligibility and enrollment processes for many of these services are in the process of being integrated into the DC Access System (DCAS). As of fiscal year 2019, DCAS manages eligibility and enrollment for MAGI Medicaid, SNAP, TANF, LIHEAP, and well as a number of state and local assistance programs.

DHCF is measuring the adoption and use of HIE tools, including the use of Direct, over time. By harmonizing the performance and reporting requirements of grants and contracts, DHCF is receiving monthly updates on HIE measures, such as the number of providers with Direct accounts, the number of users who logged into CRISP DC in the last 30 days, and the number of organizations contributing clinical document architecture (CDAs) to CRISP DC. |

	In fiscal year 2019 the District awarded a planning grant to screen, e-refer, and conduct follow-up for social needs and services, which was awarded to the DC Primary Care Association (DCPCA). This planning grant will inform the design and build of a technical screening and referral solution that will leverage the HIE network, called the DC Community Resource Information Exchange, or CoRIE. Funding for CoRIE was approved by CMS as part of the District's fall 2018 HITECH IAPD submission (approved on December 3, 2018) and is in active procurement. The CoRIE grant will be a competitively-bid and is a two to three-year grant that will be awarded in fall 2019.
	Future State: DCAS Release 3 will further integrate eligibility and enrollment for Non-MAGI Medicaid (Elderly and Disability Population), Alliance (Unknown Citizenship Status), Immigrant Children's Program, and Homeless Services. These programs will be incorporated into the DCAS system by spring 2020. Centralized data management will reduce data entry and improve data consistency and quality of care coordination information across programs. The CoRIE grant will conclude in 2021 and enable greater integration of services to facilitate transitions of care and e-referral from physician and mental health providers to community-based supports. DHCF is exploring strategies to achieve interoperability between DCAS and CoRIE to streamline screening and e-referrals for community-based supports.
	Summary of Actions Needed: Execute current workplans and timeline for DCAS deployment and CoRIE grant procurement. Continue efforts to facilitate interoperability between systems. (Timeline: 18-24 months)

Electronic Care Plans and Medical Records (Section 2)

2.1 The state and its providers can create and use an electronic care plan	*Current State:* DBH Policy 115.6 requires that MHRS and Adult Substance Abuse Rehabilitative Services (ASARS) providers maintain a behavioral health record and an electronic care plan.[9] Of the 62 MHRS, ASARS, and FSMHC providers that billed Medicaid in fiscal year 2018, 52 were known to have EHRs, though most were reliant on DBH-financed and supported systems which are not certified technology. Only 20 practices had a stand-alone EHR. As of summer 2019, nine of these behavioral health providers are participating with CRISP DC, the regional HIE. Among the nine acute care hospitals and six non-acute care hospitals in the District of Columbia, nearly all have an electronic health record. However, one of the two Institutes of Mental Disease, the Psychiatric Institute of Washington (PIW) documents care on paper. Saint Elizabeth's Hospital EHR must be upgraded to take full advantage of emerging HIE opportunities. Electronic care plans are developed as a requirement of the My DC Health Home program and the My Health GPS Health Home program.

---

[9] https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/115.6%20TL-305.PDF

	Future State: Electronic care plans will continue to be required for all health home programs and any new care coordination programs developed in future. Over time, care plan standards will evolve based on input from key stakeholders and the development of national data standard-setting organizations. This may initially be based on the CDA standard for care plans but could improve based on emerging standards such as FHIR STU 3. The District will utilize the Interoperability Standards Advisory for guidance on these standards.
	Summary of Actions Needed: DBH will update Policy 115.6. DHCF will update the My Health GPS SPA and/or provider manual as needed to convey care plan requirements. (Timeline: 12-18 months)
2.2 E-plans of care are interoperable and accessible by all relevant members of the care team, including mental health providers	*Current State:* At present, electronic care plans are not shared using a consistent technology platform or standards-based approach.
	Future State: As noted in Section 2.1, the District is working with key stakeholders to implement standards-based care plans that can be interoperable in future.
	Summary of Actions Needed: On an as-needed basis, DBH and DHCF will update program requirements to ensure care coordination programs are implementing the most current standards for interoperable and accessible e-plans of care. Key stakeholder groups such as the HIE Policy Board policy subcommittee will be asked to review current federal, state and local requirements and best practices and make recommendations regarding program requirements that will promote interoperability of care plans across physical and behavioral health providers.
2.3 Medical records transition from youth-oriented systems of care to the adult behavioral health system through electronic communications	*Current State:* Medical records for youth-oriented systems of care are currently transitioned to the adult behavioral health system via standard, paper-based methods. The DC Health Check website[10] enumerates current consensus and requirements for EPSDT providers when transitioning youth to adult systems of care. The website is comprehensive and has specific recommendations regarding transfer of medical records but does not explicitly mention electronic transitions.
	Future State: As HIE and electronic transmission of records expands across the District, the transition of records between pediatric and adult mental health services will be facilitated by easier access to information, and e-Referrals between providers. As the Children's Integrated Quality Network (CIQN), Children's National Medical Center's HIE,

---

[10] https://www.dchealthcheck.net/

	engages in bi-directional data exchange with other district HIEs the interoperability of youth-oriented systems of care the exchange of electronic records is anticipated to become easier over time.
	Summary of Actions Needed: Implement workplan and timeline for HIE connectivity grant including CNMC partners. Convene key stakeholders and the HIE Policy Board to consider recommendations to advance electronic communications around transitions between youth-oriented care and adult care. (Timeline: 18-24 months)
2.4 Electronic care plans transition from youth-oriented systems of care to the adult behavioral health system through electronic communications	*Current State:* The DC Health Check website[11] enumerates current consensus and requirements for EPSDT providers when transitioning youth to adult systems of care. The website is comprehensive and provides specific recommendations regarding the development and transfer of care plans but does not explicitly mention electronic care plans.
	Future State: Care plans are consistently transitioned electronically or are accessible between youth-oriented systems of care to the adult behavioral health system in a timely and secure manner.
	Summary of Actions Needed: Convene key stakeholders and the HIE Policy Board to consider recommendations to advance electronic communications around care plan to ensure these transitions between youth-oriented care and adult care. (Timeline: 18-24 months)
2.5 Transitions of care and other community supports are accessed and supported through electronic communications	*Current State:* As noted in Section 2, the District is aligning several IT systems to facilitate the access and exchange of transitions of care and is further aligning program requirement with these systems. For example, My DC Health Home and My Health GPS providers must use health IT and HIE to support service linkages and communication across providers. These providers are currently alerted to their patients/clients' medical events (admissions, transfers, or discharges) provided they have subscribed to CRISP DC's Encounter Notification Service (ENS). At present these alerts may be delivered in real-time via CRISP ENS PROMPT, or in a daily summary email.
	Future State: As the DCAS system and CoRIE functionalities grow, there are further opportunities to expand program requirements that will ensure providers have access to high quality information to support individual transitions of care. Centralized data management will reduce data entry and improve data consistency and quality of care coordination

---

[11] Ibid.

	information across programs. Based on these data, in the event of a medical or social need–or emergency–providers with whom a client or beneficiary has a relationship will receive an alert.
	Summary of Actions Needed: DHCF to implement workplan for the HIE Core Capabilities and Connectivity Grants to expand access to the ENS service among behavioral health providers. DHCF to implement workplans for DCAS and CoRIE and design for interoperability among systems to the extent feasible. DBH and DHCF will continue to review program requirements related to the Health Home programs to ensure these efforts are successfully supporting consistent use of electronic alerts and workflow that uses alerts in an efficient manner that improves transitions of care. (Timeline: 18-24 months)

Consent - E-Consent (42 CFR Part 2/HIPAA) (Section 3)

3.1 Individual consent is electronically captured and accessible to patients and all members of the care team, as applicable, to ensure seamless sharing of sensitive health care information to all relevant parties consistent with applicable law and regulations (e.g., HIPAA, 42 CFR part 2 and state laws)	*Current State:* All DBH clients for MHRS services complete and sign a standard consent form. This includes care coordination programs such as the My DC Health Home program. The District's HIE governance approach is based on an opt-out process implemented at the provider level. Individual level consent is not required for data exchange, provided the provisions of the Health Insurance Portability and Accountability Act (HIPAA) are met by providers and the HIE. The HIEs do not currently have a consent management system in place; individuals who submit an opt-out request are simply opted out of all HIE services. Until the past few years, the exchange of mental health data was not allowable in the District. As a result, all Medicaid claims that include one of an identified set of mental health ICD-9/10 codes are suppressed by CRISP DC (approximately 27 percent of all Medicaid claims) and are not exchanged. Pursuant to changes in the DC Mental Health Information Act in December 2016 providers may now use the HIE to exchange mental health encounter information, including care relationships, as long as notice has been provided to beneficiaries. CRISP DC has created a workgroup with the DC Behavioral Health Association to support mental health providers' participation in HIE. Counseling notes and 42 CFR part 2 information may not be exchanged without consent. DHCF is in the process of updating our Notice of Privacy Practices (NPP) and CRISP DC is contacting all of their participating providers to update their NPPs to allow for exchange of mental health encounter information. DBH has also expressed an intent to update provider NPPs to clarify provider policies and allow beneficiaries to opt out of HIE services. The DC HIE Policy Board subcommittee on Policy has a workgroup that is focusing on approaches to consent management.

	Future State: If all participating providers update their NPPs to allow for exchange of mental health encounter information, it is estimated that the proportion of suppressed claims will drop to approximately 7 percent, depending on opt outs. The vast majority of suppressed claims of claims will be suppressed (primarily because of 42 CFR part 2).
	Among District HIEs, CRISP DC is exploring options to implement more granular consent management to allow beneficiaries to opt out of exchanging some data, such as mental health data, but not physical health information.
	Based on recommendations that may emerge from the DC HIE Policy Board, DHCF may modify requirements for notice or consent management via the DC HIE Rule.
	Summary of Actions Needed: DBH will continue current consent practices. DHCF and DBH will continue to engage stakeholders in the development of appropriate governance policies to guide implementation of notice and opt out for HIE services. DHCF will work with participating HIEs and the DC HIE Policy Board to consider and recommend approaches to consent management. (Timeline: 18-24 months)
Interoperability in Assessment Data (Section 4)	
4.1 Intake, assessment and screening tools are part of a structured data capture process so that this information is interoperable with the rest of the HIT ecosystem	*Current State:* DBH has several assessment tools and requirements for their use in place for MHRS services and plans to release practice standards in the fall on the development of comprehensive assessments. This will include a discussion of EHR's role. However, the assessment tools are not interoperable with the broader Health IT ecosystem at present.
	DCPCA has convened a community-based collaborative called DC PACT (Positive Accountable Community Transformation). Throughout these stakeholder discussions, DC PACT participants–including behavioral health providers–have consistently prioritized the need for a standardized community mental health screening tool. At a minimum the group will propose a suite of standardized screening and assessment tools that can be harmonized to share information on community-wide mental health needs. DCPCA, in its role managing the CoRIE planning grant, is currently evaluating clinical and social service providers' use of behavioral health screeners such as the PHQ-9. One of the final deliverables from the CoRIE planning grant will include recommendations regarding assessment and screening tools.
	Future State: As more behavioral health providers participate in HIE, and as DCAS and CoRIE mature, the ability to exchange mental health screening information in an interoperable manner will expand.
	Given the sensitivity of mental health information exchange, DBH, DHCF, and HIEs participating in the District HIE will proceed cautiously to implement mental health information sharing as appropriate and in line with stakeholder feedback.

	As previously indicated, an HIE Policy Board Policy subcommittee is evaluating issues of patient notice and consent. Governance processes to manage the exchange of mental health assessment and screening data would likely be incorporated into the discussion and recommendations from the group in the context of implementing CoRIE. In addition, the CRISP DC clinical committee, which approves all allowable HIE use cases, and CRISP DC's behavioral health workgroup will be consulted on these important governance issues.
	Summary of Actions Needed: Continue current DBH screening and assessment processes. Implement HIE Core Capabilities and Connectivity grant workplans in fiscal years 2019, 2020, and 2021, which will increase behavioral health provider participation in HIE. Implement CoRIE work plan and timeline and facilitate data exchange with DCAS to the extent feasible. Conduct regular policy governance discussions and develop recommendations with key stakeholders, including members of the HIE Policy Board, the HIE entities participating in the District HIE, and large health systems that are active users of HIEs.
Electronic Office Visits – Telehealth (Section 5)	
5.1 Telehealth technologies support collaborative care by facilitating broader availability of integrated mental health care and primary care	*Current State:* The District provides telemedicine reimbursement for behavioral health services in our FFS program. The District's Medicaid Telemedicine rule itemizes the broad categories of services covered via telemedicine.[12] Currently, the Medicaid Telemedicine rule has been adopted on an emergency basis and is not final. As a result, these requirements are not yet included in the District's MCO contracts. However, the MCOs have nonetheless offered reimbursement for some pilot projects or services delivered via telemedicine. DHCF's Telemedicine Provider Manual provides more detail on the exact services covered via telemedicine, including a wide-range of behavioral health services.[13] The majority of Medicaid FFS billing for telemedicine is for tele-psych visits for individuals or families. Most other telemedicine claims are submitted by providers participating in care coordination programs, specifically, My Health GPS.
	Future State: District providers have expressed strong interest in continuing to expand telehealth modalities of care, both to minimize travel burden for patients and improve efficient use of provider time. DHCF is evaluating the extent to which future, approved uses of telemedicine may also include the home as an originating site of care. Telemedicine

---

[12] https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/Medicaid-Reimbursable-Telemedicine-Services-Notice-of-Fourth-Emergency-and-Proposed-Rulemaking.pdf

[13] https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/Telemedicine%20Provider%20Guidance_FINAL_5_5_17.pdf

	can also be used as an effective modality of care to provide MAT. DBH and DHCF will implement a TeleMAT pilot in fiscal year 2020 to explore further uses of telemedicine for individuals with co-occurring disorders.
	Summary of Actions Needed: Finalize DHCF telehealth rule for FFS. Implement MCO contract modifications to clarify telemedicine payment policy. Clarify policies and continue to share best practices implementing telemedicine for SMI/SED. (Timeline: 12-18 months)

Alerting/Analytics (Section 6)

6.1 The state can identify patients that are at risk for discontinuing engagement in their treatment, or have stopped engagement in their treatment, and can notify their care teams in order to ensure treatment continues or resumes (Note: research shows that 50% of patients stop engaging after 6 months of treatment[14])	*Current State:* My Health GPS and FQHC providers have access to advanced analytic reports for population health management through HealthEC. This capability supports care coordination and panel management and is based on both claims and clinical data for the provider's panel of patients. In the base year of the Core HIE Capabilities grant with CRISP DC (fiscal year 2019), they will expand the number of providers who have access to these analytic tools and provide training at practice sites. *Patient Care Snapshot* is another CRISP DC tool that provides health information such as a patient's recent visits, procedures, and medications, in addition to a detailed list of organizations, providers, and care managers who have an existing relationship with the patient. CRISP DC also has an encounter notification service (ENS) which enables providers and care coordinators to receive real-time alerts when a patient has a hospital encounter. Organizations can customize ENS to receive the alerts that are most relevant to them, such as hospital admission, hospital discharge, or emergency room visits. To date, there are nearly 90 District practices enrolled in ENS and all Medicaid beneficiaries are on an active ENS panel with either their provider or MCO.
	Future State: CRISP DC and their partners will work together to create additional reports and an enhanced analytics capability to support care coordination and panel management, using claims and clinical data. Enhancements will allow staff and providers to address health issues in specific patient populations, thus delivering appropriate and targeted medical services when they are most needed. Later this year, CRISP DC will alert clinicians and discharge planners when a patient is enrolled in a care management program, such as a formal Health Home or an informal arrangement with an MCO case manager. In fiscal year 2020, integration of Fire and EMS data into the HIE will allow providers to be alerted via ENS of ambulance visits, even if these FEMS visits do not result in a transport or hospital encounter. Providing CRISP DC data

---

[14] Interdepartmental Serious Mental Illness Coordinating Committee. (2017). *The Way Forward: Federal Action for a System That Works for All People Living With SMI and SED and Their Families and Caregivers*. Retrieved from
https://www.samhsa.gov/sites/default/files/programs_campaigns/ismicc_2017_report_to_congress.pdf

	to Fire and EMS providers at the point of care also has the potential to eliminate unnecessary or duplicative treatment plans.
	Summary of Actions Needed: CRISP DC's work under the Core HIE grant is ongoing and will continue through 2023.
6.2 Health IT is being used to advance the care coordination workflow for patients experiencing their first episode of psychosis	*Current State:* At present, only acute care hospitals that can electronically exchange information on emergency psychiatric episodes. However, practices are just starting to implement the new notice process to share information on mental health diagnoses which is required to electronically exchange information via HIE. As discussed in Section 6.1, CRISP DC's encounter notification service (ENS) is being used to alert nearly 90 District practices when their patients are admitted, discharged or transferred to/from regional hospitals.
	Future State: As HIE capabilities expand, ENS alerts will provide an effective tool to notify beneficiaries' care teams in the event of an emergency. Doing so will enhance behavioral health providers' ability to better facilitate care coordination for beneficiaries with SMI/SED and bolster care management programs such as My DC Health Home. CRISP DC has recently implemented technology to deploy specific care alerts for conditions or situations within the HIE, such as first episode of psychosis. DHCF and DBH will work with appropriate stakeholder groups and the District HIE to explore the potential of implementing such an alert via the District HIE.
	Summary of Actions Needed: Implement workplans and timelines for the HIE Core Capabilities grant (fiscal year 2019 to fiscal year 2023) and HIE Connectivity grants (fiscal year 2019 to fiscal year 2021). Both grants will increase behavioral health provider participation in HIE. In addition, the grants will ensure technical assistance is provided to most effectively use HIE services to coordinate care and workflow for patients experiencing their first episode of psychosis. DHCF and DBH will facilitate ongoing policy governance discussions with key stakeholders, including members of the HIE Policy Board and the District HIE, to consider implementation of specific care alerts for initial episodes of psychosis and training for providers to use alerts. (Timeline: 18-24 months)
Identity Management (Section 7)	
7.1 As appropriate and needed, the care team has the ability to tag or link a child's electronic	*Current State:* Ability to link parent-child relations is a feature of some certified EHRs, however, this is not a current feature of HIE or broadly available in the District's health system.

medical records with their respective parent/caretaker medical records	*Future State:* Per the Office of Civil Rights (OCR) Request for Information (RFI) in December 2018 on modifying HIPAA rules to improve coordinated care,[15] it is clear that there is great interest in the potential to link parent and child medical records. The District will pay close attention to proposed rulemaking by OCR on this topic and follow federal guidance as finalized.
	Summary of Actions Needed: As comments from OCR and rulemaking are released, DHCF will raise comments and recommendations with District stakeholders in relevant venues such as the quarterly HIE Policy Board and the SECDCC. Pending further guidance at the federal level, DHCF and DBH will implement local requirements.
7.2 Electronic medical records capture all episodes of care, and are linked to the correct patient	*Current State:* As of 2016, 89 percent of medical providers in the District have access to EHRs. In contrast, of the 62 behavioral health practices enrolled in Medicaid, 52 are known to have EHRs, of which 35 percent (n=22) have fully-integrated solutions and 48 percent (n=30) have partially-integrated EHRs or the DATA/WITS system. Among the nine acute care hospitals and six non-acute care hospitals in the District, nearly all have an EHR. Among, IMDs, Netsmart's Avatar product is certified by ONC. PIW does not have an EHR and documents care on paper. HIE has expanded substantially in the District over the past few years. As of 2019, 32 percent of ambulatory Medicaid practices participate in CRISP DC.
	Future State: Leverage HITECH IAPD funded activities in the District including MEIP program support and technical assistance, as well as the HIE Core Capabilities Grant, and the HIE Connectivity grant. Collectively, these programs will expand access to certified EHR technology, HIE connectivity, and technical assistance to promote interoperability and effective care coordination using health information. Concurrent investment in value-based purchasing initiatives and technical assistance to support care coordination programs such as My Health GPS will encourage provider participation. Over time, this suite of investments will enable participating behavioral health providers to have confidence in the identity and relative completeness of patient records.
	Summary of Actions Needed: Implement workplan and timeline for MEIP program support and technical assistance, the HIE Core Capabilities Grant, and the HIE Connectivity grant. Maintain and evolve data and information exchange standards for value-based purchasing initiates. (Timeline: 18-24 months)

---

[15] https://www.federalregister.gov/documents/2018/12/14/2018-27162/request-for-information-on-modifying-hipaa-rules-to-improve-coordinated-care

Section 3: Relevant documents

See Attachment A – DHCF and DBH State Plan for Medical Assistance (State Plan) Memorandum of Understanding (MOU).

ATTACHMENT D
Section 1115 SUD Demonstration Implementation Plan

CMS' Opioid and Other SUDs 1115 Demonstration Initiative:

Goals and Milestones to be Addressed in State Implementation Plan Protocols

CMS is committed to working with states to provide a full continuum of care for people with opioid use disorder (OUD) and other SUDs and in supporting state-proposed solutions for expanding access and improving outcomes in the most cost-effective manner possible.

Goals:

1. Increased rates of identification, initiation and engagement in treatment for OUD and other SUDs;
2. Increased adherence to and retention in treatment for OUD and other SUDs;
3. Reductions in overdose deaths, particularly those due to opioids;
4. Reduced utilization of emergency departments and inpatient hospital settings for OUD and other SUD treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services;
5. Fewer readmissions to the same or higher level of care where readmissions is preventable or medically inappropriate for OUD and other SUD; and
6. Improved access to care for physical health conditions among beneficiaries with OUD or other SUDs.

Milestones:

1. Access to critical levels of care for OUD and other SUDs;
2. Widespread use of evidence-based, SUD-specific patient placement criteria;
3. Use of nationally recognized, evidence-based, SUD program standards to set residential treatment provider qualifications;
4. Sufficient provider capacity at each level of care, including MAT;
5. Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD; and
6. Improved care coordination and transitions between levels of care.

Section I – Milestone Completion

Milestones

1. **Access to Critical Levels of Care for OUD and Other SUDs**

Specifications:

To improve access to OUD and SUD treatment services for Medicaid beneficiaries, it is important to offer a range of services at varying levels of intensity across a continuum of care since the type of treatment or level of care needed may be more or less effective depending on the individual beneficiary. To meet this milestone, state Medicaid programs must provide coverage of the following services:

- Outpatient Services;
- Intensive Outpatient Services;
- Medication assisted treatment (medications as well as counseling and other services);
- Intensive levels of care in residential and inpatient settings; and
- Medically supervised withdrawal management

Current State:

The District's Department of Health Care Finance (DHCF) currently covers a wide array of OUD and SUD treatment services for Medicaid beneficiaries, including the range of services specified in Milestone 1. District SUD treatment services include assessment and diagnostic services; clinical care coordination; crisis intervention; individual, group, and family counseling; withdrawal management (WM) services; medication management; and medication-assisted treatment (MAT). Each of these services, with the exception of WM delivered in IMD settings, are covered by the Medicaid State Plan.

Residential treatment (ASAM levels 3.1, 3.3, and 3.5), as well as short-term, medically monitored WM services (level 3.7-WM) delivered in an IMD, are currently provided with local-only funding through the District's Department of Behavioral Health (DBH).

SUD treatment providers in the District provide services in accordance with the District of Columbia's Municipal Regulations (DCMR) and the individual needs of the client. The Medicaid State Plan governs the qualified practitioners for Medicaid covered services. For services that are not covered by Medicaid but are provided with local-only funding, qualified practitioner types are governed by DCMR Title 22, Chapter 63. See Appendix I for additional description of SUD treatment services and qualified practitioners. See Appendix II for additional requirements indicated by the ASAM level of care at which a provider is certified by DBH.

Future State:

The District is requesting waiver authority to allow for Medicaid reimbursement of residential treatment (ASAM levels 3.1, 3.3, and 3.5) as well as short-term, medically monitored WM services (level 3.7-WM) delivered in an IMD.

Below is a table that describes: 1) current SUD treatment services covered by the District at each level of care; 2) plans to improve access to SUD treatment services for Medicaid beneficiaries; and 3) a summary of action items that need to be completed to meet the milestone requirements.

Table 1. Milestone #1: Access to Critical Levels of Care for OUD and Other SUDs

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Coverage of outpatient services	The Medicaid State Plan provides coverage for a wide array of outpatient services, including:[1] • Assessment and diagnostic • Clinical care coordination • Crisis intervention • Counseling • Medication management • MAT See Appendix II for additional requirements indicated by ASAM level 1.0.	Already provided.	No action needed.

Coverage of intensive outpatient services	The Medicaid State Plan provides coverage for a wide array of intensive outpatient services, including:[2] • Assessment and diagnostic • Clinical care coordination • Crisis intervention • Counseling • Medication management • MAT See Appendix II for additional requirements indicated by ASAM levels 2.1 and 2.5.	Already provided.	Conduct stakeholder engagement to identify potential modifications to current provider guidance and/or other DHCF and DBH policy to improve access to intensive outpatient services. (Timeline: 18-24 months)

---

[1] See State Plan Attachment 3.1A: Other Diagnostic, Screening, Preventive, and Rehabilitative Services (p. 5-6), Supplement 6 to Attachment 3.1A (p. 1-18), Attachment 3.1B: Other Diagnostic, Screening, Preventive, and Rehabilitative Services (p. 5), and Supplement 3 to Attachment 3.1B (p. 1-18).
[2] Ibid.

Coverage of medication assisted treatment (medications as well as counseling and other services)	The Medicaid State Plan provides coverage for all FDA-approved medications for use in MAT, as well as counseling and other services.[1]	Already provided.[2]	No action needed.
Coverage of intensive levels of care in residential and inpatient settings	The Medicaid State Plan provides coverage for inpatient hospitalizations in non-IMD settings.[3] Intensive residential care at ASAM levels 3.1, 3.3, and 3.5 is provided with local-only funding through DBH.[4] See Appendix II for additional requirements indicated by ASAM levels 3.1, 3.3, and 3.5.	Medicaid waiver and expenditure authority for intensive care delivered in an IMD setting is requested under this demonstration.	Medicaid waiver and expenditure authority requested.
Coverage of medically supervised withdrawal management	The Medicaid State Plan provides coverage for medically supervised WM in non-IMD settings.[5] WM services delivered in IMD settings are provided with local-only funding. See Appendix II for additional requirements indicated by ASAM level 3.7-WM.	Medicaid waiver and expenditure authority for WM services delivered in an IMD setting is requested under this waiver.	Medicaid waiver and expenditure authority requested.

―――――――――――――――

[1] See State Plan Attachment 3.1A: Prescribed Drugs, Dentures, and Prosthetic Devices and Eyeglasses (p. 5), Supplement 1 to Attachment 3.1A (p. 20), Attachment 3.1B: Prescribed Drugs, Dentures, and Prosthetic Devices and Eyeglasses (p. 4-5), and Supplement 1 to Attachment 3.1B (p. 19).

[2] Waiver authority is requested under this demonstration to exempt medications for MAT from the $1 co-payment otherwise associated with outpatient prescription medications.

[3] See state plan Attachment 3.1A: Inpatient Hospital Services (p. 1), Supplement 1 to Attachment 3.1A (p. 1-3), Attachment 3.1B: Inpatient Hospital Services (p. 2), and Supplement 1 to Attachment 3.1B (p. 1-3).

[4] See DCMR Title 22, Chapter 63.

[5] See State Plan Attachment 3.1A: Other Diagnostic, Screening, Preventive, and Rehabilitative Services (p. 5-6), Supplement 6 to Attachment 3.1A (p. 1-18), Attachment 3.1B: Other Diagnostic, Screening, Preventive, and Rehabilitative Services (p. 5), and Supplement 3 to Attachment 3.1B (p. 1-18).

2. Use of Evidence-based, SUD-specific Patient Placement Criteria

Specifications:

Implementation of evidence-based, SUD-specific patient placement criteria is identified as a critical milestone that states are to address as part of the demonstration. To meet this milestone, states must ensure that the following criteria are met:

- Providers assess treatment needs based on SUD-specific, multi-dimensional assessment tools, e.g., the ASAM Criteria, or other patient placement assessment tools that reflect evidence-based clinical treatment guidelines; and

- Utilization management approaches are implemented to ensure that (a) beneficiaries have access to SUD services at the appropriate level of care, (b) interventions are appropriate for the diagnosis and level of care, and (c) there is an independent process for reviewing placement in residential treatment settings.

Current State:

Managed care organizations (MCOs) contracted with DHCF are required to provide behavioral health services, including SUD services, as defined in the State Plan, including physician and mid-level visits, inpatient hospitalization and emergency department services, Psychiatric Residential Treatment Facility (PRTF) services for enrollees less than 22 years old, and inpatient detoxification. MCOs are also required to provide inpatient treatment for enrollees aged 21 to 64 years old in an IMD, so long as the facility is a hospital providing SUD inpatient care or a sub-acute facility providing SUD residential services, and length of stay is of no more than 15 days. MCOs are required to develop and maintain a Utilization Management Program and conduct concurrent reviews and post-service reviews in accordance with their written Utilization Management policies and procedures. MCO Utilization Management policies and procedures are required to promote timely access to preventive treatment and rehabilitation services in accordance with evidence-based standards of health care, like InterQual Behavioral Health Criteria and Milliman Care Guidelines, and conform to managed health care industry standards. In addition, MCOs are responsible for referrals to DBH for outpatient SUD treatment.

For those services, as well as other DBH-funded services, the District's Assessment and Referral Center (ARC), managed by DBH, provides same day assessment and referral for individuals seeking treatment for SUD. There is also one mobile ARC, which visits communities throughout the District to conduct assessment and referral, as well as providing other services. DBH recently certified four additional intake and assessment sites where clients can be assessed and referred for SUD services.

To refer individuals seeking treatment to the appropriate program, qualified clinicians at the ARC, intake and assessment sites, and the mobile ARC conduct comprehensive assessments that includes the nature of the addiction, use history, any mental health care needs, and overall health status. The ARC, the intake and assessment sites, and the mobile ARC use an assessment tool called the Treatment Assignment Protocol (TAP), which incorporates both the Addiction Severity Index and ASAM criteria to ensure referral to an appropriate level of care and services.

After the appropriate level of care is determined, individuals can choose from a list of certified providers.

In addition to the intake and assessment providers, all SUD providers can perform ongoing and comprehensive assessments in the event of a change in an individual's status or to determine whether a different level of care or services is necessary. Authorizations for additional services or changes to placement or level of care are handled through DBH's Access Helpline (AHL). Providers submit the necessary documentation, including results from the TAP, urinalysis testing, and other clinical notes to AHL to request changes to or additional authorizations. Behavioral health professionals at AHL review the documentation and assessment results from providers to ensure interventions are appropriate for the diagnosis and level of care.

DBH's Program Integrity (PI) division conducts claims audits, false claiming investigations, and independent reviews to ensure all service delivery and documentation standards for SUD services are met.

Future State:

Concurrent with the demonstration, DBH is planning to further decentralize ARC services. In addition to the four newly certified intake and assessment providers, this will allow more certified community-based SUD providers to provide intake, assessment, and referrals, thereby creating multiple points of entry into the District's system of care for individuals in need of SUD services. DBH will ensure assessments continue to be based on tools like the TAP that are SUD-specific and reflect evidence-based clinical treatment guidelines.

DBH will continue PI activities and coordinate with DHCF's PI division, which will continue to ensure all standards are met for all services billed to Medicaid.

Below is a table that describes: 1) current use of evidence-based, SUD-specific patient placement criteria and utilization management approach in the District; 2) plans to increase the use of evidence-based, SUD-specific placement criteria and enhance utilization management; and 3) a summary of action items that need to be completed to meet the milestone requirements.

Table 2. Milestone #2: Use of Evidence-based, SUD-specific Patient Placement Criteria

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Implementation of requirement that providers assess treatment needs based on SUD-specific, multi-dimensional assessment tools that reflect evidence-based clinical treatment guidelines	The ARC, intake and assessment sites, and the mobile ARC use the TAP, which incorporates both the Addiction Severity Index and ASAM criteria, to determine appropriate level of care and services.	Decentralized intake, assessment, and referral system, where all SUD providers can provide intake and assessment services, to create multiple points of entry into the District's system of care.	DBH will ensure assessments continue to be based on tools like the TAP and issue updated rulemaking, policies, bulletins, and/or care agreements as necessary. (Timeline: 12-18 months)

Implementation of a utilization management approach such that (a) beneficiaries have access to SUD services at the appropriate level of care	AHL ensures beneficiaries have access to SUD services at the appropriate level of care. MCOs develop and maintain Utilization Management Programs to ensure beneficiaries have access to services, including SUD services, at the appropriate level of care.	Already implemented.	No action needed.
Implementation of a utilization management approach such that (b) interventions are appropriate for the diagnosis and level of care	AHL ensures interventions are appropriate for the diagnosis and level of care. MCOs develop and maintain Utilization Management Programs to ensure interventions are appropriate for the diagnosis and level of care.	Already implemented.	No action needed.

Implementation of a utilization management approach such that (c) there is an independent process for reviewing placement in residential treatment settings	DBH PI division ensures all service delivery and documentation standards for SUD services are met. The ARC, the intake and assessment sites, and the mobile ARC use the TAP to ensure all placements in residential treatment settings are appropriate. AHL ensures any changes to placement or level of care, including in residential treatment settings, are appropriate. AHL also authorizes any requests for additional services and provides oversight of lengths of stay in residential treatment settings. MCOs develop and maintain Utilization Management Programs that include reviewing placements in residential treatment settings.	Already implemented.	No action needed.

3. Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities

Specifications:

Through the new Section 1115 initiative, states will have an opportunity to receive federal financial participation (FFP) for a continuum of SUD services, including services provided to Medicaid enrollees residing in residential treatment facilities that qualify as institutions for mental diseases. To meet this milestone, states must ensure that the following criteria are met:

- Implementation of residential treatment provider qualifications (in licensure requirements, policy manuals, managed care contracts, or other guidance) that meet the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding the types of services, hours of clinical care and credentials of staff for residential treatment settings;

- Implementation of a state process for reviewing residential treatment providers to assure compliance with these standards; and

- Implementation of a requirement that residential treatment facilities offer MAT on-site or facilitate access off site.

SUD treatment and recovery providers in the District, including all residential treatment providers, are regulated by DBH. DCMR Title 22, Chapter 63 specifies the certification standards for SUD treatment providers. The treatment framework of DCMR Title 22, Chapter 63 "is based on levels of care established by the American Society of Addiction Medicine (ASAM)"[1] and the certification process for each level of care aligns with the criteria set out by ASAM for all levels of care. Appendix II details the types of services, hours of clinical care, and staffing requirements at each ASAM level of care. SUD treatment providers must be certified by DBH in order to participate as District Medicaid providers.

Upon receipt of a complete application, DBH determines whether the applicant's facility services and activities meet the certification standards. To do so, DBH schedules and conducts an on-site survey. DBH is allowed access to all records necessary to verify compliance with certification standards and may conduct interviews with staff, others in the community, and clients (with client consent). DBH may deny certification if the applicant fails to comply with any certification standard. For approved providers, DBH issues one certificate valid only for the programs, premises, and levels of care as specified on the application.

Full certification as a SUD treatment provider is for one (1) calendar year for new applicants and two (2) calendar years for existing providers seeking renewal. Certification starts from the date of issuance of certification by DBH and is subject to the provider's continuous compliance with certification standards. A provider seeking renewal of certification is required to submit their certification application at least ninety (90) days prior to the termination of its current certification.

SUD providers are visited at least annually by DBH staff. DBH staff may conduct an on-site survey at the time of certification application, renewal, or at any other time during the period of certification. Upon presentation of proper identification, DBH staff have the authority to enter the premises of a SUD treatment or recovery program during operating hours for the purpose of conducting announced or unannounced inspections and investigations.

Decertification is the revocation of DBH certification and is issued by the Director of DBH. A decertified SUD provider may not provide any SUD treatment and shall not be reimbursed for any services as a SUD provider. Grounds for revocation include: failure to comply with certification requirements; breach of the contract with DBH for use of local funds, also known as a Human Care Agreement; violations of Federal or District law; or any other action that constitutes a threat to the health or safety of clients.

DCMR Title 22, Chapter 63 states that any certified provider may not deny admission for services to an otherwise qualified client because that person is receiving MAT services, even if the MAT services are provided by a different provider.[2]Additionally, under DBH Policy 311.3

---

[1] See DCMR Title 22, Chapter 63, Section 6300.4.
[2] See DCMR Title 22, Chapter 63, Section 6300.8.

(dated August 19, 2015), access to methadone shall be made available to all clients including those in residential treatment, as clinically appropriate. SUD residential treatment providers who are not certified to provide MAT services are required to provide transportation for clients to obtain medications at the MAT clinic and participate in the coordination of client care with MAT providers.[1]

Future State:

DHCF and DBH will work with stakeholders to establish policies to ensure that appropriate facilitation between residential providers and clients occurs for all FDA-approved types of medications used in MAT.

Below is a table that describes: 1) current provider qualifications for residential treatment facilities; 2) plans to enhance provider qualifications for residential treatment; and 3) a summary of action items that need to be completed to meet the milestone requirements.

Table 3. Milestone #3: Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Implementation of residential treatment provider qualifications in licensure requirements, policy manuals, managed care contracts, or other guidance. Qualification should meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding, in particular, the types of services, hours of clinical care, and credentials of staff for residential treatment settings	DCMR Title 22, Chapter 63 lays out the certification standards for SUD treatment providers and aligns with the ASAM Criteria. Appendix II details the types of services, hours of clinical care, and staffing requirements at each ASAM level of care.	Already implemented.	No action needed.

---

[1] https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/311.3%20TL-287.PDF

Implementation of a state process for reviewing residential treatment providers to ensure compliance with these standards	All SUD treatment providers in the District must apply for DBH certification. Upon receipt of a complete application, DBH determines whether the applicant's facility services and activities meet the certification standards as detailed in DCMR Title 22, Chapter 63. Full certification as a SUD treatment provider is for one (1) calendar year for new applicants and two (2) calendar years for existing providers seeking renewal. DBH staff may conduct an on-site survey at the time of certification application, renewal, or at any other time during the period of certification. SUD providers are visited at least annually by DBH staff.	Already implemented.	No action needed.

Implementation of requirement that residential treatment facilities offer MAT on-site or facilitate access off-site	DCMR Title 22, Chapter 63 states that any certified provider may not deny admission for services to an otherwise qualified client because that person is receiving MAT services, even if the MAT services are provided by a different provider. Under DBH Policy 311.3, access to methadone shall be facilitated for all clients including those in residential treatment, as clinically appropriate.	Ensure residential treatment facilities offer MAT for all FDA-approved types of medication on-site or facilitate access off-site.	DHCF and DBH will conduct stakeholder engagement and issue updated rulemaking, policies, bulletins, and/or care agreements as necessary to ensure residential treatment facilities offer or facilitate access to all FDA-approved medications for use in MAT. (Timeline: 12-18 months)

4. Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD

Specifications:

To meet this milestone, states must complete an assessment of the availability of providers enrolled in Medicaid and accepting new patients in the critical levels of care listed in Milestone 1. This assessment must determine availability of treatment for Medicaid beneficiaries in each of these levels of care, as well as availability of MAT and medically supervised withdrawal management, throughout the state. This assessment should help to identify gaps in availability of services for beneficiaries in the critical levels of care.

Current State:

The District is entirely urban and there are certified SUD providers in each of the eight wards across the city. Appendix III lists all certified SUD providers in the District by level of care that are enrolled in Medicaid. There are no providers certified at ASAM level 3.7 (Short-Term Medically Monitored Intensive Withdrawal Management) in the District. Currently, all withdrawal management treatment in the District is provided in an inpatient hospital setting.

SUD providers work with DBH's Network Development team to continually maintain an up-to-date list of providers who are accepting referrals for new patients, are not accepting new patients, or who have temporarily suspended accepting new patients. This information is shared with the ARC and the AHL to ensure that they have current information when offering provider options to clients.

Additionally, the District is currently conducting a comprehensive assessment of the availability of SUD treatment services and beds using funding from the District of Columbia Opioid Response (DCOR) grant. The assessment will analyze SUD service adequacy with respect to demographics such as age, gender, and payer, and will assess the efficiency and effectiveness of the District's SUD treatment referral system.

Finally, DHCF contracts detail MCO provider network composition and access requirements. MCOs are required to develop and maintain a provider network which is sufficient to provide timely access to the full range of covered services to enrollees, including behavioral health services.

Future State:

The District is requesting waiver authority to allow for Medicaid reimbursement of residential treatment (ASAM levels 3.1, 3.3, and 3.5) as well as short-term, medically monitored WM services (level 3.7-WM) delivered in an IMD.

Concurrent with this demonstration, the District will work to certify additional providers to allow for treatment of individuals with SUD (ASAM level 3.7-WM), thereby increasing capacity to treat individuals with SUD for short-term, intensive stays in the community.

After the DCOR service assessment is complete, DBH and DHCF will consider strategies to address any gaps identified.

DHCF will also modify existing contracts, as necessary, to ensure sufficient provider capacity at critical levels of care is maintained for MCO enrollees.

Below is a table that describes: 1) current capacity to provide SUD treatment at each level of care; 2) plans to enhance provide capacity infrastructure; and 3) a summary of action items that need to be completed to meet the milestone requirements.

Table 4. Milestone #4: Sufficient Provider Capacity at Critical Levels of Care including for MAT for OUD

Milestone Criteria	Current State	Future State	Summary of Actions Needed

Completion of assessment of the availability of providers enrolled in Medicaid and accepting new patients in the following critical levels of care throughout the state (or at least in participating regions of the state) including those that offer MAT: Outpatient Services; Intensive Outpatient Services; Medication Assisted Treatment (medications as well as counseling and other services); Intensive Care in Residential and Inpatient Settings; Medically Supervised Withdrawal Management.	There are certified SUD providers in each of the eight wards across the District. The District has 23 providers at 26 locations providing outpatient services. The District has 19 providers at 20 locations providing intensive outpatient services. The District has 3 opioid treatment programs (OTPs). In addition, in fiscal year 2018, 148 unique Medicaid providers prescribed buprenorphine and/or naltrexone. So far in fiscal year 2019, 167 unique Medicaid providers have prescribed buprenorphine and/or naltrexone.[2] The District has 8 providers in 9 locations providing intensive care in residential settings. Intensive care in residential settings is provided with local-only funding through DBH.	Medicaid waiver and expenditure authority is requested under this demonstration to exempt medications for MAT from the $1 co-payment otherwise associated with outpatient prescription medications. Medicaid waiver and expenditure authority for intensive care in an IMD setting is requested under this demonstration. Medicaid waiver and expenditure authority for WM services delivered in an IMD setting is requested under this demonstration. Expanded services to include WM.	Medicaid waiver and expenditure authorities requested. The District will also work to improve future assessments of SUD provider capacity, especially the availability of MAT and 3.7-WM services. (Timeline: 18-24 months)

---

[2] Source: DC MMIS data accessed July 26, 2019, up to date as of July 19, 2019. These numbers only capture prescribed, non-injectable MAT medications.

	One private psychiatric hospital in the District provides WM services. The District's 7 acute care hospitals also all provide WM services. The Network Development team at DBH maintains an up-to-date list of SUD providers accepting new patients. As of July 2019, all providers are accepting referrals.		

5. Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD

Specifications:

To meet this milestone, states must ensure that the following criteria are met:

- Implementation of opioid prescribing guidelines along with other interventions to prevent prescription drug abuse;
- Expanded coverage of and access to naloxone for overdose reversal; and
- Implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs.

Current State:

The District has implemented opioid prescribing guidelines. In 2018, DHCF updated its clinical prior authorization requirements on opioid prescriptions to include a program that limits the quantity and days of supply covered under the District's fee-for-service (FFS) Medicaid pharmacy benefit, on the basis of opioid-morphine milligram equivalents (MME). The program is designed to reduce the availability and utilization of high MME prescriptions and lessen the risk of SUD and diversion among Medicaid beneficiaries.[1] Between October 1, 2018 and July 1, 2019, there were 4,082 FFS Medicaid beneficiaries whose submitted opioid prescription claims exceeded the MME quantity and/or days of supply limits and triggered a review. Of those 4,082 FFS Medicaid beneficiaries, 1,057 received an authorization to exceed the MME quantity and/or days of supply limits based on medical need. The other 3,025 FFS Medicaid beneficiaries did not receive an authorization to exceed the MME and/or days of supply limits, thus lessening the potential risk of opioid misuse, addiction, and overdose.

DHCF covers naloxone for overdose reversal. Naloxone can be prescribed to Medicaid beneficiaries without prior authorization or any other restrictions. Other District agencies are also expanding access to naloxone for overdose reversal. For example, DC Health conducts a narcan/naloxone training every other month that is open to the public. The District Metropolitan Police Department (MPD) has also implemented a policy to require trained officers in specified units to carry naloxone while on duty. Naloxone-equipped members are to provide immediate assistance to overdose victims in accordance with MPD training.[2]

DC Health directs the District's Prescription Drug Monitoring Program (PDMP) with support from the vendor, Appriss, and has ongoing activities to increase utilization and improve functionality. As of July 2019, DC Health has implemented 22 direct PDMP integrations for District providers. DC Health is also conducting an extensive public awareness campaign regarding prescription-related opioid use. As a result of these efforts, the District has seen a 24 percent increase in average number of PDMP queries per month between 2017 and 2018 and has experienced a 37 percent increase in total number of PDMP approved registrations in 2019 alone. The District also currently participates in interstate data sharing via the National

---

[1] https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/Transmittal%2018-25.pdf
[2] https://go.mpdconline.com/GO/GO_307_02.pdf

Association of Boards of Pharmacy (NABP) Prescription Monitoring Program InterConnect (PMPI) data sharing system. Additional information about the DC PDMP is included in Attachment A.

In 2019, the DC Council passed legislation requiring all controlled substance prescribers to register for the DC PDMP, which is also anticipated to substantially increase PDMP registration and query.[1] Consistent with the legislation, DHCF requires all prescribers of MAT-related buprenorphine and naltrexone for Medicaid beneficiaries to check the DC PDMP and record findings in the patient's medical record.[2]

Concurrent with this demonstration, in July 2019, DBH launched its Community Response Team (CRT), a multi-site, 24/7 model of care consisting of a multidisciplinary team of licensed clinicians, community behavioral health specialists, and individuals with lived experience. The CRT provides critical incidents response, targeted community outreach, supportive behavioral health services, and community education.

In addition to the activities described above, District agencies have taken a number of other steps to address the opioid epidemic, including:

- **Opioid Task Force:** The multi-agency task force, jointly led by DBH and DC Health, monitors trends and identifies opportunities for policy interventions to reduce the frequency and severity of opioid-related overdoses. The task force meets monthly to review public health data and identify cross-agency strategies.

- **Medicaid Opioid Data Dashboard:** In 2018, DHCF was selected to participate in an IAP technical assistance program to create a Medicaid Opioid Data Dashboard. The dashboard presents metrics on OUD diagnoses, utilization of services, emergency room utilizations, and MAT utilization that can be shared with other District agencies to improve and better target service delivery.

- **Opioid Strategic Plan:** The District's opioid strategic plan, LIVE.LONG.DC.,[3] which can be located at https://dbh.dc.gov/publication/live-long-dc, was published in December 2018 and updated in March 2019. The plan identifies seven goals and related strategies to reduce opioid use, misuse, and related deaths through 2020.

  Work to implement the opioid strategic plan is already underway. In 2018, the District launched an anti-stigma social marketing campaign to increase awareness about opioid use, treatment, and recovery. The campaign provided community members with training on effective communication related to SUD and educated and promoted Good Samaritan laws for community members and law enforcement. The District also conducted provider

---

[1] http://lims.dccouncil.us/Download/38775/B22-0459-SignedAct.pdf
[2] https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/Policy%20%2319-001%20Removal%20of%20Prior%20Auth.%20Req.%20for%20Medication-Assis_0.pdf
[3] https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/LIVE.%20LONG.%20DC-%20Washington%20DC%27s%20Opioid%20Strategic%20Plan-%20March%20Revision.pdf

continuing education on evidence-based guidelines for opioid prescribing and extended emergency legislation to make drug testing kits legal.

- **Removing Prior Authorization for MAT:** Consistent with the goals outlined in the opioid strategic plan, in April 2019 DHCF eliminated prior authorization requirements for buprenorphine and naltrexone for extended-release injectable suspension when used as part of MAT.[1]

- **DBH SOR Grant:** DBH received a two-year, $53 million State Opioid Response (SOR) grant from SAMHSA. The grant, known locally as the District of Columbia Opioid Response (DCOR) grant, will fund opioid-related prevention, treatment, and recovery support activities.

- **Buprenorphine-Waivered Provider Training:** The HIV/AIDS, Hepatitis, STD, and TB Administration (HAHSTA) at DC Health has established a partnership via grant agreement with Howard University Hospital to provide DATA 2000 waiver training. The program conducts capacity building activities and provides technical support to clinicians–including physicians, NPs, PAs, and clinical pharmacists–eligible to apply for or already waived to prescribe buprenorphine-based treatment. The program aims to increase and expand the availability of providers willing to address OUD through appropriate prescribing and linkage to recovery services.

  HAHSTA also supports naloxone training and distribution, safe medication disposal, needle exchange programs, and other harm reduction initiatives.

In addition to the targeted responses to the opioid epidemic described above, the Prevention and Early Intervention Division at DBH broadly develops and delivers prevention and early intervention services, education, support, and outreach activities to help inform and identify children, youth, and their families who may be at risk or affected by some level of mental health and/or SUD. The division applies a public health and community-based approach to delivering evidence-based substance abuse prevention and mental health promotion programs.

The division administers grants and contracts that support four DC Prevention Centers located throughout the city. Each Prevention Center serves two designated wards. The Prevention Centers are dynamic hubs designed to strengthen the community's capacity to prevent and curtail the use of drugs at the local level. Each Prevention Center focuses on building collaborations and partnership within the wards and promoting healthy drug-free living. The staff at each Prevention Center works with communities and neighborhoods to provide substance abuse education, engage community leaders, youth, and families in taking action to reduce the risks and use of alcohol, tobacco, and other drugs, and address local conditions and elements that lead to substance abuse.

---

[1] https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/Policy%20%2319-001%20Removal%20of%20Prior%20Auth.%20Req.%20for%20Medication-Assis_0.pdf

Future State:

DHCF has already implemented opioid prescribing guidelines and covers naloxone for overdose reversal. Through SOR grant funding, DBH will enhance naloxone kit distribution by increasing the number of providers and sites distributing naloxone and providing additional training and naloxone kits for MPD.

The District will implement legislative changes mandating that all controlled substance prescribers in the District register for the DC PDMP. DC Health's outreach efforts to encourage PDMP registration, utilization, and integration are ongoing.

While the cornerstone of this demonstration is to expand the continuum of care by providing Medicaid reimbursement for individuals with SUD (or SMI) in residential and inpatient IMD settings, the District also plans to complement new residential and inpatient IMD services by bolstering the availability of community-based interventions, including:

- Crisis stabilization and mobile crisis outreach services in the community;
- Adding Recovery Support Services for individuals with SUD, including services delivered by certified peer specialists;
- Piloting Supported Employment Services for individuals with SUD, connecting individuals with training and skills to promote and maintain employment;
- Behavioral health services provided by independent and hospital-affiliated psychologists and other licensed behavioral health providers;
- Eliminating $1 co-payment cost-sharing requirement for prescriptions associated with MAT; and
- Transition planning services to permit certain behavioral health providers to participate in the discharge treatment planning process for individuals being discharged from an inpatient residential or other institutional setting.

Opioid-related prevention, treatment, and recovery support activities funded through the SOR grant are also ongoing. Through SOR, the District will initiate more than 70 activities, including:

- Implementation of a comprehensive, coordinated, and accessible system of OUD treatment and recovery care with multiple access points;
- Deployment of SBIRT, motivational interviewing, and peer support specialists across the continuum of care to identify and engage individuals in care;
- Training, technical assistance, and ECHO consultation for health care professionals to enhance their ability to treat clients with complex needs;
- Hospital emergency room MAT induction pilot to screen emergency room patients for potential SUD risk using SBIRT and connect interested patients who are identified as at-risk to a peer recovery coach to discuss recovery strategies and options, including initiating MAT; and
- Harm reduction efforts, such as using peers to engage individuals with SUD in harm reduction services, as well as developing a stakeholder workgroup to consider safe injection sites.

The District will evaluate the effectiveness of SOR grant activities to determine additional Medicaid changes through demonstration amendments or other means.

Overall, the demonstration will complement ongoing District efforts under the Medicaid State Plan and administration operations to enhance Adult Substance Abuse Rehabilitative Services (ASARS) and Mental Health Rehabilitation Services (MHRS) and identify opportunities for system improvements. The District's goal is to build a system of care that provides a greater continuum of behavioral health services; reduces substance use, misuse, and overdose fatalities; and moves Medicaid toward a more holistic, integrated approach to health care treatment.

Below is a table that describes: 1) current treatment and prevention strategies to reduce opioid abuse; 2) plans to implement additional prevention strategies and 3) a summary of action items that need to be completed to meet the milestone requirements.

Table 5. Milestone #5: Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Implementation of opioid prescribing guidelines along with other interventions to prevent opioid abuse	DHCF has implemented MME limits, including a tapering period for "Current Users" of high doses of opioids, references to non-opioid pain management substitution strategies, and referral to SUD treatment. DHCF requires all prescribers to check the PDMP before providing prescriptions of buprenorphine.	Already implemented.	No action needed.

| Expanded coverage of, and access to, naloxone for overdose reversal | Naloxone is covered by Medicaid and can be prescribed without prior authorization or any other restrictions.

The District MPD requires trained officers in specified units to carry naloxone while on duty. | Through SOR, the District will distribute additional naloxone kits and conduct additional training. | Activities funded through the SOR grant are ongoing. |
|---|---|---|---|

	DC Health conducts naloxone training every other month.		
Implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs	DC Health directs the DC PDMP with support from the vendor, Appriss. As of July 2019, DC Health has implemented 22 direct PDMP integrations for District providers. DC Health is also conducting an extensive public awareness campaign regarding prescription-related opioid use. In 2019, the DC Council passed legislation requiring all controlled substance prescribers to register for the DC PDMP. Consistent with the legislation, DHCF requires all prescribers of MAT-related buprenorphine or naltrexone for Medicaid beneficiaries to check the PDMP and record findings in the patient's medical record. Additional information about the DC PDMP is included in Attachment A.	The District will implement legislative changes mandating that all controlled substance prescribers in the District register for the DC PDMP. Additional information about the DC PDMP is included in Attachment A.	DC Health will update and clarify relevant rulemaking, as necessary. DC Health's outreach efforts to encourage PDMP registration, utilization, and integration are ongoing. Additional information about the DC PDMP is included in Attachment A.
Other	Various opioid-related prevention, treatment, and recovery support activities through SOR grant.	Under this demonstration, the District proposes to expand the service	Medicaid waiver and expenditure authority requested.

	DBH CRT responds to individual and community crises, conducts targeted community engagement and outreach, provides supportive behavioral health services, and community education.	continuum for SUD treatment, including: • Crisis stabilization and mobile crisis outreach services • Recovery Support Services • Supported Employment Services pilot • Behavioral health services provided by independent and hospital-affiliated psychologists and other licensed behavioral health providers • Eliminate $1 co-payment cost-sharing requirement for prescriptions associated with MAT • Transition planning services Opioid-related prevention, treatment, and recovery support activities funded through the SOR grant will continue.	DHCF and DBH will issue rulemaking, policies, bulletins, and/or care agreements as necessary for waiver services. (Timeline: 12-18 months) The District will evaluate the effectiveness of SOR grant activities to determine additional Medicaid changes through demonstration amendments or other means. (Timeline: 18-24 months) District efforts under the Medicaid State Plan and administration operations to enhance ASARS and MHRS services and identify opportunities for system improvements are ongoing.

6. Improved Care Coordination and Transitions between Levels of Care

Specifications:

To meet this milestone, states must implement policies to ensure residential and inpatient facilities link beneficiaries, especially those with OUD, with community-based services and supports following stays in these facilities.

Current State:

Under current District regulations, all SUD providers must provide services to beneficiaries with co-occurring mental illness and cannot decline to provide services due to a co-occurring mental illness. All SUD providers must also provide clinical care coordination services. Clinical care coordination is the initial and ongoing process of identifying, planning, and evaluating options and services to best meet a client's health needs, including medical and psychiatric conditions. The focus of clinical care coordination is linking clients as they transition through the levels of care and ensuring that the treatment plan is formulated with the overarching goal of recovery. Clinical care coordination also includes oversight of linkages to off-site services to meet needs related to co-occurring medical and/or psychiatric conditions, as documented in the treatment plan. A clinical care coordinator is responsible for ensuring the treatment plan and subsequent care is coordinated with any mental health providers.[1]

Prior to a beneficiary's transition to a new level of care, including discharge from residential and inpatient facilities, an assessment must be performed by the provider and approved by the Access Helpline (AHL) to ensure that the beneficiary is an appropriate fit for the recommended level of care. A clinical care coordinator is responsible for ensuring appropriate referral, obtaining authorization from AHL, and transition to the new level of care.[2] In addition, ASAM level 3.7-WM providers operating under a Human Care Agreement in the District must admit discharged clients directly into a lower level residential SUD treatment program, via a "bed-to-bed" transfer, unless AHL authorizes an exception or the client refuses admission into the lower level residential program.[3]

The Medicaid Health Home program is another key component of the District's care coordination strategy. The District currently operates two Health Home programs. My DC Health Home, the District's first Health Home program, is administered by DBH and provides comprehensive care management services delivered by community mental health providers to Medicaid beneficiaries with SMI. The District's second Health Home program, My Health GPS, focuses on the unmet care management needs of Medicaid beneficiaries with multiple chronic conditions, including behavioral health conditions; specifically, SUD and SMI are included in the list of chronic conditions that determine eligibility for My Health GPS.

Since My Health GPS launched in 2017, over 5,000 beneficiaries have received care coordination services delivered by interdisciplinary teams in the primary care setting. Over 60 percent (more than 3,000) of these beneficiaries have a behavioral health diagnosis and nearly 12 percent (nearly 600 beneficiaries) have an opioid dependence.

Early results of the My Health GPS program are promising, especially since it often takes a few years to demonstrate the impact of care coordination programs. Analyses of those who enrolled in the first four months of the program show:

---

[1] See DCMR Title 22, Chapter 63, Section 6302.
[2] See DCMR Title 22, Chapter 63, Section 6326.
[3] See DCMR Title 22, Chapter 63, Section 6334.

- Reductions in both non-emergency ED visits for members with low acuity illnesses and avoidable inpatient stays, and
- A lower growth rate for total acute care costs. Overall, the total cost of acute care for the baseline cohort grew at only 1 percent, largely resulting from reductions in ED use (-8 percent) and prescription drugs (-3 percent).

District FQHCs and MCOs are also incented to improve care coordination and transitions between levels of care. The FQHC payment methodology includes costs related to care coordination. Additionally, part of the FQHC Alternative Payment Methodology (APM) includes a bonus payment for achieving benchmarks related to outcomes, access, and transitions of care measures. The bonus payments are based on outcomes largely derived from improved care coordination and transitional services.

To receive full capitated payment, District MCOs must reduce preventable admissions, low acuity emergency department visits, and 30-day readmissions. Again, these payments are based on outcomes largely derived from improved care coordination and transitional services. MCOs contracted with DHCF are required to coordinate services for MCO beneficiaries between settings of care, including appropriate discharge planning for stays in residential and inpatient facilities. MCOs are required to assist in the development of an appropriate discharge plan prior to an MCO beneficiary's discharge or change in treatment setting and when possible, participate in discharge planning meetings. As part of clinical management, MCOs are responsible for collaborating with staff in other District agencies, community service organizations, and other providers to meet beneficiaries' health care needs. MCOs are also responsible for care coordination and case management for beneficiaries receiving services through DBH.

Future State:

This demonstration proposes to add Medicaid reimbursement for transition planning services provided by certain health care providers for individuals with SUD (and/or SMI/SED) being discharged into their care from an inpatient, residential or other institutional setting. An individual's physical and mental health needs, as well as the need for non-clinical supports, are to be assessed during the discharge planning process. Enabling these health care providers to be part of plan development with the individual and the institution's treatment team promotes continuity of care and helps ensure that appropriate treatment services and supports are available and accessed after discharge. These transition services can be provided in person, remotely via telemedicine, and/or outside of the care delivery setting.

DHCF and DBH will establish protocols to ensure no duplication of payment for transition planning services and health home services delivered in the same month. The transition planning services proposed under this demonstration are consistent with the health home framework and could increase enrollment in the Health Home programs to provide continued care management for beneficiaries with more significant needs. The District also plans to evaluate and potentially take advantage of the opportunity for two additional quarters of enhanced FMAP for certain SUD-focused health homes recently announced by CMS.

DBH provides technical assistance to SUD providers as needed. DBH will develop additional opportunities to provide training and technical assistance for SUD providers on clinical care coordination for both physical and mental health co-occurring conditions.

The District is also hoping to better integrate data-sharing between SUD treatment providers and other health care providers. However, federal guidance under 42 CFR Part 2 limits data-sharing of SUD information because the requirements have been interpreted to require an individual's consent for every single SUD-related disclosure. District agencies are aware that this limitation interferes with providers' ability to care for patients. The District hopes to work with interested stakeholders to identify opportunities for data-sharing within any limitations of federal and District law.

Below is a table that describes: 1) current care coordination and transition services; 2) plans to enhance care coordination and transition services; and 3) a summary of action items that need to be completed to meet the milestone requirements.

Table 6. Milestone #6: Improved Care Coordination and Transitions between Levels of Care

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Implementation of policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities	Prior to transitioning to a new level of care, an assessment must be performed by the provider and approved by AHL. The clinical care coordinator is responsible for ensuring appropriate referral, obtaining authorization from AHL, and transition to the new level of care. Additionally, ASAM level 3.7-WM providers must admit discharged clients directly into a lower level residential SUD treatment program unless an exception is	Under this demonstration, the District proposes to add Medicaid reimbursement for transition planning services for individuals being discharge from residential and inpatient facilities.	DHCF and DBH will issue rulemaking, policies, bulletins, and/or care agreements as necessary for transition planning services. (Timeline: 12-18 months)

	authorized exception or the client refuses. The Medicaid Health Home program is another key component of the District's care coordination strategy. The District currently operates two Health Home programs: My DC Health Home and My Health GPS. District FQHCs and MCOs are also incentivized to improve care coordination and transitions between levels of care.		
Additional policies to ensure coordination of care for co- occurring physical and mental health conditions	All SUD providers must provide clinical care coordination services, including screening for co- occurring physical and mental health conditions and linking beneficiaries to off-site services to best meet all of their health needs as documented in the treatment plan. The District's two Health Home programs support work to integrate and coordinate the full array of eligible beneficiaries' primary, acute, behavioral health, and long-term services.	DBH provides additional opportunities for training and technical assistance on clinical care coordination services for SUD providers.	DBH will develop additional training and technical assistance on clinical care coordination services. (Timeline: 12-18 months) The District will work with stakeholders to identify opportunities for data-sharing between SUD treatment providers and other health care providers, within any limitations of federal and District law. (Timeline: 18-24 months)

Section II – Implementation Administration

The District's point of contact for the Implementation plan is:

Name and Title: Melisa Byrd, Senior Deputy Director and State Medicaid Director
Telephone Number: 202-442-9075
Email Address: melisa.byrd@dc.gov

Section III – Relevant Documents

Not Applicable.

<u>**Attachment A – SUD Health Information Technology (IT) Plan**</u>

Section I.

Specifications:

SUD Demonstration Milestone 5.0, Specification 3: Implementation of Strategies to Increase Utilization and Improve Functionality of PDMP

The specific milestones to be achieved by developing and implementing an SUD Health IT Plan include:
- Enhancing the health IT functionality to support PDMP interoperability; and
- Enhancing and/or supporting clinicians in their usage of the state's PDMP.

Current State:

DC Health implemented the District's PDMP in 2016 and directs the DC PDMP with support from the vendor, Appriss. Dispensers in the District are required to report prescription data on dispensation of Schedule II, III, IV and V drugs, as well as products that contain butalbital and cyclobenzaprine.

As of July 2019, there are more than 8,000 health care professionals registered with the program who have conducted more than 150,000 PDMP queries, including patient lookups and self-checks. Data from 2018 show that the number of reported opioids dispensed in the District decreased by 8.5 percent compared to 2017 during a period in which the DC PDMP substantially increased the number of registered prescribers.

The District currently participates in interstate data sharing via the National Association of Boards of Pharmacy (NABP) Prescription Monitoring Program InterConnect (PMPI) data sharing system. The District currently shares data with 21 states. Through the District's PDMP vendor, Appriss, the District also has access to multi-state data via NarxCare. NarxCare is also a decision support platform that allows providers to coordinate care and actively manage a patient's risk or need for referral. NarxCare can also automatically deliver risk scores when a patient presents for care.

Multiple grants through the CDC and SAMHSA enabled DC Health to enhance the functionality of the DC PDMP, including implementation of quarterly prescriber reports, Appriss Analytics Package, and NarxCare. Beginning in April 2018, quarterly prescriber reports are available through providers' DC PDMP account dashboards. These reports summarize providers prescribing of covered substances and their standing among peers, which may positively influence prescribing and treatment decisions.

The DC PDMP has Tableau analytic software that enables DC Health and participating prescribers to view, track, and analyze trends in long-term prescribing. Current PDMP data

indicate a decline in opioid prescribing in the District. Additionally, a clear majority of District providers' long-term trend in opioid prescribing shows patterns are generally in line with or below CDC opioid-morphine milligram equivalents (MME) guidelines.

Additional CDC funding is available to support PDMP integration with electronic health records (EHRs) in the District. As of July 2019, the DC PDMP program has implemented 22 connections with health entities, such as pharmacy dispensing systems, HIEs, and EHRs, through the Statewide Gateway integration. DC Health is also conducting an extensive public awareness campaign regarding prescription-related opioid use. As a result of these efforts, the District has seen a 24 percent increase in average number of PDMP queries per month between 2017 and 2018 and has experienced a 37 percent increase in total number of PDMP approved registrations in 2019 alone.

The Medicaid program has additional treatment and prevention strategies to address SUD, including a Pharmacy Lock-in Program (PLP). The PLP restricts Medicaid beneficiaries to the use of one pharmacy when their medication history reflects safety concerns.[1] The PLP is designed to safeguard the appropriate use of mediations when a Medicaid beneficiary misuses drugs in excess of the customary dosage for the proper treatment of a given diagnosis or misuses multiple drugs in a manner that can be medically harmful.

In 2018, DHCF imposed new limits on opioid-MME in Medicaid prescriptions.[2] The limits are designed as a preventive method to reduce the risk of opioid-naïve and opioid-experienced beneficiaries from unintentionally becoming addicted to or overdosing on prescription opioids. The limits are based on national best practices, including the CDC Guideline for Prescribing Opioids for Chronic Pain.

In 2019, the DC Council passed legislation requiring all controlled substance prescribers to register for the DC PDMP, which is also anticipated to substantially increase PDMP registration and query.[3] Consistent with the legislation, DHCF requires all prescribers of MAT-related buprenorphine and naltrexone for Medicaid beneficiaries to check the District's Prescription Drug Monitoring Program (PDMP) and record findings in the patient's medical record.[4]

Future State:

DC Health's work to improve participation in the PDMP is ongoing. In July 2019, all licensed prescribers and dispensers of controlled substances will be required to register with the DC PDMP. DC Health will work closely with all District health care professional licensing boards and stakeholder organizations to ensure prescribers and pharmacists are aware of the new mandate and are able to register in a timely manner to ensure compliance.

---

[1] https://www.dcregs.dc.gov/Common/NoticeDetail.aspx?NoticeId=N0020609
[2] https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/Transmittal%2018-25.pdf
[3] http://lims.dccouncil.us/Download/38775/B22-0459-SignedAct.pdf
[4] https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/Policy%20%2319-001%20Removal%20of%20Prior%20Auth.%20Req.%20for%20Medication-Assis_0.pdf

In addition, DC Health will continue supporting further integration with EHRs and pharmacy management systems. Integration with regional health information exchange, via CRISP DC and other District HIEs, is also planned. The ultimate goal is to ensure that prescribers and dispensers have single sign-on access to the DC PDMP in order to facilitate PDMP query for all prescriptions of mandated covered substances, while minimizing disruptions to clinical workflow.

DC Health will also continue engaging partners from other jurisdictions to expand data sharing agreements to access PDMP data. In addition, the CDC will require participation in the federal database, RxCheck, which may provide further opportunities for interstate data sharing.

Below is a table that describes: 1) current PDMP functionalities; 2) plans to enhance PDMP functionalities and interoperability; and 3) a summary of action items that need to be completed to meet the milestone requirements.

Table 1. State Health IT / PDMP Assessment & Plan

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Prescription Drug Monitoring Program (PDMP) Functionalities			
Enhanced interstate data sharing in order to better track patient specific prescription data	DC Health and the DC PDMP participate in the NABP PMP InterConnect data sharing system. The District currently shares data with 21 states. Through the District's PDMP vendor, Appriss, the District also has access to multi-state data via NarxCare. Utilizing multi-state data, NarxCare can automatically deliver risk scores when a patient presents for care.	Already implemented.	DC Health will explore integration with RxCheck. (Timeline: 18-24 months)
Enhanced "ease of use" for prescribers and other state and federal stakeholders	The DC PDMP includes the Appriss Analytics Package which enables the system to generate prescriber reports	Expanded DC PDMP-EHR integrations with clinical organizations.	In summer and fall 2019, DC Health will use CDC funding to integrate additional EHRs with the DC PDMP.

	summarizing prescribing patterns and comparing prescribing practices to peers. Through CDC funding, DC Health has supported the initial cost of PDMP integration with EHRs so that providers can view information from the DC PDMP without having to open a separate window or system. To date, the DC PDMP program has implemented 22 connections with health entities, such as pharmacy dispensing systems, HIEs, and EHRs, through the Statewide Gateway integration.		
Enhanced connectivity between the state's PDMP and any statewide, regional or local health information exchange	District providers who have participation agreements with CRISP DC, one District HIE, have access to data available via NABP's PMPI.	DC PDMP integrated with CRISP DC to track prescribing and facilitate query.	DC Health will integrate District HIEs with the DC PDMP via Appriss. (Timeline: 18-24 months)
Enhanced identification of long-term opioid use directly correlated to clinician prescribing patterns[1] (see also	The DC PDMP has Tableau analytic software that enables DC Health and participating prescribers to view, track, and analyze	Expanded use of Tableau analytics software to conduct additional compliance reviews and analysis of trends.	DC Health's work to enhance the analytic capabilities within the DC PDMP is ongoing.

---

[1] Shah A, Hayes CJ, Martin BC. Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015. MMWR Morb Mortal Wkly Rep 2017;66:265–269. DOI: http://dx.doi.org/10.15585/mmwr.mm6610a1.

"Use of PDMP" #2 below)	trends in long-term prescribing. DC Health's outreach and clinical coordinators provide academic detailing to ensure District providers have updated information on CDC guidelines on opioid prescribing. DHCF has a Pharmacy Lock-in Program (PLP) to restrict Medicaid beneficiaries to the use of one pharmacy when their medication history reflects safety concerns. DHCF has limits on opioid-MME in Medicaid prescriptions.	The District's Drug Utilization Review (DUR) Board will offer provider education seminars on safely prescribing opioids for chronic pain.	DC Health's academic detailing activities are ongoing. DHCF's PLP will remain in place. DHCF's opioid-MME limits will remain in place. The District's DUR Board will create and offer provider education seminars on safely prescribing opioids for chronic pain. (Timeline: 12-18months)
Current and Future PDMP Query Capabilities			
Facilitate the state's ability to properly match patients receiving opioid prescriptions with patients in the PDMP (i.e. the state's master patient index (MPI) strategy with regard to PDMP query)	The District's PDMP vendor, Appriss, maintains a proprietary patient matching algorithm to match patients receiving opioid prescriptions. With respect to the District's MPI for health information exchange, the MPI for CRISP DC has	As the DC PDMP is integrated with HIE, a workflow similar to other national patient matching approaches will be implemented in order to leverage the strength of existing patient matching algorithms.[2]	District stakeholders will continue collaborating to ensure the District's approach to patient matching increasingly meets the criteria for Level 4 of the Sequoia Project's patient matching maturity model, indicating *"innovation, on-going optimization,*

---

[2] The integration of MPIs is anticipated to function using the following workflow: 1) Patient is searched in HIE using the HIE's matching algorithm; 2) User selects patient; 3) The patient's demographics are sent to the DC PDMP; and 4) The DC PDMP matches to the nearest likely patient and presents the data.

	arguably achieved Level 3 maturity using the Sequoia Project's model, which indicates "*advanced use of existing technologies with associated management controls and senior management awareness, use of quality metrics.*"[1]		*and senior management active involvement.*"
Use of PDMP – Supporting Clinicians with Changing Office Workflows / Business Processes			
Develop enhanced provider workflow/ business processes to better support clinicians in accessing the PDMP prior to prescribing an opioid or other controlled substance to address the issues which follow	The DC PDMP is available to all providers in the District. Through CDC funding, DC Health has supported the initial cost of PDMP integration with EHRs so that providers can view information from the DC PDMP in the prescribing workflow, without having to open a separate window or system. To date, the DC PDMP program has implemented 22 connections with health entities, such as pharmacy dispensing systems, HIEs, and EHRs, through the Statewide Gateway integration.	Expanded DC PDMP-EHR integrations and DC PDMP-HIE integrations will support workflow and business process improvements.	In summer and fall 2019, DC Health will use CDC funding to integrate additional EHRs with the DC PDMP. Training and technical assistance for organizations utilizing HIE services is ongoing.

---

[1] See: https://sequoiaproject.org/resources/patient-matching/

Develop enhanced supports for clinician review of the patients' history of controlled substance prescriptions provided through the PDMP—prior to the issuance of an opioid prescription	The DC PDMP provides access to individual patients' history of controlled substance prescriptions prior to issuance of an opioid prescription. NarxCare provides additional analytics to summarize patient history.	Already implemented.	No action needed.
Master Patient Index / Identity Management			
Enhance the master patient index (or master data management service, etc.) in support of SUD care delivery.	The District's PDMP vendor, Appriss, maintains a proprietary patient matching algorithm to match patients receiving opioid prescriptions. Enhancements to the Appriss MPI have been provided as part of ongoing system updates. The MPI for CRISP DC, one of the District's HIEs, has arguably achieved Level 3 maturity using the Sequoia Project's model.	As the DC PDMP is integrated with HIE, a workflow similar to other national patient matching approaches will be implemented in order to leverage the strength of existing patient matching algorithms.	DC Health and DHCF will continue to monitor if more complete and thorough matches are possible when data is shared across the PDMP and HIE. District stakeholders will continue collaborating to ensure the District's approach to patient matching increasingly meets the criteria for Level 4 of the Sequoia Project's patient matching maturity model.

Overall Objective for Enhancing PDMP Functionality & Interoperability			
Leverage the above functionalities/ capabilities/supports (in concert with any other state health IT, TA or workflow effort) to implement effective controls to minimize the risk of inappropriate opioid overprescribing—and to ensure that Medicaid does not inappropriately pay for opioids	The District has several programs in place to implement effective controls and minimize risk of inappropriate opioid overprescribing, including: • Pharmacy Lock-in Program • Limits on opioid-MME in Medicaid prescriptions • A Medicaid Opioid Data Dashboard created with technical assistance from CMS	All implemented programs will benefit from increased utilization of and integration with the DC PDMP.	DC Health and DHCF will explore streamlining communication between these programs and the DC PDMP. (Timeline: 18-24 months)

Section II. Implementation Administration

The District's point of contact for the SUD Health IT Plan is:

Name and Title: Melisa Byrd, Senior Deputy Director and State Medicaid Director
Telephone Number: 202-442-9075
Email Address: melisa.byrd@dc.gov

Section III. Relevant Documents

Not Applicable.

Appendix I – SUD Treatment Services and Qualified Practitioners

Medicaid SUD Treatment Services and Qualified Practitioners[1]

Service Description	Qualified Practitioners
Assessment/Diagnostic and Treatment Planning Services: Assessment/diagnostic services include the evaluation and ongoing collection of relevant information about a client to determine or confirm a SUD diagnosis and the appropriate level of care. The assessment serves as the basis for the plan of care, which establishes medical necessity, and is designed to help the client achieve and sustain recovery.	Physician, psychologist, licensed independent clinical social worker (LICSW), licensed graduate social worker (LGSW), licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), advance practice registered nurse (APRN), certified addiction counselor (CAC) I and II, and registered nurse (RN)
Clinical Care Coordination (CCC): The initial and ongoing process of identifying, planning, coordinating, implementing, monitoring, and evaluating options and services to best meet a client's care needs. CCC services focus on linking clients as they transition through the levels of care and ensuring that the plan of care is formulated with the overarching goal of recovery, regardless of the client's current status.	Physician, psychologist, LICSW, LGSW, APRN, RN, licensed independent social worker (LISW), LPC, and LMFT
Crisis Intervention: Immediate short-term treatment intervention, which assists a client to resolve an acute personal crisis that significantly jeopardizes the client's treatment, recovery progress, health, or safety.	Physician, psychologist, LICSW, LGSW, APRN, RN, LISW, LPC, LMFT, and CAC I and II
SUD Counseling/Therapy, including individual/group/family/group psychoeducation: Individual SUD counseling/therapy is a face-to-face service for symptom and behavior management; development, restoration, or enhancement of adaptive behaviors and skills; and enhancement or maintenance of daily living skills to facilitate long-term recovery. Group therapy includes cognitive behavioral groups, support groups, and interpersonal process groups. Family counseling/therapy is a planned, goal-oriented therapeutic interaction between the practitioner and the client's family, with or without the client present.	Physician, psychologist, LICSW, LGSW, APRN, RN, LISW, LPC, LMFT, and CAC I and II

---

[1] The Medicaid State Plan governs the qualified practitioners for Medicaid covered services.

Psychoeducational groups are designed to educate clients about substance abuse and related behaviors and consequences.	
Medication Management: Includes the coordination and evaluation of medications consumed by clients, monitoring potential side effects, drug interactions, compliance with doses, and efficacy of medications. Also includes the evaluation of a client's need for MAT, the provision of prescriptions, and ongoing medical monitoring/evaluation related to the use of psychoactive drugs.	Physician, APRN, RN, licensed practical nurse (LPN), PA, LICSW, LISW, LGSW, LPC, and CAC I and II within scope of respective licenses
Medication Assisted Treatment (MAT): The use of pharmacotherapy treatment for opioid or other forms of dependence. A client who receives MAT must also receive SUD counseling/therapy. Use of this service should be in accordance with ASAM service guidelines.	Physician, APRN, PA (supervised by physician), RN, and LPN (supervised by MD, RN, or APRN)

Non-Medicaid SUD Treatment Services and Qualified Practitioners[1]

Service Description	Qualified Practitioner
Case Management: Implementation of the plan of care and administrative facilitation of the client's service needs, including, but not limited to, scheduling of appointments, assisting in completing applications, facilitating transportation, tracking appointments, and collecting information about the client's progress. Also encompasses the coordination of linkages such as vocational/educational services, housing services, legal monitoring entities, child care, public assistance, and social services. Also includes training in the development of life skills necessary to achieve and maintain recovery.	Clinical staff authorized to provide treatment and other services based on their license; individual with at least a bachelor's degree from an accredited college or university in social work, counseling, psychology, or closely related field; individual with at least a GED or high school diploma, four (4) years of relevant, qualifying full-time-equivalent experience in human service delivery; certified recovery coaches; or certified peer specialists.
Drug Screening: Toxicology sample collection and breathalyzer and urine testing to determine and detect the use of alcohol and other drugs.	There is no specific qualified practitioner type but providers must comply with all District regulations on drug screening, including chain of custody requirements and proper training to collect samples.

---

[1] For services that are not covered by Medicaid, qualified practitioner types are governed by DCMR Title 22, Chapter 63.

Appendix II – Additional Provider Requirements by ASAM Level of Care[1]

ASAM Level of Care	Provider Requirements
Level 1.0: Opioid Treatment Program (OTP)	OTPs deliver medication assisted treatment (MAT) in accordance with District and Federal regulations, as well as with ASAM practice guidelines. Under DBH policy, the provision of MAT must be accompanied by a clinically appropriate array of SUD treatment services including counseling. Under DHCF policy, the expectation is that providers will provide linkages to these services if not offer them directly and encourage beneficiaries to seek continued support.[2]
Level 1.0: Outpatient	Providers shall have the capacity to provide up to eight (8) hours of SUD treatment services per week, per client.
Level 2.1: Intensive Outpatient Program (IOP)	Providers shall have the capacity to provide a minimum of nine (9) hours of a mixture of SUD treatment services per week for adults and at least six (6) hours of SUD treatment services per week for youth under the age of twenty-one (21).
Level 2.5: Day Treatment	Providers shall have the capacity to provide a minimum of twenty (20) hours of a mixture of SUD treatment services per week, per client.
Level 3.1: Clinically Managed Low-Intensity Residential	Providers shall have the capacity to provide a minimum of five (5) hours of a mixture of SUD treatment services per week, per client.
Level 3.3: Clinically Managed Population-Specific High-Intensity Residential	Providers shall have the capacity to provide a minimum of twenty (20) hours of mixture of SUD treatment services per week, per client. Case management alone does not satisfy the minimum service hour requirements.
Level 3.5: Clinically Managed High-Intensity Residential	Providers shall have the capacity to provide a minimum of twenty-five (25) hours of a mixture of SUD treatment services per week, per client. Case management alone does not satisfy the minimum service hour requirements.
Level 3.7: Short-Term Medically Monitored Intensive Withdrawal Management	Twenty-four (24) hour medically directed evaluation and withdrawal management services shall be provided. Additionally, providers must have a physician on staff that is able to respond within one (1) hour of notification. Providers shall have medical staff (MD, PA, APRN, or RN) on duty twenty-four (24) hours per day, seven (7) days per week. Medical staff shall have a client-to-staff ratio of 12-to-1 during daytime operating hours, a 17-to-1 ratio during

---

[1] DCMR Title 22, Chapter 63.
[2] https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/Final%20Policy%20Access%20to%20Buprenorphine.pdf

|	evening hours, and a 25-to-1 ratio during the night shift. Providers shall have psychiatric services available on-site, through consultation or referral as medically necessary.

Appendix III – Certified SUD Providers by ASAM Level of Care Enrolled in Medicaid[1]

ASAM Level of Care	Certified Providers Enrolled in Medicaid
Level: Opioid Treatment Program (OTP)	• Partners in Drug Abuse Rehabilitation and Counseling (PIDARC) • Good Hope Institute • United Planning Organization
Level 1.0: Outpatient	• Calvary's Healthcare • Clean and Sober Streets • Community Connections • Family and Medical Counseling Services Inc. • Federal City Recovery Services • Good Hope Institute • Hillcrest Children and Family Center (2 locations) • Holy Comforter Community Action Group Outpatient Program • Inner City Family Services • LaClinica Del Pueblo • Latin American Youth Center • Life Stride, Inc. • MBI Health Services, LLC (2 locations) • PIDARC • Regional Addiction Prevention (RAP) Inc. • Salvation Army Harbor Light Center • So Others Might Eat (SOME) (2 locations) • United Planning Organization • Volunteers of America • Washington Hospital Center Outpatient Behavioral Health Services • Whitman Walker Clinic (2 locations)
Level 2.1: Intensive Outpatient Program (IOP)	• Calvary's Healthcare • Clean and Sober Streets • Community Connections • Family and Medical Counseling Services Inc. • Federal City Recovery Services • Goshen Health Care and Management Services • Hillcrest Children and Family Center (2 locations) • Holy Comforter Community Action Group Outpatient Program • LaClinica Del Pueblo • Life Stride, Inc. • MBI Health Services, LLC (2 locations)

[1] Data current as of July 2019.

	• Regional Addiction Prevention (RAP) Inc. • Salvation Army Harbor Light Center • So Others Might Eat (SOME) (2 locations) • Washington Hospital Center Outpatient Behavioral Health Services
Level 2.5: Day Treatment	• Holy Healthcare Behavioral Services • MBI Health Services, LLC • Regional Addiction Prevention (RAP) Inc.
Level 3.1: Clinically Managed Low-Intensity Residential	• Clean and Sober Streets • Federal City Recovery Services (2 locations) • Salvation Army Harbor Light Center • Samaritan Inns Inc. (2 locations)
Level 3.3: Clinically Managed Population-Specific High-Intensity Residential	• Regional Addiction Prevention (RAP) Inc. • Samaritan Inns Inc. (2 locations)
Level 3.5: Clinically Managed High-Intensity Residential	• Clean and Sober Streets • Federal City Recovery Services • Regional Addiction Prevention (RAP) Inc. • Safe Haven Outreach Ministry, Inc. – Sibley Plaza • Salvation Army Harbor Light Center • Samaritan Inns Inc.

Appendix IV – SUD Provider Locations in the District, by ASAM Level of Care[1]
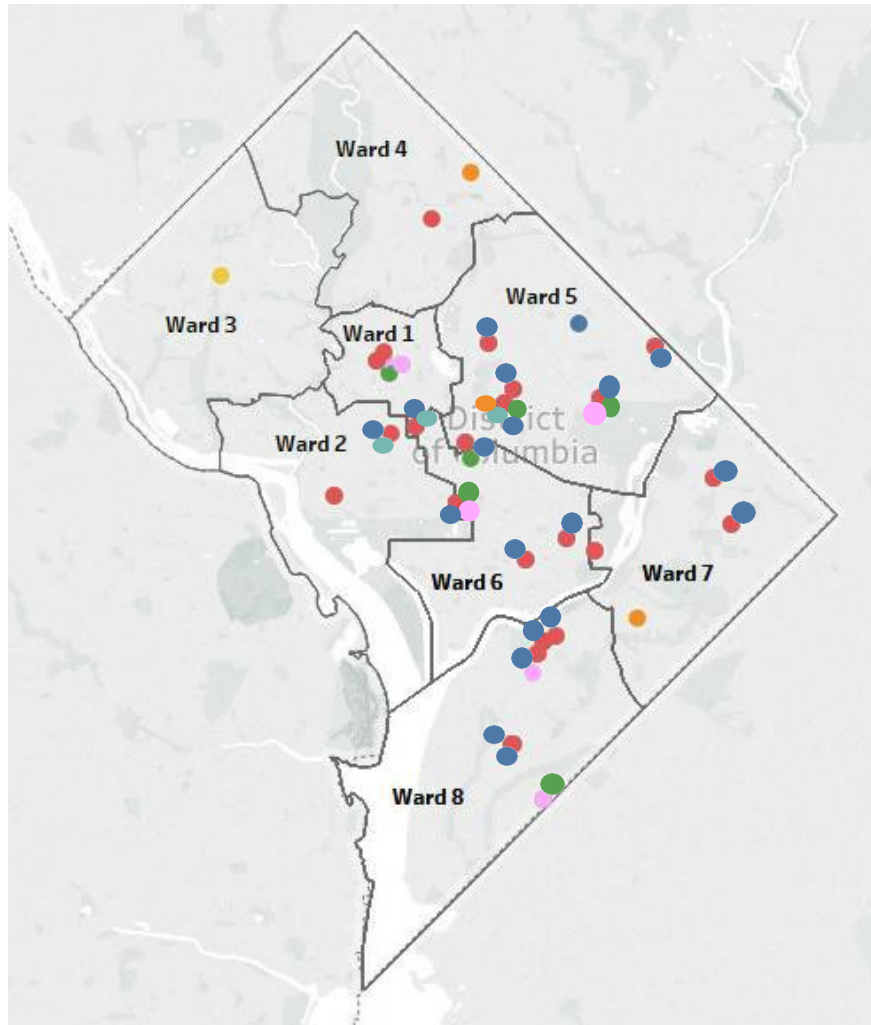
ASAM Level of Care	
🔴	Level 1.0: OTP or Outpatient
🔵	Level 2.1: Intensive Outpatient Program
🟠	Level 2.5: Day Treatment
🟣	Level 3.1: Clinically Managed Low-Intensity Residential
🟢	Level 3.3: Clinically Managed Population-Specific High-Intensity Residential
🟢	Level 3.5: Clinically Managed High-Intensity Residential
🟡	Level 3.7: Short-Term Medically Monitored Intensive Withdrawal Management

---

[1] Data current as of July 2019.